Exhibit 22

Financial Assistance Policy

I. STATEMENT OF POLICY

The purpose of this Financial Assistance Policy (FAP) is to establish standard procedures for the determination of Financial Assistance to patients of Children's National Medical Center (CNMC) and its substantially related entities that are in financial need. Throughout the remainder of the FAP, use of the term "CNMC" refers to Children's National Medical Center and its substantially related entities.

As part of this FAP, CNMC will offer Financial Assistance to patients who are unable to pay their hospital and/or clinic bills due to difficult financial situations regardless of age, gender, race, creed, disability, social or immigrant status, sexual orientation, or religious affiliation. A CNMC Financial Counselor, designated business office representative, or committee with authority to offer Financial Assistance will review individual cases and make a determination of Financial Assistance that may be offered.

Accordingly, this FAP:

- Includes eligibility criteria for Financial Assistance
- Describes the basis for calculating amounts charged to patients eligible for Financial Assistance under this FAP:
- Describes the method by which patients may apply for Financial Assistance
- Describes how the hospital will widely publicize the FAP within the community served by the hospital

CNMC will provide, without discrimination, care for Emergency Medical Conditions to individuals regardless of whether they are eligible for Financial Assistance. CNMC shall comply with the Emergency Medical Treatment and Labor Act (EMTALA) by providing medical screening examinations and stabilizing treatment and referring or transferring an individual to another facility, when appropriate, and provide emergency services. CNMC prohibits any actions that would discourage individuals from seeking emergency medical care.

This FAP is in compliance with the Patient Protection and Affordable Care Act of 2010.

CNMC Entities Covered by this Policy

The services covered by this FAP include all emergency and other medically necessary care provided by CNMC and its substantially related entities, physicians and medical professionals employed by CNMC and Children's National Medical Associates.

Providers Not Covered by this Policy

The physicians and medical professionals not employed by CNMC or its subsidiaries are not covered by this policy.

II. DEFINITIONS

For the purpose of this FAP, the terms below are defined as follows:

Amounts Generally Billed (AGB): Means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with Treasury Regulations §1.501(r)-5(b).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count).

Financial Assistance: Reduction in the amount of gross charges for patients with demonstrated inability to pay.

Gross Charges: CNMC's full, established price for medical care that it consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

Medically Necessary Care: Medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related illness, condition or disability including services necessary to prevent a detrimental change in either medical, behavioral, mental, or dental health status.

Substantially Related Entities: Companies affiliated or owned by Children's National Medical Center that provide Medically Necessary Care, including Children's National Specialists of Virginia, all hospital facilities, regional outpatient centers, health centers, ambulatory surgery centers, mobile care centers, and offsite emergency rooms, and members of Children's National Medical Associates.

Uninsured: The patient has no level of insurance or is not being represented by an attorney, auto insurance, or filed a workmen's compensation claim to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance, but still has out-of-pocket medical expenses that are greater than 30% of their Family Income less housing expenses.

CNMC Primary Service Area (PSA):

Cities Washington, DC
Alexandria City, Virginia

Maryland Counties
Anne Arundel
Calvert County
Charles County
Frederick County
Howard County
Montgomery County
Prince Georges County
Washington County

Virginia Counties
Arlington County
Fairfax County
Fauquier County
Loudon County
Prince William County
Stafford County

III. PROCEDURES

Eligibility for Financial Assistance
Eligibility for Financial Assistance will be considered for individuals who are uninsured, underinsured, ineligible for any government health care benefit program, or unable to pay for their care, based upon a determination of financial need in accordance with this FAP, and have resided in the PSA for at least 6 months. This policy may cover patients that do not reside in our PSA when the hospital is required to stabilize the medical condition of the patient before discharge.

Financial need will be determined in accordance with procedures that involve verifying income and residency in our PSA. The patient or the patient's guarantor will be required to cooperate and complete the FAP Application and provide the following:

1. Documentation of gross monthly Family Income. These documents will include pay stubs for the last six (6) weeks worked, or award letters for unemployment, worker's compensation, or public assistance, alimony, retirement, and/or

disability income. This can include notarized support and unemployment statements. If self- employed, provide an income tax return for the past 2 years.

