CN App #21-59

Received 02/02/21-KN

Washington State Department of Health

Certificate of Need Application
Ambulatory Surgical Facilities
Ambulatory Surgery Centers

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Name, Title, and Signature of Responsible Officer: Mark A. Kontos, Physician/Owner	Phone Number: 509.928.8040
Dated: 01/06/2021	Email Address: jai.nelson@empireeye.com
Legal Name of Applicant: Empire Eye Physicians, PS	Number of Operating Rooms requested – include procedure rooms: Two
Address of Applicant: 1414 N. Houk Rd. Suite 103 Spokane Valley, WA 99216	Estimated Capital Expenditure: $1,412,811

Identify the Planning Area for this project as defined in WAC 246-310-270(3):

Spokane County

TABLE OF CONTENTS

Applicant Description

Answers to the following questions will help the department fully understand the role of applicants. Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. Provide the legal name(s) and address(es) of the applicant(s)
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity. WAC 246-310-010(6)

   Dr. Mark Kontos (50% ownership)
   1414 N. Houk Rd. Suite 103
   Spokane Valley, WA 99216

   Dr. Chris Sturbaum (50% ownership)
   1414 N. Houk Rd. Suite 103
   Spokane Valley, WA 99216

2. Identify the legal structure of the applicant (LLC, PLLC, etc.) and if known, provide the UBI number.

   Professional Services - UBI 600-602-937

3. Provide the name, title, address, telephone number, and email address of the contact person for this application.

   Lance Baldwin
   CN Consultant
   3621 156th PL SE
   Bothell, WA 98012
   318-792-8215
   lbaldwin@s-p.net

4. Provide the name, title, address, telephone number, and email address of any other representatives authorized to speak on your behalf related to the screening of this application (if any).

   Jai Nelson
   Executive DIrector
   1414 N. Houk Rd. Suite 103
   Spokane Valley, WA 99216

509-922-3937 ext. 409
jai.nelson@empireeye.com

5. Provide an organizational chart that clearly identifies the business structure of the applicant(s) and the role of the facility in this application.

Empire Eye Physicians, PS is a physician owned entity with two locations. A clinic and ASC in Spokane Valley, WA and a clinic in Coeur D'alene, ID.

Project Description

Answers to the following questions will help the department fully understand the type of facility you are proposing as well as the type of services to be provided. Your answers in this section will provide context for the reviews under Need (WAC 246-310-210) and Structure and Process of Care (WAC 246-310-230)

1. Provide the name and address of the existing facility.

Empire Eye Surgery Center
16010 East Indiana Ave
Spokane Valley, WA

2. Provide the name and address of the proposed facility. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.

Same as above

3. Provide a detailed description of the proposed project.

Empire Eye is constructing a CN exempt ambulatory surgery center located in Spokane Valley, WA. The project is being completed utilizing a CN exemption issued by Washington DOH. Based on the Certificate of Need decision, Empire Eye proposes to convert the ambulatory surgery center from CN exempt to CN approved. The project does not propose an increase of operating rooms or change in service line from the CN exemption.

4. With the understanding that the review of a Certificate of Need application typically takes at least 6-9 months, provide an estimated timeline for project implementation, below:

Event	Anticipated Month/Year
Design Complete	N/A
Construction Commenced	June 2020
Construction Completed	June 2021
Facility Prepared for Survey	June 2021
Project Completion	July 2021

5. Identify the surgical specialties to be offered at this facility by checking the applicable boxes below. Also attach a list of typical procedures included within each category.

□ Ear, Nose, & Throat	□ Maxillofacial	□ Pain Management
□ Gastroenterology	X Ophthalmology	□ Plastic Surgery
□ General Surgery	□ Oral Surgery	□ Podiatry
□ Gynecology	□ Orthopedics	□ Urology

□ Other? Describe in detail:_____

6. If you checked gastroenterology, above, please clarify whether this includes the full spectrum of gastroenterological procedures, or if this represents a specific sub-specialty:

□ Endoscopy □ Bariatric Surgery □ Other:_____

7. For existing facilities, provide a discussion of existing specialties and how these would or would not change as a result of the project.

Empire Eye is constructing a CN exempt ambulatory surgery center located in Spokane Valley, WA. The project is being completed utilizing a CN exemption issued by Washington DOH. Based on the Certificate of Need decision, Empire Eye proposes to convert the ambulatory surgery center from CN exempt to CN approved. The project does not propose an increase of operating rooms or change in service line from the CN exemption.

8. Identify how many operating rooms will be at this facility at project completion. Note, for certificate of need and credentialing purposes, “operating rooms” and “procedure rooms” are one and the same.

Two operating rooms

9. Identify if any of the operating rooms at this facility would be exclusively dedicated to endoscopy, cystoscopy, or pain management services. WAC 246-310-270(9)

N/A

10. Provide a general description of the types of patients to be served by the facility at project completion (e.g. age range, etc.).

    To ensure evidence-based standards of care, compliance with FDA regulations,patient safety and properly trained providers and staff, Empire Eye Physicians has implemented age restrictions and requirements.

    PROCEDURES:
    All patients must meet the following requirements:
    All patients must in 18 years and older, with these exceptions:
    - **o Cross-linking:**
    - **o Cross-linking is FDA approved for ages 14 and older. Pre-procedure cross-linking patients may be seen at 12 years-old or older.**

    Note: Cross-linking is not covered for age 65 and older, however patients can sign an ABN and have the procedure as self-pay.

    In-house vision plan:

    Qualified staff may have their dependents seen by an OD at age 8 years-old or older.

    Refractive Lensectomy: Patients must be 50 years-old or older.

11. If you submitted more than one letter of intent for this project, provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.

See Exhibit 1

12. Provide single-line drawings (approximately to scale) of the facility, both before and after project completion.

See Exhibit 4

13. Confirm that the facility will be licensed and certified by Medicare and Medicaid, which is a requirement for CN approval. If this application proposes the expansion of an existing facility, provide the existing facility's identification numbers.

This facility will be a licensed facility certified by Medicare and Medicaid. Certification is pending construction, licensure, and certification.

14. Identify whether this facility will seek accreditation. If yes, identify the accrediting body.

This facility will be accredited through AAAHC.

15. **OPTIONAL –** The Certificate of Need program highly recommends that applicants consult with the office of Construction Review Services (CRS) early in the planning process. CRS review is required prior to construction and licensure (WAC 246-330-500, 246-330-505, and 246-330-510). Consultation with CRS can help an applicant reliably predict the scope of work required for licensure and certification. Knowing the required construction standards can help the applicant to more accurately estimate the capital expenditure associated with a project.

    If your project includes construction, please indicate if you've consulted with CRS and provide your CRS project number.

The project has been approved by the Washington Construction Review Services CRS #61023632.

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-270 provides specific criteria for ambulatory surgery applications. Documentation provided in this section must demonstrate that the proposed facility will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing facilities proposing to expand. For any questions that are not applicable to your project, explain why.

Some of the questions below require you to access facility data in the planning area. Please contact the Certificate of Need Program for any planning area definitions, facility lists, and applicable survey responses with utilization data.

1. List all surgical facilities operating in the planning area – to include hospitals, ASFs, and ASCs.

Table 1 - All surgical facilities operational in Spokane Planning Area.

Facility Name	**CN Approved**
Chesnut Institute of Cosmetic & Reconstructive Surgery	Yes
Providence Surgery and Procedure Center	Yes
Rockwood Eye Surgery	Yes
Facility Name	
South Perry Endoscopy [Endoscopy Only]	Exempt
Spokane Digestive Disease [Endoscopy/Pain Management Only]	Exempt
Facility Name	
Advanced Dermatology & Skin Surgery	No
Aesthetic Plastic Surgical Center	No
Carol Hathaway, MD PS	No
Columbia Surgery Center	No
Empire Eye Surgery Center	No
Inland Northwest Surgery Center	No
Liberty Oral and Maxillofacial Center	No
NEOS Surgery Center	No
Northwest Orthopedic Specialists-	No
Northwest Surgery Center Inc.	No
Pacific Cataract & Laser Institute	No
Spokane Plastic Surgeons	No
Spokane Surgery Center	No
Spokane Valley ASC	No
SRM Spokane	No
The Plastic Surgicenter	No
The Spokane Eye Surgery Center	No
Women's Health Connection	No
Hospital Facilities	
MultiCare Health System-Deaconess Hospital	Yes
MultiCare Health System-Valley Hospital and Medical Center	Yes

Providence Holy Family Hospital	Yes
Providence Sacred Heart Medical Center and Children's Hospital	Yes
Shriners Hospital for Children-Spokane	Yes

2. Identify which, if any, of the facilities listed above provide similar services to those proposed in this application.

Table 2 - Spokane Planning Area facilities that provide Ophthalmic Surgical Services

Facility Name	**CN Approved**	**Ophthalmic Procedures**
Rockwood Eye Surgery	Yes	Yes
Empire Eye Surgery Center (Applicant)	No	Yes
NEOS Surgery Center	No	Yes
Pacific Cataract & Laser Institute	No	Yes
The Spokane Eye Surgery Center	No	Yes

3. Provide a detailed discussion outlining how the proposed project will not represent an unnecessary duplication of services.

Empire Eye currently performs surgery at an existing CN exempt facility that will be replaced with the current project. Because Empire Eye already performs ophthalmic procedures and has an established history of services. The facility proposed in this project will supplant current services already being provided in the current planning area.

4. Complete the methodology outlined in WAC 246-310-270, unless your facility will be exclusively dedicated to endoscopy, cystoscopy, or pain management. If your facility will be exclusively dedicated to endoscopy, cystoscopy, or pain management, so state. If you would like a copy of the methodology template used by the department, please contact the Certificate of Need Program.

Shown in Table 1 above, out of the 23 ASFs listed above, three are CN approved ASFs, and the number of surgeries and the number of ORs will be counted in the numeric methodology.

Of the 20 remaining ASFs, two provide endoscopy or endoscopy/pain management only. The numeric methodology excludes these special purpose rooms and cases from the calculations.

This exclusion leaves 18 ASFs remaining. All 18 are located within the offices of private physicians, whether in a solo or group practice that have received an exemption (considered a Certificate of Need-exempt ASF). The use of these ASFs is restricted to physicians that are employees or members of the clinical practices that operate the facility. Therefore, these 18 facilities do not meet the ASF definition in WAC 246-310-010. For Certificate of Need- exempt ASFs, the number of surgeries, but not ORs, is included in the methodology for the planning area.

In summary, surgical cases and ORs for the 5 hospitals and 3 CN approved surgery centers will be counted in the numeric methodology. Surgical cases, but not ORs, for the 18 CN exempt surgery centers will be counted in the numeric methodology.

The data points used in the department's numeric methodology are identified in Table 3. The methodology and supporting data used by the department is provided in Exhibit 15 attached to this evaluation.

Table 3 - Methodology Assumptions

Assumption	Data Used
Planning Area	Spokane County
Population Estimates and Forecasts	Office of Financial Management data released August 2015 Age Group: 0-85+ Year 2019 – 519,734 Year 2024 – 550,947
Use Rate	Divide total calculated surgical cases by 2019population results in the service area use rate of 202.998/1,000 population
Year 2019 Total Number of Surgical Cases	61,884 – Inpatient or Mixed-Use; 43,621 – Outpatient 105,505 – Total Cases

Percent of surgery: outpatient vs. inpatient	Based on DOH survey and ILRS: 41.34% outpatient; 58.66% inpatient

Table 4 - CN approved OR capacity in Spokane Planning Area

Facility	Special Procedure Rooms	Dedicated Inpatient ORs	Dedicated Outpatient ORs	Mixed Use ORs
MultiCare Health System-Deaconess Hospital	0	0	0	17
MultiCare Health System-Valley Hospital and Medical Center	0	0	0	8
Providence Holy Family Hospital	0	0	0	19
Providence Sacred Heart Medical Center and Children's Hospital	0	0	0	41
Shriners Hospital for Children-Spokane	0	0	0	2
Chesnut Institute of Cosmetic & Reconstructive Surgery	0	0	2	0
Providence Surgery and Procedure Center	0	0	4	0
Rockwood Eye Surgery	0	0	2	0
South Perry Endoscopy [Endoscopy Only]	0	0	2	0
Spokane Digestive Disease [Endoscopy/Pain Management Only]	0	0	4	0
Advanced Dermatology & Skin Surgery	0	0	6	0
Aesthetic Plastic Surgical Center	0	0	1	0
Carol Hathaway, MD PS	0	0	1	0
Columbia Surgery Center	0	0	4	0
Empire Eye Surgery Center (Applicant)	0	0	1	0
Inland Northwest Surgery Center	0	0	1	0
Liberty Oral and Maxillofacial Center	0	0	6	0
NEOS Surgery Center	0	0	1	0
Northwest Orthopedic Specialists-	0	0	5	0
Northwest Surgery Center Inc.	0	0	2	0
Pacific Cataract & Laser Institute	0	0	3	0
Spokane Plastic Surgeons	0	0	1	0
Spokane Surgery Center	0	0	2	0

Spokane Valley ASC	0	0	2	0
SRM Spokane	0	0	2	0
The Plastic Surgicenter	0	0	2	0
The Spokane Eye Surgery Center	0	0	11	0
Women's Health Connection	0	0	1	0
Totals	**0**	**0**	**66**	**87**
Totals (Excluding Endoscopy and Pain Management			**10**	

Facilities in blue CN approved and applicant

Estimation of numeric need as defined in WAC 246-310-270 requires calculation of current surgical capacity (exclusive of capacity dedicated to endoscopy and pain management).[1] Hospitals and ASCs voluntarily report OR utilization through an annual utilization survey distributed by the Washington Department of Health. As of January 2020, OR utilization data for 2019 was available for all planning area hospitals and majority of ASCs. For the remainder, we have relied on earlier survey years. In all cases, we have utilized the most recent data available. Table 4 lists the current supply of operating rooms in the Spokane Planning Area not dedicated to endoscopy or pain management.

From Table 4, there are 97 CN-approved ORs in the Spokane Planning Area, including 87 inpatient/mixed use ORs and 10 CN-approved outpatient ORs (this includes the 2 ORs proposed for this project). Operating rooms dedicated to GI/endoscopy pain management are neither counted in the number of planning area ORs nor is their utilization used to determine planning area surgery use rates.[2]

[1] It is our understanding that the Department of Health numeric need methodology excludes these rooms. For example, see "Evaluation Dated October 9, 2018, for the certificate of need application from Virginia Mason Medical Center a subsidiary of Virginia Mason Health System proposing to construct a five operating room ambulatory surgery center in Bellevue within East King County". Department of Health, October 9, 2018, page 9.

[2] WAC 246-310-270(9)(iv)

The data and assumptions used in the numeric need calculations are presented in Table 3. These are generated from population forecasts by Claritas and planning area utilization data from the 2019 Department of Health ASC Survey, the 2018 Department of Health ASC Survey, and the 2017 Department of Health ASC Survey, where priority is given to the most recent data.

WAC 246-310-270(9) — Methodology

(a) Existing Capacity

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and cleanup time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/cleanup time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)
(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

Dedicated outpatient CN- approved ORs in the planning area=10

Capacity = 68,850 minutes per year per OR

Total annual capacity in minutes: 10*68,850 = 688,500 minutes

Minutes per surgery = 33.89 minutes

Total annual capacity in outpatient surgeries:

688,500 / 33.89 = **20,319 annual [dedicated] outpatient surgeries**

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

Inpatient/mixed use, CN-Approved ORs in the planning area = 87

Capacity = 94,250 minutes per year per OR

Total annual capacity in minutes: 87*94,250 = 8,199,750 minutes

Minutes per surgery = 101.75 minutes

Total annual capacity in inpatient/mixed use surgeries:

8,199,750 / 101.75 = **80,587 annual inpatient/mixed use surgeries**

(b) Future need

(i) Project the number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

Based on the forecast population in 2024 and the use rate of 202.998 per 1,000 residents, there is a projected total of 111,841 surgeries in the Spokane Planning area. [(b) (i)]

An estimated 58.66 of surgeries were performed as inpatient/mixed use and 41.34% as outpatient surgeries. Thus, of the 111,841 forecasted surgeries for 2024, 65,600 would be inpatient/mixed use surgeries and 46,241 outpatient surgeries [(b) (i)].

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b) (iv) of this subsection.

Outstanding demand for outpatient surgeries:

46,241 – 20,319 = 25,922 outpatient surgeries

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

Inpatient/mixed use surgery minutes = 6,296,695

Inpatient/mixed use cases = 61,884

Average inpatient/mixed use minutes per case = 101.75

Outpatient surgery minutes = 1,478,098

Outpatient cases = 43,621

Average outpatient minutes per case = 33.89

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

Inpatient minutes: 65,600 surgeries * 101.75 minutes/surgery = 6,674,848 minutes, or [(b)(i) * (b)(iii)]

Remaining outpatient minutes: (25,922) surgeries (b)(i) * 33.89 minutes/surgery (b)(iii) = (878,366) minutes, or [(b)(ii) * (b)(iii)]

Sum of projected inpatient operating room time needed and projected remaining outpatient operating room time needed:

6,674,848 minutes + 878,366 minutes = 7,553,214 minutes (b)(iv)

(c) Net Need

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(a.iv. 8,199,750 - b.iv. 7,553,214 = 646,536)/94,250 = 6.86

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b) (iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

b.iv. 878,366 /68,850 = 12.76

The model shows a surplus of mixed-use ORs of 6.86 and a numeric need for an additional 12.76 dedicated outpatient ORs in 2023.

5. If the methodology does not demonstrate numeric need for additional operating rooms, WAC 246-310-270(4) gives the department flexibility. WAC 246-310-270(4) states: "Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need."

   These circumstances could include but are not limited to: lack of CN approved operating rooms in a planning area, lack of providers performing widely utilized surgical types, or significant in-migration to the planning area. If there isn't sufficient numeric need for the approval of your project, please explain why the department should give consideration to this project under WAC 246-310-270(4). Provide all supporting data.

The Interpretive Statement issued on January 19, 2018, instructs applicants that cannot show a need to utilize WAC 246-310-270(4). "This regulation provides discretion for the CN Program to approve operating rooms that would not ordinarily be approved. For example, the CN Program can issue a CN without a showing of numeric need if the applicant can show that through existing volumes the facility will have no impact on market share, the facility is necessary to provide access to specific surgical types, or the existing healthcare system supports continued operation of the facility." Empire Eye's application can satisfy these criteria:

No Impact on Market Share. **This ASF has been in operation since 1985 and continues to provide high quality outpatient surgical services to its patients. Empire Eye performs nearly 2000 surgeries per year. Allowing Empire Eye to operate as a CON-approved facility will not detrimentally impact the other providers of outpatient surgeries in the planning area.**

6. For existing facilities, provide the facility's historical utilization for the last three full calendar years.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

Table 5 - Empire Eye Historical Utilization

2017	2018	2019	2020
1907	1994	2016	1488

Note: 2017 has been included due to the impact the COVID 19 had on utilization in 2020.

7. Provide projected surgical volumes at the proposed facility for the first three full years of operation, separated by surgical type. For existing facilities, also provide the intervening years between historical and projected. Include the basis for all assumptions used as the basis for these projections.

Table 6- Facilities in planning area performing Ophthalmic Surgery

Facility Name	**CN Approved**	**Ophthalmic Procedures**
Rockwood Eye Surgery	Yes	Yes
Empire Eye Surgery Center (Applicant)	No	Yes
NEOS Surgery Center	No	Yes

Pacific Cataract & Laser Institute	No	Yes
The Spokane Eye Surgery Center	No	Yes

National Center for Health Statistics, Ambulatory Surgery Utilization Estimates		
Procedure Description (ICD9-CM Code)	**ICD9- CM Code**	**Utilization Rate/10,00**
Operations on the Eye	08-16	254.7
Source: Ambulatory Surgery in the United Sates, 2010," US Department of Health and Human Services, National Health Statistics, National Health Statistics Reports, Number 102, February 28, 2017		

In this study, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory basis in a hospital or freestanding center's general ORs, dedicated ambulatory surgery rooms, and other specialized rooms. This NCHS survey study is the principal source for published national data on the characteristics of visits to hospital-based and freestanding ASFs. The report was updated and revised in 2017 and contains NCHS estimates on ambulatory surgery case counts for the year 2010. Estimates of population use rates were calculated by dividing the surgery case counts by 2010 U.S. Census population counts and multiplying by 10,000. Please see Exhibit 8 for a copy of the NCHS survey study used in the forecast methodology.

The NCHS use rates were multiplied by 2020-2024 Spokane Planning Area population forecasts, and then divided by 10,000 in order to forecast the potential ophthalmic surgeries of the resident ambulatory planning area.

Table 7 - Spokane Ambulatory Ophthalmic Surgery Forecast 2021-2024

Procedure Description ICD9 -CM Code)	**2010 Utilization Rate**	**Total Number of Procedures, Spokane Planning Area**					
		2019	**2020**	**2021**	**2022**	**2023**	**2024**
Operations on the Eye (08-16)	254.7	13,237	13,396	13,555	13,714	13,873	14,032
Service Area Population	Spokane	519,734	525,976	532,219	538,462	544,704	550,947
Source: Applicant							

Existing facilities current market share figure was created by evaluating established market. Data is based on the 2017-2019 DOH surveys and applied to utilization rate established in Table 7. All ASCs that perform ophthalmic

procedures are assumed to only perform Operations on the Eye based on websites and physicians employed.

Table 8 - Spokane Planning area Market Share

Procedure Description ICD9 -CM Code)	2010 Utilization Rate	Total Number of Procedures, Spokane Planning Area	
		Reported Annual Procedures	Market Share Percentage of 2019 Projected Need 13,396 Operations of the Eye
Operations on the Eye (08-16)	254.7		
Pacific Cataract and Laser	Operations on the Eye (08-16)	3,566	18.05%
Rockwood Eye Surgery	Operations on the Eye (08-16)	1,501	7.60%
NEOS Surgery Center	Operations on the Eye (08-16)	569	2.88%
Empire Eye Surgery Center (Applicant)	Operations on the Eye (08-16)	2,016	10.21%
The Spokane Eye Surgery Center	Operations on the Eye (08-16)	12,100	61.26%
Total		19,752	100%
Surplus		6,356	

This project is the conversion of a CN-exempt construction project into a CN-approved facility. Both projects are based on the historical ASC operated by Empire Eye. Production is based on established policy and procedures, number of physicians available, number of operating rooms, and Spokane Planning area share of market. Growth is limited to projected population growth of 1.11%

Table 9 - Empire Eye Projected Procedures

Procedure Description ICD9 -CM Code)	2010 Utilization Rate	Total Number of Procedures, Spokane Planning Area				
	254.7	**2020**	**Jul-Dec 2021**	**2022**	**2023**	**2024**

Operations on the Eye (08-16)Procedure Count		1,488 (2,038 - nonCOVID projection)	1,031	2,083	2,107	2,130
Service Area Population	Spokane	347,046	350,698	354,438	358,271	362,199
Source: Applicant						

8. Identify any factors in the planning area that could restrict patient access to outpatient surgical services. WAC 246-310-210(1) and (2)

None noted

9. In a CN-approved facility, WAC 246-310-210(2) requires that "all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services." Confirm your facility will meet this requirement.

See Exhibit 5

10. Provide a copy of the following policies:
    - Admissions policy
    - Charity care or financial assistance policy
    - Patient Rights and Responsibilities policy
    - Non-discrimination policy
    - Any other policies directly related to patient access to care.

See Exhibit 5

B. Financial Feasibility (WAC 246-310-220)
Financial feasibility of a project is based on the criteria in WAC 246-310-220.

1. Provide documentation that demonstrates that the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:
    - Utilization projections. These should be consistent with the projections provided under "Need" in section A. Include the basis for all assumptions.
    - Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include the basis for all assumptions.
    - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include the basis for all assumptions.
    - For existing facilities, provide three years of historical revenue and expense statements, including the current year. Ensure these are in the same format as the pro forma projections. For incomplete years, identify whether the data is annualized.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

See Exhibit 2 & 16

2. Provide the following applicable agreements/contracts:
   - Management agreement
   - Operating agreement
   - Medical director agreement
   - Development agreement
   - Joint Venture agreement

   Note that all agreements above must be valid through at least the first three full years following completion of the project or have a clause with automatic renewals. Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

See Exhibit 5

3. Certificate of Need approved ASFs must provide charity care at levels comparable to those at the hospitals in the ASF planning area. You can access charity care statistics from the Hospital Charity Care and Financial Data (HCCFD) website. Identify the amount of charity care projected to be provided at this facility, captured as a percentage of gross revenue, as well as charity care information for the planning area hospitals. The table below is for your convenience but is not required. WAC 246-310-270(7)

Planning Area Hospital 3-year Average Charity Care as a Percentage of Total Revenue	0.57%
Projected Facility Charity Care as a Percentage of Total Revenue	0.6%

See Exhibit 12

4. Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site. If a lease agreement is provided, the terms must be for at least five years following project completion. The costs identified in these documents should be consistent with the Pro Forma provided in response to question 1.

The ownership of Empire Eye, PS also owns Empire Eye Land which controls the property. A lease is forthcoming. Included is a deed for the site. See Exhibit 17

5. For new facilities, confirm that the zoning for your site is consistent with the project.

Location confirmed by Certificate of Need Department as the Spokane Planning Area.

6. Complete the table below with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed below, please include the items with a definition of the line item. Include all assumptions used as the basis the capital expenditure estimate.

The project capital expenditure is $1,412,811. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

7. Identify the entity or entities responsible for funding the capital expenditure identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for all.

See Exhibit 18

8. Please identify the amount of start-up costs expected for this project. Include any assumptions that went into determining the start-up costs. If no start-up costs are needed, explain why.

No start-up costs expected. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.

Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.

CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA

CN-approved ASC - Current project.

9. Provide a non-binding contractor's estimate for the construction costs for the project.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.

Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.

CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA

CN-approved ASC - Current project.

10. Explain how the proposed project would or would not impact costs and charges to patients for health services. WAC 246-310-220

The service opportunities gained by Empire Eye will result in increased cost savings for patients' due to the efficiency and cost-effectiveness of an

ASF in comparison to hospital outpatient surgery departments. As evidenced in the National Health Statistics Reports (NHSR)[1], the efficiency of an ASF can be measured by the time spent for the procedure to include the operating room, the actual surgery time and the postoperative care. Table 10 outlines the findings within the report.

Table 10 – Distribution of times for surgical visits, by ambulatory surgery facility type; United States, 2010

	Hospital		ASF		All Facilities	
Calculated time of ambulatory surgical visit	**Average Time (minutes)**	**Standard Error**	**Average Time (minutes)**	**Standard Error**	**Average Time (minutes)**	**Standard Error**
Operating Room	63	2	50	4	57	2
Surgical	37	2	29	3	33	2
Postoperative Care	89	3	51	4	70	3
Total Time	189		130		160	

Source: *"Ambulatory Surgery Data from Hospitals and Ambulatory Surgery Centers: United States, 2010", U.S. Department of Health and Human Services, National Center for Health Statistics, Report Number 102, February 28, 2017. Table C, page 6.*

In an article in the Ambulatory Surgery Center Association (ASCA) a publication titled "A Positive Trend in Health Care" identifies that the increase and rise of Ambulatory Care Facilities can be attributed to physicians, high-quality, cost-effective alternative to the inpatient hospital setting and the value an ASF adds to the economy.[2]

An article published in the Ophthalmology Times "The future of cataract surgery" identifies the growing need for ophthalmologist.[3] Based on the fact that the formation of cataracts is directly proportional with age and the life expectancy is increasing, the number of cataract surgeries will also increase. In 2015, there were 9,000 ophthalmologists doing 3.6 million cataract surgeries. Extending those numbers out it is estimated

[1] NHSR report is Exhibit 8.
[2] ASCA "A Positive Trend in Health Care" is Exhibit 9.
[3] Ophthalmology Times "The Future of Cataract Surgery" is Exhibit 10.

that there will be a need for 125,000 surgeons worldwide to treat 50 million cataracts. This number rises to 250,000 surgeons worldwide in 2025.

"A Positive Trend in Healthcare" identifies the cost savings within an ASF compared to a hospital setting is substantial. The recent trend in how Medicare reimburses a procedure done in a hospital outpatient setting compared to reimbursement of that same procedure in an ASF has widened. In 2003 the difference in reimbursement was only 16%, at the time of the article's publication there was a difference of 72% in reimbursement. In an article titled "Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up"[4], explained that in 2003, the Medicare Prescription Drug, Improvement, and modernization Act froze ASF's payment updates. For the next couple of years, they phased in a new ASF's prospective payment based on the outpatient prospective payment system. This ASF fee schedule set rates for procedures done in an ASF to no more than 59% of payments to hospitals who provided the same procedure. This went into full effect in 2012.

Table 11 – Cost Comparison:

ASC v. Hospital Outpatient Department

	Patient Cost		**Medicare Cost**	
	ASF Co-pay	**HOPD Co-pay**	**Total Procedure Cost ASF**	**Total Procedure Cost HOPD**
Cataract	$193.00	$490.00	$964.00	$1,670.00
Upper Gi Endoscopy	$68.00	$139.00	$341.00	$591.00
Colonoscopy	$76.00	$186.00	$378.00	$655.00

Source: "ASCs: A Positive Trend in Health Care", Ambulatory Surgery Center Association, Page 2.

In an article published in "Michigan Medicine; University of Michigan"[5], the authors evaluated the national data that shows the shift in eye

[4] Health Affairs article "Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down and Ability To Meet Demand Up" is found in Exhibit 39.
[5] Michigan Medicine; University of Michigan article is in Exhibit 36.

surgeries from hospitals to an ASF because of the lower cost to the patients and insurers. The rise of cataract surgeries performed in an ASF has gone from 43.6% in 2001 to 73% in 2014. This cost savings to Medicare equated to a savings of over $829 million in 2011. The article suggests that the rate of increase for ambulatory surgery use for cataract surgery is 2.34% per year, which is similar to the rate increase for strabismus and retina surgeries; the study further found that the rate of increase of glaucoma surgeries was even faster.

The economic growth that ASFs have added to our economy has been considerable. The following Table illustrates the impact witnessed in 2009.

Table 12 – Total Nationwide Impact ASFs had on the economy;

United States, 2009

Year 2009	
Total Tax Payments	$5.8 Billion
Total FTE	117,700
Total Nationwide Economic Impact	$90 Billion

Source: "ASCs: A Positive Trend in Health Care", Ambulatory Surgery Center Association, Page 1.

"A Positive Trend in Healthcare" also identifies the top "Medicare Case Volume by Specialty" that was derived from analyzing CMS claim data in 2010. The three main specialty services that are performed in an ASF are gastroenterology (31%), ophthalmology (28%) and pain management (22%). The article also provides the results of a survey that was taken on the satisfaction rate of patients having their procedures performed within an ASF coming in at 92% favorable.

Based on the analysis of physician preference, cost effectiveness, efficiency and quality of care, Empire Eye, as an ophthalmic specialty surgical facility, will be in a position to continue to meet the current needs of the residents of Spokane planning area with an approved CON. AS the population ages and demand for ophthalmic surgery rises, Empire Eye is preparing to be able to meet the future need by seeking CON approval.

In conclusion, an approved CON application is a crucial part of (1) increasing emphasis on local, cost-effective care in outpatient settings, (2) meeting the commitment of Empire Eye to create access when and where people need it and (3) meeting the need for ophthalmic ORs minutes in the Spokane planning area.

11. Provide documentation that the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges to patients for health services in the planning area. WAC 246-310-220

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

12. Provide the **projected** payer mix by gross revenue and by patients using the example table below. If "other" is a category, define what is included in "other."

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.

CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

Payer	Percentage by Revenue WAC 246-310-220(1)	Percentage by Patient WAC 246-310-210(2)
Medicare	35%	40%
Medicaid	2%	4%
Commercial Payer	18%	18%
Self Pay	42%	35%
Federal	3%	3%
Total	100%	100%

13. If this project proposes CN approval of an existing facility, provide the historical payer mix by revenue and patients for the existing facility for the most recent year. The table format should be consistent with the table shown above.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

14. Provide a listing of new equipment proposed for this project. The list should include estimated costs for the equipment. If no new equipment is required, explain.

No new equipment required. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide

only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

15. Provide a letter of financial commitment or draft agreement for each source of financing (e.g. cash reserves, debt financing/loan, grant, philanthropy, etc.). WAC 246-310-220.

16. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized. WAC 246-310-220

17. Provide the applicant's audited financial statements covering the most recent three years. WAC 246-310-220

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

See Exhibit 2

C. Structure and Process of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220 and will be marked as such.

1. Identify all licensed healthcare facilities owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities, and should identify the license/accreditation status of each facility.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

2. Provide a table that shows FTEs [full time equivalents] by classification (e.g. RN, LPN, Manager, Scheduler, etc.) for the proposed facility. If the facility is currently in operation, include at least the last three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff classifications should be defined.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for

historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

3. Provide the basis for the assumptions used to project the number and types of FTEs identified for this project.

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

4. Provide the name and professional license number of the current or proposed medical director. If not already disclosed under WAC 246-310-220(1) above, identify if the medical director is an employee or under contract.

Dr Mark Kontos (MD00030698) is the assigned Medical Director

5. If the medical director is/will be an employee rather than under contract, provide the medical director's job description.

The Medical director is employed by the organization.

6. Identify key staff by name, if known (e.g. nurse manager, clinical director, etc.)

See Exhibit 6

7. Provide a list of physicians who would use this surgery center, including their names, license numbers, and specialties. WAC 246-310-230(3) and (5).

See Exhibit 6

8. For existing facilities, provide names and professional license numbers for current credentialed staff. WAC 246-310-230(3) and (5).

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

9. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project. WAC 246-310-230(1)

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA

CN-approved ASC - Current project.
See Exhibit XXXX

10. For existing facilities, provide a listing of ancillary and support services already in place. WAC 246-310-230(2)

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

See Exhibit 5

11. For new facilities, provide a listing of ancillary and support services that will be established. WAC 246-310-230(2)

No new services will be established - current services will be utilized. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

12. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project. WAC 246-310-230(2)

No services are expected to change. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

13. If the ASF is currently operating, provide a listing of healthcare facilities with which the ASF has working relationships. WAC 246-310-230(4)

N/A

14. Identify whether any of the existing working relationships with healthcare facilities listed above would change as a result of this project. WAC 246-310-230(4)

No changes will occur.

15. For a new facility, provide a listing of healthcare facilities with which the ASF would establish working relationships. WAC 246-310-230(4)

Current relationships will not be changed. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in

determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

16. Provide a copy of the existing or proposed transfer agreement with a local hospital. WAC 246-310-230(4)

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

See Exhibit 7

17. Provide an explanation of how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230(4)

This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for

historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

18. Provide an explanation of how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230(4).

Empire Eye has an established relationship with the service area's existing health care systems. This project is the conversion of a current construction build that is CN exempt to a CN approved facility. Because of this the facility does not have historical utilization. Empire Eye has operated in the planning area since 1985 and has a long history of providing ophthalmic services in Spokane County and surrounding areas. The current construction will provide only ophthalmic services as indicated in this application and all processes, procedures, and utilization will be duplicated as much as possible from the historical location. To aid the Certificate of Need department in determining utilization requests for historical utilization, financial models, and staffing needs will be based on the historical ASC.
Historical ASC - Empire Eye ASC located at 1414 N Hauk Rd, Spokane Valley , WA. The Empire Eye organization has been operating since 1985.
CN-exempt ASC - Empire Eye ASC construction project in place currently. Located at 16010 E Indiana Ave, Spokane Valley, WA
CN-approved ASC - Current project.

19. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or
    b. A revocation of a license to operate a healthcare facility; or
    c. A revocation of a license to practice as a health profession; or

d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

Empire Eye has no history of any of the above actions.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project.

NWES Considered the following options:

- No project – continue as a licensed, certificate of need exempt facility
- Certificate of Need facility and the requested project.

Table 13- Alternative Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:
No project	● Increasing facility costs due to rent increase, decreases the organizations ability to offer the highest quality services (Disadvantage) ● The principal disadvantage is this option does nothing to address the ambulatory surgery OR shortages forecast in the Planning Area. (Disadvantage)
Requested Project	● The requested project best meets current and future access issues identified in the Planning Area and provides a low-cost alternative to all area ophthalmologists. (Advantage) ● From an improved access perspective, there are no disadvantages. (Advantage)

Source: Empire Eye Director Discussion

Table 14- Alternative Analysis: Promoting Quality of Care

Option:	Advantages/Disadvantages:
No project	● There are no advantages from a quality of care perspective. However, there are no current quality of care issues. (Neutral) ● The principal disadvantage with maintaining the current situation is driven by projected shortages of outpatient ambulatory surgery suites. Over time, as access in constrained, there will be adverse impacts on quality of care if Planning Area physicians and their patients either have to wait for surgical capacity or travel to other locations outside the Planning Area, assuming this is an option. (Disadvantage)
Requested Project	● The requested project best meets and promotes quality and continuity of care issues in the Planning Area. (Advantage) ● From a quality of care perspective, there are only advantages. (Advantage)

Source: Empire Eye Director Discussion

Table 24 - Alternative Analysis: Promoting Cost and Operating Efficiency

Option:	Advantages/Disadvantages:
No project	● Under this option, there will be increase in operating costs due to rent increase – the surgery center will make significant changes to adapt to increased costs. (Disadvantage) ● However, Empire Eye has already incurred all capital costs for two OR operating suite. It is much more efficient (lower cost) to better utilize fixed plant and equipment with greater volumes/throughput – average operating costs fall. This option constrains others' use of the ASC, and as a result, constrains case volumes at the ASC. As a direct result, the No Project option will reduce efficiency and cost-effectiveness. This is the principal disadvantage from an efficiency perspective. (Disadvantage)
Requested Project	● Empire Eye is constructing ASC under CN exemption, a relocation that will overall decrease costs after the second year of operation. (Advantage) ● There are no disadvantages. (Neutral)

Source: Empire Eye Director Discussion

Table 15 - Alternative Analysis: Staffing Impact

Option:	Advantages/Disadvantages:
No project	● There are no disadvantages from a staffing point-of-view. (Neutral)
Requested Project	● The principal disadvantage would be the necessity for Empire Eye to hire, employ, and train additional ASC staff. (Disadvantage)

Source: Empire Eye Director Discussion

Table 16- Alternative Analysis: Legal Restrictions

Option:	Advantages/Disadvantages:
No project	● There are no legal restrictions to continuing operations as presently. (Advantage)
Requested Project	● The requested project will improve access, quality and continuity of care and promote highest, efficient use of Empire Eye assets as compared to the No Project option. (Advantage) ● Requires certificate of need approval. This requires time and expense. (Disadvantage)

Source: Empire Eye Director Discussion

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

   See Response above

3. Identify any aspects of the facility's design that lead to operational efficiency. This could include but is not limited to: LEED building, water filtration, or the methods for construction, etc. WAC 246-310-240(2) and (3).

   N/A

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Commonly Referenced Rules for Ambulatory Surgery Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-160	Regular Review Process
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment
246-310-270	Ambulatory Surgery

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Construction Review Services Resources:
Construction Review Services Program Web Page
Phone: (360) 236-2944
Email: CRS@doh.wa.gov

Licensing Resources:
Ambulatory Surgical Facilities Laws, RCW 70.230
Ambulatory Surgical Facilities Rules, WAC 246-330
Ambulatory Surgical Facilities Program Web Page

Hospital Charity Care and Financial Data (HCCFD) Program Resources
HCCFD Web Page
Email: CharityCare@doh.wa.gov

Exhibit 1

EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone)
Coeur d'Alene, ID 83814
Phone (208) 664-9888
Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103
Spokane Valley, WA 99216
Phone (509) 928-8040
Fax (509) 928-0784

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 3:11 pm, Nov 24, 2020

November 24, 2020

LOI20-11EEASCS
ex: MAY 24, 2021

Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Tumwater, WA 98501

RE: Letter of Intent – Empire Eye Physicians

In accordance with WAC 246-310-080, Empire Eye Physicians, PS hereby submits a letter of intent proposing to establish and operate the Empire Eye Surgery Center at 16010 East Indiana Avenue Spokane Valley, Washington as a free-standing ambulatory surgery center (ASC) in the Spokane County planning area.

In conformance with WAC 246-310-080, the following information is provided:

1. A description of the extent of services proposed:
    a. Empire Eye Physicians proposes to establish and operate Empire Eye Surgery Center as a two-room surgical center free-standing ASC.
2. Estimated cost of the proposed project:
    a. The estimated capital expenditure is $1,412,811.
3. Description of the service areas:
    a. The primary service area is the Spokane County planning area.

Thank you for your interest in this matter. Please contact our office with any questions.

Sincerely,

Dr. Mark A. Kontos
Physician/Owner

Dr. Christopher W. Sturbaum
Physician/Owner

Exhibit 2

EMPIRE EYE PHYSICIANS, PS

FINANCIAL STATEMENTS
Years Ended December 31, 2017 and 2016

EMPIRE EYE PHYSICIANS, PS

FINANCIAL STATEMENTS
Years Ended December 31, 2017 and 2016

Table of Contents

FRUCI & ASSOCIATES
A Professional Service Corporation
Since 1938

INDEPENDENT ACCOUNTANTS' COMPILATION REPORT

To the Stockholders
Empire Eye Physicians, PS
Spokane, Washington

Management is responsible for the accompanying financial statements of Empire Eye Physicians, P.S. (a corporation), which comprise the statement of assets, liabilities, and stockholders' deficit– income tax basis as of December 31, 2017 and 2016, and the related statements of revenues collected, expenses paid, and accumulated deficit – income tax basis for the twelve months then ended in accordance with the income tax basis of accounting, and for determining that the income tax basis of accounting is an acceptable financial reporting framework. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any assurance on these financial statements.

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared in accordance with the income tax basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

Fruci and Associates

Spokane, Washington
June 13, 2018

Members of
WSCPA
AICPA
PCPS

802 N. Washington
PO Box 2163
Spokane, Washington
99210-2163

P 509-624-9223
TF 1-877-264-0486
F 509-742-9211
mail@fruci.com
www.fruci.com

EMPIRE EYE PHYSICIANS, PS
STATEMENTS OF ASSETS, LIABILITIES AND STOCKHOLDERS' DEFICIT
INCOME TAX BASIS

As of December 31, 2017 and 2016

Assets

	2017	2016
Current assets		
Cash	**$ 391,206**	$ 54,979
Federal income tax receivable	**5,000**	5,000
Shareholder loan	**-**	22,500
Employee advances	**3,250**	-
Inventory	**1,219**	564
Total current assets	**400,675**	83,043
Operational assets (note 2)		
Furniture and fixtures	**235,194**	242,727
Leasehold improvements	**971,421**	971,891
Instruments	**152,254**	135,210
Medical equipment	**2,462,483**	2,354,242
Accumulated depreciation	**(3,269,273)**	(3,102,996)
Total operational assets	**552,079**	601,074
Other assets		
Loan fees net of accumulated amortization	**4,191**	4,511
Vendor deposits	**56,163**	-
Security deposits	**5,000**	7,440
Total other assets	**65,354**	11,951
Total assets	**$ 1,018,108**	$ 696,068

Liabilities and Stockholders' Deficit

	2017	2016
Current liabilities		
Accounts payable	**$ 56,475**	$ 2,665
Credit cards	**114,309**	31,450
Line of credit	**-**	70,000
State income tax payable	**2,645**	30
Sales tax payable	**-**	8,805
Other tax payable	**-**	5,598
Company health insurance	**-**	500
Profit-sharing contribution payable	**-**	101
Currrent portion of capital lease obligation	**-**	82,652
Current portion of long-term debt	**257,500**	183,700
Total current liabilities	**430,929**	385,501
Long-term liabilities		
Equipment loans (note 3)	**1,015,474**	1,209,247
Stearns Bank	**45,150**	-
Equipment capital lease	**-**	82,652
Less: current portion of capital lease obligation	**-**	(82,652)
Less: current portion of long-term debt	**(257,500)**	(183,700)
Total long-term liabilities	**803,124**	1,025,547
Total liabilities	**1,234,053**	1,411,048
Stockholders' deficit		
Common stock, $1 par value 50,000 shares authorized 1,500 shares issued and outstanding	**1,500**	1,500
Additional paid-in capital	**79,570**	79,570
Accumulated deficit	**(297,015)**	(796,050)
Total stockholders' deficit	**(215,945)**	(714,980)
Total liabilities and stockholders' equity	**$ 1,018,108**	$ 696,068

See accountants' compilation report and accompanying notes to these financial statements.

EMPIRE EYE PHYSICIANS, PS
STATEMENTS OF REVENUES, EXPENSES, AND ACCUMULATED DEFICIT
INCOME TAX BASIS

For the years ended December 31, 2017 and 2016

	2017	%	2016	%
Patient receipts	$ 8,202,183	100.0	$ 6,011,504	100.0
Net professional revenue	8,202,183	100.0	6,011,504	100.0
Professional expenses				
Amortization	320	-	294	-
Anesthesia services	2,040	-	1,080	-
Auto	5,003	0.1	16,570	0.3
Continuing education	19,062	0.2	10,499	0.2
Copies	3,674	-	3,763	0.1
Depreciation and amortization	198,940	2.4	502,914	8.4
Donations	750	-	-	-
Doctor salary	350,000	4.3	277,083	4.6
Drugs and supplies	2,598,633	31.7	1,423,066	23.6
Dues and subscriptions	22,546	0.3	14,129	0.2
Employee benefits	113,614	1.4	89,003	1.5
Employee retirement	54,324	0.7	56,254	0.9
Excise taxes	90,927	1.1	83,301	1.4
Insurance - general	43,810	0.5	43,584	0.7
Laundry	15,481	0.2	30,670	0.5
Manager salary	83,837	1.0	70,792	1.2
Meals and entertainment	20,955	0.3	5,329	0.1
Miscellaneous	708	-	365	-
Office and computer expense	369,052	4.5	204,414	3.4
Optometrist salary	263,820	3.2	240,888	4.0
Payroll taxes	155,027	1.9	147,733	2.5
Professional fees	53,886	0.7	47,910	0.8
Promotion	51,705	0.6	39,527	0.7
Rent	301,807	3.7	285,039	4.7
Repairs and maintenance	181,781	2.2	150,788	2.5
Salaries - office	1,199,794	14.6	1,169,646	19.5
Sales tax	27,633	0.3	39,177	0.7
Taxes	21,271	0.3	15,032	0.3
Telephone	34,016	0.4	32,987	0.5
Travel expenses/reimbursements	11,340	0.1	8,893	0.1
Utilities	18,137	0.2	14,274	0.2
Recruitment	180	-	1,157	-
Total professional expenses	6,314,073	76.9	5,026,161	83.6
Profit from profession	$ 1,888,110	23.1	$ 985,343	16.4

See accountants' compilation report and accompanying notes to these financial statements.

	2017	%	2016	%
Profit from profession (forward)	$ 1,888,110	23.1	$ 985,343	16.4
Other income (expenses)				
Gain (loss) on sale	(189)	-	-	-
Interest expense	(56,150)	(0.7)	(63,484)	(1.1)
Interest income	2	-	2	-
Officers' benefits	(48,308)	(0.6)	(50,187)	(0.8)
Officers' payroll taxes	(33,022)	(0.4)	(31,093)	(0.5)
Officers' retirement plan	(72,035)	(0.9)	(70,000)	(1.2)
Officers' salary	(1,176,703)	(14.3)	(1,125,044)	(18.7)
Total other income (expense)	(1,386,405)	(16.9)	(1,339,806)	(22.3)
Profit (loss) before income taxes	501,705	6.2	(354,463)	(5.9)
Current income taxes expense	(2,670)	-	(30)	-
Net profit (loss)	499,035	6.2	(354,493)	(5.9)
Accumulated deficit, beginning	(796,050)		(441,557)	
Accumulated deficit, ending	$ (297,015)		$ (796,050)	

EMPIRE EYE PHYSICIANS, PS
NOTES TO THE FINANCIAL STATEMENTS

For the years ended December 31, 2017 and 2016

Note 1 - Nature of Operations

The company provides ophthalmology services in two locations. The main office, resulting in 69% of total revenue, is located in Spokane, Washington. The others are in Idaho, resulting in 31% of total revenues.

Note 2 - Summary of Significant Accounting Policies

These statements have been prepared on the basis of accounting used to prepare the Company's income tax return, which is cash transactions with the exception of the accrual of federal and state income tax expense (if applicable) and profit-sharing plan expense.

Operational assets - All assets are recorded at cost. Depreciation is provided based on estimated useful lives using principally accelerated methods. Section 179 direct asset expense depreciation is reflected when applicable. A carryover of total disallowed Section 179 $410,170 was generated in 2016 and used in 2017. The estimated useful lives used in determining depreciation are:

Medical equipment and instruments	5 years
Furniture and fixtures	7 years
Leasehold improvements	39 years
Leasehold improvements – 2008	15 years

The presentation of financial statements requires management to make estimates and assumptions that affect reported amounts of assets, liabilities revenue and expenses. Actual results could differ from those estimates.

Management has evaluated subsequent events through June 13, 2018, the date on which the financial statements were available to be issued.

Note 3 - Long-Term Debt

The Corporation currently carries two equipment loans with a total balance of $1,015,474. The first equipment loan, in the amount of $163,689, includes a monthly payment of $7,753.10, at a current interest rate of 4.00%. The Corporation is using the equipment as collateral against the loan.

Note 3 - Long-Term Debt (continued)

The Corporation currently carries a second equipment loan in the amount of $851,785. The terms for this loan include twelve interest-only payments followed by 72 payments $13,384.59, with a current interest rate of 4.50%. The Corporation is using the equipment as collateral against the loan.

Maturities for the debt for the next five years are as follows:

2018	$ 257,500
2019	213,700
2020	136,100
2021	142,300
2022	148,900
Thereafter	116,974
Total	$ 1,015,474

Note 4 - Profit-Sharing Plan

The Corporation has a defined contribution profit-sharing plan covering substantially all full-time employees. Employer contributions for the years ended December 31, 2017 and 2016 were $126,359 and $126,254, respectively.

Note 5 - Leasing Activities

The Corporation leases its Spokane office from the Valley Hospital Doctors' Building on a ten-year renewable lease. Historically rent paid for this doctors' building increase 2% annually. However, the new rate effective July 1, 2014 was a reduction of rent due in prior years. Average monthly rent for the 100, 102, and 103 doctors' buildings was $13,780 per month.

The Corporation leases space from Eyedentity, an unrelated business in North Spokane. The terms of the lease are $1,700 per month. This is an annual lease with an automatic renewal clause.

The Corporation leases its Hayden office on a one-year oral agreement. Rent was $1,900 monthly and reduced to $475 per month starting in July 2016. The lease can be terminated with 60 days notice. Rent for the Kellogg, Idaho office is $55 per day used. This is also oral agreement.

Note 5 – Leasing Activities (continued)

Beginning in 2016, the Corporation began a 63 month lease for office space from Idaho Retail Building, an unrelated business, in Coeur d'Alene, Idaho. The terms of the lease are $4,657 per month for twelve months.

Minimum lease commitments for the next four fiscal years are as follows:

2018	$ 58,696
2019	59,667
2020	60,641
2021	10,262
	$ 189,266

Note 6 – Income Taxes/Net Operating Loss Carryover

The Corporation is currently carrying a net operating loss from the 2016 tax year. There is a balance of $233,984 carrying forward to 2018 from 2017. If unused, $233,984 will be set to expire in 2036.

The Company files income tax returns in the U.S. federal jurisdiction and the state of Idaho; both have a statute of limitations of three years. Tax returns prior to years ended December 31, 2014 are closed.

Note 7 – Correction of An Error in The Prior Year

Dr. Kontos was issued a 1099-Misc for 2016 for $22,500 for reimbursements/honorariums. Dr. Kontos turned the funds over to the Corporation in 2017 for income earned in 2016, but not recorded until 2017. The Corporate return was amended for 2016 to record the outstanding deposit.

EMPIRE EYE PHYSICIANS, PS

FINANCIAL STATEMENTS
Years Ended December 31, 2018 and 2017

EMPIRE EYE PHYSICIANS, PS

FINANCIAL STATEMENTS
Years Ended December 31, 2018 and 2017

Table of Contents

FRUCI & ASSOCIATES
A Professional Service Corporation
Since 1938

INDEPENDENT ACCOUNTANTS' COMPILATION REPORT

To Management
Empire Eye Physicians, PS
Spokane, Washington

Management is responsible for the accompanying financial statements of Empire Eye Physicians, PS (a corporation), which comprise the statement of assets, liabilities, and stockholders' deficit – income tax basis as of December 31, 2018 and 2017, and the related statements of revenues, expenses, and accumulated deficit – income tax basis for each of the twelve months then ended in accordance with the income tax basis of accounting, and for determining that the income tax basis of accounting is an acceptable financial reporting framework. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any assurance on these financial statements.

