ORIGINAL

16-021

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
MAY 17 2016
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Silver Cross Ambulatory Surgery Center		
Street Address: Southwest Corner of Route 6 and Silver Cross Boulevard		
City and Zip Code: New Lenox, Illinois 60451		
County: Will	Health Service Area: 009	Health Planning Area: 009

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Silver Cross Ambulatory Surgery Center LLC
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Name of Registered Agent: John Krepps
Name of Chief Executive Officer: Paul Pawlak
CEO Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Telephone Number: (815) 300-4965

Type of Ownership of Applicant/Co-Applicant

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact
[Person to receive all correspondence or inquiries during the review period]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

Additional Contact
[Person who is also authorized to discuss the application for permit]

Name: Ruth Colby
Title: Senior Vice President, Chief Strategy Officer
Company Name: Silver Cross Hospital & Medical Centers
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Telephone Number: (815) 300-7002
E-mail Address: rcolby@silvercross.org
Fax Number: (815) 300-7047

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E-mail Address: rcolby@silvercross.org
Fax Number: (815) 300-7047

Post Permit Contact

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

Name: Ruth Colby
Title: Senior Vice President, Chief Strategy Officer
Company Name: Silver Cross Hospital & Medical Centers
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Telephone Number: (815) 300-7002
E-mail Address: rcolby@silvercross.org
Fax Number: (815) 300-7047

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Silver Cross Hospital & Medical Centers
Address of Site Owner: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Street Address or Legal Description of Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Silver Cross Ambulatory Center LLC
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60654

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.hfsrb.illinois.gov)**.

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

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

Silver Cross Ambulatory Surgery Center LLC ("SCASC") and Silver Cross Hospital and Medical Centers ("Silver Cross Hospital," and collectively with SCASC, the "Applicants") seek authority from the Illinois Health Facilities & Services Review (the "Board") to establish a multi-specialty ambulatory surgical treatment center (the "Surgery Center") on the Silver Cross Hospital campus, near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois (the "Project"), in order to reduce the high utilization and projected demand for outpatient surgical services at Silver Cross Hospital.

The Surgery Center will contain three operating rooms, nine recovery rooms and appropriate clinical support space. The Surgery Center will also include non-clinical areas such as administration, a waiting room, visitor and staff support, supply rooms and storage. In total, the Surgery Center will occupy 13,849 gross square feet of space. The building that will house the Surgery Center, and land upon which the Surgery Center will sit, will be owned by Silver Cross Hospital (the "Surgery Center Facility").

A total of 2,165 cases (or 3,489 surgical hours) have been committed to the Surgery Center in 2018 (i.e., the first year of operation for the Surgery Center) by physicians on the Medical Staff at Silver Cross Hospital. **ALL** of the committed surgical cases are currently being performed in the operating rooms at Silver Cross Hospital and **ONLY** primary service area zip code volume was used. Because all of the committed surgical cases will be shifted from Silver Cross Hospital to the Surgery Center, there will be **NO** impact on the other hospitals or ambulatory surgery centers in the Surgery Center's service area.

The eleven operating rooms at Silver Cross Hospital had a utilization rate of 119.3% in 2014. In 2015, the utilization rate increased to 129.7%. 2016 is even busier, with the eleven operating rooms on pace to hit a utilization rate of 138.5%. The surgical projections for 2017, 2018 and 2019 are just as daunting and show that Silver Cross Hospital will need nineteen operating rooms by 2019. Thus, Silver Cross Hospital can easily support the three operating rooms being proposed at the Surgery Center on the Silver Cross Hospital campus. In addition, the Applicants commit not to add any additional operating rooms at Silver Cross Hospital until the Surgery Center achieves its target utilization rate for twelve months.

The Surgery Center will have the same charity care, access to care, and financial aid policies as Silver Cross Hospital. Thus, the Surgery Center will treat Medicare, Medicaid and charity care patients. The proposed charges for comparable procedures at the Surgery Center will be lower than those currently charged at Silver Cross Hospital.

At this point, Silver Cross Hospital is the sole member of SCASC. If this Certificate of Need Application ("Application") is approved by the Board, SCASC intends to sell up to forty nine percent (49%) of the membership units in SCASC to physicians (the "Syndication"). No physician will be allowed to purchase more than a two and one-half percent (2.5%) interest in SCASC. Prior to the Syndication, SCASC and Silver Cross Hospital will also enter into a fair market value lease for the Surgery Center Facility.

SCASC may also contract with a management company to provide management services at the Surgery Center. If a management company is ultimately engaged, and the management company seeks ownership as part of its management agreement, thereby decreasing Silver Cross Hospital's interest in SCASC below fifty percent (50%), the Applicants will file a Certificate of Need (Change of Ownership) Application with the Board.

The anticipated completion date of the Project is March 31, 2018.

Project Costs/Project Classification

The total cost of the Project will be **$11,091,426**. Pursuant to Section 1110.40(b) of the Illinois Administrative Code, the Project is considered Substantive. The Project is subject to review under Section 1100 and Section 1120 of the Illinois Administrative Code.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation	5,956	4,044	10,000
Site Preparation	714,766	485,234	1,200,000
Off Site Work			
New Construction Contracts	3,307,849	2,245,600	5,553,449
Modernization Contracts			
Contingencies	330,784	224,560	555,344
Architectural/Engineering Fees	326,125	221,396	547,521
Consulting and Other Fees	228,143	154,879	383,022
Movable or Other Equipment (not in construction contracts)	2,311,970	530,120	2,842,090
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	7,225,594	3,865,832	11,091,426
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	7,225,594	3,865,832	11,091,426
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	7,225,594	3,865,832	11,091,426

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

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

Estimated start-up costs and operating deficit cost is $ 0.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): June 30, 2018

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

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

State Agency Submittals

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

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
ASTC (Clinical Portions)			8,249 BGSF	8,249 BGSF			
NON REVIEWABLE							
ASTC (Non-Clinical Portions)			5,600 BGSF	5,600 BGSF			
TOTAL			**13,849 BGSF**	**13,849 BGSF**			

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Silver Cross Hospital		**CITY: 1900 Silver Cross Blvd., New Lenox, Illinois**			
REPORTING PERIOD DATES:	**From:**	**01/01/2015**	**to:**	**12/31/2015**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	185	13,935	50,756	0	185
Obstetrics	30	2,905	7,120	0	30
Pediatrics	8	242	515	0	8
Intensive Care	28	1,728	6,714	0	28
Comprehensive Physical Rehabilitation	25	962	5,864	0	25
Acute/Chronic Mental Illness	20	589	7,552	0	20
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	296	20,361	78,521	0	296

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of Silver Cross Hospital & Medical Centers* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Paul Pawlak
PRINTED NAME

President & CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 28 day of April 2016

Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

SIGNATURE

John Krepps
PRINTED NAME

Senior VP Finance/CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 28 day of April 2016

Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
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*Insert EXACT legal name of the applicant

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PRINTED NAME

President & CEO
Silver Cross Hospital & Medical Centers
Manager
PRINTED TITLE

Notarization:
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this 28 day of April 2016

Denise L. Tatgenhorst
Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

SIGNATURE

John Krepps
PRINTED NAME

Senior VP Finance/CFO
Silver Cross Hospital & Medical Centers
Manager
PRINTED TITLE

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Subscribed and sworn to before me
this 28 day of April 2016

Denise L. Tatgenhorst
Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

*Insert EXACT legal name of the applicant

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

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

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

    c. The project involves the conversion of existing space that results in excess square footage.

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

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

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

PROJECT SERVICES UTILIZATION:

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

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

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

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;

3. Evidence that the shell space is being constructed due to
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

H. Non-Hospital Based Ambulatory Surgery

This section is applicable to all projects proposing to establish or modernize a non-hospital based ambulatory surgical treatment center or to the addition of surgical specialties.

1. **Criterion 1110.1540(a), Scope of Services Provided**

   Read the criterion and complete the following:

   a. Indicate which of the following types of surgery are being proposed:

_____Cardiovascular	__X__Obstetrics/Gynecology	_____Pain Management
_____Dermatology	__X__Ophthalmology	__X__Podiatry
_____Gastroenterology	_____Oral/Maxillofacial	_____Thoracic
__X__General/Other	__X__Orthopedic	_____Otolaryngology
_____Neurology	_____Plastic	__X__Urology

   b. Indicate if the project will result in a _____ limited or __X__ a multi-specialty ASTC.

2. **Criterion 1110.1540(b), Target Population**

   Read the criterion and provide the following:

   a. On a map (8 ½" x 11"), outline the intended geographic services area (GSA).

   b. Indicate the population within the GSA and how this number was obtained.

   c. Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.

3. **Criterion 1110.1540(c), Projected Patient Volume**

   Read the criterion and provide signed letters from physicians that contain the following:

   a. The number of referrals anticipated annually for each specialty.

   b. For the past 12 months, the name and address of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility.

   c. A statement that the projected patient volume will come from within the proposed GSA.

   d. A statement that the information in the referral letter is true and correct to the best of his or her belief.

4. **Criterion 1110.1540(d), Treatment Room Need Assessment**

   Read the criterion and provide:

   a. The number of procedure rooms proposed.

   b. The estimated time per procedure including clean-up and set-up time and the methodology used in arriving at this figure.

5. **Criterion 1110.1540(e), Impact on Other Facilities**

   Read the criterion and provide:

   a. A copy of the letter sent to area surgical facilities regarding the proposed project's impact on their workload. NOTE: This letter must contain: a description of the project including its size, cost, and

projected workload; the location of the proposed project; and a request that the facility administrator indicate what the impact of the proposed project will be on the existing facility.

b. A list of the facilities contacted. **NOTE**: Facilities must be contacted by a service that provides documentation of receipt such as the US. Postal Service, FedEx or UPS. The documentation must be included in the application for permit.

6. Criterion 1110.1540(f), Establishment of New Facilities

Read the criterion and provide:

a. A list of services that the proposed facility will provide that are not currently available in the GSA; or

b. Documentation that the existing facilities in the GSA have restrictive admission policies; or

c. For co-operative ventures,

a. Patient origin data that documents the existing hospital is providing outpatient surgery services to the target population of the GSA, and

b. The hospital's surgical utilization data for the latest 12 months, and

c. Certification that the existing hospital will not increase its operating room capacity until such a time as the proposed project's operating rooms are operating at or above the target utilization rate for a period of twelve full months; and

d. Certification that the proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

7. Criterion 1110.1540(g), Charge Commitment

Read the criterion and provide:

a. A complete list of the procedures to be performed at the proposed facility with the proposed charge shown for each procedure.

b. A letter from the owner and operator of the proposed facility committing to maintain the above charges for the first two years of operation.

8. Criterion 1110.1540(h), Change in Scope of Service

Read the criterion and, if applicable, document that existing programs do not currently provide the service proposed or are not accessible to the general population of the geographic area in which the facility is located.

APPEND DOCUMENTATION AS ATTACHMENT-27, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

$11,091,426	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$11,091,426		**TOTAL FUNDS AVAILABLE**

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

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

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

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

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	**Year**	**Year**
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I
Attachment 1
Applicant Identification

The Certificates of Good Standing for Silver Cross Ambulatory Surgery Center LLC ("SCASC") and Silver Cross Hospital & Medical Centers ("Silver Cross Hospital," and collectively, with SCASC, the "Applicants") are attached at ATTACHMENT 1.

SCASC will be the license holder of the multi-specialty ambulatory surgical treatment center (the "Surgery Center) proposed in this Project.

File Number 0576867-5

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS AMBULATORY SURGERY CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 20, 2016, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* APRIL *A.D.* 2016 .

Jesse White

SECRETARY OF STATE

Authentication #: 1611601994 verifiable until 04/25/2017

Authenticate at: http://www.cyberdriveillinois.com

Attachment 1

File Number 0548-203-8

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS HOSPITAL AND MEDICAL CENTERS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 16, 1891, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* APRIL *A.D.* 2016 .

Authentication #: 1611602000 verifiable until 04/25/2017

Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Attachment 1

Section I
Attachment 2
Site Ownership

Silver Cross Hospital currently owns the site parcel (the "Site Parcel") upon which the Surgery Center will sit. A Certification from John Krepps setting forth Silver Cross Hospital's ownership in the Site Parcel and in support of this Criterion is attached at ATTACHMENT 2.

The legal description of the Site Parcel is as follows:

> The East half of the Southeast quarter of Section 5 in Township 35 North, Range 11, East of the Third Principal Meridian, in Will County, Illinois, excepting that part described as follows:
>
> Beginning at the Southeast corner of said section; Thence North along the East Section Line of said Section 250 Feet, Thence Westerly along a line which is 250 Feet North of and parallel with the South Section line of said Section 796.21 Feet, Thence Southwesterly 353.02 Feet More or Less to a point in the South Section Line of said Section which is 1046.02 Feet West of the Point of Beginning; Thence East along the South Section Line of said Section to the Place of Beginning, and
>
> Excepting the North Five Hundred and Fifty Feet (550) of the East Half of the Southeast Quarter of Section 5 in Township 35 North, Range 11, East of the Third Principal Meridian, in Will County, Illinois.

The Project will not encompass all of the land referenced above.

SILVER CROSS
HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

April 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Corporate Ownership of Site Parcel

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, as follows:

1. Silver Cross Hospital and Medical Centers ("Silver Cross") owns the property located near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois (the "Site Parcel"), and legally described as follows:

> The East half of the Southeast quarter of Section 5 in Township 35 North, Range 11, East of the Third Principal Meridian, in Will County, Illinois, excepting that part described as follows:
>
> Beginning at the Southeast corner of said section; Thence North along the East Section Line of said Section 250 Feet, Thence Westerly along a line which is 250 Feet North of and parallel with the South Section line of said Section 796.21 Feet, Thence Southwesterly 353.02 Feet More or Less to a point in the South Section Line of said Section which is 1046.02 Feet West of the Point of Beginning; Thence East along the South Section Line of said Section to the Place of Beginning, and
>
> Excepting the North Five Hundred and Fifty Feet (550) of the East Half of the Southeast Quarter of Section 5 in Township 35 North, Range 11, East of the Third Principal Meridian, in Will County, Illinois.

Attachment 2

2. The proposed Silver Cross Ambulatory Surgery Center in New Lenox, Illinois, will not encompass the entire Site Parcel referenced above.

Sincerely,

John Krepps
Senior Vice President Finance
Chief Financial Officer

SUBSCRIBED AND SWORN
to before me this 28 day
of April, 2016.

Denise L. Tatgenhorst
Notary Public

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Section I
Attachment 3
Operating Entity/Licensee

SCASC will be the license holder of the proposed Surgery Center.

The Certificate of Good Standing for SCASC is attached at ATTACHMENT 3.

File Number 0576867-5

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS AMBULATORY SURGERY CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 20, 2016, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* APRIL *A.D.* 2016 .

Authentication #: 1611601994 verifiable until 04/25/2017
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Section I
Attachment 4
Organizational Relationships

The organizational charts for the Applicants are attached at ATTACHMENT 4.

Silver Cross Ambulatory Surgery Center LLC (An Illinois Limited Liability Company)
Silver Cross Hospital & Medical Centers (100%) (Sole Member)

Attachment
4

Section I
Attachment 5
Flood Plain Requirements

As set forth in ATTACHMENT 5, the building site for the proposed Surgery Center is not in a designated flood plain. An Affidavit from John Krepps, the Senior Vice President of Finance and Chief Financial Officer of Silver Cross Hospital, attesting to the fact that the Applicants will comply with Executive Order #5 (2006), to the extent Executive Order #5 (2006) is applicable, is also attached at ATTACHMENT 5.

Attachment 5

Attachment 5

SILVER CROSS
HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

April 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification Re: Compliance with Illinois Executive Order #5

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, as follows:

1. Silver Cross Hospital and Medical Centers ("Silver Cross") owns the property located near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois, and legally described as follows:

> The East half of the Southeast quarter of Section 5 in Township 35 North, Range 11, East of the Third Principal Meridian, in Will County, Illinois, excepting that part described as follows:
>
> Beginning at the Southeast corner of said section; Thence North along the East Section Line of said Section 250 Feet, Thence Westerly along a line which is 250 Feet North of and parallel with the South Section line of said Section 796.21 Feet, Thence Southwesterly 353.02 Feet More or Less to a point in the South Section Line of said Section which is 1046.02 Feet West of the Point of Beginning; Thence East along the South Section Line of said Section to the Place of Beginning, and
>
> Excepting the North Five Hundred and Fifty Feet (550) of the East Half of the Southeast Quarter of Section 5 in Township 35 North, Range 11, East of the Third Principal Meridian, in Will County, Illinois.

Attachment 5

2. Silver Cross has reviewed and will comply with the development requirements of Illinois Executive Order #5 (2006), to the extent Illinois Executive Order #5 (2006) is applicable.

Sincerely,

John Krepps
Senior Vice President/Finance
Chief Financial Officer

SUBSCRIBED AND SWORN
to before me this 28 day
of April, 2016.

Notary Public

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Section I
Attachment 6
Historic Resources Preservation Act Requirements

Attached at ATTACHMENT 6 is documentation from the Illinois Historical Preservation Agency regarding compliance with the requirements of the Illinois Historic Resources Preservation Act.

Illinois Historic Preservation Agency

1 Old State Capitol Plaza, Springfield, IL 62701-1512

FAX 217/524-7525
www.illinoishistory.gov

Will County
New Lenox
SW of US Route 6 & Silver Cross Blvd.
Section:5-Township:35N-Range:11E
IHFSRB
New construction, Silver Cross Ambulatory Surgery Center

PLEASE REFER TO: IHPA LOG #013033016

April 29, 2016

Ruth Colby
Silver Cross Hospital
1900 Silver Cross Blvd.
New Lenox, IL 60451

Dear Ms. Colby:

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

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

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

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

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

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

Section I
Attachment 7
Project Costs & Sources of Funds

Attached at ATTACHMENT 7 is the equipment listing/summary for the Project.

	Equipment	
	Clinical Equipment (see attached)	$2,311,970
	Copiers, Office Equipment & Appliances	$18,500
	Furniture	$100,250
	Security	$55,534
	Shelving	$48,000
	Support Carts	$2,500
	Medical Records	$10,000
	Artwork	$10,000
	IT Network / Voice Installation	$60,000
	Miscellaneous Building Support Items	$11,500
	Signage	$75,000
	IT Network & Desktop Hardware	$106,903
	IT Software, Setup & Training	$31,933
	Total	**$2,842,090**

HELP Equipment Planning
Silver Cross
Budget Forecast by Department and Item Description Report

				Total	
				Ext Qty	Wkg Budget (USD)
Surgery	Description	Status	Funding		
	Ablation System, Radio-Frequency	Draft (New)	Project	1	$37,550.20
	Ablation System, Uterine	Draft (New)	Project	1	$20,390.40
	Anesthesia Machine, General	Draft (New)	Project	3	$103,545.00
	Bracket, Monitor, Wall	Draft (New)	Project	9	$401.40
	Bracket, Television, Wall, Flat Panel	Draft (New)	Project	3	$373.98
	Bucket, Kick	Draft (New)	Project	3	$519.32
	Cabinet, Storage, Clinical, Medication,	Draft (New)	Project	2	$2,230.20
	Cart / Truck, Soiled Utility	Draft (New)	Project	2	$796.50
	Cart, Anesthesia, 6-drawer	Draft (New)	Project	3	$7,009.20
	Cart, Procedure, Resuscitation	Draft (New)	Project	1	$1,156.52
	Cart, Procedure, Resuscitation, Pediatri	Draft (New)	Project	1	$3,292.20
	Cart, Supply, Chrome, 60 inch	Draft (New)	Project	1	$729.59
	Cart, Supply, Linen, 60"	Draft (New)	Project	1	$1,328.56
	Cart, Utility, Polymer	Draft (New)	Project	10	$2,484.02
	Cart, Utility, Wire	Draft (New)	Project	1	$382.32
	Cart, Washer/Disinfector, Transfer	Draft (New)	Project	2	$3,008.65
	Column, Service, Ceiling, Fixed	Draft (New)	Project	3	$10,513.80
	Defibrillator, Monitor, w/Pacing	Draft (New)	Project	1	$12,260.79
	Dispenser, Glove, Triple Box	Draft (New)	Project	17	$649.94
	Electrosurgical Unit, Bipolar/Monopolar	Draft (New)	Project	3	$24,213.60
	Flowmeter, Oxygen	Draft (New)	Project	10	$302.67
	Hamper, Linen	Draft (New)	Project	6	$1,006.78
	Ice Machine, Dispenser, Nugget, Count	Draft (New)	Project	1	$4,354.20
	Instruments, Surgical, Allowance	Draft (New)	Project	5	$488,000.00
	Integration System, Surgical, Video	Draft (New)	Project	3	$122,130.00
	Laryngoscope Set, Fiberoptic	Draft (New)	Project	6	$3,686.20
	Laryngoscope Set, Video	Draft (New)	Project	1	$16,840.13
	Lid, Cube Truck	Draft (New)	Project	2	$324.97
	Light, Surgical, Allowance	Draft (New)	Project	6	$6,569.53
	Light, Surgical, Single, Ceiling, w/Monit	Draft (New)	Project	6	$189,930.20
	Microscope, Operating, Ophthalmic	Draft (New)	Project	1	$57,348.00
	Monitor, Physiologic, Bedside, Portable	Draft (New)	Project	9	$81,778.25
	Monitor, Video, 26 - 32 inch, Display	Draft (New)	Project	3	$1,752.30
	Monitor, Video, 26 - 32 inch, Medical G	Draft (New)	Project	6	$38,015.35
	Morcellator, Tissue	Draft (New)	Project	1	$9,239.40
	Phacoemulsifier, Ophthalmic	Draft (New)	Project	1	$87,907.05
	Pump, Infusion, Syringe	Draft (New)	Project	3	$5,017.95

Pump, Suction/Aspirator, Uterine, Mobi	Draft (New)	Project	1	$6,743.70
Refrigerator, Undercounter	Draft (New)	Project	2	$2,674.12
Regulator, Suction, Continuous, 3 Mod	Draft (New)	Project	10	$1,550.52
services, installation	Draft (New)	Project	1	$900.00
Services, Installation	Draft (New)	Project	4	$9,750.00
Stand, Basin, Single	Draft (New)	Project	3	$806.06
Stand, IV, Stainless Steel	Draft (New)	Project	6	$2,268.43
Stand, Mayo, Foot-Operated	Draft (New)	Project	3	$1,580.26
Sterilizer, Hydrogen Peroxide, Mobile	Draft (New)	Project	1	$51,560.10
Sterilizer, Steam (Electric), Recessed,	Draft (New)	Project	2	$103,014.00
Stirrups, Allowance	Draft (New)	Project	1	$823.05
Stirrups, Universal	Draft (New)	Project	2	$6,114.04
Stool, Anesthetist	Draft (New)	Project	3	$2,159.31
Stool, Exam, Cushion-Seat	Draft (New)	Project	6	$1,038.64
Stool, Step, Stackable	Draft (New)	Project	6	$1,108.73
Stretcher, Procedure / Recovery	Draft (New)	Project	4	$19,647.00
Stretcher, Procedure, EYE/ ENT	Draft (New)	Project	6	$36,129.24
Table, Instrument, 48 inch	Draft (New)	Project	3	$1,854.25
Table, Instrument, 60 inch	Draft (New)	Project	3	$2,587.03
Table, Overbed, General	Draft (New)	Project	9	$3,412.21
Table, Surgical, Extremity	Draft (New)	Project	1	$1,060.94
Table, Surgical, Major	Draft (New)	Project	3	$129,033.00
Table, Surgical, Accessories Allowan	Draft (New)	Project	3	$39,366.22
Table, Utility, General Purpose	Draft (New)	Project	3	$1,398.65
Table, Work, Central Supply	Draft (New)	Project	1	$3,398.40
Thermometer, Temporal Artery	Draft (New)	Project	4	$1,550.52
Ultrasonic Cleaner, Countertop	Draft (New)	Project	1	$3,478.05
Ultrasound, Imaging, Multipurpose, Por	Draft (New)	Project	1	$35,577.00
Video System, Allowance	Draft (New)	Project	3	$223,020.00
Viewbox, 1 Panel, Recessed	Draft (New)	Project	3	$866.59
Washer / Disinfector, Allowance	Draft (New)	Project	1	$4,619.70
Washer / Disinfector, Electric	Draft (New)	Project	1	$79,650.00
Water Treatment System, Ice Maker, W	Draft (New)	Project	1	$223.02
Wheelchair, Adult, Extra Large	Draft (New)	Project	3	$1,029.08
X-Ray Unit, C-Arm, Mobile	Draft (New)	Project	1	$145,175.40
All Departments				**$2,272,206.43**

Draft (New)		
		$2,272,206.43
Freight		$39,763.61
		$2,311,970.04

Section III
Attachment 11
Background of the Applicants

1. Silver Cross Hospital is a fully licensed, Medicare-certified, Joint Commission accredited, Illinois not-for-profit general hospital. Copies of the current licenses and Joint Commission accreditation for Silver Cross Hospital are attached at ATTACHMENT 11.

2. SCASC is an Illinois limited liability company. Silver Cross Hospital is the sole member of SCASC. SCASC was organized for the purpose of owing and operating the Surgery Center.

3. There have been no adverse actions taken against any facility owned or operated by Silver Cross Hospital or SCASC during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 11.

4. An authorization letter granting access to the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to verify information about the Applicants is attached at ATTACHMENT 11.

HF109950

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
2/25/2017		0005827

General Hospital

Effective: 02/26/2016

Silver Cross Hospital and Medical Centers
1900 Silver Cross Blvd
New Lenox, IL 60451

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

0046

Attachment 11

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 2/25/2017

Lic Number 0005827

Date Printed 1/5/2016

Silver Cross Hospital and Medical Cen

1900 Silver Cross Blvd
New Lenox, IL 60451

FEE RECEIPT NO.

Silver Cross Hospital

New Lenox, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

January 18, 2014

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7365
Print/Reprint Date: 03/28/2014

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.

SILVER CROSS
HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

May 12, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.230, No Adverse Actions Certification

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § 1110.230, as follows:

1. There have been no adverse actions taken against any facility owned or operated by Silver Cross Hospital and Medical Centers during the three (3) years prior to the filing of this application.

2. There have been no adverse actions taken against any facility owned or operated by Silver Cross Ambulatory Surgery Center LLC during the three (3) years prior to the filing of this application.

Sincerely,

Paul Pawlak
President & CEO
Silver Cross Ambulatory Surgery Center LLC
Silver Cross Hospital and Medical Centers

Subscribed and Sworn to before me
this 12th day of May, 2016.

Notary Public

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

Attachment 11

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

April 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.230, Authorization to Access Information

Dear Mr. Constantino:

Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Silver Cross Ambulatory Surgery Center LLC and Silver Cross Hospital and Medical Centers with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

Paul Pawlak
President & CEO
Silver Cross Ambulatory Surgery Center LLC
Silver Cross Hospital and Medical Centers

Subscribed and Sworn to before me
this 28 day of April, 2016.

Denise L. Tatgenhorst
Notary Public

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Attachment
11

Section III
Attachment 12
Purpose of Project

Purpose Statement

The Applicants are seeking permission from the Board to establish a multi-specialty ambulatory surgical treatment center on the Silver Cross Hospital campus, near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois (the "Surgery Center"), in order to reduce the high utilization and projected demand for outpatient surgical services at Silver Cross Hospital.

Supporting Statements & Documentation

General Statements

1. The Surgery Center will contain three operating rooms, nine recovery rooms and appropriate clinical support space. The Surgery Center will also include non-clinical areas such as administration, a waiting room, visitor and staff support, supply rooms and storage. In total, the Surgery Center will occupy 13,849 gross square feet of space.

2. A total of 2,165 cases or 3,489 surgical hours have been committed to the Surgery Center in 2018 (the first year of operation for the Surgery Center) by 23 physicians on the Medical Staff at Silver Cross Hospital. **ALL** of the committed surgical cases are currently being performed in the operating rooms at Silver Cross Hospital and **ONLY** primary service area zip code volume was used. Because all of the committed surgical cases will be shifted from Silver Cross Hospital to the Surgery Center, there will be **NO** impact on the other hospitals or ambulatory surgery centers in the Surgery Center's service area.

3. The eleven operating rooms at Silver Cross Hospital had a utilization rate of 119.3% in 2014. In 2015, the utilization rate increased to 129.7%. 2016 is even busier, with the eleven operating rooms on pace to hit a utilization rate of 138.5%. The surgical projections for 2017, 2018 and 2019 are just as daunting and show that Silver Cross Hospital will need nineteen operating rooms by 2019. Thus, Silver Cross Hospital can easily support the three operating rooms being proposed at the Surgery Center on the Silver Cross Hospital campus. In addition, the Applicants commit not to add any additional operating rooms at Silver Cross Hospital until the Surgery Center achieves its target utilization rate for twelve months.

4. Much research has been conducted on ambulatory surgical treatment centers ("ASTCs"). One recent study reported that ambulatory surgical surgery centers "provide cheaper, faster and better care for outpatient procedures than hospitals." That same study also concluded stated that ASTCs offer cost effective treatment and superior patient outcomes. See Costs and Benefits of Competing Healthcare Providers: Trade-Offs in the Outpatient Surgery Market, Elizabeth L. Munnich and Stephen T. Parente, University of Notre Dame, May 2013, attached at ATTACHMENT 12.

5. In another research paper, Drs. Brent Fulton and Sue Kim concluded that ASTCs "saved the Medicare program and its beneficiaries $7.5 billion over the four-year period from 2008 to 2011." They added that "even under the most conservative assumptions, the future savings generated by ASTCs are substantial." And while they noted that their research was focused entirely on the Medicare program, the researchers noted that because ASTCs generally "charge

private payers less than their hospital outpatient department counterparts, similar savings also exist in the commercial health market." See Medicare Savings Tied to Ambulatory Surgery Centers, University of California-Berkley School of Public Health, September 2013, attached at ATTACHMENT 12.

6. Satisfaction for ambulatory surgery center patients also tends to be much higher than those reported by patients treated in a hospital setting. ASTC patients have easier access to care, fewer problems parking, less wait times and more efficient treatment processes.

7. Satisfaction for surgeons operating at ASTCs also tends to be higher than when performing similar procedures in a hospital setting. There generally is a more streamlined approach in an ASTC with respect to room scheduling and room turnover. ASTC schedules are not interrupted with emergency, urgent or trauma cases that typically impact a hospital operating room schedule.

Define the Planning Area or Market Area

8. The primary service area for the Surgery Center is the same as Silver Cross Hospital's primary service area as identified in the Target Population table that follows:

Silver Cross Ambulatory Surgery Center, LLC
Target Service Area Population

Area	Zip Code	City	2016		2021		5 Year Change	5 Year Percent Change
			Census	Percent to Total	Projected Population	Percent to Total		
Target Area	60403	Crest Hill	17,536	5.2%	17,826	5.3%	290	1.7%
	60421	Elwood	4,005	1.2%	4,068	1.2%	63	1.6%
	60423	Frankfort	31,595	9.4%	32,211	9.5%	616	1.9%
	60432	Joliet	21,026	6.3%	20,579	6.1%	(447)	-2.1%
	60433	Joliet	16,463	4.9%	15,985	4.7%	(478)	-2.9%
	60435	Joliet	47,103	14.0%	46,212	13.7%	(891)	-1.9%
	60436	Joliet	17,316	5.2%	16,796	5.0%	(520)	-3.0%
	60439	Lemont	24,086	7.2%	25,066	7.4%	980	4.1%
	60441	Lockport	36,958	11.0%	37,314	11.0%	356	1.0%
	60442	Manhattan	10,196	3.0%	10,410	3.1%	214	2.1%
	60448	Mokena	24,730	7.4%	25,115	7.4%	385	1.6%
	60451	New Lenox	34,470	10.3%	34,940	10.3%	470	1.4%
	60467	Orland Park	27,615	8.2%	28,714	8.5%	1,099	4.0%
	60491	Homer Glen	22,960	6.8%	22,815	6.7%	(145)	-0.6%
Total			**336,059**		**338,051**		**1,992**	**0.6%**

Source: Claritas/Nielsen (Feb 2016)

9. The service area population is expected to continue gradual growth over the next five years. The proposed Surgery Center will improve healthcare for patients that reside within Silver Cross Hospital's primary service area and that are already being served by Silver Cross Hospital.

10. Section 1110.1540 defines the geographic service area for ASTCs as those communities that are located within 45 minutes driving time of the proposed Project. A listing of the zip codes and the communities they represent are identified in the table that follows. (Zip

codes are included if any part of that zip code fell within 45 minutes unadjusted travel time from the proposed Surgery Center.)

Zip Codes within 45 Minutes Travel of Proposed Project (unadjusted)

Zip	City	State
46303	Cedar Lake	IN
46304	Chesterton	IN
46307	Crown Point	IN
46310	Demotte	IN
46311	Dyer	IN
46312	East Chicago	IN
46319	Griffith	IN
46320	Hammond	IN
46321	Munster	IN
46322	Highland	IN
46323	Hammond	IN
46324	Hammond	IN
46327	Hammond	IN
46341	Hebron	IN
46342	Hobart	IN
46347	Kouts	IN
46349	Lake Village	IN
46356	Lowell	IN
46368	Portage	IN
46373	Saint John	IN
46375	Schererville	IN
46383	Valparaiso	IN
46385	Valparaiso	IN
46392	Wheatfield	IN
46394	Whiting	IN
46402	Gary	IN
46403	Gary	IN
46404	Gary	IN
46405	Lake Station	IN
46406	Gary	IN
46407	Gary	IN
46408	Gary	IN
46409	Gary	IN
46410	Merrillville	IN
47943	Fair Oaks	IN
60004	Arlington Heights	IL
60005	Arlington Heights	IL
60007	Elk Grove Village	IL
60008	Rolling Meadows	IL
60010	Barrington	IL
60016	Des Plaines	IL
60018	Des Plaines	IL
60025	Glenview	IL
60026	Glenview	IL
60029	Golf	IL
60043	Kenilworth	IL
60053	Morton Grove	IL
60056	Mount Prospect	IL
60067	Palatine	IL
60068	Park Ridge	IL
60070	Prospect Heights	IL
60076	Skokie	IL
60077	Skokie	IL
60082	Techny	IL
60091	Wilmette	IL
60093	Winnetka	IL
60101	Addison	IL

Zip Codes within 45 Minutes Travel of Proposed Project (unadjusted)

Zip	City	State
60103	Bartlett	IL
60104	Bellwood	IL
60106	Bensenville	IL
60107	Streamwood	IL
60108	Bloomingdale	IL
60110	Carpentersville	IL
60111	Clare	IL
60112	Cortland	IL
60115	Dekalb	IL
60118	Dundee	IL
60119	Elburn	IL
60120	Elgin	IL
60123	Elgin	IL
60124	Elgin	IL
60126	Elmhurst	IL
60130	Forest Park	IL
60131	Franklin Park	IL
60133	Hanover Park	IL
60134	Geneva	IL
60135	Genoa	IL
60136	Gilberts	IL
60137	Glen Ellyn	IL
60139	Glendale Heights	IL
60140	Hampshire	IL
60141	Hines	IL
60143	Itasca	IL
60145	Kingston	IL
60148	Lombard	IL
60150	Malta	IL
60151	Maple Park	IL
60153	Maywood	IL
60154	Westchester	IL
60155	Broadview	IL
60157	Medinah	IL
60160	Melrose Park	IL
60162	Hillside	IL
60163	Berkeley	IL
60164	Melrose Park	IL
60165	Stone Park	IL
60169	Hoffman Estates	IL
60171	River Grove	IL
60172	Roselle	IL
60173	Schaumburg	IL
60174	Saint Charles	IL
60175	Saint Charles	IL
60176	Schiller Park	IL
60177	South Elgin	IL
60178	Sycamore	IL
60181	Villa Park	IL
60184	Wayne	IL
60185	West Chicago	IL
60187	Wheaton	IL
60188	Carol Stream	IL
60190	Winfield	IL
60191	Wood Dale	IL
60192	Hoffman Estates	IL
60193	Schaumburg	IL
60194	Schaumburg	IL
60195	Schaumburg	IL
60201	Evanston	IL
60202	Evanston	IL
60203	Evanston	IL
60208	Evanston	IL

Zip Codes within 45 Minutes Travel of Proposed Project (unadjusted)

Zip	City	State
60301	Oak Park	IL
60302	Oak Park	IL
60304	Oak Park	IL
60305	River Forest	IL
60401	Beecher	IL
60402	Berwyn	IL
60403	Crest Hill	IL
60404	Shorewood	IL
60406	Blue Island	IL
60407	Braceville	IL
60408	Braidwood	IL
60409	Calumet City	IL
60410	Channahon	IL
60411	Chicago Heights	IL
60415	Chicago Ridge	IL
60416	Coal City	IL
60417	Crete	IL
60419	Dolton	IL
60420	Dwight	IL
60421	Elwood	IL
60422	Flossmoor	IL
60423	Frankfort	IL
60424	Gardner	IL
60425	Glenwood	IL
60426	Harvey	IL
60428	Markham	IL
60429	Hazel Crest	IL
60430	Homewood	IL
60431	Joliet	IL
60432	Joliet	IL
60433	Joliet	IL
60435	Joliet	IL
60436	Joliet	IL
60437	Kinsman	IL
60438	Lansing	IL
60439	Lemont	IL
60440	Bolingbrook	IL
60441	Lockport	IL
60442	Manhattan	IL
60443	Matteson	IL
60444	Mazon	IL
60445	Midlothian	IL
60446	Romeoville	IL
60447	Minooka	IL
60448	Mokena	IL
60449	Monee	IL
60450	Morris	IL
60451	New Lenox	IL
60452	Oak Forest	IL
60453	Oak Lawn	IL
60455	Bridgeview	IL
60456	Hometown	IL
60457	Hickory Hills	IL
60458	Justice	IL
60459	Burbank	IL
60460	Odell	IL
60461	Olympia Fields	IL
60462	Orland Park	IL
60463	Palos Heights	IL
60464	Palos Park	IL
60465	Palos Hills	IL
60466	Park Forest	IL
60467	Orland Park	IL

Zip Codes within 45 Minutes Travel of Proposed Project (unadjusted)

Zip	City	State
60468	Peotone	IL
60469	Posen	IL
60470	Ransom	IL
60471	Richton Park	IL
60472	Robbins	IL
60473	South Holland	IL
60475	Steger	IL
60476	Thornton	IL
60477	Tinley Park	IL
60478	Country Club Hills	IL
60479	Verona	IL
60480	Willow Springs	IL
60481	Wilmington	IL
60482	Worth	IL
60487	Tinley Park	IL
60490	Bolingbrook	IL
60491	Homer Glen	IL
60501	Summit Argo	IL
60502	Aurora	IL
60503	Aurora	IL
60504	Aurora	IL
60505	Aurora	IL
60506	Aurora	IL
60510	Batavia	IL
60511	Big Rock	IL
60512	Bristol	IL
60513	Brookfield	IL
60514	Clarendon Hills	IL
60515	Downers Grove	IL
60516	Downers Grove	IL
60517	Woodridge	IL
60520	Hinckley	IL
60521	Hinsdale	IL
60523	Oak Brook	IL
60525	La Grange	IL
60526	La Grange Park	IL
60527	Willowbrook	IL
60531	Leland	IL
60532	Lisle	IL
60534	Lyons	IL
60538	Montgomery	IL
60539	Mooseheart	IL
60540	Naperville	IL
60541	Newark	IL
60542	North Aurora	IL
60543	Oswego	IL
60544	Plainfield	IL
60545	Plano	IL
60546	Riverside	IL
60548	Sandwich	IL
60549	Serena	IL
60550	Shabbona	IL
60551	Sheridan	IL
60552	Somonauk	IL
60554	Sugar Grove	IL
60555	Warrenville	IL
60556	Waterman	IL
60558	Western Springs	IL
60559	Westmont	IL
60560	Yorkville	IL
60561	Darien	IL
60563	Naperville	IL

Zip Codes within 45 Minutes Travel of Proposed Project (unadjusted)

Zip	City	State
60564	Naperville	IL
60565	Naperville	IL
60585	Plainfield	IL
60586	Plainfield	IL
60601	Chicago	IL
60602	Chicago	IL
60603	Chicago	IL
60604	Chicago	IL
60605	Chicago	IL
60606	Chicago	IL
60607	Chicago	IL
60608	Chicago	IL
60609	Chicago	IL
60610	Chicago	IL
60611	Chicago	IL
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60655	Chicago	IL
60656	Chicago	IL
60657	Chicago	IL
60659	Chicago	IL
60660	Chicago	IL
60661	Chicago	IL
60666	Chicago	IL
60706	Harwood Heights	IL
60707	Elmwood Park	IL
60712	Lincolnwood	IL

Zip Codes within 45 Minutes Travel of Proposed Project (unadjusted)

Zip	City	State
60714	Niles	IL
60803	Alsip	IL
60804	Cicero	IL
60805	Evergreen Park	IL
60827	Riverdale	IL
60901	Kankakee	IL
60913	Bonfield	IL
60914	Bourbonnais	IL
60915	Bradley	IL
60917	Buckingham	IL
60935	Essex	IL
60940	Grant Park	IL
60941	Herscher	IL
60950	Manteno	IL
60954	Momence	IL
60961	Reddick	IL
60964	Saint Anne	IL
61311	Ancona	IL
61313	Blackstone	IL
61319	Cornell	IL
61325	Grand Ridge	IL
61341	Marseilles	IL
61350	Ottawa	IL
61360	Seneca	IL
61364	Streator	IL

Identify the Existing Problems or Issues that need to be Addressed

11. Silver Cross Hospital has eleven combined operating rooms that are used for both inpatient and outpatient surgeries. Those operating rooms are all housed in Silver Cross Hospital's Procedural Care Unit.

12. Silver Cross Hospital has been experiencing tremendous growth in outpatient surgery in recent years. In the past two years alone, Silver Cross Hospital's outpatient surgery cases have increased by more than 11% and outpatient surgery hours have grown by more than 15%. The table that follows summarizes Silver Cross Hospital's most recent surgical activity:

Calendar Year	Operating Rooms	Inpatient Surgery Cases	Outpatient Surgery Cases	Total Surgery Cases	Inpatient Surgery Hours	Outpatient Surgery Hours	Total Surgery Hours	Operating Room Utilization
2014	11	3801	6153	9954	10021	9670	19691	119.3%
2015	11	3854	6834	10688	10246	11148	21394	129.7%

Source: Annual Hospital Questionnaire

13. Silver Cross Hospital's operating rooms have been operating well above the state required minimum utilization level of 80%. Silver Cross Hospital has managed its surgical services department extremely efficiently and has been offering extended hours of operation during weekdays and providing surgical time on the weekends to manage the high surgical volumes and utilization. In fact, weekend hours have recently become great satisfiers for both patients and physicians and that is expected to continue. These patient and physician satisfiers have prompted increasing demand for surgical services at Silver Cross Hospital. Developing a freestanding surgery center on the Silver Cross Hospital campus will improve access to surgical

services for the community and will address this growing demand for surgical care at Silver Cross Hospital.

Cite the Sources of Information Provided as Documentation

- Silver Cross Hospital surgery department data
- Silver Cross Hospital surgery department throughput analysis
- ASTC analysis by Surgical Consultants
- Costs and Benefits of Competing Healthcare Providers: Trade-Offs in the Outpatient Surgery Market, Elizabeth L. Munnich and Stephen T. Parente, University of Notre Dame, May 2013
- Medicare Savings Tied to Ambulatory Surgery Centers, University of California-Berkley School of Public Health, Brent Fulton and Sue Kim, School of Public Health, University of California-Berkeley, September 2013
- Illinois Hospital Association, COMPdata
- Claritas and US Census Bureau Data
- Hospital and ASTC Profiles, Inventories and Other Data available on the Board's website
- Other health care literature regarding current health care trends

Detail how the Project will Address or Improve the Previously Referenced Issues as well as the Population's Health Status and Well-Being

14. The proposed Surgery Center will provide capacity in order for Silver Cross Hospital to offload some outpatient surgical volume from its Procedural Care Unit, which has been operating well above the State's required minimum utilization for the past few years. The proposed Surgery Center will improve efficiencies in patient care for patients at the proposed Surgery Center. The proposed Surgery Care Center will also improve patient satisfaction and efficiency for the patients who will continue to be treated in Silver Cross Hospital's Procedural Care Unit. Physicians providing services at the proposed Surgery Center will also benefit from more streamlined processes that are typically found in a freestanding surgery center.

15. Utilization of the proposed Surgery Center will come entirely from cases that would otherwise be performed at Silver Cross Hospital. Because these cases will be coming entirely from Silver Cross Hospital's existing Primary Service Area – a model was built on historical volumes by service area to project activity in years over the next four years for the entire Silver Cross Hospital surgical enterprise (i.e., Silver Cross Hospital Procedural Care Unit and the proposed Surgery Center combined), for the proposed Surgery Center and for that portion that will remain at Silver Cross Hospital. This model was based on historical growth rates and based on average case times as reported on Silver Cross Hospital's Annual Hospital Questionnaire.

Provide Goals with Quantified and Measurable Objectives with Specific Timeframes that Relate to Achieving the Stated Goals

16. It is projected that 2,165 cases will be performed at the Surgery Center in 2018 (i.e., the first year of operation for the proposed Surgery Center) and 2,252 cases in 2019 (i.e., the second year of operation for the proposed Surgery Center).

17. The proposed Surgery Center is expected to reach a utilization level that exceeds the State required minimum of 80% in 2019.

18. The Applicants commit not to add any additional operating rooms at Silver Cross Hospital until the Surgery Center achieves its target utilization rate for twelve months.

19. the Applicants' construction schedule for the Surgery Center is as follows:

Goal	Percentage Completed	Expected Completion Date
Erect shell and core	50%	06/30/2017
Frame interior rooms	75%	11/15/2017
Complete Village and State inspections and obtain licenses to operate	100%	03/31/2018

20. Letters of support for the Project are attached at ATTACHMENT 12.

21. See Criterion 1110.230(c) and the 1110.1540 Criteria for further support for this Criterion.

Costs and Benefits of Competing Health Care Providers: Trade-Offs in the Outpatient Surgery Market

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ABSTRACT

Over the past 30 years, outpatient surgery has become an increasingly important part of medical care in the United States. This paper examines ambulatory surgery centers (ASCs), which have been praised as a low-cost, convenient alternative to outpatient surgery in hospitals, but criticized for "cream skimming" profitable patients and procedures, important sources of revenue for general hospitals. For a national sample of Medicare patients that varies over time and controlling for physician fixed effects, we show that ASCs treat healthier patients than hospital outpatient departments—the highest risk quartile of patients were half as likely to be treated in an ASC than those in the healthiest quartile. Controlling for patient characteristics, we find that ASCs perform procedures faster than hospital outpatient departments. Combined with the fact that ASCs receive lower reimbursements than hospitals, outpatient surgery is less costly in ASCs. To the extent that ASCs provide cheaper and faster care than hospitals, we then consider whether they do so at the expense of quality of care. Using the variation in ASC use generated by exogenous changes in Medicare payments, we find that treatment in an ASC is associated with better health outcomes, holding patient risk constant; in fact, high-risk patients treated in an ASC are less likely to be admitted to an inpatient hospital within 0, 7, 14, or 30-Day of outpatient surgery. These results suggest that health policy planners have to trade off the superior and cheaper treatment in ASCs against the subsidy outpatient surgeries provide to hospitals.

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1. Introduction

Technological developments in medicine have drastically changed the provision of surgical care in the United States over the last 30 years. Advances in anesthesia and laparoscopic techniques in the 1980s and 1990s made it possible for patients who previously spent days in the hospital recovering from a surgical procedure to instead be discharged the same day as surgery (Sloss et al. 2006, Kozak et al. 1999). The introduction of the inpatient prospective payment system (IPPS) in 1983 created additional incentives for hospitals to shift patient care from inpatient to outpatient departments (Leader and Moon 1989). Subsequently, the number of outpatient surgeries nationwide increased considerably, from 3.5 million in 1981 to over 17 million in 2010, and outpatient procedures now represent roughly 60 percent of all surgeries (Avalere Health and American Hospital Association 2007 and 2011).

A large part of the growth in outpatient surgery has occurred in ambulatory surgical centers (ASCs). Whereas hospitals with outpatient departments provide other types of care, such as inpatient and emergency services, ASCs exclusively provide outpatient surgery. The share of all outpatient procedures performed in ASCs grew from 4 percent in 1981 to almost 40 percent in 2005 (Avalere Health and American Hospital Association 2007 and 2011). Over 90 percent of ASCs are physician-owned, and 96 percent are for-profit (ASC Association 2007, MedPAC 2010).[1] Since surgeons often have operating privileges in both freestanding ASCs and hospitals, they may choose to refer patients to either type of outpatient setting.

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 (Hair, Hussy, and Wynn 2012, Paquette et al. 2008, Grisel et al. 2009, Haugh 2006, Government Accountability Office 2006). Additionally, since most surgery centers focus on a limited number of services, ASCs may provide higher quality care at a lower cost than hospital outpatient departments that provide a broad range of services

[1] Only 18 percent of U.S. general hospitals are for-profit and less than one percent are physician-owned (American Hospital Association 2012, Silva 2010). Due to the federal "Stark Law," physicians are prohibited from referring Medicare or Medicaid patients to hospitals with which they have a financial relationship (e.g., investment or ownership), limiting physician ownership of general hospitals. However, the law exempts physicians who have an ownership stake in an entire hospital, such as an ASC or specialty hospital. See Casalino (2008) for more details on the Stark laws.

(Casalino, Devers, and Brewster 2003). The U.S. Office of the Inspector General has promoted "greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities" (Office of the Inspector General 1999). If ASCs provide faster, cheaper outpatient services, do they do so at the expense of quality of care or breadth of procedures?

Critics of ASCs argue that these facilities "cream skim" or "cherry pick" more profitable patients and procedures, drawing patients who are more likely to have better outcomes, as well as important revenue streams, from hospitals. Representing the American Hospital Association (AHA) at a Federal Trade Commission hearing in 2003, the CEO of the AtlantiCare hospital system noted that, "The rapid growth of specialty care providers threatens community access to basic health services and jeopardizes patient safety and quality of care" (Lynn 3/27/03, p. 27-28).[2] In response to arguments that ASCs face lower costs than hospital outpatient departments, the Centers for Medicare and Medicaid Services (CMS) froze ASC payment rates in 2003 and has steadily reduced ASC payments, while increasing payments to hospital outpatient departments, since 2008. Despite the rapid growth in ASCs and the policy responses to this growth, there is little empirical evidence backing the claims attributed to them. Likewise, there has been almost no research examining the impact on ASC operation of such policy factors as reimbursement rates.

In this paper, we fill this void by addressing two questions about ambulatory surgery centers. First, do ASCs treat a different patient mix than hospitals? Physicians, ASCs, and hospital outpatient departments each receive a separate payment for every outpatient procedure, which does not vary by the health of the patient. Therefore, one way to increase ASC profitability is to substitute towards relatively healthier patients who may be less costly to treat. This may be a particularly acute problem for hospitals if surgeons have access to both the ASC and hospital sectors. In a cross sectional data set, it is difficult to identify cream skimming if physicians have different client bases and receive different payments based on

[2] Examples of specialty hospitals, as described by Lynn, include ambulatory surgery centers, children's hospitals, psychiatric hospitals, heart hospitals, cancer hospitals, dialysis clinics, pain centers, imaging centers, and mammography centers.

where a procedure is performed. We circumvent both problems by using Medicare claims from 2007 through 2009. We restrict our analysis to Medicare patients in order to study a subset of patient claims that do not vary by insurer. The Medicare data also contain unique physician identifiers, which allows us to control for the underlying patient case mix for physicians via physician fixed effects. Our model then asks whether, holding physician constant, physicians sent risker patients to one sector or another. We construct a measure of patient risk using ICD-9 diagnosis codes, age, and sex. We find that holding the identity of the physician constant, the probability of the surgery being performed in an ASC is monotonically decreasing in patient risk. Patients in the highest risk quartile were half as likely to be treated in an ASC compared to those in the healthiest quartile.

As part of this analysis, we estimate cost differences between procedures performed in ASCs and hospital outpatient departments, and between patients of different levels of underlying health. Since ASCs have not historically reported cost data to organizations such as Medicare or Medicaid, this question is at present difficult to address. It is made more difficult by the fact that we demonstrate that ASCs treat much healthier patients than hospitals. Despite these limitations, we can infer one aspect of cost: the time it takes to perform procedures. Using data from the 2006 National Survey of Ambulatory Surgery, we establish that holding physician characteristics (including risk score) constant, it takes substantially longer to perform outpatient surgeries in a hospital setting than in an ASC. Therefore, given a fixed capacity at any point in time, ASCs can perform more procedures per day than hospitals. After controlling for patient characteristics, patients spend nearly 26 percent less time in ASCs than in hospitals for outpatient procedures. The disparity in the time per procedure is also a function of patient risk level. Not surprisingly, our results indicate that patient health is a strong predictor of time spent in surgery and in post-operative care. Holding facility constant, patients in the highest quartile of patient risk take 13 percent longer in surgery than the healthiest quartile of patients. This suggests an important mechanism through which cream skimming could directly affect hospital volume and revenue if hospitals treat increasingly unhealthy patients.

The second question our research addresses is: do ASCs provide superior care to hospital outpatient departments? One argument in favor of ASCs is that they may offer higher quality care due to specialization. However, if hospitals are better equipped to treat high-risk patients than surgery centers, we may expect that treating higher risk patients in ASCs will have negative consequences for patient outcomes. In order to address this question, we use exogenous changes in facility fees across outpatient setting, procedure, and over time that affect a physician's decision about whether to treat patients in an ASC or a hospital. In the Medicare program, there are two types of payments for each surgical procedure. The first is a physician payment that is the same amount per procedure regardless of where the procedure if performed. The second is a facility fee that varies over time and by procedure, where the fee is a function of the setting in which the procedure is performed. Medicare payments for outpatient services are set according to federally determined payment groups and adjusted for local labor costs using the hospital inpatient wage index. Medicare fees for ASCs and hospital outpatient facilities have historically been based on different payment systems, so the ratio of the two payments varies across procedure, time, and geographic area.

We estimate the relationship between scaled ASC payments, interacted with a patient's risk score quartile, and whether a patient was treated in an ASC. We find that Medicare facility fees are an important determinant of whether a patient was treated at an ASC or a hospital, and that as ASC payments increase relative to hospital payments, riskier patients are treated in ASCs. Although the riskiest quartile of patients are much less likely to be treated in an ASC than the healthiest quartile, a 0.1 increase in the ASC/hospital payment ratio is associated with a .015 percentage point (3.5 percent) increase in the probability of being treated in an ASC for this group.

We examine the health outcomes associated with treating higher risk patients in surgery centers by focusing on one quality of care measure: inpatient admission within 0, 7, 14, and 30 days of an outpatient procedure. Since Medicare facility fees are determined nationally, they represent a plausibly exogenous source of variation at the local-level. We use the interaction between a patient's risk score quartile and the ASC/hospital payment ratio in his or her hospital region as an exogenous source of

variation in ASC treatment, to examine differences in patient outcomes across facility settings. We find that ASC treatment reduces the probability of inpatient admission within 7, 14, and 30 days for the quartile of patients with the greatest morbidity. This suggests that ASCs provide higher quality care than hospital outpatient departments, even for the riskiest patients.

A number of papers have documented that increased competition with ASCs is associated with lower hospital outpatient volume (Courtemanche and Plotzke 2010, Lynk and Longley 2002, Bian and Morrisey 2007), and anecdotal evidence suggests that hospitals respond to losing profitable cases to ASCs by raising prices for other hospital service lines (Berenson, Bodenheimer, Pham 2006, MedPAC 2006). To date, proponents and critics of ASCs have predominantly voiced their appeals in isolation of one another, without acknowledging the trade-offs that exist between providing cost-effective, high quality care, and subsidizing less profitable procedures and patients. In this paper, we use exogenous variation in Medicare facility payments to inform this trade-off. Our findings indicate that ASCs do in fact provide faster, cheaper, and better outpatient care, but, as this prior literature illustrates, this may come at the cost of reducing revenue sources from hospitals that provide services which may be socially important.

2. Background

2.1 Growth in Outpatient Procedures and Ambulatory Surgery Centers

Outpatient surgery (i.e., ambulatory surgery) is surgery that does not require an overnight stay. In 2010, 64 percent of surgeries in the U.S. were done on an outpatient basis, in hospital outpatient departments, ambulatory surgery centers, and physician offices (American Hospital Association 2011). The number of outpatient surgeries has grown considerably in the U.S. since the early 1980s. Figure 1 shows the growth in outpatient surgeries accompanied by a decline in inpatient surgeries between 1981 and 2010. Previous research on the outpatient surgery market has attributed much of its growth to two factors: technological advances in medicine, and changes in Medicare reimbursement policy (FASA 2005, Koenig et al. 2009). Indeed, Figure 1 indicates that most of the change in outpatient surgeries occurred in

the early 1980s, when Medicare both began covering procedures performed in ASCs and also introduced the Inpatient Prospective Payment System (IPPS), and leveled out in 2002, shortly after Medicare introduced the Outpatient Prospective Payment System (OPPS). Inpatient surgeries declined until about 1995, and have since remained constant. These trends suggest that between 1981 and 1995, there was substitution of outpatient for inpatient surgeries, as well as expansion in the surgery market.

CMS defines an ambulatory surgery center (ASC) as a "distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission" (Ambulatory Surgical Services 2009). The share of all outpatient surgeries in freestanding ASCs increased from 4 percent of the market in 1981 to 38 percent in 2005, shown in Figure 2. While the share of surgeries performed in physician offices grew over this period as well, ASCs in particular have posed a competitive threat to hospitals. Hospital executives have expressed concern that ASCs have potentially "unfair" cost advantages because they treat healthier patients, are not required to provide unprofitable services, and are less regulated than hospitals (Casalino, Devers, Brewster 2003, Vogt and Romley 2009).[3] Accordingly, hospital systems and industry organizations like the American Hospital Association (AHA) have waged "a full scale attack on niche providers through their lobbying efforts" (Cimasi 2005). CMS has also made deliberate efforts to change policies to encourage treatment in one type of facility over another (Scully 3/23/03, p. 46).

The vast majority of ASC patients are covered by private insurance or Medicare. Figure 3 shows the number of outpatient surgeries in ASCs and hospitals by insurance type for 1996 and 2006. The number of surgeries in ASCs has increased relative to the number of surgeries in hospitals for all types of insurance coverage categories (private or commercial, Medicare, Medicaid, self-pay, and other).[4] Among

[3] All Medicare-certified ASCs must be certified by a state agency, or private accredited. Although facilities must initially obtain this qualification, the Office of Inspector General has criticized CMS for insufficient oversight of states and accreditors regarding recertification and compliance, leading to very lenient regulation of ASCs. CMS also requires participating hospitals to comply with patients' rights requirements and implement quality improvement programs, which it does not require of ASCs (CMS 2003, Office of Inspector General 2002).

[4] Other insurance types include TRICARE, worker's compensation, and other government insurance.

Medicare patients, the number of surgeries in ASCs grew nearly 300 percent, compared to an 18 percent increase in the number of surgeries in hospital outpatient departments.

2.2 Overview of Medicare Payments

Before examining changes in the ASC market for Medicare patients, it is instructive to outline the structure of Medicare payments for outpatient surgical procedures. For any surgical procedure, Medicare payments are separated into three components: a facility fee (e.g., to cover overhead costs, nursing and tech staff, and equipment and drugs directly related to the procedure), professional (physician) fees, and fees for other services (e.g., physical therapy, a skilled nursing facility, and durable medical equipment). While physicians receive the same amount for an outpatient procedure regardless of whether it occurred in an ASC or a hospital, facility payments differ across settings. In general, reimbursements for outpatient procedures in hospitals are set higher than in ASCs because hospitals must meet additional regulatory requirements and treat patients who are more medically complex (MedPAC 2003b). For example, in 2003, the national facility fee for a cataract removal was $973 in an ASC and $1,160 in a hospital. However, that same year, the facility fee for an upper gastrointestinal (GI) endoscopy was $446 in an ASC and $387 in a hospital (MedPAC 2003a). Over 90 percent of ASCs are at least partly owned by physicians. When a physician treats a patient in an ASC over which he or she has some ownership, that physician captures part of the facility fee from Medicare. Consequently, previous research has found that physicians with financial interests in hospitals have a higher rate of self-referrals, and volume in surgery centers is higher for physician owners than non-owners (Yee 2011, He and Mellor 2012, Mitchell 2008 and 2010, Casalino 2008, Lynk and Longley 2002).

Differences between ASC and hospital outpatient payments have varied over time. When Medicare first started covering outpatient procedures in 1982, hospital procedures were reimbursed using a cost-based system where ASC procedures were grouped into one of 4 payment categories based on cost and clinical similarity, and every procedure in a particular category was reimbursed at the same rate. Importantly, across both settings, facilities were paid the same fee for a procedure regardless of the health

of the patient. These payments were updated annually for inflation—hospital procedures by the hospital market basket and ASC procedures by the Consumer Price Index for All Urban Consumers (CPI-U)—but were not otherwise adjusted until Medicare expanded to eight payment groups in 1990, and nine in 1991 (MedPAC 2010).

In 2000, Medicare's traditional cost-based reimbursement system for outpatient care in hospitals was replaced with the Outpatient Prospective Payment System (OPPS). Like the payment group structure of ASCs, OPPS established 200 Ambulatory Payment Classifications (APCs) for hospital outpatient procedures. Noting the drastic growth in ASCs relative to hospital outpatient departments around the same time, CMS subsequently made efforts to reduce ASC payments. In the 2003 Federal Trade Commission hearings on health care and competition, the former Administrator of CMS, Thomas Scully, remarked, "I can tell you when I drive around the country and see where ASCs are popping up, I can tell who we're overpaying" (Scully 2/26/03, p. 46). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 froze ASC payment updates and directed the Government Accountability Office (GAO) to examine the relative costs of procedures performed in ASCs and hospital outpatient departments to inform implementation of a new cost structure by January 1, 2008 (GAO 2006). Between 2008 and 2011, Medicare phased in a new system for ASC payments based on the 200 Ambulatory Payment Classifications (APC) in the OPPS, and expanded the number of covered ASC procedures (MedPAC 2010). The rates were set such that facility fees for ASCs would be approximately 59 percent of facility fees for hospital outpatient departments, phased in fully by 2012.

This policy change reduces incentives to treat patients in ASCs, benefitting hospitals that use revenue from outpatient procedures to subsidize less profitable procedures. However, if ASCs provide more cost effective outpatient services without compromising patient safety, this could have negative consequences for overall healthcare spending on outpatient care. In the sections that follow, we examine differences in treatment patterns across outpatient setting to estimate cost and quality differences between ASCs and hospital outpatient departments.

3. Do ASCs treat a different patient mix than hospitals?

3.1 Cream Skimming

ASCs have been criticized for skimming the most profitable patients in the outpatient surgery market. It has been well documented that patients who have health insurance with higher reimbursement rates are more likely to be treated in ambulatory surgery centers (Mitchell 2010, Pham et al. 2004, Hadley and Reschovsky 2006, Gabel et al. 2008, Hollingsworth et al. 2010). Similarly, ASCs on average treat healthier patients and perform higher profit procedures than hospital outpatient departments (Wynn et al. 2004, Winter 2003, Plotzke and Courtemanche 2011). Research on cream skimming has been conducted for other physician-owned facilities such as specialty hospitals as well. For example, Swanson (2012) examines patient selection in cardiac specialty centers, and concludes that the distribution of patients across hospitals is driven by physicians' average preferences over hospitals rather than cherry picking.

Although previous research documents differences in the composition of patients and procedures across facility types, it often relies on cross-sectional data and is unable to account for variation between physicians. For example, there may be underlying differences between physicians who work in ASCs and those who work in hospitals that influence the types of patients that are referred to each type of facility. The authors are also unable to make statements about differences in the quality of care across outpatient settings, since healthier patients likely have better surgical outcomes than riskier patients regardless of the quality of care they receive, and healthier patients may be more likely to choose ASCs over hospital outpatient departments.[5] In this paper, we restrict our analysis to cases performed by physicians who operate in both ASCs and hospitals. In doing so, we are able to identify within-physician patient selection to account for sorting of patients by acuity between physicians.

The impact of cream skimming on finances of general hospitals remains to be shown (Casalino, Devers, and Brewster 2003). As one hospital administrator remarked, "It cannot be described any other

[5] While patient preferences are also a factor in the location of treatment, coinsurance rates did not vary over the period of our study so we do not expect that preferences changed during this time. The variation we exploit comes from facility fees, discussed later.

way as that they skim and cherry-pick on the front end.... They don't take Medicaid patients, they certainly don't take charity cases and medical conditions. The comorbidities come to the hospitals" (Ralph 3/26/03, p. 12). However, since physician reimbursement and facility fees per outpatient procedure do not vary by the health of the patient, it is not immediately evident why it would benefit surgery centers to favor healthier patients. Holding insurance provider constant, a higher risk patient would be more costly to care for only if he or she required more resources.

One critical resource for outpatient procedures is time. For example, in a study of knee arthroscopies (knee scopes) performed by one surgeon, Gadinsky et al. (2012) found that patients with a BMI greater than 40 spent significantly longer (28 minutes, or 23 percent) in the operating room than those with a BMI under 25. If this finding is generalizable to other surgeons, settings, or procedures, it suggests that a patient's health could impact the total volume of surgeries. In this paper we focus on a sample of Medicare patient claims to estimate cream skimming among patients for whom a particular type of outpatient facility receives the same payment for a procedure regardless of the health of the patient.

3.2 Estimating Cream Skimming in ASCs

One problem with previous research on cream skimming is that surgeons who operate in ASCs have a different patient mix than those who only operate in hospitals, so the patients of these two types of physicians may have very different outcomes regardless of the type of care they receive. These differences could reflect physician preferences for different types of patients (or vice versa), differences in patient mix across hospital systems, or sorting within physician practices, e.g., if older physicians have more leverage in a practice and therefore more ability to choose settings and patients. If physicians who operate more in ASCs have a healthier group of patients than those who do not, any estimation of the relationship between patient health and ASC treatment that does not account for differences in case mix would be biased.

To address this, we construct an empirical model that estimates the relationship between a patient's health and the likelihood of ASC treatment that accounts for physician heterogeneity using physician fixed effects

$$ASC_i = X_i\beta + \sum_r Risk_{ir}\alpha_r + \sum_p Proc_{ip}\delta_p + \sum_j Phys_{ij}\gamma_j + \sum_p\sum_j Proc_{ip} \times Phys_{ij}\rho_{jp} \sum_t Year_{it}\theta_t + \varepsilon_i \quad (1)$$

In this model, ASC_i is an indicator equal to one if the procedure for patient claim i was performed in an ASC. We include a vector of demographic characteristics, X_i, including age group, sex, ethnicity, and an indicator variable equal to one if a patient is eligible for Medicare because of end stage renal disease. $Risk_{ir}$ is a dummy variable indicating a patient's health risk quartile r, where the first (healthiest) quartile is omitted. Since different procedures may be more prevalent in one type of facility, which could affect a patient's probability of treatment in an ASC, we include procedure fixed effects ($Proc_{ip}$). To account for physician-specific characteristics that may drive treatment decisions, as discussed earlier, we also include fixed effects for physicians ($Phys_{ij}$) and physician by procedure fixed effects ($Physn_{ij}$ x $Proc_{ip}$).[6] The variation in our model is therefore driven by a particular physician's decision to treat patients in one outpatient sector over another, for physicians who care for patients in both ASCs and hospitals. Finally, we control for time varying factors that are common across patients by including a vector of dummy variables for year of procedure ($Year_{it}$). If a patient's risk score group is negatively related to ASC treatment—i.e., if α_2, α_3, and α_4, are less than zero—then riskier patients are less likely to be treated in an ASC than in a hospital outpatient department. To account for possible correlation within a geographic region over time, we cluster standard errors by Hospital Service Area (HSA).

In order to estimate the above model, we need a dataset that includes detailed patient and surgery information, as well physician identifiers. We achieve this using the Medicare Limited Data Set for 2007 through 2009. These data contain all institutional and non-institutional claims for a 5 percent sample of Medicare beneficiaries, including both hospital outpatient departments and ASCs. For each patient claim, we observe patient diagnoses and procedures, payment amount, dates of service, patient demographics,

[6] The physician fixed effects absorb geographic fixed effects. Therefore, we do not need to separately include state or other geographic fixed effects in this model.

and an identifier for the attending and operating physicians in the procedure.[7] Procedures in Medicare claims are coded using the Health Care Common Procedure Coding System (HCPCS). Each HCPCS code is assigned to a procedure category using Berenson-Eggers Type of Service (BETOS) Codes, which represent readily understood clinical categories as well as groupings used in Medicare payments. For the remainder of this paper, we define "procedure" in Medicare claims as the BETOS code.

Descriptive statistics for patient claims are presented by physician and facility type in Table 1.[8] We consider two types of physicians: the full sample of physicians (those who treat patients in either ASCs or hospitals, or both), and those who treat patients in both types of facilities, which is the group that identifies the key parameters of interest in our fixed effect model.[9] Overall, patients treated by physicians who operate in both ASCs and hospitals are very similar to patients in the full sample.[10] We then compare characteristics of patients in ASCs with those in hospitals for each physician type. For the full physician sample, patients treated in hospitals are younger, less likely to be female, more likely to be black, and more likely to have end stage renal disease or a disability as the primary for Medicare entitlements.[11] Patients treated in ASCs and hospitals are in general much more alike for the subset of physicians who operated in both types of settings than for the full sample of physicians, though patients in hospitals are more likely to be on disability or have end stage renal disease.

