APPLICATION FOR CERTIFICATE OF NEED
Health Care Facility Projects
(excluding nursing home, hospital, or CCRC related projects)

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 hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer Beth Marker Director of Finance Evergreen Eye Center Signature: Beth Marker	Date: 1 Aug 2018 Telephone Number: 800.340.3595
Legal Name of Applicant Evergreen Eye Center, Inc PS Address of Applicant Evergreen Eye Center 716 South 348th St Federal Way, WA 98003	Type of Application: [X] Ambulatory Surgical Facility [] Kidney Disease Treatment Center Type of Project (check all that apply) [X] New Health Care Facility [] Capital expenditure over expenditure minimum [] Pre-development Expenditure [] Increase in the number of dialysis stations in a kidney disease center
Intended date of incurring contractual obligation to construct, acquire, lease or finance capital asset: Estimated capital expenditure: $ 0	Intended date of undertaking project: Proposed project is CON approval of existing exempt facility; thus, commencement will be upon CON approval. Intended date for beginning to offer services or operate completed project: Project completion upon CON approval; Anticipated date of 15 Dec 2018 Project Summary: CON approval to convert existing exempt one-operating room ambulatory surgical facility (ASF) into a CON approved ASF in Federal Way, WA.

AMBULATORY SURGERY CENTER
FEE REQUIRED

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

Ambulatory Surgery Center: $20,427

Applicant Name: Evergreen Eye Center (EEC Federal Way)

Date of Submission: _____

Check Number: _____

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Application Instructions

The department will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. (RCW 78.38.115, WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, WAC 246-310-240. For kidney disease treatment centers-WAC 246-310-280 thru 289, and for ambulatory surgery centers- WAC 246-310-270.

General Instructions:

- Include a Table of contents for major application sections and appendices
- Number **all** pages consecutively
- **Do not** bind or 3-hole punch the application.
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide detailed descriptions of assumptions used for all projections.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.

Submission Instructions:

- Number of Copies-Initial application:
    - original,
    - one copy,
    - one electronic (pdf) version

- Number of Copies-all other submissions**:**
    - Original
    - one copy
    - one electronic (pdf) version

To be accepted, the application must include:

- A completed and signed Certificate of Need application face sheet
- The review fee of:
    - **$20,427** for Ambulatory Surgical Centers**.** Make check payable to **Department of Health**
    - **$25,054** for Kidney Disease Treatment Centers. Make check payable to **Department of Health**

- Send application to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Other Than by Mail:

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

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PROJECT OVERVIEW:

Evergreen Eye Surgeons, Inc PS (EEC)

Evergreen Eye Surgeons, Inc PS (EEC) is a for-profit Washington State professional service organization professionally owned by four doctors, consisting of four MD’s. Evergreen Eye Center began as the practice of John S. Jarstad, MD. The Evergreen Eye Center was established on October 2, 1989 in the Medical Office Building of The St. Francis Community Hospital in Federal Way, Washington. The suite was designed to include four examination lanes, two offices, a reception office and waiting room space for ten chairs. The practice began with Dr. Jarstad, one technician and one front desk staff.

During 1993 plans for a new eye center and ambulatory surgery center were developed to meet the increased demand for services. Upon completion of construction drawings in 1994 and review by the Washington State Department of Health, ground was broken in October for an ophthalmic clinic and surgery center.

On January 1, 1994, an optometrist was added to the practice in and a contract with Franciscan Family Care for ophthalmic services was concluded for the Tacoma area. In 1995 two additional ophthalmic technicians were added and surgery volumes increased to the maximum allowed by St. Francis Hospital and average patient visits

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increased to 40.7 per day in the clinic. As Evergreen Eye Center and Dr. Jarstad reached the saturation point in present facilities the new structure was taking shape and was completed in December 1995.

In November 1995 Evergreen Eye Center, Inc. purchased both the Rockey Eye Clinic and The Rainier Eye Clinic in Auburn, Washington, opening the Auburn/Southeast King County area for Evergreen Eye patient convenience. Dean M. Rockey, M.D. became the second ophthalmologist on staff.

The new building was occupied on December 15, 1995 and the patient per day ratio increased by 23%, and with the inclusion of Rainier Eye Clinic, The Rockey Eye Clinic and the Tacoma Franciscan facility.
In March 1996 a registered nurse was hired to develop the surgery center and in July Medicare certified the surgery center for surgery.

In 1996, the ASC received initial CMS certification and began operations, with the addition of an RN to the staff. In 1997, Evergreen purchased another local practice and added a third MD, Dr. Thomas Roe. Shortly thereafter, Dr. Roe retired and Dr. Aaron Weingeist joined the practice. In the years that followed, the organization purchased the practices of several local ophthalmologists as they retired, but opened no new locations. Dr. Charles Birnbach, a fellowship-trained retina surgeon, joined the practice in 2000. A short time later, in 2002, Dr. Linda Day joined the practice part-time, providing medical retina services, as well as comprehensive ophthalmology.

In 2004, Evergreen purchased two practices in the Burien area and opened an Evergreen Eye Center clinic in that location. That same year, Dr. Robert Tester joined the practice directly from residency. The next year, Dr. Gary Chung also joined the practice directly from residency. That same year, both Dr. Weingeist and Dr. Birnbach left the practice and sold their shares in Evergreen Eye Center. As of the end of 2005, Evergreen Eye Center had five MDs and one OD on staff, operated three clinic locations and one ASC.

In 2015, Dr. Jarstad sold his interest in the practice to Dr. Tester and Dr. Chung, who became the sole owners of Evergreen Eye Center. The shareholders and administrator conducted the first strategic planning session the practice had done in a number of years. They created a new vision for the practice, along with guiding principles by which the shareholders and leadership would organization and through which every employee could govern their own behavior and performance as Evergreen employees.

This new vision focused on “leading-edge, patient-centered care” and becoming an “employer of choice” within ophthalmology regionally, a practice where patients would experience exceptional outcomes and have all treatment options made available to them, including cutting edge, advanced technologies. It focused on becoming a practice with an exceptional corporate culture, where the best employees would seek employment, a thought-leader within ophthalmology in the Puget Sound region. The shareholders also laid out some ambitious goals for their new administrator: in the first year or two, his focus would be assessing the practice, making changes as necessary, building a new administrative team, and laying the groundwork for growth – after which it was their intent to seek aggressive growth, in locations, physicians, and sub-specialties.

In August 2016, Dr. Day left the practice. Rather than fill her position, the practice decided to create a full-time medical retina/comprehensive ophthalmology position and hired Dr. Kelly Bui. Later that same year, after two years as an associate, the shareholders began the process of having Dr. Nicholson buy into the practice as an equal shareholder. Just a short time later, in early 2017, talks began with Dr. John Whitehead, sole owner and physician at Northwest Glaucoma and Cataract Surgery to acquire his practice through a merger that would establish him as an equal shareholder. The shareholders are on schedule to sign documents on both these transactions by the end of April 2018, with an execution date for the merger set as August 1, 2018.

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Growth prospects for the Seattle location are very promising. Northwest Glaucoma and Cataract Surgery was the first new ophthalmology practice to open in Seattle proper in over 20 years, and while the conventional wisdom is that the area is oversaturated, our market research shows that it is actually underserved.

Applicant – Evergreen Eye Center located in Federal Way (EEC Federal Way)

Evergreen Eye Centers located at the Federal Way location (referred to as EEC Federal Way) is located within the Southeast King County secondary planning area. EEC Federal Way owns and operates a two-operating room Certificate of Need exempt ambulatory surgery facility, only allowing access to this facility to members and employees of the practice. EEC Federal Way was established in 1994, with the current lease agreement starting in 2015. EEC Federal Way is licensed by the Washington State Department of Health, is Medicare and Medicaid certified, and is accredited in good standing by the Joint Commission. EEC Federal Way received a determination of non-reviewability from the Certificate of Need program to perform specialized ophthalmic surgery in Federal Way in July 1996, within Southeast King County secondary planning area.

With this application, EEC Federal Way proposes to establish a Certificate of Need ambulatory surgical facility located in Federal Way, within Southeast King County secondary planning area. After Certificate of Need approval, EEC Federal Way would continue to operate at the current location of 34719 6th Ave.S Federal Way, WA 98003.

For the purposes of this application, EEC Federal Way is a dual operating room for specialized ophthalmic surgical services. One operating room is for traditional ophthalmic surgery procedures and the other is for laser-based, invasive ophthalmic procedures. This reasoning is based on definitions provided in WAC 246-330-010. An operating room "means a room intended for invasive procedures." An invasive procedure is a "procedure involving puncture or incision of the skin or insertion of an instrument or foreign material into the body including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations. Excluded are venipuncture and intravenous therapy."

EEC Federal Way serves patients 18 years and older that meet EEC Federal Way surgical admission guidelines. The specialized ophthalmic surgical services performed can be done appropriately in an outpatient setting.

Our CON exempt status requires us to become a CON approved ASF to extend privileges of using the ASF to physicians not part of EEC practice. Because the additional ophthalmic surgeons will not be employees, this action requires prior Certificate of Need review and approval before opening up additional operating minutes used by non-EEC surgeons in the area. Each interested surgeon will be required to become credentialed and maintain the standards EEC sets for privileges. There is no capital expenditure associated with this project, as there is no project-associated construction or equipment purchase. EEC Federal Way is a fully equipped two-operating room ASF and with approval of the Certificate of Need will be increasing the operating minutes available within the Southeast King County secondary planning area. The costs associated with the increased minutes will be treated as operating expenses, rather than capital expenditure.

With an approval of the Certificate of Need application, EEC Federal Way will begin to operate immediately as a Certificate of Need facility as soon as the Certificate of Need is granted. In accordance with the timeline and upon approval, EEC Federal Way expects this to be within this year 2018. 2019 will be the first full year of operation as a Certificate of Need facility and will be used within this proposal as such.

I. APPLICANT DESCRIPTION:

Legal name(s) of applicant(s)

Evergreen Eye Center, Inc PS

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Please see Letter of Intent for the requested project in Exhibit 1.

For the project purpose, Evergreen Eye Center will be referred to as EEC.

Name and address of the proposed/existing facility.

Evergreen Eye Center
34719 6th Ave. S
Federal Way, WA 98003

For the project purpose, Evergreen Eye Center location will be referred as EEC Federal Way.

Type of ownership (public/private/corporation, etc.).

EEC is a private for-profit physician owned Professional Service Corporation.

EEC was formed on October 2, 1989 and is currently owned by 4 doctors.

Please refer to Table 4 – to identify the Partners of EEC.

Name and address of owning entity at completion of project (unless same as applicant).

Evergreen Eye Surgeons, Inc PS
716 South 348th St
Federal Way, WA 98003

Name, title, address, and telephone number of the person to whom questions regarding this application should be directed.

Lance Baldwin, CoN Consultant
2103 143rd PL SW
Lynnwood, WA 98087
lance@m-exec.com
(509)818-0787

Beth Marker
Director of Finance
Evergreen Eye Center
716 South 348th St
Federal Way, WA 98003
Beth@evergreeneye.com
(800)343595

Corporate structure and related parties. Attach chart showing organizational relationship to related parties.

Please see Appendix

Name and address of operating entity at completion of project (unless same as applicant).

34719 6th Ave.S
Federal Way, WA 98003

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General description and address of each facility owned and/or operated by applicant

Table 1 – Name, CON license, and general description of N.W. Eye Surgeons Facilities

Ambulatory Surgery Centers/DBA	Exempt CON License	Physical Address	Description
Federal Way	July 1996	34719 6th Ave.S Federal Way, WA 98003	Clinic with adjoining exempt CON two-operating room ASF.
Auburn	N/A	700 M St. NE Auburn, WA 98002	Clinic without an adjoining ASF.
Burien	N/A	15153 5th Ave SW Burien, WA 98166	Clinic without an adjoining ASF.
Seattle	July 2018	1229 Madison St, STE 1250 Seatte, WA 98104	Clinic with adjoining exempt CON two-operating room ASF.
Federal Way-Administration Office	N/A	716 South 348th St Federal Way, WA 98003	Administrative Offices

Source: EEC

Facility licensure/accreditation status.

EEC Federal Way has active licenses from the Washington State Department of Health as well as Centers for Medicare and Medicaid Services certification.

Medicare CCN Number: 50C0001095

NPI Number: 1821167479

ASF License: ASF.FS. 60099942; expires on 12/12/2019

Is applicant reimbursed for services under Titles V, XVIII, and XIX of Social Security Act?

Yes, EEC Federal Way is reimbursed for services under Titles V, XVIII, and XIX of Social Security Act. Please review the Table below for historical reimbursed numbers and projected reimbursed numbers.

Table 2 – EEC Federal Way Historical and Projected Reimbursed Numbers for Medicare and Medicaid

	2016	2017	2018	2019	2020
Medicare	$1,608,416	$1,678,509	$1,723,829	$1,770,372	$1,818,172
Medicaid	$108,894	$188,556	$193,647	$198,876	$204,245

Source: EEC Federal Way pro forma and 2016 financials

Geographic identification of primary service area.

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For the purposes of quantitative ambulatory surgery need analysis, the Southeast King County Secondary Health Services Planning area ("Southeast King planning area") will be used to define in WAC 246-310-270 (3).

Table 3 – South East King County Secondary Health Services Planning Area

Zip Codes for South East King County	Cities within the Zip Code	Zip Codes for South East King County	Cities within the Zip Codes
98001	Auburn	98038	Maple Valley
98002	Auburn	98042	Kent/Covington
98003	Federal Way	98047	Pacific
98010	Black Diamond	98051	Ravensdale
98022	Enumclaw	98055	Renton
98023	Federal Way	98056	Renton/Newcastle
98030	Kent	98057	Renton
98031	Kent	98058	Renton
98032	Kent	98059	Renton/Newcastle
		98092	Auburn

Source: Washington State Department of Health, Department of Need Division

List physician specialties represented on active medical staff and indicate number of active staff per specialty.

Table 4 – List of Partners and Employed Surgeons credentialed, with privileges and in good standing with EEC

Name	Partner or Employed	Specialty	License	Recorded Sanctions
Kelly Bui	Employed	Cataract and Lens Implant Surgery, Medical Retina	MD60470169	No
Gary Chung	Partner	Cataract and Lens Implant Surgery, Cornea, Refractive	MD00045207	No
Brice Nicholson	Partner	Cataract and Lens Implant Surgery, Refractive	OP60251025	No

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Robert Tester	Partner	Cataract and Lens Implant Surgery, Medical Retina	MD00043755	No
Laura Periman	Employed	Ocular Surface Disease Specialist	MD0003796	No
John Whitehead	Partner	Cataract and Lens Implant Surgery, Glaucoma	MD60070926	No

Source: EEC

EEC also employs optometrist who work within the clinic area of the facility. They are not identified within this proposal as they do not work within the ASF environment. Please refer to www.evergreeneye.com for a list of current EEC optometrists.

List all other generally similar providers currently operating in the primary service area.

Similar providers are Hospital's with capacity to include inpatient, mixed use and outpatient operating rooms within the Southeast King planning area. ASF's within the Southeast King planning area are also considered similar providers.

Table 5 – Hospitals and ASF's within the Southeast King County Secondary Health Services Planning Area

Facility	Certificate of Need
FHS St Elizabeth	Yes
FHS ST Francis	Yes
Multicare Auburn Medical Center	Yes
Multicare Covington Hospital	Yes
Valley Medical Center	Yes
Auburn Surgery Center	No
Proliance Orthopedic Associates	No
Sound Interventional Pain Management	No
Virginia Mason Center	No
Sports Medicine Day Surgery	No
VP Surgey Center of Auburn	Yes
Valley Medical Center ASC	Yes
St Francis Hospital Outpatient Endoscopy Center	Yes
South Sound Surgery, PLLC	No
Cascade Surgery Center	No
Evergreen Eye Center Inc PS	No
Rainier Surgical Center	No
Fogel Endoscopy	No
ENT Facial Plastic Surgery and Allergy of Western WA	No

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Valley Eye and Laser Center	No
Southlake Clinic ASC	No
Northwest Eye Surgeons	No
Plastic and Reconstructive Surgeons ASC	No
Valley Orthopedic Associates Ambulatory Surgery Center	No

Source: Washington State Department of Health Facility Search. List includes current (01/01/2018) active facilities.

For existing facilities, provide applicant's overall utilization for the last five years, as appropriate.

Table 6 – Number of operations of the Eye performed at EEC Federal Way for the past 5 years

Year	Surgeries Performed
2013	4221
2014	4463
2015	5271
2016	4704
2017	4727

Source: EEC Federal Way EMR Data

Describe the history of applicant entity with respect to criminal convictions related to ownership/operation of health care facility, license revocations, and other sanctions described in WAC 246-310-230 (5)(a). If there have been no such convictions or sanctions, please state.

EEC has no history of convictions or sanctions as described in WAC 246-310-230 (5) (a)

The office of the Inspector General's (OIG) List of Excluded individual/Entities (LEIE) provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. EEC Providers, Corporate Officers and Billing Personnel are not on the OIG exclusion list.

II. PROJECT DESCRIPTION:

Include the following elements in the project description. Be aware that an amendment to a Certificate of Need is required for certain project modifications as described in WAC 246-310-100 (1).

Describe the project for which Certificate of Need approval is sought.

EEC Federal Way is currently an exempt CON facility as a two-operating room ASF and operates in the Southeast King planning area.

EEC Federal Way is requesting CON approval to expand services (operating minutes) to the Southeast King planning area. A non-exempt ASF is an integral step allowing EEC Federal Way to expand their current offerings of local, affordable, and quality ophthalmic ambulatory surgery options to the Southeast King planning area residents. CON approval will open the ASF to all surgeons in the community who are able to become credentialed and privileged with EEC. This will ultimately increase the operating minutes within EEC Federal Way single-operating room ASF and thus improve the Southeast King planning area residents'

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ability to receive a full range of surgical eye specialties. *EEC Federal Way will remain a two-operating room entity and the type of services will continue to be ophthalmic only.*

Please review Appendix for Credentialing and Privileging policy.

Total estimated capital expenditures.

The proposed project does not require any construction or change in physical property. As such, there are no associated capital expenditures for the proposed project. EEC Federal Way will remain a one-operating room entity and the type of services will continue to be ophthalmic only.

Total estimated operating expense for the first and second years of operation *(please show separately)*.

Table 7 – Estimated operating expense for the first and second years of operation

Year	Projected Operating Expenses
2019	$3,884,667
2020	$3,995,439

Source: EEC Federal Way pro forma

New services/changes in services represented by this project.

EEC Federal Way is currently a two operating room ASF. The intention of the project is to be able to increase the utilization of minutes in the operating room by allowing non-EEC ophthalmic physicians to perform ophthalmic surgery in the facility.

EEC Surgeons perform Operations of the Eye which includes eye, the orbit, and the tissue and musculature surrounding the Eye. As a projection of services, this list in Exhibit 9 may be incomplete because procedures are continually being created as well as new techniques and devices that can be used to care for the Eye.

Please see Appendix for details of the type of historical services offered at EEC Federal Way. It is measured by the top 30 CPT codes performed at EEC Federal Way from years 2015-2017.

General description of types of patients to be served by the project.

EEC Federal Way 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. EEC Federal Way'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).

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Table 8 – Average of 2014, 2015, 2016 Hospital Charity Care; EEC Federal Way projected charity care

	% of Total Revenue (Three Year Average)	% of Adjusted Revenue (Three Year Average)
Hospitals in Southeast King County planning area	0.98%	2.38%
Hospitals in King County	1.02%	2.25%
EEC Federal Way 2017	0.49%	0.87%
EEC Federal Way 2019 Projected	1.36%	2.38%

Source: Washington State Department of Health, Summary of charity care amounts provided by hospitals in Washington, 2015-2006 (Excel), Zip codes in King County; see also EEC Federal Way pro forma.

Projected utilization of service(s) for the first and second year of operation following project completion (*please show separately*). This should be expressed in appropriate workload unit measures.

Table 9 – Utilization of service(s) for the first and second year of operation

Year	Projected Number of Operations of the Eye
2019	4,986
2020	5,121

Source: EEC Federal Way pro forma

A copy of the letter of intent, per WAC 246-310-080.

Please refer to Appendix

Sources of patient revenue (Medicare, etc.) with anticipated percentage of revenue from each source. Estimate the percentage of change for each of the courses of revenue by payer that will result from this project.

Table 10 – Sources of patient revenue with anticipated percentages

Payer	% Patients	% Payer Source
Medicare	25.4%	39.9%
Medicaid	6.5%	4.5%
Commercial/Health Care Contractor	58.6%	45.5%
HMO	1.5%	1.3%
Other Government/L&I	1.1%	1.8%
Self-Pay	6.9%	7%
Total	100%*	100%*

Source: EEC Federal Way pro forma
*Percentages may not equal 100 because of rounding.

Source(s) of financing.

The proposed project does not require any construction or change in physical property. EEC Federal Way is a fully equipped single-operating room ASF and with approval of the CON will be increasing the operating

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minutes available within the Southeast King 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.

Equipment proposed:
Description of equipment proposed.
Description of equipment to be replaced, including cost of the equipment, and salvage value (if any) or disposal, or use of the equipment to be replaced.

The EEC Federal Way operating room is currently equipped to provide ophthalmic surgeries for high-quality, safe, and state-of-the-art patient care. Additional equipment will not be purchased and equipment will not be replaced for the purpose of this proposal.

Drawings:
Single line drawings, *at least approximately to scale,* of current locations which identify current department and services.

Please see Appendix

Total net and gross square feet of project.

Total building square feet is 10,235 useable sq. ft.

Anticipated dates of both commencement and completion of project.

Table 11 – Anticipated Timeline of CON submission, review and approval

Action	Timeline	Actual/Anticipated Date
Letter of Intent Submitted		Received in CON Department 21 May 2018
Application Submitted	30 days after LOI submitted	1 August 2018
Department's pre-review activities **a) DOH 1st Screening Letter** **b) Applicant's Responses Received**	15 days for response from DON*; 45 days for applicant response	15 September 2018
Beginning of Review	45 days	
Public Hearing Conducted	Within the first 35 days of 45-day review	
Public Comments accepted through end of public comment	Within the first 35 days of 45-day review	
Rebuttal Comments Due	Last 10 days of 45-day review	

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Department's Anticipated Decision Date	45 days	15 December 2018

Source: EEC Directors Discussion

*Department of Need

Describe the relationship of this project to the applicant's long-range plan and long-range financial plan (if any).

EEC goal is to be the premier provider of outpatient ophthalmic surgery services in Washington State.

With the approval of a CON, EEC Federal Way will be able to offer more operating minutes in the Southeast King planning area that will not only engage non-EEC surgeons, but it will also provide more access to specialized ophthalmic surgeries. This will work toward the goal that EEC has set.

Describe any of the following which would currently restrict usage of the proposed site and/or alternate site for the proposed project: (a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right-of-ways; (g) building restrictions; (h) water and sewer access; (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) others (please explain).

EEC Federal Way is currently an operational facility, and has been since July 1996. There are no issues that would prevent the continued usage of the site by the proposed project. Construction review available in Appendix.

Provide documentation that the proposed site may be used for the proposed project. Documentation may Include, but not limited to a letter from any appropriate municipal authority, zoning information, and signed letter from leasing agent or realtor attesting to appropriate usage.

EEC Federal Way is located in the basement the first floor of a medical office building, the combined office/ASF facility is approximately 10,235 sq. ft. of useable space.

Please also see Appendix for a copy of the lease agreement.

Provide documentation that the applicant has sufficient interest in the site or facility proposed. "*Sufficient interest*" includes but not limited to one of the following:

a lease for at least one year with, options to renew for not less than a total of five years

Please refer to Appendix for a copy of the lease agreement. EEC Federal Way is currently within the original lease period of 10 years. The original lease expires September 2025. EEC Federal Way has the right to extend the term of the lease 5 years after expiration of the original lease.

III. PROJECT RATIONALE:

Provide documentation to establish conformance of this project with applicable review criteria.

A. Need (WAC 246-310-210)

Identify and analyze the unmet health services needs and/or other problems toward which this project is directed.

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Overview of Project Rationale

EEC is requesting CON approval to convert an existing, two-operating room ambulatory surgical facility into a CON approved facility. This facility has been operational since July 1996 and received a determination of non-reviewability in July 1996. As no construction is needed for this project, the project will be completed upon CON approval.

Currently, only employed surgeons of EEC are providing services through the EEC Federal Way. By becoming CON approved, EEC will open up the facility to surrounding area ophthalmic surgeons, which will better enhance access to ophthalmology services within the Southeast King 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 Southeast King planning area; our project will help address this need.

The service opportunities gained by EEC Federal Way 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 12 outlines the findings within the report.

Table 12 – Distribution of times for surgical visits, by ambulatory surgery facility type; United States, 2010

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

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

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

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

[1] NHSR report is Exhibit 32.
[2] ASCA "A Positive Trend in Health Care" is Exhibit 33.
[3] Ophthalmology Times "The Future of Cataract Surgery" is Exhibit 35.

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

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

Table 13 – 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.

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

Table 14 – Total Nationwide Impact ASFs had on the economy;
United States, 2009

Year 2009	
Total Tax Payments	$5.8 Billion

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

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

Population Overview and Summary of Need

Unmet health services need of the defined populations should be differentiated from physical plant and operating (*service delivery*) deficiencies that are related to present arrangements.

Physical plant deficiencies are non-existent with regards to this project. The facility itself is capable of handling increased operating room minutes.

The ability to deliver the service of increased operating minutes is only limited to staffing availability, in which EEC Federal Way has not had trouble of finding, hiring and employing qualified staff.

The negative impact and consequences of unmet needs and deficiencies should be identified.

Application of WAC 246-310-270 to the Southeast King planning area demonstrates need for additional ambulatory surgery suites. Without the project, the available operating minutes will remain where it is today which is insufficient to meet the projected demand resulting in limited access to affordable outpatient care.

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Define the population that is expected to be served by the project. The specific manner of definition is of necessity based on the specific project proposed, and may require definitions for different elements of the project.

Table 15 – Southeast King Secondary Health Planning Area Population

	2010	Pct of Tot Pop	2016 Est	Pct of Tot Pop	Pct Chg 2010-2015	2021 Proj.	Pct of Tot Pop	Pct Chg 2016-2021
Total Pop.	**552,226**	**100.0%**	**606,892**	**100.0%**	**9.9%**	**652,104**	**100.0%**	**7.4%**
Pop. By Age								
0-17	140,097	25.4%	147,563	24.3%	5.3%	156,291	24.0%	5.9%
18-44	208,015	37.7%	224,281	37.0%	7.8%	229,742	35.2%	2.4%
45-64	149,443	27.1%	162,700	26.8%	8.9%	172,950	26.5%	6.3%
65-74	31,637	5.7%	45,113	7.4%	42.6%	59,276	9.1%	31.4%
75-84	16,260	2.9%	19,668	3.2%	21.0%	25,905	4.0%	31.7%
85+	6,774	1.2%	7,567	1.2%	11.7%	7,940	1.2%	4.9%
Tot. 0-64	497,555	90.1%	534,544	88.1%	7.4%	558,983	85.7%	4.6%
Tot. 65+	54,671	9.9%	68,934	11.9%	32.3%	93,121	14.3%	28.7%

Patient population served are adults who have been thoroughly evaluated by the operating surgeon for their emotional maturity, ability to comply with instructions and understand of what will be required of them.

In addition, because of the nature of the specialization that EEC Federal Way provides, the age of our patient demographic falls into the senior category. Because of this our highest payers are Commercial and Medicare, consisting of 85.4%[6] of our revenue. In contrast, Medicaid is low at 4.2%.[7]

[6] Reference to Table 10.

[7] VMG Health's Intellimarker Ambulatory Surgical Centers Financial & Operational Benchmarking Study 2017 report. The study includes an analysis of more than 278 licensed freestanding ASC covering more than 1.3 million cases. The payer mix for an ASC was identified and recorded as a mean, median, 25%, 75% and 90%. Medicare median was 24% and Medicaid median was 5%.

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Table 16 – EEC Federal Way patient sorted by age and reported by percentage; 2017

Age Group	Count	Patient %
18-20	3	0.1%
21-30	79	1.7%
31-40	103	2.2%
41-50	139	2.9%
51-60	508	10.7%
61-70	1423	30.1%
71-80	1780	37.7%
81-90	626	13.2%
91-100	66	1.4%
TOTAL	**4727**	**100%***

Source: EEC Federal Way EMR Data
*Percentages may not equal 100 because of rounding.

Below is a summary of our patient origin for the year of 2017. Please find the actual breakdown by zip code, city, planning area, amount and percentage in Appendix.

Table 17 – Summary of Patient Origin for EEC Federal Way; 2017

	Number of Patients	%
Southeast King Planning Area	1449	44.2%
Remaining Areas of Washington	3278	55.8%
Total	**4727**	**100%***

Source: EEC Federal Way EMR Data
*Percentages may not equal 100 because of rounding.

The patient origin of EEC Federal Way shows that the ASF serves patients from all over the area, with only 44.2% coming from the actual Southeast King planning area.

The population expected to be served can be defined according to specific needs and circumstances of patients (e.g., alcoholism treatment, renal dialysis), or by the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

Provide utilization forecasts for each service included in the project. Include the following:
Utilization forecasts for at least five years following project completion.
The complete quantitative methodology used to construct each utilization forecast.

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Need Methodology:

The utilization forecast was created using the National Health Statistics Report (NHSR)[8] utilization rate, the projected population for Southeast King planning area and EEC Federal Way patient demographics in Y2017.
The NHSR identified the utilization rate for operation of the eye to be 237.6/10,000. Due to our senior patient population (Table 16), we will use the forecasted population, the rate that corresponds to the specific age group along with EEC Federal Way Y2017 patient data broken down into the percentage of age to provide a more accurate number for this project.

Table 17 - Rate for the rate of ambulatory surgery procedures; United States, 2006

		SEX			AGE			
Procedure Category	**.08-16 ICD-9-CM code**	**Total**	**Male**	**Female**	**Under 15 years**	**15-44 years**	**45-64 years**	**65+years**
		Rate per 10,000 population						
Operations of the eyelid	0.08	12.9	9.4	16.4	4.7	3.1	20.9	43.55
Extraction of lens	13.1-13.6	102.5	78.8	125.5		3	81.6	646.7
Insertion of prosthetic lens (pseudophakos)	13.7	86.6	67.4	105.2		2.6	70.1	543.5
Other		35.6	35.7	35.2	12.3	12.5	48.2	127.9
TOTAL		237.6	191.3	282.3	17	21.2	220.8	1361.5

Source: "Ambulatory Surgery in the United States, 2006", U.S. Department of Health and Human Services, National Center for Health Statistics, Report Number 11, January 28, 2009, revised September 4, 2009. Table 7, page 18.

The following outlines how EEC Federal Way calculated their projections for surgical cases by year.

The expected ophthalmic surgical case frequencies for various populations (rate per 10,000 capita by gender and age) were then calculated with the following explanation.

Ages were grouped as follows

- Under 15 years old (< 15) — 17 Surgeries on the eye per 10,000
- Between 15 and 44 years old (15 – 44) — 21.2 ""
- Between 45 and 64 years old (45 – 64) — 220.8 ""
- 65 and older — 1361 ""

Calculation

Assume the projected 45 – 64-year-old population for year X is 20,000.
To preserve generality, let the surgical case frequency amongst the specified population be Y.
Let our projected population be Z.

[8] NHSR report found in Exhibit 31.

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Then, we would calculate the associated projected number of surgeries (PS) on 45 to 64-year-olds in year X as follows

PS(X) = (Z / 10,000) * Y
PS(X) = (20,000 / 10,000) * 220.8
PS(X) = (2) * 220.8
PS(X) = 441.6

Table 18 – Operations of the Eye

Operations of the Eye by Age Group for Southeast Planning Area							
		2016	2017	2018	2019	2020	2021
Pop. By Age	**Utilization rate**						
Total Population 18 and older		606,892	615,388	624,004	632,740	641,598	650,581
18-44		208,015	210,927	213,880	216,875	219,911	222,990
45-65		149,443	151,535	153,657	155,808	157,989	160,201
65+		54,671	55,436	56,213	56,999	57,797	58,607
Operations of the Eye	0.02376	14,420	14,622	14,826	15,034	15,244	15,458
Operations of the Eye 18-44 Years	0.00212	441	447	453	460	466	473
Operations of the Eye 45-65 Years	0.02208	3,300	3,346	3,393	3,440	3,488	3,537
Operations of the Eye 65+ Years	0.13615	7,443	7,548	7,653	7,760	7,869	7,979

WAC (246-310-270) describes how to take current surgical capacity, hospital and ambulatory surgery utilization figures and population estimates and forecasts to prepare a planning area need forecast to determine if there is need for additional inpatient/mixed use and/or outpatient ORs.

After identifying planning area inpatient/mixed use and outpatient surgical capacity, surgery volumes by active licensed surgery centers were obtained from the data from the Washington State Certificate of Need

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Program 2017 Annual Operating Room Use Survey. This is specific for surgical procedures performed during CY2016. Not all facilities had responded in 2017, therefore the CON Program indicated that using the 2015 data for unresponsive facilities was appropriate. Operating rooms identified in the methodology were used only from CON approved facilities with an active license on 01/01/2018.[9]

Table 19 – Need Methodology Assumption Data Summary

Need Methodology Assumptions and Data	
Assumption	Data Used
Planning Area (zip codes identified in Table 3, facilities identified in Table 5)	Southeast King County
Population Forecasts (Table 15)	Age Group: 0-75+ Year 2016 – 606,892 Year 2021 – 652,104
Use Rate (Exhibit 24)	Divided calculated surgical cases by 2016 population results in the service area use rate of 70.31/1,000 population
OR Annual capacity in minutes (Exhibit 38)	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes (per methodology in rule)
Existing providers/OR's (Exhibit 24, based on survey information)	Based on listing of Southeast King County Providers that are CON approved; 33 – dedicated mixed use ORs 11 – dedicated outpatient ORs
Methodology Results	**Numeric Need for an additional 11.24 outpatient ORs**

*Not all facilities turned in a 2016 survey in 2017. We were instructed by CON to use facilities 2015 data if 2016 was unavailable.

Using WAC (246-310-270) regulations as a guide, **the methodology shows that there is a net need for 11.24 outpatient ORs** in the Southeast King planning area in 2021.

Identify and justify all assumptions related to changes in use rate, market share, intensity of service, and others.

Referencing Table 16, In 2017, 55.8% of EEC Federal Way patients originated outside of the Southeast King planning area with only 44.2% of their patients within the planning area.

In regard to market share within the Southeast King planning area, EEC Federal Way performs 29% of the ophthalmic procedures. The other ophthalmic surgery centers in the planning area perform another 36% of the ophthalmic predicted procedures leaving a large number of patients to seek care potentially outside the planning area.

As evidence in Table15, EEC Federal Way patient age over the age of 65 is 70.06%. As described in our method of projecting the utilization for ophthalmic surgery, we used the rate associated with the age to provide a more accurate number in the projection of utilization.

[9] https://fortress.wa.gov/doh/facilitysearch/

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Evidence of the number of persons now using the service(s) who will continue to use the service(s). Utilization experience for existing services involved in the project should be reported for up to the last ten years, as available. Such utilization should be reported in recognized units of measure appropriate to the service.

In part, this question is not applicable to this project. The surgeries and procedures performed at EEC Federal Way are done on a one or two-time basis, with the complications as the only exception, and patients do not need subsequent services.

EEC Federal Way utilizes its co-management program with the patient's primary care physician, OD, nurse practitioner, or physician assistant for follow up and continuity of care.[10]

As evidence in Table 6, the number of ophthalmic surgeries has increased over the past 5 years suggesting an increase in patient utilization of EEC Federal Way.

Evidence of the number of persons who will begin to use the services(s).

As outlined in the above "Overview of the Project Rationale", it is evidenced that the use of ASF's for surgeries that can be performed safely in an outpatient setting are becoming the location of choice. National trends show a safe, cost savings approach with physicians preferring to operate in an ASF. Additionally, ophthalmology makes up 28% of all procedures done in an ASFs

In an article printed in the American Academy of Ophthalmology[11], the reasons why there is a rising cataract surgery rate were identified. "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. 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." Second eye surgery is now performed earlier and more frequent then it was before simply because "people don't know what they want until you show it to them" (Steve Jobs). The patient's expectations have been met and they want both eyes functioning correctly. In regard to supply and demand, George Gilder, author of Wealth and Poverty stated, "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". The author of the article, Jay C. Erie, M.D. believes that this statement describes the evolution of ophthalmology and the specialty surgical procedures to include cataract surgery. With improved technologies, the ophthalmic surgery has become very safe and effective, which is providing better outcomes and ultimately improving patient lives. This in itself is increasing patient demand. The article also points out that at the time of publication, the World Health Organization has set a minimum number of cataract surgeries per year to eliminate cataract blindness. This number is 3,000 per million people. In developed countries, the cataract surgeries performed range from 7,000 – 11,000 per million people.
Additionally, increased ophthalmic surgery rates can be explained by the aging population, ability for the procedures to be safely performed in an outpatient (ASF) facility, and adopting widening thresholds for the indication of the ophthalmic surgery.

Reasons why ophthalmic surgery at EEC Federal Way has increased over the years can be attributed to the quality surgeons and staff within the EEC organization. In 2017, five EEC surgeons were listed as a

[10] EEC Federal Way's Co-Management philosophy can be found on their website under the provider link.
[11] "Rising Cataract Surgery Rates; Demand and Supply" is located in Exhibit 34.

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"Castle Connolly Top Doctors".[12] Nine EEC physicians were recognized as 2017 Top Doctors in the August issue of Seattle Met Magazine.[13]

As evidenced by the percent of patient origin is 64% outside of the planning area, it would suggest that patients are driving to be seen by the EEC surgeons.

Provide information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "*compete*" with the applicant.

Identify all existing providers of services similar to those proposed and include sufficient utilization experience of those providers that demonstrates that such existing services are not available in sufficient supply to meet all or some portion of the forecaster utilization.

A list of existing providers in the Southeast King planning area is listed in Table 5.

If existing services are available to the defined population, demonstrate that such services are not accessible to that population. Time and distance factors, among others, are to be analyzed in this section.

As previously discussed, demand for outpatient ambulatory surgeries is increasing for a number of factors. With a shortage of outpatient facilities, patients in need will need to resort to traveling farther distances in order to receive appropriate services. This is particularly problematic for patients with limited mobility, or those who depend on transit systems or third-party transportation services. In addition, EEC Federal Way is the one of two ASF in the Southeast King planning area performing specialized ophthalmic surgery.

If existing services are available and accessible to the defined population, justify why the proposed project does not constitute an unnecessary duplication of services.

EEC Federal Way is one of three existing ASF facility that does outpatient primaryily ophthalmic surgery. EEC Federal Way currently provides 29% of the market for specialized ophthalmic surgery. Without EEC Federal Way, the projected utilization forecast will not be met.

In the context of the criteria contained in WAC 246-310-210 (1) (a) and (b), document the manner in which:

Access of low-income persons, racial and ethnic minorities, women, mentally handicapped persons, and other under-served groups to the services proposed is commensurate with needs for the health services.

Patients are admitted to EEC Federal Way based on clinical need. Our services are provided regardless of race, color, sex, national origin, religion, sexual preference, or disabilities; as is illustrated in the Patient Rights and Responsibility policy and Non-Discrimination policy (Appendix).

As shown in Table 10, Medicare is 39.9% of our payer source and 25.4% of our patients. It is projected that the amount of revenue received from Medicare will increase as EEC continues to serve those patients in need, based on population forecasts and trending increase in need of ASFs.

[12] https://www.castleconnolly.com/doctors/index.cfm?type=
[13] www.seattlemet.com/articles/2017/7/20/top-doctors-2017

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In the case of the relocation of a facility or service, or the reduction or elimination of a service, the present needs of the defined population for that facility or service, including the needs of under-served groups, will continue to be met by the proposed relocation by alternative arrangements.

As this is a Certificate of Need application of an existing facility with no intent of relocating, this question does not apply.

Applicants should include the following:

Copy of admissions policy;

Please see Appendix

Copy of community service policy;

Please see Appendix

Copy of its charity care policy

Please see Appendix

Reference appropriate access problems and discuss how this project addresses such problems;

As EEC Federal Way is one of three ASFs that performs primarily ophthalmic surgeries, it provided 29% of the total procedures performed in an ASF in 2017. The continued operation of EEC Federal Way will provide an easily accessible and less costly alternative for ophthalmic surgeries within Southeast King planning area. Opening EEC Federal Way ASF to non-employed physicians will increase access to patients needing eye related surgeries within the area.

As appropriate, reference health facility related access problems of under-served groups noted in social services plan documents;

Not applicable

As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

Not applicable

The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable

The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

Not applicable

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B. Financial Feasibility (WAC 246-310-220)

Proposed capital expenditures should be broken out in detail and should account for at least the following:

The EEC Federal Way project does not require any construction or change in physical property. As such there is no associated capital expenditures for the proposed project.