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared in accordance with the income tax basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

Fruci and Associates

Spokane, Washington
April 26, 2019

Members of
WSCPA
AICPA
PCPS

802 N. Washington
PO Box 2163
Spokane, Washington
99210-2163

P 509-624-9223
TF 1-877-264-0486
F 509-742-9211
mail@fruci.com
www.fruci.com

EMPIRE EYE PHYSICIANS, PS
STATEMENTS OF ASSETS, LIABILITIES AND STOCKHOLDERS' DEFICIT
INCOME TAX BASIS

As of December 31, 2018

Assets

	2018	2017
Current assets		
Cash	**$ 318,489**	$ 391,206
Federal income tax receivable	**5,000**	5,000
Employee advances	**-**	3,250
Inventory	**908**	1,219
Total current assets	**324,397**	400,675
Operational assets (note 2)		
Furniture and fixtures	**241,386**	235,194
Leasehold improvements	**971,421**	971,421
Instruments	**166,543**	152,254
Medical equipment	**2,546,441**	2,462,483
Accumulated depreciation	**(3,466,799)**	(3,269,273)
Total operational assets	**458,992**	552,079
Other assets		
Loan fees net of accumulated amortization	**3,871**	4,191
Vendor deposits	**1,881**	56,163
Security deposits	**15,000**	5,000
Total other assets	**20,752**	65,354
Total assets	**$ 804,141**	$ 1,018,108

Liabilities and Stockholders' Deficit

	2018	2017
Current liabilities		
Accounts payable	**$ 119,012**	$ 56,475
Credit cards	**9,570**	114,309
State income tax payable	**4,519**	2,645
Sales/use tax payable	**8,614**	-
Company health insurance	**2,204**	-
Profit-sharing contribution payable	**23,798**	-
Current portion of long-term debt	**213,600**	257,500
Total current liabilities	**381,317**	430,929
Long-term liabilities		
Equipment loans (note 3)	**810,544**	1,015,474
Stearns Bank	**-**	45,150
Less: current portion of long-term debt	**(213,600)**	(257,500)
Total long-term liabilities	**596,944**	803,124
Total liabilities	**978,261**	1,234,053
Stockholders' deficit		
Common stock, $1 par value 50,000 shares authorized 1,500 shares issued and outstanding	**1,500**	1,500
Additional paid-in capital	**79,570**	79,570
Accumulated deficit	**(255,190)**	(297,015)
Total stockholders' deficit	**(174,120)**	(215,945)
Total liabilities and stockholders' deficit	**$ 804,141**	$ 1,018,108

See independent accountants' compilation report and accompanying notes to these financial statements.

MPIRE EYE PHYSICIANS, PS
STATEMENTS OF REVENUES, EXPENSES, AND ACCUMULATED DEFICIT
INCOME TAX BASIS

For the years ended December 31, 2018 and 2017

	Revenue			
	2018	**%**	2017	%
Patient receipts	**$ 9,862,704**	**100.0**	$ 8,202,183	100.0
Net professional revenue	**9,862,704**	**100.0**	8,202,183	100.0
Professional expenses				
Amortization	**320**	**-**	320	-
Anesthesia services	**1,680**	**-**	2,040	-
Auto	**10,738**	**0.1**	5,003	0.1
Continuing education	**34,487**	**0.3**	19,062	0.2
Copies	**1,602**	**-**	3,674	-
Depreciation and amortization	**249,662**	**2.5**	198,940	2.4
Donations	**25**	**-**	750	-
Doctor salary	**418,501**	**4.2**	350,000	4.3
Drugs and supplies	**3,192,178**	**32.4**	2,598,633	31.7
Dues and subscriptions	**34,628**	**0.4**	22,546	0.3
Employee benefits	**142,147**	**1.4**	113,614	1.4
Employee retirement	**75,063**	**0.8**	54,324	0.7
Excise taxes	**112,274**	**1.1**	90,927	1.1
Insurance - general	**42,334**	**0.4**	43,810	0.5
Laundry	**20,003**	**0.2**	15,481	0.2
Manager salary	**112,052**	**1.1**	83,837	1.0
Meals and entertainment	**46,019**	**0.5**	20,955	0.3
Miscellaneous	**586**	**-**	708	-
Office and computer expense	**708,017**	**7.2**	369,052	4.5
Optometrist salary	**394,116**	**4.0**	263,820	3.2
Payroll taxes	**164,067**	**1.7**	155,027	1.9
Professional fees	**62,849**	**0.6**	53,886	0.7
Promotion	**82,321**	**0.8**	51,705	0.6
Recruitment	**7,859**	**0.1**	180	-
Rent	**281,320**	**2.9**	301,807	3.7
Repairs and maintenance	**151,188**	**1.5**	181,781	2.2
Salaries - office	**1,240,070**	**12.6**	1,199,794	14.6
Sales tax	**53,273**	**0.5**	27,633	0.3
Taxes	**17,958**	**0.2**	21,271	0.3
Telephone	**30,523**	**0.3**	34,016	0.4
Travel expenses/reimbursements	**82,168**	**0.8**	11,340	0.1
Utilities	**21,371**	**0.2**	18,137	0.2
Total professional expenses	**7,791,399**	**79.0**	6,314,073	76.9
Profit from profession	**$ 2,071,305**	**21.0**	$ 1,888,110	23.1

See independent accountants' compilation report and accompanying notes to these financial statements.

	2018	**%**	2017	%
Profit from profession (forward)	**$ 2,071,305**	**21.0**	$ 1,888,110	23.1
Other income (expenses)				
Gain (loss) on sale	**3,640**	**-**	(189)	-
Interest expense	**(41,043)**	**(0.4)**	(56,150)	(0.7)
Interest income	**16**	**-**	2	-
Officers' benefits	**(48,343)**	**(0.5)**	(48,308)	(0.6)
Officers' payroll taxes	**(40,952)**	**(0.4)**	(33,022)	(0.4)
Officers' retirement plan	**(73,000)**	**(0.7)**	(72,035)	(0.9)
Officers' salary	**(1,825,353)**	**(18.5)**	(1,176,703)	(14.3)
Total other income (expense)	**(2,025,035)**	**(20.5)**	(1,386,405)	(16.9)
Profit (loss) before income taxes	**46,270**	**0.5**	501,705	6.2
Current income tax expense	**(4,445)**	**-**	(2,670)	-
Net profit (loss)	**41,825**	**0.5**	499,035	6.2
Accumulated deficit, beginning	**(297,015)**		(796,050)	
Accumulated deficit, ending	**$ (255,190)**		$ (297,015)	

EMPIRE EYE PHYSICIANS, PS
NOTES TO THE FINANCIAL STATEMENTS

For the years ended December 31, 2018 and 2017

Note 1 - Nature of Operations

Empire Eye Physicians provides ophthalmology services in two locations. The main office, resulting in 73% of total revenue, is in Spokane, Washington. The other is in Idaho, resulting in 27% of total revenues.

Note 2 - Summary of Significant Accounting Policies

These statements have been prepared on the basis of accounting used to prepare the Company's income tax return, which is based on cash transactions with the exception of the accrual of federal and state income tax expense (if applicable) and profit-sharing plan expense.

Operational assets - All assets are recorded at cost. Depreciation is provided based on estimated useful lives using principally accelerated methods. Section 179 direct asset expense depreciation is reflected when applicable. The estimated useful lives used in determining depreciation are:

Medical equipment and instruments	5 years
Furniture and fixtures	7 years
Leasehold improvements	39 years
Leasehold improvements – 2008	15 years

The presentation of financial statements requires management to make estimates and assumptions that affect reported amounts of assets, liabilities revenue and expenses. Actual results could differ from those estimates.

Management has evaluated subsequent events through April 26, 2019, the date on which the financial statements were available to be issued.

Note 3 - Long-Term Debt

The Corporation currently carries two equipment loans with a total balance of $810,544. The first equipment loan, in the amount of $83,130, includes a monthly payment of $7,753.10, at a current interest rate of 4.00%. The Corporation is using the equipment as collateral against the loan.

Note 3 - Long-Term Debt (continued)

The Corporation currently carries a second equipment loan in the amount of $727,414. The terms for this loan include twelve interest-only payments followed by 60 payments $13,384.59, with a current interest rate of 4.50%. The Corporation is using the equipment as collateral against the loan.

Maturities for the debt for the next five years are as follows:

2019	$ 213,600
2020	136,100
2021	142,300
2022	148,900
2023	155,700
Thereafter	13,944
Total	$ 810,544

Note 4 - Profit-Sharing Plan

The Corporation has a defined contribution profit-sharing plan covering substantially all full-time employees. Employer contributions for the years ended December 31, 2018 and 2017 were $148,063 and $126,359, respectively.

Note 5 - Leasing Activities

The Corporation leases its Spokane office from the Valley Hospital Doctors' Building on a ten-year renewable lease. Historically rent paid for this doctors' building increase 2% annually. Average monthly rent for the 100, 102, and 103 doctors' buildings was $15,721 per month.

The Corporation leases space from Eyedentity, an unrelated business in North Spokane. The terms of the lease are $1,700 per month. This is an annual lease with an automatic renewal clause.

The Corporation leases its Hayden office on a one-year oral agreement. Rent was $1,900 monthly and reduced to $475 per month starting in July 2016. The lease can be terminated with 60-day notice. Rent for the Kellogg, Idaho office is $55 per day used. This is also based on an oral agreement.

Note 5 - Leasing Activities (continued)

Beginning in 2016, the Corporation began a 63-month lease for office space from Idaho Retail Building, an unrelated business, in Coeur d'Alene, Idaho. The terms of the lease are $4,657 per month for twelve months.

Minimum lease commitments for the next three fiscal years are as follows:

2019	$ 59,667
2020	60,641
2021	10,262
	$ 130,570

Note 6 - Income Taxes/Net Operating Loss Carryover

The Corporation is currently carrying a net operating loss from the 2016 tax year. There is a balance of $158,253 carrying forward to 2019 from 2018. If unused, $158,253 will be set to expire in 2036.

The Company filed income tax returns in the U.S. federal jurisdiction and the state of Idaho; both have a statute of limitations of three years. Tax returns, prior to years ended December 31, 2015 are closed.

EMPIRE EYE PHYSICIANS, PS

FINANCIAL STATEMENTS
Years Ended December 31, 2019 and 2018

EMPIRE EYE PHYSICIANS, PS

FINANCIAL STATEMENTS
Years Ended December 31, 2019 and 2018

Table of Contents

FRUCI & ASSOCIATES
A Professional Service Corporation
Since 1938

INDEPENDENT ACCOUNTANTS' COMPILATION REPORT

To Management
Empire Eye Physicians, PS
Spokane, Washington

Management is responsible for the accompanying financial statements of Empire Eye Physicians, PS (a corporation), which comprise the statements of assets, liabilities, and stockholders' deficit – income tax basis as of December 31, 2019 and 2018, and the related statements of revenues collected, expenses paid, and accumulated deficit – income tax basis for each of the twelve months then ended in accordance with the income tax basis of accounting, and for determining that the income tax basis of accounting is an acceptable financial reporting framework. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any assurance on these financial statements.

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared in accordance with the income tax basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

Fruci and Associates

Spokane, Washington
May 25, 2020

Members of
WSCPA
AICPA
PCPS

802 N. Washington
PO Box 2163
Spokane, Washington
99210-2163

P 509-624-9223
TF 1-877-264-0486
F 509-742-9211
mail@fruci.com
www.fruci.com

EMPIRE EYE PHYSICIANS, PS
STATEMENTS OF ASSETS, LIABILITIES, AND STOCKHOLDERS' DEFICIT
INCOME TAX BASIS

As of December 31, 2019 and 2018

Assets

	2019	2018
Current assets		
Cash	**$ 273,437**	$ 318,489
Federal income tax receivable	**5,000**	5,000
State income tax receivable	**1,932**	-
Inventory	**72,528**	908
Total current assets	**352,897**	324,397
Operational assets (note 2)		
Furniture and fixtures	**158,095**	241,386
Leasehold improvements	**899,736**	971,421
Instruments	**157,379**	166,543
Medical equipment	**2,273,573**	2,546,441
Accumulated depreciation	**(3,099,662)**	(3,466,799)
Total operational assets	**389,121**	458,992
Other assets		
Loan fees net of accumulated amortization	**3,550**	3,871
Vendor deposits	**3,383**	1,881
Security deposits	**15,000**	15,000
Related-party receivable	**123,214**	-
Total other assets	**145,147**	20,752
Total assets	**$ 887,165**	$ 804,141

See independent accountants' compilation report and accompanying notes to these financial statements.

	2019	2018
Current liabilities		
Accounts payable	**$ 310,487**	$ 119,012
Credit cards	**132,136**	9,570
State income tax payable	**-**	4,944
Payroll taxes payable	**44**	-
Sales/use tax payable	**-**	8,189
Company health insurance	**6,678**	2,204
Profit-sharing contribution payable	**9,500**	23,798
Current portion of long-term debt	**137,000**	213,600
Total current liabilities	**595,845**	381,317
Long-term liabilities		
Equipment loans (note 3)	**597,255**	810,544
Less: current portion of long-term debt	**(137,000)**	(213,600)
Total long-term liabilities	**460,255**	596,944
Total liabilities	**1,056,100**	978,261
Stockholders' deficit		
Common stock, $1 par value		
50,000 shares authorized		
1,500 shares issued and outstanding	**1,500**	1,500
Additional paid-in capital	**79,570**	79,570
Accumulated deficit	**(250,005)**	(255,190)
Total stockholders' deficit	**(168,935)**	(174,120)
Total liabilities and stockholders' deficit	**$ 887,165**	$ 804,141

EMPIRE EYE PHYSICIANS, PS
STATEMENTS OF REVENUES, EXPENSES, AND ACCUMULATED DEFICIT
INCOME TAX BASIS

As of December 31, 2019 and 2018

	2019	%	2018	%
Professional revenue				
Patient receipts	**$ 9,636,757**	**100.0**	$ 9,862,704	100.0
Professional expenses				
Amortization	**320**	**-**	320	-
Anesthesia services	**3,200**	**-**	1,680	-
Auto	**2,890**	**-**	10,738	0.1
Continuing education	**12,736**	**0.1**	34,487	0.3
Copies	**9,595**	**0.1**	1,602	-
Depreciation and amortization	**126,355**	**1.3**	249,662	2.5
Donations	**899**	**-**	25	-
Doctor salary	**239,615**	**2.5**	418,501	4.2
Drugs and supplies	**3,836,551**	**39.8**	3,192,178	32.4
Dues and subscriptions	**25,847**	**0.3**	34,628	0.4
Employee benefits	**135,260**	**1.4**	142,147	1.4
Employee retirement	**59,308**	**0.6**	75,063	0.8
Excise taxes	**106,135**	**1.1**	112,274	1.1
Insurance - general	**50,999**	**0.5**	42,334	0.4
Laundry	**22,349**	**0.2**	20,003	0.2
Manager salary	**517,675**	**5.4**	112,052	1.1
Meals and entertainment	**28,782**	**0.3**	46,019	0.5
Miscellaneous	**1,775**	**-**	586	-
Office and computer expense	**684,739**	**7.1**	708,014	7.2
Optometrist salary	**357,819**	**3.7**	394,116	4.0
Payroll taxes	**163,008**	**1.7**	164,067	1.7
Professional fees	**123,273**	**1.3**	62,849	0.6
Promotion	**116,281**	**1.2**	82,321	0.8
Recruitment	**8,773**	**0.1**	7,859	0.1
Rent	**287,136**	**3.0**	281,320	2.9
Repairs and maintenance	**109,098**	**1.1**	151,188	1.5
Salaries - office	**844,366**	**8.8**	1,240,070	12.6
Sales tax	**30,726**	**0.3**	53,276	0.5
Taxes	**13,711**	**0.1**	17,796	0.2
Telephone	**14,549**	**0.2**	30,523	0.3
Travel expenses/reimbursements	**54,144**	**0.6**	82,168	0.8
Utilities	**17,529**	**0.2**	21,371	0.2
Total professional expenses	**8,005,443**	**83.0**	7,791,237	78.9
Profit from profession	**$ 1,631,314**	**17.0**	$ 2,071,467	21.1

See independent accountants' compilation report and accompanying notes to these financial statements.

Profit from profession (forward)	**$ 1,631,314**	**17.0**	$ 2,071,467	21.1
Other income (expenses)				
Gain on sale	**1,647**	**-**	3,640	-
Interest expense	**(35,268)**	**(0.4)**	(41,043)	(0.4)
Interest income	**2**	**-**	16	-
Officers' benefits	**(37,917)**	**(0.4)**	(48,343)	(0.5)
Officers' payroll taxes	**(37,811)**	**(0.4)**	(40,952)	(0.4)
Officers' retirement plan	**(76,871)**	**(0.8)**	(73,000)	(0.7)
Officers' salary	**(1,439,403)**	**(14.9)**	(1,825,353)	(18.5)
Total other income (expense)	**(1,625,621)**	**(16.9)**	(2,025,035)	(20.5)
Profit before income taxes	**5,693**	**0.1**	46,432	0.6
Current income taxes expense	**(508)**	**-**	(4,607)	-
Net profit	**5,185**	**0.1**	41,825	0.6
Accumulated deficit, beginning	**(255,190)**		(297,015)	
Accumulated deficit, ending	**$ (250,005)**		$ (255,190)	

Note 1 - Nature of Operations

The Company provides ophthalmology services in two locations. The main office, resulting in 76% of total revenue, is located in Spokane, Washington. The others are in Idaho, resulting in 24 % of total revenues.

Note 2 - Summary of Significant Accounting Policies

These statements have been prepared on the modified cash basis of accounting, which is used to prepare the Company's income tax returns. There are exceptions with the accrual of federal and state income tax expense (if applicable) and profit-sharing plan expense.

Operational assets - All assets are recorded at cost. Depreciation is provided based on estimated useful lives using principally accelerated methods. Section 179 direct asset expense depreciation is reflected when applicable. The estimated useful lives used in determining depreciation are:

Medical equipment and instruments	5 years
Furniture and fixtures	7 years
Leasehold improvements	39 years
Leasehold improvements – 2008	15 years

The presentation of financial statements requires management to make estimates and assumptions that affect reported amounts of assets, liabilities revenue and expenses. Actual results could differ from those estimates.

Management has evaluated subsequent events through May 25, 2020, the date on which the financial statements were available to be issued.

Note 3 - Long-Term Debt

The Corporation currently carries an equipment loan in the amount of $597,255. The terms for this loan include twelve interest-only payments followed by 60 payments $13,384.59, with a current interest rate of 4.50%. The Corporation is using the equipment as collateral against the loan.

Maturities for the debt for the next five years are as follows:

2020	$137,000
2021	142,300
2022	148,900
2023	155,700
2024	13,355
Total	$597,255

Note 4 - Profit-Sharing Plan

The Corporation has a defined contribution profit-sharing plan covering substantially all full-time employees. Employer contributions for the years ended December 31, 2019 and 2018 were $136,179 and $148,063, respectively.

Note 5 - Leasing Activities

The Corporation leases its Spokane office from the Valley Hospital Doctors' Building on a ten-year renewable lease. Historically rent paid for this doctors' building increases 2% annually. However, the new rate effective July 1, 2014 was a reduction of rent due in prior years. As for the 2019 tax year, the average monthly rent for the 100, 102, and 103 doctors' suites was $15,721 per month.

The Corporation leases space from Eyedentity, an unrelated business in North Spokane. The terms of the lease are $1,700 per month. This is an annual lease with an automatic renewal clause.

Note 5 - Leasing Activities (continued)

Beginning in 2016, the Corporation began a 63-month lease for office space from Idaho Retail Building, an unrelated business, in Coeur d'Alene, Idaho. The terms of the lease are $5,046.45 per month for twelve months.

Minimum lease commitments for the next two fiscal years are as follows:

2020	$	60,641
2021		10,262
	$	70,903

Note 6 - Income Taxes/Net Operating Loss Carryover

The Corporation is currently carrying a net operating loss from the 2016 tax year. There is a balance of $127,400 carrying forward to 2020 from 2019. If unused, $127,400 will be set to expire in 2036.

The Company filed income tax returns in the U.S. federal jurisdiction and the state of Idaho; both have a statute of limitations of three years. Tax returns prior to years ended December 31, 2016 are closed.

Exhibit 3

Project Comment Form
April 28, 2020

Washington State Department of Health
Construction Review Services

PO Box 47852
111 Israel Rd. SE.
Tumwater, WA. 98501
www.doh.wa.gov/crs
tel. 360-236-2944
fax.360-236-2321

Project Information:

CRS# 61023632
Empire Eye Physicians & Eye Surgery Center
Chapter 246-330 WAC Ambulatory Surgery Facility

Project Title: Proposed New ASC

Project Location: 16010 E Indiana Ave
Spokane, WA. 99216

Local Permit #:

Electronic Submittal. Plans will be delivered to:
Name: Claire Kincaid-Slate
Email: cslate@bwarch.com
Phone #: 509-458-8023

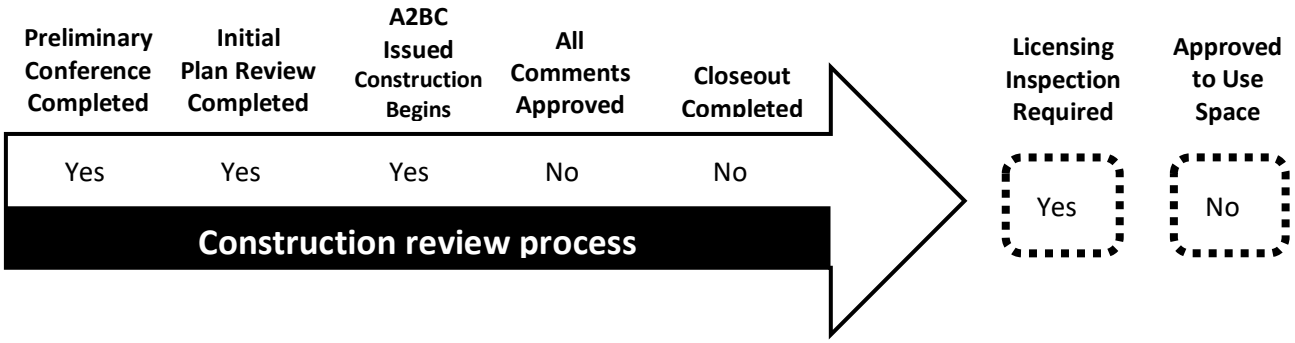
Key Contacts:	Company	Name	Phone	Email
DOH Reviewer		Steve Pennington	(360) 236-2941	steve.pennington@doh.wa.gov
Facility Contact:			(000) 000-0000	
Facility Admin.:	Empire Eye	Jai Nelson	509-922-3937	jai.nelson@empireeye.com
Arch./Eng.:	Bernardo Will Architects	Claire Kincaid-Slate	509-458-8023	cslate@bwarch.com
Other:	Bernardo Will Architects	Don Nielson	509-323-1563	don@summitpro.org
Other:	Dumais Romans Inc	Jeff Romans PE	509-893-9646	jeff@dumaisromans.com
Other:	Bernardo Will Architects	Manasa Vishwanath	509-458-8035	mvishwanath@bwarch.com
Other:	Bernardo Will Architects	Ryan Xane	509-838-4511	rzane@bwarch.com
Local AHJ:	City of Spokane	Dermott Murphy	(509) 625-6142	dgmurphy@spokanecity.org

Addt'l Copies To: ☐ L&I Electrical Section ☐ L&I Factory Assembled Structures ☐ Local Electrical AHJ

Project Status:

-Authorized to Begin Construction-
Comments are NOT APPROVED

The Construction Documents have been reviewed and found acceptable. All plan review comments have not been approved. **Construction can begin**, subject to construction permitting from the local building official. See page two for important next steps.



To avoid delays it is important you follow these Next Steps:

Respond to Comments:
• **Revise** project documents to be compliant with applicable rules and the review comments attached to this form. • **Respond**, in writing, to the comments attached to this form. • **Submit** revised plans and responses to comments to the Construction Review Services.
During Construction
• **Maintain** a copy of the A2BC drawing set on the project site. • **Submit** any changes to the A2BC set to CRS for review and approval prior to executing the work.

If you have any questions please contact Construction Review Services (360) 236-2944. You can monitor project status and history at www.doh.wa.gov/crs.

Project Details (for internal use only)

Occupancy Type IBC: B IBC: IBC: NFPA 101: Ambulatory Healthcare	Construction Type IBC: 5-B IBC: IBC: NFPA 101: Type V (000) NFPA 101:	Fed Code: 2012 NFPA 101 Building Code: 2015 IBC Licensing Code: FGI 2006
Number of Beds Added: N/A Removed:	CON Required? ☒ Yes ☐ No	CON Approved ☐ Yes ☐ No

	Req'd	Provided	Type/category	
				Are Hospital inpatients seen at this location? ☐ Yes ☒ No
Automatic Fire Sprinkler System:	Yes	Yes	13	Are planned residents/patients **incapable** of self preservation? ☒ Yes ☐ No
Automatic Fire Alarm System:	Yes	Yes		If yes, how many? 4
Emergency Power System:	Yes	Yes	Type 1 EES	Is sedation provided? ☒ Yes ☐ No
Medical Gas System:	Yes	Yes	Category 1	If yes, max. planned level? General Anesthesia
Smoke Compartmentation:	No	No		Is space Medicare certified? ☒ Yes ☐ No

Building Department contacted? No	Estimated construction completion: March, 2021

REVIEW NOTES

Two Class "B" operating rooms for eye surgical procedures

DSHS

For Assisted Living Facilities Only	Total Sleeping rooms
Minimum required area of day rooms/areas	Total Approved beds
Total area provided in day rooms/areas	Total Contract beds

NOTES TO SURVEY

Preliminary Comments:

Comment ID#	

Preliminary Conference – January 14th, 2020

Attendees:

Steve Pennington (steve.pennington@doh.wa.gov)	-	Department of Health
Jai Nelson	-	Empire Eye
Manasa Vishwanath	-	Bernardo/Wills
Claire Kincaid-State	-	Bernardo/Wills
Jeff Romans	-	Dumais Romans Inc.

Comments made during this preliminary conference, both oral and written, represent guidance provided by the Department of Health, Construction Review Services, for your facility to meet the applicable licensing requirements for this project. These comments are provided as information and for use in preparing the construction documents. They may be revised and/or additional preliminary comments may be made during subsequent submissions.

These preliminary comments should not be considered as an exemption or alternate from the requirements of any federal, state or local authority who may have jurisdiction and they do not guarantee compliance or approval by these authorities. In the event of conflicts between other jurisdictions and these comments, please contact this office immediately.

	General:
T1	Your CRS Project number is 61023632 and all submittals/ emails should reference this number. Here are some advance pieces of information that will aid in the processing of documents for my plan review. (a) The technical assistance application will require an amendment for the formal plan review submittal, with the plan review fee based on the construction value of the project. Fee schedules can be found in WAC 246-314 or use the fee calculator on our website at www.doh.wa.gov/crs (b) All of our plan review is electronic, to be submitted to the "Box" site and you will need to contact 360-236-2944 after we receive the updated application and fee, to receive a password from our front office staff for all uploads. (c) I will need for my plan review; ➢ Complete set of construction documents. (same as what you will send to the City) ➢ A functional program, describing all the resident types, treatments, security systems if needed and operational functions of the facility. ➢ Set of project specifications. ➢ Cut sheets on selected pieces of equipment to be defined during our technical assistance. (d) If I have a complete submittal package, I normally have my initial review completed within 28 days.
T2	**Family of Codes Used for this review** • 2010 Standard for the Installation of Sprinkler Systems – NFPA 13 • 2010 National Fire Alarm Code Handbook – NFPA 72 • Washington State Administrative Code - WAC 246-330 - Ambulatory surgery facility • 2015 International Building Code (IBC) • 2015 Washington State amendments (WAC 51-50) • 2015 International Mechanical Code (IMC) • 2015 International Fire Code • 2015 International fuel & Gas Code (IFGC) • 2015 Uniform Plumbing Code (UPC) • 2017 National Electric code (NEC) NFPA 70 • 2012 NFPA 101 • 2012 NFPA 99 • 2006 FGI • Other standards as reference in above.

T3	Basis of understanding for notes: ➢ Two Class "B" operating rooms. ➢ One treatment room for Laser procedures. ➢ Facility to use general anesthesia ➢ Facility will bill Medicare for the facility fee. ➢ Laundry will be contracted out for sanitization ➢ Facility medical records are electronic ➢ Performing eye procedures including; cataract extraction with intraocular lens (IOL) implants, refractive lensectomy with IOL implant, IOL exchanges, and IOL rotations. The EESC will also perform pterygiums, penetrating keratoplasty, lamellar keratoplasty, conjunctival cyst removals, and Descemet stripping automated endothelial keratoplasty. ➢ The facility infra-structure would be a Category 1 system per 2012 NFPA 99 Chapter 4.
	Architectural:
T4	Provide a common area vestibule to allow a dedicated entrance for the ASF/ASC meeting the distinct entity requirements of Medicare rules CFR 416.2
T5	The janitor's closet can be eliminated if the facility elects an alternate cleaning method using micro-pads consistent with CDC standards.
T6	The patient restroom will require either an out-swinging door or break away door hardware to prevent entrapment. Note: Public in the waiting room cannot use the patient restroom.
T7	Level one recovery could be performed in the operating room, if the facility wants to only provide level 2 recovery bays. (Chair model)
T8	Re-label sterile processing as such, to avoid any assumptions this is a sterile core.
T9	Sterile processing must include; ➢ Work flows from clean to cleaner. ➢ Clean and sterile storage is permitted. ➢ A hand washing sink is required in this room. ➢ If this room is used for storage, it may require the one hour rating of this space, with 45 minute rated doors. ➢ We discussed turning a portion of the adjacent hall into a formal rated storage room.
T10	Decontamination room must include; ➢ Work flows from dirty to clean. ➢ Provide space within the work flow for storage of infectious waste and garbage. ➢ Storage is only allowed in this room as related to the cleaning products. No clean instruments can be stored in this room.

T11	Scrubs are best stored within the changing rooms and within a cabinet to prevent cross contamination.
T12	Doors between the waiting room and the clinical space need to be secured by a locking mechanism to protect patients during treatment.
T13	Provide a room for the medical vacuum pump. This can be located remotely.
	Life Safety:
T14	The one hour fire resistive wall that separates the ASC/ ASF from all other entities would have 20 minute doors in all openings and provide continuity to the exterior wall sheathing horizontally and vertically to the underside of the roof sheathing.
T15	Provide a soiled holding room with a one hour fire rating.
T16	Storage rooms 100 square feet and larger will require a one hour rating.
T17	The medical gas storage room will require a one hour rating.
T18	Provide in the life safety plan, dimensions assuring; ➢ Common path of travel is not exceeded. ➢ Travel distances are not exceeded. ➢ Distances between exits minimums are met.
T19	Spaces 2,500 square feet and larger require two exits per the 2012 NFPA 101 Chapter 20.
	HVAC:
T20	Any louvers for the newly relocated Medical gas manifold room cannot discharge to the building exit door side and must discharge away from exits.
T21	Operating room; ➢ 15 ACH of which 3 must come from the outside of building. ➢ Primary air filter Merv 8 ➢ Final air filter Merv 14 ➢ Two low wall returns at outside corners as far apart as possible. ➢ Laminar flow supply air diffusers meeting ASHRAE 170 for layout. ➢ Humidity must be monitored. ➢ Humidity can be built-in to control room environment between 20-60% RH or they could operationally monitor humidity and not start a procedure if the humidity is out of range per Policy and Procedure.

T22	Provide in construction documents a spread sheet showing how the ASF systems meet Table 2.1-2 of the 2006 FGI for pressure relationships, ACH etc.
	Plumbing:
T23	Medical gas zone valves are required to be located; ➢ For operating rooms directly outside of each operating room door. ➢ For recovery, it cannot be located within the gas outlet environment. Must be separated by a wall.
T24	Need area alarm for operating rooms located where it is fully monitored during business hours. No area alarm required for recovery rooms as level 2 recovery is not considered critical care.
T25	Master medical gas alarm, generator enunciator to be located at main nurse station.
	Electrical:
T26	Generator is required to meet a Category 1 essential electrical system per 2012 NFPA 99 Chapter 4. ➢ Needs to meet NFPA 110 and NFPA 99 requirements ➢ On-site fuel supply to meet Appendix "Z" assessments as completed by owner and review of DOH. ➢ Loads required to be picked up are based on 2012 NFPA 99.

Plan Review Comments:

Comment ID#	Approved	Not Approved	
			General:
1		☒	A pdf version of the plans and specifications for the fire alarm system installation or modification shall be submitted for review and approval prior to system installation. The department reserves the right to defer plan review and inspections to the local authority having jurisdiction (AHJ). Plans and specifications shall include, but not be limited to, a floor plan; location of all alarm-initiating and alarm-signaling devices; alarm-control and trouble-signaling equipment; annunciation; power connection; battery calculations; conductor type and sizes; voltage drop calculations; name, address, and phone number of the agency receiving off-premises transmission of alarm; and the manufacturer, model numbers, and listing information for all equipment, devises, and materials. Incomplete plans and specifications will be returned without review. Plans and specifications may be submitted separately from the construction documents during the construction of the project. For small renovation projects in which devices are only to be relocated or very few devices are to be added, provide two plans that shows the relocation of devices which may be submitted for review in lieu of the above requirements. This information can be included on the electrical or architectural plans. Verify with the Department staff to determine if the scope of your project meets this criteria. Section 907.1, International Fire Code Provide fire alarm pull stations at all exits from the ASF/ASC per 2012 NFPA 101 Chapter 20.3.4.2 Response: **Fire alarm plans and specifications are design-build. Contractor will provide once available.**
2		☒	A pdf version of the sprinkler system working plans shall be submitted for review and approval before any equipment is installed or remodeled. The department reserves the right to defer plan review and inspections to the local authority having jurisdiction (AHJ). Deviation from approved plans will require permission. Plans and specifications, including hydraulic calculations, that are incomplete or are not stamped by a Washington State Licensed Fire Sprinkler Contractor, will be returned without review. Plans and specifications may be submitted separately from construction documents during the construction of the project. For small renovation projects in which heads are only to be relocated, a plan that shows the relocation of devices can be submitted for review in lieu of the above requirements. Section 903.1, International Fire Code

			Provide clean room fire sprinkler heads in the operating rooms to meet the monolithic finish requirements of 2006 FGI 3.7 Response: **Fire sprinkler plans and specifications are design-build. Contractor will provide once available.**
3	☒		Provide cut sheets on the following per WAC 246-330-510; ➢ Cubicle curtains meeting NFPA 701 ➢ Health zone acoustical tile. ➢ Medical vacuum pump. ➢ Medical gas manifolds for a level 1 system. ➢ Emergency power generator ➢ Operating room laminar flow supply air diffusers. ➢ Humidifiers ➢ Operating room task light fixtures. ➢ Hand washing sink faucets. ➢ Scrub sink and faucet. Response: See attached cut sheets provided. **Approved 4/28/2020 – Based on cut sheets received and reviewed.**
4	☒		Provide in the functional program per 2006 FGI 1.2-2.1; (a) Where will the PACU function be performed? Will they recover through this step in the operating room or in another location? Response: The answer to the is question is primarily noted in the Functional Plan on page 4 under Recovery: Describe the typical time frames for recovery in determining the number of recovery spaces needed for both level 1 and/or level 2. *Our typical moderate sedation timeframe for recovery will be 15-20 minutes from surgery end time. For general anesthesia, the level 2 recovery will occur in the OR for around 30 minutes until the patient has regained consciousness and is able to move to level 1 recovery. At that point, the patient will move to a PACU bay for another 30-45 minutes or however long it takes for the patient to be able to self-preserve.* Therefore, for general anesthesia the PACU function will begin in the OR and then transfer to the PACU area. All other patients (with the procedure utilizing conscious sedation) will be immediately taken from the OR to the PACU for recovery. **Approved 4/28/2020 – Based on comment response that confirmed PACU recovery would not be in the operating room.**

4a	☒		With the confirmation of the PACU location per comment # 4. Provide 4 feet of clearance from the gurney to the wall while maintaining the minimum clearance between gurneys of no less than five feet for PACU recovery stations, per 2006 FGI 3.7-2.4.1.2 (2) **Approved 4/28/2020 – Based on phone call with architect the clearance to wall will be changed to three feet, leaving at least 5 feet between gurneys.**
			Life Safety:
5	☒		Provide a one hour rated enclosure around 109 square foot storage room # 125A per 2015 IBC Table 509, with a 45 minute rated doors. Response: Room has been modified to be less than 100 SF so no fire rating will be required. See revised plan. **Approved 4/28/2020 – Based on comment response.**
6			Provide a one hour rated wall and one hour rated door on the north vestibule wall to protect that exit path in the case of a medical gas room fire. 2015 IFC 1031.2 **1031.2 Reliability.** Required *exit accesses*, *exits* and *exit discharges* shall be continuously maintained free from obstructions or impediments to full instant use in the case of fire or other emergency where the building area served by the *means of egress* is occupied. An *exit* or *exit passageway* shall not be used for any purpose that interferes with a *means of egress*. Response: This code section references that the exit shall be continuously free from obstructions. It does not stipulate any requirements for additional fire rating. **Omitted 4/28/2020 - Based on comment response and that the potential risk does not exist in the pathway, but in an adjacent space.**
7	☒		Provide in the door schedule per WAC 246-330-510, the following ratings per Table 8.3.4.2 of the 2012 NFPA 101; (a) Gas manifold room door # 111A to be 60 minutes. (b) Storage room doors # 125A/125B to be 45 minutes (c) Storage room doors # 118B & 118A to be 45 minutes. Response: Door ratings have been updated, please see revised drawings attached. Doors 125A & 125B are not applicable with updated plan. **Approved 4/28/2020 – Based on comment response.**

8	☒		How is the one hour rated horizontal separation of garage to the ASF provided per 2012 NFPA 101 Chapter 6.1.14.4.4 Response: The garage ceiling/floor assembly is rated 1 hr, refer to floor assembly detail W/A0.1. **Approved 4/28/2020 – Based on comment response.**
9	☒		Add a note to the door schedule, that states; all door gaps/undercuts in rated door assemblies must not exceed the requirements of the 2010 NFPA 80. (2012 NFPA 101 – 7.2.1.15.2) Response: Note has been added to door schedule, see revised drawings attached. **Approved 4/28/2020 – Based on comment response and added note.**
			Architectural:
10	☒		Patient restroom door # 108A must either swing out or have break-away hardware to prevent patient entrapment per 2006 FGI 5.2.1.4 Response: Door hardware has been revised to be break-away and prevent patient entrapment. **Approved 4/28/2020 – Based on comment response.**
11	☒		Recommend that upper cabinets in the ASF side be provided with valances or sloped tops, to eliminate ledges that need to be cleaned and/or to cover raw wood top end panels. In the operating rooms one of the options will be required to meet the monolithic finish requirements of 2006 FGI 3.7-5.2.2.4 (3) to meet the terminal cleaning requirements. Response: All upper cabinets are design with an upper soffit covering the top to prevent any cleanliness issues. **Approved 4/28/2020 – Based on comment response.**

12	☒		Sheet A6.1 calls for the following door hardware for the operating rooms. Does the hospital latch allow for staff to enter the room without touching the door hardware after scrubbing in? HARDWARE - 09 (OPERATING ROOM DOORS) 3 EA HINGE FBB179 4.5"x4.5" 1 EA HOSPITAL LATCH HL6, US26D 1 EA BUMPER 1270WV, 626 1 EA SILENCER 1229B Response: Hospital latch can be activated by elbow. See cut sheet attached for more information. **Approved 4/28/2020 – Based on comment response.**
13	☒		Provide details on product and installation/joining method of WC-1 in the operating rooms. WAC 245-330-510 (Standard factory joining using applicable strips are not acceptable.) Response: See revised detail 30/A5.6 calling out continuous caulking in lieu of manufacturer's standard joining system. **Approved 4/28/2020 – Based on detail # 30 providing a monolithic finish, free of cracks and crevices by caulking top of wainscot, bottom of wainscot to floor coving per detail and caulking inside corners without factory corner connector.**
14	☒		Restrooms # 108A, 129A and 130A calls for rubber base, but 2015 IBC Chapter 1210..2.1 requires; **1210.2.1 Floors and wall bases.** In other than *dwelling units*, toilet, bathing and shower room floor finish materials shall have a smooth, hard, nonabsorbent surface. The intersections of such floors with walls shall have a smooth, hard, nonabsorbent vertical base that extends upward onto the walls not less than 4 inches (102 mm). Response: Restrooms are noted to have 12" porcelain tile base at all walls. **Approved 4/28/2020 – Based on comment response.**
15	☒		How would an ADA patient parking the garage gain access to the upper floor services? WAC 246-330-510 Response: The lower level garage parking is for staff only. All patient ADA parking is located in the main parking lot with direct access to both entrances. **Approved 4/28/2020 – Based on comment response.**

16	☒		Provide a stamped engineers design for the operating room boom lights supports and generator pad design per WAC 246-330-510 (Reference sheet S2.2) Response: Refer to revised structural drawings for exam light support & generator slab design. Not Approved 4/28/2020 – Based on details not found in re-submittal drawings/documents. **Approved 5/5/2020 – Based on updated stamped drawings received.**
			Mechanical:
17	☒		Relocate Low wall return in operating room # 119A to be behind the door # 119B to be as far apart as practical per 2006 FGI 3.7 -7.2.3.1 (1)(b) Response: Sheet M3.2 has been updated to show the low wall return serving OR 119A to be behind door #119B in Sterile Processing 124A. **Approved 4/28/2020 – Based on updated sheet M3.2**
18	☒		Provide a one line drawing of the medical gas manifold room piping configuration per WAC 246-330-510. Response: Detail 15 on Sheet M5.1 has been added showing the piping for the medical gas manifold. **Approved 4/28/2020 – Based on updated sheet M5.1 and contingent upon relief line discharge having a screen at discharge point to prevent bugs from getting into line.**
19	☒		Modify note # 6 on sheet M3.2 to show 6" instead of 12" per 2015 IFC 5306.2.1 with each vent a minimum of 24 square inches. Response: Clarified Comment with Steve Pennington on 3/23. Comment is referring to Plan Note 3 on Sheet M3.2. Note has been revised. **Approved 4/28/2020 – Based on updated sheet M3.2**
20	☒		Provide Merv. 8 and Merv. 14 air filters for all patient care, treatment, and/or diagnosis, and those areas providing direct service or clean supplies such as sterile and clean processing, etc. 2006 FGI Table 3.1-1 (Reference table of sheet M3.2) and show their installed location. Response: See Sheet M3.2. MERV 14 final filters were added to FC-3, FC-4, RT-3 and RT-4. **Approved 4/28/2020 – Based on updated sheet M3.2**

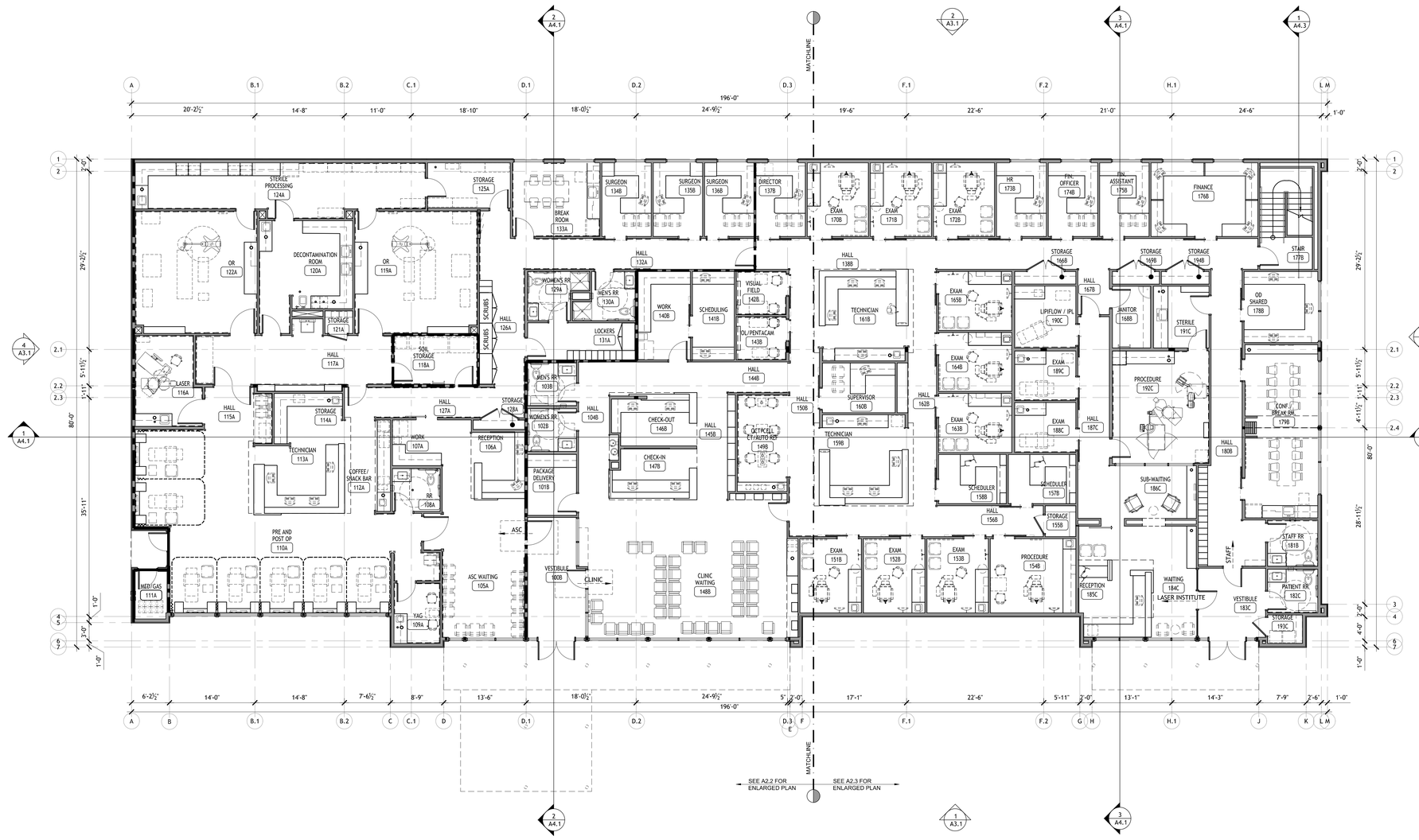
21	☒		Provide final filters of Merv. 14 downstream of the humidifier beyond the absorption range of the steam wand in both operating rooms. ASHRAE 170 & 2006 FGI 1.6-2.2.2.1 (a) Response: Sheet M3.2 has been updated to show the steam distribution pipe from H-1 and H-2 upstream of the final filter. **Approved 4/28/2020 – Based on updated sheet M3.2**
22	☒		Provide a table showing the pressure relationships of each room and the air exchange rate. WAC 246-330-510 and Table 2.1-2 of the 2006 FGI. Response: Sheet M3.2 has been updated to include pressure relationships and air change rates for Rooms 116A, 118A, 131A, 133A, and 125A. **Approved 4/28/2020 – Based on updated sheet M3.2**
23	☒		Demonstrate how the partially covered operating room table supply air array meets ASHRAE 170 to provide a curtain of air over the patient and table. Current configuration has gaps that would only allow this room to be used for eye procedures only. No other surgical procedure could be performed, unless additional LFD were added at a later date. Response: Diffuser Array has been revised in OR 122A and 119A on Sheet M3.2 to allow for a broader scope of future surgical procedures to be performed. **Approved 4/28/2020 – Based on updated sheet M3.2**
24	☒		Modify Section 15290 – Ductwork insulation to show no duct liner on the ASF side per 2006 FGI 1.6 - 2.2.1.2 (3) Response: Specification Section 15290 has been updated on Sheet M6.1 to read “PROVIDE ACOUSTICAL LINING WITH R-VALUE AS INDICATED IN TABLE 1 IN DUCTWORK ONLY WHERE INDICATED ON THE DRAWINGS.” No duct liner is shown in air systems serving operating rooms in accordance with 2006 FGI 1.6 2.2.1.2 (3). **Approved 4/28/2020 – Based on this detail also covering the sterile processing space, clean storage.**

25	☒		It appears that there are exhaust fans within 25 feet of air intakes on the gas packs on the ASF side of the roof installations. Provide 25' clear from intakes per 2006 FGI 3.1-7.2.5.4 (1)(a) (Reference sheet M3.4) Response: Sheet M3.4 and M3.2 have been updated to relocate Exhaust Fan EF-3 and all exhaust terminations at on the ASF side of the building. Plumbing Vents have also been relocated on Sheet M2.3 to provide proper clearance. **Approved 4/28/2020 – Based on comment response.**
			Electrical:
26	☒		Provide confirmation from information seen on sheet E0.2, that none of the operating room lights or electrical receptacles are on a daylight sensor or occupancy sensor. As this would be a safety hazard per WAC 246-330-205 (3)(d) Note: Any HVAC after hours shut down would not be permitted. The pressure relationships must be maintained 24/7. Response: The under-cabinet lighting occupancy sensors have been removed. No lighting or receptacles in either of the Operating Rooms are occupancy or daylight sensed. Refer to revised drawings attached. **Approved 4/28/2020 – Based on comment response.**
27	☒		Provide a letter from the natural gas purvey that their source is reliable per 2010 NFPA 110 as follows; **5.1 Energy Sources.** **5.1.1*** The following energy sources shall be permitted to be used for the emergency power supply (EPS): (1)*Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas *Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.* Response: See email from Avista attached. **Approved 4/28/2020 – Based on email from Avista that there is high reliability in that area with their gas pressure.**
28	☒		Provide a light directly above the scrub sink, so the surgical staff can scrub up and see their hands clearly. WAC 246-330-060 (1)(g) Response: See revise lighting plan with additional under-cabinet light fixture & recessed can fixture at scrub sink for additional lighting. **Approved 4/28/2020 – Based on comment response.**

29	☒		Provide verification that the electrical receptacles shown by the table of the operating rooms are in the ceiling and not the floor. WAC 246-330-510. (Reference sheet E3.1) Response: The receptacle locations in the Operating Rooms have been revised. All receptacles are now located in the walls. Refer to revised drawings attached. **Approved 4/28/2020 – Based on comment response.**
30	☒		Provide an emergency code button in each of the operating rooms reporting to a fully monitored location within the ASF during business hours. 2006 FGI 3.7-2.3.2 Response: An emergency code button is now shown in each of the Operating Rooms. Refer to revised drawings attached. **Approved 4/28/2020 – Based on comment response.**
			Close out:
31			A final inspection by CRS is required at substantial completion. **General contractor & Owner will coordinate substantial completion date.**

Compliance with the comments above provided by the Department of Health, Construction Review Services, are necessary for this facility to meet the cited requirements of the applicable licensing regulations found in the Washington State Administrative Code and associated references. These comments, authorization to begin construction or final project approval do not relieve the facility from the responsibility to meet the requirements of any applicable federal, state or local regulations. In the event of conflicts between other jurisdictions and these written comments, the most stringent shall apply. The building owner or operator is ultimately responsible for safety and insuring the building is in compliance with all applicable laws.

Exhibit 4



1 Overall Main Level Floor Plan

SCALE: 1/8" = 1'-0"

NORTH

GENERAL NOTES

A. SEE SCHEDULE SHEETS FOR EXTERIOR WALL AND PARTITION TYPES.

B. SEE SCHEDULE SHEETS FOR DOOR AND WINDOW SCHEDULES.

C. ALL DIMENSIONS ARE TO: FACE OF EXTERIOR SHEATHING, FACE OF MASONRY VENEER, CENTERLINE OF STUDS, U.N.O. NEW WALLS ARE TYPICALLY SHOWN SHADED ; EXISTING WALLS ARE SHOWN UNSHADED.

E. DRAWINGS AND ASSOCIATED CONSTRUCTION DOCUMENTS ARE SUBJECT TO CHANGE PENDING PERMIT REVIEW BY GOVERNING MUNICIPALITY. ALL WORK SHALL COMPLY WITH APPLICABLE CODES IN FORCE AT THE TIME OF CONSTRUCTION.

F. FIELD VERIFY ALL DIMENSIONS PRIOR TO THE COMMENCEMENT OF ANY WORK. THE ARCHITECT IS TO BE IMMEDIATELY NOTIFIED OF ANY DISCREPANCY, ERRORS OR OMISSIONS PRIOR TO THE COMMENCEMENT OF THE EFFECTED WORK.

G. THE CONTRACTOR SHALL CONSULT PLANS OF ALL TRADES FOR ALL OPENINGS AND ROUGH-OUTS THROUGH SLABS, WALLS, CEILING SAND ROOFS FOR DUCTS, PIPES, CONDUITS, CABINETS AND EQUIPMENT, AND SHALL VERIFY SIZE AND LOCATION BEFORE PROCEEDING WITH WORK.

H. THE CONTRACTOR SHALL VERIFY ALL ROUGH-IN DIMENSIONS AND EQUIPMENT, FURNISHED AND INSTALLED BY CONTRACTOR OR OTHERS, PRIOR TO PROCEEDING WITH WORK.

I. MECHANICAL AND ELECTRICAL INFORMATION SHOWN ON ARCHITECTURAL DRAWINGS IS PROVIDED FOR CLARITY AND/OR GENERAL LOCATION PURPOSES ONLY. SEE MECHANICAL AND ELECTRICAL DRAWINGS.

J. PROVIDE BLOCKING OR BACKING FOR WALL OR CEILING MOUNTED MATERIALS IN FULL ACCORDANCE WITH MANUFACTURER'S RECOMMENDATIONS OR REQUIREMENTS PRIOR TO INSTALLATION.

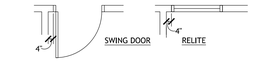
K. ALL WALLS ARE TO INTERSECT AT 45° OR 90° U.N.O.

L. ALL PENETRATIONS IN THE BUILDING ENVELOPE WILL BE CAULKED, WEATHERSTRIPPED OR OTHERWISE SEALED AIR AND WATER TIGHT.

M. INTERIOR DOOR AND RELITE FRAMES TO BE RACO CLASSIC ALUMINUM OR WESTERN INTEGRATED ALUMINUM AS EQUAL. FINISH TO BE MILL FINISH ALUMINUM.

N. ALL NEW DOORS AND HARDWARE TO COMPLY WITH ADA ACCESSIBILITY STANDARDS.

O. INSTALL DOORS AND RELITES SHALL LEAVE 4" FROM FACE OF ADJOINING WALL AND FRAME, TYP. , UNLESS NOTED OTHERWISE.



P. CONTRACTOR TO COORDINATE ALL OWNER FURNISHED ITEMS AND EQUIPMENT. PROVIDE ALL REQUIRED MECHANICAL AND ELECTRICAL CONNECTIONS, INCLUDING STUB OUTS FOR NEW AND FUTURE WORK.