2. Proof of ineligibility for State/Federal/Local medical assistance programs unless applicant is known not to be eligible for such coverage. (If we are unable to determine your eligibility by your income, you must provide proof of a denial).

3. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization or any picture ID with the name and address printed on it.

4. Proof of address – This can include a copy of your lease, mortgage statement, rent receipt, or a notarized letter from your landlord.

5. If applicable, school verification or report card for patient.

The granting of Financial Assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, creed, disability, social or immigrant status, sexual orientation, or religious affiliation. CNMC shall determine whether or not patients are eligible to receive Financial Assistance for deductibles, co-insurance, or co-payment responsibilities.

CNMC will make reasonable efforts to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. CNMC may make inquiries to obtain reports from third parties such as credit agencies, on certain patients to determine whether they may be presumptively eligible (presumptive eligibility) for Financial Assistance to relieve the financial burden.

A preliminary application stating family size and income will be accepted and a determination of probable eligibility will be made within two business days. Final determination will be provided to each patient or family within 30 business days of inquiry with the submission of a completed application, including all required documentation. Financial Assistance will be denied for patient's that submit an incomplete application, or submit documents that cannot be verified. The grant of Financial Assistance by CNMC will expire 6 months from the approval date ("Expiration Date"). At that time, patients will need to re-apply for continued Financial Assistance by contacting the Financial Information Center.

Basis for Determining Financial Assistance

Services eligible under this FAP will be made available to the patient in accordance with financial need as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Once a patient has been determined by CNMC to be eligible for Financial Assistance, that patient shall not be responsible for any future bills until the Expiration Date. The basis for the amounts CNMC will charge patients qualifying for Financial Assistance is as follows:

a. Patients whose Family Income is at or below 400% of the FPL and who have resided in our PSA for at least 6 months are eligible for full Financial Assistance.[1]

[1] This provision is intended to meet the definition of "sliding scale fee" as defined by the DC Health Professional Loan Repayment Regulations (D.C. Code § 7-751.01- §7-751.17, as may be amended from time to time) and applicable Guidelines.

All patients eligible for Financial Assistance are charged less than AGB as all eligible patients do not receive a bill for emergency or Medically Necessary Care.

For patients who qualify for Financial Assistance and who are cooperating in good faith to resolve their hospital bills, CNMC will not send unpaid bills to outside collection agencies, and will cease all collection efforts. CNMC will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient.

Method for Applying for Financial Assistance

Referral of patients for Financial Assistance may be made by any member of the CNMC staff including by not limited to physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

Contact the following for information about this FAP or assistance with the FAP application process.

Counselors	Location	Phone
Financial Counselors	Financial Information Center	Based on guarantors name: • **A-K:** 202-476-5002 • **L-Z:** 202-476-5505
Customer Service	Patient Accounts Phone Calls	301-572-3542 or 1-800-787-0021

Communication of Financial Assistance to Patients and within the Community

Notification about Financial Assistance available from CNMC shall include a contact number and be disseminated through various means, including but not limited to, the publication of notices in patient statements, and by posting notices in emergency rooms, at urgent care centers, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as CNMC may select. CNMC will publish and widely publicize a summary of this FAP on facility websites, in brochures which will be available in patient access sites, and at other places within the community served by the hospital as CNMC may select. Such notices and summary information will be provided in the primary languages spoken by the population serviced by CNMC.

Regulatory Requirements

In implementing this FAP, CNMC management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this FAP.

