Washington State Department of Health

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CERTIFICATE OF NEED PROGRAM
DEPARTMENT OF HEALTH

CN 20-22

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.

Signature and Title of Responsible Officer: Brandie Somers Executive Director The Harman Eye Clinic Dated: 12.13.19	Phone Number: 360.435.8595 Email Address: Brandie@20better.com
Legal Name of Applicant: Cascade Regional Eye Center, Inc. P.S. Address of Applicant: The Harman Eye Clinic 903 Medical Center Drive Arlington, WA 98223	Number of Surgery Rooms requested – include operating room and procedure rooms: one Estimated Capital Expenditure: $0

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

North Snohomish

TABLE OF CONTENTS

CERTIFICATE OF NEED APPLICATION

APPENDIX 31

Applicant Description

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)

   Bruce J. Ballon
   903 Medical Center Drive
   Arlington, WA 98223

   Bruce E. Wietharn
   903 Medical Center Drive
   Arlington, WA 98223

   Natalia V. Bajenova
   903 Medical Center Drive
   Arlington, WA 98223

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

   Professional Service Corporation: Cascade Regional Eye Center, INC., P.S.

   UBI# 600-623-658

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

   Brandie Somers
   Executive Director
   The Harman Eye Clinic
   903 Medical Center Drive
   Arlington, WA 98223
   360.435.8595
   Brandie@20better.com

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

   Lance Baldwin
   ASC Consultant
   3621 156th PL SE

Bothell, WA 98012
318.792.8215
lance@m-exec.com

5. Provide an organizational chart that clearly identifies the business structure of the applicant(s).

   See Exhibit 2

6. Identify all 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.

Facility	Address	ASF License
The Harman Eye Clinic	903 Medical Center Drive Arlington, WA 98223	ASF.FS.60115032

Project Description

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

   The Harman Eye Clinic
   903 Medical Center Drive
   Arlington, WA 98223

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.

   Harman Eye Clinic (HEC) is currently an exempt CON facility as a one-operating room ASF and operates in the North Snohomish planning area.

   Harman Eye Clinic is requesting CON approval to expand services (operating minutes) to the North Snohomish planning area. A non-exempt ASF is an integral step allowing Harman Eye Clinic to expand their current offerings of local, affordable, and quality ophthalmic ambulatory surgery options to the North Snohomish planning area residents. CON approval will open the ASF to all surgeons in the community who are able to become credentialed and privileged with Harman Eye Clinic. This

will ultimately increase the operating minutes within Harman Eye Clinic single-operating room ASF and thus improve the North Snohomish planning area residents' ability to receive a full range of surgical eye specialties. *Harman Eye Clinic will remain a one-operating room entity and the type of services will continue to be ophthalmic only.*

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	N/A
Construction Completed	N/A
Facility Prepared for Survey	N/A
Project Completion	At completion of CON

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.

Harman Eye Clinic will continue to provide ophthalmic surgical care within its scope of service in which it is currently licensed. The patients are persons from the age of 18 and older who require ophthalmic surgery and are not expected to require hospitalization and can be served appropriately in an outpatient surgical setting. Harman Eye Clinic's operating rooms are equipped to provide ophthalmic surgeries for high-quality, safe, and state-of-the-art patient care. Surgeries performed in the ASF will be supported by moderate sedation/analgesia (conscious sedation).

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.

   Single operating room

9. Identify if any of the surgery rooms at this facility would be exclusively dedicated to endoscopy, cystoscopy, or pain management services.

   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, diagnoses, etc).

    See Exhibit 3 – Scope of Care Policy

11. 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 15

13. Confirm that the facility will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing facility, provide the existing facility’s identification numbers.

    ASF.FS. 60115032

    Medicare #: 50C0001063

    Medicaid #: 91-1312321

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

    No

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.

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

   Table 1 – North Snohomish Surgical Facilities

North Snohomish Surgical Facilities	Ophthalmic Surgery
The Harman Eye Clinic	Yes
Cascade Valley Arlington Surgery Center	No
Skagit Regional Hospital	No

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

   See Table 1 above

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

   Harman Eye Clinic will continue to provide ophthalmic surgical care within its scope of service in which it is currently licensed. The patients are persons from the age of 18 and older who require ophthalmic surgery and are not expected to require hospitalization and can be served appropriately in an outpatient surgical setting. Harman Eye Clinic's operating rooms are equipped to provide ophthalmic surgeries for high-quality, safe, and state-of-the-art patient care. Surgeries performed in the ASF will be supported by moderate sedation/analgesia (conscious sedation). Harman Eye Clinic is the only surgery facility in the North Snohomish Planning Area that performs ophthalmic procedures. The proposed project does not represent unnecessary duplication of services.

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 us at FSLCON@doh.wa.gov.

   See Exhibit 19 & 20

5. If the methodology does not demonstrate numeric need for additional operating rooms, WAC 246-310-270(4) gives the department flexibility to approve the addition of outpatient operating room(s) under extraordinary circumstances. Extraordinary circumstances could include but are not limited to: lack of CN approved operating rooms in a planning area or lack of providers performing widely utilized surgical types. 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.

Methodology demonstrates numeric need of **4.21** inpatient and **1.97** outpatient ORs.

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

Type	**2016**	**2017**	**2018**
Ophthalmic	1939	1873	1834

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 all assumptions used to make these projections.

Type	**2019**	**2020**	**2021**	**2022**
Ophthalmic	1925	2022	2123	2229

5% growth annually

8. For existing facilities, provide patient origin zip code data for the most recent full calendar year of operation.

   See Exhibit 21

9. 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.

10. Identify how this project will be available and accessible to low-income persons, racial and ethnic minorities, women, mentally handicapped persons, and other under-served groups. WAC 246-310-210(2)

HEC is requesting CON approval to convert an existing, single-operating room ambulatory surgical facility into a CON approved facility. This facility has been operational since 1984. As no construction is needed for this project, the project will be completed upon CON approval.

Currently, only employed surgeons of HEC are providing services. By becoming CON approved, HEC will open up the facility to surrounding area ophthalmic surgeons, which will better enhance access to ophthalmology services within the North Snohomish planning area.

We are confident that CON approval will improve the access and the available operating minutes available to other physicians and their patients in the planning area. As demonstrated through the needs analysis below, there is a projected net need for additional outpatient surgery rooms in the North Snohomish planning area; our project will help address this need.

11. If this project proposes either a partial or full relocation of an existing facility, provide a detailed discussion of the limitations of the current site consistent with WAC 246-310-210(2).

    The proposed project does not require any construction or change in physical property. Harman eye Clinic is a fully equipped single-operating room ASF and with approval of the CON will be increasing the operating minutes available within the North Snohomish planning area. The costs associated with the increased minutes will be treated as operating expenses, rather than capital expenditure. Our estimated capital expenditure is $0.

12. If this project proposes either a partial or full relocation of an existing facility, provide a detailed discussion of the benefits associated with relocation consistent with WAC 246-310-210(2).

    N/A

13. 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**

    See Exhibits 3,9,&13

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 all assumptions.
- Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include all assumptions.
- Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.
- For existing facilities, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the proforma projections. For incomplete years, identify whether the data is annualized.

See Exhibits 20-22

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.

   See Exhibit 33

3. CN approved ASFs must provide charity care at levels comparable to those at the hospitals in the ASF planning area. Identify the amount of charity care projected to be provided at this facility, captured as a percentage of gross revenue. (WAC 246-310-270(7))

   Harman Eye Clinic will provide charity care at a rate greater than 0.25% of patient service revenue. The average of charity care as a percentage provided the hospitals in the North Snohomish panning area is 0.245%.

   See Exhibit 14

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.

   See Exhibit 16

5. For new facilities, provide county assessor information and zoning information for the site. If zoning information for the site is unclear, provide documentation or letter from the municipal authorities showing the proposed project is allowable at the identified site.

   N/A

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 to create the capital expenditure estimate.

Item	**Cost**
a. Land Purchase	$0
b. Utilities to Lot Line	$0
c. Land Improvements	$0
d. Building Purchase	$0
e. Residual Value of Replaced Facility	$0
f. Building Construction	$0
g. Fixed Equipment (not already included in the construction contract)	$0
h. Movable Equipment	$0

i. Architect and Engineering Fees	$0
j. Consulting Fees	$0
k. Site Preparation	$0
l. Supervision and Inspection of Site	$0
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	$0
1. Land	$0
2. Building	$0
3. Equipment	$0
4. Other	$0
n. Washington Sales Tax	$0
Total Estimated Capital Expenditure	**$0**

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.

   N/A

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.

   N/A

9. 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.

   N/A

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

    N/A

11. Provide a detailed narrative regarding how the project would or would not impact costs and charges for health services. WAC 246-310-220

The service opportunities gained by NWES 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 2 outlines the findings within the report.

Table 2 – 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 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.

[1] NHSR report is Exhibit 32.
[2] ASCA "A Positive Trend in Health Care" is Exhibit 26.
[3] Ophthalmology Times "The Future of Cataract Surgery" is Exhibit 28.

"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 3 – 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 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.

[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 32.
[5] Michigan Medicine; University of Michigan article is in Exhibit 29.

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

Table 4 – 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, HEC, as an ophthalmic specialty surgical facility, will be in a position to continue to meet the current needs of the residents of North Snohomish planning area with an approved CON. AS the population ages and demand for ophthalmic surgery rises, HEC 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 HEC to create access when and where people need it and (3) meeting the need for additional ORs minutes in the North Snohomish planning area.

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." HEC's application can satisfy each of these criteria:

1. *No Impact on Market Share.* This ASF has been in operation since 1984 and continues to provide high quality outpatient surgical services to its patients. HEC performs over 1800 surgeries per year. HEC is the only free- standing ASF in the planning area capable that focuses on outpatient ophthalmic surgeries. Allowing HEC to operate as a CON-approved facility will not detrimentally impact the other providers of outpatient surgeries in the planning area.

2. *Facility is Necessary to Provide Access to Specific Surgical Types.* As noted above, HEC is the only outpatient ASF in the planning area providing these types of surgeries. HEC has the necessary equipment to serve these patients in an outpatient setting. With the continued push by Medicare and private payers to free standing ambulatory surgery centers, HEC's facility is necessary to provide lower cost and high quality ophthalmic surgeries.

3. Existing Healthcare System Supports Continued Operation of the Facility. Without the continued operation of HEC, patients requiring cataracts, glaucoma, and other eye related surgeries would have no other option but to have the surgeries performed at a hospital or outside of the planning area. The existence of HEC as a free-standing ASF open to all surgeons is necessary to continue to provide patients access to care and choice of providers.

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

    N/A

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

Table 5 – Projected Payer Mix

Payer	Percentage by Revenue	Percentage by Patient
Medicare	30%	23%
Medicaid	1%	8%
AARP United Healthcare	17%	14%
Regence	13%	11%
Premera Blue Cross	8%	8%
Kaiser Permanente	5%	4%

Humana Insurance Company	5%	4%
All Others (Payers <1% of Revenue or Patient Population)	21%	28%
Total	100%	100%

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

Table 6 – Historical Payer Mix

Payer	Percentage by Revenue	Percentage by Patient
Medicare	30%	23%
Medicaid	1%	8%
AARP United Healthcare	17%	14%
Regence	13%	11%
Premera Blue Cross	8%	8%
Kaiser Permanente	5%	4%
Humana Insurance Company	5%	4%
All Others	21%	28%
Total	100%	100%

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

N/A

16. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

N/A

17. 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

    N/A

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

    See Exhibit 15

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 federal and state requirements.

1. Provide a table that shows FTEs [full time equivalents] by classification 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.

Table 7 – FTE by Classification

Role	License	2016	2017	2018	2019	2020	2021	2022
Nurse	RN	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Nurse	RN	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Nurse	LPN	0.88	0.88	0.88	0.88	0.88	0.88	0.88
Nurse	RN	PRN*	PRN	PRN	PRN	PRN	PRN	PRN
Surgical Technician	RST	0.88	0.88	0.88	0.88	0.88	0.88	0.88
Surgical Technician	RST	0.88	0.88	0.88	0.88	0.88	0.88	0.88
Medical Assistant	MA	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Medical Assistant	MA	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Surgery coordinator	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00
ASC Administrative Assistant	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00
ASC Director	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00

*PRN – Pro re nata or as the need arises. PRN staff are utilized to fill in gaps related to staff turnover or employee time off. They do not have a set schedule and are not considered part-time staff.

2. Provide the assumptions used to project the number and types of FTEs identified for this project. If known, identify the salaries, wages, and employee benefits for

each FTE category. This will assist the department in validating your financial projections.

Role	Salary Range Low	Salary Range High	License	Annual FTE	2018	2018 Low	2018 High
Pro Forma Cost					**$ 525,898**		
Nurse Manager	$ 70,000	$ 83,500	RN	1.00	1.00	$ 70,000	$ 83,500
Nurse	$ 62,400	$ 83,200	RN	1.00	1.00	$ 62,400	$ 83,200
Licensed Practical Nurse	$ 45,760	$ 49,920	LPN	1.00	0.88	$ 45,760	$ 49,920
Surgical Technician	$ 58,240	$ 49,920	RST	1.00	0.88	$ 58,240	$ 49,920
Surgical Technician	$ 58,240	$ 60,320	RST	1.00	0.88	$ 58,240	$ 60,320
Medical Assistant	$ 41,600	$ 45,760	MA	1.00	1.00	$ 41,600	$ 45,760
Medical Assistant	$ 41,600	$ 45,760	MA	1.00	1.00	$ 41,600	$ 45,760
Surgery coordinator	$ 40,040	$ 44,200	-	1.00	1.00	$ 40,040	$ 44,200
ASC Administrative Assistant	$ 39,000	$ 44,200	-	1.00	1.00	$ 39,000	$ 44,200
ASC Director	$ 65,000	$ 85,000	-	1.00	1.00	$ 65,000	$ 85,000
Total				10.00	9.64	$ 521,880	$ 591,780

3. 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.

   Medical director – Bruce Wietharn

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

   See Exhibit 4

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

Table 8 – Key Staff by Name

Role	**License**	Name
Nurse	RN	Brittany Gross, RN
Nurse	RN	Kathy Slate, RN
Nurse	LPN	Rebecca Martinez
PRN Nurse	RN	Jenny Blancset, RN
Nurse	RN	Nadia Makarevich, RN
Nurse	RN	Anna Tereshchuck, RN
Surgical Technician	RST	Sheila McCarty, COA, MA, RST
Surgical Technician	RST	Rain Phillips, CMA, COA, RST
Medical Assistant	CMA	Michelle Carlsen, CMA
Medical Assistant	CMA	Cynthia Garrison, CMA
Surgery coordinator	-	Rebecca Trudel
ASC Administrative Assistant	-	Joyce Bowley
ASC Director	COA, RST	Brandie Somers, COA, RST

6. Provide a list of physicians who would use this surgery center, including their names, license numbers, and specialties.

Table 9 – List of Surgeons

Physician	**Specialty**	**License**
Bruce Wietharn	Comprehensive Ophthalmologist	MD00043436
Bruce Ballon	Comprehensive Ophthalmologist	MD00029300
Natalia Bajenova	Comprehensive Ophthalmologist	MD60274788

7. For existing facilities, provide names and professional license numbers for current credentialed staff.

Table 10 – List of Credentialed Staff

Physician	Specialty	License
Bruce Wietharn	Comprehensive Ophthalmologist	MD00043436
Bruce Ballon	Comprehensive Ophthalmologist	MD00029300
Natalia Bajenova	Comprehensive Ophthalmologist	MD60274788
Drew Scheele	Anesthesiologist	MD00026188
Marlene Brannen	Certified Registered Nurse Anesthetist	AP30005052

8. 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.

Harman Eye Clinic uses word of mouth, position posting publicly, and promoting from within. HEC utilizes King County as a benchmark for pay scales rather than remote or rural benchmarks. The organization had 0 % turnover year to date.

9. For existing facilities, provide a listing of ancillary and support service vendors already in place.

   Exhibit 34

10. For new facilities, provide a listing of ancillary and support services that will be established.

    N/A

11. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

    None are expected to change.

12. If the ASF is currently operating, provide a listing of healthcare facilities with which the ASF has working relationships.

    See Exhibit 23

13. Identify whether any of the existing working relationships with healthcare facilities listed above would change as a result of this project.

    None are expected to change.

14. For a new facility, provide a listing of healthcare facilities with which the ASF would establish working relationships.

    N/A

15. Provide a copy of the existing or proposed transfer agreement with a local hospital.

    See Exhibit 23

16. 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

    Harman Eye Clinic will continue to provide ophthalmic surgical care within its scope of service in which it is currently licensed. The patients are persons from the age of 18 and older who require ophthalmic surgery and are not expected to require hospitalization and can be served appropriately in an outpatient surgical setting. Harman Eye Clinic's operating rooms are equipped to provide ophthalmic surgeries for high-quality, safe, and state-of-the-art patient care. Surgeries performed in the ASF will be supported by moderate sedation/analgesia (conscious sedation). Harman Eye Clinic is the only surgery facility in the North Snohomish Planning Area that performs ophthalmic procedures. The proposed project does not represent unnecessary duplication of services.

17. 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).

    Harman Eye Clinic was established in 1984 in the Arlington area as a comprehensive ophthalmic practice. HEC utilizes co-management to work with the optometrists in the area to provide comprehensive ophthalmic surgeries. HEC also receives referrals from local primary care providers. As evidenced by HEC's patient origin list (Exhibit 17), HEC provides and will continue to provide care throughout the community. HEC maintains a transfer agreement with Cascade Regional Hospital (Exhibit 23)

18. 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.

No practitioner associated with this application has a history of the actions listed. HEC's compliance and quality assurance programs will continue to monitor annually and as needed to ensure that the facility is operated in a safe manor and to continue providing quality care.

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.

   See Discussion to question D2 below.

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.

HEC is requesting certificate of need approval of its existing one-operating room ASF to convert to a CON-approved ASF. Our project will help address net need for outpatient operating rooms in North Snohomish planning area by providing non-HEC surgeons and their patients access to our ASF. This will increase the number of case as well as expand the availability of lower cost outpatient operating rooms for physicians and patients.

HEC Considered the following options:

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

Table 11- Alternative Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:

No project	• There is no advantage or disadvantage to Continuing as is in terms of improving access. The current HEC surgical center has been in place for many years without access issues. (Neutral) • 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: HEC Director Discussion

Table 12- 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: HEC Director Discussion

Table 13 - Alternative Analysis: Promoting Cost and Operating Efficiency

Option:	Advantages/Disadvantages:
No project	• Under this option, there would be no impacts on cost or efficiency – the surgery center would continue as presently. (Neutral) • However, HEC has already incurred all capital costs for one 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	• HEC has already incurred all capital costs for its operating suite. It is much more efficient to better utilize fixed plant and equipment with greater volumes/throughput. This option allows HEC to best utilize its ASF resources, hence improves efficiency and increases cost-effectiveness. (Advantage) • There are no disadvantages. (Neutral)

Source: HEC Director Discussion

Table 14 - Alternative Analysis: Staffing Impact

Option:	Advantages/Disadvantages:
No project	• There are no disadvantages from a staffing point-of-view. (Neutral)
Requested Project	• This Requested Project allows HEC the opportunity to hire a modest number of additional staff, which will likely create economies of scale for HEC across its staff as volumes increase and staff are utilized more productively. Greater volumes will also increase the attractiveness of HEC to employment candidates – this can act to improve staff quality. (Advantage) • The principal disadvantage would be the necessity for HEC to hire, employ, and train additional ASC staff. (Disadvantage)

Source: HEC Director Discussion

Table 15- Alternative Analysis: Legal Restrictions

Option:	Advantages/Disadvantages:
No project	• There are no legal restrictions to continuing operations as presently. (Advantage)
Requested Project	• The principal advantage would be allowing HEC the ability to "open" its ASC to non-HEC physicians. This will improve access, quality and continuity of care and promote highest, efficient use of HEC assets as compared to the No Project option. (Advantage) • Requires certificate of need approval. This requires time and expense. (Disadvantage)

Source: HEC Director Discussion

Table 16 - Alternative Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	• Advantage – If partnering with another provider and/or hospital to develop a new ASF, the ASF would be advantageous if it did more than ophthalmology. An ASF fee schedule is substantially lower than a hospital setting making it more affordable compared to a hospital. In addition, an ASF runs more efficiently then a hospital in-regards to OR time. More operating minutes would be available with another surgery center for a variety of procedures. Referencing the above statement, HEC does not intend to do any other type of procedure other than ophthalmology with this project. • Disadvantage – Creating a new center would be subject to CN approval and would have to show a need, in which it may or may not be able to. If it does not show a need, the new center would not have a history to show the need that was identified in the CN department interpretive statement issued on January 19, 2018. Partnering, building, licensing and credentialing a new surgery center would take several years before patients can realize an increase in access. • In-regards to ophthalmology, HEC already has a fully functional ASF that is equipped for ophthalmic surgery. Opening up another center with just ophthalmic services without increasing the minutes available at HEC would not improve access to ophthalmology services in the immediate future.
Any other options considered	• Discussion – Access to ophthalmology services would not improve if HEC downsized and closed their ASF. If HEC opened up another ASF within the planning area, they would have to go through the CN process. By making the

(Example would be downsizing, HECopening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology)	current ASF more efficient by extending hours and allowing non-HEC surgeons to operate would make the increase to access immediate. Opening up the ASF to other procedures besides ophthalmology requires more time, money and credentialing then HEC would like to pursue at this time. • Utilizing the fully operational ASF at HEC by allowing non-HEC to operate would be the most cost-effective approach for HEC to increase access to ophthalmology in the North King planning area.

Table 17 -Alternative Analysis: Promoting Quality of Care

Option:	**Advantages/Disadvantages:**
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	• Advantages – Partnering with others to create a new surgery center would bring all the advantages of having a surgery center as compared to a hospital. There is a higher infection rate in a hospital setting; CDC showed that in 2010, 8.95/1000 developed a surgical site infection within the hospital setting, whereas in an ASF, 4.84/1000 developed a surgical site infection. Within the ASF setting there are generally higher satisfaction rates, patients and families feel it is a more personable setting, and there is better pricing within an ASF that allows for more affordable care. • Disadvantage – At times, larger institutions (more levels of management and/or partners) can allow small key components that make up quality to fall through the cracks. This can be the cause of poor communication or the inability to fix problems in a fast-efficient manner. • The ASF setting is the concept that HEC believes in and uses to provide excellent quality care for ophthalmology. HEC does not need to partner with an entity to continue to provide and promote quality of care.
Any other options considered (Example would be downsizing, HEC opening another site within the planning area, extending hours of operation and/or add additional procedures	• Discussion – Downsizing HEC organization would not affect the quality of care that is provided at HEC Seattle. The ASF quality of care would continue even if another HECASF was built within the planning area. Adding additional non-ophthalmic procedures may decrease the quality of care until the level of proficiency is reached through education and repetition. • By extending the minutes and allowing non-HEC surgeons to operate, the quality of care would not be diminished for ophthalmic surgeries. The same quality care, policies and procedures that are currently given and followed would continue. As the art of eye care develops with new procedures and care plans, HEC is able to monitor and adapt because it is their specialty and their focus.

besides ophthalmology).	

Table 18 - Alternative Analysis: Promoting Cost and Operating Efficiency

Option:	Advantages/Disadvantages:
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	• Advantages – by partnering with a larger system to open up a new center the resources for training, job description specialization, streamlining processes, purchasing and negotiating power increases. • Disadvantage – If HEC partnered with a hospital, the fee scheduled would be based on HOPD rates, increasing the cost of ophthalmic services to their patients. Partnering with another entity, which increases the size of the organization, usually diminishes response time with regards to change which can lead to inefficiency and higher overhead costs. • In-regards to ophthalmology, HEC already has a fully functional ASF that is equipped for ophthalmic surgery. Opening up another center with just ophthalmic services without increasing the minutes available at HEC would result in an unnecessary cost.

Any other options considered (Example would be downsizing, HEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	• Discussion – HEC downsizing may or may not promote cost or operating efficiency. As the organization grows in a sustainable manner, it relies on all locations for leveraging costs and efficiency. It is not cost efficient to open up another HEC facility within the planning area when there is already a fully operational HECASF that has the ability to add more physicians and operating minutes. Although HEC does not intend to add other services besides ophthalmology, adding additional services would promote a cost savings for the planning area by offering outpatient services outside a hospital setting. HEC does not want to spend the time, cash and resources to open up to other specialties at this time. • As an ASF, HEC promotes a cost savings approach for their ophthalmic patients. With the number of facilities HEC has, it allows for their processes to be ran in an efficient manner.

Table 19-Alternative Analysis: Staffing Impact

Option:	**Advantages/Disadvantages:**
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	• Advantages – Partnering with someone to open a new center would increase the number of healthcare positions available in the planning area, improving the economy within the area. Additionally, with a new surgery center that does multiple procedures, it would allow a "working" interview for HEC to hire and pick from the personnel pool within the facility. • Disadvantages – Working for a large organization can be a deterrent for some people because they feel that their voice doesn't matter, or they don't feel as valued for their work efforts. It is also discouraging when change is needed but it takes a while for it to happen.
Any other options considered (Example would be downsizing, HEC opening another site within the planning area,	• Discussion – Downsizing HEC would mean that personnel would have to be let go. The positive side of the downsize/restructure would be that the best employees could be retained. HEC opening up another ASF within the planning area would also increase the number of personnel, having a positive impact on the economy. Opening up to additional procedures would have a positive impact on the staffing because of the increase in the personnel pool and the ability to specialize in their field of expertise. • HEC continues to look for those employees who stand out in their field. The overall impact of downsizing, adding an additional facility or expanding the

extending hours of operation and/or add additional procedures besides ophthalmology).	services would not have a large impact on the staffing practices of HEC because the process of finding, hiring and retaining a competent staff is already in place.

Table 20 -Alternative Analysis: Legal Restrictions

Option:	**Advantages/Disadvantages:**
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	• Advantages – Partnering with someone to build out a new surgery center would spread out the risk of the venture. • Disadvantages – Time, expense and partners are a disadvantage. There may not be an alignment in goals or outcomes. The larger the organization becomes, the more legal and government involvement. At times, this involvement may outweigh the desire to follow an idea and can stifle growth.
Any other options considered (Example would be downsizing, HEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	• Discussion – Out of the three examples given, downsizing would probably result in the least amount of time spent and expense. Opening up another ASF in the planning area and adding additional services will all require a significant amount of legal time and governmental regulations that need to be met before actually opening up for patient access. • Using the operational ASF facility and expanding the minutes and ability for non-physicians to practice, allows HEC to meet the needs of the public with the least amount of legal and government restrictions.

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

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

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

Exhibit 1
Letter of Intent

THE HARMAN EYE CLINIC
World Class Laser and Cataract Surgery North of Seattle

BRUCE JAY BALLON, M.D.
EYE PHYSICIAN AND SURGEON
BRUCE E. WIETHARN, M.D.
EYE PHYSICIAN AND SURGEON
NATALIA V. BAJENOVA, M.D.
EYE PHYSICIAN AND SURGEON
BRANDIE SOMERS
EXECUTIVE DIRECTOR

WWW.20BETTER.COM
903 MEDICAL CENTER DRIVE, SUITE 100, ARLINGTON, WASHINGTON 98223 (360)435-8595 (800)755-3937 FAX (360) 435-5233

September 09, 2019

Janis Sigman, Manager
Certificate of Need Program
Department of Health
111 Israel Road SE
Tumwater, WA 98501

Re: Letter of Intent, Cascade Regional Eye Center, Inc., P.S. d/b/a. The Harman Eye Clinic

In accordance with WAC 246-310-080, Cascade Regional Eye Center, Inc, P.S. d/b/a The Harman Eye Clinic hereby submits this Letter of Intent proposing to operate the The Harman Eye Clinic Surgery Center as a certificate of need approved ambulatory surgery center in the North Snohomish County Planning Area. The Harman Eye Clinic Surgery Center has historically operated as a certificate of need exempt ASC.

Pursuant to WAC 246-310-080, Cascade Regional Eye Center, Inc., P.S. d/b/a The Harman Eye Clinic submits the following information:

1. **Description of proposed services:** Cascade Regional Eye Center, Inc., P.S. d/b/a The Harman Eye Clinic proposes to operate The Harman Eye Clinic Surgery Center as a one-operating room free-standing ambulatory surgical center.

2. **Estimated cost of proposed project:** There are no capital expenditures associated with this project. The operating room is fully built-out and operational.

3. **Identification of service area**: The service area is the North Snohomish County Planning Area.

Thank you for your assistance in this matter. Please contact me if you have any questions, please contact my administrator, Brandie Somers: 360.435.8595 ex. 18 or brandie@20better.com.