The distribution of procedures also varies by physician type. In the full sample of physicians, all of the top 5 procedures in terms of ASC volume (cataract removals, colonoscopies, upper GI endoscopies, minor musculoskeletal procedures, and other eye procedures) comprised much larger shares of total procedures in ASCs than in hospitals. Again, these differences are much smaller for the restricted group of physicians. For example, cataract surgeries comprised 3 percent of procedures performed in hospitals

[7] CMS changed its system for identifying physicians from unique physician identification numbers (UPIN) to National Provider Identifiers (NPI) beginning in 2007. We obtain NPI values where missing from the National Plan and Provider Enumeration System (NPPES), available at http://nppes.viva-it.com/NPI_Files.html.

[8] Over 40 percent of patients of physicians who operate in both types of facilities undergo more than one outpatient procedure in a year, so we observe multiple claims for these individuals.

[9] Physicians who work in both types of facilities are a subset of physicians who work in either type of facility.

[10] Given the large sample size, all differences are statistically significant.

[11] Patients who are under age 65 can qualify for Medicare benefits if they have a disability or end stage renal disease. Since a greater share of patients treated in hospitals are on disability as their primary reason for entitlement, it is not surprising that the average age of patients in ASCs is higher than the average age of patients treated in hospitals.

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Attachment 12

among the full sample of physicians and 28 percent of procedures performed in ASCs. Among claims for procedures done by physicians that worked in both types of facilities, cataract surgeries represented 10 percent of hospital claims and 14 percent of ASC claims. This suggests that a number of physicians only provide some services, e.g., cataract surgeries, in one type of setting. Including physicians who exclusively treat patients in either ASCs or hospitals, and do not make case-by-case decisions to operate in one facility over another that would lead to cream skimming, would bias our estimates.

The results from Table 1 suggest that if we were to include all Medicare claims without accounting for idiosyncratic differences among physicians, our cream skimming estimates would be biased because physicians who operate in both types of facilities have a different patient composition than those who just operate in one type of setting. To address this problem, we restrict our sample to claims from procedures performed by physicians who operate in both types of facilities. We employ a physician fixed effects model to control for underlying differences between physicians that do not vary over time.

To measure underlying patient health, we generate patient risk scores using the Johns Hopkins University ACG Case-Mix System (v. 10) developed by the Health Services Research and Development Center. The ACG System uses ICD-9CM diagnosis codes and patient characteristics to construct measures of health status. The predictive modeling feature of the ACG software produces a concurrent weight (CW) that is a summary measure of the current individual health status and resource utilization. The CW is constructed so that the national average is 1.0 with higher values denoting poorer health and likely higher expenditures; for example, a patient with a weight of 2.0 is twice as sick, and expected to use twice as many resources, as a person with a weight of 1.0.

Patient acuity varies across outpatient settings. Figure 4 shows kernel density plots of patient risk scores in hospital outpatient departments and ASCs. Panel A presents the distribution of risk scores using Medicare claims for physicians who treated patients for any type of procedure in both types of facilities. Panel B presents the risk score distribution using all Medicare patients from the 2006 National Survey of Ambulatory Surgery (NSAS). Both panels indicate that greater shares of patients with lower risk scores are treated in ASCs than in hospital outpatient departments. For ease of interpretation, we use aggregated

measures of risk scores that have been grouped into four quartiles based on predicted patient resource utilization.

Table 2 presents results for the physician fixed effects model using Medicare 5 percent claims. The first column includes estimates for all procedures in the full physician sample. Results in columns 2 and 3 include all procedures in the sample of physicians restricted to those who work in both ASCs and hospitals, without and with physician fixed effects, respectively. Since the scope of procedures is much larger in hospitals than in ASCs, we also restrict our analysis to the top 5 procedures by ASC volume to ensure that we are using a comparable set of procedures across settings.[12] Estimates for these 5 procedures are provided in the second column. The remaining columns indicate results from separate regressions for each of the top 5 procedures based on ASC surgical volume: cataract surgeries, colonoscopies, upper GI endoscopies, minor musculoskeletal procedures, and other eye procedures. The share of patients treated in an ASC by risk quartile, and the share of claims in each risk quantile, are included in curly and square brackets, respectively. In all cases, patients that are less healthy (i.e., higher risk score quartiles) are significantly less likely to be treated in an ASC than those in lower risk score quartiles. Among claims in the full physician sample, 18 percent of first quartile (healthiest) patients are treated in an ASC compared with 6 percent of fourth quartile (riskiest) patients. For the restricted physician sample (Columns 2 and 3), 76 percent of first quartile (healthiest) patients are treated in an ASC compared to 36 percent of fourth quartile (riskiest) patients. ASC treatment also varies by procedure. Whereas 85 percent of first quartile patients undergoing cataract surgery were treated in an ASC, only 76 percent of patients in the same risk score group undergoing minor musculoskeletal procedures were treated in an ASC. The probability of ASC treatment is monotonically decreasing in risk for cataract surgeries, colonoscopies, and upper GI endoscopies.

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[12] The top 5 procedures by ASC volume account for 82 percent of claims in ASCs compared to 74 percent of claims in hospital outpatient departments.

Regression results indicate that the probability of being treated in an ASC decreases as a patient's risk score group increases, across all types of procedures. Results are much larger for the full physician sample than for the restricted sample, indicating that including all physicians leads to overstating the extent of cream skimming. Including fixed effects for the restricted physician sample reduces the magnitude of the coefficients slightly (column 3).[13] Holding physician constant, patients in the highest risk score quartile undergoing any procedure are still nearly 40 percentage points less likely to be treated in an ASC than patients in the healthiest quartile. In other words, the riskiest quartile of patients is more than half as likely to be treated in an ASC as the healthiest quartile. Cataract patients in the highest risk quartile are 68 percentage points less likely than the healthiest patients to be treated in an ASC. These results indicate that even accounting for differences across physicians and only looking at the subset of physicians who treat patients in both hospitals and ASCs, physicians are much more likely to refer healthy patients to ASCs.

3.3 Cost Differences Between Outpatient Procedures in ASCs and Hospitals

In Section 3.2, we documented that a substantial amount of cream skimming exists in ASCs. If outcomes are better for risky patients when they are treated in hospitals, then physicians may choose to treat riskier patients in hospitals where they are likely to fare better. Given that facilities are paid the same fee for an outpatient procedure regardless of the underlying health of the patient, it is not immediately obvious why hospitals would be opposed to cream skimming. In other words, a facility does not capture a higher payment from Medicare by treating patients of higher or lower risk. For healthier patients to be more profitable, it must be the case that they are less costly to care for than riskier patients. In this section we examine the cost of treating risky patients in terms of one important cost to hospitals: time. We consider the potential cost to physicians of treating riskier patients by estimating the relationship between a patient's risk score quartile, defined earlier, and procedure time:

[13] Differences between specifications with and without physician fixed effects are significant at the 10 percent level.

$$ln(Time_i) = X_i\beta_1 + NumProc_i\beta_2 + \sum_r Risk_{ir}\alpha_r + \sum_p Proc_{ip}\delta_p + \sum_k Facility_{ik}\gamma_k + \varepsilon_i \quad (2)$$

In this model, $Time_i$ denotes the procedure time in minutes for patient claim i. $NumProc_i$ is the total number of procedures for a claim. $Risk_{ir}$ is a dummy variable indicating the group r in which a patient's risk score falls, where the healthiest group of patients (risk score group 1) is omitted. As before, we include procedure fixed effects ($Proc_{ip}$) to account for time differences across procedures. Some hospitals or ASCs may on average be quicker at doing all cases; to account for this heterogeneity, we include facility fixed effects ($Facility_{ik}$) so that our model measures differences in time by patient risk, not the efficiency of any particular hospital.[14] We also include controls for patient demographic characteristics X_i (age, sex, and disabled).[15] The coefficients α_2, α_3, and α_4 therefore capture the average percent difference in procedure time for patients in higher risk groups relative to the healthiest group of patients.

We know of only one nationally representative data set that includes information about surgery time. The National Survey of Ambulatory Surgery (NSAS) is a survey of ambulatory surgery in hospitals and freestanding surgery centers in the U.S., conducted by the Centers for Disease Control from 1994 to 1996, and 2006. The 2006 data include patient diagnoses, demographics, and surgical procedure(s) as well as information about length of surgery and recovery for 52,000 visits at 437 facilities. The data include separate measures of time spent in the operating room (OR) prior to surgery, time in surgery, time in post-operative care, and total procedure time.[16]

Table 3 presents descriptive statistics for three groups of patients from the 2006 NSAS: all patients, patients using Medicare as any source of payment, and, for reasons described earlier, Medicare patients undergoing one of the top 10 procedures based on surgical volume, in ASCs.[17] ASC patients in the NSAS are, on average, older, more likely to live in an MSA, and less likely to be disabled than

[14] Since the facility fixed effects capture whether a facility is an ASC or a hospital, we do not include a dummy for ASC treatment in addition to the facility fixed effects.
[15] We classify a patient as disabled if he or she is under age 65 and on Medicare.
[16] Total procedure time includes non-surgery OR time, surgery time, post-operative time, and transport time between the OR and recovery room time.
[17] Procedures in the NSAS are coded based on the ICD9-CM procedure codes and grouped into clinical categories using the Clinical Classifications Software from the Healthcare Cost and Utilization Project. These do not exactly correspond to procedures in Medicare data, which are based on BETOS codes. The top 10 procedures by ASC surgical volume are listed for each sample in Table A.1.

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patients in hospital outpatient departments. ASCs also treat fewer patients with Medicaid as their primary source of insurance, but more patients with other types of insurance or self-pay. We calculate risk scores using the same methods discussed in Section 3.2, and divide patients into risk score quartiles based on the full sample of patients. Not surprisingly, ASC patients are more likely to fall in a lower risk score group than hospital patients, and much less likely to be in the highest risk score groups.

Medicare patients in the NSAS are older than other patients, and less healthy in terms of risk score than the full sample of patients. Among Medicare patients, differences between ASC and hospital patients are similar to differences discussed for the full sample of NSAS patients. While Medicare patients on the whole are slightly riskier than the full sample of patients, those undergoing one of the top 10 procedures based on ASC volume are on average much healthier than other patients. Among Medicare patients undergoing one of the top 10 surgical procedures, those treated in ASCs are older, more likely to live in an MSA, more likely to be disabled, and more likely to be female.

Average surgery times vary considerably by and within procedure, and across settings. Since our procedure categories each contain several individual procedures and also vary somewhat across datasets due to different procedure coding systems, we focus on procedure time for three procedure groups that contain a small number of procedures and are comparable across datasets: cataract surgeries, colonoscopies, and upper GI endoscopies. Figure 5 presents the distribution of total time spent in an outpatient facility, between entering the OR and leaving post-operative care, for the each of these procedures among Medicare patients.[18] Much like the risk score density plots in Figure 4, the distribution of time in ASCs is to the left the time distribution of hospitals. The figures indicate that at any particular point in the distribution, patients spend less time in ASCs than in hospital outpatient departments for a given procedure. Additionally, the variance in total procedure time is larger in hospitals, suggesting that either hospitals receive a wider range of patients for whom procedure time varies, or hospitals are not as consistent at timing procedures as ASCs.

[18] Patients that underwent more that one procedure are omitted from Figure 5.

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Table 4 presents results from the Model (2), with separate regressions for non-surgery OR time, surgery time, post-operative time, and total procedure time. For each time outcome, we run separate regressions with and without facility fixed effects. Regressions without facility fixed effects give an estimate of how much faster ASCs are, on average, at performing procedures than hospitals, controlling for observed patient characteristics. Since the NSAS data do not contain physician identifiers, we are concerned that average differences in procedure time may be masked by the fact that different types of physicians operate in different types of facilities. We therefore include facility fixed effects so that our estimates are driven by differences in patient risk level rather than average differences across facilities.

Specifications without facility fixed effects suggest that ASCs are substantially faster than hospitals. Patients spend on average 25.5 percent less total time (30 minutes) in ASCs than in hospitals for outpatient procedures. Much of this appears to be driven by differences in non-surgery OR and post-operative time. Patient risk level is also a strong predictor of all time components. However, facility fixed effects account for much of the difference in non-surgery OR time; once we add in fixed effects, the difference in time between the highest and lowest risk score quartiles practically disappears for this category. Controlling for differences across facilities, total time is 6.3 percent (7 minutes) longer for third quartile patients and 5.1 percent (6 minutes) longer for fourth quartile patients relative to the healthiest quartile of patients. Surgery for a patient in the highest two risk quartiles on average takes 9.6 percent (2.9 minutes) and 13.3 percent (4 minutes) longer, respectively, than surgery on patients in the healthiest group. Patients in these groups also spend longer in post-operative care—6.3 percent (4 minutes) and 4.1 percent (3 minutes), respectively. Importantly, these results suggest that higher risk patients are more costly to physicians and facilities in terms of time. This also suggests that the different composition of patients in hospitals and ASCs, in terms of patient risk, may contribute to the time differences across outpatient settings depicted in Figure 5.

Given that ASCs and hospitals have different distributions of procedure time, we next examine whether the relationship between patient risk and time in a facility is confined to a particular part of the distribution. Since both time in surgery and in post-operative care vary with patient risk, we run these

regressions for total procedure time. Table 5 presents results from quantile regressions of risk score quartile on total time, controlling for the same covariates used in the previous model. The first gives results from OLS regressions of risk score quartile on total time, from column 4 of Table 4. We used STATA's *qreg* command to produce these estimates, which does not allow us to include probability weights or facility fixed effects. For comparability, column 2 shows results from the specification in column 1 without facility effects, and column 3 gives these results without facility effects or weights. Where we do not include facility fixed effects, we include a dummy variable indicating whether a procedure was performed in an ASC. Comparing these results to column 1, it appears that these modifications have little effect.

We find that the positive association between patient risk and total time is similar across the conditional time distribution. However, being treated in an ASC is associated with a downward shift in the time distribution, particularly at higher quantiles; that is, the time advantage for ASCs grows as we move from 10th to 90th percentile of the time distribution. While the relationship between patient health and procedure time does not appear to be confined to a particular part of the distribution, the coefficients on the ASC indicator across the distribution suggest that ASCs have the biggest time advantage in the higher conditional quantiles.

We have shown that cream skimming exists to a large extent in ASCs, controlling for physician fixed effects—very healthy patients are more than twice as likely to be treated in ASCs than the highest risk patients. In both types of outpatient settings, higher risk patients take longer in surgery and in post-operative care than very healthy patients. Holding patient risk constant, ASCs appear to be substantially faster at treating patients than hospital. Together these results suggest that treating patients in ASCs is faster and cheaper (in terms of time costs) than treating patients in hospital outpatient departments, supporting previous claims that ASCs provide services at lower costs than hospital outpatient departments (Hair, Hussy, and Wynn 2012, Haugh 2006, Government Accountability Office 2006, Office of the Inspector General 1999).

4. Do ASCs Provide Superior Care to Hospital Outpatient Departments?

We have documented that ASCs on average treat healthier patients than hospitals, but that, holding patient risk constant, they are cheaper and faster at doing so. In this section, we consider whether ASCs are also "better" than hospitals in terms of quality of patient care. Estimating quality of care outcomes in ASCs is difficult in single equation models because, as we have shown, ASCs have a different patient mix than hospital outpatient departments. Because ASCs treat healthier patients, differences in patient outcomes between ASCs and hospitals may be due to differences in underlying health rather than differences in quality of care. We address this problem by using variation in ASC use generated by changes in Medicare facility fees to estimate the effect of ASC treatment on patient outcomes by risk score group. Before doing this, we consider the relationship between facility payments and ASC market share.

4.1 Facility Payments and ASC Market Share

In addition to sicker patients being more costly to treat, ASCs and hospitals receive different facility fees. Medicare payments to outpatient facilities are set nationally and adjusted to account for geographic differences in labor costs.[19] Specifically, the facility fee consists of a labor portion that is adjusted by a local wage index, and an unadjusted non-labor portion. CMS estimates that labor costs are higher in hospitals than in ASCs, and therefore set the labor portion as 60 percent of the facility fee for hospital outpatient departments and 50 percent of the fee for ASCs (MedPAC 2003a).[20] The wage index is updated annually based on average wages in acute care hospitals in a labor market area relative to the national average hourly wage, calculated separately for individual urban areas, with one rural wage index for each state (MaCurdy et al. 2009).[21] Because Medicare calculates the wage indexes using large geographic areas, hospitals that are located in the same urban area but that face different costs may

[19] Outpatient payments are also adjusted for rural, cancer, and children's hospitals as well as extraordinarily costly services and new technologies (MedPAC 2008).
[20] Coinsurance rates also vary by outpatient facility, but did not change for hospitals during the period of our analysis.
[21] Medicare defined urban areas by Metropolitan Statistical Areas (MSAs) until 2003, and Core Based Statistical Areas (CBSAs) thereafter. In 2008, there were 374 MSAs and 3,436 CBSAs in the U.S. (Nussle 2008).

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receive the same wage index value. At the same time, hospitals that are near one another but in different urban areas would have different indices. Importantly, since facility payments are set at the federal level, adjustments are relatively coarse, and ASC and hospital payments are adjusted by the same wage index, changes in ASC and hospital payments represent a plausibly exogenous source of variation in Medicare reimbursement.

To look at this mechanism, we consider the relationship between the share of Medicare outpatient surgeries treated in an ASC and the ratio of the average ASC payment to average hospital payment. We use total facility payments from Medicare claims data to calculate the average payment for each facility type (ASC and hospital outpatient department), by Hospital Service Area (HSA) and year.[22] HSAs, or local hospital markets, are defined by assigning ZIP codes to the hospital area where the greatest proportion of their Medicare residents were hospitalized in a region. The U.S. is comprised of 3,436 HSAs. We obtained HSA-zip code crosswalks from the Dartmouth Atlas of Healthcare.[23]

To generate ratios of ASC payments to hospital payments, we first let φ_{ifpht} denote the facility fee for patient claim i, in facility type f (ASC or hospital), for procedure p, in HSA h, in year t. We denote the median payment from all claims for a particular facility type, procedure, HSA, and year as $\tilde{\varphi}_{fpht}$. To scale the payment amount for each procedure, we divide y the median ASC payment in year t by the median hospital outpatient payment in 2007, adjusted annually for inflation using the Center for Medicare and Medicaid Services' hospital market basket:

$$P_{pht} = \frac{\tilde{\varphi}_{ASC,pht}}{\tilde{\varphi}_{Hospital,ph}}$$

This measurement of the ratio of ASC payments to hospital outpatient payments therefore varies by procedure, HSA, and year. We restrict our sample to HSAs where we observe at least 10 claims in both

[22] To generate payment estimates, we use the combined revenue center payment and patient responsibility amount associated with a procedure for the Medicare outpatient plains, and the total allowed charges (which includes the line provider payment amount, deductible, and coinsurance) for ASC claims. In both cases we restrict our analysis to the first procedure listed for each claim.

[23] http://www.dartmouthatlas.org/tools/downloads.aspx

ASCs and hospitals in a particular year, allowing us to calculate the ratio of payments between the two types of facilities.

Average HSA payments by facility are shown by year and procedure for the five highest volume ASC procedures in Table 6. Instead of national payment rates, which are fixed across all localities, we use facility payments from Medicare claims that have been adjusted for local labor costs, so level and relative payments to ASCs and hospitals vary across procedure and over time. For all procedures except minor musculoskeletal procedures, payments for hospitals exceeded payments to ASCs in 2007. During the period of our study, ASC payments stayed roughly constant or decreased while hospital payments increased, and the average ratio of ASC payments to hospital outpatient payments decreased. These changes correspond to policy changes made by CMS to reduce ASC payments relative to hospital payments, discussed earlier.[24]

To illustrate changes in ASC payments relative to hospital payments over time, Figure 6 plots ASC and hospital payments by procedure for 2007 and 2009. ASC payments are presented on the horizontal axis and hospital outpatient payments are on the vertical axis. Each bubble represents the median facility payment for one of the top 5 outpatient procedures; the size of the bubble denotes the number of Medicare claims for a particular procedure. The 45-degree line denotes equal payment to ASCs and hospital outpatient departments. Like the average HSA-level payments presented in Table 6, Panel A of Figure 6 shows that in 2007, facility fees for most of the top 5 procedures were higher in hospitals than ASCs, i.e., the ratio of ASC to hospital payments was less than one. While payments to ASCs stayed roughly constant or decreased between 2007 and 2009, most payments for hospital outpatient surgeries increased; consequently, the graph for 2009 (Panel B) shows a shift in the payment ratio in favor of hospitals.

[24] The "Average ASC/Hospital Payment Ratio" value in Table 6 is the average of the HSA-level payment ratios, which is calculated by first constructing the ratio of the median ASC payment in a year to the median hospital outpatient payment in 2007, by HSA, and averaging these values across all HSAs. It is therefore not the same as the ratio of the average ASC payment and average hospital payment listed in Table 6.

Using this variation in facility fees, we examine the relative payments made to ASCs and hospitals as a possible mechanism driving ASC growth. We first consider the relationship between relative ASC/hospital payments and the share of all Medicare procedures in an HSA that were performed in an ASC. The scatterplot in Figure 7 depicts the relationship between the change in scaled ASC payments between 2007 and 2009, and ASC market share for HSAs where we observe at least 10 Medicare claims for procedures in both types of outpatient settings. Each point denotes the change in the ASC/hospital payment ratio and the change in the share of Medicare patients treated in an ASC for a particular procedure from 2007 to 2009. The figure shows that the ASC/hospital payment ratio is positively correlated with ASC market share.

We estimate this relationship more precisely with the following model:

$$ASCShare_{pht} = P_{pht}\beta_1 + \delta_p + \lambda_h + \nu_t + \varepsilon_{pht} \quad (3)$$

Here, $ASCShare_{pht}$ is the share of all patients treated in ASCs for procedure p, in HSA h, in year t. P_{pht} is the ratio of ASC to hospital payments by HSA and year in one of the top 5 procedure groups: cataract removal/lens insertion, colonoscopy, upper GI endoscopy, minor musculoskeletal procedures, or other eye procedures. As in earlier specifications, we also include procedure, HSA, and year fixed effects, and balance the data across all three of these dimensions. Therefore, only HSAs with claims for procedures in both ASCs and hospitals in all years of the data are included in our sample.[25]

Results presented in Table 7 confirm that higher ratios of ASC to hospital payments are associated with higher ASC market share, holding fixed procedure, HSA, and year. To put this in context, an annual increase of 0.1 in a payment ratio—a change that we find plausible based on estimates in Table 6—would be associated with a 0.003 increase in ASC market share. Over the period of our study, ASC-to-hospital ratios decreased. As an example, between 2007 and 2009, the payment ratio for upper GI endoscopies decreased from 0.91 to 0.76, a change of 0.15; using the estimates in Table 1.7, this change would be associated with a 0.004 percentage point *drop* in ASC market share. In our balanced panel of

[25] Because we balance panels across facility type, procedure, and year for each HSA, we lose observations as we add additional procedures with fewer annual claims. We therefore limit our sample for this analysis to the top 5 procedures.

HSAs, 44 percent of all upper GI endoscopies were performed in ASCs in 2007, so the change in the payment ratio would equate to a one percent drop in ASC market share for this procedure in two years. These results suggest that Medicare facility payments are important drivers of ASC market share and CMS policies to decrease ASC payments relative to hospital payments may have contributed to the leveling out of market growth depicted in Figure 1.

4.2 Payment Ratios and ASC Treatment

The results presented thus far indicate that physicians care for healthier patients in ASCs than in hospital outpatient departments. We have also shown that the ratio of ASC/hospital payments is positively associated with ASC market share. Building on Equation (2), we use the variation in ASC use generated by fee changes to estimate the relationship between treatment in an ASC and interactions between the average ratio of ASC to hospital payments in a patient's HSA and his or her risk score quantile.

$$ASC_i = X_i\beta + \sum_r \left(Risk_{i,r}\alpha_{1,r} + Risk_{i,r} \times P_i^{phr}\alpha_{2,r} \right) + \sum_p Proc_{ip}\delta_p + \sum_j Phys_{ij}\gamma_j + \sum_p \sum_j Proc_{ip} \times Phys_{ij}\rho_{jp} + \sum_t Year_{it}\theta_t + \varepsilon_i \quad (4)$$

In this model, P_i^{phr} denotes the payment ratio that corresponds to claim i based on procedure, HSA, and year. The coefficients $\alpha_{2,1}$, $\alpha_{2,2}$, $\alpha_{2,3}$, and $\alpha_{2,4}$ capture the change in the probability of treatment in an ASC by risk score quantile as ASC payment rates increase relative to those in hospital outpatient departments in 2007. We estimate this model by breaking patient risk scores into halves, terciles, and quartiles; this strategy enables us to determine which types of patients, based on risk score quantile, are driving changes in ASC treatment. Shares of all procedures performed in an ASC are presented, by risk score quantile, in Table 8.

Results are presented in column 1 of Table 9 using two risk groups (Panel A), three risk groups (Panel B), or four risk groups (Panel C). By increasing the number of quantiles, we show that the relationship between risk score group and likelihood of ASC treatment is driven by patients in the third and fourth risk score quartiles, though results are less precise as we increase the number of risk score groups. As in Table 2, the likelihood of treatment in an ASC decreases monotonically as patient health

decreases, across all panels. However, as ASC payments increase, riskier patients are more likely to be treated in an ASC. This is not surprising given that the share of patients treated in ASCs is much lower for sicker groups of patients than for healthier ones; for example, 83 percent of first quartile patients undergoing one of the top 5 procedures did so in ASCs compared to 42 percent of fourth quartile patients (Table 2). This group therefore has the greatest margin for change.

4.3 Location of Treatment and Patient Outcomes

The benefits of treating patients in ASCs in terms of cost efficiency would be mitigated if patient health outcomes were worse in these settings. The risk of serious complications associated with outpatient procedures is low relative to many inpatient procedures, but not trivial. For example, for screening colonoscopies, the risk of an adverse event—such as perforation of the bowel, bleeding, or reaction to anesthetic—is 2.8 per 1000 procedures (American Society of Gastrointestinal Endoscopy 2011). Stein et al. (2011) found that, among Medicare patients, the probability of serious complication for cataract surgery was 0.4 percent.

Several papers have tried to assess differences in quality of care between ASCs and hospitals (Hollingsworth et al. 2012, Fleisher et al. 2004). Since the patient mix in ASCs is on average healthier than in hospital outpatient departments, simply comparing patient outcomes across settings would likely lead to overestimations of the quality of care that ASCs provide relative to hospitals. Similarly, evidence presented earlier suggests that patients treated by physicians who work in both ASCs and hospitals are different from patients of physicians who work exclusively in one type of setting. Even after adjusting for patient risk factors, if unobserved patient characteristics are correlated both with probability of ASC treatment and outcomes, estimates of the relationship between ASC treatment and patient outcomes would be biased.

We use variation in Medicare facility fees between 2007 and 2009 as a source of exogenous variation in ASC treatment, to estimate the effect of ASC use on patient outcomes. We focus our analysis on one patient outcome: inpatient admission. Fleisher et al. (2004) compared inpatient hospital admission

for Medicare patients for 1994 through 1999 and found a 7-day inpatient admission rate following outpatient procedures of 0.84 percent in ASCs and 2.1 percent for hospital outpatient departments. Estimates of inpatient admission rates for all patients in our sample of Medicare claims are presented in Table 1. In our sample of Medicare patients, we use inpatient claims data from 2007 through 2009 to identify inpatient admissions following outpatient procedure. We calculate the time in days between an outpatient procedure and inpatient admission using the date of the outpatient procedure and the date of the first subsequent inpatient admission. Among all claims in our restricted physician sample, 1.2 percent of patients were admitted to a hospital within 7 days of outpatient surgery, and 4.7 percent were admitted within 30 days. However, this rate also varies by outpatient setting: for the full sample, 0.9 percent of claims in ASCs and 4.8 percent of claims in hospital outpatient departments resulted in an inpatient admission within 7 days of outpatient surgery. Among procedures performed by physicians who operated in both ASCs and hospitals, 1.1 percent of ASC claims and 1.4 percent of hospital outpatient claims resulted in hospital admission within 7 days.

We estimate a reduced form model to identify the effect of being treated in an ASC on inpatient admission, where the dependent variable is an indicator for whether a patient was admitted to a hospital following outpatient surgery. Since changes in ASC payment are positively related to ASC market share, we use this ratio as a source of exogenous variation in ASC treatment:

$$Admit_i = X_i\beta + \sum_r \left(Risk_{i,r}\omega_{1,r} + Risk_{i,r} \times P_i^{phi}\omega_{2,r} \right) + \sum_p Proc_{ip}\delta_p + \sum_j Phys_{ij}\gamma_j + \sum_p \sum_j Proc_{ip} \times Phys_{ij}\rho_{jp} + \sum_t Year_{it}\theta_t + \varepsilon_i \quad (5)$$

$Admit_i$ denotes whether a patient had an inpatient admission within 0, 7, 14, or 30 days of outpatient surgery.[26] The remaining variables are defined as in Equation (4), and we cluster standard errors by HSA.

The results in Table 9 (columns 2 to 4) show that when ASC payments increase, inpatient admission rates within 7, 14, and 30 days decline for the highest risk patients. We find no relationship between facility payments and same day inpatient admission. These reduced form results indicate that the

[26] Inpatient admission within zero days of outpatient surgery indicates a same day hospital admission.

decline in hospitalizations is coming from higher quality ASC care as long as Medicare fee schedule changes are exogenous to relative quality changes in ASC versus hospital care.

In conjunction with the first stage results from Equation (4), these estimates provide the local average treatment effect of ASC treatment on inpatient admission. To scale results reported in Table 9 and estimate of the effect of ASC treatment on inpatient admission, we use an instrumental variables (IV) model where we instrument the four payment ratio-by-quantile interactions for the four (endogenous) ASC-by-quantile interactions. If patients are better off when treated in ASCs, we expect the probability of inpatient admission would decrease as treatment in ASCs increases. On the other hand, if ASCs do a poorer job than hospitals of treating relatively sicker patients, we expect that patients would be more likely to get admitted to a hospital as the payment ratio increases. IV estimates of the effect of ASC treatment on inpatient admission, by quantile, are presented in Table 10. F-statistics from first stage regressions, shown in brackets, are large, alleviating concerns about weak instruments.[27] Results are large and statistically significant, and suggest that the shift of the riskiest patients to ASCs does not appear to have negative consequences for patient health in terms of inpatient admission.

Diagnostic or exploratory procedures, such as colonoscopies and upper GI endoscopies, make up a large share of outpatient surgeries. While these procedures have complications that might result in inpatient admission, discussed earlier, they also detect more serious diseases that could result in inpatient admission for reasons other than complications associated with a diagnostic outpatient procedure. To ensure that our results are not driven by inpatient admissions associated with these procedures, we estimate the IV model restricted to corrective procedures. We use descriptions of the top HCPCS codes for each procedure category to approximate the intent and scope of a procedure in order to assign procedures to one of these two categories. Among the top 5 procedures, we define corrective procedures as cataract surgery, minor musculoskeletal procedures, and other eye procedures; 78,995 (41 percent) in our sample are considered corrective.

[27] Results for all first stage regressions are shown in Table A.2.

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Descriptive statistics for the top 5 procedures broken down into exploratory and corrective categories are presented in Table 8. Exploratory procedures were more likely than corrective procedures to be performed in ASCs, especially for the middle third of risk scores (Panel B). Patients undergoing an exploratory procedure were in almost all cases more likely to be admitted to a hospital within 7, 14, or 30 days than patients undergoing a corrective procedure. IV estimates for corrective procedures are presented in Table 11. When we isolate our investigation by procedure type, the sample sizes decrease leading to less precise estimation. Still, the results indicate that the highest risk patients undergoing one of the three identified corrective procedures in an ASC are less likely to be admitted for an inpatient hospital stay within 7, 14, and 30 days of an outpatient procedure as well as on the same day as an outpatient procedure. This suggests that the positive effects of ASC treatment on inpatient admission are not driven solely by diagnoses associated with exploratory procedures that lead to inpatient admission.

5. Conclusions

In this paper, we examined cream skimming in ASCs and the quality of care in these facilities. We showed that ASCs have a healthier patient mix than hospitals, but estimates that include procedures performed by all physicians likely overstate the effect of cream skimming because physicians who refer physicians to both types of facilities have a very different patients mix from those that only refer patients to one type of facility. However, even limiting our sample to a subset of physicians who work in both ASC and hospital sectors, healthier patients are much more likely to be treated in ASCs. Using exogenous changes in the ratio of ASC facility fees to hospital outpatient facility fees for Medicare patients between 2007 and 2009, we find that changes in payments that favor ASCs induce physicians to refer increasingly risky patients to ASCs. Further, these patients have better health outcomes in terms of inpatient admission within 7, 14, and 30 days of admission.

We have documented that one way this cream skimming affects hospitals is that riskier patients are more costly to treat in terms of time spent both in surgery and recovery for an outpatient procedure. While ASCs offer cost effective treatment and superior patient outcomes for many outpatient procedures,

acute care hospitals provide a wider range of outpatient services and provide unprofitable services that may be valuable to society. Hospital administrators argue that through cream skimming in ASCs, hospitals are losing important revenue streams that subsidize less profitable procedures and patients. With less ability to cost shift across procedures, hospitals may reduce the amount of unprofitable services they provide or offer lower quality care overall in order to reduce costs. On the other hand, hospitals could increase use of profitable services that are not provided in ASCs or try to attract patients with other amenities. Both of these responses could lead to higher overall medical costs.

The findings in this paper provide insight into anticipated effects of recent changes in Medicare policies that increase hospital payments relative to ASC payments. We have shown that ASCs on average provide cheaper, faster, and better care for outpatient procedures than hospitals. Reducing payments to ASCs appears to have limited growth in the ASC market, suggesting that policymakers are subsidizing hospitals at the expense of providing cheap, high quality care in ASCs. However, one way in which ASCs may provide superior care is through specialization. Table 1 indicates that the top 5 highest volume procedures in ASCs comprise over 80 percent of all cases, whereas hospitals take on a much larger range of outpatient procedures. This may be due in part to limitations by insurance companies on what procedures are reimbursed in ASCs. In 2008, CMS began covering an additional 800 outpatient procedures in ASCs, including any surgical procedures other than those that pose a significant safety risk or generally require an overnight stay. If more procedures are offered at different types of facilities, patients will have greater flexibility over location of treatment, which could increase demand for ASCs and possibly outpatient care in general and offset the slowing rate of ASC growth discussed in Section 4. On the other hand, if ASCs start providing more services, this could also negatively impact any gains from specialization observed in previous years.

This illustrates a trade-off for health policy planners, between the superior and cheaper treatment patients receive in ASCs, and the subsidy these services provide for hospitals. While ASCs provide superior care at lower costs for a subset of outpatient services, hospitals provide a broader range of services and care for unprofitable patients. Future research should consider the effect of competition with

ASCs on hospital finances as well as the quality and scope of the care that hospitals provide. Likewise, health care policies should jointly consider the faster, cheaper, and better care provided in ASCs with the socially valued services that hospitals provide.

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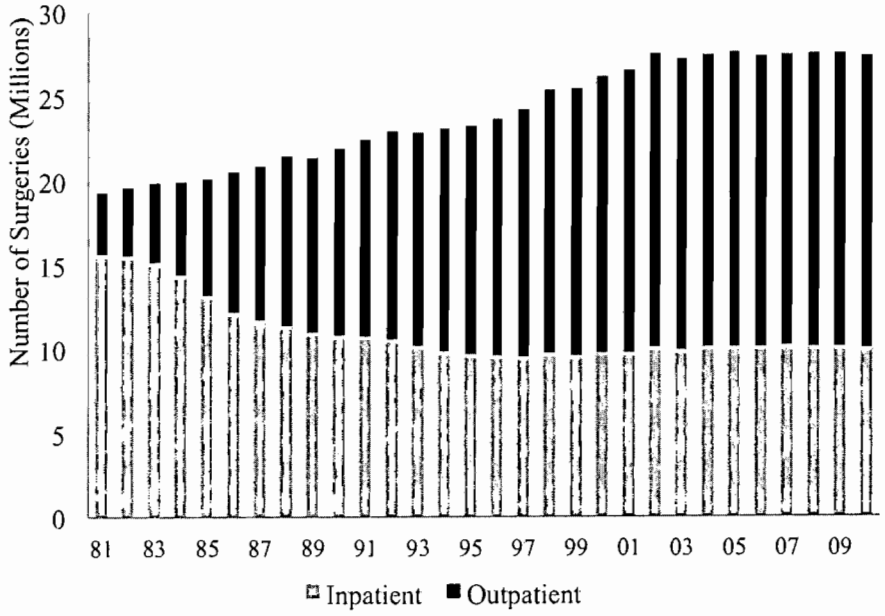
Figure 1
Inpatient and Outpatient Surgery Volume, 1981-2010



Source: American Hospital Association and Avalere Health (2007, 2011)

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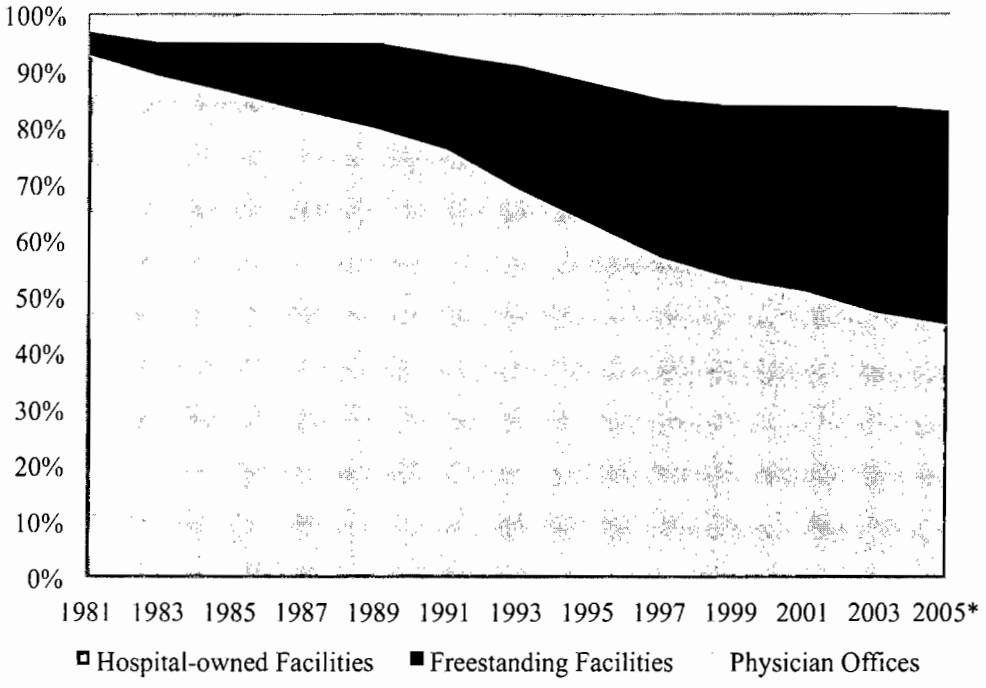
Figure 2
Percent of Outpatient Surgeries by Facility Type, 1981-2005



Source: American Hospital Association and Avalere Health (2011)

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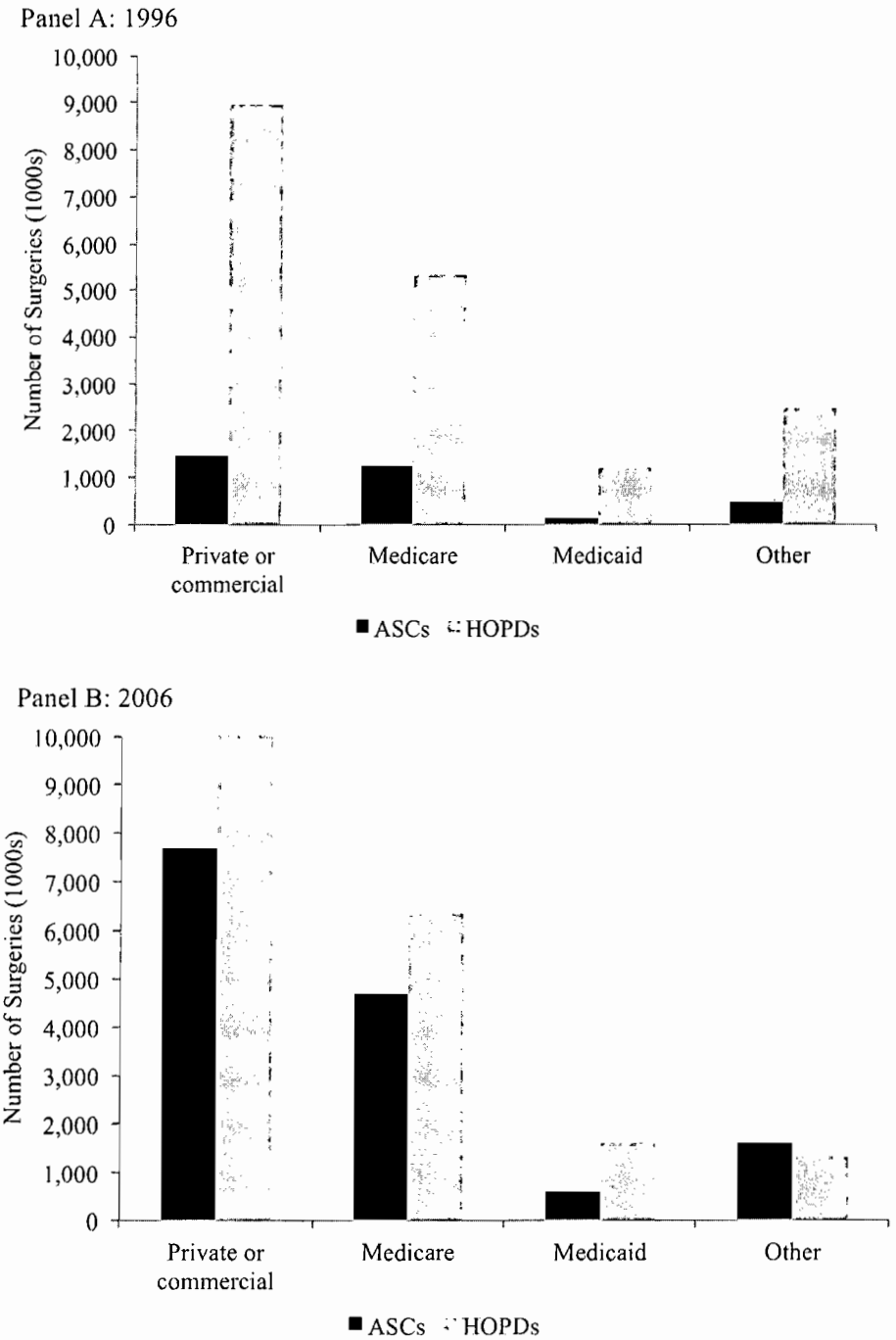
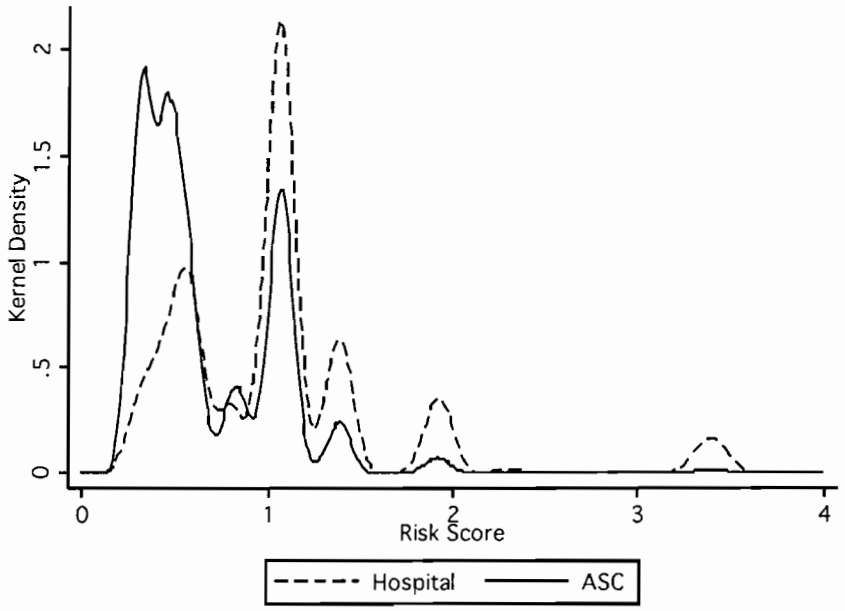
Figure 3
Outpatient Surgeries by Patient's Primary Insurance
National Survey of Ambulatory Surgery



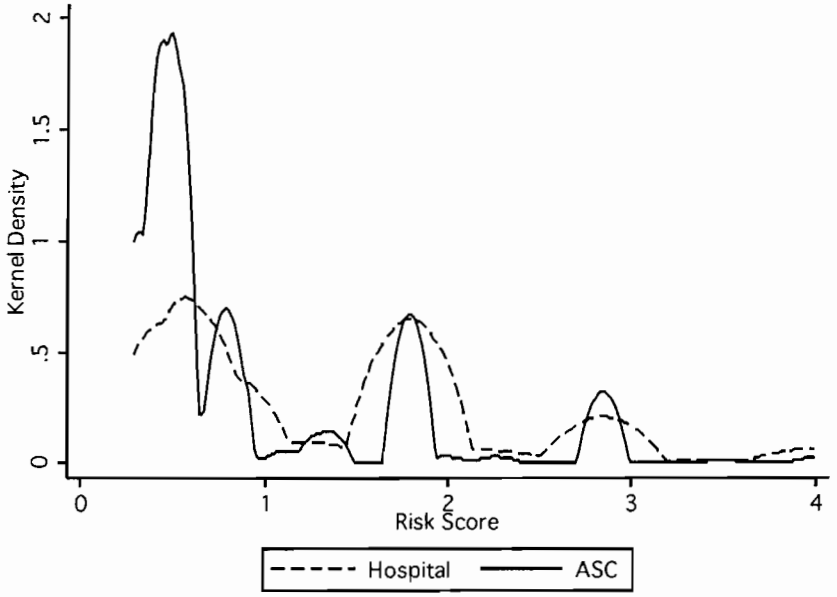
Notes: "Other insurance" includes Worker's Compensation, TRICARE, charity care, and other government insurance.

Figure 4
Patient Risk Score Kernel Density Plots by Facility Type, Medicare Patients, All Procedures

Panel A: Medicare 5 Percent Claims, 2007-2009



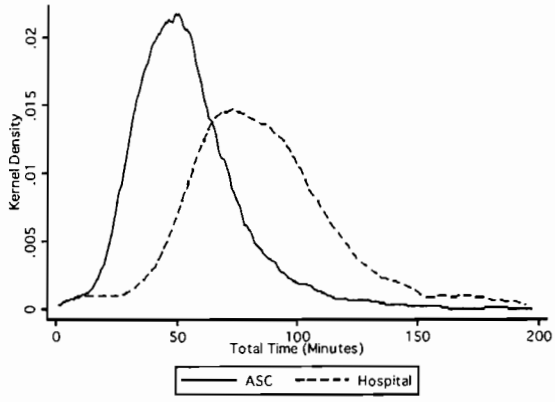
Panel B: National Survey of Ambulatory Surgery, 2006



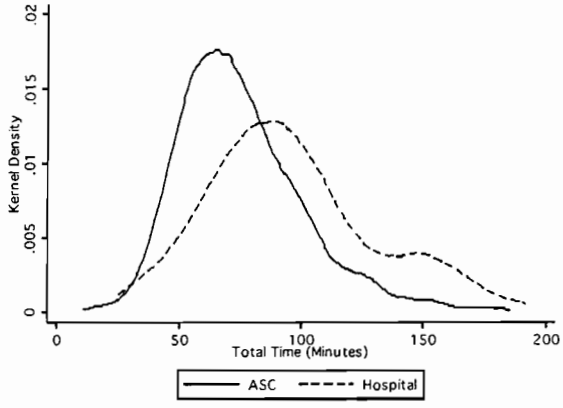
Notes: Sample size is 706,033 patient claims in Panel A, and 16,925 patient claims in Panel B. Graphs restricted to claims for patients with risk scores less than 4 (less than 1 percent of claims are from patients with risk scores greater than 4). Risk scores are based on concurrent weights calculated using the Johns Hopkins University ACG Case-Mix System (v. 10).

Figure 5
Total Time by Procedure and Facility, All Medicare Patients
2006 National Sample of Ambulatory Surgery

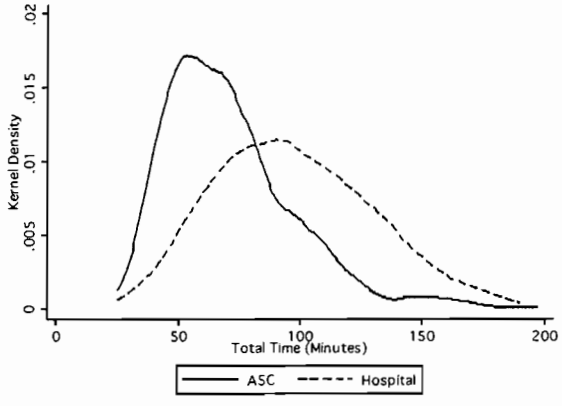
Panel A: Cataract Procedures



Panel B: Colonoscopies



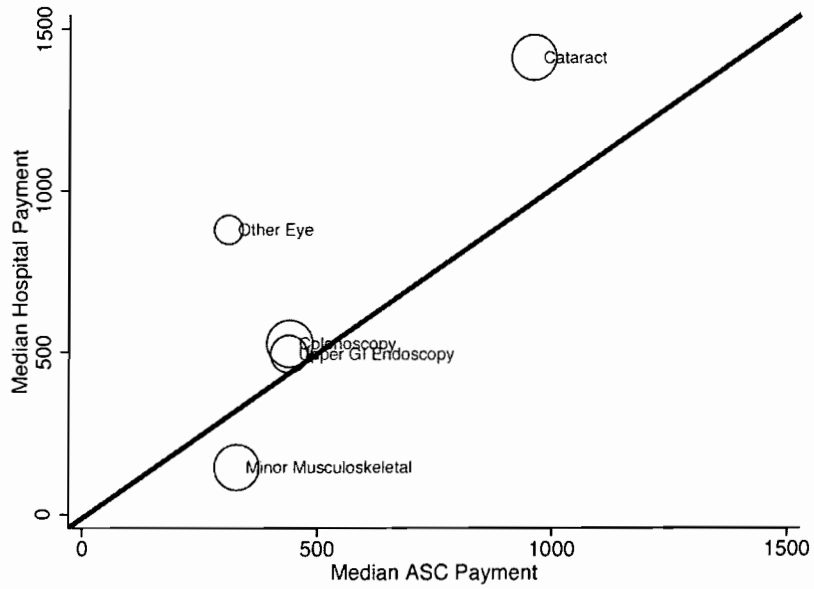
Panel C: Upper GI Endoscopies



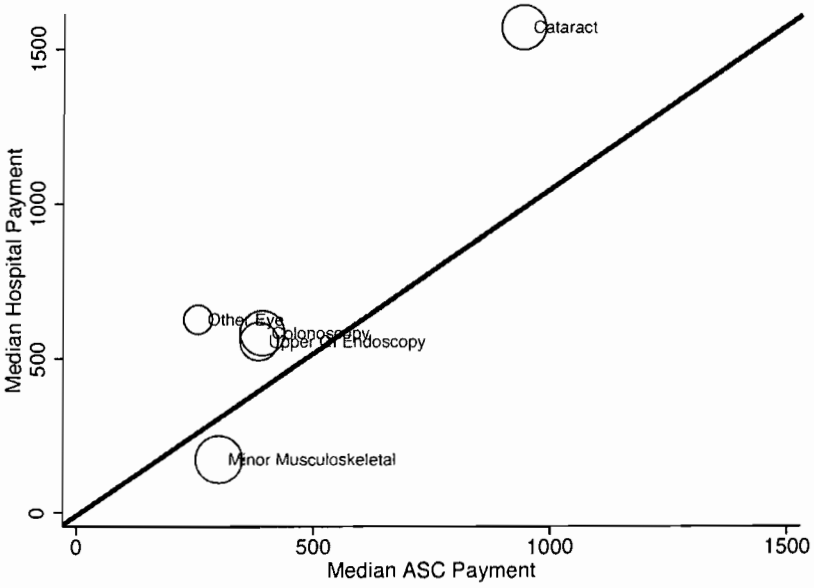
Notes: Total time includes the time in minutes between entering the operating room and leaving postoperative care, including transport or waiting time.

Figure 6
ASC and Hospital Outpatient Payments (Nominal $), by Procedure
Medicare 5 Percent Claims, 2007 & 2009

Panel A: 2007



Panel B: 2009



Notes: Bubble size represents number of Medicare claims for a particular procedure, based on HSAs where with at least 10 claims for each procedure in both ASCs and hospitals. Line is 45-degree line. Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted.

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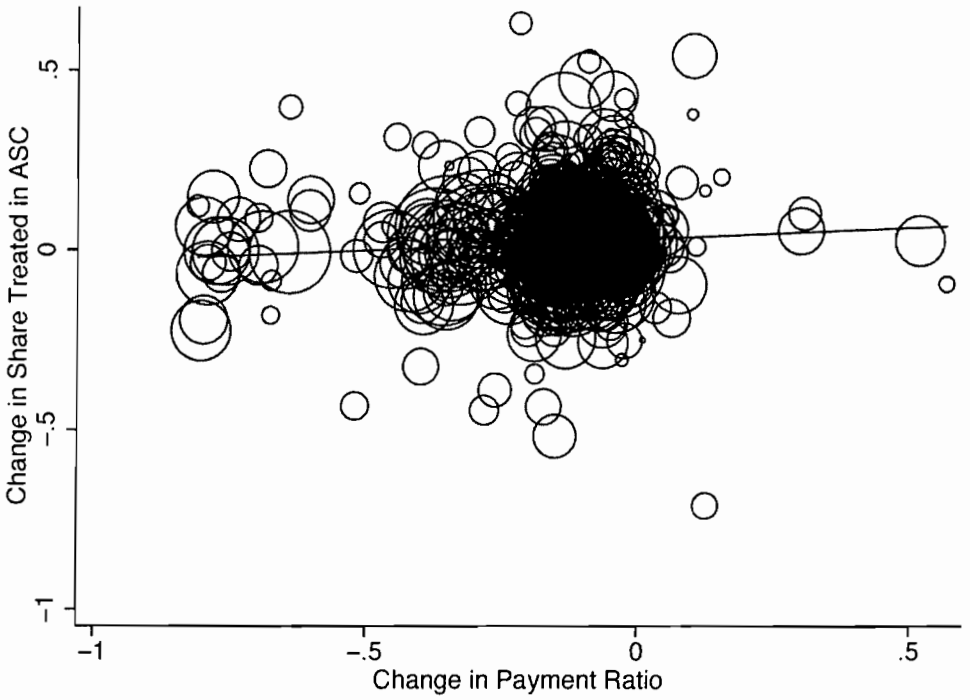
Figure 7
ASC/Hospital Payment Ratio and Share of Patients Treated in ASC, By Hospital Service Area
Top 5 Procedures, 2007 & 2009
Medicare 5% Claims



Notes: Each point represents a Hospital Service Area (HSA). Bubble size represents number of claims in an HSA in 2009. Payment ratio is calculated by dividing the median ASC payment for each year by the median hospital payment in 2007, by HSA and procedure. Change calculated as difference in payment ratio, or share of patients treated in an HSA, between 2007 and 2009. Top 5 procedures include cataract removal, colonoscopy, upper GI endoscopy, minor musculoskeletal procedures, and other eye procedures. Change calculated only for HSAs where with at least 10 claims for each procedure in both ASCs and hospitals. Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted.

Table 1
Descriptive Statistics for Outpatient Claims by Facility Type
All Procedures, Medicare 5 Percent Claims Data, 2007-2009
Means (Standard deviations)

Physician Sample:	All			Treats in Both		
Facility Type:	All	Hospitals	ASCs	All	Hospitals	ASCs
Patient Demographics						
Age	71.28	70.85	73.58	72.60	72.35	72.79
	(13.11)	(13.64)	(9.50)	(10.29)	(11.11)	(9.63)
Female	0.608	0.605	0.624	0.611	0.613	0.609
	(0.488)	(0.489)	(0.484)	(0.488)	(0.487)	(0.488)
Black	0.098	0.105	0.064	0.071	0.076	0.068
	(0.298)	(0.306)	(0.244)	(0.257)	(0.265)	(0.252)
Hispanic	0.017	0.017	0.016	0.014	0.014	0.014
	(0.129)	(0.129)	(0.126)	(0.117)	(0.118)	(0.116)
ESRD as Primary Reason for Medicare Receipt	0.029	0.033	0.008	0.013	0.020	0.008
	(0.169)	(0.179)	(0.092)	(0.114)	(0.139)	(0.091)
Disability as Primary Reason for Medicare Receipt	0.196	0.215	0.095	0.126	0.149	0.109
	(0.397)	(0.411)	(0.294)	(0.332)	(0.356)	(0.311)
Type of Procedure						
Cataract Removal	0.066	0.027	0.276	0.120	0.097	0.137
	(0.248)	(0.161)	(0.447)	(0.325)	(0.295)	(0.344)
Colonoscopy	0.070	0.043	0.214	0.252	0.153	0.326
	(0.255)	(0.203)	(0.410)	(0.434)	(0.360)	(0.469)
Upper GI Endoscopy	0.048	0.037	0.108	0.160	0.157	0.163
	(0.213)	(0.188)	(0.310)	(0.367)	(0.364)	(0.369)
Minor Musculoskeletal	0.071	0.061	0.130	0.105	0.082	0.122
	(0.258)	(0.238)	(0.337)	(0.307)	(0.274)	(0.328)
Other Eye Procedure	0.024	0.010	0.098	0.039	0.030	0.046
	(0.152)	(0.100)	(0.297)	(0.194)	(0.171)	(0.209)
Inpatient Admission After Outpatient Procedure						
0-Day	0.014	0.017	0.001	0.001	0.001	0.002
	(0.118)	(0.128)	(0.035)	(0.036)	(0.028)	(0.040)
7-Day	0.042	0.048	0.009	0.012	0.014	0.011
	(0.200)	(0.214)	(0.095)	(0.110)	(0.118)	(0.104)
14-Day	0.062	0.071	0.017	0.024	0.029	0.020
	(0.242)	(0.256)	(0.129)	(0.152)	(0.167)	(0.139)
30-Day	0.099	0.111	0.034	0.047	0.057	0.039
	(0.298)	(0.314)	(0.182)	0.211	(0.232)	(0.194)
Number of Claims	4,534,825	3,825,431	709,394	623,309	267,879	355,430

Notes: Procedures where physician identifier was missing were omitted. The physician sample "Treats in Both" indicates the sample of physicians for whom we observe patient claims in both ASCs and hospital outpatient departments.

Table 2
Probability of Treatment in ASC, Linear Probability Model with Physician Fixed Effects, by Procedure
Parameter Estimate (Standard Error) {Share Treated in ASC} [Share of Claims in Risk Score Quartile]
Medicare 5 Percent Claims Data, 2007-2009

Sample	(1) All Procedures	(2) All Procedures	(3) All Procedures	(4) Top 5 Procedures	(5) Cataract	(6) Colonoscopy	(7) Upper GI Endoscopy	(8) Minor Musculoskeletal	(9) Other Eye
Risk Score Quartile 1	*Omitted*	*Omitted*	*Omitted*	*Omitted*	*Omitted*	*Omitted*	*Omitted*	*Omitted*	*Omitted*
	{0.4078}	{0.7567}	{0.7567}	{0.8310}	{0.8506}	{0.8732}	{0.8534}	{0.7628}	{0.7690}
	[0.1769]	[0.2511]	[0.2511]	[0.2615]	[0.6649]	[0.1141]	[0.1501]	[0.2847]	[0.5194]
Risk Score Quartile 2	-0.1158***	-0.1166***	-0.0884***	-0.0857***	-0.1730***	0.0048	-0.0589***	-0.1047***	-0.0316**
	(0.0028)	(0.0046)	(0.0037)	(0.0043)	(0.0191)	(0.0033)	(0.0054)	(0.0113)	(0.0123)
	{0.1596}	{0.6692}	{0.6692}	{0.8110}	{0.6844}	{0.8726}	{0.7823}	{0.5354}	{0.7862}
	[0.2115]	[0.2500]	[0.2500]	[0.2413]	[0.0506]	[0.3663]	[0.2645]	[0.1185]	[0.2608]
Risk Score Quartile 3	-0.1704***	-0.2818***	-0.2542***	-0.2572***	-0.5891***	-0.1308***	-0.2453***	-0.0711***	-0.3347***
	(0.0041)	(0.0064)	(0.0059)	(0.0067)	(0.0143)	(0.0069)	(0.0082)	(0.0135)	(0.0195)
	{0.1119}	{0.4925}	{0.4925}	{0.5949}	{0.2171}	{0.6951}	{0.5276}	{0.7015}	{0.3396}
	[0.2675]	[0.2490]	[0.2490]	[0.2506]	[0.1591]	[0.2722]	[0.2336]	[0.3607]	[0.1180]
Risk Score Quartile 4	-0.2003***	-0.4343***	-0.3853***	-0.4131***	-0.6838***	-0.2945***	-0.4207***	-0.1758***	-0.4977***
	(0.0046)	(0.0074)	(0.0070)	(0.0077)	(0.0141)	(0.0086)	(0.0095)	(0.0188)	(0.0218)
	{0.0599}	{0.3590}	{0.3590}	{0.4230}	{0.1477}	{0.5218}	{0.3413}	{0.5592}	{0.2301}
	[0.3440]	[0.2500]	[0.2500]	[0.2467]	[0.1255]	[0.2474]	[0.3518]	[0.2360]	[0.1018]
# Observations	4,524,827	620,952	620,952	419,522	74,438	156,013	99,406	65,286	24,379
# Physicians	358,723	26,819	26,819	16,323	3,225	8,200	7,439	4,212	3,024
R^2	0.3889	0.2681	0.5988	0.4757	0.5874	0.4190	0.4392	0.5315	0.6093
Restricted Sample	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Physician FE	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Procedure FE	No	No	Yes	Yes	No	No	No	No	No
Physician x Procedure FE	No	No	Yes	Yes	No	No	No	No	No
Year FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Notes: Risk score group 1 denotes the healthiest group of patients. "Restricted sample" indicates that procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted. Controls include age <65, age 70-74, age 75-79, age 80-84, age 85+, black, female, Hispanic, and an indicator where ESRD was the only reason for Medicare eligibility. Standard errors clustered by HSA.

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Attachment 12

Table 3
Descriptive Statistics, 2006 National Survey of Ambulatory Surgery
Means (Standard Deviations)

	All Patients		Medicare Patients		Medicare - Top 10 Procedures	
	Hospitals	ASCs	Hospitals	ASCs	Hospitals	ASCs
Observations	16,673	35,560	4,633	12,354	2,323	9,850
Demographic Characteristics						
Age	51.30	53.17	70.62	71.60	71.57	72.08
	(21.70)	(20.52)	(11.83)	(10.78)	(10.61)	(9.95)
Female	0.57	0.58	0.55	0.59	0.57	0.60
	(0.49)	(0.49)	(0.50)	(0.49)	(0.50)	(0.49)
MSA Status	0.78	0.95	0.73	0.94	0.64	0.93
	(0.41)	(0.21)	(0.44)	(0.24)	(0.48)	(0.25)
Disabled	0.06	0.04	0.18	0.13	0.14	0.12
	(0.24)	(0.20)	(0.38)	(0.34)	(0.35)	(0.32)
Type of Insurance (Principal)						
Private	0.52	0.52	0.02	0.02	0.02	0.02
	(0.50)	(0.50)	(0.15)	(0.15)	(0.15)	(0.15)
Medicare	0.32	0.31	0.97	0.97	0.97	0.97
	(0.47)	(0.46)	(0.17)	(0.16)	(0.16)	(0.16)
Medicaid	0.08	0.04	0.00	0.00	0.00	0.00
	(0.27)	(0.19)	(0.05)	(0.01)	(0.05)	(0.00)
Other Insurance	0.03	0.05	0.00	0.00	0.00	0.00
	(0.17)	(0.22)	(0.03)	(0.04)	(0.00)	(0.00)
Self-Pay	0.02	0.05	0.00	0.00	0.00	0.00
	(0.16)	(0.21)	(0.01)	(0.00)	(0.00)	(0.00)
Risk Score Quartile						
Risk Score Quartile 1	0.17	0.27	0.19	0.41	0.29	0.46
	(0.37)	(0.44)	(0.39)	(0.49)	(0.45)	(0.50)
Risk Score Quartile 2	0.18	0.25	0.11	0.15	0.09	0.13
	(0.39)	(0.43)	(0.31)	(0.35)	(0.28)	(0.33)
Risk Score Quartile 3	0.29	0.28	0.21	0.22	0.20	0.20
	(0.45)	(0.45)	(0.41)	(0.41)	(0.40)	(0.40)
Risk Score Quartile 4	0.36	0.21	0.49	0.23	0.43	0.22
	(0.48)	(0.40)	(0.50)	(0.42)	(0.49)	(0.41)

Note: All estimates weighted using sample weights. "Other insurance" includes Worker's Compensation, TRICARE, charity care, and other government insurance. Disabled indicates Medicare recipient under age 65. Top 10 procedures are listed in Table A.1.

Table 4
OLS Estimates for Procedure Time, All Procedures, All Facilities
2006 National Survey of Ambulatory Surgery

Dependent Variable Ln(Minutes) Spent In:	(1) Non-Surgery OR	(2) Non-Surgery OR	(3) Surgery	(4) Surgery	(5) Post-Op	(6) Post-Op	(7) Total	(8) Total
ASC	-0.331***		-0.177***		-0.183***		-0.255***	
	(0.042)		(0.049)		(0.013)		(0.009)	
Risk Score Quartile 2	0.028	-0.002	0.009	0.027	0.007	0.023	0.010	0.017
	(0.031)	(0.029)	(0.039)	(0.030)	(0.023)	(0.022)	(0.016)	(0.015)
Risk Score Quartile 3	0.026	0.019	0.075**	0.096***	0.063***	0.063***	0.057***	0.063***
	(0.026)	(0.022)	(0.030)	(0.025)	(0.020)	(0.022)	(0.015)	(0.013)
Risk Score Quartile 4	0.066**	0.009	0.103***	0.133***	0.036*	0.041	0.051***	0.051***
	(0.033)	(0.024)	(0.034)	(0.023)	(0.020)	(0.026)	(0.014)	(0.014)
Age	0.000	0.001	0.002***	0.002***	0.001***	0.001**	0.001***	0.001***
	(0.001)	(0.000)	(0.001)	(0.001)	(0.000)	(0.001)	(0.000)	(0.000)
Female	0.004	-0.000	-0.018	-0.016	0.020	0.009	0.004	-0.000
	(0.012)	(0.011)	(0.017)	(0.016)	(0.013)	(0.012)	(0.009)	(0.008)
Disabled	0.003	0.010	0.061*	0.033	0.065**	0.037	0.063***	0.038*
	(0.031)	(0.028)	(0.032)	(0.031)	(0.033)	(0.030)	(0.024)	(0.021)
Medicare	-0.032	-0.031*	-0.035*	-0.029	-0.037*	-0.016	-0.033**	-0.022*
	(0.024)	(0.019)	(0.019)	(0.018)	(0.019)	(0.017)	(0.013)	(0.012)
Medicaid	0.032	0.029	-0.070**	-0.072***	-0.008	0.040	0.012	0.019
	(0.029)	(0.027)	(0.027)	(0.025)	(0.031)	(0.026)	(0.020)	(0.018)
TRICARE	-0.069	-0.057*	-0.035	-0.062	0.196***	0.021	0.084**	-0.013
	(0.052)	(0.030)	(0.044)	(0.061)	(0.055)	(0.045)	(0.035)	(0.033)
Worker's Comp	0.017	-0.011	0.070	0.069	0.102***	0.049	0.052**	0.030
	(0.041)	(0.029)	(0.076)	(0.044)	(0.036)	(0.031)	(0.026)	(0.024)
Other Government	0.004	-0.017	-0.074	-0.018	0.141**	0.047	0.055	0.025
	(0.050)	(0.070)	(0.069)	(0.046)	(0.056)	(0.050)	(0.037)	(0.040)
Self-Pay	0.104**	0.031	0.278***	0.236***	0.068	0.074*	0.148***	0.117***
	(0.050)	(0.030)	(0.074)	(0.053)	(0.044)	(0.043)	(0.030)	(0.029)
# Procedures	0.050***	0.062***	0.196***	0.235***	0.068***	0.076***	0.094***	0.110***
	(0.013)	(0.010)	(0.025)	(0.014)	(0.009)	(0.010)	(0.006)	(0.006)
Mean of Dependent Variable	20.83 (25.55)	20.83 (25.55)	29.47 (36.48)	29.47 (36.48)	62.96 (57.51)	62.96 (57.51)	115.87 (88.67)	115.87 (88.67)
Observations	34,467	34,467	34,467	34,467	34,467	34,467	34,467	34,467
R-squared	0.356	0.501	0.461	0.531	0.236	0.505	0.470	0.606
Procedure FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Facility FE	No	Yes	No	Yes	No	Yes	No	Yes

Notes: Data are balanced across surgery and post-operative time components. Total time includes the time in minutes between entering the operating room and leaving postoperative care, including transport or waiting time. Controls include age, female, disabled (Medicare recipients under age 65), type of insurance, and total number of procedures. All estimates weighted using sample weights. Standard errors, clustered by facility, in parentheses. *** p<0.01, ** p<0.05, * p<0.1

0105

Attachment 12

Table 5
OLS and Quantile Estimates for Total Procedure Time, All Procedures and All Facilities
2006 National Survey of Ambulatory Surgery

	OLS			Quantile				
	(1)	(2)	(3)	(4) 0.10	(5) 0.25	(6) 0.5	(7) 0.75	(8) 0.9
ASC		-0.255***	-0.253***	-0.177***	-0.213***	-0.246***	-0.283***	-0.295***
		(0.009)	(0.006)	(0.009)	(0.008)	(0.007)	(0.009)	(0.010)
Risk Score Quartile 2	0.017	0.010	0.040***	0.033**	0.035***	0.021*	0.018	0.028*
	(0.015)	(0.016)	(0.009)	(0.015)	(0.012)	(0.011)	(0.011)	(0.015)
Risk Score Quartile 3	0.063***	0.057***	0.066***	0.080***	0.070***	0.053***	0.060***	0.061***
	(0.013)	(0.015)	(0.009)	(0.013)	(0.011)	(0.011)	(0.011)	(0.012)
Risk Score Quartile 4	0.051***	0.051***	0.070***	0.082***	0.073***	0.053***	0.058***	0.068***
	(0.014)	(0.014)	(0.009)	(0.013)	(0.012)	(0.010)	(0.011)	(0.013)
Observations	34,467	34,467	34,467	34,467	34,467	34,467	34,467	34,467
R^2	0.606	0.470	0.494	0.296	0.308	0.330	0.328	0.309
Procedure FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Facility FE	Yes	No	No	No	No	No	No	No
Weights	Yes	Yes	No	No	No	No	No	No

Note: Data are balanced across time components. Total time is the time between entering the operating room and leaving postoperative care, not including transport or waiting time. All estimates weighted using sample weights. Controls include age, female, disabled (Medicare recipients under age 65), type of insurance, and total number of procedures. Bootstrapped standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1

0106

Attachment 12

Table 6
HSA Facility Payments in Nominal Dollars and Payment Ratios by Procedure, 2007-2009
Medicare 5 Percent Carrier Claims and Hospital Outpatient Data
Means (Standard Deviations)

		2007	2008	2009
Cataract Removal	Average ASC Payment	$962	$966	$960
		($87)	($73)	($76)
	Average Hospital Payment	$1,437	$1,515	$1,601
		($169)	($154)	($171)
	Average Payment Ratio	0.689	0.691	0.640
		(0.278)	(0.053)	(0.263)
	Number of HSAs	308	294	286
Colonoscopy	Average ASC Payment	$441	$419	$396
		($44)	($49)	($43)
	Average Hospital Payment	$542	$568	$604
		($57)	($55)	($84)
	Average Payment Ratio	0.821	0.796	0.688
		(0.112)	(0.082)	(0.085)
	Number of HSAs	265	253	250
Upper GI Endoscopy	Average ASC Payment	$430	$403	$385
		($61)	($66)	($52)
	Average Hospital Payment	$494	$528	$562
		($87)	($107)	($97)
	Average Payment Ratio	0.906	0.868	0.760
		(0.263)	(0.244)	(0.219)
	Number of HSAs	257	251	252
Minor Musculoskeletal Procedures	Average ASC Payment	$327	$312	$305
		($49)	($68)	($56)
	Average Hospital Payment	$221	$232	$253
		($141)	($159)	($172)
	Average Payment Ratio	2.402	2.313	2.050
		(1.669)	(1.621)	(1.531)
	Number of HSAs	247	238	242
Other Eye Procedures	Average ASC Payment	$351	$325	$318
		($116)	($131)	($162)
	Average Hospital Payment	$985	$814	$900
		($705)	($653)	($663)
	Average Payment Ratio	0.644	0.629	0.568
		(0.558)	(0.561)	(0.533)
	Number of HSAs	253	242	236

Notes: Payment ratio is calculated by dividing the median ASC payment for each year by the 2007 median hospital payment, by Hospital Service Area and procedure; the average payments are calculated over HSA-level median values, for all HSAs with at least 10 claims for each procedure in both ASCs and hospitals.