IV. ACCOUNTABLE EXECUTIVE AND REVIEWER(S)

A. Accountable Executive: Vice President of Revenue Cycle
B. Division Responsible for Review: Finance
C. Committee Responsible for Review: Leadership Council

V. APPROVAL

Approved by:

_____ _____
Leadership Council Date

_____ _____
Chairman of the Board, CNMC Date

VI. APPLICABILITY

All Children's National employees

VII. REVIEW OR REVISION DATE

July 1, 2016
January 1, 2018

Exhibit 23

Transfer Agreement

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT ("Agreement") is made effective on March 13, 2017 ("Effective Date") and is entered into by and between **CHILDREN'S HOSPITAL**, a not-for-profit corporation organized and existing under the laws of the District of Columbia, having its principal place of business at 111 Michigan Avenue NW, Washington, DC 20010 ("CH") and Children's National of Prince George's County, a corporation organized and existing under the laws of Maryland, having its principal place of business at 2900 North Campus Way, Glenarden, Maryland, 20706 and are sometimes individually referred to herein as "facility" and collectively as "facilities."

RECITALS:

A. The parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities located in the District of Columbia and Maryland.

B. The parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by that facility ("Transferring Facility") as requiring the services of the other facility ("Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office, inpatient unit or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Both facilities agree to retain data regarding performance measures of services provided herein for the purpose of certification or accreditation. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:

1. Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer.

2. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations.

3. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility.

4. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient.

5. Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall arrange care for the medical needs of the patient and who will accept responsibility for such care.

6. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient.

7. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician.

8. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and, with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible.

9. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items.

10. Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a health care assistance program established by a county, local, or public district.

11. Notify the Receiving Facility of the estimated time of arrival of the patient.

12. Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer.

13. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated

provider.

14. Recognize the right of a patient to request to transfer into the care of a physician of the patient's choosing.

15. Recognize the right of a patient to refuse consent to treatment or transfer.

16. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility.

3. **RESPONSIBILITIES OF THE RECEIVING FACILITY.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

1. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient.

2. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility.

3. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, unless such are needed by the Receiving Facility for an emergency.

4. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility.

5. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician.

6. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

7. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.

8. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient.

9. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider.

4. BILLING. All charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party coverage, Medicare or Medicaid, or other sources normally billed by that facility. In addition, it is understood that professional fees will be billed by the physicians or other professional providers that may participate in the care and treatment of the patient at usual and customary charges. Each facility agrees to provide information in its possession to the other facility and such physicians/providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payor.

5. RETRANSFER; DISCHARGE. The Transferring Facility agrees to re-admit the patients at such time as the patient is ready for transfer back to the Transferring Facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, unless the patient is to be transferred to another agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. RESPONSIBILITY; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. TERM; TERMINATION.

1. The initial term of this Agreement ("Initial Term") shall be for a period of one (1) year, commencing on the Effective Date, unless sooner terminated as provided herein. At the end of the Initial Term and each Renewal Term (as hereinafter defined), if any, this Agreement will be automatically renewed for an additional term of one (1) year ("Renewal Term").

2. Either party may terminate this Agreement without cause upon thirty (30) days written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided

such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:

A. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately.
B. Either facility loses its license, is convicted of a criminal offense related to health care, or is listed by a federal agency as being debarred, excluded or otherwise ineligible for federal program participation.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the District of Columbia. The provisions of this Paragraph shall survive expiration or other termination of this Agreement regardless of the cause of such termination.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to Children's National of Prince George's County:
111 Michigan Avenue NW
Washington, DC 20010
Attention: Charles Weinstein

and

If to CH:
Children's Hospital
111 Michigan Avenue NW
Washington, DC 20010
Attention: Todd Kirby

Children's National Medical Center
Legal Department
111 Michigan Avenue NW
Washington, DC 20010

Attention: Executive Vice President and Chief Legal Officer

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assignees.