Sincerely,

Bruce Ballon, MD, CEO

Exhibit 2
Organizational Chart

THE HARMAN EYE CLINIC
World Class Laser and Cataract Surgery North of Seattle

BRUCE JAY BALLON, M.D.
EYE PHYSICIAN AND SURGEON
BRUCE E. WIETHARN, M.D.
EYE PHYSICIAN AND SURGEON
NATALIA V. BAJENOVA, M.D.
EYE PHYSICIAN AND SURGEON
BRANDIE SOMERS
EXECUTIVE DIRECTOR

WWW.20BETTER.COM
903 MEDICAL CENTER DRIVE, SUITE 100, ARLINGTON, WASHINGTON 98223 (360) 435-8595 (800) 755-3937 FAX (360) 435-5233

Organizational Chart

Corporate Governing Board
Bruce J Ballon, MD
Bruce E Wietharn, MD
Natalia V Bajenova, MD
Brandie Somers, Executive Director

ASC Governing Board
Bruce J Ballon, MD
Bruce E Wietharn, MD
Natalia V Bajenova, MD
Brandie Somers, ASC Director

Practice Administrator
Brandie Somers, COA, RST, MA-R

Refractive Counselor
Pam Miller

ASC Director
Brandie Somers

Accountant
Judy Hinderlie

Head Nurse
Brittany Gross, RN

ASC
Registered Nurse - 2
Licensed Practical Nurse - 1
Surgical Technician - 2
Certified Medical Assistant - 2
Surgical Coordinator - 2

Clinic
Patient Coordinator - 2
Patient Experience Operators - 2
Ophthalmic Technicians - 10

Business office
Billing Specialists - 2

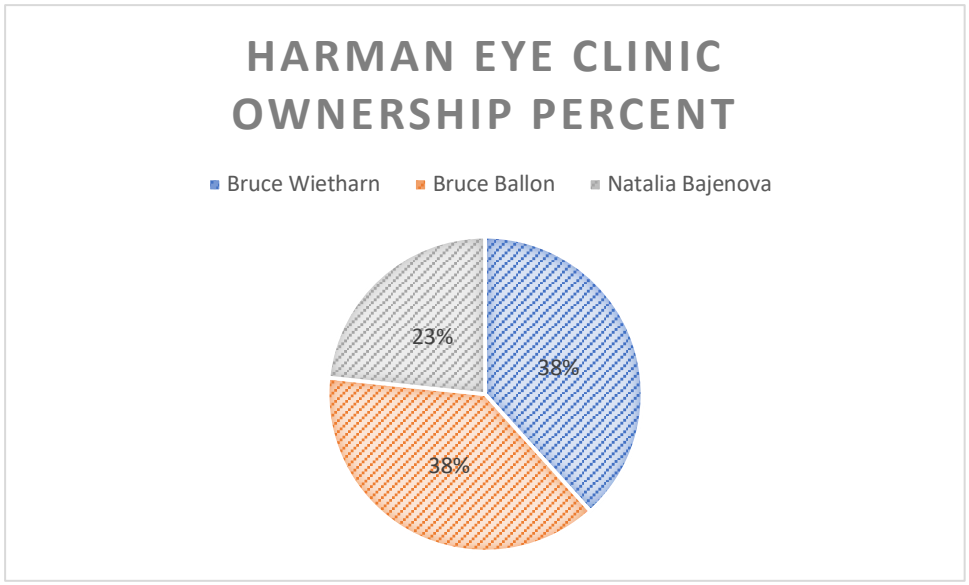

HARMAN EYE CLINIC
OWNERSHIP PERCENT
Bruce Wietharn
Bruce Ballon
Natalia Bajenova
23%
38%
38%

Exhibit 3
Scope of Care Policy

SCOPE OF CARE POLICY:

The Harman Eye Clinic is a licensed Medicare Certified Ambulatory Surgery Center. The hours of operation are by appointment only. The center performs elective surgical procedures to ophthalmic ambulatory patients in ASA level one, two or three.

PROCESS:
The procedures are performed by physicians with credentialed privileges at the center and they are assisted by appropriately trained personnel.

THESE PROCEDURES ARE:

General Ophthalmology

Conjunctiva

Conjunctival cryopexy

Conjunctivoplasty - without graft

Conjunctivoplasty - with sliding graft

Conjunctivoplasty - with mucous membrane graft

Excision conjunctival cyst

Excision of conjunctival tumor

Flap to repair/restore anterior chamber

Gunderson flap

Laser ablation of vessels

Pterygiectomy

Pterygiectomy with Amniotic Membrane

Punctal occlusion

Punctal cautery

Repair of major laceration

Scleral buckle

Tear duct probe

Tear duct irrigation

Cornea

Astigmatic keratotomy

Corneal transplant

Epikeratophakia

Epithelial debridement

Excision pterygium

Excision Pterygium with Amniotic Membrane

Keratectomy

Keratomileusis

Keratoplasty - lamellar

Limbal relaxing incision - LRI

Radial keratotomy

Removal of corneal epithelium with or without chemo-cautorization (abrasion or curettage)

Removal of corneal lesion

Removal of (superficial) foreign body

Removal of (deep) foreign body

Repair of laceration

Repair of wound leak

Resuturing for astigmatism

Sclera

Ahmed Valve/Tube Placement with Scleral Patch Graft

Anterior Chamber Paracentesis

Pupilloplasty Reformation

Removal of foreign body

Repair of laceration

Sclerotomy - partial of full thickness - for variety of glaucoma procedures

Tap/irrigation

Trabeculectomy

Lids

Blepharopigmentation

Blepharoplasty

Browlift

Canthoplasty

Chalazion incision and drainage

CO2 laser skin resurfacing (eyelids, perioral, facial)

Dermatochalasis repair

Destruction of lesion

Ectropion repair

Electrolysis

Entropion repair

Excision of lesion with reconstruction/plastic repair

Excision of lesion with skin graft

Levator resection

Mullerectomy

Ptosis repair

Punctal repair

Repair major laceration

Repair marginal laceration

Severing tarsorrhaphy

Steroid injection for treatment of stye, hordeolum, chalazion, lesion, etc.

Tarsorrhaphy

Lacrimal System

Dacryocystorhinostomy (DCR)

Lacrimal duct probing

Lacrimal duct Probing with dilation and/or irrigation

Orbit

Removal of tumor

Revision/plastic repair of socket

Intubation with silicone tube

Irrigation and drainage

Punctal and canalicular exploration with or without plastic repair

Enucleation

Evisceration

Orbitotomy (lateral)

Foreign body removal

Abscess drainage

Lens

Capsulotomy

Discission

Exchange of IOL (Replacement)

Extraction - extracapsular

Extraction - intracapsular

Extraction with IOL implant

Insertion of lens implant (IOL) or prosthesis

Removal/Reposition of IOL

YAG laser capsulotomy

Retinal

Argon laser photocoagulation - Panretinal or Focal

Laser photocoagulation (tears or lesions)

Membrane peeling

Pneumatic retinopexy

Retinal cryoplexy (tears or lesions)

Surgical Repair of detached retina

Transscleral cryopexy

Vitreous

Removal of foreign body

Vitreous tap

Vitrectomy (anterior or posterior chamber)

Vitreous aspiration

Vitreous injection

Extraocular Muscles

Biopsy

Botulinum toxin injection

Repair of laceration

Repair of wound or extraocular muscle, tendon or Tenon's capsule

Strabismus procedure

Iris

Argon laser trabeculectomy

Excision of lesion

Iridectomy

Iridoplasty

Iridotomy

Laser photocoagulation

Repair of dialysis

Repair of prolapse

Selective Laser Trabeculoplasty (SLT)

YAG Laser Peripheral Iridotomy

Ciliary Body

Cyclocryopexy

Cyclocryotherapy

Cyclodialysis

Cyclodiathermy

Excision of prolapse

Repair of dialysis

Miscellaneous

Anterior membranectomy

Automated lamellar keratoplasty

Excision and biopsy

Examination under anesthesia

Excimer laser

Eye muscle surgery

Goniopuncture

Goniotomy

Holmium laser

LASIK

Orbital fracture (blow - out)

Paracentesis

Placement of Lacricath Balloon for dilation

Recession of eye muscles

Resection of eye muscles

Suture removal

Synechiolysis

Anesthesia

MAC – Monitored Anesthesia Care

Local/Topical

Peribulbar Block

Retrobulbar Block

General

Manage an Emergency

Exhibit 4
Medical Director

ASC Abilities

Oversee operations of ASC services:

Quality
Surgeon performance
Support services
Peri-operative efficiency

Actively support the mission and objectives of the facility as set by the Governing Board.

Collaborate with Governing Board in developing and implementing strategic peri-operative services, goals and objectives.

Provide support to the Executive Director and Governing Board to achieve financial performance objectives and grow volume in the ASC.

Remain familiar with standards for compliance - licensure, Medicare, accreditation, etc.

Work in conjunction with Quality Assurance and Performance Improvement (QAPI) program to oversee the following:

- Patient care and safety standards as mandated by regulatory agencies
- Periodic review of facility policy and procedures
- Designing and implementing utilization and cost management strategies
- Review of Adverse Events, Quality Monitoring Activities and Incident reports
- Performance Peer Review

Link to: ASC Governing Board

Exhibit 5
Medical Staff Policy

THE HARMAN EYE CLINIC

Policy Name:	**PHYSICIAN CODE OF CONDUCT**
Section:	Administration
Purpose	To establish protocol

POLICY:

It is the policy of The Harman Eye Clinic that all individuals within its facility be treated courteously, respectfully, and with dignity. To that end, the Governing body requires all practitioners conduct themselves in a professional and cooperative manner when performing services on behalf of The Harman Eye Clinic. All practitioners are expected to refrain from disruptive, abusive, or otherwise inappropriate conduct toward patients, employees, visitors, and other practitioners. This policy has been adopted and will be enforced in recognition of the position that disruptive practitioners conduct adversely affects the quality of patient care.

OBJECTIVE: The objective of this policy is to promote optimum patient care by preventing, to the extent possible, conduct that disrupts operations, interferes with the ability of others to carry out their responsibilities, creates a hostile work environment for practitioners and fosters a negative public image for the surgery center. When a practitioner's conduct disrupts the operations of the surgery center, it affects the ability of others to get their jobs done, creates a "hostile work environment" for The Harman Eye Clinic employees or other practitioners, or begins to interfere with the practitioner's own ability to practice competently, action must be taken. Courts have consistently held that if a practitioner creates disharmony or disruption, The Harman Eye Clinic has a duty to intervene.

DEFINITION OF DISRUPTIVE CONDUCT: Disruptive conduct can take many forms. Raised voice, profanity, name-calling, throwing things, abusive treatment of patients or employees, sexual harassment, disruption of meetings, repeated violations of policies or rules, or behavior that disparages or undermines confidence in the surgery center or its staff may be disruptive behavior, although this is not an exhaustive list.

Unacceptable disruptive conduct can also include such behavior as:

Attacks (verbal or physical) leveled at others, which are personal, irrelevant, or go beyond the bounds of fair professional comment.

Impertinent and inappropriate comments written or illustrations drawn in patient medical records, or other official documents, impugning the quality of care in The Harman Eye Clinic, or attacking particular practitioners, employees, or the surgery center policy.

Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence.

Refusal to accept or to participate in committee or departmental affairs on anything but his or her own terms or to do so in a disruptive manner.

REPORTING AND DOCUMENTING DISRUPTIVE BEHAVIOR:

Any employee, practitioner, patient, or visitor who observes behavior by a practitioner that disrupts the smooth operation of The Harman Eye Clinic or jeopardizes patient care shall report the incident verbally to the immediate supervisor, with a follow up written report within the shift of the incident, if possible.

The identity of the person who observes the disruptive behavior and files the report shall not be revealed to the person exhibiting the disruptive behavior.

Documentation of disruptive conduct is critical since it is ordinarily not one incident that justifies disciplinary action, but rather a pattern of conduct. The documentation shall be reported on the incident report for violation of physician code of conduct. (Form to follow this policy)

MEETING WITH THE practitioner:

A single confirmed incident of a non-aggressive nature warrants a discussion with the practitioner. The medical director or other appropriate person shall meet with the practitioner and emphasize that such conduct is inappropriate. The practitioner shall be given a copy of this policy and advised to take immediate steps to end the behavior.

If it appears to the medical director that a pattern of disruptive behavior is developing, he/she shall discuss the matter with the practitioner, emphasizing that if the behavior continues; formal action will be taken to stop it. It is neither necessary nor appropriate to await several incidents before making this determination. Smooth operation of the Hospital and protection of patients, employees or others within The Harman Eye Clinic from mistreatment and abuse is a paramount concern. A letter to the practitioner shall follow up the meeting, stating that the practitioner is required to behave professionally and cooperatively.

All meetings with the practitioner shall be documented.

Informal meetings with the practitioner do not constitute a “hearing” subject to the procedural requirements of the Medical Staff Bylaws; however, the practitioner may submit a rebuttal to the complaint.

After each meeting with the practitioner, with the exception of the first meeting, a letter shall be sent to the practitioner confirming that the practitioner is required to behave professionally and cooperatively, or that formal action will be taken.

If the practitioner’s disruptive behavior continues, or if the Governing body determines it to be necessary, the medical director, or an individual acting on the governing body’s behalf shall meet with and advise the practitioner that such conduct must stop. This meeting constitutes the practitioner’s final warning. It shall be followed with a letter reiterating the warning. That letter becomes a part of the practitioner’s permanent file. This letter shall articulate in detail, as specific as possible, what behavior is unacceptable and shall state that the consequences of unacceptable behavior will include suspension or termination of privileges in accordance with the Medical Staff Bylaws.

While this policy outlines several warnings and meetings with a practitioner, the conduct at issue may be so egregious as to make these multiple opportunities inappropriate. Based on the misconduct at issue, corrective action under the Medical Staff Bylaws may be pursued immediately.

THE HARMAN EYE CLINIC

MEDICAL STAFF BYLAWS

Whereas, The Harman Eye Clinic is organized under the laws of the State of Washington, is a free standing outpatient ambulatory surgery center designed to provide quality care for eligible patients who are scheduled to undergo procedures which meet the criteria for ambulatory care; and

Whereas, it is recognized there is a need to provide quality care and leadership;

Therefore, the physicians practicing in the Center shall organize their activities in order to carry out the functions delegated to the Medical Staff by the Governing Body in conformity with these Bylaws.

DEFINITIONS

For the purposes of these Bylaws, the following definitions shall apply:

Medical Staff The physicians who have been granted membership and privileges to care for patients at the Center.

Physician An individual with an M.D. or D.O. degree who is licensed to practice medicine, surgery, dentistry, podiatry, or osteopathy with the State of Washington.

Admitting Physician A physician who has been granted medical staff membership at the Center whose clinical privileges support initiating the admission of a patient to the Center.

Medical Advisory Committee - The committee comprised of the Medical Director and representative members from the Medical Staff shall govern the Medical Staff as described in these Bylaws. The Administrator/Clinical Director of the Center may serve as an exofficio member of the Medical Advisory Committee except that the Administrator shall not participate in any proceedings or activities of the Medical Advisory Committee when it is acting as a peer review and medical review committee.

Governing Body – The body responsible for the overall management of the Center and is comprised of at least one representative selected Managing Partner and the Administrator and other members as deemed necessary by Managing Partner. The Governing Body President will be a standing member of this Committee.

Privileges The permission granted to Medical Staff members to provide patient care and includes use of the Center's resources necessary to exercise effectively those privileges.

ARTICLE 1 - NAME

The name of the organization shall be The Harman Eye Clinic Medical Staff ("Medical Staff").

ARTICLE II - PURPOSE

To ensure that all patients treated in this facility regardless of race, gender, disability, age, creed, veteran status, sexual orientation or national origin shall receive quality medical care.

To serve as the primary means for accountability to the Governing Body for the quality and appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that the patient care in the facility is consistently maintained at the level of quality and efficiency by the state of the healing arts and the resources locally available.

To provide an appropriate setting to maintain scientific and clinical standards.

To initiate and maintain rules and regulations for the governance of the Medical Staff.

To provide a means where issues concerning the Medical Staff and the Center can be discussed by the Medical Staff with the leadership of the Center.

To provide quality care through adherence to the standards and guidelines of accrediting bodies.

To promote the public's confidence in the utilization of comprehensive outpatient services performed by the Medical Staff of the Center.

ARTICLE III – MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Membership

Membership of the Medical Staff of the Center is a privilege extended to ethical, competent physicians who meet the standards and requirements set forth in these Bylaws. No person otherwise qualified as provided in these Bylaws shall be denied appointment or reappointment to medical staff membership or particular privileges solely on the basis of gender, race, age, creed, disability, or national origin.

Section 2. Qualifications for Membership

Physicians licensed to practice in the State of Washington and who apply for membership on the medical staff shall possess:

Current, valid license to practice in the State of Washington.

Current, valid DEA license.

Training and experience relevant to the clinical privileges requested.

Current demonstrated professional competence as determined by the Medical Advisory Committee.
Physical and mental health to exercise the privileges granted.

Maintain insurance in the amount of 1 to 3 million, and with an insurer, deemed satisfactory by the Governing Body.
Admitting physicians might have similar clinical privileges at a local hospital, if the capability to perform the same or similar clinical privileges exists at an area hospital.

All admitting physicians must have admitting privileges at an area hospital or the center will have a transfer agreement with a local hospital.

A record free of felony convictions related to or impacting on patient care, and suspensions or terminations from the Medicare/Medicaid programs.

Acceptance of membership to the Medical Staff shall constitute the staff member's agreement that he/she will strictly abide by the Code of Ethics of the American Medical Association or American Osteopathic Association, whichever is applicable; and these Medical Staff Bylaws, Rules and Regulations; a willingness to work cooperatively with others so as not to adversely affect patient care; and to willingly participate in and properly discharge Medical Staff responsibilities.

The foregoing qualifications shall not be exclusive of other qualifications and conditions deemed by the Medical Staff to be relevant in considering an applicant's qualifications for membership and privileges at the Center.

Section 3. Clinical Privileges

Each medical staff member practicing at The Center by virtue of medical staff membership shall be entitled to exercise those specific clinical privileges granted to him/her by the Medical Advisory Committee and Governing Body.

Documentation of similar privileges at an area hospital shall be considered relevant, but shall not be the sole factor in granting membership.

Application for additional privileges shall be made in writing, and shall contain supporting documentation of the physician's relevant training and experience, and if requested, documentation of said privileges at a local hospital.

ARTICLE IV
PROCEDURE FOR APPOINTMENTAND REAPPOINTMENT TO MEDICAL STAFF

Section 1. Application for Appointment

Application for appointment to the Medical Staff shall be made in writing and signed by the applicant on a printed form endorsed by the Medical Advisory Committee. The application shall contain detailed information concerning the applicant's professional qualifications as requested and specified by the Medical Advisory Committee, and include a statement indicating the applicant has read the Bylaws, Rules and Regulations of the Medical Staff and agrees to abide by the terms thereof for as long as his/her membership continues.

Every initial application for staff appointment must contain a request for the specific clinical privileges requested. The evaluation of such request shall be based upon the applicant's education, training, experience, and demonstrated competence and references. This information will include the involuntary limitation, reduction, or loss of clinical privileges and any other pertinent information.

The applicant has the burden of producing adequate information for proper evaluation of professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications including voluntary or involuntary termination of medical staff membership at another organization. This information must include any previously successful or currently pending challenges to licensure or registration or any voluntary relinquishment of licensure or registration.

Section 2. Procedure for Appointment

Upon receiving the application, the Medical Advisory Committee shall delegate responsibility

to an appropriate staff member at the Center for researching and verifying all necessary references, licensure, and other information concerning the applicant's qualifications for the requested staff privileges.

The completed application shall be transmitted to the Medical Director.

Within 180 days the completed application along with all the supporting documentation and with the recommendation from the Medical Director shall be submitted to the Medical Advisory Committee. The Medical Advisory Committee shall evaluate the character, qualifications, professional standing and suitability of the applicant, and shall make a recommendation regarding appointment after this evaluation is completed. When determining qualifications, the Medical Advisory Committee shall recommend privileges for specific procedures be granted, commensurate with the physician's documented education, training, and experience, as provided in these Bylaws.

All applicants, as well as members of the Medical Staff, consent to the release of pertinent information for any purpose set forth in these Bylaws, and release from liability and agree to hold harmless any person or entity furnishing or releasing such information concerning application for Medical Staff status.

The recommendation of the Medical Advisory Committee shall be transmitted to the Governing Body for review. The Governing Body shall have ultimate authority in all decisions concerning medical staff appointments.

In the event the Medical Advisory Committee or Governing Body should decide to recommend against Medical Staff membership or the granting of some or all of the staff privileges for which an applicant has applied, the applicant shall be notified in writing of its recommendation, in accordance with Article VI.

Section 3. Temporary Privileges

The Medical Director is empowered, where good cause exists and upon the basis of the information contained within the completed application, to grant temporary privileges to the applicant. Prior to granting temporary privileges, a completed application for privileges must be on file with a current medical license, valid DEA license, State controlled substances certificate, current CV, and evidence of acceptable malpractice insurance and malpractice history.

If there is a failure on the part of the applicant to provide accurate information or an inability to verify the accuracy of information, his/her temporary privileges will automatically be terminated. Temporary privileges will remain in effect until the next Medical Advisory Committee meeting, or for a period not to exceed 90 consecutive days, unless extended for one additional period not to exceed 90 consecutive days b the Medical Advisory Committee upon recommendation of the Medical Director. It must reasonably appear from the information available that a favorable decision is likely on the application considering the applicant’s qualifications, ability, and judgement. In such cases, the applicant shall act under the supervision of the Medical Director. Any denial of temporary staff membership or temporary privileges shall be final and not appealable.

Upon receipt of a written request, special temporary staff membership and clinical privileges may be granted by the Medical Director and the Administrator to a practitioner who is not otherwise an applicant for membership, to treat one or more specific patients. Privileges in this situation shall be granted with the above stated requirements. See Section 3 (1). Such privileges may be restricted to the treatment of a limited number of patients or for coverage of another staff physician under limited circumstances for a period not to exceed 30 days, after which such practitioner shall be required to apply for staff membership in order to attend additional patients.

Section 4. Active Staff

All staff members who have completed the credentialing process and approved by the medical advisory and governing body shall be Active Staff members. Active Staff members have full rights and responsibilities of Medical Staff membership, unless limited, according to procedures herein, for a period not to exceed two (2) years.

Section 5. Procedure for Reappointment

Procedure for Reappointment

The Medical Advisory Committee shall review and evaluate each Physician's privileges for appointment at least every two (2) years in the following manner:

Application for reappointment to the Medical Staff shall be made in writing, signed by the applicant on a printed form endorsed by the Medical Advisory Committee. **Specific consideration shall be given to each member with respect to:**

Current, valid license to practice in the State of Washington.

Current, valid DEA license and State controlled substances certificate.

Training and experience relevant to the clinical privileges requested.

Current demonstrated professional competence as determined by the Medical Advisory Committee.

Physical and mental health to exercise privileges granted.

Maintain insurance in an amount of 1 to 3 million, and with an insurer, deemed satisfactory by the Governing Body.

Admitting physicians shall have had similar clinical privileges at a local hospital, if the capability to perform the same or similar clinical privileges exists at an area hospital. The center has a signed transfer agreement to provide for emergency admitting to the local hospital. All admitting physicians must have admitting privileges at an area hospital. (Dentists or podiatrists who are denied the opportunity for medical staff membership at an area hospital must provide evidence of a physician sponsor who will accept responsibility for patient transfers to an area hospital when needed or at transfer agreement).

A record free of felony convictions related to or impacting on patient care, and suspensions or terminations from the Medicare/Medicaid programs.

Ethics, conduct and cooperation with Center personnel.

General attitude toward patients, the Center, and the public.

Utilization patterns.

Compliance with Medical Staff Bylaws, Rules and Regulations.

The completed application shall be submitted to the Medical Director for review.

The completed application along with the recommendation from the Medical Director shall be submitted to the Medical Advisory Committee. The Medical Advisory Committee shall evaluate the character, qualifications, professional standing and suitability of the applicant,

and shall make a recommendation regarding appointment after this evaluation is completed. The Medical Advisory Committee will make and record their recommendation concerning acceptance, deferment, or denial of the applicant.

The recommendation of the Medical Advisory Committee shall be transmitted to the Governing Body for review at its next regularly scheduled meeting. The Governing Body shall have ultimate authority in all decisions concerning reappointments.

If the Medical Advisory Committee or Governing Body should decide to recommend against medical staff membership or the granting of some, or all of the staff privileges for which a physician has reapplied, the physician shall be notified according to Article VI. The fair hearing process the physician may use is delineated in Article VI of these Bylaws.

ARTICLE V - CORRECTIVE ACTION and LOSS OF PRIVILEGES

Section 1. Initiation

Whenever the activities or professional conduct of any physician with clinical privileges are not consonant with these standards of the Medical Staff or are disruptive to the operations of the facility, or are detrimental to patient care, corrective action against such physician may be requested by any member of the Medical Staff, Governing Body, or Administrator.

All requests shall be made in writing to the Medical Advisory Committee and shall be supported by reference to the specific activity or conduct which constitutes such grounds for the request.

Section 2. Grounds

Grounds for requesting corrective action include but are not limited to:

Activities or professional conduct inconsistent with the standards of the Medical Staff as a whole in the community.
Activities disruptive to the Center including sexual harassment.

Unexpected outcomes involving patient injury.

Substandard practices which may or may not have caused patient injury.

Unethical practices.

Conduct reasonably probable of being in violation of the Bylaws, Rules and Regulations, or other Center policies.

Failure to keep adequate records.

Signs of physical or mental impairment which impact the quality of care provided.

Loss or limitation of privileges at any hospital of which physician is a member.

Confirmed, adverse information pertaining to physician competence and/or performance from outside sources such as, but not limited to, the National Practitioner Data Bank, and

other healthcare facilities.

Section 3. Investigation

Upon receiving a request the Medical Advisory Committee shall investigate the matter. The Medical Advisory Committee may appoint an Ad Hoc Investigation Committee to manage the investigation.

It shall be the function of the Medical Advisory Committee (or the Ad Hoc Committee) to conduct a factfinding investigation within thirty (30) days after the receipt of the request to determine the facts and circumstances surrounding each incident that is the basis for the request for corrective action.

The Medical Advisory Committee shall review the results of the investigation, make a written report of its findings, and take action on the request within the following thirty (30) day period.

Section 4. Interview

Prior to the making of such report, the physician against whom corrective action has been requested, shall have the opportunity for an interview with the Medical Advisory Committee, if the physician so desires.

In such interview, the physician will be informed of the general nature of the charges made against him/her and will be invited to discuss, explain, or refute them. This interview shall be preliminary in nature, shall not constitute a hearing and none of the procedural rules provided in these Bylaws pertaining to a hearing shall apply.

A record of such interview shall be made by the Medical Advisory Committee. Failure of the physician to attend a scheduled interview shall constitute a waiver of the right to this interview.

Section 5. Actions

The action of the Medical Advisory Committee may be to reject a corrective action or to recommend any appropriate sanctions including but not limited to:

Letter of Warning

Letter of Admonition

Letter of Reprimand to impose terms of probation; requirement for consultation; reduction; suspension, clinical privileges; suspension; or revocation of Medical Staff membership.

The Clinical Director will report ALL limited privileges and/or monitoring of actions to:

By Mail:

Washington Department of Health
101 Israel Road SE
Tumwater, WA 47890
(360) 236-4030

Any recommendation by the Medical Advisory Committee for denial, alteration, or limitation of clinical privileges of the Medical Staff membership is subject to hearing rights as provided for in Article VI of these Bylaws except as mentioned in this Article.

Section 6. Summary Suspension

Whenever a physician's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood or immediate injury or damage to the health or safety of any patient, the Medical Director, or at least two physicians who are not in direct economic competition and who are on the Medical Advisory Committee, or Administrator, whoever is available, shall have the authority to summarily suspend the medical staff membership or any and all clinical privileges of such physician. Such suspension shall become effective immediately upon imposition.

The Medical Director with the Medical Advisory Committee shall initiate an investigation of the charges as soon as possible.

In the event of a summary suspension taken for any reason, except as defined below, summary suspension may last for a period of no longer than fourteen (14) days, during which the investigation is conducted to determine the need for corrective action. In the event of summary suspension because of imminent danger to the health of any individual, the summary suspension shall last until the conclusion of the investigation, whether or not within the fourteen (14) day period.

Upon the conclusion of the investigation, the Medical Advisory Committee may recommend modification, continuance, or termination of the summary suspension. If, as a result of such investigation, the Medical Advisory Committee finds the suspension should stand as is or needs to be modified, the Suspension remains in effect and the physician is entitled to the procedural rights of a fair hearing outlined in Article VI.

Section 7. Automatic Suspension

Any of the following actions is grounds for automatic suspension without hearing rights:

Suspension or limitation of member's license.

Suspension of DEA license or State controlled substances certificate.

Failure to maintain the amount of professional liability insurance deemed appropriate by the Center.

Suspension of member from the Medicare/Medicaid program.

Actions taken by the Medical Examiners Board or Osteopathic Board of Examiners in Washington restricting a Medical Staff member's license or placing him /her on probation will be the subject of immediate review by the Medical Advisory Committee and/or Governing Body as to the reason(s) for the disciplinary measures. Appropriate actions will be taken pending the outcome of the review.

Reinstatement of the physician to former medical staff status and clinical privileges is directly dependent on reversal of the event that triggered the suspension. However, the facts that led to a state medical board or DEA sanction may be the basis for corrective action by the Medical Advisory Committee.

Section 8. Automatic Termination

Any of the following actions is grounds for automatic termination without hearing rights:

Revocation of member's license to practice medicine.

Revocation of DEA license or State controlled substances certificate.

Conviction for a felony related to or impacting patient care.

Loss of hospital privileges such that Physician has no hospital privileges in the local area.

Falsification, misrepresentations, or omissions of any aspect of application for membership or privileges, without exception.

Should there be a reversal of the list above and the physician desires reinstatement of Medical Staff membership and privileges, the physician must reapply in writing for all surgical center privileges. Such reapplication shall be processed in the same manner as reappointment to the Medical Staff, as set forth in Article IV, Section 5.

ARTICLE VI - PROCEDURAL FAIRNESS

Section 1. Right to Hearing

When any physician receives notice from the Medical Advisory Committee of a recommendation that will adversely affect his/her status as a member of the Medical Staff, or his/her clinical privileges, as stated in (2) below, the physician shall be entitled to a hearing before an Ad Hoc Hearing Committee appointed by the Medical Advisory Committee.
The grounds for a hearing are:

Denial of staff appointment or reappointment.
Suspension of medical staff membership (except as set forth in Article V, Sections 7 & 8).
Revocation of staff membership (except as set forth in Article V, Sections 7 & 8).
Denial of advancement in medical staff membership.
Denial of requested privileges.
Reduction of privileges.
Denial of increase in privileges.
Suspension of privileges.
Termination of privileges.
All hearings shall be in accordance with the procedural safeguards set forth in this Article.

Section 2. Request for Hearing

The Medical Director shall be responsible for giving prompt written notice by Certified Mail, Return Receipt Requested, of an adverse recommendation or decision to any affected physician who is entitled to a hearing.

This should include and not be limited to, reasons for proposed action, a statement that the physician has a right to request a hearing on the proposed action within thirty (30) days of receipt of the notice, and a summary of the physician's rights with respect to the conduct of the hearing.

The Notice of Hearing shall summarize in concise language, the acts or omissions with which the physician is charged.

Within thirty (30) days of receipt of such notice, the affected physician may make a written request either in person or by Certified Mail, Return Receipt Requested, to the Medical Director for a hearing. The failure of a physician to request a hearing to which he/she is

entitled to by these Bylaws within the time and in the manner herein provided, shall be deemed a waiver of the right to such a hearing. Once such a hearing has been waived, the adverse recommendation or decision shall become the final recommendation or decision of the Medical Staff.

Postponement of the hearing beyond the time set forth in these Bylaws may only be done after approval of the Medical Advisory Committee. Such postponement shall only be for good cause as requested by the affected physician and at the discretion of the Medical Advisory Committee.