Q. CONTRACTOR TO COORDINATE THE ALARM SYSTEM AND OVERHEAD MUSIC WITH OWNER.

4198 REGISTERED ARCHITECT
GARY M. BERNARDO
STATE OF WASHINGTON

Revision Date:
PERMIT REVISIONS 3-6-20
PERMIT REVS. #2 3-13-20
DOH REVISIONS 4-7-20

CONSTRUCTION SET

Overall Main Level Floor Plan

153 SOUTH JEFFERSON SPOKANE WASHINGTON 99201 509.838.4511 FAX 509.838.4505 WWW.BERNARDOWILLS.COM

Empire Eye Physicians
Clinic and ASC
16010 E INDIANA AVE
Spokane Valley, WA

B W A BERNARDO | WILLS ARCHITECTS PC

Project No: 18-10-210
Drawn by:
Date: 3.6.2020

A2.1

Exhibit 5

EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

COVID-19 CONSENT

Patient Name: _____ DOB: _____ MRN: _____

_____ °F Temperature

State law guarantees the right and obligation to make decisions concerning healthcare. I understand that I am consenting to an exam/treatment/procedure/surgery that may not be urgent or emergent. I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I understand that COVID-19 is extremely contagious. I understand that Empire Eye Physicians, Laser Institute and/or Empire Eye Surgery Center have put in place reasonable preventive measures to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding.

By signing this consent form, I have read the following statements and are positively affirming agreement. If I'm unable to positively affirm these statements, I will be asked to postpone or reschedule the visit to a later date.

_____ **I do not currently, nor have I had in the last two weeks, a fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea.**

_____ **To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has had a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 14 days.**

For my protection and the protection of the doctors, nurses and staff, I will properly wear a face mask during my appointment and will not remove or otherwise disrupt the protective purpose of the face mask while receiving care, unless specifically directed to do so by a healthcare provider.

By signing this form, I agree that I will not hold Empire Eye Physicians or any of its doctors, nurses, contractors or staff personally responsible should I, or someone I come in contact with, be diagnosed with COVID-19. I assume full responsibility for any illness that may result and further release and discharge Empire Eye Physicians for injury, loss, or damage arising out of any illness and visit.

I have read and understand this consent or someone has read it to me. I have the choice to reschedule my appointment to a later date. By signing this consent form, I accept any risk and give my permission to proceed with my exam, treatment, procedure and/or surgery.

_____ _____

Patient Signature Date

A46 09/22/2020

Section 1 Policies and Procedures	Empire Eye Surgery Center	
Policy Name: **ADMISSION / TREATMENT**		Page 1 of 1
Approved:	Revised:	

POLICY:

It is the policy of this facility to admit and treat all persons without regard to race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age. The same requirements are applied to all, and patients are assigned without regard to race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age. All services are available without distinction to patients and visitors regardless of race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age. All persons and organizations having occasion to refer persons for services or to recommend the center are advised to do so without regard to the person's race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age.

PHYSICIAN/CRNA CREDENTIALING APPLICATION PACKET:

Each physician applicant to the facility medical staff must complete or submit the following:

- Physician application
- Authorization to Release Information
- Liability Questionnaire
- Privilege Request Form (appropriate to the individual physician specialty)
- Practitioner Information for the National Practitioner Data Bank (NPDB)
- Copy of malpractice binder face sheet
- Request for Staff Appointment
- License and/or certificate as applicable
- Quality Management Peer Review Confidentiality Agreement

PHYSICIAN CREDENTIALING FILE:

This facility shall maintain a credentialing file for each practitioner, to include the following: (Instructions follow.)

A. STATISTICS

1. Application
2. Copy of Driver's License
3. Liability Questionnaire
4. Questionnaire Explanations, if applicable
5. Authorization for Release of Information
6. CV (curriculum vitae)

B. LICENSES/CERTIFICATIONS

1. State Medical/ CRNA License
2. State Medical/CRNA Board Verification of License
3. DEA Permit
4. DEA Permit Verification
5. Malpractice Insurance Face Sheet
6. AMA or AOA Profile or Other Primary Source Verification of Education and Training
7. AMA Profile or other source Board Certification Verification (for physicians only)
8. National Practitioners Data Bank Response (NPDB)
9. OIG (Office of Inspector General) Exclusion Report

C. VERIFICATION

1. Verification of Hospital Privileges
2. Conflict of Interest Form, if applicable
3. Peer References

D. APPROVAL

1. Request for Medical Staff Appointment
2. Privilege Request
3. Correspondence
4. Medical Staff Bylaws Acknowledgment

E. EDUCATION

1. Orientation Checklist
2. Education Documentation, if applicable

F. MISCELLANEOUS

1. Other Miscellaneous Documentation
2. Quality Management Peer Review Agreement

Organize the files in 6-face pressboard file folders with fasteners. Each section (A-F) should be placed on a separate face of the folder.

****NOTE: Print off forms for each applicant from disk provided with electronic forms rather than making copies from this binder.***

INSTRUCTIONS:

A.1., A.3., A.5. Each practitioner will complete an application, answering each question in total (not referencing another document such as a CV). The practitioner will complete a **Liability Questionnaire** and an **Authorization for Release of Information.**

A.2. Obtain copy of driver's license from practitioner.

A.4. Practitioner shall provide an explanation for any **YES** answers to **Liability Questionnaire** questions. All explanations should be signed and dated by the physician.

A.6. Practitioner shall provide a CV, which includes a five (5) year work history.

B.1., B.2. Practitioner shall provide a legible copy of his/her current state license. Contact the appropriate state board (State Medical Board, State Board of Dental Examiners, etc.) for verification of license renewal. Print online verification. If the license has expired, request a copy of the renewed license and document verification. If the license has expired and has not been renewed, contact the Nurse Supervisor immediately. **A practitioner may not see patients in the facility without a current license.**

For CRNAs, go to this website (http://aptify.aana.com/ekPages/CertRecert.aspx) and print a certification verification in addition to their state RN and CRNA license verifications from the appropriate state Board of Registered Nursing.

B.3., B.4. Practitioner is to provide a legible copy of his/her current DEA permit. To verify DEA status, go to https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp
Type in the DEA#, name, SSN, and Tax ID. Print out the verification for the file.

B.5. Practitioner is to provide a copy of his/her current liability insurance declaration. This must include the name of the practitioner, the policy number, the amount of coverage per incident (no less than $1,000,000) and aggregate (no less than $3,000,000), expiration date, and name and address of the insurance company.

B.6. Primary or secondary source verification of education, training and experience is required. This can be obtained in one of three ways:

- Refer to PSS Client Resources for a list of NCQA approved Credentialing Verification Organizations (CVOs).

- Original documents from the educational institutions, which provided education, internship and residency, verifying program completion and dates of attendance. There must be original documents, not copies.
- America Osteopathic Association (AOA) profile for each doctor. To obtain AOA physician profiles, go to this website: https://aoaprofiles.org/create_account.cfm
- American Medical Association (AMA) physician profile for medical doctors. To obtain AMA physician profiles, either call the AMA credentialing department at (800) 665-2882 or go to their website at:

  https://profiles.ama-assn.org/amaprofiles/

  and click on "new customer registration".

  They are located in Chicago, IL. Follow instructions to register your facility to order AMA physician profiles. You will need a credit card.

For medical staff of less than ten (10) members, secondary source verification using the AMA or AOA profile is recommended. These reports meets NCQA standards for verification of education, residency and board certification.

NOTE: THE PROFILES MUST BE CURRENT (WITHIN 120 DAYS) AT THE TIME OF REVIEW FOR MEDICAL STAFF APPOINTMENT.

B.7. Verification of MD Board Certification may be obtained via the AMA, or AOA report **AND** (not or) a copy of the Board Certification Certificate provided by the physician. After the initial verification is obtained the American Board of Medical Specialties (ABMS) can be used for verification upon reappointment and board certification expiration. http://www.abms.org/verify-certification/

B.8. Register the facility as an **ORGANIZATION** of the National Practitioner Data Bank-Healthcare Integrity Data Bank at

http://www.npdb-hipdb.hrsa.gov/hcorg/register.jsp

On this page you will find detailed instructions at the link "how to get started" and "registration process". You will need to print 2 copies of the registration form, and complete them with a notary and then mail them to the NPDB in Virginia. Once you are registered and receive your entity registration with DCN and log in you must query each practitioner applicant. To submit a query, follow the instructions at this link:

http://www.npdb-hipdb.hrsa.gov/hcorg/howToSubmitAQuery.jsp

Use the **Practitioner Data Collection For Online Queries** form. This is a tool for the credentialing coordinator. You can use these completed forms to input the data for the NPDB queries without having to go through every credentialing file to locate the required information. You will need a credit card.

When submitting the queries be sure to:

- Save your query to your subject database, and
- Request email notification when queries responses are ready.

Print the Temporary Record of Submission for your records. You can shred this document once you download and print the query response. Place the query response in the credentialing file.

NOTE: THE NPDB QUERY REPORT MUST BE CURRENT (WITHIN 120 DAYS) AT THE TIME OF REVIEW FOR MEDICAL STAFF APPOINTMENT.

B.9. Verification of exclusion from the Medicare/Medicaid program can be obtained by clicking on the OIG website at: http://exclusions.oig.hhs.gov/. Print out a copy of the report after submitting the name of the Physician. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.

B.1., B.2., B.3., B.4., B.7. A tickler system should be maintained to anticipate the expiration of license, DEA and liability insurance documents for all members of the Medical Staff. Expired documents are never discarded. They remain in the credentialing file. Most current documents are placed on top of expired documents.

C.1. Using the Verification of Privileges form, obtain verification of hospital privileges for the practitioner's primary hospital affiliation as stated on the application. If the practitioner has no hospital affiliation, privileges can be verified with a surgery center where they have current privileges. Call the medical staff office of the facility to inquire about a charge for privilege verification. Some hospitals charge up to twenty-five dollars ($25). If there is a charge, and it is not included with the request, it will delay the response from the hospital. Attach a photocopy of the physician's Authorization to Release Information form to the request prior to mailing. Include a self-addressed envelope to expedite the return. Mailing should be done early as some facilities take three (3) to five (5) weeks to respond. Request should be addressed: **Hospital Name; ATTN: Medical Staff Office; Street Address; City; State; Zip code.**

C.2. If a conflict of interest cannot be avoided, it must be disclosed to the compliance officer. A waiver of a conflict will be considered only when full written disclosures and appropriate reviews have been approved by the Governing Body. See Compliance Program in Administration section 4.

C.3. Reference verifications should be sent to those listed as references on the application. A self-addressed envelope should be included to assist in the return. You should obtain at least 3 for each applicant.

D.1., D.2. Approval signatures must be documented on **Request for Medical Staff Appointment** and **Privilege Request.** It is helpful to flag the pages that require signatures in preparation for the committee review process.

D.3. Correspondence may be filed in chronological order in this section with most recent on top. Once appointed, a letter of notification of appointment, with effective date should be sent to the medical staff member and a copy of the letter filed in the credentialing file. A copy of the medical staff member's approved privileges should also be sent with a copy of the letter of notification of appointment.

D.4. Medical Staff members must receive and read the medical staff bylaws and agree to abide by them. This acknowledgement can be signed once appointment is approved by the Governing Body.

E.1. Medical Staff members must have a general orientation to the facility. See Human Resources section 1.

E.2. If additional training is necessary (i.e. a new laser), place documentation in file. Education must be verified at the education institution(s) for DMDs. The AMA and AOA reports meet NCQA standards for verification of medical education.

F.1. Other miscellaneous document may be filed in chronological order in this section with the signed **QAPI/Peer Review Confidentiality Agreement** on top.

GENERAL INFORMATION:

- Expired documents will be kept in practitioners' credential file. As expired documents are renewed, the current documents should be in the appropriate place in the file as outlined in this guide. The expired documents may be accumulated behind a colored piece of paper, behind current documents.

- Use the Expiration Table to track all documents, which expire. This may include but not be limited to:

    - State license
    - DEA certificate
    - Malpractice insurance face sheet

  Create a legend to indicate each document and write the year of expiration in the appropriate month on the table after each applicant name. Check the table once a month, in advance and send a notification letter of expiring documents.

- Online verification queries should be run when updated copies of documents are received for state license, DEA certificate.

- Letters requesting documentation such as a renewal license or insurance face sheet may be discarded after the item requested is received.

- Highlight items on reports, such as the AMA, for quick recognition. Items might include provider name, school, board certification, date of report.

- All licenses must be current; insurance must be current; documents may be no more than 120 days old.

- The completed file will be presented to the Governing Body. The Request for Staff Appointment and Privilege Request forms will be signed by the Governing Body when privileges are approved.

- Correspondence – Once appointed, a letter of notification of appointment, with effective date should be sent to the medical staff member and a copy of the letter filed in the credentialing file.

RECREDENTIALING:

- Forty-five (45) days prior to re-credentialing, this facility will review the file checking for current licensing and other documentation. At this time, a:

    - ***Request for Staff Reappointment***
    - ***Authorization to Release Information***

  will be sent to the provider, along with a request for any licenses or needed supporting documentation, and indicating a return date of no more than ten (10) working days (for your convenience).

- License, DEA and Malpractice Insurance should be current on a monthly basis. However, verify that these items will not expire prior to Credentialing Committee Review. **It is a good idea to schedule Recredentialing at a time several months away from document / license expiration. Again, remember that supporting documentation, i.e., NPDB, application, etc., must be no more than 120 days old at the time of Committee Review.**

- Upon receipt of the completed recredentialing documents, this facility will obtain the following:

    - Verification of hospital/surgery center privileges
    - NPDB
    - State Medical / CRNA Board verification of current license
    - Medicare and Medicaid sanctions will be reviewed after verification of exclusions from OIG

- The facility will complete the **Physician Reappointment Profile** in preparation for the Credentialing Committee meeting.

Medical Files	Empire Eye Physicians	
Policy Name: **MEDICAL CLEARANCE GUIDELINES**		Page 1 of 2
Approved: 08/29/2018	Reviewed: 08/14/2018	Revised: 09/30/2020

POLICY:

To ensure patient safety during the perioperative process and administration of anesthesia, Empire Eye Surgery Center may require the requisition of medical records from a patient's Primary Care Provider or other medical specialist for preoperative medical clearance.

Requested medical records will be scanned into the EMR for to the anesthesia provider to review at least 3 days prior to the patient's scheduled surgical appointment. The anesthesia provider will review the medical records and if necessary, advise the Surgical Coordinator regarding the patient's suitability to undergo anesthesia for their surgical procedure. All medical records will be maintained in the patient's surgery chart for further review.

PROCEDURES:

To obtain appropriate medical records, the following guidelines shall be followed:

A. The Preanesthetic Evaluation form is filled out by the Surgical Coordinator as a preoperative screening tool.

B. Medical records, including the most recent History & Physical and the most recent EKG, are required from the patient's **Cardiologist** if the patient has had any of the following cardiac issues within the *past 6 months*:

   1. A myocardial infarction (MI) or heart attack
   2. Cardiac stent placement
   3. Cardiac surgery

C. Medical records, including the most recent History & Physical, are required from the patient's **Primary Care Provider (PCP)** if the patient has *three or more* of the following current diagnoses:

   1. Heart issues within the past 3 years – a myocardial infarction (MI) or heart attack, cardiac stents, cardiac surgery, or angina.

   2. Respiratory issues – Continuous oxygen use, Chronic Obstructive Pulmonary Disease (COPD) requiring oxygen, uncontrolled asthma, and/or a tracheotomy,

a. Mild Chronic Obstructive Pulmonary Disease (COPD) or asthma that is well controlled does not require medical records unless the patient also has other co-morbidities listed in this policy.

3. Hypertension

4. Diabetic- insulin dependent

5. Renal failure- on dialysis

6. Seizure - within the past 1 year

7. Cerebrovascular Accident (CVA/Stroke) - within the past 2 years

D. For any patient who has experienced a major health event such as a stroke (CVA), heart attack (MI), or heart surgery (Coronary artery bypass grafting (CABG), or stent placement), a *3-month waiting period from the date of the event* and medical records from a follow up visit will be required before the scheduling of surgical appointments.

E. If the patient has visited the Emergency Department of an acute care facility and/or been hospitalized *within the past 4 weeks,* medical records, including the most recent History & Physical are required.

Safety	Empire Eye Surgery Center	
Policy Name: **WEIGHT RESTRICTIONS AND WEIGHT-BEARING REQUIREMENTS**		Page 1 of 1
Approved: 09/30/2020	Reviewed:	Revised:

POLICY:

To ensure patient safety during the perioperative process, Empire Eye Surgery Center has implemented weight restrictions for patients. Additionally, these restrictions are to prevent staff injury and to prevent the hazardous operation of equipment and stay within the manufacture's recommendations for weight limits.

PROCEDURES:

All surgical patients must be able to ambulate or self-transfer with minimal assist.

- **Surgery:** Patients who weigh at or over 350 pounds are restricted from having a surgical procedure.
- **Laser:** Patients who weigh at or over 325 pounds are restricted from having a laser procedure.
- **YAG Laser:** Patients who weigh at or over 350 pounds are restricted from having a YAG laser procedure.

POLICY:

The Governing Body sets policy for, and has the overall and ultimate responsibility and authority for determining, implementing and monitoring policies governing the facility's total operation. The Governing Body may delegate operational responsibility to the Executive Director, who manages the day-to-day operation and provides regular reporting to the Governing Body. Delegation of operational responsibility does not relieve the Governing Body of their rightful and legal responsibility, which includes but is not limited to:

- Adopting a statement of the mission, goals and objectives of, and a description of the services provided at the facility.
- Adopting policies, procedures, rules and regulations for the development, conduct and management of the facility.
- Oversight and accountability for the Quality Assessment and Performance Improvement program.
- Ensuring the facility policies and programs are administered so as to provide quality healthcare in a safe environment.
- Develop and maintain a disaster preparedness plan.
- Reviewing and taking appropriate action with respect to the legal conduct of the facility and its staff.
- Establishing a system of financial management and accountability for the facility.
- Establishing an annual budget for, and adopting and modifying a schedule of fees and charges to be utilized in the operation of the facility.
- Establishing a policy on the rights and responsibilities of patients of the facility.
- Approving all major contracts and arrangements affecting the medical care rendered at the facility including, but not limited to:

  - Proper credentialing of health care physicians;
  - The provision of radiology, pathology and medical laboratory services directly or through external providers of such services; and
  - The provision of ancillary services to the facility by other persons or organizations.

- Formulating long-range plans in accordance with the mission and goals of the facility.
- Operating the facility without limitation by reason of race, age, sex, ethnicity, religion, sexual orientation, or disability.
- Establishing an organizational structure for the facility, electing, appointing or employing officers and/or Executive Directors to direct the clinical and administrative activities of the facility, and documenting the authority, responsibility and function of such positions.
- Making initial appointments and reappointments to the medical staff of the facility ("medical staff"), and assigning or curtailing clinical privileges with the documented advice and recommendations of the credentialing committee of the medical staff.

Age Protocols	Empire Eye Physicians	
Policy Name: **AGE RESTRICTIONS AND REQUIREMENTS**		Page 1 of 1
Approved: 10/30/2020	Reviewed:	Revised:

POLICY:

To ensure evidence-based standards of care, compliance with FDA regulations, patient safety and properly trained providers and staff, Empire Eye Physicians has implemented age restrictions and requirements.

PROCEDURES:

All patients must meet the following requirements:

- **All patients must in 18 years and older, with these exceptions:**
    - **Cross-linking:**
    - Cross-linking is FDA approved for ages 14 and older. Pre-procedure cross-linking patients may be seen at 12 years-old or older.
    - Note: Cross-linking is not covered for age 65 and older, however patients can sign an ABN and have the procedure as self-pay.

    - **In-house vision plan:**
    - Qualified staff may have their dependents seen by an OD at age 8 years-old or older.

    - **Refractive Lensectomy:** Patients must be 50 years-old or older.

Section 1 Policies and Procedures	Empire Eye Surgery Center	
Policy Name: **SECURITY IN ELECTRONIC HEALTH RECORDS**		Page 1 of 3
Approved:	Revised:	

PURPOSE:

To reduce the risks related to the integrity, security and confidentiality of sources of health care information, and to limit access and use.

POLICY:

Medical records information maintained electronically shall be made available only to authorized people, and solely for legitimate care purposes. System access will be limited. Persons who shall have this level of security shall include the actual providers involved in the patient's care, the patient and their legal representatives, third party payers, and those entities and representatives who are otherwise authorized to have access as a result of a legal consent or court order. In any case, electronic health information shall be made available only for legitimate purposes. The network software, not the application software, controls security at this level. Such purposes shall include:

- Documentation of services, authorized and rendered
- Outcomes management; e.g., peer review, quality and utilization review
- Reimbursement
- Defense of pending claims and/or litigation

Application Program Access

Access to the various application programs and system maintenance functions are controlled individually with "sign-on" and "password" codes. Access should be granted on a need basis. The network Executive Director and a designated assistant should be the only staff members with system access and system backup accessibility. This will limit the chance of accidental change to network settings. Network settings control how all the components of a computer system work together. Any change could cause problems in functionality as well as potential loss of data.

Application program access is granted on a need basis. In some cases, application programs like Accounts Payable and General Ledger are installed on individual workstations instead of the file server, which further limits the access to financial sensitive data.

There shall be a method of tracking access to the record in order to block unauthorized access of the electronic record.

The facilities management systems have extensive security capabilities of their own. Each module – scheduling, registration, case history, costing, etc. – have password and sign-on access functionality. Further control is available in "view" and "update" rights assigned to each user. The data in the management systems contain patient treatment data as well as financial data including staff salary. Access is limited to only staff members that require information and only to the modules that each staff members require to perform their functions. The ability to change passwords, sign-on and security level is to be controlled by the system Executive Director.

Data Backup

Cloud-based backup of the application data on a daily basis is mandatory. The system IT Consultant's primary responsibilities are to ensure the integrity of the data and to prevent the potential of data loss. Data will be backed up according to software and hardware vendor recommendations.

This schedule will ensure a daily backup in case the system or disk crashes so that the recovery will be limited to input of the information since the last backup. The extended backups for the weekly saves and the monthly saves will enable data recovery in the event of data corruption that is not discovered right away.

Should the information system and/or EMR be inaccessible for any reason (scheduled or unscheduled interruptions), paper records will be available for use.

Just as important as doing backup, is checking the data on the backup media. The backup media shall be tested at least once every two months to ensure that the equipment is working properly.

Communications

Access to the system via modem or some other device shall be limited. The modem shall be installed on workstations rather than the file server as a further limitation of access.

The Internet is a tremendous source of information. It is also a substantial source of problems. Whenever information is downloaded from an outside source, the potential for computer viruses being introduced to the system is real. Granting access to the Internet is limited to workstations that can be isolated from the network and the file server.

Computer Viruses

Computer viruses can be transmitted anytime an outside source has access to the workstation, file server or input device attached to your system. In order to decrease the likelihood of a virus contamination that no one can add software to the system without approval of the system Executive Director. Software includes any application software, screen savers, games, etc.

Each workstation shall have a current virus detection program that runs automatically whenever the system is turned on. These detection programs must be kept current with updates provided by the manufacturer.

PROCEDURE:

- Assign access codes to authorized persons. Maintain code log in a secure place.
- Orient and train staff to record security policies, confidentiality agreements and technical safeguards (i.e., audits).
- Perform periodic record review to identify information that has been touched by the user, to determine the appropriateness of the access according to the user's role and the resulting need to know the particular information accessed.

NOTE: Any deviation from this security policy will result in corrective measures. Such measures shall be consistently implemented at all levels of the organization.

Exhibit 6

Dr. Mark A. Kontos	MD	Ophthamologist
Dr. Christopher W. Stur	MD	Ophthamologist
Dr. Casey D. Claypool	OD	Optomitrist
Dr. Ali M. Heaton	OD	Optomitrist
Jai Nelson	RN	
Tyler Brown	RN	
Jenelle Pope	RN	
Monika Hebky	RN	
Noreen Side	RN	
Claudia Wilkinson	RN	
Bethany Coski	RN	
Trisha Shoemaker	RN	

EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

STRATEGIC PLAN – STAFFING
2020 – 2025

Clear Objectives and Foundation

- Vision Statement - *proposed*
- Mission Statement
- Core Values - *proposed*
- SWOT Analysis
- Yearly Objectives
- Long-Term Goals
- Action Plans

OUR VISION
Changing the Way You See the World

OUR MISSION
Empire Eye Physicians delivers the highest standard of medical and surgical ophthalmology services within a professional and compassionate patient centered environment.

CORE VALUES

- Excellence in Eyecare
- Compassionate, Personalized Care
- State-of-the-Art Innovative Care
- Professionalism and Integrity
- Commitment to Collaborative Patient Care
- Respectful and Supportive Clinic Environment

Strategic Data Points

- Opportunities to excel
- Increase surgery and clinic patient satisfaction
- Increase provider production
- Goal setting

EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

- Metrics with expectations, benchmarks, and accomplishments
- Data driven decisions

Growth Strategies

There are four avenues toward practice growth:

- Patient acquisition
- Insurance-based business
- Cash-based business
- Value-added services

1. Staffing:

a. Focus on retention, staffing levels/ratio, employee satisfaction, maximize workforce potential
b. HR Coordinator started July, 2019 and is focused on maximizing the skills of the workforce

SWOT: Strengths/Weaknesses/Threats/Opportunities	
Strengths (Internal) HR Coordinator position Extensive staff appreciation program	**Weaknesses (Internal)** Turnover Rising benefit costs Generational influences
Threats (External) Reimbursement levels Unemployment level	**Opportunities (external)** Increase efficiencies Expand staff appreciation Develop HR Coordinator role

Staffing Action Plan:

- Individualized training plans for all clinic technicians are being developed and will be implemented August 22, 2019 with goals of OSA, COA and COT certifications for all technicians.
- Front Desk updated training plans – plan implemented August 22, 2019
- Enhance Technician work-up times: HR to shadow technicians with national benchmarks to compare, assess weaknesses and strengthen skills to overcome weakness and improve work-up times. To begin week of August 26, 2019.
- Develop a practice-wide safety committee, update of employee handbook and priorities from HR assessment conducted in 1st Qtr 2019.

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

- Practice leadership meeting planned for late August, 2019 to communicate clear expectations

Clinic staff ratio: 4:1
Staff includes three Technicians and one Scribe per provider clinic day

Laser Institute Procedures staffing plan: 4:1
Laser operator, Pre/post Technician, Scrub Technician, Patient Care Coordinator

Empire Eye Surgery Center: surgery day staff
CRNA: 1
Pre/Post RN: 2
Circulating RN: 1
Sterile Technician: 1
Scrub Technician: 1
Pre/Post Technician/MA: 2

2. Providers

SWOT: Strengths/Weaknesses/Threats/Opportunities	
Strengths (Internal)	**Weaknesses (Internal)** Decreased OD liaison time Competition
Threats (External)	**Opportunities (external)**

Providers Action Plan:
Production – maximize each providers production
Increase appointment templates

a. Staffing ratio goal
Increase to 4:1, to be composed of 3 ophthalmic technicians and 1 scribe

b. Analyze hiring new providers, specialty, location(s), services
c. New Ophthalmologist – June 2021
Action Plan: Onboarding process for Dr. Croskrey underway, July, 2020
Croskrey Internship and Onboarding plan: completed December 6, 2020

EMPIRE EYE
PHYSICIANS

EmpireEye.com

COEUR D'ALENE OFFICE

2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE

1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

Exhibit 7

PATIENT TRANSFER AGREEMENT
Providence Sacred Heart Medical Center & Children's Hospital

This Patient Transfer Agreement ("Agreement") is entered into this 8th day of June, 2009 (the "Effective Date"), between Providence **Sacred Heart Medical Center & Children's Hospital** ("Hospital"), and **Empire Eye Surgery Center** ("Transferring Facility").

To facilitate continuity of patient care and the timely transfer of patients and records from Transferring Facility to Hospital, the parties agree as follows:

1. If a determination is made by the attending physician that a patient requires transfer from the Transferring Facility to the Hospital, Hospital agrees to admit the patient as promptly as possible, as long as it has the available space, qualified personnel and appropriate services for the treatment of the patient, and the requirements of (i) Hospital's applicable polices/protocols, and (ii) applicable federal and state laws and regulation are met.

2. Transferring Facility has the responsibility for transferring the patient to the Hospital and agrees to use qualified personnel and necessary equipment, including medically appropriate life support measures, during the transfer.

3. Transferring Facility agrees to provide the Hospital with appropriate documentation as necessary to ensure continuity of patient care. This information should include, as a minimum, the patient's medical record (i.e., summary of physician findings, nursing notes, flow sheets, lab and radiology reports, copy of EKG, relevant transfer forms, signed consent for transfer, etc.). This documentation will be sent to the Hospital at the time of transfer unless doing so would jeopardize the patient; in which case, the documentation will be sent as promptly as possible after the transfer.

4. To the extent possible, patients will be stabilized prior to transfer to ensure the transfer will not, within reasonable medical probability, result in harm to the patient or jeopardize their survival.

5. All transfers will be done in accordance with (i) Hospital's applicable polices/protocols, (ii) applicable federal and state laws and regulations and (iii) in accordance with the standards of The Joint Commission.

6. Transferring Facility will be responsible for the transfer or other appropriate disposition of the patient's personal effects, particularly money and valuables.

7. Charges for services performed by either party shall be collected by the party rendering the service from the patient, third party payor, or other sources normally billed by the

party. Neither party shall have any liability to the other for such charges, except to the extent such liability would exist separate from this Agreement. The parties shall cooperate with each other in exchanging information about financial responsibility for services rendered by them to patients transferred to the Hospital.

8. Transferring Facility shall indemnify, hold harmless and defend the Hospital, its agents and employees from and against any claim, loss damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Transferring Facility, its agents and employees of any duty or obligation of the Transferring Facility under this Agreement.

9. Hospital shall indemnify, hold harmless and defend the Transferring Facility, its agents and employees from and against any claim, loss damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Hospital, its agents and employees of any duty or obligation of the Hospital under this Agreement.

10. The parties shall maintain at their own expense comprehensive general and professional liability insurance and property damage insurance adequate to insure them against risks arising out of this Agreement, with limits no less than those customarily carried by similar facilities. Upon request, each party shall furnish the other party with evidence of such insurance. During the term of this Agreement, each party shall immediately notify the other of any material change in such insurance.

11. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility or entity on a limited or general basis.

12. Transferring Facility represents and warrants that neither Transferring Facility nor Transferring Facility's shareholders, owners, principals, partners or members (if applicable) are presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in any federally funded health care program, including Medicare and Medicaid. Transferring Facility agrees to immediately notify Hospital of any threatened, proposed, or actual debarment, suspension, or exclusion from any federally funded health care program, including Medicare and Medicaid.

13. This Agreement shall be in effect on the date it is signed by both parties and shall continue until terminated as follows: (i) either party may terminate this Agreement immediately upon a breach of its terms by the other party, or (ii) either party may terminate this Agreement without cause by giving the other party not less than ninety (90) days written notice.

14. This Agreement may be signed in counterparts each of which will be considered an original.

15. This Agreement shall be interpreted and construed in accordance with laws of the state in which Hospital is located. Venue for any action to enforce its terms shall be in the county in which Hospital is located. This Agreement embodies the entire agreement of the parties relating to transfer of patients from Transferring Facility to Hospital, and supercedes all prior agreements, representations and understandings of the parties. This Agreement may only be modified or amended in writing. Amendments and modifications must be signed by both parties to be effective.

SIGNATURES APPEAR ON NEXT PAGE.

HOSPITAL:
PROVIDENCE SACRED HEART MEDICAL CENTER & CHILDREN'S HOSPITAL

By: _____
Name: ANDREW AGWUNOBI, M.D.
Title: CFO

TRANSFERRING FACILITY:
EMPIRE EYE SURGERY CENTER

By: _____
Name: CHRISTOPHER W. STURBAUM, M.D.
Title: Presidnet

Exhibit 8

An error discovered in the processing of the 2006 National Survey of Ambulatory Surgery procedure data resulted in a revised data set. All analyses involving procedure data were rerun and some reported findings have changed. The required revisions have been made. In addition, some standard errors for both visits and procedures were printed incorrectly in the original report and these have been corrected in this revised report. For more information, see the explanation at the end of the report.

National Health Statistics Reports

Number 11 ■ January 28, 2009–Revised September 4, 2009

Ambulatory Surgery in the United States, 2006

by Karen A. Cullen, Ph.D., M.P.H.; Margaret J. Hall, Ph.D.; and Aleksandr Golosinskiy, Division of Health Care Statistics

Abstract

Objectives—This report presents national estimates of surgical and nonsurgical procedures performed on an ambulatory basis in hospitals and freestanding ambulatory surgery centers in the United States during 2006. Data are presented by types of facilities, age and sex of the patients, and geographic regions. Major categories of procedures and diagnoses are shown by age and sex. Selected estimates are compared between 1996 and 2006.

Methods—The estimates are based on data collected through the 2006 National Survey of Ambulatory Surgery by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS). The survey was conducted from 1994–1996 and again in 2006. Diagnoses and procedures presented are coded using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

Results—In 2006, an estimated 53.3 million surgical and nonsurgical procedures were performed during 34.7 million ambulatory surgery visits. Of the 34.7 million visits, 19.9 million occurred in hospitals and 14.9 million occurred in freestanding ambulatory surgery centers. The rate of visits to freestanding ambulatory surgery centers increased about 300 percent from 1996 to 2006, whereas the rate of visits to hospital-based surgery centers remained largely unchanged during that time period. Females had significantly more ambulatory surgery visits (20.0 million) than males (14.7 million), and a significantly higher rate of visits (132.0 per 1,000 population) compared with males (100.4 per 1,000 population).

Average times for surgical visits were higher for ambulatory surgery visits to hospital-based ambulatory surgery centers than for visits to freestanding ambulatory surgery centers for the amount of time spent in the operating room (61.7 minutes compared with 43.2 minutes), the amount of time spent in surgery (34.2 minutes compared with 25.1 minutes), the amount of time spent in the postoperative recovery room (79.0 minutes compared with 53.1 minutes), and overall time (146.6 minutes compared with 97.7 minutes).

Although the majority of visits had only one or two procedures performed (59.8 percent and 27.7 percent, respectively), 1.0 percent had five or more procedures performed. Frequently performed procedures on ambulatory surgery patients included endoscopy of large intestine (5.7 million), endoscopy of small intestine (3.5 million), extraction of lens (3.1 million), injection of agent into spinal canal (2.0 million), and insertion of prosthetic lens (2.6 million). The leading diagnoses at ambulatory surgery visits included cataract (3.0 million); benign neoplasms (2.0 million), malignant neoplasms (1.2 million), diseases of the esophagus (1.1 million), and diverticula of the intestine (1.1 million).

Keywords: Outpatients • Diagnoses • Procedures • ICD–9–CM • National Survey of Ambulatory Surgery

Introduction

This report presents data from the 2006 National Survey of Ambulatory Surgery (NSAS). The survey, previously conducted annually from 1994 through 1996, was conducted by NCHS to gather and disseminate data about ambulatory surgery in the United States. For NSAS, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory (outpatient) basis in a hospital or freestanding center's general operating rooms, dedicated ambulatory surgery rooms, and other specialized rooms, such as endoscopy units and cardiac catheterization laboratories. NSAS is the principal source for national data on the characteristics of visits to hospital-based and freestanding ambulatory surgery centers.

Ambulatory surgery has been increasing in the United States since the early 1980s. Two major reasons for the increase are advances in medical technology and changes in payment arrangements. The medical advances include improvements in anesthesia, which enable patients to regain consciousness more quickly with fewer after effects and better analgesics for relief of pain. In addition, minimally invasive and noninvasive procedures have been developed and are being used with increasing frequency. Examples include laser surgery, laparoscopy, and endoscopy. These medical advances have made surgery less complex and risky (1) and have allowed many

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

procedures to move from inpatient to ambulatory settings (2–6).

At the same time, concern about rising health care costs led to changes in the Medicare program that encouraged the development of ambulatory surgery. In the early 1980s, the Medicare program was expanded to cover care in ambulatory surgery centers, and a prospective payment system based on diagnosis-related groups was adopted for hospital inpatient care that created strong financial incentives for hospitals to shift less complex surgery to outpatient settings. Many state Medicaid plans and private insurers followed the lead of the Medicare program and adopted similar policies (7).

Additional changes in the health care system, such as the growth of managed care along with consolidation of hospitals, have furthered the growth of ambulatory surgery (3,8). As these changes occurred, many types of surgeries done in hospitals were increasingly performed during ambulatory visits. Both in conjunction with and as a result of these changes, the number of freestanding ambulatory surgery centers (ASCs) grew from 239 in 1983 (9) to over 3,300 nearly two decades later (3,10). The number of procedures being performed in ASCs also increased dramatically—from 380,000 procedures in 1983 to 31.5 million in 1996 (5).

The National Hospital Discharge Survey (NHDS), which has been conducted by NCHS every year since 1965, includes information on surgical and nonsurgical procedures performed in inpatient settings (11–13). Although NHDS remains a good source of data for procedures that can be done only on an inpatient basis, such as open-heart surgery or cesarean delivery, NHDS estimates have become incomplete for procedures that can be performed on an ambulatory basis. NSAS was undertaken to obtain information about ambulatory procedures. For many types of procedures, data from both NHDS and NSAS are now required to obtain national estimates. Reports that present both ambulatory and inpatient procedure data for 1994, 1995, and 1996 have been published (14–16).

NSAS and NHDS are two of the NCHS provider-based surveys that constitute the National Health Care Surveys (NHCS). The NHCS were designed to provide nationally representative data on the use of health care resources of major sectors of the health care delivery system. Information on ambulatory procedures is also collected in two other NHCS surveys. The National Ambulatory Medical Care Survey obtains information on procedures ordered or performed during visits to physicians' offices (17), and the National Hospital Ambulatory Medical Care Survey (NHAMCS) collects data on procedures ordered or performed during visits to hospital outpatient and emergency departments (18).

Methods

Data source

NSAS covers procedures performed in ambulatory surgery centers, both hospital-based and freestanding. The hospital universe includes noninstitutional hospitals exclusive of federal, military, and Department of Veterans Affairs hospitals located in the 50 states and the District of Columbia. Only short-stay hospitals (hospitals with an average length of stay for all patients of fewer than 30 days), or those whose specialty was general (medical or surgical), or children's general were included in the survey. These hospitals must also have had six beds or more staffed for patient use. This universe definition is the same as that used for the NHDS and the NHAMCS. For the 2006 NSAS, the hospital sample frame was constructed from the products of Verispan, L.L.C., specifically its "Healthcare Market Index, Updated June 15, 2005" and its "Hospital Market Profiling Solution, Second Quarter, 2005" (19). These products were formerly known as the SMG Hospital Market Database. In 2006, the sample consisted of 224 hospitals. Of the 224 hospitals, 35 were found to be out-of-scope (ineligible) because they went out of business or otherwise failed to meet the criteria for the NSAS universe. Of the 189 in-scope (eligible) hospitals, 142 hospitals responded to the survey for a response rate of 75.1%.

The universe of freestanding facilities included ones that were regulated by the states or certified by the Centers for Medicare & Medicaid Services (CMS) for Medicare participation. The sampling frame consisted of facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database (20) and Medicare-certified facilities included in the CMS Provider-of-Services (POS) file (21). Facilities specializing in dentistry, podiatry, abortion, family planning, or birthing were excluded. However, procedures commonly found in these settings were not excluded from in-scope locations. In 1994–1996, pain block locations were also excluded; however, they were included in the 2006 NSAS. In 2006, the sample consisted of 472 freestanding ASCs. Of the 472 freestanding ambulatory surgery centers, 74 were found to be out-of-scope (ineligible) because they failed to meet the criteria for the NSAS universe. Of the 398 in-scope (eligible) freestanding ambulatory surgery centers, 295 responded to the survey for a response rate of 74.1%. The overall response rate was 74.4%.

Sample design

The NSAS sampled facilities were selected using a multistage probability design with facilities having varying selection probabilities. Independent samples of hospitals and freestanding ambulatory surgery centers were drawn. Unlike the 1994–1996 NSAS, which used a three-stage stratified cluster design, with the first stage consisting of geographic primary sampling units or PSUs, the 2006 NSAS used a two-stage list-based sample design. Facilities were stratified by facility type (hospital compared with freestanding), ambulatory surgery status of hospitals (i.e., whether or not the hospital performed such surgery), facility specialty, and geographic region.

The first stage of the design consisted of selection of facilities using systematic random sampling with probabilities proportional to the annual

number of ambulatory surgeries performed. For the stratum of hospitals which, according to the sampling frame data, did not have ambulatory surgery, a national sample of 25 hospitals was selected to permit estimates of surgery in hospitals that either added ambulatory surgery since the frame was selected or differed from the frame.

At the second stage, within sampled facilities, a sample of ambulatory surgery visits was selected using a systematic random sampling procedure. Selection of visits within each facility was performed separately for each location where ambulatory surgery was performed. These locations included main operating rooms; dedicated ambulatory surgery units; cardiac catheterization laboratories; and rooms for laser procedures, endoscopy, and laparoscopy. Locations within hospitals dedicated exclusively to abortion, dentistry, podiatry, or small procedures were not included. The exclusion of these specialty locations, as well as the exclusion of facilities dedicated exclusively to those specialties, was recommended based on the feasibility study for the NSAS that was conducted in 1989–1991. Based on the recommendation of outside experts who were consulted prior to the design of the 2006 NSAS, the 2006 NSAS includes pain block facilities, whereas the 1994–1996 NSAS did not (22). Because NSAS data are collected from a sample of visits, persons with multiple visits during the year may be sampled more than once. NSAS estimates are of the number of visits to or procedures performed in ambulatory surgery facilities, not the number of persons served by these facilities.

Data collection

Sample selection and abstraction of information from medical records were performed at the facilities. Facility staff did the sampling in about 40 percent of facilities that participated in the 2006 survey, and facility staff abstracted the data in about 30 percent of the participating facilities. In the remaining facilities, the work was performed by personnel of the U.S. Census Bureau acting on behalf of NCHS. Data processing and medical coding were performed by the Constella Group Inc., Durham, North Carolina. Editing and estimation were completed at NCHS.

The abstract form (''Technical Notes'') contains items relating to the personal characteristics of the patients such as age, sex, race, and ethnicity; and administrative items such as date of procedure, disposition, and expected sources of payment. The medical information includes up to seven diagnoses and six procedures, which were coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) (23).

A quality control program was conducted on the coding and entering of data from abstracts to electronic form. Approximately 10 percent of the abstractions were independently recoded by an NSAS coder at the Constella Group, Inc., with discrepancies resolved by a chief coder. The overall error rate for the 2006 NSAS was 0.3 percent for diagnosis coding and keying, 0.2 percent for procedure coding and keying, and 0.3 percent for demographic coding and keying.

Estimation

Because of the complex multistage design of the NSAS, the survey data must be inflated or weighted in order to produce national estimates. The estimation procedure produces essentially unbiased national estimates, and has three basic components: inflation by reciprocals of the probabilities of sample selection, adjustment for nonresponse, and population weighting ratio adjustments. These three components of the final weight are described in more detail in another report (22).

Standard errors

The standard error (SE) is primarily a measure of sampling variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. Estimates of the sampling variability for this report were calculated using Taylor approximations in SUDAAN, which takes into account the complex sample design of the NSAS. A description of the software and the approach it uses has been published (24). The SEs of statistics presented in this report are included in each of the tables.

Testing of significance and rounding

In this report, statistical inference is based on the two-sided *t*-test with a critical value of 2.58 (0.01 level of significance). Terms such as ''higher'' and ''less'' indicate that differences are statistically significant. Terms such as ''similar'' or ''no difference'' mean that no statistically significant difference exists between the estimates being compared. A lack of comment on the difference between any two estimates does not mean that the difference was tested and found not to be significant.

The feasibility of using one weight to calculate estimates and variances was assessed to determine whether the SEs produced from the single-weight variable were for the most part greater than the SEs produced by the variance weights for the same estimates. For certain estimates, the single weights produced variances that underestimated the true variances. This underestimation can lead to Type I errors in which the null hypothesis is incorrectly rejected when using the commonly used significance level of alpha=0.05. As a result, the decision was made that an alpha of 0.01 should be used to reduce the likelihood of committing a Type I error.

Estimates of counts in the tables have been rounded to the nearest thousand. Therefore, figures within tables do not always add to the totals. Rates and percentages were calculated from unrounded figures and may not precisely agree with rates or percentages calculated from rounded data.

Nonsampling error

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include

reporting and processing errors as well as biases due to nonresponse and incomplete response. The magnitude of the nonsampling errors cannot be computed. However, these errors were kept to a minimum by procedures built into the operation of the survey. To eliminate ambiguities and to encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions. Quality control procedures and consistency and edit checks reduced errors in data coding and processing. The unweighted response rate for the 2006 NSAS was 74.4%. Table 1 presents weighted characteristics of NSAS respondents and nonrespondents, along with weighted response rates. Responding compared with nonresponding distributions were similar, with the exception of higher cooperation among facilities in a nonmetropolitan statistical area. The effect of this differential response is minimized in the visit estimates in most cases, as NSAS uses a nonresponse adjustment factor that takes annual visit volume, specialty, facility type, and geographic region into account. Item nonresponse rates in NSAS are generally low (5% or fewer). However, levels of nonresponse may vary considerably in the survey.

NSAS does not completely measure ambulatory procedures that are performed in locations such as physicians' offices, for example, injections of therapeutic substances, skin biopsies, and certain plastic surgery procedures. The National Ambulatory Medical Care Survey has data about procedures in physicians' offices (17) and the National Hospital Ambulatory Medical Care Survey provides information about procedures in other hospital outpatient and emergency departments (18). As medical technology continues to advance and changes in payment policy promote it, increasing numbers and types of procedures may move from NSAS facilities to elsewhere.

Because certain freestanding facilities and certain specialized locations within hospitals and freestanding facilities are excluded from the NSAS design, ambulatory procedures performed in some specialties are not completely measured by the survey. Excluded specialties include dentistry, podiatry, abortion, family planning, and birthing; and locations that perform small procedures, such as removal of skin lesions, were also excluded. However, procedures in these specialties performed in general operating rooms or other in-scope locations are included in the survey.

The determination of whether an ambulatory surgery facility is a hospital or a freestanding center is based on the universe from which the facility was selected. In most cases, it was apparent whether a facility was a hospital or a freestanding ambulatory surgery center, but some facilities were not easily classified. For example, a ''freestanding'' facility may be owned by a hospital but located some distance away. If such a facility is separately listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database or in the CMS POS file and is selected into the NSAS sample from this universe, it is considered a freestanding facility. Additional definitions of terms used in the NSAS have been published (22).

Use of tables

The statistics presented in this report are based on a sample, and therefore may differ from the figures that would be obtained if a complete census had been taken. Visits are reported by first-listed diagnosis, which is the one specified as the principal diagnosis on the face sheet or discharge summary of the medical record, or if a principal diagnosis was not specified, the first one listed on the face sheet or discharge summary of the medical record. It was usually the main cause of the visit. The number of first-listed diagnoses is the same as the number of visits.

The estimates shown in this report include surgical procedures, such as tonsillectomy; diagnostic procedures, such as ultrasound; and other therapeutic procedures, such as injection or infusion of cancer chemotherapeutic substance. Up to six procedures are coded for each visit. All-listed procedures include all occurrences of the procedure coded regardless of the order on the medical record.

The diagnoses and procedures appear in separate tables of this report, presented by chapter of the ICD–9–CM. Within these chapters, subcategories of diagnoses or procedures are shown. These specific categories were selected primarily because of their large numbers or because they are of special interest.

According to the 2006 NSAS, an estimated 287,000 ambulatory surgery visits with procedures were admitted to the hospital as inpatients. Of these, 269,000 (93.8 percent) were visits to hospitals and 18,000 (6.2 percent) were visits to freestanding centers. In most instances, the ambulatory procedures for these patients become part of their inpatient records. People admitted as inpatients were included in this report, and procedures for these patients were included in the summaries of outpatient procedures, as described in the first version of this report for 1994 (5). These patients were excluded in the 1995 and 1996 *Advance Data Reports* (4,5) and will be excluded to avoid double counting from the Series 13 report in which data from the 2006 NHDS and 2006 NSAS will be presented together, following the same process as reports published using the 1994–1996 data (14–16).

The chances are about 40 in 100 that an estimate from the sample would differ from a complete census by more than the SE. The chances are 9 in 100 that the difference would be more than twice the SE, and about 4 in 100 that the difference would be more than 2.5 times as large as the SE.

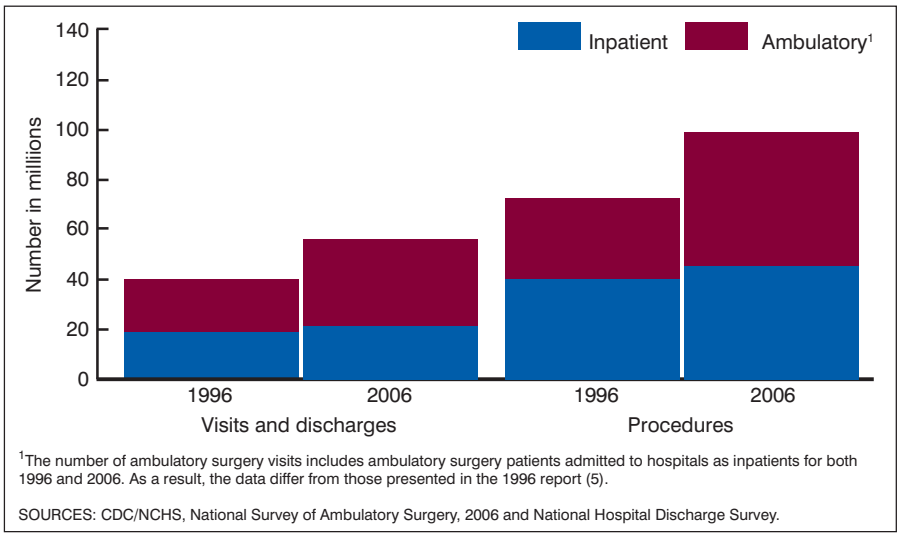
The relative standard error (RSE) of an estimate is obtained by dividing the SE by the estimate itself. The RSE is expressed as a percentage of an estimate and can be multiplied by the estimate to obtain the SE. Because of low reliability, estimates with a RSE of more than 30 percent or those based on a sample of fewer than 30 records are replaced by asterisks (*). The estimates that are based on 30 to 59 patient records are preceded by an asterisk (*) to indicate that they also have low reliability.

The population estimates used in computing rates are for the U.S. civilian population, including institutionalized persons, as of July 1, 2006. Rates are computed using adjustments made after the 2000 census (postcensal estimates) of the civilian population of the United States. The data are from unpublished tabulations provided by the U.S. Census Bureau. Facilities are classified by location into one of the four geographic regions of the United States that correspond to those used by the U.S. Census Bureau.

Results

Patient and facility characteristics

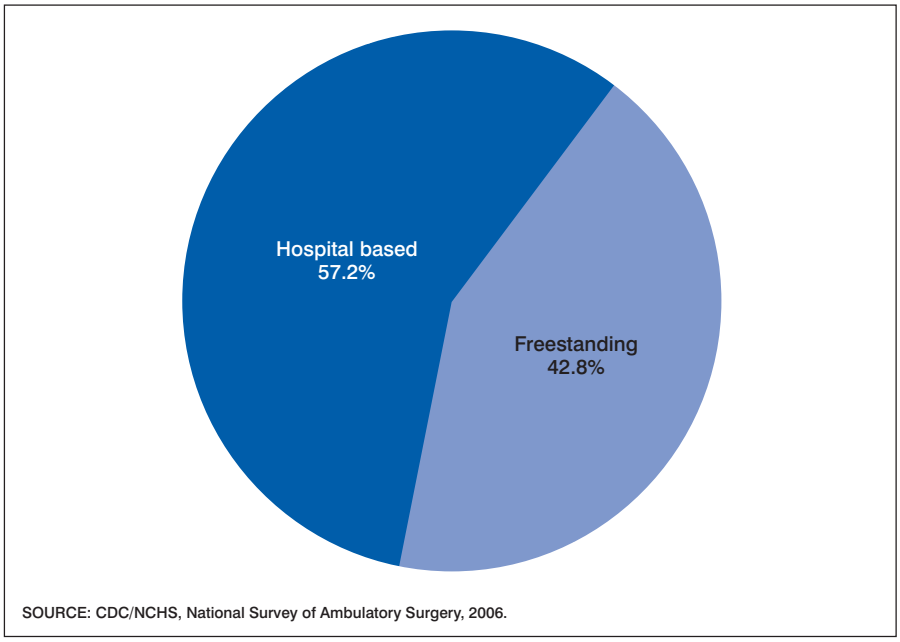
- In 2006, an estimated 53.3 million surgical and nonsurgical procedures were performed during 34.7 million ambulatory surgery visits (Table 2).
- The 34.7 million ambulatory surgery visits accounted for about 61.6 percent of the combined total of ambulatory surgery visits and inpatient discharges with surgical and nonsurgical procedures (56.4 million) (Figure 1).
- An estimated 19.9 million (57.2 percent) of the ambulatory surgery visits occurred in hospitals and 14.9 million (42.8 percent) occurred in freestanding centers (Table 2, Figure 2).
- From 1996 to 2006, the change in the rate of visits to freestanding centers was larger than that for visits to hospital-based ambulatory surgery centers. The rate of visits to freestanding ambulatory surgery centers increased about 300 percent from 1996 to 2006, while the rate in hospital-based centers was flat (Figure 3).
- Females had significantly more ambulatory surgery visits (20.0 million) than males (14.7 million), and a significantly higher rate of visits (132.0 per 1,000 population) compared with males (100.4 per 1,000 population) (Table 2).
- Although the vast majority of ambulatory surgery visits had routine discharges (93.1 percent), 0.8 percent were admitted as inpatients (Table 3).
- Although general anesthesia alone was provided in 30.7 percent of ambulatory surgery visits, 20.8 percent received anesthesia only intravenously, and 20.8 percent received multiple types of anesthesia (data not shown).



[1]The number of ambulatory surgery visits includes ambulatory surgery patients admitted to hospitals as inpatients for both 1996 and 2006. As a result, the data differ from those presented in the 1996 report (5).

SOURCES: CDC/NCHS, National Survey of Ambulatory Surgery, 2006 and National Hospital Discharge Survey.