Table 7
OLS Regressions of ASC Share on Facility Payment Ratio for Top 5 Procedures by HSA
Medicare 5 Percent Claims Data, 2007-2009

Payment Ratio	0.027**
	(0.011)
Colonoscopy	-0.085***
	(0.022)
Upper GI	-0.264***
	(0.022)
Minor Musculoskeletal	-0.355***
	(0.023)
Other Eye	-0.114***
	(0.021)
Year (2008)	0.018***
	(0.004)
Year (2009)	0.024***
	(0.006)
Mean of Dependent Variable	0.549
	(0.251)
Observations	2,055
R^2	0.685
HSA Fixed Effects	Yes

Notes: Panels balanced by Hospital Service Area (HSA) across year and each of 5 procedures in terms of ASC volume. Payment ratio is calculated by dividing the median ASC payment for each year by the median hospital payment in 2007, by HSA and procedure for all HSAs with at least 10 claims for each procedure in both ASCs and hospitals. All estimates weighted by population of Medicare enrollee claims in each procedure-HSA-year cell. Standard errors, clustered by HSA, in parentheses. *** p<0.01, ** p<0.05, * p<0.1

0108

Attachment
12

Table 8
Descriptive Statistics, ASC Treatment and Hospital Inpatient Admission
Medicare 5% Claims, Top 5 Procedures, 2007-2009
Means (Standard Deviations)

	Top 5 Procedures					Exploratory Procedures					Corrective Procedures				
Dependent Variable	ASC	Inpatient Admission 0-Day	7-Day	14-Day	30-Day	ASC	Inpatient Admission 0-Day	7-Day	14-Day	30-Day	ASC	Inpatient Admission 0-Day	7-Day	14-Day	30-Day
Panel A: Risk Score Halves															
Bottom Half	0.822	0.001	0.009	0.017	0.035	0.850	0.002	0.011	0.021	0.040	0.788	0.000	0.006	0.013	0.029
	(0.383)	(0.032)	(0.095)	(0.131)	(0.184)	(0.357)	(0.039)	(0.106)	(0.143)	(0.197)	(0.409)	(0.020)	(0.080)	(0.114)	(0.169)
Top Half	0.510	0.001	0.012	0.024	0.048	0.530	0.002	0.014	0.027	0.054	0.468	0.000	0.008	0.017	0.037
	(0.500)	(0.036)	(0.110)	(0.153)	(0.215)	(0.499)	(0.041)	(0.119)	(0.163)	(0.226)	(0.499)	(0.019)	(0.088)	(0.129)	(0.189)
Panel B: Risk Score Terciles															
1st Tercile	0.813	0.001	0.008	0.015	0.031	0.834	0.001	0.010	0.019	0.035	0.800	0.000	0.006	0.013	0.029
	(0.390)	(0.028)	(0.087)	(0.122)	(0.174)	(0.372)	(0.039)	(0.099)	(0.135)	(0.185)	(0.400)	(0.019)	(0.079)	(0.113)	(0.167)
2nd Tercile	0.736	0.001	0.012	0.022	0.044	0.783	0.002	0.013	0.024	0.046	0.562	0.000	0.008	0.016	0.036
	(0.441)	(0.037)	(0.108)	(0.147)	(0.205)	(0.412)	(0.040)	(0.113)	(0.152)	(0.209)	(0.496)	(0.021)	(0.086)	(0.125)	(0.187)
3rd Tercile	0.462	0.001	0.013	0.025	0.051	0.480	0.002	0.015	0.029	0.056	0.421	0.000	0.008	0.018	0.038
	(0.499)	(0.036)	(0.112)	(0.157)	(0.219)	(0.500)	(0.041)	(0.120)	(0.167)	(0.230)	(0.494)	(0.019)	(0.089)	(0.131)	(0.191)
Panel C: Risk Score Quartiles															
1st Quartile	0.831	0.001	0.008	0.015	0.031	0.864	0.002	0.011	0.020	0.038	0.818	0.000	0.006	0.013	0.028
	(0.375)	(0.028)	(0.087)	(0.120)	(0.174)	(0.343)	(0.040)	(0.103)	(0.139)	(0.192)	(0.386)	(0.020)	(0.079)	(0.112)	(0.166)
2nd Quartile	0.811	0.001	0.011	0.020	0.040	0.844	0.002	0.012	0.021	0.041	0.656	0.000	0.007	0.015	0.034
	(0.392)	(0.036)	(0.103)	(0.141)	(0.195)	(0.363)	(0.039)	(0.107)	(0.145)	(0.198)	(0.475)	(0.018)	(0.083)	(0.123)	(0.181)
3rd Quartile	0.595	0.001	0.011	0.021	0.043	0.636	0.002	0.013	0.024	0.047	0.524	0.000	0.008	0.016	0.037
	(0.491)	(0.035)	(0.106)	(0.145)	(0.204)	(0.481)	(0.042)	(0.114)	(0.154)	(0.212)	(0.499)	(0.019)	(0.091)	(0.127)	(0.188)
4th Quartile	0.423	0.001	0.013	0.027	0.054	0.436	0.002	0.015	0.030	0.059	0.388	0.000	0.007	0.017	0.038
	(0.494)	(0.036)	(0.114)	(0.162)	(0.225)	(0.496)	(0.040)	(0.123)	(0.171)	(0.237)	(0.487)	(0.018)	(0.085)	(0.131)	(0.191)

Notes; Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted. For 7-, 14-, and 30-day inpatient admission rates, observations that occurred within 7, 14, and 30-Day of the end of the calendar year (respectively) were omitted. Exploratory procedures include colonoscopy and upper gastrointestinal endoscopy. Corrective procedures include cataract removal, minor musculoskeletal procedures, and other eye procedures.

Table 9
ASC Treatment and Hospital Inpatient Admission by Risk Score Quantile, Top 5 Procedures
Linear Probability Model with Physician-Procedure Fixed Effects
Medicare 5 Percent Claims, 2007-2009

Dependent Variable	ASC	Inpatient Admission			
		0-Day	7-Day	14-Day	30-Day
Panel A: Risk Score Halves					
Top Half	0.3447***	0.0008**	0.0042***	0.0075***	0.0145***
	(0.0129)	(0.0003)	(0.0010)	(0.0015)	(0.0022)
Bottom Half*Payment Ratio	0.0586**	0.0003	-0.0009	-0.0005	-0.0045
	(0.0288)	(0.0003)	(0.0011)	(0.0022)	(0.0038)
Top Half*Payment Ratio	0.1459***	-0.0001	-0.0025**	-0.0038*	-0.0090**
	(0.0286)	(0.0002)	(0.0010)	(0.0022)	(0.0037)
N	194,099	194,099	192,622	189,701	180,439
R^2	0.5354	0.0933	0.0914	0.0969	0.1084
Panel B: Risk Score Terciles					
Middle Third	-0.1449***	0.0004	0.0049***	0.0084***	0.0111***
	(0.0090)	(0.0004)	(0.0011)	(0.0016)	(0.0026)
Top Third	-0.4039***	0.0007*	0.0052***	0.0096***	0.0207***
	(0.0145)	(0.0004)	(0.0012)	(0.0016)	(0.0022)
Bottom Third*Payment Ratio	0.0562*	0.0003	-0.0007	-0.0004	-0.0036
	(0.0300)	(0.0003)	(0.0011)	(0.0022)	(0.0038)
Middle Third*Payment Ratio	0.1068***	0.0000	-0.0031***	-0.0053**	-0.0081*
	(0.0305)	(0.0002)	(0.0012)	(0.0024)	(0.0046)
Top Third*Payment Ratio	0.1505***	-0.0001	-0.0026**	-0.0039*	-0.0097***
	(0.0291)	(0.0002)	(0.0011)	(0.0023)	(0.0037)
N	194,099	194,099	192,622	189,701	180,439
R^2	0.5344	0.0933	0.0914	0.0970	0.1085
Panel C: Risk Score Quartiles					
2nd Quartile	-0.0828***	-0.0005	0.0006	0.0007	0.0024
	(0.0087)	(0.0005)	(0.0015)	(0.0022)	(0.0029)
3rd Quartile	-0.3229***	0.0005	0.0034**	0.0060***	0.0092***
	(0.0141)	(0.0003)	(0.0014)	(0.0019)	(0.0029)
4th Quartile	-0.4734***	0.0005	0.0061***	0.0107***	0.0238***
	(0.0164)	(0.0004)	(0.0015)	(0.0022)	(0.0030)
1st Quartile*Payment Ratio	0.0503*	0.0003	-0.0004	-0.0005	-0.0037
	(0.0300)	(0.0002)	(0.0012)	(0.0023)	(0.0039)
2nd Quartile*Payment Ratio	0.0620**	0.0005	-0.0007	0.0002	-0.0042
	(0.0289)	(0.0006)	(0.0013)	(0.0025)	(0.0042)
3rd Quartile*Payment Ratio	0.1383***	0.0000	-0.0012	-0.0030	-0.0065
	(0.0297)	(0.0002)	(0.0012)	(0.0025)	(0.0041)
4th Quartile*Payment Ratio	0.1543***	-0.0001	-0.0038***	-0.0046*	-0.0114***
	(0.0287)	(0.0002)	(0.0011)	(0.0023)	(0.0039)
N	194,099	194,099	192,622	189,701	180,439
R^2	0.5442	0.0933	0.0914	0.0970	0.1086

Notes: Controls include age <65, age 70-74, age 75-79, age 80-84, age 85+, black, female, Hispanic, and ESRD as the only reason for Medicare eligibility, as well year and physician-procedure fixed effects. Payment ratio is calculated by dividing the median ASC payment for each year by the median hospital payment in 2007, by Hospital Service Area (HSA) and procedure for all HSAs with at least 10 claims for each procedure in both ASCs and hospitals. Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted. For regressions with 7-, 14-, and 30-day inpatient admission as the dependent variable, observations that occurred within 7, 14, and 30-Day of the end of the calendar year (respectively) were omitted. Standard errors, clustered by HSA, in parentheses.

Table 10
Two-Stage Least Squares Estimates of the Effect of ASC Treatment on Inpatient Hospital Admission
By Risk Square Quantile, Top 5 Procedures
Linear Probability Model with Physician-Procedure Fixed Effects
Medicare 5 Percent Claims, 2007-2009
(Standard Error)[First Stage F-Statistic]

	Inpatient Admission			
Dependent Variable	0-Day	7-Day	14-Day	30-Day
Panel A: Risk Score Halves				
Bottom Half*ASC	0.0062	-0.0170	0.0002	-0.0787
	(0.0055)	(0.0188)	(0.0393)	(0.0649)
	[70.83]	[71.62]	[72.74]	[71.00]
Top Half*ASC	-0.0031*	-0.0179***	-0.0320***	-0.0552***
	(0.0018)	(0.0056)	(0.0109)	(0.0193)
	[1435.49]	[1435.29]	[1391.95]	[1329.67]
Observations	192,421	190,956	188,058	178,868
R-squared	0.0850	0.0838	0.0879	0.0994
Panel B: Risk Score Terciles				
Bottom Tercile*ASC	0.0082	-0.0086	0.0169	-0.0633
	(0.0071)	(0.0224)	(0.0457)	(0.0754)
	[35.45]	[35.73]	[36.00]	[36.08]
Middle Tercile*ASC	-0.0040	-0.0482***	-0.0914***	-0.0909*
	(0.0044)	(0.0126)	(0.0231)	(0.0505)
	[209.07]	[206.10]	[197.14]	[186.77]
Top Tercile *ASC	-0.0031*	-0.0191***	-0.0318***	-0.0635***
	(0.0017)	(0.0063)	(0.0116)	(0.0174)
	[830.23]	[828.78]	[810.67]	[780.23]
Observations	192,421	190,956	188,058	178,868
R-squared	0.0850	0.0839	0.0880	0.0996
Panel C: Risk Score Quartiles				
1st Quartile*ASC	0.0160	-0.0119	0.0386	-0.0726
	(0.0174)	(0.0347)	(0.0640)	(0.1038)
	[53.04]	[52.91]	[51.78]	[50.18]
2nd Quartile*ASC	-0.0149	-0.0088	-0.0789	-0.0674
	(0.0235)	(0.0558)	(0.0981)	(0.1416)
	[33.24]	[32.88]	[31.57]	[29.61]
3rd Quartile*ASC	-0.0010	-0.0079	-0.0225	-0.0365
	(0.0015)	(0.0082)	(0.0152)	(0.0273)
	[691.82]	[695.68]	[673.06]	[638.96]
4th Quartile*ASC	-0.0034**	-0.0316***	-0.0359***	-0.0757***
	(0.0015)	(0.0077)	(0.0126)	(0.0194)
	[349.09]	[350.67]	[348.03]	[344.21]
Observations	192,421	190,956	188,058	178,868
R-squared	0.0850	0.0839	0.0880	0.0997

Notes: Controls include age <65, age 70-74, age 75-79, age 80-84, age 85+, black, female, Hispanic, ESRD as the only reason for Medicare eligibility, and quantile dummy variables, as well year and physician-procedure fixed effects. Payment ratio is calculated by dividing the median ASC payment for each year by the median hospital payment in 2007, by Hospital Service Area (HSA) and procedure for all HSAs with at least 10 claims for each procedure in both ASCs and hospitals. Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted. For regressions with 7-, 14-, and 30-day inpatient admission as the dependent variable, observations that occurred within 7, 14, and 30-Day of the end of the calendar year (respectively) were omitted. Standard errors, clustered by HSA, in parentheses.

Table 11
Two-Stage Least Squares Estimates of the Effect of ASC Treatment on Inpatient Hospital Admission
By Risk Square Quantile, Corrective Procedures
Linear Probability Model with Physician-Procedure Fixed Effects
Medicare 5 Percent Claims, 2007-2009
(Standard Error)[First Stage F-Statistic]

	Inpatient Admission			
Dependent Variable	0-Day	7-Day	14-Day	30-Day
Panel A: Risk Score Halves				
Bottom Half*ASC	0.0038	-0.0174	-0.0104	-0.1038*
	(0.0042)	(0.0170)	(0.0366)	(0.0617)
	[146.48]	[146.33]	[147.07]	[145.56]
Top Half*ASC	-0.0008	-0.0092*	-0.0173*	-0.0356**
	(0.0009)	(0.0047)	(0.0095)	(0.0169)
	[2637.45]	[2624.33]	[2553.93]	[2439.41]
Observations	77,673	77,099	75,873	72,081
R-squared	0.0925	0.0773	0.0827	0.0959
Panel B: Risk Score Terciles				
Bottom Tercile*ASC	0.0041	-0.0176	-0.0145	-0.1123
	(0.0048)	(0.0194)	(0.0408)	(0.0702)
	[91.08]	[90.49]	[90.33]	[91.73]
Middle Tercile*ASC	-0.0020	-0.0184***	-0.0414***	-0.0470
	(0.0016)	(0.0069)	(0.0137)	(0.0293)
	[686.31]	[678.08]	[654.96]	[621.41]
Top Tercile *ASC	-0.0007	-0.0101*	-0.0148	-0.0354**
	(0.0009)	(0.0054)	(0.0101)	(0.0159)
	[1295.73]	[1289.37]	[1263.90]	[1217.61]
Observations	77,673	77,099	75,873	72,081
R-squared	0.0925	0.0774	0.0828	0.0960
Panel C: Risk Score Quartiles				
1st Quartile*ASC	-0.0032	-0.0107	-0.0429	-0.1264
	(0.0091)	(0.0350)	(0.0619)	(0.0885)
	[70.65]	[70.10]	[69.32]	[69.29]
2nd Quartile*ASC	0.0219	-0.0218	0.0722	-0.0354
	(0.0342)	(0.0691)	(0.1128)	(0.1571)
	[37.58]	[37.24]	[36.00]	[34.97]
3rd Quartile*ASC	-0.0001	-0.0040	-0.0160	-0.0320
	(0.0009)	(0.0068)	(0.0129)	(0.0229)
	[1040.10]	[1043.29]	[1018.00]	[967.39]
4th Quartile*ASC	-0.0007	-0.0175***	-0.0153	-0.0397**
	(0.0007)	(0.0061)	(0.0106)	(0.0181)
	[564.73]	[565.14]	[561.18]	[555.80]
Observations	77,673	77,099	75,873	72,081
R-squared	0.0925	0.0775	0.0828	0.0960

Notes: Corrective procedures include cataract removal, minor musculoskeletal, and other eye procedures. Controls include age <65, age 70-74, age 75-79, age 80-84, age 85+, black, female, Hispanic, ESRD as the only reason for Medicare eligibility, and quantile dummy variables, as well year and physician-procedure fixed effects. Payment ratio is calculated by dividing the median ASC payment for each year by the median hospital payment in 2007, by Hospital Service Area (HSA) and procedure for all HSAs with at least 10 claims for each procedure in both ASCs and hospitals. Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted. For regressions with 7-, 14-, and 30-day inpatient admission as the dependent variable, observations that occurred within 7, 14, and 30-Day of the end of the calendar year (respectively) were omitted. Standard errors, clustered by HSA, in parentheses.

Table A.I
Top 10 Procedures Based on ASC Surgical Volume
Medicare 5 Percent Claims and National Survey of Ambulatory Surgery

Medicare 5 Percent Claims (2007)		National Survey of Ambulatory Surgery (2006)	
Procedure Group	Percent of All Procedures	Procedure Group	Percent of All Procedures
Cataract Removal/Lens Insertion	26.95	Lens and Cataract Procedures	28.69
Endoscopy - Colonoscopy	22.74	Colonoscopy and Biopsy	21.86
Minor Procedures - Musculoskeletal	12.71	Upper GI Endoscopy; Biopsy	10.80
Endoscopy - Upper GI	10.45	Insertion of Catheter or Spinal Stimulator	8.21
Eye Procedure - Other	9.35	Other non-OR Lower GI Therapeutic Procedures	4.61
Ambulatory Procedures - Other	3.19	Arthroscopy	1.98
Ambulatory Procedures - Musculoskeletal	2.72	Endoscopy and Biopsy of the Urinary Tract (Cystoscopy)	1.66
Endoscopy - Cystoscopy	2.62	Other Therapeutic Procedures on Eyelids	1.52
Endoscopy - Arthroscopy	1.88	Other Therapeutic Procedures on Muscles	1.32
Ambulatory Procedures - Skin	1.82	Excision of Skin Lesion	1.23

Notes: Medicare procedures coded using the Healthcare Common Procedure Coding System (HCPC) and grouped by Berenson-Eggers Type of Service (BETOS) Codes. NSAS procedures are coded by ICD-9 procedure codes and grouped using Clinical Classifications Software from the Healthcare Cost and Utilization Project.

0113

Attachment 12

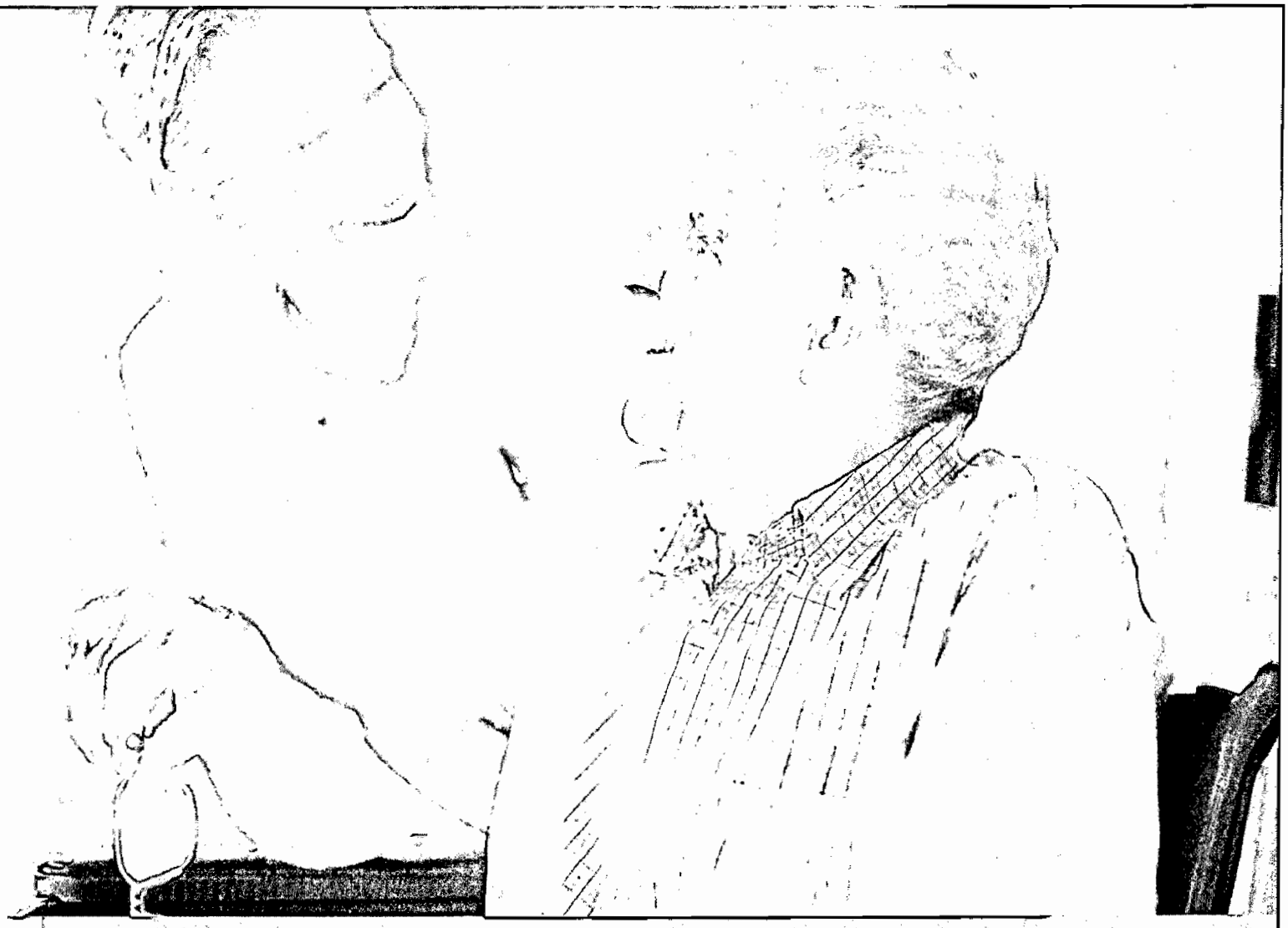
Table A.2
First Stage Estimates of Effect of ASC Payments on ASC Treatment by Risk Score Quantile, Top 5 Procedures
Linear Probability Model with Physician-Procedure Fixed Effects
Medicare 5 Percent Claims, 2007-2009

Dependent Variable	Bottom Half* ASC	Top Half* ASC	Bottom Tercile* ASC	Middle Tercile* ASC	Top Tercile* ASC	1st Quartile* ASC	2nd Quartile* ASC	3rd Quartile* ASC	4th Quartile* ASC
Bottom Half *Payment Ratio	0.1070***	0.0451***							
	(0.0172)	(0.0158)							
Top Half *Payment Ratio	0.0072	0.0572***							
	(0.0170)	(0.0166)							
Bottom Tercile*Payment Ratio			0.0485***	0.0110	0.0029				
			(0.0171)	(0.0093)	(0.0122)				
Middle Tercile*Payment Ratio			0.0390**	0.0607***	0.0143				
			(0.0167)	(0.0107)	(0.0128)				
Top Tercile*Payment Ratio			0.0380**	0.0084	0.1103***				
			(0.0157)	(0.0091)	(0.0129)				
1st Quartile*Payment Ratio						0.0373**	0.0226***	-0.0043	0.0008
						(0.0170)	(0.0058)	(0.0117)	(0.0096)
2nd Quartile*Payment Ratio						0.0407***	0.0045	0.0121	0.0108
						(0.0157)	(0.0108)	(0.0111)	(0.0099)
3rd Quartile*Payment Ratio						0.0251	0.0170***	0.0958***	0.0073
						(0.0157)	(0.0057)	(0.0121)	(0.0099)
4th Quartile*Payment Ratio						0.0310**	0.0174***	0.0070	0.1048***
						(0.0149)	(0.0057)	(0.0115)	(0.0114)
F-Statistic	70.83	1435.49	35.45	209.07	830.23	53.04	33.24	691.82	349.09
Observations	192,421	192,421	192,421	192,421	192,421	192,421	192,421	192,421	192,421
R-squared	0.6094	0.8179	0.8483	0.7620	0.5753	0.8747	0.8317	0.6710	0.5443

Notes: Controls include age <65, age 70-74, age 75-79, age 80-84, age 85+, black, female, Hispanic, ESRD as the only reason for Medicare eligibility, and quantile dummy variables, as well year and physician-procedure fixed effects. Payment ratio is calculated by dividing the median ASC payment for each year by the median hospital payment in 2007, by Hospital Service Area (HSA) and procedure for all HSAs with at least 10 claims for each procedure in both ASCs and hospitals. Procedures performed by physicians who only treated patients in one type of facility (ASC or hospital) were omitted. For regressions with 7-, 14-, and 30-day inpatient admission as the dependent variable, observations that occurred within 7, 14, and 30-Day of the end of the calendar year (respectively) were omitted. Standard errors, clustered by HSA, in parentheses.

0114

Attachment 12



Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

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EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

I. AN INTRODUCTION TO AMBULATORY SURGERY CENTERS

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

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

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

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

What is an ASC?

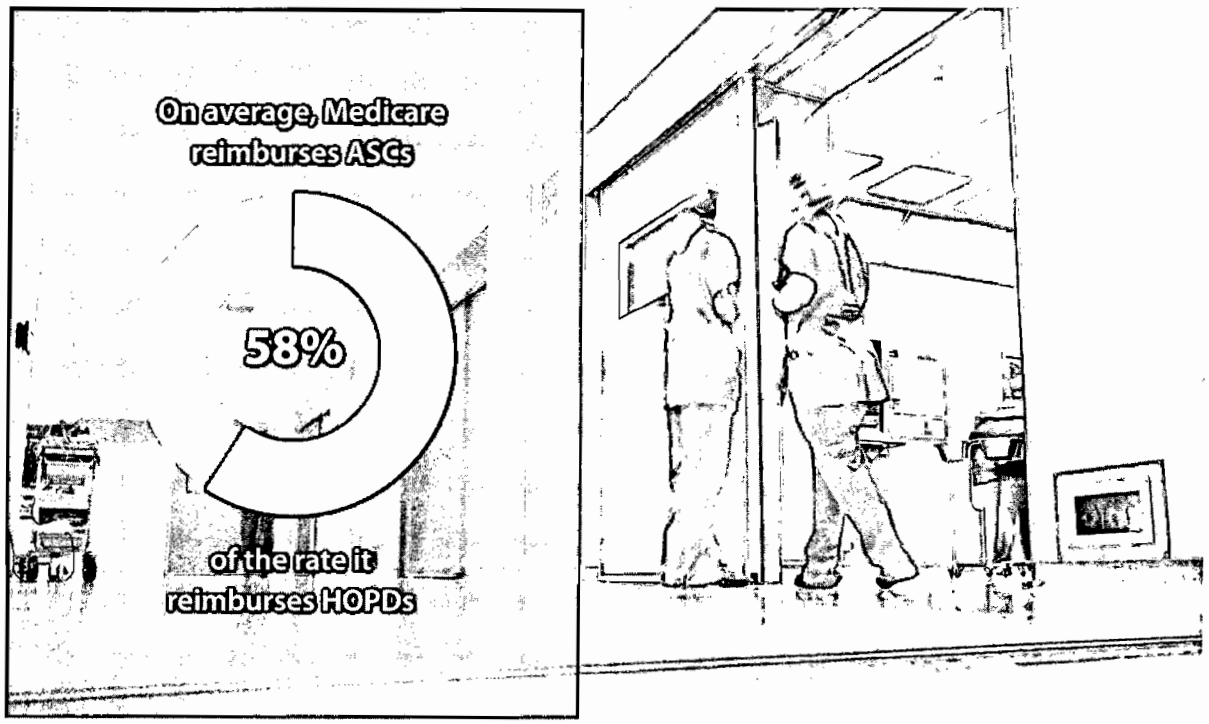
Ambulatory Surgery Centers are modern health care facilities focused on providing a range of same-day surgical care, the same types of procedures that were once performed exclusively in hospitals. Today, as a result of medical advancements and new technologies—including minimally invasive surgical techniques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

II. ASCS: SAVING THE SYSTEM

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

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

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



III. COST SAVINGS ANALYSIS

Data and Methodology

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

Government data was used to ascertain the volume of procedures performed in ASCs, HOPDs and physician offices from 2008 through 2011, as well as the reimbursement rates for procedures done at ASCs and HOPDs. The volume data reports are from the Medicare Physician Supplier Procedure Specific file available from CMS. It excludes Medicare Advantage enrollees. The ASC reimbursement rates are from the ASC Addendum AA[1], and the HOPD reimbursement rates are from Hospital Outpatient Prospective Payment System Addendum.[2]

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

To ensure a realistic baseline for their analysis and predictions, the analysts limited the data set to the 120 procedures most commonly performed at ASCs in 2011, which represented 73 percent of the total volume of all procedures performed in ASCs in 2011.[4]

Past Savings

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

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

1 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
2 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html
3 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf (p.51).
4 The data set was initially narrowed to 148 procedures, which represented about 90% of the total volume. Twenty-seven procedures were dropped because of missing data on the number of procedures or reimbursement rates. One additional procedure was dropped the ASC share was 100%, and it thus provided no basis for comparison with HOPDs.

These findings are illustrated in the following chart.

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

Notes:

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

**Savings are reported in nominal dollars.

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

Future Savings

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

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

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

1. The ASC share of each procedure in 2011 will remain constant between 2013 and 2022. *This is a baseline assumption that assumes ASC share does not grow at all in the coming decade.*

2. The ASC share of each procedure will increase by 2 percent per year from 2013 through 2022, equivalent to the average increase across procedures from 2008 through 2011.[6] The analysts capped the share for any given procedure at 90 percent to avoid implausible assumptions.

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

   - The "low" group included procedures that had negative or no growth in the share of procedures performed at ASCs during 2008–2011. The analysts assumed that the ASC share of these procedures will increase 1 percent annually from 2013–2022. This group included approximately 30 percent of the procedures.

   - The "middle" group included procedures that had up to 5 percent growth in share of procedures performed at ASCs during 2008–2011. It was assumed that the ASC share of these procedures will increase 5 percent annually from 2013–2022. This group included approximately 43 percent of the procedures.

   - The "high" group included procedures that had greater than 5 percent growth in share of procedures performed at ASCs during 2008–2011. This group had a median ASC share growth rate of about 11 percent annually during 2008–2011. The analysts projected that the ASC share of these procedures will increase 10 percent annually from 2013–2022. This group included approximately 27 percent of the procedures.

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

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

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

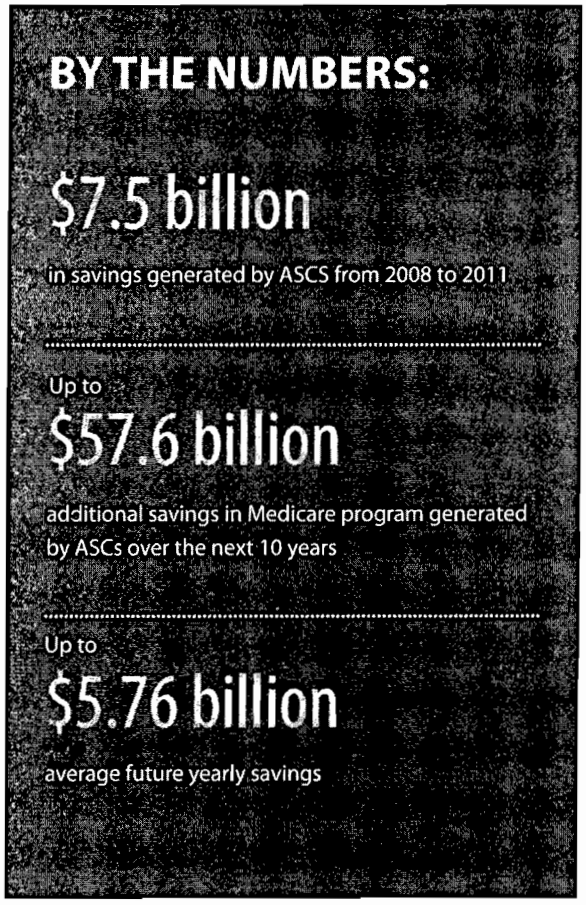
Projected Savings ($Billion)	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2018-2022	2013-2022
A: Volume of Procedures per 1,000 Medicare Beneficiaries Remains Constant and:													
A1. ASC share remains constant	$2.3	$2.5	$2.8	$3.0	$3.2	$3.3	$3.5	$3.7	$4.0	$4.2	$13.7	$18.7	$32.5
A2.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

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

Conclusions

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

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



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

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

IV. POLICY IMPLICATIONS AND CONSIDERATIONS

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

AVOIDING ASC TO HOPD CONVERSIONS

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

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

When an ASC is acquired by a hospital, in what is known as "an ASC to HOPD conversion," the Medicare reimbursement rate jumps roughly 75 percent and all savings to the Medicare program and its beneficiaries are promptly lost. The continuing reduction in reimbursement led more than 60 ASCs to terminate their participation in Medicare over the last three years. If policymakers allow this gap in reimbursements to continue widening, the cost-saving advantage that ASCs offer could morph into a perverse market incentive that drives ASCs from the Medicare program.

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

ASCS AS PART OF BROADER COST-SAVINGS EFFORTS

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

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

APPENDIX: METHODOLOGY AND CHART OF INDIVIDUAL PROCEDURE SAVINGS

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

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

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

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

No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)[2]	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
1	66984	Cataract surg w/iol 1 stage	$829	-3.56%	56%	69%	62%	54.9	76.0	$1,500	$1,870	$1,670	$2,370	$2,950	$2,650	1%	$740
2	66982	Cataract surgery complex	$63	-0.96%	52%	65%	59%	4.4	6.1	$116	$144	$129	$180	$224	$201	1%	$740
3	64483	Inj foramen epidural l/s	$60	-3.02%	35%	44%	39%	20.6	28.5	$106	$132	$119	$173	$215	$193	1%	$229
4	62311	Inject spine l/s (cd)	$53	-13.67%	26%	33%	29%	24.1	33.4	$73	$91	$82	$152	$188	$169	1%	$229
5	66821	After cataract laser surgery	$43	-2.96%	43%	54%	48%	16.2	22.4	$86	$107	$96	$124	$154	$138	1%	$169
6	29881	Knee arthroscopy/surgery	$25	-0.25%	39%	48%	43%	2.0	2.7	$51	$64	$57	$71	$89	$79	1%	$903
7	28285	Repair of hammertoe	$22	-0.22%	37%	46%	41%	2.4	3.3	$38	$47	$43	$64	$79	$71	1%	$681
8	43235	Uppr gi endoscopy diagnosis	$21	-0.18%	34%	43%	38%	6.1	8.5	$38	$47	$42	$59	$73	$66	1%	$268
9	64622	Destr paravertebrl nerve l/s	$18	-4.98%	35%	44%	40%	3.6	5.0	$28	$34	$31	$52	$64	$58	1%	$386
10	52000	Cystoscopy	$16	-0.03%	8%	10%	9%	24.4	33.8	$33	$41	$37	$47	$58	$52	1%	$224
11	62310	Inject spine c/t	$14	-13.54%	30%	37%	33%	5.5	7.6	$18	$23	$20	$39	$49	$44	1%	$229
12	29848	Wrist endoscopy/surgery	$11	-0.10%	51%	63%	57%	0.7	0.9	$20	$25	$23	$32	$40	$36	1%	$903
13	29823	Shoulder arthroscopy/surgery	$10	-2.73%	28%	35%	31%	0.7	0.9	$14	$17	$16	$29	$36	$32	1%	$1,460
14	63650	Implant neuroelectrodes	$9	-20.87%	24%	29%	26%	1.2	1.7	$10	$12	$11	$26	$32	$29	1%	$846
15	20680	Removal of support implant	$7	-1.14%	26%	32%	29%	1.1	1.5	$14	$17	$15	$21	$27	$24	1%	$720
16	28296	Correction of bunion	$7	-0.91%	41%	50%	45%	0.5	0.7	$15	$18	$17	$20	$25	$23	1%	$1,002
17	52005	Cystoscopy & ureter catheter	$7	-0.11%	25%	31%	28%	0.9	1.3	$12	$15	$13	$19	$24	$22	1%	$794
18	45381	Colonoscopy submucous inj	$7	-4.10%	43%	54%	48%	1.5	2.0	$7	$9	$8	$19	$23	$21	1%	$281
19	36561	Insert tunneled cv cath	$6	-1.43%	7%	8%	7%	2.6	3.7	$12	$15	$13	$17	$21	$19	1%	$927
20	29875	Knee arthroscopy/surgery	$5	-1.21%	46%	57%	51%	0.3	0.4	$8	$10	$9	$14	$17	$15	1%	$903
21	30520	Repair of nasal septum	$5	-0.30%	30%	37%	34%	0.6	0.8	$8	$9	$8	$14	$17	$15	1%	$773
22	52281	Cystoscopy and treatment	$5	-0.75%	9%	11%	10%	2.7	3.7	$11	$13	$12	$14	$17	$15	1%	$530
23	58558	Hysteroscopy biopsy	$4	-2.25%	13%	17%	15%	1.1	1.5	$7	$9	$8	$10	$13	$12	1%	$696
24	65426	Removal of eye lesion	$3	-0.03%	59%	73%	66%	0.2	0.2	$5	$6	$6	$8	$10	$9	1%	$736
25	64626	Destr paravertebrl nerve c/t	$3	-7.96%	38%	48%	43%	0.8	1.2	$4	$5	$5	$8	$10	$9	1%	$229
26	14041	Skin tissue rearrangement	$3	-2.49%	13%	16%	15%	1.0	1.4	$5	$6	$6	$7	$9	$8	1%	$519
27	43251	Operative upper GI endoscopy	$2	-0.85%	35%	44%	39%	0.6	0.9	$4	$5	$4	$6	$8	$7	1%	$268
28	64627	Destr paravertebral n add-on	$2	-0.43%	39%	48%	43%	1.9	2.6	$3	$3	$3	$6	$8	$7	1%	$80
29	44361	Small bowel endoscopy/biopsy	$2	-1.36%	53%	66%	60%	0.3	0.5	$4	$5	$4	$6	$7	$6	1%	$307
30	62264	Epidural lysis on single day	$2	-17.63%	29%	36%	32%	0.4	0.5	$2	$2	$2	$5	$6	$5	1%	$386

No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			%ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
31	13132	Repair of wound or lesion	$2	-4.69%	6%	7%	6%	5.3	7.4	$2	$3	$3	$5	$6	$5	1%	$140
32	62319	Inject spine w/cath l/s (cd)	$2	-18.47%	30%	38%	34%	0.4	0.5	$2	$2	$2	$4	$6	$5	1%	$386
33	64520	N block lumbar/thoracic	$1	-13.74%	23%	29%	26%	0.6	0.8	$1	$2	$2	$3	$4	$4	1%	$229
34	64450	N block other peripheral	$1	-1.62%	1%	2%	1%	10.2	14.1	$1	$1	$1	$3	$4	$3	1%	$226
35	11042	Deb subq tissue 20 sq cm/<	$1	-14.48%	1%	1%	1%	28.9	40.0	$1	$2	$2	$2	$3	$2	1%	$82
36	20552	Inj trigger point 1/2 musc	$1	-7.74%	1%	2%	1%	8.3	11.5	$1	$1	$1	$2	$2	$2	1%	$163
37	43239	Upper gi endoscopy biopsy	$143	0.58%	45%	55%	76%	32.8	45.5	$243	$303	$416	$409	$509	$700	5%	$268
38	45380	Colonoscopy and biopsy	$107	1.11%	48%	59%	82%	21.8	30.2	$197	$245	$336	$306	$380	$523	5%	$281
39	45385	Lesion removal colonoscopy	$82	2.10%	46%	58%	79%	17.2	23.9	$162	$202	$278	$236	$293	$403	5%	$281
40	45378	Diagnostic colonoscopy	$66	0.27%	40%	49%	68%	16.2	22.4	$157	$195	$268	$190	$236	$324	5%	$281
41	29826	Shoulder arthroscopy/surgery	$38	1.27%	33%	40%	56%	2.2	3.1	$53	$66	$91	$110	$137	$188	5%	$1,460
42	G0105	Colorectal scrn; hi risk ind	$30	2.48%	52%	64%	88%	6.3	8.7	$54	$68	$93	$85	$105	$145	5%	$249
43	64721	Carpal tunnel surgery	$25	1.01%	40%	50%	68%	3.0	4.2	$50	$62	$85	$72	$90	$124	5%	$577
44	64623	Destr paravertebral n add-on	$24	4.03%	36%	44%	61%	8.1	11.2	$31	$39	$53	$69	$86	$118	5%	$229
45	G0121	Colon ca scrn not hi rsk ind	$24	2.22%	45%	56%	77%	5.8	8.0	$42	$52	$72	$68	$84	$115	5%	$249
46	29827	Arthroscop rotator cuff repr	$23	3.71%	32%	39%	54%	1.4	1.9	$44	$55	$75	$66	$82	$112	5%	$1,460
47	29880	Knee arthroscopy/surgery	$21	1.64%	41%	51%	71%	1.5	2.1	$44	$55	$76	$59	$73	$100	5%	$903
48	45384	Lesion remove colonoscopy	$19	0.93%	42%	52%	71%	4.5	6.3	$40	$49	$68	$56	$69	$95	5%	$281
49	67904	Repair eyelid defect	$17	3.55%	63%	79%	90%	1.2	1.7	$32	$40	$46	$48	$60	$69	5%	$603
50	64484	Inj foramen epidural add-on	$16	3.71%	34%	42%	58%	11.2	15.6	$23	$29	$40	$46	$58	$79	5%	$117
51	26055	Incise finger tendon sheath	$16	1.20%	44%	55%	76%	1.9	2.7	$28	$35	$49	$46	$58	$79	5%	$517
52	43248	Uppr gi endoscopy/guide wire	$14	0.86%	53%	67%	90%	2.6	3.6	$25	$31	$42	$39	$49	$66	5%	$268
53	29824	Shoulder arthroscopy/surgery	$11	0.45%	33%	42%	57%	1.0	1.4	$15	$19	$26	$32	$40	$55	5%	$903
54	49505	Prp i/hern init reduc >5 yr	$11	2.77%	15%	19%	26%	1.9	2.7	$23	$28	$39	$30	$38	$52	5%	$997
55	67917	Repair eyelid defect	$10	3.72%	60%	74%	90%	0.8	1.0	$18	$23	$27	$28	$35	$43	5%	$603
56	23412	Repair rotator cuff chronic	$10	3.46%	33%	41%	56%	0.6	0.8	$20	$25	$34	$27	$34	$47	5%	$1,426
57	14060	Skin tissue rearrangement	$9	0.50%	18%	22%	30%	2.6	3.6	$18	$22	$30	$25	$31	$43	5%	$519
58	55700	Biopsy of prostate	$8	2.92%	12%	14%	20%	5.1	7.0	$17	$21	$29	$24	$30	$42	5%	$393
59	66180	Implant eye shunt	$8	3.44%	52%	65%	89%	0.3	0.4	$16	$20	$27	$22	$27	$38	5%	$1,303
60	43450	Dilate esophagus	$8	1.82%	54%	67%	90%	1.9	2.7	$8	$11	$14	$22	$27	$36	5%	$198

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										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
61	25447	Repair wrist joint(s)	$7	1.12%	47%	58%	80%	0.4	0.5	$14	$17	$23	$21	$26	$36	5%	$1,184
62	43249	Esoph endoscopy dilation	$7	1.08%	30%	38%	52%	2.2	3.1	$12	$15	$20	$19	$24	$33	5%	$268
63	66170	Glaucoma surgery	$6	4.40%	61%	76%	90%	0.4	0.5	$13	$16	$19	$18	$23	$27	5%	$736
64	29822	Shoulder arthroscopy/surgery	$6	2.28%	36%	45%	61%	0.5	0.7	$10	$13	$17	$18	$23	$31	5%	$903
65	14040	Skin tissue rearrangement	$6	1.83%	16%	20%	27%	2.1	2.9	$13	$16	$22	$18	$23	$31	5%	$519
66	28270	Release of foot contracture	$5	3.02%	28%	35%	48%	0.8	1.1	$9	$12	$16	$15	$19	$26	5%	$681
67	15260	Skin full graft een & lips	$5	4.70%	18%	22%	31%	1.5	2.0	$10	$12	$17	$14	$18	$25	5%	$519
68	45383	Lesion removal colonoscopy	$5	1.36%	36%	45%	62%	1.3	1.8	$10	$13	$18	$14	$17	$24	5%	$281
69	66711	Ciliary endoscopic ablation	$5	1.70%	79%	90%	90%	0.3	0.4	$7	$8	$8	$14	$16	$16	5%	$539
70	67924	Repair eyelid defect	$5	3.72%	61%	76%	90%	0.3	0.5	$9	$11	$13	$13	$17	$20	5%	$603
71	52353	Cystouretero w/lithotripsy	$4	4.90%	13%	16%	21%	0.8	1.2	$8	$10	$14	$12	$15	$21	5%	$1,126
72	67028	Injection eye drug	$4	3.19%	1%	1%	2%	54.4	75.4	$6	$8	$11	$11	$14	$19	5%	$169
73	52234	Cystoscopy and treatment	$4	1.27%	19%	24%	33%	0.7	0.9	$7	$9	$13	$11	$13	$18	5%	$794
74	64718	Revise ulnar nerve at elbow	$4	3.70%	36%	45%	62%	0.5	0.7	$6	$8	$11	$11	$13	$18	5%	$577
75	28308	Incision of metatarsal	$3	1.92%	38%	48%	65%	0.4	0.5	$5	$7	$9	$10	$12	$17	5%	$681
76	26123	Release palm contracture	$3	1.37%	47%	58%	80%	0.2	0.3	$8	$10	$13	$10	$12	$17	5%	$897
77	26160	Remove tendon sheath lesion	$3	0.77%	44%	55%	75%	0.4	0.6	$6	$8	$11	$10	$12	$17	5%	$517
78	67950	Revision of eyelid	$3	2.29%	64%	80%	90%	0.2	0.3	$5	$7	$7	$9	$12	$13	5%	$603
79	52224	Cystoscopy and treatment	$3	4.95%	8%	11%	14%	1.3	1.9	$7	$9	$12	$9	$12	$16	5%	$794
80	52310	Cystoscopy and treatment	$3	0.06%	9%	11%	16%	1.8	2.5	$6	$8	$10	$9	$11	$15	5%	$530
81	67961	Revision of eyelid	$3	1.27%	55%	69%	90%	0.2	0.3	$5	$6	$9	$9	$11	$14	5%	$603
82	52235	Cystoscopy and treatment	$3	2.23%	14%	18%	24%	0.7	1.0	$6	$7	$10	$9	$11	$15	5%	$794
83	66986	Exchange lens prosthesis	$3	0.17%	63%	78%	90%	0.2	0.2	$5	$6	$7	$8	$10	$12	5%	$740
84	64479	Inj foramen epidural c/t	$3	0.16%	31%	38%	53%	1.1	1.5	$5	$6	$9	$8	$10	$14	5%	$229
85	66250	Follow-up surgery of eye	$2	1.83%	37%	46%	64%	0.3	0.4	$4	$5	$7	$6	$7	$10	5%	$539
86	14061	Skin tissue rearrangement	$2	1.01%	16%	19%	27%	0.7	0.9	$4	$5	$7	$6	$7	$10	5%	$519
87	17311	Mohs 1 stage h/n/hf/g	$1	3.76%	1%	2%	2%	14.8	20.5	$2	$2	$3	$3	$4	$5	5%	$162
88	13121	Repair of wound or lesion	$1	0.48%	6%	7%	10%	2.8	3.8	$1	$1	$1	$2	$2	$3	5%	$95
89	15823	Revision of upper eyelid	$41	6.61%	68%	85%	90%	2.4	3.4	$84	$105	$111	$117	$146	$155	10%	$671
90	50590	Fragmenting of kidney stone	$13	10.88%	18%	23%	52%	1.5	2.1	$25	$31	$72	$36	$45	$103	10%	$1,265

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										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
91	67042	Vit for macular hole	$13	7.78%	42%	53%	90%	0.7	0.9	$26	$32	$55	$36	$45	$77	10%	$1,234
92	52332	Cystoscopy and treatment	$10	5.10%	13%	16%	36%	2.6	3.6	$15	$18	$42	$27	$34	$78	10%	$794
93	67041	Vit for macular pucker	$9	7.36%	40%	50%	90%	0.5	0.6	$19	$24	$42	$24	$30	$54	10%	$1,234
94	65855	Laser surgery of eye	$8	10.98%	22%	28%	63%	4.0	5.6	$18	$23	$52	$24	$30	$68	10%	$257
95	67900	Repair brow defect	$8	7.23%	68%	85%	90%	0.4	0.6	$14	$18	$19	$24	$30	$32	10%	$801
96	31255	Removal of ethmoid sinus	$8	11.19%	39%	49%	90%	0.6	0.8	$17	$21	$38	$22	$28	$51	10%	$933
97	67036	Removal of inner eye fluid	$6	10.53%	38%	47%	90%	0.4	0.5	$13	$16	$31	$18	$23	$43	10%	$1,234
98	31267	Endoscopy maxillary sinus	$6	11.09%	37%	46%	90%	0.5	0.7	$11	$14	$26	$18	$22	$44	10%	$933
99	30140	Resect inferior turbinate	$6	16.88%	39%	48%	90%	0.5	0.7	$12	$15	$28	$16	$20	$37	10%	$773
100	67108	Repair detached retina	$6	11.99%	34%	43%	90%	0.4	0.5	$11	$14	$29	$16	$20	$42	10%	$1,234
101	47562	Laparoscopic cholecystectomy	$5	11.18%	6%	7%	16%	1.8	2.5	$11	$14	$32	$16	$19	$44	10%	$1,442
102	66761	Revision of iris	$5	5.24%	27%	34%	78%	2.2	3.1	$11	$13	$31	$15	$19	$43	10%	$237
103	67040	Laser treatment of retina	$5	8.70%	33%	41%	90%	0.3	0.4	$10	$12	$27	$13	$17	$36	10%	$1,234
104	52204	Cystoscopy w/biopsy(s)	$5	7.61%	19%	24%	55%	0.8	1.1	$9	$11	$25	$13	$16	$37	10%	$794
105	20610	Drain/inject joint/bursa	$4	18.62%	0.5%	1%	1%	153.1	212.0	$8	$10	$24	$12	$14	$33	10%	$149
106	31256	Exploration maxillary sinus	$4	8.96%	37%	46%	90%	0.3	0.4	$7	$9	$18	$12	$14	$28	10%	$933
107	31276	Sinus endoscopy surgical	$4	22.38%	33%	41%	90%	0.4	0.5	$10	$12	$27	$11	$14	$31	10%	$933
108	64640	Injection treatment of nerve	$4	75.05%	13%	16%	36%	1.8	2.4	$6	$8	$18	$10	$13	$29	10%	$437
109	67255	Reinforce/graft eye wall	$3	6.57%	50%	63%	90%	0.3	0.3	$4	$6	$8	$9	$12	$17	10%	$706
110	69436	Create eardrum opening	$3	11.68%	40%	50%	90%	0.3	0.5	$6	$8	$14	$7	$9	$17	10%	$522
111	45330	Diagnostic sigmoidoscopy	$2	15.64%	17%	21%	48%	1.3	1.7	$5	$6	$14	$7	$9	$20	10%	$324
112	68815	Probe nasolacrimal duct	$2	9.08%	51%	64%	90%	0.2	0.3	$4	$5	$6	$7	$9	$12	10%	$603
113	46221	Ligation of hemorrhoid(s)	$2	59.92%	11%	14%	33%	1.7	2.4	$4	$5	$11	$6	$8	$18	10%	$296
114	67840	Remove eyelid lesion	$2	15.10%	8%	10%	24%	1.4	2.0	$4	$4	$10	$5	$6	$15	10%	$422
115	45331	Sigmoidoscopy and biopsy	$1	5.08%	34%	43%	90%	0.7	0.9	$3	$3	$7	$4	$5	$11	10%	$175
116	67210	Treatment of retinal lesion	$1	10.61%	7%	9%	21%	2.9	4.0	$3	$4	$9	$4	$5	$11	10%	$169
117	67228	Treatment of retinal lesion	$1	11.58%	7%	9%	20%	2.3	3.2	$2	$3	$6	$3	$4	$8	10%	$169
118	11642	Exc face-mm malig+marg 1.1-2	$1	7.98%	3%	4%	10%	3.5	4.9	$2	$2	$4	$3	$4	$8	10%	$226
119	64480	Inj foramen epidural add-on	$1	17.51%	29%	36%	83%	0.8	1.0	$2	$2	$5	$3	$3	$8	10%	$117
120	51700	Irrigation of bladder	$0.5	29.91%	3%	4%	10%	4.0	5.5	$1	$1	$3	$1	$2	$4	10%	$99
		Total or Mean**	**$2,307**	**3.46%**	**32%**	**40%**	**52%**	**5.62**	**7.78**	**$4,203**	**$5,231**	**$6,013**	**$6,604**	**$8,212**	**$9,383**	**N/A**	**$589**

NOTES:

*Increases volume per 1,000 Medicare beneficiaries by 3% annually.

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

Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

Produced with cost savings analysis from

Berkeley
UNIVERSITY OF CALIFORNIA

0133

Attachment
12

Margo McDermed
State Representative • 37th District

April 27, 2016

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
535 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Letter of Support for Silver Cross Ambulatory Surgery Treatment Center

Dear Ms. Avery:

It is with my constituents' interests in mind that I express my support for Silver Cross Hospital's proposal for an Ambulatory Surgery Treatment Center on its New Lenox campus.

As a resident of Mokena, I know all too well what Silver Cross Hospital means to our community. Citizens in my district which include all or parts of New Lenox, Mokena, Tinley Park, Frankfort, Homer Glen, Joliet, Lockport and Orland Park have access to the highest quality surgical care at nearby Silver Cross Hospital. This project will make sure that same care is possible in a more appropriate, convenient, and cost-effective location.

I fully support Silver Cross' proposed Ambulatory Surgery Treatment Center and urge you to approve this project.

Sincerely,

Margo McDermed
State Representative
37th Legislative District

District 37 Office: 11032 W. Lincoln Hwy., Frankfort, IL 60423 I 815-277-2079
Springfield Office: 204-N Stratton Office Building, Springfield, IL 62706 I 217-782-0424
Email: McDermed@ilhsgop.org I Website: www.repmcdermed.com

RECYCLED PAPER • SOYBEAN INKS

Attachment 12

VILLAGE OF NEW LENOX

1 VETERANS PARKWAY
NEW LENOX, ILLINOIS 60451

VILLAGE OFFICE	815.462.6400
FAX NUMBER	815.462.6449
COMMUNITY DEVELOPMENT FAX	815.462.6469

MAYOR
TIMOTHY BALDERMANN

ADMINISTRATOR
KURT T. CARROLL

VILLAGE CLERK
LAURA RUHL

TRUSTEES
ANNETTE BOWDEN
DAVID BUTTERFIELD
DOUGLAS E. FINNEGAN
EMILY JOHNSON
KEITH MADSEN
DAVID SMITH

April 25, 2016

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
535 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Silver Cross Ambulatory Surgery Center

Dear Ms. Avery:

As the Mayor of the Village of New Lenox, I would like to take this opportunity to express my support to Silver Cross Hospital for their proposed Ambulatory Surgery Center in New Lenox.

New Lenox is a rapidly growing community that benefits in many ways from having Silver Cross Hospital easily accessible to our residents. The hospital, aside from being the largest employer in New Lenox, has always been an active supporter and participant in a variety of community endeavors – from sponsoring our Triple Play Concert Series and Proud American Days Festival to providing their leadership to the New Lenox Safe Communities Coalition and New Lenox Chamber of Commerce to training our paramedics and first responders.

By planning to build an ambulatory surgery center across the street from their hospital campus on the north side of town is just another example of how Silver Cross continues to bring new services and treatments, enhanced expertise and safe care to improve the quality of life for our residents and their patients from surrounding communities.

We are very excited about the continued commitment and investment Silver Cross Hospital is making in New Lenox and we look forward to growing with them. We hope the Illinois Health Facilities Planning Board approves this new facility.

Sincerely,

VILLAGE OF NEW LENOX

Timothy Baldermann
Mayor

302 N. Chicago Street
Joliet, Illinois 60432

(815) 774-7480
Fax (815) 740-4600

Lawrence M. Walsh
Will County Executive

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
535 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Letter of Support for Silver Cross Ambulatory Surgery Treatment Center

Dear Ms. Avery:

I am writing on behalf of the residents of Will County to support Silver Cross Hospital's Certificate of Need application to open an Ambulatory Surgery Treatment Center at I-355 and Route 6 in New Lenox.

Silver Cross has always been an economic engine and a leading provider of healthcare in Will County. With over 2,300 employees, the hospital is the third largest employer in the county. Since opening the replacement hospital in 2012, Silver Cross has created more than 500 jobs in Will County. This project will create another 16 jobs in a low cost setting.

Will County is one of the 100 largest counties in the nation and continues to grow. Since 2010, we have seen a 10% increase in residents and added more than 60,000 single-family homes. To meet the growing demand of our 800,000+ residents, Silver Cross must also grow in size and statue.

Silver Cross Hospital has always been a forward-thinking organization and good steward of financial resources. Their outstanding reputation in the community as providing safe, quality healthcare is unprecedented. Residents have come to expect that lifesaving medical and surgical care is available close to home when they need it. In order to do this, Silver Cross must expand their surgical facilities.

For the benefit of all Will County current and future residents, I urge you to approved Silver Cross Hospital's application for an ambulatory surgery center.

Sincerely,

Lawrence M. Walsh

Lawrence M. Walsh
Will County Executive

1224 Longworth House Office Building
Washington, DC 20515
202-225-3515

2711 East New York Street, Suite 204
Aurora, IL 60502
630-585-7672

195 Springfield Avenue, Suite 102
Joliet, IL 60435
815-280-5876

COMMITTEE ON FINANCIAL SERVICES
Subcommittee on Capital Markets and Government-Sponsored Enterprises
Subcommittee on Monetary Policy and Trade

COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY
Subcommittee on Environment

BILL FOSTER
Congress of the United States
11th District, Illinois

May 4, 2016

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
535 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery,

I am writing to express my support for Silver Cross Hospital's proposal for an Ambulatory Surgery Treatment Center in New Lenox, and urge the Health Facilities and Services Review Board to approve it.

As a scientist, I know that we have made significant strides in medical research, disease treatment, and the improvement of quality of life. Medical advancements such as robotics and noninvasive surgery have changed procedures in operating rooms across the country. More patients are opting for surgery to cure their diseases and illnesses. This, in turn, creates need for more surgical facilities designed in a way that is cost-effective to further relieve the stress of financing our nation's healthcare system.

The proposed Ambulatory Surgery Treatment Center, to be located adjacent to Silver Cross Hospital, is designed to help address this need. I believe the proposal, if implemented, would have a significant positive impact for local residents, including the constituents of the 11th Congressional District.

I support the proposal for an Ambulatory Surgery Treatment Center submitted by Silver Cross Hospital and request that it receive all due consideration. If you have any questions regarding this matter, please contact Gabriel Lopez by email, at Gabriel.Lopez@mail.house.gov, or by phone at 202-225-3515.

Sincerely,

Bill Foster

Bill Foster
Member of Congress

Attachment 12

Section III
Attachment 13
Criterion 1110.230(c), Alternatives to Proposed Project

The Applicants considered five alternatives before electing to file this Application. As discussed below, the five alternatives reviewed with respect to this Project included: (1) the "do nothing" alternative; (2) expand Silver Cross Hospital's Procedural Care Unit; (3) establish a surgery center in Homer Glen on the same campus that houses the Silver Cross Free Standing Emergency Care Center; and (4) construct a stand-alone, hospital based outpatient department on the Silver Cross Hospital Campus in New Lenox; and (5) establish a separately licensed surgery center on the Silver Cross Hospital campus in New Lenox.

Alternative No. 1: Do Nothing/Maintain the Status Quo

As set forth herein, Silver Cross Hospital has eleven combined operating rooms that are used for both inpatient and outpatient surgeries. Those operating rooms are all housed in Silver Cross Hospital's Procedural Care Unit. The Procedural Care Unit had a utilization rate of 119.3% in 2014 and a utilization rate of 129.7% in 2015. 2016 is even busier, with the Procedural Care Unit on pace to hit a utilization rate of 138.5%. Most of that growth has been fueled by outpatient surgeries. In the past two years alone, Silver Cross Hospital's outpatient surgery cases have increased by more than 11% and outpatient surgery hours have grown by more than 15%. Because additional capacity is needed to meet the growing demand for surgical services at Silver Cross Hospital, the "do nothing" alternative was rejected. Cost: $0

Alternative No 2: Expand Silver Cross Hospital's Procedural Care Unit

Silver Cross Hospital also evaluated several different options for expanding its existing Procedural Care Unit. The most logical option would be to expand the Procedural Care Unit east on all levels with a new entrance on the south side of Silver Cross Hospital. This model would add approximately 33,150 square feet with the addition of two new operating rooms, two shelled operating rooms, one universal procedure room, 14 new pre/post-surgical rooms, expand SPD, add shell space on the first floor, and renovate 7,100 gsf of existing space. While this option would add the requisite number of operating rooms as outlined in the proposed Project, this Alternative was rejected because it would be too costly, would take longer to complete, and would be extremely disruptive to existing patient care and hospital operations. Cost: $29,378,313

Alternative No. 3: Establish a Surgery Center on the Existing Homer Glen Campus

Silver Cross also evaluated the feasibility of constructing a surgery center in Homer Glen, on the same campus that houses the Silver Cross Free Standing Emergency Care Center and medical offices. At first blush, this was a very appealing option. The surgery center could be located adjacent to the Silver Cross Freestanding Emergency Care Center and medical offices, which would have created a truly ambulatory site in Homer Glen. Unfortunately, the Homer Glen site is landlocked and Silver Cross would have to acquire additional parking and make other improvements to accommodate the staff and patients. In addition, the Homer Glen campus is approximately 10 miles away from the Silver Cross Hospital campus in New Lenox. So, physicians would have to travel between Silver Cross Hospital and the surgery center. Based on Silver Cross Hospital's sampling of the referring physicians, leadership and staff, it became obvious that the New Lenox location was preferred. Cost: $12,199,075

Alternative No. 4: Construct A Stand Alone, Hospital Based Outpatient Department on the Silver Cross Hospital Campus in New Lenox.

Silver Cross Hospital also explored constructing a stand-alone, hospital based outpatient department on the Silver Cross Hospital Campus in New Lenox. Under this alternative, Silver Cross Hospital would not construct and establish a separately licensed surgery center; rather, Silver Cross would just construct a stand-alone, surgical building/department on the Silver Cross Hospital Campus (the "HOPD"). The HOPD would remain under the general acute care hospital license of Silver Cross Hospital and would operate under Silver Cross Hospital's Medicare provider number. On the positive side, this option would NOT require Board approval – and would, thus, take less time. On the negative side, this option would not provide the lowest cost setting for patients. While reimbursement is higher for HOPDs, patients would have higher out-of-pocket costs. In addition, certain commercial payers are now directing physicians to perform outpatient cases in separately licensed surgery centers if clinically appropriate. For these reasons, the HOPD alternative was rejected. Cost: $10,971,735 (exactly the same cost as the proposed Surgery Center less CON consulting fees, CON attorney fees, and CON filing fees).

Alternative No 5: Establish a Surgery Center on the Silver Cross Hospital Campus

The proposed Surgery Center Project is superior to the other alternatives based on the following reasons: (1) it is less expensive to construct a freestanding surgery center as compared to expanding Silver Cross Hospital's Procedural Care Unit; (2) providing ambulatory surgical and procedural services in a dedicated freestanding surgery center is more efficient for patients and physicians than trying to accommodate those services in a mixed inpatient/outpatient setting; (3) the patient experience will be enhanced in a dedicated ambulatory care setting; (4) there will be financial benefit to patients and payers as outpatient surgical services will be lower; (5) ancillary services (e.g., labs, radiology, etc.) will be immediately accessible to the proposed Surgery Center due to its location on the Silver Cross Hospital campus; (6) physician access will be enhanced due to its proximity to Silver Cross Hospital and the numerous medical office buildings on the Silver Cross Hospital campus; (7) the Silver Cross Hospital campus has ample parking; and (8) capacity will be increased in Silver Cross Hospital's Procedural Care Unit for inpatient procedures, more complex outpatient procedures, robotic procedures and trauma cases. Cost: $11,091,426.

Alternative	Meet Surgical Demand	Patient Satisfaction	Physician Satisfaction	Access to Ancillary Services	Parking	Cost
1	No	The Silver Cross Procedural Unit is overutilized and surgical demand is increasing. At a certain point, patients are going to have to wait long for procedures.	The Silver Cross Procedural Unit is overutilized and surgical demand is increasing. At a certain point, physicians will have a difficult time scheduling surgeries.	Yes	Yes	$0
2	Yes	Disruptive to	Disruptive to	Yes	Yes	$29,378,313.