The method and sources for calculating construction costs and other estimated capital expenditures should be fully explained.

The question is not applicable because there is no construction required for the proposed project.

Documentation of project impact on (a) capital costs, and (b) operating costs and charges for health services.

Capital Expenditures

There will be no capital expenditures relative to this project. See Fixed Operating Expenses for a note on depreciation expense.

Revenues

2017 gross and net revenue are the actual revenues observed by EEC prior to any adjusting journal entries ordered by their accounting firm.

Revenues exclude the professional component, i.e., revenues from physician professional services. Revenues manifesting from the professional component of the case are awarded to the provider and clinic where the surgery was originally ordered. All mentions of revenue are specifically referencing the facility component.

The 2017 gross revenues by payer illustrate which payer class would have been considered primary on the claim. The 2017 actual was found by pulling all claims for a sample period and recording the primary payer percentages. Projected payer mix is assumed to remain constant through the projection.

Inflation of gross revenue was set to a constant 2.3% year over year. From 2015 to 2017, EEC has experienced about 2.3% annual increase in gross revenue. EEC believes this is a good indicator of future growth.

Cost of Revenue

Cost of revenue was observed at a rate of 59.5% of net revenue in 2017. Going forward this figure is assumed to remain constant.

Variable Operating Expenses

2017 FTE figures are representative of the EEC current Seattle ASC-specific employee census (by job category).

Wage and salary figures for each class of FTE are representative of 2017 averages pulled from the payroll roster. It is assumed that an FTE works 2,080 hours per year.

Actual 2017 benefits, taxes, etc. were calculated as 24% of total wages and salaries. This figure is representative of EEC 2017 actuals.

All other “variable” operating expenses are assumed to continue at the actual rate relative to net revenue observed in 2017.

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Fixed Operating Expenses

All fixed operating expenses are based on 2017 actuals. Each subsequent year is expected to experience inflation at a constant 3%.

It is worth noting that depreciation expense is not treated any differently than the other fixed operating expenses. There will be no significant capital expenditures associated with certificate of need approval. Hence, a constant 3% inflation rate is appropriate.

All indirect (billing office, call center, compliance, etc.) people costs are outlined in the "Allocations LESS bad debt" section of the pro forma. These line items include all expenses associated with the specified cost center, not just people costs. Once again, they are expected to grow at a constant rate of 3% year over year.

Source(s) of financing (*loan, grant, gifts, etc.*). Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

EEC Federal Way did not procure financing for this project because there will be no capital expenditures. The costs associated with the increased minutes will be treated as operating expenses, rather than capital expenditure.

Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and interfund loan or bank loan. Provide the rationale for choosing the financing method selected.

As the proposed project is a request for CON approval of an existing facility with no change in services or operating rooms, this questions not applicable.

Provide a pro forma balance sheet and the accounting statement, statement of changes in financial position of unrestricted funds and changes in components of working capital.

Please see Appendix for EEC Federal Way forecast pro forma income statement. There are no capital expenditures associated with the process, therefore the pro forma balance sheet was omitted. The following items should help to clarify some of the figures/methodologies present within the pro forma.

Revenue

Inflation of gross revenue was set to a constant 2.3% year over year. From 2015 to 2017, EEC has experienced about 2.3% annual increase in gross revenue. EEC believes this is a good indicator of future growth.

Gross revenues represent ONLY the facility component of the claim. All professional components have been excluded from these figures. Credit for the professional component of each claim is allocated back to the appropriate clinic profit center.

The payer mix breakdown is an illustration of the expected percentage of gross revenues being billed to each (primary) payer class. The proportions are representative of 2017 actual primary payer responsibility.

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It is worth noting that the distribution of charges by primary payer responsibility will NOT follow the distribution of patients by insurance class. The major difference will be due to various 100% elective/patient-pay (not covered by insurance) add-ons. These patients would be classified according to their primary insurance subscription, while 100% patient-pay charges ($) would be classified as "Self-pay".

Cost of Revenue

Cost of revenue consists of a few different classes of items/expenses.

- **Medication** – InjecTables, drops, and oral medications that are not billed for explicitly using a HCPCS code.
- **Medical Supplies** – this describes any medical supplies not being billed for explicitly.
- **Pass-Thru Technology** – implants and tissues being billed for explicitly using a HCPCS code.
- **Financing Discount** – If a patient chooses to finance their procedure(s) through a 3rd party financing company, EEC observes an expense due to the 3rd party not paying the surgery in full.

Operating Expenses

Operating expenses have been classified as VARIABLE and FIXED. Excluding personnel expense, it is assumed that the variable variety will scale similar to revenue. Hence, the projection maintains a constant percentage. Personnel expense will scale according to the FTE breakdown. All fixed operating expenses assume a constant 3% inflation year over year.

FTE

The FTE projections are based off 2017 actual figures pulled from our payroll software.

Provide a capital expenditure budget through the project completion and for three years following completion of the project.

The question is not applicable as there are no associated capital expenditures for the proposed project.

The expected sources of revenues for the applicant's total operations (e.g., Medicaid, Blue Cross, Labor and Industries, etc.) with anticipated percentage of revenue from each source.

Please refer to Table 10 – Sources of patient revenue with anticipated percentages

Expense and revenue statements for the last three full years.

Included are income statements for EEC for the most recent three-year period (2015, 2016, and 2017).

Cash flow statement for the last three full years.

Included are the Cash Flow Statements for EEC for the most recent three-year period (2015, 2016, 2017).

Balance sheets detailing the assets, liabilities, and net worth of facility for the last three full *fiscal* years

Included are the Balance Sheets for EEC Southeast King for the most recent three-year period (2015, 2016, 2017).

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Indicate the reduction or addition of FTEs with the salaries, wages, employee benefits for each FTE affected.

Table 20– Historical and Projected Full-Time Equivalent (FTE) Employees, By Type 2017-2023

Number of FTEs per Year (Productive)	2017	2018	2019	2020	2021	2022	2023
Office/Clerical Employees	1.25	1.25	1.25	1.25	1.25	1.25	1.25
Registered Nurses	2.75	2.75	2.75	2.75	2.75	2.75	2.75
Operating Room Technicians	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Manager	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Total FTE's		8.00	8.00	8.00	8.00	8.00	8.00
Total Wages and Salaries							
Office/Clerical Employees	33,853	43,586	44,893	46,240	47,627	49,056	50,528
Registered Nurses	163,479	168,383	173,435	178,638	183,997	189,517	195,202
Operating Room Technicians	157,181	122,117	125,780	129,554	133,440	137,444	141,567
Manager	109,825	113,120	116,513	120,009	123,609	127,317	131,137
Total Employee Salaries	464,338	447,206	460,622	474,440	488,674	503,334	518,434
Employee Benefits & Taxes	72,679	107,329	110,549	113,866	117,282	120,800	124,424
		-	-	-	-	-	-
Total Salaries and Benefits	$ 537,017	$ 554,535	$ 571,171	$ 588,306	$ 605,955	$ 624,134	$ 642,858
Annual Change		$ 5,990	$ 16,636	$ 17,135	$ 17,649	$ 18,179	$ 18,724

Source: EEC Federal Way pro forma

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

Please document the following associated with structure and process of care.

The availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.

EEC Federal Way offers a facility and work environment that is attractive to work for, along with competitive hours and pay. EEC Federal Way has not had a problem recruiting, hiring and retaining qualified medical professionals.

Identify the facility's Medical Director, Director of Nursing, and other key staff. For each provide their professional license number for Washington. If they are also licensed in other states, provide their license number for those states.

Table 21 – EEC Federal Way Professional Directors

Medical Director	Robert Tester	MD00043755
Director of Surgical Services	Kelly Goff	MR60632038

Source: EEC Organizational Chart

For the Medical Director indicate if he/she will be an employee of the facility or contractual. If performing his/her duties through a contract, provide a copy. A draft is acceptable only if all parties identified in the draft agreement provide a signed "Letter of Intent to finalize" the agreement and all terms and costs are included.

Dr. Testor is an employed surgeon for EEC. There is not an additional contractual agreement and there is not a financial reward with the position.

The relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.

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EEC Federal Way currently provides ophthalmic surgery in the Southeast King planning area. Our existing support capacity and third-party contracts sufficiently support the services offered at EEC Federal Way and meet all the demands of patient care within the facility.

The specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.

EEC Federal Way works closely with the medical professionals they associate with. Valuing a commitment to collaborative care, EEC advocates cooperative care of postsurgical patients. EEC believes that once patients are stable following surgery, their care can be managed safely and successfully by their optometric physician. EEC Federal Way strives to facilitate the communication with their patients and their patients primary care provider so that the best quality can be performed to promote safe and effective care that will leave patients feeling satisfied and happy.

EEC Federal Way physicians have transfer agreements with Multicare Auburn Medical Center, Highline Medical Center, and St. Francis Hospital for patients requiring hospitalization.

Fully describe any history of the applicant entity with respect to the actions noted in Certificate of Need rules and regulations WAC 246-310-230 (5) (a). If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.

EEC has no history of convictions or sanctions as described in WAC 246-310-230(5)(a).

EEC Surgeons, Corporate Officers and Billing Personnel are not on the OIG exclusion list.

Services to be provided will be provided (a) in a manner that ensures safe and adequate care, and (b) in accord with applicable federal and state laws, rules, and regulations.

EEC Federal Way is a currently licensed ASF with the State of Washington and as such must meet certain regulations set by the State of Washington to remain so. EEC Federal Way is subject to inspections from investigators at the state level and has a duty to comply with any recommendations that are set forth.

EEC Federal Way is also licensed and subject to investigations with Medicare and Medicaid.

All visits by any investigator has left EEC Federal Way in a position to continue to provide quality safe care.

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

Please document the following associated with cost containment.

Exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, merger, contract services, and different methods of service provision, including different spacial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:

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- Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.):*
- Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria;
- Capital costs;
- Staffing impact.

EEC Federal Way is requesting certificate of need approval of its existing two-operating room ASF to convert to a CON-approved ASF. Our project will help address net need for outpatient operating rooms in Southeast King planning area by providing non-EEC 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.

EEC Federal Way 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 22- 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 EEC Federal Way 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: EEC Director Discussion

Table 23- 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: EEC Director Discussion

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Table 24 - 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, EEC has already incurred all capital costs for two operating suites. 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	• EEC has already incurred all capital costs for its two operating suites. It is much more efficient to better utilize fixed plant and equipment with greater volumes/throughput. This option allows EEC to best utilize its ASF resources, hence improves efficiency and increases cost-effectiveness. (Advantage) • There are no disadvantages. (Neutral)

Source: EEC Director Discussion

Table 25 - 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 EEC the opportunity to hire a modest number of additional staff, which will likely create economies of scale for EEC across its staff as volumes increase and staff are utilized more productively. Greater volumes will also increase the attractiveness of EEC to employment candidates – this can act to improve staff quality. (Advantage) • The principal disadvantage would be the necessity for EEC to hire, employ, and train additional ASC staff. This disadvantage is temporary because EEC has administrative, technical, human resource support to accommodate surgical centers in the northwest with as many or more FTEs that will be required in Seattle. (Disadvantage)

Source: EEC Director Discussion

Table 26- 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 EEC the ability to "open" its ASC to non-EEC physicians. This will improve access, quality and continuity of care and promote highest, efficient use of EEC assets as compared to the No Project option. (Advantage) • Requires certificate of need approval. This requires time and expense. (Disadvantage)

Source: EEC Director Discussion

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Table 27 - 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, EEC 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, EEC 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 EEC would not improve access to ophthalmology services in the immediate future.
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology)	• Discussion – Access to ophthalmology services would not improve if EEC downsized and closed their ASF. If EEC opened up another ASF within the planning area, they would have to go through the CN process. By making the current ASF more efficient by extending hours and allowing non-EEC 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 EEC would like to pursue at this time. • Utilizing the fully operational ASF at EEC by allowing non-EEC to operate would be the most cost-effective approach for EEC to increase access to ophthalmology in the North King planning area.

Table 28 -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.

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	• The ASF setting is the concept that EEC believes in and uses to provide excellent quality care for ophthalmology. EEC 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, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	• Discussion – Downsizing EEC organization would not affect the quality of care that is provided at EEC Seattle. The ASF quality of care would continue even if another EEC ASF 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-EEC 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, EEC is able to monitor and adapt because it is their specialty and their focus.

Table 29 - 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 EEC 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, EEC 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 EEC would result in an unnecessary cost.
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	• Discussion – EEC 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 EEC facility within the planning area when there is already a fully operational EEC ASF that has the ability to add more physicians and operating minutes. Although EEC 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. EEC does not want to spend the time, cash and resources to open up to other specialties at this time. • As an ASF, EEC promotes a cost savings approach for their ophthalmic patients. With the number of facilities EEC has, it allows for their processes to be ran in an efficient manner.

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Table 30-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 EEC 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, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	• Discussion – Downsizing EEC 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. EEC 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. • EEC continues to look for those employees who stand out in their field. The overall impact of downsizing, adding an additional facility or expanding the services would not have a large impact on the staffing practices of EEC because the process of finding, hiring and retaining a competent staff is already in place.

Table 31 -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, EEC opening another site within the planning area, extending hours	• 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 EEC to meet the needs of the public with the least amount of legal and government restrictions.

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of operation and/or add additional procedures besides ophthalmology).	

The specific ways in which the project will promote staff or system efficiency or productivity.

In the above analysis, we found that the best option for EEC Federal Way would be to move forward in trying to establish the facility as a CON approved facility. As the population grows along with the age of the population, the foreseeable future dictates that the need for ophthalmic surgery will not be diminished, but in fact continue to grow. Increasing the operating minutes of the Southeast King planning area in an already established ASF will contribute to a cost saving approach for those looking to improve their eye health. As an approved CON, EEC Federal Way will be able to attract non EEC surgeons and give them an opportunity to do their patient surgeries within an ASF setting.

In the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

This question is not applicable as there is no associated construction, renovation, or expansion for the requested CON approval of the existing EEC Federal Way ASF.

In the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.

This question is not applicable as there is no associated construction, renovation, or expansion for the requested CON approval of the existing EEC Federal Way ASF.

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Exhibit 1
EEC Federal Way Letter of Intent

EVERGREEN EYE CENTER
Leadership. Technology. Commitment.

May 21, 2018

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

Re: Letter of Intent – Evergreen Eye Center Federal Way

Dear Janis Sigman, Program Manager:

In Accordance with WAC 246-310-080, Evergreen Eye Center Inc. P.S. ("Evergreen Eye Center') hereby submits a letter of intent proposing to establish and operate the Evergreen Eye Center Federal Way surgery center as a free-standing ambulatory surgery center (ASC) in South East King County. Evergreen Eye Center Federal Way surgery center historically operates as a certificate of need exempt ASC.

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

1. A Description of the Extent of Services Proposed:
    a. Evergreen Eye Center proposes to establish and operate the Evergreen Eye Center Federal Way existing one-operating room surgical center as a free-standing ASC.

2. Estimated Cost of the Proposed Project:
    a. The estimated capital expenditure is $0. This operating room is fully built-out and operational.

3. Description of the Service Areas:
    a. The primary service area will be South East King Health Services planning area.

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

Sincerely,

John J. Whitehead, M.D.
Owner

Exhibit 2
EEC Organizational Chart

Evergreen Eye Center

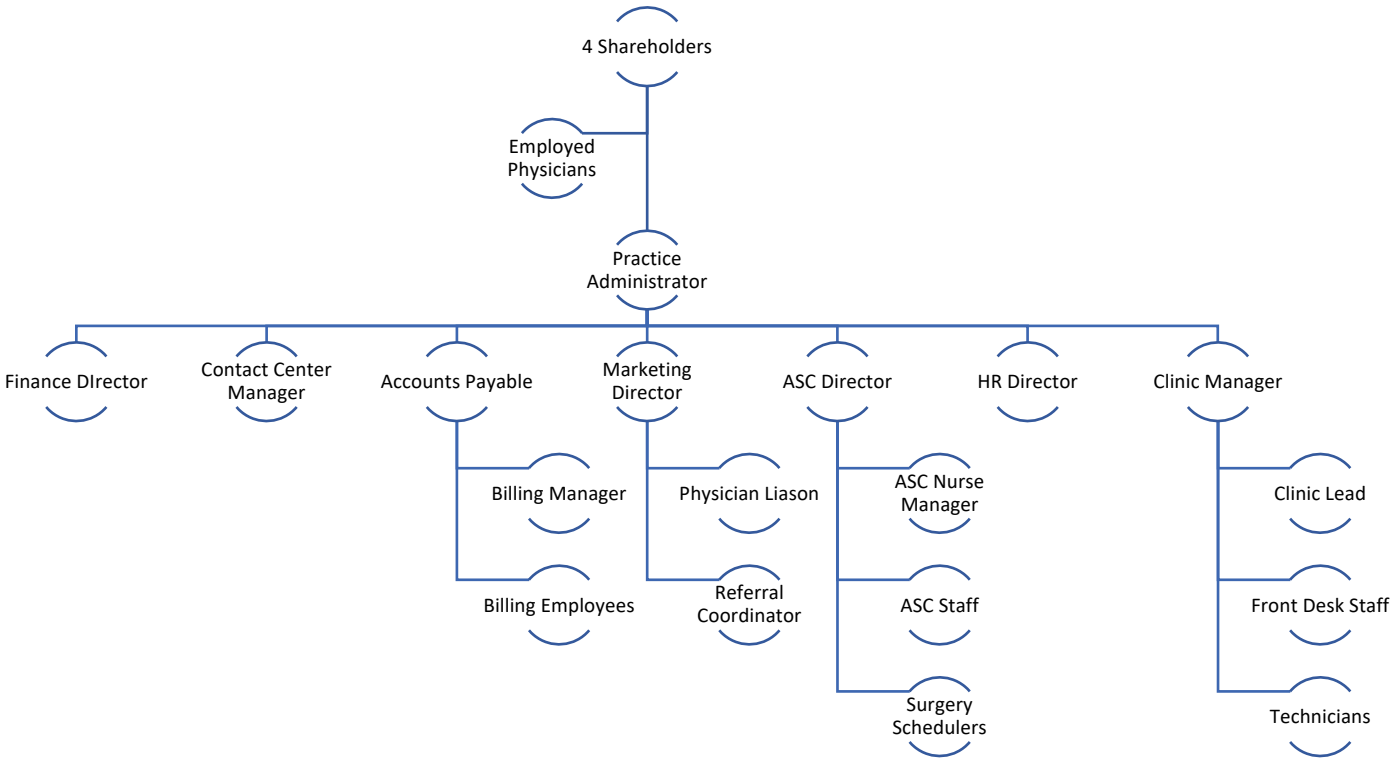

Exhibit 3
Governance Policy

GOVERNING BODY BYLAWS

The name of the facility shall be Evergreen Eye Surgery Center whose principal address is 34719 6th Avenue South, Federal Way, WA 98003.

This facility serves to provide care for patients in need of ambulatory surgical procedures.

PREAMBLE

WHEREAS, Evergreen Eye Surgery Center is a for-profit company organized under the laws of the state of Washington; and

WHEREAS, its purpose is to serve as an ambulatory surgical center providing care and service to patients; and

WHEREAS, it is recognized that the medical staff is responsible for the quality of medical care in the facility and must accept and discharge the responsibility, subject to the ultimate authority of the facility's Governing Body, and the cooperative effort of the medical staff, the Clinical Director and the Governing Body are necessary to fulfill the facility's obligations to its patients; and

WHEREAS, the Governing Body, the medical staff, and any of their committees or agents, in order to promote professional peer review activity designated to establish a harmonious environment in which appropriate standards of medical care may be achieved, constitute themselves as professional review bodies as defined in the Health Care Quality Improvement Act of 1986, and claim all of the privileges and immunities of this act.

INITIAL OBJECTIVES

- Making the decision to build Evergreen Eye Surgery Center.
- Approving plans and design.
- Developing staffing plan.
- Developing the organizational structure.
- Appointing a Medical Director.
- Appointing a Clinical Director.
- Developing Governing Body and Medical Staff bylaws.
- Developing a list of surgeries to be performed in this facility.

DEFINITIONS

Appropriateness
The extent to which a particular procedure, treatment, test or service is efficacious, is clearly indicated, is not excessive, is adequate in quantity, and is provided in the setting best suited to the patient's needs.

Bylaws
These bylaws of the Governing Body and medical staff of Evergreen Eye Surgery Center.

Clinical Privileges
The permission granted to the physician to render specific diagnostic, therapeutic, medical or surgical procedures.

Clinical Director
A registered nurse (RN) appointed to oversee all aspects of patient care on a daily basis.

Function
A group of related duties and responsibilities in a given area of care or service.

Governing Body
The individual(s), group or agency that has ultimate authority and responsibility for the overall operation of the organization.

Medical Staff
All physicians and limited license practitioners who are privileged to attend to patients in the facility.

Medical Director
Physician who is chief officer of the medical staff appointed by the Governing Body.

Minutes
A record of business introduced, transactions and reports made, conclusions reached, and recommendations made. Reports to officers and committees may be summarized briefly or mentioned as having been presented

Monitoring
The systematic and routine collection, compilation and organization of data pertaining to important aspects of care in order that problems or opportunities to improve care can be identified.

Nursing Process
A systematic, dynamic way of providing care to patients; it is an ongoing process that begins when a patient is admitted to the facility and continues until he or she is discharged. The nursing process includes four components: assessment, planning, intervention and evaluation.

Nursing Service
Patient care services pertaining to the curative, restorative and preventative aspects of nursing that are performed and/or supervised by a registered nurse pursuant to the medical care plan of the physician and the nursing care plan.

Peer Review
Peer review functions shall include the review of competence and professional conduct of professional health care providers leading to determinations concerning the granting of privileges or medical staff membership, the scope and condition of such privileges of membership, and the modification of such privileges or membership. Evaluation of patient care shall include the accuracy of diagnosis, propriety, quality, appropriateness or necessity of care. Peer review functions may be performed by a Peer Review Committee, a Medical Advisory Committee, an outside physician who has agreed to perform peer review or other structure approved by the Governing Body.

Physician
An individual who has received a Doctor of Medicine or a Doctor of Osteopathy degree and who holds a fully unrestricted license to practice medicine in the state.

Professional Review Action
An action or recommendation of a peer review committee, which is taken or made in the conduct of professional review activity or peer review.

Quality
The degree of adherence to generally recognized contemporary standards of good practice and the achievement of anticipated outcomes for a particular service, procedure, diagnosis or clinical problem.

Registered Nurse
An individual who is qualified by an approved post secondary program or baccalaureate or higher degree in nursing and licensed by the state to practice nursing.

ARTICLE I
PHILOSOPHY AND OBJECTIVES

1.1 PHILOSOPHY

Evergreen Eye Surgery Center is a specialty care facility designed to provide individual, quality care for patients undergoing outpatient surgical procedures, which meet the criteria for medical necessity of surgical care.

Evergreen Eye Surgery Center is designated as a facility which is planned and administered to render a safe, comfortable, effective environment for patients and personnel, and to give assistance to the medical staff in meeting certain restorative health needs of patients without regard to race, color, religion, sex, age or national origin.

1.2 OBJECTIVES

- To create a safe physical environment in preparation for the scheduled procedure, during the procedure and immediately following the procedure.
- To provide an atmosphere of compassion and understanding with minimal stress and anxiety.
- To function at a high level of efficiency to accommodate the convenience of both the patient and the physician.
- To assist the physicians in execution of a method of surgical treatment individually designed for each patient.
- To promote knowledge and skills of Evergreen Eye Surgery Center staff as a means of meeting technical and scientific progress in the delivery of health care and to be aware of new research, new products and new ideas which may modify and improve present activities and procedures.
- To initiate and maintain rules and regulations of self-governance for the medical staff as set forth by the Governing Body.

ARTICLE II
GOVERNING BODY RESPONSIBILITY

The Governing Body assumes full legal responsibility for determining, implementing and monitoring policies governing Evergreen Eye Surgery Center's total operation. The Governing Body has oversight and accountability for the annual operating budget, Quality Assessment and Performance Improvement Program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. When services are contracted with an outside resource, the Governing Body at Evergreen Eye Surgery Center will assure that these services are provided in a safe and effective manner (Reference: Federal Regulation # 416.41).

The Governing Body shall ensure that all personnel for whom state licenses, certification or registration are required are currently licensed, certified or registered as appropriate, in Washington. The Governing Body also ensures that practices of the facility and the improvement of patient care as indicated by the involvement and participation of the Quality Assessment and Performance Improvement (QAPI) committee include a physician peer review.

The Governing Body shall develop its mission, goals, objectives and long range plan, and will review it at least annually. Additions, deletions or revisions to the scope of services, policies and procedures, and organizational programs shall be reviewed concurrently. Procedures to be performed must be approved by the Governing Body and updated as needed. The Governing Body shall establish a system of financial management and accountability.

The Governing Body shall appoint officers and/or employ personnel to direct the clinical and business activities of the organization. The authority, responsibility and functions are documented in job descriptions specific to each position. The Governing Body encourages personnel to participate in continuing education relevant to their responsibilities.

ARTICLE III
COMMITTEES

The Governing Body, by resolution, adopted by a majority of the full Governing Body may designate a Medical Advisory Committee and any other appropriate committees.

The Governing Body shall be responsible for total overall operation of the facility and the approval of the medical staff appointments as recommended by the Medical Advisory Committee. The Governing Body shall have documented evidence on file that physicians admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications. The Governing Body shall have the power for granting, restricting and terminating privileges. The Governing Body shall conduct medical staff reappointments every two years. The reappointment process shall include any relevant findings of peer review activities.

The Governing Body shall assure the medical staff complies with its medical staff bylaws, rules and regulations.

The Governing Body shall review all policy and procedure manuals, ancillary and/or contracted services, and all other programs annually to assure they comply with applicable state and federal regulations.

The Governing Body shall review the QAPI subcommittee's quarterly reports and approve its implementation to assure quality patient care is being provided.

The Governing Body shall act on all medico-administrative matters of the organization.

The Governing Body is ultimately responsible for all activity of the facility, which is demonstrated by protecting patient’s rights and responsibilities and their privacy and confidentiality.

ARTICLE IV
GOVERNING BODY QUALIFICATIONS

Members of the Governing Body shall be selected on the basis of interest in and agreement with the objectives and philosophies of the medical staff, willingness to accept responsibility for governance, ability to participate actively and effectively in governing activities and experience in organizational and community activities.

ARTICLE V
FUNCTIONS

The Governing Body shall perform their duties as members of any committee of the Governing Body upon which they may serve, in good faith, in a manner they reasonably believe to be in the best interest of the facility, and with such care as an ordinarily prudent person in a like position would use under similar circumstances.

ARTICLE VI
TERM OF OFFICE, ELECTION AND VACANCIES

John Jarstad, MD, Robert Tester, MD and Gary Chung, MD are the Shareholders of Evergreen Eye Surgery Center. For the purposes of governance, John Jarstad, MD, Robert Tester, MD and Gary Chung, MD, serve as the permanent Governing Body. They will remain in this position until such time as (1) they retire or become disabled or unable to function; or (2) in the event of death.

ARTICLE VII
RESIGNATION AND REMOVAL OF DIRECTORS

The Governing Body may resign at any time by documenting such resignation. Unless otherwise specified therein, such resignation shall take effect immediately.

ARTICLE VIII
MEETINGS

The Governing Body, or its designated representative, shall meet quarterly with the Medical Advisory Committee. A permanent record of minutes shall be kept. A copy will be approved and signed by the Governing Body. Should the occasion arise for interim decision making prior to the next scheduled meeting, the issue will be addressed and handled accordingly by a Shareholder of the Governing Body and communicated to concerned parties.

Exhibit 4
Medical Staff Policies

MEDICAL STAFF BYLAWS

EVERGREEN EYE SURGERY CENTER

PREAMBLE

These bylaws are adopted in order to provide for the organization of the medical staff of Evergreen Eye Surgery Center. These bylaws are prepared for compliance with appropriate licensing laws and accreditation standards to provide the professional and legal structure for medical staff operations and relations with applicants and members of the medical staff.

DEFINITIONS

Authorized Representative or Evergreen Eye Surgery Center Authorized Representative

An individual designated by the Medical Advisory Committee to provide information to, and request information from, the National Practitioner Data Bank and other agencies according to the terms of these bylaws.

Clinical Privileges or Privileges

Specified services that may be exercised by authorized individuals on approval of the Governing Body, based on the individual's professional license, documented current competence, education, training, health status, experience and judgment.

Facility

Evergreen Eye Surgery Center

Governing Body

The Governing Body of this facility, delegated authority and responsibility and appointed by the owners of the facility.

Investigation

A process specifically initiated by the Medical Advisory Committee to determine the validity, if any, of a concern or complaint raised against a member of the medical staff.

Medical Advisory Committee

The committee responsible for governing the medical staff as described in these bylaws.

Medical Disciplinary Cause or Reason (MDCR)

That aspect of an applicant's or member's competence or professional conduct which is likely to be detrimental to patient safety or the delivery of patient care.

Medical Staff

All physicians, (M.D. or D.O.) and CRNAs holding current, unrestricted licenses in Washington, who are privileged to attend to patients in the facility within their scope of licensure and approved clinical privileges.

Medical Staff Year

The period from January 1 through December 31.

Member

A physician who has been granted and maintains medical staff membership and clinical privileges in good standing pursuant to these bylaws.

Physician

"Physician" as defined in 1861(r), of the Social Security Act to include:

- Doctor of Medicine or Osteopathy;
- Doctor of Dental Surgery or of Dental Medicine
- Doctor of Podiatric Medicine

All of the above must practice in accordance with state licensure.

Practitioner

A physician with a current, unrestricted license issued by Washington.

MISCELLANEOUS

The use of masculine pronouns he, his and him throughout these bylaws is applicable to either male or female.

ARTICLE I
NAME

These are the bylaws of the medical staff of Evergreen Eye Surgery Center.

ARTICLE II
PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES OF THE MEDICAL STAFF

Purposes of the medical staff are to:

- provide an organized body through which the benefit of staff membership may be obtained by each staff member and the obligations of staff membership may be fulfilled;
- serve as the primary means for accountability to the Governing Body for the quality and appropriateness of professional performance and ethical conduct of its members;
- develop a structure that adequately defines responsibility, and when appropriate the authority and accountability of each medical staff member; and
- provide a means through which the medical staff may contribute to policy-making and planning within the facility.

2.2 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the medical staff, which may be performed by the Medical Advisory Committee, are to account for the quality and appropriateness of patient care rendered in the facility by the following means:

- processing credentials in a manner that aligns qualifications, performance and competence with clinical privileges;
- making recommendations to the Governing Body with respect to medical staff appointments, reappointments and clinical privileges;
- participating in the Quality Assessment and Performance Improvement Program by conducting objectively all required peer evaluation activities through medical staff review;
- providing continuing education that is relevant to patient care provided in the facility as determined, to the degree reasonably possible, from the findings of quality improvement activities;
- initiating and pursuing corrective action when indicated;

- enforcing these medical staff bylaws uniformly and consistently; and

- striving to continuously improve the quality of patient care.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the medical staff is a privilege extended only to professionally competent physicians who continuously meet the qualifications, standards and requirements set forth in these bylaws, and all policies adopted pursuant thereto. Appointment to and subsequent membership on the medical staff shall confer on the member only such clinical privileges and rights as have been granted by the Governing Body in accordance with these bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

General Qualifications

Only physicians and CRNAs who:

- document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, (5) current active hospital privileges, and (6) adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

- are determined to (1) adhere to the ethics of their respective professions, (2) be able to work cooperatively with others so as not to adversely affect patient care, (3) keep confidential, as required by law, all information or records received in the physician-patient relationship, and (4) be willing to participate in and properly discharge those responsibilities determined by the medical staff;

- maintain in force professional liability insurance in not less that the minimum policy limits of $1,000,000 per claim and $3,000,000 aggregate per year or other such amounts as may be deemed appropriate by the Governing Body and provide the facility with a current certificate of insurance;

- are board eligible or board certified by the applicable and recognized board of the applicant's surgical specialty or submit documentation of a current, validated curriculum of post-graduate training and five (5) years of practice in good standing in applicant's specialty at an accredited health care facility, with the exception of CRNAs; and

- when applicable, provide proof of certification and training for new or innovative procedures applied for, for example, laser, accompanied by evidence that applicant's malpractice coverage includes the new or innovative procedures, shall be deemed to possess qualifications for membership on the medical staff.

Particular Qualifications

- *Medical Doctor or Osteopaths*. An applicant for medical doctor or osteopath membership on the medical staff must hold a MD or DO degree, and must also hold a valid and unrestricted certificate to practice medicine issued by the Medical Board of Washington or the Board of Osteopathic Examiners of the State of Washington.

3.3 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of race, age, sex, sexual orientation, ethnicity, religion or disability.

3.4 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

In addition to the other responsibilities and obligations listed in these bylaws, each applicant, by applying for or being granted membership or clinical privileges, thereby obligates himself to:

- adhere to generally recognized standards of professional ethics of his profession;

- provide continuous care and supervision of his patients;

- perform all of the applicable obligations of a member of the medical staff and voluntarily subject himself to the processes, decisions and judgments made concerning his practice at the facility;

- participate in peer review activities, including proctoring when asked to do so by the Medical Director and/or Clinical Director;

- prepare and complete in timely fashion medical records for all the patients to whom the member provides care in the facility;
- obtain appropriate informed consent from all patients and/or other appropriate persons;
- work cooperatively with others so as not to adversely affect patient care;
- reasonably cooperate with the facility in its efforts to comply with accreditation, reimbursement and legal or other regulatory matters;
- maintain confidentiality of all medical staff peer review matters, pursuant to these bylaws;
- understand and accept that any act, communication, report, recommendation or disclosure concerning his practice, performed or made at the request of an authorized representative of Evergreen Eye Surgery Center or any other health care facility for the purpose of achieving or maintaining quality patient care in this facility or any other health care facility, shall be pursued to the fullest extent permitted by law;
- give immediate notice to the Medical Advisory Committee in the event that his professional license, DEA number or professional liability insurance is revoked or suspended or in the event that his privileges or membership at any other health facility are curtailed, limited, suspended or revoked upon the grounds of actual or asserted medical cause or reason and irrespective of the fact that, in the opinion of the physician, such action is not justified;
- consent to the facility's inspection of all records and documents that may be material to an evaluation of his professional qualifications for the clinical privileges requested;
- avoid disruptive or other inappropriate behavior while at the facility;
- refuse to engage in improper inducements for patient referral; and
- acknowledge that there shall be, to the fullest extent permitted by law, immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed or made in connection with this or any other health care institution's activities related, but not limited to:
    - application for appointment or clinical privileges;
    - periodic reappraisals for reappointment or clinical privileges;

- o corrective action, including summary suspension;
- o hearings and reviews;
- o medical care evaluations;
- o utilization reviews, and
- o other Evergreen Eye Surgery Center's activities related to quality patient care and inter-professional conduct.

3.5 CONDITIONS AND DURATION OF APPOINTMENT

The Governing Body upon the advice and recommendations of the Medical Advisory Committee shall make all appointments and reappointments to the medical staff. Initial appointments and reappointments shall be for a period of two (2) years, commencing on the effective date of the appointment. The above notwithstanding, appointments and reappointments shall expire on the last day of the month of the expiration of the two (2) year term. Appointment to the medical staff confers on the appointee only such clinical privileges as have been specifically granted to the member.

ARTICLE IV
CATEGORIES OF MEDICAL STAFF MEMBERSHIP

4.1 CATEGORIES

The categories of medical staff shall be active, courtesy, temporary and emergency. At each time of reappointment, the member's staff category shall be determined.

4.2 ACTIVE STAFF

Qualifications

The active medical staff shall consist of members who:

- meet the general qualifications for membership set forth in Section 3.2; and
- regularly care for an excess of ten (10) patients per calendar year in the facility.

Prerogatives

Except as otherwise provided, the prerogatives of an active medical staff member shall be entitled to:

- admit patients and exercise such clinical privileges as granted pursuant to Article VI;
- attend and vote on matters presented at general and special meetings of the medical staff and of the committees of which he is a member; and
- hold staff office and serve as a voting member of committees to which he is duly appointed or elected by the medical staff or duly authorized representative thereof.

4.3 COURTESY MEDICAL STAFF

Qualifications

The courtesy medical staff shall consist of members who:

- meet the general qualifications for membership set forth in Section 3.2; and
- regularly care for not more than nine (9) patients per calendar year in the facility.

Prerogatives

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

- admit patients and exercise such clinical privileges as granted pursuant to Article VI; and
- attend meetings of the medical staff in a non-voting capacity, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the medical staff.

Courtesy Reappointment

The Governing Body shall have the authority not to renew a member's courtesy staff privileges if such member has not admitted or cared for any patient in the facility during the prior two years.

4.4 TEMPORARY PRIVILEGES

Qualifications For Temporary Privileges

Prior to temporary privileges being granted, a physician must demonstrate that he has appropriate professional qualifications, a valid license in Washington, a current DEA and applicable Washington drug registration and professional liability
insurance coverage, and a query may be submitted to the National Practitioner Data Bank. By applying for temporary privileges all physicians agree to be bound by the medical staff bylaws, rules and regulations, and applicable facility policies.

Authority To Grant Temporary Privileges/Conditions

The Medical Director, or his designee, may grant temporary privileges under the circumstances described below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed sixty (60) days. After that period of time, the physician may request a renewal of temporary privileges for another specific period of time, not to exceed sixty (60) days. Temporary privileges shall terminate automatically at the end of the specific time period for which they were granted, without the hearing and appeal rights set forth in these bylaws. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges.

- *Care of a Specific Patient*: Temporary privileges may be granted to a physician who is not an applicant for membership but is required for the care of a specific patient. Such privileges are restricted to the treatment of no more than five (5) patients by any one physician, after which he shall be required to apply for staff membership before being permitted to attend to additional patients.

- *Locum Tenens*: Temporary privileges may be granted to a qualified physician service locum tenens for a member of the medical staff. Such privileges shall be limited based on the locum tenens physician's individual training, experience and qualifications.

- *Pending Appointment to the Medical Staff*: In addition to the requirements noted under "Qualifications for Temporary Privileges" above, the applicant's professional degree must be verified (e.g., M.D., D.O.) as well as his current license, current DEA registration, any specialty training claimed, at least two (2) references relating positively to his professional and ethical status, which shall include at least two (2) letters from peers and documentation of the current requisite amount of professional liability insurance coverage. Under no circumstances shall temporary privileges be extended under this paragraph for more than a total of one hundred twenty (120) days. The Medical Director or his designee may impose special consultation requirements and reporting.

Denial, Termination or Restriction of Temporary Privileges

Temporary privileges, unless acted upon pursuant to other provisions of these bylaws, shall terminate automatically at the end of the specific period for which they are granted, without the hearing and appeal rights under these bylaws. The Medical Director or his designee may terminate or restrict temporary privileges for any reason, at any time. A physician is entitled to the hearing and appeal rights set forth in these bylaws for a denial, non-renewal, restriction or termination of temporary privileges based on the physician's professional conduct or competence. In the event a physician's temporary privileges are terminated or restricted, the Medical Director shall assign the physician's patients then in the facility to another physician. The wishes of the patient shall be considered, when feasible, in choosing a substitute physician.

4.5 EMERGENCY PRIVILEGES

In the event of an emergency, any physician, to the extent permitted by his license and regardless of staff status, or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm.

For the purpose of this section, "emergency" is defined as the condition, which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger.

ARTICLE V
APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL

Except as otherwise specified herein, no person shall exercise clinical privileges in the organization unless that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws.

5.2 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the medical staff shall be made as set forth in these bylaws.

5.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the medical staff shall be for a period of two (2) years. Reappointments shall be for a period of two (2) years.

5.4 APPLICATION FOR APPOINTMENT AND REAPPOINTMENT

Application Form

An application form shall be developed, which shall require detailed information including, but not be limited to, information concerning:

- the applicant's qualifications, including but not limited to, education, professional training and experience, current licensure, current DEA registration and continuing medical education information related to the services to be performed by the applicant;
- peer references familiar with the applicant's professional competence and ethical character;
- request for specified clinical privileges;
- past or pending professional disciplinary action, licensure limitations or related matters;
- physical and mental health status;
- final judgments or settlements made against the applicant in professional liability cases and any filed cases pending; and

- professional liability coverage.

Each application for initial appointment to the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws, the medical staff rules and regulations and summaries or other applicable policies relating to clinical practice in the facility, if any.

Effect Of Application

By applying for appointment to the medical staff each applicant:

- signifies willingness to appear for interviews regarding the applications;

- authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

- consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

- releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

- releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

- consents for disclosure to other organizations, hospitals, medical associations, licensing boards and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the organization or medical staff may have, and releases the medical staff and Governing Body from liability for so doing to the fullest extent permitted by law; and

- pledges to provide for continuous quality care for patients in the facility.

