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February 18, 2014

Via Email and Hand Delivery
Rebecca Goldman, Health Policy Analyst
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **Rockville Eye Surgery, LLC d/b/a Palisades Eye Surgery Center**
Matter No. 14-15-2352
Response to Completeness Questions

Dear Ms. Goldman:

With this letter, we are submitting the required ten (10) copies of our responses to the Completeness Questions in your January 17 letter regarding the above-referenced project. We will also provide an electronic copy of our response and exhibits.

I hereby certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as noted below.

Sincerely,

Howard L. Sollins by JJE

Howard L. Sollins

HLS:tjr
Enclosures
cc: Ulder Tillman MD, MPH
Health Officer, Montgomery County
Kevin McDonald, Chief
Maryland Health Care Commission
Ms. Ruby Potter
Health Facilities Coordination Officer
Penelope Williams, RN, MS/MHA
Andrew Solberg, CON Consultant
A.L.S. Healthcare Consultant Services
John J. Eller, Esquire

Palisades Eye Surgery Center
Matter Number 14-15-2352
Responses to Completeness Questions
Received on 1/17/14

Part I - Project Identification and General Information

1. **Regarding the Project Drawings, please clarify if the Scrub Corridor labeled in the project drawings is a sterile corridor.**

   The corridor marked Scrub Corridor on the Project Drawings is a sterile corridor.

Part III - Consistency with General Review Criteria at COMAR I0.24.01.08G(3)

2. **Regarding COMAR I0.24.10.04A(2), Charity Care Policy:**
   a. **The policy must include the provision which states that determination of eligibility of charity care be made "within two business days following a patient's request for charity care services, application for medical assistance, or both." Please address this in your policy.**

   The following statement was added to the Charity Care Policy.

   > Within 2 business days following a patient's request for charity care services, application for medical assistance or both, PESC will make a determination of probable eligibility.

   The revised policy is attached as Exhibit 1.

   b. **Please provide the amount of charity care provided by PESC for 2011 and 2012, so that Staff can better evaluate PESC's track record in the provision of charity care.**

   As shown on Table 3, P. 46 of the CON application, Palisades provided $16,921 in charity care in 2011, $13,324 in 2012, and $37,335 in 2013.

   c. **Please provide a specific plan for achieving the current level of charitable care provisions to which PESC has committed in its policy (1.2, which was the statewide average for 2011). Charity care should only include those services offered free of charge to patients within**

the income qualification and within the facility's service area. Charity care should not include service or equipment provided free of charge to patients outside of the service area.

In addition to posting and promoting its Medical Financial Assistance Program to PESC affiliated physician practices, the Center has as an outreach plan that models a public health approach and aligns with partners of mutual interest. The target population is adult patients (>18 years of age), who reside in Montgomery County, and who currently receive Medicaid, or are uninsured, or underinsured. The goal is to provide approximately 80 cataract surgeries per year (40 patients x 2 eyes) in 2018, to patients requiring 100 percent financial assistance.

One of the strategies for reaching this population is to work with affiliated physician practices that serve or have patients in this targeted group. Several of these practices, including Visionary Ophthalmology, Washington Eye Consultants, Montgomery Eyes Center, Dr. Kane of Hammerman, Wanicur, Kane, and Kalyani, and Dr. Ghafouri currently serve Medicaid, uninsured and underinsured patients. Surgeons from each of these practices are confident that they can contribute to PESC meeting this goal. Two of the groups have provided written statements (See Exhibit 2) that support their interest and intention.

A second outreach strategy is to collaborate with local public health agencies that serve the target population. While a formal partnership and plan is being discussed, the Director at PESC is meeting with Dr. William Flynt, Chief Executive Officer of Community Health Integrated Partnership, a non-profit organization that provides high-quality primary care and health-related services for medically under-served persons in Montgomery and northern Prince Georges Counties.

Collectively, the outreach strategies and approaches not only meet the direct care needed for patients served but also do so in a way that integrates a continuum of care. Patients qualified for and receiving treatment through the Medical Financial Assistance Program will receive follow up care from their providing surgeon and have the opportunity to be seen by a number of ophthalmology specialists within the PESC network, if unforeseen needs or complications in their medical care or treatment plan require consultation with a specialist.

3. **Regarding the applicant's response to COMAR 10.24.11.05B(2), Need, provide documentation from each surgeon listed in Table C affirming their intention to conduct surgeries at PESC and the case volume that they are likely to perform at PESC. These projections should specify the case volume that will be shifted from other surgical facilities to PESC. This documentation should address why the physician expects the projected growth in their practice, with consideration regarding the stage of their career, among other factors.**

At the Completeness Conference, MHCC Staff asked PESC to state in which year PESC would meet the MHCC's optimal capacity level for three ORs. To calculate this, PESC had to extend its projections that were filed in the CON application to future years. In doing so, PESC discovered that, in the CON application, it had not added the cases that the physicians had identified that they would bring from other sites (except for Dr. Ghafouri's cases) in its volume projections. While these cases were discussed in the context of the impact standard, they were not reflected in the volume projections.

This resulted in a revised Table C, which Penelope Williams, Clinical Director at PESC, shared with each of the surgeons who are listed on Table C. Each of the physicians agreed that the projections appeared reasonable, given their ages,

expectations of the projected growth in their practices, and the stage of their career, with the following comments.

Dr. Martinez explained that his volumes had declined because he had been moving certain cases to his own office. He believes that he has reached the optimal capacity of his office and that his volumes at PESC will now grow in the future. PESC has assumed that they will stabilize at the 2013 levels.

Dr. Ghafouri stated that he would be transferring between 800-900 cases to PESC. PESC had used the lower end of this range in its projections. PESC is now projecting the midpoint of the range (850 cases).

Consequently, PESC revised its Table C to reflect these changes.

Table C Revised
Projected Need for ORs at PESC
2014-2018

	2011	2012	2013	Basis for Projections	2014	2015	2016	2017	2018
Chu	311	227	335	CAGR	348	361	375	389	403
Clinch	603	740	694	CAGR	745	799	857	919	986
Frank	258	263	323	CAGR+ 3 from Suburban in 2015	361	407	456	510	571
Kane	216	252	276	CAGR	312	353	399	451	509
Kang	467	571	534	CAGR	571	611	653	698	747
Martinez	562	530	477	Stable at 2013 levels	477	477	477	477	477
Pluznik	300	345	376	CAGR	421	471	528	591	661
Allen	80	77	107	CAGR	124	143	166	191	221
Fischer	136	164	128	CAGR	124	120	117	113	110
Gupta	30	1	35	CAGR	38	41	44	48	51
Mayer	89	138	173	CAGR+ 70 from Friendship in 2015	241	406	566	790	1,101
Vicente	1			CAGR	-	-	-	-	-
Zeller	21	22	23	CAGR + 260 from Shady Grove in 2015	24	285	298	312	327
Green-Simms		1	36	5%, 15% + 27 from Friendship, 25%, 15%, 15%	38	70	88	101	116
Nguyen		20	16	5%, 15%, 25%, 15%, 15%	17	19	24	28	32
Cremers			12	5%, 15% + 9, 25%, 15%, 15%	13	23	29	34	39
Chaudhary			3	5%, 15% + 39 from Friendship, 25%, 15%, 15%	3	43	53	61	70
Gess			16	5%, 15% + 2 from G.W., 25%, 15%, 15%	17	21	27	31	35

Yin			9	5%, 15%, 25%, 15%, 15%	9	13	16	18	21
Schor				5%, 15%, 25%, 15%, 15%	17	19	24	28	32
Ghafouri				Phase in of 850 Cases	100	600	800	850	850
Totals	3,074	3,341	3,573		3,961	5,221	5,994	6,663	7,420
Avg Minutes/Case			25		25	25	25	25	25
Total OR Minutes			89,325		99,035	130,516	149,851	166,577	185,509
Turn Around Time in Minutes/Case			15		15	15	15	15	15
Total TAT in Minutes			53,595		59,421	78,310	89,911	99,946	111,306
Total OR and TAT Minutes			142,920		158,457	208,826	239,762	266,523	296,815
Optimal Capacity/OR			97,920		97,920	97,920	97,920	97,920	97,920
Needed ORs			1.46		1.62	2.13	2.45	2.72	3.03

Ms. Williams obtained statements from each of the physicians that they believe that these projections are reasonable for their practices. These can be found in Exhibit 3.

None of PESC's surgeons are at retirement age, and all of practices have shown considerable growth and vitality. The newer surgeons realize that the more established surgeons with the larger caseloads will have priority at PESC in terms of scheduling OR time.

Exhibit 4 includes a revised Table 1.

Exhibit 5 includes a revised Table 3.

Exhibit 6 includes a revised Table 5.

All tables have been extended through 2018.

4. Regarding the applicant's historical utilization listed in response to COMAR 10.24.01.08G(3)(b), Need:

a. On page 21 of the application, the applicant states that PESC operating cases increased to 3,87l. However, on page 22, the number of cases listed in 2013 is 3,573. Please reconcile this discrepancy.

The reference to a volume of 3,871 on page 21 is a typographical error. The number of cases shown on page 22 (3,573) is correct and agrees with Table 1.

b. On page 10 of the application, under the project description, the applicant states that average operating room time is 25 minutes and clean-up time is 20 minutes. However, total operating room time is listed at 40 minutes per case. On page 23, the turnaround time is listed at 15 minutes per case. Please confirm the accurate operating case time and clean-up/turnaround time.

Turnaround time per case at PESC is approximately 15 minutes, and PESC used 15 minutes per case in the need calculations. The reference to 20 minutes on page 10 is a typographical error. The sum of 25 minutes of operating time and 15 minutes turnaround time equals 40 minutes of total operating room time per case.

c. Please describe what accounted for the decrease in Dr. Gupta's patient volume in 2012? How do volume projections factor in potential declines in patient volume like this one?

Dr. Gupta went on Maternity Leave in 2012.

5. Regarding the applicant's utilization projections in response to COMAR 10.24.01.08G(3)(b), Need:

a. Explain how the existing practice will be able to accommodate the increase in case volume from the 3,573 cases in 2013 to 3,961cases in 2014 before the proposed addition of two operating rooms, given the heavy utilization of the existing operating room.