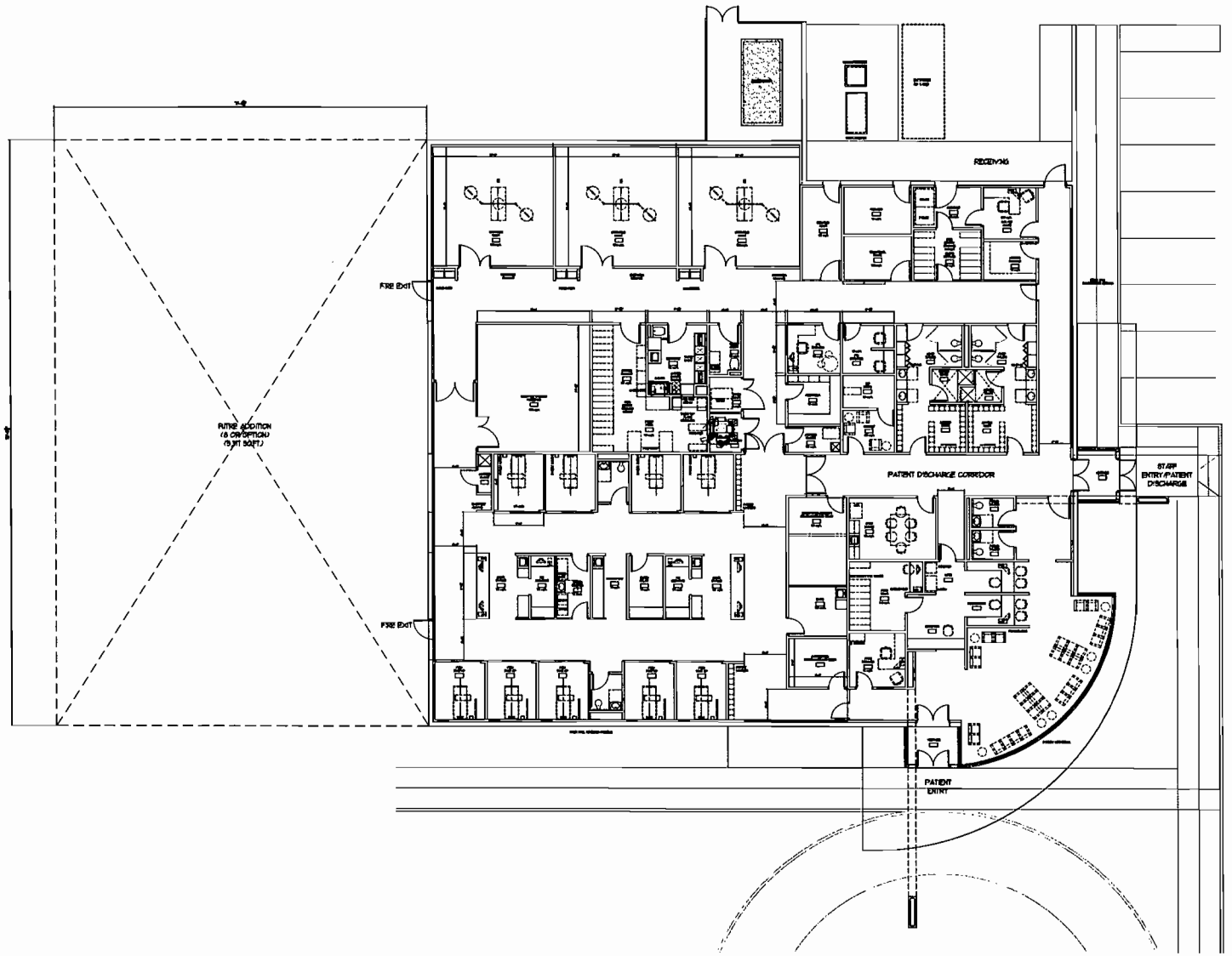
		patient care.	patient care and hospital operations.			
3	Yes	Patients prefer ambulatory settings–so patient satisfaction would be positively impacted.	Positive patient experiences, but increased travel times for physicians.	No	No	$12,199,075
4	Yes	Patients prefer ambulatory settings–so patient satisfaction would be positively impacted. Downsides include higher out-of-pocket expenses.	Certain payors are directing physicians to route cases to separately licensed surgery centers (vs. HOPDs) for cost containment reasons.	Yes	Yes	$10,971,735. The Applicants would not have to apply for a CON and could thus save time and avoid CON costs.
5	Yes	Patients prefer ambulatory settings–so patient satisfaction would be positively impacted.	Enhanced efficiency and close proximity to Silver Cross Hospital and Medical Office Buildings.	Yes	Yes	$11,091,426

Section IV
Attachment 14
Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(a), Size of Project

The proposed Surgery Center will have 3 operating rooms and 9 recovery rooms. The floor plan for the proposed Surgery Center is attached at ATTACHMENT 14. A detailed space program for the proposed Surgery Center is attached at ATTACHMENT 14.

The following chart summarizes the sizing analysis of the clinical and non-clinical portions of the proposed Surgery Center:

Sizing Analysis					
Department/Area	Rooms Proposed	Proposed BGSF	State Standard BGSF	Difference BGSF	Meets State Standard?
Freestanding ASTC	Clinical Portions	8,249	2,075 to 2,750 BGSF Per Operating Room 3*2,750 = 8,250	1 BGSF Below State Norm	Yes
	Non Clinical Portions	5,600	No Standard	N/A	N/A
Total		13,849			N/A



A ASTC PLAN OPTION - (3 PLUS)
1/8" = 1'-0"

PLAN NORTH

BGSF: 13,849 SQFT.
CLINICAL SPACE: 8,249 SQFT.
NON-CLINICAL: 5600 SQFT.
STANDARD: 3 ROOMS X 2750 = 8,250 SQFT.

Anderson Mikos Architects ltd.

One Parkview Plaza
17W110 22nd Street, Suite 200
Oakbrook Terrace, Illinois 60181
Tel. 630 - 573 - 5149
Fax 630 - 573 - 5176

SILVER CROSS HOSPITAL

1900 SILVER CROSS BLVD.
NEW LENOX, IL 60451

ASTC planning

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Revision

Date	No.	Description
4-20-16		PLAN UPDATE AREA CALCS
4-22-16		PLAN UPDATE PER KICK OFF MTG DISCUSSIONS
4-14-16		INITIAL KICK OFF MEETING
3-23-16		PRELIM. PRICING PLAN
3-10-16		PRELIM. PLANNING OPTIONS-ISSUED FOR REVIEW

Date 03-15-16 Scale AS NOTED
Drawn DK Job No. 16082.00
Checked MAM
Approved

NOT FOR CONSTRUCTION

A1-0

Silver Cross ASTC

Space Program

April 25, 2016

	Net Area	Quantity	Total Area		Clinic	Non-Clinical
Public						
Reception	116	1	116			116
Waiting	1016	1	1016			1016
Public Toilets	46	2	92			92
Vestibules	71	2	142			142
Subtotal			**1366**			
Administration						
Registration	147	1	147			147
Registration Work	93	1	93			93
Files Room	164	1	164			164
Staff Lounge	199	1	199			199
Materials Mgmt Office	100	1	100			100
Vendor Storage	74	1	74			74
Consult	80	1	80			80
Education/Classroom	187	1	187			187
Conference Room	105	1	105			105
Subtotal			**1149**			
Clinical - Sterile						
Operating Rooms	529	3	1587		1587	
Equipment Storage	529	1	529			529
Decontamination	152	1	152		152	
Prep/Pack	174	1	174		174	
Supplies	201	1	201			201
Sterilizer Room	44	1	44		44	
Anesthesia Office	95	1	95		95	
OR Managers Office	94	1	94		94	
Clean Supplies	124	1	124		124	
Soiled Linen/Trash	41	1	41		41	
Soiled Utility	58	1	58		58	
Janitors Closet	50	1	50		50	
MD Dictation	92	1	92		92	
Lockers Male	122	1	122		122	
Lockers Female	122	1	122		122	
Toilet/ Shower	187	2	374		374	
Subtotal			**3859**			
Clinical - Non-Sterile						
Prep/Recovery	105	9	945		945	
Nurse Stations	120	2	240		240	
Patient Toilet	48	2	96		96	
MD Dictation	54	2	108		108	
Soiled Utility	78	1	78		78	
Clean Utility	78	1	78		78	
Nourishment	78	1	78		78	
Janitors' Closet	50	1	50		50	
Exam Room	105	1	105		105	
PACU Managers Office	112	1	112		112	
Subtotal			**1890**			
Building Support						
Data	62	1	62			62
Medical Gases	116	1	116			116
Mechanical	108	1	108			108
Electrical	132	1	132			132
Breakout	99	1	99			99
Subtotal			**517**			
Total Net Sqft.			**8781**		**5019**	**3762**
Grossing Factor			*1.58*	*Circulation (includes fire exit)*	*3,230*	*1838*
Building Gross Square Footage			**13849**		**8249**	**5600**

Section IV
Attachment 15
Criterion 1110.234(b), Project Services Utilization

The Applicants are proposing, and can easily justify, three operating rooms at the proposed Surgery Center. A total of 2,165 surgeries (or 3,489 hours) in 2018 and 2,252 surgeries (or 3,628 hours) in 2019 have been committed to the proposed Surgery Center by physicians on the Medical Staff at Silver Cross Hospital.

Year	Projected Surgeries	Projected Surgical Hours	Number of Proposed Operating Rooms	State Utilization Standard	Meets State Norm?
2018	2,165	3,489	3	1,500 Surgical Hours Per Operating Room 3,489/1,500= 2.326 Which Rounds Up to 3	Yes
2019	2,252	3,628	3	1,500 Surgical Hours Per Operating Room 3,628/1,500= 2.418 Which Rounds Up to 3	Yes

The Applicants are proposing nine (9) recovery rooms. The state norms allow a maximum of four (4) recovery rooms per operating room. Thus, the number of proposed recovery rooms satisfies the state norms.

See Section VII, Specific Service Review Criteria, Non-Hospital Based Ambulatory Surgical Treatment Centers, Criterion 1110.1540(d)(1) & (2), Service Demand – Establishment, and Criterion 1110.1540(e)(1) & (2), Service Demand – Expansion, for additional support for this Criterion.

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(a)(5)(A) & (B), Introduction & Identification

The Applicants seek authority from the Board to establish a multi-specialty ambulatory surgical treatment center (the "Surgery Center") on the Silver Cross Hospital campus, near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois, in order to reduce the high utilization and projected demand for outpatient surgical services at Silver Cross Hospital.

The Surgery Center will contain three operating rooms, nine recovery rooms and appropriate clinical support space. The Surgery Center will also include non-clinical areas such as administration, a waiting room, visitor and staff support, supply rooms and storage. In total, the Surgery Center will occupy 13,849 gross square feet of space.

The following surgical services are proposed for the Surgery Center: General Surgery, Obstetrics/Gynecology, Ophthalmology, Orthopedic, Podiatry, and Urology (the "Proposed Surgical Specialties").

A total of 2,165 cases (or 3,489 surgical hours) in the Proposed Surgical Specialties have been committed to the proposed Surgery Center in 2018 (i.e., the first year of operation for the proposed Surgery Center) by physicians on the Medical Staff at Silver Cross Hospital. **ALL** of the committed surgical cases are currently being performed in the operating rooms at Silver Cross Hospital and **ONLY** primary service area zip code volume for Silver Cross Hospital was used. Because all of the committed surgical cases will be shifted from Silver Cross Hospital to the proposed Surgery Center, there will be **NO** impact on the other hospitals or ambulatory surgery centers in the proposed Surgery Center's geographic service area (the "GSA").

The eleven operating rooms at Silver Cross Hospital had a utilization rate of 119.3% in 2014. In 2015, the utilization rate increased to 129.7%. 2016 is even busier, with the eleven operating rooms on pace to hit a utilization rate of 138.5%. The surgical projections for 2017, 2018 and 2019 are just as daunting and show that Silver Cross Hospital will need nineteen operating rooms by 2019. Thus, Silver Cross Hospital can easily support the three operating rooms being proposed at the Surgery Center on the Silver Cross Hospital campus. In addition, the Applicants commit not to add any additional operating rooms at Silver Cross Hospital until the Surgery Center achieves its target utilization rate for twelve months.

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(b)(1), (2), (3) & (4), Background of the Applicants

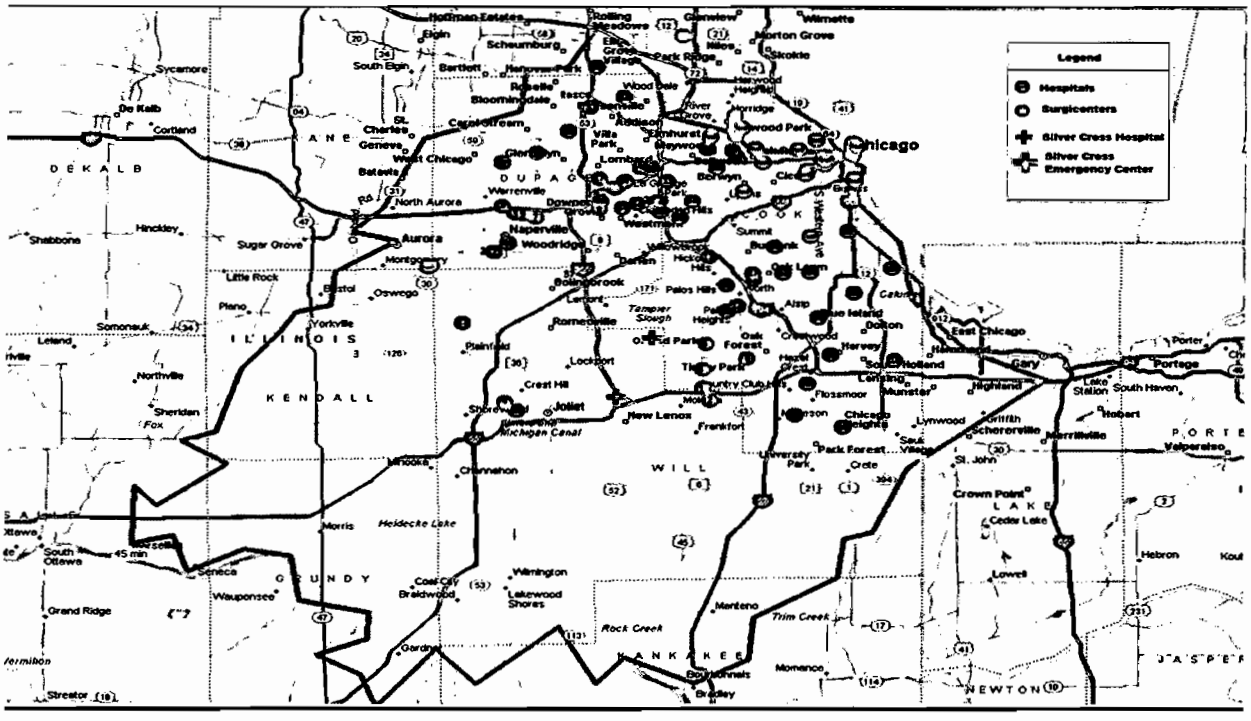
The Applicants have the qualifications, background, character and financial resources to adequately provide services at the Surgery Center. All relevant information regarding this Criterion is set forth in Section III, Criterion 1110.230 (Background) and at ATTACHMENT 11.

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(c)(A) & (B), Service to Geographic Service Area Residents.

Criterion 1110.1540(c)(A), Geographic Service Area

The proposed Surgery Center will be located on the Silver Cross Hospital campus, near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois. A map showing the GSA for the proposed Surgery Center, which is comprised of zip codes located with 45 minutes normal travel time from the proposed Surgery Center site, is set forth below. Estimated travel times of zip codes from the proposed Surgery Center site were obtained from MapQuest. Normal travel times were estimated by applying the adjustment factor of 1.15 allowed under Section 1100.510(d) Normal Travel Time Determinations for the Chicago Metropolitan region to the MapQuest travel time.

This same map shows the existing surgery centers and hospitals located within the GSA for the proposed Surgery Center. The relevant MapQuest maps are attached at ATTACHMENT 27. A detailed listing of the existing surgery centers and hospitals located within the GSA for the proposed Surgery Centers follows the map.



AMBULATORY SURGERY TREATMENT CENTERS WITHIN 45 MINUTES ADJUSTED TRAVEL TIME FROM PROPOSED ASTC

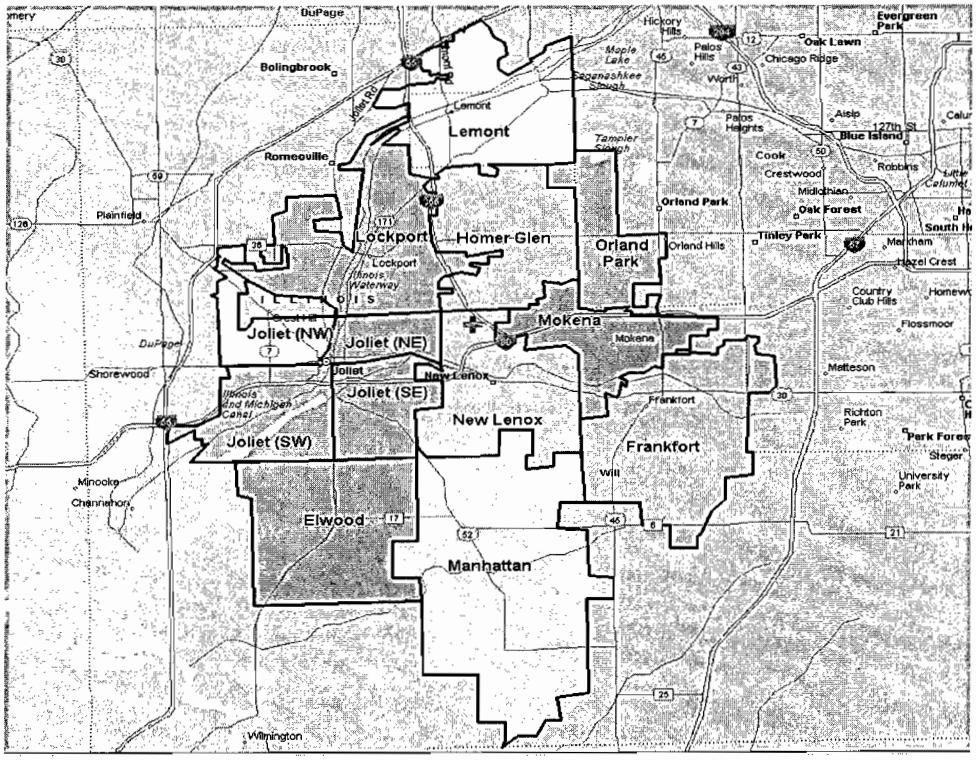
MAP #	FACILITY NAME	ADDRESS	CITY	STATE	ZIP	DISTANCE (Miles) (Mapquest)	TIME (Minutes) (Mapquest)	ADJUSTED TIME (1.15 X Mapquest Time)
1	TINLEY WOODS SURGERY CENTER	18200 LaGrange Road	TINLEY PARK	IL	60487	8.5	11	12.7
2	SOUTHWEST SURGERY CENTER, L.L.C.	9295 West 191st Street	MOKENA	IL	60448	8.7	11	12.7
3	ORLAND PARK SURGICAL CENTER, LLC	9550 WEST 167TH STREET	ORLAND PARK	IL	60467	8.3	13	15.0
4	HEALTHSOUTH AMSURG SURGERY CENTER	998 129th INFANTRY DRIVE	JOLIET	IL	60435	14.1	19	21.9
5	Preferred Surgicenter, LLC	10 Orland Square Drive	Orland Park	IL	60467	11.0	19	21.9
6	INGALLS SAME DAY SURGERY	6701 WEST 159TH STREET	TINLEY PARK	IL	60477	15.7	20	23.0
7	Lisle Center for Pain Management	2867 East Ogden Avenue	Lisle	IL	60532	22.1	25	28.8
8	AMBUL. SURGICENTER OF DOWNERS GROVE	4333 MAIN STREET	DOWNERS GROVE	IL	60515	22.4	27	31.1
9	Naperville Fertility Center	1175 East Diehl Road	Naperville	IL	60540	24.5	28	32.2
10	MIDWEST CENTER FOR DAY SURGERY	3811 HIGHLAND AVENUE	DOWNERS GROVE	IL	60515	22.9	28	32.2
11	FOREST MEDICAL-SURGICAL CENTER	9050 West 81st Street	Justice	IL	60458	24.8	28	32.2
12	PALOS SURGICENTER, LLC	7340 WEST COLLEGE DRIVE	PALOS HEIGHTS	IL	60463	16.3	28	32.2
13	THE CENTER FOR SURGERY	475 EAST DIEHL ROAD	NAPERVILLE	IL	60563	25.1	29	33.4
14	DuPage Medical Group Surgery Center	1801 South Highland	Lombard	IL	60148	24.4	29	33.4
15	DuPage Orthopedic Group Surgery Center	27650 Ferry Road	Warrenville	IL	60565	26.8	30	34.5
16	HINSDALE SURGICAL CENTER	12 Salt Creek Lane	HINSDALE	IL	60521	25.3	30	34.5
17	OAK BROOK SURGICAL CENTER, THE	2425 WEST 22ND STREET	OAKBROOK	IL	60523	25.6	30	34.5
18	MIDWEST EYE CENTER, S.C.	1700 WEST ROAD	CALUMET CITY	IL	60409	25.3	30	34.5
19	Eye Surgery Center of Hinsdale	950 North York Road	Hinsdale	IL	60521	25.7	31	35.7
20	Palos Hills Surgery Center	10330 South Roberts Road	Palos Hills	IL	60465	17.6	31	35.7
21	Edward Plainfield Surgery Center	24600 W 127th Street	Plainfield	IL	60544	18.5	32	36.8
22	Salt Creek Surgery Center	530 NORTH CASS AVENUE	WESTMONT	IL	60559	21.8	32	36.8
23	MIDWEST ENDOSCOPY CENTER	1243 Rickert Drive	NAPERVILLE	IL	60540	23.2	33	38.0
24	NAPERVILLE SURGICAL CENTRE	1263 RICKERT DRIVE	NAPERVILLE	IL	60540	23.4	33	38.0
25	CHICAGO PROSTATE CANCER SURGERY CENTER	815 PASQUINELLI DRIVE	WESTMONT	IL	60559	23.8	33	38.0
26	ELMHURST MEDICAL & SURGICAL CENTER	340 WEST BUTTERFIELD ROAD	ELMHURST	IL	60148	27.7	33	38.0
27	NOVAMED SURGERY CENTER OF OAK LAWN	6309 WEST 95TH STREET	OAK LAWN	IL	60453	28.4	33	38.0
28	OAK LAWN ENDOSCOPY	9921 SOUTHWEST HIGHWAY	OAK LAWN	IL	60453	18.6	33	38.0
29	CHILDREN'S MEM. SPEC. PED.	2301 ENTERPRISE DRIVE	WESTCHESTER	IL	60154	29.4	34	39.1
30	United Therapy-LaGrange	120 North LaGrange Road	LaGrange	IL	60525	26.3	34	39.1
31	ALDEN CENTER FOR DAY SURGERY CENTER, LLC	1580 WEST LAKE STREET	ADDISON	IL	60101	31.9	36	41.4
32	ELMHURST OUTPATIENT SURGERY CENTER	1200 SOUTH YORK ROAD	ELMHURST	IL	60126	29.5	36	41.4

33	LOYOLA AMB. SURG. CTR. AT OAKBROOK TERRACE	1S224 Summit Ave	Oakbrook Terrace	IL	60181	26.6	38	43.7
34	DuPage Eye Surgery Center	2015 North Main Street	Wheaton	IL	60187	32.7	39	44.9

HOSPITALS WITHIN 45 MINUTES ADJUSTED TRAVEL TIME FROM PROPOSED ASTC

MAP #	FACILITY NAME	ADDRESS	CITY	STATE	ZIP	DISTANCE (Miles) (Mapquest)	TIME (Minutes) (Mapquest)	ADJUSTED TIME (1.15 X Mapquest Time)
35	Presence Saint Joseph Medical Center	333 North Madison Street	Joliet	IL	60435	12.7	17	19.6
36	Advocate South Suburban Hospital	17800 South Kedzie Avenue	Hazel Crest	IL	60429	17.9	20	23.0
37	Adventist Bolingbrook Hospital	400 Medical Center Drive	Bolingbrook	IL	60440	16.7	21	24.2
38	Franciscan St. James Hospital & Health Center	20201 South Crawford	Olympia Fields	IL	60461	18.8	21	24.2
39	Ingalls Memorial Hospital	One Ingalls Drive	Harvey	IL	60426	20.0	23	26.5
40	Palos Community Hospital	12251 South 80th Avenue	Palos Heights	IL	60463	14.9	26	29.9
41	MetroSouth Medical Center	12935 South Gregory Street	Blue Island	IL	60406	21.9	26	29.9
42	Advocate Good Samaritan Hospital	3815 Highland Avenue	Downers Grove	IL	60515	24.3	27	31.1
43	Adventist Hinsdale Hospital	120 North Oak Street	Hinsdale	IL	60521	23.4	27	31.1
44	Franciscan St. James Hospital & Health Center	1423 Chicago Road	Chicago Heights	IL	60411	23.4	29	33.4
45	Adventist LaGrange Memorial Hospital	5101 South Willow Springs Road	LaGrange	IL	60525	23.3	30	34.5
46	Edward Hospital	801 South Washington	Naperville	IL	60566	22.5	31	35.7
47	Roseland Community Hospital	45 West 111th Street	Chicago	IL	60628	26.1	31	35.7
48	Advocate Trinity Hospital	2320 East 93rd Street	Chicago	IL	60617	31.2	33	38.0
49	Adventist Glen Oaks Medical Center	701 Winthrop Avenue	Glendale Heights	IL	60139	30.6	34	39.1
50	Elmhurst Memorial Hospital	155 East Brush Hill Road	Elmhurst	IL	60126	29.1	34	39.1
51	St. Bernard Hospital	326 West 64th Street	Chicago	IL	60621	32.0	34	39.1
52	Central DuPage Hospital	0N025 Winfield Road	Winfield	IL	60190	30.8	35	40.3
53	MacNeal Memorial Hospital	3249 South Oak Park Avenue	Berwyn	IL	60402	29.2	35	40.3
54	Little Company of Mary Hospital and Health Care Center	2800 West 95th Street	Evergreen Park	IL	60642	29.5	35	40.3
55	Alexian Brothers Medical Center	800 Biesterfield Road	Elk Grove Villa	IL	60007	35.8	37	42.6
56	Loyola University Medical Center/Foster G. McGaw	2160 South 1st Avenue	Maywood	IL	60153	34.5	38	43.7
57	Advocate Christ Hospital and Medical Center	4440 West 95th Street	Oak Lawn	IL	60453	21.2	39	44.9
58	VHS Westlake Hospital	1225 W Lake St	Melrose Park	IL	60160	34.4	39	44.9

That said, the Applicants believe that the patients for the proposed Surgery Center will actually come from Silver Cross Hospital's primary service area (which is much smaller than the GSA). Silver Cross Hospital's primary services area is set forth in the below map:



The estimated and projected population for Silver Cross Hospital's primary service area (and hence, the service area for the proposed Surgery Center) is set forth below:

Area	Zip Code	City	2016 Census	2016 Percent to Total	2021 Projected Population	2021 Percent to Total	5 Year Change	5 Year Percent Change
Target Area	60403	Crest Hill	17,536	5.2%	17,826	5.3%	290	1.7%
	60421	Elwood	4,005	1.2%	4,068	1.2%	63	1.6%
	60423	Frankfort	31,595	9.4%	32,211	9.5%	616	1.9%
	60432	Joliet	21,026	6.3%	20,579	6.1%	(447)	-2.1%
	60433	Joliet	16,463	4.9%	15,985	4.7%	(478)	-2.9%
	60435	Joliet	47,103	14.0%	46,212	13.7%	(891)	-1.9%
	60436	Joliet	17,316	5.2%	16,796	5.0%	(520)	-3.0%
	60439	Lemont	24,086	7.2%	25,066	7.4%	980	4.1%
	60441	Lockport	36,958	11.0%	37,314	11.0%	356	1.0%
	60442	Manhattan	10,196	3.0%	10,410	3.1%	214	2.1%
	60448	Mokena	24,730	7.4%	25,115	7.4%	385	1.6%
	60451	New Lenox	34,470	10.3%	34,940	10.3%	470	1.4%
	60467	Orland Park	27,615	8.2%	28,714	8.5%	1,099	4.0%
	60491	Homer Glen	22,960	6.8%	22,815	6.7%	(145)	-0.6%
Total			**336,059**		**338,051**		**1,992**	**0.6%**

Source: Claritas/Nielsen (Feb 2016)

YOUR TRIP TO:

Provena St Joseph Medical Ctr

17 MIN | 12.7 MI

Trip time based on traffic conditions as of 12:49 PM on March 23, 2016. Current Traffic: Light

Start of next leg of route

1. Start out going **east** on Maple Rd/US-6 E toward Silver Cross Blvd.

Then 0.32 miles — 0.32 total miles

2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the **left** toward **I-80** (Portions toll).

Then 1.16 miles — 1.48 total miles

3. Merge onto I-80 W via EXIT 0B toward **Iowa**.

Then 9.14 miles — 10.61 total miles

4. Merge onto S Larkin Ave/IL-7 N via EXIT 130B.

Then 1.49 miles — 12.10 total miles

5. Turn **left** onto Glenwood Ave.

Then 0.51 miles — 12.61 total miles

6. Take the 2nd **left** onto Madison St.

Then 0.06 miles — 12.67 total miles

7. Provena St Joseph Medical Ctr, 333 MADISON ST.

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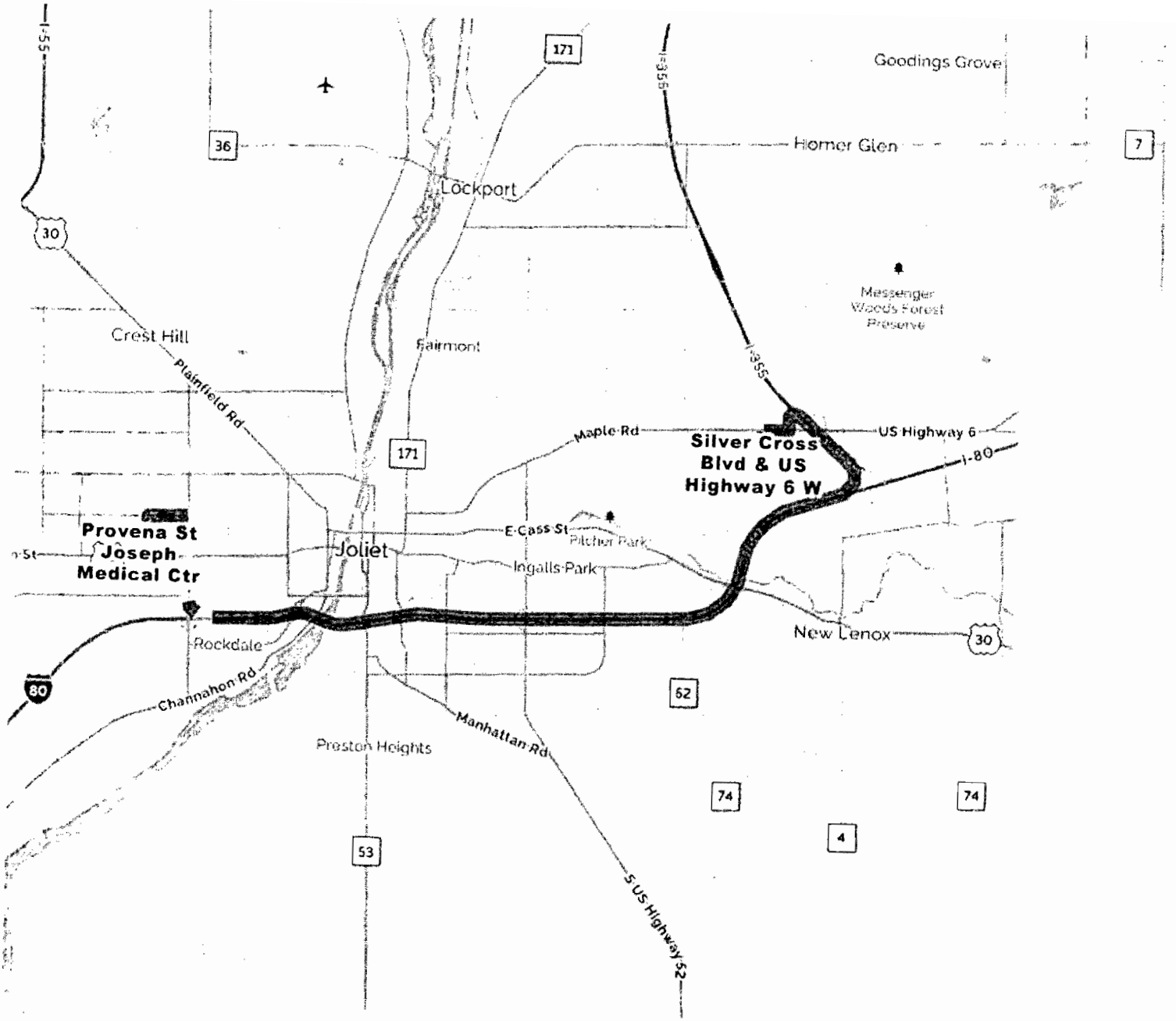
I-55
171
I-355
Goodings Grove
36
Homer Glen
7
Lockport
30
Messenger Woods Forest Preserve
Crest Hill
Fairmont
Plainfield Rd
I-355
Maple Rd
US Highway 6
Silver Cross Blvd & US Highway 6 W
171
I-80
Provena St Joseph Medical Ctr
E Cass St
Pilcher Park
Joliet
Ingalls Park
New Lenox
30
Rockdale
80
Channahon Rd
52
Manhattan Rd
Preston Heights
74
74
4
53
US Highway 52

YOUR TRIP TO:

Advocate Health And Hospitals Corporation

20 MIN | 17.9 MI

Trip time based on traffic conditions as of 1:48 PM on March 23, 2016. Current Traffic: Moderate

1.	Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd.	
	Then 0.32 miles	0.32 total miles
2.	Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the **left** toward I-80 (Portions toll).	
	Then 1.16 miles	1.48 total miles
3.	Merge onto I-80 E via the exit on the **left** toward Indiana.	
	Then 15.03 miles	16.50 total miles
4.	Take the Kedzie Ave exit, EXIT 154.	
	Then 0.25 miles	16.75 total miles
5.	Turn slight right onto Kedzie Ave.	
	Then 1.04 miles	17.78 total miles
6.	Turn right.	
	Then 0.09 miles	17.87 total miles
7.	Take the 1st left	
	Then 0.05 miles	17.92 total miles
8.	Advocate Health And Hospitals Corporation, 17800 KEDZIE AVE.	

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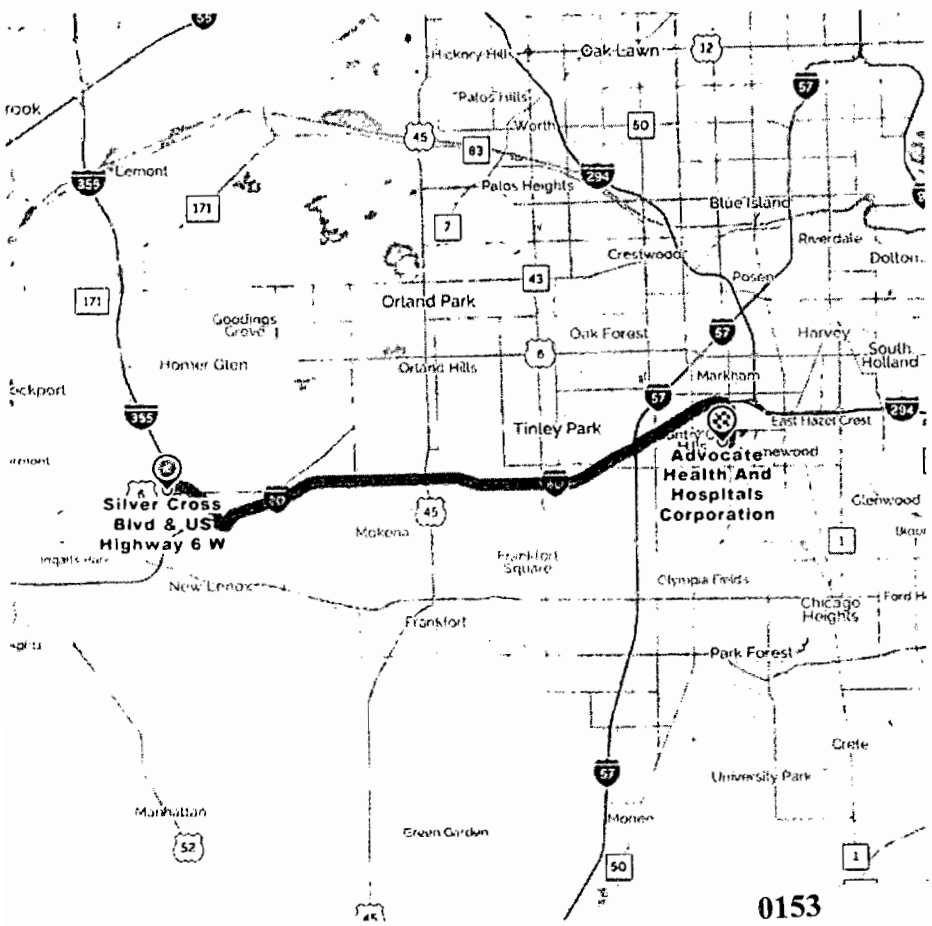

Attachment 27

YOUR TRIP TO:

Adventist Bolingbrook Hospital

21 MIN | 16.7 MI

Trip time based on traffic conditions as of 12:54 PM on March 23, 2016. Current Traffic: Moderate

1. Start out going **east** on Maple Rd/US-6 E toward Silver Cross Blvd.
   Then 0.75 miles — 0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the **left** toward **West Suburbs** (Portions toll)
   Then 11.86 miles — 12.62 total miles
3. Merge onto I-55 S via EXIT 12B toward **St Louis**
   Then 2.35 miles — 14.97 total miles
4. Take the IL-53 exit, EXIT 267, toward **Bolingbrook**
   Then 0.31 miles — 15.27 total miles
5. Merge onto S Bolingbrook Dr/IL-53 toward **Bolingbrook**
   Then 0.16 miles — 15.43 total miles
6. Turn **left** onto Remington Blvd
   Then 1.32 miles — 16.74 total miles
7. Adventist Bolingbrook Hospital, 500 REMINGTON BLVD

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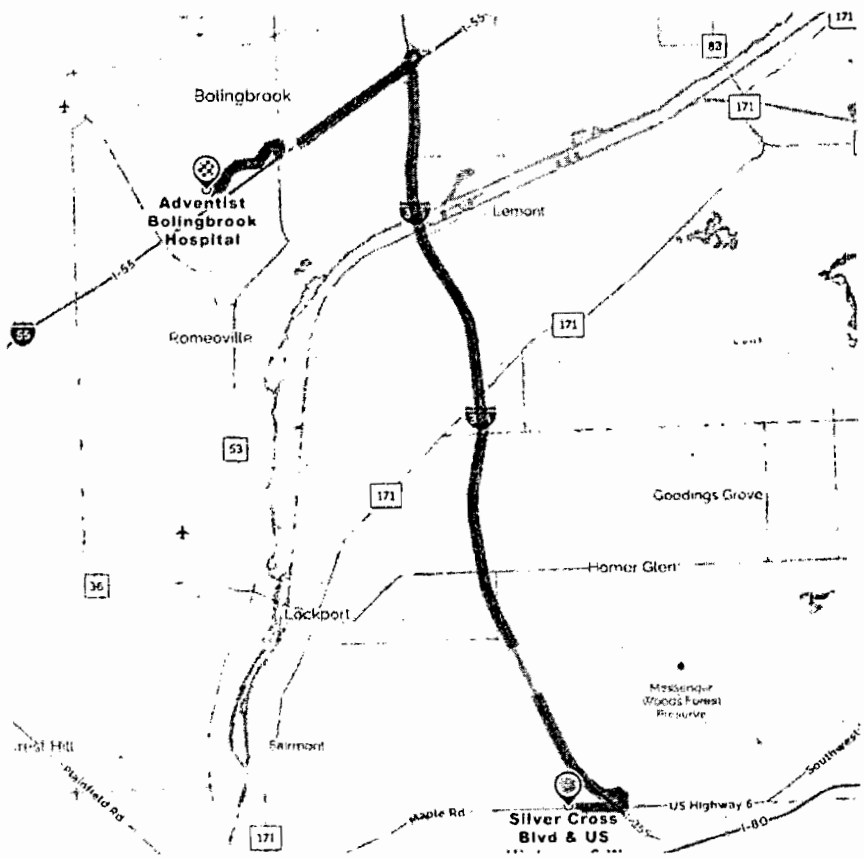

YOUR TRIP TO:

Franciscan St James Health

21 MIN | 18.8 MI

Trip time based on traffic conditions as of 1:43 PM on March 23, 2016. Current Traffic: Light

Start of next leg of route	
1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd	
Then 0.32 miles	0.32 total miles
2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)	
Then 1.16 miles	1.48 total miles
3. Merge onto I-80 E via the exit on the left toward Indiana.	
Then 11.92 miles	13.40 total miles
4. Merge onto I-57 S via EXIT 151A toward Memphis	
Then 2.77 miles	16.16 total miles
5. Take the Vollmer Rd E exit, EXIT 342A	
Then 0.31 miles	16.48 total miles
6. Merge onto Vollmer Rd.	
Then 1.53 miles	18.01 total miles
7. Turn right onto Crawford Ave.	
Then 0.50 miles	18.51 total miles
8. Turn left onto W 203rd St	
Then 0.11 miles	18.62 total miles
9. Take the 1st left.	
Then 0.13 miles	18.76 total miles
10. Franciscan St James Health, 20201 CRAWFORD AVE.	

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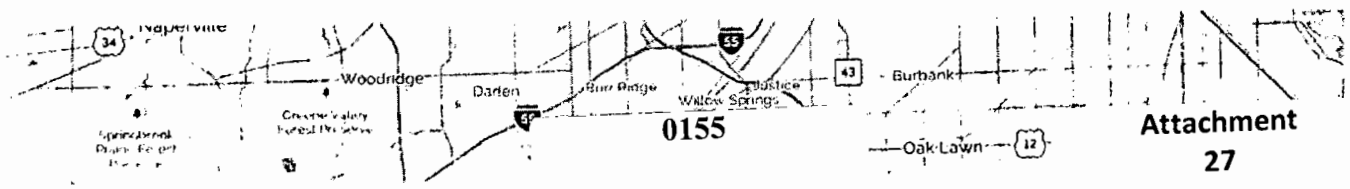

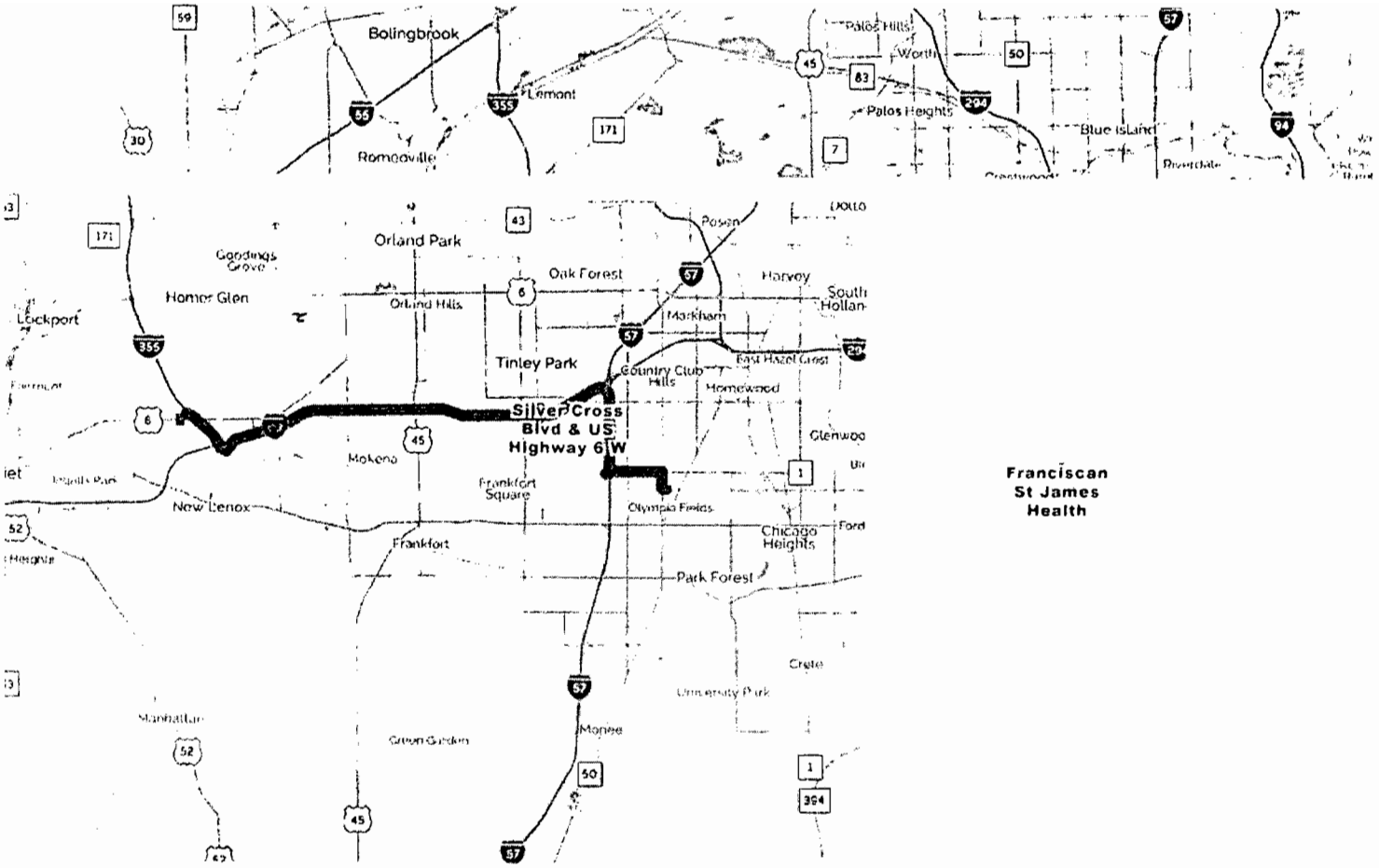
Bolingbrook
Romeoville
Lemont
Palos Hills
Worth
Palos Heights
Blue Island
Orland Park
Oak Forest
Harvey
South Holland
Homer Glen
Orland Hills
Markham
Lockport
Tinley Park
Country Club Hills
Homewood
Silver Cross Blvd & US Highway 6 W
Mokena
Frankfort Square
Olympia Fields
New Lenox
Frankfort
Chicago Heights
Park Forest
Crete
University Park
Manhattan
Monee
Posen
Franciscan St James Health

YOUR TRIP TO:

ngalls Memorial Hospital

23 MIN | 20.0 MI

Trip time based on traffic conditions as of 1:56 PM on March 23, 2016. Current Traffic: Light

Start of next leg of route

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd.

Then 0.32 miles — 0.32 total miles

2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)

Then 1.16 miles — 1.48 total miles

3. Merge onto I-80 E via the exit on the left toward Indiana.

Then 12.22 miles — 13.69 total miles

4. Merge onto I-57 N via EXIT 151B on the left toward Chicago.

Then 2.99 miles — 16.68 total miles

5. Merge onto W 159th St/US-6 E via EXIT 348

Then 2.87 miles — 19.55 total miles

6. Turn left onto Wood St

Then 0.38 miles — 19.93 total miles

7. Turn right onto W 156th St

Then 0.07 miles — 19.99 total miles

8. Turn left onto Ingalls Dr

Then 0.03 miles — 20.02 total miles

9. Ingalls Memorial Hospital, 1 INGALLS DR is on the left

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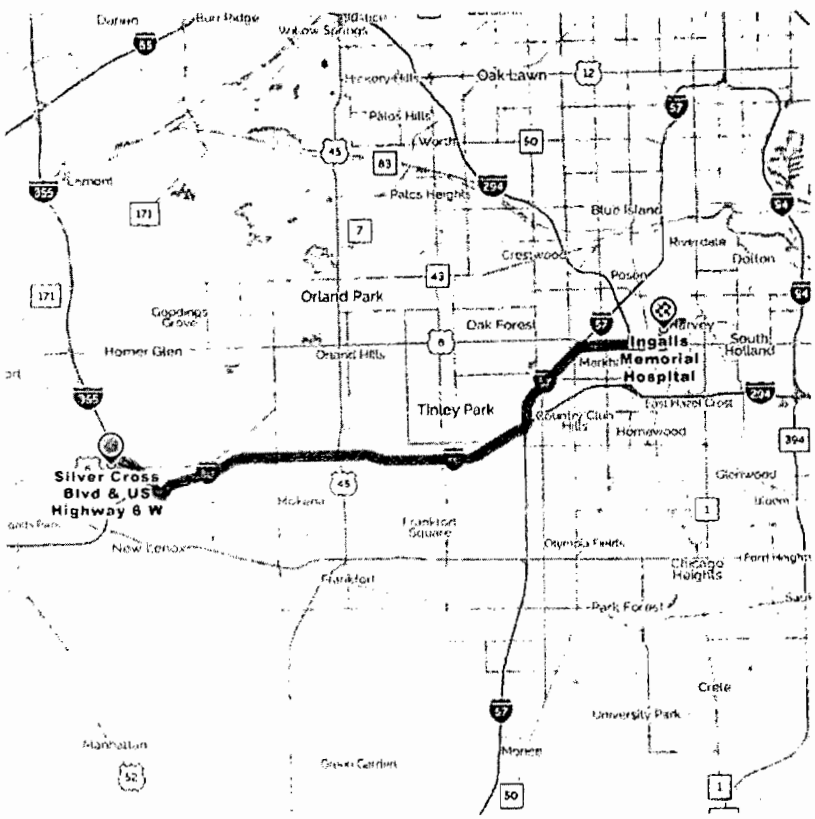

Attachment 27

YOUR TRIP TO:

Palos Community Hospital

26 MIN | 14.9 MI

Trip time based on traffic conditions as of 1:29 PM on March 23, 2016. Current Traffic: Moderate

1. Start out going **east** on Maple Rd/US-6 E toward Silver Cross Blvd. Continue to follow US-6 E

Then 5.57 miles — 5.57 total miles

2. Turn **left** onto Wolf Rd/US-6 E. Continue to follow Wolf Rd

Then 3.88 miles — 9.45 total miles

3. Turn **right** onto 143rd St/IL-7

Then 1.65 miles — 11.10 total miles

4. Turn **left** onto Southwest Hwy/IL-7.

Then 2.99 miles — 14.09 total miles

5. Turn **slight right** onto ramp

Then 0.09 miles — 14.18 total miles

6. Turn **slight right** onto W 123rd St

Then 0.67 miles — 14.85 total miles

7. Turn **left** onto S 80th Ave

Then 0.09 miles — 14.94 total miles

8. Palos Community Hospital, 12251 S 80TH AVE is on the right

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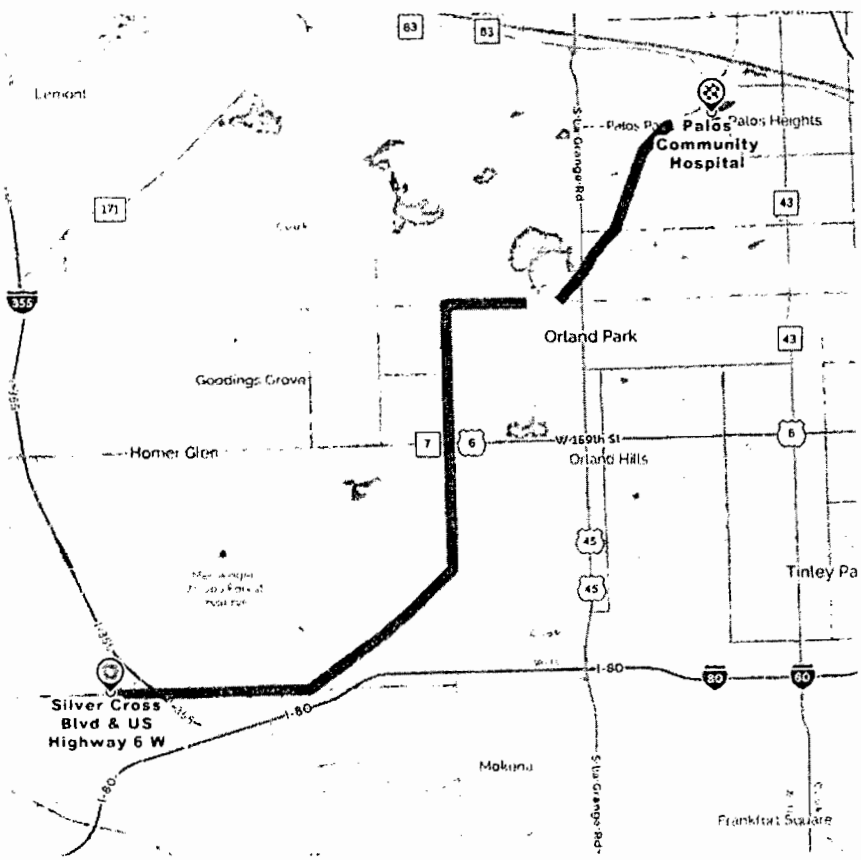

YOUR TRIP TO:

MetroSouth Medical Center

26 MIN | 21.9 MI

Trip time based on traffic conditions as of 1:53 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd Then 0.32 miles	0.32 total miles
2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll) Then 1.16 miles	1.48 total miles
3. Merge onto I-80 E via the exit on the left toward Indiana Then 12.22 miles	13.69 total miles
4. Merge onto I-57 N via EXIT 151B on the left toward Chicago. Then 5.29 miles	18.99 total miles
5. Take the IL-83/147th St exit, EXIT 350, toward Sibley Blvd Then 0.23 miles	19.22 total miles
6. Merge onto W 147th St/IL-83 toward HARVEY Then 0.25 miles	19.47 total miles
7. Turn left onto S Western Ave. Then 2.27 miles	21.73 total miles
8. S Western Ave becomes Gregory St Then 0.18 miles	21.91 total miles
9. MetroSouth Medical Center, 12935 GREGORY ST	

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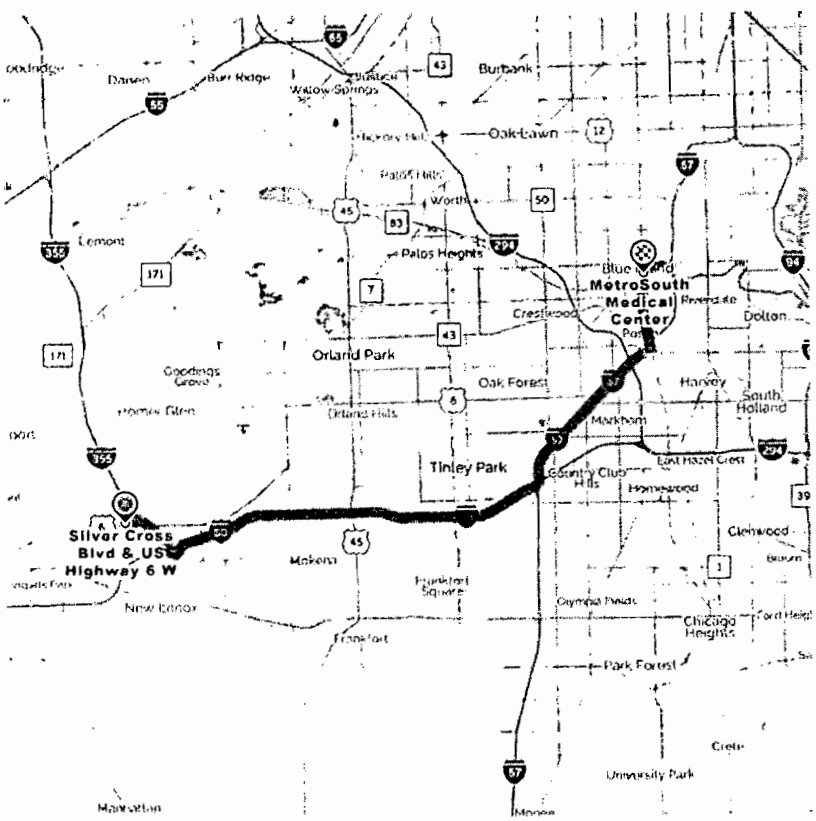

YOUR TRIP TO:

Advocate Good Samaritan Hosp

27 MIN | 24.3 MI

Trip time based on traffic conditions as of 1:07 PM on March 23, 2016. Current Traffic: Light

Start of next leg of route	
1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd.	
Then 0.75 miles	0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward **West Suburbs** (Portions toll)	
Then 13.29 miles	14.04 total miles
3. Keep left to take I-355 N/Veterans Memorial Tollway N toward **ELECTRONIC TOLL ONLY** (Portions toll) (Electronic toll collection only)	
Then 5.23 miles	19.27 total miles
4. Merge onto I-88 E/Chicago-Kansas City Expressway E/Ronald Reagan Memorial Tollway E via EXIT 20A toward **Chicago** (Portions toll)	
Then 3.58 miles	22.85 total miles
5. Take the Highland Ave exit	
Then 0.32 miles	23.17 total miles
6. Turn slight right onto Highland Ave/County Hwy-9.	
Then 0.97 miles	24.14 total miles
7. Turn left onto Good Samaritan Hospital.	
Then 0.03 miles	24.16 total miles
8. Turn right to stay on Good Samaritan Hospital	
Then 0.10 miles	24.26 total miles
9. Advocate Good Samaritan Hosp, 3815 HIGHLAND AVE	

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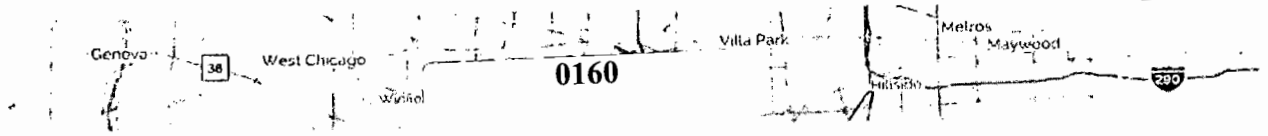
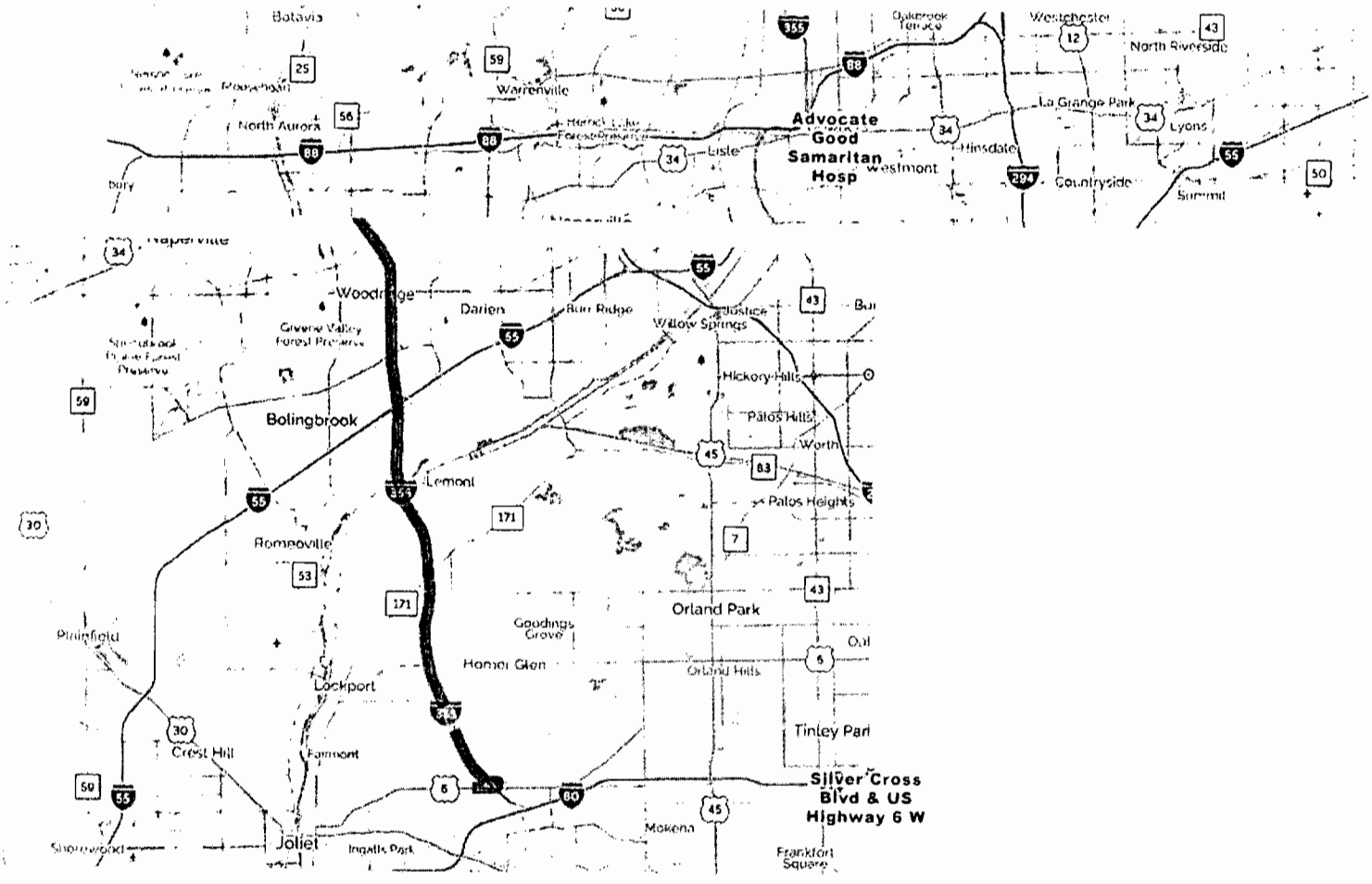
Attachment 27





Attachment
27

YOUR TRIP TO:

Adventist Hinsdale Hospital

27 MIN | 23.4 MI

Trip time based on traffic conditions as of 1:08 PM on March 23, 2016. Current Traffic: Light

1. Start out going **east** on Maple Rd/US-6 E toward Silver Cross Blvd.	
Then 0.75 miles	0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the **left** toward **West Suburbs** (Portions toll).	
Then 11.48 miles	12.24 total miles
3. Merge onto I-55 N via EXIT 12A toward **Chicago**	
Then 7.26 miles	19.50 total miles
4. Take EXIT 276B toward **County Line Rd N**.	
Then 0.32 miles	19.82 total miles
5. Merge onto S County Line Rd.	
Then 3.28 miles	23.10 total miles
6. Turn **left** onto E Chicago Ave.	
Then 0.13 miles	23.23 total miles
7. Take the 1st **right** onto N Oak St	
Then 0.14 miles	23.37 total miles
8. Adventist Hinsdale Hospital, 120 N OAK ST is on the **left**.	

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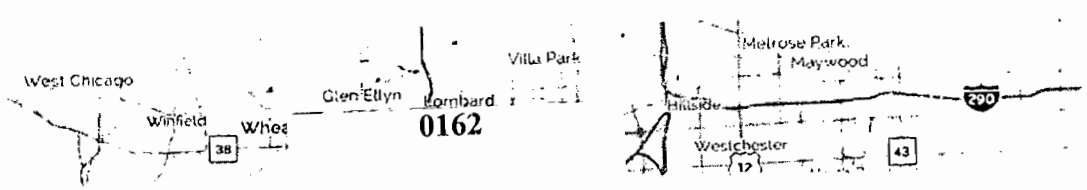
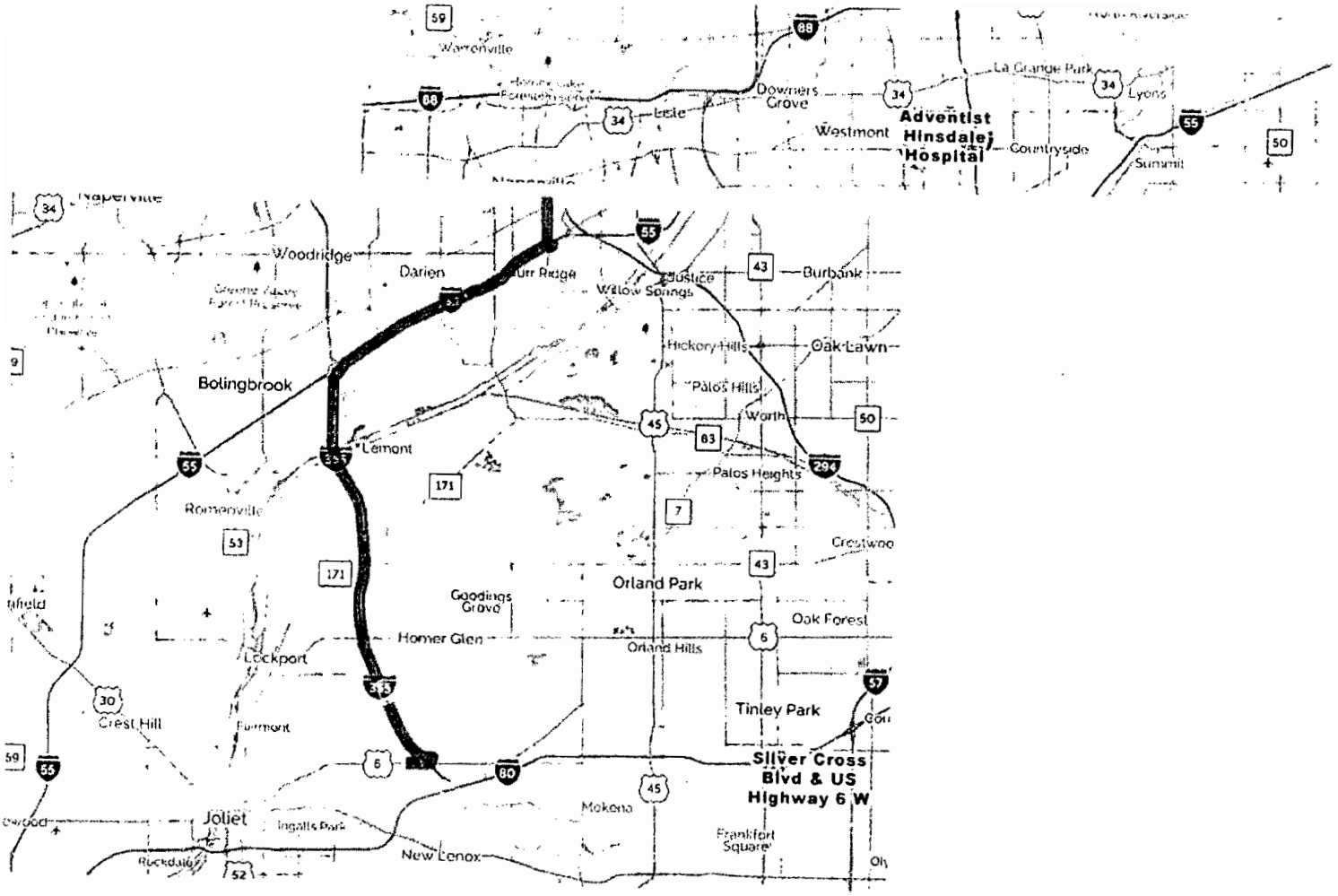
Attachment 27





Attachment
27

YOUR TRIP TO:

Franciscan St James Hospital & Health Centers

29 MIN | 23.4 MI

Trip time based on traffic conditions as of 1:51 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd
   Then 0.32 miles — 0.32 total miles
2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)
   Then 1.16 miles — 1.48 total miles
3. Merge onto I-80 E via the exit on the left toward Indiana
   Then 11.92 miles — 13.40 total miles
4. Merge onto I-57 S via EXIT 151A toward Memphis
   Then 4.20 miles — 17.60 total miles
5. Merge onto US-30 E/Lincoln Hwy via EXIT 340A.
   Then 5.61 miles — 23.21 total miles
6. Turn right onto Chicago Rd/IL-1
   Then 0.12 miles — 23.33 total miles
7. Make a U-turn at W 15th St onto Chicago Rd/IL-1
   Then 0.07 miles — 23.40 total miles
8. Franciscan St James Hospital & Health Centers, 1423 CHICAGO RD is on the right

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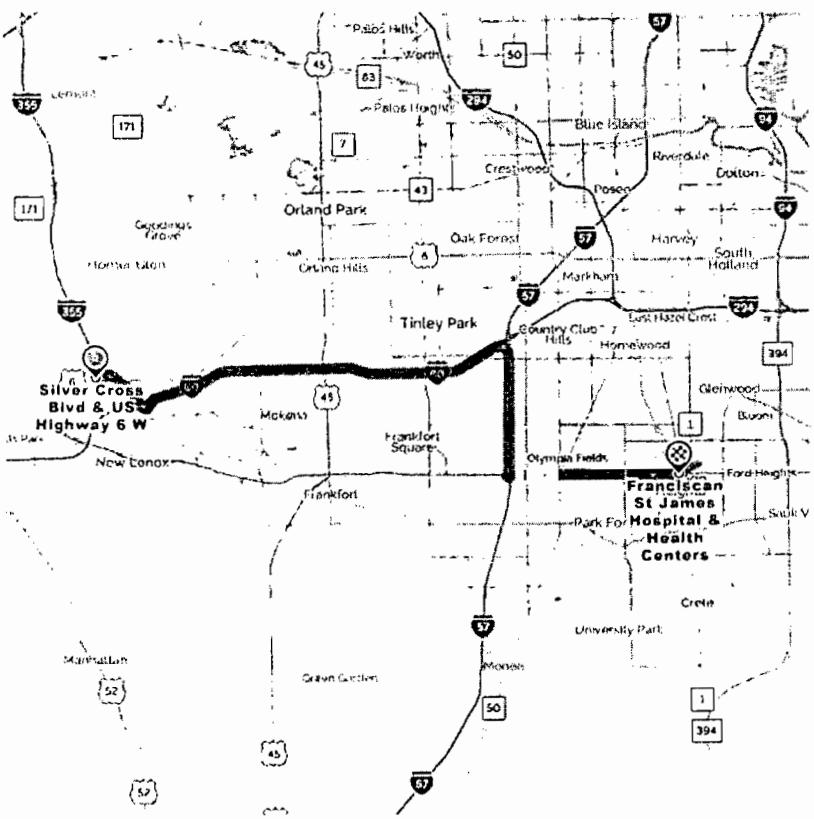

YOUR TRIP TO:

Adventist La Grange Memorial Hospital

10 MIN | 23.3 MI

Trip time based on traffic conditions as of 1:31 PM on March 23, 2018. Current Traffic: Moderate

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd
   Then 0.75 miles — 0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward West Suburbs (Portions toll).
   Then 11.48 miles — 12.24 total miles
3. Merge onto I-55 N via EXIT 12A toward Chicago
   Then 7.57 miles — 19.80 total miles
4. Merge onto Joliet Rd via EXIT 276C on the left
   Then 1.42 miles — 21.23 total miles
5. Turn left onto Willow Springs Rd
   Then 1.90 miles — 23.12 total miles
6. Turn right onto Memorial Dr
   Then 0.09 miles — 23.21 total miles
7. Turn right
   Then 0.04 miles — 23.25 total miles
8. Turn right onto Memorial Dr.
   Then 0.01 miles — 23.27 total miles
9. Adventist La Grange Memorial Hospital, 5101 WILLOW SPRINGS RD

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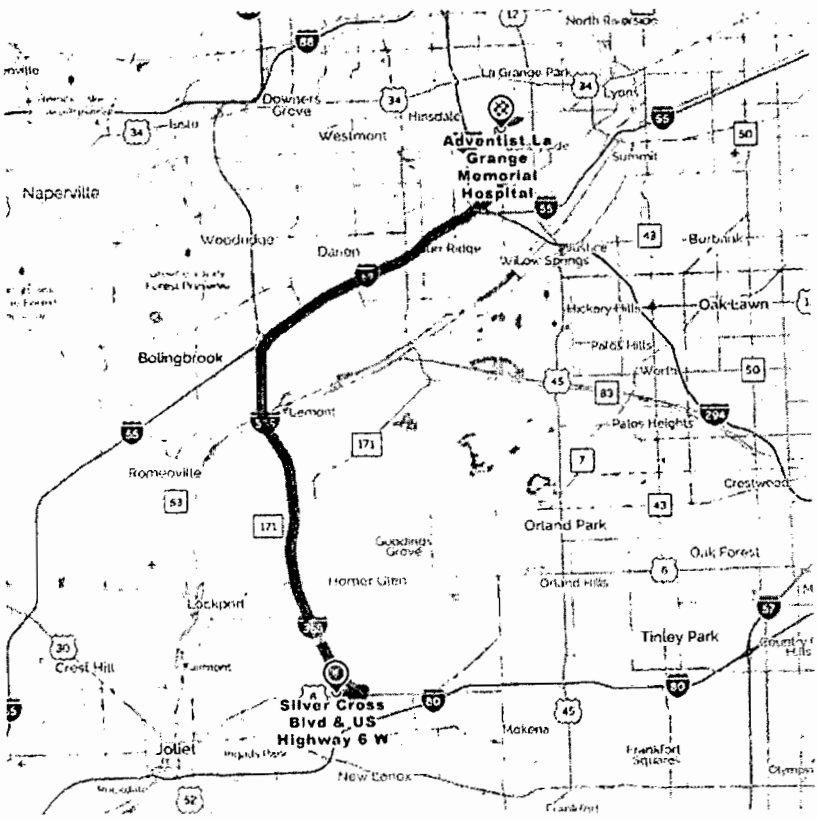

Attachment 27

YOUR TRIP TO:

801 S Washington St

31 MIN | 22.5 MI

Trip time based on traffic conditions as of 1:22 PM on March 23, 2016. Current Traffic: Moderate

Edward Hospital, 801 S Washington, Naperville, IL

1. Start out going **east** on Maple Rd/US-6 E toward Silver Cross Blvd

Then 0.75 miles — 0.75 total miles

2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the **left** toward **West Suburbs** (Portions toll).