15. CHANGES IN LAW.

1. **Legal Event; Consequences.** Notwithstanding any other provision of this Agreement, if, subsequent to the effective date hereof, the governmental agencies that administer the Medicare, Medicaid, or other federal programs (or their representatives or agents), or any other federal, state or local governmental or nongovernmental agency, or any court or administrative tribunal passes, issues or promulgates any law, rule, regulation, standard, interpretation, order, decision or judgment, including but not limited to those relating to any Safe Harbor regulations pursuant to 42 U.S.C. 1320-7b (anti-kickback statute) or any self-referral regulations pursuant to 42 U.S.C. 1395nn ("Stark II") (collectively or individually, "Legal Event"), which, in the good faith judgment of one party (the "Noticing Party"), materially and adversely affects either party's licensure, accreditation, certification, or ability to refer, to accept any referral, to bill, to claim, to present a bill or claim, or to receive payment or reimbursement from any federal, state or local governmental or non-governmental payor, or which subjects the Noticing Party to a risk of prosecution or civil monetary penalty, or which, in the good faith judgment of the Noticing Party, indicates a Safe Harbor rule or regulation with which the Noticing Party desires further compliance, then the Noticing Party may give the other party notice of intent to amend or terminate this Agreement in accordance with the next Subparagraph.

2. **Notice Requirements.** The Noticing Party shall give notice to the other party together with an opinion of counsel setting forth the following information:

   A. The Legal Event(s) giving rise to the notice;
   B. The consequences of the Legal Event(s) as to the Noticing Party;
   C. The Noticing Party's intention to either:

      (i) Terminate this Agreement due to unacceptable risk of prosecution or civil monetary penalty; or

(ii) Amend this Agreement, together with a statement that the purpose thereof is one or more of the following:

(a) to further comply with any Safe Harbor rules or regulations created or affected by the Legal Event(s); and/or
(b) to satisfy any licensure, accreditation or certification requirements created or affected by the Legal Event(s); and/or
(c) to preserve the Noticing Party's ability to refer, accept referrals, or present bills or claims to or from the other party or any other person or entity; and/or
(d) to eliminate or minimize the risk of prosecution or civil monetary penalty;

D. The Noticing Party's proposed amendment(s); and
E. The Noticing Party's request for commencement of the Renegotiation Period (as defined below).

3. **Renegotiation Period; Termination.** In the event of notice under either Subparagraph 2(C)(i) or 2(C)(ii) above, the parties shall have ten (10) days from the giving of such notice ("Renegotiation Period") within which to attempt to amend this Agreement in accordance with the Noticing Party's proposal (if any) or otherwise as the parties may agree. If this Agreement is not so amended within the Renegotiation Period, this Agreement shall terminate as of midnight on the 10th day after said notice was given. Except as otherwise required by applicable law, any amounts owing to either party hereunder shall be paid, on a pro rata basis, up to the date of such termination, and any obligation hereunder that is to continue beyond expiration or termination shall so continue pursuant to its terms. All opinions of counsel presented by the Noticing Party hereunder, and any corresponding opinions given by the other party in response, shall be deemed confidential and given solely for purposes of renegotiation and settlement of a potential dispute, and shall not be deemed disclosed so as to waive any privileges otherwise applicable to said opinions.

IN WITNESS WHEREOF, the undersigned parties affirm that they have the authority to enter into agreements on behalf of their respective institutions and have caused this Agreement to be executed duly authorized and empowered.

CHILDREN'S HOSPITAL

By: 
Name: Kathleen C. Gorman, MSN, RN, FAAN
Title: Executive Vice President of Patient Care Services and Chief Operating Officer
Date: March 13, 2018

Children's National of Prince George's County

By: 
Name: David L. Wessel, MD
Title: Executive Vice President and Chief Medical Officer for Hospital and Specialty Services
Date: March 13, 2018

Exhibit 24

Completeness Questions, Table 1

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Alexandra Espinel	n/a	n/a	533	20,029	121	4,547	128	4,810	140	5,261	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
69436 TYMPANOSTOMY, GEN ANESTHESIA	n/a	308
42820 REM TONSILS/ADENOIDS <12YR	n/a	192
42830 ADENOIDECTOMY PRIMARY >12 YEAR	n/a	53
31526 DX LARYNGOSCOPY W/OPER SCOPE	n/a	26
42821 T&A; AGE 12 OR MORE	n/a	14