PESC will soon initiate extended hours. Currently, PESC begins its first case is at 7:30 AM and begins its last case at 4 PM. PESC will extend its operating hours to 6, 7, or 8 PM, as needed, to accommodate the additional volumes.

b. Explain why it is reasonable to project continued growth using the compound annual growth rates for the period between 2011 and 2013 for each physician who currently practices at PESC.

The compound annual growth rate ("CAGR") reflects the trends shown on Table A on page 22. Where a surgeon's volumes have been growing, the CAGR reflects that growth. Conversely, where a surgeon's volumes have been declining, that trend would

also be reflected. Unless there is a change expected, the CAGR reflects the ongoing experience. Also, the CAGR predicts a trend that actually includes the last point of known data. For example, the CAGR for Dr. Chu is 3.79%. In 2011, Dr. Chu performed 311 cases. Using the CAGR would predict that Dr. Chu's 2013 caseload would be 335 cases, which it was.

The CAGR is more conservative than using a simple average. For example, the average annual growth for Doctor Chu calculates to 3.9% [(335/311-1)/2 = 0.039), whereas the CAGR for the same period is 3.79%. The CAGR is lower than the average growth rate for all of the physicians.

PESC's projections are conservative in another way, as well. PESC's growth is currently constrained by its lack of capacity. Consequently, the CAGR is reflecting the constrained growth.

PESC's surgeons have reviewed the projections and the growth that resulted from its approach, and all but three thought that the projections were reasonable. The other three thought that they were reasonable, but requested specific changes to them. These have resulted in revised volume projections. These are discussed in response to question 5g below.

c. Provide case volumes by surgeon, just as shown in Table A on page 22, for 2010 and 2009.

Unfortunately, PESC is not able to provide case volume by surgeon for any years prior to 2011. PESC changed its billing company in October 2010. The former billing company has since filed for bankruptcy, and PESC is currently in litigation with the

company. PESC's Database during those years was held by the billing company, and it is no longer available to PESC.

d. Explain the basis for the rates of growth specified for newer surgeons listed in Table C on pages 23 and 24 - the growth rates of 5, 15, 25, and 15 percent for years 2014, 2015, 2016, and 2017, respectively?

The Commission should note that all of the surgeons to whom these percentages apply are parts of larger group practices, all of which are continuing to grow.

PESC believes that these percentages (which apply only to younger surgeons who are near the beginning of their practices) reasonably reflect the growth of an early practice, based on information from PESC's Opthalmic Surgery Management Consultant with experience opening 135 similar facilities. Because these surgeons have been practicing for a short time, one cannot use the CAGR to project future growth.

In 2014, capacity will be severely constrained, and the more established surgeons with the higher caseloads will have priority in OR time. Still, PESC will expand its hours to give the surgeons a small measure of growth. Consequently, PESC assumed that they will grow by only 5%.

In 2015, while the additional ORs will be open, PESC anticipates that the newer surgeons' cases will have the opportunity to increase even more. However, surgical cases grow over time, and PESC does not believe that any one of these surgeons will have a massive increase in volumes. PESC projects that 15% growth will follow the year of 5% growth.

In 2016, PESC believes that these surgeons will "come into their own," and, given the available capacity, will begin to establish the kind of growth in cases that they would see in the future, assuming available capacity. PESC projects 25% growth in this year.

In 2017 and 2018, capacity begins to become constrained, again, and these surgeons will again be competing with more established surgeons for OR time. Hence, PESC has reduced their growth to 15%.

e. Please provide the source of the forecast for ophthalmology surgery (47% growth by 2020), cited on page 35 of the application.

The source of the growth forecast is from an article entitled, "The Aging Population and Its Impact on the Surgery Workforce," by David A. Etzioni, MD, MSHS, Jerome H. Liu, MD, MSHS,† Melinda A. Maggard, MD, and Clifford Y. Ko, MD, MSHS. The article was published in *Annals of Surgery*, August 2003; 238(2): 170–177. The article can be found at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1422682/. A copy of the article is also attached as Exhibit 7.

The following is the relevant reference in the article.

> Specialties in which older patients constitute a greater share of procedure-based work have larger forecasted increases in workloads (Fig. 2). The projected growth in procedure-based work closely parallels growth in the number of procedures performed by each specialty (Table 5). Of all the surgical specialties examined, ophthalmology has the largest forecasted increase in work (15% by 2010; 47% by 2020). These projections reflect that older patients are the predominant consumers of cataract surgery; the incidence of cataract surgery in individuals 65 years old or older is more than 8 times the incidence in a patient 45–64 years old. In addition, cataract surgeries (lens fragmentation, insertion of intraocular lens; ICD-9 codes 13.41 and 13.71) comprise 55% of the overall procedure-based workload of ophthalmologists.

TABLE 5. Forecasted Percent Increases in Number of Procedures and Work by Specialty

Specialty	2010		2020	
	No. Procedures Performed	Work RVUs	No. Procedures Performed	Work RVUs
Cardiothoracic surgery	18%	19%	41%	42%
General surgery	13%	13%	28%	31%
Neurosurgery	14%	15%	27%	28%
Ophthalmology	15%	15%	47%	47%
Orthopedic surgery	13%	13%	25%	28%
Otolaryngology	6%	8%	14%	14%
Urology	14%	15%	33%	35%

Figures listed are proportional increases relative to 2001.

f. Please clarify whether the figures in Tables 1 and 3 are for Calendar Year or Fiscal Year.

Tables 1 and 3 both reflect Calendar Years.

g. In what year does PESC project optimal utilization for the three ORs?

PESC projects that it will exceed optimal utilization of the three ORs in 2018 as demonstrated above.

6. Regarding the applicant's response to COMAR I0.24.01.08G(3)(d), Viability of the Proposal:

a. Please specify the source of Other Operating Revenues listed in Table 3, line 1.h.

The Other Operating Revenue reflects physician usage fees for LenSx and ORA equipment and the revenue from premium intra-ocular lenses.

b. Under Section 4. B. Patient Days/Visits/Procedures for year 2012, the sum of the categories amounts to only 70. Please adjust this to reflect 100 of Patient Days/Visits/Procedures.

The error resulted from a typographical error in the percentage that Medicare comprised of the total. The 19% that was shown for Medicare in 2012 should have

been 49%, which is consistent with the other years shown. This has been corrected on the revised Table 3 found in Exhibit 5.

c. There appear to be miscalculations of Net Patient Revenues and Expenses. The following net patient revenues are presented in the application.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years			
	2011	2012	2013	2014	2015	2016	2017
c. Gross Patient Service Revenues	6,422,073	7,222,270	8,116,857	8,522,700	10,653,375	11,718,712	12,890,585
d. Allowance For Bad Debt	25,351	35,513	35,271	37,035	37,195	50,923	56,015
e. Contractual Allowance	2,157,829	2,495,020	3,207,410	3,367,781	4,209,726	4,630,698	5,093,769
f. Charity Care	16,921	13,324	37,335	52,611	64,795	74,722	81,045
g. Net Patient Services Revenue	4,221,972	4,678,413	4,836,841	*5,078;683*	6,348,354	6,983,189	*7,681,509*

However, using the same figures in lines c through f, Staff calculates the following net patient revenues:

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years			
	2011	2012	2013	2014	2015	2016	2017
g. Net Patient Services Revenue	4,221,972	4,678,413	4,836,841	*5,065,273*	6,341,659	6,962,369	7,659,756

There also appear to be miscalculations in total operating expenses. This total appears in the application:

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years			
	2011	2012	2013	2014	2015	2016	2017
k. Total Operating	3,290,699	3,940,294	4,032,765	*4,384,224*	5,399,564	6,226,872	6,753,755

Expenses							

Staff calculates these Total Expenses, based on figures submitted for each category:

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years			
	2011	2012	2013	2014	2015	2016	2017
k. Total Operating Expenses	3,290,699	3,940,294	4,032,765	4,585,637	5,844,334	6,734,982	*7,337,049*

Please submit a corrected Table 3.

Exhibit 5 includes a revised Table 3.

d. Will the cash contribution for the proposed project come from PESC's accounts with PNC? If so, please provide additional documentation of the account history and average cash balance referenced in the letter from Deniz Unal of PNC Bank. This documentation should verify the availability of $260,000.

Exhibit 8 includes another letter from Deniz Unal, Vice President of Business Banking at PNC Bank. The letter attests that the "average collected balances in the last 12 months are $361,318.71. Average collected balances over the last 6 months have increased to $400, 241.29. Historic balances since 2012 have exceeded $275,000."

7. Regarding the information presented in Table 5, Manpower Information, please ensure that the total expense listed in this table matches the expense for salaries and wages listed in the last projected year in Table 3.

Exhibit 6 includes a revised Table 5. The projected expense for salaries and wages matches the last projected year in the revised Table 3.

8. Regarding the applicant's response to COMAR 10.24.01.080(3)(e), Impact on Existing Providers, it appears that most of the projected impact on

existing providers will be on Providence Hospital in D.C. Please provide information regarding the hospital's existing caseload. What is the likely impact of losing 800 cases to PESC?

PESC has attempted to determine the surgical caseload at Providence Hospital. The only data PESC could obtain was from the D.C. Hospital Association website, which includes a document entitled *2012 Annual Utilization Indicators*. (See Exhibit 9.) This report includes the following table:

	Ambulatory Surgeries		
	2012	2011	% Change
Acute Care			
Children's National Medical Center	12,438	11,315	9.9%
George Washington University Hospital	9,105	8,136	11.9%
Howard University Hospital	8,771	8,776	-0.1%
MedStar Georgetown University Hospital	8,644	8,173	5.8%
MedStar Washington Hospital Center	11,896	11,784	1.0%
Providence Hospital	8,741	8,892	-1.7%
Sibley Memorial Hospital	7,009	7,604	-7.8%
United Medical Center	2,219	2,354	-5.7%
ACUTE TOTAL	68,823	67,034	2.7%
Federal			
Veterans Affairs Medical Center	2,532	1,895	33.6%
Walter Reed National Military Medical Center	11,367	8,961	26.8%
SUBTOTAL – DC ONLY	71,355	68,929	3.5%
GRAND TOTAL	82,722	77,890	6.2%

The number of ambulatory surgeries continues to increase steadily. Visits were up by over 4,800 visits, or 7.6 percent, over the past five years and up 10,500 visits, or 18.0 percent, over the last decade.