Verification Of Information

The applicant shall deliver a completed application to the appropriate individual per application instructions. The Medical Advisory Committee or its designee shall expeditiously seek to collect and verify the references, licensure status and other evidence submitted in support of the application. The facility's authorized representative will query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Medical Advisory Committee for inclusion in the applicant's or member's credentialing file. The applicant shall be notified of any problems in obtaining the required information. When collection and verification is accomplished, all such information shall be transmitted to the Medical Advisory Committee.

Medical Advisory Committee Action

At the next regularly scheduled meeting after receipt of the completed application file, or as soon thereafter as practicable, the Medical Advisory Committee shall consider the application. The Medical Advisory Committee may request additional information, and/or elect to interview the applicant. The Medical Advisory Committee shall render a decision in writing as to medical staff appointment and, if appointment is recommended, any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for the decision shall be stated.

Effect Of Medical Advisory Committee Action

- *Favorable Recommendation*: When the recommendation of the Medical Advisory Committee is favorable to the applicant, it shall be promptly forwarded to the Governing Body together with supporting documentation.

- *Adverse Recommendation:* When a final recommendation of the Medical Advisory Committee is adverse to the applicant, the applicant shall be promptly informed by written notice advising the applicant of his hearing and appeal rights set forth in these bylaws.

- *Notice:* Notice of adverse recommendation shall be forwarded to the Governing Body for its information, but shall not be acted upon until after the affected individual has exercised or waived his right to a hearing under these bylaws.

Action on the Application

In taking action under this section, the Governing Body shall give great weight to the recommendation of the Medical Advisory Committee and shall not act arbitrarily or capriciously.

- If the Governing Body adopts the recommendation of the Medical Advisory Committee, it shall become the final action of the facility.

- If the Governing Body does not adopt the recommendation of the Medical Advisory Committee, the Governing Body may refer the matter back to the Medical Advisory Committee with instructions for further review and recommendation. The Medical Advisory Committee shall review the matter and promptly forward its recommendation to the Governing Body. If the Governing Body adopts the recommendation of the Medical Advisory Committee, it shall become the final action of the facility.

- If the action of the Governing Body is adverse to the applicant, the Governing Body shall notify the Medical Advisory Committee, and the chairman shall promptly send a written notice to the applicant advising the applicant of his hearing and appeal rights under these bylaws.

- An adverse decision of the Governing Body shall not become final until the applicant has exercised or waived his hearing and appeal rights under these bylaws. The fact that such adverse decision is not yet final shall not be deemed to confer membership or privileges when none existed before.

After all the affected individual's hearing and appeal rights under these bylaws have been exhausted or waived, the Governing Body shall take final action. All decisions to appoint shall include a delineation of clinical privileges, staff category and any applicable conditions and the applicant shall be so notified.

Subject to any applicable provisions of Article VIII, notice of the Governing Body shall be given in writing through the chairmen of the Medical Advisory Committee to the applicant within five (5) days of the arbitrator's final decision.

Notice Of Final Decision

- Notice of the final decision shall be given to the applicant.

- A decision and notice to appoint or reappoint shall include, if applicable, (1) the clinical privileges granted and (2) any special conditions attached to the appointment.

5.5 REAPPOINTMENT

Medical staff privileges must be periodically reappraised, not less than every two (2) years. The scope of procedures performed in the organization must be periodically reviewed and amended as appropriate. The reappointment time is every two (2) years.

Reapplication

At least three (3) months prior to the expiration date of the current staff appointment, a reapplication form, developed by the Medical Advisory Committee, shall be mailed or delivered to the member. At least thirty (30) days prior to the expiration date, each medical staff member shall submit to the Medical Advisory Committee the completed application form for renewal of appointment to the staff, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. Upon receipt of the application, the information shall be processed.

Failure To File Reappointment Application

If the member fails without good cause to file a completed application within seven (7) days past the date it was due, the member shall be deemed to have resigned membership in the facility and the hearing and appeal rights set forth in these bylaws shall not apply.

ARTICLE VI
CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a member providing clinical services at this facility shall be entitled to exercise only those clinical privileges specifically granted. These privileges and services must be organization specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon. Medical staff privileges may be granted, continued, modified or terminated by the Governing Body only upon recommendation of the Medical Advisory Committee, only for reasons directly related to quality of care and other provisions of these medical staff bylaws, and only following the procedures outlined in these bylaws.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

Requests

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

Basis For Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from outside sources.

6.3 PROCTORING

General Provisions

Except as otherwise determined by the Medical Advisory Committee, all new members and all members granted new clinical privileges may be subject to a period of proctoring. All efforts will be made to conduct on-site proctoring. If on-site proctoring cannot be reasonably carried out within the confines of the facility, evidence of proctoring from a local organization or hospital may be accepted. Performance on an appropriate number of cases as established by the Medical Advisory Committee may be observed by the appropriate members, as determined by the Medical Advisory Committee during the period of proctoring specified by the Medical Advisory Committee, to determine suitability to continue to perform services within the facility. The member shall remain subject to such proctoring until the Medical Advisory Committee furnishes a report describing the types and number of cases observed, an evaluation of the applicant's performance, and a statement that the applicant appears to meet all of the qualifications for unsupervised practice in the facility.

Failure To Obtain Certification

If a new member or member exercising new clinical privileges fails to obtain such certification within the time allowed by the Medical Advisory Committee, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article VIII, if such failure is due to a medical disciplinary cause or reason.

ARTICLE VII
CORRECTIVE ACTION

7.1 CORRECTIVE ACTION

Criteria For Initiation

Any person may provide information to the Medical Advisory Committee about the conduct, performance, or competence of medical staff members. When reliable information indicates a member may have exhibited acts, demeanor or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the organization; (2) unethical; (3) contrary to the medical staff bylaws and rules and regulations; or (4) below applicable professional standards, a request for an investigation or action against such members may be made.

Initiation

A request for an investigation must be in writing, submitted to the Medical Advisory Committee, and supported by reference to specific activities or conduct alleged. If the Medical Advisory Committee initiates the request, it shall file appropriate documentation of the reasons.

Investigation

If the Medical Advisory Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Advisory Committee may conduct the investigation to be undertaken. The Medical Advisory Committee may conduct the investigation itself, or may assign the task to an appropriate medical staff member or committee. If the investigation is delegated to a member or committee, such person(s) shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Advisory Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VIII, nor shall the procedural rules with respect to hearings apply. Despite the status of any investigation, the Medical Advisory Committee shall retain authority and discretion at all times to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process or other action.

Medical Advisory Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Advisory Committee shall take action, which may include, without limitation:

- determining no corrective action be taken and, if the Medical Advisory Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- deferring action for a reasonable time;
- issuing letters of admonition, censure, reprimand or warning. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- recommending the imposition of terms of probation or special limitation upon continued organization membership including, without limitation, requirements for mandatory consultation or monitoring; and
- recommending termination of membership.

Subsequent Action

- If the Medical Advisory Committee recommends corrective action, that recommendation shall be subject to final action by the Governing Body.
- So long as the recommendation is supported by substantial evidence, the recommendation of the Medical Advisory Committee shall be adopted by the Governing Body as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VIII, if applicable.

7.2 SUMMARY RESTRICTION OR SUSPENSION

Criteria for Initiation

Whenever a member's conduct appears to require immediate action be taken to reduce a substantial and imminent likelihood of significant impairment of the life, health or safety of any person, the Medical Advisory Committee, may summarily suspend the membership of such member. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the member and the Governing Body. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

Medical Advisory Committee Action

As soon as practical after such summary restriction or suspension has been imposed, a meeting of the Medical Advisory Committee as a whole shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Advisory Committee may impose. In no event, however, shall any meeting of the Medical Advisory Committee, with or without the member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply. The Medical Advisory Committee may recommend modification, continuance or termination of the summary suspension. Such recommendation will be subject to final action of the Governing Body.

Subsequent Action

- The Medical Advisory Committee recommendation shall be subject to final action by the Governing Body.

- So long as the recommendation is supported by substantial evidence, the recommendation of the Medical Advisory Committee shall be adopted by the Governing Body as final action unless the member requires a hearing, in which case the final decision shall be determined as set forth in Article VIII, if applicable.

Procedural Rights

Unless the Governing Body promptly terminates the summary suspension, the member shall be entitled to the procedural rights afforded by Article VIII.

7.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, membership may be suspended or limited as described, and a hearing, if requested, shall be an informal hearing before the Medical Advisory Committee limited to the questions of whether the grounds for automatic suspension as set forth below have occurred.

Licensure

- *Revocation and Suspension*: Whenever a member's license or other legal credential authorizing practice in Washington, is revoked or suspended, medical staff membership shall be automatically revoked as of the date such action becomes effective.

- *Restriction*: Whenever a member's license or other legal credential authorizing practice in Washington, is limited or restricted by the applicable licensing or certifying authority, any clinical privileges exercised at Evergreen Eye Surgery Center which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

- *Probation*: Whenever a member is placed on probation by the applicable licensing or certifying authority, his membership status shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

Controlled Substances

- Whenever a member's DEA certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

- *Probation*: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

Medical Records

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Advisory Committee, and in any event no later than thirty (30) days from the date treatment was provided. A limited suspension, in the form of withdrawal of the right to treat future patients at the facility until medical records are completed, shall be imposed by the Medical Advisory Committee, after notice of delinquency or failure to complete medical records within such period. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Advisory Committee. The suspension shall continue until lifted by the Medical Advisory Committee.

Professional Liability Insurance

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges, and if within seven (7) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

ARTICLE VIII
HEARINGS

These procedures apply to all applicant/member physicians applying to practice or practicing within the facility.

8.1 TIMELY COMPLETION OF PROCESS

The hearing process shall be completed within a reasonable time.

8.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing, if such action occurred in part for a medical disciplinary cause or reason (MDCR), even if there were other reasons for the action.

- Denial of medical staff membership;
- Denial of medical staff reappointment;
- Suspension of medical staff membership;
- Revocation of medical staff membership;
- Denial of requested clinical privileges;
- Involuntary reduction of current clinical privileges;
- Suspension of clinical privileges;
- Termination of all clinical privileges; or
- Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to privilege status or otherwise for purposes of investigation only).

Exhaustion of Remedies: If any of the above adverse actions are taken or recommended, the member must exhaust the remedies afforded by these procedures before resorting to legal action.

8.3 NOTICE OF REASONS/ACTION

Whenever any of the actions listed above are taken or proposed for a non-MDCR, the member shall receive a written statement of the reasons therefore. However, the Article VIII sections below apply only where action was taken or proposed for an MDCR.

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2 for MDCR, the Medical Advisory Committee shall give the member prompt written notice of, (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the medical board of Washington; (2) the reasons for the proposed action, including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 7.4, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws. If the recommendation or final proposed action adversely affects the clinical privileges of a physician for a period longer than thirty (30) days, said written notice shall state that the action, if adopted, will be reported to the National Practitioner Data Bank, and shall state the text of the proposed report.

8.4 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of action taken or proposed for MDCR to request a hearing. The request shall be in writing, addressed to the Medical Advisory Committee with a copy to the Governing Body. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

8.5 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Advisory Committee shall schedule a hearing and within fifteen (15) days, give notice to the member of the time, place and date of the hearing. Unless extended by the arbitrator, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request for a hearing; provided, however, that when the request is received from a member whose membership has been terminated, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

8.6 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by a member under summary suspension, the Medical Advisory Committee shall provide a list of the charts in question, where applicable, and a list of witnesses (if any) expected to testify at the hearing on behalf of the Medical Advisory Committee. The content of this list is subject to update pursuant to Section 8.10.

8.7 ARBITRATOR

When a hearing is requested, the Medical Advisory Committee and the member may select an arbitrator mutually agreeable to both sides or, if they cannot agree, each side selects one arbitrator and the two arbitrators selected will appoint a third.

8.8 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or action involved.

8.9 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause or upon agreement of the parties.

8.10 PRE-HEARING PROCEDURES

If either party to the hearing requests, in writing, a list of witnesses, within fifteen (15) days of such a request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges, which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Advisory Committee and any exculpatory evidence in the possession of the facility. The member and the Medical Advisory Committee shall have the right to receive all evidence, which will be made available to the arbitrator.

- The Medical Advisory Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his possession or control as soon as practicable after receiving the request.

- The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

- The arbitrator shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In doing so, the arbitrator shall consider:

    - whether the information sought may be introduced to support or defend the charges;
    - the exculpatory or inculpatory nature of the information sought, if any;
    - the burden imposed on the party in possession of the information sought, if access is granted; and
    - any previous requests for access to information submitted or resisted by the parties.

- It shall be the duty of the member and the Medical Advisory Committee to exercise reasonable diligence in notifying the arbitrator of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made succinctly at all times at the hearing.

8.11 REPRESENTATION

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a physician licensed to practice in the state of Washington, who is not also an attorney at law, and the Medical Advisory Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses and respond to appropriate questions. An attorney at law shall not represent the Medical Advisory Committee if the member is not so represented.

8.12 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the arbitrator. The cost of attendance of the shorthand reporter shall be borne by the organization, but the cost of the transcript, if any, shall be borne by the party requesting it. The arbitrator may, but shall not be required to, order that oral evidence shall be taken only on an oath administered by any person lawfully authorized to administer such oaths.

8.13 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Advisory Committee and examined as if under cross-examination.

8.14 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence shall not apply to a hearing conducted under these procedures. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The arbitrator may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the arbitrator may request or permit both sides to file written arguments.

8.15 BURDENS OF PRESENTING EVIDENCE AND PROOF

At the hearing, unless otherwise determined for good cause, the Medical Advisory Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

An applicant shall bear the burden of persuading the arbitrator, by a preponderance of the evidence, of his current qualifications for membership and reasonable doubts concerning his current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process unless the applicant establishes the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above for applicants, throughout the hearing, the Medical Advisory Committee shall bear the burden of persuading the arbitrator, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

8.16 ADJOURNMENT AND CONCLUSION

The arbitrator may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Advisory Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

8.17 BASIS FOR DECISION

The decision of the arbitrator shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

8.18 DECISION OF THE ARBITRATOR

Within thirty (30) days after final adjournment of the hearing, the arbitrator shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the parties. If the member's membership is currently terminated however, the time for the decision and report shall be fifteen (15) days. The report shall contain a concise statement of the reasons in support of the decision, including finding of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. The decision of the arbitrator shall be the final action.

8.19 NATIONAL PRACTITIONER DATA BANK REPORTING

Adverse Actions

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the arbitrator. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

Dispute Process

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Medical Advisory Committee and a Governing Body member.

If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE IX
OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

Identification

The officers of the medical staff shall be the Medical Director and the Assistant Medical Director.

Qualifications

Officers must be members of the active medical staff at the time of their nominations and election or appointment, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

Appointment

Officers shall be appointed by the principals of the facility.

Term of Elected Office

Each officer shall serve a two (2) year term, commencing on the first day of the medical staff year following his appointment. Each officer shall serve in each office until the end of that officer's term, or until a successor is appointed, unless that officer shall resign sooner or be removed from office.

Recall of Officers

Except as otherwise provided, recall of a medical staff officer may be initiated by the Medical Advisory Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the Governing Body.

9.2 DUTIES OF OFFICERS

Medical Director

The Medical Director shall serve as the chief officer of the medical staff. The duties of the Medical Director shall include, but not be limited to:

- enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- calling, presiding at and being responsible for the agenda of all meetings of the medical staff;
- serving as chairman of the Medical Advisory Committee;
- serving as an ex officio member of all other staff committees without vote, unless his membership in a particular committee is required by these bylaws;
- interacting with the Governing Body in all matters of mutual concern within the facility;
- appointing, in consultation with the Medical Advisory Committee, committee members for all standing and special medical staff, liaison or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairperson of these committees; and
- performing such other functions as may be assigned to the Medical Director by these bylaws, the medical staff or by the Medical Advisory Committee.

Assistant Medical Director

The Assistant Medical Director shall assume all duties and authority of the Medical Director in the absence of the Medical Director. The Assistant Medical Director shall be a member of the Medical Advisory Committee and shall perform such other duties as the Medical Director may assign or as may be delegated by these bylaws, or by the Medical Advisory Committee.

ARTICLE X
COMMITTEES

10.1 GENERAL CONSIDERATIONS

Committee Structure

The Medical Advisory Committee shall be responsible for the general supervision of the medical staff and for the duties and responsibilities described in these bylaws.

Other committees shall be identified and structured as the Medical Advisory Committee, the Governing Body, or these bylaws designate.

The committee shall maintain a permanent record of their proceedings, including pertinent discussion and any conclusions, recommendations and actions.

The Medical Director and a Governing Body designee may serve on all medical staff committees to which they are not expressly appointed.

Whenever these bylaws require that a function be performed by:

- a medical staff committee, but no committee has been specified, the Medical Advisory Committee shall perform the function or designate a committee to perform it;

- the Medical Advisory Committee, but a committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

All committee participants shall sign and date a confidentiality statement acknowledging that each agrees to maintain the confidentiality of all committee matters.

10.2 MEDICAL ADVISORY COMMITTEE

Composition

The Medical Advisory Committee shall be a standing committee of the medical staff and shall consist of the officers of the medical staff and additional members as appointed by the Governing Body. Ex-officio members, without vote, may include the Administrator, Clinical Director and others as appointed by the Medical Director. Each voting member shall have one vote. The Governing Body shall resolve a tie vote. The Governing Body shall have the authority to establish the number of consecutive terms a member may serve as a voting member.

Duties

The duties of the Medical Advisory Committee shall be to:

- perform the functions outlined in these bylaws;
- coordinate and implement the professional and organizational activities and policies of the medical staff;
- receive and act upon reports and recommendations from medical staff committees;
- recommend actions to the Governing Body on matters of a medico-administrative nature;
- review, investigate and recommend to the Governing Body on all matters relating to credentialing, appointments and reappointments, clinical privileges, staff category and clinical and corrective action;
- when designated allied health professionals provide or are recommended to provide services in the facility, make recommendations to the Governing Body on their qualifications and the degree of supervision required;
- coordinate activities of, and policies adopted by the staff and committees;
- fulfill the medical staff's accountability to the Governing Body for the medical care delivered in the facility;
- initiate, investigate and pursue corrective action when warranted, in accordance with these bylaws;
- designate such committees and make appointments to those committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff;
- take all reasonable steps to assure professional ethical conduct, competence and clinical performance;
- designate the organization's authorized representative for National Practitioner Data Bank purposes;
- review medical staff bylaws and rules and regulations annually and make recommendations for modifications to these documents as necessary;

- formulate appropriate administrative policies and procedures regarding employment of personnel, fiscal concerns and the purchasing of equipment;

- report to the medical staff and Governing Body the findings and results of all medical staff quality management activities;

- promote medical staff and facility staff continuing education activities, relevant to the care and services provided in the facility, and in particular, to the findings of peer review and other quality management activities;

- monitor compliance with licensure and certification; and

- perform such other duties as the Governing Body may reasonably request.

Other specific responsibilities of the Medical Advisory Committee shall include:

- implementation of a Quality Management program to include the functions of performance improvement, utilization review, risk management, peer review, infection control, tissue review, pharmacy and therapeutics, medical record documentation and other functions and activities as necessary to ensure quality patient care at Evergreen Eye Surgery Center.

Meetings

The Medical Advisory Committee shall meet as often as necessary, but at least quarterly and shall maintain a record of its proceedings and actions. The quarterly meeting may be in conjunction with the Governing Body meeting.

ARTICLE XI
CONFIDENTIALITY/IMMUNITY FROM LIABILITY

11.1 CONFIDENTIALITY

Records and proceedings of all medical staff committees having the responsibility for the quality of care rendered in this facility, including, but not limited to, meetings of the medical staff committee of the whole, meetings of committees, and meetings of special or ad hoc committees created by the Medical Advisory Committee and including information regarding any member or applicant to this medical staff, shall be confidential, subject to release only in accordance with policies of the medical staff and privileged to the fullest extent permitted by law.

All individuals participating in or attending committee meetings or entitled to access information, agree to keep all proceedings, minutes and documents related to any peer review or quality management matter confidential and subject to release only in accordance with policies of the medical staff.

Inasmuch as effective peer review, credentialing and quality management activities must be based on free and candid discussions, any breach of confidentiality of the discussion, deliberations or records of any medical staff meeting is outside appropriate standards of conduct and will be deemed disruptive to the operation of the facility and as having an adverse impact on the quality of patient care.

11.2 IMMUNITY

Privileges

Any act, communication, report, recommendation or disclosure with respect to any applicant or member of the medical staff, committee member or clinical privileges performed or made for the purpose of assessing patient care or achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.

Application

Such privileges shall extend to the facility and its affiliates, and to all individuals participating in the process of assessing patient care or achieving and maintaining quality patient care including, but not limited to, members of the medical staff, Governing Body, Medical Director, Administrator, Clinical Director and all third parties who supply information to any of the individuals authorized to receive, release or act upon such information. For the purpose of this Article, the term “third parties” means both individuals and organizations from which information has been requested and/or received by an authorized representative of the facility, its Governing Body, medical staff or any committee or component thereof.

Immunity

Immunity from civil liability for any act, communication, report, recommendation or disclosure shall be absolute and to the fullest extent permitted by law. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with the facility or any other health care organization’s activities related to, but not limited to:

- applications for appointment of clinical privileges;

- periodic appraisals for appointment of clinical privileges;
- any and all investigations and all corrective action, including summary suspension;
- hearings and reviews;
- quality management activities and medical care evaluations;
- peer review materials;
- utilization review materials; and,
- other facility or committee related activities related to quality patient care and intraprofessional conduct.

The acts, communications, reports, recommendations and disclosures referred to in Article XI may relate to a physician's professional qualifications, clinical competency, character, mental or emotional stability, criminal activity, disruptive behavior, physical condition, ethics or any other matters that might directly or indirectly have an effect on patient care.

11.3 APPLICATION

The confidentiality, immunities, privileges, releases and other items in this Article XI shall be express conditions to any physician's application for or exercise of privileges at the facility and shall survive a physician's corrective action.

11.4 RELEASES

All applicants or members shall execute releases of liability and of confidentiality upon request of the facility in accordance with this Article.

ARTICLE XII
ADOPTION AND AMENDMENTS OF BYLAWS, RULES AND REGULATIONS

12.1 RULES AND REGULATIONS

The medical staff (through the Medical Advisory Committee) shall initiate and adopt such rules and regulations, as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules and regulations shall be submitted to the Medical Advisory Committee for review and evaluation prior to presentation for consideration by the medical staff as a whole under such review or approval mechanism as the medical staff shall establish. Following adoption, such rules and regulations shall become effective. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment or repeal of the medical staff rules and regulations.

12.2 BYLAWS

Upon the request of the Medical Advisory Committee or upon timely written petition signed by at least ten percent of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment or repeal of these bylaws. Such action shall be taken at a regular or special meeting provided, (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the medical staff, and such changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

Action On Bylaw Change

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmation vote of fifty-one percent of the members voting in person or by written ballot.

SCOPE OF CARE
AT
EVERGREEN EYE SURGERY CENTER

Evergreen Eye Surgery Center is a licensed, Medicare Certified Ambulatory Surgery Center. Its hours of operation are Monday through Friday, 6 am to 5 pm, except holidays. The facility performs elective surgical procedures to ambulatory patients in ASA level one, two or three. Physicians, with privileges at the facility, perform the procedures and appropriately trained personnel assist them. These procedures are:

ANESTHESIA (CRNA)

Emergency treatment
Emergency/therapeutic laryngoscopy
Intravenous Anesthesia
Local Anesthesia
Monitored Anesthesia Care
Pre and postop consultation and evaluation
Regional Anesthesia
Resuscitation
Topical Anesthesia

OPHTHALMOLOGY

Conjunctiva
- Repair of major laceration
- Conjunctivoplasty – without graft
- Conjunctivoplasty – with sliding graft
- Conjunctivoplasty – with mucous membrane graft
- Flap to repair/restore anterior chamber
- Gundersen flap
- Excision of conjunctival tumor
- Excision of conjunctival cyst
- Pterygiectomy

Cornea
- Repair of laceration
- Removal of (superficial) foreign body
- Keratomileusis
- Keratoplasty – lamellar
- Excision of pterygium with/without graft
- Repair of wound leak
- Resuturing for astigmatism
- Astigmatic keratotomy

OPHTHALMOLOGY (cont)

Sclera
- Repair of laceration
- Sclerotomy
- Sclerotomy – partial of full thickness

Anterior Chamber
- Tap/irrigation
- Reformation
- Removal of foreign body
- Paracentesis
- Pupilloplasty

Lid
- Repair major laceration
- Repair marginal laceration
- Canthoplasty
- Tarsorrhaphy
- Blepharoplasty
- Excision of lesion with reconstruction
- Excision of lesion with skin graft
- Punctal repair
- Entropian repair
- Ectropian repair
- Ptosis repair
- Dermatochalasis repair
- Severing tarsorrhaphy

Lens
- Discission
- Capsulotomy
- Extraction – extracapsular
- Extraction – intracapsular
- Extraction with intraocular lens implant
- Removal/reposition intraocular lens
- Exchange intraocular lens (replacement)

Iris
- Iridotomy
- Iridectomy
- Excision of lesion
- Repair of prolapse
- Repair of dialysis
- Laser photocoagulation
- Iridoplasty
- Argon laser trabeculectomy
- Trabeculoplasty

OPHTHALMOLOGY (cont)

Ciliary Body
- Cyclodiathermy
- Cyclocryopexy
- Excision of prolapse
- Cyclodialysis
- Repair of dialysis

Miscellaneous
- Anesthesia: local
- Anesthesia: regional
- Anesthesia: topical
- History and physical
- Supervision of non-physician personnel
- Goniotomy
- Goniopuncture
- Vitreous tap
- Vitrectomy, anterior
- Vitrectomy, posterior
- Laser photocoagulation for branch retinal vein occlusion
- Anterior membranectomy
- Synechiolysis
- Yag laser capsulotomy
- Lasik

MEDICAL STAFF RULES AND REGULATIONS

EVERGREEN EYE SURGERY CENTER

ADMISSION

Every patient must be admitted by and remain under the care of a member of the medical staff.

Patients will be admitted to Evergreen Eye Surgery Center for treatment without regard to race, color, religion, sex, age, national origin, handicap or sexual preference.

Patients must be accompanied to and from Evergreen Eye Surgery Center by a "responsible individual".

It is the responsibility of the physician to obtain "written informed consent", by the patient, parent or legal guardian, for any surgery performed at Evergreen Eye Surgery Center. The patient will sign a facility consent validating that they did receive informed consent from their surgeon.

No lab work is required at Evergreen Eye Surgery Center. All female patients in child bearing years (ages 10-54) will have a screening pregnancy test (HCG) or sign a refusal for testing. All diabetic patients will have their blood glucose tested preoperatively.

A comprehensive history and physical examination, current within 30 days, which contains a provisional diagnosis and current medications, shall be on the patient chart prior to the surgical procedure.

Patients who are admitted to the facility will remain under the care of a medical staff member throughout their stay in the facility.

ANESTHESIA

Anesthetic procedures performed at Evergreen Eye Surgery Center may include regional, topical, local, oral controlled substances and/or monitored anesthesia care (MAC). The amount of local anesthesia and intraoperative medication shall not exceed toxic levels.

The administration of anesthesia for cases shall be the responsibility of a qualified anesthesiologist or a CRNA.

Anesthesia will not be started until the surgeon is present at Evergreen Eye Surgery Center.

Administration of local, topical and/or infiltrative anesthesia for local cases shall be the sole responsibility of the medical staff physician.

No explosive agents will be available at the facility. The prevention of certain explosive anesthetic agents from being used in the operating room suite is the responsibility of the anesthesia providers.

Strict adherence to the recommended safety precautions outlined in the 2000 edition of the NFPA Life and Safety Code 101 are in effect at the facility.

DRUGS

Drugs used shall meet the standards of the U.S. Pharmacopoeia, National Formulary and New and Non-Official Remedies.

Only those drugs approved for use in the Evergreen Eye Surgery Center formulary may be administered in the facility.

No drugs will be dispensed from Evergreen Eye Surgery Center.

DISCHARGE

Patients shall be discharged after a discharge order is signed by the physician who performed the procedure, as outlined in the policies and procedures incorporated by the medical staff and approved by the Governing Body.

After the patient has been sedated, discharge from the facility is based upon the patient's ability to leave the facility safely when accompanied by a responsible adult and when the physician's postoperative orders have been completed. If no sedative is administered, the patient may be discharged without a chaperone following the written discharge orders of the physician.

An anesthesiologist / anesthetist or another physician qualified in resuscitative techniques is present or immediately available until all patients operated on that day have been discharged.

MEDICAL RECORDS

The physician shall be responsible for the preparation of a complete medical record for each patient.

The medical record must contain an operative summary with a complete description of the operative procedure, any complications and the physician’s signature. Prognosis and infection classification, when appropriate, should be included.

The physician shall oversee the record is complete and signed.

All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse and signed by the physician, at his/her next visit to the facility, or within forty eight (48) hours.

Orders dictated over the telephone shall be signed by the person to whom dictated, with the name of the physician, per his/her own name. The physician shall sign such orders, with signature, at his/her next visit to the facility, or within forty eight (48) hours.

Medical records remaining incomplete for thirty (30) days following the patient's discharge shall be considered delinquent. Physicians with delinquent charts will be notified verbally and this will be recorded. If charts are not completed within thirty (30) days, surgical privileges may be suspended until records are completed.

All surgical procedures performed shall be fully described by the operating surgeon and placed in the patient's chart.

All tissue (except as noted on the tissue exempt list) removed during the operative procedure shall be sent to the facility's contracted lab, which shall make such examinations as may be considered necessary to arrive at a pathological diagnosis.

The surgeon will sign, date and time the pathology report, which shall become a part of the permanent medical record.

All records shall remain the property of Evergreen Eye Surgery Center and shall not be taken from the facility without the express written permission of the Governing Body.

In the case of re-admission of a patient, previous records will be made available for the use of the physician. This shall apply whether the patient is to be attended by the same or another physician.

Members of the medical staff, who are in good standing, shall have access to medical records of all patients under his/her care.

Upon written permission of the Governing Body, patient records may be used for approved study and research, while preserving the confidentiality of personal information regarding the individual patients.

Subject to the discretion of the Governing Body of Evergreen Eye Surgery Center, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all procedures in which they attended their patients in this facility.

Abbreviations used in the medical record must appear on the Evergreen Eye Surgery Center Approved Abbreviations list.

Errors during documentation in the medical record shall be corrected in the proper manner. The method shall include: a) a single line through the part to be corrected; b) corrections made; c) initials of person correcting; and d) date and time correction is made, with an explanation for the correction if appropriate.

POST ANESTHESIA CARE UNIT (PACU)

The PACU will be under the direction of the Medical Director or his/her designate. The Clinical Director will oversee daily operations of the entire facility, reporting to the Medical Director.

Evergreen Eye Surgery Center will not provide accommodations for overnight observation. The admitting practitioner will transfer patients requiring prolonged or overnight observation, due to unanticipated complications, to a hospital.

SCHEDULING

All treatment provided at Evergreen Eye Surgery Center shall be on an elective and pre-scheduled basis.

Physicians admitting patients shall be responsible for giving any known information, as necessary, to secure the protection of other patients and staff from those who are a source of danger from any cause whatsoever.

Patient Criteria for Scheduling**:**

Patients who are candidates for outpatient procedures must meet the following criteria:

- The patient must be in good health (A.S.A. Class I) or with mild systemic disease, which is under good control and does not require special case management (A.S.A. Class II). A.S.A. Class III patients must have recent medical evaluation sufficient to assure that the mild systemic disease is in good control, and such documentation must accompany the patient at the time of admission; e.g., medical clearance from the patient's private physician.

- The patient and/or person signing the consent for procedures must knowingly agree with the concept of outpatient procedures/anesthesia, and must exhibit the ability to use judgment and follow instruction.

- The patient's physical and emotional environment must be conducive to successful outcome.

Criteria for scheduling procedures: Procedures are recommended by the medical staff and approved by the Governing Body**.** Only those procedures approved in the Evergreen Eye Surgery Center's scope of care will be performed in the facility.

STAFF PRIVILEGES

Only physicians who have submitted proper credentials and have been duly appointed to the medical staff by the Governing Body may treat patients.

All case privileges must be granted in writing for each procedure and signed by the Medical Director and Governing Body of Evergreen Eye Surgery Center.

NOTE: A case privilege is a request to perform a procedure, which is not outlined in the privilege request included on the application of the physician.

Temporary privileges may be granted in accord with the parameters outlined in the medical staff bylaws, subject to the approval of the Medical Director and Governing Body.

STAFF REQUIREMENTS

The admitting physician will be available at the facility within sufficient time to evaluate the patient adequately before procedures.

Physicians shall be in the operating room and ready to commence the surgery at the time scheduled, and the operating room will not be held longer than fifteen (15) minutes after the time scheduled. The case may be rescheduled when reasonably possible.

All members of the medical staff must abide by the policies of Evergreen Eye Surgery Center.

COMMITTEE RELATIONSHIPS

EVERGREEN EYE SURGERY CENTER

The Governing Body, by resolution, adopted by a majority of the full Governing Body may designate a Medical Advisory Committee and any other appropriate committees.

The Governing Body, by resolution, adopted in accordance with its article, may designate one or more members as alternate members of any such committee, who may act in the place and instead of, any absent member or members at any meeting of such committee.

MEDICAL ADVISORY COMMITTEE

The Medical Advisory Committee shall consist of the Medical Director, who shall be its chairman. Additional members may include Assistant Medical Director, other members of the medical staff, the Administrator and the Clinical Director.

The committee may include ad hoc members such as the various professional consultants with whom the facility shall have agreements for health related services. The ad hoc members may include a pharmacist, risk manager, infection control specialist, medical records, etc. The committee shall meet at least quarterly in combined meetings with the Governing Body in conjunction with the QAPI committee to review all matters relating to the operation of the facility, including, but not limited to, infection control, tissue review, pharmacy and therapeutics, scope of care, safety and medical records. The committee shall serve as the medical administrative liaison between the medical staff and the Governing Body concerning all rules and regulations for the governance of the facility, or amendments thereto, which the committee considers to be in the best interests of the facility and to assure the proper care of its patients.

AD HOC COMMITTEES

The Medical Advisory Committee may appoint ad hoc committees with the concurrence of the Governing Body for such special tasks as circumstances warrant. An ad hoc committee shall limit its activities to the accomplishments of the task for which it is appointed and shall have no power to act except as specifically authorized by action by the Governing Body. Upon completion of the task for which it is appointed, such ad hoc committees shall stand discharged.

STATEMENT OF MISSION, GOALS AND OBJECTIVES

EVERGREEN EYE SURGERY CENTER

MISSION

Provide quality elective ambulatory surgical care to promote the health and optimal function required to lead active lives.

VISION

Evergreen Eye Surgery Center will provide excellent ambulatory surgical care in our community. We will be the ambulatory surgery healthcare provider of choice. We will have a team of professional personnel who are passionate about patient care and committed to continuously improving our services to our patients. A spirit of collaboration and trust is evident among the medical staff, nursing staff, administrative staff and ancillary personnel.

GOALS AND OBJECTIVES

- To create a safe, convenient and user-friendly environment for patients, physicians and staff
- To provide an atmosphere of compassion and understanding with minimal stress and anxiety.
- To function at a high level of efficiency to accommodate the convenience of both the patient and the physician.
- To facilitate a plan of diagnostic and surgical treatment for each patient.
- To promote knowledge and skills of the facility's staff as a means of meeting technical and scientific progress in the delivery of health care and to be aware of new research, new products and new ideas which may modify and improve present activities and procedures.
- To assure that all information regarding patients is kept private and confidential.
- To ensure that the medical staff, clinical and non-clinical personnel display professional performance and conduct.
- To ensure all patients receive the highest quality care on a completely non-discriminatory basis as to sex, race, color, creed or national origin.

NARRATIVE PROGRAM

EVERGREEN EYE SURGERY CENTER

1. Evergreen Eye Surgery Center is an ambulatory surgical facility established to provide 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.

2. The staffing will consist of:

Administrator	Admissions Clerk
Clinical Director	Instrument Technician
LPN	Medical Assistant
Preop/PACU RN	Operating Room RN
Surgical Technologist	

3. The office will be open for telephone calls and deliveries between 6 am and 5 pm, Monday through Friday.

4. The anticipated surgical volume will initially require approximately 9 hours of operation in one (1) operating room and two (2) procedure room, five (5) days per week.

5. The center will consist of the following rooms and areas, encompassing approximately 3000 square feet:

6. The facility will employ sufficient numbers of professional and support staff to ensure efficient, quality patient care, which might include RNs, LPNs, assistants and technicians. A registered nurse will direct clinical operations.

7. The facility will develop and ensure fiscal soundness through proper budgeting and performance analysis.

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

9. The patient flow process will be as follows:

- The patient and responsible party will enter the waiting room, be greeted by a receptionist, 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.

- The patient will be escorted to the assigned preoperative area. Here, they may remove some of their “street clothes” and don appropriate surgical attire. All patients entering the restricted area will don head covers. Patient belongings will be secured in a locker.

- The patient is made comfortable in the preoperative area.

- The preoperative nurse will interview the patient, perform a preoperative assessment, confirm the patient’s history and understanding of the planned procedure, confirm surgical site identification and implement preoperative physician orders.

- The anesthesia provider will assess the patient preoperatively to evaluate the risk of anesthesia and of the procedure to be performed. This will include a heart and lung assessment. The proposed plan for anesthesia will be discussed with the patient at this time. This will be documented in the patient’s medical record.

- The surgeon will confirm the surgical site identification and examine the patient preoperatively for any changes in the patient’s condition since completion of the most recently documented medical history and physical assessment. This will be documented in the patient’s medical record.

- After the operating room nurse has reconfirmed surgical site identification with the patient, the patient will be transported into the operating room or procedure room. The operating room nurse will position the patient and anesthesia personnel will attach monitoring devices to the patient.

- Anesthesia appropriate to the length and nature of the surgical procedure is administered. This may involve an anesthesiologist/anesthetist, the surgeon and/or an RN nurse monitor.

- The patient is prepped with an antiseptic solution as ordered by the surgeon and sterile drapes are applied to establish a sterile field per surgeon preference.

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

- Soiled instruments are covered and transferred, to soiled utility for decontamination per facility protocol.
- Decontaminated instruments are then transferred to clean utility for sterile processing and storage.
- All soiled waste is removed from the operating room daily and between cases as needed, and securely stored in the biohazard/dirty linen room.
- Biohazardous waste is collected by qualified vendors for proper disposal.
- Soiled linen is collected by qualified vendors for laundering.
- The PACU nursing staff monitors the patient, provides appropriate pain management as needed, and discharge instructions are given to the patient and family as appropriate.
- Prior to discharge, a physician assesses the patient and a discharge order is documented in the medical record.
- The patient is offered nourishment, assisted with changing clothes as needed, and released from the facility to the care of a responsible adult.

EXEMPT TISSUE LIST

EVERGREEN EYE SURGERY CENTER

All tissues removed from the patient during operative and diagnostic procedures will be reviewed by a pathologist with the following exceptions:

- Skin
- Cataracts
- Intraocular lenses
- Foreign bodies
- Cysts
- Chalazion
- Pterygium

Exhibit 5
Federal Way ASF License and Accreditation

Evergreen Eye Surgery Center, Inc.

Federal Way, WA

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Ambulatory Health Care Accreditation Program

August 19, 2015

Accreditation is customarily valid for up to 36 months.

ID #572352

Print/Reprint Date: 08/20/2015

Rebe Patchin, MD
Chair, Board of Commissioners

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care financing Admin.
Region X
Blanchard Plaza Building
Room 800, MIS RX-48
2201 6th Avenue
Seattle, Washington 98121-2J00
Voice 206/61-'·2313
FAX 206/61J-243l

September 10, 1996

Provider No.••
50-C0001131

Richard A. Boudreau,'Administrator
Evergreen Eye Surgery Center•
34 719 6th Avenue South
Federal War, Washington 98003

Dear Mr. Boudreau:

Effect·ive August 20, 1996, we have approved your r·equest to participate as an ambulatory surgical center'"under the Medicare Program. A copy of your Health Insurance Benefit Agreement is enclosed and shou ld be retained for your files.

You should report :to the State Survey. Agency any changes in staffing, services, or othercharacteristics which may affect compliance with the conditions set ·out Iri·'the regulations. The state will visit you•periodical1y to determine'that these conditions are still met.

Aet ;•''£ife·Insurance companywill be in touch with you t;:o .assist you with billing and reimbursement questions.

The provider number shown above should be entered on all forms and correspondence relating to the Medicare Program.

You need to notify us promptly if there is a change of ownership 42 CFR 489.18(b).

If you have any questions about your approval, please let us know.

Sincerely,

Teresa Trimble, Manager
Certification Improvement

Enclosure

cc: PRO-West

Aetna Life Insurance Company
Medicare Claims Administration
PO Box 91099
Seattle, WA 98111-9199
206-621-0359 (Beneficiaries)
206-621-0070 (Providers)

Medicare

Date: 0 nz/t'.'.'!J ,:::;-4 f?7(;?