Figure 1. Ambulatory surgery visits and discharges of hospital inpatients with procedures: United States, 1996 and 2006 (revised)

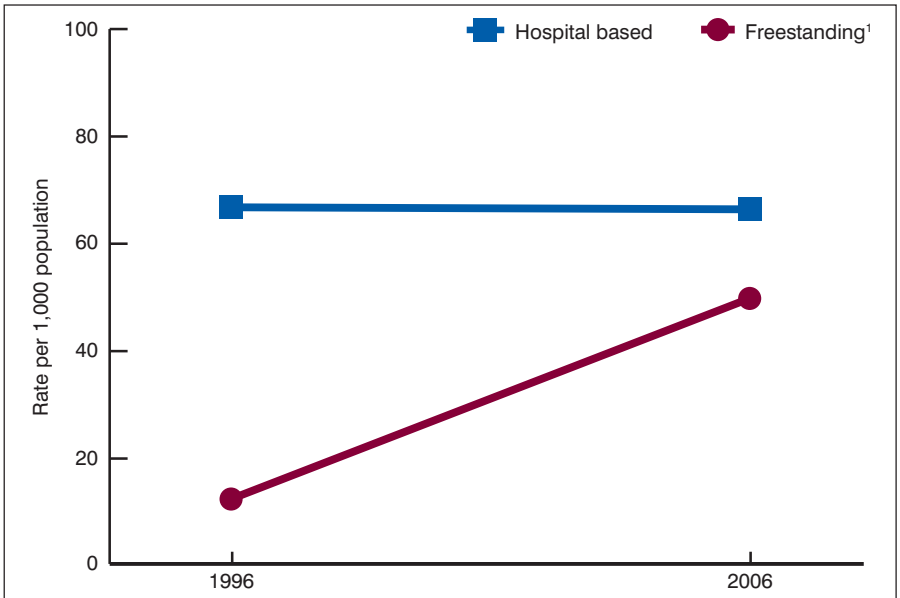


SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery, 2006.

Figure 2. Percent distribution of ambulatory surgery visits by type of facility: United States, 2006

Surgical times for ambulatory surgery visits

- Total time is defined as the length of time from when the patient enters the operating room to the time he or she leaves postoperative care. Operating room time is the length of time the patient is in the operating room. The surgical time is the portion of the



[1]The rate of ambulatory surgery visits includes ambulatory surgery patients admitted to hospitals as inpatients for both 1996 and 2006. As a result, the data differ from those presented in the 1996 report (5).

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Figure 3. Rates of ambulatory surgery visits by facility type: United States, 1996 and 2006

time spent in the operating room during which the surgical procedure occurs. Typically, the surgical time is the time from when the incision is made until the wound is closed. After the surgical procedure, the patient recovers in the postoperative room before he or she is discharged; the time spent here is considered the post operative room time. Average times for surgical visits were higher for ambulatory surgery visits to hospital-based ambulatory surgery centers than for visits to freestanding ambulatory surgery centers for the amount of time spent in the operating room (61.7 minutes compared with 43.2 minutes), the amount of time spent in surgery (34.2 minutes compared with 25.1 minutes), the amount of time spent in the postoperative recovery room (79.0 minutes compared with 53.1 minutes), and overall time (146.6 minutes compared with 97.7 minutes) (Table 4).

- The average time spent in surgery also varied with the diagnosis. The average surgical time for inguinal hernia diagnoses was more than twice that for diagnoses of benign neoplasm of the colon (49.4 minutes compared with 21.8 minutes) (Table 5).

Ambulatory procedures

- Females had significantly more ambulatory surgery procedures (30.6 million) than males (22.7 million) and a significantly higher rate of procedures (2,020.2 per 10,000 population) than males (1,548.1 per 10,000 population) (Tables 6,7). This was driven by differences for females between 15 and 64 years of age (Figure 4).
- Although the majority of visits had only one or two procedures performed (59.8 percent and 27.7 percent, respectively), 1.0 percent had five or more procedures performed (Figure 5).
- Frequently performed procedures on ambulatory patients included endoscopy of large intestine (5.7 million), endoscopy of the small intestine (3.5 million), extraction of lens (3.1 million), injection of agent into spinal canal (2.0 million), and insertion of prosthetic lens (2.6 million) (Table 6).
- Females had higher rates per 10,000 population than males for certain ambulatory procedures, such as extraction (125.5 compared with 78.8) and insertion (105.2 compared with 67.4) of lens and endoscopy of the small (134.7 compared with 97.1) and large (217.8 compared with 166.4) intestine (Table 7).
- Ambulatory procedures often performed on children under 15 years included myringotomy with insertion of tube (667,000), tonsillectomy with or without adenoidectomy (530,000), and adenoidectomy without tonsillectomy (132,000) (Table 6).
- Common ambulatory procedures for persons 15–44 years of age were endoscopy of large intestine (779,000); endoscopy of small intestine (770,000); injection of agent into spinal canal (533,000); injection or infusion of therapeutic or prophylactic substance (429,000); and operations on muscle, tendon, facia, and bursa (403,000) (Table 6).
- Ambulatory surgery procedures commonly performed on persons 45–64 years of age were endoscopy of large intestine (2.9 million), endoscopy of small intestine (1.4 million), injection of agent into spinal canal (835,000), and operations on muscle, tendon, fascia and bursa (755,000) (Table 6).
- For persons 65–74 years of age, endoscopy of large intestine (1.2 million), extraction of lens (1.1 million), insertion of lens (923,000), endoscopy of small intestine (648,000), and endoscopic polypectomy of the large intestine (424,000) were the most frequent ambulatory procedures (Table 6).
- Common ambulatory procedures for those 75 years of age or over were extraction of lens (1.3 million), insertion of lens (1.1 million), endoscopy of large intestine (778,000), endoscopy of small intestine (550,000), and injection of agent into spinal canal (336,000) (Table 6).

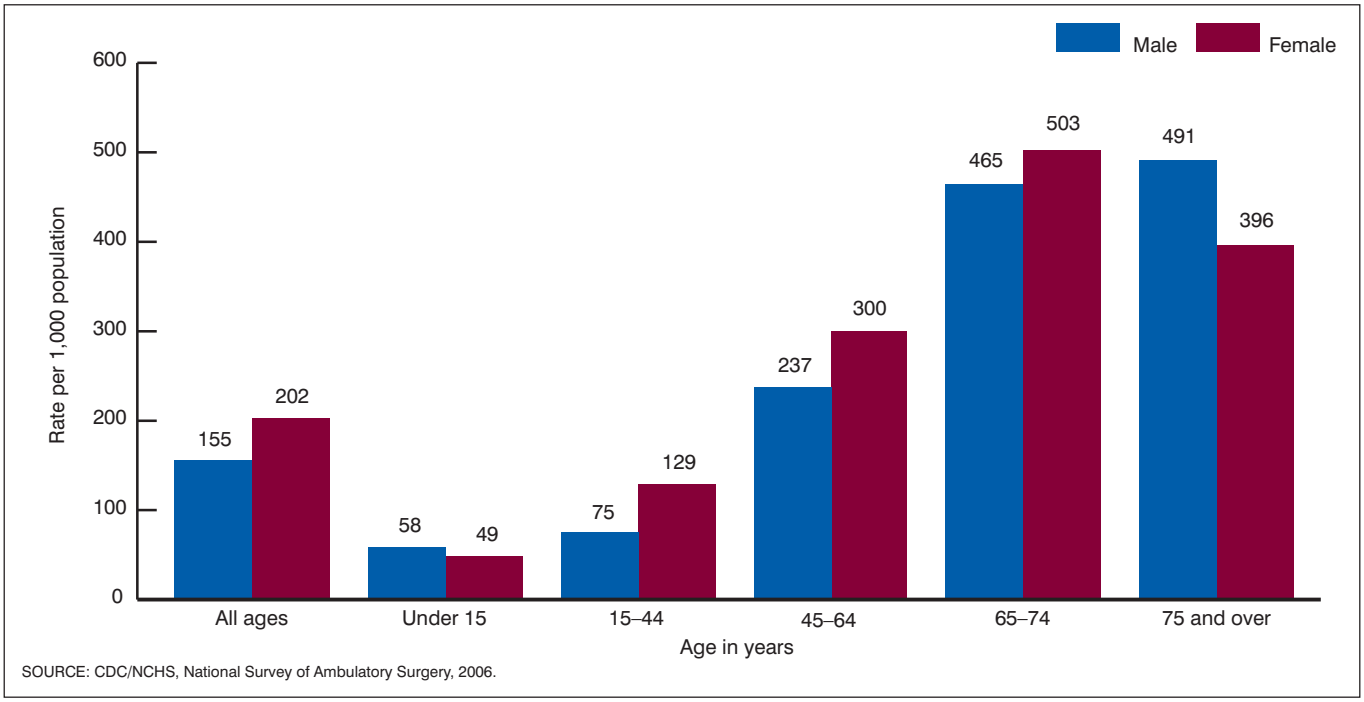


Figure 4. Rate of ambulatory surgery procedures by age and sex: United States, 2006 (revised)

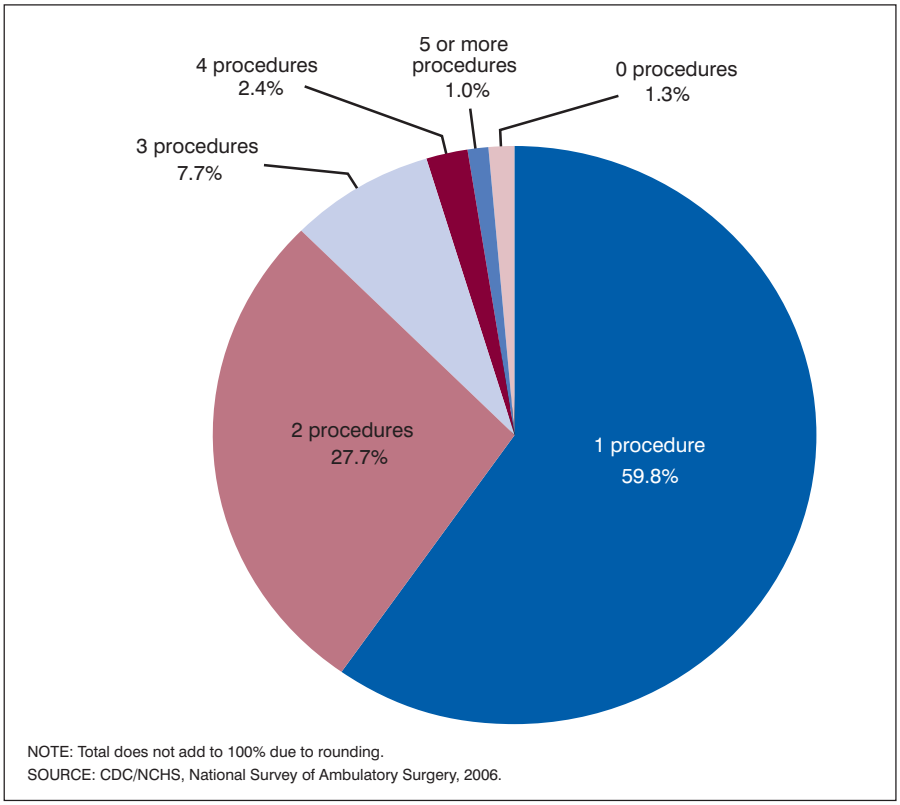


Figure 5. Percent distribution of the number of ambulatory surgery procedures performed per visit: United States, 2006 (revised)

Diagnoses for ambulatory surgery visits

- The leading diagnoses at ambulatory surgery visits included cataract (3.0 million); benign neoplasms (2.0 million), malignant neoplasms (1.2 million), diseases of the esophagus (1.1 million), and diverticula of the intestine (1.1 million) (Table 8).
- Rates of ambulatory surgery visits per 10,000 population varied by gender. For example, the rate of ambulatory surgery visits was higher for females than for males for first-listed diagnoses of cataract (123.5 compared with 77.5) (Table 9).

Discussion

May 2009 revisions of NSAS 2006 data file originally released on October 22, 2008

Identification of a double coding issue with NSAS 2006 data set

The 2006 NSAS public-use data files were released in October 2008. A

researcher contacted NCHS in mid February questioning the fact that the number of myringotomies in the 2006 NSAS was double the number of children under 15 years of age receiving this procedure. In the 1996 NSAS data, there was close to a one-to-one correspondence between these two estimates. The reason for the difference was that in 1996, myringotomy was coded once per record, even if the procedure was performed bilaterally; in 2006, myringotomy was coded twice if performed bilaterally. This inconsistency was unintentional.

Given this inconsistency, the entire 2006 NSAS data set was examined to see if there were other records with multiple identical procedure codes. It was determined that a total of 4,923 records (including myringotomies) of the original 52,233 records in 2006 NSAS had multiple coding (approximately 9%). Double coding was present in only 35 records of 125,000 in the 1996 NSAS.

Coding guidelines followed for the 2006 NSAS data

The 1994–1996 NSAS procedure coding guidelines were based upon *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) inpatient coding guidelines that were in effect at that time. With the use of these guidelines, multiple coding rarely occurred, even if bilateral or other multiple procedures codes were listed in the record more than one time. Instead of using these ICD–9–CM inpatient coding guidelines, the 2006 NSAS used National Hospital Ambulatory Medical Care Survey (NHAMCS) procedure coding guidelines. Although NHAMCS guidelines were also based on ICD–9–CM codes, they differed in allowing double coding if the following circumstances occurred: if more than one site was specified, if a procedure was bilateral, and if an abstractor recorded a procedure multiple times. In NHAMCS, an editing process removed all double codes that were determined to be inappropriate. However, this step in the editing process was not incorporated into the 2006 NSAS data production, thereby creating the double coding issue.

Table A. A comparison of estimates of procedures from Table 2, by selected characteristics: United States, 2006

Characteristic	Original NSAS (Number in thousands)	Revised NSAS (Number in thousands)	Revised/ original (Percent)	Decrease	Percent decrease
Total procedures	57,062	53,329	93.5	3,733	7
Facility type					
Hospital based	32,320	30,761	95.2	1,559	5
Freestanding	24,742	22,568	91.2	2,174	9
Male					
Hospital based	14,051	13,286	94.6	765	5
Freestanding	10,277	9,395	91.4	882	9
Female					
Hospital-based	18,270	17,475	95.6	795	4
Freestanding	14,465	13,173	91.1	1,292	9
Region					
Northeast	8,551	8,018	93.8	533	6
Midwest	13,583	12,575	92.6	1,008	7
South	25,509	24,023	94.2	1,486	6
West	9,420	8,713	92.5	707	8
Male					
Northeast	3,710	3,486	94.0	224	6
Midwest	5,803	5,321	91.7	482	8
South	10,755	10,143	94.3	612	6
West	4,060	3,730	91.9	330	8
Female					
Northeast	4,841	4,532	93.6	309	6
Midwest	7,780	7,254	93.2	526	7
South	14,754	13,879	94.1	875	6
West	5,359	4,983	93.0	376	7
Metropolitan status					
Metropolitan statistical area	48,874	45,691	93.5	3,183	7
Nonmetropolitan statistical area	8,189	7,638	93.3	551	7
Male					
Metropolitan statistical area	20,821	19,399	93.2	1,422	7
Nonmetropolitan statistical area	3,507	3,282	93.6	225	6
Female					
Metropolitan statistical area	28,053	26,292	93.7	1,761	6
Nonmetropolitan statistical area	4,682	4,356	93.0	326	7

NOTES: Table A is a comparison of the January 28, 2009, *National Health Statistics Report*, Number 11, procedure estimates (taken from Table 2) to the revised estimates in this September 4, 2009, revision. NSAS is the National Survey of Ambulatory Surgery.

Revising the NSAS Data Set and How It Affected the Data

To maintain comparability with the 1994–1996 NSAS data, since multiple codes were not included in the 1996 NSAS, all multiple procedure codes were removed from the 2006 NSAS data. As a result, the estimate for the total number of 2006 NSAS procedures fell from 57,062,000 to 53,329,000, a 6.5% decrease. Categories were differentially affected. Tables A and B show the 2006 NSAS original and the 2006 NSAS revised estimates for some of the major procedure categories included in this and the January 28, 2009, NSAS *National Health Statistics Report*. The tables also include ratios of the revised estimates to the original estimates to show relative changes. As expected, the revised estimates decreased most for bilateral and other multiple site procedures.

Table B. A comparison of estimates of procedures from Table 6, by selected characteristics: United States, 2006

Characteristic	Original NSAS (Number in thousands)	Revised NSAS (Number in thousands)	Revised/ original (Percent)	Decrease	Percent decrease
Total procedures	57,062	53,329	93.5	3,733	7
Age					
Under 15 years	4,034	3,266	81.0	768	19
15–44 years	13,691	12,780	93.3	911	7
45–64 years	21,369	20,167	94.4	1,202	6
65–74 years	9,622	9,182	95.4	440	5
75 years and over	8,345	7,934	95.1	411	5
Sex					
Male	24,328	22,681	93.2	1,647	7
Female	32,734	30,648	93.6	2,086	6
Procedure category					
Nervous system	4,106	3,198	77.9	908	22
Eye	7,296	7,085	97.1	211	3
Ear	1,723	1,114	64.7	609	35
Nose, mouth, and pharynx	3,179	2,864	90.1	315	10
Respiratory system	448	445	99.3	3	1
Cardiovascular system	1,395	1,376	98.6	19	1
Digestive system	14,677	14,414	98.2	263	2
Urinary system	1,799	1,776	98.7	23	1
Male genital organs	655	631	96.3	24	4
Female genital organs	2,503	2,497	99.8	6	0.2
Musculoskeletal system	8,439	7,944	94.1	495	6
Integumentary system	4,108	3,581	87.2	527	13
Misc diagnostic/therapeutic and new technologies	6,387	6,060	94.9	327	5
Other (includes endocrine system, hemic and lymphatic system, and obstetrical procedures	346	344	99.4	2	1

NOTES: Table B is a comparison of the January 28, 2009, *National Health Statistics Reports*, Number 11, procedure estimates (taken from Table 6) to the revised estimates in this September 4, 2009, revision. NSAS is the National Survey of Ambulatory Surgery.

The procedure estimates for the following chapters were most affected by the deletion of multiple codes:

- Operations on the nervous system decreased 22% largely due to multiple coding of injection of agent into spinal canal.
- Operations on the ear decreased 35% largely due to double coding of myringotomy with insertion of tube.
- Operations on the nose, mouth, and pharynx decreased 10%.
- Operations on the integumentary system decreased 13% largely due to multiple coding of excision or destruction of lesion or tissue of skin and subcutaneous tissue.

Since myringotomies are a common procedure for children, estimates for both myringotomies and for overall procedures for children decreased a great deal after double coding was eliminated. The children's estimate decreased by 19% and the myringotomy estimate decreased by 44%.

Steps taken to improve coding in the future

A coding manual for the 2009 Ambulatory Surgical Center (ASC) data (now being gathered through NHAMCS) that clarifies the multiple coding issue is being prepared for coding of NHAMCS data. The differences between CPT and ICD–9–CM coding principles are discussed in the new manual along with what to do if the record contains only CPT codes. For the 2009 coding of ASC data, a crosswalk has been developed to generate ICD–9–CM codes from CPT codes. Instructions detailing how to handle duplicate codes are also included.

When the 2009 NHAMCS data are processed, NCHS will examine all double coding and remove any codes that are found to be inappropriate.

Your suggestions are welcomed on how to handle multiple codes in future ASC data. Please send any suggestions to Nancy Sonnenfeld at nsonnenfeld@cdc.gov.

Steps data users should take upon receiving the revised data

All data analyses based on the original NSAS data set should not be used. Instead, the analyses should be rerun using the revised data set. Similarly, any estimates or standard errors taken from the original NSAS *National Health Statistics Reports* (January 28, 2009) should not be used. Instead, these numbers should be obtained from this revised (September 4, 2009) report. Changes in this report are not limited to procedure estimates and standard errors affected by the method of handling multiple codes. Printing errors were also discovered, which affected some of the standard errors for visits and for procedures. These errors have been corrected in this revised report.

What has changed in the revised NSAS data set

As was indicated previously in the discussion of the data set revision, the estimates of some procedures (PROC1-PROC6), particularly those that were coded multiple times, have changed. They are lower because duplicates have been deleted. The values for other variables that were derived from the procedure data had to be derived again from the newer data set. The variables affected were NUMPROC (number of procedures per visit), SGFLAG1-SGFLAG6 (flags indicating if the procedures were surgical or nonsurgical), and PD1CLASS-PD6CLASS (the Agency for Health Care Research and Quality's Procedure Class Tool variables). Because of the changes in certain estimates, standard errors for these estimates may also have changed.

References

1. Warner MA, Shields SE, Chute CG. Major morbidity and mortality within 1 month of ambulatory surgery and anesthesia. JAMA 270(12):1437–41. 1993.
2. Lumsdon K, Anderson HJ, Burke M. New surgical technologies reshape hospital strategies. Hospitals 40–2 66(9):30–6. 1992.
3. Winter A. Comparing the mix of patients in various outpatient surgery settings. Health Affairs 22(6):68–75. 2003.
4. Hall MJ, Lawrence L. Ambulatory surgery in the United States, 1995. Advance data from vital and health statistics; no 296. Hyattsville, MD: National Center for Health Statistics. 1997.
5. Hall MJ, Lawrence L. Ambulatory surgery in the United States, 1996. Advance data from vital and health statistics; no 300. Hyattsville, MD: National Center for Health Statistics. 1998.
6. Kozak LJ, Hall MJ, Pokras R, Lawrence L. Ambulatory surgery in the United States, 1994. Advance data from vital and health statistics; no 283. Hyattsville, MD: National Center for Health Statistics. 1997.
7. Leader S, Moon M. Medicare trends in ambulatory surgery. Health Affairs 8(1):158–70. 1989.
8. Cuellar AE, Gertler PJ. Trends in hospital consolidation: The formation of local systems. Health Affairs 22(6):77–87. 2003.
9. Durant G. Ambulatory surgery centers: Surviving, thriving into the 1990s. J Medical Group Management 36(2):16–8, 20. 1989.
10. Casalino LP, Devers KJ, Brewster LR. Focused factories? Physician-owned specialty facilities. Health Affairs 22(6):56–67. 2003.
11. Pokras R, Kozak LJ, McCarthy E, Graves EJ. Trends in hospital utilization, 1965–86. Am J Pub Health 80(4):488–90. 1990.
12. Gillum BS, Graves EJ, Kozak LJ. Trends in hospital utilization: United States, 1988–1992. National Center for Health Statistis. Vital Health Stat 13(124). 1996.
13. DeFrances CJ, Lucas CA, Buie VC, Golosinskiy A. 2006 National Hospital Discharge Survey. National health statistics reports; no 5. Hyattsville, MD: National Center for Health Statistics. 2008. Available from: www.cdc.gov/nchs/data/nhsr/nhsr005.pdf.
14. Pokras R, Kozak LJ, McCarthy EH. Ambulatory and inpatient procedures in the United States, 1994. National Center for Health Statistics. Vital Health Stat 13(132). 1997.
15. Kozak LJ, Owings MF. Ambulatory and inpatient procedures in the United States, 1995. National Center for Health Statistics. Vital and Health Stat 13(135). 1998.
16. Owings MF, Kozak LJ. Ambulatory and inpatient procedures in the United States, 1996. National Center for Health Statistics. Vital and Health Stat 13(139). 1998.
17. Cherry DK, Hing E, Woodwell DA, Rechtsteiner EA. National Ambulatory Medical Care Survey: 2006 summary. National health statistics reports; no 3. Hyattsville, MD: National Center for Health Statistics. 2008. Available from: www.cdc.gov/nchs/data/nhsr/nhsr003.pdf.
18. Schappert SM, Rechtsteiner EA. Ambulatory medical care utilization estimates for 2006. National health statistics reports; no 8. Hyattsville, MD: National Center for Health Statistics. 2008. Available from: www.cdc.gov/nchs/data/nhsr/nhsr008.pdf.
19. Verispan LLC. Healthcare Market Index, Updated May 15, 2005. Hospital Market Profiling Solution, Second Quarter, 2005.
20. Verispan LLC. Freestanding Outpatient Surgery Centers Database. Chicago: Healthcare Information Specialists. 2005.
21. Centers for Medicare and Medicaid Services. Provider of Services File. Baltimore, MD. 2005.
22. McLemore T, Lawrence L. Plan and Operation of the National Survey of Ambulatory Surgery. National Center for Health Statistics. Vital and Health Stat 1(37). 1997.
23. U.S. Department of Health and Human Services. National Center for Health Statistics, Centers for Medicare and Medicaid Services. International Classification of Diseases, Ninth Revision, Clinical Modification. Washington: Public Health Service. 2004.
24. Research Triangle Institute. SUDAAN User's Manual, Release 9.0.1. Research Triangle Park, NC: Research Triangle Institute. 2005.

Table 1. Characteristics of the 2006 National Survey of Ambulatory Surgery facility respondents and nonrespondents: United States

Facility characteristic	Number of sampled in-scope facilities	Total percent distribution (weighted)	Responding facility percent distribution (weighted)	Nonresponding facility percent distribution (weighted)	Weighted response rate	Standard error
All facilities	587	100.0	100.0	100.0	83.7	2.6
Facility type						
Hospital based	189	49.9	51.2	43.1	85.9	3.8
Freestanding	398	50.1	48.8	56.9	81.5	3.3
Geographic region						
Northeast	90	11.7	12.5	8.2	88.7	4.5
Midwest	126	24.1	23.7	25.9	82.5	6.8
South	222	40.4	41.8	33.2	86.6	3.6
West	149	23.7	22.0	32.8	77.5	5.2
Metropolitan status[1]						
Metropolitan statistical area	521	73.1	70.1	88.6	80.3	2.9
Nonmetropolitan statistical area	66	26.9	29.9	11.4	93.1	3.7
Growth area[2]						
Below 7.8% growth	209	43.3	46.1	29.3	89.0	3.5
Above 7.8% growth	378	56.7	53.9	70.7	80.0	3.4
Poverty status of area[2]						
Below 13.1% in poverty	337	51.9	52.1	51.3	83.9	3.1
Above 13.1% in poverty	250	48.1	47.9	48.7	83.5	4.2
Primary care shortage area[2]						
Nonshortage area	99	22.5	24.3	13.7	90.1	5.0
Shortage area	488	77.5	75.7	86.3	81.8	3.1

[1]Distribution between respondents and nonrespondents is significantly different ($p < 0.05$).
[2]Based on the Area Resource File value for the county in which the facility is located. Growth is based on the population difference between 2006 and 1996. Poverty is based on the percentage of population below the poverty level. Shortage area includes full or partial shortage area for primary care physicians.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 2. Number, percent distribution, and rate of ambulatory surgery visits and all-listed procedures, by facility characteristics and sex: United States, 2006

Characteristic	Both sexes		Male		Female	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
			Number in thousands			
Total visits	34,738	1,829	14,707	781	20,032	1,072
Facility type						
Hospital based	19,869	880	8,491	395	11,379	518
Freestanding	14,869	1,603	6,216	674	8,653	939
Region						
Northeast	5,298	645	2,248	273	3,051	385
Midwest	8,047	610	3,378	272	4,669	355
South	15,931	1,540	6,749	656	9,182	897
West	5,462	427	2,331	179	3,130	266
Metropolitan status						
Metropolitan statistical area	29,715	1,943	12,566	825	17,149	1,138
Nonmetropolitan statistical area	5,024	937	2,140	407	2,883	537
			Percent distribution			
Total visits	100.0	...	100.0	...	100.0	...
Facility type						
Hospital based	57.2	2.9	57.7	2.9	56.8	2.9
Freestanding	42.8	2.9	42.3	2.9	43.2	2.9
Region						
Northeast	15.3	1.7	15.3	1.7	15.2	1.8
Midwest	23.2	1.8	23.0	1.8	23.3	1.8
South	45.9	2.7	45.9	2.8	45.8	2.8
West	15.7	1.3	15.9	1.3	15.6	1.4
Metropolitan status						
Metropolitan statistical area	85.5	2.7	85.4	2.8	85.6	2.7
Nonmetropolitan statistical area	14.5	2.7	14.6	2.8	14.4	2.7
			Rate per 1,000 population[1]			
Total visits	116.5	6.1	100.4	5.3	132.0	7.1
Facility type						
Hospital based	66.6	3.0	58.0	2.7	75.0	3.4
Freestanding	49.9	5.4	42.4	4.6	57.0	6.2
Region						
Northeast	96.9	11.8	84.6	10.3	108.5	13.7
Midwest	121.7	9.2	103.8	8.3	139.0	10.6
South	147.0	14.2	127.3	12.4	165.7	16.2
West	79.2	6.2	67.8	5.2	90.5	7.7
Metropolitan status						
Metropolitan statistical area	119.3	7.8	102.7	6.7	135.5	9.0
Nonmetropolitan statistical area	99.6	18.6	85.3	16.2	113.8	21.2

See footnotes at end of table.

Table 2. Number, percent distribution, and rate of ambulatory surgery visits and all-listed procedures, by facility characteristics and sex: United States, 2006—Con.

Characteristic	Both sexes		Male		Female	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
			Number in thousands			
Total procedures	53,329	2,654	22,681	1,138	30,648	1,575
Facility type						
Hospital based	30,761	1,276	13,286	593	17,475	751
Freestanding	22,568	2,328	9,395	971	13,173	1,385
Region						
Northeast	8,018	898	3,486	392	4,532	530
Midwest	12,575	904	5,321	412	7,254	532
South	24,023	2,224	10,143	939	13,879	1,316
West	8,713	690	3,730	299	4,983	430
Metropolitan status						
Metropolitan statistical area	45,691	2,853	19,399	1,213	26,292	1,686
Nonmetropolitan statistical area	7,638	1,387	3,282	613	4,356	791
			Percent distribution			
Total procedures	100.0	. . .	100.0	. . .	100.0	. . .
Facility type						
Hospital based	57.7	2.7	58.6	2.7	57.0	2.8
Freestanding	42.3	2.7	41.4	2.7	43.0	2.8
Region						
Northeast	15.0	1.6	15.4	1.6	14.8	1.6
Midwest	23.6	1.7	23.5	1.8	23.7	1.8
South	45.0	2.6	44.7	2.6	45.3	2.7
West	16.3	1.3	16.4	1.4	16.3	1.4
Metropolitan status						
Metropolitan statistical area	85.7	2.6	85.5	2.7	85.8	2.6
Nonmetropolitan statistical area	14.3	2.6	14.5	2.7	14.2	2.6
			Rate per 1,000 population[1]			
Total procedures	178.8	8.9	154.8	7.8	202.0	10.4
Facility type						
Hospital based	101.3	4.3	89.4	4.0	112.7	4.9
Freestanding	77.5	7.8	65.4	6.6	89.3	9.1
Region						
Northeast	146.6	16.4	131.3	14.7	161.1	18.8
Midwest	190.2	13.7	163.5	12.7	215.9	15.8
South	221.6	20.5	191.3	17.7	250.5	23.8
West	126.3	10.0	108.4	8.7	144.0	12.4
Metropolitan status						
Metropolitan statistical area	183.5	11.5	158.5	9.9	207.7	13.3
Nonmetropolitan statistical area	151.5	27.5	130.8	24.4	172.0	31.2

. . . Category not applicable.

[1]Rates were calculated using U.S. Census Bureau 2000-based postcensal estimates of the civilian population as of July 1, 2006.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 3. Number of ambulatory surgery visits by disposition and principal expected source of payment: United States, 2006

Characteristic	Estimate	Standard error	Percent distribution	Standard error
		Number in thousands		
All visits	34,738	1,829	100	. . .
Disposition of patient				
Routine[1]	32,356	1,792	93.1	0.9
Observation status	401	66	1.2	0.2
Inpatient admission	287	43	0.8	0.1
Surgery cancelled	79	19	0.2	0.1
Not stated	944	174	2.7	0.5
Other	*	*	*	*
Principal expected source of payment				
Private insurance	18,070	1,045	53.0	1.2
Medicare	10,996	660	32.2	0.9
Medicaid	2,204	189	6.5	0.5
Workers compensation	627	101	1.8	0.3
Other government insurance	309	63	0.9	0.2
Self pay	1,131	185	3.3	0.5
Other	783	170	2.3	0.5

. . . Category not applicable.
* Figure does not meet standards of reliability or precision.
[1]Patients with routine disposition were those who were discharged to their normal place of residence, i.e., home, nursing home, or prison.
SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 4. Distribution of times for surgical visits by ambulatory surgery facility type: United States, 2006

Calculated time in minutes	Mean	Standard error	25th percentile	Median	75th percentile
			Total		
Total[1]	124.5	3.6	65	100	153
Operating room[2]	53.7	1.4	25	40	65
Surgical[3]	30.3	0.8	11	20	36
Postoperative room[4]	66.9	2.0	32	51	81
			Hospital based		
Total[1]	146.6	5.3	84	120	177
Operating room[2]	61.7	1.6	33	50	75
Surgical[3]	34.2	0.9	13	24	43
Postoperative room[4]	79.0	3.2	25	39	60
			Freestanding		
Total[1]	97.7	3.8	53	76	120
Operating room[2]	43.2	2.0	20	30	50
Surgical[3]	25.1	1.4	9	15	27
Postoperative room[4]	53.1	2.3	29	43	66

[1]Total time was calculated by subtracting the time when the patient entered the operating room from the time the patient left postoperative care.
[2]Operating room time was calculated by subtracting the time when the patient entered the operating room from the time the patient left the operating room.
[3]Surgical time was calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.
[4]Postoperative room time was calculated by subtracting the time when the patient entered postoperative care from the time the patient left postoperative care.
SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 5. Average surgical duration by selected diagnoses and ambulatory surgery facility type: United States, 2006

Selected diagnoses and ICD–9–CM codes	Average total time (in minutes)[1]	Standard error	Average surgical time (in minutes)[2]	Standard error
		Total		
Cataract .366	70.2	2.7	18.1	0.7
Benign neoplasm of the colon .211.3	90.3	4.1	21.8	0.7
Diverticula of the intestine .562	79.5	4.2	16.9	0.7
Intervertebral disc disorders .722	82.9	7.2	21.1	3.0
Hemorrhoids .455	86.7	4.0	18.2	0.9
Gastritis and duodenitis .535	91.0	6.5	14.2	1.3
Chronic diseases of tonsils and adenoids .474	155.2	7.9	22.5	1.0
Otitis media and Eustachian tube disorders .381–382	65.7	5.1	12.3	1.0
Carpal tunnel syndrome .354.0	96.0	3.6	18.2	0.9
Inguinal hernia .550	169.0	6.4	49.4	1.6
		Hospital based		
Cataract .366	88.4	3.7	22.7	1.5
Benign neoplasm of the colon .211.3	111.5	7.5	24.6	1.4
Diverticula of the intestine .562	102.7	5.0	19.0	1.7
Intervertebral disc disorders .722	107.4	14.8	29.9	5.4
Hemorrhoids .455	112.0	6.6	20.7	1.3
Gastritis and duodenitis .535	111.4	7.8	17.9	1.7
Chronic diseases of tonsils and adenoids .474	161.6	11.0	23.4	1.5
Otitis media and Eustachian tube disorders .381–382	75.0	4.9	13.5	1.4
Carpal tunnel syndrome .354.0	111.2	5.6	19.1	1.1
Inguinal hernia .550	177.2	7.2	52.0	1.8
		Freestanding		
Cataract .366	57.3	2.4	14.9	0.5
Benign neoplasm of the colon .211.3	77.9	3.0	20.0	0.7
Diverticula of the intestine .562	68.3	4.0	15.9	0.7
Intervertebral disc disorders .722	61.4	5.3	12.8	2.2
Hemorrhoids .455	75.1	4.0	16.9	1.3
Gastritis and duodenitis .535	68.9	6.6	10.0	1.0
Chronic diseases of tonsils and adenoids .474	148.9	10.2	20.6	0.9
Otitis media and Eustachian tube disorders .381–382	56.8	5.8	10.2	0.6
Carpal tunnel syndrome .354.0	83.8	3.2	17.1	1.3
Inguinal hernia .550	145.8	7.7	40.1	2.3

[1]Total time was calculated by subtracting the time when the patient entered the operating room from the time the patient left postoperative care.

[2]Surgical time was calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 6. Number of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006

Procedure category and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Number in thousands							
All procedures	53,329	22,681	30,648	3,266	12,780	20,167	9,182	7,934
Operations on the nervous system .01–05	3,198	1,272	1,926	*	888	1,385	427	484
Injection of agent into spinal canal .03.91–03.92	1,991	844	1,147	*	533	835	286	336
Release of carpal tunnel .04.43	577	179	398	*	143	279	73	81
Operations on the eye .08–16	7,085	2,803	4,283	103	266	1,651	2,289	2,775
Operations on eyelids .08	386	137	249	*29	39	156	75	87
Extraction of lens .13.1–13.6	3,058	1,154	1,904	*	38	610	1,070	1,335
Insertion of prosthetic lens (pseudophakos) .13.7	2,582	987	1,595	*	33	524	923	1,098
Operations on the ear .18–20	1,114	568	545	858	118	59	*38	41
Myringotomy with insertion of tube .20.01	715	382	333	667	*32	*	*	*
Operations on the nose, mouth, and pharynx .21–29	2,864	1,441	1,423	1,050	937	617	162	97
Incision, excision, and destruction of nose .21.1,21.3–21.4,21.6	293	142	151	*	144	77	*34	*18
Turbinectomy .21.6	196	100	96	*	110	54	*	*
Repair and plastic operations on the nose .21.8	308	160	147	*	153	100	*27	*
Operations on nasal sinuses .22	606	328	278	*	222	276	*	*
Tonsillectomy with or without adenoidectomy .28.2–28.3	737	314	423	530	186	*	*	–
Adenoidectomy without tonsillectomy .28.6	140	83	57	132	*	*	–	–
Operations on the respiratory system .30–34	445	225	220	*34	70	176	88	*77
Bronchoscopy with or without biopsy .33.21–33.24,33.27	173	71	102	*	*	*67	*43	*
Operations on the cardiovascular system .35–39,00.50–00.51,00.53–00.55,00.61–00.66	1,376	712	664	*	165	605	284	312
Cardiac catheterization .37.21–37.23	492	280	212	*	*41	238	123	88
Operations on the digestive system .42–54	14,414	6,500	7,914	*	2,824	6,448	2,925	1,956
Dilation of esophagus .42.92	341	140	201	*	*37	152	83	66
Endoscopy of small intestine with or without biopsy .45.11–45.14,45.16	3,467	1,423	2,044	*	770	1,390	648	550
Endoscopy of large intestine with or without biopsy .45.21–45.25	5,741	2,438	3,304	*	779	2,921	1,233	778
Endoscopic polypectomy of large intestine .45.42	1,399	788	611	*	69	701	424	207
Laparoscopic cholecystectomy .51.23	503	87	416	*	229	193	*	*
Hernia repair .53.0–53.1,53.2–53.9	920	724	196	73	298	331	133	84
Repair of inguinal hernia .53.0–53.1	526	482	*45	39	139	186	88	74
Operations on the urinary system .55–59	1,776	932	844	*	375	624	369	356
Cystoscopy with or without biopsy .57.31–57.33	751	406	345	*	147	271	157	169
Operations on the male genital organs .60–64	631	631	...	166	146	143	109	67
Operations on the female genital organs .65–71	2,497	...	2,497	*	1,633	689	109	*60
Hysteroscopy .68.12	313	...	313	–	159	121	*	*
Dilation and currettage of uterus .69.0	611	...	611	–	334	227	*29	*
Operations on the musculoskeletal system .76–84,00.70–00.73,00.80–00.84	7,944	3,856	4,088	295	2,602	3,696	871	479
Partial excision of bone .76.2–76.3,77.6–77.8	449	231	218	*	121	228	57	*31
Reduction of fracture .76.7,79.0–79.3	495	310	185	102	213	115	*35	*29
Injection of therapeutic substance into joint or ligament .76.96,81.92	218	87	131	*	45	112	32	*26
Removal of implanted devices from bone .76.97,78.6	212	108	104	27	85	58	*	*
Excision and repair of bunion and other toe deformities .77.5	461	68	394	*	115	226	83	*30
Arthroscopy of knee .80.26	956	502	455	*	358	448	103	*32
Excision of semilunar cartilage of knee .80.6	690	384	307	*	204	352	90	*42
Replacement or other repair of knee .81.42–81.47,81.54–81.55,00.80–00.84	463	260	203	*	216	190	*35	*
Operations on muscle, tendon, fascia, and bursa .82–83	1,465	642	823	55	403	755	165	88

See footnotes at end of table.

Table 6. Number of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Number in thousands							
Operations on the integumentary system 85–86	3,581	1,045	2,535	166	1,223	1,415	435	341
Biopsy of breast 85.11–85.12	261	*	250	*	79	130	*28	*
Local excision of lesion of breast (lumpectomy) 85.21	329	*	317	*	110	133	*52	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue 86.2–86.4	1,092	542	550	100	332	395	139	127
Miscellaneous diagnostic and therapeutic procedures and new technologies[1] 87–99,00	6,060	2,617	3,442	242	1,456	2,517	999	846
Arteriography and angiocardiography using contrast material 88.4–88.5	1,054	561	492	–	*74	471	297	213
Diagnostic ultrasound 88.7,00.21–00.25,00.28,00.29	322	159	162	*	53	147	70	50
Injection or infusion of therapeutic or prophylactic substance 99.1–99.2	1,462	529	933	35	429	599	202	196
Operations on the endocrine system, operations on the hemic and lymphatic system, and obstetrical procedures 06–07,40–41,72–75	344	78	266	*	77	140	*78	*41

* Figure does not meet standards of reliability or precision.

. . . Category not applicable.

– Quantity zero.

[1]Chapter 00 codes included in this category: 00.01–00.03, 00.09, 00.10–00.18, 00.21–00.25, 00.28–00.29, 00.31–00.35, 00.39, 00.40–00.43, 00.45–00.48, 00.52, 00.74–00.76, and 00.91–00.93.

NOTES: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM). The standard error (SE) of an estimate can be obtained by multiplying the estimate by the corresponding relative standard error (RSE). The RSE can be obtained by dividing the SE of the rate by the rate in Table 7.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 7. Rate and standard error for the rate of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006

Procedure category and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Rate per 10,000 population[1]							
All procedures	1,788.3	1,548.1	2,020.2	537.5	1,019.2	2,695.9	4,854.0	4,325.3
Operations on the nervous system .01–05	107.2	86.9	126.9	*	70.8	185.2	225.7	263.8
Injection of agent into spinal canal .03.91–03.92	66.8	57.6	75.6	*	42.5	111.6	151.3	183.4
Release of carpal tunnel .04.43	19.3	12.2	26.2	*	11.4	37.3	38.7	44.2
Operations on the eye .08–16	237.6	191.3	282.3	17.0	21.2	220.8	1,210.0	1,513.0
Operations on eyelids .08	12.9	9.4	16.4	*4.7	3.1	20.9	39.6	47.5
Extraction of lens .13.1–13.6	102.5	78.8	125.5	*	3.0	81.6	565.7	727.6
Insertion of prosthetic lens (pseudophakos) .13.7	86.6	67.4	105.2	*	2.6	70.1	488.2	598.7
Operations on the ear .18–20	37.3	38.8	35.9	141.2	9.4	7.9	*20.2	22.3
Myringotomy with insertion of tube .20.01	24.0	26.1	21.9	109.7	*2.6	*	*	*
Operations on the nose, mouth, and pharynx .21–29	96.0	98.3	93.8	172.9	74.7	82.5	85.8	53.1
Incision, excision, and destruction of nose .21.1,21.3–21.4,21.6	9.8	9.7	9.9	*	11.5	10.3	*18.1	*9.6
Turbinectomy .21.6	6.6	6.8	6.4	*	8.8	7.2	*	*
Repair and plastic operations on the nose .21.8	10.3	11.0	9.7	*	12.2	13.3	*14.4	*
Operations on nasal sinuses .22	20.3	22.4	18.3	*	17.7	36.9	*	*
Tonsillectomy with or without adenoidectomy .28.2–28.3	24.7	21.4	27.9	87.2	14.9	*	*	–
Adenoidectomy without tonsillectomy .28.6	4.7	5.6	3.8	21.8	*	*	–	–
Operations on the respiratory system .30–34	14.9	15.4	14.5	*5.6	5.6	23.6	46.3	*42.1
Bronchoscopy with or without biopsy .33.21–33.24,33.27	5.8	4.8	6.8	*	*	*9.0	*22.7	*
Operations on the cardiovascular system .35–39,00.50–00.51,00.53–00.55,00.61–00.66	46.1	48.6	43.8	*	13.2	80.9	150.0	169.9
Cardiac catheterization .37.21–37.23	16.5	19.1	14.0	*	*3.2	31.9	65.0	48.0
Operations on the digestive system .42–54	483.3	443.7	521.7	*	225.2	861.9	1,546.3	1,066.2
Dilation of esophagus .42.92	11.4	9.6	13.2	*	*3.0	20.4	43.7	35.8
Endoscopy of small intestine with or without biopsy .45.11–45.14,45.16	116.3	97.1	134.7	*	61.4	185.9	342.6	299.6
Endoscopy of large intestine with or without biopsy .45.21–45.25	192.5	166.4	217.8	*	62.1	390.4	651.6	424.3
Endoscopic polypectomy of large intestine .45.42	46.9	53.8	40.3	*	5.5	93.7	223.9	112.6
Laparoscopic cholecystectomy .51.23	16.9	5.9	27.4	*	18.2	25.9	*	*
Hernia repair .53.0–53.1,53.2–53.9	30.9	49.4	12.9	11.9	23.8	44.3	70.6	46.0
Repair of inguinal hernia .53.0–53.1	17.7	32.9	*2.9	6.5	11.1	24.9	46.6	40.2
Operations on the urinary system .55–59	59.6	63.6	55.7	*	29.9	83.5	195.3	194.1
Cystoscopy with or without biopsy .57.31–57.33	25.2	27.7	22.7	*	11.7	36.2	83.1	92.2
Operations on the male genital organs .60–64	21.2	43.1	. . .	27.4	11.6	19.2	57.4	36.7
Operations on the female genital organs .65–71	83.7	. . .	164.6	*	130.2	92.1	57.4	*32.7
Hysteroscopy .68.12	10.5	. . .	20.7	–	12.7	16.2	*	*
Dilation and currettage of uterus .69.0	20.5	. . .	40.2	–	26.7	30.3	*15.4	*
Operations on the musculoskeletal system .76–84,00.70–00.73,00.80–00.84	266.4	263.2	269.5	48.6	207.5	494.1	460.5	261.3
Partial excision of bone .76.2–76.3,77.6–77.8	15.1	15.8	14.4	*	9.6	30.5	29.9	*17.0
Reduction of fracture .76.7,79.0–79.3	16.6	21.2	12.2	16.8	17.0	15.4	*18.5	*16.0
Injection of therapeutic substance into joint or ligament .76.96,81.92	7.3	5.9	8.6	*	3.6	14.9	16.9	*14.2
Removal of implanted devices from bone .76.97,78.6	7.1	7.3	6.9	4.4	6.8	7.7	*	*
Excision and repair of bunion and other toe deformities .77.5	15.5	4.6	26.0	*	9.1	30.3	44.1	*16.5
Arthroscopy of knee .80.26	32.1	34.2	30.0	*	28.5	59.9	54.3	*17.7
Excision of semilunar cartilage of knee .80.6	23.1	26.2	20.2	*	16.3	47.1	47.8	*22.8
Replacement or other repair of knee .81.42–81.47,81.54–81.55,00.80–00.84	15.5	17.7	13.4	*	17.2	25.4	*18.6	*
Operations on muscle, tendon, fascia, and bursa .82–83	49.1	43.8	54.2	9.0	32.1	100.9	87.3	47.8

See footnotes at end of table.

Table 7. Rate and standard error for the rate of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
				Rate per 10,000 population[1]				
Operations on the integumentary system .85–86	120.1	71.3	167.1	27.3	97.5	189.2	229.9	186.1
Biopsy of breast .85.11–85.12	8.8	*	16.5	*	6.3	17.4	*14.7	*
Local excision of lesion of breast (lumpectomy) .85.21	11.0	*	20.9	*	8.8	17.8	*27.4	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue .86.2–86.4	36.6	37.0	36.3	16.4	26.5	52.8	73.4	69.2
Miscellaneous diagnostic and therapeutic procedures and new technologies[2] .87–99,00	203.2	178.6	226.9	39.8	116.1	336.4	528.1	461.4
Arteriography and angiocardiography using contrast material .88.4–88.5	35.3	38.3	32.5	–	*5.9	62.9	156.8	116.0
Diagnostic ultrasound .88.7,00.21–00.25,00.28,00.29	10.8	10.9	10.7	*	4.2	19.7	36.8	27.5
Injection or infusion of therapeutic or prophylactic substance .99.1–99.2	49.0	36.1	61.5	5.7	34.2	80.1	107.0	107.0
Operations on the endocrine system, operations on the hemic and lymphatic system, and obstetrical procedures .06–07,40–41,72–75	11.5	5.3	17.5	*	6.1	18.7	*41.2	*22.5
				Standard error				
All procedures	89.00	77.65	103.83	72.44	57.38	148.54	286.03	231.38
Operations on the nervous system .01–05	11.32	10.57	12.94	*	9.57	19.50	27.43	37.71
Injection of agent into spinal canal .03.91–03.92	8.97	8.72	10.01	*	7.31	15.38	23.29	29.95
Release of carpal tunnel .04.43	2.07	1.55	2.99	*	1.95	5.05	6.50	9.35
Operations on the eye .08–16	21.50	16.25	27.63	3.06	3.11	21.09	142.35	134.99
Operations on eyelids .08	1.36	1.33	1.95	*1.30	0.58	3.23	6.31	8.37
Extraction of lens .13.1–13.6	10.02	7.09	13.29	*	0.54	9.41	67.74	67.42
Insertion of prosthetic lens (pseudophakos) .13.7	9.02	6.28	12.08	*	0.49	8.58	63.85	57.88
Operations on the ear .18–20	6.87	6.09	8.04	30.27	1.87	1.43	*5.08	6.62
Myringotomy with insertion of tube .20.01	5.20	5.28	5.41	25.32	*0.73	*	*	*
Operations on the nose, mouth, and pharynx .21–29	10.76	10.54	12.78	25.76	8.67	12.86	16.80	10.80
Incision, excision, and destruction of nose .21.1,21.3–21.4,21.6	1.28	1.34	1.83	*	2.14	1.63	*4.72	*2.33
Turbinectomy .21.6	0.95	1.14	1.23	*	1.45	1.35	*	*
Repair and plastic operations on the nose .21.8	1.17	1.58	1.24	*	1.66	2.12	*3.82	*
Operations on nasal sinuses .22	3.27	3.64	4.08	*	3.36	9.02	*	*
Tonsillectomy with or without adenoidectomy .28.2–28.3	4.15	3.52	5.17	16.93	2.15	*	*	–
Adenoidectomy without tonsillectomy .28.6	0.99	1.41	0.86	4.79	*	*	–	–
Operations on the respiratory system .30–34	1.98	2.17	2.48	*1.45	1.31	4.51	9.96	*8.10
Bronchoscopy with or without biopsy .33.21–33.24,33.27	0.97	0.78	1.63	*	*	*2.32	*6.07	*
Operations on the cardiovascular system .35–39,00.50–00.51,00.53–00.55,00.61–00.66	5.69	6.51	5.44	*	2.05	11.89	23.17	24.91
Cardiac catheterization .37.21–37.23	2.51	3.07	2.24	*	*0.84	5.78	12.17	11.18
Operations on the digestive system .42–54	41.17	39.15	44.18	*	20.69	77.38	158.44	94.26
Dilation of esophagus .42.92	1.63	1.55	2.14	*	*0.80	3.45	9.02	7.33
Endoscopy of small intestine with or without biopsy .45.11–45.14,45.16	10.46	9.45	12.04	*	7.33	18.77	32.51	29.46
Endoscopy of large intestine with or without biopsy .45.21–45.25	21.68	19.32	24.41	*	10.15	43.49	87.41	46.99
Endoscopic polypectomy of large intestine .45.42	5.76	6.72	5.30	*	1.25	11.00	36.55	14.02
Laparoscopic cholecystectomy .51.23	1.51	0.84	2.79	*	2.25	2.98	*	*
Hernia repair .53.0–53.1,53.2–53.9	2.42	4.22	1.29	2.58	2.20	4.99	10.61	7.07
Repair of inguinal hernia .53.0–53.1	1.48	2.87	*0.56	1.17	1.39	2.93	8.53	6.97
Operations on the urinary system .55–59	4.82	5.39	5.38	*	3.99	9.10	24.40	20.98
Cystoscopy with or without biopsy .57.31–57.33	2.95	3.40	3.05	*	2.29	4.82	12.46	12.97
Operations on the male genital organs .60–64	1.87	3.81	. . .	5.07	1.35	3.06	8.85	6.77
Operations on the female genital organs .65–71	7.20	. . .	14.15	*	11.67	9.85	11.27	*8.52
Hysteroscopy .68.12	1.60	. . .	3.14	–	2.37	2.54	*	*
Dilation and currettage of uterus .69.0	2.17	. . .	4.27	–	3.07	4.00	*3.48	*

See footnotes at end of table.