Note: Walter Reed Army Medical Center closed in August 2011 and Services were consolidated at the former National Naval Medical Center, Bethesda, and the hospital was renamed Walter Reed National Military Medical Center.

Note: Includes data for all hospitals providing ambulatory surgeries.

DCHA

Source: http://www.dcha.org/wp-content/uploads/2012-Utilization.pdf; accessed 2/13/14

PESC also found the comparable report for 2011, which includes a comparable table.

	Ambulatory Surgeries		
	2010	2011	% Change
Acute Care			
Children's National Medical Center	10,441	11,315	8.4%
George Washington University Hospital	8,136	8,136	0.0%
Howard University Hospital	8,364	8,776	4.9%
MedStar Georgetown University Hospital	8,002	8,173	2.1%
MedStar Washington Hospital Center	11,920	11,784	-1.1%
Providence Hospital	8,338	8,892	6.6%
Sibley Memorial Hospital	8,089	7,604	-6.0%
United Medical Center	1,813	2,354	29.8%
ACUTE TOTAL	**65,103**	**67,034**	**3.0%**
Federal			
Veterans Affairs Medical Center	3,223	1,895	-41.2%
Malcolm Grow Medical Clinic	1,646	1,478	-10.2%
Walter Reed National Military Medical Center	8,538	8,961	5.0%
SUBTOTAL – DC ONLY	**76,734**	**68,929**	**0.9%**
GRAND TOTAL	86,918	79,368	1.1%

The number of ambulatory surgeries continues to increase steadily. Visits were up by over 3,800 visits, or 6.0 percent, over the past five years and up 11,500 visits, or 20.7 percent, over the last decade.

Note: *Walter Reed Army Medical Center closed in August 2011 and services were consolidated at the former National Naval Medical Center, Bethesda, and the hospital was renamed Walter Reed National Military Medical Center.*

Note: *Includes data for all hospitals providing ambulatory surgeries.*

Definition: *Ambulatory Surgeries - The number of scheduled surgical services provided to patients who do not remain in the hospital overnight.*

Source: *DCHA Monthly Utilization Survey*

Source: http://www.dcha.org/wp-content/uploads/2011-Utilization.pdf; accessed 2/13/14

Using these, data, PESC can summarize Providence Hospital's volumes as follows:

Year	2010	2011	2012
Ambulatory Surgeries	8,338	8,892	8,741

The MHCC's Surgery Section (COMAR 10.24.11) Section .06 (Operating Room Capacity and Needs Assessment) C. (Assessing Impact) (4)(a) states:

> (a) If the needs assessment includes surgical cases performed by one or more physicians perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent of the operating room capacity at a hospital, then the applicant shall include, as part of the impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility; and
>
> (b) The operating room capacity assumptions in .06A of this Chapter and the operating room inventory rules in .06D of this Chapter shall be used in the impact assessment.

PESC does not know how many ORs Providence Hospital has. However, PESC will use the largest volume of the three years as a proxy, assuming that Providence Hospital has, at least, capacity to accommodate those volumes.

To obtain the average number of minutes per case, PESC reviewed four recent CON applications of hospitals which reported actual outpatient surgery minutes per case. These are shown below:

PGHC	67.71
MHE	78.84
Germantown	59
WAH 2013	60

PESC assumed that Providence Hospital experiences 60 minutes per case. PESC used the Commission's default Clean-Up Time of 25 minutes per case.

Because Dr. Ghafouri's cases are cataract cases, PESC assumed that his minutes per case and Clean-Up Time mirrors the experience that PESC used in its need projections. (25 minutes of OR time and 15 Clean-Up minutes per case.)

The result, as shown below, is that losing Dr. Ghafouri's cases to PESC would only impact Providence Hospital's capacity by 4.5%.

2011 Ambulatory Surgeries	8,892
Assumed Avg Minutes/Case	60
OR Minutes	533,520
MHCC's Default Clean-Up Time	25
Clean-Up Minutes	222,300
Total Minutes	755,820
Dr. Ghafouri's Cases	850
Avg. OR Time	25
OR Minutes	21,250
PESC's Clean-Up Time	15
Clean-Up Minutes	12,750
Total Minutes	34,000
Percent of OR Capacity Lost to PESC	4.5%

Exhibits

1 Revised Charity Care Policy

2 Physician Letters Regarding Charity Care

3 Physician Affirmation of Projections

4 Revised Table 1.

5 Revised Table 3.

6 Revised Table 5

7 *Annals of Surgery* Article

8 Letter from PNC Bank

9 DCHA's *2012 Annual Utilization Indicators*

10 Affirmations

TAB 1

Exhibit 1

Revised Charity Care Policy

Section 2-1 Medical Financial Assistance Program

Palisades Eye Surgery Center is committed to improving health care access for medically necessary care, to uninsured and underinsured persons, by waiving or reducing their fees for services provided at the facility. Each applicant for financial assistance or reduced fee must meet criteria as set by PESC Medical Financial Assistance Program and federal guidelines. PESC medical financial assistance is not a substitute for employer-sponsored, public, or individually purchased insurance.

1. PESC Medical Financial Assistance Program shall meet Maryland Health Care Commission's expected level for the population in the service area, measured as 1.2 percent of total expenses, in the most recent year reported.
2. Public notice and information regarding the facility's charity care policy shall be published in the *Montgomery Gazette* on an annual basis. Notices regarding PESC's Medical Financial Assistance policy shall be posted in PESC's registration area and business office and on the company website; www.palisadeseye.com.
3. Individual notice of the availability of medical assistance shall be provided to persons by way of their PESC surgeon's pre-operative education and paperwork.
4. Request for financial assistance must be made at least 5 days prior to service being rendered. To request assistance, persons must complete a PESC Medical Financial Assistance Application (see attached).
5. PESC will address any financial concerns of persons not less than 2 days prior to a person's arrival for surgery.
6. Eligibility is based on federal financial need. These guidelines may be found on the website for the US Department of Health and Human Services: http://aspe.hhs.gov/poverty.
    i. Persons with family income below 100 percent of the current poverty level who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge.
    ii. Persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands.
    iii. Proof of income and verification of the number of dependents based upon the previous year's tax return must be provided. If this is not available, the last two months paycheck stubs will be accepted. Dependents must meet IRS definition of dependents to qualify as household members.
    iv. Proof that Medical Assistance has been applied for and rejected. If the rejection is for non-compliance with all Medical Assistance paperwork requirements, reduced fee or charity will not be granted. If Medical Assistance rejection is based on income, disability, or assets, PESC will review person's Medical Financial Assistance Application. If the person has not yet applied for Medical Assistance, PESC staff will assist the person with the application.

Financial Qualifications

(Assumes a Family of Two)

Family Income	Discount Rate
<$15,510	100%
$15,510-$19,388	30%
$19,389-$23,265	20%
$23,266-$27,143	15%
$27,144-$31,020	10%
>$31,020	0%

v. Within 2 business days following a patient's request for charity care services, application for medical assistance or both, PESC will make a determination of probable eligibility.

TAB 2

Exhibit 2

Physician Letter Regarding Charity Care

Visionary Ophthalmology

Comprehensive, leading-edge
eye care you can trust

February 5, 2014

Dear Ms. Williams,

I project that my case load, as indicated in the figures I submitted for the Certificate of Need, and those cases also projected for our practice, will support the objectives for Palisades Eye Surgery Center's Medical Financial Assistance Program.

If you have any questions, please feel free to contact me.

Regards,

Fritz Allen, MD

Office : 301-896-0890
Fax : 301-896-0968
One Central Plaza
11300 Rockville Pike, Suite 1202
Rockville, MD 20852

Washington Eye Consultants

ROBERT H. CHU, M.D.

6333 Executive Blvd
Rockville, Maryland 20852

DAN YIN, M.D.

Tel: (301) 770-2020
Fax: (866) 483-5740

January 31, 2014

Penelope Williams, MS/MHA, RN
Director
Palisades Eye Surgery Center
4818 Del Ray Avenue
Bethesda, MD 20814

Dear Ms. Williams:

I project that my charity caseload will be 20 cases per year for 2014, and will escalate 10% per year.

If you have any questions, I hope you will not hesitate to contact me at any time.

With warm regards,

Robert H. Chu, M.D.

TAB 3

Exhibit 3

Physician Affirmation of Projections

January 28, 2014

I Omar Chamaney affirm that I have reviewed and
Please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

Date 1/28/14

January 28, 2014

I Kristen Zeller affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

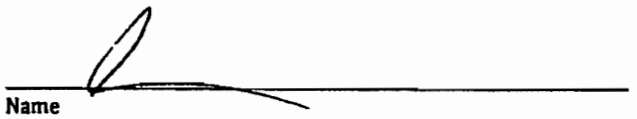
1/31/14
Date

Attn: Penelope Williams
FAX 301-657-4121

January 28, 2014

I Adam Gess affirm that I have reviewed and
print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.