Within a period of not less than thirty (30) days after receipt of a request for a hearing from a physician entitled to same, the Medical Director shall schedule and arrange for a hearing and shall, through the Chairperson of the Medical Advisory Committee, notify the affected physician of the time, place, list of witnesses expected to testify, and hearing date so scheduled, by Certified Mail, Return Receipt Requested. Another date may be mutually agreed upon. The hearing date shall not be greater than sixty (60) days from the date of receipt of request for the hearing. In the case of a summary suspension, the hearing will be held as soon as reasonably possible, and with the consent of the affected physician, sooner than thirty (30) days after receipt of the request for the hearing.

Section 3. Composition of the Hearing Committee

The hearing shall be conducted by an Ad Hoc Hearing Committee composed of no less than three (3) members, and no more than seven (7) members of the Medical Staff. The Governing Body will appoint such committee.

No staff member who has actively participated in consideration of the adverse recommendation or action, and no physician who is in direct economic competition with the affected physician shall be appointed a member of this hearing committee.

Section 4. Conduct of Hearing

The hearing provided for in these Bylaws is for the purpose of resolving matters bearing on professional competency and conduct. The Ad Hoc Hearing Committee shall consider any relevant issues of individual, professional competence or conduct, or allegations that administrative or Medical Staff Bylaws, policies, or rules that have been applied in an arbitrary, capricious, or discriminatory manner. The committee will make its determination based on administrative or Medical Staff Bylaws, Rules and Regulations, and policies and procedures in effect at the time a physician receives notice of an adverse action.

The affected physician for whom the hearing has been scheduled shall be required to be physically present throughout the hearing. A physician who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her right to a hearing and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become the final recommendation or decision of the Medical Staff.

The affected staff member may be represented by an attorney. The Medical Staff may also have legal representation present at the hearing.

The affected physician shall be entitled to be accompanied at the hearing by a member of the Medical Staff in good standing, or by a member of his/her professional society.

A Hearing Officer shall be chosen by the Ad Hoc Hearing Committee and shall preside over the hearing, determine the order of procedures during the hearing, ensure that all participants

in the hearing have a reasonable opportunity to present oral and documentary evidence, rule on any issues or questions that might arise, maintain decorum, and ensure that all parties present their positions promptly and without unnecessary delay. The Hearing Officer may, but need not be, an attorney at law capable of presiding over a quasijudicial hearing. If the Hearing Officer is a Medical Staff member and a member of the Ad Hoc Hearing Committee, the Hearing Officer shall have voting rights. Otherwise, the Hearing Officer shall not have voting rights.

The hearing need not be conducted strictly according to the rules of civil procedure relating to the examination of witnesses or presentation of evidence. Any relevant matter on which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make the evidence inadmissible. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue. Such memoranda shall become part of the hearing record.

The Medical Staff's appointed representative and the affected physician shall have the following rights:
To be provided with all information available to the Ad Hoc Hearing Committee.

To call, examine and crossexamine witnesses.

To introduce and rebut written evidence.

To submit a written statement at the close of the hearing.

An accurate, independent record of the hearing must be kept (e.g., court reporter, taping with transcriptions). The mechanism shall be established by the Ad Hoc Hearing Committee. All involved parties shall receive a copy of the hearing record upon written request. A fee may be charged for copies of the proceedings.

The Ad Hoc Hearing Committee may recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Ad Hoc Hearing Committee shall thereupon, at a time convenient to itself, promptly conduct its deliberations outside the presence of the affected staff member.

No Hearing Committee member may vote by proxy.

Section 5. Final Decision

The majority recommendation of the Ad Hoc Hearing Committee will be the final decision on the matter subject to approval by the Governing Body. The Medical Advisory Committee shall send notice of the decision to the physician within three (3) days of completion of the hearing, along with a statement of the basis of the decision by Certified Mail, Return Receipt Requested.

ARTICLE VII - APPELLATE REVIEW PROCEDURE

Section 1. Nature of Proceedings

The proceedings by the Governing Body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee and that committee's report. The

Governing Body shall also consider material as may be presented and accepted under Section 3 and 4 of this Article. The Governing Body will meet quarterly.

Section 2. Presiding Officer

The Chairman of the Governing Body shall be the presiding officer. He shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

Section 3. Oral Statement

The Governing Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put to him by members of the Governing Body.

Section 4. Consideration of New or Additional Matters

Additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only at the discretion of the Governing Body, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

Section 5. Powers

The Governing Body shall have all powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to discharge its responsibilities.

Section 6. Presence of Members and Vote

A majority of the Governing Body must be present throughout the review and deliberations. If a member of the Governing Body is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

Section 7. Recesses and Adjournment

The Governing Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

Section 8. Action Taken

The Governing Body may affirm, modify, or reverse the action taken by the Ad Hoc Hearing Committee or the Medical Advisory Committee.

Section 9. Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps have been completed or waived. The Governing Body's decision is final and shall not be subject to further hearing or appellate review. The Governing Body shall send notice to the affected physician by Certified Mail, Return Receipt Requested.

ARTICLE VIII - ALLIED HEALTH PROFESSIONAL APPOINTMENTS

Section 1. Definition

Allied health professionals shall be defined as nonphysician healthcare workers. They may be employed by The Center, a Medical Staff member, or practice as independent practitioners, if

permitted by State law. **Allied health professionals shall include, but may not be limited to the following individuals:**

Nonphysician surgical assistants.

Private physicians' scrub nurses or technicians.

Physician Assistants.

Registered Nurses.

Section 2. Procedure for Appointment

Application for appointment to the Allied Health Professional Staff shall be made in writing, and signed by the applicant on a printed form endorsed by the Medical Advisory Committee. The application shall contain detailed information concerning the applicant's professional qualifications and include a statement indicating the applicant has read the applicable sections of the Bylaws, Rules and Regulations, and Policy and Procedure manuals of The Center, and agrees to abide by the terms.

The application shall be signed by the employing Medical Staff. The Medical Staff member's agreement to be fully responsible for the Allied Health Professional's actions in dealing with patients treated at The Center.

When requested by the Medical Staff, the employing Medical Staff member and/or supervising physician shall provide a statement in the application indemnifying The Center against the actions or omissions of the Allied Health Professional Staff member(s) requesting appointment. If the applicant is not employed by a Medical Staff member, the applicant shall provide evidence of professional liability insurance coverage.

The application shall outline a description of duties the applicant desires to perform at The Center, the scope of the practice, and the level of supervision to be provided by the Medical Staff member.

The applicant shall submit a current Washington license or registration certification or other legal credentials authorizing their practice, when applicable.

The completed application shall be reviewed by the Medical Director who shall recommend or deny granting temporary privileges.

The completed application along with the recommendation from the Medical Director shall be submitted to the Medical Advisory Committee. The Medical Advisory Committee shall make its decision based upon the applicant's current license (if applicable), education, training, experience, and the references of the applicant.

The recommendation of the Medical Advisory Committee shall be transmitted to the Governing Body for review. The Governing Body shall have ultimate authority in all decisions concerning Allied Health Professional appointments.

Section 3. Procedure for Reappointment

Allied Health Professionals shall be reappointed in writing according to the same procedure as listed in Section 2 above.

Section 4. Removal from Staff

An Allied Health Professional who ceases employment with the employing Medical Staff member will be terminated from the Allied Health Professional Staff, effective the date of termination from the employment of the Medical Staff member. The employing Medical Staff member is responsible for notifying the Medical Advisory Committee of the termination.

Allied Health Professionals may be terminated from the Allied Health Professional Staff for activities or professional conduct inconsistent with the standards of The Center, after review by the Medical Advisory Committee.

Independent practitioners and other Allied Health Professional are entitled to an interview with the Medical Advisory Committee regarding their termination of privileges if the termination of privileges is for reasons other than a change in employment status. Appeal will be to the Governing Body.

ARTICLE IX - GOVERNANCE AND COMMITTEES

Section 1. Medical Advisory Committee

The Medical Advisory Committee shall be a standing committee and shall consist of representatives from each major specialty of the Medical Staff in addition to the Medical Director. The Administrator of The Center may serve as an exofficio member of the Medical Advisory Committee but shall not participate in any proceedings or activities of the Medical Advisory Committee when it is acting as a peer review or medical review committee.

The Medical Advisory Committee has been empowered by the Governing Body for the establishment, maintenance, and improvement of professional and quality care. Therefore, the Medical Advisory Committee shall encourage and participate in the ongoing monitoring and review of the factors that relate to quality patient care.

The chairperson shall report to the Governing Body.

Recommendations and decisions of the Medical Advisory Committee will be determined by majority vote of its members.

The duties of the Medical Advisory Committee shall be:

To represent and act on behalf of the Medical Staff subject to limitations as may be imposed by these Bylaws.

To receive committee reports and make recommendations to the Governing Body.

To implement the Bylaws and Rules and Regulations of the Medical Staff.

To provide a liaison between the Medical Staff and the Center.

To recommend action to the Medical Director.

To make recommendations on the management of the Center.
To fulfill the Medical Staff's accountability for quality care provided to patients at the Center.

To review the credentials of all applicants to the Medical and Allied Health Professional Staffs, make recommendations on appointments, reappointments, and delineation of privileges of such.

To review periodically or at least every two (2) years, current information available regarding the performance and clinical competence of physicians and other practitioners with clinical privileges and make recommendations for changes in clinical privileges.

To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff members.
To serve as a hearing committee when requested.

To report any changes in patient care rules and regulations and participate in organizational performance improvement activities.

To make such other recommendations as deemed necessary.

To report to the Governing Body.

The Medical Advisory Committee shall meet as often as is necessary but not less than four (4) times a year. The Medical Advisory Committee shall maintain a permanent record of its proceedings and actions. A quorum shall consist of at least three (3) members of the Medical Advisory Committee.

Section 3. Quality Assurance, Performance Improvement Committee

The Quality Assurance, Performance Improvement Committee should consist of the Medical Director, Administrator, business office representative, risk management coordinator, performance enhancement coordinator, representatives from each clinical area preoperative, operating room, and recovery and other staff members as deemed necessary.

The Quality Assurance, Performance Improvement Committee shall be responsible for activities relating to quality of care, risk management, medical records, nursing, utilization, infection control, pharmacy and therapeutics, surgical case review, tissue review, and such other functions as the Medical Advisory Committee shall from time to time assign to it.

The Quality Assurance, Performance Improvement Committee shall meet quarterly and shall keep a permanent record of its proceedings. Minutes of each meeting shall be forwarded to the Medical Advisory Committee.

Section 4. Medical Staff Meeting

A meeting shall be called when the Medical Advisory Committee or Governing Body deems it necessary. The Medical Advisory Committee shall arrange the time and place of such meeting. Written notice stating the place, date, and hour of the meeting of the Medical Staff shall be delivered either personally or by mail to each member of the Medical Staff.

The agenda at Medical Staff meetings shall be:

Reading of the notice calling the meeting.
Transaction of business for which the meeting was called.
Adjournment.

A copy of minutes will be circulated to Medical Staff members in attendance at the meeting asking for input and corrections prior to final documentation.

A majority vote of those present is required to carry out any motion or vote brought before the membership.

ARTICLE X - IMMUNITY FROM LIABILITY

The following shall be express conditions to any person's application or Medical Staff member's exercise of clinical privileges at the Center.

FIRST, that any act, communication, report, recommendation, or disclosure with respect to any such physician, performed or made in good faith and without malice at any request of an authorized representative of this Medical Staff or any other health facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.

SECOND, that such confidentiality shall extend to members of the Medical Staff, the Medical Advisory Committee, to other practitioners who supply information, and to third parties who receive, release, or act upon the, same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Medical Staff or The Center.

THIRD, that there shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure, even when the information involved would otherwise be deemed privileged.

FOURTH, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in good faith in connection with this or any other health care facilities' activities related, **but not limited to:**

Applications for appointment or clinical privileges; Periodic reappraisals for reappointment of clinical privileges; Corrective action including summary suspension; Hearings and review; medical care evaluations; Infection control; Committee activities related to quality patient care and interprofessional conduct.

FIFTH, that the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a physician's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or other matters which may directly or indirectly have an impact on patient care.

SIXTH, that in furtherance of the foregoing, each applicant and/or Medical Staff member shall, upon request of the Medical Director of The Center, execute a written release in accordance with the tenor and import of this Article in favor of the individuals and organization specified in paragraph "SECOND" and whether or not such written release is requested or executed, each applicant and/or Medical Staff member agrees to such release.

ARTICLE XI - GENERAL PROVISIONS

Section 1. Rules and Regulations

Subject to the approval of the Governing Body, the Medical Advisory Committee shall adopt such Rules and Regulations as may be necessary to implement these Bylaws. The Rules and Regulations shall relate to the proper conduct of Staff organizational activities and shall embody the level of practice required of each Staff appointee. Rules and Regulations may not conflict

with or contravene the Bylaws. In all cases where there are discrepancies or divergent interpretations, the Bylaws shall prevail.

Section 2. Professional Liability Insurance

Each practitioner and other individuals granted clinical privileges in the Center shall continuously maintain in force professional liability insurance in the amount of 1 to 3 million, as may be determined by the Governing Body, with full coverage for all clinical privileges or services provided in the Center. The Governing Body shall determine the amount of professional liability insurance deemed satisfactory. Upon request, each practitioner shall provide satisfactory evidence of such coverage to the Medical Advisory Committee, including full information as to exceptions or exclusions from coverage, and shall immediately notify the Medical Advisory Committee of any change in such coverage. Each such policy shall provide that it will not be canceled except on thirty (30) days prior notice to the Center.

Section 3. No Contract Intended

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact, by implication or otherwise, a contract of any nature between or among the Center or the Governing Body or the Medical Staff and any member of the Medical Staff or any person granted clinical privileges. Any privileges are simply privileges which permit conditional use of the Center's facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the foregoing, the provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon physicians and those granted clinical privileges in the Center.

Section 4. No Agency

Physicians and practitioners shall not, by virtue of these Bylaws, membership or privileges, be authorized to act on behalf of, or bind the Center, and shall not hold themselves out as agents, apparent agents, or ostensible agents of the Center, except where specifically and expressly authorized in a separate written contract with the Center.

Exhibit 6
Health Services
Planning Area Map

Pop-Facts Demographic Trend

Map

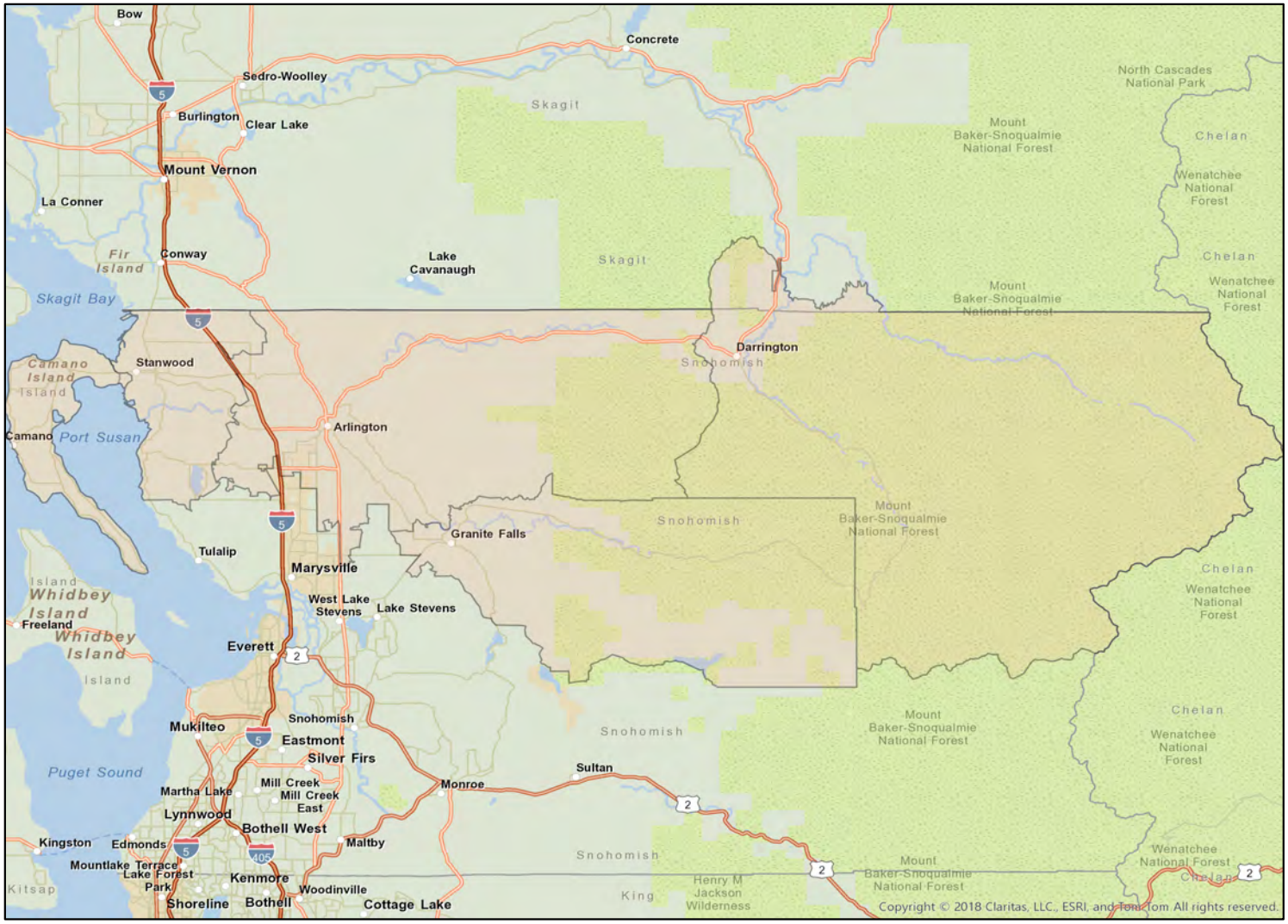


Exhibit 7
Credentialing and Privileging Policy

Credentialing Medical Staff

POLICY:

The medical staff of the ASC are accountable to the governing body. Medical staff privileges may be granted both to physician and non-phycisian practitioners, consistent with their permitted scope of practice in the state, as well as their training and experience.

PROCESS:

Members of the medical staff must be *legally and professionally qualified* for the positions to which they are appointed and for the performance of privileges granted.

"legally qualified" means the practitioner has a current license to practice within Washington state and the privileges fall within Washington's permitted scope of practice.

"professionally qualified" means that the practitioner has demonstrated competence in the area for which privileges are sought and/or granted. Competence is demonstrated through evidence of specialized training and experience. Their performance is reviewed quarterly through Peer Review.

PROCEDURE:

INITIAL CREDENTIALING

Cover Letter: Request for Medical Staff Privileges/Appointment

Request for staff priveleges:appointment.pages.zip

- Application to include:
  - WA State Practitioner Application (WPA)

<<Link to WAMSS for the current QPA>>

  - WPA Release
    <<Link to WAMSS for the current QPA>>
  - Face Sheet for Professional Malpractice Insurance
  - Delineation of Privileges Request Form

DOP ophthalmology 09.09.11.doc

Anesthesia DOP 10.29.13.pages

Required Document Copies

- Medical License
- DEA Federal
- Board Certification - or Plan for Board Certification (if applicable)
- Face Sheet of Malpractice Insurance
- Copy of ACLS

Verifications

- Cover letter for Verification of Hospital Privileges

  request for verification of hospital privileges.docx
- Verification of Hospital Privileges Form

verification of privileges hosp.pages.zip

- Cover letter for Peer References

Request for peer references.docx

- Personal/Professional Reference Form

Personal Reference.pages.zip

RE-CREDENTIALING AND REAPPRAISAL:

As long as the number of the surgeons in our center remain at 6 or less, we will use the process of Quarterly Peer Review to monitor performance, in lieu of bi-annual re-credentialing.

The ASC Governing Board calendar is reviewed monthly for any expiring required documentation for Medical Staff Privileges.

Along with Quarterly Peer Review the following are also monitored regularly:

- OIG exclusion list - Checked monthly
  - Results located in Shared > HR November 2014.sparseimage > OIG Exclusions by Month
- State License - On ASC Governing Board calendar and reviewed monthly
  - MD Employee license located in Shared > Disk Image.sparseimage > Contracts Provider
  - Non-employee Credentialed staff licenses located in Shared > HR November 2014.sparseimage > ASC Staff Credentialing
- BLS/ACLS - On ASC Governing Board calendar and reviewed monthly
  - MD Employee certification located in Shared > Disk Image.sparseimage > Contracts Provider
  - Non-employee Credentialed staff certification located in Shared > HR November 2014.sparseimage > ASC Staff Credentialing
- Malpractice Insurance - On ASC Governing Board calendar and reviewed monthly
  - MD Employee insurance face sheet located in Shared > Disk Image.sparseimage > Contracts Provider
  - Non-employee Credentialed staff insurance face sheet located in Shared > HR November 2014.sparseimage > ASC Staff Credentialing
- DEA License - On ASC Governing Board calendar and reviewed monthly
  - MD Employee license located in Shared > Disk Image.sparseimage > Contracts Provider
  - Non-employee Credentialed staff licenses located in Shared > HR November 2014.sparseimage > ASC Staff Credentialing
- TB Testing - TB - Tuberculosis Screening Program
  - Located in Shared > HR November 2014.sparseimage > TB Verification by Year
- Current Hospital Privileges - On ASC Governing Board Calendar and reviewed monthly
  - Located in Shared > Disk Image > Contracts Provider

Any instance of gross misconduct by medical staff or the practitioner requires a complete clinical performance review and re-credentialing process.

Clinical performance review to include but is not limited to:

- Number of infections reported
- Number of complications reported
- Number of hospital admissions or transfers
- Patient satisfaction trends
- Incident reports involving the medical staff member

Re-credentialing procedure:

Prior to re-credentialing, The Harman Eye Clinic will review the file checking for current licensing and other documentation. A Re-credentialing Request Packet will be sent to the provider, along with a request for any licenses or needed supporting documentation indicating a return date of no more than 30 days.

Re-credentialing Request Packet to include:

- Re-credentialing/Reappointment cover letter

Reappointment_Recredentialing Cover Letter.pages

- WA State Practitioner Application/Reappointment Attestation
  <<Link to WAMSS for the current QPA>>
- Delineation of Privileges Request (DOP)

See above from above

Documentation required to complete Re-credentialing (requested in cover letter):

- Current License
- Current DEA Certificate
- Current Board Certification (if applicable)
- Current Proof of Professional Liability/Malpractice Insurance
- Current CPR (BLS and/or ACLS) Certificate
- Evidence of current vaccinations

Upon receipt of the completed Re-credentialing Application, The Harman Eye Clinic will obtain the following:

- State Medical Board verification of current license
- Verification of privileges held elsewhere
- Review of Medicare and Medicaid sanctions

Remember that supporting documentation, i.e., NPDB, application, etc., should be no more than 90 days old at the time of review.

The completed re-credentialing application with be presented to the ASC Governing Board for reappointment.

Exhibit 8
Historic Services; Identified by Top 30 CPT Codes

2018 Production Detailed by Procedure

Procedure	Description	# Units
66984	Fac Cat Ext	1083
66821	Fac Yag	362
V2632	IOL Post Cham	1008
66982	Fac Complx	97
ORA	ORA System Technology	501
R	Toric IOL	43
65855	FAC Trabeculoplasty **10	108
15823	FAC Bleph UL Excess Skin	15
67840	FAC Bx lid lesion ASC	30
66761	FAC Irid	27
0191T	IStent Facility	2
66985	Fac Sec IOL	5
67800	FAC Ex Chal,	19
68810	Fac PrbIrr	9
66825	FAC Repos	4
RLE	Refractive Lens	1
65426	FAC Ptr W/g	2
65865	FAC Sev Adh	2
66682	FAC suture	2
67036	FAC Vitrec, Mechan, ParsPlana	1
68440	FAC Snip	7
68760	FAC Closure of punctum by thermocauterization	6
67908	FAC Ptosis	2
67825	FAC Epilation other than forcepts	6
C9447	Omidria Phenylephrine and ketorolac injection 4ML	4
65435	FAC Rem	4
65860	FAC Sev Adhsns Anterior Seg Laser	4
66986	FAC Lens	1

Exhibit 9
Patient Admission, Assessment and Discharge Policy

ADMISSION POLICY:

The Harman Eye Clinic provides surgical services in a safe, efficient, cost-effective and user-friendly environment. Procedures performed are limited to those identified in the Scope of Care as approved by the Governing Body. Surgical services are limited to those which can be safely and effectively provided on an outpatient basis and are typically elective and non-emergent in nature. Any time a procedure is done in the surgery center, an RN and an MD will be present.

PROCESS:

The ASC staffing consists of:

Operating Surgeon

Anesthesia Providers, when required

Director of ASC, when required

Circulating RN and/or LPN

Operating Room Technician(s)

Preop/post and PACU R.N.

Discharge Nurse CNA or MA

Surgery Care Coordinator(s)

Business and Clinic Personnel are readily available when the ASC is open except in an after-hour emergency surgery.

Hours of Operation:

The office will be open for telephone calls and deliveries between 8:00 a.m.- 4:30 p.m. Monday through Friday. However, the ASC is not open unless patients are scheduled and an RN and an MD is present.

The ASC Facility consists of:

Designated Reception/Waiting Area

Staff Changing

Patient Changing / Restroom

Pre-Op Area

Operating Room / Procedure Room

Post Anesthesia Care Unit Area

Janitor Closet

Storage Room

Medical Gas Storage

Pre-Op Beds/Chairs

Post-Op Beds/Chairs

Nurses' Station

Sterile Processing Room

Soiled Utility

PROCEDURES

The center will employ sufficient numbers of professional and support staff to ensure efficient, quality patient care, which may include R.N.'s, L.P.N.'s, CNA's, MA's, nursing assistants and technicians. A registered nurse will be present to direct the day in collaboration with the Director of the ASC.

The center annually develops and ensures fiscal soundness through proper budgeting and performance analysis:

Annual Budget

Weekly Production Report

Month-end Financial Report, including accounts receivable and payable report, and growth status charts.

The center may utilize professional consultants, as needed, to ensure legal and regulatory compliance.

The patient flow process will be as follows:

- BEFORE PROCEDURE DAY: When scheduling the surgical procedure, the scheduler will instruct the patient regarding the surgical day, time, pre-operative physical requirements, etc. The patient will also be informed to bring someone with them who can drive them home after discharge, unless they will not be sedated.

- DAY OF PROCEDURE: The patient and responsible party will enter the waiting room, be greeted by a surgery care coordinator, and checked in for the surgical encounter. Every effort will be made to complete all necessary paperwork prior to admission. Any remaining documentation will be completed at this time. Verification of receipt of physician ownership disclosure statement, patient rights and responsibilities and facility policy regarding advanced directives will be discussed at this time. Patient will be verified using the Every Person Every Time procedure. Patient ID band will be placed on patient's wrist and a surgical site mark placed above the operative eye/site. This will also indicate whether the patient has chosen to proceed with additional procedures such as an ORA wavescan.

- The patient will be escorted to the change room and be offered to use the restroom. Here, they may remove some of their "street clothes" and don appropriate surgical attire depending on the nature of the planned procedure. All patients entering the restricted area will don a head cover and booties. Patient belongings will be secured in a locked locker or a labeled patient belongings bag which will remain with the patient throughout the encounter.

- The patient is offered a blanket and made comfortable in the pre-op area.

- The pre-op nurse will interview the patient, confirm the patient's history and understanding of the planned procedure then complete the pre-op checklist and implement any pre-op physician orders. The patient will be identified by using the Every Person Every Time procedure. The Anesthesiologist will meet with the patient prior to entering the operating room for an assessment including but not limited to any significant history of pain and possible anesthesia complications will be assessed.

- When the OR team is ready, the circulation nurse will escort the patient into the operating room or procedure room. The perioperative team will position the patient and attach monitoring devices to the patient.

- The patient is prepped with an antiseptic solution as ordered by the surgeon and sterile drapes are applied to establish a sterile field. During this time a final time out is performed, prior to making the incision, which will include the surgeon, anesthesia provider, the circulating nurse and scrub personnel.

- Anesthesia appropriate to the length and nature of the surgical procedure is administered.

- When the procedure has been completed, a sterile dressing is applied, if necessary. The drapes are discarded, monitoring devices are removed and the patient is transferred to PACU.

- The PACU nursing staff monitors the patient, provides appropriate pain management, and discharge instructions are given to the patient and family as appropriate. The patient is offered nourishment and intake is documented.

- Prior to discharge, the patient is assessed by a physician and a discharge order is documented in the medical record according to discharge criteria.

- The patient is offered the restroom and is assisted with removing surgical attire and changing clothes as needed.

- The patient or responsible party along are signed out by a nurse and released from the facility to the care of a responsible adult.

- The patient is escorted to the car (or appropriate mode of transportation) by a staff member to ensure safety.

Exhibit 10
Interpretive Statement

Department of Health
Office of Community Health Systems

Interpretive Statement

Revised – 10/18/11

Title:	Certificate of Need – Interpretation of WAC 246-310-010(5), Definition of Ambulatory Surgical Facility	*Number: CN 01-18*
References:	Chapter 70.38 RCW, WAC 246-310-010	
Contact:	Nancy Tyson, Executive Director	
Phone:	360.236.4796	
Email:	Nancy.Tyson@doh.wa.gov	
Effective Date:	January 19, 2018	
Supersedes:	n/a	
Approved By:	John Wiesman, DrPH, MPH, Secretary of Health	

The Washington Department of Health (Department) is making this statement to clarify and provide consistency to the future application of the definition of "ambulatory surgical facility" in Washington Administrative Code (WAC) 246-310-010(5):

> "Ambulatory surgical facility" means any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. This term does not include a facility in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using the facility is not extended to physicians or dentists outside the individual or group practice."

The Problem

The Department has received complaints that the Certificate of Need (CN) Program has been inconsistent over a number of years in its application of this rule. Apparently, persons both in and outside the Program have interpreted the last sentence of the definition to exempt some facilities that operate primarily for the purpose of performing surgical procedures from CN review because a private physician or a group of private physicians owned and exclusively used the facility.

Any decision to exempt an ambulatory surgical facility operating primarily to perform surgical procedures from CN review would have been in error because such as decision is inconsistent with the Department's statutory authority.