Then 13.29 miles — 14.04 total miles

3. Keep **right** to take I-355 N/Veterans Memorial Tollway N toward **CASH** (Portions toll)

Then 1.38 miles — 15.42 total miles

4. Take the **75th St** exit

Then 0.34 miles — 15.76 total miles

5. Keep **left** to take the ramp toward **Woodridge**

Then 0.02 miles — 15.78 total miles

6. Turn **left** onto 75th St

Then 4.95 miles — 20.72 total miles

7. Turn **right** onto S Washington St

Then 1.50 miles — 22.23 total miles

8. Turn **left** onto W Martin Ave

Then 0.02 miles — 22.25 total miles

9. Take the **1st left**

Then 0.06 miles — 22.31 total miles

10. Turn **right**

Then 0.01 miles — 22.32 total miles

11. Turn **right** onto W Martin Ave

Then 0.07 miles — 22.40 total miles

12. Turn **right** onto S Washington St

Then 0.11 miles — 22.51 total miles

13. 801 S Washington St, Naperville, IL 60540-7430, 801 S WASHINGTON ST is on the **right**.

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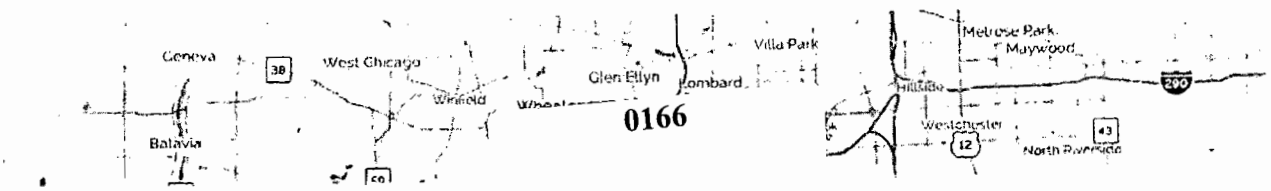
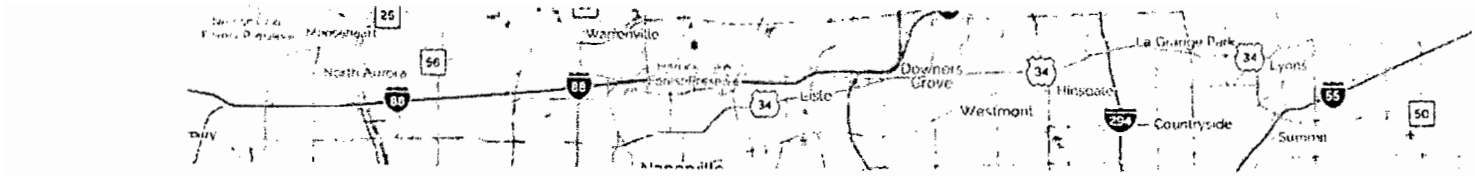
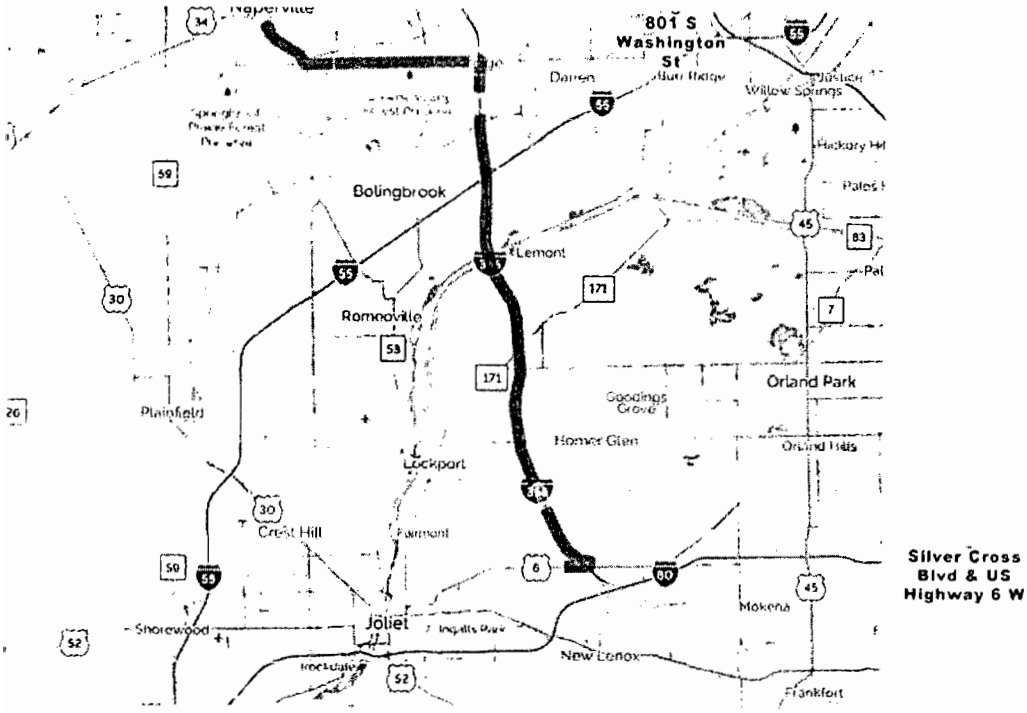
Attachment 27




Warrenville
North Aurora
Downers Grove
Westmont
Hinsdale
La Grange Park
Lyons
Countryside
Summit


801 S Washington St
Darien
Willow Springs
Bolingbrook
Lemont
Romeoville
Orland Park
Goodings Grove
Homer Glen
Orland Hills
Plainfield
Lockport
Crest Hill
Fairmont
Joliet
Shorewood
New Lenox
Mokena
Frankfort
Silver Cross Blvd & US Highway 6 W

YOUR TRIP TO:

Roseland Community Hosp

31 MIN | 26.1 MI

Trip time based on traffic conditions as of 2:21 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd-US-6 E toward Silver Cross Blvd

Then 0.32 miles — 0.32 total miles

2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)

Then 1.16 miles — 1.48 total miles

3. Merge onto I-80 E via the exit on the left toward Indiana.

Then 12.22 miles — 13.69 total miles

4. Merge onto I-57 N via EXIT 151B on the left toward Chicago

Then 10.15 miles — 23.85 total miles

5. Take EXIT 355 toward Monterey Ave/111th St

Then 0.27 miles — 24.11 total miles

6. Merge onto S Hemlet Ave

Then 0.24 miles — 24.36 total miles

7. Turn right onto W 111th St

Then 1.79 miles — 26.15 total miles

8. 45 W 111TH ST is on the right

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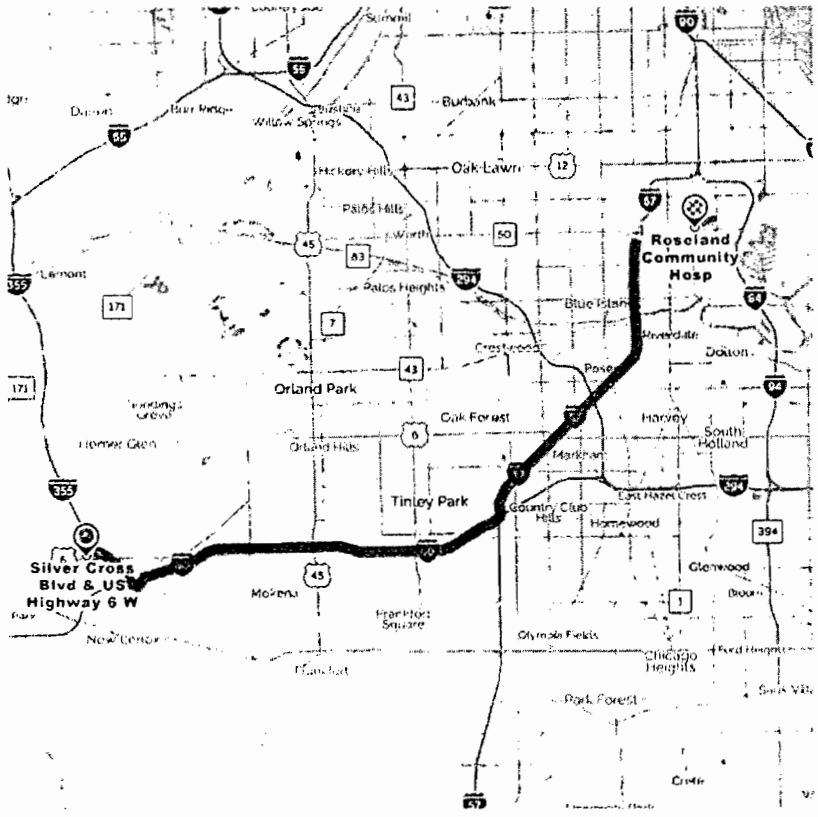

YOUR TRIP TO:

Advocate Trinity Hospital

33 MIN | 31.2 MI

Trip time based on traffic conditions as of 2:17 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd	
Then 0.32 miles	0.32 total miles
2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)	
Then 1.16 miles	1.48 total miles
3. Merge onto I-80 E via the exit on the left toward Indiana	
Then 12.22 miles	13.69 total miles
4. Merge onto I-57 N via EXIT 151B on the left toward Chicago	
Then 13.24 miles	26.94 total miles
5. Merge onto I-94 E/Bishop Ford Fwy S toward Indiana	
Then 1.46 miles	28.40 total miles
6. Take the Stony Island Ave N exit, EXIT 65, toward 95th St	
Then 1.46 miles	29.86 total miles
7. Merge onto S Stony Island Ave	
Then 0.19 miles	30.05 total miles
8. Take the 1st right onto E 95th St/US-20 E/US-12 E	
Then 0.75 miles	30.80 total miles
9. Turn left onto S Paxton Ave	
Then 0.25 miles	31.05 total miles
10. Turn right onto E 93rd St	
Then 0.18 miles	31.23 total miles
11. Advocate Trinity Hospital: 2320 E 93RD ST is on the left	

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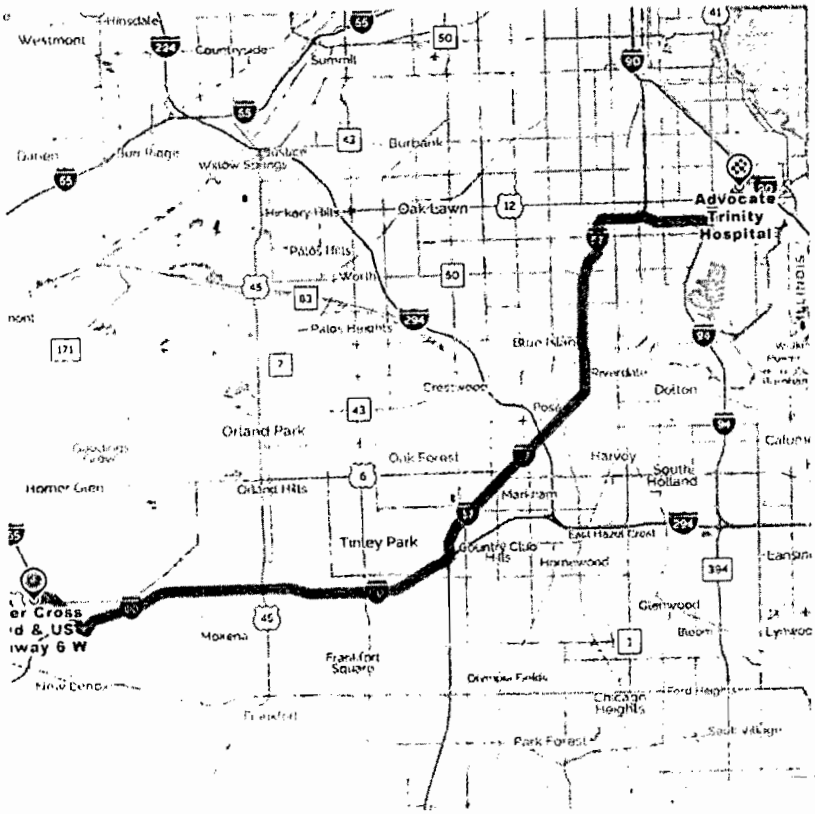

Attachment 27

YOUR TRIP TO:

Adventist Glenoaks

34 MIN | 30.6 MI

Trip time based on traffic conditions as of 1:11 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd.	
Then 0.75 miles	0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward West Suburbs (Portions toll)	
Then 13.29 miles	14.04 total miles
3. Keep right to take I-355 N/Veterans Memorial Tollway N toward CASH (Portions toll)	
Then 13.70 miles	27.74 total miles
4. Take the IL-64/North Ave exit, EXIT 27	
Then 0.30 miles	28.04 total miles
5. Keep left to take the ramp toward Glendale Hts/Carol Stream	
Then 0.06 miles	28.10 total miles
6. Turn left onto IL-64/North Ave	
Then 1.32 miles	29.42 total miles
7. Turn right onto Glen Ellyn Rd	
Then 0.81 miles	30.23 total miles
8. Turn right onto Winthrop Ave	
Then 0.18 miles	30.41 total miles
9. Winthrop Ave becomes Jill Ct	
Then 0.03 miles	30.44 total miles
10. Turn right	
Then 0.11 miles	30.55 total miles
11. Turn slight right	
Then 0.04 miles	30.59 total miles
12. Turn right	
Then 0.05 miles	30.64 total miles
13. Adventist Glenoaks, 701 WINTHROP AVE	

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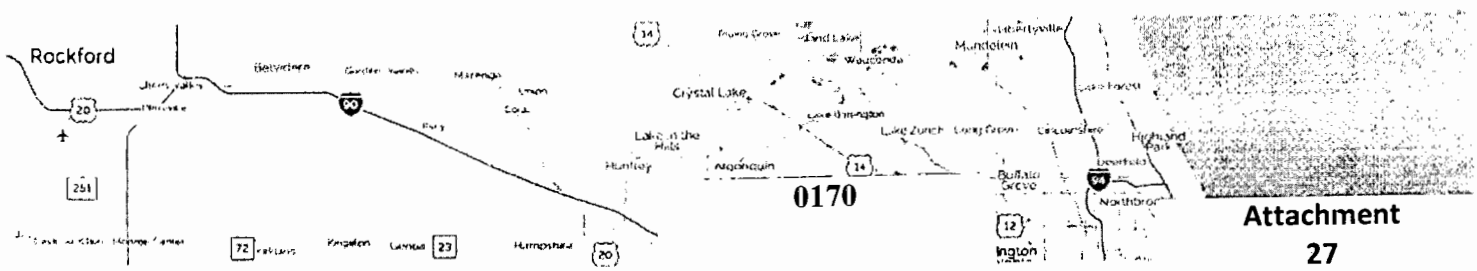

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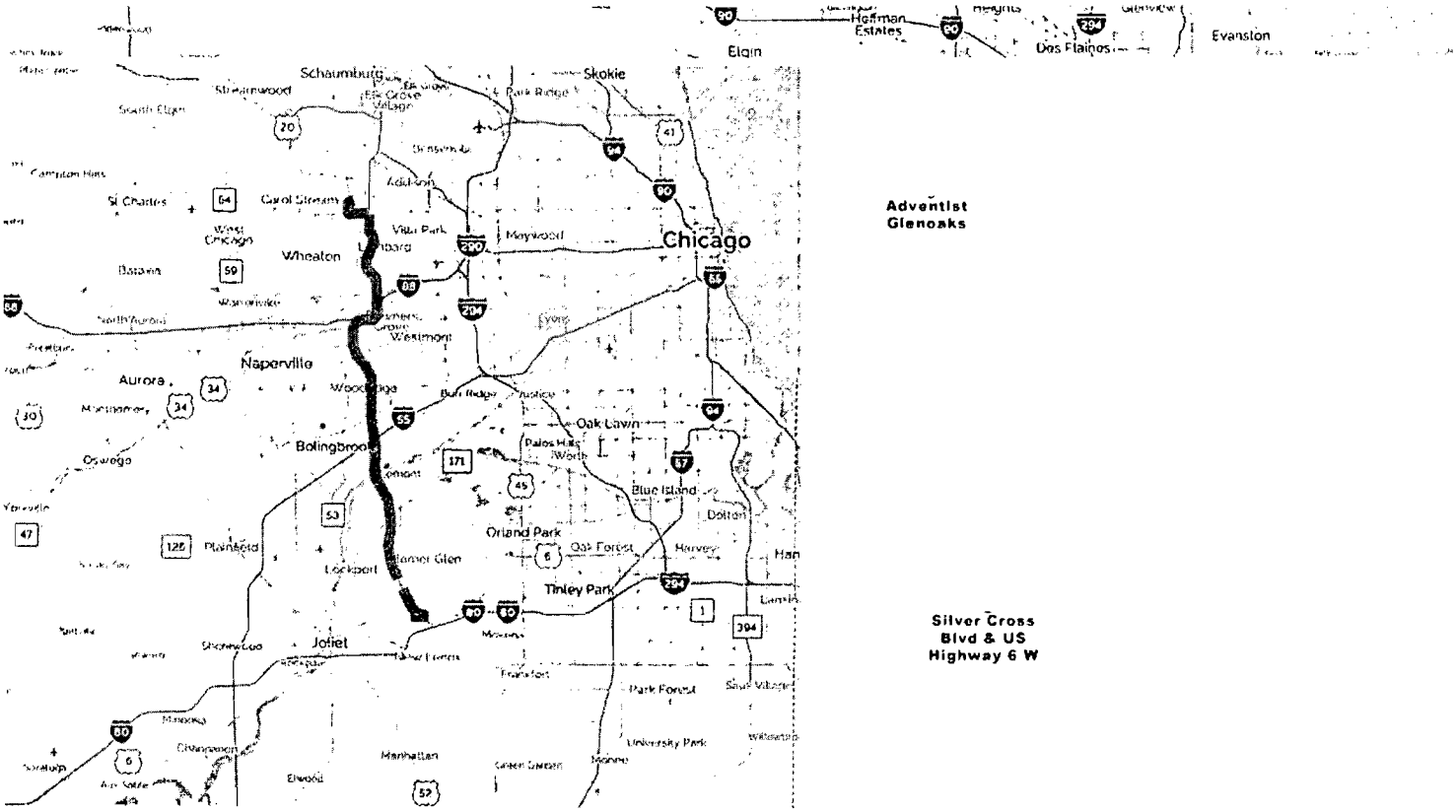
Elgin
Hoffman Estates
Des Plaines
Evanston
Schaumburg
Skokie
Streamwood
Elk Grove Village
Park Ridge
South Elgin
Addison
St Charles
Carol Stream
West Chicago
Villa Park
Lombard
Meyrwood
Chicago
Wheaton
Batavia
Warrenville
North Aurora
Naperville
Aurora
Bolingbrook
Oak Lawn
Palos Hills
Worth
Blue Island
Dolton
Oswego
Plainfield
Lockport
Orland Park
Oak Forest
Harvey
Tinley Park
Joliet
Park Forest
University Park
Manhattan
Elwood
Adventist Glenoaks
Silver Cross Blvd & US Highway 6 W

YOUR TRIP TO:

Elmhurst Memorial Hospital

34 MIN | 29.1 MI

Trip time based on traffic conditions as of 1:27 PM on March 23, 2016. Current Traffic: Moderate

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd.	
Then 0.75 miles	0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward **West Suburbs** (Portions toll)	
Then 13.29 miles	14.04 total miles
3. Keep right to take I-355 N/Veterans Memorial Tollway N toward **CASH** (Portions toll).	
Then 5.23 miles	19.27 total miles
4. Merge onto I-88 E/Chicago-Kansas City Expressway E/Ronald Reagan Memorial Tollway E via EXIT 20A toward **Chicago** (Portions toll)	
Then 8.12 miles	27.39 total miles
5. Keep right to take I-294 S toward Indiana (Portions toll)	
Then 0.36 miles	27.75 total miles
6. Take the **York Rd** exit	
Then 0.24 miles	27.99 total miles
7. Turn right onto York Rd.	
Then 0.51 miles	28.50 total miles
8. Stay straight to go onto S York St.	
Then 0.32 miles	28.82 total miles
9. Turn left onto E Brush Hill Rd	
Then 0.25 miles	29.07 total miles
10. Elmhurst Memorial Hospital, 155 E. BRUSH HILL ROAD	

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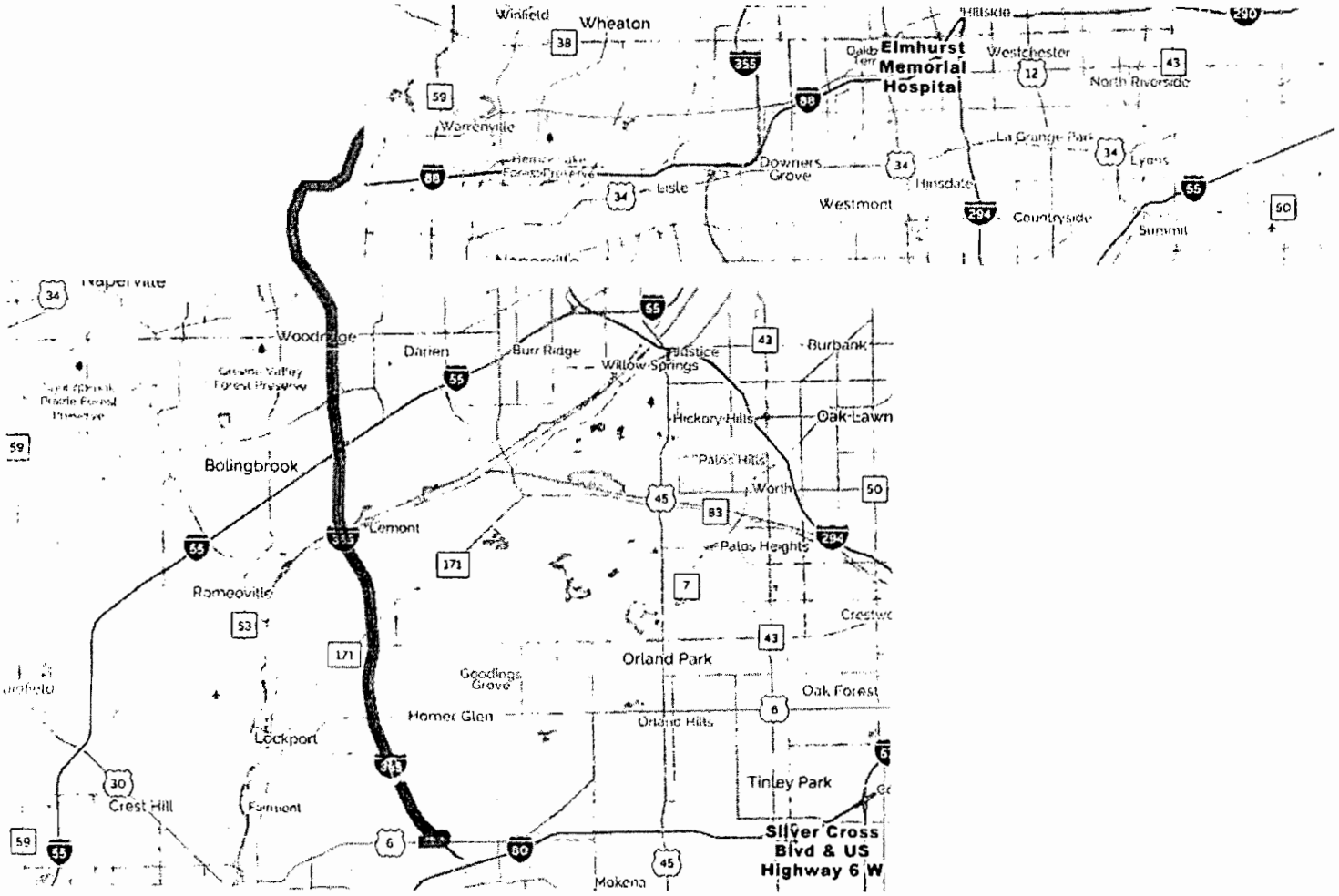
West Chicago

Melrose Park

Attachment 27



Attachment 27

YOUR TRIP TO:

St. Bernard Hospital and Health Care Center

34 MIN | 32.0 MI

Trip time based on traffic conditions as of 2:07 PM on March 23, 2016. Current Traffic: Light

1.	Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd	
	Then 0.32 miles	0.32 total miles
2.	Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)	
	Then 1.16 miles	1.48 total miles
3.	Merge onto I-80 E via the exit on the left toward Indiana	
	Then 12.22 miles	13.69 total miles
4.	Merge onto I-57 N via EXIT 151B on the left toward Chicago	
	Then 13.94 miles	27.63 total miles
5.	I-57 N becomes I-94 W	
	Then 3.13 miles	30.76 total miles
6.	Take the Marquette Rd/67th St exit, EXIT 59B.	
	Then 0.26 miles	31.03 total miles
7.	Keep right at the fork in the ramp	
	Then 0.22 miles	31.24 total miles
8.	Turn left onto W Marquette Rd	
	Then 0.33 miles	31.57 total miles
9.	Turn right onto S Yale Ave	
	Then 0.38 miles	31.95 total miles
10.	Take the 3rd left onto W 64th St	
	Then 0.08 miles	32.03 total miles
11.	St. Bernard Hospital and Health Care Center: 326 W 64TH ST is on the right.	

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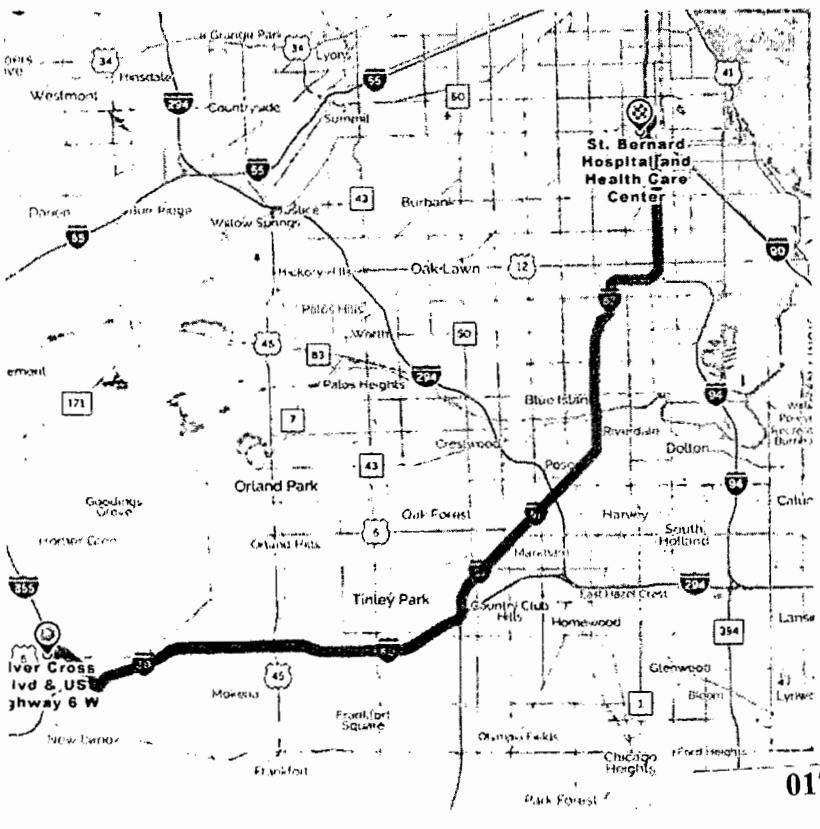

Attachment 27

YOUR TRIP TO:

Central Du Page Hospital

35 MIN | 30.8 MI

Trip time based on traffic conditions as of 1:09 PM on March 23, 2016. Current Traffic: Light

1. Start out going **east** on Maple Rd/US-6 E toward Silver Cross Blvd

   Then 0.75 miles — 0.75 total miles

2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the **left** toward **West Suburbs** (Portions toll)

   Then 13.29 miles — 14.04 total miles

3. Keep **right** to take I-355 N/Veterans Memorial Tollway N toward **CASH** (Portions toll)

   Then 5.23 miles — 19.27 total miles

4. Merge onto I-88 W/Chicago-Kansas City Expressway W/Ronald Reagan Memorial Tollway W via EXIT 20A toward **Aurora** (Portions toll)

   Then 6.45 miles — 25.72 total miles

5. Take the **Winfield Road** exit

   Then 0.42 miles — 26.14 total miles

6. Take the ramp toward **Warrenville/MARIANJOY REHAB CENTER/DEPAUL UNIVERSITY NAPERVILLE CAMPUS/CANTIGNY**

   Then 0.03 miles — 26.16 total miles

7. Merge onto Winfield Rd

   Then 4.67 miles — 30.83 total miles

8. Central Du Page Hospital 0N025 WINFIELD RD

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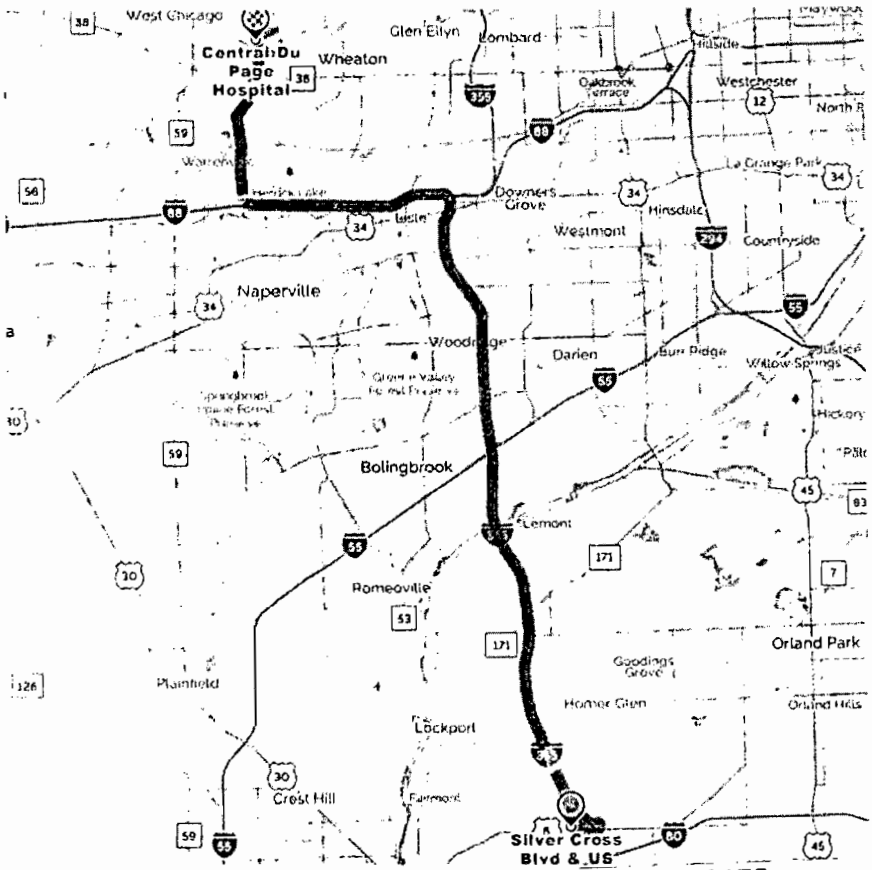

Attachment 27

YOUR TRIP TO:

MacNeal Hospital

35 MIN | 29.2 MI

Trip time based on traffic conditions as of 1:41 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd

   Then 0.75 miles — 0.75 total miles

2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward **West Suburbs** (Portions toll).

   Then 11.48 miles — 12.24 total miles

3. Merge onto I-55 N via EXIT 12A toward **Chicago**.

   Then 14.03 miles — 26.27 total miles

4. Take the **IL-43/Harlem Ave** exit, EXIT 283

   Then 0.27 miles — 26.53 total miles

5. Turn left onto IL-43/Harlem Ave

   Then 1.77 miles — 28.30 total miles

6. Turn right onto Ogden Ave

   Then 0.57 miles — 28.88 total miles

7. Turn left onto Oak Park Ave

   Then 0.37 miles — 29.24 total miles

8. MacNeal Hospital, 3249 OAK PARK AVE

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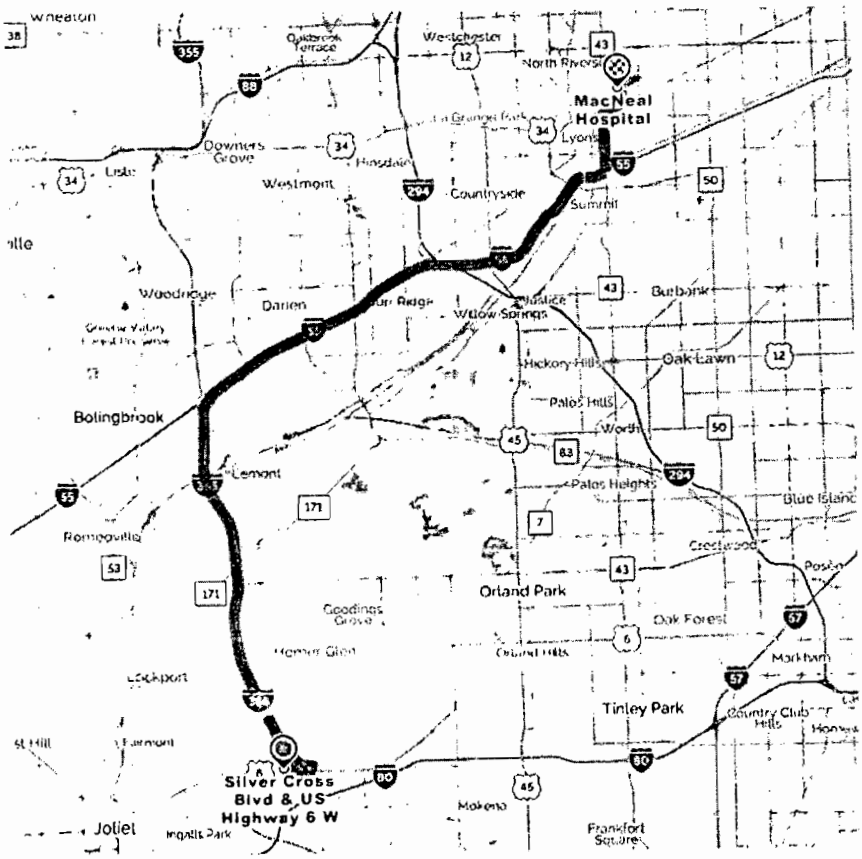

Attachment 27

YOUR TRIP TO:

ittle Co Of Mary Hospital

35 MIN | 29.5 MI

Trip time based on traffic conditions as of 2:00 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd	
Then 0.32 miles	0.32 total miles
2. Merge onto I-355 S/Veterans Memorial Tollway S via the ramp on the left toward I-80 (Portions toll)	
Then 1.16 miles	1.48 total miles
3. Merge onto I-80 E via the exit on the left toward Indiana	
Then 12.22 miles	13.69 total miles
4. Merge onto I-57 N via EXIT 151B on the left toward Chicago.	
Then 12.50 miles	26.20 total miles
5. Take EXIT 357 toward IL-1/Halsted St	
Then 0.17 miles	26.36 total miles
6. Merge onto W 99th St	
Then 0.06 miles	26.42 total miles
7. Turn left onto IL-1/S Halsted St. Continue to follow S Halsted St.	
Then 0.50 miles	26.93 total miles
8. Turn left onto W 95th St/US-20 W/US-12 W	
Then 2.57 miles	29.50 total miles
9. Little Co Of Mary Hospital 2800 W 95TH ST is on the right	

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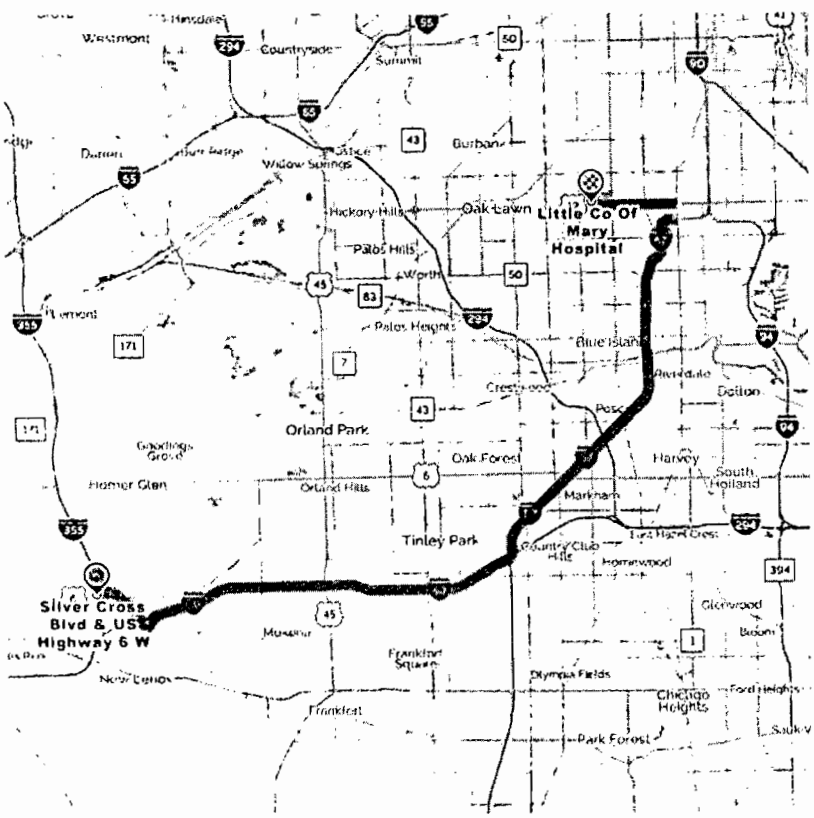

YOUR TRIP TO:

Alexian Brothers Medical Ctr

37 MIN | 35.8 MI

Trip time based on traffic conditions as of 1:18 PM on March 23, 2016. Current Traffic: Light

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd.
   Then 0.75 miles — 0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward West Suburbs (Portions toll)
   Then 13.29 miles — 14.04 total miles
3. Keep right to take I-355 N/Veterans Memorial Tollway N toward CASH (Portions toll)
   Then 15.08 miles — 29.12 total miles
4. Keep right to take I-355 N toward CASH (Portions toll).
   Then 3.33 miles — 32.45 total miles
5. I-355 N becomes I-290 W
   Then 2.32 miles — 34.77 total miles
6. Take the Biesterfield Rd exit, EXIT 4 toward IL-53 S
   Then 0.41 miles — 35.18 total miles
7. Turn right onto Biesterfield Rd
   Then 0.53 miles — 35.71 total miles
8. Turn left onto Leicester Rd
   Then 0.07 miles — 35.78 total miles
9. Turn left
   Then 0.07 miles — 35.85 total miles
10. Alexian Brothers Medical Ctr, 800 BIESTERFIELD RD.

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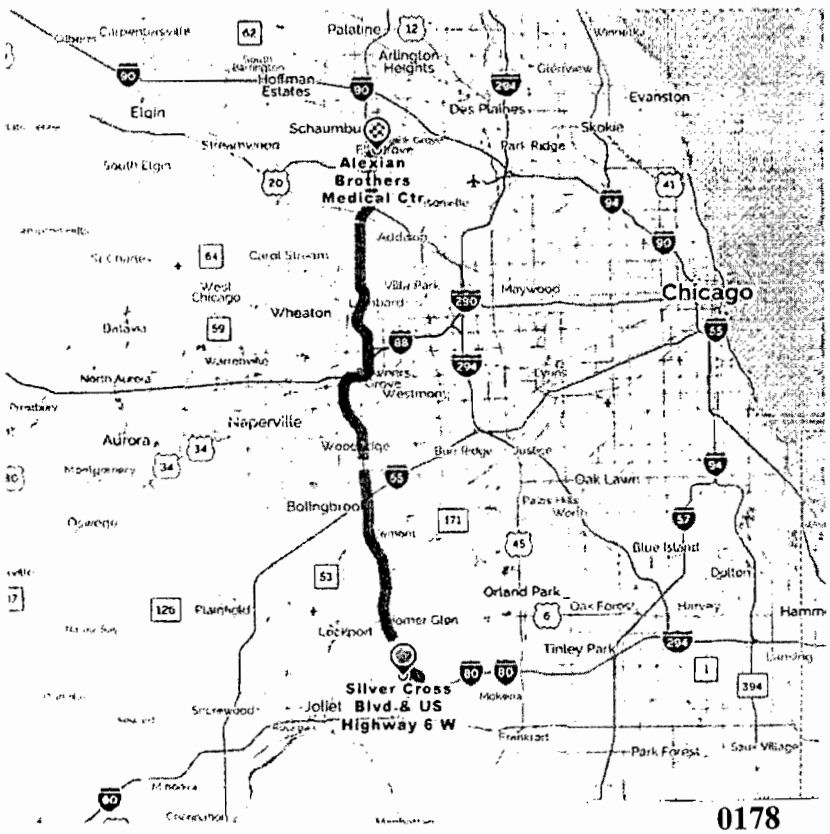

Attachment 27

YOUR TRIP TO:

Loyola University Medical Center

38 MIN | 34.5 MI

Trip time based on traffic conditions as of 2:35 PM on March 23, 2016, Current Traffic: Light

Start of next leg of route	
1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd	
Then 0.75 miles	0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward **West Suburbs** (Portions toll) (Electronic toll collection only)	
Then 13.28 miles	14.04 total miles
3. Keep left to take I-355 N/Veterans Memorial Tollway N toward **ELECTRONIC TOLL ONLY** (Portions toll) (Electronic toll collection only)	
Then 5.23 miles	19.26 total miles
4. Merge onto I-88 E/Chicago-Kansas City Expressway E/Ronald Reagan Memorial Tollway E via EXIT 20A toward **Chicago** (Portions toll)	
Then 8.12 miles	27.39 total miles
5. Keep left to take Chicago-Kansas City Expressway E toward **I-290/Chicago/Rockford/I-294 N/O'Hare/Milwaukee** (Portions toll)	
Then 5.78 miles	33.17 total miles
6. Take EXIT 20 toward IL-171/1st Ave	
Then 0.16 miles	33.33 total miles
7. Merge onto Bataan Dr	
Then 0.07 miles	33.40 total miles
8. Turn right onto S 1st Ave/IL-171	
Then 0.76 miles	34.16 total miles
9. Turn right onto 15th St	
Then 0.11 miles	34.27 total miles
10. Turn right	
Then 0.09 miles	34.36 total miles
11. Take the 1st left	
Then 0.07 miles	34.42 total miles
12. Take the 1st right	
Then 0.07 miles	34.49 total miles
13. Loyola University Medical Center 2160 S 1ST AVE	

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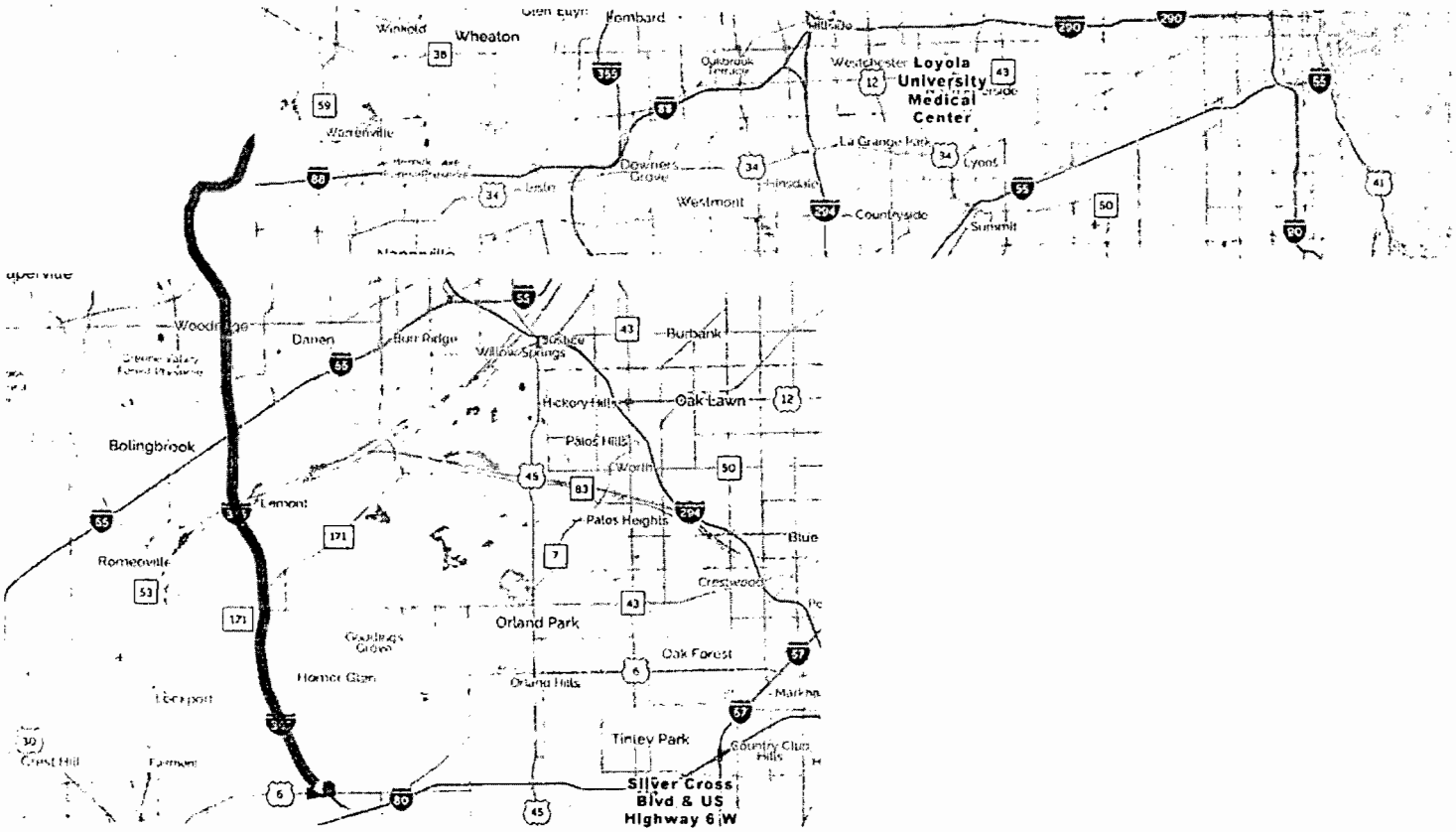
Attachment 27


Wheaton
Loyola University Medical Center
Downers Grove
Westmont
Countryside
Summit
Woodridge
Darien
Burr Ridge
Willow Springs
Burbank
Hickory Hills
Oak Lawn
Palos Hills
Bolingbrook
Lemont
Palos Heights
Romeoville
Orland Park
Oak Forest
Orland Hills
Tinley Park
Country Club Hills
Silver Cross Blvd & US Highway 6 W

YOUR TRIP TO:

Advocate Christ Medical Center

39 MIN | 21.2 MI

Trip time based on traffic conditions as of 1:34 PM on March 23, 2016. Current Traffic: Moderate

1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd. Continue to follow US-6 E

   Then 5.57 miles — 5.57 total miles

2. Turn left onto Wolf Rd/US-6 E. Continue to follow Wolf Rd

   Then 3.88 miles — 9.45 total miles

3. Turn right onto 143rd St/IL-7

   Then 1.65 miles — 11.10 total miles

4. Turn left onto Southwest Hwy/IL-7. Continue to follow Southwest Hwy

   Then 8.08 miles — 19.18 total miles

5. Turn right onto W 95th St/US-20 E/US-12 E.

   Then 1.95 miles — 21.13 total miles

6. Make a U-turn at S Kostner Ave onto W 95th St/US-20 W/US-12 W

   Then 0.04 miles — 21.17 total miles

7. Advocate Christ Medical Center, 4400 W 95TH ST is on the right

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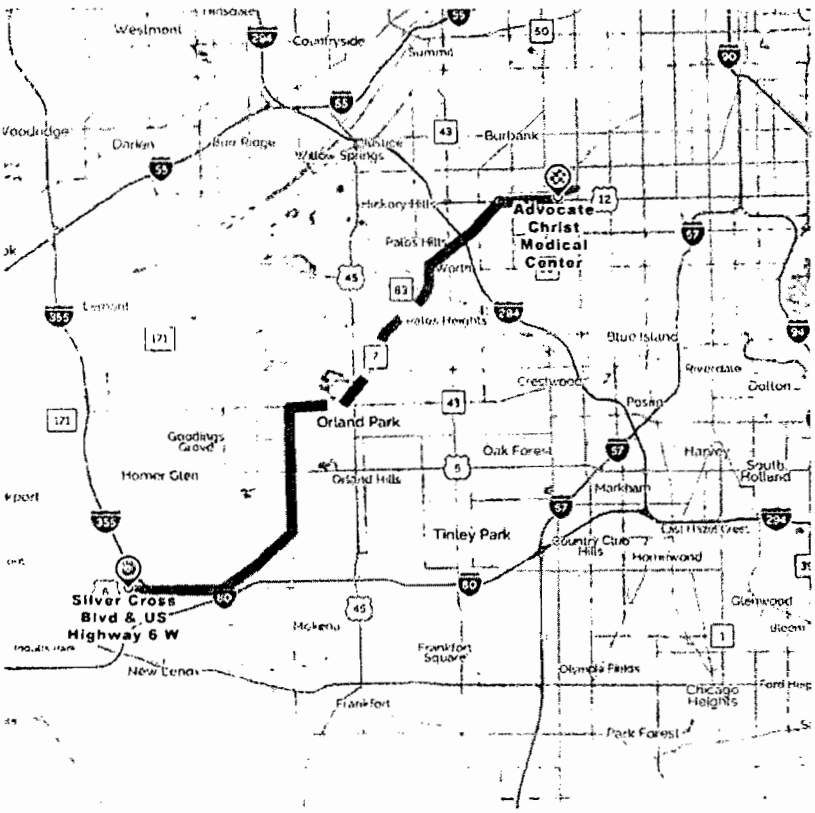

Attachment 27

YOUR TRIP TO:

Westlake Hospital

39 MIN | 34.4 MI

Trip time based on traffic conditions as of 2:29 PM on March 23, 2015. Current Traffic: Light

Start of next leg of route	
1. Start out going east on Maple Rd/US-6 E toward Silver Cross Blvd	
Then 0.75 miles	0.75 total miles
2. Merge onto I-355 N/Veterans Memorial Tollway N via the ramp on the left toward West Suburbs (Portions toll) (Electronic toll collection only)	
Then 13.28 miles	14.04 total miles
3. Keep left to take I-355 N/Veterans Memorial Tollway N toward ELECTRONIC TOLL ONLY (Portions toll) (Electronic toll collection only)	
Then 5.23 miles	19.26 total miles
4. Merge onto I-88 E/Chicago-Kansas City Expressway E/Ronald Reagan Memorial Tollway E via EXIT 20A toward Chicago (Portions toll)	
Then 8.12 miles	27.39 total miles
5. Keep left to take Chicago-Kansas City Expressway E toward I-290/Chicago/Rockford/I-294 N/O'Hare/Milwaukee (Portions toll)	
Then 4.76 miles	32.15 total miles
6. Take EXIT 19A toward 17th Ave	
Then 0.20 miles	32.35 total miles
7. Merge onto Bataan Dr	
Then 0.54 miles	32.89 total miles
8. Turn left onto S 9th Ave	
Then 1.38 miles	34.27 total miles
9. Turn left onto W Lake St	
Then 0.15 miles	34.42 total miles
10. Westlake Hospital 1225 W LAKE ST	

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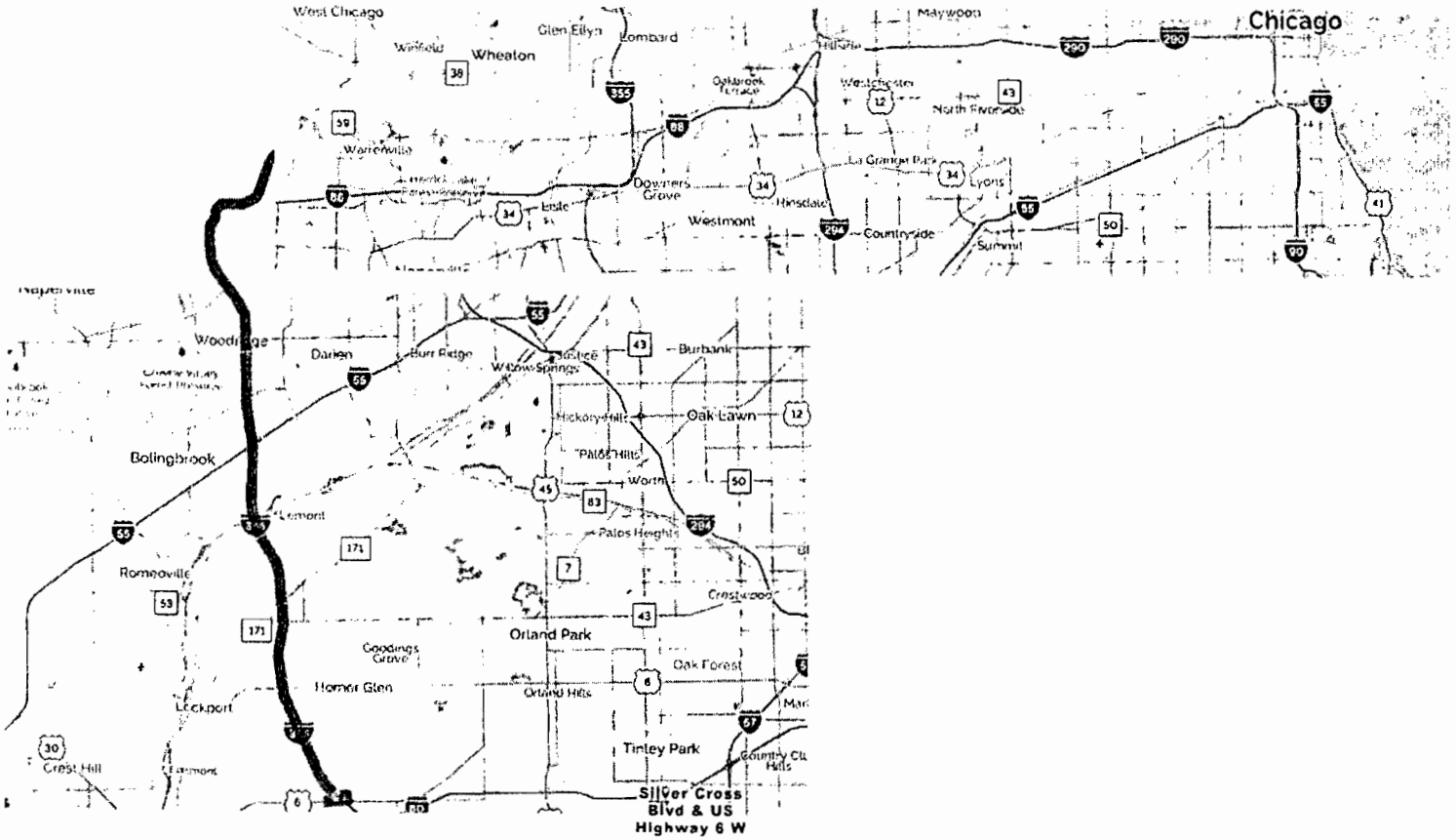

Attachment 27

Criterion 1110.1540(c)(B), Geographic Service Area Patient Origin Data

Twenty-three (23) physicians have indicated a commitment to performing surgery procedures at the proposed Surgery Center. These same physicians are currently on them medical staff at Silver Cross Hospital. One hundred percent (100%) of the patients for the proposed Surgery Center are projected to come from Silver Cross Hospital's primary service area (and thus, the GSA), well in excess of the fifty percent (50%) GSA threshold set forth in Criterion 1110.1540(c)(B).

The following chart summarizes the number of anticipated referrals from each physician by specialty. Copies of the physician referral letters are attached at ATTACHMENT 27.

Anticipated Physician Referrals

SURGEON	SPECIALTY	ANTICIPATED CASES	PROJECTED HOURS
BOKHARI, SYED	General Surgery	110	198
DANIELSON, MARK	General Surgery	205	369
GAMAGAMI, REZA	General Surgery	400	720
YAMADA, SHISHIN	General Surgery	100	180
1.8 hours per General Surgery Case		**815**	**1,467**
GARCINI, FRANCISCO	Gyne	80	144
PIERRE, GAMILAH	Gyne	80	144
VIENNE, PETER	Gyne	75	135
1.8 hours per Gyne Case		**235**	**423**
KISLA, TIMOTHY	Opthalmology	475	428
0.9 hous per Opthalmology Case		**475**	**428**
ANTKOWIAK, TOMASZ	Ortho	50	95
BURGESS, BRIAN	Ortho	11	21
BURRA, GIRIDHAR	Ortho	50	95
DALEY, ROBERT	Ortho	20	38
DWORSKY, BRADLEY	Ortho	41	78
HURBANEK, JASON	Ortho	28	53
NACKE, ELLIOT	Ortho	40	76
SEMBA, ROBERT	Ortho	130	247
TEMPLIN, CARY	Ortho	7	13
TRKSAK, PAUL	Ortho	106	201
1.9 Hours per Ortho Case		**483**	**918**
SINK, CYNTHIA	Podiatry	12	20
SMIT, BRUCE	Podiatry	18	31
1.7 Hours per Podiatry Case		**30**	**51**
ANDROS, GREGORY	Urology	35	56
MANECKE, RYAN	Urology	42	67
SAWHNEY, SANDEEP	Urology	50	80
1.6 Hours per Urology Case		**127**	**203**
TOTAL		**2,165**	**3,489**

Over the past fiscal year (i.e., October 1, 2014 and September 31, 2015), the referring physicians for the proposed Surgery Center have performed 2,330 outpatient surgeries at Silver Cross Hospital. One hundred percent (100%) of those 2,330 patients came from Silver Cross

Hospital's primary service area (and thus, the GSA for the proposed Surgery Center). The patient origin for those outpatient procedures is set forth below:

Referring Physician Outpatient Surgery Patient Origin

PHYSICIAN	PATIENT ORIGIN	CASES
ANDROS, GREGORY	60403 - Crest Hill, IL	3
	60421 - Elwood, IL	1
	60423 - Frankfort, IL	8
	60432 - Joliet, IL	7
	60433 - Joliet, IL	1
	60435 - Joliet, IL	5
	60436 - Joliet, IL	1
	60439 - Lemont, IL	1
	60441 - Lockport, IL	7
	60442 - Manhattan, IL	1
	60448 - Mokena, IL	1
	60451 - New Lenox, IL	5
	60491 - Homer Glen, IL	5
Subtotal		**46**
ANTKOWIAK, TOMASZ	60421 - Elwood, IL	1
	60423 - Frankfort, IL	4
	60432 - Joliet, IL	2
	60435 - Joliet, IL	1
	60436 - Joliet, IL	1
	60441 - Lockport, IL	1
	60442 - Manhattan, IL	2
	60451 - New Lenox, IL	6
Subtotal		**18**
BOKHARI, SYED	60403 - Crest Hill, IL	10
	60421 - Elwood, IL	2
	60423 - Frankfort, IL	3
	60432 - Joliet, IL	16
	60433 - Joliet, IL	12
	60435 - Joliet, IL	10
	60436 - Joliet, IL	12
	60439 - Lemont, IL	3
	60441 - Lockport, IL	11
	60442 - Manhattan, IL	1
	60448 - Mokena, IL	7
	60451 - New Lenox, IL	6
	60467 - Orland Park, IL	9
	60491 - Homer Glen, IL	5
Subtotal		**107**
BURGESS, RICHARD	60423 - Frankfort, IL	3
	60432 - Joliet, IL	1
	60433 - Joliet, IL	3
	60435 - Joliet, IL	1
	60439 - Lemont, IL	1
	60441 - Lockport, IL	3
	60442 - Manhattan, IL	1
	60448 - Mokena, IL	2
	60451 - New Lenox, IL	4
	60467 - Orland Park, IL	5
	60491 - Homer Glen, IL	1
Subtotal		**25**
BURRA, GIRIDHAR	60403 - Crest Hill, IL	1
	60432 - Joliet, IL	2
	60433 - Joliet, IL	2
	60435 - Joliet, IL	5
	60436 - Joliet, IL	1
	60439 - Lemont, IL	4

PHYSICIAN	PATIENT ORIGIN	CASES
	60441 - Lockport, IL	5
	60442 - Manhattan, IL	4
	60448 - Mokena, IL	2
	60451 - New Lenox, IL	9
	60467 - Orland Park, IL	1
Subtotal		**36**
DALEY, ROBERT	60436 - Joliet, IL	1
	60491 - Homer Glen, IL	1
Subtotal		**2**
DANIELSON, MARK	60403 - Crest Hill, IL	8
	60421 - Elwood, IL	7
	60423 - Frankfort, IL	12
	60432 - Joliet, IL	4
	60433 - Joliet, IL	17
	60435 - Joliet, IL	25
	60436 - Joliet, IL	7
	60439 - Lemont, IL	1
	60441 - Lockport, IL	20
	60442 - Manhattan, IL	11
	60448 - Mokena, IL	8
	60451 - New Lenox, IL	47
	60467 - Orland Park, IL	3
	60491 - Homer Glen, IL	4
Subtotal		**174**
DWORSKY, BRADLEY	60403 - Crest Hill, IL	3
	60421 - Elwood, IL	1
	60423 - Frankfort, IL	1
	60432 - Joliet, IL	5
	60433 - Joliet, IL	1
	60435 - Joliet, IL	4
	60436 - Joliet, IL	2
	60439 - Lemont, IL	3
	60441 - Lockport, IL	3
	60442 - Manhattan, IL	3
	60448 - Mokena, IL	2
	60451 - New Lenox, IL	13
Subtotal		**41**
GAMAGAMI, REZA	60403 - Crest Hill, IL	19
	60421 - Elwood, IL	28
	60423 - Frankfort, IL	90
	60432 - Joliet, IL	56
	60433 - Joliet, IL	56
	60435 - Joliet, IL	63
	60436 - Joliet, IL	23
	60439 - Lemont, IL	38
	60441 - Lockport, IL	99
	60442 - Manhattan, IL	55
	60448 - Mokena, IL	86
	60451 - New Lenox, IL	254
	60467 - Orland Park, IL	27
	60491 - Homer Glen, IL	59
Subtotal		**953**
GARCINI, FRANCISCO	60403 - Crest Hill, IL	2
	60421 - Elwood, IL	7
	60423 - Frankfort, IL	8
	60432 - Joliet, IL	8
	60433 - Joliet, IL	3
	60435 - Joliet, IL	11
	60436 - Joliet, IL	4
	60439 - Lemont, IL	1
	60441 - Lockport, IL	15

PHYSICIAN	PATIENT ORIGIN	CASES
	60442 - Manhattan, IL	3
	60448 - Mokena, IL	4
	60451 - New Lenox, IL	22
	60467 - Orland Park, IL	2
	60491 - Homer Glen, IL	2
Subtotal		**92**
HURBANEK, JASON	60403 - Crest Hill, IL	1
	60421 - Elwood, IL	1
	60423 - Frankfort, IL	2
	60432 - Joliet, IL	1
	60433 - Joliet, IL	1
	60435 - Joliet, IL	4
	60436 - Joliet, IL	4
	60439 - Lemont, IL	1
	60441 - Lockport, IL	3
	60442 - Manhattan, IL	1
	60448 - Mokena, IL	1
	60451 - New Lenox, IL	5
	60491 - Homer Glen, IL	3
Subtotal		**28**
KISLA, TIMOTHY	60403 - Crest Hill, IL	7
	60421 - Elwood, IL	8
	60423 - Frankfort, IL	17
	60432 - Joliet, IL	21
	60433 - Joliet, IL	14
	60435 - Joliet, IL	17
	60436 - Joliet, IL	6
	60439 - Lemont, IL	3
	60441 - Lockport, IL	21
	60442 - Manhattan, IL	17
	60448 - Mokena, IL	28
	60451 - New Lenox, IL	88
	60467 - Orland Park, IL	10
	60491 - Homer Glen, IL	16
Subtotal		**273**
MANECKE, RYAN	60421 - Elwood, IL	2
	60432 - Joliet, IL	3
	60433 - Joliet, IL	4
	60435 - Joliet, IL	3
	60436 - Joliet, IL	2
	60439 - Lemont, IL	1
	60441 - Lockport, IL	2
	60442 - Manhattan, IL	3
	60448 - Mokena, IL	5
	60451 - New Lenox, IL	6
	60467 - Orland Park, IL	1
	60491 - Homer Glen, IL	3
Subtotal		**35**
NACKE, ELLIOT	60403 - Crest Hill, IL	1
	60421 - Elwood, IL	1
	60423 - Frankfort, IL	2
	60432 - Joliet, IL	2
	60433 - Joliet, IL	1
	60435 - Joliet, IL	1
	60436 - Joliet, IL	1
	60439 - Lemont, IL	4
	60441 - Lockport, IL	11
	60442 - Manhattan, IL	2
	60448 - Mokena, IL	1
	60451 - New Lenox, IL	6
	60467 - Orland Park, IL	1

PHYSICIAN	PATIENT ORIGIN	CASES
Subtotal		34
PIERRE, GAMILAH	60403 - Crest Hill, IL	4
	60421 - Elwood, IL	3
	60423 - Frankfort, IL	8
	60432 - Joliet, IL	4
	60433 - Joliet, IL	4
	60435 - Joliet, IL	4
	60436 - Joliet, IL	6
	60439 - Lemont, IL	2
	60441 - Lockport, IL	9
	60442 - Manhattan, IL	1
	60448 - Mokena, IL	7
	60451 - New Lenox, IL	23
	60467 - Orland Park, IL	3
	60491 - Homer Glen, IL	1
Subtotal		79
SAWHNEY, SANDEEP	60423 - Frankfort, IL	2
	60432 - Joliet, IL	9
	60433 - Joliet, IL	3
	60435 - Joliet, IL	2
	60436 - Joliet, IL	2
	60439 - Lemont, IL	1
	60441 - Lockport, IL	6
	60442 - Manhattan, IL	5
	60448 - Mokena, IL	3
	60451 - New Lenox, IL	8
	60467 - Orland Park, IL	5
	60491 - Homer Glen, IL	2
Subtotal		48
SEMBA, ROBERT	60421 - Elwood, IL	3
	60423 - Frankfort, IL	9
	60432 - Joliet, IL	6
	60433 - Joliet, IL	5
	60435 - Joliet, IL	12
	60436 - Joliet, IL	6
	60439 - Lemont, IL	8
	60441 - Lockport, IL	22
	60442 - Manhattan, IL	9
	60448 - Mokena, IL	6
	60451 - New Lenox, IL	20
	60467 - Orland Park, IL	6
	60491 - Homer Glen, IL	10
Subtotal		122
SINK, CYNTHIA 1639168503	60439 - Lemont, IL	3
	60441 - Lockport, IL	2
	60442 - Manhattan, IL	1
	60448 - Mokena, IL	2
	60451 - New Lenox, IL	2
	60467 - Orland Park, IL	2
	60491 - Homer Glen, IL	1
Subtotal		13
SMIT, BRUCE	60403 - Crest Hill, IL	1
	60423 - Frankfort, IL	6
	60433 - Joliet, IL	1
	60448 - Mokena, IL	3
	60451 - New Lenox, IL	1
Subtotal		12
TEMPLIN, CARY	60441 - Lockport, IL	1
	60451 - New Lenox, IL	1
Subtotal		2

PHYSICIAN	PATIENT ORIGIN	CASES
TRKSAK, PAUL	60403 - Crest Hill, IL	1
	60421 - Elwood, IL	7
	60423 - Frankfort, IL	5
	60432 - Joliet, IL	4
	60433 - Joliet, IL	4
	60435 - Joliet, IL	6
	60436 - Joliet, IL	3
	60439 - Lemont, IL	3
	60441 - Lockport, IL	10
	60442 - Manhattan, IL	8
	60448 - Mokena, IL	10
	60451 - New Lenox, IL	39
	60467 - Orland Park, IL	2
	60491 - Homer Glen, IL	4
Subtotal		**106**
VIENNE, PETER	60421 - Elwood, IL	1
	60435 - Joliet, IL	1
	60441 - Lockport, IL	2
Subtotal		**4**
YAMADA, SHISHIN	60403 - Crest Hill, IL	3
	60421 - Elwood, IL	2
	60423 - Frankfort, IL	4
	60432 - Joliet, IL	8
	60433 - Joliet, IL	5
	60435 - Joliet, IL	7
	60436 - Joliet, IL	7
	60439 - Lemont, IL	3
	60441 - Lockport, IL	19
	60442 - Manhattan, IL	1
	60451 - New Lenox, IL	8
	60467 - Orland Park, IL	2
	60491 - Homer Glen, IL	11
Subtotal		**80**
Grand Total		**2330**

Source: IHA COMPdata

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(d)(1) & (2), Service Demand -- Establishment
Criterion 1110.1540(e)(1) & (2), Service Demand -- Expansion

The Applicants are proposing, and can easily justify, three operating rooms. The Applicants have received physician referral letters for the following surgical specialties: General Surgery, Gynecology, Ophthalmology, Orthopedics, Podiatry, and Urology, copies of which are attached at ATTACHMENT 27.