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Ro

:.P4tr2 «ttJ ea 59i:3

RE: &;.q,.rpv rd&PrN: di)(tQ1t,.) 2 Effective: 05-30-96

Specialty: a":,L!rf£ic! Group #_________ Effective: __________

This is a notification of your Provider Identification Number (PrN) assigned to you by \led:c;;rc. Please use this number on all claims submitted to Medicare by you or your staff.

You specialty is listed above. If this is incorrect, please notify our office.

If you joined a group, please note your Medicare Group Provider Number above. You shouid ,efer to this number when you advise our office of any changes to your file. Each provider in the group :las been assigned an individual PrN. Please refer to the attached listing if more than one provider is being added to the group. Please note that when Medicare issues a Group Provider Identification Number for your group or clinic, Medicaid must be notified. If not. claims that are submitted to the Medicare office will not be crossed ove,.

Your locality is: --""O?D-'-'-'-·•= ---

You are listed as a:

☐-Participating Provider.

DNon-Partic:patinl provider.

Reference Materials:

f:9-New Provider Billing Manual

O Specialty Billing Handbook----- -----

ITI-Locality Fee Schedule

O ASC Packet

O Medicare 10i Video

[]}fMc Information Packet

IJhvledicare Newsletters (6 months)

O Other: _________

Enclosed are reference materials you may find helpful when billing Medicare. If you need additional info,mation or require further assistance, please contact our Provider Relations Department at (206) 621-0070, 9:00 am to 4:00 pm, Monday to Friday.

Sincerely,

Provider Enrollment
Medicare Claim Administration
Aetna Life Insurance Company

Washington State Department of Health

This organization

Evergreen Eye Center

is authorized by RCW 70.230 to have an

Ambulatory Surgical Facility License

Operated by: **Evergreen Eye Center Inc PS**

Medicare # **G217105600**

Located at: **34719 6th Ave S**
Federal Way, WA 98003-8714

Secretary

Credential Number
ASF.FS.60099942

Status	Effective Date	Expiration Date
ACTIVE	**12/12/2016**	**12/12/2019**

THIS LICENSE IS NON-TRANSFERABLE

Exhibit 6
South King County Secondary Health Services Planning Area

Map of Southeast King Planning Area

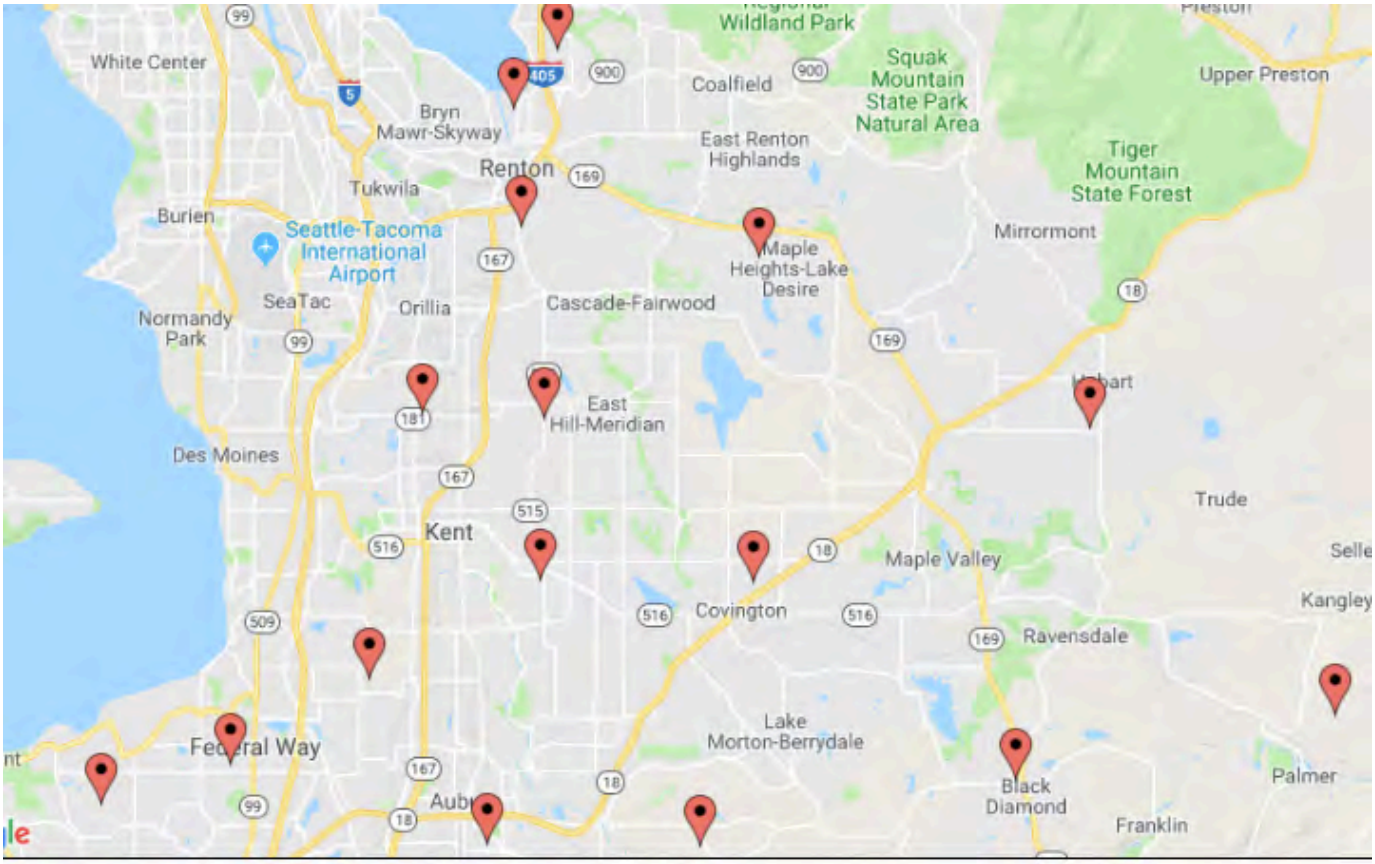

Exhibit 7
Federal Way Historic Services; Identified by Top 30 CPT Codes

	Top 30 procedures performed amounts per year							
	CPT	**2014**	**CPT**	**2015**	**CPT**	**2016**	**CPT**	**2017**
1	66984	2333	66984	2407	66984	2401	66984	2572
2	66821	1489	66999	1746	66999	1946	66821	1206
3	65855	166	66821	1716	66821	1448	66999	585
4	7E+06	137	65855	293	65855	295	65855	302
5	66982	110	66982	151	66761	174	66761	206
6	66761	50	66761	97	66982	156	66982	137
7	65426	38	65426	32	65426	41	S0800	121
8	65756	24	66986	12	66986	11	65426	73
9	7E+06	21	66825	11	65756	8	S0810	55
10	66986	15	65756	9	66020	7	65756	7
11	66825	10	65420	8	66825	7	66986	5
12	669991	6	65730	4	65400	5	61330	2
13	7E+06	5	68110	4	68110	5	65420	2
14	68110	5	65436	3	66985	3	66020	2
15	669999	4	67031	3	67031	3	66825	2
16	65730	4	15823	2	65780	2	66840	2
17	65420	4	65755	2	65865	2	66920	2
18	65400	3	65865	2	66840	2	65780	1
19	66985	3	66250	2	68115	2	66850	1
20	66170	3	65285	1	S0800	2	67036	1
21	66250	3	65400	1	66682	1	67121	1
22	669996	2	65435	1	67840	1	67840	1
23	15822	2	65772	1	68330	1		
24	67810	2	66020	1	S0810	1		
25	66840	2	66170	1				
26	65435	2	66625	1				
27	66850	2	66680	1				
28	68100	1	66985	1				
29	67880	1	67005	1				
30	669992	1	67810	1				

Exhibit 8
Patient Admission and Expected Outcomes Policy

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: **ADMISSION / TREATMENT**		Page 1 of 1
Approved: Jan 2018	Revised: Jan 2018	

POLICY:

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

POLICY:

Evergreen Eye Surgery Center provides ambulatory surgical care.

Patients Served

The patient population served by this facility includes adult patients seeking surgical intervention to diagnose, maintain or restore optimal wellness.

The following defines Evergreen Eye Surgery Center's patient population:
- Young Adult (19-45 years)
- Middle Adult (45-60 years)
- Older Adult (>60 years)

Scope and Complexity of Patient Care Needs

The facility provides a safe and comfortable environment for patients and personnel to assist providers in meeting the health care needs of our patients. The staff provides quality, cost effective, competent care respectful of each patient's rights and dignity. Only ophthalmology procedures are performed at this facility. In the immediate post-procedure phase of the surgical encounter, patients are under the direct supervision of the surgeon or a qualified anesthesia provider, who maintains responsibility for the patient until they have been appropriately discharged from the facility.

Invasive procedures and/or procedures requiring sedation will be performed in an operating room and/or procedure room to meet established facility patient monitoring and personnel requirements.

Staffing

Members of the staff will be assigned daily patient care responsibilities by the Clinical Director. Sufficient nursing personnel will be available to assist with preoperative, intra-operative and postoperative care of patients undergoing surgical procedures per the following standards:

- An ACLS certified RN will be present in the facility whenever patients are present.

- During the intraoperative phase, an RN and physician will be present in the operating room.

- An RN will be present in the PACU area while patients are present.

- The schedule will be evaluated and personnel assigned to nursing care in preoperative area, the operating rooms, PACU areas or other areas, as needed. Other personnel will be assigned according to the type of procedure, expertise, abilities, etc., keeping in mind the number of personnel available, as well as ancillary tasks to be performed, to allow for smooth functioning of the ambulatory surgery facility.

- A physician will be present, not merely immediately available, until all patients operated on that day have been physically discharged.

- In the event of their prolonged absences, the Clinical Director and Medical Director will determine the division of duties among the remaining personnel. During short-term absence such as illness or vacation, a designated RN will assume daily duties.

Staff Qualifications

The nursing staff maintains current licensure and BLS certification. ACLS certification is required for RN's. Organizational membership in the Association of Peri-Operative Registered Nurses (AORN), and the American Society of Post Anesthesia Nurses (ASPAN) is encouraged. A continuous program of inservice education and periodic skills for all personnel is maintained to ensure quality care is provided.

Standards of Practice

The Association of Peri-Operative Registered Nurses (AORN), the American Society of Post Anesthesia Nurses (ASPAN) and the Association for the Advancement of Medical Instrumentation (AAMI) standards are referenced as used in the formulation and review of policies and standards of practice, as well as input from the expertise of the staff.

POLICY:

The patient, who upon a physician's order submits to an outpatient surgery procedure, can expect to be discharged from the facility with the following assurances:

- That the patient understands each form, which requires a signature, and why their signature, or that of a responsible party, is necessary.
- That the patient understands who and how financial responsibility for the procedure will be handled and who generates the bills, if other than the facility.
- That the patient's safety is assured, when appropriate, by having a responsible person available to provide transportation home.
- That the procedures were coordinated in such a way as to provide for accuracy of scheduling as well as efficiency of time.
- That the procedure was performed safely and accurately by qualified personnel and only according to the physician's specific instructions and plan of care.
- That qualified personnel were available at all times to answer questions.
- That the patient's privacy has been provided for and respected.
- That the patient suffered no undue anxiety because the procedure was insufficiently explained.
- That the patient's pain was treated as effectively as possible.
- That precaution to ensure the patient's safety has been practiced at all times.
- That, should a sudden change in the patient's condition occur requiring emergency interventions, trained personnel and necessary equipment were readily available.
- That the patient's valuables and belongings have been kept in safekeeping until discharge.
- That the patient understands what the postop prescriptions are for, when to take them and precautions to observe when taking certain drugs which affect sensory-motor function, when applicable.

- That the patient and responsible party understand exactly how to take responsibility for home care.

- That the patient and responsible party know exactly what untoward signs and/or symptoms to look for after discharge, which would alert them to possible problems.

- That the patient knows who to call for help, if untoward signs and/or symptoms become apparent.

- That the patient was treated as a unique individual with the respect and dignity, which are recognized as a fundamental right of every patient entering this facility.

Exhibit 9
Patient Rights and Responsibilities

Evergreen Eye Surgery Center has established this Patient's Bill of Rights as a policy with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her physician, and the facility organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organized structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

No catalog of rights can guarantee the patient the kind of treatment he has a right to expect. This facility has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his/her dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy and security for self and property.
- Have a surrogate (parent, legal guardian, person with medical power of attorney) exercise the Patient Rights when you are unable to do so, without coercion, discrimination or retaliation.
- Confidentiality of records and disclosures and the right to access information contained in your clinical record. Except when required by law, you have the right to approve or refuse the release of records.
- Information concerning your diagnosis, treatment and prognosis, to the degree known.
- Participate in decisions involving your healthcare and be fully informed of and to consent or refuse to participate in any unusual, experimental or research project without compromising your access to services.
- Make decisions about medical care, including the right to accept or refuse medical or surgical treatment after being adequately informed of the benefits, risks and alternatives, without coercion, discrimination or retaliation.

- Self-determination including the rights to accept or to refuse treatment and the right to formulate an advance directive.
- Competent, caring healthcare providers who act as your advocates and treats your pain as effectively as possible.
- Know the identity and professional status of individuals providing service and be provided with adequate education regarding self-care at home, written in language you can understand.
- Be free from unnecessary use of physical or chemical restraint and or seclusion as a means of coercion, convenience or retaliation. Be able to access protective services as needed.
- Know the reason(s) for your transfer either inside or outside the facility.
- Impartial access to treatment and spiritual care regardless of race, age, sex, ethnicity, religion, sexual orientation, or disability.
- Receive an itemized bill for all services within a reasonable period of time and be informed of the source of reimbursement and any limitations or constraints placed upon your care.
- File a grievance with the facility by contacting the Clinical Director, via telephone or in writing, when you feel your rights have been violated.

  Jill Fielding, RN
  34719 6th Avenue South
  Federal Way, WA 98003
  (206) 212-2118 Phone

- Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
- Know about any business relationships among the facility, healthcare providers, and others that might influence your care or treatment.
- File a complaint of suspected violations of health department regulations and/or patient rights. Complaints may be filed at:

  HSQA Complaint Intake
  Post Office Box 47857
  Olympia, WA 98504-7857
  (360) 236-4700
  (800) 633-6828
  HSQAComplaintIntake@doh.wa.gov

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

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).
- Following the treatment plan recommended by the primary physician involved in your case.
- Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.
- Indicating whether you clearly understand a contemplated course of action, and what is expected of you, and ask questions when you need further information.
- Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
- Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.
- Providing information about, and/or copies of any living will, power of attorney or other directive that you desire us to know about.

COMO PACIENTE, USTED TIENE DERECHO A:

- En todo momento y bajo cualquier circunstancia se le debe tratar con respeto y consideración a su dignidad personal.
- Privacidad personal e informacional al igual que seguridad propia y de propiedad.
- Tener un sustituto (padre, madre, guardián, persona con poder medico de un abogado) que ejerza los derechos del paciente dado que sea incapaz de hacerlo, sin coerción, discriminación, o venganza.
- Confidencialidad de información, registros e revelaciones y el derecho a conseguir acceso a información contenida en su registro clínico. Aparte de cuando la información sea requerida por la ley, usted tiene el derecho de aprobar o negar el hacer público sus registros.
- Información respecto al diagnóstico, tratamiento y pronóstico, del tema tratado.
- Participar y estar informado en decisiones que estén relacionadas con su salud y la aprobación o la negación de participar en algo inusual, experimental o algún proyecto de investigación sin comprometer su acceso a servicios.

- Tomar decisiones sobre su cuidado medico, incluyendo el derecho a aceptar o negar tratamiento médico o quirúrgico después de haber sido informado adecuadamente de los beneficios, riesgos y alternativas sin coacción, discriminación, o venganza.

- Personal competente que actúe como su defensor y que trate su dolor tan efectivamente como sea posible.

- Saber la identidad y capacidad profesional de las personas que le proveen un servicio y ser proveído con los conocimientos adecuados de sus cuidados en casa, escritos en un lenguaje que usted pueda entender.

- Ser libre de uso innecesario de restricción física o química y del aislamiento como un medio de coerción, conveniencia o venganza. Ser capaz de acceder a los servicios de protección, según sea necesario.

- Conocer la razón de su traslado dentro o afuera de la sala quirúrgica.

- Acceso imparcial de tratamiento y la atención espiritual, sin importar raza, edad, sexo, etnicidad, orientación sexual, nacionalidad, religión, o discapacidad.

- Recibir la cuenta desglosada por todos los servicios en un periodo de tiempo razonable y ser informado de la fuente de reembolso y cualquier limitación o restricción colocado sobre su cuidado.

- Cuando crees que tus derechos han sido violados reporta un agravio con la facilidad con el director de la clínica a:

  Jill Fielding, RN
  34719 6th Avenue South
  Federal Way, WA 98003
  (206) 212-2118 Phone

- Reportar cualquier comentario sobre la cualidad de los servicios recibidos en su estadía en la clínica y recibir un seguimiento justo a sus comentarios.

- Conocer de cualquier relación de negocios que tenga el lugar, proveedores de cuidado y otros que puedan influenciar su cuidado o tratamiento.

- Presentar una queja de sospecho de violaciones de regulaciones o derechos de pacientes del departamento de salud. Quejas pueden ser presentadas a:

  HSQA Complaint Intake
  Post Office Box 47857
  Olympia, WA 98504-7857
  (360) 236-4700
  (800) 633-6828
  HSQAComplaintIntake@doh.wa.gov

Oficina de Beneficiario de Medicare Defensor del Pueblo
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

COMO UN PACIENTE, USTED ES RESPONSABLE DE:

- Proveer lo mejor que pueda de información completa acerca de su salud e actual historial médico pasado y reportar cualquier cambio inesperado a los practicantes presentes.
- Seguir el tratamiento recomendado por el médico involucrado directamente en su caso.
- Asignar a una persona adulta que lo transporte a casa después de una cirugía, así como también un adulto responsable por su cuidado en casa por las primeras 24 horas después de la cirugía.
- Indicar claramente si ha entendido, el curso de acción y que es esperado de su parte. Así como hacer preguntas cuando necesite; información adicional.
- Sus acciones si se niega al tratamiento, abandona, el lugar en contra de lo expuesto por el practicante, y/o no seguir las indicaciones del practicante que estén relacionadas con su cuidado.
- Asegurarse de que sus obligaciones financieras por su cuidado medico estén cubiertas.
- Proveer información acerca de o copias de cualquier testamento en vida, poder legal u otra indicación que usted tenga dispuesta.

Exhibit 10
Non-Discrimination Policy

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: **EMPLOYEE NON-DISCRIMINATION**		Page 1 of 1
Approved: Jan 2018	Revised: Jan 2018	

POLICY:

With regard to employment, the facility does not discriminate on the basis of disability; in addition, there is no discrimination on the basis of age, sex, sexual orientation, race, color, religion and national origin where such discrimination would have a discriminatory effect on beneficiaries.

This information is presented to all employees and volunteers as part of new employee orientation. This information is reviewed annually with each employee as part of the health and safety training.

All applicants for positions at the facility are presented with the policy of non-discrimination upon application.

Employees are assured immunity from discrimination, if they decline an assignment as a matter of conscience or religious values.

Policies and procedures have been established for patients and employees to file a grievance when an issue of perceived discrimination arises.

Exhibit 11
Charity Care and Community Service Plan Policy

EVERGREEN EYE CENTER
Leading-edge, patient-centered care.

Financial Hardship Policy

Patients are expected to pay for services rendered. Billing will assist patients who indicate they are unable to meet their financial obligations resulting from care provided by our practice. Patients may be determined as eligible for partial to full discounts utilizing the current poverty guidelines issued by the state and federal government.

1. Exclusions from this policy are:
    a. Medical care defined as not medically necessary (cosmetic surgery, etc)
    b. Services rendered to persons who are eligible, but have not applied for, medical insurance or assistance programs sponsored by Federal, State, or local government.

2. Financial Hardship/Charity Care may be extended to those who qualify for all four (4) of these reasons:
    a. The patient is not eligible for Medicaid or pending Medicaid approval;
    b. The patient is determined to be unable to pay for services provided;
    c. The patient is unable to accept an installment payment arrangement; and
    d. The patient agrees to make payment at the time the discount is granted.

If a patient is identified by the billing office to be considered for financial hardship/charity care they will be mailed a "Financial Hardship" application to complete which must be returned within 30 days to be eligible. The patient must also provide one of the accepted OIG documents listed below to verify income.

    a. W-2 withholding statements
    b. Income tax return
    c. Forms from Medicaid or other state funded medical programs
    d. Forms from employers or welfare agencies.

2. Patient has other circumstances that indicate financial hardship:
    a. Catastrophic situations (death or disability in family)
    b. Other documentation that shows patient would not be able to pay the medical bill.

Rev 3/22/2017

Financial hardship or charity care discounts will be calculated using a percentage based on the patient's annual income and the current State/Federal Poverty Level.

Percent of State/Federal Poverty Level-Annual Income 2017		
Family Size	**100% = 75%**	**200% = 50%**
1	$12,060	$24,120
2	$16,240	$32,480
3	$20,420	$40,840
4	$24,600	$49,200
5	$28,780	$57,560
6	$32,960	$65,920
7	$37,140	$74,289
8	$41,320	$82,640
Each Add'l	$4,180	$8,360

Returned Hardship applications will be given the billing manager to review and determine if the patient qualifies for any type of financial assistance. The patient will be sent a notification letter within 30 days of receipt outlining whether or not their application has been approved. The documents will be scanned into the "secured billing tab" in Nextech and the discount amount granted will be entered in the patient's account notes tab. The manager will adjust the balance using the adjustment category code "Hardship".

The patient's account status will never be permanently designated as charity care or financial hardship. The financial assistance is considered/approved for the current balance due at the time the request is made.

Rev 3/22/2017

EVERGREEN EYE CENTER
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Patient Financial Hardship Application

PATIENT INFORMATION			
Name		Date(s) of Service	
Phone		☐ Employed *Employer name and address:*	☐ Unemployed *If unemployed, how long?*
Name of Responsible Party			
Relationship to Patient			
Address, City, State, ZIP			

HOUSEHOLD INFORMATION			
Spouse Name		Number of family members living in household	
☐ Employed *Employer name and address:*	☐ Unemployed *If unemployed, how long?*	Other family member employer name and address	Other family member employer name and address
Employer Address, City, State, ZIP			

MONTHLY FAMILY INCOME AND SOURCE			
	☑ Patient ☐ Spouse ☐ Responsible Party ☐ Children Working		
Monthly Salary (Gross)	$	Social Security Benefits	$
Public Assistance Benefits	$	Worker's Compensation	$
Unemployment Benefits	$	Child Support:	$
Other (Alimony, etc.) *Specify*	$		
Deny		**Total Family Income:**	**$**

AGREEMENT

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.

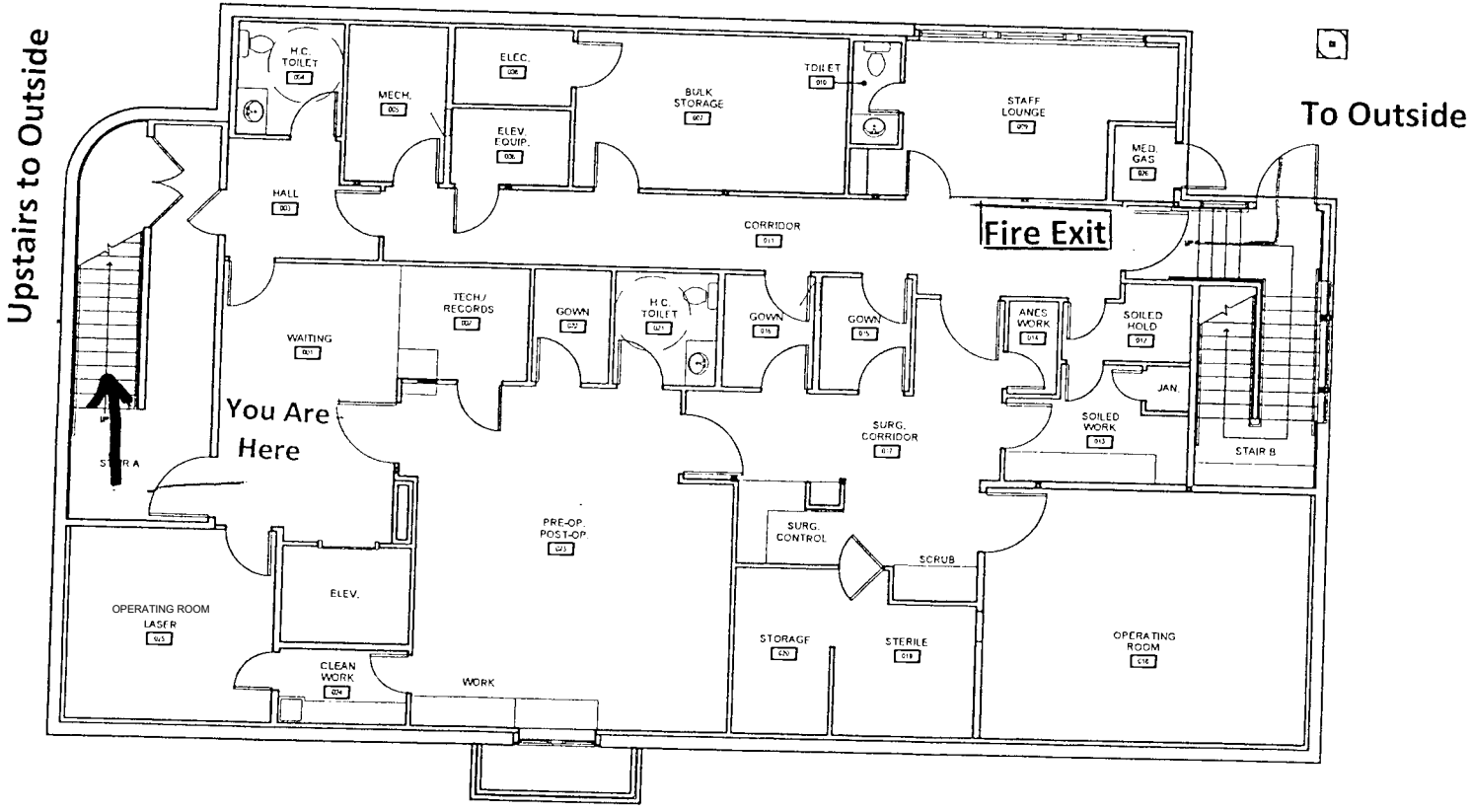
SIGNATURE(S)			
Signature		Signature	
Print Name		Print Name	
Date		Date	

Your request will NOT be processed if this application is not signed and/or the requested information is not provided.
Application must be returned by mail or in-person within 30 days of receipt to be considered.

Disapproved by: _____ Date: _____ -This section staff use only- Approved by: _____ Date: _____

Exhibit 12
Single Line Drawing

Surgery Center



BASEMENT PLAN

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

BOMA CALCULATIONS FOR

EVERGREEN EYE CENTER

FEDERAL WAY, WA

Exhibit 13
Lease Agreement

FW

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)

THIS LEASE AGREEMENT (the "Lease") is entered into and effective as of September 1, 2015 (date), between Jarstad Family, LLC, a Washington limited liability company ("Landlord"), and Evergreen Eye Center, Inc. P.S., a Washington corporation (Tenant"). Landlord and Tenant agree as follows:

1. LEASE SUMMARY.

a. **Leased Premises.** The leased commercial real estate (the "Premises") consists of the real property legally described on attached Exhibit A, and all improvements thereon, and commonly described as Evergreen Eye Center Building, 34719 6th Avenue South, Federal Way, WA 98003

b. **Lease Commencement Date.** The term of this Lease shall be for a period of 126 months and shall commence on September 1, 2015 or such earlier or later date as provided in Section 3 (the "Commencement Date").

c. **Lease Termination Date.** The term of this Lease shall terminate at midnight on February 28, 2026 or such earlier or later date as provided in Section 3 (the "Termination Date"). Tenant shall have no right or option to extend this Lease, unless otherwise set forth in a rider attached to this Lease (e.g., Option to Extend Rider, CBA Form OR).

d. **Base Rent.** The base monthly rent shall be (check one): ☐ $_____, or ■ according to the Rent Rider attached hereto ("Base Rent"). Rent shall be payable at Landlord's address shown in Section 1(h) below, or such other place designated in writing by Landlord.

e. **Prepaid Rent.** Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $ N/A as prepaid rent, to be applied to the Rent due for the months _____ through _____ of the Lease.

f. **Security Deposit.** Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $ (See Addendum) to be held as a security deposit pursuant to Section 5 below. The security deposit shall be in the form of (check one): ☐ cash, or ☐ letter of credit according to the Letter of Credit Rider (CBA Form LCR) attached hereto.

g. **Permitted Use.** The Premises shall be used only for Medical Office, Surgical Procedures and related services.

and for no other purpose without the prior written consent of Landlord (the "Permitted Use").

h. **Notice and Payment Addresses.**

Landlord: Jarstad Family, LLC
832 S W 295th St
Federal Way, WA 98023
Fax No..
Email:

Tenant: Evergreen Eye Center, Inc P S.
P O Box 25020
Federal Way, WA 98093
Fax No :
Email:

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)
(Continued)

2. PREMISES.

a. Lease of Premises. Landlord leases to Tenant, and Tenant leases from Landlord the Premises upon the terms specified in this Lease.

b. Acceptance of Premises. Except as specified elsewhere in this Lease, Landlord makes no representations or warranties to Tenant regarding the Premises, including the structural condition of the Premises or the condition of all mechanical, electrical, and other systems on the Premises. Except for any tenant improvements to be completed by Landlord as described on attached Exhibit B (the "Landlord's Work"), Tenant shall be responsible for performing any work necessary to bring the Premises into a condition satisfactory to Tenant. By signing this Lease, Tenant acknowledges that it has had an adequate opportunity to investigate the Premises; acknowledges responsibility for making any corrections, alterations and repairs to the Premises (other than the Landlord's Work); and acknowledges that the time needed to complete any such items shall not delay the Commencement Date.

c. Tenant Improvements. Attached Exhibit B sets forth all Tenant's Work, if any, and all tenant improvements to be completed by Tenant (the "Tenant's Work"), if any, that will be performed on the Premises. Responsibility for design, payment and performance of all such work shall be as set forth on attached Exhibit B. If Tenant fails to notify Landlord of any defects in the Landlord's Work within thirty (30) days of delivery of possession to Tenant, Tenant shall be deemed to have accepted the Premises in their then condition. If Tenant discovers any major defects in the Landlord's Work during this 30-day period that would prevent Tenant from using the Premises for the Permitted Use, Tenant shall notify Landlord in writing and the Commencement Date shall be delayed until after Landlord has notified Tenant that Landlord has corrected the major defects and Tenant has had five (5) days to inspect and approve the Premises. The Commencement Date shall not be delayed if Tenant's inspection reveals minor defects in the Landlord's Work that will not prevent Tenant from using the Premises for the Permitted Use. Tenant shall prepare a punch list of all minor defects in Landlord's Work and provide the punch list to Landlord, which Landlord shall promptly correct.

3. TERM. The term of this Lease shall commence on the Commencement Date specified in Section 1, or on such earlier or later date as may be specified by notice delivered by Landlord to Tenant advising Tenant that the Premises are ready for possession and specifying the Commencement Date, which shall not be less than N/A days (thirty (30) days if not filled in) following the date of such notice.

a. Early Possession. If Landlord permits Tenant to possess or occupy the Premises prior to the Commencement Date specified in Section 1, then such early occupancy shall not advance the Commencement Date or the Termination Date set forth in Section 1, but otherwise all terms and conditions of this Lease shall nevertheless apply during the period of early occupancy before the Commencement Date.

b. Delayed Possession. Landlord shall act diligently to make the Premises available to Tenant; provided, however, neither Landlord nor any agent or employee of Landlord shall be liable for any damage or loss due to Landlord's inability or failure to deliver possession of the Premises to Tenant as provided in this Lease. If possession is delayed, the Commencement Date set forth in Section 1 shall also be delayed. In addition, the Termination Date set forth in Section 1 shall be modified so that the length of the Lease term remains the same. If Landlord does not deliver possession of the Premises to Tenant within days (sixty (60) days if not filled in) after the Commencement Date specified in Section 1, Tenant may elect to cancel this Lease by giving written notice to Landlord within ten (10) days after such time period ends. If Tenant gives such notice of cancellation, the Lease shall be cancelled, all prepaid rent and security deposits shall be refunded to Tenant, and neither Landlord nor Tenant shall have any further obligations to the other.

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)

The first "lease year" shall commence on the Commencement Date and shall end on the date which is twelve (12) months from the end of the month in which the Commencement Date occurs. Each successive lease year during the initial term and any extension terms shall be twelve (12) months, commencing on the first day following the end of the preceding Lease Year. To the extent that the tenant improvements are not completed in time for the Tenant to occupy or take possession of the Premises on the Commencement Date due to the failure of Tenant to fulfill any of its obligations under this Lease, the Lease shall nevertheless commence on the Commencement Date set forth in Section 1.

4. **RENT**.

a. Payment of Rent. Tenant shall pay Landlord without notice, demand, deduction, or offset, in lawful money of the United States, the monthly Base Rent stated in Section 1 in advance on or before the first day of each month during the Lease term beginning on (check one): ■ the Commencement Date, or ☐ _____ (if no date specified, then on the Commencement Date), and shall also pay any other additional payments due to Landlord ("Additional Rent"), including Operating Costs (collectively the "Rent") when required under this Lease. Payments for any partial month at the beginning or end of the Lease shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall also constitute Additional Rent, and upon failure of Tenant to pay any such costs, charges or expenses, Landlord shall have the same rights and remedies as otherwise provided in this Lease for the failure of Tenant to pay rent.

b. Triple Net Lease. This Lease is what is commonly called a "Net, Net, Net" or "triple-net" Lease, which means that, except as otherwise expressly provided herein, Landlord shall receive all Base Rent free and clear of any and all other impositions, taxes, liens, charges or expenses of any nature whatsoever in connection with the ownership and operation of the Premises. In addition to Base Rent, Tenant shall pay to the parties respectively entitled thereto, or satisfy directly, all Additional Rent and other impositions, insurance premiums, repair and maintenance charges, and any other charges, costs, obligations, liabilities, requirements, and expenses,, which arise with regard to the Premises or may be contemplated under any other provision of the Lease during its term, except for costs and expenses expressly made the obligation of Landlord in this Lease.

c. Late Charges; Default Interest. If any sums payable by Tenant to Landlord under this Lease are not received within five (5) business days after their due date, Tenant shall pay Landlord an amount equal to the greater of $100 or five percent (5%) of the delinquent amount for the cost of collecting and handling such late payment in addition to the amount due and as Additional Rent. All delinquent sums payable by Tenant to Landlord and not paid within five (5) business days after their due date shall, at Landlord's option, bear interest at the rate of fifteen percent (15%) per annum, or the highest rate of interest allowable by law, whichever is less (the "Default Rate"). Interest on all delinquent amounts shall be calculated from the original due date to the date of payment.

d. Less Than Full Payment. Landlord's acceptance of less than the full amount of any payment due from Tenant shall not be deemed an accord and satisfaction or compromise of such payment unless Landlord specifically consents in writing to payment of such lesser sum as an accord and satisfaction or compromise of the amount which Landlord claims. Any portion that remains to be paid by Tenant shall be subject to the late charges and default interest provisions of this Section 4.

5. **SECURITY DEPOSIT**. Upon execution of this Lease, Tenant shall deliver to Landlord the security deposit specified in Section 1 above. Landlord's obligations with respect to the security deposit are those of a debtor and not of a trustee, and Landlord may commingle the security deposit with its other funds. If Tenant breaches any covenant or condition of this Lease, including but not limited to the payment of Rent, Landlord may apply all or any part of the security deposit to the payment of any sum in default and any damage suffered

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)
(Continued)

by Landlord as a result of Tenant's breach. Tenant acknowledges, however, that the security deposit shall not be considered as a measure of Tenant's damages in case of default by Tenant, and any payment to Landlord from the security deposit shall not be construed as a payment of liquidated damages for Tenant's default. If Landlord applies the security deposit as contemplated by this Section, Tenant shall, within five (5) days after written demand therefore by Landlord, deposit with Landlord the amount so applied. If Tenant complies with all of the covenants and conditions of this Lease throughout the Lease term, the security deposit shall be repaid to Tenant without interest within thirty (30) days after the surrender of the Premises by Tenant in the condition required hereunder by Section 11 of this Lease.

6. **USES**. The Premises shall be used only for the Permitted Use specified in Section 1 above, and for no other business or purpose without the prior written consent of Landlord. No act shall be done on or around the Premises that is unlawful or that will increase the existing rate of insurance on the Premises, or cause the cancellation of any insurance on the Premises. Tenant shall not commit or allow to be committed any waste upon the Premises, or any public or private nuisance. Tenant shall not do or permit anything to be done on the Premises which will obstruct or interfere with the rights of other tenants or occupants of the Premises, or their employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees or to injure or annoy such persons.

7. **COMPLIANCE WITH LAWS**. Tenant shall not cause or permit the Premises to be used in any way which violates any law, ordinance, or governmental regulation or order. Landlord represents to Tenant that, as of the Commencement Date, to Landlord's knowledge, but without duty of investigation, and with the exception of any Tenant's Work, the Premises comply with all applicable laws, rules, regulations, or orders, including without limitation, the Americans With Disabilities Act, if applicable, and Landlord shall be responsible to promptly cure at its sole cost any noncompliance which existed on the Commencement Date. Tenant shall be responsible for complying with all laws applicable to the Premises as a result of the Permitted Use, and Tenant shall be responsible for making any changes or alterations as may be required by law, rule, regulation, or order for Tenant's Permitted Use at its sole cost and expense. Otherwise, if changes or alterations are required by rule, law, regulation, or order unrelated to the Permitted Use, Landlord shall make changes and alterations at its expense.

8. **UTILITIES**. Landlord shall not be responsible for providing any utilities to the Premises and shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and rent shall not abate as a result thereof, except to the extent due to the intentional misconduct or gross negligence of Landlord. Tenant shall be responsible for determining whether available utilities and their capacities will meet Tenant's needs. Tenant shall install and connect, if necessary, and directly pay for all water, sewer, gas, janitorial, electricity, garbage removal, heat, telephone, and other utilities and services used by Tenant on the Premises during the term, whether or not such services are billed directly to Tenant. Tenant will also procure, or cause to be procured, without cost to Landlord, all necessary permits, licenses or other authorizations required for the lawful and proper installation, maintenance, replacement, and removal on or from the Premises of wires, pipes, conduits, tubes, and other equipment and appliances for use in supplying all utilities or services to the Premises. Landlord, upon request of Tenant, and at the sole expense and liability of Tenant, shall join with Tenant in any reasonable applications required for obtaining or continuing such utilities or services.

9. **TAXES**. Tenant shall pay all Taxes (defined below) applicable to the Premises during the Lease term. All payments for Taxes shall be made at least ten (10) days prior to their due date. Tenant shall promptly furnish Landlord with satisfactory evidence that Taxes have been paid. If any Taxes paid by Tenant cover any period of time before or after the expiration of the term, Tenant's share of those Taxes paid will be prorated to cover only the period of time within the tax fiscal year during which this Lease was in effect, and Landlord shall

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)
(Continued)

promptly reimburse or credit Tenant to the extent required. If Tenant fails to timely pay any Taxes, Landlord may pay them, and Tenant shall repay such amount to Landlord upon demand. Landlord may also elect to pay all such Taxes directly to the appropriate taxing authority/ies and receive reimbursement thereof from Tenant within ten (10) days after invoice, either of the full amount paid or at Landlord's election in equal monthly installments.

The term "Taxes" shall mean: (i) any form of tax or assessment imposed on the Premises by any authority, including any city, county, state or federal government, or any improvement district, as against any legal or equitable interest of Landlord or Tenant in the Premises or in the real property of which the Premises are a part, or against rent paid for leasing the Premises; and (ii) any form of personal property tax or assessment imposed on any personal property, fixtures, furniture, tenant improvements, equipment, inventory, or other items, and all replacements, improvements, and additions to them, located on the Premises, whether owned by Landlord or Tenant. "Taxes" shall exclude any net income tax imposed on Landlord for income that Landlord receives under this Lease.

Tenant may, upon reasonable prior notice to Landlord, contest the amount or validity, in whole or in part, of any Taxes at its sole expense, only after paying such Taxes or posting such security as Landlord may reasonably require in order to protect the Premises against loss or forfeiture. Upon the termination of any such proceedings, Tenant shall pay the amount of such Taxes or part of such Taxes as finally determined, together with any costs, fees, interest penalties, or other related liabilities. Landlord shall reasonably cooperate with Tenant in contesting any Taxes, provided Landlord incurs no expense or liability in doing so.