The Department's Statutory Authority

Under RCW 70.38.105, the Legislature requires new healthcare facilities to obtain a CN. RCW 70.38.025(6) defines healthcare facilities to include ambulatory surgical facilities. The Legislature did not authorize the Department to exempt any ambulatory surgical facility from this obligation. Therefore, the only possible reason for the final sentence in WAC 246-310-010(5) is to clarify that the rooms in private offices used intermittently and exclusively by physicians to perform minor surgery as an incident to their clinical practice are not ambulatory surgical facilities.

The Correct Application of WAC 246-310-010(5)

The correct application of WAC 246-310-010(5) when reviewing applications for determination of reviewability is to first examine whether a proposed ambulatory surgical facility or center "operates primarily for the purpose of performing surgical procedures." If it does, it is required to obtain a CN. An example of a surgical facility not required to obtain a CN is a room in a private physician's clinic where office-based surgical procedures are performed incidental to the physician's clinical practice. Another example not required to obtain a CN is a private physician's clinic that closes as a clinic on an intermittent basis to open as a Medicare-certified ambulatory surgical facility, provided physicians outside the practice do not use the facility.

The CN Program's Current Course of Action

The CN Program is applying WAC 246-310-010(5) consistent with this statement. This statement does not affect any determinations of reviewability issued prior to the date of this statement, unless the existing owner relocates the facility, adds operating rooms, or adds specialties. If the facility transfers ownership, the new owner must apply for an exemption or a CN.

If there is no numerical need for operating rooms in the applicable planning area when a new owner acquires a previously exempt ambulatory surgical facility, the facility can apply under 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. Having only one operating room will not be a limitation preventing a previously exempt facility from obtaining a CN.

Exhibit 11
Patient Rights and Responsibilities and Grievances

Patient Rights

As a patient, you have the right

- To have access to the patient rights and responsibilities established by this center.
- To see posted written notice of the patient rights in a place or places within the facility likely to be noticed by patients (or their representative, if applicable) waiting for treatment. The written poster will include name, address, and telephone number of a representative of the state agency to whom the patient can report complaints, as well as the website for the Office of the Medicare Beneficiary Ombudsman.
- To be treated and cared for with respect, consideration and dignity.
- To spiritual care. To be respected for your cultural and personal values, beliefs and preferences.
- To effective communication. The center communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that fits the patient's need.
- To receive information in a manner tailored to the patient's age, language, and ability to understand. The center provides interpreting and translation services.
- To be provided appropriate privacy. Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.
- To access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.
- To receive care in a safe setting, free from all forms of abuse, neglect or harassment.
- To refuse participation in experimental research. Care will not be hindered should the patient refuse to participate in research. When authorized, the center obtains informed consent for research in accordance with law and regulation.
- To pain management.
- To be fully informed about a treatment or procedure and the expected outcome before the procedure is performed.

  Patients are provided, to the degree known, complete information, concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or a legally authorized person.

  The center provides the patient or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the patient needs in order to participate in current and future health care decisions.

  The center informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment.
- To have the opportunity to participate in decisions involving your healthcare, treatment, or services, except when such participation is contraindicated for medical reasons. The center involves the patient's family in care, treatment, or services decisions, to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.
- To be informed of your right to change your provider if other qualified providers are available.
- To have appropriate information regarding the absence of malpractice insurance coverage.
- To truthful marketing and advertising regarding the competence and capabilities of the organization.
- To exercise your rights without being subject to coercion, discrimination, reprisal, or interruption of care that could adversely affect you.

- To information about procedures for expressing suggestions, complaints, and grievances, including those required by state and federal regulations.
- To receive in advance of the procedure the center's policies on advance directives, including a description of applicable state health and safety laws and if requested, official state advance directive information forms.
- To receive written information about your physician's possible ownership in The Harman Eye Clinic. Patients are informed about physician ownership prior to the procedure.
- To information regarding fee for services and payment policies.
- To information regarding the services available at the organization, provisions for after-hour emergency care, and the credentials of healthcare professionals.
- *If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.*
- *If a state court has not adjudged a patient incompetent, any legal representative designated by the patient, in accordance with the state law, may exercise the patient's rights to the extend allowed by state law.*

Advance Notice of Rights

The patient has the right to receive verbal and written notice in advance of the procedure, in a language and manner that the patient or the patient's representative understands. The center gives brochures to each patient being admitted with the center's written policies and the nurse making the preoperative call informs the patient verbally.

Patient Responsibilities

As a patient, you have the responsibility

- To provide complete and accurate information to the best of your ability about your health, any medications, including over the counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by your provider.
- To provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.
- To inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
- To accept personal financial responsibility for any charges not covered by your insurance.
- To be respectful of the health care providers and staff, as well as other patients.

Advance Directives Policy

Because of the elective nature of your procedure, the The Harman Eye Clinic does not honor the do not resuscitate (DNR) advance directive. If you have an advanced directive, we will include it in your chart. In an emergency, it will be transferred with you to the hospital. If you have questions about this policy, please feel free to call the center to ask.

Disclosure of Ownership

Cascade Regional Eye Center, Inc., PS, dba The Harman Eye Clinic, is owned by:
Bruce J. Ballon, MD and Bruce E. Wietharn, MD and Natalia V. Bajenova, MD

Grievance Policy

The center strives to provide high quality of care and achieve patient satisfaction. Patient grievances/ complaints provide a means to measure achievement of this goal and to identify a need for performance improvement.

Grievance/Complaint: Grievances are defined as care that the ASC provided or allegedly failed to provide.

Neglect – Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR 488.301).

Abuse – The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR 488.301).

All complaints received by the center personnel shall be forwarded to the clinical director or his/her designee immediately, at least the same day. The clinical director will respond in writing to the grievance within 3 days of receiving it.

For a full copy of the grievance procedure, please ask any center personnel.

To report a grievance:

Administrator: Brandie Somers
PHONE: 360-435-8595

HSQA Complaint Intake
PO Box 47857
Olympia, WA 98504-7857

Hotline: 800-633-6828 (complaints only)

Phone: 360-236-4700
Fax: 360-236-2626
Email: HSQAComplaintIntake@doh.wa.gov

Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
Medicare Help and Support: 1-800-MEDICARE

THE HARMAN EYE CLINIC
903 Medical Center Drive
Arlington, WA 98223
ASC HOURS: 8:00 AM – 4:30 PM

Exhibit 12
Non-Discrimination Policy

- The Harman Eye Clinic recognizes and supports the rights of each patient: The patient has the right to considerate and respectful care.
- The Harman Eye Clinic will include the patient in the decision making for his/her health care whenever possible.
- The Harman Eye Clinic will check your glasses against your glasses prescription and re-refract your vision should you have concern about the effectiveness of your new glasses. This will be a no-charge visit.
- The Harman Eye Clinic will honor advanced directives from the patient.
- The Harman Eye Clinic will also recognize a representative designated by a patient to be the decision maker in the event the patient is incapable of making that decision.
- The patient has the right to privacy and to confidentiality of all information pertaining to his/her health care.
- The patient has the right to expect The Harman Eye Clinic to provide access, within its capacity, to appropriate heath care to all citizens in and surrounding Snohomish County. The Harman Eye Clinic will make a reasonable response to the request for service.
- The patient has the right to receive an explanation of his/her bill regardless of source of payment.
- The patient has a right to a second opinion.
- The patient has the right to express any concern to the Administrator or any member of our staff team.

Exhibit 13
Charity Care and Community Service Plan Policy

CHARITY CARE Policy:

The Harman Eye Clinic is committed to the extraordinary care of our patients. This commitment extends to their financial well being. Due to the non-emergent and elective nature of our procedures, if a patient is in need of charitable services, every effort should be made to make financial arrangements in advance of the clinical appointment or surgical procedure.

Our insurance contracts require that we make every effort to collect patient responsibility: i.e. co-insurance, co-pays and deductibles, etc.

Procedure:

Payment options: Any balance owed by the patient is due at the time of service. The balance can be paid in any of the following ways:

- Cash
- Check
- MasterCard
- VISA
- American Express
- Discover
- CareCredit

Cash Pay: We offer pricing for patients who do not have health insurance coverage and wish to pay out-of-pocket. The “cash” fee schedule is based on amounts generally reimbursed for patients who have insurance.
Coverage assistance: A patient may be eligible for other government and community programs. We can help to determine whether these programs can help cover the patients medical bills. We can help the patient apply for these programs through the following resources:

- Apple Health Advocate at Cascade Valley Hospital (Skagit Regional Health): 360.814.7575
- www.WAHealthPlanFinder.org

Payment Plans: On occasion, you may wish to champion the patient by arranging payments. This should be coordinated through the financial office with the written approval of the executive director.
Please use the "Credit Card Promissory" form. Once the form is completed and signed, this becomes confidential information and needs to be delivered directly to the financial office so it can be locked up. Do not ever scan this Promissory Note (with credit card information) into attachments. It is not part of the medical record.

Credit Card Promissory.pdf

Financial Hardship/Charity:
The Harman Eye Clinic allows for a financial hardship/charity discount of up to 100% off the total visit cost to provide care for local indigent population. Any patient applying to receive financial assistance/charity care must submit an application and provide supporting documentation.

To qualify for the charity care discount, patients must satisfy the following:
1. The patients monthly income must be at, or below, 150% of the Federal Poverty Level. Current poverty guidelines can be found on the US Department of Health and Human Services website: https://aspe.hhs.gov/poverty-guidelines
or

2. If the physician or clinic is not a contracted provider for the patients insurance, and the patient presents with valid insurance:

- The physician elects to see the patient and

- The patient acknowledges financial responsibility

The Harman Eye Clinic Executive Director reserves the right to approve patients with financial hardship for charity care without satisfying the above conditions.

Exhibit 14
2017 North Snohomish County hospital's charity care

Updated 11/02/2017

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 2016

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
Cascade Valley Hospital	72,816,806	25,440,266	18,896,769	28,479,771	147,881	0.20%	0.52%
Skagit Valley Hospital	1,013,946,788	444,093,980	166,363,321	403,489,487	2,937,279	0.29%	0.73%

Exhibit 15
Single Line Drawing

The Harman Eye Clinic

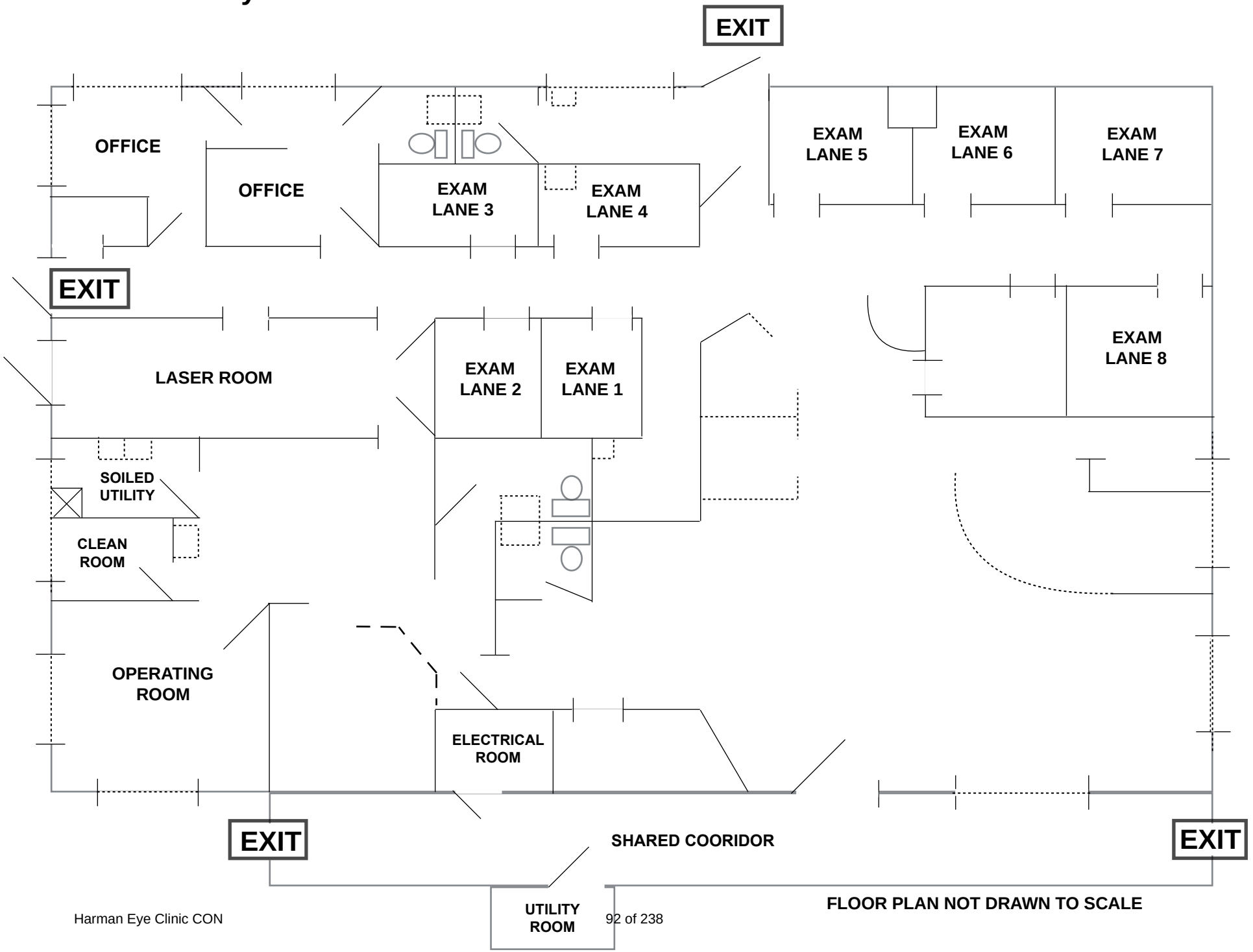


Exhibit 16
Lease Agreement

MEDICAL BUILDING LEASE

1. PARTIES AND AGREEMENT. The Landlord is Richard Lee Harman, M.D. and Judy Harman, husband and wife, ("Landlord"), and the Tenant is Cascade Regional Eye Center, Inc., P.S., a Washington professional service corporation d/b/a The Harman Eye Clinic ("Tenant"). Tenant acknowledges that Landlord is the lessee under a long term ground lease ("Ground Lease") and is not the fee owner of the real property on which the Building and Premises are located. Any references to the ownership by Landlord in this lease shall refer to Landlord's Ground Lease interest and, for sake of convenience, the parties to this lease shall be referred to as Landlord and Tenant rather than as tenant and sub-tenant.

2. LEASE AND DESCRIPTION OF PROPERTY. Landlord leases to Tenant Unit A of the Cascade Medical Center, A Condominium (the "Premises") which Premises consist of Building 1 of two buildings as outlined on the plan attached as Attachment 1 located at 903 Medical Center Dr., Arlington, Washington ("Buildings"), consisting of a portion of the real property legally described in Attachment 2 ("Real Property").

3. TERM.

3.1 The term of this Lease shall be for two hundred forty (240) months commencing on February 1, 2002 (the "Commencement Date") and terminating two hundred forty (240) months thereafter.

4. RENT.

4.1 BASIC MONTHLY RENT. The basic monthly rent shall be Ten Thousand Two Hundred Forty-two and No/100 ($10,242.00) Dollars. In the event that the Commencement Date is other than the first day of a calendar month, the rent for the initial and final periods shall be prorated accordingly.

4.2 COST OF LIVING ADJUSTMENTS.

4.2.1 Price Index. For purposes of calculating cost of living adjustments of the Basic Monthly Rent, "Price Index" shall mean the Consumer Price Index-All Urban Consumers: U.S. City Average-All Items, (1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics. If the aforementioned CPI Index is discontinued, the parties shall select another similar index which reflects consumer prices; if the parties cannot agree on another index, Tenant shall continue to pay an amount equal to the Basic Monthly Rent payable for the last month before the latest Rent Adjustment Date until the adjusted Basic Monthly Rent can be determined at which time Tenant shall pay to Landlord the difference, if any, between the Basic Monthly Rent paid by Tenant and the adjusted Basic Monthly Rent determined to be payable after the Rent Adjustment Date.

4.2.2 Adjustments to Basic Monthly Rent. Effective the first day of each February ("Rent Adjustment Date"), commencing on February 1, 2003, the Basic Monthly Rent payable under the Lease shall be increased by the percentage of increase, if any, in the Price

Index over the preceding twelve (12) month period ("Rent Adjustment Period"). In no event, however, shall the Basic Monthly Rent be less than that payable during the period immediately preceding the Rent Adjustment Date. The Basic Monthly Rent as adjusted shall be the Basic Monthly Rent due under the Lease until the next Rent Adjustment Date and shall be the basis upon which the next Rent Adjustment shall be made.

4.2.3 Billing for Rent Adjustments. Any delay or failure of Landlord, beyond the Rent Adjustment Date, in computing or billing for the Rent Adjustment hereinabove provided, shall not constitute a waiver of or in any way impair the Tenant's obligation to pay such Rent Adjustment hereunder. In the event of any such delay or failure of Landlord to notify Tenant of the Rent Adjustment, Tenant shall continue paying the Basic Monthly Rent as adjusted upward on the immediately preceding Rent Adjustment Date until notified by Landlord of the Rent Adjustment.

4.3 OPERATIONAL AND MAINTENANCE EXPENSES.

4.3.1 In addition to the basic monthly rent, Tenant shall pay directly to the various providers and suppliers, Tenant's Pro Rata Share of the Operational Expenses defined below. Any Lease provision providing for Landlord to pay an expense or perform a service shall not limit Tenant's agreement to pay, directly, or to reimburse Landlord for Tenant's Pro Rata Share of Operational Expenses incurred by Landlord.

4.3.2 Landlord shall be entitled at any time, upon demand, to examine Tenant's records to ensure Tenant's prompt and full payment of the Operational Expenses.

4.3.3 Operational Expenses are all costs incurred by Landlord for operation, maintenance and repair of the Real Property including but not limited to water, electricity, natural gas if supplied, heat, sewer and garbage removal; licenses, permits and inspection fees; customary and reasonable property management fees; materials and services for operation and maintenance of the Buildings including any common area janitorial services and repairs; landscaping, irrigation or sprinkling systems, resurfacing, painting, striping, restriping, cleaning, snow removal, sweeping, lighting and signs; all roof repairs and maintenance including but not limited to patching, resurfacing and preventative maintenance and painting or renovation of the exterior portion of all or any part of the Buildings; maintenance and repair of any fire protection systems, lighting systems, storm drainage systems and any other utility systems; repair and maintenance by Landlord, payments due to the Cascade Medical Center Condominium Association, Insurance Premiums and Taxes and all sums which the Landlord is obligated to pay under the Ground Lease after the Commencement Date; but shall not include depreciation, or Capital Improvements. Capital Improvements shall be deemed to include maintenance by Landlord of the foundation and structural elements of the Buildings excluding roof repairs and maintenance. "Insurance Premiums" are the expense of insurance maintained by Landlord as contemplated by this Lease together with any insurance required by the Ground Lease or an unrelated lender holding a first lien mortgage or deed of trust on the Buildings including, but not limited to, rental loss insurance. "Taxes" are all real estate taxes, any installment of any improvement or other special assessment, personal property taxes charged to the Landlord and all

other governmental charges or requirements related to the ownership or operation of the Real Property, the Buildings, this Lease or the collecting of rents hereunder, and regardless whether ordinary or extraordinary in nature and whether presently enacted or enacted in the future. Federal and state income taxes computed on Landlord's net income shall not be included in Taxes. If Landlord causes utilities for the Premises to be separately metered from utilities for other portions of the Buildings or otherwise provides services (including air conditioning and heating) separately for either the Premises or other portions of the Buildings, Landlord may elect to require the recipient of such services or utilities to pay directly for all such separately metered or provided utilities or services as received. In the event that such utilities or services to the Premises or other areas of the Buildings are so separately metered or charged, Tenant's Pro Rata Share (as to such utilities or services) shall be adjusted to equitably compensate for separately charging of such utilities or services. In the event that Landlord determines in good faith that Tenant's utilization of any service or utility materially exceeds the typical utilization of such service or utility by other tenants and that it is not desirable to separately meter the utilization of such service or utility, Tenant agrees to pay the cost or expense of such excess utilization, in addition to Tenant's Pro Rata Share of Operational Expenses, as reasonably and equitably determined by Landlord. Should Landlord make available to Tenant or other tenants of the Buildings land other than the Real Property for parking or other common area purposes, then Landlord's expenses in connection with such land shall be included in Operational Expenses to the same extent as for the Real Property.

4.3.4 Tenant shall pay directly and when due any personal property tax assessed against any personal property or leasehold improvements owned by Tenant and any governmental charges resulting from Tenant's use or occupancy of the Premises.

4.4 TENANT'S PRO RATA SHARE. Tenant and Landlord agree that Tenant's Pro Rata Share is 100% of the costs allocable to the Premises.

5. PAYMENT.

5.1 The Tenant will pay all rents at the office of Landlord, in advance, on or before the first day of each calendar month, at such reasonable location as Landlord designates.

5.2 In the event any payment is not received within ten days of the date due, a late charge shall be assessed, which late charge shall be equal to ten percent (10%) of the payment so due for each calendar month or portion thereof until paid in full. In the event that payment of any check given by Tenant to Landlord is refused by reason of insufficient funds in Tenant's account, Tenant shall also pay a processing fee of fifty dollars ($50.00) to Landlord.

6. QUIET ENJOYMENT. Landlord warrants it has the right to make this Lease, and Tenant, if not in default, shall have quiet and peaceful possession and enjoyment of the Premises for the term of this Lease.

7. NO ASSIGNMENT AND SUBLETTING. Without Landlord's prior written consent, Tenant shall not assign, mortgage. or in any manner transfer this Lease whether voluntarily or involuntarily or by operation of law, or sublet or license the Leased Premises, or any part of it.

Consent to an assignment or sublease shall not be considered to be a consent to any subsequent assignment or sublease. Tenant shall reimburse Landlord for any expense incurred by Landlord as a result of any request for such consent including any new or revised signage and attorney fees for review or preparation of related documents. Sub-tenants or assignees shall become directly liable to Landlord for all of Tenant's Lease obligations without limiting the liability of Tenant for the full, complete and prompt performance of Tenant's obligations under this Lease. Tenant agrees that any modification, release or extension granted by Landlord to any subtenant or assignee shall not relieve Tenant of any liability to Landlord. If Tenant is a partnership or corporation, a change in the ownership of Tenant shall not require Landlord's consent but only if each of the owners of Tenant personally guarantees the full payment and performance of this lease; provided that any change in the ownership of Tenant which (taken together with the aggregate of all prior ownership changes of Tenant) which would transfer a majority of the ownership or outstanding voting stock shall constitute an assignment for the purposes of this paragraph and shall require the written consent of Landlord as well as the personal guarantee of the full payment and performance of this lease by all owners of Tenant. If Tenant is notified of such events and is instructed to make Tenant's rental payments to the Ground Lease Lessor or mortgagee, Tenant agrees to attorn to the Ground Lease Lessor, in the event of a termination of the Ground Lease or, in the event of a proceeding to foreclose a mortgage on Landlord's interest in the Ground Lease, to the mortgagee.

8. ALTERATIONS.

8.1 Tenant shall not alter the Premises without first obtaining the written consent of Landlord. Landlord may impose such reasonable conditions of its consent including approval of plans, contractor and waiver of lien rights. Prior to the termination of the Lease, Tenant shall, at Tenant's expense, remove any alterations made by Tenant (other than any alterations or improvements made by Tenant within six months of the Commencement Date of this Lease), designated by Landlord to be removed, and repair any damage to the Premises caused by the alteration or removal. Unless designated by Landlord for removal, any alterations made by Tenant shall become the property of Landlord at the termination of the Lease. If Tenant desires any alteration requiring boring or cutting, Landlord will direct where and how the boring and cutting for installation will be permitted.

8.2 Tenant agrees that it will not install any equipment that will exceed or overload the capacity of any utility equipment serving the Buildings and that if any equipment installed by Tenant shall require additional capacity the same shall be installed at Tenant's expense.

9. REPAIRS AND USE OF PREMISES BY TENANT.

9.1 At all times, Tenant will keep the Premises neat and clean and maintain the Premises in as good condition and repair as they now are, or may hereafter be put, reasonable use and wear excepted, and further to return the Premises to Landlord in such condition at the end of the term of this Lease. All damage or injury done to the Premises, including the cracking or breaking of glass of any windows or otherwise, by Tenant or by any person who may be in the Buildings and common areas shall be immediately repaired by Tenant at Tenant's cost and

expense. If Tenant shall fail to maintain the Premises in such required condition, Landlord may at its option perform the required repairs at Tenant's expense. Tenant shall conserve heat, air-conditioning, water and electricity and shall use due care in the use of the Premises, common areas and facilities of the Buildings, and without qualifying the foregoing, shall not neglect or misuse water fixtures, electric lights, or heating and air-conditioning apparatus.

9.2 The Premises shall be used by Tenant (and any subtenant, assignee, employee or other occupant of the Premises) only for the practice of the medical specialty of Ophthalmology and for no other use or medical specialty without the prior written consent of the Landlord which consent Landlord may provide or withhold in Landlord's sole discretion and judgment. In addition to the consent of Landlord, Tenant must also obtain, at Tenant's expense, the consent of the Ground Lease Lessor to any change of use of the Premises.

9.3 Tenant will not permit anything in the Premises that will increase the rate of any insurance or prevent Landlord from taking advantage of any ruling of an insurance bureau which would allow reduced rates for insurance policies; or that may be dangerous to any person or the Buildings or permit any objectionable noise, vibration or odor to be emitted from the Premises. Tenant will comply at Tenant's own cost and expense with all orders, notices, regulations, or requirements of any municipality, state or other governmental authority arising from Tenant's use of said Premises and will not make or allow any use of the Premises that would be in violation of any applicable law, including but not limited to court decisions, statutes, regulations, zoning and other use restrictions.

9.4 Tenant shall not use, dispose, treat, generate, store or sell any Hazardous Substances in the Buildings or Premises; provided, however, that the use or storage of drugs, chemicals or substances used in the treatment of Tenant's patients shall not be deemed to be a violation of this provision so long as such substances are used, sold, transported, treated, stored and disposed of by Tenant in strict accordance with all applicable laws and regulations as well as the applicable professional standard of care. "Hazardous Substances" shall be deemed to be any substance (or one which contains components) designated as hazardous, dangerous, toxic or harmful and/or which are subject to regulation by any law or regulation. Tenant shall be fully and completely liable to Landlord for any and all cleanup costs, and any and all other charges, fees, and penalties (civil and criminal) imposed by any governmental authority with respect to Tenant's use, disposal, transportation, generation and/or sale of Hazardous Substances (whether or not used in connection with the treatment of Tenant's patients) in or about the Premises or Buildings. Tenant shall indemnify, defend and save Landlord harmless from any and all of the costs, fees, penalties and charges assessed against or imposed upon Landlord in connection with any Hazardous Substances possessed or controlled by Tenant.

9.5 Tenant shall violate the Declaration and Covenants, Conditions, Restrictions and Reservations for Cascade Medical Center, a Condominium recorded February 10, 1992 under Snohomish County Recording No. 9202100182 and rerecorded under Recording No. 9203100256, or the Bylaws of Cascade Medical Center Condominium Owner's Association dated March 7, 1994, as either have been amended or may be amended in the future.

10. **MECHANICS' LIEN.** Tenant agrees that it will pay or cause to be paid all costs for work done by it or caused to be done by it on the Premises, and will keep the Premises free and clear of all mechanics' liens and other liens on account of work done for it. Tenant agrees to and shall indemnify, defend and hold Landlord harmless against liability, loss, damage, costs, attorneys' fees and all other expenses on account of claims of lien of laborers or materialmen or others for work performed or material or supplies furnished for Tenant. If Tenant shall desire to contest any claim of lien, it shall furnish Landlord adequate security in the value or in the amount of the claim, plus estimated costs and interest. If a final judgment establishing the validity or the existence of a lien for any amount is entered which affects the estate of Landlord, Tenant shall pay and satisfy the same at once. Should any claims of lien be filed against the Premises or any action affecting the title to such property be commenced, Tenant shall forthwith give Landlord written notice thereof.

11. **SERVICES.**

11.1 Landlord will furnish:

11.1.1 Heating (and air-conditioning if installed in the Buildings) to maintain reasonable temperatures under normal medical office usage, provided Tenant shall comply with Landlord's instructions regarding use of drapes and thermostats and not utilize heat generating equipment which affect the temperature otherwise maintained by any air-conditioning system.

11.1.2 Electrical current for lighting and operation of low power usage office machines.

11.1.3 Janitorial service for common areas and periodic exterior window washing.

11.1.4 Maintain in reasonable repair the exterior and common areas of the Buildings, including central mechanical, electrical, plumbing systems, and glass, and exterior landscaping and parking areas in as good repair as they are now or may hereafter be put. Landlord shall make such repair with reasonable diligence following written notice of the need therefor, provided all damage or injury to the Buildings, including clogged plumbing, caused by Tenant or any person who may be in or upon the Buildings with the consent of Tenant shall be paid for by Tenant.

11.2 If heat generating equipment is used in the Premises by Tenant which affects the temperature otherwise maintained by the air-conditioning system, Landlord may install supplementary air-conditioning units, and the cost including installation and operation shall be paid by Tenant.

11.3 Landlord does not warrant that the services will be free from interruption. Landlord shall use reasonable diligence to remedy any interruption of such services subject to any governmental restrictions on Landlord or the Buildings. Interruption of services and utilities shall not be deemed an eviction or disturbance of Tenant's use and possession of the Premises or

render Landlord liable for damages, or relieve Tenant from Tenant's obligations under this Lease including payment of rent.

12. INSURANCE BY LANDLORD.

12.1 Landlord shall maintain insurance covering the Buildings, including any alterations by Landlord for full replacement cost during the term of this Lease, providing protection against any peril included within the classification "fire and extended coverage," together with insurance against vandalism and malicious mischief. Any insurance proceeds payable under such policy shall be used to perform any obligation of Landlord to repair or rebuild the Premises or Buildings, if Landlord elects to repair or rebuild as provided in this Lease.

12.2 Landlord may maintain a separate bodily injury and property damage insurance policy with limits comparable to that to be maintained by Tenant.

12.3 Landlord may maintain other insurance in its reasonable discretion including rental loss insurance.

13. INSURANCE BY TENANT.

13.1 Tenant shall maintain, at its expense, and naming Landlord as an additional insured, the following insurance policies and furnish Landlord a certificate from its insurance carrier evidencing the insurance, that Landlord is a named insured, and that the insurance cannot be terminated without giving Landlord at least twenty (20) days' prior written notice of termination.