Name

2/5/14

Date

January 28, 2014

I Amy Gren-Simms affirm that I have reviewed and
print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name _____ Date 1/30/14

January 28, 2014

I Theresa Nguyen affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

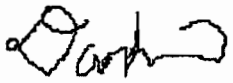
Theresa Nguyen 1/29/14

Name Date

January 28, 2014

I Dan Yin affirm that I have reviewed and
please print name

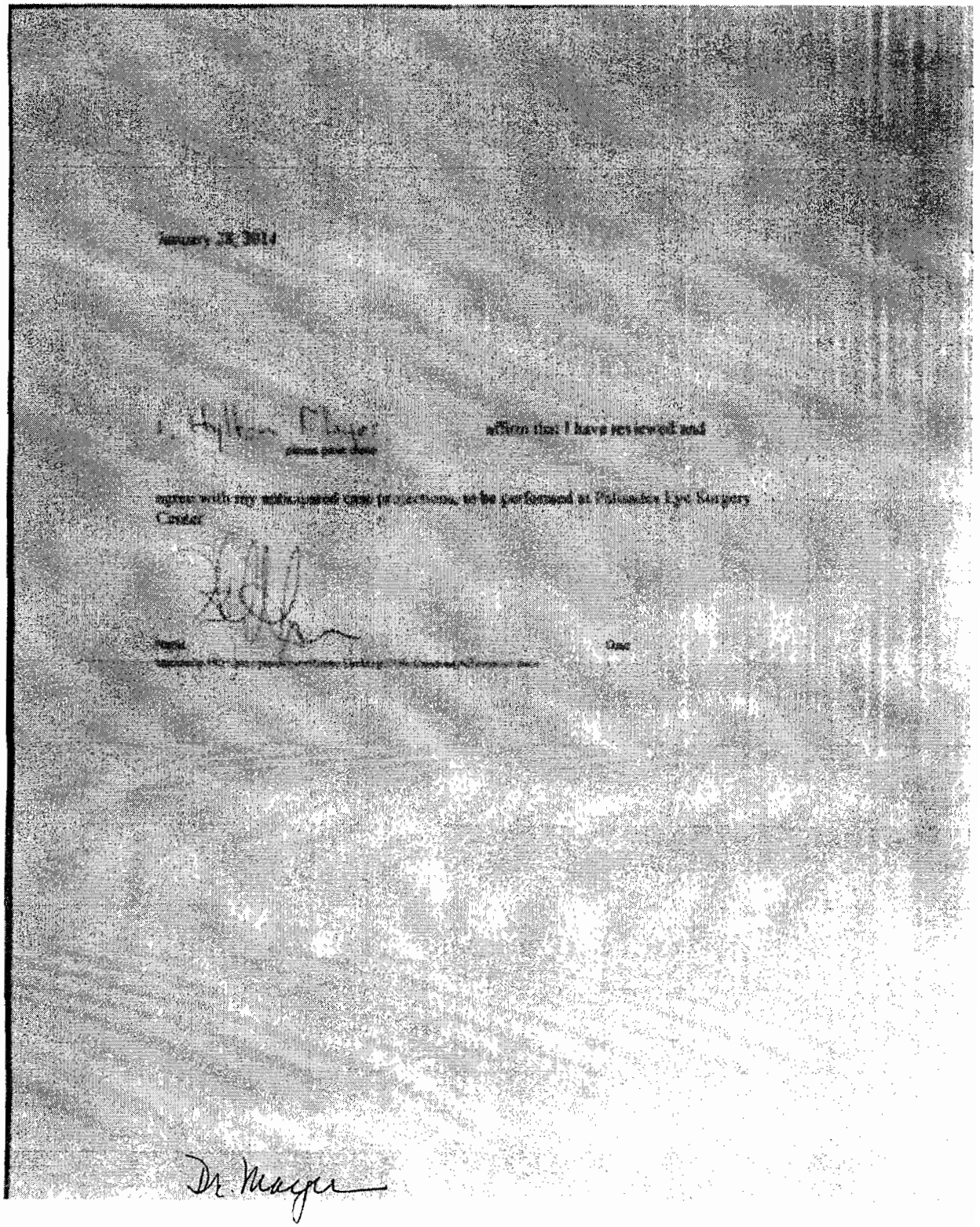
agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.



Name

1/30/14
Date

From: **Hylton Mayer** hmayer@edow.com
Subject: **Attestation**
Date: **January 31, 2014 at 2:52 PM**
To: **Penelope Williams** pwilliams@parisadeeye.net



January 31, 2014

I, Hylton Mayer, please print clearly affirm that I have reviewed and agree with my administered care of patients to be performed at Palisades Eye Surgery Center.

Dr Mayer

February3, 2014

I Seema Gupta affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

2/3/14
Date

January 28, 2014

I Mary C Fischer affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

1/31/14
Date

January 28, 2014

I FRITZ ALLEN affirm that I have reviewed and
print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name _____ Date 1/31/2014

Macintosh HD:private:var:folders:mj:c472v7v16l55yd1ltpvkjvlc0000gn:T:com.apple.mail:com.apple.mail:compose:attach:Caseload Affirmation.docx

January 28, 2014

I Daniel Pluznik affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name _____ Date 1/30/14

January 28, 2014

I J. Alberto Martinez affirm that I have reviewed and
print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

2/5/14
Date

January 28, 2014

I Paul Kang affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

1/29/14
Date

January 28, 2014

I DR. HOWARD KANE affirm that I have reviewed and
print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

JAN 31, 2014
Date

January 28, 2014

Lawrence Frank MD

I please print name affirm that I have reviewed and agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name [signature] Date 1.28.14

January 28, 2014

I Thomas E Clinch affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

T Clinch

Name

29 JAN 14

Date

January 28, 2014

I Robert H. Chu, MD affirm that I have reviewed and
please print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

Name

1-29-2014
Date

January 28, 2014

I Cameron Ghafouri affirm that I have reviewed and
print name

agree with my anticipated case projections, to be performed at Palisades Eye Surgery Center.

M. C. 2/5/14

Name Date

TAB 4

Exhibit 4

Revised Table 1

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients srvd.							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)				
CY	2011	2012	2013	2014	2015	2016	2017	2018

7. Hospice Programs								
a. SN visits								
b. Social work visits								
c. Other staff visits								
d.								
e. Total patients srvd.								
8. Ambulatory Surgical Facilities								
a. Number of operating rooms (ORs)	1	1	1	1	3	3	3	3
• Total Procedures in ORs	3,657	4,670	5,599	5,486	7,230	8,301	9,227	10,276
• Total Cases in ORs	3,074	3,341	3,573	3,961	5,221	5,994	6,663	7,420
• Total Surgical Minutes in ORs**	85,151	114,120	89,325	99,035	130,516	149,851	166,577	185,509
b. Number of Procedure Rooms (PRs)	1	2	2	2	2	2	2	2
• Total Procedures in PRs	833	1,693	2,055	2,157	2,697	2,967	3,263	3,590
• Total Cases in PRs	717	778	863	906	1,133	1,246	1,370	1,507
• Total Minutes in PRs**	8,300	16,960	20,550	17,271	21,598	23,752	26,121	28,733

TAB 5

Exhibit 5

Revised Table 3

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Calendar Year	2011	2012	2013	2014	2015	2016	2017	2018
1. Revenue								
a. Inpatient Services								
b. Outpatient Services	6,422,073	7,222,270	8,116,857	8,522,700	9,801,105	12,251,381	14,089,088	16,202,452
c. Gross Patient Services Revenues	6,422,073	7,222,270	8,116,857	8,522,700	9,801,105	12,251,381	14,089,088	16,202,452
d. Allowance for Bad debt	25,351	35,513	35,271	37,035	42,590	53,238	61,223	70,407
e. Contractual Allowance	2,157,829	2,495,020	3,207,410	3,367,781	3,872,948	4,841,185	5,567,363	6,402,467
f. Charity Care	16,921	13,324	37,335	59,664	75,735	85,624	92,803	101,086
g. Net Patient Services Revenue	4,221,972	4,678,413	4,836,841	5,058,220	5,809,832	7,271,334	8,367,699	9,628,492
h. Other Operating Revenues (Specify)		443,475	480,575	504,604	580,295	725,368	834,173	959,300
i. Net Operating Revenues	4,221,972	5,121,888	5,317,416	5,562,824	6,390,127	7,996,702	9,201,872	10,587,792

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Calendar Year	2011	2012	2013	2014	2015	2016	2017	2018
2. Expenses								
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$ 834,731	$ 791,128	$ 1,029,018	$ 1,069,342	$ 1,615,787	$ 1,662,571	$ 1,662,571	$ 1,662,571
b. Contractual Services	84,172	123,404	26,754	30,717	53,508	53,508	53,508	53,508
c. Interest on Current Debt	10,284	6,657	2,671	-	-		-	-
d. Interest on Project Debt			-	131,855	115,837	98,861	80,863	61,782
e. Current Depreciation	107,478	37,411	112,000	112,000	112,000	112,000	112,000	112,000
f. Project Depreciation			-	94,070	186,530	186,530	186,530	186,530
g. Current Amortization	10,069	10,069	10,069	-	-		-	-
h. Project Amortization			-	98,111	186,153	186,153	186,153	186,153
i. Supplies	1,747,149	2,343,367	2,302,359	2,431,277	2,795,969	3,494,961	4,019,205	4,622,085
j. Other Expenses (Specify)	496,816	628,258	659,473	622,132	759,958	791,858	837,866	891,181
k. Total Operating Expenses	3,290,699	3,940,294	4,142,344	4,589,504	5,825,742	6,586,442	7,138,696	7,775,810
3. Income								
a. Income from Operation	931,273	1,181,594	1,175,072	973,320	564,385	1,410,260	2,063,176	2,811,982
b. Non-Operating Income								
c. Subtotal	931,273	1,181,594	1,175,072	973,320	564,385	1,410,260	2,063,176	2,811,982
d. Income Taxes								
e. Net Income (Loss)	$931,273	$1,181,594	$1,175,072	$973,320	$564,385	$1,410,260	$2,063,176	$2,811,982

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Calendar Year	2011	2012	2013	2014	2015	2016	2017	2018
4. Patient Mix: **A. Percent of Total Revenue**								
1) Medicare	37%	34%	41.0%	38.0%	38.0%	39.0%	39.0%	39.0%
2) Medicaid	2%	3%	2.0%	1.0%	1.0%	1.0%	1.0%	1.0%
3) Blue Cross	10%	16%	15.0%	16.0%	16.0%	16.0%	16.0%	16.0%
4) Commercial Insurance	38%	37%	30.0%	33.0%	34.0%	33.0%	33.0%	33.0%
5) Self Pay	13%	10%	12.0%	12.0%	11.0%	11.0%	11.0%	11.0%
6) Other (Managed care)	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)								
1) Medicare	48.0%	49.0%	51.0%	50.0%	50.0%	50.0%	50.0%	50.0%
2) Medicaid	2.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
3) Blue Cross	7.0%	14.0%	13.0%	14.0%	14.0%	14.0%	14.0%	14.0%
4) Commercial Insurance	39.0%	31.0%	30.0%	32.0%	32.0%	32.0%	32.0%	32.0%
5) Self Pay	4.0%	5.0%	5.0%	3.0%	3.0%	3.0%	3.0%	3.0%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