These same referral letters indicate that these surgeons will refer 2,165 cases (or 3,489 hours) in 2018 and 2,252 cases (or 3,628 hours) in 2019 at the proposed Surgery Center. One hundred percent (100%) of the patients for the proposed Surgery Center are projected to come from Silver Cross Hospital's primary service area (and thus, the GSA).

The Applicants have elected to complete Criterion 1110.1540(d)(Establishment) and Criterion 1110.1540(e)(Expansion), because the proposed Surgery Center is being established to reduce the high utilization and projected demand for outpatient surgical services at Silver Cross Hospital. That said, the Applicants would assert that the Expansion related Criteria are more applicable.

Historical Utilization at Silver Cross Hospital

Silver Cross Hospital's Procedural Care Unit has eleven operating rooms that are used for both inpatient and outpatient surgeries. These same eleven operating rooms are used for surgeries across a variety of specialties.

Silver Cross Hospital has been experiencing tremendous growth in outpatient surgery in recent years. In the last two years alone, Silver Cross Hospital's outpatient surgery cases have increased by more than 11% and outpatient surgery hours have grown by more than 15%. Fiscal year 16 indicates continued surgical growth at 11% after 6 months. The below table summarizes Silver Cross Hospital's most recent surgical activity:

Calendar Year	Operating Rooms	Inpatient Surgery Cases	Outpatient Surgery Cases	Total Surgery Cases	Inpatient Surgery Hours	Outpatient Surgery Hours	Total Surgery Hours	Operating Room Utilization
2014	11	3801	6153	9954	10021	9670	19691	119.3%
2015	11	3854	6834	10688	10246	11148	21394	129.7%

Source: Annual Hospital Questionnaire

Silver Cross Hospital's operating rooms are operating well above the state required minimum utilization level of 80%.

Projected Utilization and Explanation of Projections

Utilization at the proposed Surgery Center will come entirely from cases surgeons are already performing at Silver Cross Hospital. As indicated above, it is projected that the proposed Surgery Center will perform 2,165 surgeries in 2018 (i.e., the proposed Surgery Center's first year of operation) and 2,252 surgeries in 2019 (i.e., the proposed Surgery Center's second year of operation.) Physician referral letters are attached at ATTACHMENT 27. Because these cases will be coming entirely from Silver Cross Hospital's existing primary service area – a model was built on historical volumes by service area to project activity in years over the next four years for the entire Silver Cross Hospital surgical enterprise (i.e., Silver Cross Hospital and the proposed Surgery Center combined), for the proposed Surgery Center and for that portion that will remain at the hospital proper. This model was based on historical growth rates and based on average case times as reported on Silver Cross Hospital's Annual Hospital Questionnaire. The table at the end of this section summarizes the historical and projected surgical activity and growth rates by service area.

Silver Cross Hospital's historical surgical activity was broken down by service area for the last two years. An historical growth rate was then calculated based on the change in activity between FY14 and FY15. Those historical growth rates were then applied to FY15 activity by service area to project future volumes over the next four years.

To project surgical hours, Silver Cross Hospital pulled the average time per case from the 2015 Annual Hospital Questionnaire data that was submitted in March 2016. Based on the 2015 AHQ data, Silver Cross Hospital had an average of 2.00 hours per case for total surgery and 1.6115 hours per case for outpatient surgery. Those rates were applied to the projected cases over the next four years to estimate surgical hours for the Silver Cross Hospital surgical enterprise in total and for the proposed Surgery Center.

It is important to note the Silver Cross Procedural Care Unit is experiencing exceptionally high utilization and that utilization is projected to remain high at Silver Cross Hospital's Procedural Care Unit after the proposed Surgery Center opens. Silver Cross Hospital manages its surgical services department extremely efficiently and has been offering extended hours of operation during weekdays and providing surgical time on weekends. This is how Silver Cross Hospital manages such high volumes and utilization. In fact, weekend hours have recently become great satisfiers for both patients and physicians and that is expected to continue.

It also bears noting that Silver Cross Hospital has been extremely conservative in developing its model. Indeed, Silver Cross Hospital has repeatedly submitted conservative (and thus, very accurate) projections to this Board. For example, in its Replacement Hospital CON Application (Project No. 07-148), filed on November 21, 2007, Silver Cross Hospital projected 5,199 endoscopy hours in 2014 and 16,096 surgical hours in 2014. In fact, Silver Cross Hospital had 6,327 endoscopy hours in 2014 and 19,691 surgical hours in 2014.

PROJECTION MODEL

SCH ENTERPRISE - TOTAL SURGERY ACTIVITY

(Inpatient and Outpatient combined – does not include any excludes GI procedure room activity)

Service Area	Historical Cases		Historical Growth Rate	Projected Cases				Avg Hours/Case (2015 AHQ)	Projected Surgery Hours				CON Hours per Room	Operating Rooms Justified (rounded up)			
	FY14 (Actual)	FY15 (Actual)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)
O.R.s	11	11							11	11	14	14					
Primary	6395	6622	4%	6858	7102	7355	7617	2.00	13716	14204	14710	15234					
Secondary-E	568	681	20%	817	980	1175	1409	2.00	1634	1960	2350	2818					
Secondary-N	483	491	2%	500	509	518	527	2.00	1000	1018	1036	1054					
Secondary-S	287	323	13%	364	410	462	520	2.00	728	820	924	1040					
Secondary-W	835	885	6%	938	995	1055	1119	2.00	1876	1990	2110	2238					
Inmigration	1343	1523	13%	1728	1960	2223	2521	2.00	3456	3920	4446	5042					
Total	9922	10536	6.2%	11205	11956	12788	13713	2.00	22410	23912	25576	27426	1500	14.9 = 15	15.9 = 16	17.1 = 18	18.3 = 19
Utilization									135.8%	113.9%	121.8%	130.6%					

I- PROPOSED FREESTANDING ASTC ACTIVITY

vice Area	Historical Cases		Historical Growth Rate	Projected Cases				Avg Hours/Case (2015 AHQ)	Projected Surgery Hours				CON Hours per Room	Operating Rooms Justified (rounded up)			
	FY14 (Actual)	FY15 (Actual)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)
.s											3	3					
mary (Service Area)		1995	4.0%			2165	2252	1.6115			3489	3628	1500			2.4 = 3.0	2.4 = 3.0

SCH HOSPITAL-BASED SURGERY ACTIVITY - REMAINING

Service Area	Historical Cases		Historical Growth Rate	Projected Cases				Avg Hours/Case (2015 AHQ)	Projected Surgery Hours				CON Hours per Room	Operating Rooms Justified (rounded up)			
	FY14 (Actual)	FY15 (Actual)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)		FY16 (Proj)	FY17 (Proj)	FY18 (Proj)	FY19 (Proj)
).R.s	11	11							11	11	11	11					
rimary	6395	4457		6858	7102	5190	5365		13716	14204	11221	11563					
econdary-E	568	681		817	980	1175	1409		1634	1960	2350	2818					
econdary-N	483	491		500	509	518	527		1000	1018	1036	1054					
econdary-S	287	323		364	410	462	520		728	820	924	1040					
econdary-W	835	885		938	995	1055	1119		1876	1990	2110	2238					
ımigration	1343	1523		1728	1960	2223	2521		3456	3920	4446	5042					
otal	9922	10536		11205	11956	10623	11461		22410	23912	22047	23755	1500	14.9 = 15	15.9 = 16	14.7 =15	15.8 = 16
tilization									135.8%	144.9%	133.6%	144.0%					

0190

Attachment 27

MARCH 8
February ___, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 107 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 110 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Syed Bokhari, M.D.
Address: Cardinal Surgical Associates
1051 Essington Rd., Suite 230A
Joliet, IL 60435

Subscribed and sworn before me
this 8th day of March, 2016

Carol J Zier

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Syed Bokhari, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	10
60421 - Elwood, IL	2
60423 - Frankfort, IL	3
60432 - Joliet, IL	16
60433 - Joliet, IL	12
60435 - Joliet, IL	10
60436 - Joliet, IL	12
60439 - Lemont, IL	3
60441 - Lockport, IL	11
60442 - Manhattan, IL	1
60448 - Mokena, IL	7
60451 - New Lenox, IL	6
60467 - Orland Park, IL	9
60491 - Homer Glen, IL	5

February 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 174 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 205 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Mark Danielson, M.D.
Address: Surgical Consultants of Joliet, Ltd.
2 Uno Circle
Joliet, IL 60435

Subscribed and sworn before me
this 28th day of February, 2016

Carol J. Zier

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Mark Danielson, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	8
60421 - Elwood, IL	7
60423 - Frankfort, IL	12
60432 - Joliet, IL	4
60433 - Joliet, IL	17
60435 - Joliet, IL	25
60436 - Joliet, IL	7
60439 - Lemont, IL	1
60441 - Lockport, IL	20
60442 - Manhattan, IL	11
60448 - Mokena, IL	8
60451 - New Lenox, IL	47
60467 - Orland Park, IL	3
60491 - Homer Glen, IL	4

February 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 953 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 400 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Reza Gamagami, M.D.
Address: Progressive Surgical Associates, SC
1890 Silver Cross Blvd., Suite 410
New Lenox, IL 60451

Subscribed and sworn before me
this 28th day of February 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Reza Gamagami, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	19
60421 - Elwood, IL	28
60423 - Frankfort, IL	90
60432 - Joliet, IL	56
60433 - Joliet, IL	56
60435 - Joliet, IL	63
60436 - Joliet, IL	23
60439 - Lemont, IL	38
60441 - Lockport, IL	99
60442 - Manhattan, IL	55
60448 - Mokena, IL	86
60451 - New Lenox, IL	254
60467 - Orland Park, IL	27
60491 - Homer Glen, IL	59

March 8, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 80 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 100 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

S. Yamada

Shishin Yamada, M.D.
Address: Silver Lining Surgeons, SC
1890 Silver Cross Blvd., Suite 560
New Lenox, IL 60451

Subscribed and sworn before me
this 8th day of March, 2016

Carol J. Zier

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Shishin Yamada, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	3
60421 - Elwood, IL	2
60423 - Frankfort, IL	4
60432 - Joliet, IL	8
60433 - Joliet, IL	5
60435 - Joliet, IL	7
60436 - Joliet, IL	7
60439 - Lemont, IL	3
60441 - Lockport, IL	19
60442 - Manhattan, IL	1
60451 - New Lenox, IL	8
60467 - Orland Park, IL	2
60491 - Homer Glen, IL	11

February 23, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 92 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 80 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Francisco Garcini, M.D., Ph.D.
Address: Partners in OB & Women's Health
1890 Silver Cross Blvd., Suite 210
New Lenox, IL 60451

Subscribed and sworn before me
this 23rd day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 201

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Francisco Garcini, M.D., Ph.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	2
60421 - Elwood, IL	7
60423 - Frankfort, IL	8
60432 - Joliet, IL	8
60433 - Joliet, IL	3
60435 - Joliet, IL	11
60436 - Joliet, IL	4
60439 - Lemont, IL	1
60441 - Lockport, IL	15
60442 - Manhattan, IL	3
60448 - Mokena, IL	4
60451 - New Lenox, IL	22
60467 - Orland Park, IL	2
60491 - Homer Glen, IL	2

February 23, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 79 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 80 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Gamilah Pierre, M.D.
Address: Partners in OB & Women's Health
1890 Silver Cross Blvd., Suite 210
New Lenox, IL 60451

Subscribed and sworn before me
this 23rd day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Gamilah Pierre, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	4
60421 - Elwood, IL	3
60423 - Frankfort, IL	8
60432 - Joliet, IL	4
60433 - Joliet, IL	4
60435 - Joliet, IL	4
60436 - Joliet, IL	6
60439 - Lemont, IL	2
60441 - Lockport, IL	9
60442 - Manhattan, IL	1
60448 - Mokena, IL	7
60451 - New Lenox, IL	23
60467 - Orland Park, IL	3
60491 - Homer Glen, IL	1

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 4 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 75 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Peter Vienne, Jr., D.O.
Address: Peter Vienne, D.O., SC
936 W. Route 6
Morris, IL 60450

Subscribed and sworn before me
this 29th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Peter Vienne, Jr., D.O.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60421 - Elwood, IL	1
60435 - Joliet, IL	1
60441 - Lockport, IL	2

March 3, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 389 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 475 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Timothy Kisla, D.O.
Address: Advanced Eyecare
1870 Silver Cross Blvd., Suite 110
New Lenox, IL 60451

Subscribed and sworn before me
this 3rd day of March, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Timothy Kisla, D.O.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	7
60421 - Elwood, IL	8
60423 - Frankfort, IL	17
60432 - Joliet, IL	21
60433 - Joliet, IL	14
60435 - Joliet, IL	17
60436 - Joliet, IL	6
60439 - Lemont, IL	3
60441 - Lockport, IL	21
60442 - Manhattan, IL	17
60448 - Mokena, IL	28
60451 - New Lenox, IL	88
60467 - Orland Park, IL	10
60491 - Homer Glen, IL	16

February 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 18 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 50 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Tomasz Antkowiak, M.D.
Address: Oak Orthopedics
19552 S. Harlem Ave.
Frankfort, IL 60423

Subscribed and sworn before me
this 28th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Tomasz Antkowiak, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60421 - Elwood, IL	1
60423 - Frankfort, IL	4
60432 - Joliet, IL	2
60435 - Joliet, IL	1
60436 - Joliet, IL	1
60441 - Lockport, IL	1
60442 - Manhattan, IL	2
60451 - New Lenox, IL	6

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 11 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 11 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Brian Burgess, D.P.M.
Address: Hinsdale Orthopaedic Associates, SC
1870 Silver Cross Blvd., Suite 200
New Lenox, IL 60451

Subscribed and sworn before me
this 29th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Brian Burgess, D.P.M.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60433 - Joliet, IL	1
60436 - Joliet, IL	3
60439 - Lemont, IL	1
60441 - Lockport, IL	1
60448 - Mokena, IL	1
60451 - New Lenox, IL	4

February 26, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 36 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 50 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Giridhar Burra, M.D.
Address: Hinsdale Orthopaedic Assc., SC
1870 Silver Cross Blvd, Suite 200
New Lenox, IL 60451

Subscribed and sworn before me
this 26th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Giridhar Burra, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	1
60432 - Joliet, IL	2
60433 - Joliet, IL	2
60435 - Joliet, IL	5
60436 - Joliet, IL	1
60439 - Lemont, IL	4
60441 - Lockport, IL	5
60442 - Manhattan, IL	4
60448 - Mokena, IL	2
60451 - New Lenox, IL	9
60467 - Orland Park, IL	1

3/10/16

February ___, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 7 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 20 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Robert Daley, M.D.
Address: Hinsdale Orthopaedic Association, SC
951 Essington Road
Joliet, IL 60431

Subscribed and sworn before me
this 10th day of March, 2016

Carol J. Zier

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Robert Daley, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 41 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 41 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Bradley Dworsky, M.D.
Address: Hinsdale Orthopaedic Assoc., SC
951 Essington Rd.
Joliet, IL 60435

Subscribed and sworn before me
this 29th day of March, 2016

Carol J Zier

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Bradley Dworsky, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	3
60421 - Elwood, IL	1
60423 - Frankfort, IL	1
60432 - Joliet, IL	5
60433 - Joliet, IL	1
60435 - Joliet, IL	4
60436 - Joliet, IL	2
60439 - Lemont, IL	3
60441 - Lockport, IL	3
60442 - Manhattan, IL	3
60448 - Mokena, IL	2
60451 - New Lenox, IL	13

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 28 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 28 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Jason Hurbanek, M.D.
Address: Hinsdale Orthopaedic Associates, SC
951 Essington Rd.
Joliet, IL 60435

Subscribed and sworn before me
this 29th day of February 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Jason Hurbanek, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	1
60421 - Elwood, IL	1
60423 - Frankfort, IL	2
60432 - Joliet, IL	1
60433 - Joliet, IL	1
60435 - Joliet, IL	4
60436 - Joliet, IL	4
60439 - Lemont, IL	1
60441 - Lockport, IL	3
60442 - Manhattan, IL	1
60448 - Mokena, IL	1
60451 - New Lenox, IL	5
60491 - Homer Glen, IL	3

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 34 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 40 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Elliot Nacke, M.D.
Address: Hinsdale Orthopaedic Associates, SC
951 Essington Rd.
Joliet, IL 60435

Subscribed and sworn before me
this 28th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Elliot Nacke, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	1
60421 - Elwood, IL	1
60423 - Frankfort, IL	2
60432 - Joliet, IL	2
60433 - Joliet, IL	1
60435 - Joliet, IL	1
60436 - Joliet, IL	1
60439 - Lemont, IL	4
60441 - Lockport, IL	11
60442 - Manhattan, IL	2
60448 - Mokena, IL	1
60451 - New Lenox, IL	6
60467 - Orland Park, IL	1

March 8, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 122 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 130 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Robert Semba, M.D.
Address: Parkview Orthopedic Group
688 Cedar Crossings Dr.
New Lenox, IL 60451

Subscribed and sworn before me
this 8th day of March, 2016

Carol J Zier

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Robert Semba, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60421 - Elwood, IL	3
60423 - Frankfort, IL	9
60432 - Joliet, IL	6
60433 - Joliet, IL	5
60435 - Joliet, IL	12
60436 - Joliet, IL	6
60439 - Lemont, IL	8
60441 - Lockport, IL	22
60442 - Manhattan, IL	9
60448 - Mokena, IL	6
60451 - New Lenox, IL	20
60467 - Orland Park, IL	6
60491 - Homer Glen, IL	10

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 7 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 7 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Cary Templin, M.D.
Address: Hinsdale Orthopaedic Association, SC
951 Essington Road
Joliet, IL 60431

Subscribed and sworn before me
this 29th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Cary Templin, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 106 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 106 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Paul Trksak, M.D.
Address: Hinsdale Orthopaedic Associates, SC
1870 Silver Cross Blvd., Suite 200
New Lenox, IL 60451

Subscribed and sworn before me
this 29th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Paul Trksak, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	1
60421 - Elwood, IL	7
60423 - Frankfort, IL	5
60432 - Joliet, IL	4
60433 - Joliet, IL	4
60435 - Joliet, IL	6
60436 - Joliet, IL	3
60439 - Lemont, IL	3
60441 - Lockport, IL	10
60442 - Manhattan, IL	8
60448 - Mokena, IL	10
60451 - New Lenox, IL	39
60467 - Orland Park, IL	2
60491 - Homer Glen, IL	4

MARCH 8, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 13 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 12 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Cynthia Sink, D.P.M.
Address: 10760 W. 143rd St., #60
Orland Park, IL 60462

Subscribed and sworn before me
this 8th day of March, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Cynthia Sink, D.P.M.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60439 - Lemont, IL	3
60441 - Lockport, IL	2
60442 - Manhattan, IL	1
60448 - Mokena, IL	2
60451 - New Lenox, IL	2
60467 - Orland Park, IL	2
60491 - Homer Glen, IL	1

~~February~~ March 8, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 12 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 18 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Bruce Smit, D.P.M.
Address: Frankfort Foot and Ankle Clinic
9875 W. Lincoln Highway, Ste. 101
Frankfort, IL 60423

Subscribed and sworn before me
this 8th day of March, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Bruce Smit, D.P.M.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	1
60423 - Frankfort, IL	6
60433 - Joliet, IL	1
60448 - Mokena, IL	3
60451 - New Lenox, IL	1

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 46 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 35 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Greg Andros, M.D.
Address: Advanced Urology Associates
1541 Riverboat Center Dr.
Joliet, IL 60431

Subscribed and sworn before me
this 29th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Greg Andos, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60403 - Crest Hill, IL	3
60421 - Elwood, IL	1
60423 - Frankfort, IL	8
60432 - Joliet, IL	7
60433 - Joliet, IL	1
60435 - Joliet, IL	5
60436 - Joliet, IL	1
60439 - Lemont, IL	1
60441 - Lockport, IL	7
60442 - Manhattan, IL	1
60448 - Mokena, IL	1
60451 - New Lenox, IL	5
60491 - Homer Glen, IL	5

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 35 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 42 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Ryan Manecke, M.D.
Address: Advanced Urology Associates
1541 Riverboat Center Dr.
Joliet, IL 60431

Subscribed and sworn before me
this 29th day of February, 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Ryan Manecke, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60421 - Elwood, IL	2
60432 - Joliet, IL	3
60433 - Joliet, IL	4
60435 - Joliet, IL	3
60436 - Joliet, IL	2
60439 - Lemont, IL	1
60441 - Lockport, IL	2
60442 - Manhattan, IL	3
60448 - Mokena, IL	5
60451 - New Lenox, IL	6
60467 - Orland Park, IL	1
60491 - Homer Glen, IL	3

February 29, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Constantino:

I am on the medical staff at Silver Cross Hospital & Medical Centers ("Silver Cross") in New Lenox, Illinois. I am writing to express my strong support for the efforts by Silver Cross to establish a multi-specialty ambulatory surgery center (the "ASC") in New Lenox, Illinois.

During the past twelve (12) months, I have performed 48 outpatient surgery procedures at Silver Cross on patients originating from the primary service area. A HIPAA compliant list of those cases by zip code is attached as Exhibit A. If the Illinois Health Facilities and Services Review Board authorizes Silver Cross to establish the ASC, I anticipate performing at least as many outpatient surgery procedures at the ASC. Indeed, given the growth of my practice, I believe that I will perform a total of 50 outpatient surgery procedures annually at the ASC.

The information contained in this letter is true and correct to the best of my knowledge.

Sincerely,

Sandeep Sawhney, M.D.
Address: Advanced Urology Associates
1541 Riverboat Center Dr.
Joliet, IL 60431

Subscribed and sworn before me
this 29th day of February 2016

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

EXHIBIT A

CON Application for Proposed Multi-Specialty Ambulatory Surgery Treatment Center in New Lenox, Illinois.

Referring Physician: Sandeep Sawhney, M.D.

Outpatient surgical patients seen at Silver Cross Hospital from October 1, 2014 to September 31, 2015 are shown in the tables below.

Zip Code Origin of Patients / City Linked to Zip Code	Number of OP Cases in Past 12 Months
60423 - Frankfort, IL	2
60432 - Joliet, IL	9
60433 - Joliet, IL	3
60435 - Joliet, IL	2
60436 - Joliet, IL	2
60439 - Lemont, IL	1
60441 - Lockport, IL	6
60442 - Manhattan, IL	5
60448 - Mokena, IL	3
60451 - New Lenox, IL	8
60467 - Orland Park, IL	5
60491 - Homer Glen, IL	2

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(f)(1) & (2), Treatment Room Need Assessment

The Applicants are proposing, and can easily justify, three operating rooms at the proposed Surgery Center. A total of 2,165 surgeries (or 3,489 hours) in 2018 and 2,252 surgeries (or 3,628 hours) in 2019 have been committed to the proposed Surgery Center by physicians on the Medical Staff at Silver Cross Hospital.

Year	Projected Surgeries	Projected Surgical Hours	Number of Proposed Operating Rooms	State Utilization Standard	Meets State Norm?
2018	2,165	3,489	3	1,500 Surgical Hours Per Operating Room 3,489/1,500= 2.326 Which Rounds Up to 3	Yes
2019	2,252	3,628	3	1,500 Surgical Hours Per Operating Room 3,628/1,500= 2.418 Which Rounds Up to 3	Yes

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(g), Service Accessibility

The Applicants have elected to complete Criterion 1110.1540(g)(Service Accessibility). However, Applicants would assert that Criterion 1110.1540(g) should not apply because the proposed Surgery Center is being established to solely reduce the high utilization and projected demand for outpatient surgical services at Silver Cross Hospital.

As set forth herein, Silver Cross Hospital has been experiencing tremendous year-over-year growth in surgical services in recent years. In 2014, its eleven operating rooms had a utilization rate of 119.3%. In 2015, its eleven operating rooms had a utilization rate of 129.7%. The surgical projections for 2016, 2017, 2018 and 2019 are just as daunting. By 2019, Silver Cross Hospital is projecting that 13,713 surgeries (representing 27,426 surgical hours) will be performed at Silver Cross Hospital, which means Silver Cross Hospital will need no less than nineteen (19) operating rooms.

The Applicants have elected to move forward with the proposed Surgery Center to address the surgical care demand issues at Silver Cross Hospital. At this point, in order to deal with the high utilization in its Procedural Care Unit, Silver Cross Hospital has been offering extended hours of operation during weekdays and providing surgical time on weekends. But, at a certain point, if Silver Cross Hospital does not expand its surgical capacity, serious delays are going to start occurring and patients seeking surgical services are going to be negatively impacted. The proposed Surgery Center is the most cost effective way for Silver Cross to relieve the demand pressure in its Procedural Care Unit and provide the surgical services that its patients are demanding.

That said, because one hundred (100%) of the projected cases for the proposed Surgery Center would have otherwise been performed at Silver Cross Hospital, no other healthcare facility within the GSA will be impacted in any manner by the proposed Surgery Center.

It also bears noting Silver Cross Hospital is currently the sole member of Silver Cross Ambulatory Surgery Center LLC ("SCASC"). If this CON Application is approved by the Board, SCASC intends to sell up to forty nine percent (49%) of the membership units in SCASC to physicians (the "Syndication"). No physician will be allowed to purchase more than a two and one-half percent (2.5%) interest in SCASC. SCASC may also contract with a management company to provide management services at the Surgery Center. If a management company is ultimately engaged, and the management company seeks ownership as part of its management agreement, thereby decreasing Silver Cross Hospital's interest in SCASC below fifty percent (50%), the Applicants will file a Certificate of Need (Change of Ownership) Application with the Board.

Accordingly, because the SCASC could become a joint venture in the near future, Silver Cross has elected to abide by the "utilization" and "charge" commitments set forth in at 1110.1540(g)(4)(C) and (D). Thus, the Applicants have committed that: (1) the Applicants will not add any additional operating rooms at Silver Cross Hospital until the proposed Surgery Center achieves its target utilization rate for twelve months pursuant to Criterion 1110.1540(4)(C); and (2) the customary rates at the proposed Surgery Center will be lower than the customary rates at Silver Cross Hospital for comparable procedures pursuant to 1110.1540(4)(D). See Utilization and Customary Rates Certification from Paul Pawlak, the President and CEO of the Applicants, attached at ATTACHMENT 27, in support of this Criterion.

See also Charge Commitment Affidavit from John Krepps, attached at ATTACHMENT 27, which sets forth the rates for comparable procedures at the proposed Surgery Center and Silver Cross Hospital.

SILVER CROSS
HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

May 12, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.1540(g)(4). Utilization and Customary Rates Certification

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § 1110.1540(g)(4), as follows:

1. Silver Cross Hospital and Medical Centers ("Silver Cross Hospital") will not increase its surgical/treatment room capacity at Silver Cross Hospital until the proposed Silver Cross Ambulatory Surgery Center (the "Surgery Center") achieves its target utilization rate for twelve (12) consecutive months.

2. The customary rates at the proposed Surgery Center will be lower than the customary rates at Silver Cross Hospital for comparable procedures.

Sincerely,

Paul Pawlak
President & CEO
Silver Cross Ambulatory Surgery Center LLC
Silver Cross Hospital and Medical Centers

Subscribed and Sworn to before me
this 12th day of May, 2016.

Notary Public

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

Attachment
27

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(h)(1) through (3), Unnecessary Duplication/Maldistribution

The Applicants have elected to complete Criterion 1110.1540(h)(Unnecessary Duplication/Maldistribution). However, Applicants would assert that Criterion 1110.1540(h) should not apply because the proposed Surgery Center is being established to solely reduce the high utilization and projected demand for outpatient surgical services at Silver Cross Hospital.

Twenty-three (23) physicians have indicated a commitment to performing surgery procedures at the proposed Surgery Center. These same physicians also are currently on staff at Silver Cross Hospital. Referrals from these twenty-three physicians will be patients that are currently receiving care at Silver Cross Hospital. One hundred percent (100%) of the patients for the proposed Surgery Center are projected to come from Silver Cross Hospital's primary service area (and thus, the GSA). Thus, the proposed Surgery Center will not result in unnecessary duplication or maldistribution of services since the total projected patient volume for the proposed Surgery Center will come entirely from Silver Cross Hospital's existing patient population. ***Therefore, the Applicants fully anticipate that no other provider will be impacted by the proposed Surgery Center.***

See Criterion 1110.1540(d)(1), (2) or (3), Projected Service Demand, as additional support for this Criterion.

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(i)(1) & (2), Staffing & Medical Director

Staffing

Silver Cross Hospital has been experiencing very favorable vacancy rates for staff subject to licensing by the Department of Financial and Professional Regulation in its Procedural Care Unit. Over the past year, the vacancy rate in Silver Cross Hospital's Procedural Care Unit has averaged below 1.6%.

Silver Cross Hospital uses a variety of tools to recruit staff to its Procedural Care Unit, including, but not limited to, web based programs and traditional sites and methods such as nurse.com, indeed.com, monster.com, careerbuilder.com, National Healthcare Career Network, Sun-Times Network, Joliet Herald, Chicago Tribune, and nursing job fairs. Silver Cross Hospital intends to use those same recruiting tools to staff the proposed Surgery Center, as well as transferring staff from the Procedural Care Unit to the proposed Surgery Center.

Thus, the Applicants are very confident that they will be able to staff the proposed Surgery Center.

Medical Director

Like Silver Cross Hospital's Procedural Care Unit, the proposed Surgery Center will have a Medical Director. The Medical Director will be board certified in his/her specialty and will be responsible for the clinical direction at the proposed Surgery Center. A copy of the proposed Medical Director Agreement for the proposed Surgery Center is attached at ATTACHMENT 27.

MEDICAL DIRECTION AGREEMENT

THIS MEDICAL DIRECTION AGREEMENT (this "Agreement"), made effective as of the _____day of _____, 2016 ("Effective Date"), by and between Silver Cross Ambulatory Surgery Center, LLC, an Illinois limited liability company (the "Company"), and _____, [**M.D.**], a physician in the State of Illinois (the "Contractor").

W I T N E S S E T H:

WHEREAS, the Company owns and operates an ambulatory surgery center located at [___ **Silver Cross Boulevard, New Lenox, Illinois 60451**] (the "Facility"); and

WHEREAS, the Contractor is a duly qualified, board certified, physician practicing the in the State of Illinois; and

WHEREAS, this Agreement supersedes and replaces any prior agreements between the Company and the Contractor involving the provision of administrative or medical services; and

WHEREAS, the Company and the Contractor desire for the Contractor to provide medical direction and administrative services in the Facility; and

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Company and the Contractor agree as follows:

Section 1. Term. This Agreement shall be effective and shall commence as of the Effective Date and shall continue in full force and effect for an initial period of two (2) years (the "Initial Term"), unless earlier terminated as set forth in this Agreement. Thereafter, this Agreement shall automatically renew for successive one year periods (each a "Renewal Term" and together with the Initial Term, the "Term") unless either party shall give written notice of non-renewal to the other party at least sixty (60) days in advance of the end of the then current Term.

Section 2. Services to be Provided by the Contractor.

(a) The Contractor agrees to act as the medical director of the Facility, providing services, including, but not limited to the following:

(i) Providing medical direction with respect to all clinical activities performed in connection with or related to all medical procedures performed at the Facility and all administrative activities related thereto and ensuring that such activities are performed in conformity with the Company's policies and procedures and the bylaws of the Facility, as amended from time to time by the Company, and all applicable laws, rules, regulations, standards and guidelines promulgated by all applicable "Regulatory Authorities". Regulatory Authorities is defined in Section 12(a) of this Agreement.

(ii) Consulting with and rendering advice to the Company, the medical staff of the Facility (the "Medical Staff"), the administrator of the Facility (the "Administrator") and all

other personnel at the Facility regarding the timely and complete documentation of all clinical records and other data and, where appropriate, reviewing such records.

(iii) Coordinating the orientation of new medical staff members and active participation in the review of medical staff membership applications and requests for privileges.

(iv) Maintaining communications with the medical staff regarding service and Facility initiatives including, but not limited to, attendance at the Facility's growth planning sessions, development and implementation of initiatives to ensure delivery of on-time starts, efficient turn over times, minimization of cancellation rates, utilization of block time, and optimal staffing and supply usage.

(v) Consulting with and rendering advice to the Company, the Medical Staff, the Administrator and all clinical and nursing personnel at the Facility regarding, and participating in, the Facility's quality assurance and risk management programs.

(vi) Consulting with and rendering advice to the Company and the Administrator regarding, and supervising compliance by the Medical Staff and all clinical and nursing personnel of the Facility with, the Company's policies and procedures and the bylaws of the Facility, as amended from time to time by the Company and the Facility, and all applicable laws, rules, regulations, standards, guidelines, policies, procedures and bylaws promulgated by all applicable Regulatory Authorities.

(vii) Consulting with and rendering advice to the Company, the Medical Staff, the Administrator and all clinical and nursing personnel at the Facility regarding, and assisting in the development and coordination of and participating in, all continuing in-service education and training programs for the Medical Staff and all clinical and nursing personnel at the Facility with respect to the performance of all medical procedures at the Facility.

(viii) Assessing the overall patient experience at the Facility by reviewing patient satisfaction surveys, patient and physician feedback and providing recommendations to the Company, the Medical Staff and/or the Administrator.

(ix) Consulting with and rendering advice to the Company and the Administrator regarding the qualifications and performance of the clinical and nursing personnel at the Facility.

(x) Conducting periodic evaluations of the adequacy and appropriateness of the medical procedures performed at the Facility and consulting with and rendering advice to the Company and the Administrator with respect to selection and acquisition of equipment, outside vendors, supplies and support services with respect to the performance of such procedures.

(xi) Cooperating with the Company, Administrator, and other medical contractors performing services at the Facility in an effort to support and improve the operational performance of the Facility.

(xii) Attending administrative meetings and accepting appointments to ad-hoc and standing committees of the Facility and of the Medical Staff, including without limitation, attendance at one regional and one national leadership meeting per year.

(xiii) Acting as a representative of and goodwill ambassador for the Facility; assisting the Company in informing the public, including, but not limited to, physicians, healthcare organizations, insurance companies, health maintenance organizations and third party payors, community agencies, local businesses, schools and other educational institutions and athletic and sports organizations, about the Facility and the services it provides. Where appropriate and as may reasonably be requested by the Company or the Administrator, the Contractor shall assist with public relations and participate in community education and speaking engagements.

(xiv) Performing such other duties as may from time to time be agreed to by the Contractor and the Company.

Such services shall be referred to herein as the "Services."

(b) Time Records. The Contractor agrees to record promptly and maintain records pertaining to the performance of the Services by the Contractor under this Agreement. Upon request of the Company, the Contractor shall execute an affidavit concerning the time spent by the Contractor in the performance of the Contractor's obligations and duties under this Agreement and concerning the records pertaining thereto prepared by the Contractor.

(c) Accountability to the Administrator. The Contractor shall be accountable to the Administrator for the performance by the Contractor of the Contractor's obligations under this Agreement.

Section 3. Compensation.

(a) Payments. As compensation for all of the Contractor's services hereunder, the Company agrees to pay the Contractor _____ Dollars ($_____) per hour during the Term of this Agreement. Such compensation shall be delivered to the Contractor each month only after the Contractor has delivered to the Company written time records showing compliance with the requirements of this Agreement.

(b) No Withholdings. The compensation to be paid to the Contractor pursuant to this Agreement shall not be subject to reduction by any withholding for federal, state or local taxes, Social Security or similar deductions. The parties understand, acknowledge and agree that the Contractor is responsible for paying any and all of such items.

(c) Compensation intended to be at Fair Market Value for Surgery Centers. The parties expressly agree and acknowledge that the compensation payable under this Agreement to the Contractor is intended to be a fair market rate for the services performed. The parties further agree to renegotiate and adjust the rate of compensation in the event any Regulatory Authority determines that the compensation exceeds fair market rates.

Section 4. Representations and Warranties of the Contractor. The Contractor makes the following representations and warranties to the Company.

(a) Authority. Neither the execution and delivery of this Agreement, nor the rendering of services by the Contractor hereunder, will violate the provisions of, or constitute a default under, any other contract or agreement to which the Contractor is a party or by which the Contractor is

bound, or which would preclude the Contractor from performing the Services required of the Contractor hereunder, or which would impose liability or obligation upon the Company for accepting the Services.

(b) Professional Qualification and Fitness. As of the date of this Agreement, and continuing throughout the Term of this Agreement, the Contractor:

(i) is board certified by the [**American Board of Surgery/ American Board of Anesthesia**];

(ii) has all necessary permits, authorizations and licenses required by all applicable Regulatory Authorities to perform the Services in Illinois, including, but not limited to, a license to practice medicine in Illinois and a valid Drug Enforcement Agency Number;

(iii) has not had any such permits, authorizations or licenses in Illinois or in any other jurisdiction, including a license to practice medicine in Illinois or a Drug Enforcement Agency Number, suspended, restricted, revoked or voluntarily relinquished and the Contractor is not aware of any such pending or threatened action or any fact or circumstance that would give rise to such action being taken against the Contractor;

(iv) has not been reprimanded, sanctioned or disciplined by any applicable Regulatory Authority and the Contractor is not aware of any such pending or threatened action or any fact or circumstance that would give rise to such action being taken against the Contractor;

(v) has not been excluded from participating in Medicare, Medicaid or any other federal or state health care program and has not been suspended, excluded, barred or sanctioned by a third-party payor and the Contractor is not aware of any such pending or threatened action or any fact or circumstance that would give rise to such action being taken against the Contractor;

(vi) has not conducted and is not currently conducting the Contractor's medical practice in such a manner as to cause the Contractor to be suspended, excluded, barred or sanctioned by a third-party payor or under any federal or state medical program, including, but not limited to, Medicare, Medicaid or any similar program;

(vii) currently maintains medical staff privileges at an acute-care facility within a reasonable distance of the Facility that provides emergency services, has not had the Contractor's medical staff privileges at any hospital or medical facility suspended, restricted or revoked and the Contractor is not aware of any such pending or threatened action or any fact or circumstance that would give rise to such action being taken against the Contractor;

(viii) has not settled without judgment, or had a final judgment entered against the Contractor with respect to a malpractice or similar action for an aggregate award or amount to the plaintiff in excess of Fifty Thousand Dollars ($50,000) during the past five (5) years and the Contractor is not aware of any such pending or threatened legal action against the Contractor or any fact or circumstance that would give rise to such legal action being taken against the Contractor; and

(ix) has not had any professional liability or medical malpractice insurance cancelled by an insurance provider or has never been refused insurance coverage and the Contractor is

not aware of any such pending or threatened action or any fact or circumstance that would give rise to such action being taken against the Contractor.

Section 5. Covenants of the Contractor. The Contractor makes the following covenants to the Company:

(a) Permits and Licenses. During the Term of this Agreement, the Contractor shall:

(i) maintain all applicable licenses, permits, accreditations and authorizations required by any applicable Regulatory Authority or as may reasonably be required by the Company for the Contractor to provide the Services under this Agreement, including, but not limited to, a license to practice medicine issued by the State of Illinois and a Drug Enforcement Agency Number and applicable board certification;

(ii) provide evidence of such licenses, permits, accreditations and authorizations to the Company upon its reasonable request;

(iii) immediately inform the Company and the Administrator of any actual or threatened action by any applicable Regulatory Authority that affects or is likely to affect the Contractor's ability to perform the Contractor's obligations and duties under this Agreement; and

(iv) in the event of any such action as set forth in Section 5(a)(iii) above, shall take immediate corrective action, if remedial.

(b) Performance of the Services. During the Term of this Agreement, the Contractor shall:

(i) perform the Services in accordance with all applicable laws, rules, regulations, standards, guidelines, policies, procedures and bylaws of all applicable Regulatory Authorities and all applicable policies and procedures of the Company and the Facility;

(ii) perform the Services faithfully, diligently and to the best of the Contractor's ability, and in such a manner as is customarily performed by providers of similar services as the Services in ambulatory surgical facilities located in the market area in the immediate vicinity of the Facility; and

(iii) perform such continuing education requirements as may be required by all applicable Regulatory Authorities and as may reasonably be required by the Company and the Administrator.

(c) Medical Staff Privileges. The Contractor shall:

(i) during the Term of this Agreement, continue to maintain membership and staff privileges on the medical staff of at least one acute-care facility within a reasonable distance of the Facility which provides emergency services; and

(ii) upon the effective date of this Agreement, seek and, during the Term of this Agreement, maintain membership and staff privileges on the active Medical Staff of the Facility.

(d) Insurance. During the Term of this Agreement, the Contractor shall:

(i) maintain private medical practice, professional liability and malpractice insurance coverage with respect to the Contractor's private medical practice in the amount not less than the greater of that required by any appropriate Regulatory Authority or the bylaws of the Medical Staff of the Facility;

(ii) provide written evidence of such insurance coverage to the Company upon its reasonable request; and

(iii) immediately notify the Company and the Administrator if such insurance coverage is reduced, modified or canceled or is threatened to be reduced, modified or canceled.

(e) Confidentiality. During the Term of this Agreement and at all times after the expiration or termination of this Agreement, the Contractor, except as may be required by law or by any appropriate Regulatory Authority, shall:

(i) keep the terms and conditions of this Agreement confidential and shall not disclose the terms and conditions of this Agreement to any person;

(ii) not disclose to any third party any confidential or proprietary information concerning: (1) the business, affairs or operations, (2) any trade secrets, new product developments, or special or unique processes or methods, or (3) any marketing, sales, advertising or other concepts or plans of the Company, (the "Company's Affiliates"); and

(iii) keep the contents of all records and reports created by the Contractor relating to the performance of services under this Agreement confidential and shall not disclose the same to any person.

(f) HIPAA; Privacy of Patients.

(i) *Compliance.* During the Term of this Agreement and at all times thereafter, the Contractor shall comply with all applicable laws, rules, regulations, standards, guidelines, policies, procedures and bylaws promulgated by all applicable Regulatory Authorities and all applicable policies and procedures of the Company and the Facility regarding maintaining the confidentiality of the identity and the privacy of the patients treated at the Facility, and of any individually identifiable health information relating to patients treated at the Facility ("Protected Health Information" or "PHI"). In particular, except as permitted or required by this Agreement or by law, the Contractor will not use or disclose patient information in a manner that would violate the requirements of the Health Insurance Portability and Accountability Act of 1996, the federal privacy regulations set forth at 45 CFR Part 160 and Part 164, and/or the Health Information Technology for Economic and Clinical Health Act and its implementing regulations (collectively, "HIPAA").

(ii) *Business Associate Agreement.* Because the Contractor provides services for the Company that involve the use and/or disclosure of PHI relating to patients who receive medical treatment at the Facility, the Contractor is deemed to be a business associate of the Company pursuant to HIPAA, and the Contractor agrees to execute a business associate agreement.

(g) Records and Reports. During the Term of this Agreement, the Contractor shall promptly prepare and submit to the Company complete and accurate reports and records in connection with the provision of the Services under this Agreement as may be required by all applicable Regulatory Authorities and the Company. The parties acknowledge and agree that the ownership of all records and reports prepared by the Contractor in connection with the performance of the Contractor's obligations under this Agreement and all documentation prepared in connection with or ancillary thereto vests exclusively with the Company; provided, however, that the Contractor may maintain and use for its own purposes copies of any records relating to its provision of Services at the Facility.

Section 6. Representations and Warranties of the Company. The Company makes the following representations and warranties to the Contractor.

(a) Existence. The Company is duly organized, validly existing and in good standing under the laws of the jurisdiction in which it was organized. The Company has the corporate power and authority to carry on its business as it is now conducted and to own, lease and operate its properties and is duly qualified to do business and is in good standing in each jurisdiction in which the nature of the business conducted or the properties or assets owned or leased by it makes such qualification necessary, except where the absence thereof would not individually, or in the aggregate, have a material adverse effect on the Company.

(b) Authority. The execution and delivery of this Agreement will not violate the provisions of, or constitute a default under, any other contract or agreement to which the Company is a party or by which the Company is bound, or which would preclude the Company from performing its obligations under this Agreement, or which would impose any liability or obligation upon the Company for accepting the Services from the Contractor.

(c) Permits and Licenses. As of the date of this Agreement:

(i) the Company is licensed and qualified and has all necessary permits, authorizations and licenses required by any applicable Regulatory Authority to operate the Facility, except where the absence thereof would not individually, or in the aggregate, have a material adverse effect on the Company or the operation of the Facility; and

(ii) the Company is not excluded from participating in Medicare, Medicaid or any other Federal health care program.

Section 7. Covenants of the Company. The Company makes the following covenants to the Contractor.

(a) Permits and Licenses. During the Term of this Agreement, the Company shall:

(i) maintain all material applicable licenses, permits and accreditations required by any applicable Regulatory Authority to operate the Facility;

(ii) immediately inform the Contractor of any actual or threatened action by any applicable Regulatory Authority that materially affects or is likely to materially affect the Company's ability to perform its obligations and duties under this Agreement; and

(iii) in the event of any such action as set forth in Section 7(a)(ii) above, take immediate corrective action, if remedial.

(b) Operation of Facility. During the Term of this Agreement, the Company shall use reasonable efforts to operate the Facility in accordance with all material applicable laws, rules, regulations, standards, guidelines, policies, procedures and bylaws of all applicable Regulatory Authorities and all material applicable policies and procedures of the Company and the Facility.

(c) Insurance. During the Term of this Agreement, the Company shall:

(i) maintain facility insurance coverage of the type and in the amounts required by any applicable Regulatory Authority and as is customary in connection with the operation of an ambulatory surgical facility; and

(ii) maintain insurance coverage with limits of up to $1,000,000 per occurrence and $3,000,000 in aggregate for the benefit of the Contractor in connection with claims made against the Contractor relating to the performance by the Contractor of the administrative duties required to be performed by the Contractor under this Agreement as medical director of the Facility. The parties acknowledge and agree that this insurance coverage does not cover the Contractor with respect to claims made against the Contractor in connection with acts and omissions made by the Contractor in connection with the Contractor's private medical practice.

(d) HIPAA; Privacy of Patients.

(i) *Compliance*. During the Term of this Agreement and at all times thereafter, the Company shall comply with all applicable laws, rules, regulations, standards, guidelines, policies, procedures and bylaws promulgated by all applicable Regulatory Authorities regarding maintaining the confidentiality of the identity and the privacy of the patients treated at the Facility, and of any PHI relating to such patients and, specifically, except as permitted or required by this Agreement or by law, will not use or disclose PHI in a manner that would violate HIPAA and the Privacy Regulations.

(ii) *Policies, Privacy Practices, and Restrictions*. The Company shall provide the Contractor with copies of any notices, policies and procedures of the Facility and/or the Company regarding privacy issues with which the Contractor is expected to comply. If the Company makes any changes to such policies or notices, or if a patient revokes or restricts the Company's right to use or disclose PHI and the Company expects the Contractor to comply with such changes or restrictions, the Company shall immediately advise the Contractor and shall allow the Contractor a reasonable period in which to bring the Contractor's own practices into compliance.

(iii) *Patient Rights*. If the Company receives a request from a patient wishing to exercise such patient's rights with respect to PHI, to exercise such rights, including (x) the right to inspect PHI within the possession or control of the Company, its business associates, and their subcontractors, (y) the right to amend such PHI, and (z) the right to obtain an accounting of certain disclosures of their PHI to third parties, and the Company reasonably believes the Contractor is in possession or control of all or portions of such PHI that is not already in the possession or control of the Company, the Company shall notify the Contractor in writing of the request.

Section 8. Government Access to Records. During the Term of this Agreement and for a period of four years after this Agreement expires or is terminated, each party shall, pursuant to Title 42 of the United States Code and applicable rules and regulations promulgated thereunder, make available, upon appropriate written request by the Secretary of the United States Department of Health and Human Services or the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the Services provided by the Contractor under this Agreement. Disclosure pursuant to this section shall not be construed as a waiver of any other legal right to which the disclosing party may be entitled under law or regulation. In the event either party is requested to disclose any books, records or documents for the purpose of an audit or investigation relating to this Agreement and the Services provided under this Agreement by the Contractor, such party shall immediately notify the other party of the nature and scope of the request and shall make available to the other party, upon receipt of a reasonable written request from such other party, copies of all documents encompassed by the request, provided the party making such request pays for the cost of making such copies.

Section 9. Term and Termination.

(a) Termination. This Agreement may be terminated:

(i) by the parties upon their mutual consent;

(ii) by any party:

(1) without cause, upon at least sixty (60) days prior written notice to the other party;

(2) immediately, if any of the other party fails to observe, keep or perform any material provision of this Agreement and such default remains uncured ten business days after written notice to cure has been given to the defaulting party;

(3) immediately, upon a determination that any of the covenants made by either party have been breached and such breach remains uncured ten business days after written notice of breach has been given to the breaching party;

(4) immediately, upon a determination that any of the representations or warranties made by either party were false or incorrect when made, or have since become false or incorrect, unless such representation or warranty is made accurate within ten business days after written notice has been given to the representing party that the representation or warranty was or has become false or incorrect;

(5) upon two (2) business days prior written notice to the other party if any material provision shall be determined to be invalid, void or unenforceable in whole or in part for any reason by a court of competent jurisdiction;

(6) immediately, if any proceeding under the Federal Bankruptcy code, as amended, is commenced by or against any party and is not dismissed within ninety (90) days of the commencement thereof, if any party is adjudged insolvent or makes any assignment for the benefit of its creditors or upon making or receiving from any of the other parties notice of a decision to

voluntarily cease operations as they substantially exist as of the date of this Agreement or otherwise voluntarily liquidate; or

(7) upon two (2) business days, if the Company dissolves, ceases to operate the Facility or is no longer licensed to operate the Facility; or

(iii) Immediately by the Company if:

(1) the Contractor dies, becomes disabled or is otherwise unable to perform the Services or substantially all of the obligations and duties required to be performed by the Contractor under this Agreement;

(2) the Contractor commits any act of fraud, misappropriation or embezzlement or is charged with a felony or any crime of moral turpitude; or

(3) the Contractor becomes uninsurable for malpractice or professional liability insurance.

(b) Effect of Termination or Expiration. Upon the expiration or termination of this Agreement, all provisions of this Agreement shall be null, void and have no further force and effect except those that clearly specify or contemplate performance after the expiration or termination of this Agreement. The parties shall comply with all obligations required to be performed by them upon the termination of this Agreement, including, but not limited to, the Contractor's compliance with 0. Compensation, if any, for Services performed by the Contractor prior to the expiration or termination of this Agreement shall be paid by the Company in accordance with the terms of this Agreement. The termination or expiration of this Agreement shall not automatically effect a termination of the Contractor's privileges on the Medical Staff at the Facility. The Contractor acknowledges that this Agreement is independent of the Medical Staff Bylaws, and upon termination of this Agreement, Contractor shall not be entitled to notice, hearing or other review or appeal as provided under the Medical Staff Bylaws.

Section 10. Independent Contractor Status.

(a) Independent Contractor. The parties agree that the Contractor is an independent contractor of the Company. The parties acknowledge and agree that no relationship of employer and employee is created by this Agreement and that the Contractor shall not be considered to be an employee of the Company, or of any of the Company's Affiliates and shall have no claims under this Agreement or otherwise against any of them for vacation pay, sick pay, retirement benefits or any other employee benefit of any kind. Furthermore, the Contractor specifically acknowledges and agrees that the Contractor shall be solely responsible for the payment of all distributions, wages, salaries, taxes, withholding payments, penalties, fees, professional education and similar expenses, professional liability insurance premiums, contributions to insurance, pension or other deferred compensation plans, licensing and regulation fees and the filing of all required documents, forms and returns pertinent to any of the foregoing.

(b) No Agency. The parties acknowledge and agree that no relationship of principal and agent is created by this Agreement. Other than as provided for in this Agreement, the Contractor has no authority to act on behalf of or bind the Company or any of the Company' s Affiliates.

(c) Private Medical Practice. The parties acknowledge that the Contractor maintains a private medical practice separate and apart from the services provided by the Contractor under this Agreement. The parties acknowledge and agree that the Contractor is solely responsible for all of the Contractor's actions taken in connection with the Contractor's private medical practice and that neither the Company nor any of the Company's Affiliates has any right to and does not control the professional judgment, treatment or professional medical services rendered by the Contractor in connection with the performance of the Contractor's private medical practice.

Section 11. Indemnification.

(a) Indemnification of the Company and Others. During the Term of this Agreement and after the expiration or termination of this Agreement, the Contractor agrees to indemnify and hold the Company, the Company's Affiliates and their respective directors, officers, employees, agents and representatives (the "Company's Indemnified Parties") harmless from and against any and all third party claims, demands, losses, liabilities, actions, lawsuits and other proceedings, judgments and awards, costs, damages and expenses (including, without limitation, court costs and attorneys' fees actually and reasonably incurred) ("Losses"), arising directly or indirectly, in whole or in part, out of (i) any breach by the Contractor of this Agreement or any Service (including supervision) to be performed or provided by the Contractor under this Agreement, including but not limited to the negligence of, or any professional acts or omissions of the Contractor; or (ii) any Losses sustained by any of the Company's Indemnified Parties under any theory of vicarious liability.

(b) Indemnification of the Contractor. During the Term of this Agreement and after the expiration or termination of this Agreement, the Company agrees to indemnify and hold the Contractor harmless from and against any and all Losses arising (i) directly out of the proper and complete performance by the Contractor of the Services; provided, however, that none of the Company's Indemnified Parties above shall be responsible for any such defense or indemnification with respect to the acts or omissions of the Contractor with respect to the performance of the Contractor's private medical practice; or (ii) directly or indirectly, in whole or in part, out of any breach by the Company of its obligations under this Agreement.

(c) Indemnity Procedures. In case any claim, demand or action shall be brought against any party entitled to indemnity under Section 11(a) or Section 11(b) above, such party shall promptly notify the other party from whom indemnity is sought in writing and the indemnifying party shall assume the defense thereof, including the employment of counsel; provided, however, that any failure to notify the indemnifying party of a claim, demand or action shall not bar a claim of indemnity unless the indemnified party has been prejudiced or damaged, in which case the right to be indemnified shall be reduced by the damages suffered as a result of a failure to give notice. The indemnified party shall have the right to employ separate counsel in any such action and to participate in the defense thereof, but the fees and expenses of such counsel shall be at the expense of such indemnified party unless the employment of such counsel has been specifically authorized by the indemnifying party or unless a conflict of interest exists between the interests of the indemnified and indemnifying parties that requires a separate representation, in which case the fees and expenses of separate counsel shall be paid by the indemnifying party. The indemnifying party shall not be liable for any settlement of any action effected without its consent, but if settled with the consent of the indemnifying party or if there shall be a final judgment for the plaintiff in any such action, the indemnifying party shall indemnify and hold harmless the indemnified party from and against any loss or liability by reason of such settlement or judgment.

Section 12. Miscellaneous Provisions.

(a) Definitions. For the purpose of this Agreement, the term "Regulatory Authorities" shall mean all federal, state and local governments, and all departments, agencies and divisions thereof, which have regulatory and administrative control with respect to or in connection with all facilities which provide medical services, including, but not limited to, the Facility, its personnel, independent contractors providing services at or to the Facility, including, but not limited to, surgical and medical services, anesthesia services, laboratory services, pathology services, pharmacy services and all administrative services related thereto and to the operation of the Facility. Such Regulatory Authorities shall include, but shall not be limited to, all federal, state and local licensing boards, specialty boards, societies or state insurance commissions/funds, including, but not limited to, the Illinois Medical Association; the Illinois Board of Medical Examiners; the Illinois Board of Pharmacy; the American Medical Association the American Society of Anesthesiologists and the College of American Pathologists, the Joint Commission on Accreditation of Healthcare Organizations; the Center for Medicare and Medicaid Services, the Office of Inspector General for the United States Department of Health and Human Services, the Illinois Medicaid Program and the U.S. Department of Justice Drug Enforcement Administration.

(b) Entire Agreement. This document contains the entire agreement between the parties and supersedes any and all prior and contemporaneous agreements between the parties, written or oral, with respect to the transactions contemplated in this Agreement.

(c) Additional Acts. All parties to this Agreement hereby agree to perform any further acts and to execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

(d) Amendments. This Agreement and all exhibits, schedules and attachments hereto may be amended only by an agreement in writing executed by all of the parties.

(e) Modifications and Renewals. If either party terminates this Agreement without cause or decides not to renew this Agreement, the parties shall not enter into the same or a similar agreement with each other unless the new agreement does not have the effect of altering or modifying the payment provisions of this Agreement, if any, during what otherwise would have been the remainder of the first year of the Term then in effect. The intent of this provision is to prohibit the parties from terminating this Agreement without cause and then entering into a new agreement in order to alter or modify the payment provisions prior to the expiration of the first year of the Initial Term or any Renewal Term of this Agreement.

(f) Referrals. It is not the purpose of this Agreement to induce the referral of patients. The parties acknowledge that there is no requirement under this Agreement or any other agreement between the Company and the Contractor that either party refer patients to the other for products or services. Additionally, no payment made by any party under this Agreement is in return for the referral of patients to the other party for products or services. Both parties may refer patients to any other entity providing such products or services and will make such referrals, if any, in a manner consistent with its professional medical judgment and the needs and wishes of the individual patients. Neither party will intentionally conduct itself under the terms of this Agreement in a manner constituting a violation of the Medicare and Medicaid Fraud and Abuse provisions nor make any payments prohibited thereunder or under any other state or federal law.

(g) No Assignment or Subcontracting. Except as otherwise provided in this Agreement, the Contractor may not assign this Agreement (by operation of law or otherwise) or subcontract any or all of the Services or obligations to be performed by the Contractor under this Agreement to any other person or entity.

(h) Notices. All notices, requests and communications required or permitted by this Agreement or any document or agreement executed and delivered in connection with this Agreement shall be deemed sufficient and properly given if it is in writing and is hand delivered, or sent by overnight courier, and addressed to the respective party to whom such notice request or communication relates at the addresses set forth below or at such other addresses as shall be furnished in writing by any party to the other party. All such notices, requests or communications shall be deemed received when hand delivered or two business days after delivered to the overnight courier. Notice of a change in address of one of the parties shall be given in writing to the other party as provided above, but shall be effective only upon actual receipt.

If to the Contractor: _____
_____
_____

If to the Company: Silver Cross Ambulatory Surgery Center, LLC
_____
_____
_____

With a copy to: Edward J. Green, Esq.
Foley & Lardner LLP
321 N. Clark Street, Suite 2800
Chicago, Illinois 60654

(i) Compliance with Laws. It is expressly understood that the parties intend that this Agreement and their performance under this Agreement will comply with all applicable laws, rules, regulations, standards, guidelines, policies, procedures and bylaws of all applicable Regulatory Authorities. The parties agree to renegotiate in good faith, any term, condition or provision of this Agreement that any Regulatory Authority determines to be in contravention of any such law, rule, regulation, standard, guideline, policy, procedure or bylaw, or if any interpretation is issued by any Regulatory Authority that prohibits the Company from billing for a referral received from the Contractor or any of its physician employees.

(j) Remedies. Any party resorting to legal action to enforce its rights under this Agreement, shall be entitled to obtain any available legal or equitable remedy, including an injunction, without bond, and specific performance. The prevailing party shall be entitled to recover the expenses incurred in such action, including without limitation, court costs and attorneys' fees reasonably and actually incurred.

(k) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and, if applicable, their respective successors and permitted assigns.

(l) No Third Party Beneficiaries. This Agreement is an agreement between the parties executing it. Under no circumstances shall there be any third-party beneficiaries nor shall any third party have any rights or benefits under this Agreement.

(m) Waiver/Consents. All consents or waivers, express or implied, given by any party to this Agreement with respect to or in connection with the performance of, or any breach or default by any other party are event specific and shall not be construed to be a consent or waiver to any subsequent performance, breach or default of the same nature or to any other performance, breach or default at any time. The granting of any consent or approval by any party shall not be construed as abrogating the need for such consent or approval in any other or subsequent instance. Failure on the part of any party to enforce performance of any other party, to complain of any act or failure to act by any other party or to declare any other party in breach or default under this Agreement, irrespective of how long such failure continues, shall not constitute a waiver by such party of its rights under this Agreement.

(n) Severability. In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

(o) Survivability. With the exception of this section and any provision of this Agreement which requires performance after the Term of this Agreement has expired or been terminated, no provision of this Agreement shall survive the expiration or termination of this Agreement.

(p) Force Majeure. All parties to this Agreement may be excused for failures and delays in performance of its respective obligations under this Agreement due to any cause beyond the control and without the fault of such party, including without limitation, any act of God, war, riot or insurrection, law or regulation, strike, flood, fire, explosion or the inability to obtain the necessary labor, materials or facilities resulting from one of the above referenced events. All parties are, however, not released from using their best efforts to avoid or remove such causes and shall continue performance under this Agreement immediately following the removal or end of such events. Any party wishing to claim under this section shall provide prompt written notice of its claim to all other parties to this Agreement.

(q) No Rule of Construction. The parties acknowledge that this Agreement was initially prepared by the Company as a convenience. All parties acknowledge that they have read this Agreement and have had an opportunity to review its terms with legal counsel and to negotiate the language used in this Agreement. All parties acknowledge and agree that no rule of construction shall apply to this Agreement which construes ambiguity or unclear language in favor of or against any party by reason of that party's role in the initial preparation and drafting of this Agreement.

(r) Headings; Interpretation. The captions or headings contained in this Agreement are for convenience and reference purposes only and shall not be construed to describe, define or limit the scope or the intent of the provisions of this Agreement. Any singular term contained in this Agreement shall be deemed to include the plural, and any plural term the singular. Any reference to gender in this Agreement shall be deemed to include the other.

(s) Exhibits, Schedules and Attachments. All exhibits, schedules and attachments referred to in this Agreement are deemed to be and are hereby incorporated into this Agreement.

(t) Governing Law. This Agreement shall be interpreted, construed and enforced under and in accordance with the laws of Illinois.

(u) Counterparts. This Agreement may be executed in several counterparts, each of which when so executed, shall be deemed to be an original, and all such counterparts shall, together, constitute one instrument.

[Signature page follows]

IN WITNESS WHEREOF, the parties to this Agreement have caused this Agreement to be executed by themselves or by their duly authorized representatives on their behalf on the date written below to be effective as of the Effective Date.

Company:

Silver Cross Ambulatory Surgery Center, LLC

By:_____

Name: _____

Its: _____

CONTRACTOR:

_____

_____

Section VII-Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(j), Charge Commitment

See Charge Commitment Affidavit from John Krepps, attached at ATTACHMENT 27, in support of this Criterion.

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

April 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.1540(j), Charge Commitment

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, and pursuant to 77 Ill. Admin. Code § 1110.1540(j), that the usual and customary charges set forth on the attached table will not be increased, at a minimum, for the first two years of operation following the licensure and opening of the proposed Silver Cross Ambulatory Surgery Center, to be located near the southwest corner of Route 6 and Silver Cross Boulevard in New Lenox, Illinois, unless a permit is first obtained pursuant to 77 Ill. Admin. Code § 1130.310(a).

Sincerely,

John Krepps
Senior Vice President/Finance
Chief Financial Officer

SUBSCRIBED AND SWORN
to before me this 28 day
of April, 2016.