Table 7. Rate and standard error for the rate of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Standard error							
Operations on the musculoskeletal system .76–84,00.70–00.73,00.80–00.84	19.47	21.20	20.32	5.85	19.10	38.44	48.77	24.82
Partial excision of bone .76.2–76.3,77.6–77.8	1.45	1.92	1.59	*	1.33	3.98	5.48	*3.78
Reduction of fracture .76.7,79.0–79.3	1.68	2.44	1.37	2.21	2.28	2.67	*4.88	*3.33
Injection of therapeutic substance into joint or ligament .76.96,81.92	0.87	1.00	1.16	*	0.78	2.26	3.20	*3.27
Removal of implanted devices from bone .76.97,78.6	0.94	1.29	1.01	1.20	1.27	1.17	*	*
Excision and repair of bunion and other toe deformities .77.5	1.79	0.84	3.30	*	1.69	4.23	8.82	*4.01
Arthroscopy of knee .80.26	3.72	4.43	3.69	*	3.98	7.18	9.35	*4.45
Excision of semilunar cartilage of knee .80.6	1.99	2.86	1.80	*	1.88	4.51	6.94	*4.92
Replacement or other repair of knee .81.42–81.47,81.54–81.55,00.80–00.84	1.97	2.81	1.64	*	2.86	3.28	*3.95	*
Operations on muscle, tendon, fascia, and bursa .82–83	5.22	3.37	8.29	1.75	4.43	12.84	13.25	7.76
Operations on the integumentary system .85–86	8.53	6.42	13.24	3.92	9.50	14.66	20.62	19.98
Biopsy of breast .85.11–85.12	1.26	*	2.43	*	1.23	2.93	*3.56	*
Local excision of lesion of breast (lumpectomy) .85.21	1.17	*	2.29	*	1.45	2.22	*6.37	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue .86.2–86.4	3.20	3.92	3.33	2.57	3.24	5.25	13.11	10.15
Miscellaneous diagnostic and therapeutic procedures and new technologies[2] .87–99,00	16.60	15.67	19.36	5.56	14.75	30.74	48.83	47.14
Arteriography and angiocardiography using contrast material .88.4–88.5	5.40	6.50	4.91	–	*1.61	10.60	27.50	25.38
Diagnostic ultrasound .88.7,00.21–00.25,00.28,00.29	1.76	1.79	2.12	*	0.95	3.86	8.70	6.49
Injection or infusion of therapeutic or prophylactic substance .99.1–99.2	7.20	4.86	10.46	1.09	7.30	13.78	16.48	13.21
Operations on the endocrine system, operations on the hemic and lymphatic system, and obstetrical procedures .06–07,40–41,72–75	1.16	0.77	1.98	*	1.07	2.53	*7.97	*5.08

* Figure does not meet standards of reliability or precision.

– Quantity zero.

. . . Category not applicable.

[1]Rates were calculated using U.S. Census Bureau 2000-based postcensal estimates of the civilian population as of July 1, 2006.

[2]Chapter 00 codes included in this category: 00.01–00.03, 00.09, 00.10–00.18, 00.21–00.25, 00.28–00.29, 00.31–00.35, 00.39, 00.40–00.43, 00.45–00.48, 00.52, 00.74–00.76, 00.91–00.93.

NOTES: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM). The relative standard error (RSE) can be obtained by dividing the standard error (SE) of the rate by the rate. The SE of a number in Table 6 can be obtained by multiplying the RSE by the estimate.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 8. Number of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006

Category of first-listed diagnosis and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Number in thousands							
All conditions	34,738	14,707	20,032	2,471	8,351	12,948	5,887	5,081
Infectious and parasitic diseases .001–139	145	64	81	*	*	*42	*	*
Neoplasms .140–239	3,285	1,626	1,659	69	381	1,474	772	589
Malignant neoplasms .140–208,230–234	1,173	534	639	*	117	446	285	314
Malignant neoplasm of skin .172–173,176.0,198.2	303	164	139	*	34	87	59	123
Malignant neoplasm of breast .174–175,198.81	235	*	234	–	*35	121	*52	*
Benign neoplasms .210–229	2,000	1,039	961	53	241	985	468	253
Benign neoplasm of colon .211.3	1,389	785	604	–	90	730	380	189
Lipoma .214	126	61	64	*	*23	76	*	*
Endocrine, nutritional and metabolic diseases, and immunity disorders .240–279	266	74	192	*	91	103	*34	*
Diseases of the nervous system and sense organs .320–389	5,308	2,114	3,194	729	412	1,243	1,317	1,607
Carpal tunnel syndrome .354.0	552	171	381	–	138	263	66	86
Cataract .366	3,009	1,135	1,874	*	34	592	1,066	1,313
Disorders of the eyelid .373–374	174	71	103	*	*12	58	45	48
Otitis media and Eustachian tube disorders .381–382	623	324	299	577	*	*	*	*
Diseases of the circulatory system .390–459	1,736	832	904	*	256	860	353	264
Heart disease .391–392.0,393–398,402,404,410–416,420–429	540	318	222	*	*41	241	131	128
Hemorrhoids .455	715	287	427	*	151	411	108	*45
Diseases of the respiratory system .460–519	1,294	591	703	572	396	207	81	*38
Deviated nasal septum .470	134	77	57	*	75	42	*	*
Chronic sinusitis .473	141	82	59	*	52	56	*	*
Chronic disease of tonsils and adenoids .474	680	273	407	496	172	*	–	–
Diseases of the digestive system .520–579	6,808	3,081	3,727	326	1,597	2,688	1,242	955
Diseases of teeth and supporting structures .520–525	221	114	107	171	*	*	*	*
Diseases of esophagus .530	1,132	531	601	*	255	447	224	177
Gastritis and duodenitis .535	703	228	475	*	170	257	146	118
Hernia .550–553	1,141	764	377	64	335	418	174	149
Inguinal hernia .550	515	470	*45	33	131	189	91	71
Noninfectious enteritis and colitis .555–558	228	102	126	*	81	87	*34	*
Diverticula of intestine .562	1,135	513	622	*	*59	522	306	248
Cholelithiasis .574	376	*64	312	*	178	130	*	*
Diseases of the genitourinary system .580–629	2,932	847	2,085	115	1,143	1,050	358	267
Calculus of kidney and ureter .592	381	178	204	*	144	165	*40	*31
Benign mammary dysplasias .610	94	–	94	–	*35	*45	*	*
Lump or mass in breast .611.72	198	*	191	*	83	85	*	*
Disorders of menstruation and other abnormal vaginal bleeding .626,627.0–627.1	481	. . .	481	–	250	201	*	*
Complications of pregnancy, childbirth, and the puerperium .630–677	322	. . .	322	–	315	*	–	–
Abortion and ectopic and molar pregnancy .630–639	260	. . .	260	–	253	*	–	–
Diseases of the skin and subcutaneous tissue .680–709	631	292	339	56	224	233	*	49
Sebaceous cyst .706.2	134	69	65	*	*44	53	*	*
Diseases of the musculoskeletal system and connective tissue .710–739	4,523	1,875	2,648	67	1,336	2,035	599	486
Arthropathies and related disorders .710–719	809	378	431	*	276	378	89	52
Internal derangement of knee .717	321	177	144	*	116	150	*33	*
Intervertebral disc disorders .722	861	404	456	–	312	389	93	67
Lumbago .724.2	156	64	91	–	35	57	31	33
Rheumatism, excluding back .725–729	968	382	586	*26	287	484	114	57
Acquired deformities of toe .735	287	58	229	*	74	121	61	*28

See footnotes at end of table.

Table 8. Number of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006—Con.

Category of first-listed diagnosis and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
Congenital anomalies .740–759	479	184	*	132	126	*	*	*
Symptoms, signs, and ill-defined conditions .780–799	1,390	548	842	*	403	520	185	147
Abdominal pain .789.0	167	51	116	*	53	71	*	*
Injury and poisoning .800–999	2,230	1,255	976	169	777	848	270	166
Fractures .800–829	513	321	192	102	237	107	*32	*35
Current tear of medial cartilage or meniscus of knee .836.0	424	253	171	*	120	231	53	*20
Supplementary classifications .V01–V85	3,134	1,245	1,890	74	778	1,406	503	373
Visit for sterilization .V25.2	292	50	242	*	263	*	–	–
Diseases of the blood and blood-forming organs, mental disorders, and certain conditions originating in the perinatal period .280–289,290–319,760–779	255	80	174	*	*47	88	*47	*62
Anemias .280–285	189	*58	131	*	*	*61	*40	*62

* Figure does not meet standards of reliability or precision.

– Quantity zero.

. . . Category not applicable.

NOTES: Diagnostic categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM). The standard error (SE) of an estimate can be obtained by multiplying the estimate by the corresponding relative standard error (RSE). The RSE can be obtained by dividing the SE of the rate by the rate in Table 9.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 9. Rate and standard error for the rate of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006

Category of first-listed diagnosis and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Rate per 10,000 population[1]							
All conditions	1,164.9	1,003.8	1,320.4	406.7	666.0	1,731.0	3,111.9	2,769.8
Infectious and parasitic diseases .001–139	4.9	4.4	5.4	*	*	*5.6	*	*
Neoplasms .140–239	110.2	111.0	109.4	11.4	30.4	197.0	408.2	320.9
Malignant neoplasms .140–208,230–234	39.3	36.4	42.1	*	9.3	59.6	150.9	171.1
Malignant neoplasm of skin .172–173,176.0,198.2	10.2	11.2	9.2	*	2.7	11.6	31.2	67.0
Malignant neoplasm of breast .174–175,198.81	7.9	*	15.4	–	*2.8	16.1	*27.4	*
Benign neoplasms .210–229	67.1	70.9	63.3	8.7	19.2	131.7	247.3	137.7
Benign neoplasm of colon .211.3	46.6	53.6	39.8	–	7.1	97.6	200.9	103.1
Lipoma .214	4.2	4.2	4.2	*	*1.8	10.2	*	*
Endocrine, nutritional and metabolic diseases, and immunity disorders .240–279	8.9	5.1	12.7	*	7.3	13.8	*18.2	*
Diseases of the nervous system and sense organs .320–389	178.0	144.3	210.5	120.1	32.8	166.1	696.1	876.3
Carpal tunnel syndrome .354.0	18.5	11.7	25.1	–	11.0	35.1	35.1	46.6
Cataract .366	100.9	77.5	123.5	*	2.7	79.2	563.7	715.6
Disorders of the eyelid .373–374	5.8	4.8	6.8	*	*0.9	7.7	24.0	26.0
Otitis media and Eustachian tube disorders .381–382	20.9	22.1	19.7	95.0	*	*	*	*
Diseases of the circulatory system .390–459	58.2	56.8	59.6	*	20.4	115.0	186.8	144.1
Heart disease .391–392.0,393–398,402,404,410–416,420–429	18.1	21.7	14.7	*	*3.2	32.2	69.2	69.7
Hemorrhoids .455	24.0	19.6	28.2	*	12.0	54.9	57.1	*24.3
Diseases of the respiratory system .460–519	43.4	40.3	46.3	94.2	31.5	27.7	42.6	*20.9
Deviated nasal septum .470	4.5	5.3	3.8	*	6.0	5.6	*	*
Chronic sinusitis .473	4.7	5.6	3.9	*	4.1	7.5	*	*
Chronic disease of tonsils and adenoids .474	22.8	18.6	26.8	81.7	13.7	*	–	–
Diseases of the digestive system .520–579	228.3	210.3	245.7	53.6	127.4	359.3	656.7	520.6
Diseases of teeth and supporting structures .520–525	7.4	7.8	7.1	28.1	*	*	*	*
Diseases of esophagus .530	37.9	36.2	39.6	*	20.3	59.8	118.2	96.5
Gastritis and duodenitis .535	23.6	15.5	31.3	*	13.6	34.3	77.0	64.4
Hernia .550–553	38.3	52.1	24.9	10.6	26.7	55.8	92.2	81.4
Inguinal hernia .550	17.3	32.1	*3.0	5.4	10.5	25.3	48.0	38.9
Noninfectious enteritis and colitis .555–558	7.6	6.9	8.3	*	6.4	11.7	*18.2	*
Diverticula of intestine .562	38.1	35.0	41.0	*	*4.7	69.8	161.7	135.0
Cholelithiasis .574	12.6	*4.4	20.6	*	14.2	17.4	*	*
Diseases of the genitourinary system .580–629	98.3	57.8	137.4	18.9	91.1	140.4	189.1	145.5
Calculus of kidney and ureter .592	12.8	12.1	13.4	*	11.5	22.0	*21.2	*16.8
Benign mammary dysplasias .610	3.2	–	6.2	–	*2.8	*6.0	*	*
Lump or mass in breast .611.72	6.6	*	12.6	*	6.6	11.4	*	*
Disorders of menstruation and other abnormal vaginal bleeding .626,627.0–627.1	16.1	. . .	31.7	–	20.0	26.9	*	*
Complications of pregnancy, childbirth, and the puerperium .630–677	10.8	. . .	21.2	–	25.1	*	–	–
Abortion and ectopic and molar pregnancy .630–639	8.7	. . .	17.1	–	20.2	*	–	–
Diseases of the skin and subcutaneous tissue .680–709	21.2	19.9	22.3	9.3	17.9	31.2	*	27.0
Sebaceous cyst .706.2	4.5	4.7	4.3	*	*3.5	7.1	*	*
Diseases of the musculoskeletal system and connective tissue .710–739	151.7	128.0	174.6	11.0	106.5	272.1	316.9	264.7
Arthropathies and related disorders .710–719	27.1	25.8	28.4	*	22.0	50.6	46.9	28.3
Internal derangement of knee .717	10.8	12.1	9.5	*	9.2	20.0	*17.2	*
Intervertebral disc disorders .722	28.9	27.6	30.1	–	24.9	52.0	49.1	36.4
Lumbago .724.2	5.2	4.4	6.0	–	2.8	7.6	16.6	17.8
Rheumatism, excluding back .725–729	32.5	26.1	38.6	*4.2	22.9	64.7	60.5	31.1
Acquired deformities of toe .735	9.6	3.9	15.1	*	5.9	16.2	32.2	*15.5

See footnotes at end of table.

Table 9. Rate and standard error for the rate of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006—Con.

Category of first-listed diagnosis and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
				Rate per 10,000 population[1]				
Congenital anomalies .740–759	16.1	12.6	*	21.7	10.0	*	*	*
Symptoms, signs, and ill-defined conditions .780–799	46.6	37.4	55.5	*	32.2	69.5	97.7	80.3
Abdominal pain .789.0	5.6	3.5	7.7	*	4.2	9.4	*	*
Injury and poisoning .800–999	74.8	85.6	64.3	27.9	62.0	113.4	142.6	90.4
Fractures .800–829	17.2	21.9	12.7	16.8	18.9	14.3	*17.0	*19.1
Current tear of medial cartilage or meniscus of knee .836.0	14.2	17.3	11.3	*	9.5	30.9	28.0	*10.7
Supplementary classifications .V01–V85	105.1	84.9	124.6	12.2	62.1	187.9	265.9	203.4
Visit for sterilization .V25.2	9.8	3.4	16.0	*	20.9	*	–	–
Diseases of the blood and blood-forming organs, mental disorders, and certain conditions originating in the perinatal period .280–289,290–319,760–779	8.5	5.5	11.5	*	*3.8	11.8	*25.1	*33.8
Anemias .280–285	6.3	*4.0	8.6	*	*	*8.2	*21.1	*33.8
				Standard error				
All conditions	61.32	53.33	70.69	54.26	35.76	100.68	195.86	156.70
Infectious and parasitic diseases .001–139	0.90	0.85	1.24	*	*	*1.37	*	*
Neoplasms .140–239	7.96	8.89	7.90	1.94	2.75	16.81	39.52	25.97
Malignant neoplasms .140–208,230–234	2.76	3.20	3.01	*	1.22	5.11	15.04	18.58
Malignant neoplasm of skin .172–173,176.0,198.2	1.26	1.60	1.21	*	0.61	1.92	5.43	13.56
Malignant neoplasm of breast .174–175,198.81	0.77	*	1.52	–	*0.76	2.17	*5.07	*
Benign neoplasms .210–229	6.27	7.19	6.04	1.55	2.18	13.86	31.43	14.94
Benign neoplasm of colon .211.3	5.42	6.13	5.18	–	1.68	12.00	28.25	12.22
Lipoma .214	0.61	0.84	0.84	*	*0.46	1.93	*	*
Endocrine, nutritional and metabolic diseases, and immunity disorders .240–279	1.10	0.84	1.76	*	1.38	2.07	*4.00	*
Diseases of the nervous system and sense organs .320–389	13.69	10.58	17.50	22.75	3.62	13.98	75.05	75.91
Carpal tunnel syndrome .354.0	2.02	1.51	2.92	–	1.95	4.87	6.23	9.54
Cataract .366	9.90	6.98	13.19	*	0.50	9.24	67.68	66.28
Disorders of the eyelid .373–374	0.65	0.76	0.88	*	*0.25	1.34	4.50	4.36
Otitis media and Eustachian tube disorders .381–382	4.19	3.94	4.65	20.45	*	*	*	*
Diseases of the circulatory system .390–459	5.11	6.22	5.23	*	2.71	11.07	22.02	19.84
Heart disease .391–392.0,393–398,402,404,410–416,420–429	2.68	3.57	2.37	*	*0.86	5.61	12.87	13.80
Hemorrhoids .455	3.16	3.20	3.61	*	2.39	7.12	9.11	*5.26
Diseases of the respiratory system .460–519	5.73	5.15	6.92	20.07	3.55	4.41	7.87	*5.32
Deviated nasal septum .470	0.66	0.92	0.84	*	1.17	1.37	*	*
Chronic sinusitis .473	0.71	1.00	0.84	*	0.85	1.66	*	*
Chronic disease of tonsils and adenoids .474	4.48	3.48	5.71	18.27	2.03	*	–	–
Diseases of the digestive system .520–579	18.04	16.10	20.74	8.11	11.77	31.61	64.45	47.47
Diseases of teeth and supporting structures .520–525	1.21	1.38	1.35	4.99	*	*	*	*
Diseases of esophagus .530	4.31	4.28	4.86	*	2.81	7.88	17.63	12.02
Gastritis and duodenitis .535	3.12	2.19	4.38	*	2.43	4.92	13.40	11.48
Hernia .550–553	3.38	4.71	2.88	2.33	2.90	5.97	11.16	11.74
Inguinal hernia .550	1.58	3.09	*0.56	1.13	1.33	3.49	8.56	6.92
Noninfectious enteritis and colitis .555–558	1.42	1.38	2.11	*	1.68	2.28	*4.54	*
Diverticula of intestine .562	5.25	6.01	5.21	*	*1.03	12.67	22.33	19.19
Cholelithiasis .574	1.20	*0.71	2.22	*	1.98	2.42	*	*
Diseases of the genitourinary system .580–629	5.71	4.23	8.89	3.46	5.70	10.17	20.18	18.20
Calculus of kidney and ureter .592	1.32	1.54	1.60	*	1.95	2.73	*4.20	*4.63
Benign mammary dysplasias .610	0.61	–	1.21	–	*0.69	*1.48	*	*
Lump or mass in breast .611.72	1.07	*	2.04	*	1.22	2.57	*	*
Disorders of menstruation and other abnormal vaginal bleeding .626,627.0–627.1	1.90	. . .	3.73	–	2.59	3.25	*	*

See footnotes at end of table.

Table 9. Rate and standard error for the rate of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006—Con.

Category of first-listed diagnosis and ICD–9–CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15–44 years	45–64 years	65–74 years	75 years and over
	Standard error							
Complications of pregnancy, childbirth, and the puerperium .630–677	1.35	. . .	2.65	–	3.17	*	–	–
Abortion and ectopic and molar pregnancy .630–639	1.27	. . .	2.50	–	2.99	*	–	–
Diseases of the skin and subcutaneous tissue .680–709	3.02	3.02	4.06	2.04	2.41	7.03	*	5.30
Sebaceous cyst .706.2	0.69	1.11	0.77	*	*0.77	1.44	*	*
Diseases of the musculoskeletal system and connective tissue .710–739	11.91	11.38	13.53	1.64	10.18	21.94	28.02	32.52
Arthropathies and related disorders .710–719	2.96	3.44	3.01	*	3.58	5.37	6.84	4.84
Internal derangement of knee .717	1.79	2.69	1.36	*	2.22	3.04	*4.09	*
Intervertebral disc disorders .722	4.49	4.23	5.10	–	5.40	7.26	9.32	6.28
Lumbago .724.2	0.93	0.95	1.18	–	0.80	1.51	4.55	4.40
Rheumatism, excluding back .725–729	2.26	2.23	3.08	*0.97	2.12	5.56	7.55	5.40
Acquired deformities of toe .735	1.35	0.81	2.21	*	1.21	2.78	8.32	*3.65
Congenital anomalies .740–759	4.79	2.66	*	3.51	2.75	*	*	*
Symptoms, signs, and ill-defined conditions .780–799	7.79	6.81	9.04	*	4.91	12.20	15.95	11.22
Abdominal pain .789.0	0.95	0.71	1.49	*	0.89	2.16	*	*
Injury and poisoning .800–999	5.15	6.22	5.27	3.51	5.05	8.65	20.49	11.84
Fractures .800–829	1.49	2.23	1.31	2.23	2.20	2.51	*4.74	*4.17
Current tear of medial cartilage or meniscus of knee .836.0	1.58	2.46	1.28	*	1.54	3.80	5.29	*2.77
Supplementary classifications .V01–V85	8.88	8.70	10.44	2.06	5.93	19.34	31.05	24.27
Visit for sterilization .V25.2	1.15	0.52	2.20	*	2.43	*	–	–
Diseases of the blood and blood-forming organs, mental disorders, and certain conditions originating in the perinatal period .280–289,290–319,760–779	1.19	1.12	1.71	*	*0.74	2.78	*6.55	*7.27
Anemias .280–285	1.01	*0.93	1.42	*	*	*2.09	*5.94	*7.27

* Figure does not meet standards of reliability or precision.

– Quantity zero.

. . . Category not applicable.

[1]Rates were calculated using U.S. Census Bureau 2000-based postcensal estimates of the civilian population as of July 1, 2006.

NOTES: Diagnostic categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM). The relative standard error (RSE) can be obtained by dividing the standard error (SE) of the rate by the rate. The SE of a number in Table 8 can be obtained by multiplying the RSE by the estimate.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Technical Notes

Form NSAS-5 (1-2000)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

NATIONAL SURVEY OF AMBULATORY SURGERY

MEDICAL ABSTRACT

Form Approved OMB No. 0920-0334, Approval Expires 11/30/2000

Notice – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden of this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or an other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333; ATTN: PRA (0920-0334)

A. PATIENT INFORMATION

1. Facility number
2. NSAS number and list used
3. Date of surgery — Month, Day, Year 2 0 0
4. Residence ZIP Code

B. PATIENT CHARACTERISTICS

5. Date of birth — Month, Day, Year
6. Age (Complete only if date of birth not given) — Units: 1 Years, 2 Months, 3 Days
7. Sex (Mark (X) one): 1 Male, 2 Female, 3 Not stated
8. Ethnicity (Mark (X) one): 1 Hispanic or Latino, 2 Not Hispanic or Latino, 3 Not Stated
9. Race (Mark (X) all that apply): 1 White, 2 Black or African American, 3 American Indian or Alaska Native, 4 Asian, 5 Native Hawaiian or Other Pacific Islander, 6 Other – Specify, 7 Not Stated
10. Status/Disposition of Patient (Mark (X) the appropriate box): 1 Routine discharge to customary residence, 2 Discharge to observation status, 3 Discharge to post-surgical recovery care facility, 4 Admitted to hospital as inpatient, 5 Surgery canceled or terminated, 6 Other – Specify, 7 Status/Disposition not stated

C. PAYMENT INFORMATION

11. Expected source of payment

	Principal	Other sources
GOVERNMENT SOURCES		
Medicare	☐	☐
If available, also note whether –		
Fee-for-service	☐	
HMO	☐	
PPO	☐	
Medicaid	☐	☐
If available, also note whether –		
Fee-for-service	☐	
HMO	☐	
PPO	☐	
TRICARE	☐	☐
Worker's compensation	☐	☐
Other government *If so, please specify*	☐	☐
PRIVATE INSURANCE		
Private or commercial	☐	☐
If available, also note whether –		
Fee-for-service	☐	
HMO	☐	
PPO	☐	
OTHER SOURCES		
Self pay	☐	☐
Not covered by insurance	☐	
Had no health insurance	☐	
Charity care/Write off	☐	☐
No charge	☐	☐
Other *Please specify*	☐	☐
No source of payment indicated	☐	

12. Total charges $ .00 ☐ Not available

D. SURGICAL VISIT INFORMATION

13. Time — Not available

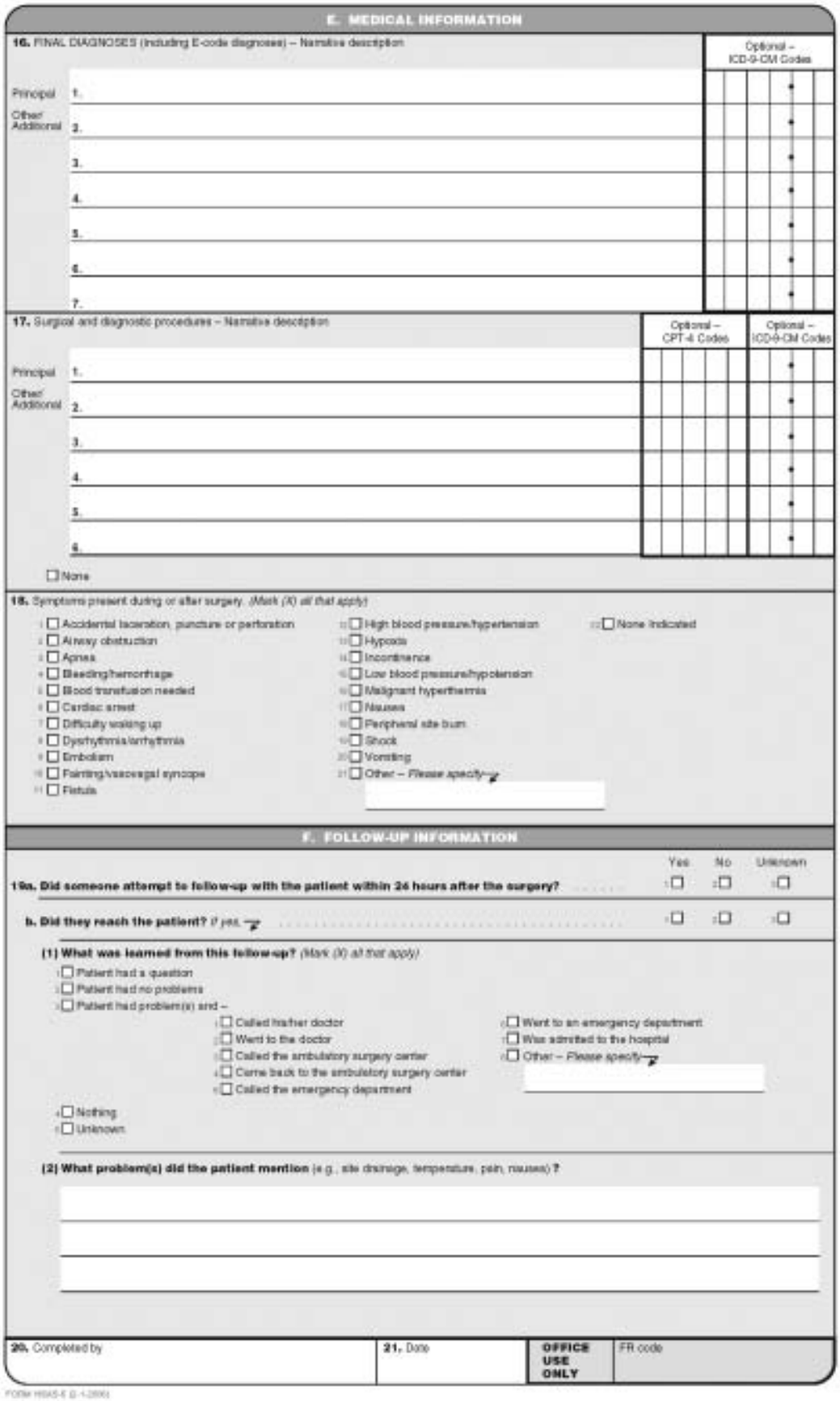
a. Time in to operating room	a.m. p.m.	☐
b. Time surgery began	a.m. p.m.	☐
c. Time surgery ended	a.m. p.m.	☐
d. Time out of operating room	a.m. p.m.	☐
e. Time in to postoperative care	a.m. p.m.	☐
f. Time out of postoperative care	a.m. p.m.	☐

14. Type of anesthesia (Mark (X) all that apply)

a. Topical/local ☐
b. IV sedation ☐
c. MAC (Monitored Anesthesia Care) ☐
d. Regional
(1) Epidural ☐
(2) Spinal ☐
(3) Retrobulbar block ☐
(4) Peribulbar block ☐
(5) Block ☐
e. General ☐
f. Other – Specify ☐
g. None specified ☐

15. Anesthesia administered by – (Mark (X) all that apply): 1 Anesthesiologist, 2 CRNA (Certified Registered Nurse Anesthetist), 3 Surgeon/Other physician, 4 Not stated/Not specified

Please continue on the reverse side



E. MEDICAL INFORMATION

16. FINAL DIAGNOSES (Including E-code diagnoses) – Narrative description — Optional – ICD-9-CM Codes

Principal 1.
Other/Additional 2.
3.
4.
5.
6.
7.

17. Surgical and diagnostic procedures – Narrative description — Optional – CPT-4 Codes — Optional – ICD-9-CM Codes

Principal 1.
Other/Additional 2.
3.
4.
5.
6.

☐ None

18. Symptoms present during or after surgery. *(Mark (X) all that apply)*

1 ☐ Accidental laceration, puncture or perforation
2 ☐ Airway obstruction
3 ☐ Apnea
4 ☐ Bleeding/hemorrhage
5 ☐ Blood transfusion needed
6 ☐ Cardiac arrest
7 ☐ Difficulty waking up
8 ☐ Dysrhythmia/arrhythmia
9 ☐ Embolism
10 ☐ Fainting/vasovagal syncope
11 ☐ Fistula
12 ☐ High blood pressure/hypertension
13 ☐ Hypoxia
14 ☐ Incontinence
15 ☐ Low blood pressure/hypotension
16 ☐ Malignant hyperthermia
17 ☐ Nausea
18 ☐ Peripheral site burn
19 ☐ Shock
20 ☐ Vomiting
21 ☐ Other – *Please specify*
22 ☐ None Indicated

F. FOLLOW-UP INFORMATION

	Yes	No	Unknown
19a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?	1 ☐	2 ☐	3 ☐
b. Did they reach the patient? *If yes,* →	1 ☐	2 ☐	3 ☐

(1) What was learned from this follow-up? *(Mark (X) all that apply)*

1 ☐ Patient had a question
2 ☐ Patient had no problems
3 ☐ Patient had problem(s) and –
- 1 ☐ Called his/her doctor
- 2 ☐ Went to the doctor
- 3 ☐ Called the ambulatory surgery center
- 4 ☐ Came back to the ambulatory surgery center
- 5 ☐ Called the emergency department
- 6 ☐ Went to an emergency department
- 7 ☐ Was admitted to the hospital
- 8 ☐ Other – *Please specify*

4 ☐ Nothing
5 ☐ Unknown

(2) What problem(s) did the patient mention (e.g., site drainage, temperature, pain, nausea)**?**

20. Completed by	21. Date	OFFICE USE ONLY	FR code

FORM HSAS-E (2-1-2009)

Acknowledgments

This report was prepared in the Division of Health Care Statistics (DHCS). This report was edited by Gail V. Johnson, CDC/CCHIS/Division of Creative Services, Writer Editor Services Branch; typeset by Annette F. Holman and graphics produced by Gail Ogburn and Tommy C. Seibert, CDC/CCHIS/Division of Creative Services, Graphic Services Branch.

Suggested citation

Cullen KA, Hall MJ, Golosinskiy A. Ambulatory Surgery in the United States, 2006. National health statistics reports; no 11. Revised. Hyattsville, MD: National Center for Health Statistics. 2009.

U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES

Centers for Disease Control and Prevention
National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

To receive this publication regularly, contact the National Center for Health Statistics by calling 1–800–232–4636
E-mail: cdcinfo@cdc.gov
Internet: http://www.cdc.gov/nchs

DHHS Publication No. (PHS) 2009–1250
CS206178
T35151 (09/2009)

FIRST CLASS
POSTAGE & FEES PAID
CDC/NCHS
PERMIT NO. G-284

National Health Statistics Reports

Number 102 ■ February 28, 2017

Ambulatory Surgery Data From Hospitals and Ambulatory Surgery Centers: United States, 2010

by Margaret J. Hall, Ph.D., Alexander Schwartzman, Jin Zhang, and Xiang Liu, Division of Health Care Statistics

Abstract

Objectives—This report presents national estimates of surgical and nonsurgical ambulatory procedures performed in hospitals and ambulatory surgery centers (ASCs) in the United States during 2010. Patient characteristics, including age, sex, expected payment source, duration of surgery, and discharge disposition are presented, as well as the number and types of procedures performed in these settings.

Methods—Estimates in this report are based on ambulatory surgery data collected in the 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). NHAMCS has collected outpatient department and emergency department data since 1992 and began gathering ambulatory surgery data from both hospitals and ASCs in 2010. Sample data were weighted to produce annual national estimates.

Results—In 2010, 48.3 million surgical and nonsurgical procedures were performed during 28.6 million ambulatory surgery visits to hospitals and ASCs combined. For both males and females, 39% of procedures were performed on those aged 45–64. For females, about 24% of procedures were performed on those aged 15–44 compared with 18% for males, whereas the percentage of procedures performed on those under 15 was lower for females than for males (4% compared with 9%). About 19% of procedures were performed on those aged 65–74, while about 14% were performed on those aged 75 and over. Private insurance was listed as the principal expected source of payment for 51% of ambulatory surgery visits, Medicare for 31% of visits, and Medicaid for 8% of visits. The most frequently performed procedures included endoscopy of large intestine (4.0 million), endoscopy of small intestine (2.2 million), extraction of lens (2.9 million), insertion of prosthetic lens (2.6 million), and injection of agent into spinal canal (2.9 million). Only 2% of visits with a discharge status were admitted to the hospital as an inpatient.

Keywords: outpatient surgery • procedures • ICD–9–CM • National Hospital Ambulatory Medical Care Survey (NHAMCS)

Introduction

This report presents nationally representative estimates of ambulatory surgery performed in hospitals and ambulatory surgery centers (ASCs) gathered by the 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). Ambulatory surgery, also called outpatient surgery, refers to surgical and nonsurgical procedures that are nonemergency, scheduled in advance, and generally do not result in an overnight hospital stay.

Ambulatory surgery has increased in the United States since the early 1980s (1,2). Two factors that contributed to this increase were medical and technological advancements, including improvements in anesthesia and in analgesics for the relief of pain, and the development and expansion of minimally invasive and noninvasive procedures (such as laser surgery, laparoscopy, and endoscopy) (3–6). Before these advances, almost all surgery was performed in inpatient settings. Any outpatient surgery was likely to have been minor, performed in physicians' offices, and paid for by Medicare and insurers as part of the physician's office visit reimbursement.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

The above advances and concerns about rising health care costs led to changes in the Medicare program in the early 1980s that encouraged growth in ambulatory surgery. Medicare expanded coverage to include surgery performed in ASCs (both hospital-based and freestanding). In addition, a prospective payment system for hospitals based on diagnosis-related groups was adopted, and that created strong financial incentives for hospitals to shift some surgery out of the hospital (1–5). Ambulatory surgery proved to be popular among both physicians and patients (3,4,7,8), and the number of Medicare-certified ASCs increased steadily, from 239 in 1983 to 5,316 in 2010 (9,10).

This report covers ambulatory surgery performed in hospitals and ASCs that are independent of hospitals. Ambulatory surgery procedures performed in physicians' offices and independent screening or diagnostic centers were not included in this report.

Methods

Data source and sampling design

Data for this analysis are from the ambulatory surgery component of the 2010 NHAMCS, a nationally representative survey of hospitals and ASCs conducted by the National Center for Health Statistics (NCHS). This survey has provided data on ambulatory medical care services provided in hospital emergency and outpatient departments since 1992. From 2010 through 2012, NHAMCS gathered data on ambulatory surgery procedures in both hospitals and ASCs. In 2013, data collection in ASCs was suspended so a new sampling frame could be developed. Previously, during 1994–1996 and in 2006, the National Survey of Ambulatory Surgery (NSAS) gathered data from hospital-based ASCs (HBASCs) and from facilities independent of hospitals [then called freestanding ASCs (FSASCs)] (2). The terms HBASC and FSASC are no longer in use because Medicare, and other insurers following Medicare's lead, changed the name and nature of the reimbursement categories for these services. Ambulatory surgery performed in hospitals is now called hospital outpatient department surgery. Facilities independent of hospitals that specialize in ambulatory surgery are now known as ASCs.

Independent samples of hospitals and ASCs were drawn for the NHAMCS ambulatory surgery component. The NHAMCS hospital sample (11) was selected using a multistage probability design, first sampling geographic units and then hospitals. Locations within the hospital where the services of interest were provided, in this case ambulatory surgery, were sampled next. Lastly, patient visits within these locations were sampled.

The hospitals that qualify for inclusion in this survey (the universe) include noninstitutional hospitals (excluding federal, military, and Department of Veterans Affairs hospitals) located in the 50 states and the District of Columbia. Only short-stay hospitals (hospitals with an average length of stay for all patients of fewer than 30 days), those with a general specialty (medical or surgical), and children's general were included in the survey. These hospitals must also have six or more beds staffed for patient use. The 2010 NHAMCS hospital sample frame was constructed from the products of SDI Health's "Healthcare Market Index," which was updated July 15, 2006, and its "Hospital Market Profiling Solution, Second Quarter, 2006" (12). These products were formerly known as the SMG Hospital Market Database.

In 2010, the sample consisted of 488 hospitals, of which 74 were out-of-scope (ineligible) because they went out of business or otherwise failed to meet the criteria for the NHAMCS universe. Of the 414 in-scope (eligible) hospitals, 275 had eligible ambulatory surgery locations. Of these, 227 participated, yielding an unweighted hospital ambulatory surgery response rate of 82.6% and a weighted response rate of 90.9%. All of the 321 ambulatory surgery locations within the 227 participating hospitals were selected for sampling, and 281 of these fully or adequately responded [at least one-half of the number of expected patient record forms (PRFs) were completed]. The resulting hospital ambulatory surgery location sample response rate was 87.5% unweighted, and 86.9% weighted. The overall hospital response rate was 72.2% unweighted and 79.0% weighted. In all, 18,469 PRFs for ambulatory surgery visits were submitted by hospitals.

The ASCs that qualified for inclusion in the 2010 NHAMCS (the universe) only included facilities in the 2006 NSAS sample. This sample was drawn in 2005 from a universe consisting of facilities listed in the 2005 Verispan (later called SDI Health and then IMS Health) Freestanding Outpatient Surgery Center Database (13) or the Centers for Medicare & Medicaid Services' (CMS) Medicare Provider of Services file (14). Using both of these sources resulted in a list of facilities that were regulated or licensed by the states and those certified by CMS for Medicare participation. More details about the 2006 NSAS sample have been published elsewhere (2). Selection of the 2010 ASC sample began with the NSAS 2006 stratified list sample of 472 FSASCs, which had strata defined by four geographic regions and 17 facility specialty groups. Seventy-four facilities were out-of-scope, leaving 398 facilities from which to select the 2010 NHAMCS ASC sample. To the extent possible, the ASC sample was selected from the NHAMCS geographic sampling units. The 17 specialty group strata used in the 2006 NSAS sample were collapsed into 5 strata (ophthalmic, gastrointestinal, multispecialty, general, and other).

All of the in-scope 2006 NSAS sample facilities located within the NHAMCS geographic sampling units were selected, yielding 216 facilities. To achieve the desired 246 facilities, a stratified list sample of 30 facilities was drawn from the remaining in-scope 2006 NSAS sample facilities that were located outside of the NHAMCS geographic sampling units. Strata were defined by the four regions and the five collapsed surgery specialty groups.

There were 149 in-scope (eligible) ASCs and, of this number, 109 responded to the survey for an unweighted response rate of 73.2% and a weighted response rate of 70.2%. In all, 8,492 PRFs were submitted for ASCs.

The overall response rate for hospitals combined with ASCs was 72.2% unweighted and 79.0% weighted.

The combined number of PRFs from both of these settings was 26,961.

Facilities were selected using a multistage probability design, with facilities having varying selection probabilities. Patient visits to ASCs and to locations in the hospital where ambulatory surgery was provided were selected using systematic random sampling procedures.

Within each sampled hospital, a sample of ambulatory surgery visits was selected from all of the ambulatory surgery locations identified by hospital staff. These locations included main or general operating rooms; dedicated ambulatory surgery units; cardiac catheterization laboratories; and rooms for endoscopy, laparoscopy, laser procedures, and pain block. Locations within hospitals dedicated exclusively to abortion, dentistry, podiatry, family planning, birthing, or small procedures were excluded, but these procedures were included if performed at in-scope locations. In ASCs with in-scope specialties, all visits were sampled. Facilities specializing in abortion, dentistry, podiatry, family planning, birthing, or small procedures were excluded, but these procedures were included if performed at in-scope ASCs.

To minimize response burden for hospitals and ASCs, the samples were divided into 16 nationally representative panels, and those panels were randomly ordered for rotation over reporting periods of 4 weeks each. Within the reporting periods, patient visits were systematically selected. The visit lists could be sign-in sheets or appointment lists. The total targeted number of ambulatory surgery visit forms to be completed in each hospital and in each ASC was 100. In facilities or hospitals with volumes higher than these desired figures, visits were sampled by a systematic procedure that selects every *n*th visit after a random start. Visit sampling rates were determined from the expected number of patients to be seen during the reporting period and the desired number of completed PRFs.

Data collection

Medical record abstraction was performed by facility staff or U.S. Census Bureau personnel acting on behalf of NCHS. A PRF for each sampled visit was completed. A visit is defined as a direct personal exchange between a physician or a staff member operating under a physician's direction, for the purpose of seeking ambulatory surgery. Visits solely for administrative purposes and visits in which no medical care was provided are out-of-scope.

The PRF contains items relating to the personal characteristics of the patients, such as age, sex, race and ethnicity, and administrative items, such as the date of the procedure, expected source(s) of payment, and discharge disposition. Medical information collected includes provider of anesthesia and type of anesthesia, length of time in both the operating room and in surgery, symptoms present during or after the procedure, and up to five diagnoses and seven procedures, which were coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) (15). Information on up to 12 new or continuing prescription and over-the-counter drugs ordered, supplied, or administered during the visit or at discharge was also collected, and these drugs were coded using Multum Lexicon (16), a proprietary drug classification system used by NCHS.

Limitations of NHAMCS Ambulatory Surgery Data

Limited resources did not permit updating the ASC frame for the 2010 NHAMCS, so the NSAS 2006 sample, based on ASCs in existence in 2005, was used. Based on annual data on the number of Medicare-certified ASCs from CMS, the increase in the number of these facilities was taken into account in the calculation of NHAMCS ASC survey weights. The visit total related to the increase in the number of ASCs was also accounted for in the weights, but any possible change in the number of visits per ASC was not accounted for because no data were available on the number of visits to ASCs over time. Final weighting is described in more detail elsewhere (11).

Based on the assumption that the characteristics of ambulatory surgery visits probably do not vary with facility age, the sample should enable the measurement of 2010 characteristics (if not numbers) of ambulatory visits. To the extent that the ASCs that existed in 2005 were different from those in existence in 2010, these differences would not have been fully captured by the 2010 NHAMCS (17).

Due to limited resources, the sample sizes for hospitals and for ASCs for the NHAMCS ambulatory surgery component were only about one-half of what they were for the 2006 NSAS, so the most recent estimates have larger standard errors. This makes it more difficult for differences to achieve statistical significance.

Until 2008, hospital ambulatory surgery was included under Medicare's HBASC payment category. Beginning in 2008, Medicare discontinued its use of this category and instead began paying for hospital ambulatory surgery as part of hospital outpatient department services. Hospitals also dropped the HBASC designation and, in some hospitals, this change led to a greater dispersion of ambulatory surgery procedures throughout the hospitals, including to various parts of the outpatient departments and locations within medical clinics.

Some hospitals had difficulty identifying all of the locations in the hospital where in-scope procedures were performed, especially in the first year of NHAMCS ambulatory surgery data collection (2009). This same year, after the problems became apparent, U.S. Census Bureau and NCHS staff provided additional information to field staff about how to identify locations in the hospital that were in-scope and out-of-scope for the ambulatory surgery component of NHAMCS. More formal training material on this point was provided in a 2010 training CD that was sent to all field staff. These efforts are believed to have corrected this problem. However, due to these issues, it is likely that some in-scope procedures were undercounted in 2009 and 2010.

A number of changes occurred in the health care system during 2008–2010 that could have affected the amount

of ambulatory surgery care that was provided in settings covered by this report and the amount provided in out-of-scope settings (e.g., physicians' offices). More information about the difficulties of gathering and comparing data on ambulatory surgery from these two time periods and surveys is available (18).

Results

Ambulatory surgery procedure and visit overview

- In 2010, 28.6 million ambulatory surgery visits to hospitals and ASCs occurred (Table 1). During these visits, an estimated 48.3 million surgical and nonsurgical procedures were performed (Table 2).
- An estimated 25.7 million (53%) ambulatory surgery procedures were performed in hospitals and 22.5 million (47%) were performed in ASCs (Table A).
- Private insurance was the expected payment source for 51% of the visits for ambulatory surgery, Medicare payment was expected for 31%, and Medicaid for 8%. Only 4% were self-pay (Figure 1).
- Ninety-five percent of the visits with a specified discharge disposition had a routine discharge, generally to the patient's home. Patients were admitted to the hospital as inpatients during only 2% of these visits (Table B).

Ambulatory surgery procedures, by sex and age

- For both males and females, 39% of procedures were performed on those aged 45–64 (Figure 2).
- For females, about 24% of procedures were performed on those aged 15–44 compared with 18% for males, whereas the percentage of procedures performed on those under 15 was lower for females than for males (4% compared with 9%).
- About 19% of procedures were performed on those aged 65–74, with about 14% performed on those aged 75 and over.

Table A. Ambulatory surgery procedures and visits to hospitals and ambulatory surgery centers: United States, 2010

Ambulatory surgery utilization	Estimate	Standard error
Procedures (millions)	48.3	4.3
in hospitals	25.7	2.6
in ASCs	22.5	3.3
Visits (millions)	28.6	2.4
in hospitals	15.7	1.6
in ASCs	12.9	1.8

NOTE: ASC is ambulatory surgery center.

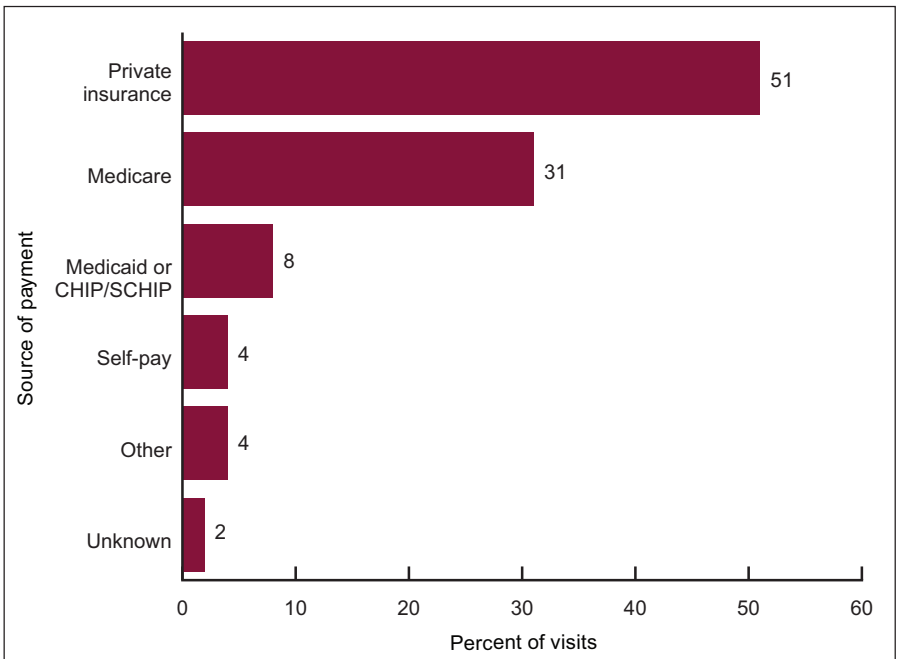
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table B. Percent distribution of ambulatory surgery visits in hospitals and ambulatory surgery centers, by discharge disposition: United States, 2010

Discharge disposition	Percent of visits
Routine discharge[1]	95
Observation status[2]	2
Admission to hospital as inpatient	2
Other[3]	1
Total[4]	100

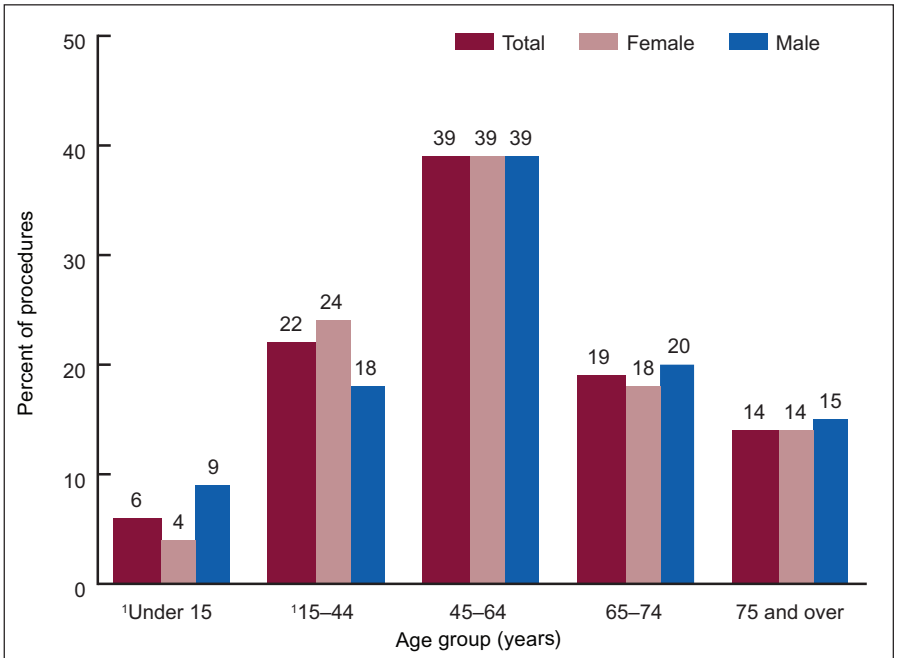
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6 million total visits with an unknown discharge disposition.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.



NOTE: CHIP is Children's Health Insurance Program and SCHIP is State Children's Health Insurance Program.
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Figure 1. Percent distribution of ambulatory surgery visits in hospitals and ambulatory surgery centers, by principal expected source of payment: United States, 2010



[1]Differences between females and males in these age groups are statistically significant.
NOTES: Numbers may not add to totals because of rounding. See Table 2 in this report (NHSR 102, "Ambulatory Surgery Data From Hospitals and Ambulatory Surgery Centers: United States, 2010") for standard errors.
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Figure 2. Percent distribution of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by age and sex: United States, 2010

Types of procedures

Seventy percent of the 48.3 million ambulatory surgery procedures were included in the following clinical categories: operations on the digestive system (10 million or 21%), operations on the eye (7.9 million or 16%), operations on the musculoskeletal system (7.1 million or 15%), operations on the integumentary system (4.3 million or 9%), and operations on the nervous system (4.2 million or 9%) (Table 3). These procedure categories made up 72% of procedures performed on females and 67% of those performed on males. Within the above-mentioned categories, data on procedures performed more than 1 million times are presented below.

Under operations on the digestive system, endoscopy of large intestine—which included colonoscopies—was performed 4.0 million times, and endoscopy of small intestine was performed 2.2 million times. Endoscopic polypectomy of large intestine was performed an estimated 1.1 million times.

Eye operations included extraction of lens, performed 2.9 million times; insertion of lens, performed 2.6 million times for cataracts; and operations on eyelids, performed 1.0 million times.

Musculoskeletal procedures included operations on muscle, tendon, fascia, and bursa (1.3 million).

Operations on the integumentary system included excision or destruction of lesion or tissue of skin and subcutaneous tissue (1.2 million).

Operations on the nervous system included injection of agent into spinal canal (2.9 million), including injections for pain relief.

Duration of surgery

The average time in the operating room for ambulatory surgery was almost 1 hour (57 minutes). On average, about one-half of this time (33 minutes) was spent in surgery. Postoperative care averaged 70 minutes. Time spent in the operating room, surgery, and receiving postoperative care were all significantly longer for ambulatory surgery performed in hospitals compared with ASCs (Table C).

The average surgical times for selected ambulatory surgery procedures are shown in Table D. Endoscopies averaged 14 minutes, while endoscopic polypectomy of the large intestine averaged 21 minutes. For cataract surgery, extraction or insertion of lens (often done together) averaged 10 minutes, and operations on the eyelids averaged 23 minutes. Arthroscopy of the knee averaged 32 minutes.

Discussion

Keeping in mind the limitations that should be taken into account when comparing 2006 NSAS data and 2010 NHAMCS ambulatory surgery data, the 53.3 million ambulatory surgery procedures estimated using 2006 NSAS data were compared with the 48.3 million ambulatory surgery procedures estimated using 2010 NHAMCS data. The difference between these two figures was not statistically significant. A significant decrease of 18% (from 34.7 to 28.6 million) was seen in the number of ambulatory surgery visits during this same time period. It had been expected based upon the limited data that were available and on projections from past trends, that there would have been an increase in the numbers of both ambulatory surgery visits and procedures (9,10,19).

One reason for these findings could be an undercount in NHAMCS in 2010. Another reason that ambulatory surgery visit estimates could have decreased and ambulatory surgery procedures remained steady, could be the deep economic recession that began in 2007. By 2010, when NHAMCS began gathering ambulatory surgery data in both hospitals and ASCs, the economy had not fully recovered. The rate of unemployment and the number of people who did not have health insurance were higher in 2010 compared with 2006, and both of these factors could have affected patients' use of ambulatory surgery (20,21). Even for those who continued to have health insurance, increased out-of-pocket costs (higher deductibles and coinsurance payments) may have contributed to a decrease in the number of visits for ambulatory surgery (22).