TAB 6

Exhibit 6

Revised Table 5

Position	Title	2013 FTE	Change FTE	2018 Proposed FTE	Base Salary	Employee/ Contractual	Total Salary
Administration							
	Director	1.0		1.0	$105,000	Employee	$105,000
	Nurse Manager	1.0		1.0	$79,040	Employee	$79,040
	Office Manager		1.0	1.0	$62,400	Employee	$62,400
Support							
	Receptionist	1.0		1.0	$35,360	Employee	$35,360
	Account Payable	1.0		1.0	$39,520	Employee	$39,520
	Scheduling	1.0		1.0	$37,440	Employee	$37,440
	Medical Assistant I	0.3		0.3	$24,960	Employee	$6,240
Direct Patient							
	Pre Operative RN	1.0	1.0	2.0	$72,800	Employee	$145,600
	Post Operative RN	1.0	1.0	2.0	$72,800	Employee	$145,600
	Operating Room RN	1.0	2.0	3.0	$72,800	Employee	$218,400
	Medical Assistant I	1.0	1.0	2.0	$24,960	Employee	$49,920
	Medical Assistant II	1.0	2.0	3.0	$41,600	Employee	$124,800
	Medical Assistant III	1.0		1.0	$45,760	Employee	$45,760
	Medical Assistant III	1.0		1.0	$45,760	Employee	$45,760
	Scrub Technician Lead	1.0		1.0	$72,800	Employee	$72,800
	Scrub Technician	1.0	1.5	2.5	$52,000	Employee	$130,000
PRN							
	RN	1.0		1.0	$72,800	Employee	$72,800
Subtotal		15.3	9.5	24.8			$1,416,440
Contract Labor							
	Accounts Receivable and Accountant	1.0	1.0	2.0	$26,754	Contract	$53,508
Total		16.3	10.5	26.8			$1,469,948
Benefits							$246,131
Salary/Benefits/Contract Total		16.25	10.5	26.75			$1,716,079

Employee Salary	$1,416,440
Employee Benefits	$246,131
Salary and Benefits	$1,662,571
Benefits/Salary %	17.4%
Contract Services	$53,508

TAB 7

Exhibit 7

Annals of Surgery Article

ANNALS OF SURGERY
A Monthly Review of Surgical Science Since 1885

Ann Surg. 2003 August; 238(2): 170–177.
doi: 10.1097/01.SLA.0000081085.98792.3d
PMCID: PMC1422682

The Aging Population and Its Impact on the Surgery Workforce

David A. Etzioni, MD, MSHS,*† Jerome H. Liu, MD, MSHS,† Melinda A. Maggard, MD,*† and Clifford Y. Ko, MD, MSHS

From the *Department of Surgery, VA Greater Los Angeles Health Care System, Los Angeles, CA; and the †Department of Surgery, David Geffen School of Medicine at UCLA, Los Angeles, CA.

Abstract

Go to

Objective:

To predict the impact of the aging population on the demand for surgical procedures.

Summary Background Data:

The population is expanding and aging. According to the US Census Bureau, the domestic population will increase 7.9% by 2010, and 17.0% by 2020. The fastest growing segment of this population consists of individuals over the age of 65; their numbers are expected to increase 13.3% by 2010 and 53.2% by 2020.

Methods:

Data on the age-specific rates of surgical procedures were obtained from the 1996 National Hospital Discharge Survey and the National Survey of Ambulatory Surgery. These procedure rates were combined with corresponding relative value units from the Centers for Medicare and Medicaid Services. The result quantifies the amount of surgical work used by an average individual within specific age groups (<15 years old, 15–44 years old, 45–64 years old, 65+ years old). This estimate of work per capita was combined with population forecasts to predict future use of surgical services.

Results:

Based on the assumption that age-specific per capita use of surgical services will remain constant, we predict significant increases (14–47%) in the amount of work in all surgical fields. These increases vary widely by specialty.

Conclusions:

The aging of the US population will result in significant growth in the demand for surgical services. Surgeons need to develop strategies to manage an increased workload without sacrificing quality of care.

The population is expanding and aging. According to the US Census Bureau, the domestic population will increase 7.9% by 2010, and 17.0% by 2020. The fastest growing segment of this population consists of individuals over the age of 65; their numbers are expected to increase 13.3% by 2010 and 53.2% by 2020. Two main factors are responsible for these forecasts. First, we are living longer; life expectancy has increased from 66.7 years for individuals born in 1946 to 76.1 years for those born in 1996.[1] Second, the baby boomers (those born between 1946 and 1964) are a wave of population density that will begin to hit retirement age in 2011.[2]

Older individuals require more medical services relative to their younger counterparts. The National Hospital Discharge Survey (NHDS) reported that in 1999, patients aged 65 years or older comprised 12% of the population, but constituted 40% of hospital discharges and 48% of days of inpatient care.[3] As the proportion of elderly patients in the population increases, the medical system will face new challenges. Will there be enough surgeons to meet the increased demand for surgical services?

The last decade has been notable for a perception of balance with regard to the physician supply relative to demand. Against this calm background, we sought to isolate and predict the effect of the aging population on the use of surgical services and the need for surgeons. We hypothesized that the surgical workload will increase significantly over the next 2 decades due in large part to the aging of the US population. Toward evaluating this hypothesis, we employed an approach based upon historical patterns of care. Data from national surveys of medical and surgical services were used to establish a profile of age-specific rates of surgical use. This profile was then used to model the impact of forecasted population shifts on surgical work.

MATERIALS AND METHODS

Go to

Source of Data

Nationwide census forecasts for the years 2001–2020 were obtained through the US Census Bureau. Information regarding the rates of specific surgical procedures was obtained from the 1996 NHDS and the 1996 National Survey of Ambulatory Surgery (NSAS).[4] The 1996 NHDS and NSAS are the most current surveys of surgical services that include an ambulatory surgery component. These surveys were based on a probability sample of nationwide inpatient and ambulatory surgery facilities. Sample sizes were 300,000 and 125,000, respectively.[5,6] The NHDS and NSAS report procedure rates according to the *International Classification of Disease, Revision 9* (ICD-9) procedural coding scheme. Each procedural code is listed along with the number of times it was performed in the survey sample; results are listed by patient age group (< 15 years old, 15–44 years old, 45–64 years old, 65+ years old). Reporting standards for these surveys preclude the accurate reporting of rates for procedures with a low sampled frequency (less than 60 cases present in sample). Procedures for which an age-specific procedure rate could not be determined based on NHDS and NSAS data were excluded from analysis.

Each ICD-9 code was linked to the Current Procedural Terminology (CPT) code that was most relevant to each procedure. Through the Centers for Medicare and Medicaid Services, a database linking each CPT code to pertinent resource-based relative value units (RVU) was obtained. The RVU, which is generally used for calculating reimbursement, includes 3 components: physician work, practice (overhead), and malpractice costs.[7–9] In this analysis, the physician work component was used to estimate the amount of surgical work required to perform the procedure. For example, the number of work RVUs assigned to a laparoscopic cholecystectomy is 11.09, whereas a total hip replacement is 20.12, and a three-vessel coronary artery bypass graft is 31.80.

Analysis

To compute workload projections, age-specific incidence rates for each procedure were multiplied by the corresponding work RVUs. The results were tabulated by surgical specialty and population age group. Through this method, the amount of surgical work used by an average individual each year within the 4 specified age groups was calculated. These age-specific estimates of per capita work per year were combined with population forecasts to model the impact of the expanding/aging population on surgical work. Forecasts were carried out until the year 2020 using 2001 as a reference. The results were aggregated according to specialty, which included cardiothoracic surgery, general surgery, neurosurgery, ophthalmology, orthopedic surgery, otolaryngology, and urology. For the purposes of analysis, general surgery includes vascular, abdominal, gastrointestinal, hernia, breast, and pediatric surgery.

RESULTS

Go to

Analysis of Census Projections

Based on census projections, the total domestic US population will increase 7.9% by 2010 and 17.0% by 2020. Older individuals constitute a disproportionately large share of this growth. Individuals aged 65 years or older are expected to increase in number by 53.2% (18 million persons) between 2001 and 2020 (Table 1).

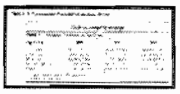


TABLE 1. Forecasted Population by Age Group

Initially, gains will be the largest in 45–64 year olds; by 2010, the population in this age group will have increased in size 26.0% relative to 2001 (Fig. 1). Individuals aged 65 years or older will increase in number by 13.3% during the same time period. After 2010, population growth will occur primarily in the 65 years or older age group. By 2020, individuals aged 65 years or older will have increased in number by 53.2% relative to 2001, whereas those aged 45–64 years of age will have increased 28.1%. Between 2001 and 2020, younger individuals (0–44 years old) are projected to have relatively little population growth.

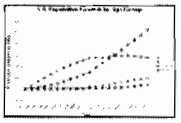


FIGURE 1. US population growth by age group.

Analysis of Age-Specific Surgical Procedure Rates

A total of 214 procedures met the inclusion criterion. The number of procedures included for analysis is listed by specialty in Table 2. A sample of 6 procedures along with their corresponding age-specific incidence rates is provided in Table 3. Individuals in older age groups had higher rates of surgical use than patients in younger age groups. For example, the incidence rate for a three-vessel coronary artery bypass graft in an individual 65 years of age or older (1.95 procedures per 1,000 persons per year) is more than twice as high as in a 45–64-year-old (0.82 procedures per 1,000 persons per year). For 58% of the surgical procedures analyzed in the study, the incidence rate for individuals 65 years of age or older was higher than for any of the other 3 age groups.

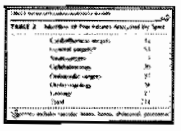


TABLE 2. Number of Procedures Analyzed by Specialty

TABLE 3. Sample of Incidence Rates by Age Group

The proportion of surgical work by age group was computed for each surgical specialty (Table 4). There was significant variation between specialties in terms of the age group(s) of patients that constituted the bulk of procedure-based work. For example, patients aged 65 years or older constituted a larger proportion of procedure-based work in ophthalmology (88%) and cardiothoracic surgery (70%) than in otolaryngology (8%).