Denise L Tatgenhorst
Notary Public

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Specialty	CPT Code	CPT Code Description	Volume	ASC fee	Hospital Fee
GEN SURG	10022	FNA W/IMAGE	2	$ 662	NA
GEN SURG	10140	DRAINAGE OF HEMATOMA/FLUID	11	$ 3,535	$ 5,050
GEN SURG	11200	REMOVAL OF SKIN TAGS <W/15	2	$ 5,604	$ 8,006
GEN SURG	11403	EXC TR-EXT B9+MARG 2.1-3CM/<	23	$ 5,997	$ 8,567
GEN SURG	11423	EXC H-F-NK-SP B9+MARG 2.1-3	20	$ 9,212	$ 13,160
GEN SURG	11450	REMOVAL SWEAT GLAND LESION	4	$ 5,647	$ 12,894
GEN SURG	11606	EXC TR-EXT MAL+MARG >4 CM	4	$ 5,647	$ 25,921
GEN SURG	11770	REMOVE PILONIDAL CYST SIMPLE	14	$ 5,647	$ 9,386
GEN SURG	11771	REMOVE PILONIDAL CYST EXTEN	2	$ 5,647	$ 10,636
GEN SURG	14301	TIS TRNFR ANY 30.1-60 SQ CM	2	$ 8,535	$ 25,893
GEN SURG	19081	BX BREAST 1ST LESION STRTCTC	2	$ 2,576	$ 3,680
GEN SURG	19101	BIOPSY OF BREAST OPEN	2	$ 2,951	$ 4,216
GEN SURG	19120	REMOVAL OF BREAST LESION	25	$ 7,382	$ 10,546
GEN SURG	19125	EXCISION BREAST LESION	24	$ 8,736	$ 14,252
GEN SURG	19281	PERQ DEVICE BREAST 1ST IMAG	6	$ 13,754	$ 19,648
GEN SURG	19300	REMOVAL OF BREAST TISSUE	25	$ 8,736	$ 18,611
GEN SURG	20205	DEEP MUSCLE BIOPSY	4	$ 5,295	$ 7,564
GEN SURG	21012	EXC FACE LES SBQ 2 CM/>	6	$ 5,647	$ 9,936
GEN SURG	23071	EXC SHOULDER LES SC 3 CM/>	4	$ 4,943	$ 7,062
GEN SURG	25999	FOREARM OR WRIST SURGERY	2	$ 11,126	$ 15,894
GEN SURG	27337	EXC THIGH/KNEE LES SC 3 CM/>	2	$ 5,647	$ 9,772
GEN SURG	27339	EXC THIGH/KNEE TUM DEP 5CM/>	4	$ 5,647	$ 15,812
GEN SURG	36561	INSERT TUNNELED CV CATH	29	$ 8,973	$ 13,021
GEN SURG	36590	REMOVAL TUNNELED CV CATH	4	$ 3,444	$ 7,069
GEN SURG	36821	AV FUSION DIRECT ANY SITE	16	$ 8,973	$ 15,399
GEN SURG	36825	ARTERY-VEIN AUTOGRAFT	2	$ 10,695	$ 15,278
GEN SURG	37609	TEMPORAL ARTERY PROCEDURE	2	$ 5,616	$ 8,023
GEN SURG	38500	BIOPSY/REMOVAL LYMPH NODES	8	$ 8,736	$ 18,621
GEN SURG	38525	BIOPSY/REMOVAL LYMPH NODES	2	$ 8,736	$ 29,196
GEN SURG	44180	LAP ENTEROLYSIS	6	$ 14,067	$ 20,095
GEN SURG	45350	SGMDSC W/BAND LIGATION	16	$ 3,006	$ 4,731
GEN SURG	45990	SURG DX EXAM ANORECTAL	10	$ 6,634	$ 8,700
GEN SURG	46080	INCISION OF ANAL SPHINCTER	6	$ 6,634	$ 10,999
GEN SURG	46200	REMOVAL OF ANAL FISSURE	2	$ 6,634	$ 14,000
GEN SURG	46221	LIGATION OF HEMORRHOID(S)	9	$ 1,260	$ 6,908
GEN SURG	46230	REMOVAL OF ANAL TAGS	2	$ 6,634	$ 13,804
GEN SURG	46250	REMOVE EXT HEM GROUPS 2+	2	$ 6,634	$ 10,722
GEN SURG	46255	REMOVE INT/EXT HEM 1 GROUP	2	$ 6,634	$ 9,908
GEN SURG	46270	REMOVE ANAL FIST SUBQ	2	$ 6,634	$ 11,738
GEN SURG	46280	REMOVE ANAL FIST COMPLEX	6	$ 6,634	$ 7,526
GEN SURG	46285	REMOVE ANAL FIST 2 STAGE	2	$ 6,634	$ 8,958
GEN SURG	46320	REMOVAL OF HEMORRHOID CLOT	2	$ 3,987	$ 5,696
GEN SURG	46910	DESTRUCTION ANAL LESION(S)	2	$ 1,296	$ 7,647
GEN SURG	46945	REMOVE BY LIGAT INT HEM GRP	9	$ 1,585	$ 13,741
GEN SURG	46947	HEMORRHOIDOPEXY BY STAPLING	9	$ 7,834	$ 11,192
GEN SURG	46999	ANUS SURGERY PROCEDURE	33	$ 9,090	$ 12,986
GEN SURG	47379	LAPAROSCOPE PROCEDURE LIVER	2	$ 19,965	$ 28,521
GEN SURG	47563	LAPARO CHOLECYSTECTOMY/GRAPH	52	$ 14,359	$ 21,770
GEN SURG	49320	DIAG LAPARO SEPARATE PROC	30	$ 14,359	$ 16,337
GEN SURG	49505	PRP I/HERN INIT REDUC >5 YR	47	$ 10,431	$ 13,731
GEN SURG	49520	REPAIE ING HERNIA REDUCE	2	$ 10,431	$ 14,552

Specialty	CPT Code	CPT Code Description	Volume	ASC fee	Hospital Fee
GEN SURG	49560	RPR VENTRAL HERN INIT REDUC	17	$ 10,431	$ 20,184
GEN SURG	49585	RPR UMBIL HERN REDUC > 5 YR	73	$ 10,431	$ 14,006
GEN SURG	49587	RPR UMBIL HERN BLOCK > 5 YR	25	$ 10,431	$ 14,933
GEN SURG	49650	LAP ING HERNIA REPAIR INIT	133	$ 14,359	$ 21,828
GEN SURG	49651	LAP ING HERNIA REPAIR RECUR	35	$ 14,359	$ 21,063
GEN SURG	49652	LAP VENT/ABD HERNIA REPAIR	2	$ 14,359	$ 20,404
GEN SURG	49653	LAP VENT/ABD HERN PROC COMP	8	$ 14,359	$ 26,322
GEN SURG	49654	LAP INC HERNIA REPAIR	8	$ 18,222	$ 26,032
GEN SURG	49655	LAP INC HERN REPAIR COMP	4	$ 19,025	$ 27,179
GEN SURG	49659	LAPARO PROC HERNIA REPAIR	4	$ 15,814	$ 22,592
GYNE	49321	LAPAROSCOPY BIOPSY	2	$ 14,359	$ 23,370
GYNE	49322	LAPAROSCOPY ASPIRATION	6	$ 14,359	$ 22,570
GYNE	56605	BIOPSY OF VULVA/PERINEUM	4	$ 10,603	$ 15,147
GYNE	56740	REMOVE VAGINA GLAND LESION	3	$ 6,979	$ 9,971
GYNE	57288	REPAIR BLADDER DEFECT	32	$ 12,923	$ 24,538
GYNE	57500	BIOPSY OF CERVIX	4	$ 8,210	$ 11,729
GYNE	57520	CONIZATION OF CERVIX	4	$ 7,266	$ 10,381
GYNE	58301	REMOVE INTRAUTERINE DEVICE	1	$ 15,036	$ 21,480
GYNE	58353	ENDOMETR ABLATE THERMAL	1	$ 9,305	$ 13,293
GYNE	58558	HYSTEROSCOPY BIOPSY	70	$ 7,431	$ 12,649
GYNE	58561	HYSTEROSCOPY REMOVE MYOMA	4	$ 11,647	$ 16,638
GYNE	58563	HYSTEROSCOPY ABLATION	7	$ 9,478	$ 13,540
GYNE	58571	TLH W/T/O 250 G OR LESS	25	$ 18,538	$ 26,483
GYNE	58572	TLH UTERUS OVER 250 G	1	$ 26,151	$ 37,358
GYNE	58573	TLH W/T/O UTERUS OVER 250 G	3	$ 20,673	$ 29,532
GYNE	58578	LAPARO PROC UTERUS	1	$ 13,776	$ 19,680
GYNE	58579	HYSTEROSCOPE PROCEDURE	1	$ 11,355	$ 16,222
GYNE	58661	LAPAROSCOPY REMOVE ADNEXA	12	$ 14,359	$ 24,002
GYNE	58662	LAPAROSCOPY EXCISE LESIONS	26	$ 14,359	$ 23,822
GYNE	58671	LAPAROSCOPY TUBAL BLOCK	27	$ 14,359	$ 17,505
GYNE	58679	LAPARO PROC OVIDUCT-OVARY	1	$ 12,556	$ 17,938
OPTHAL	66984	CATARACT SURG W/IOL 1 STAGE	473	$ 5,682	$ 8,118
OPTHAL	67700	DRAINAGE OF EYELID ABSCESS	2	$ 1,042	$ 7,784
ORTHO	10060	DRAINAGE OF SKIN ABSCESS	1	$ 470	$ 2,212
ORTHO	10120	REMOVE FOREIGN BODY	1	$ 754	$ 1,699
ORTHO	11042	DEB SUBQ TISSUE 20 SQ CM/<	1	$ 11,054	$ 15,791
ORTHO	11421	EXC H-F-NK-SP B9+MARG 0.6-1	1	$ 6,551	$ 9,359
ORTHO	20550	INJ TENDON SHEATH/LIGAMENT	1	$ 8,471	$ 12,101
ORTHO	20610	DRAIN/INJ JOINT/BURSA W/O US	3	$ 2,250	$ 3,214
ORTHO	20680	REMOVAL OF SUPPORT IMPLANT	9	$ 5,647	$ 11,604
ORTHO	22850	REMOVE SPINE FIXATION DEVICE	1	$ 14,842	$ 21,203
ORTHO	23120	PARTIAL REMOVAL COLLAR BONE	17	$ 9,565	$ 14,449
ORTHO	23415	RELEASE OF SHOULDER LIGAMENT	1	$ 9,565	$ 14,239
ORTHO	23430	REPAIR BICEPS TENDON	1	$ 13,296	$ 18,995
ORTHO	23630	TREAT HUMERUS FRACTURE	1	$ 16,005	$ 22,864
ORTHO	23700	FIXATION OF SHOULDER	3	$ 4,378	$ 9,825
ORTHO	24105	REMOVAL OF ELBOW BURSA	1	$ 5,811	$ 9,113
ORTHO	24341	REPAIR ARM TENDON/MUSCLE	1	$ 9,565	$ 28,407
ORTHO	24342	REPAIR OF RUPTURED TENDON	1	$ 9,565	$ 21,206
ORTHO	24346	RECONSTRUCT ELBOW MED LIGMNT	3	$ 17,848	$ 25,497
ORTHO	24358	REPAIR ELBOW W/DEB OPEN	1	$ 7,069	$ 10,099

Specialty	CPT Code	CPT Code Description	Volume	ASC fee	Hospital Fee
ORTHO	24515	TREAT HUMERUS FRACTURE	1	$ 14,599	$ 20,856
ORTHO	24665	TREAT RADIUS FRACTURE	1	$ 7,529	$ 10,755
ORTHO	25000	INCISION OF TENDON SHEATH	2	$ 5,811	$ 11,424
ORTHO	25111	REMOVE WRIST TENDON LESION	3	$ 5,811	$ 7,042
ORTHO	25115	REMOVE WRIST/FOREARM LESION	1	$ 5,811	$ 7,800
ORTHO	25210	REMOVAL OF WRIST BONE	1	$ 9,565	$ 15,782
ORTHO	25310	TRANSPLANT FOREARM TENDON	2	$ 9,565	$ 15,969
ORTHO	25400	REPAIR RADIUS OR ULNA	1	$ 13,183	$ 18,833
ORTHO	25431	REPAIR NONUNION CARPAL BONE	1	$ 17,752	$ 26,422
ORTHO	25447	REPAIR WRIST JOINTS	1	$ 9,565	$ 14,582
ORTHO	25609	TREAT FX RADIAL 3+ FRAG	7	$ 14,775	$ 21,107
ORTHO	25624	TREAT WRIST BONE FRACTURE	1	$ 4,378	$ 16,616
ORTHO	26055	INCISE FINGER TENDON SHEATH	6	$ 5,263	$ 7,518
ORTHO	26370	REPAIR FINGER/HAND TENDON	1	$ 8,214	$ 11,734
ORTHO	26615	TREAT METACARPAL FRACTURE	1	$ 9,565	$ 14,997
ORTHO	26765	TREAT FINGER FRACTURE EACH	2	$ 5,811	$ 12,299
ORTHO	27005	INCISION OF HIP TENDON	1	$ 16,357	$ 23,368
ORTHO	27062	REMOVE FEMUR LESION/BURSA	1	$ 9,565	$ 28,322
ORTHO	27310	EXPLORATION OF KNEE JOINT	1	$ 5,118	$ 7,312
ORTHO	27328	EXC THIGH/KNEE TUM DEEP <5CM	1	$ 5,647	$ 9,791
ORTHO	27347	REMOVE KNEE CYST	1	$ 9,565	$ 13,922
ORTHO	27403	REPAIR OF KNEE CARTILAGE	1	$ 5,811	$ 28,113
ORTHO	27416	OSTEOCHONDRAL KNEE AUTOGRAFT	1	$ 17,752	$ 28,440
ORTHO	27425	LAT RETINACULAR RELEASE OPEN	17	$ 4,645	$ 6,635
ORTHO	27428	RECONSTRUCTION KNEE	1	$ 20,540	$ 29,343
ORTHO	27570	FIXATION OF KNEE JOINT	5	$ 4,378	$ 7,658
ORTHO	27635	REMOVE LOWER LEG BONE LESION	1	$ 9,565	$ 10,803
ORTHO	27658	REPAIR OF LEG TENDON EACH	1	$ 9,565	$ 19,517
ORTHO	27675	REPAIR LOWER LEG TENDONS	1	$ 9,565	$ 12,743
ORTHO	27687	REVISION OF CALF TENDON	1	$ 9,565	$ 26,663
ORTHO	27705	INCISION OF TIBIA	1	$ 9,565	$ 19,364
ORTHO	27814	TREATMENT OF ANKLE FRACTURE	4	$ 17,360	$ 24,799
ORTHO	27829	TREAT LOWER LEG JOINT	1	$ 9,565	$ 24,502
ORTHO	28104	REMOVAL OF FOOT LESION	1	$ 5,811	$ 6,542
ORTHO	28285	REPAIR OF HAMMERTOE	1	$ 5,811	$ 18,276
ORTHO	28289	REPAIR HALLUX RIGIDUS	3	$ 9,565	$ 12,206
ORTHO	28415	TREAT HEEL FRACTURE	1	$ 23,640	$ 33,771
ORTHO	28750	FUSION OF BIG TOE JOINT	1	$ 17,752	$ 26,230
ORTHO	29824	SHOULDER ARTHROSCOPY/SURGERY	53	$ 9,565	$ 23,175
ORTHO	29826	SHOULDER ARTHROSCOPY/SURGERY	55	$ 16,801	$ 24,002
ORTHO	29827	ARTHROSCOP ROTATOR CUFF REPR	6	$ 17,752	$ 25,086
ORTHO	29828	ARTHROSCOPY BICEPS TENODESIS	1	$ 17,752	$ 25,043
ORTHO	29834	ELBOW ARTHROSCOPY/SURGERY	1	$ 9,565	$ 13,334
ORTHO	29846	WRIST ARTHROSCOPY/SURGERY	2	$ 9,565	$ 16,689
ORTHO	29855	TIBIAL ARTHROSCOPY/SURGERY	1	$ 17,169	$ 24,528
ORTHO	29862	HIP ARTHRO W/DEBRIDEMENT	4	$ 17,752	$ 27,946
ORTHO	29867	ALLGRFT IMPLNT KNEE W/SCOPE	1	$ 15,904	$ 22,721
ORTHO	29877	KNEE ARTHROSCOPY/SURGERY	18	$ 9,565	$ 10,639
ORTHO	29880	KNEE ARTHROSCOPY/SURGERY	53	$ 9,565	$ 12,820
ORTHO	29881	KNEE ARTHROSCOPY/SURGERY	101	$ 9,565	$ 12,028
ORTHO	29891	ANKLE ARTHROSCOPY/SURGERY	1	$ 9,565	$ 20,544

Specialty	CPT Code	CPT Code Description	Volume	ASC fee	Hospital Fee
ORTHO	29914	HIP ARTHRO W/FEMOROPLASTY	16	$ 17,752	$ 28,612
ORTHO	63030	LOW BACK DISK SURGERY	2	$ 17,752	$ 26,653
ORTHO	64718	REVISE ULNAR NERVE AT ELBOW	3	$ 5,560	$ 17,328
ORTHO	64721	CARPAL TUNNEL SURGERY	38	$ 5,560	$ 9,308
PODIATRY	20103	EXPLORE WOUND EXTREMITY	1	$ 2,678	$ 3,826
PODIATRY	27650	REPAIR ACHILLES TENDON	1	$ 9,565	$ 16,581
PODIATRY	28008	INCISION OF FOOT FASCIA	2	$ 5,811	$ 11,534
PODIATRY	28043	EXC FOOT/TOE TUM SC < 1.5 CM	1	$ 5,647	$ 8,196
PODIATRY	28060	PARTIAL REMOVAL FOOT FASCIA	1	$ 5,811	$ 8,148
PODIATRY	28080	REMOVAL OF FOOT LESION	1	$ 5,811	$ 12,045
PODIATRY	28090	REMOVAL OF FOOT LESION	1	$ 5,811	$ 12,778
PODIATRY	28110	PART REMOVAL OF METATARSAL	1	$ 5,811	$ 13,858
PODIATRY	28119	REMOVAL OF HEEL SPUR	1	$ 9,565	$ 17,327
PODIATRY	28296	CORRECTION OF BUNION	15	$ 9,565	$ 14,543
PODIATRY	28755	FUSION OF BIG TOE JOINT	5	$ 9,565	$ 15,066
UROLOGY	17111	DESTRUCT LESION 15 OR MORE	1	$ 6,409	$ 9,156
UROLOGY	52005	CYSTOSCOPY & URETER CATHETER	15	$ 6,015	$ 13,126
UROLOGY	52204	CYSTOSCOPY W/BIOPSY(S)	1	$ 6,015	$ 13,682
UROLOGY	52234	CYSTOSCOPY AND TREATMENT	7	$ 8,958	$ 11,698
UROLOGY	52235	CYSTOSCOPY AND TREATMENT	5	$ 8,958	$ 11,186
UROLOGY	52240	CYSTOSCOPY AND TREATMENT	4	$ 8,958	$ 15,823
UROLOGY	52260	CYSTOSCOPY AND TREATMENT	23	$ 5,580	$ 7,971
UROLOGY	52318	REMOVE BLADDER STONE	2	$ 12,455	$ 23,250
UROLOGY	52332	CYSTOSCOPY AND TREATMENT	11	$ 8,958	$ 17,932
UROLOGY	52354	CYSTOURETERO W/BIOPSY	2	$ 8,958	$ 20,928
UROLOGY	52356	CYSTO/URETERO W/LITHOTRIPSY	31	$ 12,455	$ 25,454
UROLOGY	54161	CIRCUM 28 DAYS OR OLDER	4	$ 5,984	$ 8,548
UROLOGY	54530	REMOVAL OF TESTIS	8	$ 10,431	$ 14,972
UROLOGY	54640	SUSPENSION OF TESTIS	2	$ 10,431	$ 11,826
UROLOGY	54840	REMOVE EPIDIDYMIS LESION	1	$ 8,958	$ 15,625
UROLOGY	55040	REMOVAL OF HYDROCELE	2	$ 8,981	$ 12,830
UROLOGY	55250	REMOVAL OF SPERM DUCT(S)	3	$ 6,015	$ 14,008
UROLOGY	55550	LAPARO LIGATE SPERMATIC VEIN	5	$ 11,566	$ 16,523
Total			2,165		

Section VII
Specific Service Review Criteria
Non-Hospital Based Ambulatory Surgical Treatment Centers
Criterion 1110.1540(k), Assurances

Silver Cross Hospital has a robust peer review program for its Procedural Care Unit. Silver Cross Hospital will also establish a robust peer review program (the "Peer Review Program") at the proposed Surgery Center. Consistent with Criterion 1110.1540(k)(1), the Applicants commit that the Peer Review Program will evaluate whether patient outcomes are consistent with quality standards established by professional organizations for ambulatory surgical treatment centers and if outcomes do not meet or exceed those quality standards, a quality improvement program will be initiated. See Peer Review Program Certification from Paul Pawlak, the President and CEO of the Applicants, attached at ATTACHMENT 27, in support of this Criterion.

As set forth herein, the Applicants have documented that the proposed Surgery Center, in its second year of operation, will meet or exceed the relevant utilization standards.

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

May 12, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.1540(k)(1), Peer Review Program Certification

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § 1110.1540(k)(1), as follows:

1. Silver Cross Hospital and Medical Centers ("Silver Cross Hospital") has a robust peer review program.

2. Silver Cross Hospital will establish a robust peer review program (the "Peer Review Program") at the proposed Silver Cross Ambulatory Surgery Center (the "Surgery Center").

3. The Surgery Center's Peer Review Program will evaluate whether patient outcomes are consistent with quality standards established by professional organizations for ambulatory surgical treatment centers and if outcomes do not meet or exceed those quality standards, a quality improvement plan will be initiated.

Sincerely,

Paul Pawlak
President & CEO
Silver Cross Ambulatory Surgery Center LLC
Silver Cross Hospital and Medical Centers

Subscribed and Sworn to before me
this 17th day of May, 2016.

Notary Public

"OFFICIAL SEAL"
CAROL J. ZIER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES JUNE 17, 2019

Attachment
27

Section VIII
Availability of Funds
Criterion 1120.120

Silver Cross Hospital will be funding this Project with cash and cash equivalents. An Affidavit of Available Funds from John Krepps, the Senior Vice President of Finance and Chief Financial Officer of Silver Cross Hospital ("Mr. Krepps"), in support of this Criterion is attached at ATTACHMENT 36. Silver Cross Hospital's most recent audited financial statements are also attached at ATTACHMENT 36 and show that Silver Cross Hospital was holding more than $150,912,000 in cash, cash equivalents, available invested funds, and funds specifically directed for capital improvements, as of its last audited financial statement (September 30, 2015). Thus, Silver Cross Hospital has sufficient cash available to fund this Project.

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

April 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1120.120(a) Available Funds Certification

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § 1120.120(a), that Silver Cross Ambulatory Surgery Center LLC and Silver Cross Hospital and Medical Centers (collectively, "Silver Cross") have sufficient and readily accessible cash and cash equivalents to fund the obligations of Silver Cross set forth in the Certificate of Need Application for the "Silver Cross Ambulatory Surgery Center" Project.

Sincerely,

John Krepps
Senior Vice President Finance
Chief Financial Officer

SUBSCRIBED AND SWORN
to before me this 28 day
of April, 2016.

Denise L. Tatgenhorst
Notary Public

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Attachment
36

KPMG

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements and Schedules

September 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

KPMG LLP
Aon Center
Suite 5500
200 East Randolph Drive
Chicago, IL 60601-6436

Independent Auditors' Report

The Boards of Trustees
Silver Cross Health System
and Affiliates:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Silver Cross Health System and Affiliates, which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations and changes in unrestricted net assets, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Silver Cross Health System and Affiliates as of September 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG").

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

January 27, 2016

Attachment
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SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

September 30, 2015 and 2014

(Amounts in thousands)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	30,462	26,950
Short-term investments		2,812	3,010
Assets whose use is limited or restricted, required for current liabilities		371	1,559
Patient accounts receivable, net of estimated uncollectibles of $13,767 in 2015 and $14,767 in 2014		44,637	47,830
Other receivables		5,031	1,324
Prepaid expenses and other		4,939	3,643
Total current assets		88,252	84,316
Assets whose use is limited or restricted, excluding assets required for current liabilities:			
By board for capital improvements and other		120,483	100,638
By board for self-insurance		22,787	22,385
Under bond indenture agreements – held by trustee		8,713	32,570
Pledges receivable		918	1,253
Donor-restricted investments		9,031	9,118
		161,932	165,964
Land, buildings, and equipment, net		455,053	468,226
Other assets:			
Land held for sale		25,270	25,270
Estimated excess insurance recovery receivables		4,435	4,558
Other long-term assets		6,752	4,630
Deferred finance charges		4,082	4,573
Total assets	$	745,776	757,537

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets		2015	2014
Current liabilities:			
Current installments of long-term debt	$	6,935	5,610
Accounts payable		21,912	22,651
Accrued salaries and wages		25,907	23,214
Accrued expenses		5,324	7,984
Estimated payables under third-party reimbursement programs		34,192	32,882
Total current liabilities		94,270	92,341
Estimated self-insured professional and general liability claims		37,802	33,047
Long-term debt, excluding current installments, and unamortized bond discounts and premiums		419,236	381,686
Capital lease and other long-term liabilities, net of current portion		6,686	891
Total liabilities		557,994	507,965
Commitments and contingent liabilities			
Net assets:			
Unrestricted		177,833	239,201
Temporarily restricted		3,793	4,011
Permanently restricted		6,156	6,360
Total net assets		187,782	249,572
Total liabilities and net assets	$	745,776	757,537

SILVER CROSS HEALTH SYSTEM
AND AFFILIATES

Consolidated Statements of Operations and Change in Unrestricted Net Assets

Years ended September 30, 2015 and 2014

(Amounts in thousands)

	2015	2014
Revenue:		
Net patient service revenue	$ 338,418	323,776
Provision for bad debts	(11,832)	(14,146)
Net patient service revenue less provision for bad debts	326,586	309,630
Other revenue	22,218	37,847
Total revenue	348,804	347,477
Expenses:		
Salaries and wages	118,339	110,983
Payroll taxes and fringe benefits	36,682	36,049
General and administrative	75,516	92,396
Supplies	62,889	56,882
Depreciation and amortization	28,283	27,990
Interest	22,343	25,680
Total expenses	344,052	349,980
Income (loss) from operations	4,752	(2,503)
Nonoperating gains (losses):		
Investment return, net	1,219	8,192
Loss on early extinguishment of long-term debt	(69,841)	—
Loss on sale of land, buildings, and equipment	(72)	(38)
Other, net	2,101	189
Total nonoperating (losses) gains, net	(66,593)	8,343
Revenue and gains (deficient) in excess of expenses and losses	(61,841)	5,840
Other changes in unrestricted net assets:		
Net assets released from restriction for land, building, and equipment acquisitions financed by temporarily restricted net assets	473	1,240
Increase (decrease) in unrestricted net assets	$ (61,368)	7,080

See accompanying notes to consolidated financial statements.

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2015 and 2014

(Amounts in thousands)

	2015	2014
Unrestricted net assets:		
Revenue and gains (deficient) in excess of expenses	$ (61,841)	5,840
Other changes in unrestricted net assets:		
Net assets released from restriction for land, building, and equipment acquisitions financed by temporarily restricted net assets	473	1,240
Increase (decrease) in unrestricted net assets	(61,368)	7,080
Temporarily restricted net assets:		
Contributions for specific purposes	402	1,223
Net realized and unrealized gains and losses on temporarily restricted investments	(44)	79
Net assets released from restriction for operating purposes	(103)	(99)
Net assets released from restriction for land, building, and equipment acquisitions	(473)	(1,240)
Decrease in temporarily restricted net assets	(218)	(37)
Permanently restricted net assets:		
Permanently restricted contributions	21	1
Net realized and unrealized gains and losses on permanently restricted investments	(225)	252
Increase (decrease) in permanently restricted net assets	(204)	253
Change in net assets	(61,790)	7,296
Net assets at beginning of year	249,572	242,276
Net assets at end of year	$ 187,782	249,572

See accompanying notes to consolidated financial statements.

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended September 30, 2015 and 2014

(Amounts in thousands)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ (61,790)	7,296
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	28,283	27,990
Amortization included in interest expense	12	379
Provision for bad debts	11,832	14,146
Income from equity basis investments	(3,677)	(1,835)
Cash received from equity basis investments	1,555	33
Loss on early extinguishment of long-term debt	69,841	—
Net loss on sale of land, buildings, and equipment	72	38
Permanently and temporarily restricted contributions	(423)	(1,224)
Net assets released from restriction for operating purposes	103	99
Net realized and unrealized gains and losses on permanently and temporarily restricted investments	269	(331)
Net change in unrealized gains and losses on unrestricted investments	6,484	(2,061)
Net realized gains and losses on unrestricted investments	(3,165)	(2,993)
Changes in assets and liabilities:		
Patient accounts receivable	(8,639)	(339)
Estimated excess insurance recovery receivables	123	295
Other assets	(5,141)	(109)
Estimated payables under third-party reimbursement programs	1,310	4,795
Accounts payable, accrued expenses, and other liabilities	15,924	(730)
Net cash provided by operating activities	52,973	45,449
Cash flows from investing activities:		
Acquisition of land, buildings, and equipment	(21,415)	(11,802)
Proceeds from sale of land, buildings, and equipment and land held for sale	233	113
Development of land held for sale	—	(8)
Net change in assets whose use is limited or restricted	1,632	(22,561)
Net change in short-term investments	198	2,837
Net cash used in investing activities	(19,352)	(31,421)
Cash flows from financing activities:		
Repayment of capital leases	(80)	—
Repayments of long-term debt	(359,208)	(5,375)
Proceeds from issuance of debt, including premium	332,095	—
Payment of bond issuance cost	(3,236)	—
Net assets released from restriction for operating purposes	(103)	(99)
Permanently and temporarily restricted contributions	423	1,224
Net cash used in financing activities	(30,109)	(4,250)
Net increase in cash and cash equivalents	3,512	9,778
Cash and cash equivalents at beginning of year	26,950	17,172
Cash and cash equivalents at end of year	$ 30,462	26,950
Supplemental disclosures of cash flow information:		
Assets acquired under capital lease	$ 6,000	—
Cash paid for interest	23,028	24,351

See accompanying notes to consolidated financial statements.

(1) Organization and Purposes

Silver Cross Health System (Health System) was incorporated during 1981 for charitable, educational, and scientific purposes to support health and human services by providing management assistance, and in all other relevant ways. The accompanying consolidated financial statements include the accounts of the Health System and the following affiliates, which it controls (collectively referred to as the Corporations):

- Silver Cross Hospital and Medical Centers (Hospital), a not-for-profit acute care hospital of which the Health System is the sole member.
- Silver Cross Foundation (Foundation), a not-for-profit corporation of which the Health System is the sole member, which is dedicated to the advancement of healthcare in Will, Grundy, South Cook, and DuPage counties in Illinois.
- Health Service Systems, Inc. (HSSI), a wholly owned subsidiary of the Health System, which was incorporated to provide administrative and management services to its affiliates and other businesses.
- Midwest Community Real Estate Corporation (MCREC), a not-for-profit corporation of which the Health System is the sole member, which was incorporated to establish and maintain healthcare centers and other facilities for the benefit of the Health System and its affiliates.
- Silver Cross Managed Care Organization (SCMCO), a not-for-profit corporation of which the Health System is the sole member, which was incorporated to provide alternative forms of healthcare delivery services. SCMCO ceased operations as of December 31, 2014.
- Silver Cross Medical Associates, Inc. (SCMA), a not-for-profit corporation that operates medical practices in Joliet and surrounding areas. MCREC serves as the sole and exclusive manager and administrator for all matters relating to the operations of SCMA, including, but not limited to, the financial and management operations of SCMA.

On July 1, 2008, the Hospital received approval from the Illinois Health Facilities Planning Board to construct a replacement hospital facility on a parcel of land owned by the Hospital in New Lenox, Illinois. The replacement hospital facility has 296 licensed beds and was completed in February 2012.

Subsequent to the relocation of Hospital operations to the replacement hospital facility, the Health System continues to own some facilities at its previous hospital location. The Health System's Board of Trustees and management, with input from constituents of the local community, are currently evaluating all possible alternative uses for the previous Hospital campus.

During 2015, the Health System sold property for $233 and recorded a loss on the sale of $72, which is recorded in loss on the sale of land and improvements, buildings, and equipment. During 2014, the Health System sold property for $113 and recorded a loss on the sale of $38, which is recorded in loss on the sale of land, buildings, and equipment.

The Corporations engage in transactions in the ordinary course of business with organizations with which members of management and the boards of directors are affiliated. Such transactions are conducted at arm's length and fully disclosed to the respective members of management and boards of directors.

All significant intercompany balances and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Summary of Significant Accounting Policies

Significant accounting policies of the Corporations that conform to general practice within the healthcare industry are as follows:

- The preparation of consolidated financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.
- Transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as revenue and expenses. Transactions incidental to the provision of healthcare services are reported as gains and losses.
- The consolidated statements of operations and changes in unrestricted net assets include revenue and gains in excess (deficient) of expenses and losses. Changes in unrestricted net assets, which are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets).
- The Corporations consider demand deposits with banks, cash on hand, and all highly liquid debt instruments (including repurchase agreements) purchased with terms of three months or less to be cash and cash equivalents, excluding those instruments classified as assets whose use is limited or restricted. Short-term investments consist of money market funds or mutual funds that are held and managed by an external broker. These funds are not intended to be used for operations but have not had a specific limitation placed on them to classify them as assets whose use is limited or restricted.
- Assets whose use is limited or restricted include: assets set aside by the Corporations' boards of directors for future capital improvements, self-insurance funding, and for other purposes over which the boards retain control and may at their discretion use for other purposes; assets designated by the Foundation's board of directors for endowment development purposes; assets held by a trustee and limited as to use in accordance with the requirements of bond indenture agreements; pledges receivable; and temporarily and permanently restricted investments. Assets whose use is limited required for current liabilities are reported as current assets.
- Investment return (including realized and unrealized gains and losses on investments, interest, and dividends) is included in revenue and gains in (deficient) excess of expenses and losses, as all investments are considered to be trading securities, unless the income or loss is restricted by donors, in which case the investment return is recorded directly to temporarily or permanently restricted net assets. Investment return of unrestricted investments is reported as nonoperating gains. Unrealized gains and losses of permanently and temporarily restricted investments are recorded directly to permanently and temporarily restricted net assets.

- The Corporations apply the provisions of Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, for fair value measurements of financial assets and liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a framework for measuring fair value and expands disclosures about fair value measurements (note 7).

- In conjunction with the application of ASC Topic 820, the Corporations apply the measurement provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in mutual funds that do not have readily determinable fair values. This guidance amends ASC Topic 820 and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value (NAV) per share or its equivalent. Interests in mutual funds are generally reported at the NAV reported by fund managers, which is used as a practical expedient to estimate the fair value interest therein, unless it is probable that all or a portion of the investment will be sold for an amount different than NAV. As of September 30, 2015, the Corporations had no plans or intentions to sell investments at amounts different from NAV.

- The Corporations have adopted the provisions of ASC Topic 825, *Financial Instruments*. ASC Topic 825 gives the Corporations the irrevocable option to report most financial assets and financial liabilities at fair value on an instrument-by-instrument basis, with changes in fair value reported in earnings. The Corporations' management did not elect to measure any additional eligible financial assets or financial liabilities at fair value.

- Except as otherwise disclosed, the carrying value of all financial instruments of the Corporations approximates fair value.

- Land, buildings, and equipment are stated at cost. Depreciation is provided over the estimated useful lives of depreciable assets and is computed on the straight-line method.

- The Corporations evaluate long-lived assets, such as buildings and equipment, for impairment on an annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. No impairments have been recorded for the year ended September 30, 2015 or 2014.

- Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received (fair value of pledges is considered a Level 3 measurement in the fair value hierarchy). All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to permanently or temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported

as net assets released from restriction. Temporarily restricted net assets used for operating purposes are included in other operating revenue to the extent expended during the period. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Donor-restricted contributions whose restrictions are met within the same year as received are reported directly within the consolidated statements of operations and changes in unrestricted net assets.

- Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Temporarily restricted net assets include the Hospital's interest in a charitable remainder trust. Investment income of the charitable remainder trust is distributable within specified limits to an unrelated party. All other temporarily restricted net assets are restricted primarily for land, building, and equipment acquisitions at both September 30, 2015 and 2014.

- Permanently restricted net assets represent beneficial interest in perpetual trusts and donor-restricted contributions, the principal amount of which may not be expended. Permanently restricted net assets include the Foundation's interest in a charitable remainder trust. Investment income of the charitable remainder trust is distributable within specified limits to an unrelated party. Based upon donor intentions, investment income earned on permanently restricted net assets is reported as either nonoperating investment income or as a direct addition to temporarily restricted net assets. Unrealized and realized gains and losses are recorded directly to permanently restricted net assets.

- The Corporations apply ASC Topic 958, *Not-for-Profit Entities*, which provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of Uniform Prudent Management of Institutional Funds Act (UPMIFA). ASC Topic 958 also enhances disclosures related to both donor-restricted and board-designated endowment funds (note 14).

- Provisions for estimated self-insured professional, general liability, workers' compensation, and employee healthcare risks include estimates of the ultimate cost of both reported losses and losses incurred but not reported as of the respective consolidated balance sheet dates.

- Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Those adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

- The Electronic Health Record (EHR) Incentive Program (the Program) provides incentive payments to eligible hospitals and professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. The Corporations account for the Program using the grant model. For the years ended September 30, 2015 and 2014, the Corporations recognized $2,503 and $3,624, respectively, as other revenue related to EHR incentives, which have been received or are expected to be received based on certifications prepared by management under the appropriate guidelines.

- Deferred finance charges and unamortized bond discounts and premiums are amortized using the straight-line method over the periods the related obligations are outstanding.

- The Health System, the Hospital, MCREC, the Foundation, and SCMA are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. A provision for income taxes has not been recorded for HSSI, as there are net operating losses of approximately $21,972 available for carryforward, which expire at various future dates through 2035. SCMCO is a not-for-profit corporation, which is subject to federal and state income taxes. A provision for income taxes has not been recorded for SCMCO, as there are net operating losses of approximately $677 available for carryforward, which expire at various future dates through 2026. In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Deferred tax assets have been offset in their entirety by valuation allowances at both September 30, 2015 and 2014.
- The Corporations account for tax positions in accordance with ASC Topic 740, *Income Taxes*. ASC Topic 740 clarifies the accounting for uncertainty in tax positions and also provides guidance on when the tax positions are recognized in an entity's consolidated financial statements and how the values of these positions are determined. The Corporations do not have any liabilities recognized for uncertain tax positions.
- The Corporations incur expenses for the provision of healthcare services and related general and administrative activities.
- Certain 2014 amounts have been reclassified to conform to the 2015 consolidated financial statement presentation.

Other significant accounting policies are set forth in the consolidated financial statements and in the following notes.

(3) Net Patient Service Revenue

The Hospital, HSSI, and SCMCO (collectively referred to as the Providers) have agreements with third-party payors that provide for reimbursement at amounts different from their established rates. Estimated contractual adjustments arising under third-party reimbursement programs principally represent the differences between the Providers' billings at list price and the amounts reimbursed by Medicare, Blue Cross, and certain other contracted third-party payors; the difference between the Providers' billings at list price and the allocated cost of services provided to Medicaid patients; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the reimbursement methodologies with major third-party payors follows:

(a) Medicare

The Hospital is paid for inpatient acute care, outpatient, rehabilitative, and home health services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospital's classification

of patients under the prospective payment systems and the appropriateness of patient admissions are subject to validation reviews.

For certain services rendered to Medicare beneficiaries, the Providers' reimbursement is based upon cost or other reimbursement methodologies. The Providers are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. Medicare reimbursement reports through September 30, 2009 have been audited and final settled by the Medicare fiscal intermediary.

(b) Medicaid

The Hospital is paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rate per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Medicaid outpatient services are reimbursed based on fee schedules. Medicaid reimbursement methodologies may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the State of Illinois Medicaid program, and any such changes could have a significant effect on the Hospital's revenue.

The Hospital participates in the State of Illinois (the State) provider assessment program that assists in the financing of its Medicaid program. The program has been renewed by the State since its inception in 2004. Pursuant to this program, hospitals within the State are required to remit payment to the State of Illinois Medicaid program under an assessment formula approved by the Centers for Medicare and Medicaid Services (CMS). The Corporations have included their assessment of $6,988 for each of the years ended September 30, 2015 and 2014 within general and administrative expense in the accompanying consolidated statements of operations and changes in unrestricted net assets. The assessment program also provides hospitals within the State with additional Medicaid reimbursement based on funding formulas also approved by CMS. The Corporations have included their additional reimbursement of $8,768 and $14,684 for each of the years ended September 30, 2015 and 2014 within net patient service revenue in the accompanying consolidated statements of operations and changes in unrestricted net assets.

As of and for the year ended September 30, 2015 and 2014, the Corporations have included its related assessment of $3,381 and 7,267, respectively, under the Enhanced Hospital Assessment Program, within general and administrative expenses in the accompanying 2015 consolidated statement of operations and changes in unrestricted net assets. The Enhanced Hospital Assessment Program provides hospitals within the State with additional Medicaid reimbursement, based on funding formulas also approved by CMS. The Corporations have included its additional related reimbursements for the year ended September 30, 2015 and 2014 of $10,728 and $11,109, respectively, within net patient service revenue in the accompanying 2015 consolidated statement of operations and changes in unrestricted net assets.

During 2015, CMS approved Illinois' request for a new supplemental payment to hospitals for services provided to newly eligible Medicaid beneficiaries under the Affordable Care Act. The new supplemental payment to hospitals was approved retroactive to March 1, 2014. Illinois will use same pro rata allocation as a percentage of the gross assessment payments under the existing Hospital

Assessment Programs. The Corporations have included its additional related reimbursements for the year ended September 30, 2015 of $5,700 within net patient service revenue in the accompanying 2015 consolidated statement of operations and change in unrestricted net assets.

(c) Blue Cross

The Hospital also participates as a provider of healthcare services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the Hospital and a review by Blue Cross. The Blue Cross reimbursement reports for September 30, 2014 and prior years have been reviewed by Blue Cross.

(d) Other

The Providers have also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements is negotiated by the Providers and includes prospectively determined rate per discharge, discounts from established charges, capitation, and prospectively determined per diem rates.

SCMCO is involved in various risk-based contracts with managed care organizations. Under these arrangements, SCMCO receives capitation payments based on the demographic characteristics of covered members in exchange for providing all primary care physician services, as well as certain outpatient diagnostic and specialist physician services. Additionally, SCMCO is eligible for incentive payments based on favorable utilization experience. Capitation revenue related to risk-based contracts totaled approximately $5,168 and $21,274 for 2015 and 2014, respectively, and is included with other revenue in the accompanying consolidated statements of operations and changes in unrestricted net assets. Pursuant to risk-based contracts, SCMCO estimates its liability for covered medical claims, including claims incurred but not reported as of the consolidated balance sheet dates, based upon historical costs incurred and payment processing experience. This liability approximated $878 and $2,101 at September 30, 2015 and 2014, respectively, and is included with accounts payable in the accompanying consolidated balance sheets.

Net patient service revenue for the years ended September 30, 2015 and 2014 include approximately $181 and $450, respectively, of favorable retrospectively determined prior year settlements with third-party payors.

A summary of the Providers' utilization percentages based upon gross patient service revenue follows:

	2015	2014
Medicare	40.9%	39.2%
Medicaid	11.1	9.9
Managed care/commercial	45.2	46.6
Self-pay and other	2.8	4.3
	100.0%	100.0%

Patients' accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of patients' accounts receivable, the Corporations analyze their past history and identify trends for each of their major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Corporations analyze contractually due amounts and provide an allowance for doubtful accounts and a provision for bad debts, if necessary (e.g., for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes patients without insurance), the Corporations record a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Corporations' allowance for uncollectible accounts for self-pay patients, which includes uninsured patients and residual copayments and deductibles for which insurance has already paid increased to 94.1% of self-pay accounts receivable at September 30, 2015, from 80.9% of self-pay accounts receivable at September 30, 2014. In addition, the Corporations' self-pay write-offs decreased to $14,316 for fiscal year 2015 from $15,197 for fiscal year 2014. The Corporations do not maintain a material allowance for uncollectible accounts from third-party payors, nor did it have significant write-offs from third-party payors.

The Corporations recognize gross patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Corporations recognize revenue on the basis of their standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Corporations' uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Corporations record a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources is as follows:

		2015	2014
Medicare	$	111,267	97,704
Medicaid		38,752	35,257
Managed care/commercial		180,680	182,781
Self-pay and other		7,719	8,034
Net patient service revenue	$	338,418	323,776

(4) Concentration of Credit Risk

The Providers grant credit without collateral to their patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of September 30, 2015 and 2014 follows:

	2015	2014
Medicare	32.6%	30.5%
Medicaid	12.4	12.3
Blue Cross	11.5	9.8
Managed care/contract payors	22.7	24.7
Patients	12.1	14.5
Other	8.7	8.2
	100.0%	100.0%

(5) Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. In addition, reimbursement for services provided to Medicaid program beneficiaries is substantially less than the cost to the Hospital for providing these services.

The Hospital maintains records of the amount of charges forgone and related cost for services and supplies furnished under its charity care policy, as well as the estimated differences between the cost of services provided to Medicaid patients and the reimbursement under that program estimated based on an overall cost to charge ratio. The following information measures the level of charity care provided and unreimbursed cost under the Medicaid program during 2015 and 2014:

		2015	2014
Charity care costs for non-Medicaid patients	$	5,605	8,071
Excess of cost over reimbursement for services provided to Medicaid patients (1)		6,046	6,201

(1) Net impact of Medicaid assessment program has been allocated to each year based upon the State's fiscal year

(6) Investments

The Corporations report investments at fair value. A summary of the composition of the Corporations' investment portfolio at September 30, 2015 and 2014 follows:

		2015	2014
Cash and cash equivalents	$	11,614	19,140
Money market funds		2,348	2,607
Common stock		9,577	9,766
U.S. Treasury securities		11,679	5,330
Equity mutual funds		67,010	58,109
Fixed income mutual funds		22,478	17,820
Corporate bonds and notes		23,459	32,342
U.S. agency securities		11,596	16,302
Asset-backed securities		4,436	7,864
	$	164,197	169,280

Investments are reported in the accompanying consolidated balance sheets at September 30 as follows:

		2015	2014
Short-term investments	$	2,812	3,010
Assets whose use is limited or restricted, excluding pledges receivable:			
Required for current liabilities		371	1,559
By board for capital improvements and other		120,483	100,638
By board for self-insurance		22,787	22,385
Under bond indenture agreements – held by trustee		8,713	32,570
Donor-restricted investments		9,031	9,118
	$	164,197	169,280

The composition of investment return on the Corporations' investment portfolio for 2015 and 2014 is as follows:

		2015	2014
Interest and dividend income, net of fees and expenses	$	4,538	3,138
Net realized gains on sale of investments		3,441	3,213
Net change in unrealized gains and losses during the holding period		(7,029)	2,172
	$	950	8,523

The Corporations have designated all unrestricted investments to be trading securities. Investment return is included in the accompanying consolidated financial statements for the years ended September 30, 2015 and 2014 as follows:

		2015	2014
Nonoperating gains – investment income, net	$	1,219	8,192
Net realized and unrealized gains and losses on temporarily restricted investments		(44)	79
Net realized and unrealized gains and losses on permanently restricted investments		(225)	252
	$	950	8,523

(7) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Corporations in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, short-term investments, patient accounts receivable, accounts payable and accrued expenses, and estimated third-party payor settlements.

- Assets whose use is limited or restricted: Fair values are estimated based on prices provided by its investment managers and custodian banks. Common stocks and U.S. Treasury securities are measured using quoted market prices at the reporting date multiplied by the quantity held. Corporate bonds and notes, U.S. agency securities, and asset-backed securities are measured using observable market inputs. Mutual funds are valued using NAV. Changes in market conditions and the economic environment may impact the NAV of the funds and consequently the fair value of the Corporations' interest in the funds. The carrying value equals fair value.

- Beneficial interest in perpetual trusts: The assets held by third-party trustees comprise common stock, mutual funds, money market funds, corporate bonds and notes, U.S. agency securities, and U.S. Treasury notes. The Corporation uses quoted market prices or other observable market inputs to estimate the fair value of its beneficial interests.

- Fair value of fixed rate long-term debt is estimated based on market indications for the same or similar debt issues. At September 30, 2015 and 2014, the fair value of total long-term debt was approximately $412,059 and $444,301, respectively (fair value of debt is considered a Level 2 measurement in the fair value hierarchy).

(b) Fair Value Hierarchy

ASC Subtopic 820-10 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Corporations have the ability to access at the measurement date.
- Level 2 inputs are observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

The following table presents assets and liabilities that are measured at fair value on a recurring basis at September 30, 2015:

	Total	Level 1	Level 2	Level 3
Assets:				
Short-term investments:				
Money market funds	$ 2,348	2,348	—	—
Equity mutual funds	464	464	—	—
Assets whose use is limited or restricted:				
Cash and cash equivalents	11,614	11,614	—	—
Common stock	9,577	9,577	—	—
U.S. Treasury securities	11,679	11,679	—	—
Equity mutual funds	66,546	66,546	—	—
Fixed income mutual funds	22,478	—	22,478	—
Corporate bonds and notes	23,459	—	23,459	—
U.S. agency securities	11,596	—	11,596	—
Asset-backed securities	4,436	—	4,436	—
Total	$ 164,197	102,228	61,969	—

The following table presents assets and liabilities that are measured at fair value on a recurring basis at September 30, 2014:

	Total	Level 1	Level 2	Level 3
Assets:				
Short-term investments:				
Money market funds	$ 2,607	2,607	—	—
Equity mutual funds	403	403	—	—
Assets whose use is limited or restricted:				
Cash and cash equivalents	19,140	19,140	—	—
Common stock	9,766	9,766	—	—
U.S. Treasury securities	5,330	5,330	—	—
Equity mutual funds	57,706	57,706	—	—
Fixed income mutual funds	17,820	—	17,820	—
Corporate bonds and notes	32,342	—	32,342	—
U.S. agency securities	16,302	—	16,302	—
Asset-backed securities	7,864	—	7,864	—
Total	$ 169,280	94,952	74,328	—

The Corporation's policy is to recognize transfers between levels of the fair value hierarchy in the year of the event or change in circumstances that caused the transfer. There were no transfers into or out of Level 1 or Level 2 for the years ended September 30, 2015 and 2014.

(8) Land, Buildings, and Equipment, Net

A summary of land, buildings, and equipment, net at September 30, 2015 and 2014 follows:

	2015		2014	
	Cost	Accumulated depreciation	Cost	Accumulated depreciation
Land	$ 29,566	—	29,752	—
Land improvements	14,999	2,932	14,910	2,302
Buildings, building improvements, and fixed equipment	403,126	68,796	395,719	56,156
Major movable equipment	202,706	125,606	192,466	110,699
Construction in progress	1,990	—	4,536	—
	$ 652,387	197,334	637,383	169,157

The Corporations are currently engaged in various construction and renovation projects. There were no significant contractual commitments as of September 30, 2015. Interest cost is capitalized as a component cost of significant capital projects, net of any interest income earned on unexpended project-specific borrowed funds. No interest was capitalized during 2015 or 2014.

(9) Long-Term Debt

A summary of long-term debt at September 30, 2015 and 2014 follows:

	2015	2014
Illinois Finance Authority Revenue Bonds, Series 2009, principal is due annually at fixed interest rates of 6.75% to 7.25%. Redeemed in 2015	$ —	259,725
Illinois Finance Authority Revenue Refunding Bonds, Series 2008A, principal is due annually at fixed interest rates of 5.00% to 5.82%. Interest is due semiannually depending upon date of maturity through August 15, 2030	81,885	82,750
Illinois Finance Authority Revenue Bonds, Series 2005A, principal is due annually at fixed interest rates from 4.00% to 5.25%. Redeemed in 2015	—	11,930
Illinois Finance Authority Fixed Rate Revenue Bonds, Series 2005C, principal due annually at fixed interest rates of 2.85% to 5.58%. Redeemed in 2015	—	12,725
Illinois Finance Authority Revenue Refunding Bonds, Series 1999, principal due annually at fixed interest rates of 5.43% to 5.65%. Redeemed in 2015	—	3,805
Illinois Finance Authority Revenue Refunding Bonds, Series 2010A, at a variable interest rate (effective rates of 1.15% and 1.13% for September 30, 2015 and 2014, respectively) maturing in fiscal year 2020	12,940	13,455
Illinois Finance Authority Revenue Refunding Bonds, Series 2010B, at a variable interest rate (effective rate of 1.32% and 1.30% for September 30, 2015 and 2014, respectively) maturing in fiscal year 2021	8,640	8,980
Illinois Finance Authority Revenue Refunding Bonds, Series 2015A, at a variable interest rate (effective rates of 1.91% for September 30, 2015 maturing in fiscal year 2024	15,235	—
Illinois Finance Authority Revenue Refunding Bonds, Series 2015B, at a variable interest rate (effective rate of 2.15% for September 30, 2015 maturing in fiscal year 2020	7,080	—

	2015	2014
Illinois Finance Authority Revenue Refunding Bonds, Series 2015C, principal due annually at fixed interest rate of 5%. Interest is due semiannually depending on date maturity through 2035	$ 282,675	—
Total fixed and variable rate debt	408,455	393,370
Less unamortized net bond discounts (premiums)	(17,716)	6,074
Total debt	426,171	387,296
Less current installments	6,935	5,610
Total long-term debt, excluding current installments	$ 419,236	381,686

The Hospital and the Health System (collectively known as the Obligated Group) entered into an Amended and Restated Master Trust Indenture (Master Trust Indenture) dated as of June 1, 1996, as subsequently supplemented and amended. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust Indenture requires members of the Obligated Group to make principal and interest payments on notes issued for their benefit as well as other Obligated Group members, if the other members are unable to make such payments. The Master Trust Indenture requires the Obligated Group comply with financial and other covenant requirements, including making deposits with the bond trustees for payment of principal and interest when due on the individual series of bonds. The Obligated Group pledged a security interest in their gross revenue as collateral on borrowings under the Master Trust Indenture. The Obligated Group also maintains a debt service reserve fund with the bond trustees for the benefit of the Series 2008A and Series 2009 bonds (redeemed in 2015). The Obligated Group has executed mortgages on the real estate and improvements of the previous hospital campus and the replacement facility campus (note 1).

Series 2010 principal is payable annually, with a balloon payment of $10,365 for 2010A due in fiscal year 2020 and a balloon payment of $6,600 for 2010B due in fiscal year 2021. Interest on the Series 2010A bonds is variable based on 68% of the sum of one-month LIBOR plus 150 basis points and is payable monthly. Interest on the Series 2010B bonds is variable based on 68% of the sum of one-month LIBOR plus 175 basis points and is payable monthly. If the Hospital chooses to extend the debt beyond the date of the balloon payment, the interest rates will be reset by the lenders at a rate not to exceed 12%.

On January 1, 2015, the Illinois Finance Authority issued variable rate revenue bonds, Series 2015A and Series 2015B, in the aggregate amount of $26,860 on behalf of the Hospital. On April 22, 2015, the Illinois Finance Authority issued fixed rate revenue refunding bonds, Series 2015C in the amount of $286,435 on behalf of the Hospital. The Hospital received a bond premium of $18,800 and paid bond issue costs of $3,236, related to these issuances. The proceeds of 2015A, 2015B, and 2015C were used to refund prior outstanding bonds 1999, 2009, 2005A, and 2005C, which were fixed rate debt. As a result of this issuance, the Hospital incurred a noncash loss of $69,841 for previously unamortized bond issue costs.

Scheduled annual principal payments on long-term debt for the ensuing five years are as follows:

Year:	
2016	$ 6,935
2017	7,115
2018	7,305
2019	7,505
2020	7,715
Thereafter	371,880
	$ 408,455

(10) Capital Leases

The Hospital leases a building under a capital lease. Included with property, plant, and equipment is $6,000 of assets held under capital leases and $114 of related accumulated amortization at September 30, 2015, respectively. A summary of future minimum lease payments and the present value of future minimum lease payments related to capital leases at September 30, 2015 are as follows:

	Amount
Year:	
2016	$ 501
2017	511
2018	521
2019	532
2020	542
Thereafter	5,515
Total future minimum lease payments	8,122
Less amount representing interest at 5%.	2,202
Present value of future minimum lease payments	5,920
Less current portion of obligations under capital leases included in accounts payable	125
Obligations under capital leases, excluding current portion included in capital leases and other long-term liabilities	$ 5,795

(11) Pension Plans

The Health System, HSSI, and the Hospital sponsor various voluntary, defined-contribution, and money purchase pension plans for all qualified full-time employees. Benefits for individual employees are the amounts that can be provided by the sums contributed and accumulated for each individual employee. The Health System, HSSI, and the Hospital recognized expense under the terms of the plans in the amount of $4,624 and $4,095 for 2015 and 2014, respectively. The Health System, HSSI, and the Hospital fund the plans on a current basis.

The Health System also sponsors several supplemental retirement plans. Eligibility for these plans is limited to specified employees. The supplemental plans are defined benefit plans and are not qualified plans under Section 401 of the Code. The Health System has recognized expense under the terms of these supplemental retirement plans in the amount of $794 and $846 for 2015 and 2014, respectively. Amounts owed to specified employees under the supplemental retirement plans are included in accrued salaries and wages.

(12) Self-Insured Risks

(a) Professional and General Liability

The Corporations maintain a self-insurance program for professional and general liability coverage. The self-insurance program includes varying levels of self-insured retention and excess malpractice insurance coverage purchased from commercial insurance carriers. In connection with the self-insurance program, the Corporations have engaged the services of a professional actuarial consultant to assist in the estimation of self-insurance provisions and claim liability reserves.

Provisions for estimated self-insured professional and general liability claims amounted to $10,483 and $7,894 in 2015 and 2014, respectively, and are included in general and administrative expenses. It is the opinion of management that the estimated professional and general liabilities accrued at September 30, 2015 and 2014 are adequate to provide for the ultimate cost of potential losses resulting from pending or threatened litigation; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. The Corporations have also designated attorneys to handle legal matters relating to malpractice and general liability claims. No portion of the accrual for estimated self-insured professional and general liability claims has been reported as a current liability. The liability for estimated self-insured professional and general liability claims has been discounted at 1.25% and 1.00% at September 30, 2015 and 2014.

(b) Workers' Compensation

The Health System, HSSI, and the Hospital maintain a self-insurance program for workers' compensation coverage. This program limits the self-insured retention to $500 per occurrence. Coverage from commercial insurance carriers is maintained for claims in excess of the self-insured retention. Provisions for workers' compensation claims amounted to $4,194 and $2,602 for 2015 and 2014, respectively, and are included in payroll taxes and fringe benefits expense. Management believes the estimated self-insured workers' compensation claims liability, which is included within accrued salaries and wages at September 30, 2015 and 2014, is adequate to cover the ultimate liability; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved.

(c) Healthcare

The Health System, HSSI, and the Hospital also have a program of self-insurance for employee healthcare coverage. Stop-loss reinsurance coverage is maintained for claims in excess of stop-loss limits. Provisions for employee healthcare claims amounted to $16,429 and $18,440 for 2015 and 2014, respectively, and are included with payroll taxes and fringe benefits expense. It is the opinion of management that the estimated healthcare costs accrued, which is included within accrued salaries

and wages at September 30, 2015 and 2014, are adequate to provide for the ultimate liability; however, final payouts as claims are paid may vary significantly from estimated claim liabilities.

(13) Investment in Joint Ventures

(a) Wilmington Building Partnership

On June 1, 2007, MCREC sold property, including a parcel of land and a medical office building, located in Wilmington, Illinois to Harris N.A. Concurrently with the sale of property, MCREC became a founding member of the Wilmington Building Partnership (Wilmington) whose purpose is to lease the medical office building. Harris N.A. serves as the trustee for Wilmington. MCREC provided Wilmington with an initial $500 equity contribution during 2007, which satisfied the capital contribution provisions of the operating agreement. Pursuant to the operating agreement, profits and losses are allocated to the members in accordance with the proportion of their membership units to the aggregate membership units of Wilmington, of which MCREC holds a 50% interest. Effective July 1, 2007, Harris N.A. entered into an agreement with a physician to lease the medical office building.

MCREC accounts for its investment in Wilmington on the equity method of accounting. As of and for the year ended September 30, 2015, Wilmington had total assets and members' equity of $1,007, revenue of $179, and net income of $109. As of and for the year ended September 30, 2014, Wilmington had total assets and members' equity of $1,000, revenue of $173, and net income of $102. Wilmington made cash distributions of $109 in 2015 and $65 in 2014. The carrying value of MCREC's investment in Wilmington is included in other long-term assets in the accompanying consolidated balance sheets.

(b) UCMC/SCH Oncology JV, LLC

On March 22, 2010, the Hospital, along with the University of Chicago Medical Centers (UCMC), became the founding members of UCMC/SCH Oncology JV, LLC (the Cancer Center) whose purpose was to develop and operate a radiation oncology cancer center on the Hospital's campus. The board is governed equally by the two members, who each have a 50% voting share. Pursuant to the operating agreement, profits and losses are allocated 60% to the Hospital and 40% to UCMC.

The Hospital accounts for its investment in the Cancer Center on the equity method of accounting. As of and for the year ended September 30, 2015, the Cancer Center had total assets of $13,506, members' equity of $11,006, revenue of $33,001, and net income of $6,036. As of and for the year ended September 30, 2014, the Cancer Center had total assets of $11,213, members' equity of $7,500, revenue of $23,952, and net income of $2,974. The Cancer Center made cash distributions of $2,500 in 2015. The carrying value of the Hospital's investment in the Cancer Center is included in other long-term assets in the accompanying consolidated balance sheets.

(14) Endowments

The Corporations have donor-restricted endowment funds (collectively referred to as the Funds), the principal of which may not be expended. The interest and dividend income from investment of the Funds is to be used for a variety of purposes consistent with the intent of the donor. The interest and dividend income earned on the Funds are transferred to temporarily restricted net assets until appropriated for expenditure by

the Corporations. All other changes in the Funds, including unrealized and realized gains and losses, are recorded directly to the Funds, which are classified as permanently restricted net assets.

The Corporations also have beneficial interests in trusts (collectively referred to as the Trusts). The Corporations have recorded their share of the principal of the Trusts as permanently restricted net assets. Distributions from the Trusts are recorded within unrestricted net assets if unrestricted; otherwise, they are classified as temporarily restricted net assets until appropriated for expenditure.

The activity of the Funds and Trusts for the year ended September 30, 2015 is as follows:

	Total	Donor-restricted endowment funds	Beneficial interest in trusts
Beginning fair value	$ 6,360	650	5,710
Current year contributions	285	285	—
Investment return:			
Interest and dividends	136	1	135
Realized gains, net	251	37	214
Change in unrealized gains and losses, net	(399)	(30)	(369)
Disbursements:			
Fees and expenses	(51)	—	(51)
Assets released from restriction	(426)	(264)	(162)
Ending fair value	$ 6,156	679	5,477

The activity of the Funds and Trusts for the year ended September 30, 2014 is as follows:

	Total	Donor-restricted endowment funds	Beneficial interest in trusts
Beginning fair value	$ 6,107	648	5,459
Current year contributions	1	1	—
Investment return:			
Interest and dividends	120	5	115
Realized gains, net	205	9	196
Change in unrealized gains and losses, net	108	8	100
Disbursements:			
Fees and expenses	(66)	(4)	(62)
Assets released from restriction	(115)	(17)	(98)
Ending fair value	$ 6,360	650	5,710

The historical cost basis of the Funds was approximately $679 and $1,019 for September 30, 2015 and 2014, respectively. The fair value of assets associated with individual donor-restricted endowment funds may fall below the amount of the original donation as a result of unfavorable market conditions. There were no such deficiencies as of September 30, 2015 or 2014.

(15) Commitments and Contingencies

(a) Operating Leases

The Corporations occupy space in certain facilities and lease various pieces of equipment under long-term noncancelable operating lease arrangements. Total equipment rental, asset lease, and facility rental expense in 2015 and 2014 were $4,768 and $4,072, respectively.

The following is a schedule by year of future minimum lease payments to be made under operating leases as of September 30, 2015 that have initial or remaining lease terms in excess of one year:

	Amount
Year ending September 30:	
2016	$ 5,775
2017	4,975
2018	5,033
2019	5,079
2020	4,759
Thereafter	33,867

(b) Medicare Reimbursement

The Hospital recognized $111,267 of net patient service revenue during 2015 from services provided to Medicare beneficiaries. Federal legislation routinely includes provisions to modify Medicare payments to healthcare providers. Changes in Medicare reimbursement as a result of the CMS implementation of the provisions of Medicare legislation and other healthcare reform initiatives may have an adverse effect on the Hospital's net patient service revenue.

(c) Litigation

The Corporations are involved in litigation arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Corporations' financial position or results of operations.

(d) Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The Corporations are subject to these regulatory efforts. Management is currently unaware of any regulatory matters, which may have a material adverse effect on the Corporations' financial position or results of operations.

(e) The Patient Protection and Affordable Care Act

In March 2010, the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act) was enacted. Some of the provisions of the Affordable Care Act took effect immediately, while others will take effect or will be phased in over time, ranging from a few months to 10 years following approval. The Affordable Care Act was designed to make available, or subsidize the premium costs of, healthcare insurance for some of the millions of currently uninsured or underinsured consumers below certain income levels. An increase in utilization of healthcare services by those who are currently avoiding or rationing their healthcare was expected. Although bad debt expenses and/or charity care provided were expected to be reduced, increased utilization would be associated with increased variable and fixed costs of providing healthcare services, which may or may not be offset by increased revenue.

The Affordable Care Act contains more than 32 Sections related to healthcare fraud and abuse and program integrity. The potential for increased legal exposure related to the Affordable Care Act's enhanced compliance and regulatory requirements could increase operating expenses.

Key provisions of the Affordable Care Act include:

- Annual Medicare market basket updates for hospitals will be reduced based on productivity adjustments through September 30, 2019.
- Payments under "Medicare Advantage" programs (Medicare managed care) will be reduced.
- A value-based purchasing program was established to provide incentive payments or payment reductions to hospitals based on performance on quality and efficiency measures.
- Commencing October 1, 2013, Medicare disproportionate share hospital (DSH) payments are reduced initially by 75%. DSH payments will be adjusted thereafter to account for the national rate of consumers who do not have healthcare insurance and receive care.
- Expansion of Medicaid programs to a broader population.
- The Hospital Readmissions Reduction Program, which began in October 2012, reduces Medicare payments to hospitals that have a high rate of potentially preventable readmissions of Medicare patients with certain clinical conditions to account for such excessive and "preventable" costs associated with hospital readmissions. As of October 1, 2014, Medicare payments to certain hospitals that experience high levels of hospital-acquired conditions are being reduced by 2%.
- Introduced a requirement that healthcare insurers include quality improvement covenants in their contracts. Commencing January 1, 2015, healthcare insurers participating in the health insurance exchanges may contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care.

The Corporations continue to monitor the impact of these regulations.

(f) Tax Exemption for Sales Tax and Property Tax

Effective June 14, 2012, the Governor of Illinois signed into law, *Public Act 97-0688*, which creates new standards for state sales tax and property tax exemptions in Illinois. The law establishes new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. Silver Cross certified in 2015 and has not recorded a liability for related property taxes based upon management's current determination of qualified services provided.

(g) Investment Risk and Uncertainties

The Corporations invest in various investment securities. Investment securities are exposed to various risks such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the accompanying consolidated balance sheets.

(16) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with the recently issued ACS Topic 855, *Subsequent Events*, the Corporations evaluated subsequent events after the consolidated balance sheet date of September 30, 2015 through January 27, 2016, which was the date the consolidated financial statements were available to be issued.

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Balance Sheet Information

September 30, 2015

(Amounts in thousands)

Assets	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Current assets:								
Cash and cash equivalents	$ 966	274	28,081	96	117	928	—	30,462
Short-term investments	—	464	2,348	—	—	—	—	2,812
Assets whose use is limited or restricted, required for current liabilities	—	—	371	—	—	—	—	371
Patient accounts receivable, net of estimated uncollectibles of $13,767 in 2015 and $14,767 in 2014	—	611	44,026	—	—	—	—	44,637
Due from affiliates	9,146	—	38,773	2,661	1,017	3,500	(55,097)	—
Other receivables	(67)	68	765	—	104	4,161	—	5,031
Prepaid expenses and other	272	2	4,645	—	20	—	—	4,939
Total current assets	10,317	1,419	119,009	2,757	1,258	8,589	(55,097)	88,252
Assets whose use is limited or restricted, excluding assets required for current liabilities:								
By board for capital improvements and other	—	—	120,483	—	—	—	—	120,483
By board for self-insurance	22,787	—	—	—	—	—	—	22,787
Under bond indenture agreements – held by trustee	—	—	8,713	—	—	—	—	8,713
Pledges receivable	—	—	918	—	—	—	—	918
Donor-restricted investments	—	—	9,031	—	—	—	—	9,031
	22,787	—	139,145	—	—	—	—	161,932
Land, buildings, and equipment, net	3,803	397	423,127	—	27,726	—	—	455,053
Other assets:								
Land held for sale	—	—	25,270	—	—	—	—	25,270
Investments	22,650	—	—	—	—	—	(22,650)	—
Estimated excess insurance recovery receivables	4,435	—	—	—	—	—	—	4,435
Other long-term assets	—	—	6,284	—	468	—	—	6,752
Deferred finance charges	—	—	4,082	—	—	—	—	4,082
Total assets	$ 63,992	1,816	716,917	2,757	29,452	8,589	(77,747)	745,776

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Attachment 36

(Continued)

Schedule 1

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Balance Sheet Information

September 30, 2015

(Amounts in thousands)

Liabilities and Net Assets	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Current liabilities:								
Current installments of long-term debt	$ —	—	6,935	—	—	—	—	6,935
Accounts payable	105	50	16,749	—	—	5,008	—	21,912
Accrued salaries and wages	5,189	942	19,776	—	—	—	—	25,907
Accrued expenses	9	35	2,395	—	2,885	—	—	5,324
Estimated payables under third-party reimbursement programs	—	—	34,192	—	—	—	—	34,192
Due to affiliates	9,393	8,172	3,500	2,200	31,832	—	(55,097)	—
Total current liabilities	14,696	9,199	83,547	2,200	34,717	5,008	(55,097)	94,270
Estimated self-insured professional and general liability claims	37,802	—	—	—	—	—	—	37,802
Long-term debt, excluding current installments and unamortized bond discounts and premiums	—	—	419,236	—	—	—	—	419,236
Capital lease and other long-term liabilities, net of current portion	—	—	6,686	—	—	—	—	6,686
Total liabilities	52,498	9,199	509,469	2,200	34,717	5,008	(55,097)	557,994
Net assets (deficit):								
Unrestricted	11,494	(7,383)	197,499	557	(5,265)	3,581	(22,650)	177,833
Temporarily restricted	—	—	3,793	—	—	—	—	3,793
Permanently restricted	—	—	6,156	—	—	—	—	6,156
Total net assets (deficit)	11,494	(7,383)	207,448	557	(5,265)	3,581	(22,650)	187,782
Total liabilities and net assets	$ 63,992	1,816	716,917	2,757	29,452	8,589	(77,747)	745,776

See accompanying independent auditors' report.