10. **ALTERATIONS**. Tenant may make alterations, additions or improvements to the Premises, including any Tenant Work identified on attached Exhibit C (the "Alterations"), only with the prior written consent of Landlord, which, with respect to Alterations not affecting the structural components of the Premises or utility systems therein, shall not be unreasonably withheld, conditioned, or delayed. Landlord shall have thirty (30) days in which to respond to Tenant's request for any Alterations so long as such request includes the name of Tenant's contractors and reasonably detailed plans and specifications therefore. The term "Alterations" shall not include the installation of shelves, movable partitions, Tenant's equipment, and trade fixtures that may be performed without damaging existing improvements or the structural integrity of the Premises and Landlord's consent shall not be required for Tenant's installation or removal of those items. Tenant shall perform all work at Tenant's expense and in compliance with all applicable laws and shall complete all Alterations in accordance with plans and specifications approved by Landlord, using contractors approved by Landlord. Tenant shall pay, when due, or furnish a bond for payment (as set forth in Section 18) all claims for labor or materials furnished to or for Tenant at or for use in the Premises, which claims are or may be secured by any mechanics' or materialmens' liens against the Premises or any interest therein. Tenant shall remove all Alterations at the end of the Lease term unless Landlord conditioned its consent upon Tenant leaving a specified Alteration at the Premises, in which case Tenant shall not remove such Alteration, and it shall become Landlord's property. Tenant shall immediately repair any damage to the Premises caused by removal of Alterations.

11. **REPAIRS AND MAINTENANCE; SURRENDER.** Tenant shall, at its sole expense, maintain the entire Premises including without limitation the roof surface and normal repairs and maintenance to all heating, ventilation, and air conditioning ("HVAC") equipment at the Premises, in good condition and promptly make all repairs and replacements, whether structural or non-structural, necessary to keep the Premises in safe operating condition, including all utilities and other systems serving the Premises, but excluding the roof structure, subfloor, foundation, exterior walls, and capital repairs and replacements to the HVAC system (collectively, "Landlord's Repair Items"), which Landlord shall maintain in good condition and repair at Landlord's expense, provided that Tenant shall not damage any Landlord's Repair Items and shall promptly repair any damage or injury done thereto caused by Tenant or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. Notwithstanding anything in

LEASE AGREEMENT
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(Continued)

this Section to the contrary, Tenant shall not be responsible for any repairs to the Premises made necessary by the negligence or willful misconduct of Landlord or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees therein. If Tenant fails to perform Tenant's obligations under this Section, Landlord may at Landlord's option enter upon the Premises after ten (10) days' prior notice to Tenant and put the same in good order, condition and repair and the cost thereof together with interest thereon at the default rate set forth in Section 4 shall be due and payable as Additional Rent to Landlord together with Tenant's next installment of Base Rent. Upon expiration of the Lease term, whether by lapse of time or otherwise, Tenant shall promptly and peacefully surrender the Premises, together with all keys, to Landlord in as good condition as when received by Tenant from Landlord or as thereafter improved, reasonable wear and tear and insured casualty excepted.

12. **ACCESS AND RIGHT OF ENTRY**. After twenty-four (24) hours' notice from Landlord (except in cases of emergency, when no notice shall be required), Tenant shall permit Landlord and its agents, employees and contractors to enter the Premises at all reasonable times to make repairs, inspections, alterations or improvements, provided that Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises. This Section shall not impose any repair or other obligation upon Landlord not expressly stated elsewhere in this Lease. After reasonable notice to Tenant, Landlord shall have the right to enter the Premises for the purpose of (a) showing the Premises to prospective purchasers or lenders at any time, and to prospective tenants within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term; and, (b) for posting "for lease" signs within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term.

13. **SIGNAGE**. Tenant shall obtain Landlord's written consent as to size, location, materials, method of attachment, and appearance, before installing any signs upon the Premises. Tenant shall install any approved signage at Tenant's sole expense and in compliance with all applicable laws. Tenant shall not damage or deface the Premises in installing or removing signage and shall repair any injury or damage to the Premises caused by such installation or removal.

14. **DESTRUCTION OR CONDEMNATION**.

a. Damage and Repair. If the Premises are partially damaged but not rendered untenantable, by fire or other insured casualty, then Landlord shall diligently restore the Premises to the extent required below and this Lease shall not terminate. The Premises shall not be deemed untenantable if twenty-five percent (25%) or less of the Premises are damaged. Landlord shall have no obligation to restore the Premises if insurance proceeds are not available to pay the entire cost of such restoration. If insurance proceeds are available to Landlord but are not sufficient to pay the entire cost of restoring the Premises, or if Landlord's lender shall not permit all or any part of the insurance proceeds to be applied toward restoration, then Landlord may elect to terminate this Lease and keep the insurance proceeds, by notifying Tenant within sixty (60) days of the date of such casualty.

If the Premises are entirely destroyed, or partially damaged and rendered untenantable, by fire or other casualty, Landlord may, at its option: (a) terminate this Lease as provided herein, or (b) restore the Premises to their previous condition to the extent required below; provided, however, if such casualty event occurs during the last six (6) months of the Lease term (after considering any option to extend the term timely exercised by Tenant) then either Tenant or Landlord may elect to terminate the Lease. If, within sixty (60) days after receipt by Landlord from Tenant of written notice that Tenant deems the Premises untenantable, Landlord fails to notify Tenant of its election to restore the Premises, or if Landlord is unable to restore the Premises within six (6) months of the date of the casualty event, then Tenant may elect to terminate the Lease upon twenty (20) days' written notice to Landlord unless Landlord, within such twenty (20) day period, notifies Tenant that it will in fact restore the Premises or actually completes such restoration work to the extent required below, as applicable.

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)
(Continued)

If Landlord restores the Premises under this Section 14, Landlord shall proceed with reasonable diligence to complete the work, and the base monthly rent shall be abated in the same proportion as the untenantable portion of the Premises bears to the whole Premises, provided that there shall be a rent abatement only if the damage or destruction of the Premises did not result from, or was not contributed to directly or indirectly by the act, fault or neglect of Tenant, or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. No damages, compensation or claim shall be payable by Landlord for inconvenience, loss of business or annoyance directly, incidentally or consequentially arising from any repair or restoration of any portion of the Premises. Landlord shall have no obligation to carry insurance of any kind for the protection of Tenant or any alterations or improvements paid for by Tenant; any Tenant Improvements identified in Exhibit C (regardless of who may have completed them); Tenant's furniture; or on any fixtures, equipment, improvements or appurtenances of Tenant under this Lease, and Landlord's restoration obligations hereunder shall not include any obligation to repair any damage thereto or replace the same.

b. Condemnation. If the Premises are made untenantable by eminent domain, or conveyed under a threat of condemnation, this Lease shall automatically terminate as of the earlier of the date title vests in the condemning authority or the condemning authority first has possession of the Premises and all Rents and other payments shall be paid to that date. If the condemning authority takes a portion of the Premises that does not render the Premises untenantable, then this Lease shall continue in full force and effect and the base monthly rent shall be equitably reduced based on the proportion by which the floor area of any structures is reduced The reduction in Rent shall be effective on the earlier of the date the condemning authority first has possession of such portion or title vests in the condemning authority. Landlord shall be entitled to the entire award from the condemning authority attributable to the value of the Premises and Tenant shall make no claim for the value of its leasehold. Tenant shall be permitted to make a separate claim against the condemning authority for moving expenses, provided that in no event shall Tenant's claim reduce Landlord's award.

15. INSURANCE.

a. Tenant's Liability Insurance. During the Lease term, Tenant shall pay for and maintain commercial general liability insurance with broad form property damage and contractual liability endorsements. This policy shall name Landlord, its property manager (if any), and other parties designated by Landlord as additional insureds using an endorsement form acceptable to Landlord, and shall insure Tenant's activities and those of Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees with respect to the Premises against loss, damage or liability for personal injury or bodily injury (including death) or loss or damage to property with a combined single limit of not less than $2,000,000, and a deductible of not more than $10,000. Tenant's insurance will be primary and noncontributory with any liability insurance carried by Landlord. Landlord may also require Tenant to obtain and maintain business income coverage for at least six (6) months, business auto liability coverage, and, if applicable to Tenant's Permitted Use, liquor liability insurance and/or warehouseman's coverage.

b. Tenant's Property Insurance. During the Lease term, Tenant shall pay for and maintain special form clauses of loss coverage property insurance (with coverage for earthquake if required by Landlord's lender and, if the Premises are situated in a flood plain, flood damage) for all of Tenant's personal property, fixtures and equipment in the amount of their full replacement value, with a deductible of not more than $10,000.

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(Continued)

c. Miscellaneous. Tenant's insurance required under this Section shall be with companies rated A-/VII or better in Best's Insurance Guide, and which are admitted in the state in which the Premises are located. No insurance policy shall be cancelled or reduced in coverage and each such policy shall provide that it is not subject to cancellation or a reduction in coverage except after thirty (30) days prior written notice to Landlord. Tenant shall deliver to Landlord upon commencement of the Lease and from time to time thereafter, copies of the insurance policies or evidence of insurance and copies of endorsements required by this Section. In no event shall the limits of such policies be considered as limiting the liability of Tenant under this Lease. If Tenant fails to acquire or maintain any insurance or provide any policy or evidence of insurance required by this Section, and such failure continues for three (3) days after notice from Landlord, Landlord may, but shall not be required to, obtain such insurance for Landlord's benefit and Tenant shall reimburse Landlord for the costs of such insurance upon demand. Such amounts shall be Additional Rent payable by Tenant hereunder and in the event of non-payment thereof, Landlord shall have the same rights and remedies with respect to such non-payment as it has with respect to any other non-payment of rent hereunder.

d. Waiver of Subrogation. Landlord and Tenant hereby release each other and any other tenant, their agents or employees, from responsibility for, and waive their entire claim of recovery for any loss or damage arising from any cause covered by property insurance required to be carried or otherwise carried by each of them. Each party shall provide notice to the property insurance carrier or carriers of this mutual waiver of subrogation, and shall cause its respective property insurance carriers to waive all rights of subrogation against the other. This waiver shall not apply to the extent of the deductible amounts to any such property policies or to the extent of liabilities exceeding the limits of such policies.

16. INDEMNIFICATION.

a. Indemnification by Tenant. Tenant shall defend, indemnify, and hold Landlord and its property manager, if any, harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Tenant or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises, or arising from any breach of this Lease by Tenant. Tenant shall use legal counsel reasonably acceptable to Landlord in defense of any action within Tenant's defense obligation.

b. Indemnification by Landlord. Landlord shall defend, indemnify and hold Tenant harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Landlord or Landlord's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises, or arising from any breach of this Lease by Landlord. Landlord shall use legal counsel reasonably acceptable to Tenant in defense of any action within Landlord's defense obligation.

c. Waiver of Immunity. Landlord and Tenant each specifically and expressly waive any immunity that each may be granted under the Washington State Industrial Insurance Act, Title 51 RCW. Neither party's indemnity obligations under this Lease shall be limited by any limitation on the amount or type of damages, compensation, or benefits payable to or for any third party under the Worker Compensation Acts, Disability Benefit Acts or other employee benefit acts.

d. Exemption of Landlord from Liability. Except to the extent of claims arising out of Landlord's gross negligence or intentional misconduct, Landlord shall not be liable for injury to Tenant's business or assets or any loss of income therefrom or for damage to any property of Tenant or of its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, or any other person in or about the Premises.

e. Survival. The provisions of this Section 16 shall survive expiration or termination of this Lease.

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17. **ASSIGNMENT AND SUBLETTING**. Tenant shall not assign, sublet, mortgage, encumber or otherwise transfer any interest in this Lease (collectively referred to as a "Transfer") or any part of the Premises, without first obtaining Landlord's written consent which shall not be unreasonably withheld, conditioned, or delayed. No Transfer shall relieve Tenant of any liability under this Lease notwithstanding Landlord's consent to such Transfer. Consent to any Transfer shall not operate as a waiver of the necessity for Landlord's consent to any subsequent Transfer. In connection with each request for consent to a Transfer, Tenant shall pay the reasonable cost of processing same, including attorneys' fees, upon demand of Landlord, up to a maximum of $1,250.

    If Tenant is a partnership, limited liability company, corporation, or other entity, any transfer of this Lease by merger, consolidation, redemption or liquidation, or any change in the ownership of, or power to vote, which singularly or collectively represents a majority of the beneficial interest in Tenant, shall constitute a Transfer under this Section.

    As a condition to Landlord's approval, if given, any potential assignee or sublessee otherwise approved by Landlord shall assume all obligations of Tenant under this Lease and shall be jointly and severally liable with Tenant and any guarantor, if required, for the payment of Rent and performance of all terms of this Lease. In connection with any Transfer, Tenant shall provide Landlord with copies of all assignments, subleases and assumption agreement or documents.

18. **LIENS**. Tenant is not authorized to subject the Landlord's assets to any liens or claims of lien. Tenant shall keep the Premises free from any liens created by or through Tenant. Tenant shall indemnify and hold Landlord harmless from liability for any such liens including, without limitation, liens arising from any Alterations. If a lien is filed against the Premises by any person claiming by, through or under Tenant, Tenant shall, within 10 days after Landlord's demand, at Tenant's expense, either remove the lien or furnish to Landlord a bond in form and amount and issued by a surety satisfactory to Landlord, indemnifying Landlord and the Premises against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien.

19. **DEFAULT**. The following occurrences shall each constitute a default by Tenant (an "Event of Default):

    a. Failure To Pay. Failure by Tenant to pay any sum, including Rent, due under this Lease following five (5) days' notice from Landlord of the failure to pay.

    b. Vacation/Abandonment. Vacation by Tenant of the Premises (defined as an absence for at least fifteen (15) consecutive days without prior notice to Landlord), or abandonment of the Premises (defined as an absence of five (5) days or more while Tenant is in breach of some other term of this Lease). Tenant's vacation or abandonment of the Premises shall not be subject to any notice or right to cure.

    c. Insolvency. Tenant's insolvency or bankruptcy (whether voluntary or involuntary), or appointment of a receiver, assignee or other liquidating officer for Tenant's business; provided, however, that in the event of any involuntary bankruptcy or other insolvency proceeding, the existence of such proceeding shall constitute an Event of Default only if such proceeding is not dismissed or vacated within sixty (60) days after its institution or commencement.

    d. Levy or Execution. The taking of Tenant's interest in this Lease or the Premises, or any part thereof, by execution or other process of law directed against Tenant, or attachment of Tenant's interest in this Lease by any creditor of Tenant, if such attachment is not discharged within fifteen (15) days after being levied.

    e. Other Non-Monetary Defaults. The breach by Tenant of any agreement, term or covenant of this Lease other than one requiring the payment of money and not otherwise enumerated in this Section or elsewhere in this Lease, which breach continues for a period of thirty (30) days after notice by Landlord to Tenant of the breach.

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f. Failure to Take Possession. Failure by Tenant to take possession of the Premises on the Commencement Date or failure by Tenant to commence any Tenant's Work in a timely fashion.

Landlord shall not be in default unless Landlord fails to perform obligations required of Landlord within a reasonable time, but in no event less than thirty (30) days after notice by Tenant to Landlord. If Landlord fails to cure any such default within the allotted time, Tenant's sole remedy shall be to seek actual money damages (but not consequential or punitive damages) for loss arising from Landlord's failure to discharge its obligations under this Lease. Nothing herein contained shall relieve Landlord from its duty to perform of any of its obligations to the standard prescribed in this Lease.

Any notice periods granted herein shall be deemed to run concurrently with and not in addition to any default notice periods required by law.

20. **REMEDIES**. Landlord shall have the following remedies upon an Event of Default. Landlord's rights and remedies under this Lease shall be cumulative, and none shall exclude any other right or remedy allowed by law.

a. Termination of Lease. Landlord may terminate Tenant's interest under the Lease, but no act by Landlord other than notice of termination from Landlord to Tenant shall terminate this Lease. The Lease shall terminate on the date specified in the notice of termination. Upon termination of this Lease, Tenant will remain liable to Landlord for damages in an amount equal to the Rent and other sums that would have been owing by Tenant under this Lease for the balance of the Lease term, less the net proceeds, if any, of any reletting of the Premises by Landlord subsequent to the termination, after deducting all of Landlord's Reletting Expenses (as defined below). Landlord shall be entitled to either collect damages from Tenant monthly on the days on which rent or other amounts would have been payable under the Lease, or alternatively, Landlord may accelerate Tenant's obligations under the Lease and recover from Tenant: (i) unpaid rent which had been earned at the time of termination; (ii) the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds the amount of rent loss that Tenant proves could reasonably have been avoided; (iii) the amount by which the unpaid rent for the balance of the term of the Lease after the time of award exceeds the amount of rent loss that Tenant proves could reasonably be avoided (discounting such amount by the discount rate of the Federal Reserve Bank of San Francisco at the time of the award, plus 1%); and (iv) any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the Lease, or which in the ordinary course would be likely to result from the Event of Default, including without limitation Reletting Expenses described in Section 20(b) below.

b. Re-Entry and Reletting. Landlord may continue this Lease in full force and effect, and without demand or notice, re-enter and take possession of the Premises or any part thereof, expel the Tenant from the Premises and anyone claiming through or under the Tenant, and remove the personal property of either. Landlord may relet the Premises, or any part of them, in Landlord's or Tenant's name for the account of Tenant, for such period of time and at such other terms and conditions as Landlord, in its discretion, may determine. Landlord may collect and receive the rents for the Premises. To the fullest extent permitted by law, the proceeds of any reletting shall be applied: first, to pay Landlord all Reletting Expenses (defined below); second, to pay any indebtedness of Tenant to Landlord other than rent; third, to the rent due and unpaid hereunder; and fourth, the residue, if any, shall be held by Landlord and applied in payment of other or future obligations of Tenant to Landlord as the same may become due and payable, and Tenant shall not be entitled to receive any portion of such revenue. Re-entry or taking possession of the Premises by Landlord under this Section shall not be construed as an election on Landlord's part to terminate this Lease, unless a notice of termination is given to

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Tenant. Landlord reserves the right following any re-entry or reletting, or both, under this Section to exercise its right to terminate the Lease. Tenant will pay Landlord the Rent and other sums which would be payable under this Lease if repossession had not occurred, less the net proceeds, if any, after reletting the Premises and after deducting Landlord's Reletting Expenses. "Reletting Expenses" is defined to include all expenses incurred by Landlord in connection with reletting the Premises, including without limitation, all repossession costs, brokerage commissions and costs for securing new tenants, attorneys' fees, remodeling and repair costs, costs for removing persons or property, costs for storing Tenant's property and equipment, and costs of tenant improvements and rent concessions granted by Landlord to any new Tenant, prorated over the life of the new lease.

c. **Waiver of Redemption Rights.** Tenant, for itself, and on behalf of any and all persons claiming through or under Tenant, including creditors of all kinds, hereby waives and surrenders all rights and privileges which they may have under any present or future law, to redeem the Premises or to have a continuance of this Lease for the Lease term, or any extension thereof.

d. **Nonpayment of Additional Rent.** All costs which Tenant is obligated to pay to Landlord pursuant to this Lease shall in the event of nonpayment be treated as if they were payments of Rent, and Landlord shall have the same rights it has with respect to nonpayment of Rent.

e. **Failure to Remove Property.** If Tenant fails to remove any of its property from the Premises at Landlord's request following an uncured Event of Default, Landlord may, at its option, remove and store the property at Tenant's expense and risk. If Tenant does not pay the storage cost within five (5) days of Landlord's request, Landlord may, at its option, have any or all of such property sold at public or private sale (and Landlord may become a purchaser at such sale), in such manner as Landlord deems proper, without notice to Tenant. Landlord shall apply the proceeds of such sale: (i) to the expense of such sale, including reasonable attorneys' fees actually incurred; (ii) to the payment of the costs or charges for storing such property; (iii) to the payment of any other sums of money which may then be or thereafter become due Landlord from Tenant under any of the terms hereof; and (iv) the balance, if any, to Tenant. Nothing in this Section shall limit Landlord's right to sell Tenant's personal property as permitted by law or to foreclose Landlord's lien for unpaid rent.

21. **MORTGAGE SUBORDINATION AND ATTORNMENT**. This Lease shall automatically be subordinate to any mortgage or deed of trust created by Landlord which is now existing or hereafter placed upon the Premises including any advances, interest, modifications, renewals, replacements or extensions ("Landlord's Mortgage"). Tenant shall attorn to the holder of any Landlord's Mortgage or any party acquiring the Premises at any sale or other proceeding under any Landlord's Mortgage provided the acquiring party assumes the obligations of Landlord under this Lease. Tenant shall promptly and in no event later than fifteen (15) days after request execute, acknowledge and deliver documents which the holder of any Landlord's Mortgage may reasonably require as further evidence of this subordination and attornment. Notwithstanding the foregoing, Tenant's obligations under this Section to subordinate in the future are conditioned on the holder of each Landlord's Mortgage and each party acquiring the Premises at any sale or other proceeding under any such Landlord's Mortgage not disturbing Tenant's occupancy and other rights under this Lease, so long as no uncured Event of Default by Tenant exists.

22. **NON-WAIVER**. Landlord's waiver of any breach of any provision contained in this Lease shall not be deemed to be a waiver of the same provision for subsequent acts of Tenant. The acceptance by Landlord of Rent or other amounts due by Tenant hereunder shall not be deemed to be a waiver of any previous breach by Tenant.

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23. **HOLDOVER**. If Tenant shall, without the written consent of Landlord, remain in possession of the Premises and fail to return them to Landlord after the expiration or termination of the term, the tenancy shall be a holdover tenancy and shall be on a month-to-month basis, which may be terminated according to Washington law. During such tenancy, Tenant agrees to pay to Landlord 150% of the rate of rental last payable under this Lease, unless a different rate is agreed upon by Landlord. All other terms of the Lease shall remain in effect. Tenant acknowledges and agrees that this Section does not grant any right to Tenant to holdover, and that Tenant may also be liable to Landlord for any and all damages or expenses which Landlord may have to incur as a result of Tenant's holdover.

24. **NOTICES**. All notices under this Lease shall be in writing and effective (i) when delivered in person or via overnight courier to the other party, (ii) three (3) days after being sent by registered or certified mail to the other party at the address set forth in Section 1; or (iii) upon confirmed transmission by facsimile to the other party at the facsimile numbers set forth in Section 1. The addresses for notices and payment of rent set forth in Section 1 may be modified by either party only by written notice delivered in conformance with this Section.

25. **COSTS AND ATTORNEYS' FEES**. If Tenant or Landlord engage the services of an attorney to collect monies due or to bring any action for any relief against the other, declaratory or otherwise, arising out of this Lease, including any suit by Landlord for the recovery of Rent or other payments, or possession of the Premises, the losing party shall pay the prevailing party a reasonable sum for attorneys' fees in such action, whether in mediation or arbitration, at trial, on appeal, and in any bankruptcy proceeding.

26. **ESTOPPEL CERTIFICATES**. Tenant shall, from time to time, upon written request of Landlord, execute, acknowledge and deliver to Landlord or its designee a written statement specifying the following, subject to any modifications necessary to make such statements true and complete: (i) the total rentable square footage of the Premises; (ii) the date the Lease term commenced and the date it expires; (iii) the amount of minimum monthly Rent and the date to which such Rent has been paid; (iv) that this Lease is in full force and effect and has not been assigned, modified, supplemented or amended in any way; (v) that this Lease represents the entire agreement between the parties; (vi) that all obligations under this Lease to be performed by either party have been satisfied; (vii) that there are no existing claims, defenses or offsets which the Tenant has against the enforcement of this Lease by Landlord; (viii) the amount of Rent, if any, that Tenant paid in advance; (ix) the amount of security that Tenant deposited with Landlord; (x) if Tenant has sublet all or a portion of the Premises or assigned its interest in the Lease and to whom; (xi) if Tenant has any option to extend the Lease or option to purchase the Premises; and (xii) such other factual matters concerning the Lease or the Premises as Landlord may reasonably request. Tenant acknowledges and agrees that any statement delivered pursuant to this Section may be relied upon by a prospective purchaser of Landlord's interest or assignee of any mortgage or new mortgagee of Landlord's interest in the Premises. If Tenant shall fail to respond within ten (10) days to Landlord's request for the statement required by this Section, Landlord may provide the statement and Tenant shall be deemed to have admitted the accuracy of the information provided by Landlord.

27. **TRANSFER OF LANDLORD'S INTEREST**. This Lease shall be assignable by Landlord without the consent of Tenant. In the event of any transfer or transfers of Landlord's interest in the Premises, other than a transfer for collateral purposes only, upon the assumption of this Lease by the transferee, Landlord shall be automatically relieved of obligations and liabilities accruing from and after the date of such transfer, including any liability for any retained security deposit or prepaid rent, for which the transferee shall be liable, and Tenant shall attorn to the transferee.

28. **LANDLORD'S LIABILITY.** Anything in this Lease to the contrary notwithstanding, covenants, undertakings and agreements herein made on the part of Landlord are made and intended not as personal covenants, undertakings and agreements for the purpose of binding Landlord personally or the assets of Landlord but are made and intended for the purpose of binding only the Landlord's interest in the Premises, as the same may from time to time be encumbered. In no event shall Landlord or its partners, shareholders, or members, as the case may be, ever be personally liable hereunder.

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29. **RIGHT TO PERFORM.** If Tenant shall fail to timely pay any sum or perform any other act on its part to be performed hereunder, Landlord may make any such payment or perform any such other act on Tenant's behalf. Tenant shall, within ten (10) days of demand, reimburse Landlord for its expenses incurred in making such payment or performance. Landlord shall (in addition to any other right or remedy of Landlord provided by law) have the same rights and remedies in the event of the nonpayment of sums due under this Section as in the case of default by Tenant in the payment of Rent.

30. **HAZARDOUS MATERIAL.** As used herein, the term "Hazardous Material" means any hazardous, dangerous, toxic or harmful substance, material or waste including biomedical waste which is or becomes regulated by any local governmental authority, the State of Washington or the United States Government, due to its potential harm to the health, safety or welfare of humans or the environment. Landlord represents and warrants to Tenant that, to Landlord's knowledge without duty of investigation, there is no Hazardous Material on, in, or under the Premises as of the Commencement Date except as may otherwise have been disclosed to Tenant in writing before the execution of this Lease. If there is any Hazardous Material on, in, or under the Premises as of the Commencement Date which has been or thereafter becomes unlawfully released through no fault of Tenant, then Landlord shall indemnify, defend and hold Tenant harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including without limitation sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees, incurred or suffered by Tenant either during or after the Lease term as the result of such contamination.

    Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about, or disposed of on the Premises by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, except with Landlord's prior consent and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes and ordinances. If Tenant breaches the obligations stated in the preceding sentence, then Tenant shall indemnify, defend and hold Landlord harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including, without limitation, diminution in the value of the Premises; damages for the loss or restriction on use of rentable or usable space or of any amenity of the Premises, or elsewhere; damages arising from any adverse impact on marketing of space at the Premises; and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees incurred or suffered by Landlord either during or after the Lease term. These indemnifications by Landlord and Tenant include, without limitation, costs incurred in connection with any investigation of site conditions or any clean-up, remedial, removal or restoration work, whether or not required by any federal, state or local governmental agency or political subdivision, because of Hazardous Material present in the Premises, or in soil or ground water on or under the Premises. Tenant shall immediately notify Landlord of any inquiry, investigation or notice that Tenant may receive from any third party regarding the actual or suspected presence of Hazardous Material on the Premises.

    Without limiting the foregoing, if the presence of any Hazardous Material brought upon, kept or used in or about the Premises by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, results in any unlawful release of any Hazardous Materials on the Premises or any other property, Tenant shall promptly take all actions, at its sole expense, as are necessary to return the Premises or any other property to the condition existing prior to the release of any such Hazardous Material; provided that Landlord's approval of such actions shall first be obtained, which approval may be withheld at Landlord's sole discretion. The provisions of this Section shall survive expiration or termination of this Lease.

31. **QUIET ENJOYMENT.** So long as Tenant pays the Rent and performs all of its obligations in this Lease, Tenant's possession of the Premises will not be disturbed by Landlord or anyone claiming by, through or under Landlord.

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32. **MERGER.** The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation thereof, shall not work a merger and shall, at the option of Landlord, terminate all or any existing subtenancies or may, at the option of Landlord, operate as an assignment to Landlord of any or all of such subtenancies.

33. **GENERAL.**

a. **Heirs and Assigns.** This Lease shall apply to and be binding upon Landlord and Tenant and their respective heirs, executors, administrators, successors and assigns.

b. **Brokers' Fees.** Tenant represents and warrants to Landlord that except for Tenant's Broker, if any, described or disclosed in Section 35 of this Lease, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Landlord against any loss, cost, liability or expense incurred by Landlord as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Tenant. Landlord represents and warrants to Tenant that except for Landlord's Broker, if any, described and diclosed in Section 35 of this Lease, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Tenant against any loss, cost, liability or expense incurred by Tenant as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Landlord.

c. **Entire Agreement.** This Lease contains all of the covenants and agreements between Landlord and Tenant relating to the Premises. No prior or contemporaneous agreements or understandings pertaining to the Lease shall be valid or of any force or effect and the covenants and agreements of this Lease shall not be altered, modified or amended to except in writing signed by Landlord and Tenant.

d. **Severability.** Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision of this Lease.

e. **Force Majeure.** Time periods for either party's performance under any provisions of this Lease (excluding payment of Rent) shall be extended for periods of time during which the party's performance is prevented due to circumstances beyond such party's control, including without limitation, fires, floods, earthquakes, lockouts, strikes, embargoes, governmental regulations, acts of God, public enemy, war or other strife.

f. **Governing Law.** This Lease shall be governed by and construed in accordance with the laws of the State of Washington.

g. **Memorandum of Lease.** Neither this Lease nor any memorandum or "short form" thereof shall be recorded without Landlord's prior consent.

h. **Submission of Lease Form Not an Offer.** One party's submission of this Lease to the other for review shall not constitute an offer to lease the Premises. This Lease shall not become effective and binding upon Landlord and Tenant until it has been fully signed by both of them.

i. **No Light, Air or View Easement.** Tenant has not been granted an easement or other right for light, air or view to or from the Premises. Any diminution or shutting off of light, air or view by any structure which may be erected on or adjacent to the Premises shall in no way effect this Lease or the obligations of Tenant hereunder or impose any liability on Landlord.

j. **Authority of Parties.** Each party signing this Lease represents and warrants to the other that it has the authority to enter into this Lease, that the execution and delivery of this Lease has been duly authorized, and that upon such execution and delivery, this Lease shall be binding upon and enforceable against the party on signing.

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k. **Time.** "Day" as used herein means a calendar day and "business day" means any day on which commercial banks are generally open for business in the state where the Premises are situated. Any period of time which would otherwise end on a non-business day shall be extended to the next following business day. Time is of the essence of this Lease.

34. EXHIBITS AND RIDERS. The following exhibits and riders are made a part of this Lease, and the terms thereof shall control over any inconsistent provision in the sections of this Lease:

Exhibit A Legal Description of the Premises
~~Exhibit B Tenant Improvement Schedule~~

CHECK THE BOX FOR ANY OF THE FOLLOWING THAT WILL APPLY. CAPITALIZED TERMS USED IN THE RIDERS SHALL HAVE THE MEANING GIVEN TO THEM IN THE LEASE.

- ☑ Rent Rider
- ☐ Arbitration Rider
- ☐ Letter of Credit Rider
- ☐ Guaranty of Tenant's Lease Obligations Rider
- ☑ Option to Extend Rider

35. AGENCY DISCLOSURE. At the signing of this Lease, Landlord is represented by N/A
(insert both the name of the Broker and the Firm as licensed) (the "Landlord's Broker"), and Tenant is represented by N/A
(insert both the name of the Broker and the Firm as licensed) (the "Tenant's Broker").

This Agency Disclosure creates an agency relationship between Landlord, Landlord's Broker (if any such person is disclosed), and any managing brokers who supervise Landlord's Broker's performance (collectively the "Supervising Brokers"). In addition, this Agency Disclosure creates an agency relationship between Tenant, Tenant's Broker (if any such person is disclosed), and any managing brokers who supervise Tenant's Broker's performance (also collectively the "Supervising Brokers"). If Tenant's Broker and Landlord's Broker are different real estate licensees affiliated with the same Firm, then both Tenant and Landlord confirm their consent to that Firm and both Tenant's and Landlord's Supervising Brokers acting as dual agents. If Tenant's Broker and Landlord's Broker are the same real estate licensee who represents both parties, then both Landlord and Tenant acknowledge that the Broker, his or her Supervising Brokers, and his or her Firm are acting as dual agents and hereby consent to such dual agency. If Tenants' Broker, Landlord's Broker, their Supervising Brokers, or their Firm are dual agents, Landlord and Tenant consent to Tenant's Broker, Landlord's Broker and their Firm being compensated based on a percentage of the rent or as otherwise disclosed on the attached addendum. Neither Tenant's Broker, Landlord's Broker nor either of their Firms are receiving compensation from more than one party to this transaction unless otherwise disclosed on an attached addendum, in which case Landlord and Tenant consent to such compensation. Landlord and Tenant confirm receipt of the pamphlet entitled "The Law of Real Estate Agency."

36. COMMISSION AGREEMENT. If Landlord has not entered into a listing agreement (or other compensation agreement with Landlord's Broker), Landlord agrees to pay a commission to Landlord's Broker (as identified in the Agency Disclosure paragraph above) as follows:

[ ] $ N/A
[ ] N/A % of the gross rent payable pursuant to the Lease
[ ] $ N/A per square foot of the Premises
[ ] Other N/A

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Landlord's Broker ☐ shall ☐ shall not (shall not if not filled in) be entitled to a commission upon the extension by Tenant of the Lease term pursuant to any right reserved to Tenant under the Lease calculated ☐ as provided above or ☐ as follows _____ (if no box is checked, as provided above). Landlord's Broker ☐ shall ☐ shall not (shall not if not filled in) be entitled to a commission upon any expansion of the Premises pursuant to any right reserved to Tenant under the Lease, calculated ☐ as provided above or ☐ as follows _____ (if no box is checked, as provided above).

Any commission shall be earned upon execution of this Lease, and paid one-half upon execution of the Lease and one-half upon occupancy of the Premises by Tenant. Landlord's Broker shall pay to Tenant's Broker (as identified in the Agency Disclosure paragraph above) the amount stated in a separate agreement between them or, if there is no agreement, $_____ or _____% (complete only one) of any commission paid to Landlord's Broker, within five (5) days after receipt by Landlord's Broker.

If any other lease or sale is entered into between Landlord and Tenant pursuant to a right reserved to Tenant under the Lease, Landlord ☐ shall ☐ shall not (shall not if not filled in) pay an additional commission according to any commission agreement or, in the absence of one, according to the commission schedule of Landlord's Broker in effect as of the execution of this Lease. Landlord's successor shall be obligated to pay any unpaid commissions upon any transfer of this Lease and any such transfer shall not release the transferor from liability to pay such commissions.

37. BROKER PROVISIONS.

LANDLORD'S BROKER, TENANT'S BROKER AND THEIR FIRMS HAVE MADE NO REPRESENTATIONS OR WARRANTIES CONCERNING THE PREMISES; THE MEANING OF THE TERMS AND CONDITIONS OF THIS LEASE; LANDLORD'S OR TENANT'S FINANCIAL STANDING; ZONING OR COMPLIANCE OF THE PREMISES WITH APPLICABLE LAWS; SERVICE OR CAPACITY OF UTILITIES; OPERATING COSTS; OR HAZARDOUS MATERIALS. LANDLORD AND TENANT ARE EACH ADVISED TO SEEK INDEPENDENT LEGAL ADVICE ON THESE AND OTHER MATTERS ARISING UNDER THIS LEASE.

IN WITNESS WHEREOF, this Lease has been executed the date and year first above written.

JARSTAD FAMILY, LLC	EVERGREEN EYE CENTER, INC. P.S
LANDLORD	**TENANT**
John S. Jarstad MD	
LANDLORD	**TENANT**
JOHN S. JARSTAD, M.D.	GARY W CHUNG MD
BY	**BY**
ITS: MANAGER	**ITS:** Secretary

LEASE AGREEMENT
(Single Tenant for Entire Parcel - NNN)
(Continued)

STATE OF WASHINGTON
ss.
COUNTY OF KING

I certify that I know or have satisfactory evidence that JOHN S. JARSTAD 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 MANAGER of JARSTAD FAMILY, LLC to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 18 day of AUGUST, 2015.

CAROL M. OTTO
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
APRIL 1, 2019

Carol M. Otto
(Signature of Notary)

CAROL M OTTO
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at Federal Way, WA

My appointment expires 04/01/2019

STATE OF WASHINGTON
ss.
COUNTY OF KING

I certify that I know or have satisfactory evidence that GARY W. CHUNG 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 SECRETARY of EVERGREEN EYE CENTER, INC. P.S. to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 18 day of AUGUST, 2015.

CAROL M. OTTO
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
APRIL 1, 2019

Carol M. Otto
(Signature of Notary)

CAROL M OTTO
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at Federal Way, WA

My appointment expires 04/01/2019

EXHIBIT A

LEGAL DESCRIPTION

PARCEL A:

THE EAST ONE-HALF OF THE SOUTH HALF OF THE EAST HALF OF THE WEST HALF OF THE NORTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 20, TOWNSHIP 21 NORTH, RANGE 4 EAST, W.M., IN KING COUNTY, WASHINGTON;

EXCEPT THE SOUTH 50 FEET THEREOF FOR ROAD;

AND EXCEPT THE NORTH 380 FEET THEREOF;

PARCEL B:

EASEMENT FOR INGRESS, EGRESS AND UTILITIES OVER THE WEST 30 FEET OF LOT 2, WEST CAMPUS BUSINESS PARK, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 97 OF PLATS, PAGES 78 THROUGH 82, INCLUSIVE, IN KING COUNTY, WASHINGTON;

SITUATE IN THE CITY OF FEDERAL WAY, COUNTY OF KING, STATE OF WASHINGTON.

ADDENDUM TO LEASE
EVERGREEN EYE CENTER BUILDING

This is an Addendum to that Lease Agreement between Jarstad Family, LLC as "Landlord" and Evergreen Eye Center, Inc. P.S., a Washington corporation as "Tenant" for that building with a common street address of 34719 6th Ave. S., Federal Way, Washington ("Lease"), which Lease has a commencement date of September 1, 2015. The terms in this Addendum prevail over any conflicting provisions in the Lease.

1. **Rent Rider.** As provided in paragraph 1.d of the Lease, the initial Base Rent is $23,416.00 per month, which amount shall be adjusted annually. Commencing January 1, 2016, and annually thereafter on January 1st during the term of this Lease ("Adjustment Date"), the Base Rent shall be increased in accordance with the increase in the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for all Urban Consumers (all items for the geographical statistical area in which the Premises is located on the basis of 1982-1984 equals 100) (the "Index"). The Base Rent payable immediately prior to the Adjustment Date shall be increased by the percentage that the Index published for the date nearest preceding the applicable Adjustment Date has increased over the prior twelve month period. Upon the calculation of each increase, Landlord shall notify Tenant of the new Base Rent. Within twenty (20) days of the date of Landlord's notice, Tenant shall pay to Landlord the amount of any deficiency in Rent paid by Tenant for the period following the subject Adjustment Date, and shall thereafter pay the increased Base Rent until receiving the next notice of increase from Landlord. If the components of the Index are materially changed after the Commencement Date, or if the Index is discontinued during the Lease term, Landlord shall notify Tenant of a substitute index which, in Landlord's reasonable discretion, approximates the Index, and shall be used as a substitute index to make subsequent adjustments in Base Rent. In no event shall base monthly rent be decreased pursuant to this Rent Rider. Notwithstanding the terms in this paragraph, the Base Rent shall increase a minimum of 2.5% annually, and a maximum of 4.0% in any year.

2. **Security Deposit.** As provided pursuant to paragraph 1.f of the Lease, Tenant shall pay to Landlord a security deposit in the amount of $23,416.00. One half ($11,708.00) shall be paid upon the mutual execution of this Lease, and the balance shall be paid within one year of the execution of this Lease.

3. **Tenant Improvements.** Tenant intends to make certain alterations, repairs, additions and improvements to the Premises. Tenant shall present a scope of work to Landlord which shall be subject to Landlord's reasonable approval. Landlord provides Tenant an improvement allowance of $150,000.00, to reimburse Tenant for the work performed. Landlord agrees to reimburse to Tenant, so long as Tenant has first submitted to Landlord all work order receipts and proof of lien waivers for all of Tenant's leasehold improvements (pre-approved by Landlord), a total amount up to (but not to exceed) $150,000.00, to be paid by Landlord within 30 days of Tenant providing the required documentation to Landlord. Any Tenant improvements must be completed with like or better quality materials and the reasonable approval by Landlord or Landlord's representative: Karen Jarstad design.