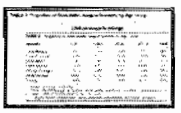


TABLE 4. Proportion of Work Within Surgical Specialty by Age Group

Forecasts for Surgical Specialties

Specialties in which older patients constitute a greater share of procedure-based work have larger forecasted increases in workloads (Fig. 2). The projected growth in procedure-based work closely parallels growth in the number of procedures performed by each specialty (Table 5). Of all the surgical specialties examined, ophthalmology has the largest forecasted increase in work (15% by 2010; 47% by 2020). These projections reflect that older patients are the predominant consumers of cataract surgery; the incidence of cataract surgery in individuals 65 years old or older is more than 8 times the incidence in a patient 45–64 years old. In addition, cataract surgeries (lens fragmentation, insertion of intraocular lens; ICD-9 codes 13.41 and 13.71) comprise 55% of the overall procedure-based workload of ophthalmologists.

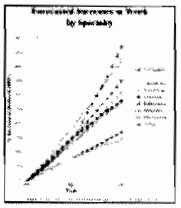


FIGURE 2. Forecasted increases in work by specialty.

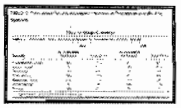


TABLE 5. Forecasted Percent Increases in Number of Procedures and Work by Specialty

Cardiothoracic surgeons care for predominantly older patients. In cardiothoracic surgery, 70% of procedure-based work was derived from patients 65 years old or older. Over the next 2 decades, the growth in surgical work in this field is forecasted to be 42%.

Orthopedics, urology, and neurosurgery also have forecasted growth. The procedure-based work in orthopedics and urology is expected to increase by 28% and 35%, respectively, by 2020. Orthopedic surgery has smaller predicted gains than urology as a result of the significant amount of procedures performed in patients under the age of 45. The profile of age-specific use of neurosurgical procedures is similar to that of orthopedics and urology. Growth in procedure-based work in neurosurgery is predicted to be 15% by 2010 and 28% by 2020.

The amount of procedure-based work in general surgery is expected to grow by 13% by 2010 and 31% by 2020. The possibility that the inclusion of pediatric surgical procedures affected the interpretation of the growth of general surgery was examined. If all pediatric surgical procedures (defined as procedures performed in patients under 15 years of age) were removed from analysis, the forecast for growth in general surgical procedures did not change significantly.

Otolaryngology is unique among the surgical specialties examined. In this field, a greater share of work (39.6%) is performed in patients under the age of 15 than in any other age group. Only a small portion of their procedure-based work (8.4%) is performed on patients over the age of 65. Growth in otolaryngology is therefore projected to be less than the population growth.

DISCUSSION

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As a result of the aging of the US population, we predict that increases in the utilization of surgical services will far outpace the rate of overall population growth. These increases will not be distributed uniformly across surgical specialties. Specialties in which a disproportionately high amount of care is provided to patients over the age of 65 (ie, ophthalmology, cardiothoracic surgery) will experience more growth in workload than those fields that care for younger as well as older patients.

In the past, needs-based models have been used to predict future demand for medical services. The landmark Graduate Medical Education National Advisory Committee (GMENAC) report, published in 1980, was based on an "adjusted needs-based" approach. Their methods relied upon an expert panel's estimation of the amount

of physician work required to care for specific medical and surgical problems. These estimates were then "adjusted" to reflect market realities. Drawing upon these estimates and a comprehensive epidemiological model of the incidence of disease processes, they forecasted the future need for medical services. The GMENAC report suggested that by the year 2000, there would be a surplus of 144,700 physicians—approximately 25% of all doctors.[10] It contained more than 107 specific recommendations to prevent a flood of unneeded physicians. Meanwhile, Congress was also acting by passing Public Law 94-484, intended to restrict the number of foreign medical graduates trained in the US.

In 1989, the Bureau of Health Professions and the Council on Graduate Medical Education contracted with ABT Associates to conduct a follow-up to the GMENAC study. This report, released in 1991, built on the earlier GMENAC model and forecasted the national need and supply of physicians by specialty. The methods used in generating this report were similar to that used by GMENAC; the major differences were a lack of "adjustment" of the needs-based model, and the convening of a new set of expert panels. This report conflicted with the earlier GMENAC report and forecasted increases in the growth of need relative to supply in certain areas. In the field of general surgery, the forecasted increase in needs between 1990 and 2010 was 32.7%.[11]

Historically, the ratio of physician supply to demand has been cyclical. The GMENAC report was produced during a period of perceived physician surplus in the 1970s and early 1980s. Over the last decade physician workforce projections have become less popular, likely the result of a transient balance between demand and supply. Currently, we are not alone in forecasting the emergence of a shortage of specialist physicians. Cooper et al have analyzed the relationship between longitudinal trends and the population-based demand for medical services.[12] Based on forecasted economic expansion, population growth, and changes in the health care workforce, they predict a 20% deficit in the number of physicians by the year 2020. The predicted shortages are greater for specialists than for primary care physicians.[12,13] Their findings, although the product of a different methodology, parallel ours. Other recent analyses have addressed the impact of population trends on the demand for medical specialists, and also predict significant shortages.[14,15]

Some researchers disagree with these predictions, and find the prospect of training more specialists an unwelcome move toward specialty-dominated medical care.[16,17] These disagreements are primarily the product of a belief that physicians, and in particular specialists, induce demand for the services they provide. Do the rates of surgical procedures depend on the number and concentrations of surgeons that perform them? In the early 1980s, Wennberg and colleagues found a correlation between regional rates of surgical procedures and physician supply.[18] More recent research has clarified this relationship. One study used Medicare data to investigate the effect of regional variations in surgeon supply. Regions with higher concentrations of surgeons have increased rates of initial visits between physicians and patients, however, the rate of procedure utilization does not seem to be affected.[19] Another study examined coronary revascularization procedures, and found that rates of surgery are determined more by local variations in the use of diagnostic procedures than the concentration of surgeons.[20] Despite these findings, the fear that increasing the number of surgeons will result in an increased use of unnecessary procedures is pervasive.

Unlike prior needs-based forecasts, the methods used in this study are based on established patterns of surgical use. We believe that this approach, by eliminating the need for the subjective estimates of an expert panel, is a more valid technique for predicting the impact of population shifts on changes in workload. Our method assumes that the age-specific profile of surgical demand will remain constant, which may be a limitation. It is possible that innovations in medical technology will decrease the demand for surgical procedures, or even make certain procedures obsolete. In general, noninvasive therapies thus far have failed to decrease the need for surgeries. One excellent example of this is in the area of cardiac surgery. Cutler et al, in 2001, examined the costs and benefits of medical technological advances in the treatment of coronary artery disease. The rapid growth of coronary angioplasty and stent technology had no discernible impact on the growth of coronary artery bypass surgery.[21] It remains to be seen whether other nonsurgical therapies (eg,

proton pump inhibitors, carotid artery stents) will affect rates of surgeries in the future (eg, Nissen fundoplication, carotid endarterectomy).

Continued technological advance may actually lead to the application of existing procedures to a wider range of individuals. Escarce et al examined the effect of the introduction of laparoscopic technology on the threshold to perform cholecystectomy. They found that the improved technology led to increased rates of surgery.[22] Minimally invasive surgical techniques are rapidly improving and finding new applications. If this trend continues, the demand for surgical procedures may see even further increases as clinical thresholds for other procedures are lowered.

Despite the potential limitation inherent in our assumption, we believe our approach realistically forecasts an important trend. That the aging population will result in more work for surgeons was a foregone conclusion. The actual forecasted growth, between 14 and 47% within each surgical specialty, is impressive. How will surgeons handle the impending increases in procedures generated by the aging US population? We propose 3 areas in which surgeons may be able to adapt to a growth in workload.

The most obvious solution would be to increase the number of practicing surgeons. Unfortunately, this is a very long-term solution. If the number of surgical residency slots was immediately increased by 10%, it would take 20 years before the number of practicing surgeons increased by 5% (assumptions: 5-year training program, average time in workforce of 30 years). The number of surgeons completing postgraduate training programs has remained remarkably constant over the last decade within all surgical specialties. Furthermore, recent trends indicate a declining medical student interest in certain surgical specialties with a perceived poor lifestyle, most notably general surgery.[23,24] Other specialties (orthopedics, otolaryngology, and urology) with more controllable lifestyles have had better success with maintaining medical student interest.[24]

A second possible solution to address the increasing workload would be to ask surgeons to work more. Unfortunately, although it is difficult to assess the number of surgeons currently in practice, it is even more difficult to determine their workloads. Jonasson et al have elegantly described the pitfalls of using physician rosters, such as the American Medical Association Masterfile, to estimate the number of surgeons in practice.[25] They pointed out that previous estimates of the size of the general surgical workforce were inflated because they counted a large number of surgeons not performing general surgery. Furthermore, attempts to estimate the workloads of general surgeons have yielded wildly inconsistent figures regarding the number of cases performed by the average surgeon. Early studies reported surgical workloads in terms of "hernia equivalents," and sparked concern about a surplus of surgeons when the average number of hernia equivalents performed per week in 1 group practice was listed as 3.1.[26] These reports are difficult to put into current perspective. More recently, Ritchie et al reported data from the surgical operative logs (SOL) from the recertification examinations offered by the American Board of Surgery.[27] These SOLs reflect a heterogeneous case-mix; the number of cases performed per year varied between 6 and 2,541 (mean = 398). The same report also examined temporal trends from 1995–1997 in terms of the number of cases per surgeon per year. There was no evidence that the workload (in terms of number of cases) increased or decreased during this 3-year period. In another report, Zelenock et al examined the number of operations performed per year by surgeons in an academic setting.[28] They reported a 30% increase between 1981 and 1995. Are surgeons performing more cases now than they did in the past? Are surgeons' hours longer? Do these caseloads reflect a significant amount of latent capacity in the current surgical workforce, or are surgeons stretched dangerously thin? These are enormously important questions that need to be answered.