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Attachment 36

Schedule 2

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Statement of Operations and Change in Unrestricted Net Assets Information

Year ended September 30, 2015

(Amounts in thousands)

	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Revenue:								
Net patient service revenue	$ —	4,365	335,007	—	—	—	(954)	338,418
Provision for bad debts	—	—	(11,832)	—	—	—	—	(11,832)
Net patient service revenue less provision for bad debts	—	4,365	323,175	—	—	—	(954)	326,586
Other revenue	8,656	392	12,411	—	2,414	9,080	(10,735)	22,218
Total revenue	8,656	4,757	335,586	—	2,414	9,080	(11,689)	348,804
Expenses:								
Salaries and wages	4,934	3,719	109,686	—	—	—	—	118,339
Payroll taxes and fringe benefits	1,493	754	34,435	—	—	—	—	36,682
General and administrative	1,370	1,348	73,026	—	2,381	9,080	(11,689)	75,516
Supplies	—	300	62,589	—	—	—	—	62,889
Depreciation and amortization	829	166	26,207	—	1,081	—	—	28,283
Interest	—	—	22,343	—	—	—	—	22,343
Total expenses	8,626	6,287	328,286	—	3,462	9,080	(11,689)	344,052
Income (loss) from operations	30	(1,530)	7,300	—	(1,048)	—	—	4,752
Nonoperating gains (losses):								
Investment income, net	389	2	828	—	—	—	—	1,219
Gain (loss) on the sale of land, buildings, and equipment	—	—	—	—	(72)	—	—	(72)
Loss on early extinguishment of long-term debt	—	—	(69,841)	—	—	—	—	(69,841)
Other, net	—	—	2,019	82	—	—	—	2,101
Total nonoperating gains (losses), net	389	2	(66,994)	82	(72)	—	—	(66,593)
Revenue and gains in excess (deficient) of expenses and losses	419	(1,528)	(59,694)	82	(1,120)	—	—	(61,841)
Other changes in unrestricted net assets:								
Net assets released from restriction for land, building, and equipment acquisitions financed by temporarily restricted net assets	—	—	473	—	—	—	—	473
Increase (decrease) in unrestricted net assets	$ 419	(1,528)	(59,221)	82	(1,120)	—	—	(61,368)

See accompanying independent auditors' report.

0301

Attachment 36

Schedule 3

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Changes in Net Assets Information

Year ended September 30, 2015

(Amounts in thousands)

	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Unrestricted net assets:								
Revenue and gains in excess of expenses	$ 419	(1,528)	(59,694)	82	(1,120)	—	—	(61,841)
Other changes in unrestricted net assets:								
Net assets released from restriction for land, building, and equipment acquisitions financed by temporarily restricted net assets	—	—	473	—	—	—	—	473
Increase (decrease) in unrestricted net assets	419	(1,528)	(59,221)	82	(1,120)	—	—	(61,368)
Temporarily restricted net assets:								
Contributions for specific purposes	—	—	402	—	—	—	—	402
Net realized and unrealized gains and losses on temporarily restricted investments	—	—	(44)	—	—	—	—	(44)
Net assets released from restriction for operating purposes	—	—	(103)	—	—	—	—	(103)
Net assets released from restriction for land, building, and equipment acquisitions	—	—	(473)	—	—	—	—	(473)
Decrease in temporarily restricted net assets	—	—	(218)	—	—	—	—	(218)
Permanently restricted net assets:								
Permanently restricted contributions	—	—	285	(264)	—	—	—	21
Net realized and unrealized gains and losses on permanently restricted investments	—	—	(231)	6	—	—	—	(225)
Increase in permanently restricted net assets	—	—	54	(258)	—	—	—	(204)
Change in net assets	419	(1,528)	(59,385)	(176)	(1,120)	—	—	(61,790)
Net assets (deficit) at beginning of year	11,075	(5,855)	266,833	733	(4,145)	3,581	(22,650)	249,572
Net assets (deficit) at end of year	$ 11,494	(7,383)	207,448	557	(5,265)	3,581	(22,650)	187,782

See accompanying independent auditors' report.

0302

Attachment 36

KPMG

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements and Schedules

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

KPMG LLP
Aon Center
Suite 5500
200 East Randolph Drive
Chicago, IL 60601-6436

Independent Auditors' Report

The Boards of Trustees
Silver Cross Health System
and Affiliates:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Silver Cross Health System and Affiliates, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations and changes in unrestricted net assets, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Silver Cross Health System and Affiliates as of September 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

January 26, 2015

SILVER CROSS HEALTH SYSTEM
AND AFFILIATES

Consolidated Balance Sheets

September 30, 2014 and 2013

(Amounts in thousands)

Assets	2014	2013
Current assets:		
Cash and cash equivalents	$ 26,950	17,172
Short-term investments	3,010	5,847
Assets whose use is limited or restricted, required for current liabilities	1,559	2,108
Patient accounts receivable, net of estimated uncollectibles of $14,767 in 2014 and $14,517 in 2013	47,830	61,637
Other receivables	1,324	810
Prepaid expenses and other	3,643	4,035
Total current assets	84,316	91,609
Assets whose use is limited or restricted, excluding assets required for current liabilities:		
By board for capital improvements and other	100,638	72,616
By board for self-insurance	22,385	21,966
Under bond indenture agreements – held by trustee	32,570	32,732
Pledges receivable	1,253	1,882
Donor-restricted investments	9,118	8,273
	165,964	137,469
Land, buildings, and equipment, net	468,226	484,565
Other assets:		
Land held for sale	25,270	25,262
Estimated excess insurance recovery receivables	4,558	4,853
Other long-term assets	4,630	2,841
Deferred finance charges	4,573	4,793
Total assets	$ 757,537	751,392

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets		2014	2013
Current liabilities:			
Current installments of long-term debt	$	5,610	5,375
Accounts payable		22,651	23,118
Accrued salaries and wages		23,214	20,764
Accrued expenses		7,984	5,952
Estimated payables under third-party reimbursement programs		32,882	28,087
Total current liabilities		92,341	83,296
Estimated self-insured professional and general liability claims		33,047	36,292
Long-term debt, excluding current installments, and unamortized bond discounts and premiums		381,686	387,137
Other long-term liabilities		891	2,391
Total liabilities		507,965	509,116
Commitments and contingent liabilities			
Net assets:			
Unrestricted		239,201	232,121
Temporarily restricted		4,011	4,048
Permanently restricted		6,360	6,107
Total net assets		249,572	242,276
Total liabilities and net assets	$	757,537	751,392

SILVER CROSS HEALTH SYSTEM
AND AFFILIATES

Consolidated Statements of Operations and Change in Unrestricted Net Assets

Years ended September 30, 2014 and 2013

(Amounts in thousands)

	2014	2013
Revenue:		
Net patient service revenue	$ 323,776	304,039
Provision for bad debts	(14,146)	(14,823)
Net patient service revenue less provision for bad debts	309,630	289,216
Other revenue	37,847	34,037
Total revenue	347,477	323,253
Expenses:		
Salaries and wages	110,983	104,340
Payroll taxes and fringe benefits	36,049	33,334
General and administrative	92,396	83,746
Supplies	56,882	56,671
Depreciation and amortization	27,990	26,945
Interest	25,680	25,280
Total expenses	349,980	330,316
Loss from operations	(2,503)	(7,063)
Nonoperating gains (losses):		
Investment income, net	8,192	7,959
Loss on sale of land, buildings, and equipment	(38)	(2,424)
Other, net	189	168
Total nonoperating gains, net	8,343	5,703
Revenue and gains in excess (deficient) of expenses and losses	5,840	(1,360)
Other changes in unrestricted net assets:		
Net assets released from restriction for land, building, and equipment acquisitions financed by temporarily restricted net assets	1,240	1,102
Increase (decrease) in unrestricted net assets	$ 7,080	(258)

See accompanying notes to consolidated financial statements.

SILVER CROSS HEALTH SYSTEM
AND AFFILIATES

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(Amounts in thousands)

		2014	2013
Increase (decrease) in unrestricted net assets	$	7,080	(258)
Temporarily restricted net assets:			
Contributions for specific purposes		1,223	907
Net realized and unrealized gains and losses on temporarily restricted investments		79	59
Net assets released from restriction for operating purposes		(99)	(51)
Net assets released from restriction for land, building, and equipment acquisitions		(1,240)	(1,102)
Decrease in temporarily restricted net assets		(37)	(187)
Permanently restricted net assets:			
Permanently restricted contributions		1	40
Net realized and unrealized gains and losses on permanently restricted investments		252	262
Increase in permanently restricted net assets		253	302
Change in net assets		7,296	(143)
Net assets at beginning of year		242,276	242,419
Net assets at end of year	$	249,572	242,276

See accompanying notes to consolidated financial statements.

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(Amounts in thousands)

	2014	2013
Cash flows from operating activities:		
Change in net assets	$ 7,296	(143)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	28,149	27,105
Provision for bad debts	14,146	14,823
Income from equity basis investments	1,835	1,195
Cash received from equity basis investments	33	32
Net loss on sale of land, buildings, and equipment	38	2,424
Permanently and temporarily restricted contributions	(1,224)	(947)
Net assets released from restriction for operating purposes	99	51
Net realized and unrealized gains and losses on permanently and temporarily restricted investments	(331)	(321)
Net change in unrealized gains and losses on unrestricted investments	(2,061)	(3,270)
Net realized gains and losses on unrestricted investments	(2,993)	(355)
Changes in assets and liabilities:		
Patient accounts receivable	(339)	(42,202)
Estimated excess insurance recovery receivables	295	(354)
Other assets	(3,779)	(2,258)
Estimated payables under third-party reimbursement programs	4,795	2,000
Accounts payable, accrued expenses, and other liabilities	(730)	13,990
Net cash provided by operating activities	45,229	11,770
Cash flows from investing activities:		
Acquisition of land, buildings, and equipment	(11,582)	(22,408)
Proceeds from sale of land, buildings, and equipment and land held for sale	113	1,317
Development of land held for sale	(8)	—
Net change in assets whose use is limited or restricted	(22,561)	(2,624)
Net change in short-term investments	2,837	(213)
Net cash used in investing activities	(31,201)	(23,928)
Cash flows from financing activities:		
Repayments of long-term debt	(5,375)	(5,150)
Net assets released from restriction for operating purposes	(99)	(51)
Permanently and temporarily restricted contributions	1,224	947
Net cash used in financing activities	(4,250)	(4,254)
Net increase (decrease) in cash and cash equivalents	9,778	(16,412)
Cash and cash equivalents at beginning of year	17,172	33,584
Cash and cash equivalents at end of year	$ 26,950	17,172
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 24,351	24,954

See accompanying notes to consolidated financial statements.

(1) Organization and Purposes

Silver Cross Health System (Health System) was incorporated during 1981 for charitable, educational, and scientific purposes to support health and human services by providing management assistance, and in all other relevant ways. The accompanying consolidated financial statements include the accounts of the Health System and the following affiliates, which it controls (collectively referred to as the Corporations):

- Silver Cross Hospital and Medical Centers (Hospital), a not-for-profit acute care hospital of which the Health System is the sole member.
- Silver Cross Foundation (Foundation), a not-for-profit corporation of which the Health System is the sole member, which is dedicated to the advancement of healthcare in Will, Grundy, South Cook, and DuPage counties in Illinois.
- Health Service Systems, Inc. (HSSI), a wholly owned subsidiary of the Health System, which was incorporated to provide administrative and management services to its affiliates and other businesses.
- Midwest Community Real Estate Corporation (MCREC), a not-for-profit corporation of which the Health System is the sole member, which was incorporated to establish and maintain healthcare centers and other facilities for the benefit of the Health System and its affiliates.
- Silver Cross Managed Care Organization (SCMCO), a not-for-profit corporation of which the Health System is the sole member, which was incorporated to provide alternative forms of healthcare delivery services.
- Silver Cross Medical Associates, Inc. (SCMA), a not-for-profit corporation that operates medical practices in Joliet and surrounding areas. MCREC serves as the sole and exclusive manager and administrator for all matters relating to the operations of SCMA, including, but not limited to, the financial and management operations of SCMA.

On July 1, 2008, the Hospital received approval from the Illinois Health Facilities Planning Board to construct a replacement hospital facility on a parcel of land owned by the Hospital in New Lenox, Illinois. The replacement hospital facility has 289 licensed beds and was completed in February 2012.

Subsequent to the relocation of Hospital operations to the replacement hospital facility, the Health System continues to own some facilities at its previous hospital location. The Health System also continues to use certain facilities at the previous Hospital campus to house various administrative and support functions, postrelocation. The Health System's Board of Trustees and management, with input from constituents of the local community, are currently evaluating all possible alternative uses for the previous Hospital campus.

During 2014, the Health System sold property for $113 and recorded a loss on the sale of $38, which is recorded in loss on the sale of land, buildings, and equipment. During 2013, the Health System sold property for $1,317 and recorded a loss on the sale of $2,424, which is recorded in loss on the sale of land, buildings, and equipment.

The Corporations engage in transactions in the ordinary course of business with organizations with which members of management and the boards of directors are affiliated. Such transactions are conducted at arm's length and fully disclosed to the respective members of management and boards of directors.

All significant intercompany balances and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Summary of Significant Accounting Policies

Significant accounting policies of the Corporations that conform to general practice within the healthcare industry are as follows:

- The preparation of consolidated financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.
- Transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as revenue and expenses. Transactions incidental to the provision of healthcare services are reported as gains and losses.
- The consolidated statements of operations and changes in unrestricted net assets include revenue and gains in excess (deficient) of expenses and losses. Changes in unrestricted net assets, which are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets).
- The Corporations consider demand deposits with banks, cash on hand, and all highly liquid debt instruments (including repurchase agreements) purchased with terms of three months or less to be cash and cash equivalents, excluding those instruments classified as assets whose use is limited or restricted. Short term investments consist primarily of certificates of deposit due in one year or less, money market funds or mutual funds that are held and managed by an external broker. These funds are not intended to be used for operations but have not had a specific limitation placed on them to classify them as assets limited as to use or restricted.
- Assets whose use is limited or restricted include: assets set aside by the Corporations' boards of directors for future capital improvements, self-insurance funding, and for other purposes over which the boards retain control and may at their discretion use for other purposes; assets designated by the Foundation's board of directors for endowment development purposes; assets held by a trustee and limited as to use in accordance with the requirements of bond indenture agreements; pledges receivable; and temporarily and permanently restricted investments. Assets whose use is limited required for current liabilities are reported as current assets. Assets whose use is limited or restricted primarily comprise domestic based corporate holdings with limited foreign exposure.

- Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in revenue and gains in excess of expenses and losses, as all investments are considered to be trading securities, unless the income or loss is restricted by donors, in which case the investment income is recorded directly to temporarily or permanently restricted net assets. Investment income of unrestricted investments is reported as nonoperating gains. Unrealized gains and losses of permanently and temporarily restricted investments are recorded directly to permanently and temporarily restricted net assets.

- The Corporations apply the provisions of Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, for fair value measurements of financial assets and liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a framework for measuring fair value and expands disclosures about fair value measurements (note 7).

  In conjunction with the application of ASC Topic 820, the Corporations apply the measurement provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in mutual funds that do not have readily determinable fair values. This guidance amends ASC Topic 820 and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value (NAV) per share or its equivalent. Interests in mutual funds are generally reported at the NAV reported by fund managers, which is used as a practical expedient to estimate the fair value interest therein, unless it is probable that all or a portion of the investment will be sold for an amount different than NAV. As of September 30, 2014, the Corporations had no plans or intentions to sell investments at amounts different from NAV.

  The Corporations apply the provisions of ASU No. 2010-06, *Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 amends ASC Subtopic 820-10, *Fair Value Measurement – Overall*, to provide additional disclosure requirements for transfers into and out of Levels 1 and 2 and for activity in Level 3 and to clarify other existing disclosure requirements.

- The Corporations have adopted the provisions of ASC Topic 825, *Financial Instruments*. ASC Topic 825 gives the Corporations the irrevocable option to report most financial assets and financial liabilities at fair value on an instrument-by-instrument basis, with changes in fair value reported in earnings. The Corporations' management did not elect to measure any additional eligible financial assets or financial liabilities at fair value.

- Except as otherwise disclosed, the carrying value of all financial instruments of the Corporations approximates fair value.

- Land, buildings, and equipment are stated at cost. Depreciation is provided over the estimated useful lives of depreciable assets and is computed on the straight-line method.

- The Corporations evaluate long-lived assets, such as buildings and equipment, for impairment on an annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. No impairments have been recorded for the year ended September 30, 2014 or 2013.

- Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received (fair value of pledges is considered a Level 3 measurement in the fair value hierarchy). All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to permanently or temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported as net assets released from restriction. Temporarily restricted net assets used for operating purposes are included in other operating revenue to the extent expended during the period. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Donor-restricted contributions whose restrictions are met within the same year as received are reported directly within the consolidated statements of operations and changes in unrestricted net assets.

- Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Temporarily restricted net assets include the Hospital's interest in a charitable remainder trust. Investment income of the charitable remainder trust is distributable within specified limits to an unrelated party. All other temporarily restricted net assets are restricted primarily for land, building, and equipment acquisitions at both September 30, 2014 and 2013.

- Permanently restricted net assets represent beneficial interest in perpetual trusts and donor-restricted contributions, the principal amount of which may not be expended. Permanently restricted net assets include the Foundation's interest in a charitable remainder trust. Investment income of the charitable remainder trust is distributable within specified limits to an unrelated party. Based upon donor intentions, investment income earned on permanently restricted net assets is reported as either nonoperating investment income or as a direct addition to temporarily restricted net assets. Unrealized and realized gains and losses are recorded directly to permanently restricted net assets.

- The Corporations apply ASC Topic 958, *Not-for-Profit Entities*, which provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of Uniform Prudent Management of Institutional Funds Act (UPMIFA). ASC Topic 958 also enhances disclosures related to both donor-restricted and board-designated endowment funds (note 13).

- Provisions for estimated self-insured professional, general liability, workers' compensation, and employee healthcare risks include estimates of the ultimate cost of both reported losses and losses incurred but not reported as of the respective consolidated balance sheet dates.
- Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Those adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.
- The Electronic Health Record (EHR) Incentive Program (the Program) provides incentive payments to eligible hospitals and professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. The Corporations account for the Program using the grant model. The Corporations apply the "ratable recognition" approach, which states that the grant income can be recognized ratably over the entire EHR reporting period once the "reasonable assurance" income recognition threshold of IAS 20 is met. For the years ended September 30, 2014 and 2013, the Corporations recognized $3,624 and $900, respectively, as other revenue related to EHR incentives, which have been received or are expected to be received based on certifications prepared by management under the appropriate guidelines.
- Deferred finance charges and unamortized bond discounts and premiums are amortized using the straight-line method over the periods the related obligations are outstanding.
- The Health System, the Hospital, MCREC, the Foundation, and SCMA are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. A provision for income taxes has not been recorded for HSSI, as there are net operating losses of approximately $20,454 available for carryforward, which expire at various future dates through 2034. SCMCO is a not-for-profit corporation, which is subject to federal and state income taxes. A provision for income taxes has not been recorded for SCMCO, as there are net operating losses of approximately $677 available for carryforward, which expire at various future dates through 2026. In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Deferred tax assets have been offset in their entirety by valuation allowances at both September 30, 2014 and 2013.
- The Corporations account for tax positions in accordance with ASC Topic 740, *Income Taxes*. ASC Topic 740 clarifies the accounting for uncertainty in tax positions and also provides guidance on when the tax positions are recognized in an entity's consolidated financial statements and how the values of these positions are determined. The Corporations do not have any liabilities recognized for uncertain tax positions.

- The Corporations incur expenses for the provision of healthcare services and related general and administrative activities.

Other significant accounting policies are set forth in the consolidated financial statements and in the following notes.

(3) Net Patient Service Revenue

The Hospital, HSSI, and SCMCO (collectively referred to as the Providers) have agreements with third-party payors that provide for reimbursement at amounts different from their established rates. Estimated contractual adjustments arising under third-party reimbursement programs principally represent the differences between the Providers' billings at list price and the amounts reimbursed by Medicare, Blue Cross, and certain other contracted third-party payors; the difference between the Providers' billings at list price and the allocated cost of services provided to Medicaid patients; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the reimbursement methodologies with major third-party payors follows:

(a) Medicare

The Hospital is paid for inpatient acute care, outpatient, rehabilitative, and home health services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospital's classification of patients under the prospective payment systems and the appropriateness of patient admissions are subject to validation reviews.

For certain services rendered to Medicare beneficiaries, the Providers' reimbursement is based upon cost or other reimbursement methodologies. The Providers are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. Medicare reimbursement reports through September 30, 2009 have been audited and final settled by the Medicare fiscal intermediary.

(b) Medicaid

The Hospital is paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rate per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Medicaid outpatient services are reimbursed based on fee schedules. Medicaid reimbursement methodologies may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the State of Illinois Medicaid program, and any such changes could have a significant effect on the Hospital's revenues.

On December 4, 2008, the State of Illinois (the State) approved an assessment program to assist in the financing of its Medicaid program for the State's fiscal years ended June 30, 2009 through June 30, 2013. Renewal for the period July 1, 2013 to December 31, 2014 has been approved by the State.

Pursuant to this program, hospitals within the State are required to remit payment to the State of Illinois Medicaid program under an assessment formula approved by the Centers for Medicare and Medicaid Services (CMS). The Corporations have included their assessment of $6,998 for each of the years ended September 30, 2014 and 2013 within general and administrative expense in the accompanying consolidated statements of operations and changes in unrestricted net assets. The assessment program also provides hospitals within the State with additional Medicaid reimbursement based on funding formulas also approved by CMS. The Corporations have included their additional reimbursement of $14,684 for each of the years ended September 30, 2014 and 2013 within net patient service revenue in the accompanying consolidated statements of operations and changes in unrestricted net assets.

As of and for the year ended September 30, 2014, the Corporations have included its related assessment of $7,267 under the Enhanced Hospital Assessment Program, approved on September 30, 2013 and retroactive to June 10, 2012, within general and administrative expenses in the accompanying 2014 consolidated statement of operations and changes in unrestricted net assets. The Enhanced Hospital Assessment Program provides hospitals within the State with additional Medicaid reimbursement, based on funding formulas also approved by CMS. The Corporations have included its additional related reimbursements for the year ended September 30, 2014 of $11,109, approved on September 30, 2013 and retroactive to June 10, 2012, within net patient service revenues in the accompanying 2014 consolidated statement of operations and changes in unrestricted net assets.

(c) Blue Cross

The Hospital also participates as a provider of healthcare services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the Hospital and a review by Blue Cross. The Blue Cross reimbursement reports for September 30, 2012 and prior years have been reviewed by Blue Cross.

(d) Other

The Providers have also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements is negotiated by the Providers and includes prospectively determined rate per discharge, discounts from established charges, capitation, and prospectively determined per diem rates.

SCMCO is involved in various risk-based contracts with managed care organizations. Under these arrangements, SCMCO receives capitation payments based on the demographic characteristics of covered members in exchange for providing all primary care physician services, as well as certain outpatient diagnostic and specialist physician services. Additionally, SCMCO is eligible for incentive payments based on favorable utilization experience. Capitation revenue related to risk-based contracts totaled approximately $21,274 and $21,512 for 2014 and 2013, respectively, and is included with other revenue in the accompanying consolidated statements of operations and changes in unrestricted net assets. Pursuant to risk-based contracts, SCMCO estimates its liability for covered medical claims, including claims incurred but not reported as of the consolidated balance sheet dates, based upon

historical costs incurred and payment processing experience. This liability approximated $2,101 and $2,128 at September 30, 2014 and 2013, respectively, and is included with accounts payable in the accompanying consolidated balance sheets.

Net patient service revenue for the years ended September 30, 2014 and 2013 include approximately $450 and $1,570, respectively, of favorable retrospectively determined prior year settlements with third-party payors.

A summary of the Providers' utilization percentages based upon gross patient service revenue follows:

	2014	2013
Medicare	39.2%	39.6%
Medicaid	9.9	9.3
Managed care/commercial	46.6	45.8
Self-pay and other	4.3	5.3
	100.0%	100.0%

Patients' accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of patients' accounts receivable, the Corporations analyze their past history and identify trends for each of their major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Corporations analyze contractually due amounts and provide an allowance for doubtful accounts and a provision for bad debts, if necessary (e.g., for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes patients without insurance), the Corporations record a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Corporations' allowance for uncollectible accounts for self-pay patients, which includes uninsured patients and residual copayments and deductibles for which insurance has already paid increased from 79.9% of self-pay accounts receivable at September 30, 2013, to 80.9% of self-pay accounts receivable at September 30, 2014. In addition, the Corporations' self-pay write-offs decreased from $15,316 for fiscal year 2013 to $15,197 for fiscal year 2014. The Corporations do not maintain a material allowance for uncollectible accounts from third-party payors, nor did it have significant write-offs from third-party payors.

The Corporations recognize gross patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Corporations recognize revenue on the basis of their standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Corporations' uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Corporations record a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources is as follows:

		2014	2013
Medicare	$	97,704	95,750
Medicaid		35,257	29,699
Managed care/commercial		182,781	165,397
Self-pay and other		8,034	13,193
Net patient service revenues	$	323,776	304,039

(4) Concentration of Credit Risk

The Providers grant credit without collateral to their patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of September 30, 2014 and 2013 follows:

	2014	2013
Medicare	30.5%	28.8%
Medicaid	12.3	10.0
Blue Cross	9.8	12.1
Managed care/contract payors	24.7	30.8
Patients	14.5	12.1
Other	8.2	6.2
	100.0%	100.0%

(5) Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. In addition, reimbursement for services provided to Medicaid program beneficiaries is substantially less than the cost to the Hospital for providing these services.

The Hospital maintains records of the amount of charges forgone and related cost for services and supplies furnished under its charity care policy, as well as the estimated differences between the cost of services provided to Medicaid patients and the reimbursement under that program estimated based on an overall cost to charge ratio. The following information measures the level of charity care provided and unreimbursed cost under the Medicaid program during 2014 and 2013:

		2014	2013
Charity care costs for non-Medicaid patients	$	8,071	8,860
Excess of cost over reimbursement for services provided to Medicaid patients (1)		6,201	7,518

(1) Net impact of Medicaid assessment program has been allocated to each year based upon the State's fiscal year

(6) Investments

The Corporations report investments at fair value. A summary of the composition of the Corporations' investment portfolio at September 30, 2014 and 2013 follows:

		2014	2013
Cash and cash equivalents	$	19,140	16,709
Money Market Funds		2,607	3,472
Certificates of deposit		—	2,166
Common stock		9,766	3,933
U.S. Treasury securities		5,330	3,313
Equity mutual funds		58,109	46,425
Fixed income mutual funds		17,820	11,537
Corporate bonds and notes		32,342	34,276
U.S. agency securities		16,302	15,841
Asset-backed securities		7,864	5,870
	$	169,280	143,542

Investments are reported in the accompanying consolidated balance sheets at September 30 as follows:

		2014	2013
Short-term investments	$	3,010	5,847
Assets whose use is limited or restricted:			
Required for current liabilities		1,559	2,108
By board for capital improvements and other		100,638	72,616
By board for self-insurance		22,385	21,966
Under bond indenture agreements – held by trustee		32,570	32,732
Donor-restricted investments		9,118	8,273
	$	169,280	143,542

The composition of investment return on the Corporations' investment portfolio for 2014 and 2013 is as follows:

		2014	2013
Interest and dividend income, net of fees and expenses	$	3,138	2,978
Net realized gains on sale of investments		3,213	2,057
Net change in unrealized gains and losses during the holding period		2,172	3,245
	$	8,523	8,280

The Corporations have designated all unrestricted investments to be trading securities. Investment return is included in the accompanying consolidated financial statements for the years ended September 30, 2014 and 2013 as follows:

		2014	2013
Nonoperating gains – investment income, net	$	8,192	7,959
Net realized and unrealized gains and losses on temporarily restricted investments		79	59
Net realized and unrealized gains and losses on permanently restricted investments		252	262
	$	8,523	8,280

(7) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Corporations in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, short-term investments, patient accounts receivable, accounts payable and accrued expenses, and estimated third-party payor settlements.
- Assets whose use is limited or restricted: Fair values are estimated based on prices provided by its investment managers and custodian banks. Common stocks and U.S. Treasury securities are measured using quoted market prices at the reporting date multiplied by the quantity held. Corporate bonds and notes, U.S. agency securities, and asset-backed securities are measured using observable market inputs. The Corporations elected to apply the concepts of ASC Subtopic 820-10 to its mutual funds using NAV as a practical expedient in estimating fair value. Changes in market conditions and the economic environment may impact the NAV of the funds and consequently the fair value of the Corporations' interest in the funds. The carrying value equals fair value.
- Beneficial interest in perpetual trusts: The assets held by third-party trustees comprise common stock, mutual funds, money market funds, corporate bonds and notes, U.S. agency securities, and U.S. Treasury notes. The Corporation uses quoted market prices or other observable market inputs to estimate the fair value of its beneficial interests.
- Fair value of fixed rate long-term debt is estimated based on market indications for the same or similar debt issues. At September 30, 2014 and 2013, the fair value of total long-term debt was approximately $444,301 and $428,923, respectively (fair value of debt is considered a Level 2 measurement in the fair value hierarchy).

(b) Fair Value Hierarchy

ASC Subtopic 820-10 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Corporations have the ability to access at the measurement date.
- Level 2 inputs are observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

The following table presents assets and liabilities that are measured at fair value on a recurring basis at September 30, 2014:

	Total	Level 1	Level 2	Level 3
Assets:				
Short-term investments:				
Money market funds	$ 2,607	2,607	—	—
Equity mutual funds	403	403	—	—
Assets whose use is limited or restricted:				
Cash and cash equivalents	19,140	19,140	—	—
Common stock	9,766	9,766	—	—
U.S. Treasury securities	5,330	5,330	—	—
Equity mutual funds	57,706	57,706	—	—
Fixed income mutual funds	17,820	—	17,820	—
Corporate bonds and notes	32,342	—	32,342	—
U.S. agency securities	16,302	—	16,302	—
Asset-backed securities	7,864	—	7,864	—
Total	$ 169,280	94,952	74,328	—

The following table presents assets and liabilities that are measured at fair value on a recurring basis at September 30, 2013:

	Total	Level 1	Level 2	Level 3
Assets:				
Short-term investments:				
Certificates of deposits	$ 2,166	2,166	—	—
Money market funds	3,472	3,472	—	—
Equity mutual funds	209	209		
Assets whose use is limited or restricted:				
Cash and cash equivalents	16,709	16,709	—	—
Common stock	3,933	3,933	—	—
U.S. Treasury securities	3,313	3,313	—	—
Equity mutual funds	46,216	46,216	—	—
Fixed income mutual funds	11,537	—	11,537	—
Corporate bonds and notes	34,276	—	34,276	—
U.S. agency securities	15,841	—	15,841	—
Asset-backed securities	5,870	—	5,870	—
Total	$ 143,542	76,018	67,524	—

The Corporation's policy is to recognize transfers between levels of the fair value hierarchy in the year of the event or change in circumstances that caused the transfer. There were no transfers into or out of Level 1 or Level 2 for the years ended September 30, 2014 and 2013.

(8) Land, Buildings, and Equipment, Net

A summary of land, buildings, and equipment, net at September 30, 2014 and 2013 follows:

	2014		2013	
	Cost	Accumulated depreciation	Cost	Accumulated depreciation
Land	$ 29,752	—	29,908	—
Land improvements	14,910	2,302	14,841	1,676
Buildings, building improvements, and fixed equipment	395,719	56,156	393,177	41,698
Major movable equipment	192,466	110,699	184,367	98,105
Construction in progress	4,536	—	3,751	—
	$ 637,383	169,157	626,044	141,479

The Corporations are currently engaged in various construction and renovation projects. There were no significant contractual commitments as of September 30, 2014. Interest cost is capitalized as a component

cost of significant capital projects, net of any interest income earned on unexpended project-specific borrowed funds. No interest was capitalized during 2014 or 2013.

Long-Term Debt

A summary of long-term debt at September 30, 2014 and 2013 follows:

	2014	2013
Illinois Finance Authority Revenue Bonds, Series 2009, principal is due annually at fixed interest rates of 6.75% to 7.25%. Interest is due semiannually depending upon date of maturity through August 15, 2020	$ 259,725	259,870
Illinois Finance Authority Revenue Refunding Bonds, Series 2008A, principal is due annually at fixed interest rates of 5.00% to 5.82%. Interest is due semiannually depending upon date of maturity through August 15, 2030	82,750	83,520
Illinois Finance Authority Revenue Bonds, Series 2005A, principal is due annually at fixed interest rates from 4.00% to 5.25%. Interest is due semiannually depending upon date of maturity through August 15, 2020	11,930	13,715
Illinois Finance Authority Fixed Rate Revenue Bonds, Series 2005C, principal due annually at fixed interest rates of 2.85% to 5.58%. Interest is due semiannually depending on date of maturity through August 15, 2025.	12,725	13,850
Illinois Finance Authority Revenue Refunding Bonds, Series 1999, principal due annually at fixed interest rates of 5.43% to 5.65%. Interest is due semiannually depending on date of maturity through 2019	3,805	4,500
Illinois Finance Authority Revenue Refunding Bonds, Series 2010A, at a variable interest rate (effective rates of 1.13% and 1.12% for September 30, 2014 and 2013, respectively) maturing in fiscal year 2016	13,455	13,970
Illinois Finance Authority Revenue Refunding Bonds, Series 2010B, at a variable interest rate (effective rate of 1.30% and 1.37% for September 30, 2014 and 2013, respectively) maturing in fiscal year 2016	8,980	9,320
Total fixed and variable rate debt	393,370	398,745
Less unamortized net bond discounts	6,074	6,233
Total debt	387,296	392,512
Less current installments	5,610	5,375
Total long-term debt, excluding current installments	$ 381,686	387,137

The Hospital and the Health System (collectively known as the Obligated Group) entered into an Amended and Restated Master Trust Indenture (Master Trust Indenture) dated as of June 1, 1996, as subsequently supplemented and amended. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust Indenture requires members of the Obligated Group to make principal and interest payments on notes issued for their benefit as well as other Obligated Group members, if the other members are unable to make such payments. The Master Trust Indenture requires the Obligated Group comply with financial and other covenant requirements, including making deposits with the bond trustees for payment of principal and interest when due on the individual series of bonds. The Obligated Group pledged a security interest in their gross revenues as collateral on borrowings under the Master Trust Indenture. The Obligated Group also maintains a debt service reserve fund with the bond trustees for the benefit of the Series 2008A and Series 2009 bonds. The Obligated Group has executed mortgages on the real estate and improvements of the previous Hospital campus and the replacement facility campus (note 1).

Payment of principal and interest when due on the Series 2005A and Series 2005B bonds is guaranteed under a municipal bond insurance policy. The municipal bond insurer requires the Obligated Group to comply with financial and other covenant requirements.

Series 2010 principal is payable annually, with a balloon payment of $21,580 in fiscal year 2016. Interest on the Series 2010A bonds is variable based on 68% of the sum of one-month LIBOR plus 150 basis points and is payable monthly. Interest on the Series 2010B bonds is variable based on 68% of the sum of one-month LIBOR plus 175 basis points and is payable monthly. If the Hospital chooses to extend the debt beyond the date of the balloon payment, the interest rates will be reset by the lenders at a rate not to exceed 12%.

Scheduled annual principal payments on long-term debt for the ensuing five years are as follows:

Year:	
2015	$ 5,610
2016	26,580
2017	5,265
2018	5,545
2019	5,840
Thereafter	344,530
	$ 393,370

(9) Pension Plans

The Health System, HSSI, and the Hospital sponsor various voluntary, defined-contribution, and money purchase pension plans for all qualified full-time employees. Benefits for individual employees are the amounts that can be provided by the sums contributed and accumulated for each individual employee. The Health System, HSSI, and the Hospital recognized expense under the terms of the plans in the amount of $4,095 and $4,061 for 2014 and 2013, respectively. The Health System, HSSI, and the Hospital fund the plans on a current basis.

The Health System also sponsors several supplemental retirement plans. Eligibility for these plans is limited to specified employees. The supplemental plans are defined benefit plans and are not qualified plans under Section 401 of the Code. The Health System has recognized expense under the terms of these supplemental retirement plans in the amount of $846 and $955 for 2014 and 2013, respectively. Amounts owed to specified employees under the supplemental retirement plans are included in accrued salaries and wages.

(10) Self-Insured Risks

(a) Professional and General Liability

The Corporations maintain a self-insurance program for professional and general liability coverage. The self-insurance program includes varying levels of self-insured retention and excess malpractice insurance coverage purchased from commercial insurance carriers. In connection with the self-insurance program, the Corporations have engaged the services of a professional actuarial consultant to assist in the estimation of self-insurance provisions and claim liability reserves.

Provisions for estimated self-insured professional and general liability claims amounted to $7,894 and $6,945 in 2014 and 2013, respectively, and are included in general and administrative expenses. It is the opinion of management that the estimated professional and general liabilities accrued at September 30, 2014 and 2013 are adequate to provide for the ultimate cost of potential losses resulting from pending or threatened litigation; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. The Corporations have also designated attorneys to handle legal matters relating to malpractice and general liability claims. No portion of the accrual for estimated self-insured professional and general liability claims has been reported as a current liability. The liability for estimated self-insured professional and general liability claims has been discounted at 1% at both September 30, 2014 and 2013.

(b) Workers' Compensation

The Health System, HSSI, and the Hospital maintain a self-insurance program for workers' compensation coverage. This program limits the self-insured retention to $500 per occurrence. Coverage from commercial insurance carriers is maintained for claims in excess of the self-insured retention. Provisions for workers' compensation claims amounted to $2,602 and $2,072 for 2014 and 2013, respectively, and are included in payroll taxes and fringe benefits expense. Management believes the estimated self-insured workers' compensation claims liability, which is included within accrued salaries and wages at September 30, 2014 and 2013, is adequate to cover the ultimate liability;

however, such estimates may be more or less than the amounts ultimately paid when claims are resolved.

(c) Healthcare

The Health System, HSSI, and the Hospital also have a program of self-insurance for employee healthcare coverage. Stop-loss reinsurance coverage is maintained for claims in excess of stop-loss limits. Provisions for employee healthcare claims amounted to $18,440 and $16,649 for 2014 and 2013, respectively, and are included with payroll taxes and fringe benefits expense. It is the opinion of management that the estimated healthcare costs accrued, which is included within accrued salaries and wages at September 30, 2014 and 2013, are adequate to provide for the ultimate liability; however, final payouts as claims are paid may vary significantly from estimated claim liabilities.

(11) Investment in Joint Ventures

(a) Wilmington Building Partnership

On June 1, 2007, MCREC sold property, including a parcel of land and a medical office building, located in Wilmington, Illinois to Harris N.A. Concurrently with the sale of property, MCREC became a founding member of the Wilmington Building Partnership (Wilmington) whose purpose is to lease the medical office building. Harris N.A. serves as the trustee for Wilmington. MCREC provided Wilmington with an initial $500 equity contribution during 2007, which satisfied the capital contribution provisions of the operating agreement. Pursuant to the operating agreement, profits and losses are allocated to the members in accordance with the proportion of their membership units to the aggregate membership units of Wilmington, of which MCREC holds a 50% interest. Effective July 1, 2007, Harris N.A. entered into an agreement with a physician to lease the medical office building.

MCREC accounts for its investment in Wilmington on the equity method of accounting; however, MCREC has not recognized its proportional share of Wilmington income in the accompanying consolidated statements of operations and changes in unrestricted net assets. Wilmington net income was $102 in 2014 and $66 in 2013. Wilmington made cash distributions of $65 in 2014 and $63 in 2013, which have been recorded within other operating revenue. As of and for the years ended September 30, 2014 and 2013, respectively, Wilmington had total assets and members' equity of $1,000 and $1,063. The carrying value of MCREC's investment in Wilmington of $468 and $500 at September 30, 2014 and 2013, respectively, is included in other long-term assets in the accompanying consolidated balance sheets.

(b) UCMC/SCH Oncology JV, LLC

On March 22, 2010, the Hospital, along with the University of Chicago Medical Centers (UCMC), became the founding members of UCMC/SCH Oncology JV, LLC (the Cancer Center) whose purpose was to develop and operate a radiation oncology cancer center on the Hospital's campus. The board is governed equally by the two members, who each have a 50% voting share. Pursuant to the operating agreement, profits and losses are allocated 60% to the Hospital and 40% to UCMC.

The Hospital accounts for its investment in the Cancer Center on the equity method of accounting. As of and for the year ended September 30, 2014, the Cancer Center had total assets of $11,213, members' equity of $7,500, revenue of $23,952, and net income of $2,974. As of and for the year ended September 30, 2013, the Cancer Center had total assets of $5,016, members' equity of $4,145, revenue of $19,206, and net income of $1,936. The carrying value of the Hospital's investment in the Cancer Center is included in other long-term assets in the accompanying consolidated balance sheets.

(12) Endowments

The Corporations apply the guidance in ASC Topic 958 on the net asset classification and disclosures for funds subject to an enacted version of UPMIFA to its donor-restricted endowment funds.

The Corporations have donor-restricted endowment funds (collectively referred to as the Funds), the principal of which may not be expended. The interest and dividend income from investment of the Funds is to be used for a variety of purposes consistent with the intent of the donor. The interest and dividend income earned on the Funds are transferred to temporarily restricted net assets until appropriated for expenditure by the Corporations. All other changes in the Funds, including unrealized and realized gains and losses, are recorded directly to the Funds, which are classified as permanently restricted net assets.

The Corporations also have beneficial interests in trusts (collectively referred to as the Trusts). The Corporations have recorded their share of the principal of the Trusts as permanently restricted net assets. Distributions from the Trusts are recorded within unrestricted net assets if unrestricted; otherwise, they are classified as temporarily restricted net assets until appropriated for expenditure.

The activity of the Funds and Trusts for the year ended September 30, 2014 is as follows:

		Total	Donor-restricted endowment funds	Beneficial interest in trusts
Beginning fair value	$	6,107	648	5,459
Current year contributions		1	1	—
Income:				
Interest and dividends		120	5	115
Realized gains, net		205	9	196
Change in unrealized gains and losses, net		108	8	100
Disbursements:				
Fees and expenses		(66)	(4)	(62)
Assets released from restriction		(115)	(17)	(98)
Ending fair value	$	6,360	650	5,710

The activity of the Funds and Trusts for the year ended September 30, 2013 is as follows:

	Total	Donor-restricted endowment funds	Beneficial interest in trusts
Beginning fair value	$ 5,805	593	5,212
Current year contributions	40	40	—
Income:			
Interest and dividends	165	5	160
Realized gains, net	269	28	241
Change in unrealized gains and losses, net	15	2	13
Disbursements:			
Fees and expenses	(54)	(4)	(50)
Assets released from restriction	(133)	(16)	(117)
Ending fair value	$ 6,107	648	5,459

The historical cost basis of the Funds was approximately $1,019 and $624 for September 30, 2014 and 2013, respectively. The fair value of assets associated with individual donor-restricted endowment funds may fall below the amount of the original donation as a result of unfavorable market conditions. There were no such deficiencies as of September 30, 2014 or 2013.

(13) Contingencies

(a) Medicare Reimbursement

The Hospital recognized $97,704 of net patient service revenue during 2014 from services provided to Medicare beneficiaries. Federal legislation routinely includes provisions to modify Medicare payments to healthcare providers. Changes in Medicare reimbursement as a result of the CMS implementation of the provisions of Medicare legislation and other healthcare reform initiatives may have an adverse effect on the Hospital's net patient service revenues.

(b) Litigation

The Corporations are involved in litigation arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Corporations' financial position or results of operations.

(c) Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The Corporations are subject to these regulatory efforts.

Management is currently unaware of any regulatory matters, which may have a material adverse effect on the Corporations' financial position or results of operations.

(d) The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (often referred to, collectively, as the Affordable Care Act of the healthcare reform law), was signed into law on March 23, 2010. The statute will change how healthcare services are delivered and reimbursed through a variety of mechanisms. The law contains stronger antifraud enforcement provisions and provides additional funding for enforcement activity.

On May 6, 2011, the CMS issued the final rule established a hospital value-based purchasing program (VBP) for acute care hospitals paid under the Medicare Inpatient Prospective Payment System. Beginning in federal fiscal year 2013, value-based incentive payments are made based upon a provider's achievement of or improvement in a set of clinical and quality measures designed to foster improved clinical outcomes. The VBP will start with a 1% reduction in Medicare inpatient payments in federal fiscal year 2014 that will increase annually by 0.25% up to 2% of payments by federal fiscal year 2017. These value-based incentives are withheld and redistributed based on the hospital performance.

The Budget Control Act of 2011 (BCA) mandated significant reductions and spending caps on the federal budget for fiscal years 2012 through 2021. The BCA also created a joint select committee on deficit reduction (the Super Committee) to develop a plan to further reduce the federal deficit. Since the Super Committee failed to act before the mandatory deadline, a 2% reduction in Medicare spending, among other reductions, was to take effect January 1, 2013 in a process known as Sequestration. The BCA also required a 26.5% reduction in the sustainable growth rate formula regarding physician reimbursement under Medicare to be effective January 1, 2013.

On January 2, 2013, the President signed into law the American Taxpayers Relief Act (ATRA), which delayed Sequestration until March 1, 2013 and is now in effect as of March 1, 2013 and will continue until Congress takes further action. The ATRA delays the reduction in physician reimbursements until 2014. As such, only the 2% reduction for nonphysician payments was effective April 1, 2013. On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014, which further delayed any cuts to Medicare reimbursements rates to physicians until March 2015.

The Corporations continue to monitor the impact of these regulations.

(e) Tax Exemption for Sales Tax and Property Tax

Effective June 14, 2012, the Governor of Illinois signed into law, *Public Act 97-0688*, which creates new standards for state sales tax and property tax exemptions in Illinois. The law establishes new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. Silver Cross certified in 2014 and has not recorded a liability for related property taxes based upon management's current determination of qualified services provided.

(f) Investment Risk and Uncertainties

The Corporations invest in various investment securities. Investment securities are exposed to various risks such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the accompanying consolidated balance sheets.

(14) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with the recently issued ACS Topic 855, *Subsequent Events*, the Corporations evaluated subsequent events after the consolidated balance sheet date of September 30, 2014 through January 26, 2015, which was the date the consolidated financial statements were available to be issued.

Schedule 1

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Balance Sheet Information

September 30, 2014

(Amounts in thousands)

Assets	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Current assets:								
Cash and cash equivalents	$ 559	167	16,464	120	234	9,406	—	26,950
Short-term investments	—	407	2,603	—	—	—	—	3,010
Assets whose use is limited or restricted, required for current liabilities	—	—	1,559	—	—	—	—	1,559
Patient accounts receivable, net of estimated uncollectibles of $14,767 in 2014 and $14,517 in 2013	—	656	47,174	—	—	—	—	47,830
Due from affiliates	8,986	—	42,222	2,535	859	—	(54,602)	—
Other receivables	245	—	464	—	79	536	—	1,324
Prepaid expenses and other	144	5	3,474	1	19	—	—	3,643
Total current assets	9,934	1,235	113,960	2,656	1,191	9,942	(54,602)	84,316
Assets whose use is limited or restricted, excluding assets required for current liabilities:								
By board for capital improvements and other	—	—	100,638	—	—	—	—	100,638
By board for self-insurance	22,385	—	—	—	—	—	—	22,385
Under bond indenture agreements – held by trustee	—	—	32,570	—	—	—	—	32,570
Pledges receivable	—	—	1,253	—	—	—	—	1,253
Donor-restricted investments	—	—	8,860	258	—	—	—	9,118
	22,385	—	143,321	258	—	—	—	165,964
Land, buildings, and equipment, net	4,629	522	434,584	—	28,491	—	—	468,226
Other assets:								
Land held for sale	—	—	25,270	—	—	—	—	25,270
Investments	22,650	—	—	—	—	—	(22,650)	—
Estimated excess insurance recovery receivables	4,558	—	—	—	—	—	—	4,558
Other long-term assets	—	—	4,162	—	468	—	—	4,630
Deferred finance charges	—	—	4,573	—	—	—	—	4,573
Total assets	$ 64,156	1,757	725,870	2,914	30,150	9,942	(77,252)	757,537

(Continued)

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Attachment 36

Schedule 1

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Balance Sheet Information

September 30, 2014

(Amounts in thousands)

Liabilities and Net Assets	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Current liabilities:								
Current installments of long-term debt	$ —	—	5,610	—	—	—	—	5,610
Accounts payable	204	49	16,060	1	—	6,337	—	22,651
Accrued salaries and wages	5,517	708	16,989	—	—	—	—	23,214
Accrued expenses	9	190	4,919	—	2,866	—	—	7,984
Estimated payables under third-party reimbursement programs	—	—	32,882	—	—	—	—	32,882
Due to affiliates	14,304	6,664	—	2,180	—	24	(23,172)	—
Total current liabilities	20,034	7,611	76,460	2,181	2,866	6,361	(23,172)	92,341
Estimated self-insured professional and general liability claims	33,047	—	—	—	—	—	—	33,047
Long-term debt, excluding current installments and unamortized bond discounts and premiums	—	—	381,686	—		—	—	381,686
Due to affiliates	—	—	—	—	31,430	—	(31,430)	—
Other long-term liabilities	—	—	891	—		—	—	891
Total liabilities	53,081	7,611	459,037	2,181	34,296	6,361	(54,602)	507,965
Net assets (deficit):								
Unrestricted	11,075	(5,854)	256,720	475	(4,146)	3,581	(22,650)	239,201
Temporarily restricted	—	—	4,011	—	—	—	—	4,011
Permanently restricted	—	—	6,102	258	—	—	—	6,360
Total net assets (deficit)	11,075	(5,854)	266,833	733	(4,146)	3,581	(22,650)	249,572
Total liabilities and net assets	$ 64,156	1,757	725,870	2,914	30,150	9,942	(77,252)	757,537

See accompanying independent auditors' report.

0334

Attachment 36

Schedule 2

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Statement of Operations and Change in Unrestricted Net Assets Information

Year ended September 30, 2014

(Amounts in thousands)

	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Revenue:								
Net patient service revenue	$ —	4,187	323,164	—	—	—	(3,575)	323,776
Provision for bad debts	—	—	(14,146)	—	—	—	—	(14,146)
Net patient service revenue less provision for bad debts	—	4,187	309,018	—	—	—	(3,575)	309,630
Other revenue	8,663	387	11,164	—	2,692	25,865	(10,924)	37,847
Total revenue	8,663	4,574	320,182	—	2,692	25,865	(14,499)	347,477
Expenses:								
Salaries and wages	5,108	3,593	102,282	—	—	—	—	110,983
Payroll taxes and fringe benefits	1,558	660	33,831	—	—	—	—	36,049
General and administrative	2,126	1,460	74,759	—	2,685	25,865	(14,499)	92,396
Supplies	—	188	56,694	—	—	—	—	56,882
Depreciation and amortization	826	160	25,911	—	1,093	—	—	27,990
Interest	—	—	25,680	—	—	—	—	25,680
Total expenses	9,618	6,061	319,157	—	3,778	25,865	(14,499)	349,980
Income (loss) from operations	(955)	(1,487)	1,025	—	(1,086)	—	—	(2,503)
Nonoperating gains (losses):								
Investment income, net	402	(9)	7,799	—	—	—	—	8,192
Gain (loss) on the sale of land, buildings, and equipment	—	—	—	—	(38)	—	—	(38)
Loss on early extinguishment of long-term debt	—	—	—	—	—	—	—	—
Other, net	—	—	109	80	—	—	—	189
Total nonoperating gains (losses), net	402	(9)	7,908	80	(38)	—	—	8,343
Revenue and gains in excess (deficient) of expenses and losses	(553)	(1,496)	8,933	80	(1,124)	—	—	5,840
Other changes in unrestricted net assets:								
Net assets released from restriction for land, building, and equipment acquisitions financed by temporarily restricted net assets	—	—	1,240	—	—	—	—	1,240
Increase (decrease) in unrestricted net assets	$ (553)	(1,496)	10,173	80	(1,124)	—	—	7,080

See accompanying independent auditors' report.

0335

Attachment 36

Schedule 3

SILVER CROSS HEALTH SYSTEM AND AFFILIATES

Consolidating Schedule – Changes in Net Assets Information

Year ended September 30, 2014

(Amounts in thousands)

	Silver Cross Health System	Health Service Systems, Inc.	Silver Cross Hospital and Medical Centers	Silver Cross Foundation	Midwest Community Real Estate Corporation	Silver Cross Managed Care Organization	Eliminations	Consolidated
Increase (decrease) in unrestricted net assets	$ (553)	(1,496)	10,173	80	(1,124)	—	—	7,080
Temporarily restricted net assets:								
Contributions for specific purposes	—	—	1,223	—	—	—	—	1,223
Net realized and unrealized gains and losses on temporarily restricted investments	—	—	79	—	—	—	—	79
Net assets released from restriction for operating purposes	—	—	(99)	—	—	—	—	(99)
Net assets released from restriction for land, building, and equipment acquisitions	—	—	(1,240)	—	—	—	—	(1,240)
Decrease in temporarily restricted net assets	—	—	(37)	—	—	—	—	(37)
Permanently restricted net assets:								
Permanently restricted contributions	—	—	1	—	—	—	—	1
Net realized and unrealized gains and losses on permanently restricted investments	—	—	250	2	—	—	—	252
Increase in permanently restricted net assets	—	—	251	2	—	—	—	253
Change in net assets	(553)	(1,496)	10,387	82	(1,124)	—	—	7,296
Net assets (deficit) at beginning of year	11,628	(4,358)	256,446	651	(3,022)	3,581	(22,650)	242,276
Net assets (deficit) at end of year	$ 11,075	(5,854)	266,833	733	(4,146)	3,581	(22,650)	249,572

See accompanying independent auditors' report.

0336

Attachment 36

Section IX
Financial Feasibility
Financial Viability
Criterion 1120.130

Silver Cross Hospital will be funding its obligations under the Project from internal sources – specifically cash and cash equivalents. Thus, Silver Cross Hospital is entitled to a financial viability waiver pursuant to Criterion 1120.130(a)(1). Mr. Krepps' Financial Viability Waiver Certification in support of this Criterion is attached at ATTACHMENT 37.

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

April 28, 2016

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1120.130(a) Financial Viability Waiver Certification

Dear Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § 1120.130(a), that Silver Cross Ambulatory Surgery Center LLC and Silver Cross Hospital and Medical Centers (collectively, Silver Cross") will fund the obligations of Silver Cross set forth in the Certificate of Need Application for the "Silver Cross Ambulatory Surgery Center LLC" Project from internal sources – specifically, cash and cash equivalents.

Sincerely,

John Krepps
Senior Vice President Finance
Chief Financial Officer

SUBSCRIBED AND SWORN
to before me this 28 day
of April, 2016.

Denise L. Tatgenhorst
Notary Public

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Attachment
37

Section X
Economic Feasibility
Criterion 1120.140

Criterion 1120.140(a), Reasonableness of Financing Arrangements

Silver Cross Hospital has satisfied this Criterion because Silver Cross Hospital will be funding the Project with cash and cash equivalents. Mr. Krepps' Affidavit of Available Funds in support of this Criterion is attached at ATTACHMENT 36.

Criterion 1120.140(c), Reasonableness of Project and Related Costs

1. The construction cost per gross square foot for the clinical portions of the Project is $401.00. The construction and contingency cost per gross square foot for the clinical portions of the Project is $441.10. The clinical portions of the Project encompass 8,249 gross square feet. The construction costs for the clinical portions of the Project total $3,307,849. The construction and contingency costs for the clinical portions of the Project total $3,638,633.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE (CLINICAL PORTIONS OF PROJECT PLUS PRORATA SHARE OF CIRCULATION)

Department	A	B	C	D	E	F	G	H	Total
(list below)	Cost/Square Foot		Gross Sq. Ft. (Clinical Portions Only)		Gross Sq. Ft.		Const. $ (Clinical Portions Only)	Mod. $	Cost (Clinical Portions Only)
	NEW	MOD	NEW	CIRC	MOD	CIRC	(A x C)	(B x E)	(G + H)
Freestanding ASTC	$441.10	---	8,249		---	---	$3,638,633	---	$3,638,633
Construction Total	$401.00	---	8,249		---	---	$3,307,849	---	$3,307,849
Contingencies	$40.10	---	8,249		---	---	$330,784	---	$330,784
Construction & Contingencies Total	**$441.10**	**---**	**8,249**		**---**	**---**	**$3,638,633**	**---**	**$3,638,633**

2. The Applicants will incur the following costs in completing this Project.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	0	0	0
Site Survey and Soil Investigation	5,956	4,044	10,000
Site Preparation	714,766	485,234	1,200,000
Off Site Work			
New Construction Contracts	3,307,849	2,245,600	5,553,449
Modernization Contracts			
Contingencies	330,784	224,560	555,344
Architectural/Engineering Fees	326,125	221,396	547,521
Consulting and Other Fees	228,143	154,879	383,022
Movable or Other Purchased Equipment (not in construction contracts; including signage, technology, security, artwork, furniture, etc.)	2,311,970	530,120	2,842,090
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$7,255,594**	**$3,865,832**	**$11,091,426**

The Applicants recognize that certain of the above components exceed the Section 1120 norms. The following chart and below discussion explain any such deviations from the Section 1120 norms.

Project Item	Project Cost (Clinical Parts Only)	Section 1120 Norm	Project Cost Compared to Section 1120 Norm
Preplanning Costs	$0	1.8% * (Construction Costs + Contingencies + Equipment) = 1.8%* $5,590,603 = $107,110.85	Below Section 1120 Norm.
Site Survey, Soil Investigation and Site Preparation	$720,722	5% * (Construction Costs + Contingencies) = 5%*$3,638,633 = $181,932	Above Section 1120 Norm. See below discussion.
Construction Contracts and Contingencies The midpoint of construction will occur in 2017	$3,638,633/8,249 GSF = $441.10 per GSF	$291 per gross square foot inflated at 3% per year through 2017 = $379.69 per gross square foot	Above Section 1120 Norm. See below discussion.
Contingencies	$330,784	10% * (Construction Costs) = 10% * $3,307,849 = $2330,784	At Section 1120 Norm. Contingencies are 10% of Construction Costs.
Architectural and Engineering Fees	$326,125	6.11% to 9.17% * (Construction Costs + Contingencies) = 6.11% to 9.17% * $3,638,633) = $222,320.47 to $333,663.64	Below Section 1120 Norm.
Consulting and Other Fees	$228,143	No Section 1120 Norm	Reasonable as compared to other approved projects.
Purchased Equipment The midpoint of construction will occur in 2017	$2,311,970 ($770,656.67 per OR)	$353,802 (inflated at 3% per year through 2017) * Number of ORs = $461,631.36 * 3 = $1,384,894	Above Section 1120 Norm. See below discussion.

As set forth above, this Project has three components that exceed the Section 1120 norms. The other components are at or below the Section 1120 norms.

The Site Survey, Soil Investigation and Site Preparation component exceeds the Section 1120 norm because the building site for the proposed Surgery Center is undeveloped farm land. Thus, the Applicants will have to pay for grading, utility hookups, access roads, parking and landscaping in order to have a pad ready site.

The Construction Contracts and Contingencies costs of $441.10 per GSF exceeds the Section 1120 norm because the proposed Surgery Center is being built according to hospital outpatient department standards. That said, construction of the proposed Surgery Center is still significantly less expensive than constructing additional operating rooms inside Silver Cross Hospital.

The Equipment component exceeds the Section 1120 norm because the types of surgeries that will be performed in the proposed Surgery Center will be comparable to the types of outpatient surgeries that would have otherwise been performed in Silver Cross Hospital. Thus, the proposed Surgery Center needs equipment capable of supporting these types of cases. Also, certain equipment costs (e.g., a sterilizer) are "sunk costs" and are capable of supporting more than just 3 operating rooms. That said, the Applicants engaged an equipment planning specialist to assist the Applicants in the selection of the equipment and to minimize the equipment costs at the proposed Surgery Center. The Applicants also reviewed other CON Applications as an audit check and it would appear that the equipment costs are in line with, or lower than, many of those projects. See, e g., Advocate Condell Ambulatory Surgery Center, Project No. 15-017 ($827,143 in clinical equipment costs per operating room).

Criterion 1120.140(d), Projected Operating Costs

The projected operating costs for the proposed Surgery Center in the first full fiscal year when the Project achieves target utilization (2019) are as follows:

Total Operating Expenses: $4,389,458

Depreciation Expense: $300,000

Bad Debt Expense: $90,678

Estimated Number of Procedures: 2,252

$$\text{Proj. Operating Costs} = \frac{\text{Total Operating Expenses} - \text{Depreciation Expense} - \text{Bad Debt Expense}}{\text{Estimated Number of Procedures}}$$

Proj. Operating Costs: 4,389,458-300,000-90,678 = 3,998,780/2,252

Proj. Operating Costs = $3,998,780 / 2,252

Proj. Operating Costs = $1,775.65 per Procedure

The remaining parts of this Project are not subject to this Criterion.

Criterion 1120.140(e), Total Effect of the Project On Capital Costs

Total Projected Annual Capital Costs in Target Utilization Year (2019) = $100,000

Total Projected Annual Capital Costs Per Procedure = $100,000/2,252 = $44.40 Per Procedure

Section XI
Safety Net Impact Statement

1. The proposed Surgery Center will have no negative impact on essential safety net services.

2. The following chart sets forth the amount of charity care provided by Silver Cross Hospital in the last three fiscal years (as reported by Silver Cross Hospital on its Annual Hospital Questionnaires.)

	FY 2013	FY 2014	FY 2015
Number of Inpatient Charity Care Patients	1,079	1,038	1,063
Number of Outpatient Charity Care Patients	3,597	3,533	3,826
Total Number of Charity Care Patients	4,676	4,571	4,889
Inpatient Charity Care Charges	$16,284,000	$16,539,000	$11,984,000
Outpatient Charity Care Charges	$ 11,791,000	$10,576,000	$7,663,000
Total Charity Care Charges	$28,075,000	$27,115,000	$19,647,000
Inpatient Cost of Charity Care	$5,139,000	$4,923,000	$3,419,000
Outpatient Cost of Charity Care	$3,721,000	$3,148,000	$2,186,000
Total Cost of Charity Care	$8,860,000	$8,071,000	$5,605,000

3. The following chart sets forth the amount of care provided to Medicaid patients by Silver Cross Hospital in the last three fiscal years (as reported by Silver Cross Hospital on its Annual Hospital Questionnaires).

	FY 2013	FY 2014	FY 2015
Number of Inpatient Medicaid Patients	2,186	2,611	2,997
Number of Outpatient Medicaid Patients	31,092	31,670	32,024
Total Number of Medicaid Patients	33,278	34,281	35,021
Net Inpatient Medicaid Revenues	$15,714,000	$14,091,000	$12,190,000
Net Outpatient Medicaid Revenues	$13,985,000	$21,165,000	$26,560,000
Total Net Medicaid Revenues	$29,699,000	$35,256,000	$38,750,000

4. The following chart sets forth the amount of care provided to self-pay patients by Silver Cross Hospital in the last three fiscal years.

	FY 2013	FY 2014	FY 2015
Number of Inpatient Self-Pay Patients	274	413	348
Number of Outpatient Self-Pay Patients	12,068	10,627	8,188
Total Number of Self-Pay Patients	12,342	11,040	8,536
Inpatient Self-Pay Revenues	$818,000	$614,000	$600,000
Outpatient Self-Pay Revenues	$9,371,000	$3,236,000	$1,140,000
Total Self-Pay Revenues	$10,189,000	$3,850,000	$1,740,000

Section XII
Charity Care Information

Silver Cross Hospital's charity care for the last three audited fiscal years is set forth below:

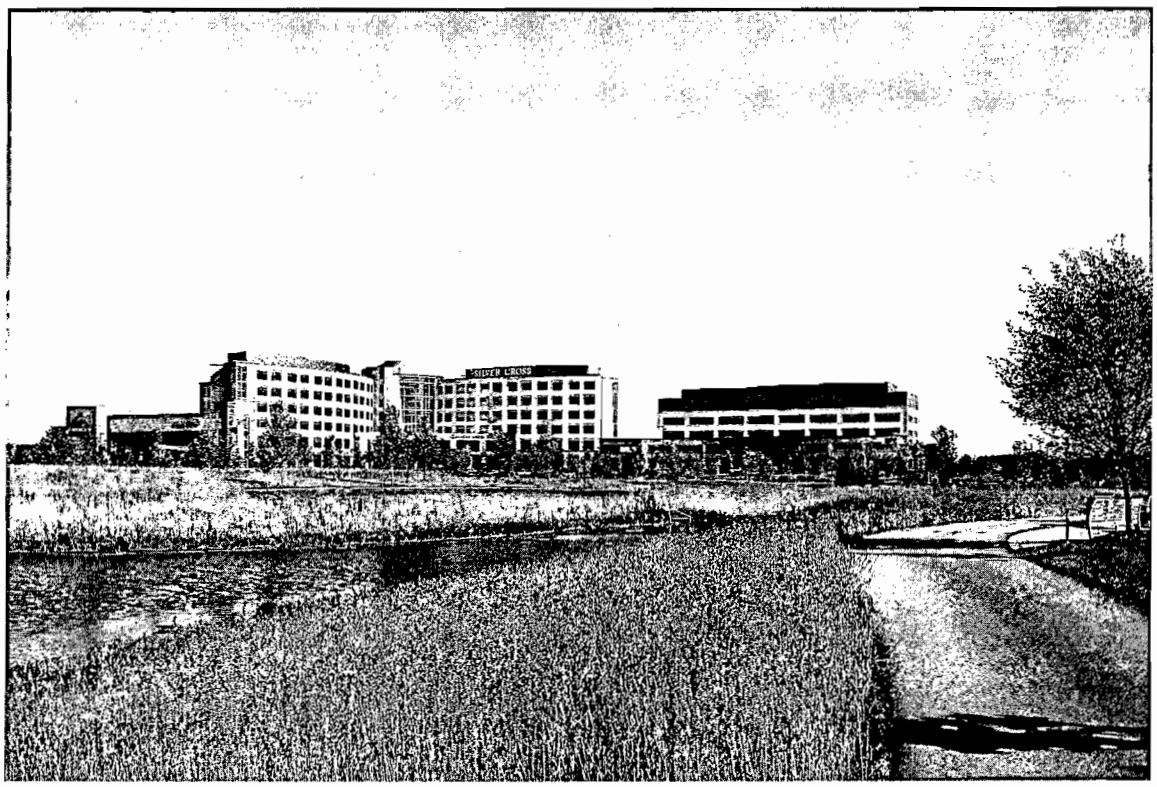
Silver Cross Charity Care			
	FY 2013	FY 2014	FY 2015
Total Net Patient Revenue	$289,786,000	$309,018,000	$323,175,000
Amount of Charity Care (Charges)	$28,075,000	$27,115,000	$19,647,000
Cost of Charity Care	$8,860,000	$8,071,000	$5,605,000
Cost of Charity Care/Total Net Patient Ratio	3.1%	2.6%	1.7%

In total, Silver Cross Hospital provided over $40,000,000 in charity care and other community benefits in FY 2015. Relevant pages from Silver Cross Hospital's Community Benefit Report for FY 2015 are attached at ATTACHMENT 41.

Silver Cross Hospital

Community Benefit Report

FY2015: October 1, 2014 to September 30, 2015



1900 Silver Cross Boulevard
New Lenox, IL 60451

www.silvercross.org

SILVER CROSS HOSPITAL
The way you *should* be treated.

Attachment 41

Defining How Much We Provide

Community Benefits Data Summary

Silver Cross Hospital is dedicated to caring and serving our community that extends beyond our walls.

In 2015, Silver Cross provided over $40 million in charity care and other community benefits. The numbers reported below are all reported at cost.

Charity Care (at cost)	$5,605,000
Gov't sponsored Indigent Health Care (unreimbursed Medicaid at cost	$6,046,000
Subtotal Uncompensated Care (Charity Care & Medicaid):	**$11,651,000**
Additional Community Benefit:	
Language Assistance	$69,000
Donations	$305,000
Volunteer Services	$2,655,000
Education	$1,400,000
Government-sponsored program services (unreimbursed Medicare at cost)	$19,250,000
Subsidized Health Services	$1,261,000
**Bad Debts (at cost)	$3,375,000
Other Community Benefits	$48,000
Total Community Benefit	**$40,014,000**

Items to Note:

****46%** of bad debt patients are uninsured = **$1,551,000** (at cost)

Reporting at cost gives a more accurate picture of true community benefit. Therefore, Silver Cross Hospital has chosen to present the data in this fashion.

Defining How Much We Provide

Uninsured in Will County

According to the most recent *Will County Community Needs Assessment and Strategic Plan*[1] *MAPP for Our Future),* in 2008 approximately 60,168 residents of Will County were Medicaid beneficiaries and 12.7% of the Will County population under the age of 65 was uninsured in 2006.

Uninsured and Medicaid at Silver Cross

The demographics at Silver Cross Hospital reflect a picture of patients being served who are in need. The hospital Emergency Department data reflects a significant picture of need in our community where **41%** of all patients were uninsured or on public aid. Many were likely using the Emergency Department for primary care. In fact, **45%** of all emergency room visits among this population were non-emergent visits.

Charity Care

In 2008, Silver Cross Hospital made a significant pledge to the community committing a minimum of $4 million a year for 10 years to reassure the community that care would be available at the hospital's new location in New Lenox. In FY15, the hospital **far exceeded** that commitment by providing **$5,605,000 charity care at cost**. Charity care includes all services for which the hospital does not expect payment. As a matter of course, we provide charitable assistance to all qualifying patients through our financial assistance program. The program is administered by the Patient Accounts Department and offers bilingual financial counselors to help with inquiries for assistance.

Applicants are asked to provide income and employment information as a part of the screening and qualification process. Silver Cross employs social workers, case managers and discharge planners who also assist in finding appropriate follow-up services at a sliding scale or for no cost to low income patients.

Providing quality care with compassion is at the center of the Silver Cross Experience regardless of ability to pay. Our goal is to work with each individual to fully explore payment options, including government assistance programs, payment plans, grants and charity. *(Charity Care Policy Attachment #2)*

Uncompensated Care (at cost)	% of Net Revenues:	
Charity Care	**$5,605,000**	**1.7%**
Gov't sponsored Indigent Health Care (unreimbursed Medicaid at cost)	**$6,046,000**	**1.9%**
Total Uncompensated Care (Charity Care & Medicaid)	**$11,651,000**	**3.6%**

[1] *Will County Community Needs Assessment and Strategic Plan 2010-2015*

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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