13.1.1 Bodily injury liability insurance with limits of not less than One Million Dollars ($1,000,000.00) per person or occurrence and property damage liability insurance with a limit of not less than Three Hundred Thousand Dollars ($300,000.00) per accident or occurrence insuring against any and all liability of the insured arising out of the maintenance, use or occupancy of the Premises, and the insurance shall specifically insure the performance by Tenant of the indemnity agreements contained in this Lease.

13.1.2 Insurance covering Tenant's property including any Tenant alterations in the Premises in an amount not less than one hundred percent (100%) of their full replacement cost from time to time during the term of this Lease providing protection against any peril included within the classification "fire and extended coverage," together with insurance against sprinkler damage, vandalism and malicious mischief. Policy proceeds shall be used to repair or replace property damaged or destroyed, and to return the Premises to a condition generally approximating the condition existing prior to such damage.

13.2 At the request of Landlord, Tenant shall cause any policies of insurance to be maintained by Tenant to also name Landlord and the Ground Lease Lessor as additional named insured and to cause appropriate certificates of insurance to be issued which certificates shall also provide that such policy of insurance cannot be terminated without the Landlord (and the Ground

Lease Lessor, if so elected by the Landlord) first having received at least thirty (30) days prior notice of such insurer's intentions.

14. WAIVER OF SUBROGATION.

Landlord and Tenant hereby waive any rights each may have against the other and other tenants on account of any loss or damage occasioned to Landlord or the Tenant, as the case may be, their respective property, the Premises, or its contents or to other portions of the Buildings, arising from any risk generally covered by fire and extended coverage insurance; and the parties each, on behalf of their respective insurance companies insuring the property of either Landlord or the Tenant against any such loss, waive any right of subrogation that it may have against Landlord or the Tenant or other tenants, as the case may be. The foregoing waivers of subrogation shall be operative only to the extent of the policy limits provided for above or the actual policy limits, whichever are greater and so long as available in the State of Washington without additional premium. If necessary, Landlord and Tenant agree to cause appropriate riders to be attached to their insurance policies to effectuate such waivers.

15. INDEMNITY AND RISK OF LOSS.

15.1 Tenant will save and hold Landlord harmless from all loss, damage, liability or expense resulting from any injury to any person or property including the Premises, caused by or resulting from any act or omission of Tenant or its agents or employees except to the extent that the loss is covered by insurance maintained by Landlord or Tenant and subrogation is waived under this Lease.

15.2 Landlord shall not be liable for damage to property or to a person occurring in the Premises, Buildings or its common areas, including any parking lot, arising out of any act or omission of any tenant, its employees and customers.

15.3 All personal property (whether owned by Tenant, its employees or others) in the Premises shall be at Tenant's sole risk. Landlord shall not be liable for any damage to or loss of such personal property.

16. VACATION OR ABANDONMENT.

Upon vacation or abandonment of the Premises by the Tenant without the written consent of Landlord, a default by Tenant shall occur and Landlord shall have all of the rights and remedies provided in this Lease. In addition to its customary meaning, abandonment shall include Tenant's failure to conduct business in the Premises for more than sixty (60) consecutive days.

17. REMEDIES FOR DEFAULT.

17.1 If Tenant fails to pay any sum when due (without necessity of notice of such failure) or in the event of Tenant's default in performing any of the other terms of this Lease for more than ten (10) days after notice of default (or within such additional time as is reasonably required to correct any default other than payment of money by Tenant), Landlord, in addition to the other rights or remedies it may have, shall have the right to immediately terminate this Lease or re-enter and attempt to relet without terminating this Lease and remove all persons and property from the Premises (which property may be removed and stored in a public warehouse or elsewhere at the cost and risk of, and for the account of Tenant) all without service or notice or resort to legal process and without being deemed guilty of trespass, or any liability of Landlord for any loss or damage which may be occasioned thereby.

17.2 It shall be a material breach of this Lease if Tenant or any guarantor of Tenant shall become bankrupt or insolvent, or commence any proceedings under any bankruptcy or insolvency laws, or if Tenant or any guarantor of Tenant shall take or have taken against it in federal or state court a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or a portion of Tenant's or such guarantor's property, if Tenant or any guarantor makes an assignment for the benefit of creditors, of if any assets of Tenant (whether located in the Premises or elsewhere) are seized or attached by any creditor of Tenant or a governmental agency.

17.3 If Landlord, without terminating this Lease, either (1) elects to re-enter the Premises and attempt to relet or (2) takes possession of the Premises pursuant to legal proceedings, or (3) takes possession of the Premises pursuant to any notice provided by law, then Landlord may, from time to time, make such alterations and repairs as may be necessary in order to relet the Premises or any part thereof for such term or terms (which may be for a term extending beyond the term of this Lease) and at such rent and other terms as Landlord in its reasonable discretion deems advisable. Upon such reletting, all rents received by Landlord from such reletting shall be applied, first, to the payment of any indebtedness of Tenant (other than any rents due hereunder) to Landlord; second, to the payment of any costs and expenses of obtaining possession and any such reletting, including expense of alterations and repairs, brokerage fees and attorney's fees; third, to the payment of any rents due and unpaid hereunder. If such rents and any other amounts received from such reletting during any month be less than that to be paid during that month by Tenant, Tenant shall immediately pay such deficiency to Landlord. No such re-entry or taking possession of the Premises by Landlord shall be construed as an election by Landlord to terminate this Lease unless a notice of such intention be given to Tenant. Notwithstanding any such reletting without termination, Landlord may at any time thereafter elect to terminate this Lease for such previous breach. Should Landlord at any time terminate this Lease for any breach, in addition to any other remedies it may have, Landlord may recover from Tenant all damages it may incur by reason of such breach, including the cost of recovering the Premises, reimbursement of any brokerage fees incurred by Landlord in connection with Tenant's lease, and all rent (accrued or to accrue during the term of the Lease) which, at Landlord's election, shall be accelerated and be due in full on demand.

17.4 Landlord's rights and remedies in this Lease are cumulative and no one of such rights and remedies shall be exclusive at law or in equity of the rights and remedies which Landlord might otherwise have by virtue of a default under this Lease, and the exercise of one such right or remedy by Landlord shall not impair Landlord's standing to exercise any other right or remedy. Landlord and Tenant shall, and do hereby, waive trial by jury in any action, suit or proceeding related to, arising out of or in connection with the terms, conditions and covenants of this Lease.

18. DAMAGE BY CASUALTY.

In the event of damage to the Buildings or the Premises by casualty which renders the Buildings, in whole or in part, or the Premises untenantable, Landlord shall within ninety (90) days after said casualty notify the Tenant whether or not Landlord elects to reconstruct. If Landlord elects not to reconstruct, this Lease shall be terminated as of the date of such damage and rents will be prorated as of this date. If Landlord elects to rebuild, there shall be an abatement of rent for the entire period of time between the date of such destruction and the date on which the Premises shall be placed in tenantable condition. If the Buildings are partially destroyed by casualty and the damage does not amount to the above extent, Landlord shall repair the Buildings with all convenient speed and shall have the right to take possession of and occupy, to the exclusion of the Tenant, all or any portion of the Buildings necessary to complete repairs, in which event there shall be an abatement of rent as the nature of the damage and its interference with the occupancy of the Premises by Tenant shall warrant. If the premises are only slightly damaged so as not to cause any material interference with the Tenant's occupancy, there shall be no abatement of rent and Landlord shall repair the damage as soon as possible. In the event of any casualty (with or without election to rebuild), Landlord shall have no obligation to replace, rebuild or repair any property of Tenant including alterations by Tenant, but such Tenant property or alterations shall be replaced, rebuilt or repaired by Tenant as soon as possible.

19. CONDEMNATION. If the entire Premises, or a portion of the Buildings required for reasonable use of the Premises, shall be taken by virtue of any condemnation or eminent domain proceeding, this Lease shall automatically terminate as of the date of such condemnation, or as of the date possession is taken by the condemning authority, whichever is earlier. Rent shall be apportioned as of the date of such termination. In case of a taking of a part of the Premises or a portion of the Buildings not required for the reasonable use of the Premises, then this Lease shall continue in full force and effect and the rental shall be equitably reduced based on the proportion by which the floor area of Premises is reduced, effective as of the date of such partial taking. No award for any partial or entire taking shall be apportioned, and Tenant hereby assigns to Landlord any award which may be made in such taking or condemnation together with any and all rights of Tenant now or hereafter arising in or to the same or any part thereof; provided, however, that nothing herein shall be deemed to give Landlord any interest in or to require Tenant to assign to Landlord any award made to Tenant for interruption of Tenant's business or Tenant's moving expenses. A condemnation or taking by public authority shall not be grounds for terminating this Lease unless twenty-five percent (25%) or more of the Premises or of the total Parking available for the use of Buildings tenants and patients is taken. If twenty-five percent (25%) or more of such areas is taken, then the paragraph shall not apply if Landlord

shall take immediate steps to provide other parking facilities substantially equal to the previously existing ratio between the common parking areas and the Premises within a reasonable period of time after such taking. In the event that Landlord does provide such other parking facilities, then this Lease shall continue in full force and effect without any reduction or abatement of rent. The provisions of this paragraph do not include any taking for a right of way for utilities and for minor street adjustments that will not unreasonably interfere with the conduct of Tenant's business or materially reduce the parking area to be provided for its patients.

20. PRIORITY AND ATTORNMENT.

20.1 This Lease is subordinate to any mortgages now a lien or hereafter placed upon the Buildings and to all advances made thereunder, and all interest thereon, and all renewals, replacements, consolidations and extensions thereof. Any mortgagee may elect to have this Lease prior in right to its mortgage, and in the event of such election, and upon notification by such mortgagee to Tenant to that effect, this Lease shall be deemed to have priority over the lien of such mortgage, whether this Lease is dated prior or subsequent to such mortgage. In addition Tenant further agrees to execute such amendments to this Lease or other related documents as Landlord's first lien lender may require; provided no such amendments or other documents shall materially affect the economic payment terms of this Lease. Tenant shall execute and deliver whatever instruments may be required from time to time by any mortgagee for any of the foregoing purposes, and in the event Tenant fails so to do within ten (10) days after demand, Tenant hereby makes and irrevocably appoints Landlord as its attorney-in-fact and in its name, place and stead so to do.

20.2 Tenant waives any right of election to terminate this Lease in the event any foreclosure proceeding is brought by any mortgagee. Tenant agrees, in the event of any foreclosure proceedings, to attorn to the purchaser, at such purchaser's request, at such foreclosure sale and to recognize such purchaser as its lessor and landlord under this Lease.

20.3 Tenant covenants and agrees that in the event of a sale or assignment of Landlord's interest in the Buildings Tenant will attorn to the transferee of Landlord's interest in the Buildings and will recognize such transferee as Tenant's lessor and landlord under this Lease. In the event of a subsequent transfer of such interest, Tenant covenants and agrees it will similarly attorn to and recognize such subsequent transferee(s). Tenant agrees, on ten (10) days' prior notice by Landlord, to execute and deliver, from time to time, any instrument which may be appropriate to evidence Tenant's attornment and Tenant irrevocably appoints Landlord, the attorney-in-fact of Tenant to execute, acknowledge, and deliver for and on behalf of Tenant any such instrument.

20.4 "Mortgage" and "mortgagee" herein shall include a mortgage, deed of trust or security agreement and the mortgagee, the beneficiary of a deed of trust or secured party. Tenant shall within ten (10) days of request by Landlord deliver an executed and acknowledged instrument amending this Lease in such respects as may be required by any present or future mortgagee, provided that such amendment does not materially alter or impair Tenant's rights or remedies under this Lease or increase its rent.

21. RULES, REGULATIONS AND MISCELLANEOUS.

21.1 REGULATIONS. Landlord may from time to time make regulations appropriate for the use and operation of the Buildings, its common areas and any parking lot so long as not inconsistent with the terms, covenants and conditions of this Lease and so long as such regulations do not unreasonably, adversely affect Tenant's business.

21.2 WASHINGTON LAW AND VENUE. Landlord and Tenant agree that this Lease shall be interpreted and enforced in accordance with the laws of the State of Washington; Landlord and Tenant each agree that all issues arising under this lease and all parties (and guarantors) to this lease shall be subject to the jurisdiction of the Washington State Superior Court for King County or Skagit County, at the election of Landlord, and that venue shall be in such court alone.

21.3 SIGNS AND WINDOWS. No signs shall be displayed or attached to any glass or woodwork in the Premises except as approved by Landlord and made by a sign maker approved by Landlord. No signs of any kind shall be placed on the windows of the Premises or the Buildings exterior unless Landlord has first approved the design and location of the proposed sign, which approval Landlord agrees to not withhold unreasonably.

21.4 ATTORNEYS' FEES. In the event of any default under this Lease, the defaulting party agrees to pay the cost of legal counsel incurred by the other party, whether incurred with or without litigation and on appeal.

21.5 HOLDING OVER. If the Tenant shall hold over after the expiration of the term of this Lease, and shall not have agreed in writing with Landlord upon the terms and provisions of a new lease prior to such expiration, the Tenant shall remain bound by all the terms, covenants and agreements hereof, except that the tenancy shall be from month to month and basic monthly rental shall be equal to one hundred twenty (120) percent of the Basic Monthly Rent due for the last month of the term of the Lease.

21.6 TIME OF ESSENCE. Time is of the essence in the performance of all of Tenant's duties hereunder and such consideration is a material element inducing Landlord to execute this lease.

21.7 LANDLORD ALTERATIONS. Landlord reserves the right to make alterations to the Buildings and common areas, (including, but not limited to, the construction or addition of additional buildings for lease) and to enter the Premises for such purpose or to accomplish any repairs for which Landlord is responsible or are necessary to avoid waste. Such entry and/or actions shall not constitute an eviction and, except as specifically provided in this Lease, shall not cause any abatement of rent. In the event of a modification of the total net rentable area of the Buildings, Tenant's Pro Rata Share shall be recomputed and shall be equal to the percentage that the net rentable area of the Premises is of the total Buildings net rentable area.

21.8 NON-DISTURBANCE OF OTHERS. The Premises shall not be used by Tenant in any manner which would be unreasonably intrusive or offensive to the other tenants of the Buildings. Furniture and bulky articles shall be removed in or out of the Premises only at such hours and in

such manner as shall least inconvenience other tenants and as Landlord shall approve. No article or articles which in the aggregate would exceed the BUILDINGS design standard shall be moved into the Premises. Landlord shall have the right to fix the Position of any article of weight in the Premises.

21.9 NO WAIVER OF BREACH OF COVENANTS. The covenants of this Lease are continuing covenants and no waiver, whether express or implied, shall be considered a waiver of a subsequent breach.

21.10 PARTIES AFFECTED, DEFINED TERMS AND HEADINGS. Subject to the restrictions on assignment or subletting, the rights, liabilities and remedies provided for herein shall extend to the heirs, legal representatives, successors and, as far as the terms of this Lease permit, assigns of the parties hereto; and that the words "Landlord," "Lessor," "Landlord" and "Tenant" include the plural as well as the singular and their accompanying verbs or pronouns, wherever used in this Lease, shall apply equally to all persons, firms or corporations which may be or become parties hereto. Words used in any gender include the masculine, feminine and neuter genders. If there be more than one Tenant, the obligation hereunder imposed upon Tenant shall be joint and several. The headings and titles to the paragraphs of this Lease are not a part of this Lease and shall have no effect upon the construction or interpretation of any part hereof.

21.11 BUILDING NAME. The name of the Buildings may be changed by Landlord.

21.12 MODIFICATION. This Lease may not be modified except by endorsement in writing attached to this Lease, dated and signed by all the parties hereto.

21.13 NOTICES. Any notice provided for in this Lease shall be considered received on the third (3rd) day following deposit of the notice into the mails or the date actually received, whichever is earlier. Any notices may be given to the other party at the below mentioned address. Either party may change its address by giving notice of such change.

21.14 ACCEPTANCE OF PREMISES. By taking possession of the Premises, Tenant acknowledges that it has inspected and examined the Premises, knows the condition thereof, and accepts same from Landlord in its present condition, and Landlord has fulfilled any obligations of Landlord in such regard.

21.15 LANDLORD'S CONSENT. Whenever Landlord's consent is required by the terms of this Lease, such consent shall not be unreasonably withheld; provided as to any requested consent to any change of use, Landlord may provide or withhold such consent in Landlord's sole discretion and judgment.

21.16 SHORT FORM LEASE. This Lease shall not be recorded. Upon request of either party, the parties hereto will execute a short form lease which may be recorded by either party.

21.17 NON-WAIVER. Any Lease provision providing for Landlord to pay an expense or perform a service shall not limit Tenant's agreement to pay, as additional rent, Tenant's Pro Rata Share of Operational Expenses incurred by Landlord.

21.18 COMMON AREAS. From time to time during the term of this Lease, Landlord may designate as Common Area such portions of the Property which are licensed for use as designated by Landlord in common by the tenants of the Property. No area which is subject to lease or exclusive rights of occupancy by any person shall be considered to be Common Area. Landlord shall be entitled, from time to time, to lease portions of the Common Area to others, to change the location, size, entrances to or the configuration of the Common Area or any improvement on the Property or to otherwise increase or decrease the area designated as Common Area so long as Landlord does not violate the applicable zoning code; any such change affecting the Common Areas shall not affect this lease or the rent payable hereunder. Tenant shall only use the Common Area for the purposes for which the Common Area is licensed in this Lease. Landlord shall be entitled to allow the use of the Common Area by such other persons and on such terms and for such uses as Landlord deems appropriate. Tenant's exclusive rights of occupancy are of the Premises only; Landlord also grants a non-exclusive license to Tenant for the term of this Lease to use the Common Area for the purposes as designated by the Landlord.

21.19 UCC FILINGS. Tenant shall not grant any security interests or pledges which either purport to affect Landlord's title to the Buildings or the Ground Lease or otherwise create a cloud on Landlord's title to the Buildings or the Ground Lease.

21.20 CERTIFICATES. At Landlord's request from time to time after the beginning of the Lease Term, Tenant agrees within fifteen (15) days of demand to execute, acknowledge and deliver to Landlord a certificate which acknowledges tenancy and possession of the Premises and recites such other facts concerning any provision of this Lease or payment made under this Lease which a prospective mortgagee or purchaser may reasonably request. Tenant's failure to deliver such statement within such time shall be conclusive upon Tenant that this Lease is in full force and effect, without modification except as may be represented by Landlord, that there are no uncured defaults in Landlord's performance, and that not more than one month's rent has been paid in advance or, at Landlord's option, such failure shall constitute a default by Tenant under this Lease.

21.21 ENTRY AND INSPECTION. Landlord reserves the right to enter the Premises for purposes of inspection, maintenance for which Landlord or Tenant is responsible, the showing of the Premises to prospective tenants during the last six (6) months of the term hereof or other proper purposes. Except in the event of an emergency, Landlord agrees to not exercise such right of entry except after reasonable advance Notice to Tenant and during normal business hours and further agrees to cooperate with Tenant, to minimize any unreasonable disruption of Tenant's affairs.

21.22 REMEDY. Tenant agrees, at all times, to look only to Landlord's interest in the land and Buildings for satisfaction of any claim whatsoever against Landlord and not to any other property or assets of Landlord.

21.23 CORRIDORS. Tenant shall not place any items in the common areas or corridors of the Buildings without Landlord's prior written consent.

21.24 LEASES ARE INDEPENDENT. Tenant shall not be deemed to be a third party beneficiary of any other lease of the Buildings; Landlord retains the sole right to determine, in its discretion, whether to enforce and the method of enforcement of compliance by other tenants and their employees with the terms of their respective leases including any restriction on use and parking; the existence of any violation of any lease provision by any other tenant shall not be deemed to be a violation of this Lease by Landlord.

21.25 PARKING. In order to provide a maximum of convenient parking to the patients of all tenants of the Buildings, Tenant and employees of Tenant shall not park any vehicles in any areas of the Buildings or its parking facilities except in such areas as Landlord shall designate, from time to time, for use by Tenant and employees of Tenant ("Employee Parking Area").

21.26 TENANT AUTHORITY. Each individual executing this Lease on behalf of Tenant represents and warrants that he is duly authorized to execute and deliver this Lease on behalf of Tenant.

Dated: February 1, 2002.

LANDLORD:

Richard Lee Harman, M.D.

Judy Harman

TENANT:

Cascade Regional Eye Center, Inc., P.S.
d/b/a The Harman Eye Clinic

By Richard Lee Harman, M.D.
Richard Lee Harman, M.D.
Its Pres/CEO

STATE OF WASHINGTON)
) ss.
COUNTY OF Snohomish)

I certify that I know or have satisfactory evidence that **Richard Lee Harman, M.D.** and **Judy Harman**, husband and wife, are the persons who appeared before me, and said persons acknowledged that they signed this instrument and acknowledged it to be their free and voluntary act for the uses and purposes stated therein.

Dated March 4, 2002.

Janice L. Rohl
NOTARY PUBLIC, State of Washington
My appointment expires 4-1-04
Janice L. Rohl

JANICE L. ROHL
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
APRIL 1, 2004

STATE OF WASHINGTON)
) ss.
COUNTY OF Snohomish

I certify that I know or have satisfactory evidence that Richard Lee Harman is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to execute the instrument and acknowledged it as the President/CEO of **Cascade Regional Eye Center, Inc., P.S. d/b/a The Harman Eye Clinic** to be the free and voluntary act of such party for the uses and purposes stated therein.

Dated March 4, 2002.

Janice L. Rohl
NOTARY PUBLIC, State of Washington
My appointment expires 4-1-04
Janice L. Rohl

JANICE L. ROHL
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
APRIL 1, 2004

ATTACHMENT 1

FOR BUILDING 1

5,000 NET USABLE SQUARE FEET (APPROXIMATE)

[NOTE: This Floor Plan is for purposes of illustration and may not be to scale or reflect final construction dimensions or details; no variation in the estimated square footage shall affect any provisions of the Lease including the amount of rent to be paid thereunder.]

ATTACHMENT 2

(Legal Description)

A portion of the South half of the Southwest quarter of the Northwest quarter of Section 12, Township 31 North, Range 5 East W.M., being more particularly described as follows:

Commencing at the Northwest comer of said subdivision; thence North 88° 37' 10" East along the North line of said subdivision for a distance of 23.59 feet to the East right-of-way line of Stillaguamish Avenue, said point lying 30.00 feet East of the centerline of Stillaguamish Avenue; thence South 3°51'28" West along said right-of-way line for a distance of 3.80 feet to the True Point of Beginning; thence South 89° 07' 21" East for a distance of 393.78 feet; thence N 1° 22' 50" W for a distance of 19.02 feet; thence North 88° 11' 44" East for a distance of 37.86 feet to a point on the North line of said subdivision; thence N 88° 37' 10" E along the North line of said subdivision for a distance of 6.77 feet; thence S 1° 22' 50" E for a distance of 205.00 feet; thence S 88° 37' 10" W for a distance of 456.55 feet to the East right-of-way line of Stillaguamish Avenue; thence N 3° 51' 28" E along said right-of-way line for a distance of 202.06 feet to the True Point of Beginning.

Subject to and together with an access and utility easement over, under, across and through the following described tract:

Commencing at the Northwest corner of said subdivision; thence N 88° 37' 10" E along the North line of said subdivision for a distance of 23.59 feet to the East right-of-way line of Stillaguamish Avenue, said point lying 30.00 feet East of the centerline of Stillaguamish Avenue; thence S 30° 5l' 28" W along said right-of-way for a distance of 148.34 feet to a point on a tangent curve to the left and the True Point of Beginning; thence Southeasterly along the arc of said curve, having a radius of 25.00 feet and consuming a central angle of 95° 14' 18", for a distance of 41.56 feet; thence N 88° 37' 10" E for a distance of 426.40 feet; thence S 1° 22' 50" E for a distance of 60.00 feet; thence S 88° 37' 10" W for a distance of 436.49 feet to a point on a tangent curve to the left; thence along the arc of said curve having a radius of 25.00 feet and consuming a central angle of 84° 45' 42", for a distance of 36.98 feet to the East right-of-way of Stillaguamish Avenue; thence N 3° 51' 28" E along said right-of-way for a distance of 110.46 feet to the True Point of Beginning.

Situate in Snohomish County, State of Washington

Said tract containing 2,000 acres of land.

Exhibit 17
Patient Origin

2018 Top 40 Zip Codes

1	98223
2	98270
3	98292
4	98271
5	98258
6	98282
7	98201
8	98290
9	98241
10	98252
11	98203
12	98208
13	98204
14	98273
15	98026
16	98020
17	98205
18	98037
19	98012
20	98272
21	98284
22	98036
23	98233
24	98275
25	98274
26	98296
27	98245
28	98250
29	98221
30	98277
31	98226
32	98087
33	98043
34	98225
35	98287
36	98155
37	98021
38	98257
39	98133
40	98206

Exhibit 18
Planning Area
Utilization Forecasts for
Operations of the Eye

Washington State Department of Health

ASC Need Methodology
North Snohomish County

Service Area Population: 2021 104,192 Claritas Age 0 - 85+
Surgeries @179.111/1,000: 3,816

a.i.	94,250	minutes/year/mixed-use OR					
a.ii.	68,850	minutes/year/dedicated outpatient OR					
a.iii.	3	dedicated outpatient OR's x 68,850 minutes =			206,550	minutes dedicated OR capacity	7,540 Outpatient surgeries
a.iv.	6	mixed-use OR's x 94,250 minutes =			565,500	minutes mixed-use OR capacity	4,158 Mixed-use surgeries
b.i.		projected inpatient surgeries =	1,237	=	168,311	minutes inpatient surgeries	
		projected outpatient surgeries =	2,579	=	70,645	minutes outpatient surgeries	
b.ii.		Forecast # of outpatient surgeries - capacity of dedicated outpatient OR's					
		2,579 -	7,540	=	-4,961	outpatient surgeries	
b.iii.		average time of inpatient surgeries		=	136.01	minutes	
		average time of outpatient surgeries		=	27.40	minutes	
b.iv.		inpatient surgeries*average time		=	168,311	minutes	
		remaining outpatient surgeries(b.ii.)*ave time		=	-135,905	minutes	
					32,406	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

565,500
- 32,406
533,094 / 94,250 = **5.66**

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.