A third solution may be to improve the ability of surgeons to focus on procedure-based work. Only a few studies have been devoted to understanding the work environment of surgeons, and the factors that contribute to increased productivity. Two studies performed in the 1970s compared the workloads of surgeons in community versus prepaid group practice. Those in group practice produced twice the surgical output, while working 1-1/2 times as many hours.[29,30] Despite the rapid proliferation of staff model HMOs, there have been no detailed investigations of the workloads and working hours of their staff surgeons. The specific elements of

surgical practice that lead to increased productivity are largely unknown. Medical fields have increasingly relied on nonphysician clinicians such as advanced practice nurses and physician assistants to shoulder part of the burden of work. Nonphysician clinicians may have expanding roles in augmenting surgical productivity.

In the near future, the aging of the US population will result in significant increases (14–47%) in the demand for surgical services. Surgeons need to develop strategies to accommodate an expanding workload without sacrificing quality of care. We believe that with the arrival of increased demand relative to supply, surgeons will find themselves empowered to explore new ways to streamline and improve their practices. Future research should be directed toward identifying the interaction between work environment, surgeon productivity, and quality of care.

Footnotes

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TAB 8

Exhibit 8

Letter from PNC Bank

PNC BANK

MD Health Care Commission
Mr. Ben Steffen, Executive Dir
4160 Patterson Ave.
Baltimore, MD 21215

January 21, 2014

Dear Mr. Steffen:

This letter is regarding the client of PNC Bank, Rockville Eye Surgery Center LLC. Rockville Eye Surgery Center currently maintains both deposit and credit accounts, that are very satisfactory with healthy balances. This relationship has been with PNC Bank since 2007. We hold this relationship in high regards and are interested in working with them to secure the anticipated financing needed for expansion. While loan details are in discussion, we are confident, based on account history and average cash balances listed below, that Rockville Eye Surgery is a viable candidate to receive funding and will be able to apply at least $260,000 as cash contribution.

The average collected balances maintained in the accounts for Rockville Eye Surgery Center in the last 12 months are $361,318.71. Average collected balances over the last 6 months have increased to $400,241.29. Historic balances since 2012 have exceeded $275,000.

If you have any questions regarding Rockville Eye Surgery, LLC, please do not hesitate calling me at 202-577-7107.

Deniz Unal

Vice President
Business Banking

TAB 9

Exhibit 9

DCHA's *2012 Annual Utilization Indicators*

Issued April 2013

UTILIZATION INDICATORS

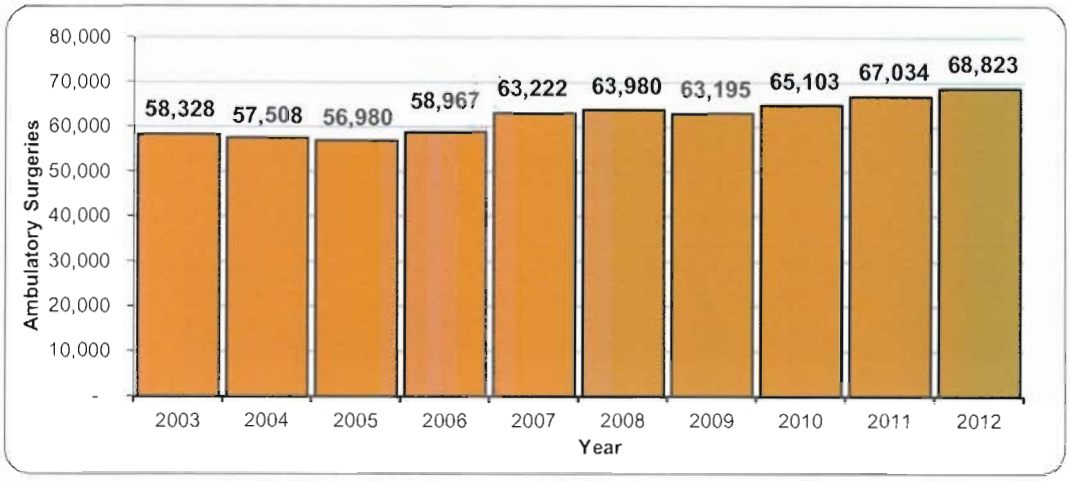
CALENDAR YEAR 2012

ABOUT THIS REPORT

The charts in this publication are intended to provide aggregate and comparative data on the utilization trends of the District of Columbia hospital community for calendar year 2012. The source of the data is the District of Columbia Hospital Association's (DCHA) Monthly Utilization Survey and Quarterly Bed Capacity and Census Survey (self-reported by individual hospitals). The graphs in this report describe utilization trends in the aggregate for the following acute care non-federal hospitals:

- Children's National Medical Center
- George Washington University Hospital
- Howard University Hospital
- MedStar Georgetown University Hospital
- MedStar Washington Hospital Center
- Providence Hospital
- Sibley Memorial Hospital
- United Medical Center

Ambulatory Surgeries



Note: *Calculations are based on reported utilization figures for the District of Columbia acute care non-federal hospitals.*

	Ambulatory Surgeries		
	2012	2011	% Change
Acute Care			
Children's National Medical Center	12,438	11,315	9.9%
George Washington University Hospital	9,105	8,136	11.9%
Howard University Hospital	8,771	8,776	-0.1%
MedStar Georgetown University Hospital	8,644	8,173	5.8%
MedStar Washington Hospital Center	11,896	11,784	1.0%
Providence Hospital	8,741	8,892	-1.7%
Sibley Memorial Hospital	7,009	7,604	-7.8%
United Medical Center	2,219	2,354	-5.7%
ACUTE TOTAL	**68,823**	**67,034**	**2.7%**
Federal			
Veterans Affairs Medical Center	2,532	1,895	33.6%
Walter Reed National Military Medical Center	11,367	8,961	26.8%
SUBTOTAL – DC ONLY	**71,355**	**68,929**	**3.5%**
GRAND TOTAL	**82,722**	**77,890**	**6.2%**

The number of ambulatory surgeries continues to increase steadily. Visits were up by over 4,800 visits, or 7.6 percent, over the past five years and up 10,500 visits, or 18.0 percent, over the last decade.

Note: *Walter Reed Army Medical Center closed in August 2011 and Services were consolidated at the former National Naval Medical Center, Bethesda, and the hospital was renamed Walter Reed National Military Medical Center.*

Note: *Includes data for all hospitals providing ambulatory surgeries.*

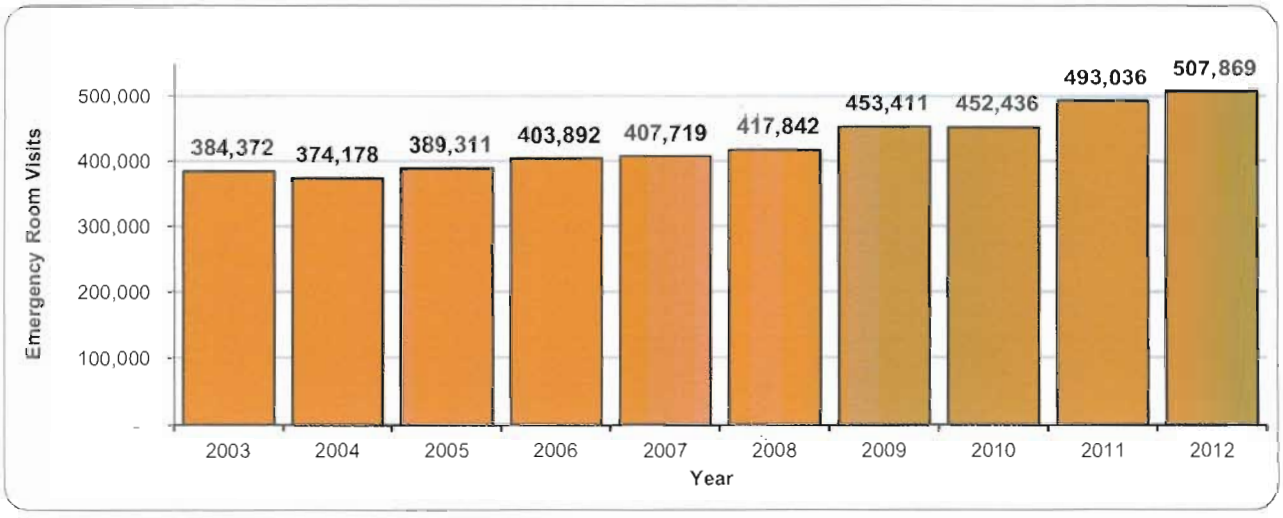
DCHA
District of Columbia Hospital Association

Emergency Department Visits

District hospitals have seen an increase in emergency department visits of more than 90,000 or 21.5 percent, over the last five years. Over the last ten years, the increase was even greater at over 123,500, or 32.1 percent.