An examination of various data sources, including Medicare, the American Hospital Association, and NHAMCS, was undertaken to evaluate if other national

Table C. Distribution of times for surgical visits, by ambulatory surgery facility type: United States, 2010

Calculated time of ambulatory surgical visit	Hospital		Ambulatory surgery center		All facilities	
	Average time (minutes)	Standard error	Average time (minutes)	Standard error	Average time (minutes)	Standard error
Operating room[1]	63	1.9	50	3.7	57	2.2
Surgical[2]	37	1.5	29	3.2	33	1.7
Postoperative care[3]	89	2.9	51	3.8	70	2.6

[1]Calculated by subtracting the time when the patient entered the operating room from the time the patient left the operating room.
[2]Calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.
[3]Calculated by subtracting the time when the patient entered postoperative care from the time the patient left postoperative care.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

data sources reached similar conclusions about trends in ambulatory surgery during 2006–2010 (19). This analysis revealed that the only nationally representative data during this time period were from the 2006 NSAS and the 2010 NHAMCS ambulatory surgery component. Medicare data on the number of certified ASCs over time existed, but only limited Medicare ambulatory surgery utilization and expenditure data were available, and almost all of it was from ASCs only and did not include data on ambulatory surgery in hospitals. Even so, Medicare utilization and expenditure data could not have been used to generalize to the entire population because Medicare only covers those aged 65 and over and people with disabilities. Close to 70% of ambulatory surgery procedures were paid for by sources other than Medicare.

Ambulatory Surgery Data

The 2010 NHAMCS ambulatory surgery data used for this report have been released in a public-use file available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHAMCS. The data base documentation for this file is available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS.

Among the options being explored for future data collection are the use of both claims data and electronic health record data.

Table D. Average surgical duration for selected procedures: United States, 2010

Selected procedure[1]	ICD–9–CM codes	Average surgical time (minutes)[2]	Standard error
Endoscopy (including colonoscopy)	45.11–45.14, 45.16, 45.21–45.25	14	0.87
Endoscopic polypectomy of large intestine	45.42	21	0.97
Extraction or insertion of lens (cataracts)	13.1–13.7	10	1.20
Operations on eyelids	08	23	3.56
Arthroscopy of knee	80.26	32	2.69

[1]Times were counted only for patients who had each of these selected procedures and no others during their ambulatory surgery visit.
[2]Calculated by subtracting the time surgery began from the time surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

References

1. Leader S, Moon M. Medicare trends in ambulatory surgery. Health Aff (Millwood) 8(1):158–70. 1989.
2. Cullen KA, Hall MJ, Golosinskiy A. Ambulatory surgery in the United States, 2006. National health statistics reports; no 11. Hyattsville, MD: National Center for Health Statistics. 2009.
3. Davis JE. Ambulatory surgery…how far can we go? Med Clin North Am 77(2): 365–75. 1993.
4. Lumsdon K, Anderson HJ, Burke M. New surgical technologies reshape hospital strategies. Hospitals 66(9):30–6. 1992.
5. Duffy SQ, Farley DE. Patterns of decline among inpatient procedures. Public Health Rep 110(6):674–81. 1995.
6. MEDPAC. Report to the Congress: Medicare payment policy. Section F: Assessing payment adequacy and updating payments for ambulatory surgical center services. Washington, DC. 2003.
7. Durant GD. ASCs: Surviving, thriving into the 1990s. Med Group Manage J 36(2):14. 1989.
8. KNG Health Consulting, LLC. An analysis of recent growth of ambulatory surgical centers: Final report. Prepared for the ASC Coalition. 2009.
9. MEDPAC. Report to the Congress: Medicare payment policy. Chapter 5: Ambulatory surgical center services. Washington, DC. 2013.
10. MEDPAC. Report to the Congress: Medicare payment policy. Washington, DC. 2012.
11. National Center for Health Statistics. 2010 NHAMCS public-use micro-data file documentation. Available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS.
12. Verispan LLC. Healthcare market index, updated July 15, 2006. Hospital market profiling solution, second quarter. Chicago: Healthcare Information Specialists. 2006.
13. Verispan LLC. Freestanding outpatient surgery centers database. Chicago: Healthcare Information Specialists. 2005.
14. Centers for Medicare & Medicaid Services. Provider of services file. Baltimore, MD. 2005.

15. Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services. International classification of diseases, ninth revision, clinical modification. 6th ed. DHHS Pub No. (PHS) 11–1260. 2011. Available from: https://www.cdc.gov/nchs/icd/icd9cm.htm.
16. Cerner Multum, Inc. Cerner Multum Lexicon. Available from: http://www.multum.com/lexicon.html.
17. Shimizu I. Sampling design for the 2010–2012 National Hospital Ambulatory Medical Care Survey. In: Proceedings from the 2011 JSM Annual Meeting. Alexandria, VA: American Statistical Association. 2012.
18. Hall MJ. The challenges of gathering and interpreting national data on ambulatory surgery over time. Proceedings from the 2013 JSM Annual Meeting. Alexandria, VA: American Statistical Association. 2014.
19. Hall MJ. Comparison of national data on ambulatory surgery from CDC's National Hospital Ambulatory Medical Care Survey, Medicare, the American Hospital Association and SDI. Proceedings from the 2014 JSM Annual Meeting. Alexandria, VA: American Statistical Association. 2015.
20. Alliance for Health Reform Briefing: Trends in health insurance coverage in the U.S.: The impact of the economy. 2010. Available from: http://www.allhealth.org/briefingmaterials/TrendsinHealthInsuranceTranscript12-6-2010-1923.pdf.
21. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. The uninsured: A primer—Key facts about health insurance on the eve of health reform. 2013. Available from: https://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-key-facts-about-health-insurance.pdf.
22. Manchikanti L, Parr AT, Singh V, Fellows B. Ambulatory surgery centers and interventional techniques: A look at long-term survival. Pain Physician 14(2):E177–215. 2011.
23. RTI International. SUDAAN (Release 9.0.1) [computer software]. 2005.

Table 1. Number and percent distribution of ambulatory surgery visits, by age and sex: United States, 2010

Age group (years)	Both sexes		Female		Male	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
	Number (thousands)					
Total	28,588	2424	16,481	1,365	12,108	1,084
Under 15	1,812	302	712	122	1,100	184
15–44	6,426	619	4,201	411	2,225	223
45–64	10,911	1,010	6,256	555	4,659	474
65–74	5,301	446	2,951	242	2,350	213
75 and over	4,139	360	2,365	205	1,774	167
	Percent distribution					
Total	100	...	100	...	100	...
Under 15	6	0.86	4	0.62	9	1.21
15–44	23	0.94	26	1.06	18	0.91
45–64	38	0.89	38	0.84	39	1.16
65–74	19	0.67	18	0.69	19	0.84
75 and over	14	0.69	14	0.72	15	0.83

... Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table 2. Number and percent distribution of ambulatory surgery procedures, by age and sex: United States, 2010

Age group (years)	Both sexes		Female		Male	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
			Number (thousands)			
Total	48,263	4,253	27,595	2,373	20,669	1,932
Under 15	2,916	500	1,118	199	1,798	310
15–44	10,478	1,014	6,708	631	3,770	418
45–64	18,783	1,876	10,789	1,060	7,994	857
65–74	9,153	802	5,053	423	4,100	403
75 and over	6,933	619	3,926	356	3,007	285
			Percent distribution			
Total	100	...	100	...	100	...
Under 15	6	0.82	4	0.57	9	1.20
15–44	22	0.89	24	0.92	18	1.10
45–64	39	1.02	39	1.05	39	1.23
65–74	19	0.79	18	0.78	20	1.00
75 and over	14	0.80	14	0.84	15	0.89

... Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table 3. Number of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Number (thousands)							
All procedures	48,263	27,595	20,669	2,916	10,478	18,783	9,153	6,933
Operations on the nervous system (01–05,17.61)	4,226	2,385	1,841	*	1,002	1,981	631	590
Injection of agent into spinal canal (03.91–03.92)	2,918	1,588	1,330	*	712	1,313	437	453
Release of carpal tunnel (04.43)	444	266	178	–	66	240	80	*58
Operations on the eye (08–16)	7,880	4,622	3,258	93	321	2,122	2,697	2,646
Operations on eyelids (08)	1,021	651	371	*	*	482	276	*
Extraction of lens (13.1–13.6)	2,861	1,705	1,156	*	*	584	1,081	1,173
Insertion of prosthetic lens (pseudophakos) (13.7)	2,553	1,526	1,027	*	*	511	951	1,043
Operations on the ear (18–20)	1,054	442	612	847	72	58	*	*
Myringotomy with insertion of tube (20.01)	754	323	431	699	*	*	*	*
Operations on the nose, mouth, and pharynx (21–29)	2,407	1,117	1,290	903	689	575	166	*75
Incision, excision and destruction of nose and lesion of nose (21.1,21.3–21.4,21.6)	302	152	*	*	126	*	*	*
Turbinectomy (21.6)	190	78	112	*	106	*40	*	*
Repair and plastic operations on the nose (21.8)	393	179	214	*	175	135	*	*
Operations on nasal sinuses (22)	433	192	241	*	164	*	*	*
Tonsillectomy with or without adenoidectomy (28.2–28.3)	399	205	193	289	102	*	*	*
Adenoidectomy without tonsillectomy (28.6)	72	*32	*40	69	*	*	–	–
Operations on the respiratory system (30–34)	282	141	141	*	*40	86	81	*37
Bronchoscopy with or without biopsy (33.21–33.24,33.27,33.71–33.73,33.78–33.79)	106	*55	51	*	*	*30	*	*
Operations on the cardiovascular system (35–39,00.40–00.49,00.50–00.55,00.57,00.61–00.66,17.51–17.52,17.71)	1,072	519	553	*	88	369	356	245
Cardiac catheterization (37.21–37.23)	339	136	203	*	*	126	113	*
Operations on the digestive system (42–54,17.1–17.3,17.63)	10,045	5,418	4,627	*	1,826	4,759	2,044	1,198
Dilation of esophagus (42.92)	172	106	66	*	*	72	36	*38
Endoscopy of small intestine with or without biopsy (45.11–45.14,45.16)	2,172	1,312	861	*	468	936	387	325
Endoscopy of large intestine with or without biopsy (45.21–45.25)	3,987	2,202	1,785	*	474	2,132	916	431
Endoscopic polypectomy of large intestine (45.42)	1,060	485	575	*	*	520	354	158
Laparoscopic cholecystectomy (51.23)	436	325	111	*	196	162	*	*
Hernia repair (53.0–53.9,17.1–17.2)	777	196	581	*	178	355	83	88
Repair of inguinal hernia (53.0–53.1,17.1–17.2)	449	*52	*	*	82	198	54	66
Operations on the urinary system (55–59)	1,349	590	759	*67	311	456	294	220
Cystoscopy with or without biopsy (57.31–57.33)	479	219	260	*	128	155	104	82
Operations on the male genital organs (60–64)	525	–	525	*	98	131	89	*54
Operations on the female genital organs (65–71)	1,766	1,766	–	*	1,093	527	91	*
Hysteroscopy (68.12)	198	198	–	*	83	83	*	*
Dilation and curettage of uterus (69.0)	328	328	–	–	172	116	*	*

See footnotes at end of table.

Table 3. Number of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Number (thousands)							
Operations on the musculoskeletal system (76–84,00.70–00.77,00.80–00.87)	7,076	3,802	3,275	173	2,114	3,456	885	448
Partial excision of bone (76.2–76.3,77.6–77.8)	241	132	109	*	49	141	*29	*
Reduction of fracture (76.7,79.0–79.3)	380	153	227	*52	160	111	*	*
Injection of therapeutic substance into joint or ligament (76.96,81.92)	267	183	84	*	*	127	*48	*
Removal of implanted devices from bone (76.97,78.6)	195	111	83	*	64	87	*	*
Excision and repair of bunion and other toe deformities (77.5)	379	327	*52	*	120	165	*55	*
Arthroscopy of knee (80.26)	692	332	359	*	254	333	80	*
Excision of semilunar cartilage of knee (80.6)	759	374	385	*	196	435	105	*
Replacement or other repair of knee (81.42–81.47,81.54–81.55,00.80–00.84)	571	285	286	*	201	*	*	*
Operations on muscle, tendon, fascia and bursa (82–83)	1,274	636	637	*	319	635	196	88
Operations on the integumentary system (85–86)	4,340	3,405	935	131	1,497	1,767	566	380
Biopsy of breast (85.11–85.12)	*	*	*	–	*	86	*	*
Local excision of lesion of breast (lumpectomy) (85.21)	268	*	*	*	64	151	*40	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue (86.2–86.4)	1,219	734	485	*	323	449	182	171
Miscellaneous diagnostic and therapeutic procedures and new technologies (87–99,00.01–00.03,00.09–00.19,00.21–00.25,00.28–00.29,00.31–00.35,00.39, 00.56, 00.58–00.59, 00.67–00.69,17.62,17.69,17.70,38.24,38.25,00.91–00.94,17.4)	5,892	3,102	2,790	228	1,225	2,358	1,158	923
Operations on the endocrine system, on the hemic and lymphatic system, and obstetrical procedures (06–07,40–41,72–75)	348	285	63	*	104	135	*62	32

* Figure does not meet standards of reliability or precision. An asterisk with a number indicates that the estimate is based on a relatively small number of cases, and while reliable, should be used with caution.
– Quantity zero.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table 4. Standard errors of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Standard error							
All procedures	4,040	2,250	1,844	492	972	1,806	765	591
Operations on the nervous system (01–05,17.61)	703	398	316	*	240	377	90	92
Injection of agent into spinal canal (03.91–03.92)	557	305	265	*	208	297	74	82
Release of carpal tunnel (04.43)	102	61	45	–	14	61	24	*16
Operations on the eye (08–16)	1,005	569	454	21	80	318	322	392
Operations on eyelids (08)	203	130	100	*	*	106	69	*
Extraction of lens (13.1–13.6)	370	217	159	*	*	77	133	179
Insertion of prosthetic lens (pseudophakos) (13.7)	356	213	147	*	*	76	124	163
Operations on the ear (18–20)	188	107	94	184	12	16	*	*
Myringotomy with insertion of tube (20.01)	161	91	83	152	*	*	*	*
Operations on the nose, mouth, and pharynx (21–29)	312	155	173	194	88	101	35	*17
Incision, excision and destruction of nose and lesion of nose (21.1,21.3–21.4,21.6)	68	*	25	*	22	*	*	*
Turbinectomy (21.6)	31	18	20	*	19	*11	*	*
Repair and plastic operations on the nose (21.8)	78	*	32	*	35	29	*	*
Operations on nasal sinuses (22)	92	48	59	*	35	*	*	*
Tonsillectomy with or without adenoidectomy (28.2–28.3)	65	36	38	53	16	*	*	*
Adenoidectomy without tonsillectomy (28.6)	15	*8	*10	14	*	*	–	*
Operations on the respiratory system (30–34)	38	22	24	*	*11	17	17	*9
Bronchoscopy with or without biopsy (33.21–33.24,33.27,33.71–33.73,33.78–33.79)	18	*12	11	*	*	*8	*	*
Operations on the cardiovascular system (35–39,00.40–00.49,00.50–00.55,00.57,00.61–00.66,17.51–17.52,17.71)	197	98	109	*	18	62	105	53
Cardiac catheterization (37.21–37.23)	88	37	54	*	*	27	*	*
Operations on the digestive system (42–54,17.1–17.3,17.63)	1,148	608	555	*	196	599	278	144
Dilation of esophagus (42.92)	32	23	14	*	*	15	*9	*11
Endoscopy of small intestine with or without biopsy (45.11–45.14,45.16)	290	171	128	*	69	144	60	47
Endoscopy of large intestine with or without biopsy (45.21–45.25)	560	292	280	*	82	319	132	83
Endoscopic polypectomy of large intestine (45.42)	195	93	108	*	*	106	77	35
Laparoscopic cholecystectomy (51.23)	64	48	20	*	27	31	*	*
Hernia repair (53.0–53.9,17.1–17.2)	113	31	89	*	30	63	14	18
Repair of inguinal hernia (53.0–53.1,17.1–17.2)	72	*	61	*	19	37	11	16
Operations on the urinary system (55–59)	184	79	114	*20	61	67	49	33
Cystoscopy with or without biopsy (57.31–57.33)	75	38	44	*	31	25	21	15
Operations on the male genital organs (60–64)	106	–	106	*	16	*	*	*15
Operations on the female genital organs (65–71)	223	223	–	*	145	81	19	*
Hysteroscopy (68.12)	33	33	–	*	17	17	*	*
Dilation and curettage of uterus (69.0)	42	42	–	–	23	21	*	*

See footnotes at end of table.

Table 4. Standard errors of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Standard error							
Operations on the musculoskeletal system (76–84,00.70–00.77,00.80–00.87)	1,156	667	501	36	305	685	144	77
Partial excision of bone (76.2–76.3,77.6–77.8)	35	27	18	*	9	26	*7	*
Reduction of fracture (76.7,79.0–79.3)	50	19	36	*10	24	16	*	*
Injection of therapeutic substance into joint or ligament (76.96,81.92)	58	43	20	*	*	32	*14	*
Removal of implanted devices from bone (76.97,78.6)	37	27	15	*	16	22	*	*
Excision and repair of bunion and other toe deformities (77.5)	72	69	*13	*	28	41	*15	*
Arthroscopy of knee (80.26)	168	80	91	*	47	100	22	*
Excision of semilunar cartilage of knee (80.6)	177	79	103	*	39	124	26	*
Replacement or other repair of knee (81.42–81.47,81.54–81.55,00.80–00.84)	141	80	66	*	36	*	*	*
Operations on muscle, tendon, fascia and bursa (82–83)	201	113	96	*	62	102	44	19
Operations on the integumentary system (85–86)	496	423	111	32	217	254	65	51
Biopsy of breast (85.11–85.12)	*	*	*	–	*	21	*	*
Local excision of lesion of breast (lumpectomy) (85.21)	39	39	*	*	15	26	*10	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue (86.2–86.4)	129	103	56	*	58	66	37	48
Miscellaneous diagnostic and therapeutic procedures and new technologies (87–99,00.01–00.03,00.09–00.19,00.21–00.25, 00.28–00.29,00.31–00.35,00.39,00.56, 00.58–00.59, 00.67–00.69,17.62,17.69,17.70,38.24,38.25,00.91–00.94,17.4)	750	376	385	50	186	327	183	123
Operations on the endocrine system, on the hemic and lymphatic system, and obstetrical procedures (06–07,40–41,72–75)	50	45	14	*	21	25	*13	*9

* Figure does not meet standards of reliability or precision. An asterisk with a number indicates that the estimate is based on a relatively small number of cases, and while reliable, should be used with caution.
– Quantity zero.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Technical Notes

Data processing and medical coding were performed by SRA International, Inc., Durham, N.C. Editing and estimation were completed by the National Center for Health Statistics.

Estimation

Because of the complex multistage design of the National Hospital Ambulatory Medical Care Survey (NHAMCS), the survey data must be inflated or weighted to produce national estimates. The estimation procedure produces essentially unbiased national estimates and has three basic components: (a) inflation by reciprocals of the probabilities of sample selection, (b) adjustment for nonresponse, and (c) population weighting ratio adjustments. These three components of the final weight are described in more detail elsewhere (11).

Because NHAMCS ambulatory surgery data are collected from a sample of visits, persons with multiple visits during the year may be sampled more than once. Therefore, estimates are of the number of visits to, or procedures performed in, hospital ambulatory surgery locations and ASCs, and not the number of persons served by these facilities.

Standard errors

The standard error is primarily a measure of sampling variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. Estimates of the sampling variability for this report were calculated using Taylor approximations in SUDAAN, which take into account the complex sample design of NHAMCS. A description of the software and the approach it uses has been published elsewhere (23). The standard errors of estimates presented in the tables of this report are included, either as part of the table or, in the case of Table 3, in a separate table (Table 4).

Data analyses were performed using the statistical packages SAS, version 9.3 (SAS Institute, Cary, N.C.) and SAS-callable SUDAAN, version 10.0 (RTI International, Research Triangle Park, N.C.).

Testing of significance and rounding

Differences in the estimates were evaluated using a two-tailed *t* test ($p < 0.05$). Terms such as "higher than" and "less than" indicate that differences are statistically significant. Terms such as "similar" or "no difference" indicate that no statistically significant difference exists between the estimates being compared. A lack of comment on the difference between any two estimates does not mean that the difference was tested and found not to be significant.

Estimates of counts in the tables have been rounded to the nearest thousand. Therefore, estimates within tables do not always add to the totals. Rates and percentages were calculated from unrounded figures and may not precisely agree with rates and percentages calculated from rounded data.

Nonsampling errors

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include reporting and processing errors as well as biases due to nonresponse and incomplete response. The magnitude of the nonsampling errors cannot be computed. However, efforts were made to keep these errors to a minimum by building procedures into the operation of the survey. To eliminate ambiguities and encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions.

Quality control procedures and consistency and edit checks reduced errors in data coding and processing. A 5% quality control sample of survey records was independently keyed and coded. Item nonresponse rates were generally low, but levels of nonresponse did vary among different variables. The data shown in this report are based upon items with low nonresponse.

Use of tables

The estimates presented in this report are based on a sample, and therefore may differ from the number that would be obtained if a complete census had been taken. The estimates shown in this report include surgical procedures, such as tonsillectomy; diagnostic procedures, such as ultrasound; and other therapeutic procedures, such as injection or infusion of cancer chemotherapeutic substance.

In 2010, up to seven procedures were coded for each visit. All listed procedures include all occurrences of the procedure coded regardless of the order on the medical record.

The procedure data in this report are presented by chapter of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM). In the Results section, selected chapters with large numbers of procedures are discussed along with specific categories of procedures performed 1 million or more times. The latter categories are included to give some examples of what was included under the chapters.

Table 3 presents data using ICD–9–CM codes for chapters of procedures as well as selected procedures within these chapters. The procedures selected for inclusion in Table 3 were those with relatively large frequencies, or because there was a clinical, epidemiological, or health services interest in them.

Data from the 2010 NHAMCS showed that an estimated 479,000 ambulatory surgery visits ended with an admission to the hospital as an inpatient. The visits made by these patients were included in this report [as they were in the 2006 National Survey of Ambulatory Surgery (NSAS) Report] (2), and the ambulatory surgery procedures they received were included in the estimates for all listed procedures.

Estimates were not presented in this report if they were based on fewer than 30 cases in the sample data or if the relative standard error (RSE) was greater than 30%. In these cases, only an asterisk (*) appears in the tables. The RSE of an estimate is obtained by dividing the standard error by the estimate itself. The result is then expressed as a percentage of the estimate. Estimates based on 30 to 59 cases include an asterisk because, while their RSE is less than 30%, these estimates are based on a relatively small number of cases and should be used with caution.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control and Prevention
National Center for Health Statistics
3311 Toledo Road, Room 4551, MS P08
Hyattsville, MD 20782–2064

National Health Statistics Reports ■ Number 102 ■ February 28, 2017

Suggested citation

Hall MJ, Schwartzman A, Zhang J, Liu X. Ambulatory surgery data from hospitals and ambulatory surgery centers: United States, 2010. National health statistics reports; no 102. Hyattsville, MD: National Center for Health Statistics. 2017.

For e-mail updates on NCHS publication releases, subscribe online at: https://www.cdc.gov/nchs/govdelivery.htm.
For questions or general information about NCHS: Tel: 1–800–CDC–INFO (1–800–232–4636) • TTY: 1–888–232–6348
Internet: https://www.cdc.gov/nchs • Online request form: https://www.cdc.gov/info
DHHS Publication No. 2017–1250 • CS273765

Exhibit 9

ASCA Ambulatory Surgery Center Association

Ambulatory Surgery Centers

A Positive Trend in Health Care

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

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

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

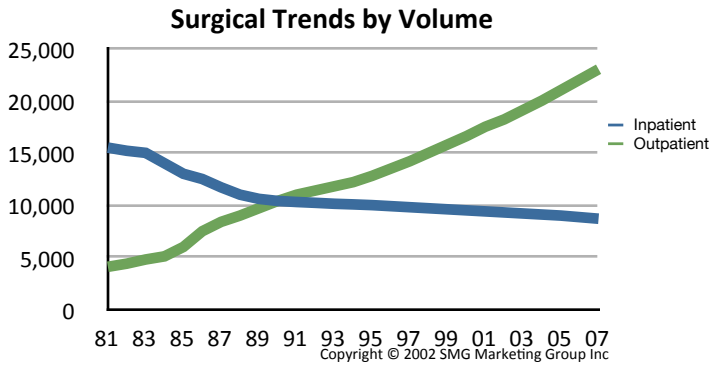
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the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

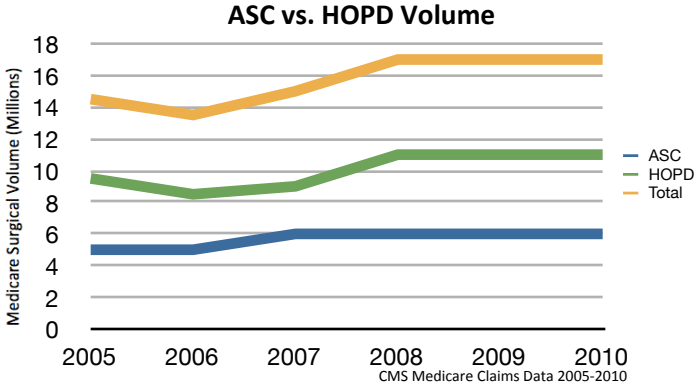
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling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

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

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

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





ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

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

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

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

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

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

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

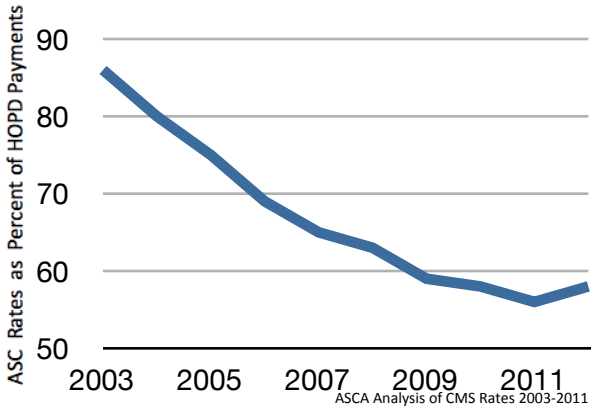
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased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

Cost Comparison:
ASC v. Hospital Outpatient Department

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

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

The Gap Between ASC and HOPD Payments Has Widened Significantly

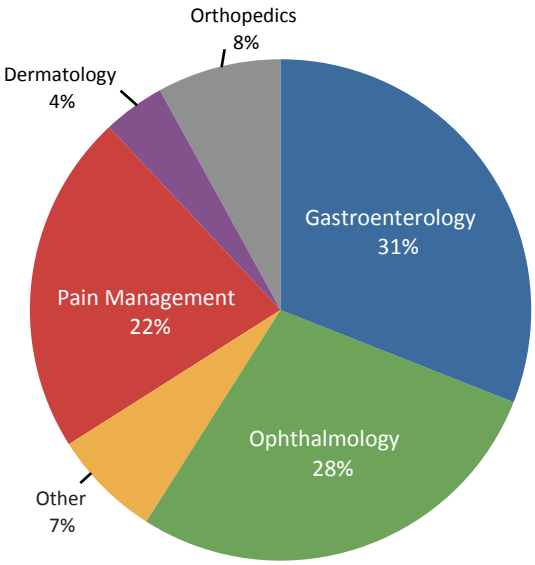


ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

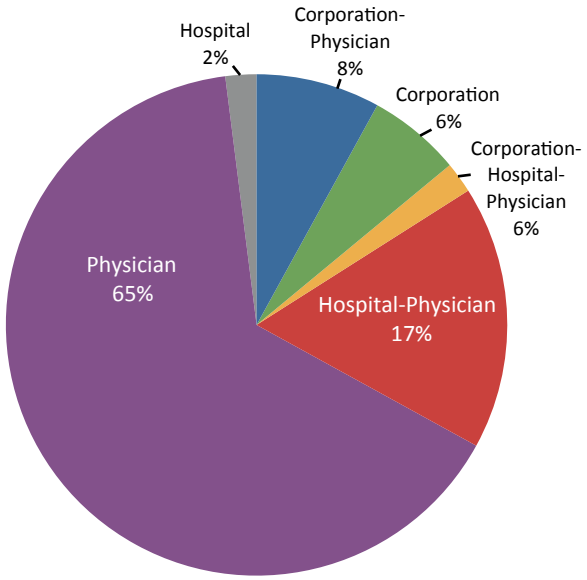
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price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

Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

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

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

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

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

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

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

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

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

<

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

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

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

ASCs: A COMMITMENT TO QUALITY

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

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

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

Reporting Measures

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

76 Federal Regulation 74492 - 74517

Specific Federal Requirements Governing ASCs

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

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

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

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

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

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

Medicare Health and Safety Requirements

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

Source: 42 CFR 416 & 482

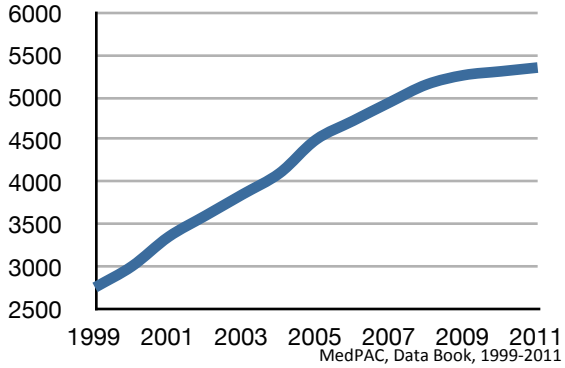
CONTINUED DEMAND FOR ASC FACILITIES

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

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

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

Number of Medicare Certified ASCs



MedPAC, Data Book, 1999-2011

ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

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

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

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

POLICY CONSIDERATIONS

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

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

END NOTES

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

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

3 Oxford Outcomes ASC Impact Analysis, 2010.

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

5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.

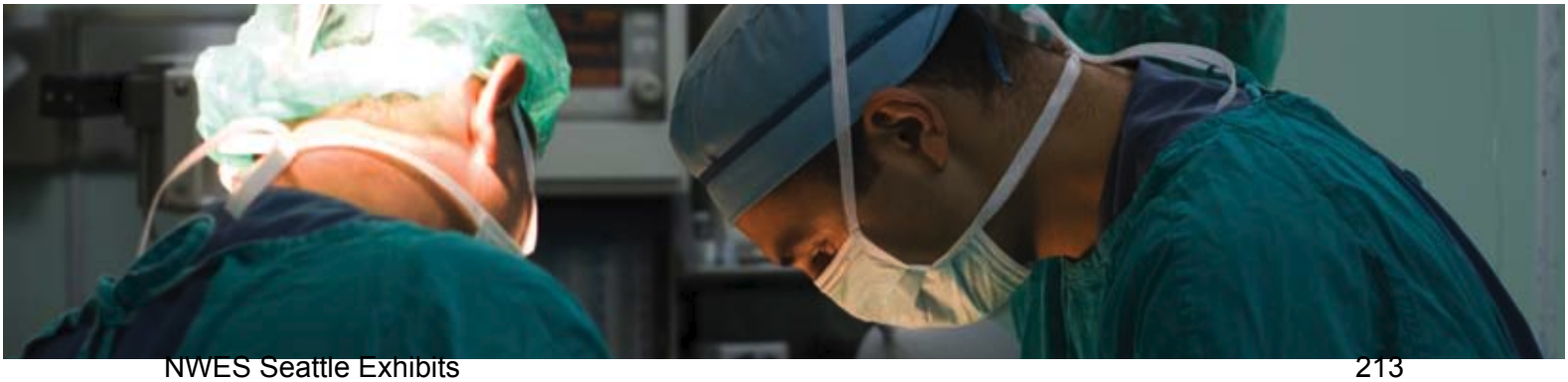


Exhibit 10

Editorial

Rising Cataract Surgery Rates: Demand and Supply

Jay C. Erie, MD - *Rochester, Minnesota*

Cataract surgery is the most frequently performed surgical procedure in many developed countries, providing significant, long-term, and cost-effective improvements in the quality of life for patients of all ages.[1,2] Advances in cataract surgery techniques and technologies over the last decades have led to improved patient safety and better surgical outcomes, resulting in significant changes in the frequency with which cataract surgery is performed.

Longitudinal, population-based data on cataract surgery rates in the United States are limited. In this issue, Klein et al[3] provide timely, informative, population-based data on the changing incidence of cataract surgery in Beaver Dam, Wisconsin, during the 20-year period when cataract surgery shifted from planned extracapsular cataract extraction to small-incision phacoemulsification. Klein et al report that the age- and sex-adjusted incidence of cataract surgery increased 6.5-fold between 1988-90 and 2008-10 (1.8% vs. 11.7%) in Beaver Dam residents aged 43 to 86 years. The greatest increases were seen in the most recent 5-year interval (between 2003-05 and 2008-10) in persons older than 65 years of age and in persons with a visual acuity better than 20/40 or without a clinically significant cataract as determined at an examination 5 years before cataract surgery.

The strengths of this study include its population basis, 2 decades of cataract surgery incidence, a standardized assessment of cataract status and visual acuity, avoidance of inclusion and recall bias, and adjustment for multiple potential risk factors. Its limitations include a small cohort size (4926 residents), a lack of geographic and racial diversity (99% white), and the interpretation of preoperative cataract status and visual acuity based on measurements performed up to 5 years before cataract surgery.

The World Health Organization has set a cataract surgery rate of 3000 per million people per year as the minimum necessary to eliminate cataract blindness.[4] This rate is greatly exceeded in many developed countries (7000−11 000 per million persons),[5–7] and surgery rates are steadily increasing. Increasing cataract surgery rates have been explained, in part, by an aging demographic structure, reduced thresholds of visual impairment as an indication for surgery, increased frequency of second eye surgery, and increasing expectations by patients for better vision.

What can we learn from the Beaver Dam Eye Study? First, the rising cataract surgery rates observed in Beaver Dam also were seen during the same time period in other areas of the United States and in many developed countries, albeit of a significantly lesser magnitude. Across the Mississippi river and 220 miles to the west of Beaver Dam, population-based data from Olmsted County, Minnesota (population 144 248 in 2010), showed a lower, but steady 2.5-fold increase in the rate of incident cataract surgery over the same time period (4400 surgeries/million residents in 1990 and 10 000 in 2010).[7] Furthermore, Olmsted County modeling showed that cataract surgery increased at a greater rate than could be attributed to changing demographics alone. Nationally, using U.S. Medicare beneficiary data, the rate of cataract surgery in persons older than 65 years of age increased 2.4-fold between 1987[8] and 2004.[9] In Australia, cataract surgery rates increased 1.4-fold between 2000 and 2005.[5] Rising surgery rates in the U.S. senior population are not unique to ophthalmology. In orthopedic surgery, improved surgical techniques and implant technologies have led to a 1.6- to 2.7-fold increase in total knee and hip arthroplasties over a comparable time period.[10]

Although cataract surgery rates were on the rise in Beaver Dam, rates in Sweden had stabilized between 2002 and 2009 at 8000 to 9000 procedures per million persons.[6] How were our Nordic colleagues able to accomplish this while at the same time slowly decreasing the surgery backlog, increasing the rate of second eye surgery, and operating on eyes with better preoperative Snellen visual acuity? The reason is multifactorial, but includes a limit on the number of annual cataract surgeries placed by many of Sweden's 22 counties/regions and increased competition for eye care resources from other fields within ophthalmology, primarily in the management of age-related macular degeneration. In 2008, the county of Stockholm removed the limit on the annual number of cataract surgeries allowed. Of note, cataract surgery rates subsequently increased in that area (Lundström M, personal communication, 2013).

Second, a reduced threshold of visual impairment is increasingly being used as an indication for surgery by surgeons, patients, and payers. Better preoperative vision before surgery has been documented in Beaver Dam, Olmsted County,[7] Australia,[5] Denmark,[11] England,[12] and Sweden.[6] In Sweden, for example, the fraction of residents with a Snellen visual acuity of 20/40 or better in the eye planned for surgery has increased from 56% in 1992 to 78% in 2009.[6] Not surprisingly, lower visual thresholds for surgery are associated with increased surgery rates. In Australia, when the visual impairment threshold changed from less than 20/200 to less than 20/30, cataract surgery rates increased approximately 5-fold.[5] However, one needs to remember that Snellen acuity alone is a functionally incomplete measure of visual function, and other quantifiable factors such as contrast sensitivity and glare contribute to patient visual dissatisfaction.

It is important for readers to note that the comments by Klein et al[3] regarding preoperative visual acuity threshold and

ISSN 0161-6420/14/$ - see front matter
http://dx.doi.org/10.1016/j.ophtha.2013.10.002

cataract status are based on measurements performed up to 5 years before cataract surgery. Although the authors think that it "seems unlikely" over a 5-year period "that a rapid change occurred in development of lens opacity and/or decreased vision related to cataract prior to surgery," previous data from the Age-Related Eye Disease Study Research Group[13] report the 5-year cumulative incidence of progression from a grade of no or mild lens opacity at baseline to a moderate cataract of any kind to be approximately 24% among participants aged 55 to 80 years. Rather than mistakenly infer that cataract surgery is being performed in eyes without a cataract, it is more likely that Beaver Dam ophthalmologists and their patients—similar to their colleagues and patients in Olmsted County and in other countries—have reduced their visual impairment threshold for cataract surgery.

Why are we observing an increasing demand for cataract surgery at lower visual impairment thresholds in nearly all age groups? Columnist Rich Karlgaard[14] recently cited George Gilder, author of *Wealth and Poverty,* who argued that in economics, increased demand is due to increased supply. "The key is not an increase in the *same* supply, but rather an increase in a new, inventive supply that exceeds people's expectations and takes them to new heights in their lives."[14] This statement, in my opinion, aptly describes cataract surgery over the last decades. Through improved technologies and techniques, today's ophthalmologists can safely and quickly remove a cloudy crystalline lens and fairly predictably decrease or eliminate postoperative spherical and astigmatic error. Our ability to provide a new, innovative cataract surgery "supply" has provided better outcomes, improved quality of life, and exceeded patient expectations, consequently, and quite naturally this has driven increased patient "demand" for our service.

To paraphrase Steve Jobs, "People don't know what they want until you show it to them."[15] For many patients, after first-eye cataract surgery, the previously minimally symptomatic 20/30 fellow eye now no longer seems adequate when compared with the new pseudophakic eye. The benefits of first-eye surgery seem to have changed our patients' perceptions of disability and visual functioning in the fellow eye. This is evidenced by the significant increase in second-eye surgery in most surveys, now accounting for approximately 40% of all cataract operations. This is for good reason. Bilateral cataract surgery is cost-effective, improves patient satisfaction, and has better outcomes than surgery in one eye only.[2,16,17] Disturbed motion perception, disturbed stereoacuity, and disturbances from anisometropia are reported disabilities that persist after unilateral cataract surgery or with a cataract in the fellow eye after first-eye surgery.[18] Perhaps because of the documented benefits of bilateral cataract surgery, in the last 7 years we have seen a doubling of the rate of second-eye surgery in Olmsted County residents within the first 3 months after first-eye surgery (60% vs. 28%), with 86% of residents now undergoing second-eye surgery within 2 years of first-eye surgery.[7]

Is more always better in cataract surgery? William Falk[19] writes that "if humans can, we will — whether or not we should." Human history amply demonstrates our tendency to race ahead of our ability to think through all of the consequences of our actions. This has been the case recently with the capabilities of drone technology and Internet metadata-analysis. The many documented benefits of cataract surgery have led to an ever-increasing demand for cataract surgery and, as a consequence, steadily higher surgery rates and an increasing need for more resources. Is this appropriate?

I believe it is. To do otherwise is to encourage mediocrity. Continued improvements in cataract surgery "supply" have naturally and appropriately stimulated patient "demand" for better vision. Predicting if or when cataract surgery rates will level off or decline is difficult. Placing limits on the annual number of cataract surgeries performed or shifting more cost to the patient will be contentious. Regardless, it is our responsibility as surgeons to continue to innovate, to improve safety and outcomes, and to reduce costs so that we enhance the value of cataract surgery for every patient we serve.

References

1. Lundström M, Wendel E. Duration of self assessment benefit of cataract extraction: a long term study. Br J Ophthalmol 2005;89:1017–20.
2. Busbee BG, Brown MM, Brown GC, Sharma S. Incremental cost-effectiveness of initial cataract surgery. Ophthalmology 2002;109:606–13.
3. Klein BEK, Howard KP, Lee KE, Klein R. Changing incidence of lens extraction over twenty years: the Beaver Dam Eye Study. Ophthalmology 2014;121:5–9.
4. World Health Organization. Global Initiative for Elimination of Avoidable Blindness. Geneva, Switzerland: World Health Organization; 2000. WHO/PBL/97.61 Rev 2.
5. Taylor HR, Hien TV, Keefe JE. Visual acuity thresholds for cataract surgery and changing Australian population. Arch Ophthalmol 2006;124:1750–3.
6. Behnig A, Montan P, Stenevi U, et al. Once million cataract surgeries: Swedish National Cataract Register 1992-2009. J Cataract Refract Surg 2011;37:1539–45.
7. Gollogly HE, Hodge DO, St. Sauver JL, Erie JC. Increasing incidence of cataract surgery: population-based study. J Cataract Refract Surg 2013;39:1383–9.
8. Javitt JC, Kendix M, Tielsch JM, et al. Geographic variation in utilization of cataract surgery. Med Care 1995;33:90–105.
9. Schein OD, Cassard SD, Tielsch JM, Gower EW. Cataract surgery among Medicare beneficiaries. Ophthalmic Epidemiology 2012;19:257–64.
10. Singh JA. Epidemiology of knee and hip arthroplasty: a systematic review. Open Orthop J 2011;5:80–5.
11. Kessel L, Haargaard B, Boberg-Ans G, Henning V. Time trends in indications for cataract surgery. J Clin Exp Ophthalmol 2012;2:174.
12. Keenan T, Rosen P, Yeates D, Goldacre M. Time trends and geographical variation in cataract surgery rates in England: study of surgical workload. Br J Ophthalmol 2007;91:901–4.
13. Koo EK, Chang JR, Agron E, et al. Ten-year incidence rates of age-related cataract in the Age-Related Eye Disease Study (AREDS): AREDS report no. 33. Ophthalmic Epidemiol 2013;20:71–81.
14. Karlgaard R. Gilder's Triumph. Knowledge and Power. *Forbes* July 15, 2013, p 30.
15. The 100 greatest Steve Jobs quotes. By Stephan Nale. Oct 2012 Permalink. Available at: www.complex.com/tech/2012/10/steve-jobs-quotes/unintended-consequences. Accessed October 28, 2013.

16. Lundström M, Stenevi U, Thorburn W. Quality of life after first and second-eye surgery; five-year data collected by the Swedish National Cataract Register. J Cataract Refract Surg 2001;27:1553–9.
17. Tan ACS, Tay WT, Zheng YF, et al. The impact of bilateral or unilateral cataract surgery on visual functioning; when does second eye cataract surgery benefit patients? Br J Ophthalmol 2012;96:846–51.
18. Lundström M, Albrecht C. Previous cataract surgery in a defined Swedish population. J Cataract Refract Surg 2003;29: 50–6.
19. Falk W. *The Week*. June 21, 2013, Vol. 13 Issue 622, p. 16.

Exhibit 11

OphthalmologyTimesArtificial intelligence

The future of cataract surgery

Changes lie ahead as pressure on surgeons increases

July 10, 2017
By Frank Goes, MD

By Dr Frank Goes
E-mail: frank@goes.be
Dr Goes is medical director, Goes Eye Centre Left Bank in Antwerp, Belgium.
Dr Goes serves as a member of the *Ophthalmology Times Europe* Editorial Advisory Board. He did not indicate any proprietary interest relevant to the subject matter.

As the most common procedure performed by the ophthalmic surgeon, in 2014, 4.3 million cataract operations took place in the European Union Member States. It is estimated that more than 23 million procedures will be performed worldwide in 2016.[1,2]

Meanwhile, during the past 35 years, life expectancy has increased by 12 years in Western countries and by more than 25 years in most developing countries.[3,4] Since we know that the occurrence of cataract increases with age; that the prevalence of cataract is greater in developing countries; and that more than 70% of people aged older than 85 years are affected[5], the medical community faces the threat of insufficient numbers of ophthalmic surgeons.

In the United States, some 9,000 ophthalmic surgeons were performing 3.6 million cataract surgeries in 2015.[2] This means that in 5 years' time, 125,000 surgeons will be required to treat 50 million cataracts per year. In 10 years from now, the number of surgeons needed worldwide could soar to 250,000.

Faced with such numbers, robots and technicians will have to take over. Cataract surgery only recently became more automated, the femtosecond laser having taken over part of the job since 2013. Femtosecond laser-assisted cataract surgery will continue to grow in popularity and the recently introduced nanolaser photo-fragmentation takes over another significant part of the surgery. The insertion of a preloaded IOL by a technician or a robot might be a future development.

Beside robotics, technology will evolve to enable successful cataract procedures in both eyes during a single session, thus saving time. Immediately sequential bilateral cataract surgery will become the norm.

Techniques will also evolve so that treatment of both eyes on patients sitting in the upright position, as happens today in the dentist's chair, will be possible.

Further advancements could be that dilation of the pupil, an inconvenience that incapacitates patients for half a day, might no longer be necessary, and IOL power calculations might be made in the operating room on the day of surgery using ray-tracing techniques. Using three-dimensional technology, a preloaded IOL would be printed in the surgery room and personalised (unifocal-, bifocal- or accommodative) for each patient.

Also in the future, human intelligence is likely to find a way around the need to use an eye speculum for cataract surgery. Unmodified for more than 100 years since it was developed by Arruga and Barraquer, it is (probably) sometimes responsible for the only annoying sensation experienced by a patient during the procedure.

Finally, alternative potential strategies involving genetics are being explored for the prevention of cataracts that could lead to the end of cataract surgery.[6,7]

In summary, implementation of these steps could provide an answer to the overwhelming increase of cataracts requiring treatment worldwide. It will be interesting to review things again in 10 years' time!

References

1. Eurostat. http://ec.europa.eu/eurostat/statistics-explained/index.php/Surgical_ope...

2. Lindstrom R. Thoughts on cataract surgery. *Review of Ophthalmology*. 9 March 2015.

3. The World Bank. *http://data.worldbank.org/indicator/SP.DYN.LE00.IN*

4. Eurostat. *http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_bi 26/12/2016*

5. Cataract Epidemiology: *http://www.news-medical.net/health/Cataract-Epidemiology.aspx*

6. Zhao L, *et al*. *Nature*. 2015;523:606-611

7. Mahesh Shanmugam P, *et al*. *Indian J Ophthalmol*. 2015;63:888-890

E:

Dr Goes is medical director, Goes Eye Centre Left Bank in Antwerp, Belgium.

Dr Goes serves as a member of the *Ophthalmology Times Europe* Editorial Advisory Board. He did not indicate any proprietary interest relevant to the subject matter.

Exhibit 12

2015 Washington State

Charity Care in Washington Hospitals

February 2017

Publication 346-084

For more information or
additional copies of this report contact:

Community Health Systems
PO Box 47853
Olympia, WA 98504-7853

360-236-4210

John Wiesman, DrPH, MPH
Secretary of Health

Contents

Executive Summary

By law, hospitals in Washington cannot deny patients access to care based on an inability to pay. To this end, hospitals are required to develop a charity care policy and submit financial data on the charity care they provide to the Department of Health (department). This report summarizes the charity care data received from Washington hospitals for the fiscal year (FY) ending in 2015.

Overall, Washington hospitals reported $532 million in charity care charges in FY 2015 or approximately $186 million in actual expenses based on a cost-to-charge formula. These total charity care charges reflect a decrease of 44 percent from that reported in FY 2014, which was 34 percent less than FY 2013. Charity care declined two consecutive years for the first time since the department began collecting these data in 1989. The decrease is likely a result of the federal Affordable Care Act (ACA) implementation. The percentage of uninsured dropped dramatically compared to previous years as more Washingtonians are now covered by health insurance, by either expanded Medicaid or private insurance plans.

The hospital with the highest dollar amount of charity care in FY 2015 was Harborview Medical Center, which alone accounted for 12 percent of the statewide total charity care charges. Wide variation was seen in charity care charges among hospitals, ranging from $0 to $62 million. The median amount of charity care per hospital was $1.6 million; however, the average was much higher at $6.0 million because several hospitals provided significant amounts of charity care.

Since the charity care data in this report are based on billed charges, not the actual payment expected by the hospital, calculating the approximate cost of providing charity care can be estimated by applying a cost-to-charge ratio. Multiplying the charity care dollars by the cost-to-charge ratio results in an approximate cost of what hospitals actually spent providing charity care to patients. The statewide cost-to-charge ratio is 0.35. Based on the $532 million reported in charity care charges in FY 2015, the overall cost of providing charity care statewide was approximately $186 million.

More information on FY 2015 charity care, including detailed reports by hospital, is available on our webpage at
http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPatientInformationandCharityCare

About this Report

The department has issued an annual report since 1990 as directed by Chapter 70.170 of the Revised Code of Washington (RCW). Your feedback is important to us. Submit your comments by email at charitycare@doh.wa.gov to help us continue to improve the charity care report.

Background on Charity Care in Washington

What is Charity Care and how is it Reported?

Charity care is defined in Chapter 70.170 RCW as the "necessary inpatient and outpatient hospital health care rendered to indigent persons." A person is considered indigent under Washington Administrative Code (WAC) 246-453-040 if family income is at or below 200 percent of the federal poverty level. Chapter 70.170 RCW prohibits any Washington hospital from denying patients access to care based on inability to pay or adopting admission policies that significantly reduce charity care.

Services eligible for charity care are defined as appropriate hospital-based medical services in WAC 246-453-010. Hospitals are required by the law and rules to submit charity care policies for review to the department at least 30 days prior to adoption. Hospitals are also required to submit an annual budget and year-end financial reports to the department within 180 days of the close of the hospital's fiscal year. Hospitals report this information using a uniform system of accounting. The department uses the financial reports submitted by hospitals to report charity care data and trends for the state each year.

What are Hospitals Required to Report and When?

Hospitals are required to report total patient services revenue, also called billed charges, and the amount of patient services revenue written-off as charity care to the department within 180 days of the close of the hospital's fiscal year. Fiscal years vary among hospitals in Washington, ending on March 31, June 30, September 30, or December 31. Hospitals are also required to report bad debt. Bad debt is different from charity care and is defined as uncollectible amounts, excluding contractual adjustments, arising from failure to pay by patients whose care has not been classified as charity care. All of these data are reported as part of the hospital's year-end financial report.

Hospitals report financial data to the department on an income statement. Below is an abbreviated example of an income statement to illustrate the relationships between the various revenue sources and expenses.

	Hospital: Sample Community Hospital	Comment	Sample Hospital Revenue
=	**TOTAL PATIENT SERVICES REVENUE**	Inpatient and outpatient revenue equivalent to Total Billed Charges	615,000,000
-	Provision for Bad Debts	Unpaid charges billed to patients who are not eligible for charity care, deducted from total revenue	*15,000,000*
-	Contractual Adjustments	Reductions from billed charges negotiated by insurance companies, deducted from total revenue	*350,000,000*
-	Charity Care	Unpaid charges billed to patients eligible for charity care, deducted from total revenue	*25,000,000*
=	**NET PATIENT SERVICE REVENUE**	Actual patient revenue received	225,000,000
+	OTHER OPERATING REVENUE	Actual revenue received for office rental, cafeteria income etc.	10,000,000
=	**TOTAL OPERATING REVENUE**	Actual patient revenue and other operating revenue	235,000,000
-	TOTAL OPERATING EXPENSES	Total expenses for operating the hospital	*220,000,000*
=	**NET OPERATING REVENUE**	Cash remaining after operation of patient services	15,000,000
+/-	NON-OPERATING REVENUE-NET OF EXPENSES	Nonpatient revenue (investments, partnership fees)	5,000,000
=	**NET REVENUE BEFORE ITEMS LISTED BELOW**	Operating plus non operating remainder	20,000,000
+/-	EXTRAORDINARY ITEM	One time cash revenue or cash expenses	0
=	**NET REVENUE OR (EXPENSE)**	Net cash remaining after all the transactions	20,000,000

How do Hospitals Report Charity Care and How is it Calculated?

The amount of charity care reported by hospitals is based on patient services revenue, or what is also called billed charges. These charges are based on the hospital's charge master rate sheet, which sets the price for every treatment and supply category a hospital uses. Every patient's total bill is comprised of the sum of the charge master rates of the various services or supplies during the stay before any adjustments based on insurance status. All patients, regardless of insurance status, receive the same billed charges for the same services.

The billed charges reflect a "markup" that varies between hospitals and is significantly higher than the amount the hospital actually expects to be paid. Medicaid and Medicare pay a set rate

for services regardless of billed charges, and private insurance companies negotiate with hospitals for large discounts off the master rate sheet.

Charity care is the amount of billed charges an indigent patient incurs for appropriate hospital-based medical services. Since these charges include the markup, the dollar amount of charity care reported by hospitals overestimates the true cost of providing charity care to indigent patients.

2015 Washington State Charity Care Data

Statewide Charity Care Charges for Hospital Fiscal Year 2015

This report describes data collected from licensed Washington hospitals for their fiscal years (FY) ending in 2015. FY 2015 includes data for the twelve (12) months prior to the end of each hospital's fiscal calendar, including data for months in 2014 if the fiscal year end is prior to December 31, 2015.

All charity care data for FY 2015 were due to the department by June 30, 2016. Although the department provides reminders and follow-up by phone and in writing to hospitals that are late in reporting data, some hospitals still have not provided data for their 2015 fiscal year. For 2015, 86 of 99 hospitals had reported charity care information in year-end financial reports in time to be used in this report. Of the 13 hospitals that did not provide year-end reports, we have provided annual financial estimates for four hospitals based on their quarterly financial reports. For the other nine hospitals, no charity care data are available because no FY 2015 financial reports were submitted to the department.