4. **Insurance.** Unless otherwise agreed in writing between Landlord and Tenant, Landlord shall maintain insurance on the Premises for damage or destruction from fire or other casualty, with the premiums for such insurance paid by Tenant, or reimbursed by Tenant to Landlord as Additional Rent pursuant to Section 4 of the Lease.

Landlord Initials

Tenant Initials

OPTION TO EXTEND RIDER

CBA Text Disclaimer: Text deleted by licensee indicated by strike. New text inserted by licensee indicated by small capital letters.

This Option to Extend Rider ("Rider") is made part of the lease agreement dated September 1, 2015 (the "Lease") between Jarstad Family, LLC ("Landlord") and Evergreen Eye Center, Inc. P.S. ("Tenant") concerning the leased space commonly known as 34719 6th Avenue S., Federal Way, WAEvergreen Eye Center Building (the "Premises"), located at the property commonly known as _____ (the "Property").

1. Extension of Lease. Provided Tenant is not in default of any provision of the Lease at the time that Tenant exercises the right to extend the Lease or at the time the new term begins, Tenant shall have five (zero if not completed) successive options to extend the term of the Lease for five years each. The term of the Lease shall be extended on the same terms, conditions and covenants set forth in the Lease, except that (i) the amount of the Base Rent stated in the Lease shall be adjusted as set forth below (provided, however, that Base Rent shall not be decreased); (ii) there shall be no free or abated rent periods, tenant improvement allowances or other concessions that may have been granted to Tenant at the beginning of the initial term hereof; and (iii) after exercise of Tenant's final extension term option, there shall be no further extension or renewal term options.

2. Notice. To extend the Lease, Tenant must deliver written notice to Landlord not less than one hundred eighty (180) days prior to the expiration of the then-current Lease term. Time is of the essence of this Rider.

3. Monthly Rent. Landlord and Tenant shall make a good faith effort to determine and agree on the fair market value of rent for the Premises for the next term of the Lease.

   a. Failure to Agree on Rent. If Landlord and Tenant are unable to agree on the fair market rental value for the Premises within thirty (30) days after Tenant gives notice to extend, they shall then have ten (10) days to select or, appoint one real estate appraiser to determine the fair market value of rent for the Premises. All appraisers selected or appointed pursuant to this Rider shall be a Member of the American Institute of Real Estate Appraisers ("M.A.I.") with at least ten (10) years experience appraising commercial properties in the commercial leasing market in which the Premises are located, or equivalent. The appraiser appointed shall determine the fair market rental value for the Premises within twenty (20) days of appointment, which determination shall be final, conclusive, and binding upon both Landlord and Tenant, and Base Rent shall be adjusted accordingly for the new term. The appraiser's fees and expenses shall be shared equally between the parties.

   b Failure to Appoint One Appraiser. If Landlord and Tenant cannot mutually agree upon an appraiser, then either party may give the other party written notice that it has selected and appointed an M.A.I. appraiser, complete with the name, address, and other identifying information about the appraiser. The party receiving such notice shall then have ten (10) days to select and appoint its own M.A.I. appraiser and respond by giving written notice to the other party, complete with the name, address, and other identifying information about the appraiser. If, however, the responding party fails to select and appoint an appraiser and give notice to the other party within ten (10) days, the determination of the appraiser first appointed shall be final, conclusive and binding upon both parties, and the Base Rent shall be adjusted accordingly for the new term The appraiser's fees and expenses shall be shared equally between the parties.

   c Method of Determining Rent. The appraisers appointed shall proceed to determine fair market rental value within twenty (20) days following their appointment. The conclusion shall be final, conclusive and binding upon both Landlord and Tenant. If the appraisers should fail to agree, but the difference in their conclusions as to fair market rental value is ten percent (10%) or less of the lower of the two appraisals, then the fair market rental value shall be deemed to be the average of the two, and Base Rent shall be adjusted accordingly for the new term. If the two appraisers should fail to agree on the fair market rental value, and the

INITIALS: LANDLORD JT DATE 8/18/15 TENANT GE DATE 8/18/15

LANDLORD _____ DATE _____ TENANT _____ DATE _____

difference between the two appraisals exceeds ten percent (10%) of the lower of the two appraisals, then the two appraisers shall appoint a third M.A.I.-qualified appraiser. If they fail to agree on a third appraiser within ten (10) days after their individual determination of the fair market rental value, either party may apply to the courts for the county in which the Premises are located, requesting the appointment of a the third M.A.I.-qualified appraiser. The third appraiser shall promptly determine the fair market rental value of the Premises. The parties shall then take the average of the two appraisals that are closest in value, which shall then constitute the fair market value; shall be final, conclusive and binding upon both parties; and Base Rent shall be adjusted accordingly for the new term. Each party shall pay the fees and expenses for its own appraiser. In the event a third appraiser must be appointed, his or her fees and expenses shall be borne equally by the parties.

INITIALS: LANDLORD JJ DATE 8/18/15 TENANT CE DATE 8/18/15

LANDLORD _____ DATE _____ TENANT _____ DATE _____

Exhibit 14
Construction Review

Project Comment Form
July 26, 2018

Washington State Department of Health
Construction Review Services

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

Project Information:

CRS# 60825214
Evergreen Eye Center
Chapter 246-330 WAC Ambulatory Surgery Facility

Project Title: Basement Lobby Renovation

Project Location: 34719 6th Ave S
Federal Way, WA. 98003

Local Permit #:

Electronic Submittal. Plans will be delivered to:
Name: Brett Reynoldson
Email: Brett@pacconpartners.com
Phone #: 425-273-2775

Key Contacts:	Company	Name	Phone	Email
DOH Reviewer		Steve Pennington	(360) 236-2941	steve.pennington@doh.wa.gov
Facility Contact:	Pacific Const Partners	Brett Reynoldson	425-273-2775	Brett@pacconpartners.com
Facility Admin.:	Evergreen Eye Center	Zach Smith	206-212-2161	zach@evergreeneye.com
Arch./Eng.:	Jackson Main	Tim Black	206-552-1314	tim.black@jacksonmain.com
Other:	Jackson Main	Bryant Bronson	206-324-4800	bryant.bronson@jacksonmain.com
Other:				
Other:				
Other:				
Local AHJ:	City of Federal Way	Scott Sproul	253-835-2607	Scott.sproul@cityoffederalway.com

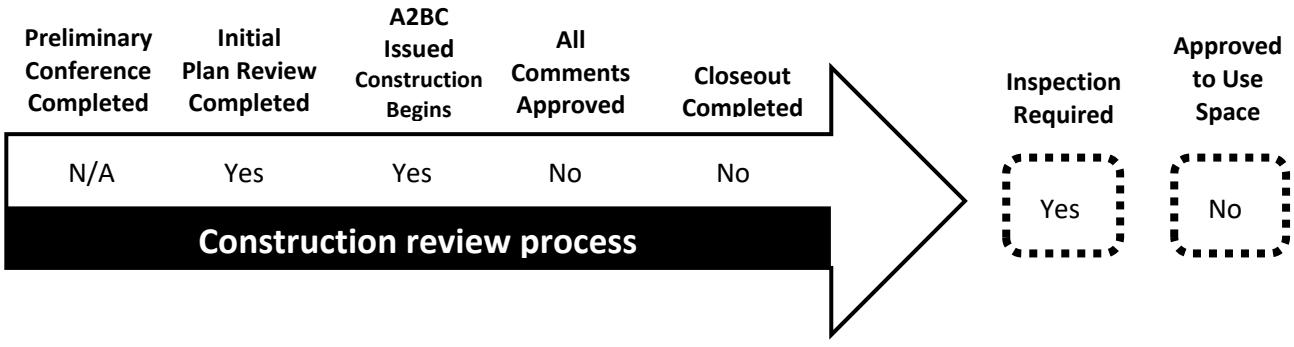
Addt'l Copies To: ☐ L&I Electrical Section ☐ L&I Factory Assembled Structures ☐ Local Electrical AHJ

Project Status:

-Authorized to Begin Construction-

Comments are NOT APPROVED

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



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

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

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

Project Details (for internal use only)

Occupancy Type IBC: B IBC: IBC: NFPA 101: Ambulatory Healthcare	Construction Type IBC: 5-A IBC: IBC: NFPA 101: Type V (111) NFPA 101:	Fed Code: 2012 NFPA 101 Building Code: 2015 IBC Licensing Code: FGI 2006
Number of Beds Added: N/A Removed:	CON Required? ☐ Yes ☒ No	CON Approved ☐ Yes ☐ No

	Req'd	Provided	Type/category	
				Are Hospital inpatients seen at this location? ☐ Yes ☒ No
Automatic Fire Sprinkler System:	Yes	Yes	13	Are planned residents/patients **incapable** of self preservation? ☐ Yes ☒ No
Automatic Fire Alarm System:	Yes	Yes		If yes, how many?
Emergency Power System:	No	No		Is sedation provided? ☒ Yes ☐ No
Medical Gas System:	Yes	Yes	Category 3	If yes, max. planned level? Minimal Sedation
Smoke Compartmentation:	No	No		Is space Medicare certified? ☒ Yes ☐ No

Building Department contacted? No	Estimated construction completion:

REVIEW NOTES

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

NOTES TO SURVEY

Plan Review Comments:

Comment ID#	Approved	Not Approved	
1		☒	Two complete plans and specifications for the fire alarm system installation or modification shall be submitted for review and approval prior to system installation. The department reserves the right to defer plan review and inspections to the local authority having jurisdiction (AHJ). Plans and specifications shall include, but not be limited to, a floor plan; location of all alarm-initiating and alarm-signaling devices; alarm-control and trouble-signaling equipment; annunciation; power connection; battery calculations; conductor type and sizes; voltage drop calculations; name, address, and phone number of the agency receiving off-premises transmission of alarm; and the manufacturer, model numbers, and listing information for all equipment, devises, and materials. Incomplete plans and specifications will be returned without review. Plans and specifications may be submitted separately from the construction documents during the construction of the project. For small renovation projects in which devices are only to be relocated or very few devices are to be added, provide two plans that shows the relocation of devices which may be submitted for review in lieu of the above requirements. This information can be included on the electrical or architectural plans. Verify with the Department staff to determine if the scope of your project meets this criteria. Section 907.1, International Fire Code Response: Drawings and notes attached. **Not Approved 3/12/18 – Drawings not found in submittal.**
2	☒		Two sets of sprinkler system working plans shall be submitted for review and approval before any equipment is installed or remodeled. The department reserves the right to defer plan review and inspections to the local authority having jurisdiction (AHJ). Deviation from approved plans will require permission. Plans and specifications, including hydraulic calculations, that are incomplete or are not stamped by a Washington State Licensed Fire Sprinkler Contractor, will be returned without review. Plans and specifications may be submitted separately from construction documents during the construction of the project. For small renovation projects in which heads are only to be relocated, a plan that shows the relocation of devices can be submitted for review in lieu of the above requirements.

			Section 903.1, International Fire Code Response: **Drawings and notes attached, only 2 sprinkler head to be lowered, no other changes required.** **Approved 3/12/18 – Based on comment response and subject to the City of Federal Way review and inspection.**
3		☒	Provide a copy of the City of Federal Way building permit. **Not Approved 3/12/18 – Permit not found in submittal.**
4	☒		Provide an Infection Control Risk Assessment and; ➢ Drawing of where temporary construction barriers will be placed to prevent dust and how odors will be controlled by a temporary exhaust fan to the outdoors. ➢ How and where will the waiting and reception function will happen during construction. (2006 FGI 1.5-2.1) Response: The ASC area of the center is closed on Friday, Saturday, Sunday and Mondays. Work will be done during this time. See phasing plan for schedule and impacts to facility. **Approved 3/12/18 – Based on comment response.**
5	☒		Provide a functional narrative per 2006 FGI 1.2-2.1 that describes the lobby project and how it ties into future phases. Response: The goal of the lobby improvement is to provide more seating, a restroom on the same floor. At this time the 2nd phase of work has been put on hold and most likely will not move forward. **Approved 3/12/18 – Based on comment response.**
6	☒		Provide a provision for drinking water for the lobby patients and family per 2006 FGI 3.1-4.1.6 Response: Drinking water station has been added near the restroom **Approved 3/12/18 – Based on comment response.**

7	☒		How are the new doors between the lobby (x3) and the treatment areas secured so that no one other than authorized people have access? WAC 246-330-125 (1)(c) Response: The existing door from the lobby to the pre/post op area and the existing door from the lobby to the hallway (to be demo'ed) have a card reader lock. The new door from the lobby to the hallway will use the relocated card reader lockset. **Approved 3/12/18 – Based on comment response.**
8	☒		Provide an additional exit sign from lobby to second exit pathway per 2012 NFPA 101 Chapter 7.10.1.2.1 Response: Included on revised drawing **Approved 3/12/18 – Based on comment response.**
9	☒		Provide reception casework details and elevations per WAC 246-330-510 Response: Included in revised drawings **Approved 3/12/18 – Based on comment response.**
10		☒	Provide electrical and ventilation drawings for the remodeled lobby and new restroom showing existing/new devices and circuitry per WAC 246-330-510 Response: See added electrical layout page **Not Approved 3/12/18 – Based on documents not found in submittal.**
11	☒		Provide specifications for the new rated door to the under stair storage off of the lobby by patient restroom. WAC 246-330-510 Response: This will be a 1hour door and frame, included in revised drawings and notes attached. **Approved 3/12/18 – Based on comment response.**
12		☒	A final inspection will be required for this project.

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

Letter of Transmittal

July 26, 2018

Construction Review Services
111 Israel Rd. SE
Tumwater, WA 98501

PO Box 47852
Olympia, Washington 98504-7852

www.doh.wa.gov/crs
tel. 360-236-2944
fax. 360-236-2321

Document Delivery Method (internal use only):
☒ Electronic ☐ Hard Copy

Evergreen Eye Center
Attn: Jill Fielding
jill@evergreeneye.com
253.227.9330

Project Info:

CRS# 60681163
Evergreen Eye Center
Chapter 246-330 WAC Ambulatory Surgery Facilities
Initial Review for ASF License

Project location: 34719 6th Ave S, Federal Way, WA 98003, Basement level

Local Permit #:

Key People:

Assigned DOH Reviewer:	Steve Pennington steve.pennington@doh.wa.gov		
Facility Administrator:	Evergreen Eye Center Zach Smith 34719 6th Ave S Federal Way, WA 98003 (206) 212-2161 x. zach@evergreeneye.com	Facility Contact:	Evergreen Eye Center Jill Fielding 34719 6th Ave S Federal Way, WA 98003 (206) 212-2118 x. jill@evergreeneye.com
Architect / Engineer:	N/A x.	Local AHJ:	City of Federal Way Scott Sproul/ Peter Lawrence Scott.sproul@cityoffederalway.com peter.lawrence@cityoffederalway.com (253) 835-2607 x. peter.lawrence@cityoffederalway.com
Consultant:	N/A x.	Consultant:	N/A x.
Contact:	N/A x.	Contact:	N/A x.

Copies To:

- ☒ Local AHJ: City of Federal Way
- ☐ Architect / Engineer: N/A
- ☐ Consultant: N/A
- ☐ Consultant: N/A
- ☐ Contact: N/A
- ☐ Contact: N/A
- ☐ DOH Child Birth Center Licensing
- ☒ DOH Office of Investigations & Inspections
- ☐ L&I Electrical Section
- ☐ L&I Factory Assembled Structures
- ☐
- ☒ CRS File

Facility Data Certificate:

Facility Name:	**Evergreen Eye Center**	**Licensee UBI#:**	**601512780**
Site Address:	**34719 6th Ave S** **Federal Way, WA 98003**	**Critical Access Facility:**	☐ **Yes** ☒ No

Estimated Date of Occupancy: Currently Occupied

ALL FACILITY TYPES

Occupancy Group:	**B**	Construction Type:	**5-A**	Applicable Code:	**2012 NFPA 101** **2006 FGI Guidelines**
Number of Beds:	Current: N/A	Added:		Removed:	Total:
Automatic Fire Sprinkler System:	☒ Yes ☐ No	Type 13			
Automatic Fire Alarm System:	☒ Yes ☐ No				
Compartmentation req'd:	☒ Yes ☐ No	Smoke Control System Provided:	☐ Yes ☒ No		
Special Delayed Egress Control:	☐ Yes ☒ No	Location:			
Certificate of Need Required:	☐ Yes ☐ No	CON Approval Granted: CON Number :	☐ Yes ☐ No		

RESIDENTIAL CARE FACILITIES ONLY

Number of units:	Private occupancy:	Two person occupancy:
Based on size of rooms used for sleeping	Residents	
Based on size of common rooms	Residents	
Maximum allowable licensable beds:		
Qualifies for Assisted Living Funding Program	☐ Yes ☐ No	Number of qualifying units:

NOTES

This is an eye surgery facility with one Class "B"operating room and one laser treatment room. They bill Medicare as an ASC and only use topical sedation.

The data above is based on the information presented to CRS. Any change in the facility or facility program that causes the above information to be incorrect is subject to review by CRS. Approval for construction is not approval for licensure. A copy of the facility data certificate will be sent to the licensing agency.

Project Status:

– Approved –

The stamped approved copy of the documents shall be kept available on site for survey and inspection staff. The local building official is responsible for building construction permitting and occupancy.

Please note the following:

- Final licensing approval may be subject to a site inspection by a licensing surveyor to verify compliance with licensing regulations.

If you have any questions please feel free to contact Construction Review Services. You can monitor project status and fill out our online survey at www.doh.wa.gov/crs.

Preliminary Comments

Comment ID #

Preliminary Conference – August 10th, 2016

Attendees:

Steve Pennington (steve.pennington@doh.wa.gov)	-	Department of Health
Jill Fielding	-	Evergreen Eye

The following are preliminary comments provided as information and for use preparing the construction documents. These preliminary comments may be revised and/or additional preliminary comments may be made during subsequent submissions.

Items Received: Plan review application, plan review fee, as-built drawings.

T1 The site inspection notes have been incorporated into the plan review comments.

Plan Review Comments:

Comment ID #	Approved	Not Approved	
			General:
1			There are four "Programs" within the Department of Health related to the State ASF Licensing process that must be contacted and each of their processes completed. The contacts for each of these "Programs" are; (1) Certificate of Need Program, contact Karen Nidermayer at (360) 236-2957 (2) Licensing Program, contact Crissa Hanson at (360) 236-4985 (3) Construction review services Program, contact Steve Pennington at (360) 236-2941 (4) Survey Program, contact Frank Schitoskey at (360) 236-4681 (5) For any overall ASF Program questions, contact John Hilger the program Manager at (360) 236-2929 The CRS website at www.doh.wa.gov/crs has links and information related to all these required contacts and program requirements.
2			This facility has been assigned a Category risk level of "3" per Chapter 4 of the 2012 NFPA 99 due to the low anesthesia risk and only discomfort would be the result to patients on loss of infra-structure support systems.
3			Notes: (Basis of review) ➢ Portable medical gases and suction are provided with no piped gases. ➢ Medical gas closet is for storage of bottles only. ➢ Laundry is sanitized on-site. ➢ Only eye procedures are performed. No plastic surgery is provided. ➢ Basement is approximately 3,756 square feet. ➢ Medical records are all electronic. ➢ The Medical gas system is a level 3 system. No redundancy is required. ➢ The housekeeping closet is used as soiled holding. ➢ Housekeeping is done using micro-pad and disinfectant. ➢ Toilet room # 004 is now the Managers office with all fixtures removed.
			Life Safety:
4	☒		Provide a copy of the most recent annual fire alarm testing report. **Approved 9/13/16 – Based on annual test received.**

5 ☒ Provide a copy of the most recent annual fire sprinkler testing report.

Approved 9/13/16 – Based on annual test received.

6 ☒ Provide a fire alarm pull station at the rear exit from the ASC per 2000 NFPA 101.

21.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.4.

21.3.4.2 Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any detection devices or detection systems required.

Response: Alarm pull station will be added within 5 feet of the back door hallway for the surgery center.

Approved 9/13/16 – Based on comment response.

7 ☒ The swing gate in the level 1 north stairwell that is one of the required exit paths for the basement ASC has the following deficiencies;

- A slide bolt has been added to hold the swing gate in place, but it also restricts egress to the public. Remove and do not replace the latching mechanism.
- The swing gate does not swing in the path of egress and without the slide bolt the public could continue unintentionally down below. The gate is required to swing in the direction of egress and will need to be removed and relocated further back on the landing and the swing reversed, so that it swings towards the exit. The new hinges will need to be spring loaded to allow the gate to close to a door stop on the wall.

The code section below is for new construction and does not specifically apply, but the intent of this swing gate has not changed in older code cycles and provides the basis for this comment.

2015 IBC 1023.8 Discharge identification. An interior exit stairway and ramp shall not continue below its level of exit discharge unless an approved barrier is provided at the level of exit discharge to prevent persons from unintentionally continuing into levels below. Directional exit signs shall be provided as specified in Section 1013.

Response: The stair gate will have the latch removed and moved back 4ft from door. It will be positioned to swing out towards the exit but not in to push people out the exit during an emergency.

Approved 9/13/16 – Based on comment response.

8 ☒ The storage room that has been added below the north stairwell lower level must be provided with a one hour fire rated separation. (2012 NFPA 99 7.2.2.5.3.2)
The following must be provided to meet this requirement;

- The exposed metal stair landing on the ceiling of the storage room must be covered by at least 2 layers of 5/8" Type X sheet gypsum board and fire taped to adjoining sheet rock surfaces.
- A door closer must be re-installed on the door and smoke seals installed on it.

Response: 2 layers of 5/8 gypsum will be placed on the ceiling the in the hallway closet and fire taped to the adjoining sheet rock surfaces.

Approved 9/13/16 – Based on comment response and contingent upon adding a door closer and smoke seals on the door.

9 ☒ Holes were found in the one hour fire barrier surrounding the ASC. Fire stop these penetrations with material meeting ASTM E 814

Response: ASTM E 814 will be used to fix holes found in the fire wall surrounding the ASC.

Approved 9/13/16 – Based on comment response.

10 ☒ Recommend the thumb turn dead bolt on the door between the recovery room and surgical area be either removed or replaced with a key control on both sides. This is to remove the potential of someone inadvertently locking this mechanism during business hours and hindering the ability to exit in an emergency event. 2012 NFPA 7.2.5.1.3

Response: The dead bolt will be removed between recovery room and nurse desk.

Approved 9/13/16 – Based on comment response.

11 ☒ Chairs and wheel chairs cannot stored in the north stairwell or that space used for waiting, as the exit stair must be exclusively used for exiting purposes only.
2012 NFPA 101 Chapter 7.1.3.2.3

Response: Chairs and wheel chairs have been removed.

Approved 9/13/16 – Based on comment response.

12 ☒ The elevator mechanical room is a one hour rated room. Fire stop all open penetrations including conduit and ductwork with fire stopping materials meeting ASTM E814

Response: Elevator mechanical room will have all openings patched with ASTM E 814

Approved 9/13/16 – Based on comment response.

Infection control:

13 ☒ Recommend caulking the gaps above the upper cabinets in the recovery area where dust can collect and is not cleanable. WAC 246-330-176 (5)(h)

Response: Cabinets will be caulked in recovery.

Approved 9/13/16 – Based on comment response.

14 ☒ Recommend that bulk linen stored on open shelves in the recovery room be covered or stored in an enclosed container to prevent cross contamination per WAC 246-330-176 (5)(d)

Response: Bulk linens have been covered.

Approved 9/13/16 – Based on comment response.

15 ☒ Recommend that the housekeeping supplies in the clinic used for cleaning the ASC are not used from that location. Dedicated cleaning supplies are required for an operating room.
All cleaning supplies be stored and used from the ASC storage area to prevent cross contamination. WAC 246-330-176 (5)(g)

Response: Creating a cart for the cleaning staff.

Approved 9/13/16 – Based on comment response.

16 ☒ Recommend that wrapping, peel pack preparations not be conducted in the decontamination room, as this is a dirty room environment, not suited for storage of clean materials like peal packs, blue wrap etc. or cleaned instruments stored for any extended period.
Recommend that these processes be conducted in the clean processing room in conjunction with your adopted processing standard for your ASC. Standards like AAMI have great language regarding best practice for all of the instrument processing.

Response: Moved wrapping process.

Approved 9/13/16 – Based on comment response and contingent upon it moving to the sterile processing room.

17 ☒ In the clean processing/sterilizing/storage room the following are required to be repaired per WAC 246-330-176 (5)(h);

- Two small holes in wall that are not cleanable need patched and painted.'
- Exposed raw wood from chipped laminate on base cabinet and on edge of cabinet behind door are not considered cleanable and need to be sealed/repaired.
- Caulk un-cleanable gaps above upper cabinet doors to soffit need filling.

- The hand spray wand in the clean sink needs either back flow protection or to be removed if not needed.

Response: Processing/sterilizing/ storage room will have the chips whole raw wood and the hand spray wand address and noted in report.

Approved 9/13/16 – Based on comment response.

18 ☒ In the operating room the following non-cleanable gaps require filling;
- Caulk gaps around the ceiling light fixtures
- Caulk gaps around the ceiling air supply diffusers.

Response: Operating room will have the gaps around ceiling lights and air supply caulked.

Approved 9/13/16 – Based on comment response.

19 ☒ Caulk non-cleanable gaps on top of the back of the scrub sink.

Response: Back of the scrub sink will be caulked.

Approved 9/13/16 – Based on comment response.

20 ☒ There is a cork board in the scrub sink area that is not cleanable. Recommend removal of the cork board. WAC 246-330-176 (5)(g)

Response: Cork board has been removed.

Approved 9/13/16 – Based on comment response.

21 ☒ The bulk storage room has supplies stored after they have broken down and not protected from dust. Provide doors on the storage cabinets, rubber cove base on the exposed wood cabinet toe kicks and paint the raw wood back of the storage cabinet to provide cleanable surfaces. WAC 246-330-176 (5)(g)

Response: Bulk storage will be receiving doors and rubber contains to protest all excess storage supplies.

Approved 9/13/16 – Based on comment response.

22 Note per response; All fixes will be complete within the next 30 days by Northwest Management Services.

Compliance with the comments above provided by the Department of Health, Construction Review Services, are necessary for this facility to meet the requirements of the applicable licensing regulations found in the Washington State Administrative Code and associated references. These comments do not relieve the facility from the responsibility to meet the requirements of any other applicable federal, state or local regulations. In the event of conflicts between other jurisdictions and these written comments, the most stringent shall apply.

Exhibit 15
South King County Planning Area Methodology Calculation Worksheet

Southeast King Planning Area
Number of Operating Rooms, and Number of Surgical Cases and Minutes, by Location, 2017

Facility	Special Procedure Rooms	Dedictted Outpatient Ors	Mixed Use ORS	Inpatient Min/case	Inpatient cases in Mixed Use Ors	Inpatient Mins, In Mixed Use Ors	OJtpatient Min/case	Outpatient cases	Outpatient Mins,	Data Source
FHSSt. Elizabeth, Enumclaw			3	80	1,680	135,000				OOH 2017 survey
FHSSt. Francis, Federal Way			8	114	5,282	603,707				OOH 201S survey
MulitGare Auburn Medic.al Center, Auburn			6	136	3,597	489,941				OOH 2016 survey
MultiGare Ccr,ington Hospital [CN #1437eZ)		3	3				98	1,359	132,675	OOH 2016 survey
Valley Medical Center, includesASC, Renton		3	B	95	10,548	1,003,504	48	2,035	97,414	OOH 2017 survey
Auburn Surge"YCenter, Auburn		2					45	240	10,800	OOH 2017 Survey
Cascade Surg11ry Center, Auburn		2					51	1,211	61,560	OOH 2017 Survey
ENT Facial & Pllergy, Enumclaw		1					45	450	20,250	OOH 2017 Survey
Evergreen EyeCenter, Federal Way		2					53	4,272	225,000	Evergreen Eye Center
Fogel Endoscopy Center, Federal Way (CN # 1302)										
Northwest 5i2 Surgeons, Renton		2					13	1,598	20,774	OOH 2017 survey
Plastic and ReconstructiveSurgeons, Renton		2					114	784	89,085	OOH 2017 survey
Proliance Orthopedic Associates, Renton		2					SO	4,296	214,800	OOH 2017 survey
Rainier Surgical Center, Federal Way		3					202	789	159,142	OOH 2017 survey
Sound Interventional Pain Management, Auburn										
Sports Medicine OaySurgery, Renton		1					SO	245	12,250	
Valley Oyeand La,e.r Center, Inc., Renton		1					50	2,100	105,000	00112017 survey
Virginia Maso, Surgery Center, Federal Way		4					SO	1,137	56,878	OOH 2017 survey
VP Surgery Crnter, Auburn [CN #1499)		3					SO	1,000	50,000	Source: OOH Oataba.e ILRS, 2016
Totals		31	33		21,107	2,232,152	917	21,516	1,255,628	
Average				106			66			
Operating Rooms counted in methodology		11	33							
Total Surgeri		21,516								
Area Population 2016		60E,892								
Use Rate		70.31								
PlanningAreaProjected Population projected 2021		652,104								
Total future surgeries based on projected population		45,849								
%Outpatient of Total Procedures		49.52%								
%Inpatient ofTotal Procedures		50.48%								
Average Inpatient Min/Case		1(•6.50								
AverageOutp..itient Min/Cas.e		ES.53								

Southeast King ASC Need Methodology, 2017

Sevice Area Population, 2021 *652,104* Cloritos, 2016

a.i.	94,250	minutes per year, inpatient/mixed use OR									
a.ii	68,850	minutes per year, outpatient OR									
a.iii	33	dedicated mixed use ORs x 94,250			=	3,110,250	=	29,204	mixed use surgeries		
a.iv	11	dedicated OP ORs x 68,850 minutes			=	757,350	=	11,558	outpatient surgeries		
b.i.		2021 Projected inpatient/mixed use surgeries			=	22,679	=	2,137,495,750	minutes, mixed use surgeries		
		2021 Projected outpatient surgeries			=	23,364	=	1,608,611,400	minutes, outpatient surgeries		
b.ii.		Forecast number of outpatient surgeries minus capacity of dedicated outpatient ORs									
		23,364	-	11,558	=		=	11,806			
b.iii.		Average time of mixed use surgeries			=	106.50	minutes				
		Average time of outpatient surgeries			=	65.53	minutes				
b.iv.		Mixed use surgeries, 2021 *average minutes/case									
					=	2,415,299	minutes				
		Remaining outpatient surgeries (b.ii) • average minutes/case									
					=	773,581	minutes				
				Total	=	3,188,880	minutes				
c.i.		If b.iv. < a.iii., divide by (a.iii. -b.iv.) 94,250 to determine surplus of mixed use ORs									
		Not applicable; proceed to c111.									
	b.iv.	3,188,880									
	a.iii.	3,110,250									
		(78,630)	+	94,250	=	(0.83)					
c.ii.		If b.iv. > a.iii., divide (mixed use part of b.iv. - a.iii.) by 94,350 to determine shortage of mixed use ORs									
	b.iv.	2,415,299									
	a.iii.	3,110,250									
		(694,951.11)	+	94,250	=	(7.37)					
		Divide outpatient part of b.iv. By 68,850 to determine the shortage of dedicated outpatient ORs									
		773,581	+	68,850	=	11.24					

Exhibit 16
Pro Forma

Federal Way Ambulatory Surgery Center

Year	2017	2018	2019	2020	2021	2022	2023
REVENUE AND EXPENSE STATEMENT							
ASC Volumes Totals OR Cases ("Procedures")	4,727	4,855	4,986	5,121	5,259	5,401	5,547
OR Minutes	89,813.00	92,245.00	94,734.00	97,299.00	99,921.00	102,619.00	105,393.00
Number of Operating Rooms Utilized*	1.30	1.34	1.38	1.41	1.45	1.49	1.53
Net Revenues							
Medicare	1,678,509	1,723,829	1,770,372	1,818,172	1,867,263	1,917,679	1,969,456
Medicaid	188,556	193,647	198,876	204,245	209,760	215,424	221,240
Commercial/Health Care Contractor	1,914,835	1,966,536	2,019,632	2,074,162	2,130,165	2,187,679	2,246,747
Self-pay	293,359	301,279	309,414	317,768	326,348	335,159	344,209
HMO	54,321	55,788	57,294	58,841	60,430	62,062	63,737
Other Government / L&I	76,596	78,664	80,788	82,969	85,209	87,510	89,872
Adjusted Revenue(Non-medicare, non-medicaide)	2,339,111	2,402,267	2,467,128	2,533,741	2,602,151	2,672,410	2,744,565
Net Revenue - Total	**$ 4,206,176**	**$ 4,319,743**	**$ 4,436,376**	**$ 4,556,158**	**$ 4,679,174**	**$ 4,805,512**	**$ 4,935,261**
Operating Expenses (VARIABLE)							
Cost of Revenue	2,310,883	2,373,276	2,437,355	2,503,163	2,570,749	2,640,159	2,711,443
People	548,545	554,535	571,171	588,306	605,955	624,134	642,858
Marketing	68,472	70,321	72,219	74,169	76,172	78,229	80,341
Office Supplies	10,391	10,672	10,960	11,256	11,560	11,872	12,192
Postage/Delivery	547	562	577	593	609	625	642
Insurance	14,103	14,484	14,875	15,276	15,689	16,113	16,548
State/Local Taxes	66,838	68,643	70,496	72,399	74,354	76,362	78,423
Total Operating Expenses (VARIABLE)	**$ 3,019,779**	**$ 3,092,492**	**$ 3,177,653**	**$ 3,265,163**	**$ 3,355,087**	**$ 3,447,492**	**$ 3,542,447**
Contribution Margin	**$ 1,186,398**	**$ 1,227,251**	**$ 1,258,723**	**$ 1,290,995**	**$ 1,324,087**	**$ 1,358,020**	**$ 1,392,814**
Non-Operating Expenses (FIXED)							
Rent	104,595	107,733	110,965	114,294	117,723	121,254	124,892
Purchased services	9,213	9,489	9,774	10,067	10,369	10,680	11,000
Utilities	14,418	14,850	15,296	15,755	16,227	16,714	17,216
Occupancy repair/maintenance	35,452	36,516	37,612	38,740	39,902	41,099	42,332
Equipment repair & maintenance	85,235	87,792	90,426	93,139	95,933	98,811	101,775
Computer contract service	26,294	27,082	27,895	28,732	29,594	30,481	31,396
Business tax & license	66,838	68,844	70,909	73,036	75,227	77,484	79,809
Depreciation & amortization	64,542	66,478	68,472	70,527	72,642	74,822	77,066
Telephone & communications	58,676	60,436	62,250	64,117	66,041	68,022	70,062
Equipment lease & rental	3,339	3,439	3,542	3,649	3,758	3,871	3,987
Education & dues	8,569	8,826	9,091	9,364	9,645	9,934	10,232
Automobile expense	182	188	194	199	205	212	218
Bank service charge	35,444	36,507	37,602	38,730	39,892	41,089	42,322
Charity Care	20,441	57,174	58,718	60,303	61,931	63,603	65,321
Computer supplies	13,541	13,948	14,366	14,797	15,241	15,698	16,169
Gifts-staff & patients	6,487	6,682	6,882	7,088	7,301	7,520	7,746
Meals & entertainment	24,356	25,086	25,839	26,614	27,413	28,235	29,082
Travel expense	1,152	1,186	1,222	1,259	1,296	1,335	1,375
Laundry & Uniforms	2,541	2,617	2,696	2,777	2,860	2,946	3,034
Total Non-Operating Expenses (FIXED)	**$ 581,315**	**$ 634,874**	**$ 653,749**	**$ 673,185**	**$ 693,200**	**$ 713,810**	**$ 735,034**
Total Operating Expenses (FIXED & VARIABLE)	*$ 3,601,094*	*$ 3,727,366*	*$ 3,831,402*	*$ 3,938,348*	*$ 4,048,287*	*$ 4,161,302*	*$ 4,277,481*
Net Income (Loss) (Pre-Tax)	**$ 605,083**	**$ 592,377**	**$ 604,974**	**$ 617,810**	**$ 630,887**	**$ 644,210**	**$ 657,780**
		$ 3,727,366	$ 3,831,402	$ 3,938,348	$ 4,048,287	$ 4,161,302	$ 4,277,481
Net Revenue	890	890	890	890	890	890	890
Total Operating Expenses	639	637	637	638	638	638	639
Total Indirect Expenses	489	131	131	131	132	132	133
Total Expenses	116	768	768	769	770	770	771
Net Income (Loss)	$ 128	$ 122	$ 121	$ 121	$ 120	$ 119	$ 119
Revenues and Expenses per OR Minute							
Net Revenue	47	47	47	47	47	47	47
Total Operating Expenses	34	34	34	34	34	34	34
Total Indirect Expenses	6	7	7	7	7	7	7
Total Expenses	40	40	40	40	41	41	41
Net Income (Loss)	$ 7	$ 6	$ 6	$ 6	$ 6	$ 6	$ 6

Footnotes:
*Operating Room is defined as 68,850 minutes of surgery minutes per Washington State Certificate of Need Department.

VOLUME AND REVENUE STATEMENT							
ASC Volumes							
Operations on the Eye	4,727.0	4,855.0	4,986.0	5,121.0	5,259.0	5,401.0	5,547.0
Total ASC Volumes	4,727.0	4,855.0	4,986.0	5,121.0	5,259.0	5,401.0	5,547.0
Cases by Payer							
Medicare	1,200	1,232	1,266	1,300	1,335	1,371	1,408
Medicaid	306	314	323	332	340	350	359
Commercial/Health Care Contractor	2,771	2,846	2,923	3,002	3,083	3,166	3,252
Self-pay	325	334	343	352	362	371	381
HMO	72	74	76	78	80	82	84
Other Government / L&I	53	54	56	57	59	61	62

Federal Way Ambulatory Surgery Center

Year	2017	2018	2019	2020	2021	2022	2023
Cases *by Payer-% of Total*							
Medicare	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
Medicaid	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%
Commercial/Health Care Contractor	58.6%	58.6%	58.6%	58.6%	58.6%	58.6%	58.6%
Self-pay	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%
HMO	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Other Government / L&I	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of FTEs per Year (Productive)							
Office/Clerical Employees	1.25	1.25	1.25	1.25	1.25	1.25	1.25
Registered Nurses	2.75	2.75	2.75	2.75	2.75	2.75	2.75
Operating Room Technicians	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Manager	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Total FTE's		8.00	8.00	8.00	8.00	8.00	8.00
Total Wages and Salaries							
Office/Clerical Employees	33,853	43,586	44,893	46,240	47,627	49,056	50,528
Registered Nurses	163,479	168,383	173,435	178,638	183,997	189,517	195,202
Operating Room Technicians	157,181	122,117	125,780	129,554	133,440	137,444	141,567
Manager	109,825	113,120	116,513	120,009	123,609	127,317	131,137
Total Employee Salaries	464,338	447,206	460,622	474,440	488,674	503,334	518,434
Employee Benefits & Taxes	72,679	107,329	110,549	113,866	117,282	120,800	124,424
Overtime and Temp Agency Labor	11,528.00	-	-	-	-	-	-
Total Salaries and Benefits	$ 548,545	$ 554,535	$ 571,171	$ 588,306	$ 605,955	$ 624,134	$ 642,858
Annual Change		$ 5,990	$ 16,636	$ 17,135	$ 17,649	$ 18,179	$ 18,724

Exhibit 17
Income Statement, Balance Statement, and Cashflow for 2015, 2016 and 2017

PERRY, SHELTON, WALKER & ASSOCIATES, PLLC
CERTIFIED PUBLIC ACCOUNTANTS • BUSINESS ADVISORS • TAX CONSULTANTS

PROVIDING
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SINCE 1979

To the Shareholders
Evergreen Eye Center, Inc. P.S.
Federal Way, Washington

Management is responsible for the accompanying financial statements of Evergreen Eye Center, Inc. P.S., which comprise the Statement of Assets, Liabilities and Shareholders' Equity - Income Tax Basis as of December 31, 2015, and the related Statement of Income and Expenses - Income Tax Basis and the Statement of Retained Earnings - Income Tax Basis for the twelve months then ended, in accordance with the income tax basis of accounting, and for determining that the income tax basis of accounting is an acceptable financial reporting framework. We have performed the compilation engagements in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

The financial statements have been prepared in accordance with the income tax basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The supplementary information included in the accompanying schedules is presented for purposes of additional analysis and is not a required part of the basic financial statements. This information is the representation of management. The information was subject to our compilation engagement; however, we have not audited or reviewed the information and, accordingly, do not express an opinion, a conclusion, nor provide any assurance on such information.

Perry Shelton Walker & Assoc., PLLC
Perry, Shelton, Walker & Associates, PLLC
Certified Public Accountants

June 6, 2016

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EVERGREEN EYE CENTER, INC., P.S.

SUPPLEMENTARY INFORMATION

FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2015

Evergreen Eye Center, Inc., P.S.