168,311
- 565,500
(397,189) / 94,250 = **-4.21**

divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated outpatient OR's

-135,905 / 68,850 = -1.97

Exhibit 19
Methodology
Calculation

Washington State Department of Health

ASC Need Methodology
North Snohomish County

Facility	Special Procedure Rooms	Dedicated Inpatient ORs	Dedicated Outpatient ORs	Mixed Use ORs	Mixed Use min/case	Inpatient Cases in Mixed Use ORs	Inpatient Mins. In Mixed Use ORs	Outpatient Min/Case	Outpatient Cases	Outpatient Mins.	Data Source
Harman Eye	0	0	1	0	0.0	0	0	20.0	1,834	36,680	Year 2017
Cacscade Valley Arlington Surgery Center	0	0	2	0	0.0	0	0	50.0	600	30,000	Year 2017, Data unavailable assumed 50 minutes per case
Skagit Regional Hospital	0	0	0	**6**	136.0	1,168	158,864	*	*	*	Year 2017, Outpatient procedures are limited to endoscopy and pain management
Totals	0	**0**	**3**	**6**	**136.0**	**1,168**	**158,864**	**70.0**	**2,434**	**66,680**	
					Avg min/case inpatient		**136.01**	Avg min/case outpatient		**27.40**	
ORs counted in numeric methodology			**3**	**6**							

ILRS: Integrated Licensing & Regulatory System
Population data source: Claritas 2019 data

Total Surgeries	3,602	
Area population 2017 [0 - 85+]	98,344	**using 2017 population b/c using 2017 survey data**
Use Rate	36.627	
Planning Area projected population Year: 2020	102,730	
% Outpatient of total surgeries	67.57%	
% Inpatient of total surgeries	32.43%	

Exhibit 20
Pro Forma

Harman Eye Clinic ASC
Pro Forma Revenue and Expense Projections

	2018	2019	2020	2021	2022	
ASC Net Revenue	1,783,094	1,872,249	1,965,861	2,064,154	2,167,362	* ASC revenue 44% of Org Total Revenue. For total operating expenses, 44% will be assigned to ASC.
Total Net Revenue	**1,783,094**	**1,872,249**	**1,965,861**	**2,064,154**	**2,167,362**	
General ASC Expenses						
Books & Subscriptions	75	75	75	75	75	* 44% of total expense
Cleaning & Yard	15,537	15,537	15,537	15,537	15,537	* 44% of total expense
Computer Expense	20,287	20,287	20,287	20,287	20,287	* 44% of total expense
Continuing Education	1,821	1,821	1,821	1,821	1,821	* 44% of total expense
Dues & Licenses	1,997	1,997	1,997	1,997	1,997	* 44% of total expense
Employee Benefits	32,549	32,549	32,549	32,549	32,549	* 44% of total expense
Employee Dental/Optical	268	268	268	268	268	* 44% of total expense
401 (k) Match	3,080	3,080	3,080	3,080	3,080	* 44% of total expense
Insurance - Property/Gen Liab	6,824	6,824	6,824	6,824	6,824	* 44% of total expense
Insurance Prof Liab	20,469	20,469	20,469	20,469	20,469	* 44% of total expense
Merchant Fees	8,279	8,279	8,279	8,279	8,279	* 44% of total expense
Office Supplies	4,572	4,572	4,572	4,572	4,572	* 44% of total expense
Phone Expense	6,673	6,673	6,673	6,673	6,673	* 44% of total expense
Postage	2,570	2,570	2,570	2,570	2,570	* 44% of total expense
Printing	1,316	1,316	1,316	1,316	1,316	* 44% of total expense
Recruiting Fees	4,393	4,393	4,393	4,393	4,393	* 44% of total expense
Repairs & Maintenance	14,879	14,879	14,879	14,879	14,879	* 44% of total expense
General Travel & Expense	459	459	459	459	459	* 44% of total expense
Utilities	6,438	6,438	6,438	6,438	6,438	* 44% of total expense
Legal	185	185	185	185	185	* 44% of total expense
Consulting - Other	4,467	4,467	4,467	4,467	4,467	* 44% of total expense
Accounting	1,170	1,170	1,170	1,170	1,170	* 44% of total expense
ASC Specific Costs & Medical Supplies						
Pharmacist	5,400	5,400	5,400	5,400	5,400	
LASIK cost	80,537	84,564	88,792	93,232	97,893	*5% increase based on increase volume
Multi focal lens cost	144,257	151,470	159,043	166,996	175,345	*5% increase based on increase volume
ORA expense	32,730	34,367	36,085	37,889	39,784	*5% increase based on increase volume
ASC supplies	319,762	335,750	352,538	370,164	388,673	*5% increase based on increase volume
Uniform/Laundry	18,731	55,004	55,004	55,004	55,004	
Operating Expenses						
Charity Care	-	4,681	4,915	5,160	5,418	* 0.25% of total net revenue
Rent - ASC	55,003	55,003	55,003	55,003	55,003	
Depreciation	32,298	32,298	32,298	32,298	32,298	
Salaries - ASC	362,827	362,827	362,827	362,827	362,827	
Salaries - Refractive	52,000	52,000	52,000	52,000	52,000	
Salaries - Admin	65,323	65,323	65,323	65,323	65,323	* 44% of total expense
Salaries - Office	45,748	45,748	45,748	45,748	45,748	* 44% of total expense
Total Taxes	7,370.44	7,739	8,126	8,532	8,959	
Interest Expense	3,444	3,444	3,444	3,444	3,444	
MD Allocation	448,774	448,774	448,774	448,774	448,774	* 44% of total expense
Total Expenses	**1,832,513**	**1,744,391**	**1,775,319**	**1,807,794**	**1,841,893**	
Earnings Before Interest & Taxes	**(38,603.80)**	**127,857.82**	**190,541.76**	**256,359.89**	**325,468.94**	
Earnings Before Taxes	**(42,048)**	**127,858**	**190,542**	**256,360**	**325,469**	
Net Earnings	**(49,419)**	**127,858**	**190,542**	**256,360**	**325,469**	

Exhibit 21
Income Statement for 2015, 2016, 2017 and 2018

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2016

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year
Patient Revenue							
Revenue - BJB - CAT	$ 22,893.02		$ 32,673.24		$ 333,238.45		$ 309,351.09
Revenue - BJB - R-IOL	8,901.50		6,877.00		81,413.50		53,040.50
Revenue - BJB - LRI	0.00		410.00		0.00		820.00
Revenue - BJB - RLE	0.00		0.00		8,738.00		3,526.00
Revenue - BJB - LASIK	0.00		5,000.00		77,200.00		67,750.00
Revenue - BJB - Lid	0.00		0.00		0.00		576.00
Revenue - BJB - YAG	4,147.20		2,534.40		31,104.00		27,878.40
Revenue - BJB - Retina	729.63		919.12		4,136.00		5,974.25
Revenue - BJB - ASC Other	2,262.34		2,665.80		29,529.66		36,159.58
Revenue - BJB - Lab	0.00		(558.76)		1,389.56		7,515.09
Revenue - BJB - Clinic	21,145.91		25,564.15		284,112.64		307,758.79
Total Dr. Ballon Revenue	60,079.60	79%	76,084.95		850,861.81	104%	820,349.70
Revenue - BEW - CAT	10,826.63		27,052.24		270,364.53		245,036.99
Revenue - BEW - R-IOL	0.00		2,424.00		25,059.50		29,159.50
Revenue - BEW - RLE	0.00		0.00		3,526.00		3,526.00
Revenue - BEW - LASIK	3,800.00		20,000.00		50,100.00		74,700.00
Revenue - BEW - YAG	4,147.20		1,152.00		24,652.80		20,966.40
Revenue - BEW - ASC Other	6,810.58		3,812.40		41,187.45		34,616.94
Revenue - BEW - Lab	0.00		383.33		1,437.47		5,390.54
Revenue - BEW - Clinic	20,934.36		19,086.75		272,918.49		266,795.00
Total Dr. Wietharn Revenue	46,518.77	63%	73,910.72		689,246.24	101%	680,191.37
Revenue - NVB - CAT	33,701.32		19,900.08		262,058.28		206,907.23
Revenue - NVB - R-IOL	5,207.00		635.50		61,470.50		40,838.50
Revenue - NVB - LRI	410.00		0.00		1,640.00		410.00
Revenue - NVB - RLE	0.00		0.00		3,526.00		0.00
Revenue - NVB - LASIK	12,500.00		25,000.00		63,200.00		59,450.00
Revenue - NVB - Lid	1,213.20		2,080.80		15,089.40		8,955.00
Revenue - NVB - YAG	1,612.80		921.60		14,054.40		11,980.80
Revenue - NVB - ASC Other	1,051.94		1,584.00		45,436.51		33,403.95
Revenue - NVB - Lab	0.00		670.82		2,252.08		6,564.48
Revenue - NVB - Clinic	27,221.70		15,423.23		260,395.08		231,742.83
Total Dr. Bajenova Revenue	82,917.96	125%	66,216.03		729,122.25	121%	600,252.79
Revenue - Prior	(224.59)		(866.44)		(5,917.25)		73.77
Total Other Revenue	(224.59)		(866.44)		(5,917.25)		73.77
Revenue - BJB - ASC	47,124.04		57,884.97		635,029.77		568,208.17
Revenue - BJB - ASC ORA	3,000.00		3,600.00		41,400.00		37,200.00
Revenue - BEW - ASC	28,991.48		48,305.79		504,157.11		465,814.43
Revenue - BEW - ASC ORA	1,500.00		3,300.00		34,500.00		25,200.00
Revenue - NVB - ASC	59,541.12		37,734.25		510,808.06		390,834.40
Revenue - NVB - ASC ORA	5,100.00		2,700.00		30,000.00		25,500.00
Revenue - NVB - ASC Injection	0.00		0.00		0.00		5,110.95
Total ASC Revenue	145,256.64	95%	153,525.01		1,755,894.94	116%	1,517,867.95
Gross Profit	334,548.38	91%	368,870.27		4,019,207.99	111%	3,618,735.58

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2016

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year	
Operating Expenses								
Print Ads	139.83		123.46		1,975.77		2,985.81	
Health Fairs	0.00		0.00		1,065.99		1,808.24	
Web/Internet	2,212.06		2,472.74		33,356.15		21,151.07	
Marketing Discounts	2,140.00		10,730.00		35,390.00		29,635.00	
Other Merchandise	1,168.45		0.00		3,310.03		3,663.80	
Holiday Gifts	7,200.00		0.00		7,200.00		0.00	
Care Credit/Chase Advance	750.11		1,370.05		16,478.87		14,483.33	
Patient Education & Brochures	1,508.50		1,628.31		6,700.58		9,211.36	
Printing	0.00		455.40		3,187.43		2,196.66	
Flower Delivery	0.00		169.62		548.85		291.37	
Total Marketing	15,118.95		16,949.58		109,213.67		85,426.64	
Auto	0.00		0.00		0.00		18.00	
Books & Subscriptions	0.00		0.00		162.85		0.00	
Cleaning & Yard	2,723.14		1,445.00		22,753.54		18,160.00	
Clinic Uniforms	73.51		37.66		779.26		322.59	
Computer Expense	4,719.01		4,538.83		48,301.09		42,397.73	
Computer - Landon	0.00		0.00		5,800.00		6,250.00	
Continuing Education	633.56		0.00		1,567.10		3,758.06	
Contributions	0.00		0.00		2,200.00		2,550.00	
Dues & Licenses	1,297.92		930.00		5,866.20		3,687.00	
Employee Benefits	8,130.77		7,148.85		77,788.93		78,336.65	
Employee Dental/Optical	61.40		52.70		432.38		1,412.41	
401(k) Match	40.00		100.00		5,110.00		7,400.27	
Insurance-Property/Gen Liab	1,366.83		0.00		14,763.34		12,884.17	
Insurance - Prof Liab	3,711.66		330.62		47,297.90		36,641.77	
Merchant Fees	2,499.25		2,350.59		24,874.18		21,430.70	
Office Supplies	1,050.66		718.40		12,458.29		9,782.24	
Phone Expense	1,252.97		1,186.83		14,160.87		14,220.69	
Postage	500.00		500.00		4,695.94		5,000.00	
Recruiting Fees	0.00		0.00		5,000.00		0.00	
Repairs & Maintenance	1,330.73		416.02		15,970.10		19,693.30	
T & E	1,034.75		929.92		1,628.62		1,312.45	
Utilities	1,217.39		1,108.48		13,784.41		13,809.56	
Water Cooler	65.41		65.23		784.02		782.76	
Legal	45.00		0.00		210.00		401.25	
Consulting - Other	0.00		0.00		0.00		3,750.00	
Accounting	0.00		0.00		1,985.00		2,235.00	
401(k) Administrative Cost	0.00		0.00		3,240.00		1,200.00	
Total General Expenses	31,753.96		21,859.13		331,614.02		307,436.60	
Clinic Supplies	816.49		1,465.96		5,021.97		6,828.23	
Lasik Costs	7,215.37	135%	13,503.82	418%	82,839.33	208%	86,795.13	285%
Punctal Plugs	0.00		0.00		1,982.00		2,654.50	
TearLab	0.00		867.28		9,324.66		16,606.06	
Multi Focal Expenses	17,569.52		6,924.85		149,945.19		101,247.38	
ORA Expense	0.00	32%	0.00	25%	10,671.80	29%	22,500.00	25%
ASC Supplies	26,204.64		29,432.68		325,847.06		237,038.38	
Avastin/Lucentis/Eylea	0.00		0.00		0.00		2,318.89	
Pharmacist	450.00		450.00		5,400.00		5,400.00	
Uniforms/Laundry	1,542.70		1,214.30		19,250.14		15,252.56	
Total Medical Supplies	53,798.72		53,858.89		610,282.15		496,641.13	

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2016

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year	
Rent	14,165.19		13,966.60		169,101.70		166,881.10	
Rent - ASC	4,583.66		4,583.66		55,003.92		55,003.92	
Total Rent	18,748.85		18,550.26		224,105.62		221,885.02	
Salaries - Admin	13,707.67		15,602.40		162,131.76		163,611.51	
Salaries - Office	12,245.58		9,020.88		107,037.42		136,390.58	
Salaries - ASC	31,621.70	22%	30,875.74	20%	366,050.22	21%	328,912.07	22%
Salaries -Clinic	37,460.77		32,173.63		437,045.87		326,887.74	
Staff Bonus	33,000.00		36,400.00		39,267.75		36,400.00	
Total Salaries (17%-24%)	128,035.72	38%	124,072.65	34%	1,111,533.02	28%	992,201.90	27%
Taxes - Excise	5,274.05		3,792.72		62,354.94		54,309.16	
Taxes - Other	1,571.99		1,891.49		19,307.66		20,875.62	
Taxes - Payroll	11,796.81		11,603.74		103,217.23		92,098.87	
Total Taxes	18,642.85		17,287.95		184,879.83		167,283.65	
Total Operating Exp (45%-65%)	266,099.05	80%	252,578.46	68%	2,571,628.31	64%	2,270,874.94	63%
Net Before MD and Other	68,449.33		116,291.81		1,447,579.68		1,347,860.64	
Dr. Ballon Expenses								
Books & Journals	0.00		0.00		0.00		135.50	
Cont. Education	0.00		1,175.00		785.00		1,882.50	
Dues & Licenses	200.00		0.00		3,016.00		2,427.00	
T & E 100%	76.53		2,362.80		6,316.17		6,952.75	
T & E 50%	336.00		885.18		709.15		1,536.08	
Total Expense Package	612.53		4,422.98		10,826.32		12,933.83	
Health Insurance	2,106.46		2,191.29		25,058.17		25,470.28	
Life & Disab. Ins.	593.00		939.18		9,080.97		8,951.15	
Phone	120.00		120.00		1,440.00		1,440.00	
BJB - Salary	52,309.16		38,345.55		290,097.12		236,287.12	
BJB Discretionary Bonus	43,350.00		45,000.00		43,350.00		45,000.00	
BJB Est. Accrued Bonus	(34,996.00)		(15,708.00)		(11,002.00)		30,603.00	
P/R Taxes	1,915.72		1,743.31		14,210.43		13,920.43	
401(k)	0.00		0.00		500.00		500.00	
Total Dr. Ballon Expenses	66,010.87	110%	77,054.31	101%	383,561.01	45%	375,105.81	46%
Dr. Wietharn Expenses								
Books & Journals	0.00		172.99		0.00		285.26	
Cont. Education	0.00		0.00		800.00		3,604.27	
Dues & Licenses	975.00		0.00		3,735.00		2,683.00	
T & E 100%	0.00		1,347.84		2,607.33		6,826.09	
T & E 50%	0.00		293.67		31.38		322.11	
Total Expense Package	975.00		1,814.50		7,173.71		13,720.73	
Health Insurance	1,165.00		1,105.05		13,680.25		13,720.90	
Life & Disability	752.35		902.82		7,852.02		7,753.66	
Phone	120.00		120.00		1,440.00		1,440.00	
BEW - Salary	24,400.16		27,283.55		213,860.62		194,959.12	
BEW Discretionary Bonus	43,350.00		45,000.00		43,350.00		45,000.00	
BEW Est Accrued Bonus	(12,513.00)		(5,516.00)		587.00		15,867.00	
P/R Taxes	1,498.84		1,396.45		13,160.48		13,010.67	
401(k)	0.00		0.00		500.00		500.00	
Total Dr. Wietharn Expenses	59,748.35	128%	72,106.37	98%	301,604.08	44%	305,972.08	45%

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2016

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year	
Dr. Bajenova Expenses								
NVB - Continuing Education	0.00		0.00		710.00		3,639.27	
Dues & Licenses	675.00		0.00		3,357.00		1,131.00	
NVB - T & E 100%	2,438.91		1,489.66		8,606.19		2,949.63	
NVB - T & E 50%	0.00		0.00		0.00		70.10	
Total Expense Package	3,113.91		1,489.66		12,673.19		7,790.00	
NVB - Health Insurance	980.98		959.72		11,665.46		12,327.44	
NVB - Life & Disability	717.35		789.78		7,853.91		7,138.52	
NVB - Phone	114.78		113.01		1,421.10		1,283.08	
NVB Salary	35,549.16		27,780.55		226,988.12		170,003.12	
NVB Est. Accrued Bonus	(9,102.00)		2,173.00		3,411.00		12,585.00	
NVB Discretionary Bonus	13,300.00		10,000.00		13,300.00		10,000.00	
NVB - P/R Taxes	742.14		598.33		11,002.85		10,271.95	
NVB - 401(k)	0.00		0.00		500.00		500.00	
Total Dr. Bajenova Expenses	45,416.32	55%	43,904.05	66%	288,815.63	40%	231,899.11	39%
Net Before Other	(102,726.21)		(76,772.92)		473,598.96		434,883.64	
Other Income & Expenses								
Interest Income	0.17		282.20		461.07		1,143.68	
Incentives	0.00		0.00		2,408.12		1,241.30	
Other Income	0.00		(4,400.42)		0.00		(4,684.29)	
Interest Expense	(856.14)		(725.83)		(14,215.61)		(9,699.66)	
Depreciation Expense	(7,479.01)		(5,565.42)		(87,834.53)		(66,785.04)	
Accrued Profit Sharing	(7,434.31)		(7,794.22)		(89,571.63)		(93,530.64)	
Total Other Income & Expenses	(15,769.29)		(18,203.69)		(188,752.58)		(172,314.65)	
Pres/CEO Salary	(22,500.00)		(22,500.00)		(270,000.00)		(270,000.00)	
Total	(22,500.00)		(22,500.00)		(270,000.00)		(270,000.00)	
Net Income	($ 140,995.50)		($ 117,476.61)		$ 14,846.38		($ 7,431.01)	

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2018

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year
Patient Revenue							
Revenue - BJB - CAT	$ 20,862.61		$ 27,477.72		$ 325,104.29		$ 359,904.78
Revenue - BJB - R-IOL	3,971.50		8,301.50		61,540.50		99,400.50
Revenue - BJB - RLE	0.00		0.00		6,652.00		3,126.00
Revenue - BJB - LASIK	0.00		0.00		34,100.00		81,950.00
Revenue - BJB - YAG	4,052.80		1,612.80		37,408.29		29,554.88
Revenue - BJB - ASC Other	1,095.00		1,036.80		21,374.67		36,265.54
Revenue - BJB - Clinic	19,584.00		17,749.59		277,884.03		301,104.90
Total Dr. Ballon Revenue	49,565.91	88%	56,178.41		764,063.78	84%	911,306.60
Revenue - BEW - CAT	22,980.27		25,836.12		291,832.17		237,482.15
Revenue - BEW - R-IOL	3,336.00		2,424.00		29,147.50		42,931.00
Revenue - BEW - RLE	0.00		3,526.00		0.00		7,052.00
Revenue - BEW - LASIK	3,800.00		15,000.00		67,700.00		90,950.00
Revenue - BEW - YAG	953.60		2,995.20		23,162.48		20,774.09
Revenue - BEW - ASC Other	1,145.44		410.40		16,362.61		25,574.62
Revenue - BEW - Clinic	16,742.25		18,508.50		288,890.36		276,178.23
Total Dr. Wietharn Revenue	48,957.56	71%	68,700.22		717,095.12	102%	700,942.09
Revenue - NVB - CAT	11,053.56		28,504.80		284,155.37		297,066.65
Revenue - NVB - R-IOL	3,971.50		7,318.50		68,624.50		93,877.50
Revenue - NVB - RLE	1,763.00		1,763.00		8,815.00		28,208.00
Revenue - NVB - LASIK	0.00		7,500.00		59,350.00		53,200.00
Revenue - NVB - Lid	0.00		1,040.40		13,163.47		13,935.60
Revenue - NVB - YAG	3,099.20		2,073.60		27,917.00		17,773.14
Revenue - NVB - ASC Other	2,041.45		2,383.20		30,526.56		29,670.16
Revenue - NVB - Clinic	20,234.18		23,766.75		288,191.87		305,751.69
Total Dr. Bajenova Revenue	42,162.89	57%	74,350.25		780,743.77	93%	839,482.74
Revenue - Prior	(314.33)		(1,975.06)		(13,840.16)		(4,754.21)
Total Other Revenue	(314.33)		(1,975.06)		(13,840.16)		(4,754.21)
Revenue - BJB - ASC	42,299.96		51,990.31		611,064.83		681,036.00
Revenue - BJB - ASC ORA	2,100.00		2,700.00		34,500.00		32,400.00
Revenue - BEW - ASC	37,955.15		50,388.00		519,335.34		447,109.96
Revenue - BEW - ASC ORA	2,700.00		4,500.00		36,350.00		29,100.00
Revenue - NVB - ASC	27,308.52		55,258.60		561,644.06		593,847.70
Revenue - NVB - ASC ORA	900.00		2,700.00		20,200.00		22,200.00
Total ASC Revenue	113,263.63	68%	167,536.91		1,783,094.23	99%	1,805,693.66
Gross Profit	253,635.66	70%	364,790.73		4,031,156.74	95%	4,252,670.88

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2018

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year	
Operating Expenses								
Print Ads	0.00		0.00		770.17		742.75	
Name Recognition Events	46.89		0.00		2,946.89		770.33	
Web/Internet	249.00		1,999.56		18,094.15		45,372.60	
Marketing Discounts	0.00		3,475.00		19,765.00		21,205.00	
Other Merchandise	192.23		32.91		4,386.26		1,504.65	
Holiday Gifts	8,250.00		0.00		8,250.00		0.00	
Care Credit Fees	1,308.77		1,590.02		15,734.32		24,934.11	
Event Advertising	0.00		0.00		0.00		3,500.00	
Patient Education & Brochures	879.70		0.00		5,188.72		9,134.00	
Total Marketing	10,926.59		7,097.49		75,135.51		107,163.44	
Books & Subscriptions	170.37		0.00		170.37		0.00	
Cleaning & Yard	2,931.37		2,908.62		35,312.69		34,903.44	
Clinic Uniforms	40.30		0.00		716.73		378.63	
Computer Expense	3,925.73		3,941.14		46,107.02		48,491.63	
Computer - Landon	0.00		0.00		5,075.00		2,065.00	
Continuing Education	78.75		0.00		4,139.49		3,222.72	
Dues & Licenses	0.00		72.28		4,539.40		5,052.51	
Employee Benefits	4,982.17		6,209.50		73,975.22		81,500.90	
Employee Dental/Optical	95.07		0.00		608.39		203.32	
401(k) Match	213.88		260.00		7,000.00		6,500.00	
Event Flowers	0.00		0.00		485.64		339.02	
Insurance-Property/Gen Liab	202.75		1,324.21		15,509.29		15,670.96	
Insurance - Prof Liab	3,908.55		3,746.31		46,520.28		44,589.33	
Merchant Fees	613.22		3,365.48		18,816.16		23,314.10	
Office Supplies	684.51		455.65		10,391.65		11,475.91	
Phone Expense	1,348.81		1,424.07		15,166.41		15,079.18	
Postage	594.10		702.40		5,840.00		5,168.08	
Printing	448.87		0.00		2,991.44		3,930.10	
Recruiting Fees	0.00		0.00		9,984.00		0.00	
Repairs & Maintenance	4,947.78		2,141.69		33,815.00		29,658.84	
T & E	497.81		1,815.42		1,044.55		2,874.56	
Utilities	1,302.88		1,268.38		14,632.82		14,001.03	
Water Cooler	0.00		0.00		0.00		654.10	
Legal	0.00		0.00		420.00		15.00	
Consulting - Other	3,564.20		0.00		10,153.60		0.00	
Accounting	0.00		0.00		2,660.00		2,380.00	
401(k) Administrative Cost	0.00		0.00		0.00		2,615.00	
Total General Expenses	30,551.12		29,635.15		366,075.15		354,083.36	
Clinic Supplies	616.42		1,386.10		14,534.55		6,323.36	
Lasik Costs	6,630.17	174%	9,041.66	40%	80,537.02	50%	90,736.44	40%
Punctal Plugs	0.00		0.00		2,355.00		1,595.00	
Multi Focal Expenses	11,430.13		20,875.00		144,257.77		209,928.37	
ORA Expense	2,727.50		2,727.50		32,730.00		59,013.80	
ASC Supplies	22,258.98	34%	29,906.32	33%	319,762.43	29%	324,535.64	35%
Omidria/Avastin/Lucentis/Eylea	0.00		0.00		0.00		5,580.00	
Pharmacist	450.00		450.00		5,400.00		5,400.00	
Uniforms/Laundry	1,763.42		1,430.57		18,731.28		19,757.31	
Total Medical Supplies	45,876.62		65,817.15		618,308.05		722,869.92	

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2018

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year	
Rent	13,575.35		13,575.35		162,897.60		163,494.02	
Rent - ASC	4,583.66		4,583.66		55,003.92		55,004.06	
Total Rent	18,159.01		18,159.01		217,901.52		218,498.08	
Salaries - Admin	10,000.00		13,326.89		148,461.43		164,884.26	
Salaries - Office	7,776.54		6,913.70		103,972.40		79,663.53	
Salaries - Refractive	4,000.00		4,200.00		52,000.00		26,000.00	
Salaries - ASC	28,079.32	25%	37,038.73	22%	362,827.29	20%	394,858.96	22%
Salaries -Clinic	29,599.84		29,975.30		443,794.32		428,315.17	
Staff Bonus	29,602.07		35,731.36		79,602.07		35,731.36	
		31%		25%		28%		26%
Total Salaries (17%-24%)	109,057.77	43%	127,185.98	35%	1,190,657.51	30%	1,129,453.28	27%
Taxes - Excise	3,974.22		4,156.02		64,634.56		64,432.86	
Taxes - Other	1,364.13		1,537.80		18,635.95		21,138.46	
Taxes - Payroll	11,413.40		12,131.84		110,706.93		103,561.96	
Total Taxes	16,751.75		17,825.66		193,977.44		189,133.28	
Total Operating Exp (45%-65%)	231,322.86	91%	265,720.44	73%	2,662,055.18	66%	2,721,201.36	64%
Net Before MD and Other	22,312.80		99,070.29		1,369,101.56		1,531,469.52	
Dr. Ballon Expenses								
Books & Journals	0.00		0.00		0.00		0.00	
Cont. Education	0.00		0.00		2,188.45		1,375.00	
Dues & Licenses	0.00		0.00		2,995.00		4,283.00	
T & E 100%	1,493.77		4,002.48		3,215.70		7,284.39	
T & E 50%	88.30		137.25		1,657.19		520.26	
Total Expense Package	1,582.07		4,139.73		10,056.34		13,462.65	
Health Insurance	2,386.44		2,245.61		27,933.13		26,251.57	
Life & Disab. Ins.	588.20		593.00		6,144.91		6,117.83	
Phone	120.00		120.00		1,440.00		1,440.00	
BJB - Salary	32,628.24		49,858.70		243,479.12		302,681.12	
BJB Discretionary Bonus	56,000.00		41,700.00		56,000.00		41,700.00	
BJB Est. Accrued Bonus	(20,598.00)		(34,645.00)		2,985.00		592.00	
P/R Taxes	1,829.29		1,849.57		14,421.23		14,940.03	
401(k)	0.00		0.00		500.00		500.00	
Total Dr. Ballon Expenses	74,536.24	150%	65,861.61	117%	362,959.73	48%	407,685.20	45%
Dr. Wietharn Expenses								
Books & Journals	0.00		0.00		0.00		0.00	
Cont. Education	0.00		0.00		325.00		2,980.20	
Dues & Licenses	0.00		0.00		3,326.00		2,274.00	
T & E 100%	0.00		0.00		3,263.51		9,448.23	
T & E 50%	0.00		0.00		38.08		406.28	
Total Expense Package	0.00		0.00		6,952.59		15,108.71	
Health Insurance	1,392.35		1,268.92		16,091.05		14,707.44	
Life & Disability	752.59		752.35		7,819.37		7,824.19	
Phone	120.00		120.00		1,440.00		1,440.00	
BEW - Salary	22,808.24		38,354.70		225,435.12		217,323.12	
BEW Discretionary Bonus	56,000.00		41,700.00		56,000.00		41,700.00	
BEW Est Accrued Bonus	(11,022.00)		(18,132.00)		153.00		1,804.00	
P/R Taxes	1,674.80		1,699.56		14,125.53		13,784.13	
401(k)	0.00		0.00		500.00		500.00	
Total Dr. Wietharn Expenses	71,725.98	147%	65,763.53	96%	328,516.66	46%	314,191.59	45%

The Harman Eye Clinic
Income Statement
For the Twelve Months Ending December 31, 2018

	Current Month This Year		Current Month Last Year		Year to Date This Year		Year to Date Last Year	
Dr. Bajenova Expenses								
NVB - Continuing Education	0.00		0.00		2,494.90		3,217.41	
Dues & Licenses	975.00		0.00		5,110.50		1,670.00	
NVB - T & E 100%	0.00		0.00		7,385.68		3,574.71	
NVB - T & E 50%	0.00		0.00		650.13		0.00	
Total Expense Package	975.00		0.00		15,641.21		8,462.12	
NVB - Health Insurance	1,206.21		1,031.32		13,783.03		12,124.14	
NVB - Life & Disability	865.40		748.50		8,032.27		6,901.28	
NVB - Phone	120.00		120.00		1,440.00		1,439.80	
NVB Salary	29,688.24		57,409.70		247,370.12		278,594.12	
NVB Est. Accrued Bonus	(20,620.00)		(34,928.00)		1,589.00		(4,051.00)	
NVB Discretionary Bonus	28,000.00		16,600.00		28,000.00		16,600.00	
NVB - P/R Taxes	888.08		1,115.23		12,111.18		12,318.07	
NVB - 401(k)	0.00		0.00		500.00		500.00	
Total Dr. Bajenova Expenses	41,122.93	98%	42,096.75	57%	328,466.81	42%	332,888.53	40%
Net Before Other	(165,072.35)		(74,651.60)		349,158.36		476,704.20	
Other Income & Expenses								
Interest Income	0.00		0.07		6.98		1.93	
Other Income	0.00		0.00		2,060.15		0.00	
Interest Expense	(537.52)		(483.87)		(7,828.52)		(7,244.87)	
Depreciation Expense	(7,026.42)		(3,389.17)		(73,405.29)		(57,029.40)	
Accrued Profit Sharing	(4,184.10)		(3,888.67)		(49,913.77)		(57,300.96)	
Total Other Income & Expenses	(11,748.04)		(7,761.64)		(129,080.45)		(121,573.30)	
Pres/CEO Salary	(22,500.00)		(22,500.00)		(270,000.00)		(270,000.00)	
Total	(22,500.00)		(22,500.00)		(270,000.00)		(270,000.00)	
Net Income	($ 199,320.39)		($ 104,913.24)		($ 49,922.09)		$ 85,130.90	

Exhibit 22
Balance Statement for 2015, 2016, 2017 and 2018

The Harman Eye Clinic
Balance Sheet
December 31, 2016

ASSETS

	Current Year	Last Year
Current Assets		
Cash on Hand	$ 342.00	$ 350.00
B of A Checking	93,791.25	(118,993.51)
B of A Savings	10,246.83	10,290.12
Total Cash	104,380.08	(108,353.39)
Accounts Receivable	894,582.31	1,002,232.11
A/R Allowance	(518,919.04)	(570,857.14)
Net Accounts Receivable	375,663.27	431,374.97
Inventory	5,475.05	8,679.57
A/R Other	18,502.57	32,620.76
A/R Dr. Bajenova	0.00	19,671.55
Pre-Paid Expenses	34,791.82	24,411.21
Total Current Assets	538,812.79	408,404.67
Property and Equipment		
Office Equipment	302,943.49	367,705.89
Medical Equipment	2,068,629.75	2,117,760.52
Leasehold Improvements	367,175.29	367,175.29
Accumulated Depreciation	(2,444,088.33)	(2,453,387.41)
Total Property and Equipment	294,660.20	399,254.29
Total Assets	$ 833,472.99	$ 807,658.96

The Harman Eye Clinic
Balance Sheet
December 31, 2016

LIABILITIES AND CAPITAL

	Current Year	Last Year
Current Liabilities		
Accounts Payable	($ 30,717.58)	($ 42,706.61)
Accrued P/R Taxes	110,609.35	3,920.84
Accrued MD Est Bonus	1,706.00	792.00
401(k) Payable	40.00	100.00
Accrued Profit Sharing	89,571.63	93,530.64
Gift Certificates	107.00	107.00
Excise Payable	5,274.70	3,792.72
Line of Credit	0.00	50,000.00
Current Portion LTD	55,329.06	75,185.61
Total Current Liabilities	231,920.16	184,722.20
Long-Term Liabilities		
Loan from MDs	7,732.74	17,760.78
deLage Landen - Scope	27,834.51	45,264.40
deLage Landen - VF	5,516.85	8,461.83
Americorp - ORA	0.00	18,575.29
EverBank - Ellex Tango	7,994.95	31,275.57
US Bank - iTrace,Phaco,UPS	71,007.79	86,554.76
US Bank - Business Loan	41,662.93	0.00
Less Current Portion LTD	(55,329.06)	(75,185.61)
Total Long-Term Liabilities	106,420.71	132,707.02
Total Liabilities	338,340.87	317,429.22
Capital		
Common Stock	13,300.00	13,300.00
Retained Earnings	466,985.74	484,360.75
Net Income	14,846.38	(7,431.01)
Total Capital	495,132.12	490,229.74
Total Liabilities & Capital	$ 833,472.99	$ 807,658.96

The Harman Eye Clinic
Balance Sheet
December 31, 2018

ASSETS

	Current Year	Last Year
Current Assets		
Cash on Hand	$ 350.00	$ 350.00
B of A Checking	0.00	(66,496.86)
WA Federal Checking	56,195.97	(32,247.59)
Building Fund	144,000.00	72,000.00
Total Cash	200,545.97	(26,394.45)
Accounts Receivable	504,237.87	1,109,448.14
A/R Allowance	(304,934.32)	(673,543.53)
	199,303.55	435,904.61
Inventory	6,921.14	9,664.80
A/R Other	19,378.72	19,745.28
Pre-Paid Expenses	42,048.57	24,341.49
Total Current Assets	468,197.95	463,261.73
Property and Equipment		
Office Equipment	324,281.40	354,061.22
Medical Equipment	2,090,202.18	2,106,404.67
Leasehold Improvements	367,175.29	367,175.29
Accumulated Depreciation	(2,582,765.00)	(2,501,117.73)
Total Property and Equipment	198,893.87	326,523.45
Total Assets	$ 667,091.82	$ 789,785.18

The Harman Eye Clinic
Balance Sheet
December 31, 2018

LIABILITIES AND CAPITAL	Current Year	Last Year
Current Liabilities		
Accounts Payable	($ 19,669.06)	($ 42,006.86)
Outstanding Checks-BofA	1,675.06	0.00
Accrued P/R Taxes	4,414.83	4,149.91
Accrued MD Est Bonus	4,778.00	51.00
401(k) Payable	213.88	260.00
Accrued Profit Sharing	49,913.77	57,300.96
Excise Payable	3,974.21	4,157.06
Current Portion LTD	57,282.22	38,698.15
Total Current Liabilities	102,582.91	62,610.22
Long-Term Liabilities		
deLage Landen - Scope	0.00	9,510.99
deLage Landen - VF	0.00	2,098.59
US Bank - iTrace,Phaco,UPS	37,362.08	54,625.47
WA Fed - Equipment Loan	0.00	40,326.24
WA Fed - Term Loan	24,623.10	0.00
US Bank - Equipment	55,886.56	0.00
US Bank - Business Loan	0.00	32,452.91
Less Current Portion LTD	(57,282.22)	(38,698.15)
Total Long-Term Liabilities	60,589.52	100,316.05
Total Liabilities	163,172.43	162,926.27
Capital		
Common Stock	13,300.00	13,300.00
Retained Earnings	540,541.48	528,428.01
Net Income	(49,922.09)	85,130.90
Total Capital	503,919.39	626,858.91
Total Liabilities & Capital	$ 667,091.82	$ 789,785.18

Exhibit 23

Medical Center Transfer Agreement

Skagit Regional Health
Skagit Valley Hospital · Skagit Regional Clinics

CASCADE VALLEY Hospital and Clinics
Close to Home
Close to Heart

May 20, 2016

Via U.S. Mail

Harman Eye Clinic
903 Medical Center Dr.
Arlington, WA 98223

Re: Notice of Assignment of Patient Transfer Agreement

Dear Harman Eye Clinic:

The letter relates to the Patient Transfer Agreement and any amendments and addendums thereto (the "Agreement"), dated as of 7/11/2011, by and between Public Hospital District No. 3, Snohomish County, Washington ("CVH"), and Harman Eye Clinic, with respect to Agreement - Patient Transfer.