Overall, Washington hospitals reported $532 million of charity care charges written off in FY 2015. These charges amounted to 0.9 percent of total patient services revenue and 2.4 percent of adjusted patient services revenue. Adjusted patient services revenue is the amount of revenue for non-Medicare and non-Medicaid payers, which includes private insurance and self-pay. Looking at the adjusted patient services revenue allows a more meaningful comparison of charity care among hospitals.

From the years 2005 through 2015, statewide charity care charges increased by only 15.6 percent over the 10-year period while statewide hospital total patient services revenue, or billed charges, increased by 165 percent (Table 1). However, from 2013 to 2015, charity care decreased 62.6 percent while total patient services increased 17 percent. As a percent of total hospital patient services revenue, charity care charges dropped from 2.9 percent to 0.9 percent from 2013 to 2015 (Table 1 and Figure 1).

Figure 1. Statewide Hospital Charity Care in Washington as a Percent of Total Hospital Patient Service Revenue and as a Percent of Adjusted Patient Service Hospital Revenue, Fiscal Year 2005 - 2015.

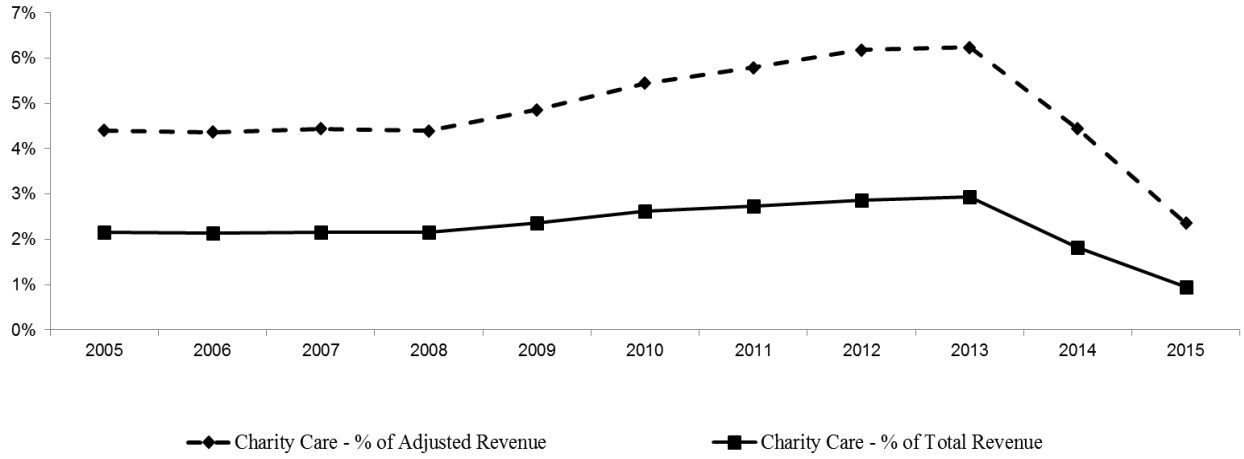


Figure 1 Notes: Adjusted patient service revenue *is the total patient service hospital revenue minus Medicare and Medicaid patient service charges. Patient Service Revenue is the same as Billed Charges.*

Table 1. Statewide Hospital Charity Care in Washington, Fiscal Year 2005-2015

	in Millions			Charity Care		
Year	Total Patient Services Revenue	Adjusted Patient Services Revenue	Total Charity Care (Billed Charges)	a % of Total Revenue	a % of Adjusted Revenue	Operating Margin %
2005	$21,357	$10,457	$461	2.2%	4.4%	4.8%
2006	$23,911	$11,667	$510	2.1%	4.4%	4.3%
2007	$27,502	$13,315	$592	2.2%	4.4%	5.5%
2008	$30,847	$15,187	$668	2.2%	4.4%	5.3%
2009	$34,884	$16,962	$824	2.4%	4.9%	6.1%
2010	$38,172	$18,378	$1,001	2.6%	5.4%	5.6%
2011	$41,182	$19,398	$1,123	2.7%	5.8%	3.4%
2012	$44,728	$20,775	$1,285	2.9%	6.2%	5.5%
2013	$48,482	$22,795	$1,422	2.9%	6.2%	4.9%
2014	$51,993	$21,288	$944	1.8%	4.4%	4.6%
2015	$56,739	$22,595	$532	0.9%	2.4%	5.3%

Table 1 Notes: Adjusted patient service revenue is the total hospital revenue minus Medicare and Medicaid charges. Operating margin is the total hospital patient service operating revenue (net of deductions) minus total patient service operating expenses expressed as a percent. Note: Patient Service Revenue is the same as Billed Charges.

What Changed in 2015?

Some parts of the federal Patient Protection and Affordable Care Act (ACA) affecting health insurance coverage became effective in 2014. The ACA was signed into law on March 23, 2010, putting into place provisions for expanding healthcare coverage, controlling healthcare costs and improving the healthcare delivery system in the United States. The law requires certain employers to offer healthcare insurance; requires citizens and legal residents to have health insurance; creates health benefit exchanges; expands Medicaid coverage; creates an essential benefits package and consumer protections; and establishes tax credits, premium credits and cost-sharing subsidies, along with many other requirements aimed at cost-containment, preventive wellness, and quality improvement.

On January 1, 2014, the healthcare coverage requirement became effective. According to the U.S. Internal Revenue Code Chapter 48 Section 5000A, "An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month." This means all affected individuals must have health insurance or pay a federal tax penalty.

As part of the implementation, new private health insurance coverage options were offered through the marketplace, known as health benefit exchanges. The exchanges provide a one-stop shop for consumers to locate, compare, and enroll in ACA-qualified health plans and access financial assistance to make coverage affordable.[1] Some states chose to use the federal government exchange while other states created state-specific exchanges. Washington created the Washington Health Benefit Exchange, launched the Washington Healthplanfinder portal, and began open enrollment on October 1, 2013.

The ACA also expanded and simplified eligibility for Medicaid so that all adults with income up to 138 percent of the federal poverty level (FPL) have coverage under the program effective January 1, 2014. Washington was one of the states that expanded Medicaid coverage, significantly increasing the number of people covered.[2] As of March 9, 2015, more than half a million adults in Washington had gained health coverage through the Medicaid expansion.[3]

[1] Advance-payment premium tax credit subsidies, available on a sliding scale to those with income between 100 percent and 400 percent of FPL, were put in place to reduce the monthly premium people pay for non-group coverage.

[2] Washington State Health Services Research Project, Research Brief No. 076, April 2016, http://ofm.wa.gov/researchbriefs/2016/brief076.pdf

[3] Ibid

How did the Affordable Care Act affect Charity Care in Washington State?

Because of the Medicaid expansion, patients who were not eligible for Medicaid in the past and therefore, were more likely to qualify for charity care are now covered. According to various sources, the uninsured rate in Washington decreased significantly in 2014 and 2015 as compared to previous years. A report published by the Washington State Insurance Commissioner estimates that 7.3 percent of the state's population was uninsured in 2015 as compared to 8.3 percent in 2014 and 14.5 percent at the end of 2013.[4] The growth of the insured population in Washington led to a 63 percent decline in the amount of hospital charges written off to charity care from 2013 to 2015.

In 2015 hospitals saw continuing decreases in the proportion of self-pay patients (those who pay strictly out of pocket) and increases in the proportion of Medicaid patients. Hospitals report revenue to the department by the payer types of Medicare, Medicaid and Other. Normally, the patient service revenue associated with each payer type increases each year about the same as the overall rate of increase. From 2014 to 2015, the Other payer revenue, which includes self-pay, increased by about 11.2 percent while Medicaid revenue increased by about 4.7 percent. In the prior 2013 to 2014 period, Other payer had actually decreased by about 2 percent. This compares to the overall increase of total patient service revenue of 9.1 percent. The result of these changes is that the proportion of total revenue from the Other payer category increased by 1.9 percent, the Medicaid proportion increased by 1 percent and the Medicare proportion decreased by 4 percent, despite total revenue in all three categories increasing. This shift toward Medicaid and Other may be the result of previously uninsured patients enrolling in Medicaid and commercial insurance at a higher rate than Medicare enrollment, which was not directly affected by the ACA.

Distribution of Charity Care among Washington Hospitals

Charity care varied widely among hospitals, ranging from $0 to $167 million. The median amount of charity care per hospital was $1.6 million; however, the average was much higher at $6 million because several hospitals provided significant charity care. Amounts varied among hospitals in rural and urban areas and in different geographic areas of the state. These variations in charity care do not seem to be explained by population size. Some of the variation may be a function of the proportion of hospital revenue coming from Medicare and Medicaid.

Differences in charity care among hospitals may reflect demographic differences in service areas, hospital service availability, and differences in charity care practices within the hospital. A high level of reported charity care, for example, may reflect greater need for charity care in the

[4] The State of Washington's Uninsured 2014-2015, Office of the Insurance Commissioner, February 3, 2016. https://www.insurance.wa.gov/about-oic/reports/commissioner-reports/documents/2014-2015-state-of-uninsured.pdf

community. Likewise, a low level of charity care may reflect a relative absence of need for charity care in a hospital's service area.

Adjusting Billed Charges to Determine Actual Cost of Providing Charity Care

Because billed charges reflect "mark-ups" that vary between hospitals and are significantly higher than the expected payment, determining the actual cost of providing charity care to eligible patients is challenging. One way to estimate the cost of providing charity care is to use a cost-to-charge ratio[5]. The formula is total operating expenses **(**the actual cost of running the hospital and providing services**)** divided by total patient services revenue (billed charges**)**. This report uses the basic formula; however, there are other focused formulas that may look at only inpatient revenue and expenses or include or exclude certain hospital revenue/expense categories.

As an example of how the cost-to-charge ratio works, if a hospital had billed charges of $1,000,000 and a cost to charge ratio of .345, the actual cost for that hospital to treat patients is $345,000. If that same hospital reported charity care billed charges of $100,000, the cost of treating those patients is $34,500. The higher the ratio, the closer the operating costs are to the actual cost of treating patients. This is only an estimate based on overall hospital performance.

Washington hospitals' cost-to-charge ratios range from .18 to 1.8. The statewide average was .35 with a majority of hospitals between .32 and .56. Below are some examples of cost to charge ratios for Washington hospitals, including a high, average, and low cost-to-charge ratio. Cost to charge ratios for all hospitals are listed in Appendix 2.

Hospital	Charity Care Charges	Cost to Charge Ratio	Estimated Cost of Charity Care
UW Medicine/Harborview	62.8 million	.414	26 million
Overlake Medical Center	8.9 million	.368	3.3 million
Cascade Medical Center	204,000	.887	181,000

[5] http://medical-dictionary.thefreedictionary.com/hospital+cost-to-charge+ratio

Contribution of all Purchasers of Care to Hospital Charity Care

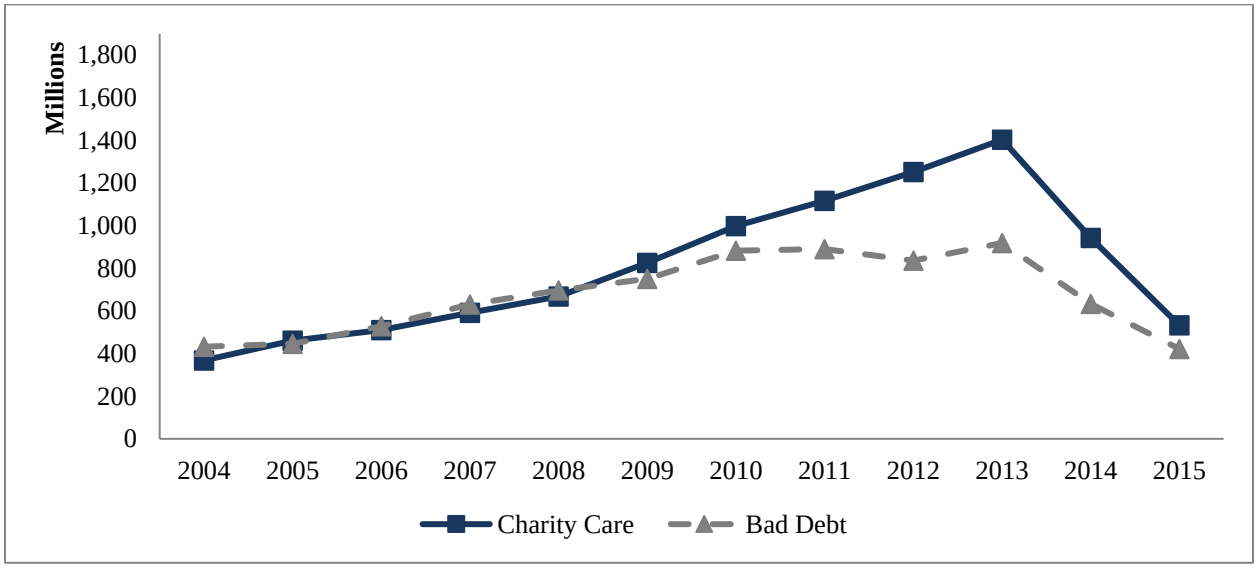
Charity care as a percent of adjusted (non-Medicare, non-Medicaid) revenue increased from 4.4 percent to 6.2 percent from FY 2005 through FY 2013, then declined to 4.4 percent in FY 2014 and 2.4 percent in FY 2015. Because charity care is unreimbursed, all payers—including insurance companies and patients who self-pay—contribute to the cost of charity care to the hospital. Throughout this time, fluctuations in statewide operating margin, which is a measure of hospital profitability, do not appear to have adversely affected the amount of charity care provided in Washington (Table 1).

Uncompensated Care in Washington

Uncompensated care includes both charity care and bad debt. Looking at uncompensated care gives us a bigger picture of the impact of the ACA and a way to compare Washington State to other states.

In 2015, the amount of charity care and bad debt continued to drop due to the increase in people with healthcare insurance. Both charity care and bad debt had been increasing over the past 10 years. In recent years, charity care was rising faster than bad debt (Figure 2). Both had more than doubled between FY 2004 and FY 2013.

Figure 2. Hospital Charity Care and Bad Debt Patient Service Charges in Washington, Fiscal Year 2005 - 2015



How does Washington Compare to the U.S. in Uncompensated Care?

There are no national charity care data available to draw comparisons between Washington and the rest of the United States (U.S.). However, national data are available for uncompensated care, which includes both charity care and bad debt. The national uncompensated care number is built using a formula that includes a cost-to-charge ratio that translates the billed charges written off to uncompensated care into a "cost" or expense. The result is a proxy with which uncompensated care expenses are then compared to total operating costs, not total patient services revenue. The Washington State uncompensated care number is built using the same formula.

Uncompensated care as a percent of hospital expenses is lower in Washington than it is in the U.S. as a whole (Figure 3). In both Washington and the U.S., uncompensated care remained relatively steady over most of the past 10 years, declining from 2013 onward. In the U.S. uncompensated care accounted for 5.3 percent of hospital expenses in FY 2014, the most recent year of data available. In Washington, uncompensated care accounted for 1.6 percent of hospital expenses in FY 2015. (Figure 3).

Figure 3. Hospital Uncompensated Care in Washington and the U.S. as a Percent of Hospital Expenses, Fiscal Years 2005 - 2015

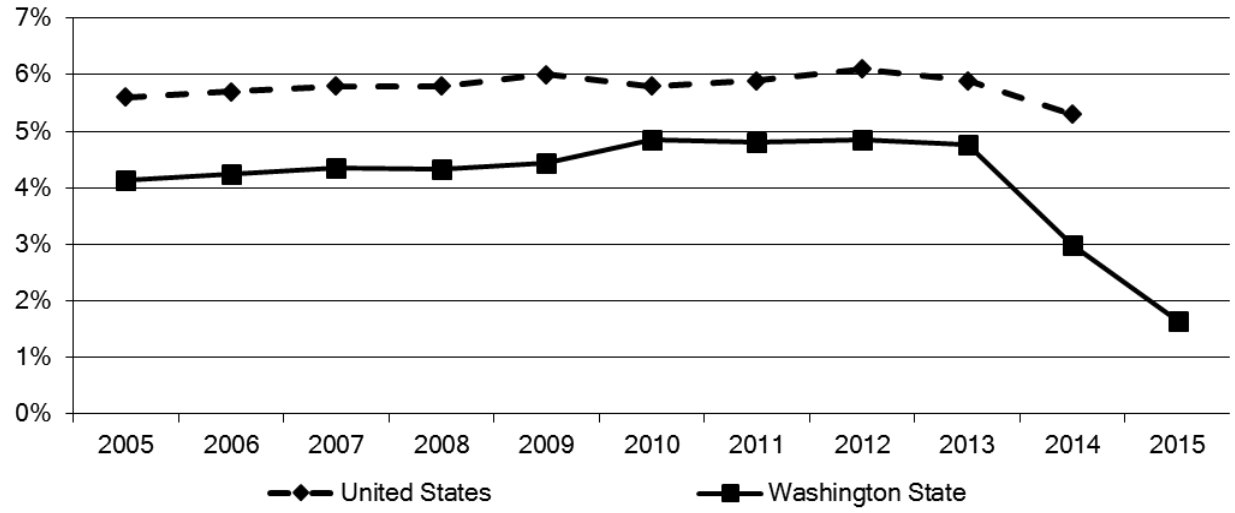


Figure 3 Notes: Uncompensated care includes bad debt and charity care. Uncompensated care as a percent of hospital expenses is calculated by multiplying uncompensated care by the ratio of total expenses to gross patient and other operating revenues. Uncompensated care data for 2015 are not yet available for the U.S. The U.S. data were derived from an American Hospital Association report[6].

[6] http://www.aha.org/content/16/uncompensatedcarefactsheet.pdf

Summary

Implementation of the ACA continues to change the landscape of charity care in Washington State. More patients have health coverage, either through Medicaid expansion or through purchase of private coverage. As a result, Washington saw the first decline in the amount of charity care reported by hospitals since the department began gathering these data.

The ACA has not been fully implemented and certain requirements may become effective over the next few years depending upon the Trump Administration and the new Congress' actions related to ACA. One major phase set for 2018 is the introduction of a penalty if an employer provides a high-cost health insurance plan. Also in 2018, all health insurance plans must cover approved preventive care and checkups without co-payment. If the ACA becomes fully effective, and the number of insured stabilizes, we will likely see a continued decline in charity care in Washington over the next few years before it levels off again.

Appendix 1 Charity Care by Hospital by Region by Adjusted Patient Service Revenue

Total Patient Service Revenue, Adjusted Patient Service Revenue, and Amount of Charity Care as a Percent for Washington Hospital Fiscal Years Ending During Calendar Year 2015

Region/Hospital	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as a % of Total Patient Service Revenue	Charity Care as a % of Adjusted Patient Service Revenue
	Revenue Categories - Patient Service Revenue - (Billed Charges)						
KING COUNTY (N=22)							
Cascade Behavioral Health	35,922,820	21,067,125	7,591,875	7,263,820	20,353	0.06%	0.28%
CHI/Highline Community Hospital	759,417,495	317,599,619	208,350,326	233,467,550	(2,245,998)	-0.30%	-0.96%
CHI/Regional Hospital	40,966,581	31,047,635	3,010,278	6,908,668	874,412	2.13%	12.66%
CHI/Saint Elizabeth Hospital	151,841,881	41,913,626	29,664,589	80,263,666	922,646	0.61%	1.15%
CHI/Saint Francis Community Hospital	969,970,981	363,113,057	217,056,838	389,801,086	8,989,727	0.93%	2.31%
EvergreenHealth/Kirkland	1,512,772,435	588,414,315	147,077,316	777,280,804	4,940,939	0.33%	0.64%
Kindred Hospital Seattle	126,139,047	61,117,016	6,029,865	58,992,166	0	0.00%	0.00%
MultiCare/Auburn Regional Medical Center*	717,781,091	305,153,866	192,604,257	220,022,968	8,175,121	1.14%	3.72%
Navos	19,147,898	6,474,729	9,155,282	3,517,887	604,020	3.15%	17.17%
Overlake Hospital Medical Center	1,269,191,611	553,309,296	83,673,084	632,209,231	8,890,648	0.70%	1.41%
Providence/Swedish - Cherry Hill	1,667,865,050	834,654,108	217,996,881	615,214,061	14,309,385	0.86%	2.33%
Providence/Swedish - First Hill	3,543,189,488	1,248,537,286	614,499,785	1,680,152,417	24,465,167	0.69%	1.46%
Providence/Swedish - Issaquah	513,667,550	173,381,194	46,580,644	293,705,712	3,834,146	0.75%	1.31%
Seattle Cancer Care Alliance	765,473,963	243,092,765	84,312,810	438,068,388	6,057,574	0.79%	1.38%
Seattle Children's Hospital	2,018,295,479	22,598,469	944,053,131	1,051,643,879	26,061,772	1.29%	2.48%
Snoqualmie Valley Hospital	40,717,733	20,804,889	5,520,928	14,391,916	1,461,873	3.59%	10.16%
UHS/BHC Fairfax Hospital	135,717,138	19,270,127	37,100,831	79,346,180	797,076	0.59%	1.00%
UW Medicine/Harborview Medical Center	2,099,326,843	630,722,132	691,789,660	776,815,051	62,804,689	2.99%	8.08%
UW Medicine/Northwest Hospital	975,532,206	443,105,476	130,044,322	402,382,408	7,341,000	0.75%	1.82%
UW Medicine/University of Washington	2,194,854,816	708,116,252	391,886,447	1,094,852,117	18,046,234	0.82%	1.65%
UW Medicine/Valley Medical Center	1,550,749,311	523,225,604	363,442,241	664,081,466	8,671,895	0.56%	1.31%
Virginia Mason Medical Center	2,107,499,167	899,466,889	128,566,297	1,079,465,981	12,496,081	0.59%	1.16%
KING COUNTY TOTALS	23,216,040,584	8,056,185,475	4,560,007,687	10,599,847,422	217,518,760	0.94%	2.05%
PUGET SOUND REGION (Less King Co. N=21)							
Cascade Valley Hospital	Hospital Late in Reporting to Department of Health			-			
CHI/Harrison Memorial Hospital	1,604,179,392	823,607,710	292,858,164	487,713,518	7,669,635	0.48%	1.57%
CHI/Saint Anthony Hospital	568,546,279	276,803,599	92,997,461	198,745,219	2,216,296	0.39%	1.12%
CHI/Saint Clare Hospital	720,758,427	298,898,160	213,360,018	208,500,249	9,094,400	1.26%	4.36%
CHI/Saint Joseph Medical Center - Tacoma	2,450,746,243	1,148,620,658	314,566,682	987,558,903	17,160,029	0.70%	1.74%
EvergreenHealth/Monroe	Hospital Late in Reporting to Department of Health			-			
Forks Community Hospital	39,955,049	12,193,582	8,863,350	18,898,117	180,274	0.45%	0.95%
Island Hospital	225,545,000	92,592,850	13,584,233	119,367,917	311,603	0.14%	0.26%
Jefferson Healthcare	164,864,437	92,843,428	30,349,902	41,671,107	1,007,943	0.61%	2.42%
MultiCare/Good Samaritan Hospital	1,702,668,468	73,929,446	365,601,432	1,263,137,590	22,002,554	1.29%	1.74%
MultiCare/Mary Bridge Children's Health	673,133,231	557,479	408,232,765	264,342,987	3,963,682	0.59%	1.50%
MultiCare/Tacoma General - Allenmore*	2,790,337,060	1,120,035,497	732,706,178	937,595,385	37,624,390	1.35%	4.01%
Olympic Medical Center	308,879,814	181,106,463	52,358,014	75,415,337	1,303,014	0.42%	1.73%
PeaceHealth/Peace Island Medical Center	18,766,468	10,097,353	2,190,385	6,478,730	140,745	0.75%	2.17%
PeaceHealth/Saint Joseph Hospital	1,172,398,898	590,364,640	214,127,953	367,906,305	6,671,949	0.57%	1.81%
PeaceHealth/United General Hospital	84,221,506	42,478,245	19,438,060	22,305,201	1,098,171	1.30%	4.92%
Providence/Regional Medical Center Everett	1,899,664,541	844,127,582	386,227,209	669,309,750	25,270,273	1.33%	3.78%
Providence/Swedish - Edmonds	720,793,408	329,573,018	119,854,714	271,365,676	7,853,691	1.09%	2.89%
Skagit Valley Hospital	913,794,508	447,784,120	203,698,429	262,311,959	4,794,499	0.52%	1.83%
UHS/BHC Fairfax Hospital - North	27,817,904	5,227,600	8,803,200	13,787,104	147,786	0.53%	1.07%
Whidbey General Hospital	234,410,493	107,068,837	36,345,598	90,996,058	851,462	0.36%	0.94%
PUGET SOUND REGION TOTALS	16,321,481,126	6,497,910,267	3,516,163,747	6,307,407,112	149,362,396	0.92%	2.37%

Total Patient Service Revenue, Adjusted Patient Service Revenue, and Amount of Charity Care as a Percent for Washington Hospital Fiscal Years Ending During Calendar Year 2015

Region/Hospital	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as a % of Total Patient Service Revenue	Charity Care as a % of Adjusted Patient Service Revenue
	Revenue Categories - Patient Service Revenue - (Billed Charges)						
SOUTHWEST WASHINGTON REGION (N=14)							
Capella/Capital Medical Center	456,192,832	175,046,912	11,639,931	269,505,989	1,187,656	0.26%	0.44%
Grays Harbor Community Hospital	377,004,651	161,864,873	104,918,138	110,221,640	1,383,763	0.37%	1.26%
Klickitat Valley Hospital	35,638,075	16,014,077	9,873,120	9,750,878	298,921	0.84%	3.07%
Legacy/Salmon Creek Hospital	745,888,157	315,480,303	171,646,822	258,761,032	12,966,543	1.74%	5.01%
Mason General Hospital	181,123,561	80,908,810	54,524,928	45,689,823	2,209,564	1.22%	4.84%
Morton General Hospital	33,617,299	19,037,575	6,349,569	8,230,155	95,921	0.29%	1.17%
Ocean Beach Hospital	32,797,644	24,283,605	491,598	8,022,441	96,387	0.29%	1.20%
PeaceHealth/Saint John Medical Center	675,707,379	327,522,739	177,196,117	170,988,523	4,958,034	0.73%	2.90%
PeaceHealth/Southwest Medical Center	1,608,840,057	655,542,318	401,330,863	551,966,876	15,527,029	0.97%	2.81%
Providence/Centralia Hospital	569,816,902	282,503,015	135,516,735	151,797,152	10,258,251	1.80%	6.76%
Providence/Saint Peter Hospital	1,604,220,493	851,833,701	279,240,243	473,146,549	16,773,244	1.05%	3.55%
Skyline Hospital	27,956,366	12,431,417	5,616,423	9,908,526	111,829	0.40%	1.13%
Summit Pacific Medical Center	57,982,978	19,623,200	17,657,619	20,702,159	485,792	0.84%	2.35%
Willapa Harbor Hospital	24,684,025	13,192,032	472,326	11,019,667	376,337	1.52%	3.42%
SOUTHWEST WASH REGION TOTALS	6,431,470,419	2,955,284,577	1,376,474,432	2,099,711,410	66,729,271	1.04%	3.18%
CENTRAL WASHINGTON REGION (N=21)							
Ascension/Lourdes Counseling Center	34,252,756	6,103,052	20,168,631	7,981,073	173,932	0.51%	2.18%
Ascension/Lourdes Medical Center	233,108,574	88,010,801	50,550,607	94,547,166	3,847,632	1.65%	4.07%
Cascade Medical Center	16,879,692	9,272,022	2,190,212	5,417,458	204,078	1.21%	3.77%
CHS/Toppenish Community Hospital	100,630,801	18,525,363	57,470,351	24,635,087	561,969	0.56%	2.28%
CHS/Yakima Regional Medical Center	575,960,865	261,675,642	138,683,455	175,601,768	1,374,246	0.24%	0.78%
Columbia Basin Hospital	19,477,007	7,915,241	6,125,736	5,436,030	57,605	0.30%	1.06%
Confluence/Central Washington Hospital*	659,632,746	359,905,146	121,505,993	178,221,607	5,302,615	0.80%	2.98%
Confluence/Wenatchee Valley Hospital	Hospital Late in Reporting to Department of Health			-			
Coulee Community Hospital	34,226,660	12,261,245	10,292,945	11,672,470	162,685	0.48%	1.39%
Kittitas Valley Hospital	119,500,425	41,358,400	19,102,603	59,039,422	638,704	0.53%	1.08%
Lake Chelan Community Hospital	42,956,753	16,548,757	9,670,359	16,737,637	376,248	0.88%	2.25%
Mid Valley Hospital	66,943,002	28,559,460	20,408,544	17,974,998	742,731	1.11%	4.13%
North Valley Hospital	37,526,542	16,836,065	11,279,723	9,410,754	298,083	0.79%	3.17%
PMH Medical Center	91,280,329	28,251,241	29,432,965	33,596,123	1,391,827	1.52%	4.14%
Providence/Kadlec Medical Center	1,433,385,271	573,018,800	323,485,049	536,881,422	14,547,155	1.01%	2.71%
Quincy Valley Hospital	Hospital Late in Reporting to Department of Health			-			
Samaritan Hospital	186,248,139	56,129,769	11,370,476	118,747,894	3,081,965	1.65%	2.60%
Sunnyside Community Hospital	Hospital Late in Reporting to Department of Health			-			
Three Rivers Hospital	19,694,182	6,573,174	1,598,572	11,522,436	363,876	1.85%	3.16%
Trios Health	489,223,045	191,453,319	118,914,861	178,854,865	3,018,675	0.62%	1.69%
Yakima Valley Memorial Hospital	939,156,729	403,809,128	250,508,938	284,838,663	7,466,519	0.80%	2.62%
CENTRAL WASH REGION TOTALS	5,100,083,518	2,126,206,625	1,202,760,020	1,771,116,873	43,610,545	0.86%	2.46%

Total Patient Service Revenue, Adjusted Patient Service Revenue, and Amount of Charity Care as a Percent for Washington Hospital Fiscal Years Ending During Calendar Year 2015

Region/Hospital	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as a % of Total Patient Service Revenue	Charity Care as a % of Adjusted Patient Service Revenue
	Revenue Categories - Patient Service Revenue - (Billed Charges)						
EASTERN WASHINGTON REGION (N=21)							
Adventist West/Walla Walla General Hospital*	146,145,896	57,432,415	32,272,011	56,441,470	2,306,608	1.58%	4.09%
CHS/Deaconess Hospital	1,167,493,910	579,593,059	260,050,939	327,849,912	2,361,694	0.20%	0.72%
CHS/Valley Hospital	509,116,270	228,012,615	112,887,090	168,216,565	2,069,346	0.41%	1.23%
Dayton General Hospital	14,661,464	6,091,612	2,587,373	5,982,479	44,389	0.30%	0.74%
East Adams Rural Hospital	10,600,417	3,980,772	1,587,868	5,031,777	26,008	0.25%	0.52%
Ferry County Memorial Hospital	Hospital Late in Reporting to Department of Health			-			
Garfield County Memorial Hospital	Hospital Late in Reporting to Department of Health			-			
Lincoln Hospital	19,263,993	10,190,286	4,041,689	5,032,018	200,103	1.04%	3.98%
Newport Community Hospital	41,779,985	17,279,144	13,141,722	11,359,119	431,044	1.03%	3.79%
Odesssa Memorial Hospital	5,510,518	1,134,898	1,655,237	2,720,383	26,613	0.48%	0.98%
Othello Community Hospital	Hospital Late in Reporting to Department of Health			-			
Providence/Holy Family Hospital	626,691,910	273,588,615	170,435,568	182,667,727	9,471,514	1.51%	5.19%
Providence/Mount Carmel Hospital	99,762,218	48,013,172	24,124,597	27,624,449	1,581,675	1.59%	5.73%
Providence/Sacred Heart Medical Center	2,255,877,755	933,228,736	573,059,032	749,589,987	24,730,105	1.10%	3.30%
Providence/Saint Joseph's Hospital	41,031,348	20,767,469	11,902,543	8,361,336	584,343	1.42%	6.99%
Providence/Saint Mary Medical Center	408,539,589	210,240,526	64,911,132	133,387,931	6,226,551	1.52%	4.67%
Pullman Regional Hospital	98,855,020	34,650,235	11,965,075	52,239,710	385,497	0.39%	0.74%
Saint Luke's Rehabilatation Institute	70,399,379	39,812,985	10,809,221	19,777,173	270,257	0.38%	1.37%
Shriners Hospital for Children - Spokane	35,017,530	-	15,309,125	19,708,405	3,448,819	9.85%	17.50%
Tri-State Memorial Hospital	119,527,461	65,999,793	12,123,996	41,403,672	1,040,211	0.87%	2.51%
Whitman Medical Center	Hospital Late in Reporting to Department of Health			-			
EASTERN WASH REGION TOTALS	5,670,274,663	2,530,016,332	1,322,864,218	1,817,394,113	55,204,777	0.97%	3.04%
STATEWIDE TOTALS (N=99)	56,739,350,310	22,165,603,276	11,978,270,104	22,595,476,930	532,425,749	0.94%	2.36%

*Hospital late in reporting final data to Department of Health. Amounts displayed are estimates calculated from quarterly reports.

Appendix 1 notes: Group Health Central Hospital is not included in this report because healthcare charges are prepaid through member subscriptions; therefore, uncompensated healthcare is generally not incurred. State-owned psychiatric hospitals, federal Veterans Affairs hospitals, and federal military hospitals are also excluded.

Appendix 2 Charity Care Adjusted for Cost to Charge Ratio

Total Patient Service Revenue, Total Operating Expense, Cost to Charge Ratio and Mark-Up for Washington Hospital Fiscal Years Ending During Calendar Year 2015

Region/Hospital	Total Patient Service Revenue	Operating Expense	Cost to Charge Ratio	Mark-Up	Charity Care as reported by the hospital	Charity Care after modified by Cost to
Adventist West/Walla Walla General Hospital*	146,145,896	63,020,339	0.431	2.319	2,306,608	994,645
BHC Fairfax Hospital	135,717,138	46,616,119	0.343	2.911	797,076	273,780
Capital Medical Center	456,192,832	91,526,612	0.201	4.984	1,187,656	238,281
Cascade Behavioral Health	35,922,820	20,005,860	0.557	1.796	20,353	11,335
Cascade Medical Center	16,879,692	14,970,256	0.887	1.128	204,078	180,993
Cascade Valley Hospital	Hospital Late in Reporting to Department of Health					-
CHI/Harrison Memorial Hospital	1,604,179,392	413,381,705	0.258	3.881	7,669,635	1,976,392
CHI/Highline Community Hospital	759,417,495	174,824,492	0.230	4.344	(2,245,998)	(517,048)
CHI/Regional Hospital	40,966,581	16,572,868	0.405	2.472	874,412	353,740
CHI/Saint Anthony Hospital	568,546,279	111,355,624	0.196	5.106	2,216,296	434,084
CHI/Saint Clare Hospital	720,758,427	129,447,603	0.180	5.568	9,094,400	1,633,347
CHI/Saint Elizabeth Hospital	151,841,881	44,726,656	0.295	3.395	922,646	271,775
CHI/Saint Francis Community Hospital	969,970,981	187,887,840	0.194	5.163	8,989,727	1,741,351
CHI/Saint Joseph Medical Center - Tacoma	2,450,746,243	585,313,128	0.239	4.187	17,160,029	4,098,340
CHS/Deaconess Hospital	1,167,493,910	264,997,698	0.227	4.406	2,361,694	536,057
CHS/Valley Hospital	509,116,270	89,542,610	0.176	5.686	2,069,346	363,953
CHS/Yakima Regional Medical Center	575,960,865	103,154,850	0.179	5.583	1,374,246	246,128
Columbia Basin Hospital	19,477,007	16,774,718	0.861	1.161	57,605	49,613
Confluence/Central Washington Hospital*	659,632,746	279,025,218	0.423	2.364	5,302,615	2,243,011
Confluence/Wenatchee Valley Hospital	Hospital Late in Reporting to Department of Health					-
Coulee Community Hospital	34,226,660	26,230,108	0.766	1.305	162,685	124,676
Dayton General Hospital	14,661,464	26,230,108	1.789	0.559	44,389	79,414
East Adams Rural Hospital	10,600,417	8,170,377	0.771	1.297	26,008	20,046
EvergreenHealth - Kirkland*	1,512,772,435	606,563,820	0.401	2.494	4,940,939	1,981,127
EvergreenHealth - Monroe	Hospital Late in Reporting to Department of Health					-
Fairfax North	27,817,904	7,250,969	0.261	3.836	147,786	38,522
Ferry County Memorial Hospital	Hospital Late in Reporting to Department of Health					-
Forks Community Hospital	39,955,049	27,360,687	0.685	1.460	180,274	123,449
Garfield County Memorial Hospital	Hospital Late in Reporting to Department of Health					-
Grays Harbor Community Hospital	377,004,651	100,678,098	0.267	3.745	1,383,763	369,530
Island Hospital	225,545,000	94,742,698	0.420	2.381	311,603	130,892
Jefferson Healthcare	164,864,437	78,772,668	0.478	2.093	1,007,943	481,598
Kindred Hospital Seattle	126,139,047	40,281,777	0.319	3.131	-	-
Kittitas Valley Hospital	119,500,425	66,068,983	0.553	1.809	638,704	353,124
Klickitat Valley Hospital	35,638,075	20,876,510	0.586	1.707	298,921	175,106
Lake Chelan Community Hospital	42,956,753	25,351,186	0.590	1.694	376,248	222,045
Legacy/Salmon Creek Hospital	745,888,157	254,068,252	0.341	2.936	12,966,543	4,416,730
Lincoln Hospital	19,263,993	22,189,037	1.152	0.868	200,103	230,487
Lourdes Counseling Center	34,252,756	17,172,452	0.501	1.995	173,932	87,200
Lourdes Medical Center	233,108,574	91,156,698	0.391	2.557	3,847,632	1,504,610
Mason General Hospital	181,123,561	86,857,600	0.480	2.085	2,209,564	1,059,594
Mid Valley Hospital	66,943,002	31,129,577	0.465	2.150	742,731	345,382
Morton General Hospital	33,617,299	24,016,207	0.714	1.400	95,921	68,526
MultiCare Auburn Regional Medical Center*	717,781,091	157,087,554	0.219	4.569	8,175,121	1,789,138
MultiCare/Good Samaritan Hospital	1,702,668,468	411,602,210	0.242	4.137	22,002,554	5,318,886
MultiCare/Mary Bridge Children's Health	673,133,231	190,231,363	0.283	3.538	3,963,682	1,120,160
MultiCare/Tacoma General - Allenmore*	2,790,337,060	709,249,883	0.254	3.934	37,624,390	9,563,395
Navos	19,147,898	9,282,664	0.485	2.063	604,020	292,821
Newport Community Hospital	41,779,985	26,543,616	0.635	1.574	431,044	273,850
North Valley Hospital	37,526,542	20,837,678	0.555	1.801	298,083	165,519
Ocean Beach Hospital	32,797,644	19,886,478	0.606	1.649	96,387	58,443

Total Patient Service Revenue, Total Operating Expense, Cost to Charge Ratio and Mark-Up for Washington Hospital Fiscal Years Ending During Calendar Year 2015

Region/Hospital	Total Patient Service Revenue	Operating Expense	Cost to Charge Ratio	Mark-Up	Charity Care as reported by the hospital	Charity Care after modified by Cost to Charge Ratio
Odesssa Memorial Hospital	5,510,518	7,506,444	1.362	0.734	26,613	36,252
Olympic Medical Center	308,879,814	152,918,844	0.495	2.020	1,303,014	645,090
Othello Community Hospital	Hospital Late in Reporting to Department of Health					-
Overlake Hospital Medical Center	1,269,191,611	467,283,698	0.368	2.716	8,890,648	3,273,308
PeaceHealth/Peace Island Medical Center	18,766,468	15,148,949	0.807	1.239	140,745	113,614
PeaceHealth/Saint John Medical Center	675,707,379	255,195,198	0.378	2.648	4,958,034	1,872,507
PeaceHealth/Saint Joseph Hospital	1,172,398,898	460,505,004	0.393	2.546	6,671,949	2,620,666
PeaceHealth/Southwest Medical Center	1,608,840,057	552,671,335	0.344	2.911	15,527,029	5,333,870
PeaceHealth/United General Hospital	84,221,506	39,615,155	0.470	2.126	1,098,171	516,545
PMH Medical Center	91,280,329	41,704,337	0.457	2.189	1,391,827	635,901
Providence/Centralia Hospital	569,816,902	151,417,795	0.266	3.763	10,258,251	2,725,931
Providence/Holy Family Hospital	626,691,910	203,546,700	0.325	3.079	9,471,514	3,076,305
Providence/Kadlec Medical Center	1,433,385,271	508,092,710	0.354	2.821	14,547,155	5,156,536
Providence/Mount Carmel Hospital	99,762,218	44,119,825	0.442	2.261	1,581,675	699,496
Providence/Regional Medical Center Everett	1,899,664,541	682,537,900	0.359	2.783	25,270,273	9,079,455
Providence/Sacred Heart Medical Center	2,255,877,755	855,828,295	0.379	2.636	24,730,105	9,382,035
Providence/Saint Joseph's Hospital	41,031,348	21,426,304	0.522	1.915	584,343	305,140
Providence/Saint Mary Medical Center	408,539,589	163,370,304	0.400	2.501	6,226,551	2,489,926
Providence/Saint Peter Hospital	1,604,220,493	442,675,619	0.276	3.624	16,773,244	4,628,482
Providence/Swedish - Cherry Hill	1,667,865,050	471,090,725	0.282	3.540	14,309,385	4,041,705
Providence/Swedish - Edmonds	720,793,408	258,206,831	0.358	2.792	7,853,691	2,813,395
Providence/Swedish - First Hill	3,543,189,488	1,187,245,516	0.335	2.984	24,465,167	8,197,744
Providence/Swedish - Issaquah	513,667,550	202,562,418	0.394	2.536	3,834,146	1,511,978
Pullman Regional Hospital	98,855,020	56,629,376	0.573	1.746	385,497	220,833
Quincy Valley Hospital	Hospital Late in Reporting to Department of Health					-
Saint Luke's Rehabilatation Institute	70,399,379	40,422,671	0.574	1.742	270,257	155,179
Samaritan Hospital	186,248,139	69,618,298	0.374	2.675	3,081,965	1,152,018
Seattle Cancer Care Alliance	765,473,963	441,516,235	0.577	1.734	6,057,574	3,493,936
Seattle Children's Hospital	2,018,295,479	1,072,908,699	0.532	1.881	26,061,772	13,854,216
Shriner Hospital for Children - Spokane	35,017,530	21,718,515	0.620	1.612	3,448,819	2,139,021
Skagit Valley Hospital	913,794,508	297,176,343	0.325	3.075	4,794,499	1,559,225
Skyline Hospital	27,956,366	17,454,165	0.624	1.602	111,829	69,819
Snoqualmie Valley Hospital	40,717,733	37,742,545	0.927	1.079	1,461,873	1,355,056
Summit Pacific Medical Center	57,982,978	23,389,907	0.403	2.479	485,792	195,965
Sunnyside Community Hospital	Hospital Late in Reporting to Department of Health					-
Three Rivers Hospital	19,694,182	12,713,844	0.646	1.549	363,876	234,905
Toppenish Community Hospital	100,630,801	20,888,493	0.208	4.818	561,969	116,651
Trios Health	489,223,045	191,371,526	0.391	2.556	3,018,675	1,180,828
Tri-State Memorial Hospital	119,527,461	65,067,077	0.544	1.837	1,040,211	566,259
UW Medicine/Harborview Medical Center	2,099,326,843	868,911,119	0.414	2.416	62,804,689	25,994,853
UW Medicine/Northwest Hospital	975,532,206	343,919,000	0.353	2.837	7,341,000	2,588,033
UW Medicine/University of Washington	2,194,854,816	1,029,969,829	0.469	2.131	18,046,234	8,468,477
UW Medicine/Valley Medical Center	1,550,749,311	502,083,025	0.324	3.089	8,671,895	2,807,682
Virginia Mason Medical Center	2,107,499,167	1,046,814,313	0.497	2.013	12,496,081	6,206,919
Whidbey General Hospital	234,410,493	99,606,131	0.425	2.353	851,462	361,805
Whitman Medical Center	Hospital Late in Reporting to Department of Health					-
Willapa Harbor Hospital	24,684,025	18,637,584	0.755	1.324	376,337	284,152
Yakima Valley Memorial Hospital	939,156,729	391,708,193	0.417	2.398	7,466,519	3,114,173
Statewide Totals	56,739,350,310	19,707,970,248	0.347	2.879	532,425,749	184,933,926

Appendix 2 notes: Cost-to-Charge formula is total operating expense / total patient services revenue while Mark up is total patient services revenue/total operating expense.

Exhibit 13

WAC 246-310-270

Ambulatory surgery.

(1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC **246-310-210**, **246-310-220**, **246-310-230**, and **246-310-240**.

(2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.

(4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(6) An ambulatory surgical facility shall have a minimum of two operating rooms.

(7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.

(8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or

minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

[Statutory Authority: RCW **70.38.135** and **70.38.919**. WSR 92-02-018 (Order 224), § 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **70.38.919**. WSR 90-16-058 (Order 073), § 248-19-700, filed 7/27/90, effective 8/27/90.]

Exhibit 14

By Elizabeth L. Munnich and Stephen T. Parente

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

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

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

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

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

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

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

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

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

This article addresses the possibilities for ASCs

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

Background On Ambulatory Surgery Centers

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

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

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

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

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

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

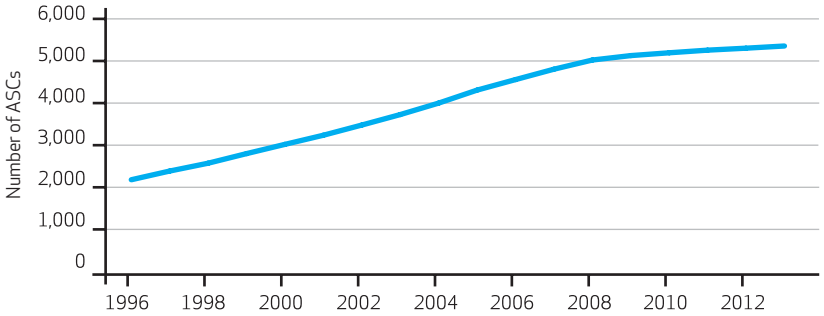
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of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

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

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

EXHIBIT 1

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



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

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

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

Study Data And Methods

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

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

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

EXHIBIT 2

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

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

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

Study Results

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

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

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

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

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

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

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

Discussion

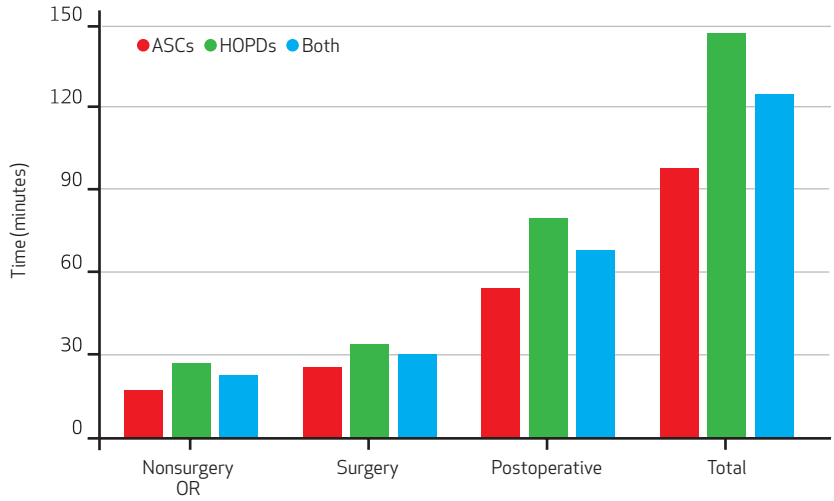
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This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

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

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

EXHIBIT 3

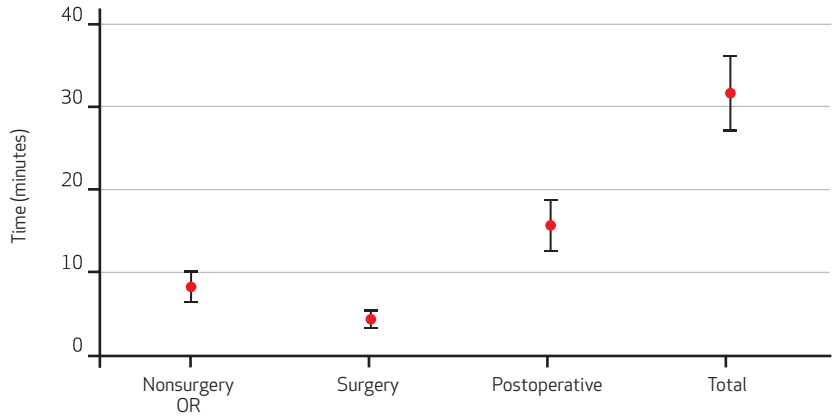
Average Outpatient Surgical Procedure Time, By Facility Type, 2006



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

EXHIBIT 4

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



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

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

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

25 million

Procedures

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

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

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

Conclusion

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

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

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

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

NOTES

1 Sloss EM, Fung C, Wynn BO, Ashwood JS, Stoto MA. Further analyses of Medicare procedures provided in multiple ambulatory settings. Santa Monica (CA): RAND; 2006 Oct.

2 Kozak LJ, McCarthy E, Pokras R. Changing patterns of surgical care in the United States, 1980–1995. Health Care Financ Rev. 1999; 21(1):31–49.

3 Leader S, Moon M. Medicare trends in ambulatory surgery. Health Aff (Millwood). 1989;8(1):158–70.

4 American Hospital Association. Chartbook: trends affecting hospitals and health systems [Internet]. Chicago (IL): AHA; [cited 2014 Mar 25]. Available from: http://www.aha.org/research/reports/tw/chartbook/index.shtml

5 Winter A. Comparing the mix of patients in various outpatient surgery settings. Health Aff (Millwood). 2003;22(6):68–75.

6 Casalino LP, Devers KJ, Brewster LR. Focused factories? Physician-owned specialty facilities. Health Aff (Millwood). 2003;22(6):56–67.

7 Spetz J, Parente ST, Town RJ, Bazarko D. Scope-of-practice laws for nurse practitioners limit cost savings that can be achieved in retail clinics. Health Aff (Millwood). 2013;32(11):1977–84.

8 Authors' analysis of data from the 1996 and 2006 National Survey of Ambulatory Surgery.

9 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2003 Mar [cited 2014 Mar 25]. Available from: http://www.medpac.gov/documents/mar03_entire_report.pdf

10 Scully TA. Statement to the Federal Trade Commission on health care and competition law [Internet]. Washington (DC): FTC; 2003 Feb 26 [cited 2014 Mar 31]. Available from: http://www.ftc.gov/sites/default/files/documents/public_events/health-care-competition-law-policy-hearings/030226trans.pdf

11 Government Accountability Office. Medicare: payment for ambulatory surgical centers should be based on the hospital outpatient payment system [Internet]. Washington (DC): GAO; 2006 Nov [cited 2014 Mar 25]. (Report No. GAO-07-86). Available from: http://www.gao.gov/assets/260/253992.pdf

12 Hair B, Hussey P, Wynn B. A comparison of ambulatory perioperative times in hospitals and freestanding centers. Am J Surg. 2012;204(1): 23–7.

13 Paquette IM, Smink D, Finlayson SR. Outpatient cholecystectomy at hospitals versus freestanding ambulatory surgical centers. J Am Coll Surg. 2008;206(2):301–5.

14 Grisel J, Arjmand E. Comparing quality at an ambulatory surgery center and a hospital-based facility: preliminary findings. Otolaryngol Head Neck Surg. 2009;141(6):701–9.

15 Munnich EL, Parente ST. Costs and benefits of competing health care providers: trade-offs in the outpatient surgery market [Internet]. Unpublished paper. 2014 Feb [cited 2014 Mar 25]. Available from: http://louisville.edu/faculty/elmunn01/research/Munnich_Parente_ASC_Quality.pdf

16 The five highest-volume procedures by ASC volume are cataract removals, other minor eye procedures, colonoscopies, upper gastrointestinal endoscopies, and minor musculoskeletal procedures. According to our calculations, the top five procedures account for 82 percent of claims in ASCs, compared to 74 percent of claims in hospital outpatient departments.

17 Fleisher LA, Pasternak LR, Herbert R, Anderson GF. Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care. Arch Surg. 2004;139(1):67–72.

18 Hollingsworth JM, Saigal CS, Lai JC, Dunn RL, Strope SA, Hollenbeck BK. Surgical quality among Medicare beneficiaries undergoing outpatient urological surgery. J Urol. 2012; 188(4):1274–8.

19 CMS.gov. ASC quality reporting [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [last modified 2012 Aug 16; cited 2014 Mar 25]. Available from: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/

20 Trentman TL, Mueller JT, Gray RJ, Pockaj BA, Simula DV. Outpatient surgery performed in an ambulatory surgery center versus a hospital: comparison of perioperative time intervals. Am J Surg. 2010;200(1): 64–7.

21 We measured underlying patient health by generating patient risk scores using the Johns Hopkins University Adjusted Clinical Groups (ACG) System, version 10. This case-mix system uses *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), diagnosis codes and patient characteristics to construct measures of health status. The predictive modeling feature of the ACG software produces a concurrent weight that is a summary measure of the patient's current health status and resource use.

22 Macario A. What does one minute of operating room time cost? J Clin Anesth. 2010;22(4):233–6.

23 Congressional Budget Office. Insurance coverage provisions of the Affordable Care Act—CBO's February 2014 baseline [Internet]. Washington (DC): CBO; 2014 Feb [cited 2014 Mar 31]. Available from: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf

24 See, for example, Dall TM, Gallo PD, Chakrabarti R, West T, Semilla AP, Storm MV. An aging population and growing disease burden will require a large and specialized health care workforce by 2025. Health Aff (Millwood). 2013;32(11):2013–20.