Supplemental Schedule of Shareholder Profit (Loss) - Income Tax Basis

For the Twelve Months Ending December 31, 2015

	Production	% Collections	Collections	% of SH Total
Total Production & Collections 2015	34,272,074	46.6%	**15,978,405**	
Less Direct Supplies (Injectibles)	(3,182,652)	88.5%	**(2,817,440)**	
Net Collections (Centricity):	**31,089,422**		**13,160,965**	
Net Collection Non-Shareholders:	11,943,076	53.9%	6,439,665	
Less Collections Direct Supplies (Injectibles)	(2,791,627)		(2,503,433)	
Non-Shareholder Net Collection - shared equally	9,151,449		3,936,232	
8-15-2015 Amount allocated 1/3 Equally			2,091,287	
8-16 to 12-31-2015 allocated 1/2 Equally			**1,844,945**	
Total Production & Collections 2015 - Jarstad	2,944,570	36.7%	**1,080,907**	
Less Collections Direct Supplies (Injectibles)	(5,374)		**(39)**	
Plus 1/3 Non-shareholder net collections:			**697,096**	
Shareholder Net Collection - Dr. Jarstad:			**1,777,964**	
Total Production & Collections 2015 - Tester	5,492,836	39.2%	**2,153,684**	
Less Collections Direct Supplies (Injectibles)	(302,125)		**(262,234)**	
Plus 1/3 Non-shareholder net collections:			**697,096**	
Plus 1/2 Non-shareholder net collections:			**922,472**	
Shareholder Net Collection - Dr. Tester:			**3,511,018**	**49.93%**
Total Production & Collections 2015 - Chung	5,098,524	37.4%	**1,906,255**	
Less Collections Direct Supplies (Injectibles)	(37,381)		**(4,742)**	
Plus 1/3 Non-shareholder net collections:			**697,096**	
Plus 1/2 Non-shareholder net collections:			**922,472**	
Shareholder Net Collection - Dr. Chung:			**3,521,081**	**50.07%**
Total Shareholder Net Collections (not including Jarstad)			**7,032,099**	**100.00%**
Net Collection Surgery Center:	8,746,923	49.7%	**4,350,902**	
NET Collections (Centricity + Nextech):	**31,089,422**	**42.3%**	**13,160,965**	

Evergreen Eye Center, Inc., P.S.

Supplemental Schedule of Shareholder Profit (Loss)

For the Twelve Months Ending December 31, 2015

Revenue and Expenses

Net Collections (Patient Revenue):	13,160,965	% Net Rev
Other Revenue: (Meaningful Use, Unallocated PT Rec & Refunds)	250,537	
Less other Direct Medical Supplies (not deducted above)	(1,007,363)	
Revenue Net of Direct Med Supplies per Finanical Statements:	12,404,139	100.0%
Total Overhead Expenses per Financial Statements:	(10,169,383)	-82.0%
Net Income before Officer Wages & Direct Exps:	2,234,756	18.0%
Other Income/<Expense>	23,175	0.2%
Adjusted Net Income before S/H expenses, and tax depreciation:	2,257,931	18.2%
Less		
Total Investments	(660,240)	-5.3%
Net Amount Allocated through 8-15-2015	(713,645)	
Current Amount for Shareholder Bonus Allocation:	884,047	7.1%

Division of Shareholder Net Profits

Shareholder Net Profits :		884,047
30% Shared Equally	30%	265,214
Dr. Tester @ 1/2 Share:	50.0%	*132,607*
Dr. Chung @ 1/2 Share:	50.0%	*132,607*
		265,214
70% Shared by Collections	70%	618,833
Dr. Tester Relative Collection %:	49.9%	308,973
Dr. Chung Relative Collection %:	50.1%	309,859
Dr. Tester's Shareholder Profit:	49.9%	441,580
Dr. Chung's Shareholder Profit:	50.1%	442,466
Allocation of Shareholder Net Profits :	100.0%	884,047

Evergreen Eye Center, Inc., P.S.

Supplemental Schedule of Shareholder Profit (Loss)

For the Twelve Months Ending December 31, 2015

Dr. John Jarstad	
Beginning Shareholder Payable, prior years:	172
Plus: Dr. Jarstad's Shareholder Profit to 8-15-15:	240,541
Less:	
Gross Wages & benefits as of 08/15/2015:	(256,850)
Shareholder Distributions from Equity	(70,189)
Deficit ending equity allocated equally	86,326
Ending Shareholder Profit (Loss): Jarstad	-
Dr. Robert Tester	
Beginning Shareholder Payable, prior years:	103,562
Plus: Dr. Tester's Shareholder Profit to 8-15-15:	235,039
Plus: Dr. Tester's 2015 Shareholder Profits to 12-31-15:	441,580
Less:	
Gross wages paid 2015	(335,360)
Benefits & Semi-personal expenses:	(101,903)
Shareholder Distributions from Equity	(121,063)
Less: Dr. Jarstad's equity deficit	(43,163)
Ending Shareholder Profit (Loss): Tester	178,693
Dr. Gary Chung	
Beginning Shareholder Payable, prior years:	181,228
Plus: Dr. Chung's Shareholder Profit to 8-15-15:	238,066
Plus: Dr. Chung's 2015 Shareholder Profits to 12-31-15:	442,466
Less:	
Gross wages paid 2015	(328,838)
S/H Buy-In Transfers not included in Wages	(8,184)
Benefits & Semi-personal expenses:	(86,342)
Shareholder Distributions from Equity	(121,063)
Less: Dr. Jarstad's equity deficit	(43,163)
* Corrected for math error <$364>	
Ending Shareholder Profit (Loss): Chung	274,171
Total Shareholder Profit (Loss) as of 12-31-2015	$ 452,864

Evergreen Eye Center, Inc., P.S.

Supplemental Schedule of Shareholder Profit (Loss)

For the Twelve Months Ending December 31, 2015

Total Shareholder Profit (Loss) as of 12/31/2015	**$ 452,864**
Cash at 12/31/2015	686,421
Security Deposit	4,893
Less AP:	(82,080)
Less Credit Card Payable:	(23,193)
Less PR Liabilities (and Pension Payable):	(128,793)
Less Distribution Payable Dr. Tester	(3,643)
Prior year adjustments:	(742)
Cash equity at 12-31-2015	**$ 452,864**

Evergreen Eye Center, Inc., P.S.

Supplemental Schedule of Shareholder Profit (Loss)

For the Twelve Months Ending December 31, 2015

Net change in Investments

Balance Sheet Accts	12/31/2014	12/31/2015	Change Use of Cash (Increase to cash)
Advance & Prepaid Expenses	72,164	14,132	
ASC Flood Restoration *(see note)	-	-	
	72,164	14,132	(58,032)
Computers	1,080,481	1,232,033	151,552
Software	435,124	457,835	22,711
Equip & Machinery	3,438,165	3,661,105	222,940
Furniture & Fixtures	519,701	530,107	10,406
Improvements	322,557	340,474	17,917
Vehicles	29,484	29,484	-
Goodwill	340,010	340,010	-
Adjust for disposed assets	-	(846)	(846)
	6,196,325	6,590,202	
Closed Loans	781,360	-	781,360
EverBank NexTech	173,208	78,731	94,477
Chase Subaru Motors	17,240	8,245	8,995
Stearns Bank - Retina Camera	108,415	87,546	20,869
Alcon Financing	-	131,750	(131,750)
Banner Bank Consolidation	-	480,360	(480,360)
	-		
	1,080,223	786,632	
Total decrease of cash due to investments			660,240

Evergreen Eye Center, Inc., P.S.
Schedule of Shareholder Equity - Income Tax Basis
As of December 31, 2015

Shareholders' Equity				
Paid In Capital			$	39,599
Shareholder Distributions				
Distributions - Jarstad				
Insurances - Jarstad	(11,110)			
Cell Phones - Jarstad	(6,738)			
Distributions - Jarstad - Other	(19,064)			
Distributions from Profits - Jarstad	(33,277)			
Distributions - Jarstad		$ (70,187)		
Distributions - Tester				
Insurance - Tester	(1,910)			
Cell Phone - Tester	(1,532)			
Non-Deductible Dues - Tester	(466)			
Distributions - Tester - Other	(8,878)			
Distributions from Profits - Tester	(108,277)			
Distributions - Tester		(121,063)		
Distributions - Chung				
Insurance - Chung	(7,503)			
Cell Phone - Chung	(4,342)			
Non-Deductible Dues - Chung	(326)			
Distributions - Chung - Other	(615)			
Distributions from Profits - Chung	(108,277)			
Distributions - Chung		(121,063)		
Total Shareholder Distributions				(312,313)
Retained Earnings				(56,876)
Net Income (Loss)				647,952
Total Shareholders' Equity			**$**	**318,362**

Evergreen Eye Center, Inc., P.S.
Supplemental Schedule of Shareholder Income & Direct Expense - Income Tax Basis
For the Twelve Months Ending December 31, 2015

	Jarstad	Tester	Chung	TOTAL
Shareholder Receipts				
Surgeon Professional Fees	723,648	1,071,302	1,017,295	$ 2,812,245
Federal Way Clinic	342,548	107,233	416,431	866,212
Auburn Clinic	14,173	860,785	5,033	879,991
Burien Clinic	253	0	356,910	357,163
Enumclaw Clinic	0	37,937	0	37,937
St. Francis Hospital	285	57	0	342
Auburn Regional Medical Center	0	14,388	113	14,501
HighLine Hospital	0	0	110,473	110,473
Enumclaw Hospital	0	61,982	0	61,982
Total Shareholder Receipts	$ 1,080,907	$ 2,153,684	$ 1,906,255	$ 5,140,846
Shareholder Expenses				
Wages				
Officer Wages	224,617	335,360	328,838	$ 888,815
Buy-in added/subtracted to Gross	(8,184)		8,184	
Wages net of Buy-in	216,433	335,360	337,022	888,815
Direct Expesnes				
Office PR Tax Exp	10,825	12,210	12,115	35,150
Officers Pension Expense	6,738	7,950	7,950	22,638
Direct Auto	25	0	0	25
Direct Depreciation Expense	0	2,756	0	2,756
Direct Dues & Licenses	1,635	3,448	1,605	6,688
Direct Education	325	2,915	525	3,765
Direct Gifts & Promotion	0	537	0	537
Direct Business Insurance	7,868	15,476	16,214	39,558
Direct Meals & Entertainment	1,460	156	227	1,843
Direct Office Expense	147	376	0	523
Direct Small Tools	67	0	0	67
Direct Telephone	620	349	0	969
Direct Travel	10,707	9,214	1,190	21,111
Direct Legal	0	46,516	46,516	93,032
Total Direct Expense	40,417	101,903	86,342	228,662
Total Shareholder Expenses	**$ 256,850**	**$ 437,263**	**$ 423,364**	**$ 1,117,477**

Evergreen Eye Center, Inc., P.S.
Supplemental Schedule of Shareholder Income & Direct Expense - Income Tax Basis
For the period August 16 2015 to December 31, 2015

	Tester	Chung	TOTAL
Shareholder Receipts			
Fees - Evergreen Eye Center	(5,298)	(2,442)	$ (7,740)
Surgeon Professional Fees	488,139	462,719	950,858
Federal Way Clinic	54,587	202,975	257,562
Auburn Clinic	418,814	1,903	420,717
Burien Clinic	0	138,474	138,474
Enumclaw Clinic	18,303	0	18,303
St. Francis Hospital	40	0	40
Auburn Regional Medical Center	9,446	0	9,446
HighLine Hospital	0	44,431	44,431
Enumclaw Hospital	25,011	0	25,011
Total Shareholder Receipts	$ 1,009,042	$ 848,060	$ 1,857,102
Shareholder Expenses			
Wages			
Officer Wages	115,385	115,385	$ 230,770
Direct Expesnes			
Office PR Tax Exp	1,494	1,552	3,046
Officers Pension Expense	1,351	1,546	2,897
Direct Depreciation Expense	1,378	0	1,378
Direct Dues & Licenses	510	510	1,020
Direct Business Insurance	8,100	8,346	16,446
Direct Meals & Entertainment	0	137	137
Direct Office Expense	90	0	90
Direct Telephone	178	0	178
Direct Travel	0	1,190	1,190
Direct Legal	26,214	26,214	52,428
Total Direct Expense	39,315	39,495	78,810
Total Shareholder Expenses	**$ 154,700**	**$ 154,880**	**$ 309,580**

Evergreen Eye Center, Inc., P.S.
Schedule of Assets, Liabilities & Shareholders' Equity - Income Tax Basis
As of December 31, 2015 and 2014

	Dec 31 2015	Dec 31 2014	$ Change
ASSETS			
Current Assets			
Checking/Savings			
Key Checking	$ 48,284	$ 179,475	$ (131,191)
Banner Bank	129,138	218,272	(89,134)
Banner Tech Fund	2,621	4,593	(1,972)
Wells Fargo	0	11,308	(11,308)
Key Bank Money Market Account	21,211	8,559	12,652
Chase Checking	71,722	72,806	(1,084)
Chase Money Market	1,007	1,006	1
US Bank Operations	84,522	0	84,522
US Bank Payroll	31,680	0	31,680
US Bank Holding	296,236	0	296,236
Total Checking/Savings	686,421	496,019	190,402
Other Current Assets			
PettyCash	466	466	0
Prepaid Expense	9,608	17,917	(8,309)
Prefunded Payroll	0	129,432	(129,432)
Total Advances	4,058	939	3,119
Due from Related Party	0	52,330	(52,330)
Total Other Current Assets	14,132	201,084	(186,952)
Total Current Assets	700,553	697,103	3,450
Fixed Assets			
Computers	1,232,033	1,080,481	151,552
Sofware	457,835	435,124	22,711
Equip & Machinery	3,661,105	3,438,165	222,940
Furniture & Fixtures	530,107	519,701	10,406
Improvements	340,474	322,557	17,917
Vehicles	29,484	29,484	0
Accumulated Depreciation	(5,757,764)	(5,286,377)	(471,387)
Total Fixed Assets	493,274	539,136	(45,862)
Other Assets			
Goodwill net of Amortization	143,982	166,322	(22,340)
Security Deposit	4,893	0	4,893
Total Other Assets	148,875	166,322	(17,447)
TOTAL ASSETS	**$ 1,342,702**	**$ 1,402,560**	**$ (59,858)**
LIABILITIES & SHAREHOLDERS' EQUITY			
LIABILITIES			
Current Liabilities			
Accounts Payable	$ 82,080	$ 26,537	$ 55,543
Credit Cards			
Closed Accounts	0	30,478	(30,478)
Visa- Alaska Airlines-Chung	452	19,748	(19,296)
Capital One - Venture	8,455	25,437	(16,982)
Visa- Alaska Airlines-Tester	542	2,144	(1,602)

Evergreen Eye Center, Inc., P.S.
Schedule of Assets, Liabilities & Shareholders' Equity - Income Tax Basis
As of December 31, 2015 and 2014

	Dec 31 2015	Dec 31 2014	$ Change
Credit Cards (continued)			
Chase EEC	10,892	97,377	(86,485)
US Bank Flex Perks	2,852	0	2,852
Total Credit Cards	23,193	175,184	(151,991)
Other Current Liabilities			
Pension Payable	0	18,651	(18,651)
Withholdings Payable	0	(368)	368
Payroll Liabilities	12,570	19,550	22,262
Health Insurance	0	21,943	(21,943)
Dental Insurance	162	3,948	(3,786)
B&O Payable	0	3,373	(3,373)
Uncashed check liability	1,061	491	570
Key Bank Line of Credit	115,000	0	115,000
Shareholder Payable	0	17,900	(17,900)
Current Portion of LT Debt	220,314	466,348	(246,034)
Distribution Payable - Tester	3,643	29,844	(26,201)
Distribution Payable - Chung	0	22,518	(22,518)
Total Other Current Liabilities	352,750	604,198	(251,448)
Total Current Liabilities	458,023	805,919	(347,896)
Long Term Liabilities			
Banner (Zeiss & Stryker)	0	76,335	(76,335)
Bank of West (Forum)	0	1,420	(1,420)
Bank of West (Aub Equip)	0	75,932	(75,932)
Bank of West (KJ Design)	0	54,597	(54,597)
Zions Credit -Canon CX-1 Camera	0	9,849	(9,849)
Banner LenSx Laser	0	261,833	(261,833)
Chase Steris Sterilizer	0	45,987	(45,987)
EverBank NexTech	78,731	173,208	(94,477)
Key Equip. Fin. - Ivoxy Servers	0	159,117	(159,117)
Tear Science-LipiView & LipiFlow	0	96,290	(96,290)
Chase Subaru Motors	8,245	17,240	(8,995)
Stearns Bank - Retina Camera	87,546	108,415	(20,869)
Alcon Financing	131,750	0	131,750
Banner Bank Consolidation	480,360	0	480,360
ST Portion of LT Debt	(220,314)	(466,348)	246,034
Total Long Term Liabilities	566,318	613,875	(47,557)
Total Liabilities	1,024,341	1,419,794	(395,453)
Shareholders' Equity			
Paid In Capital	39,599	39,599	0
Shareholder Distributions	(312,313)	(100,209)	(212,104)
Retained Earnings	(56,876)	15,439	(72,315)
Net Income	647,952	27,939	620,013
Total Shareholders' Equity	318,362	(17,232)	335,594
TOTAL LIABILITIES & SHAREHOLDERS' EQUITY	**$ 1,342,702**	**$ 1,402,560**	**$ (59,858)**

Evergreen Eye Center, Inc., P.S.
Schedule of Revenue and Expenses - Income Tax Basis
For the Twelve Months Ending December 31, 2015 and 2014

	Jan - Dec 2015	%	Jan - Dec 2014	%	$ Change
Revenue					
4000 · Fees - Evergreen Eye Center	$ 169,807		$ -		$ 169,807
4001 · Fees-Evergreen Eye Surgery Cnt.	4,393,164		3,988,919		404,245
4002 · Surgeon Professional Fees	3,599,179		3,473,034		126,145
4003 · Federal Way Clinic	1,971,571		1,888,549		83,022
4004 · Auburn Clinic	3,684,081		3,549,448		134,633
4005 · Burien Clinic	2,057,769		2,096,247		(38,478)
4006 · Enumclaw Clinic	41,314		47,752		(6,438)
4007 · St. Francis Hospital	29,450		8,039		21,411
4008 · Auburn Regional Medical Center	29,422		28,161		1,261
4009 · HighLine Hospital	110,473		97,569		12,904
4010 · Enumclaw Hospital	61,982		45,229		16,753
4030 · Referral/PQRI/Meanigful Use	80,644		94,832		(14,188)
4050 · Refunds	86		17,606		(17,520)
Total Revenue	**$ 16,228,942**	100.00%	**$ 15,335,385**	100.00%	$ 893,557
Less:					
5000 · Direct Medical Supplies					
5100 · ASC-Keycards	40,337		75,198		(34,861)
5200 · Intraoccular Lenses	653,031		627,632		25,399
5300 · Visudyne,Lucentis,Avastin,Eylea	2,772,915		2,756,174		16,741
5400 · LenSx Patient Interfaces	317,091		252,240		64,851
5500 · LipiFlow Activators	11,530		0		11,530
5000 · Other Direct Medical Supplies	29,900		0		29,900
5000 · Total Direct Medical Supplies	3,824,804	23.57%	3,711,244	24.20%	113,560
Revenue net of Direct Medical Supplies	12,404,138	76.43%	11,624,141	75.80%	779,997
Overhead Expense					
6010 · Advertising & Promotions					
6010.01 · Yellow Pages	78,874		85,485		(6,611)
6010.02 · Television	0		3,625		(3,625)
6010.03 · Radio	157,277		150,665		6,612
6010.04 · Newspaper	19,640		16,657		2,983
6010.05 · Internet	63,427		53,158		10,269
6010.06 · Gifts	568		2,666		(2,098)
6010.07 · Catering - Marketing	637		0		637
6010.08 · Brevium Total Recall	22,314		29,822		(7,508)
6010.09 · Marketing Agency	11,000		3,219		7,781
6010.12 · Marketing Forms & Brochures	7,199		1,077		6,122
6010.13 · Marketing Travel Expenses	817		0		817
6010.14 · Marketing Supplies	32,108		41,366		(9,258)
6010.15 · Marketing Events	2,943		13,167		(10,224)
6010 · Advertising & Promotions - Other	5,953		0		5,953
Total 6010 · Advertising & Promotions	402,757	2.48%	400,907	2.61%	1,850
6020 · Bad Debt	69		4,212		(4,143)
6030 · Charitable Contribution	11,117		11,895		(778)
6040 · Clinic Expenses					
6040.01 · Clinic Exempt Supplies	25,452		33,431		(7,979)

Evergreen Eye Center, Inc., P.S.
Schedule of Revenue and Expenses - Income Tax Basis
For the Twelve Months Ending December 31, 2015 and 2014

	Jan - Dec 2015	%	Jan - Dec 2014	%	$ Change
6040.02 · Clinic Non-Exempt Suppli	135,131		155,827		(20,696)
6040.04 · EyeWear	2,919		3,403		(484)
6040.06 · Rx Perscriptions	90,429		77,274		13,155
6040.07 · Small Tools - Clinic	9,679		14,523		(4,844)
Total 6040 · Clinic Expenses	263,610	1.62%	284,458	1.85%	(20,848)
6060 · Education, Dues & Licenses					
6060.01 · Education Expenses	35,007		24,573		10,434
6060.02 · Dues & Subscriptions	20,481		18,355		2,126
6060.03 · License Fees & Hospital Dues	15,799		14,829		970
6060.04 · Non-Deductible Dues	1,225		941		284
Total 6060 · Education, Dues & Licenses	72,512	0.45%	58,698	0.38%	13,814
6080 · Insurances - Business					
6080.01 · Building Hazard & Liability	1,035		6,290		(5,255)
6080.02 · Partnership Key Man Insurance	4,581		16,271		(11,690)
6080.03 · Physicians Liability Insurance	43,749		16,876		26,873
6080.05 · Surety Bond - Pension Fund	908		368		540
6080 · Insurances - Business - Other	15,415		24,869		(9,454)
Total 6080 · Insurances - Business	65,688	0.40%	64,674	0.42%	1,014
6100 · Office Expenses					
6101 · Office Supplies	86,792		62,686		24,106
6102 · Janitorial Supplies	15,752		12,208		3,544
6104 · Postage, Shipping & Handling	10,800		10,902		(102)
6106 · Forms, Brochures & Recall Services	39,155		44,288		(5,133)
6107 · Uniforms	10,546		11,453		(907)
6108 · Meals & Entertainment	56,159		60,596		(4,437)
6110 · Collections Fees	16,117		77,913		(61,796)
6111 · Reimbursements to Patients	5,564		1,615		3,949
6140 · Telephone	34,770		37,706		(2,936)
6145 · Cell Phones	8,165		8,470		(305)
6150 · Equip. Lease & Rental	37,298		39,013		(1,715)
6170 · Contract Services					
6170.00 · Contract Services Other	18,472		625		17,847
6170.01 · Casual Labor	17,099		88		17,011
6170.02 · Courier Services	1,933		0		1,933
6170.03 · Coffee Service	367		2,375		(2,008)
6170.04 · Dish Network	2,335		1,507		828
6170.05 · Equip. Repairs & Maintenance	202,814		18,936		183,878
6170.06 · Interpretation Services	8,506		8,048		458
6170.09 · Muzak Audio Services	3,513		3,970		(457)
6170.10 · Pure Health Solutions	3,651		3,727		(76)
6170.12 · Security	5,014		4,071		943
6170.13 · Storage	7,697		8,462		(765)
6170.14 · Televox	9,274		8,790		484
6170.16 · PayChex	3,256		0		3,256
Total 6170 · Contract Services	283,931	1.75%	60,599	0.40%	223,332
6190 · Miscellaneous	(17,289)		16,013		(33,302)
Total 6100 · Office Expenses	587,760	3.62%	443,462	2.89%	144,298

Evergreen Eye Center, Inc., P.S.
Schedule of Revenue and Expenses - Income Tax Basis
For the Twelve Months Ending December 31, 2015 and 2014

	Jan - Dec 2015	%	Jan - Dec 2014	%	$ Change
6200 · Occupancy Expenses					
6201 · Building Lease & Rent	836,464		781,601		54,863
6202 · Cleaning Janitorial Service	56,321		58,083		(1,762)
6203 · DOBCO	21,000		12,883		8,117
6204 · Elevator	9,149		4,948		4,201
6205 · HVAC	2,986		15,799		(12,813)
6206 · Landscape	3,614		4,906		(1,292)
6207 · Maintenance & Building Repairs	73,795		170,035		(96,240)
6208 · Real Estate Property Taxes	102,579		(3,440)		106,019
6209 · Utilities	255,480		211,013		44,467
Total 6200 · Occupancy Expenses	1,361,388	8.39%	1,255,828	8.19%	105,560
6300 · Professional Services					
6301 · Accounting & Legal Services	67,216		18,575		48,641
6302 · Bank & Finance Service Fees	64,752		57,081		7,671
6303 · Computer Professional Services	208,979		182,116		26,863
6306 · COLO Expense	9,296		0		9,296
6300 · Professional Svcs Other (Camber Health)	19,192		121,678		(102,486)
Total 6300 · Professional Services	369,435	2.28%	379,450	2.47%	(10,015)
6400 · Surgery Center Expenses					
6402 · ASC Catering/Meals & Ent	29,698		29,633		65
6404 · ASC Exempt Supplies	217,198		311,368		(94,170)
6405 · ASC Non-Exempt Supplies	316,096		365,616		(49,520)
6406 · ASC Laundry	2,451		0		2,451
6408 · ASC Pharmacist	2,000		1,200		800
6409 · ASC Prescription Medications	75,466		54,709		20,757
6410 · ASC Repairs & Maintenance	16,721		88,010		(71,289)
6411 · ASC Small Tools	40,327		62,670		(22,343)
6412 · ASC Patient Gifts	17,117		18,124		(1,007)
6415 · ASC Accreditation	24,176		0		24,176
6450 · Surgical Facility Fees	23,243		10,744		12,499
Total 6400 · Surgery Center Expenses	764,493	4.71%	942,074	6.14%	(177,581)
6500 · Business & Payroll Taxes					
6510 · B&O Taxes	231,366		209,711		21,655
6520 · Payroll Expenses	416,454		351,048		65,406
6540 · Personal Property Tax	32,655		24,523		8,132
Total 6500 · Business & Payroll Taxes	680,475	4.19%	585,282	3.82%	95,193
6600 · Travel Expenses					
6601 · Auto Expenses	11,199		8,310		2,889
6610 · Travel, Lodging & Auto Rental	36,797		20,704		16,093
Total 6600 · Travel Expenses	47,996	0.30%	29,014	0.19%	18,982
6700 · Wages, Salaries & Benefits					
6701 · MD/OD Wages	1,185,630		945,506		240,124
6702 · Non MD/OD Wages	3,735,906		3,396,164		339,742
6703 · Employees Insurance	281,556		350,110		(68,554)
6705 · HSA Company Contribution	30,485		29,186		1,299
6707· Pension Plan Expenses	125,016		119,645		5,371
6710 · Severence Pay	74,835		0		74,835
6750 · Deferred Compsensation	68,955		0		68,955
Total 6700 · Wages, Salaries & Benefits	5,502,383	33.90%	4,840,611	31.56%	661,772

Evergreen Eye Center, Inc., P.S.
Schedule of Revenue and Expenses - Income Tax Basis
For the Twelve Months Ending December 31, 2015 and 2014

	Jan - Dec 2015	%	Jan - Dec 2014	%	$ Change
6800 · Loan/Lease Interest Exp					
6800.01 · 2500 - Key Bank LOC #1101	87		7,461		(7,374)
6800.17 · 2617 - Zions Credit (Canon CR2)	0		748		(748)
6800.18 · 2618 - Banner (Zeiss & Stryker)	4,452		5,167		(715)
6800.19 · 2619 - Bank of West (Forum)	31		1,032		(1,001)
6800.20 · 2620 - Bank of West (Aub Equip)	6,012		6,994		(982)
6800.21 · 2621 - Bank of West (KJ Design)	4,569		5,144		(575)
6800.23 · 2623 - Zions Credit (Canon CX1)	413		1,595		(1,182)
6800.24 · 2624 - Banner Bank- LenSx Laser	8,049		11,459		(3,410)
6800.25 · 2625 - Chase -Steris Sterilizer	4,098		2,701		1,397
6800.28 · 2628 - Key Equip Fin (Ivoxy)	5,196		7,072		(1,876)
6800.29 · 2629 - TearScience	3,278		5,326		(2,048)
6800.30 · 2631 - Stearns Bank Retina Cam	3,511		467		3,044
Total 6800 · Loan/Lease Interest Exp	39,696	0.24%	55,166	0.36%	(15,470)
Total Overhead Expense	10,169,379	62.66%	9,355,725	61.01%	813,654
Revenue net of Overhead Expenses before Other Income/Expense and Officer Wage & Direct Exps	$ 2,234,759	13.77%	$ 2,268,416	14.79%	$ (33,657)
Other Income / (Expense)					
Other Income					
7000 · Interest Income	42		13		29
7010 · Other Income	22,758		26,998		(4,240)
7014 · Gain/Loss Sale of Asset	375		6,400		(6,025)
7200 · Depreciation & Amortization	(492,503)		(845,430)		4,491
7250 · Non-Deductible IRS Penalties	0		(4,491)		347,182
Total Other Income/ (Expense)	(469,328)	2.89%	(816,510)	5.32%	347,182
Less: Officer Wage & Direct Expense					
8100 · Officer Wages	888,815	5.80%	1,229,379	8.02%	(340,564)
8110 · Office PR Tax Exp	35,151		39,714		(4,563)
8120 · Officers Pension Expense	22,638		22,050		588
8131 · Direct Auto	25		1,609		(1,584)
8133 · Direct Depreciation	2,756		1,165		1,591
8135 · Direct Dues & Licenses	6,688		9,299		(2,611)
8136 · Direct Education	3,765		4,297		(532)
8138 · Direct Gifts & Promotion	537		80		457
8140 · Direct Business Insurance	39,558		48,777		(9,219)
8145 · Direct Meals & Entertainment	1,843		3,986		(2,143)
8146 · Direct Office Expense	523		1,925		(1,402)
8155 · Direct Small Tools	67		0		67
8155 · Direct Telephone	969		2,486		(1,517)
8160 · Direct Travel	21,111		34,206		(13,095)
8165 · Direct - Legal	93,032		15,627		77,405
8199 · Direct Expense - Other	0		9,367		(9,367)
Total Officer Wage & Direct Expense	1,117,478	6.89%	1,423,967	9.29%	(306,489)
Net Other Income/(Expenses)	(1,586,806)	9.78%	(2,240,477)	14.61%	653,671
Net Revenues over Expenses	**$ 647,952**	3.99%	**$ 27,939**	0.18%	**$ 620,013**

EVERGREEN EYE CENTER, INC., P.S.

FINANCIAL STATEMENTS

FOR THE TWELVE MONTHS ENDED
DECEMBER 31, 2015

Evergreen Eye Center, Inc., P.S.
Statement of Assets, Liabilities & Shareholders' Equity - Income Tax Basis
As of December 31, 2015

ASSETS				
Current Assets				
Checking/Savings				
Key Checking	$ 48,284			
Banner Bank	129,138			
Banner Tech Fund	2,621			
Key Bank Money Market Account	21,211			
Chase Checking	71,722			
Chase Money Market	1,007			
US Bank Operation	84,522			
US Bank Payroll	31,680			
US Bank Holding	296,236			
Total Checking/Savings		$ 686,421		
Other Current Assets				
PettyCash	466			
Employee Advances	4,058			
Pre-Paid Expense	9,608			
Total Other Current Assets		14,132		
Total Current Assets			$ 700,553	
Fixed Assets				
Computers		1,232,033		
Software		457,835		
Equip & Machinery		3,661,105		
Furniture & Fixtures		530,107		
Improvements		340,474		
Vehicles		29,484		
Accumulated Depreciation		(5,757,764)		
Total Fixed Assets			493,274	
Other Assets				
Goodwill net of Amortization		143,982		
Security Deposit		4,893		
Total Other Assets			148,875	
TOTAL ASSETS				**$ 1,342,702**
LIABILITIES & SHAREHOLDERS' EQUITY				
Liabilities				
Current Liabilities				
Accounts Payable		$ 82,080		
Credit Cards				
Visa Business Cards	$ 994			
Capital One - Venture	8,455			

Evergreen Eye Center, Inc., P.S.
Statement of Assets, Liabilities & Shareholders' Equity - Income Tax Basis
As of December 31, 2015

LIABILITIES & SHAREHOLDERS' EQUITY, continued			
Credit Cards (continued)			
Chase EEC	10,892		
US Bank Flex Perks	2,852		
Total Credit Cards		23,193	
Other Current Liabilities			
Payroll Liabilities	12,732		
Uncashed Check Liabilities	1,061		
Key Bank LOC	115,000		
Current Portion of LT Debt	220,314		
Distribution Payable - Tester	3,643		
Distribution Payable - Chung	0		
Total Other Current Liabilities		$ 352,750	
Total Current Liabilities			$ 458,023
Long Term Liabilities			
EverBank NexTech		78,731	
Chase Subaru Motors		8,245	
Stearns Bank - Retina Camera		87,546	
Alcon Financing		131,750	
Banner Bank Consolidation		480,360	
ST Portion of LT Debt		(220,314)	
Total Long Term Liabilities			566,318
Total Liabilities			1,024,341
Shareholders' Equity			
Paid In Capital		39,599	
Shareholder Distributions		(312,313)	
Retained Earnings		(56,876)	
Net Income		647,952	
Total Shareholders' Equity			318,362
TOTAL LIABILITIES &SHAREHOLDERS' EQUITY			**$ 1,342,702**

Evergreen Eye Center, Inc., P.S.
Statement of Income & Expenses - Income Tax Basis
For the Four & Half and Twelve Months Ending December 31, 2015

	Four 1/2 Months Ending		Twelve Months Ending	
	Aug 16 - Dec 31 2015	% of Income	Jan - Dec 31 2015	% of Income
Revenue				
Fees-Evergreen Eye Center	154,187	2%	169,807	1%
Fees-Evergreen Eye Surgery Cnt.	1,620,667	25%	4,393,164	27%
Surgeon Professional Fees	1,432,896	22%	3,599,179	22%
Federal Way Clinic	843,215	13%	1,971,571	12%
Auburn Clinic	1,560,841	24%	3,684,081	23%
Burien Clinic	833,504	13%	2,057,769	13%
Enumclaw Clinic	18,704	0%	41,314	0%
St. Francis Hospital	15,845	0%	29,450	0%
Auburn Regional Medical Center	11,400	0%	29,422	0%
HighLine Hospital	44,431	1%	110,473	1%
Enumclaw Hospital	25,011	0%	61,982	0%
Referral/PQRI/Meanigful Use	39	0%	80,644	0%
Refunds	(32,643)	(1%)	86	0%
Total Income	6,528,097	100%	16,228,942	100%
Less:				
Cost of Direct Medical Supplies	1,314,192	20%	3,824,803	24%
Revenue Net of Direct Medical Supplies	5,213,905	80%	12,404,139	76%
Overhead Expense				
Advertising & Promotions	112,740	2%	402,757	2%
Bad Debt	0	0%	69	0%
Charitable Contribution	5,031	0%	11,117	0%
Clinic Expenses	82,784	1%	263,610	2%
Education, Dues & Licenses	18,195	0%	72,512	0%
Insurances - Business	54,243	1%	65,688	0%
Office Expenses	315,462	5%	587,761	4%
Occupancy Expenses	527,214	8%	1,361,388	8%
Professional Services	158,512	2%	369,435	2%
Surgery Center Expenses	220,600	3%	764,494	5%
Business & Payroll Taxes	264,570	4%	680,475	4%
Travel Expenses	7,440	0%	47,996	0%
Wages, Salaries & Benefits	2,129,662	33%	5,427,548	33%
Deferred Compensation	74,835	1%	74,835	0%
Loan/Lease Interest Exp	17,749	0%	39,698	0%
Total Overhead Expense	3,989,037	61%	10,169,383	63%
Revenue net of Overhead Expenses before Other Income/Expense and Officer Wage & Direct Exps	1,224,868	19%	2,234,756	14%
Other Income/(Expense)				
Other Income	28		23,175	
Depreciation & Amortization	(372,648)	(6%)	(492,503)	(3%)
Total Other Income/(Expense)	$ (372,620)	(6%)	$ (469,328)	(3%)

Evergreen Eye Center, Inc., P.S.
Statement of Income & Expenses - Income Tax Basis
For the Four & Half and Twelve Months Ending December 31, 2015

	Four 1/2 Months Ending		Twelve Months Ending	
	Aug 16 - Dec 31 2015	% of Income	Jan - Dec 31 2015	% of Income
Less: Officer Wage & Direct Expense				
Officer Wages	230,769	4%	888,815	5%
Office PR Tax Exp	3,046		35,151	
Officers Pension Expense	2,897		22,638	
Direct Auto	0		25	
Direct Depreciation Exp	1,378		2,756	
Direct Dues & Licenses	1,020		6,688	
Direct Education	0		3,765	
Direct Gifts & Promotion	0		537	
Direct Business Insurance	16,446		39,558	
Direct Meals & Entertainment	149		1,843	
Direct Office Expense	67		523	
Small Tools	0		67	
Direct Telephone	178		969	
Direct Travel	1,190		21,111	
Direct Legal	52,429		93,032	
Total Officer Wage & Direct Expense	309,569	5%	1,117,478	7%
Net Other Income/(Expense)	(682,189)	(10%)	(1,586,806)	(10%)
Net Revenue over Expenses	**$ 542,679**	**8%**	**$ 647,952**	**4.0%**

Evergreen Eye Center, Inc., P.S.
Statement of Retained Earnings - Income Tax Basis
For the Four & Half and Twelve Months Ending December 31, 2015

Retained Earnings	Four 1/2 Months Ending December 31, 2015	Twelve Months Ending December 31, 2015
Retained Earnings at beginning of the period	$ (95,345)	$ (56,876)
Less prior period adjustments *	(4,894)	-
Less: Shareholder distributions	(163,677)	(312,313)
Plus/Less: Net Income (Net Loss)	542,679	647,952
Retained Earnings at June 30, 2015	$ 278,763	$ 278,763

* Jan - August 2015 adjustments -

Evergreen Eye Center, Inc., P.S.

SELECTED INFORMATION – SUBSTANTIALLY ALL OF THE DISCLOSURES ORDINARILY INCLUDED IN THE INCOME TAX BASIS OF ACCOUNTING ARE NOT INCLUDED

December 31, 2015

NOTE 1 – MANAGEMENT'S ELECTION TO OMIT DISCLOSURES

Management has elected to omit substantially all of the disclosures ordinarily included in financial statements prepared in accordance with the income tax basis of accounting. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the company's assets, liabilities, equity, revenue, and expenses. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Compilation Report of Independent Accountants
and Financial Statements for

Evergreen Eye Center, Inc. P.S.

December 31, 2016

MOSS-ADAMS LLP

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MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

COMPILATION REPORT OF INDEPENDENT ACCOUNTANTS

To the Stockholders
Evergreen Eye Center, Inc. P.S.

Management is responsible for the accompanying financial statements of Evergreen Eye Center, Inc. P.S. (an S corporation), which comprise the statement of assets, liabilities, and stockholders' equity- income tax basis as of December 31, 2016, and the related statements of revenue and expenses - income tax basis, changes in stockholders' equity - income tax basis, and cash flows - income tax basis for the year then ended in accordance with the tax basis of accounting, and for determining that the tax basis of accounting is an acceptable financial reporting framework. We have performed the compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the American Institute of Certified Public Accountants. We did not audit or review the accompanying financial statements, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

Management has elected to omit substantially all of the disclosures ordinarily included in the financial statements prepared in accordance with the income tax basis of accounting. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's assets, liabilities, equity, revenues, and expenses. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Moss Adams LLP

Everett, Washington
April 17,2017

EVERGREEN EYE CENTER, INC. P.S.

STATEMENT OF ASSETS, LIABILITIES, AND STOCKHOLDERS' EQUITY · INCOME TAX BASIS

DECEMBER 31, 2016

ASSETS

CURRENT ASSETS		
Cash	$	688,491
Prepaid expense		7,082
Advances		24,175
Total current assets		719,748
FIXED ASSETS, at cost		
Computer hardware and software		1,727,791
Equipment and machinery		3,874,870
Furniture and equipment		530,107
Improvements		340,474
Vehicles		49,670
		6,522,912
Less accumulatl!d depreciation		[6,193,6461
Fixed assets, M t		329,266
OTHER ASSETS		
Goodwill, net of accumulated amortization		121,523
Security deposit		16,600
Total other assets		138,123
Total assets	$	1,187,137

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES		
Credit cards	$	154,344
Current portion oflong-term debt		196,699
Distribution payable		53,731
Other current liabilities		9,891
Total current liabilities		414,665
LONG-TERM DEBT, net of current portion		556,301
Total liabilities		970,966
STOCKHOLDERS' EQUITY		
Common stock. $LOO par value, 50,000 shares authorized, 1,500 shares issued and outstanding		1,500
Paid-in capital		38,099
Retained earnings		176,572
Total stockholders' equity		216,171
Total liabilities and stockholders' equity	$	l.187.137

See compilation report of independent accountants.