CVH has entered into an Affiliation Agreement with Public Hospital District No. 1, Skagit County, Washington ("Skagit Regional Health"), whereby upon the closing date of the affiliation (the "Closing Date"), CVH will lease to Skagit Regional Health all of its facilities, and Skagit Regional Health will operate, manage and carry out all of the facilities, programs and services currently performed by CVH. As part of the transition from CVH to Skagit Regional Health, the Agreement will be assigned by CVH to Skagit Regional Health, and Skagit Regional Health will assume all of the rights and responsibilities of CVH under the Agreement.

All of your rights and obligations under the Agreement will remain as presently constituted in the Agreement. The assignment and assumption of the Agreement will be effective as of the Closing Date, which is anticipated to be as of June 1, 2016, but it could be a later date in the event the Closing Date is delayed.

After the Closing Date, please use the below addresses for billing and contracting correspondence regarding the Agreement.

For Billing Matters:
Skagit Regional Health
Attn: Accounts Payable Team / Finance
P.O. Box 1376
Mount Vernon, WA 98273

For Contracting Matters:
Skagit Regional Health
Attn: Contracts / Risk Management

1415 E. Kincaid Street
Mount Vernon, WA 98274

Please do not hesitate to contact us with any questions. For your information, our contact information is set forth below

Public Hospital District No. 3,
Snohomish County, Washington
d/b/a Cascade Valley Hospital and Clinics

W. Clark Jones
Chief Executive Officer

Public Hospital District No. 1, Skagit County, Washington
d/b/a Skagit Regional Health

Tom Litaker
Regional Vice President and Chief Financial Officer

PATIENT TRANSFER AGREEMENT

Cascade Valley Hospital

This Patient Transfer Agreement ("Agreement") is entered into this 11 day of July, 20 11 (the "Effective Date"), between Cascade Valley Hospital ("Hospital"), and Harman Eye Clinic ("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 policies/protocols, and (ii) applicable federal and state laws and regulations 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 policies/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 ay 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, of (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 the 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.

HOSPITAL:
CASCADE VALLEY HOSPITAL

By: W Clark Jones
Name: W. Clark Jones
Title: CEO

TRANSFERRING FACILITY:

By: R Lee Harman, MD, FACS
Name: R LEE HARMAN, MD, FACS
Title: Pres/CEO
The Harman Eye Clinic

Exhibit 24
National Health Statistics Reports; Number 11, January 28, 2009 - Revised September 4, 2009

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.

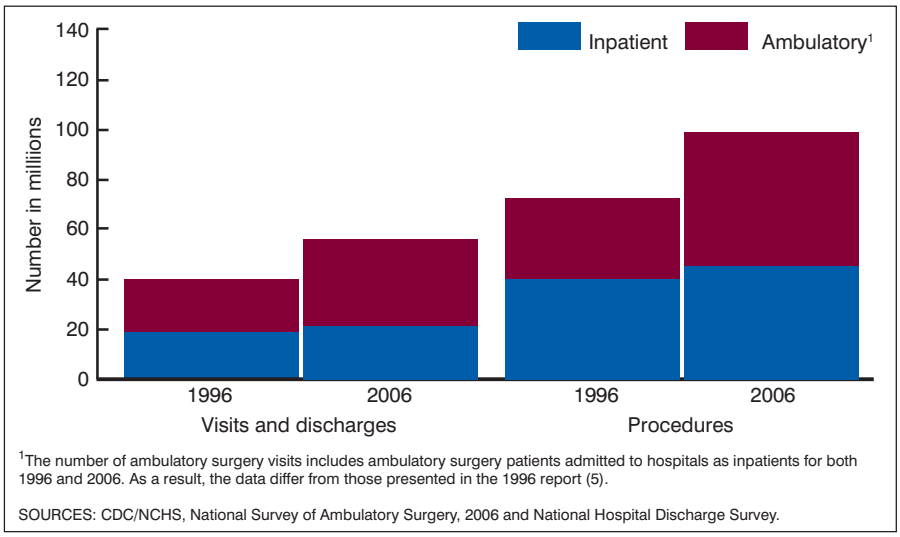
The relative standard error (RSE) of an estimate is obtained by dividing the SE by the estimate itself. The RSE is expressed as a percentage of an estimate and can be multiplied by the estimate to obtain the SE. Because of low reliability, estimates with a RSE of more than 30 percent or those based on 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

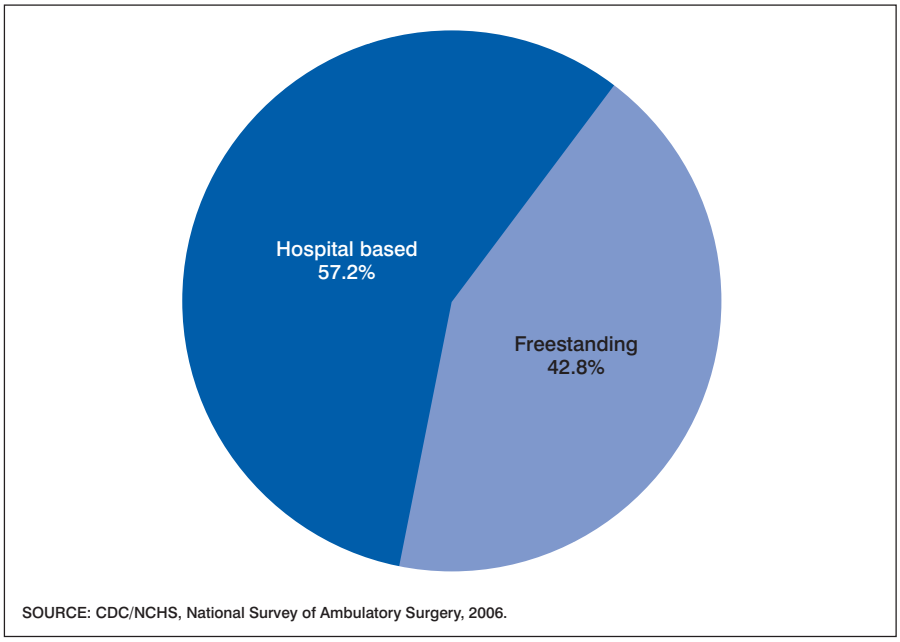
- In 2006, an estimated 53.3 million surgical and nonsurgical procedures were performed during 34.7 million ambulatory surgery visits (Table 2).
- The 34.7 million ambulatory surgery visits accounted for about 61.6 percent of the combined total of ambulatory surgery visits and inpatient discharges with 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)

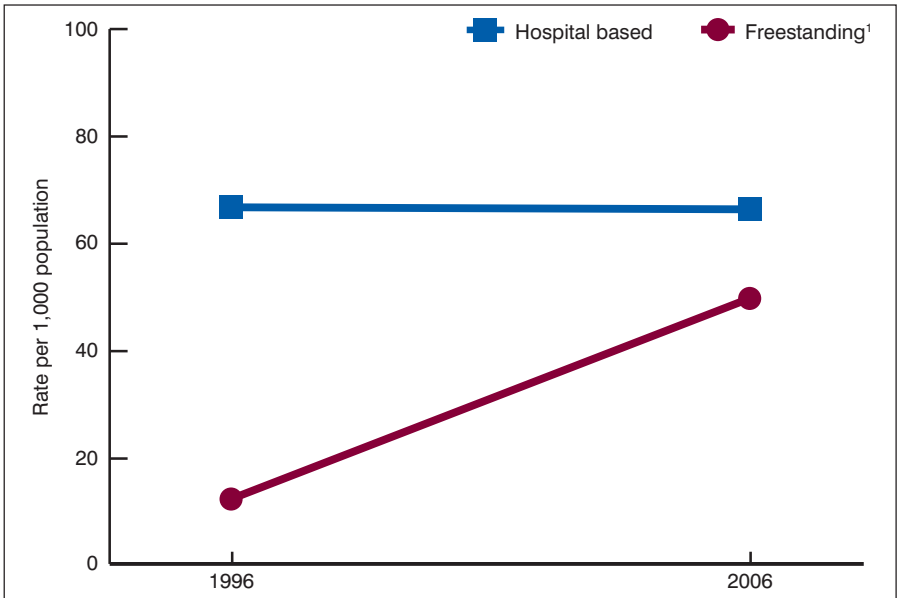


SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery, 2006.

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).

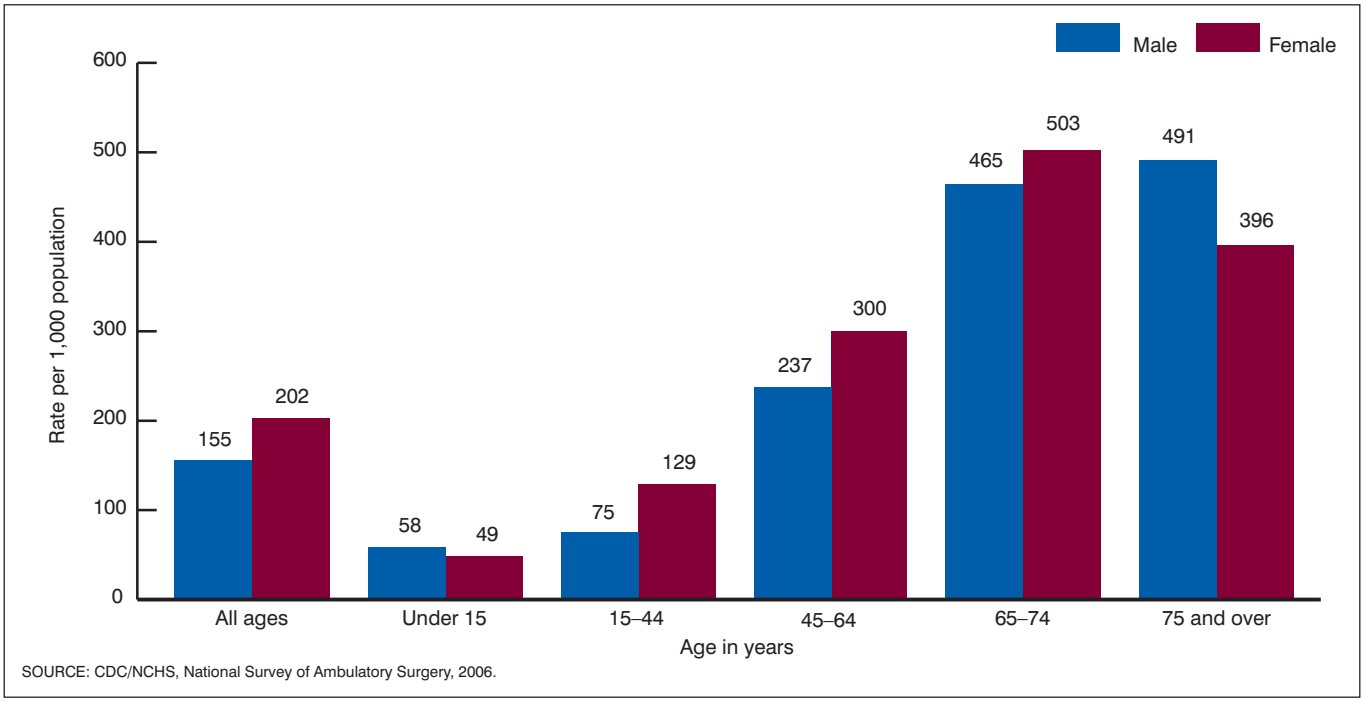


Figure 4. Rate of ambulatory surgery procedures by age and sex: United States, 2006 (revised)

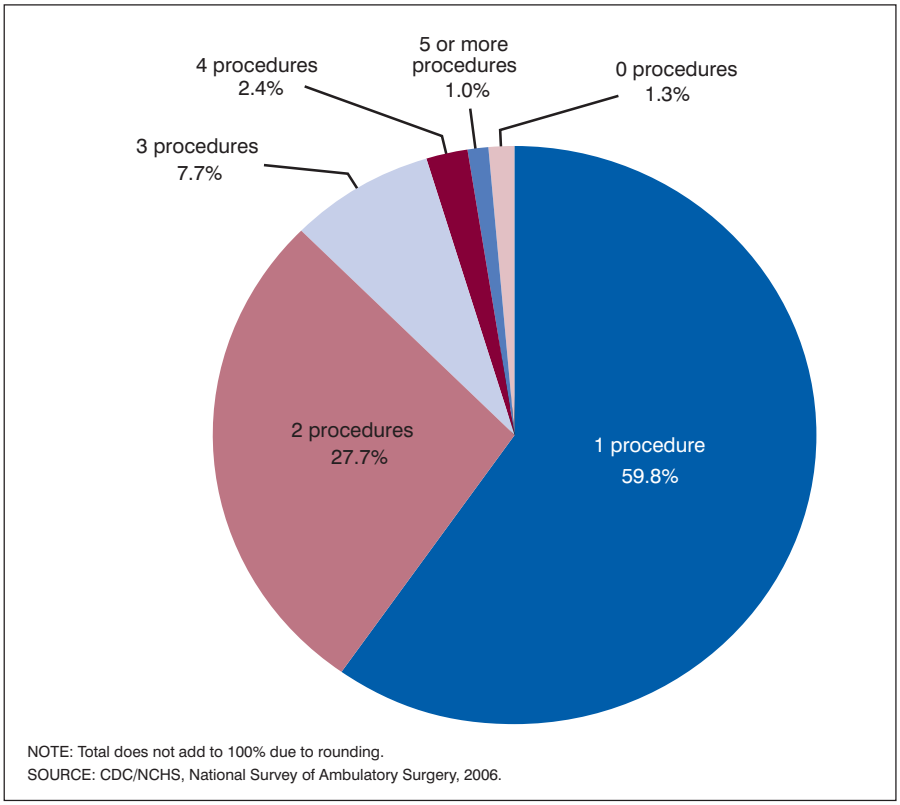


Figure 5. Percent distribution of the number of ambulatory surgery procedures performed per visit: United States, 2006 (revised)

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.

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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

NATIONAL SURVEY OF AMBULATORY SURGERY

MEDICAL ABSTRACT

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 others 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 any 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

A. PATIENT INFORMATION

1. Facility number
2. NSAS number and file 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) — Years, Months, Days
7. Sex (Mark (X) one) — Male, Female, Not stated
8. Ethnicity (Mark (X) one) — Hispanic or Latino; Not Hispanic or Latino; Not Stated
9. Race (Mark (X) all that apply) — White; Black or African American; American Indian or Alaska Native; Asian; Native Hawaiian or Other Pacific Islander; Other; Not Stated
10. Status/Disposition of Patient (Mark (X) the appropriate box) — Routine discharge to customary residence; Discharge to observation status; Discharge to post-surgical recovery care facility; Admitted to hospital as inpatient; Surgery aborted or terminated; Other – Specify; Status/Disposition not stated

C. PAYMENT INFORMATION

11. Expected source of payment

	Principal	Other sources
GOVERNMENT SOURCES		
Medicare	☐	☐
If available, also mark whether – Fee-for-service ☐ HMO ☐ PPO ☐		
Medicaid	☐	☐
If available, also mark whether – Fee-for-service ☐ HMO ☐ PPO ☐		
TRICARE	☐	☐
Worker's compensation	☐	☐
Other government (If so, please specify)	☐	☐
PRIVATE INSURANCE		
Private or commercial	☐	☐
If available, also mark 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
b. Time surgery began
c. Time surgery ended
d. Time out of operating room
e. Time in to postoperative care
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) — Anesthesiologist; CRNA (Certified Registered Nurse Anesthetist); Surgeon/Other physician; Not stated/PA was billed

Please continue on the reverse side

E. MEDICAL INFORMATION

16. FINAL DIAGNOSIS (including E-code diagnoses) – Narrative description

Optional – ICD-9-CM Codes

Principal 1.

Other Additional 2.

3.

4.

5.

6.

7.

17. Surgical and therapeutic 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)

- ☐ Accidental laceration, puncture or perforation
- ☐ Airway obstruction
- ☐ Apnea
- ☐ Bleeding/hemorrhage
- ☐ Blood transfusion needed
- ☐ Cardiac arrest
- ☐ Difficulty waking up
- ☐ Dysrhythmia/arrhythmia
- ☐ Embolism
- ☐ Fainting/vasovagal syncope
- ☐ Fistula
- ☐ High blood pressure/hypertension
- ☐ Hypoxia
- ☐ Incontinence
- ☐ Low blood pressure/hypotension
- ☐ Malignant hyperthermia
- ☐ Nausea
- ☐ Peripheral nerve injury
- ☐ Shock
- ☐ Vomiting
- ☐ Other – Please specify
- ☐ 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?	☐	☐	☐
b. Did they reach the patient? (If no, →)	☐	☐	☐

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

- ☐ Patient had a question
- ☐ Patient had no problems
- ☐ Patient had problem(s) and –
  - ☐ Called his/her doctor
  - ☐ Went to the doctor
  - ☐ Called the ambulatory surgery center
  - ☐ Came back to the ambulatory surgery center
  - ☐ Called the emergency department
  - ☐ Went to an emergency department
  - ☐ Was admitted to the hospital
  - ☐ Other – Please specify
- ☐ Nothing
- ☐ Unknown

(2) What problem(s) did the patient mention (e.g., sore throat, depression, pain, nausea)?

20. Completed by

21. Date

OFFICE USE ONLY

FR code

Acknowledgments

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Exhibit 25
National Health Statistics Reports; Number 102, February 28, 2017

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.

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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.

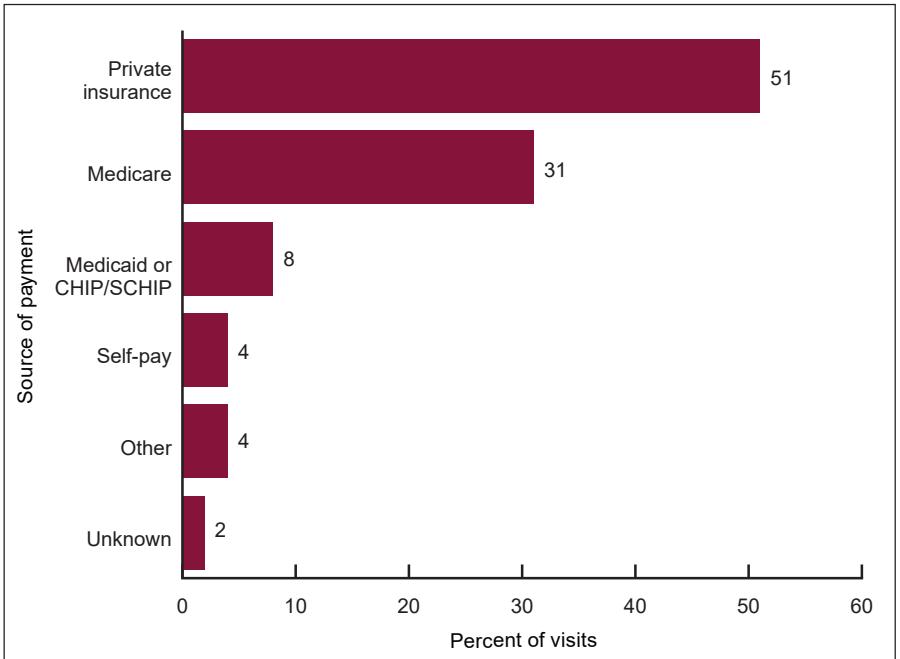
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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

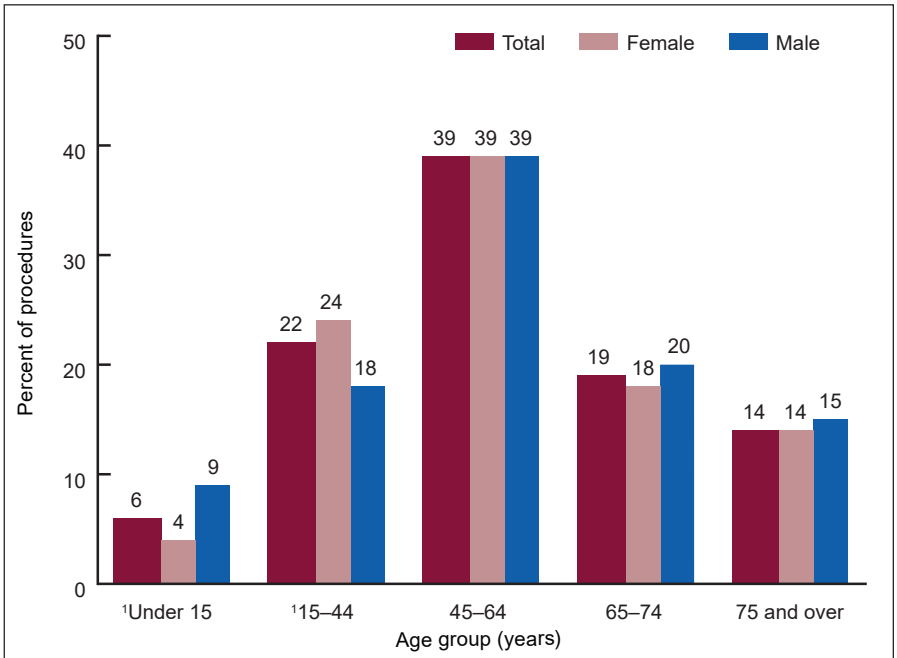
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6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

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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.

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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
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For more NCHS NHSRs, visit:
https://www.cdc.gov/nchs/products/nhsr.htm.

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Exhibit 26
ASCA
"A Positive Trend in Health Care"

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.

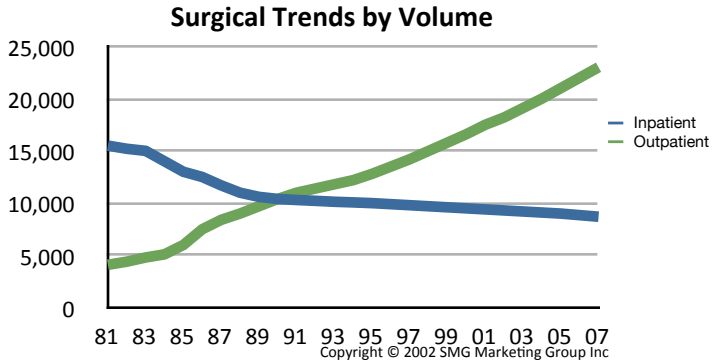
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the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

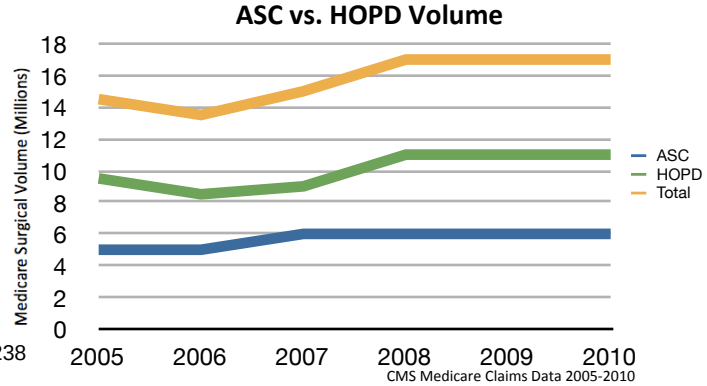
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling 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.

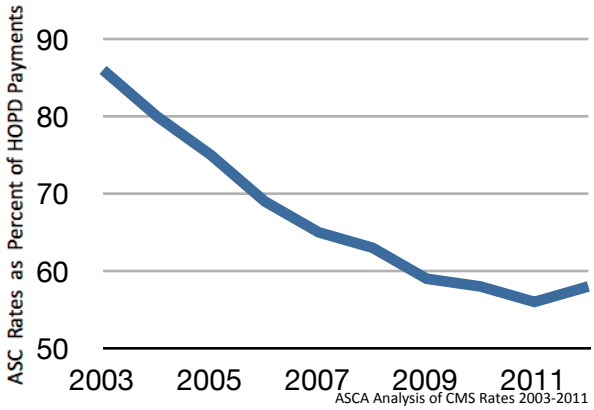
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased 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

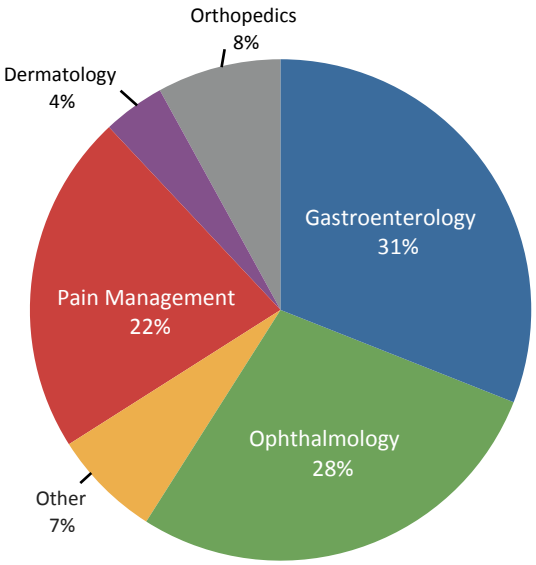


ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

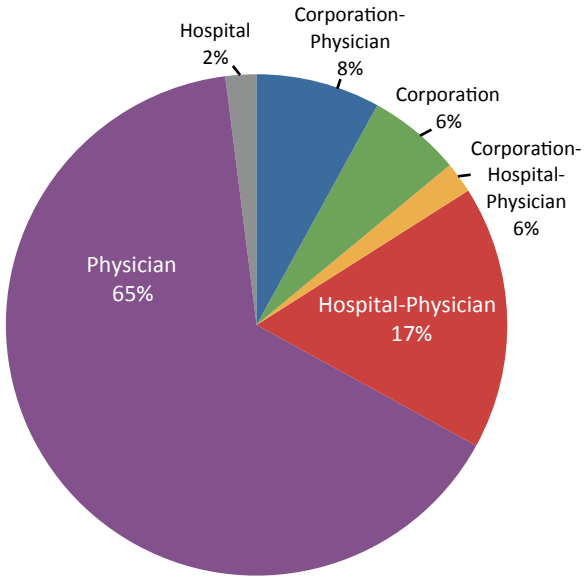
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price 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

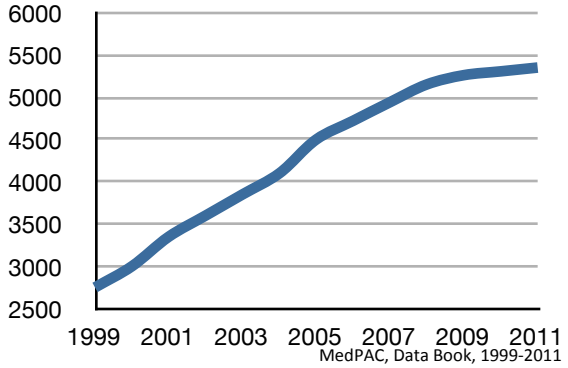
CONTINUED DEMAND FOR ASC FACILITIES

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

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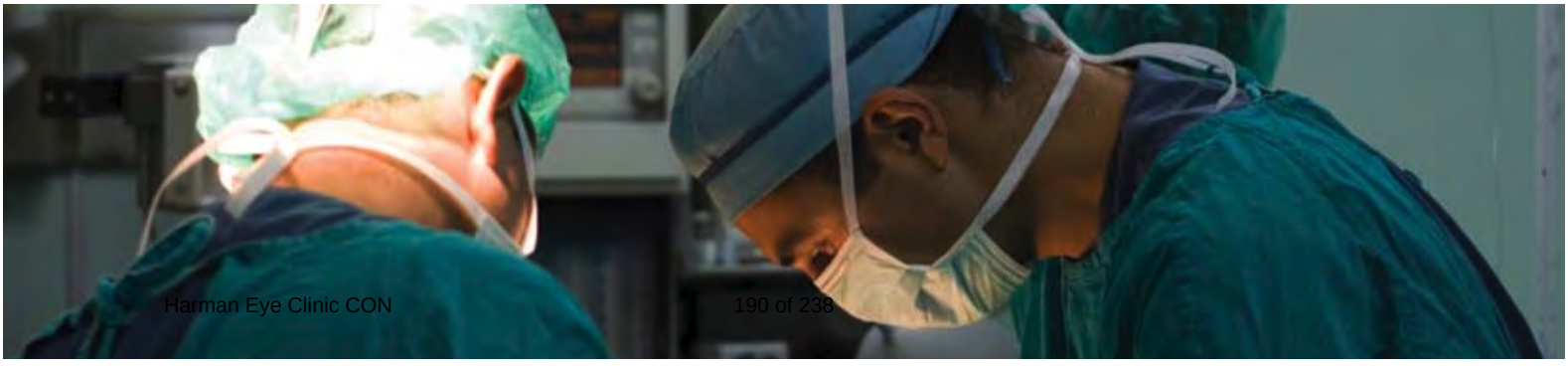

Exhibit 27
American Academy of Ophthalmology "Rising Cataract Surgery Rates: Demand and Supply"

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.