25 To access the Appendix, click on the Appendix link in the box to the right of the article online.

26 American Hospital Association. 2008 chartbook: trends affecting hospitals and health systems [Internet]. Chicago (IL): AHA; [cited 2014 Mar 25]. Available from: http://www.aha.org/research/reports/tw/chartbook/2008chartbook.shtml

27 Ambulatory Surgery Center Association. What is an ASC? [Internet]. Alexandria (VA): ASCA; 2013 [cited 2014 Mar 25]. Available from: http://www.ascassociation.org/AdvancingSurgicalCare/AboutASCs/IndustryOverview

28 Plotzke M, Courtemanche C. Does procedure profitability impact whether an outpatient surgery is performed at an ambulatory surgery center or hospital? Health Econ. 2011;20(7):817–30.

29 Bian J, Morrisey MA. Free-standing ambulatory surgery centers and hospital surgery volume. Inquiry. 2007;44(2):200–10.

30 Lynk WJ, Longley CS. The effect of physician-owned surgicenters on hospital outpatient surgery. Health Aff (Millwood). 2002;21(4):215–21.

31 Lynn G. Statement to the Federal Trade Commission on health care and competition law and policy [Internet]. Washington (DC): FTC; 2003 Mar 27 [cited 2014 Mar 31]. Available from: http://www.ftc.gov/sites/default/files/documents/public_events/health-care-competition-law-policy-hearings/030327ftctrans.pdf

Exhibit 15

Service Area Population: 2024 550,947 Claritas Age 0 - 85+
Surgeries @202.998/1,000: 111,841

a.i. 94,250 minutes/year/mixed-use OR

a.ii. 68,850 minutes/year/dedicated outpatient OR

a.iii. 10 dedicated outpatient OR's x 68,850 minutes = 688,500 minutes dedicated OR capacity 20,319 Outpatient surgeries

a.iv. 87 mixed-use OR's x 94,250 minutes = 8,199,750 minutes mixed-use OR capacity 80,587 Mixed-use surgeries

b.i. projected inpatient surgeries = 65,600 = 6,674,848 minutes inpatient surgeries
projected outpatient surgeries = 46,241 = 1,566,866 minutes outpatient surgeries

b.ii. Forecast # of outpatient surgeries - capacity of dedicated outpatient OR's
46,241 - 20,319 = 25,922 outpatient surgeries

b.iii. average time of inpatient surgeries = 101.75 minutes
average time of outpatient surgeries = 33.89 minutes

b.iv. inpatient surgeries*average time = 6,674,848 minutes
remaining outpatient surgeries(b.ii.)*ave time = 878,366 minutes
7,553,214 minutes

c.i. if b.iv. < a.iv. , divide (a.iv.-b.iv.) by 94,250 to determine surplus of mixed-use OR's
USE THIS VALUE
8,199,750
\- 7,553,214
646,536 / 94,250 = **6.86**

c.ii. if b.iv. > a.iv., divide (inpatient part of b.iv - a.iv.) by 94,250 to determine shortage of inpatient OR's
Not Applicable - Ignore the following values and use results of c.i.
6,674,848
\- 8,199,750
-1,524,902 / 94,250 = **-16.18**

divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated outpatient OR's
878,366 / **68,850** = **12.76**

Facility	Special Pr	Dedicated	Dedicated	Mixed Use	Mixed Use	2019 Inpatient Cases in Mixed Use ORs	Inpatient M	Outpatient	Outpatient Cases	Outpatient Mins.
MultiCare Health System-Deaconess Hospital	0	0	0	17	111.6	9,929	1,108,500	0	0	0
MultiCare Health System-Valley Hospital and Medical Center	0	0	0	8	120	7,616	913,770	0	0	0
Providence Holy Family Hospital	0	0	0	19	71.8	12,861	923,263	0	0	0
Providence Sacred Heart Medical Center and Children's Hospital	0	0	0	41	106.3	30,624	3,255,300	0	0	0
Shriners Hospital for Children-Spokane	0	0	0	2	112	854	95,862	0	0	0
Chesnut Institute of Cosmetic & Reconstructive Surgery	0	0	**2**	0	0	0	0	0	1,266	4,500
Providence Surgery and Procedure Center	0	0	**4**	0	0	0	0	0	5,960	223,213
Rockwood Eye Surgery	0	0	**2**	0	0	0	0	0	1,501	67,825
South Perry Endoscopy [Endoscopy Only]	0	0	2	0	0	0	0	0		
Spokane Digestive Disease [Endoscopy/Pain Management Only]	0	0	4	0	0	0	0	0		
Advanced Dermatology & Skin Surgery	0	0	6	0	0	0	0	0	180	1,313
Aesthetic Plastic Surgical Center	0	0	1	0	0	0	0	0	59	10,281
Carol Hathaway, MD PS	0	0	1	0	0	0	0	0	90	4,500
Columbia Surgery Center	0	0	4	0	0	0	0	0	5,056	252,800
Empire Eye Surgery Center (Applicant)	0	0	1	0	0	0	0	0	2,016	30,240
Inland Northwest Surgery Center	0	0	1	0	0	0	0	0	298	21,878
Liberty Oral and Maxillofacial Center	0	0	6	0	0	0	0	0	3,000	150,000
NEOS Surgery Center	0	0	1	0	0	0	0	0	569	28,450
Northwest Orthopedic Specialists-	0	0	5	0	0	0	0	0	5,593	331,680
Northwest Surgery Center Inc.	0	0	2	0	0	0	0	0	329	16,540
Pacific Cataract & Laser Institute	0	0	3	0	0	0	0	0	3,566	53,490
Spokane Plastic Surgeons	0	0	1	0	0	0	0	0	54	5,684
Spokane Surgery Center	0	0	2	0	0	0	0	0	300	15,000
Spokane Valley ASC	0	0	2	0	0	0	0	0	798	37,345
SRM Spokane	0	0	2	0	0	0	0	0	96	2,880
The Plastic Surgicenter	0	0	2	0	0	0	0	0	670	33,500
The Spokane Eye Surgery Center	0	0	11	0	0	0	0	0	12,100	180,979
Women's Health Connection	0	0	1	0	0	0	0	0	120	6,000
Totals	**0**	**0**	**66**	**87**	**522**	**61,884**	**6,296,695**	**0**	**43,621**	**1,478,098**
					Avg min/case inpatien		**101.75**	**Avg min/case outpatie**		**33.89**
ORs counted in numeric methodology			**10**	**87**						

ILRS: Integrated Licensing & Regulatory System
Population data source: Claritas 2021 data

Total Surgeries	105,505
Area population 2019 [0 - 85+]	519,734
Use Rate	202.998
Planning Area projected population Year: 2024	550,947
% Outpatient of total surgeries	41.34%
% Inpatient of total surgeries	58.66%

Exhibit 16

Empire Eye Ambulatory Surgery Center

Year	Jul-Dec 2021	2022	2023	2024
REVENUE AND EXPENSE STATEMENT				
ASC Volumes Totals OR Cases ("Procedures")	1,031	2,083	2,107	2,130
OR Minutes	19,580	39,577	40,033	40,470
Number of Operating Rooms Utilized*	0.28	0.57	0.58	0.59
Gross Revenue	$ 3,133,751	$ 6,406,556	$ 6,554,186	$ 6,701,203
Payer Adjustment	(1,441,670)	(2,947,311)	(3,015,227)	(3,082,862)
	-			
Net Revenue	$ 1,692,081	$ 3,475,534	$ 3,569,374	$ 3,665,747
Medicare	608,303	1,249,455	1,283,190	1,317,836
Medicaid	18,782	38,578	39,620	40,690
Commercial/Health Care Contractor	311,174	639,151	656,408	674,131
Self-pay	711,182	1,460,767	1,500,208	1,540,713
Federal	42,810	87,931	90,305	92,743
Total	**$ 1,692,081**	**$ 3,475,534**	**$ 3,569,374**	**$ 3,665,747**
	-			
Amoritization	46	93	94	95
Anesthesia Services	1,600	3,236	3,273	3,311
Auto	414	838	848	857
Continuing Education	1,826	3,693	3,735	3,778
Copies	1,375	2,782	2,814	2,846
Depreciation	18,113	36,639	37,056	37,479
Donations	129	261	264	267
Drugs and Supplies	549,977	1,112,484	1,125,156	1,137,972
Dues and Subscriptions	3,705	7,495	7,580	7,667
Employee Benefits	54,416	99,190	102,165	105,230
Employee Retirement	8,502	17,198	17,393	17,592
Excise Taxes	15,215	30,776	31,126	31,481
Insurance- general	7,311	14,788	14,957	15,127
Laundry	3,204	6,481	6,554	6,629
Meals and Entertainment	4,126	8,346	8,441	8,537
Miscellaneous	254	515	521	526
Office and Computer Expense	98,159	198,554	200,815	203,103
Payroll taxes	23,368	47,267	47,806	48,350
Professional Fees	17,671	35,745	36,153	36,564
Promotion	16,669	33,718	34,102	34,490
Recruitment	1,258	2,544	2,573	2,602
Rent	82,323	166,522	168,418	170,337
Repairs and Maintenance	15,639	31,635	31,995	32,360
Salaries- office	121,042	244,841	247,629	250,450
Salaries- ASC	226,732	413,290	425,689	438,460
Sales Tax	4,405	8,910	9,011	9,114
Taxes	1,965	3,976	4,021	4,067
Telephone	2,086	4,219	4,267	4,315
Travel expenses/reimbursements	7,762	15,700	15,879	16,060
Utilities	2,513	5,083	5,141	5,199
Certificate of Need Application	40,247		-	-
Charity Care	10,152	20,853	21,416	21,994
Operating Expenses	**$ 1,342,204**	**$ 2,577,670**	**$ 2,616,893**	**$ 2,656,859**
Net Income (Loss) (Pre-Tax)	**$ 349,877**	**$ 897,865**	**$ 952,480**	**$ 1,008,888**

Revenues and Expenses per Case Billed Revenues

Empire Eye Ambulatory Surgery Center

Year	Jul-Dec 2021	2022	2023	2024
Billed Revenues	3,041	3,076	3,111	3,146
Net Revenue	(1,399)	(1,415)	(1,431)	(1,447)
Total Expenses	1,302	1,237	1,242	1,247
Net Income (Loss)	$ 340	$ 423	$ 438	$ 451
Revenues and Expenses per OR Minute				
Net Revenue	86	88	89	91
Total Expenses	69	65	65	66
Net Income (Loss)	$ 18	$ 23	$ 24	$ 25

Footnotes:
*Operating Room is defined as 68,850 minutes of surgery minutes per Washington State Certificate of Need Department.

VOLUME AND REVENUE STATEMENT				
ASC Volumes				
Operations on the Eye	1,031	2,083	2,107	2,130
Total ASC Volumes	1,031	2,083	2,107	2,130
Cases by Payer				
Medicare	370	749	757	766
Medicaid	11	23	23	24
Commercial/Health Care Contractor	190	383	387	392
Self-pay	433	875	886	895
Federal	26	53	53	54
Cases *by Payer-% of Total*				
Medicare	36.0%	36.0%	36.0%	36.0%
Medicaid	1.1%	1.1%	1.1%	1.1%
Commercial/Health Care Contractor	18.4%	18.4%	18.4%	18.4%
Self-pay	42.0%	42.0%	42.0%	42.0%
Federal	2.5%	2.5%	2.5%	2.5%
	100.0%	100.0%	100.0%	100.0%
Number of FTEs per Year (Productive)				
Office/Clerical Employees	1.00	1.00	1.00	1.00
Registered Nurses	3.00	3.00	3.00	3.00
Operating Room Technicians	2.00	2.00	2.00	2.00
Manager (RN)	1.00	1.00	1.00	1.00
Total FTE's	7.00	7.00	7.00	7.00
Total Wages and Salaries				
Office/Clerical Employees	18,468	39,184	40,360	41,571
Registered Nurses	96,447	204,642	210,781	217,105
Operating Room Technicians	43,518	92,337	95,108	97,961
Manager	68,299	77,126	79,440	81,823
Total Employee Salaries	226,732	413,290	425,689	438,460
Employee Benefits	54,416	99,190	102,165	105,230
Total Salaries and Benefits	$ 281,148	$ 512,480	$ 527,854	$ 543,690
Annual Change		$ 138,406	$ 15,374	$ 15,836

Exhibit 17

DREW M. BODKER, P.S.

Attorney and Counselor at Law
2607 S. Southeast Blvd. Suite A201
Spokane, Washington 99223

Admitted to Practice in
Washington and Idaho

Phone: (509) 456-5100
Fax: (509) 456-5114
drew@bodkerlaw.com

February 20, 2019

Empire Eye Land, LLC
1414 N. Houk Road Ste. 103
Spokane, WA 99206

Re: Hanson Industries, Inc. / Empire Eye Land, LLC – Lot 6 Hanson Center East

In regard to the above-referenced transaction, enclosed please find the original, recorded Statutory Warranty Deed together with your Policy of Title Insurance which has been issued by Spokane County Title.

Very truly yours,

DREW M. BODKER
Attorney at Law

DMB/lyb
Enclosures

01/31/2019 01:40 PM Page 1 of 2 6779248
Recording Fee $ .00
Warranty Deed SPOKANE COUNTY TITLE COMPANY
Spokane County Washington

RECORDING REQUESTED BY AND
WHEN RECORDED RETURN TO:

DREW M. BODKER, P.S.
ATTORNEY AT LAW
2607 S. SOUTHEAST BLVD. SUITE A201
SPOKANE, WASHINGTON 99223

SP17748

STATUTORY WARRANTY DEED

THE GRANTOR, Hanson Industries, Inc., a Washington corporation, for and in consideration of Ten ($10.00) Dollars and other good and valuable consideration, in hand paid, conveys and warrants to Empire Eye Land, LLC, a Washington limited liability company, the following described real estate, situated in the County of Spokane, State of Washington:

LOT 7 AND THE EAST 84.00 FEET OF LOT 6, BLOCK 2, HANSON CENTER EAST, AS PER PLAT RECORDED IN VOLUME 27 OF PLATS, PAGE 10, 11 AND 12, RECORDS OF SPOKANE COUNTY;

EXCEPT THE EAST 41.00 FEET OF LOT 7;

SITUATE IN THE CITY OF SPOKANE VALLEY, COUNTY OF SPOKANE, STATE OF WASHINGTON.

APN: 45132.0419

SUBJECT TO: restrictions, reservations, and easements of record

Dated this 29th day of January, 2019.

Hanson Industries, Inc.

By Robert J. Boyle
Robert J. Boyle – President

1/31/2019 20190242
GAJ $11,635.52

STATE OF WASHINGTON)
) ss.
County of Spokane)

On this 30th day of January, 2019, before me, the undersigned, a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared Robert J. Boyle to me known to be the President of Hanson Industries, Inc., the corporation that executed the foregoing instrument and acknowledged the said instrument to be the free and voluntary act and deed of said corporation for the uses and purposes therein mentioned, and on oath stated that he is authorized to execute the said instrument.

Witness my hand and official seal hereto affixed the day and year first above written.

DREW M. BODKER
NOTARY PUBLIC
STATE OF WASHINGTON
My Commission Expires May 17, 2020

Notary Public in and for the State of Washington, residing at Spokane
My Appointment Expires: 5-17-20

OWNER'S POLICY OF TITLE INSURANCE

Policy Number OX 12448627

Issued by Old Republic National Title Insurance Company

Any notice of claim and any other notice or statement in writing required to be given to the Company under this Policy must be given to the Company at the address shown in Section 18 of the Conditions.

COVERED RISKS

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B, AND THE CONDITIONS, OLD REPUBLIC NATIONAL TITLE INSURANCE COMPANY, a Minnesota corporation (the "Company") insures, as of Date of Policy and, to the extent stated in Covered Risks 9 and 10, after Date of Policy, against loss or damage, not exceeding the Amount of Insurance, sustained or incurred by the Insured by reason of:

1. Title being vested other than as stated in Schedule A.

2. Any defect in or lien or encumbrance on the Title. This Covered Risk includes but is not limited to insurance against loss from:
   (a) A defect in the Title caused by
      (i) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;
      (ii) failure of any person or Entity to have authorized a transfer or conveyance;
      (iii) a document affecting Title not properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;
      (iv) failure to perform those acts necessary to create a document by electronic means authorized by law;
      (v) a document executed under a falsified, expired, or otherwise invalid power of attorney;
      (vi) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or
      (vii) a defective judicial or administrative proceeding.
   (b) The lien of real estate taxes or assessments imposed on the Title by a governmental authority due or payable, but unpaid.
   (c) Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land. The term "encroachment" includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.

3. Unmarketable Title.

4. No right of access to and from the Land.

5. The violation or enforcement of any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to
   (a) the occupancy, use, or enjoyment of the Land;
   (b) the character, dimensions, or location of any improvement erected on the Land;
   (c) the subdivision of land; or
   (d) environmental protection

if a notice, describing any part of the Land, is recorded in the Public Records setting forth the violation or intention to enforce, but only to the extent of the violation or enforcement referred to in that notice.

Issued through the office of:
SPOKANE COUNTY TITLE COMPANY
NORTHBANK BUILDING, SUITE 100
1010 N. NORMANDIE STREET
SPOKANE, WASHINGTON 99201

Countersigned

Authorized Officer or Agent

OLD REPUBLIC NATIONAL TITLE INSURANCE COMPANY
A Stock Company
400 Second Avenue South, Minneapolis, Minnesota 55401
(612) 371-1111

By _____ *President*

Attest _____ *Secretary*

ORT Form 4309
ALTA Owners Policy of Title Insurance 6-17-06

6. An enforcement action based on the exercise of a governmental police power not covered by Covered Risk 5 if a notice of the enforcement action, describing any part of the Land, is recorded in the Public Records, but only to the extent of the enforcement referred to in that notice.

7. The exercise of the rights of eminent domain if a notice of the exercise, describing any part of the Land, is recorded in the Public Records.

8. Any taking by a governmental body that has occurred and is binding on the rights of a purchaser for value without Knowledge.

9. Title being vested other than as stated in Schedule A or being defective

(a) as a result of the avoidance in whole or in part, or from a court order providing an alternative remedy, of a transfer of all or any part of the title to or any interest in the Land occurring prior to the transaction vesting Title as shown in Schedule A because that prior transfer constituted a fraudulent or preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws; or
(b) because the instrument of transfer vesting Title as shown in Schedule A constitutes a preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws by reason of the failure of its recording in the Public Records
(i) to be timely, or
(ii) to impart notice of its existence to a purchaser for value or to a judgment or lien creditor.

10. Any defect in or lien or encumbrance on the Title or other matter included in Covered Risks 1 through 9 that has been created or attached or has been filed or recorded in the Public Records subsequent to Date of Policy and prior to the recording of the deed or other instrument of transfer in the Public Records that vests Title as shown in Schedule A.

The Company will also pay the costs, attorneys' fees, and expenses incurred in defense of any matter insured against by this Policy, but only to the extent provided in the Conditions.

EXCLUSIONS FROM COVERAGE

The following matters are expressly excluded from the coverage of this policy, and the Company will not pay loss or damage, costs, attorneys' fees, or expenses that arise by reason of:

1. (a) Any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to

(i) the occupancy, use, or enjoyment of the Land;
(ii) the character, dimensions, or location of any improvement erected on the Land;
(iii) the subdivision of land; or
(iv) environmental protection;

or the effect of any violation of these laws, ordinances, or governmental regulations. This Exclusion 1(a) does not modify or limit the coverage provided under Covered Risk 5.
(b) Any governmental police power. This Exclusion 1(b) does not modify or limit the coverage provided under Covered Risk 6.

2. Rights of eminent domain. This Exclusion does not modify or limit the coverage provided under Covered Risk 7 or 8.

3. Defects, liens, encumbrances, adverse claims, or other matters

(a) created, suffered, assumed, or agreed to by the Insured Claimant;
(b) not Known to the Company, not recorded in the Public Records at Date of Policy, but Known to the Insured Claimant and not disclosed in writing to the Company by the Insured Claimant prior to the date the Insured Claimant became an Insured under this policy;
(c) resulting in no loss or damage to the Insured Claimant;
(d) attaching or created subsequent to Date of Policy (however, this does not modify or limit the coverage provided under Covered Risk 9 and 10); or
(e) resulting in loss or damage that would not have been sustained if the Insured Claimant had paid value for the Title.

4. Any claim, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights laws, that the transaction vesting the Title as shown in Schedule A, is

(a) a fraudulent conveyance or fraudulent transfer; or
(b) a preferential transfer for any reason not stated in Covered Risk 9 of this policy.

5. Any lien on the Title for real estate taxes or assessments imposed by governmental authority and created or attaching between Date of Policy and the date of recording of the deed or other instrument of transfer in the Public Records that vests Title as shown in Schedule A.

Spokane County Title Company

INITIAL PRIVACY POLICY NOTICE

What kinds of information we collect. We collect information about you (e.g., your name, address, telephone number), and information about your transaction, including the identity of the real property that you are buying or financing. We may obtain a copy of deeds, notes, or mortgages that are involved in the transaction. We may get this information from you or from the lender, attorney, or real estate broker that you have chosen. We may obtain information from the public records about the property. When we provide settlement services, we may obtain your social security number, date of birth, and we may receive additional information from third parties including appraisals, credit reports, land surveys, escrow account balances, and sometimes bank account information, your credit application, paycheck receipts, tax returns, and bank statements to facilitate the transaction.

How we use this information. The company giving or specifically adopting this notice does not share your information with outside marketers. There's no need to tell us to keep your information to ourselves because we share your information only to provide the service requested by you or your lender, or in other ways permitted by law. The privacy laws permit some sharing without your approval. We may share internally and with nonaffiliated third parties in order to carry out and service your transaction, to protect against fraud or unauthorized transactions, for institutional risk control, and to provide information to government and law enforcement agencies and during the course of legal proceedings. Credit information about you is shared only to facilitate your transaction or for some other purpose permitted by law.

How we protect your information. We restrict access to nonpublic personal information about you to those employees who need the information to provide products or services to you. We maintain physical, electronic, and/or procedural safeguards that comply with law to guard your nonpublic personal information. We reinforce the company's privacy policy with our employees.

CONDITIONS AND STIPULATIONS

1 DEFINITION OF TERMS

The following terms when used in this policy mean:

(a) "Amount of Insurance": The amount stated in Schedule A, as may be increased or decreased by endorsement to this policy, increased by Section 8(b), or decreased by Sections 11 and 12 of these Conditions.

(b) "Date of Policy": The date designated as "Date of Policy" in Schedule A.

(c) "Entity": A corporation, partnership, trust, limited liability company, or other similar legal entity.

(d) "Insured": The Insured named in Schedule A.

(i) The term "Insured" also includes

(A) successors to the Title of the Insured by operation of law as distinguished from purchase, including heirs, devisees, survivors, personal representatives, or next of kin;

(B) successors to an Insured by dissolution, merger, consolidation, distribution, or reorganization;

(C) successors to an Insured by its conversion to another kind of Entity;

(D) a grantee of an Insured under a deed delivered without payment of actual valuable consideration conveying the Title

(1) if the stock, shares, memberships, or other equity interests of the grantee are wholly-owned by the named Insured,

(2) if the grantee wholly owns the named Insured,

(3) if the grantee is wholly-owned by an affiliated Entity of the named Insured, provided the affiliated Entity and the named Insured are both wholly-owned by the same person or Entity, or

(4) if the grantee is a trustee or beneficiary of a trust created by a written instrument established by the Insured named in Schedule A for estate planning purposes.

(ii) With regard to (A), (B), (C), and (D) reserving, however, all rights and defenses as to any successor that the Company would have had against any predecessor Insured.

(e) "Insured Claimant": An Insured claiming loss or damage.

(f) "Knowledge" or "Known": Actual knowledge, not constructive knowledge or notice that may be imputed to an Insured by reason of the Public Records or any other records that impart constructive notice of matters affecting the Title.

(g) "Land": The land described in Schedule A, and affixed improvements that by law constitute real property. The term "Land" does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is insured by this policy.

(h) "Mortgage": Mortgage, deed of trust, trust deed, or other security instrument, including one evidenced by electronic means authorized by law

(i) "Public Records": Records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge. With respect to Covered Risk 5(d), "Public Records" shall also include environmental protection liens filed in the records of the clerk of the United States District Court for the district where the Land is located.

(j) "Title": The estate or interest described in Schedule A.

(k) "Unmarketable Title": Title affected by an alleged or apparent matter that would permit a prospective purchaser or lessee of the Title or lender on the Title to be released from the obligation to purchase, lease, or lend if there is a contractual condition requiring the delivery of marketable title.

2. CONTINUATION OF INSURANCE

The coverage of this policy shall continue in force as of Date of Policy in favor of an Insured, but only so long as the Insured retains an estate or interest in the Land, or holds an obligation secured by a purchase money Mortgage given by a purchaser from the Insured, or only so long as the Insured shall have liability by reason of warranties in any transfer or conveyance of the Title. This policy shall not continue in force in favor of any purchaser from the Insured of either (i) an estate or interest in the Land, or (ii) an obligation secured by a purchase money Mortgage given to the Insured.

3. NOTICE OF CLAIM TO BE GIVEN BY INSURED CLAIMANT

The Insured shall notify the Company promptly in writing (i) in case of any litigation as set forth in Section 5(a) of these Conditions, (ii) in case Knowledge shall come to an Insured hereunder of any claim of title or interest that is adverse to the Title, as insured, and that might cause loss or damage for which the Company may be liable by virtue of this policy, or (iii) if the Title, as insured, is rejected as Unmarketable Title. If the Company is prejudiced by the failure of the Insured Claimant to provide prompt notice, the Company's liability to the Insured Claimant under the policy shall be reduced to the extent of the prejudice.

4. PROOF OF LOSS

In the event the Company is unable to determine the amount of loss or damage, the Company may, at its option, require as a condition of payment that the Insured Claimant furnish a signed proof of loss. The proof of loss must describe the defect, lien, encumbrance, or other matter insured against by this policy that constitutes the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage.

5. DEFENSE AND PROSECUTION OF ACTIONS

(a) Upon written request by the Insured, and subject to the options contained in Section 7 of these Conditions, the Company, at its own cost and without unreasonable delay, shall provide for the defense of an Insured in litigation in which any third party asserts a claim covered by this policy adverse to the Insured. This obligation is limited to only those stated causes of action alleging matters insured against by this policy. The Company shall have the right to select counsel of its choice (subject to the right of the Insured to object for reasonable cause) to represent the Insured as to those stated causes of action. It shall not be liable for and will not pay the fees of any other counsel. The Company will not pay any fees, costs, or expenses incurred by the Insured in the defense of those causes of action that allege matters not insured against by this policy.

(b) The Company shall have the right, in addition to the options contained in Section 7 of these Conditions, at its own cost, to institute and prosecute any action or proceeding or to do any other act that in its opinion may be necessary or desirable to establish the Title, as insured, or to prevent or reduce loss or damage to the Insured. The Company may take any appropriate action under the terms of this policy, whether or not it shall be liable to the Insured. The exercise of these rights shall not be an admission of liability or waiver of any provision of this policy. If the Company exercises its rights under this subsection, it must do so diligently.

(c) Whenever the Company brings an action or asserts a defense as required or permitted by this policy, the Company may pursue the litigation to a final determination by a court of competent jurisdiction, and it expressly reserves the right, in its sole discretion, to appeal any adverse judgment or order.

CONDITIONS AND STIPULATIONS (con't)

6. DUTY OF INSURED CLAIMANT TO COOPERATE

(a) In all cases where this policy permits or requires the Company to prosecute or provide for the defense of any action or proceeding and any appeals, the Insured shall secure to the Company the right to so prosecute or provide defense in the action or proceeding, including the right to use, at its option, the name of the Insured for this purpose. Whenever requested by the Company, the Insured, at the Company's expense, shall give the Company all reasonable aid (i) in securing evidence, obtaining witnesses, prosecuting or defending the action or proceeding, or effecting settlement, and (ii) in any other lawful act that in the opinion of the Company may be necessary or desirable to establish the Title or any other matter as insured. If the Company is prejudiced by the failure of the Insured to furnish the required cooperation, the Company's obligations to the Insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such cooperation.

(b) The Company may reasonably require the Insured Claimant to submit to examination under oath by any authorized representative of the Company and to produce for examination, inspection, and copying, at such reasonable times and places as may be designated by the authorized representative of the Company, all records, in whatever medium maintained, including books, ledgers, checks, memoranda, correspondence, reports, e-mails, disks, tapes, and videos whether bearing a date before or after Date of Policy, that reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the Insured Claimant shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect, and copy all of these records in the custody or control of a third party that reasonably pertain to the loss or damage. All information designated as confidential by the Insured Claimant provided to the Company pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the Insured Claimant to submit for examination under oath, produce any reasonably requested information, or grant permission to secure reasonably necessary information from third parties as required in this subsection, unless prohibited by law or governmental regulation, shall terminate any liability of the Company under this policy as to that claim.

7. OPTIONS TO PAY OR OTHERWISE SETTLE CLAIMS; TERMINATION OF LIABILITY

In case of a claim under this policy, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Insurance.

To pay or tender payment of the Amount of Insurance under this policy together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment or tender of payment and that the Company is obligated to pay.

Upon the exercise by the Company of this option, all liability and obligations of the Company to the Insured under this policy, other than to make the payment required in this subsection, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

(b) To Pay or Otherwise Settle With Parties Other Than the Insured or With the Insured Claimant.

(i) To pay or otherwise settle with other parties for or in the name of an Insured Claimant any claim insured against under this policy. In addition, the Company will pay any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay; or

(ii) To pay or otherwise settle with the Insured Claimant the loss or damage provided for under this policy, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay.

Upon the exercise by the Company of either of the options provided for in subsections (b)(i) or (ii), the Company's obligations to the Insured under this policy for the claimed loss or damage, other than the payments required to be made, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

8. DETERMINATION AND EXTENT OF LIABILITY

This policy is a contract of indemnity against actual monetary loss or damage sustained or incurred by the Insured Claimant who has suffered loss or damage by reason of matters insured against by this policy.

(a) The extent of liability of the Company for loss or damage under this policy shall not exceed the lesser of

(i) the Amount of Insurance, or

(ii) the difference between the value of the Title as insured and the value of the Title subject to the risk insured against by this policy

(b) If the Company pursues its rights under Section 5 of these Conditions and is unsuccessful in establishing the Title, as insured,

(i) the Amount of Insurance shall be increased by 10%, and

(ii) the Insured Claimant shall have the right to have the loss or damage determined either as of the date the claim was made by the Insured Claimant or as of the date it is settled and paid.

(c) In addition to the extent of liability under (a) and (b), the Company will also pay those costs, attorneys" fees, and expenses incurred in accordance with Sections 5 and 7 of these Conditions.

9. LIMITATION OF LIABILITY

(a) If the Company establishes the Title, or removes the alleged defect, lien, or encumbrance, or cures the lack of a right of access to or from the Land, or cures the claim of Unmarketable Title, all as insured, in a reasonably diligent manner by any method, including litigation and the completion of any appeals, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused to the Insured.

(b) In the event of any litigation, including litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals, adverse to the Title, as insured.

(c) The Company shall not be liable for loss or damage to the Insured for liability voluntarily assumed by the Insured in settling any claim or suit without the prior written consent of the Company.

10. REDUCTION OF INSURANCE; REDUCTION OR TERMINATION OF LIABILITY

All payments under this policy, except payments made for costs, attorneys' fees, and expenses, shall reduce the Amount of Insurance by the amount of the payment.

CONDITIONS AND STIPULATIONS (con't)

11. **LIABILITY NONCUMULATIVE**
The Amount of Insurance shall be reduced by any amount the Company pays under any policy insuring a Mortgage to which exception is taken in Schedule B or to which the Insured has agreed, assumed, or taken subject, or which is executed by an Insured after Date of Policy and which is a charge or lien on the Title, and the amount so paid shall be deemed a payment to the Insured under this policy.

12. **PAYMENT OF LOSS**
When liability and the extent of loss or damage have been definitely fixed in accordance with these Conditions, the payment shall be made within 30 days.

13. **RIGHTS OF RECOVERY UPON PAYMENT OR SETTLEMENT**
(a) Whenever the Company shall have settled and paid a claim under this policy, it shall be subrogated and entitled to the rights of the Insured Claimant in the Title and all other rights and remedies in respect to the claim that the Insured Claimant has against any person or property, to the extent of the amount of any loss, costs, attorneys' fees, and expenses paid by the Company. If requested by the Company, the Insured Claimant shall execute documents to evidence the transfer to the Company of these rights and remedies. The Insured Claimant shall permit the Company to sue, compromise, or settle in the name of the Insured Claimant and to use the name of the Insured Claimant in any transaction or litigation involving these rights and remedies.
If a payment on account of a claim does not fully cover the loss of the Insured Claimant, the Company shall defer the exercise of its right to recover until after the Insured Claimant shall have recovered its loss.
(b) The Company's right of subrogation includes the rights of the Insured to indemnities, guaranties, other policies of insurance, or bonds, notwithstanding any terms or conditions contained in those instruments that address subrogation rights.

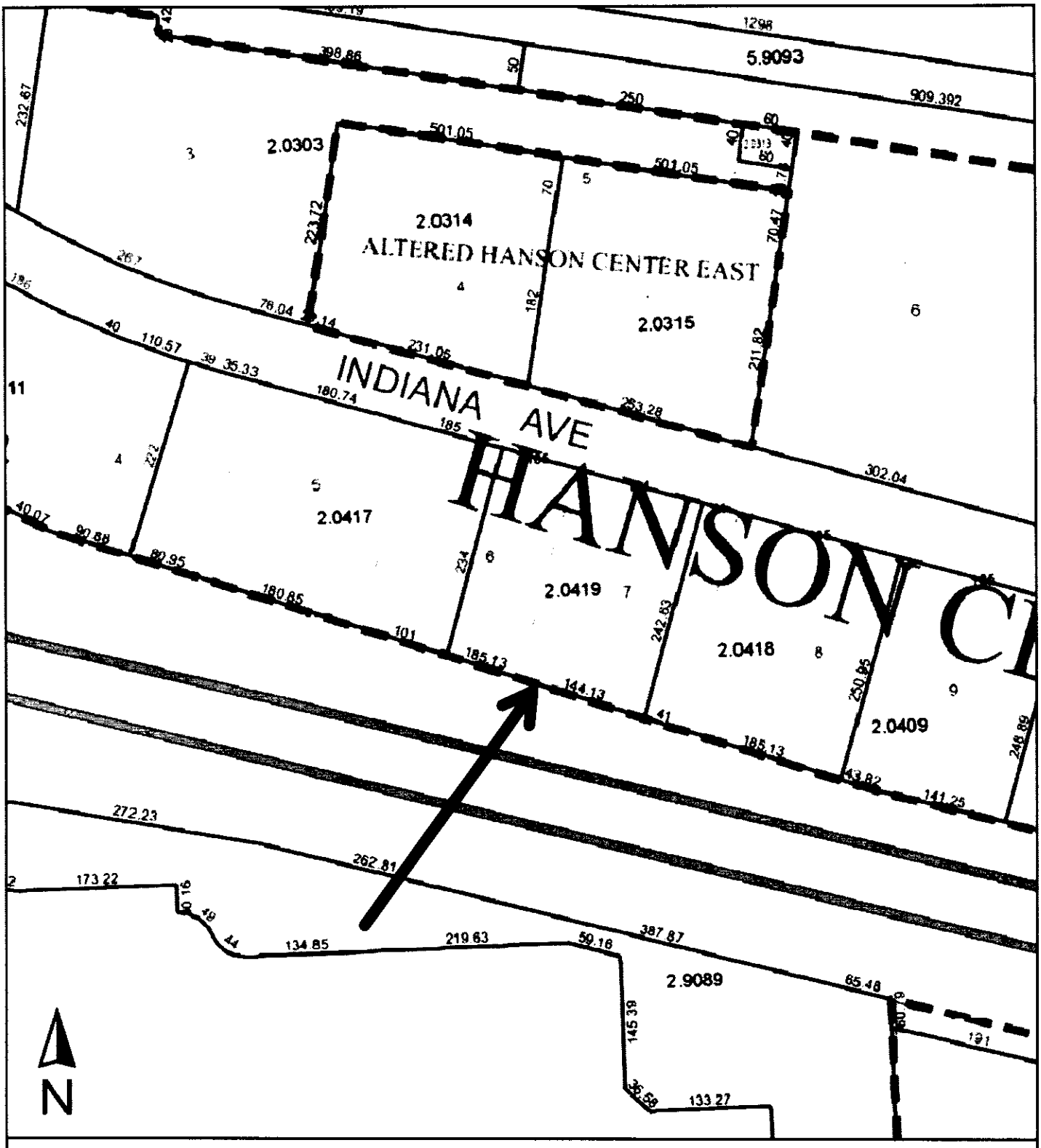
14. **ARBITRATION**
Either the Company or the Insured may demand that the claim or controversy shall be submitted to arbitration pursuant to the Title Insurance Arbitration Rules of the American Land Title Association ("Rules"). Except as provided in the Rules, there shall be no joinder or consolidation with claims or controversies of other persons. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the Insured arising out of or relating to this policy, any service in connection with its issuance or the breach of a policy provision, or to any other controversy or claim arising out of the transaction giving rise to this policy. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or the Insured. All arbitrable matters when the Amount of Insurance is in excess of $2,000,000 shall be arbitrated only when agreed to by both the Company and the Insured. Arbitration pursuant to this policy and under the Rules shall be binding upon the parties. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court of competent jurisdiction.

15. **LIABILITY LIMITED TO THIS POLICY; POLICY ENTIRE CONTRACT**
(a) This policy together with all endorsements, if any, attached to it by the Company is the entire policy and contract between the Insured and the Company. In interpreting any provision of this policy, this policy shall be construed as a whole.
(b) Any claim of loss or damage that arises out of the status of the Title or by any action asserting such claim shall be restricted to this policy.
(c) Any amendment of or endorsement to this policy must be in writing and authenticated by an authorized person, or expressly incorporated by Schedule A of this policy.
(d) Each endorsement to this policy issued at any time is made a part of this policy and is subject to all of its terms and provisions. Except as the endorsement expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsement, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance.

16. **SEVERABILITY**
In the event any provision of this policy, in whole or in part, is held invalid or unenforceable under applicable law, the policy shall be deemed not to include that provision or such part held to be invalid, but all other provisions shall remain in full force and effect.

17. **CHOICE OF LAW; FORUM**
(a) Choice of Law: The Insured acknowledges the Company has underwritten the risks covered by this policy and determined the premium charged therefor in reliance upon the law affecting interests in real property and applicable to the interpretation, rights, remedies, or enforcement of policies of title insurance of the jurisdiction where the Land is located.
Therefore, the court or an arbitrator shall apply the law of the jurisdiction where the Land is located to determine the validity of claims against the Title that are adverse to the Insured and to interpret and enforce the terms of this policy. In neither case shall the court or arbitrator apply its conflicts of law principles to determine the applicable law.
(b) Choice of Forum: Any litigation or other proceeding brought by the Insured against the Company must be filed only in a state or federal court within the United States of America or its territories having appropriate jurisdiction.

18. **NOTICES, WHERE SENT**
Any notice of claim and any other notice or statement in writing required to be given to the Company under this policy must be given to the Company at 400 Second Avenue South, Minneapolis, Minnesota 55401-2499.



ParcelID: 45132.0419
16010 E Indiana Ave
Spokane Valley, WA 99216

This map/plat is being furnished as an aid in locating the herein described land in relation to adjoining streets, natural boundaries and other land, and is not a survey of the land depicted. Except to the extent a policy of title insurance is expressly modified by endorsement, if any, the company does not insure dimensions, distances, location of easements, acreage or other matters shown thereon.

Old Republic National Title Insurance Company
ALTA 2006 STANDARD OWNERS POLICY

SCHEDULE A

FILE NO.: **SP17748** POLICY NO.: **OX 12448627**

ADDRESS REFERENCE: **16010 E INDIANA AVE SPOKANE VALLEY, WA 99216**

AMOUNT OF INSURANCE: **$653,400.00** PREMIUM: **$667.00**

DATE OF POLICY: **January 31, 2019** at **2:02 PM**

1. NAME OF INSURED:

   EMPIRE EYE LAND, LLC, A WASHINGTON LIMITED LIABILITY COMPANY

2. THE ESTATE OR INTEREST IN THE LAND WHICH IS COVERED BY THIS POLICY IS:

   Fee Simple

3. TITLE TO THE ESTATE OR INTEREST IN THE LAND IS VESTED IN:

   THE NAMED INSURED

4. THE LAND REFERRED TO IN THIS POLICY IS DESCRIBED AS FOLLOWS:

   SEE ATTACHED EXHIBIT "A"

5. THIS POLICY INCORPORATES BY REFERENCE THOSE ALTA ENDORSEMENTS LISTED BELOW:

   NONE

This policy valid only if Schedule B is attached.

FILE NO.: **SP17748** POLICY NO.: **OX 12448627**

EXHIBIT "A"

LOT 7 AND THE EAST 84.00 FEET OF LOT 6, BLOCK 2, HANSON CENTER EAST, AS PER PLAT RECORDED IN VOLUME 27 OF PLATS, PAGE 10, 11 AND 12, RECORDS OF SPOKANE COUNTY;

EXCEPT THE EAST 41.00 FEET OF LOT 7;

SITUATE IN THE CITY OF SPOKANE VALLEY, COUNTY OF SPOKANE, STATE OF WASHINGTON.

FILE NO.: **SP17748** POLICY NO.: **OX 12448627**

SCHEDULE B

EXCEPTIONS FROM COVERAGE

THIS POLICY DOES NOT INSURE AGAINST LOSS OR DAMAGE, AND THE COMPANY WILL NOT PAY COSTS, ATTORNEYS' FEES OR EXPENSES THAT ARISE BY REASON OF:

General Exceptions:

A. RIGHTS OR CLAIMS DISCLOSED ONLY BY POSSESSION, OR CLAIMED POSSESSION, OF THE PREMISES.

B. ENCROACHMENTS, OVERLAPS, BOUNDARY LINE DISPUTES WHICH WOULD BE DISCLOSED BY AN ACCURATE SURVEY OR INSPECTION OF THE PREMISES.

C. EASEMENTS, PRESCRIPTIVE RIGHTS, RIGHTS-OF-WAY, STREETS, ROADS, ALLEYS OR HIGHWAYS NOT DISCLOSED BY THE PUBLIC RECORDS.

D. ANY LIEN, OR RIGHT TO A LIEN, FOR CONTRIBUTIONS TO EMPLOYEES BENEFIT FUNDS, OR FOR STATE WORKERS' COMPENSATION, OR FOR SERVICES, LABOR OR MATERIAL HERETOFORE OR HEREAFTER FURNISHED, ALL AS IMPOSED BY LAW AND NOT SHOWN BY THE PUBLIC RECORDS.

E. UNDERGROUND EASEMENTS, SERVITUDES OR INSTALLATIONS OF WHICH NO NOTICE IS OF RECORD.

F. GENERAL TAXES NOT NOW PAYABLE; MATTERS RELATING TO SPECIAL ASSESSMENTS AND SPECIAL LEVIES, IF ANY, PRECEDING THE SAME BECOMING A LIEN.

G. ANY SERVICE, INSTALLATION, CONNECTION, MAINTENANCE, OR CONSTRUCTION CHARGES FOR SEWER, WATER, ELECTRICITY, NATURAL GAS OR OTHER UTILITIES OR GARBAGE COLLECTION AND DISPOSAL.

H. RESERVATIONS OR EXCEPTIONS IN UNITED STATES PATENTS OR IN ACTS AUTHORIZING THE ISSUANCE THEREOF.

I. INDIAN TRIBAL CODES OR REGULATIONS, INDIAN TREATY OR ABORIGINAL RIGHTS, INCLUDING EASEMENTS OR EQUITABLE SERVITUDES.

J. WATER RIGHTS, CLAIMS OR TITLE TO WATER.

This policy valid only if Schedule A is attached.

Old Republic National Title Insurance Company
ALTA 2006 STANDARD OWNERS POLICY

FILE NO.: **SP17748** POLICY NO.: **OX 12448627**

SPECIAL EXCEPTIONS:

1. GENERAL REAL ESTATE TAXES, (INCLUDING AMOUNTS FOR AQUIFER, STORM WATER, IRRIGATION, DRAINAGE WATER, AND FLOOD CONTROL, IF ANY), FOR THE YEAR 2019, NOT PAYABLE UNTIL FEBRUARY 15, 2019, IN AN AMOUNT NOT YET AVAILABLE FROM THE TREASURER'S OFFICE, THE FIRST HALF OF WHICH WILL BE DUE APRIL 30TH;
   TAX ACCOUNT NO.: 45132.0419

2. LIABILITY TO ASSESSMENTS, IF ANY, BY THE CITY OF SPOKANE VALLEY. FURTHER INFORMATION CAN BE OBTAINED BY CALLING (509) 921-1000.

3. UNPAID CHARGES AND ASSESSMENTS, IF ANY, LEVIED BY HANSON CENTER EAST PROPERTY OWNERS' ASSOCIATION.

4. DEED OF TRUST AND THE TERMS AND CONDITIONS THEREOF:

GRANTOR:	EMPIRE EYE LAND, LLC, A WASHINGTON LIMITED LIABILITY COMPANY
TRUSTEE:	UPF WASHINGTON, INCORPORATED
BENEFICIARY:	WASHINGTON TRUST BANK
AMOUNT:	$389,210.00
DATED:	January 29, 2019
RECORDED:	January 31, 2019
AUDITOR'S FILE NO.:	6779249

5. EASEMENT AND THE TERMS AND CONDITIONS THEREOF:

GRANTEE:	JOHN A. WEEK
PURPOSE:	THE RIGHT AND PRIVILEGE TO FLOW AND COVER WITH WATER
RECORDED:	November 02, 1904
AUDITOR'S FILE NO.:	108077
AREA AFFECTED:	THIS AND OTHER PROPERTY

6. EXCEPTIONS AND RESERVATIONS CONTAINED IN DEED:
   FROM: JOHN P. SULLIVAN, A WIDOWER
   RECORDED: August 28, 1930
   AUDITOR'S FILE NO.: A50716

   AS FOLLOWS: "THE PARTY OF THE FIRST PART RESERVES THE RIGHT TO USE THE WATER OF THE SPOKANE RIVER FOR WATERING STOCK THEREIN AND AN EASEMENT OF RIGHT-OF-WAY TO AND FROM THE WATER OF THE SAID RIVER FOR SAID STOCK OVER AND ACROSS SUCH PART, IF ANY, OF SAID ABOVE DESCRIBED LAND AS MAY, FROM TIME TO TIME, NOT BE FLOODED WITH WATER, AS APPURTENANT TO THE ADJOINING LAND NOW OWNED BY THE PARTY OF THE FIRST PART. IT IS EXPRESSLY UNDERSTOOD, HOWEVER, THAT THE PARTY OF THE SECOND PART MAY ENCLOSE THE SAID ABOVE DESCRIBED LAND WITH FENCES, PROVIDED THE PARTY OF THE SECOND PART SHALL LEAVE A LANE OVER ANY PART, IF ANY, THAT MAY NOT FROM TIME TO TIME BE FLOODED, EXCEPT OVER THE HEREINAFTER DESCRIBED RAILROAD RIGHT-OF-WAY, FOR THE WATERING OF SAID STOCK AND WHICH LANE SHALL OPEN AT SOME POINT ON THE SAID ADJOINING LAND OF THE PARTY OF THE FIRST PART."

7. RELINQUISHMENT OF ALL EXISTING FUTURE OR POTENTIAL EASEMENTS FOR ACCESS, LIGHT, VIEW AND AIR, AND ALL RIGHTS OF INGRESS, EGRESS AND REGRESS TO, FROM AND BETWEEN SAID PREMISES AND THE HIGHWAY OR HIGHWAYS TO BE CONSTRUCTED ON LANDS CONVEYED BY DEED RECORDED March 14, 1955, AND September 09, 1955, UNDER FILE NOS. 303233B AND 344727B, RESPECTIVELY, TO THE STATE OF WASHINGTON.

8. RESTRICTIONS, EASEMENTS, SETBACKS AND OTHER MATTERS AS MAY BE DELINEATED AND/OR CONTAINED ON THE FACE OF SAID PLAT, BUT OMITTING ANY COVENANTS OR RESTRICTIONS, IF ANY, BASED UPON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, FAMILIAL STATUS, MARITAL STATUS, DISABILITY, HANDICAP, NATIONAL ORIGIN, ANCESTRY, OR SOURCE OF INCOME, AS SET FORTH IN APPLICABLE STATE OR FEDERAL LAWS, EXCEPT TO THE EXTENT THAT SAID COVENANT OR RESTRICTION IS PERMITTED BY APPLICABLE LAW.

9. ORDINANCE AND THE TERMS AND CONDITIONS THEREOF, AS RESERVED BY;
   ORDINANCE NO.: 98-0862
   APPROVED AND FILED: November 19, 1985
   AFFECTS: THIS AND OTHER PROPERTY

   AMENDMENT THERETO:
   RECORDED: March 14, 2000
   AUDITOR'S FILE NO.: 4463162

   SATISFACTION OF CONDITIONS AGREEMENT AND THE TERMS AND CONDITIONS THEREOF;
   RECORDED: November 10, 1998
   AUDITOR'S FILE NO.: 4292087

10. AGREEMENT AND THE TERMS AND CONDITIONS THEREOF:
BETWEEN: SPOKANE COUNTY, A POLITICAL SUBDIVISION, AND HANSON INDUSTRIES, INC.
REGARDING: LATECOMER FEES
RECORDED: March 14, 2000
AUDITOR'S FILE NO.: 4463161

11. COVENANTS, CONDITIONS, RESTRICTIONS, EASEMENTS OR RESERVATIONS CONTAINED IN INSTRUMENT, BUT OMITTING ANY COVENANTS OR RESTRICTIONS, IF ANY, BASED UPON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, FAMILIAL STATUS, MARITAL STATUS, DISABILITY, HANDICAP, NATIONAL ORIGIN, ANCESTRY, OR SOURCE OF INCOME, AS SET FORTH IN APPLICABLE STATE OR FEDERAL LAWS, EXCEPT TO THE EXTENT THAT SAID COVENANT OR RESTRICTION IS PERMITTED BY APPLICABLE LAW;
RECORDED: May 01, 2001
AUDITOR'S FILE NO.: 4582480

SAID INSTRUMENT IS A RE-RECORD OF INSTRUMENT RECORDED October 13, 2000 UNDER FILE NO. 4524759.

ANNEXATION AND SUPPLEMENTARY DECLARATION;
RECORDED: November 03, 2010
AUDITOR'S FILE NO.: 5949961

SAID INSTRUMENT IS A RE-RECORD OF INSTRUMENT RECORDED April 08, 2010 UNDER FILE NO. 5890343.

SAID COVENANTS, CONDITIONS AND RESTRICTIONS HAVE BEEN MODIFIED BY INSTRUMENT;
RECORDED: December 20, 2010
AUDITOR'S FILE NO.: 5963318

12. COVENANTS, CONDITIONS, RESTRICTIONS, EASEMENTS OR RESERVATIONS CONTAINED IN INSTRUMENT, BUT OMITTING ANY COVENANTS OR RESTRICTIONS, IF ANY, BASED UPON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, FAMILIAL STATUS, MARITAL STATUS, DISABILITY, HANDICAP, NATIONAL ORIGIN, ANCESTRY, OR SOURCE OF INCOME, AS SET FORTH IN APPLICABLE STATE OR FEDERAL LAWS, EXCEPT TO THE EXTENT THAT SAID COVENANT OR RESTRICTION IS PERMITTED BY APPLICABLE LAW;
RECORDED: May 09, 2001
AUDITOR'S FILE NO.: 4584983

13. AGREEMENT AND THE TERMS AND CONDITIONS THEREOF:
BETWEEN: HANSON INDUSTRIES, INC., A WASHINGTON CORPORATION, AND SPOKANE COUNTY
REGARDING: DEVELOPER REIMBURSEMENT
RECORDED: July 17, 2002
AUDITOR'S FILE NO.: 4750178

14. EASEMENT, OR QUASI-EASEMENT, DEDICATED IN SAID PLAT FOR THE RIGHT OF THE PUBLIC TO MAKE NECESSARY SLOPES FOR CUTS OR FILLS UPON SAID PREMISES IN THE REASONABLE ORIGINAL GRADING OF STREETS, AVENUES, ALLEYS AND ROADS.

FILE NO.: **SP17748** POLICY NO.: **OX 12448627**

15. **AGREEMENT AND THE TERMS AND CONDITIONS THEREOF:**
    BETWEEN: HANSON INDUSTRIES, INC., AND THE CITY OF SPOKANE VALLEY
    REGARDING: DEVELOPER MITIGATION OF TRAFFIC-RELATED IMPACTS
    RECORDED: April 08, 2011
    AUDITOR'S FILE NO.: 5991757

16. **BOUNDARY LINE ADJUSTMENT (BLA) AND THE TERMS AND CONDITIONS THEREOF:**
    REGARDING: BLA-2014-0027
    RECORDED: October 01, 2014
    AUDITOR'S FILE NO.: 6337099

17. **MATTERS DISCLOSED BY SURVEY RECORDED December 16, 2014 UNDER AUDITOR'S FILE NO. 6356701 IN BOOK 157 OF SURVEYS, PAGE(S) 9 AND 10.**

END OF SCHEDULE B EXCEPTIONS

NOTE:

1. **GENERAL REAL ESTATE TAXES, (INCLUDING AMOUNTS FOR AQUIFER, STORM WATER, IRRIGATION, DRAINAGE, WATER, AND FLOOD CONTROL, IF ANY), FOR THE YEAR 2018 HAVE BEEN PAID IN FULL;**
   AMOUNT: $7,601.74
   TAX ACCOUNT NO.: 45132.0419

END OF NOTE

akg

Exhibit 18