EVERGREEN EYE CENTER, INC. P.S.

STATEMENT OF REVENUE AND EXPENSES · INCOME TAX BASIS

FOR THE YEAR ENDED DECEMBER 31, 2016

FEES	$ 16,563,915
DIRECT MEDICAL SUPPLIES	3,948,103
FEES, NET OF DIRECT MEDICAL SUPPLIES	12,615,812
OPERATING EXPENSES	
Salaries and benefits expense	7,102,846
Medical supplies	898,366
Rent	772,945
Marketing and promotions	471,001
Purchased services	427,987
Utilities	436,416
Repairs and maintenance	389.488
Business taxes and licenses	344,799
Depreciation and amortization	458,342
Office supplies	160,534
Insurance	93,327
Other operating expenses	392,580
TOTAL OPERATING EXPENSES	11,948,631
INCOME FROM OPERATIONS	667,181
OTHER INCOME (EXPENSE)	
Other income	66,250
Interest income	122
Interest expense	(20,141)
Officer life insurance	[16,611}
	29,620
NET INCOME	$ 696,801

See compilation report of independent accountants.

EVERGREEN EYE CENTER, INC. P.S.
STATEMENT OF CHANGES IN STOCKHOLDERS' EQUITY - INCOME TAX BASIS
FOR THE YEAR ENDED DECEMBER 31, 2016

	Common Stock		Paid-in	Retained	
	Shares	Amount	Capital	Earnings	Total
BALANCE, December 31, 201S	1,500	$ 1,500	$ 38,099	$ 278,759	$ 318,358
Distributions	-	-	-	(798,988)	(798,988)
Net incoml?	-	-	-	696,801	696,BOl
BALANCE, Dccl?mber 31, 2016	1,500	$ 1,500	$ 39,099	$ 176,572	$ 216,171

See compilation report of independent accountants.

EVERGREEN EYE CENTER, INC. P.S.
STATEMENT OF CASH FLOWS - INCOME TAX BASIS
FOR THE YEAR ENDED DECEMBER 31, 2016

CASH FLOWS FROM OPERATING ACTIVITIES	
Net income	$ 696,801
Adjustments to reconcile net income to net cash provided by operating activities	
Depreciation and amortization	458,342
Net change in assets and liabilities	
Prepaid expenses	2,526
Advances	(20,117)
Security deposits	(11,707)
Accounts payable	(82,080)
Credit cards	131,153
Related party payable	50,088
Other current liabilities	(3,902)
Net cash provided by operating activities	1,221.104
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchase affixed assets	{271,875)
Net cash used in investing activities	(271,875}
CASH FLOWS FROM FINANCING ACTIVITIES	
Distributions	(798,988)
Payment on line of credit	(115,000)
Repayment of long-term debt	(215,975)
Issuance oflong-term debt	182,343
Net cash used in financing activities	(947,620}
NET CHANGE IN CASH	1,609
CASH, beginning balance	686,882
CASH, ending balance	$ 688,491

See compilation report of independent accountants.

COMPILATION REPORT OF INDEPENDENT ACCOUNTANTS
AND FINANCIAL STATEMENTS

EVERGREEN EYE CENTER, INC. P.S.

December 31, 2017

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Compilation Report of Independent Accountants

To the Stockholders
Evergreen Eye Center, Inc. P.S.

Management is responsible for the accompanying financial statements of Evergreen Eye Center, Inc. P.S. (an S corporation), which comprise the statement of assets, liabilities, and stockholders' deficit – income tax basis as of December 31, 2017, and the related statements of revenue and expenses – income tax basis, changes in stockholders' equity/(deficit) – income tax basis, and cash flows – income tax basis for the year then ended in accordance with the tax basis of accounting, and for determining that the tax basis of accounting is an acceptable financial reporting framework. We have performed the compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the American Institute of Certified Public Accountants. We did not audit or review the accompanying financial statements, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

Management has elected to omit substantially all of the disclosures ordinarily included in the financial statements prepared in accordance with the income tax basis of accounting. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's assets, liabilities, equity, revenues, and expenses. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Moss Adams LLP

Everett, Washington
April 3, 2018

Evergreen Eye Center, Inc. P.S.
Statement of Assets, Liabilities, And Stockholders' Deficit – Income Tax Basis
December 31, 2017

ASSETS

CURRENT ASSETS		
Cash	$	574,549
Total current assets		574,549
FIXED ASSETS, at cost		
Computer hardware and software		1,632,487
Equipment and machinery		3,944,975
Furniture and equipment		467,355
Improvements		739,553
Vehicles		49,670
		6,834,040
Less accumulated depreciation		(6,174,060)
Fixed assets, net		659,980
OTHER ASSETS		
Goodwill, net of accumulated amortization		99,063
Security deposit		16,600
Total other assets		115,663
Total assets	$	1,350,192

LIABILITIES AND STOCKHOLDERS' DEFICIT

CURRENT LIABILITIES		
Credit cards	$	374,270
Current portion of long-term debt		248,438
Shareholder distributions payable		30,912
Other current liabilities		19,554
Total current liabilities		673,174
LONG-TERM DEBT, net of current portion		801,909
Total liabilities		1,475,083
STOCKHOLDERS' DEFICIT		
Common stock, $1.00 par value, 50,000 shares authorized, 1,500 shares issued and outstanding		1,500
Paid-in capital		38,099
Retained deficit		(164,490)
Total stockholders' deficit		(124,891)
Total liabilities and stockholders' deficit	$	1,350,192

Evergreen Eye Center, Inc. P.S.
Statement of Revenues and Expenses – Income Tax Basis
For The Year Ended December 31, 2017

FEES	$ 17,008,463
DIRECT MEDICAL SUPPLIES	3,655,277
FEES, NET OF DIRECT MEDICAL SUPPLIES	13,353,186
OTHER OPERATING REVENUE	22,834
TOTAL OPERATING REVENUE	13,376,020
OPERATING EXPENSES	
Salaries and benefits expense	7,515,573
Medical supplies	857,708
Rent	774,267
Marketing and promotions	444,614
Purchased services	584,343
Utilities	427,308
Repairs and maintenance	275,227
Business taxes and licenses	525,038
Depreciation and amortization	327,355
Office supplies	211,711
Insurance	121,015
Loss on disposal of fixed assets	3,556
Other operating expenses	606,255
TOTAL OPERATING EXPENSES	12,673,970
INCOME FROM OPERATIONS	702,050
OTHER INCOME (EXPENSE)	
Interest income	106
Interest expense	(35,468)
	(35,362)
NET INCOME	$ 666,688

Evergreen Eye Center, Inc. P.S.
Statement of Changes in Stockholders' Equity/(Deficit) – Income Tax Basis
For The Year Ended December 31, 2017

	Common Stock		Paid-in	Retained Equity/	
	Shares	Amount	Capital	(Deficit)	Total
BALANCE, January 1, 2017	1,500	$ 1,500	$ 38,099	$ 176,572	$ 216,171
Shareholder distributions	-	-	-	(1,007,750)	(1,007,750)
Net income	-	-	-	666,688	666,688
BALANCE, December 31, 2017	1,500	$ 1,500	$ 38,099	$ (164,490)	$ (124,891)

Evergreen Eye Center, Inc. P.S.
Statement of Cash Flows – Income Tax Basis
For The Year Ended December 31, 2017

CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$	666,688
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation and amortization		327,355
Loss on disposal of fixed assets		3,556
Net change in assets and liabilities		
Prepaid expenses		7,082
Advances		24,175
Credit cards		219,926
Other current liabilities		9,663
Net cash provided by operating activities		1,258,445
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of fixed assets		(639,165)
Net cash used in investing activities		(639,165)
CASH FLOWS FROM FINANCING ACTIVITIES		
Shareholder distributions		(1,030,569)
Repayment of long-term debt		(283,762)
Issuance of long-term debt		581,109
Net cash used in financing activities		(733,222)
NET CHANGE IN CASH		(113,942)
CASH, beginning balance		688,491
CASH, ending balance	$	574,549


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Exhibit 18
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

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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.

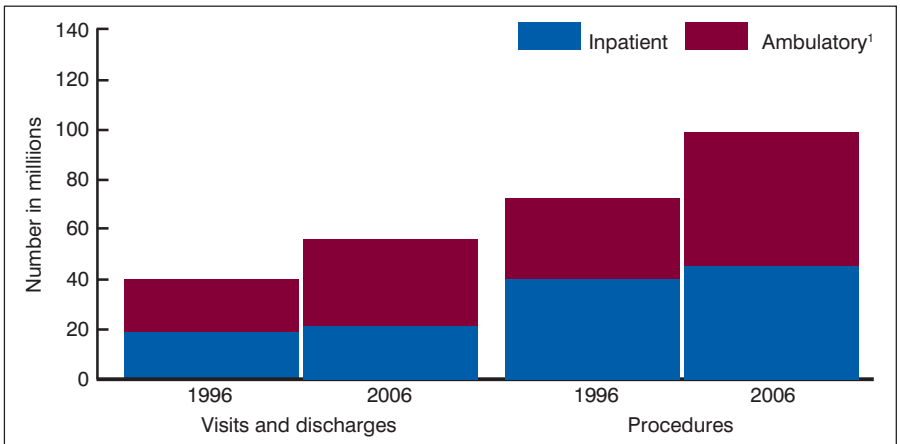
The relative standard error (RSE) of an estimate is obtained by dividing the SE by the estimate itself. The RSE is expressed as a percentage of an estimate and can be multiplied by the estimate to obtain the SE. Because of low reliability, estimates with a RSE of more than 30 percent or those based on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

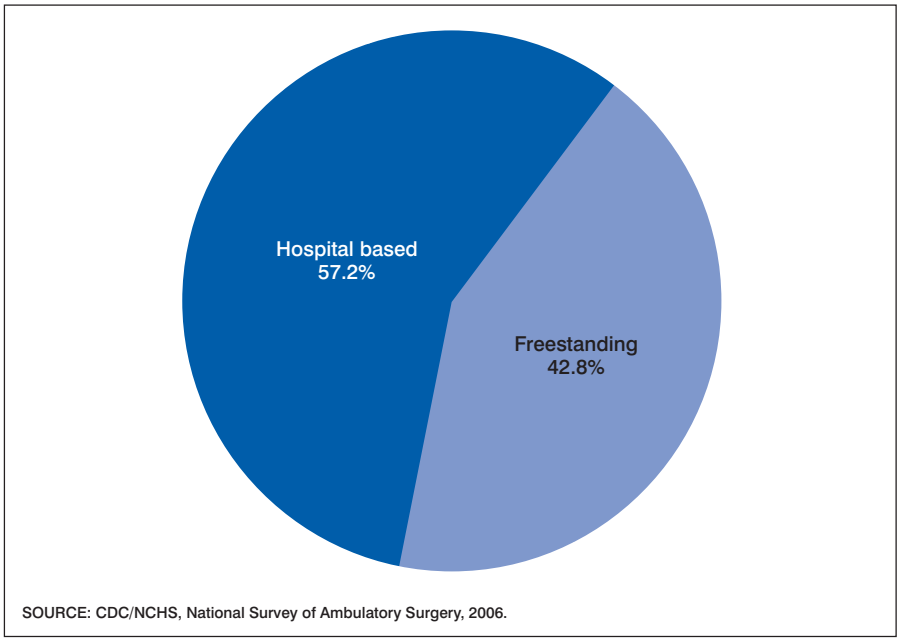
- In 2006, an estimated 53.3 million surgical and nonsurgical procedures were performed during 34.7 million ambulatory surgery visits (Table 2).
- The 34.7 million ambulatory surgery visits accounted for about 61.6 percent of the combined total of ambulatory surgery visits and inpatient discharges with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

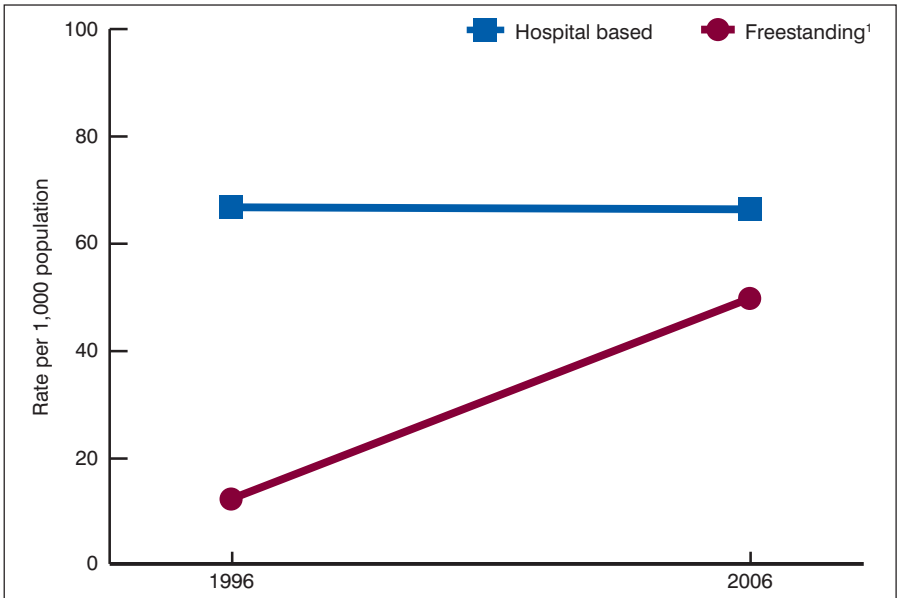


SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery, 2006.

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).

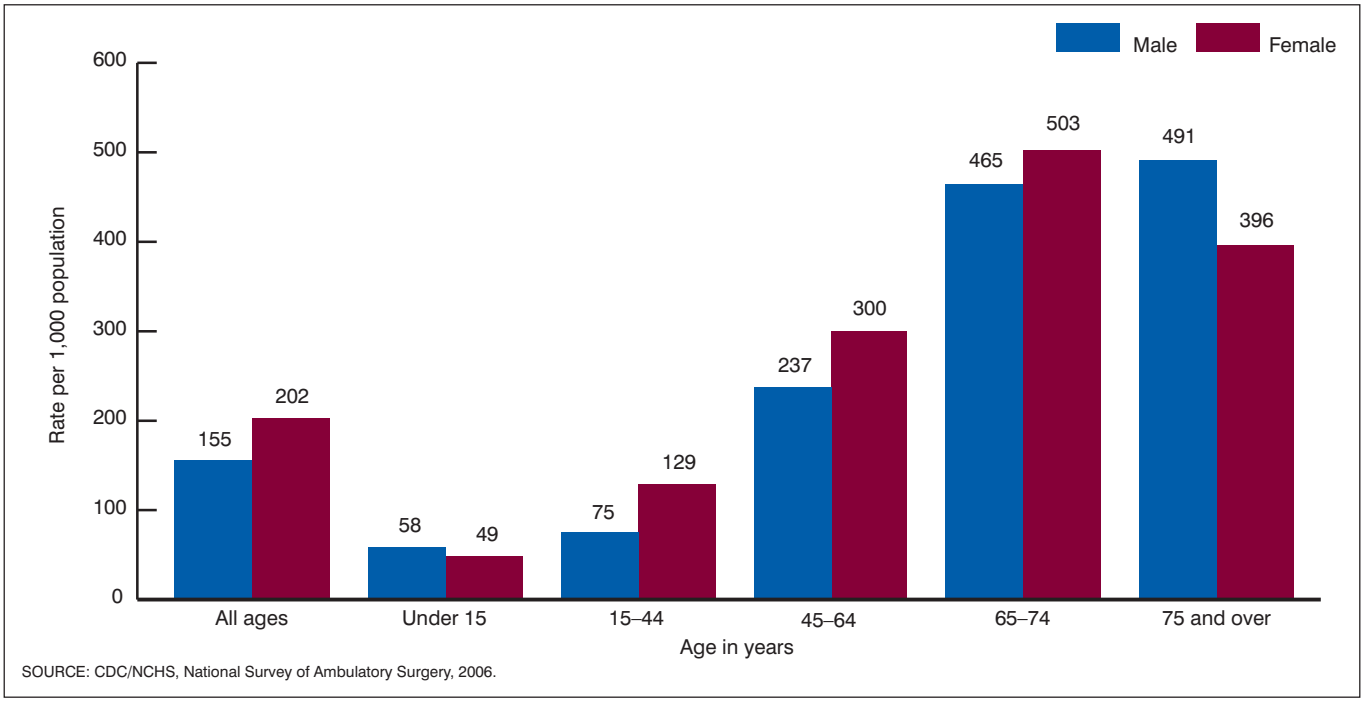


Figure 4. Rate of ambulatory surgery procedures by age and sex: United States, 2006 (revised)

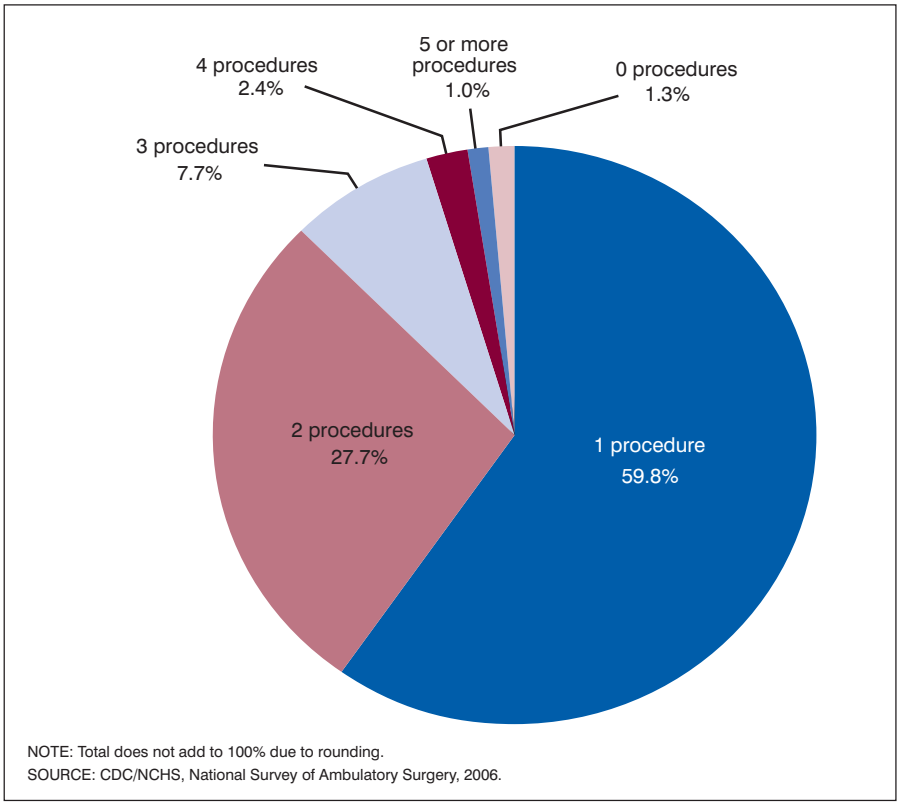


Figure 5. Percent distribution of the number of ambulatory surgery procedures performed per visit: United States, 2006 (revised)

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

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 (0920-0234)

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

12. Total charges — $ .00 ☐ Not available

D. SURGICAL VISIT INFORMATION

13. Time — Not available
a. Time in to operating room
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/FAX received

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, temperature, pain, nausea)**?**

20. Completed by

21. Date

OFFICE USE ONLY

FR code

Acknowledgments

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Exhibit 19
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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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.

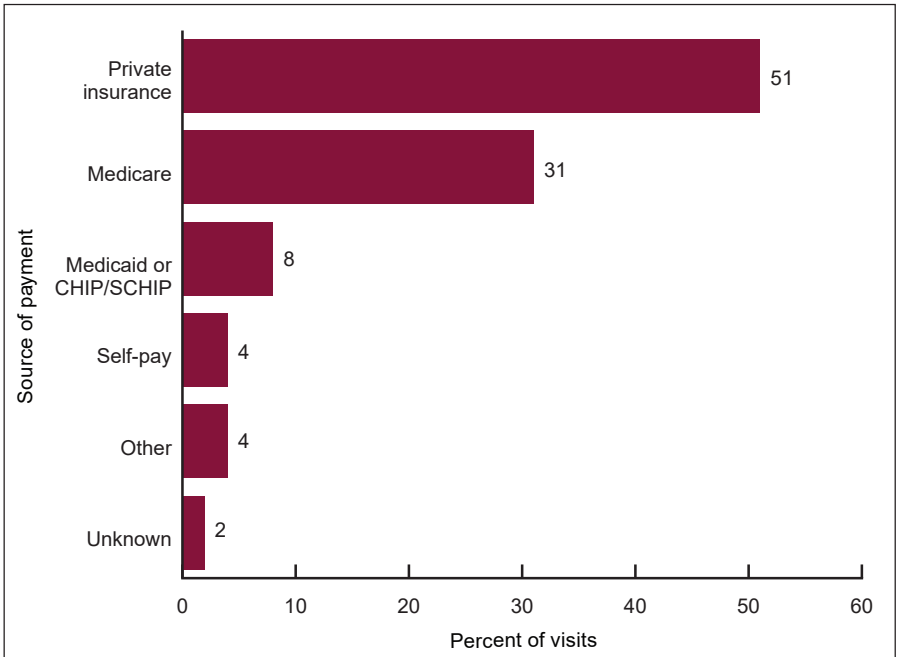
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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

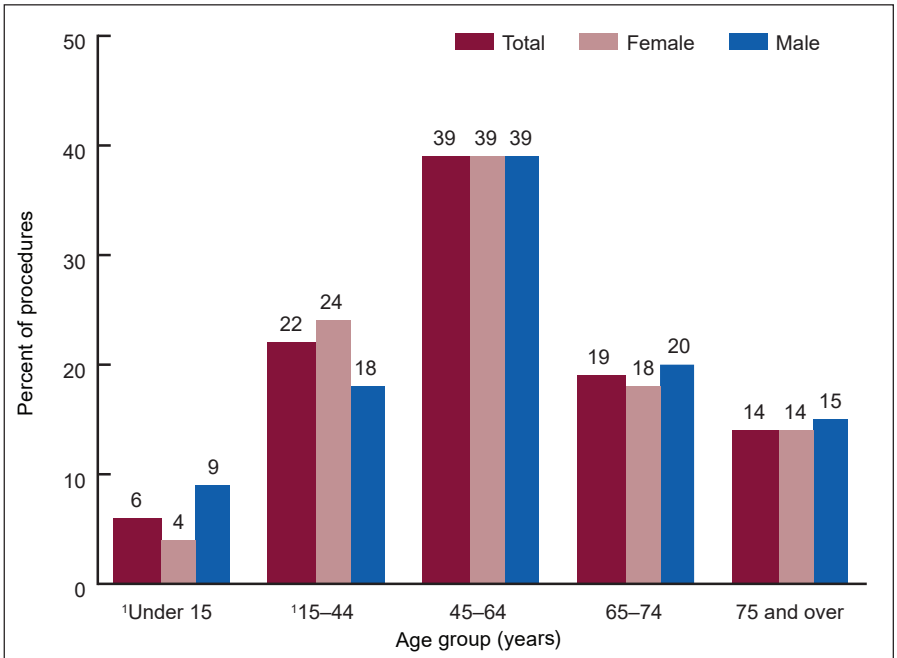
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6 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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DHHS Publication No. 2017–1250 • CS273765

Exhibit 20
Ambulatory Surgery Center Association “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.

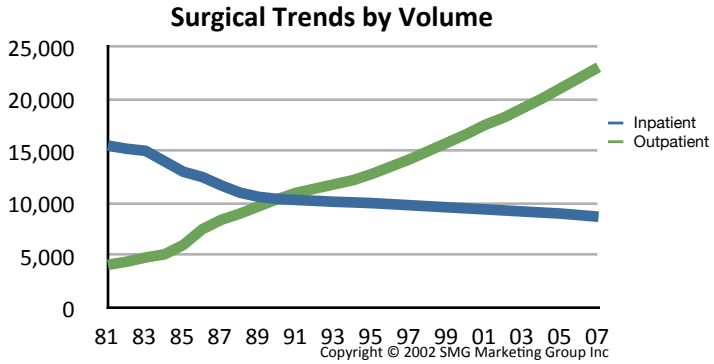
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the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

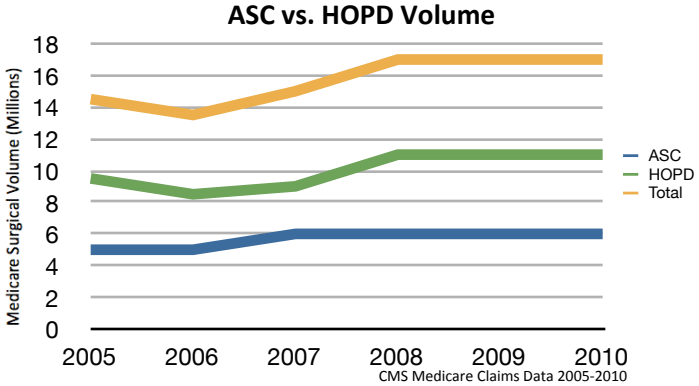
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling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

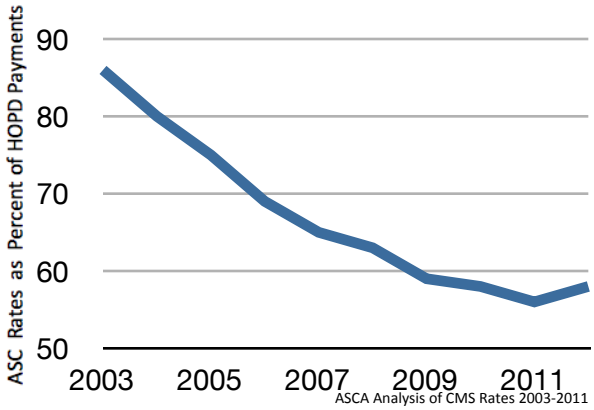
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased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

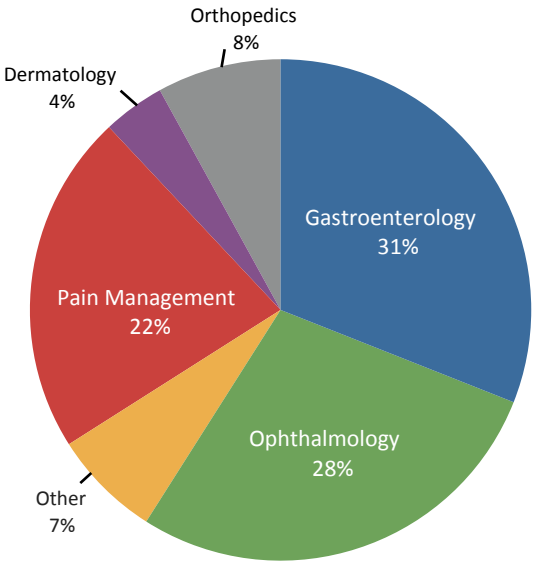


ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

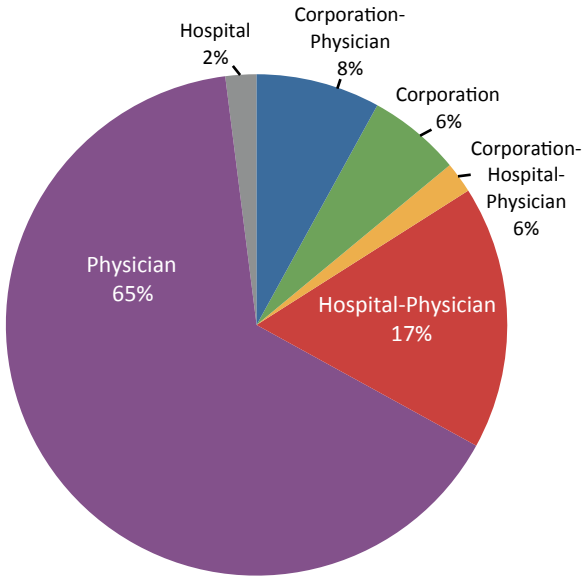
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price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

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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

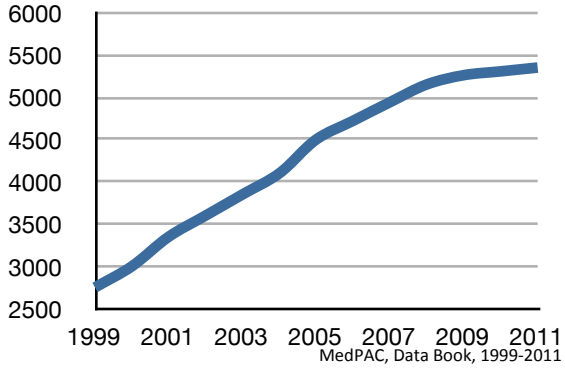
CONTINUED DEMAND FOR ASC FACILITIES

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 21
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

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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 22
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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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 23
Michigan Medicine University of Michigan “Increased Use of Ambulatory Surgery Centers for Cataract Surgery”

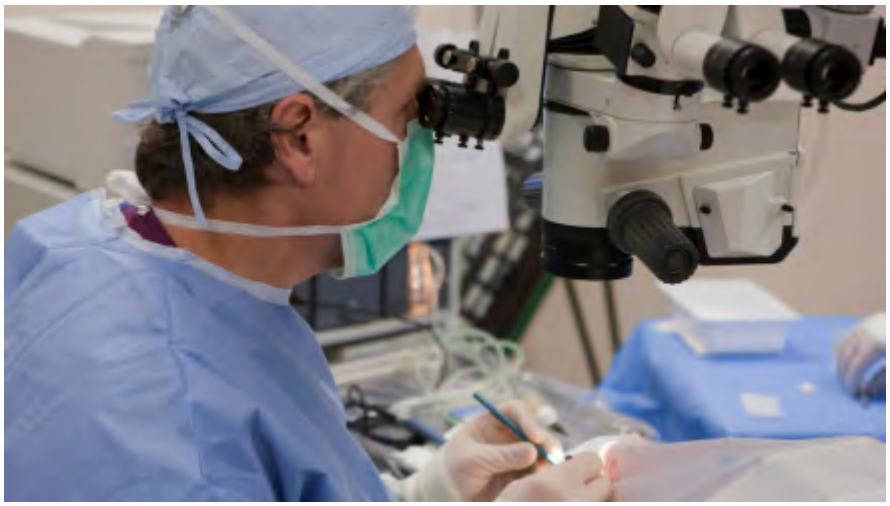
NOVEMBER 22, 2017

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.

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Exhibit 24
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:

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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.

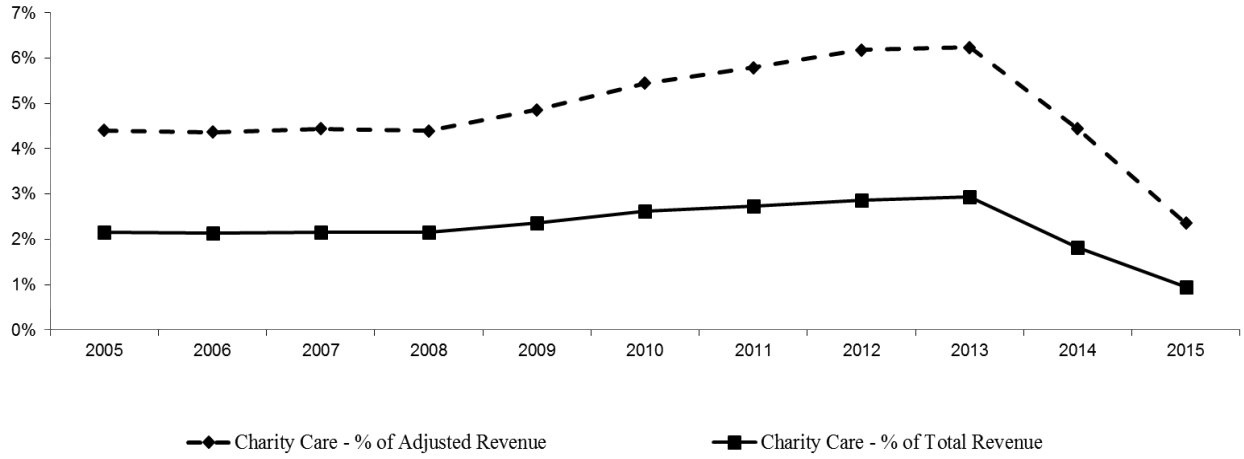


Figure 1 Notes: Adjusted patient service revenue *is the total patient service hospital revenue minus Medicare and Medicaid patient service charges. Patient Service Revenue is the same as Billed Charges.*

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

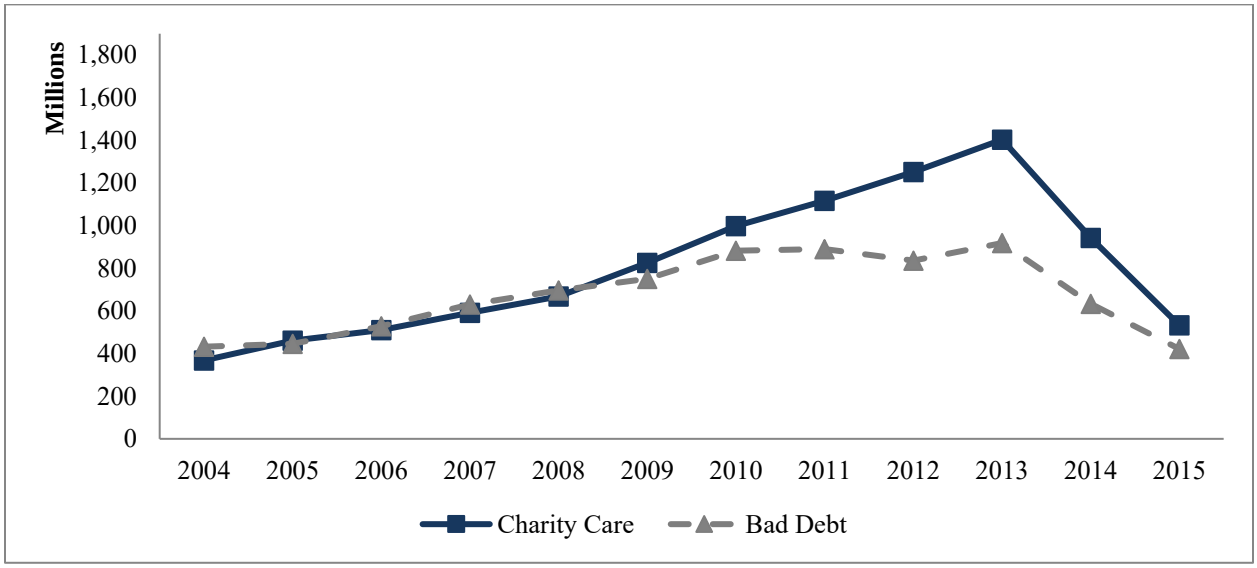
Charity care as a percent of adjusted (non-Medicare, non-Medicaid) revenue increased from 4.4 percent to 6.2 percent from FY 2005 through FY 2013, then declined to 4.4 percent in FY 2014 and 2.4 percent in FY 2015. Because charity care is unreimbursed, all payers—including insurance companies and patients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

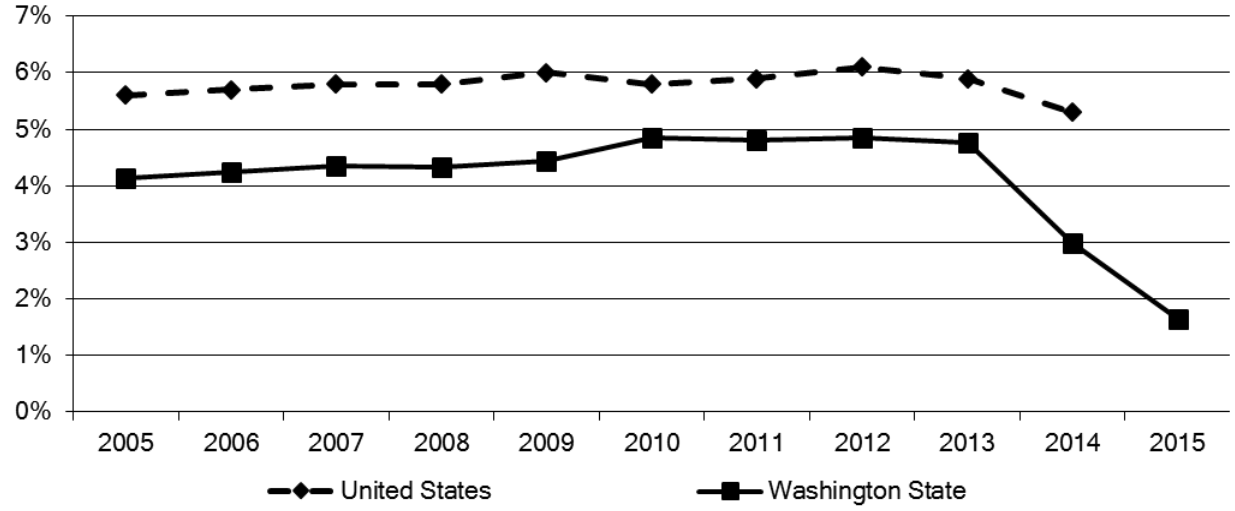


Figure 3 Notes: Uncompensated care includes bad debt and charity care. Uncompensated care as a percent of hospital expenses is calculated by multiplying uncompensated care by the ratio of total expenses to gross patient and other operating revenues. Uncompensated care data for 2015 are not yet available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

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	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 25
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 26

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.

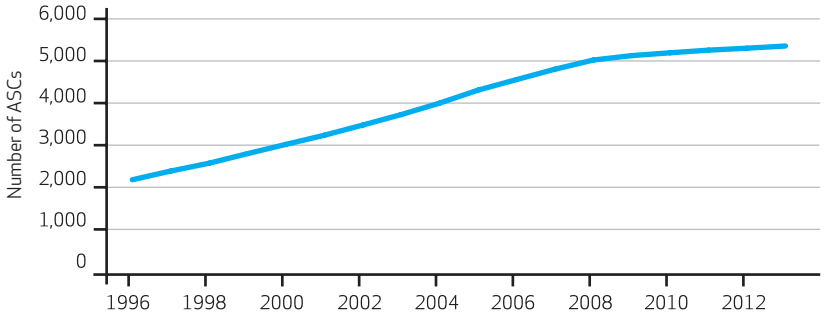
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of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

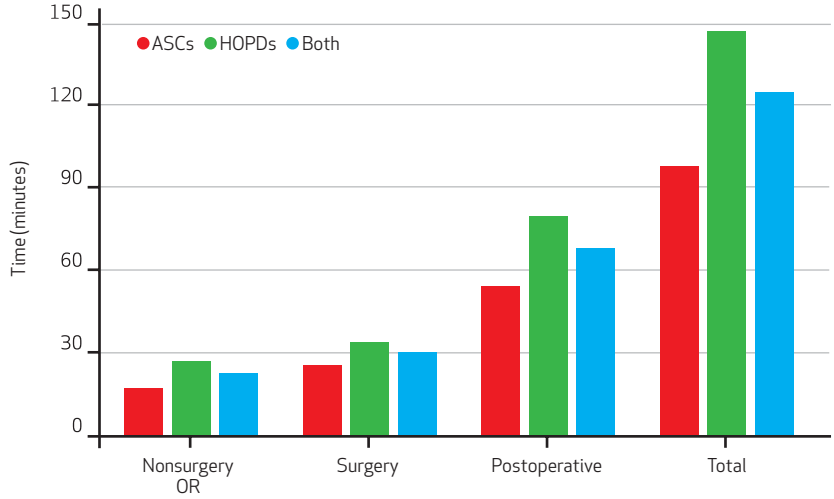
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This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

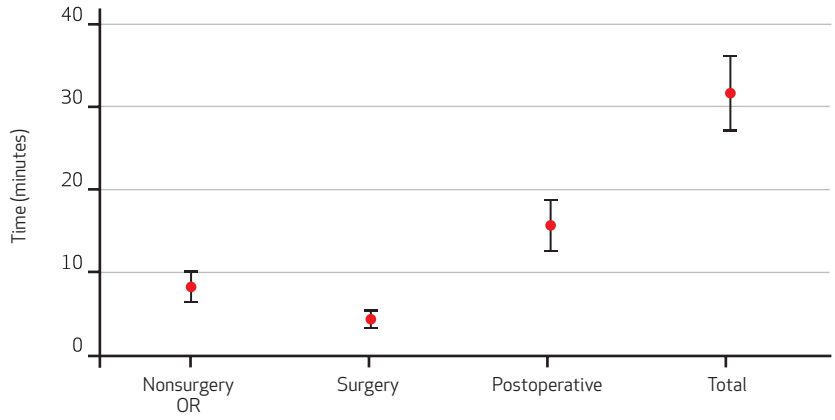
Average Outpatient Surgical Procedure Time, By Facility Type, 2006



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

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