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Exhibit 28
Ophthalmology Times
"The Future of Cataract Surgery"

OphthalmologyTimesArtificial intelligence

The future of cataract surgery

Changes lie ahead as pressure on surgeons increases

July 10, 2017
By Frank Goes, MD

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!

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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 29
Michigan Medicine University of Michigan
"Increased Use of Ambulatory Surgery Centers for Cataract Surgery"

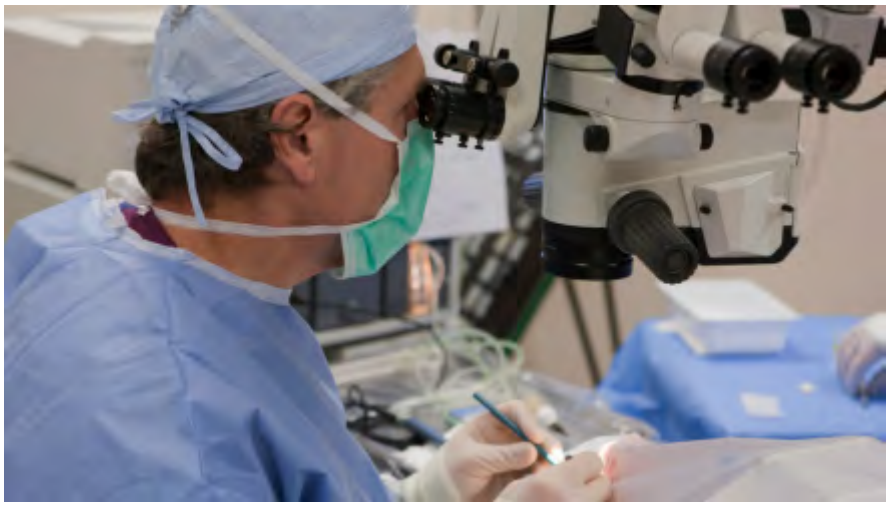
NOVEMBER 22, 2017

Media Contact: Shantell Kirkendoll (mailto: smkirk@umich.edu) 734-764-2220

Increased use of ambulatory surgery centers for cataract surgery

Study shows major shift in ocular surgery from hospitals to surgery centers

National data shows a major shift in eye surgeries from hospitals to less expensive ambulatory surgery centers where care may be delivered faster and closer to home for some patients.



(Stock image) From cataract surgery to glaucoma procedures, more patients are having eye surgery at local surgery centers.

Over the past decade the proportion of cataract surgeries performed at surgery centers increased steadily, reaching 73 percent in 2014, compared to 43.6 percent in 2001.

University of Michigan Kellogg Eye Center (http://www.umkelloggeye.org) researchers revealed the increased use of surgery centers for cataract surgery, but say more research is needed to determine if there's a difference in safety between hospitals and surgery centers.

For the large study, published Nov. 22 in *JAMA Ophthalmology* (https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2664081?utm_source=TWITTER&utm_medium=social_jn&utm_term=1149707952&utm_content=content_engagement%7carticle_engagement&utm_campaign=article_alert&linkId=44592660), researchers used claims data for 369,320 enrollees age 40 and older in a nationwide managed care network who had cataract surgery during the 13-year period.

“The increase in utilization occurred in many U.S. communities such that in some places nearly every cataract surgery took place in an ambulatory care center,” says senior author Joshua Stein (http://www.umkelloggeye.org/profile/1466/joshua-daniel-stein-md), M.D., a glaucoma specialist at Kellogg Eye Center and eye policy researcher at the U-M Institute of Healthcare Policy and Innovation.

Cataract surgery is extremely effective in restoring focusing power that can deteriorate with age. It carries little risk. But well-equipped hospitals are more prepared than a surgery center if medical complications happen.

Still the reasons for the increasing popularity of ambulatory surgery centers compared to hospital-based care include convenience, lower out-of-pocket costs for patients and decreased cost-per-case for insurers.

One analysis estimated that cataract surgeries performed at ambulatory surgery centers rather than hospitals saved Medicare $829 million in 2011.

Consumers save from the shift to surgery centers where average cataract co-pay in 2014 was $190 compared to $350 at a hospital outpatient department, authors write.

Patients were more likely to undergo cataract surgery at an ambulatory surgery center if they were younger age, had higher income, and lived in states without certificate-of-need laws. CON laws regulate the number of ambulatory care centers permitted to operate.

More affluent people were more likely to live in communities with more ambulatory care centers. This may have the indirect impact of limiting access to cataract surgery for less affluent patients.

“The increased use of ambulatory care centers raises questions about access and the effect on surgical outcomes, patient safety and patient satisfaction,” says Brian Stagg, M.D. (http://www.umkelloggeye.org/profile/4333/brian-craig-stagg-md), the study’s lead author and a clinical scholar at the U-M Institute for Healthcare Policy and Innovation.

The shift is happening beyond cataract surgery and includes cornea, glaucoma, retina and strabismus surgery.

The rate of increase in ambulatory surgery center use for cataract surgery of 2.34% a year was similar to the rate of increase for strabismus surgery and retina surgery.

The rate of increase for glaucoma surgery was faster than cataract surgery. The rate of increase for cornea surgery was slower than cataract surgery.

Physicians / Providers

News

Michigan Medicine offers groundbreaking surgery to restore eye sensation (/news/archive/201801/michigan-medicine-offers-groundbreaking-surgery-restore-eye)

U of M Med School Associate Dean Tackles Difficult Discussions Doctors have with Patients on New Podcast (/news/archive/201801/u-m-med-school-associate-dean-tackles-difficult-discussions)

University of Michigan Opens Second Clinical Simulation Center (/news/archive/201801/university-michigan-opens-second-clinical-simulation-center)

More News (/news/topic/all/all)

Major shift in performing cataract surgery at ambulatory surgery centers rather than hospitals.

Media Inquiries: 734-764-2220 8 a.m.-5 p.m. ET

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Exhibit 30
Washington State
2015 Charity Care Report

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
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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.

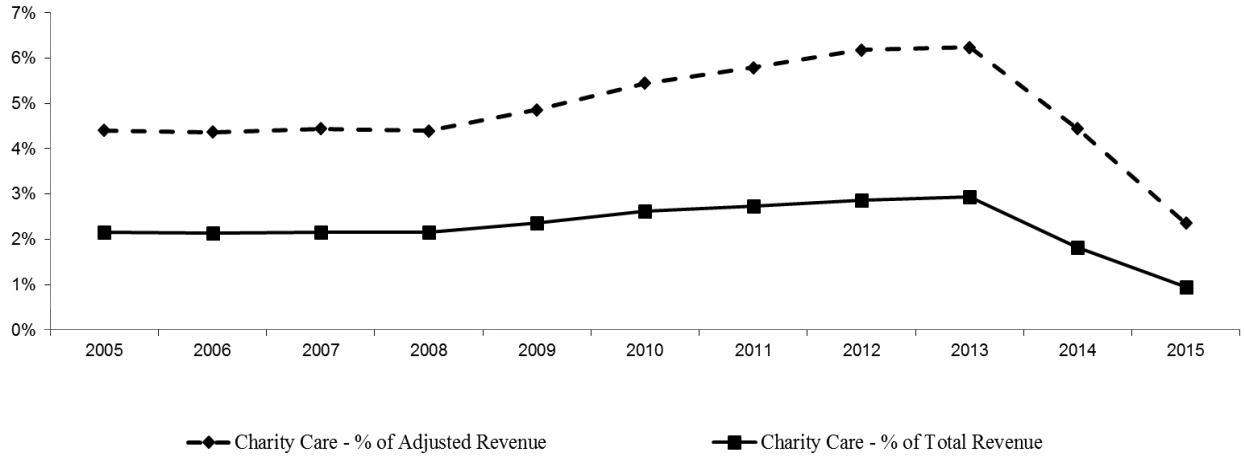


Figure 1 Notes: Adjusted patient service revenue *is the total patient service hospital revenue minus Medicare and Medicaid patient service charges. Patient Service Revenue is the same as Billed Charges.*

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

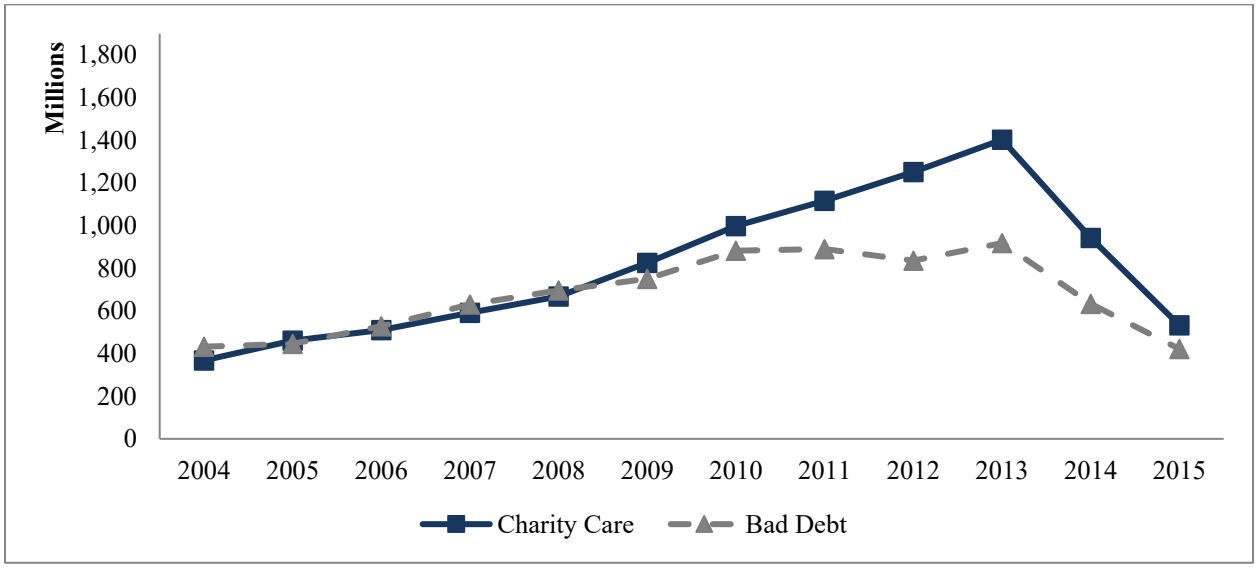
Charity care as a percent of adjusted (non-Medicare, non-Medicaid) revenue increased from 4.4 percent to 6.2 percent from FY 2005 through FY 2013, then declined to 4.4 percent in FY 2014 and 2.4 percent in FY 2015. Because charity care is unreimbursed, all payers—including insurance companies and patients 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

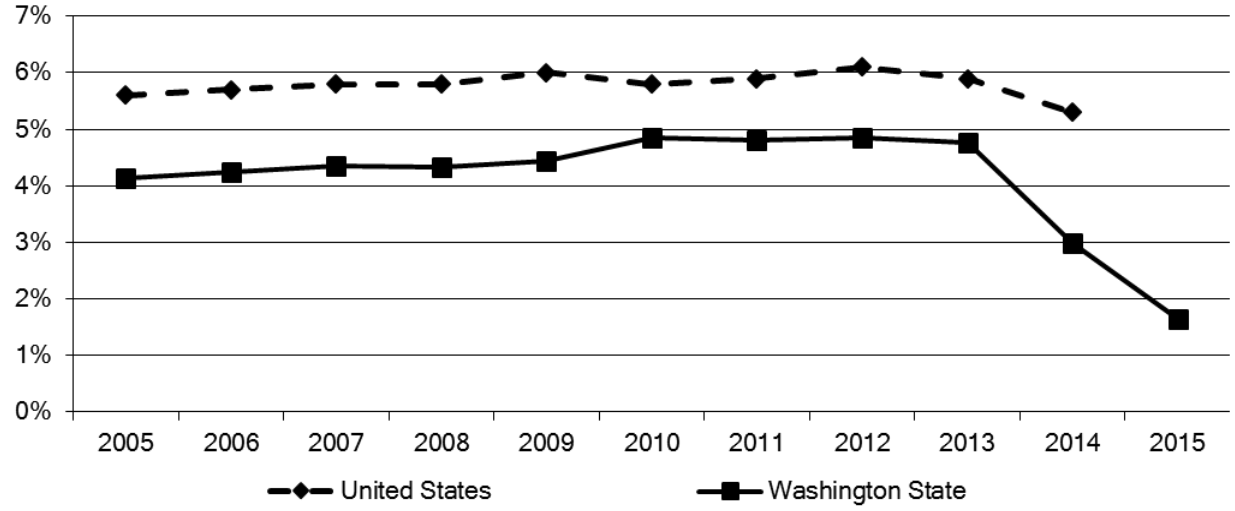


Figure 3 Notes: Uncompensated care includes bad debt and charity care. Uncompensated care as a percent of hospital expenses is calculated by multiplying uncompensated care by the ratio of total expenses to gross patient and other operating revenues. Uncompensated care data for 2015 are not yet available 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 31
WAC (246-310-270)

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 32
Health Affairs
"Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up"

By Elizabeth L. Munnich and Stephen T. Parente

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

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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.

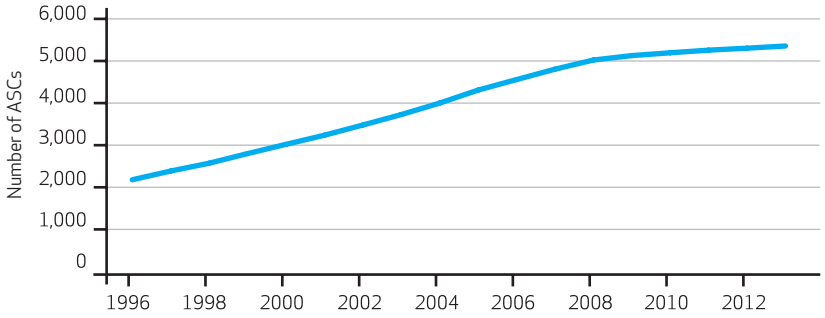
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of 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

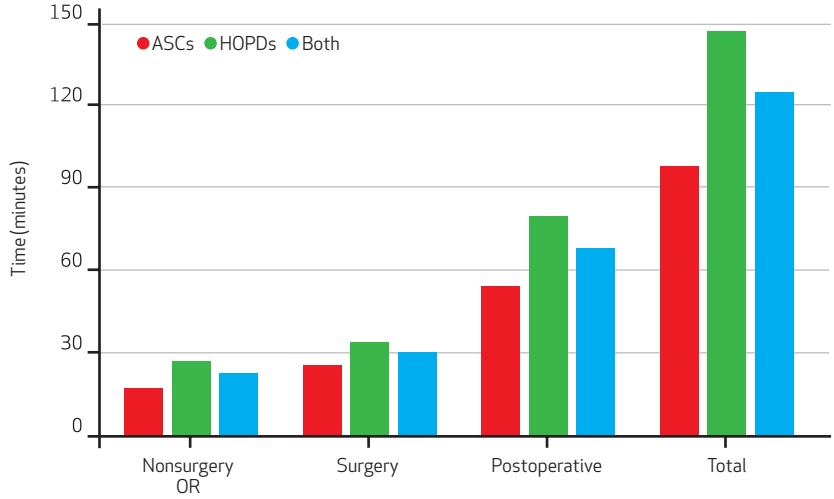
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This 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

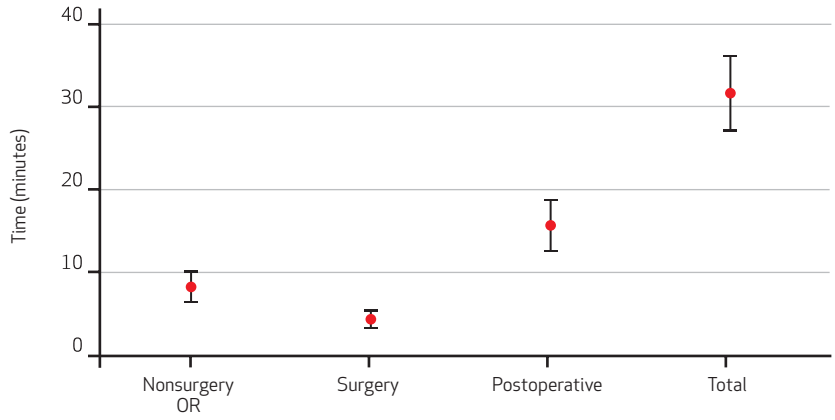
Average Outpatient Surgical Procedure Time, By Facility Type, 2006



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.

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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.

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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

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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.

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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

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29 Bian J, Morrisey MA. Free-standing ambulatory surgery centers and hospital surgery volume. Inquiry. 2007;44(2):200–10.

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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 33
Sight Partners Letter of Intent

SightPartners

Cascade Regional Eye Center, Inc., P.S.
903 Medical Center Drive Ste. 100
Arlington, WA 98223
(360) 435-8595
[redacted]

November 4, 2019

CONFIDENTIAL

Re: Letter of Intent with Respect to Cascade Regional Eye Center, Inc., P.S. (the "**Company**")

Dear Physicians:

This Letter sets forth the conceptual terms upon which Sight Partners, LLC and N.W. Eye Surgeons, P.C. (collectively, the "**Buyers**," "**we**," or "**us**," as applicable), wishes to proceed to due diligence with respect to a purchase all of the assets of the Company (the "**Transaction**"), and, upon acceptance by the Company, sets forth the terms upon which the parties will proceed in good faith.

1. **Purchase Price**. The aggregate purchase price is based on a cash-free, debt-free enterprise value of [redacted] the "**Purchase Price**").

   a. The Buyers will pay [redacted] (the "**Closing Payment**") of the Purchase Price at closing.

   b. The remainder of the Purchase Price will be paid in the form of an equity equivalence agreement, pursuant to which the [redacted] (collectively, the "Shareholders" and individually, each "Shareholder") will each receive a non-voting, non-equity interest (the "Interest") in Sight Partners, LLC. Each Shareholder will be permitted to require Sight Partners, LLC to repurchase their Interest on and any time after the [redacted] anniversary of the closing. The repurchase price of the Interest will equal the product of: (i) [redacted] and (ii) [redacted] times the trailing twelve months' EBITDA (as determined in accordance with the same manner the Company was valued for purposes of this transaction), and (iii) the percentage of shares the selling Shareholder owned in the Company at closing. It is agreed that the payment for each Shareholder's interest will be payable directly to the Shareholder electing to sell it, in consideration of the personal goodwill of the Shareholder.

   c. The Buyers will pay the Closing Payment in cash at closing. The Purchase Price and Closing Payment will be adjusted by an amount equal to any amount by which actual net working capital of the Company as of closing differs from a target net working capital. The target net working capital will be set by the parties working together in good faith upon completion of Buyers' financial and accounting due diligence, and will be the greater of the 6 or 12 month averages of net working capital of the Company. For purposes hereof, "net working capital" means the amount calculated by subtracting the consolidated current liabilities of the Company from the consolidated current assets in each case, determined in accordance with GAAP.

2. **Transaction Structure.** Subject to completion of due diligence, the Buyers anticipate acquiring one hundred percent (100%) of the assets of the Company subject to laws requiring owners of specific entities to be licensed to practice medicine (such entities, the "**Practices**"), pursuant to the terms of an asset purchase agreement (the "**Purchase Agreement**") negotiated by and reasonably acceptable to the parties. The parties hereto agree that the Buyers shall not assume any of the Company's liabilities, except the

business premises lease, current liabilities included in the net working capital calculation, and those liabilities specifically set forth in the Purchase Agreement.

3. **Indemnification.** The Purchase Agreement will contain customary representations and warranties with respect to the business and financial condition of the Company. The Company and the Shareholders (collectively, the "Owners") will be jointly and severally liable for breaches of any representations and warranties or covenants of the Company and will indemnify Buyers for any and all losses suffered by Buyers on account of any such breach; provided, that in the event of breach of a covenant referenced under Section 5.d by a Shareholder, only the breaching Shareholder will be liable. The indemnification obligations of the Company and Owners will be subject to (i) [redacted] with respect to breaches of customary non-fundamental representations and warranties (after which Buyers will be able to recover all of its losses in excess of the basket), and (ii) with respect to breaches of customary non-fundamental representations and warranties, [redacted] of the Purchase Price. The Company's and Owners liability for breaches of fundamental representations, with respect to specific indemnifications determined during due diligence, or with respect to fraud and intentional misrepresentations, will not be subject to the cap, basket, or limitation period. The fundamental representations will be defined in the Purchase Agreement and are subject to Buyers' due diligence, but are expected to be limited to ownership of the Company, organization and authority, sufficiency and title to assets, employment and employee benefits, environmental, taxes and brokerage claims. Indemnity claims for breaches of general representations and warranties will survive Closing for a period of [redacted] and indemnity claims for breaches of fundamental representation and warranties will survive Closing for the applicable statute of limitations.

4. **Closing Date.** Buyers, the Company, and Owners will seek to negotiate the Purchase Agreement with the intention of executing the Purchase Agreement and corresponding documents within [redacted] of execution of this letter of intent and a closing date within 10 days after approval of the certificate of need from the state, but in no event will closing be prior to [redacted] If Closing has not occurred by [redacted] because a condition has not been satisfied, either party may terminate the Purchase Agreement at any time thereafter.

5. **Conditions.** The closing of the Transaction will be subject to fulfillment, among other customary conditions, of the following conditions:

    a. Completion of confirmatory due diligence by Buyers of the Company and its business, affairs, customer relationships, supplier relationships, condition (financial and otherwise) and prospects, and any related matters, the results of which are satisfactory to Buyers in its sole discretion including, without limitation, review of complete financial and employee records, benefit plans, contracts, trademarks and other intellectual property, sales and marketing programs/plans, production processes, real estate, regulatory and environmental practices and conduct, on-going and threatened litigation, and management interviews.

    b. Receipt of debt and/or equity proceeds on terms satisfactory to Buyers.

    c. The Buyers anticipate retaining all members of the Company's executive management team and physicians on substantially the same compensation terms and benefits as exist prior to closing, with Shareholder compensation based on [redacted] of general ophthalmology or optometry collections personally performed for patients. The Shareholders shall be engaged pursuant to 5-year employment agreements with Buyers, terminable for good cause, the Definitive Agreement is subject to the Buyers and Shareholder's mutually approving the form of the employment agreement.

    d. The Purchase Agreement will include non-competition, non-solicitation, confidentiality and proprietary rights covenants made by the Company and each Shareholder covering the business presently undertaken by the Company and having a reasonable geographical scope to be

determined. The non-competition and non-solicitation period for Company and the Owners will commence upon the closing and expire the later of (i) [redacted] or (ii) [redacted] following the termination of the provision of each Owner's services to the Company.

e. The Company and the Owners shall use commercially reasonable efforts to maintain the Company's businesses, employees, customers, assets and operations as an ongoing concern in accordance with past practice. No material adverse change will have occurred in the business, results of operations, prospects, condition (financial or otherwise) or assets of the Company.

f. All indebtedness of the Company (excluding liabilities reflected in closing working capital), will be paid off at, or prior to, closing (or promptly as due thereafter) and the assets of the Company will be free and clear of all liens, claims and encumbrances whatsoever.

g. All required consents of governmental authorities and third parties will have been obtained.

h. Issuance of the Certificate of Need.

6. **Non-Disclosure.** Without the prior approval of the other parties hereto, the Buyers, the Company and the Owners will not disclose or discuss this letter of intent, its existence or its terms and conditions, to or with any persons other than their attorneys, accountants, financial advisors and such of the Company's executives as may be required to know the same in implementing the provisions of this letter of intent ("Insiders"). Each party shall use commercially reasonable efforts to prevent disclosure of this letter of intent (including scheduling due diligence outside of normal business hours and away from the Company's business premises) and to prevent the Insiders from disclosing or discussing this letter of intent, its existence or its terms and conditions, to or with any person that is not an Insider.

7. **Inspection and Access to Information.** The Company shall permit full access to, and shall make immediately available to Buyers' representatives for inspection and review, all properties, books, records, accounts, and documents of or relating to the Company as may be reasonably requested from time to time; and shall make accountants, attorneys and other advisors of the Company reasonably available for consultation and permit access, with the participation by the Company and the Owners at their election, to other third parties reasonably requested for confirmation of any information so obtained.

8. **Publicity; Confidential Proposal.** The Company, the Owners, the Buyers, or their respective affiliates, directors, shareholders, members, managers or representatives will not make any press release or public announcement concerning the existence of the Transaction without the prior written approval of the other parties hereto.

9. **Exclusivity.** The Company agrees to negotiate for the sale of the Company exclusively with the Buyers for a period of 120 days from the date the Company signs this term sheet, and will not discuss the disposition of the Company or any business combination involving the Company or its business with any third party during such exclusivity period. Upon the conclusion of the initial term of the exclusivity period, the exclusivity period shall automatically extend for additional thirty (30) day periods unless the Company provides at least thirty (30) days' prior written notice to Buyers of termination of the exclusivity period. Notwithstanding the above, if the parties have not entered into a Purchase Agreement within 60 days of this letter of intent, then either party may terminate this Letter by written notice to the other, and the Exclusivity will then terminate.

10. **Governing Law; Venue.** This letter of intent and any Purchase Agreement shall be governed by the internal substantive laws (and not the laws of conflicts) of the State of Washington. Venue for any dispute arising under this letter of intent, or the Purchase Agreement, shall be exclusively in the Snohomish County Superior Court and federal court located in Seattle, Washington, and each party expressly submits to the personal jurisdiction of such courts and irrevocably waives any objection to venue in such courts based on inconvenient forum, or any other rule or principle on the conflict of laws.

11. **Certificate of Need Application Fee.** Seller will pay the application fee for the Certificate of Need for the Transaction. Upon closing of the Transaction, Buyer will reimburse Seller the amount of the fee. If for any reason the Transaction fails to close, Buyer will reimburse Seller 50% of the fee.

By signing this letter of intent, the parties agree to be legally bound only by paragraphs 6 and 8 through 11. The other provisions of this letter of intent are intended as a statement of intent only, and no party shall be legally bound to proceed with the Transaction contemplated hereby unless and until a definitive Purchase Agreement has been negotiated and signed by such party, and then only upon the terms and conditions set forth in such definitive Purchase Agreement.

Please record the Company's acceptance of the terms of this Letter, including the exclusivity terms hereof, by returning an executed copy of this Letter to us.

Sincerely,
Sight Partners, LLC
DocuSigned by:
By: Sp-MLI
0E6BAECD6E1E4B8...
Name: Spencer Michael
Title: CEO
Date: 11/6/2019

N.W. Eye Surgeons, P.C.
DocuSigned by:
By: Sp-MLI
0E6BAECD6E1E4B8...
Name: Spencer Michael
Title: CEO
Date: 11/6/2019

Accepted and agreed:
Cascade Regional Eye Center, Inc., P.S.
By: Bruce Ballon MD
Name: Bruce Ballon MD
Title: CEO
Date: 11-05-19

Cascade Regional Eye Center, Inc., P.S.
By:
Name:
Title: Bajenova
Natalia Bajenova MD / Treasurer
Date: 11.6.19

Cascade Regional Eye Center, Inc., P.S.
By:
Name: President
Title: Bruce Wietharn MD
Date: 11/6/19

Exhibit 34
Ancillary and Support Vendors

Vendor List

Cascade Valley Hospital Laboratory
Northwest Biomedical Associates
Northwest Ambulance
Northwest Healthcare Linen
Aadvantage Pest Control, Inc.
Central Welding Supply
Cozy Heating
Prime Services
Pacific Power Batteries
Johnson & Johnson
merican Express
Americorp
Alcon
Bank of America
Amerisource
Evergreen Security
Bausch & Lomb
CeatusMedia Group
Demnadforce
Ellex
Modernizing Medicine , Inc
Glacial Multimedia
Hall Render Killian
Heidelberg Repair
Imprimis
The Language Exchange
MacAssist
Network Solutions
RingCentral
Rose and Associates
Tear Lab