	Emergency Department Visits		
	2012	2011	% Change
Acute Care			
Children's National Medical Center	114,184	107,541	6.2%
George Washington University Hospital	73,252	74,662	-1.9%
Howard University Hospital	59,546	59,855	-0.5%
MedStar Georgetown University Hospital	35,317	34,412	2.6%
MedStar Washington Hospital Center	91,543	88,613	3.3%
Providence Hospital	48,949	47,663	2.7%
Sibley Memorial Hospital	33,594	32,555	3.2%
United Medical Center	51,484	47,735	7.9%
ACUTE TOTAL	**507,869**	**493,036**	**3.0%**
Federal			
Veterans Affairs Medical Center	24,616	22,633	8.8%
Walter Reed National Military Medical Center	27,143	21,894	24.0%
SUBTOTAL – DC ONLY	**532,485**	**515,669**	**3.3%**
GRAND TOTAL	**559,628**	**537,563**	**4.1%**

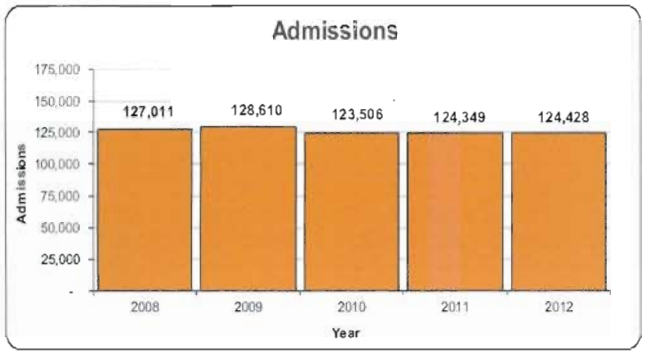
Note: *Children's National Medical Center includes 31,743 visits at its United Medical Center site.*
Note: *Walter Reed Army Medical Center closed in August 2011 and services were consolidated at the former National Naval Medical Center, Bethesda, and the hospital was renamed Walter Reed National Military Medical Center.*
Note: *Includes data for all hospitals providing emergency department visits.*
Definition: *Emergency Department Visits – The number of visits to the hospital's emergency room, including those resulting in admissions.*

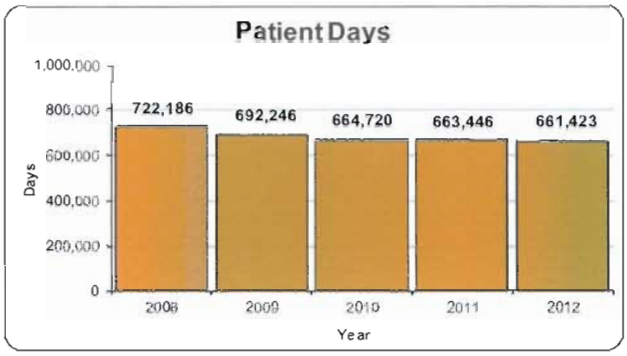


Note: *Calculations are based on reported utilization figures for the District of Columbia acute care non-federal hospitals.*

Inpatient Admissions and Patient Days

After reaching the highest point in 2006 since the early nineties, the number of inpatient admissions and patient days has declined over the last five years, by 2.0 and 8.4 percent, respectively. As evident in the overall increase in ambulatory surgeries and the decrease in inpatient days of care, the hospitals continue to provide more and more care on an outpatient basis.





Note: Calculations are based on reported utilization figures for the District of Columbia acute care non-federal hospitals.

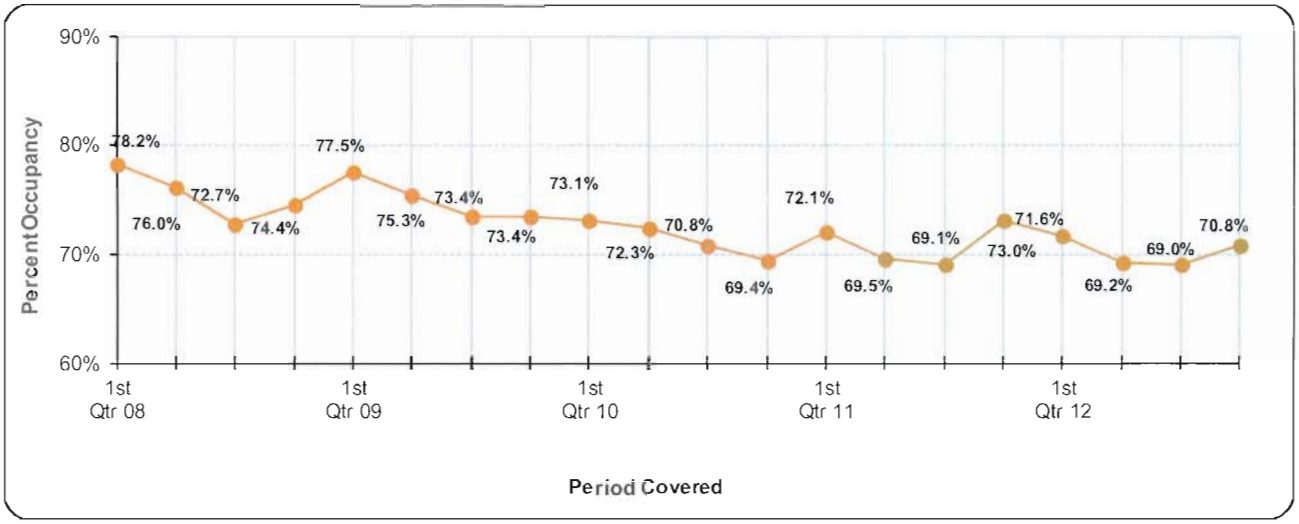
	Inpatient Admissions			Patient Days		
	2012	2011	% Change	2012	2011	% Change
Acute Care						
Children's National Medical Center	14,203	14,247	-0.3%	71,825	72,329	-0.7%
George Washington University Hospital	17,803	17,835	-0.2%	82,700	83,308	-0.7%
Howard University Hospital	10,350	11,748	-11.9%	50,406	55,756	-9.6%
MedStar Georgetown University Hospital	15,808	15,091	4.8%	104,904	101,078	3.8%
MedStar Washington Hospital Center	38,151	36,767	3.8%	222,282	216,633	2.6%
Providence Hospital	12,090	12,428	-2.7%	52,750	57,230	-7.8%
Sibley Memorial Hospital	10,643	11,100	-4.1%	43,256	45,429	-4.8%
United Medical Center	5,200	5,133	1.3%	33,300	31,863	4.5%
ACUTE TOTAL	**124,248**	**124,349**	**-0.1%**	**661,423**	**663,446**	**-0.3%**
Psychiatric and Other Specialty						
MedStar National Rehabilitation Hospital	1,965	2,090	-6.0%	37,154	36,738	1.1%
Psychiatric Institute of Washington	3,939	3,986	-1.2%	31,206	31,644	-1.4%
Saint Elizabeths Hospital	382	430	-11.2%	97,704	100,411	-2.7%
Specialty Hospital of Washington - Capitol Hill	579	629	-7.9%	19,028	19,353	-1.7%
Specialty Hospital of Washington - Hadley	780	816	-4.4%	22,078	21,981	0.4%
Federal						
Veterans Affairs Medical Center	7,115	6,990	1.8%	42,872	44,060	-2.7%
Walter Reed National Military Medical Center	14,161	10,099	40.2%	70,084	50,198	39.6%
SUBTOTAL – DC ONLY	**139,008**	**139,290**	**-0.2%**	**911,465**	**917,633**	**-0.7%**
GRAND TOTAL	**153,169**	**149,389**	**2.5%**	**981,549**	**967,831**	**1.4%**

Note: *Walter Reed Army Medical Center closed in August 2011 and services were consolidated at the former National Naval Medical Center, Bethesda, and the hospital was renamed Walter Reed National Military Medical Center.*

Definition: *Inpatient Admissions – The number of adult and pediatric patients, excluding newborns, accepted for inpatient service during the entire reporting period.*
Inpatient Days: - The number of adult and pediatric days of care, excluding newborn days of care, rendered during the entire reporting period.

Source: *DCHA Monthly Utilization Survey*

Occupancy Rate



Note: *Calculations are based on reported utilization figures for the District of Columbia acute care non-federal hospitals.*
Definition: *Occupancy percentages are calculated based on the number of operating beds. Percent occupancy is defined as the average daily census divided by the number of operating beds.*

Operating Bed Capacity

	TOTAL OPERATING BEDS	MED/SURG	OB/GYN	PEDS	ICU	NICU	Psych	Other	NURSING HOME BEDS	SUBACUTE BEDS
Acute										
Children's National Medical Center	273	0	0	128	65	54	26	0	0	0
George Washington University Hospital	343	202	45	0	48	12	20	16	0	0
Howard University Hospital	235	150	14	16	28	9	18	0	0	0
MedStar Georgetown University Hospital	404	218	32	48	57	36	13	0	0	0
MedStar Washington Hospital Center	852	683	36	0	63	24	46	0	0	0
Providence Hospital	272	191	31	0	12	9	29	0	252	0
Sibley Memorial Hospital	201	114	40	0	14	0	20	13	45	0
United Medical Center	210	145	15	0	16	0	34	0	120	0
ACUTE TOTAL	***2,790***	***1,703***	***213***	***192***	***303***	***144***	***206***	***29***	***417***	***0***
Psychiatric and Other Specialty										
MedStar National Rehabilitation Hospital	137	0	0	0	0	0	0	137	0	0
Psychiatric Institute of Washington	124	0	0	0	0	0	124	0	0	0
Saint Elizabeths Hospital	292	0	0	0	0	0	292	0	0	0
Specialty Hospital of Washington - Capitol Hill	60	0	0	0	0	0	0	60	117	0
Specialty Hospital of Washington - Hadley	82	0	0	0	0	0	0	82	62	0
Federal										
Veterans Affairs Medical Center	145	97	0	0	20	0	28	0	120	26
Walter Reed National Military Medical Center	341	184	32	14	36	24	28	23	0	0
TOTAL - DC ONLY	***3,630***	***1,800***	***213***	***192***	***323***	***144***	***650***	***308***	***716***	***26***
GRAND TOTAL	***3,971***	***1,984***	***245***	***206***	***359***	***168***	***678***	***331***	***716***	***26***

Note: *Walter Reed Army Medical Center closed in August 2011 and services were consolidated at the former National Naval Medical Center, Bethesda, and the hospital was renamed Walter Reed National Military Medical Center.*
Source: *DCHA Quarterly Bed Capacity Survey*

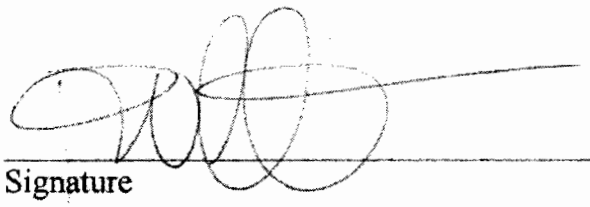
DCHA
District of Columbia Hospital Association
1152 15th Street, NW, Suite 900
Washington, DC 20005
Phone: (202) 682-1581
Fax: (202) 371-8151
www.dcha.org

TAB 10

Exhibit 10

Affirmations

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.

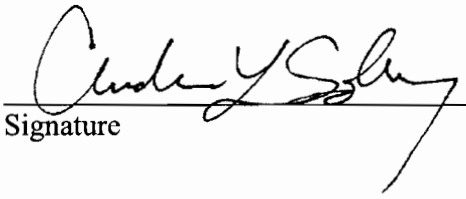


Signature

2/12/2014

Date

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.



Signature

2/13/14

Date