* List in descending order based on the cumulative 2 year volume

notes:

add 25 min/case for set-up and turnover

Dr. Espinel joined faculty 8/2016

n/a = not applicable due to surgeon started fy'17

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

Signature S Callicott

Print Name: Susan Callicott, Director

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Pamela Mudd	501	23,547	592	29,090	107	5,136	112	5,376	130	6,240	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
69436Tympanostomy, Gen Anesth	256	274
42820 Rem Tonsils/Adenoids<12yo	153	202
42830Adenoidectomy Prim>12yo	50	79
69210 Remove impacted ear wax	16	27
31526 DX Laryngoscopy w/Oper scope	21	21

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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

Signature S Callicott
Print Name: S Callicott, Director

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Maria Pena	488	20,556	564	23,821	119	5,026	123	5,166	125	5,250	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
69436 Tympanostomy, Gen Anest	394	381
42820 Rem Tonsils/Adenoids<12yo	155	198
42830 Adenoidectomy primary>12yo	48	51
69210 Remove impacted ear wax	34	29
31231 Dx Nasal Endoscopy	14	17

* List in descending order bas

notes:
add 25 min/case for set-up and turnover

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

Signature S Callicott

Print Name: Susan Callicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Diego Preciado	416	19,865	479	25,387	73	3,869	73	3,869	125	6,625	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
69436 Tympanostomy,Gen Anes	205	221
42820 Rem Tonsils/Adenoids<12yo	117	128
31526 Dx Laryngoscopy w/Oper Scope	23	34
42830 Adenoidectomy Primary >12 yo	19	24
69210 Remove Impacted Ear Wax	10	12

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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

Signature SCallicott
Print Name: Susan Callicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Mikael Petrosyan	649	35,695	672	47,712	334	21,710	344	22,360	385	25,025	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
54161Circum 28 days or older	80	59
49585RPR Umbil Hern, reduc>5 yr	51	51
49500RPR Ing Hernininit,reduce 6M<5Y	39	58
44970 Laparoscopy;appendectomy	36	48
49580 RPR UMBIL HERN, reduc <5yr	31	34

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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

Signature S Callicott
Print Name: Susan Callicott

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Sravan Matta	N/A	N/A	83	3,320	84	3,360	86	3,440	172	8,428	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
43239 UGI w/bx sgl/multiple	N/A	25
45380Colonoscopyflex w/bx sgl/mult	N/A	9
91010 Esophagus Motility Study	N/A	2
43241UGI w/Instralum tube/cath plcmn	N/A	1
91038Esoph Imped Fct test>1hr	N/A	1

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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Signature SCalliott
Print Name: SusanCalliott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
HemOnc	35	3,360	50	4,500	25	2,250	26	2,340	52	4,680	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
38220-Bone Marrow Aspiration	8	14
38221 Bone Marrow Biopsy	6	9
62270 Spinal Puncture, Lumbar Dx	2	2
38240 Bone Marrow Transplantation	1	4
11100 Bx-Skin, SQ/MM; SGL	1	

* List in descending order based on the cumulative 2 year volume

notes:

add 25 min/case for set-up & turnover

2 of the hematologists/oncologists performing sedated procedures in the OR

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Signature SCallicott

Print Name: Susan Callicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Marlet Bazemore	97	7,828	63	5,696	38	3,116	39	3,159	40	3,240	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
67311-Strabismus Surg 1 Horz Muscle	103	69
67314-Strabismus Surg 1 Vert Muscle	10	17
92018-EYE Exam w/Anesth; complete	10	8
92275-Electroretinography w/Int&RE	12	2
67332-Strabismus Surg-Pt w/Scar EO M	9	4

* List in descending order based on the cumulative 2 year volume

notes:
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Signature SCallicott
Print Name: Susan Callicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Heather deBeaufort	46	3,548	75	6,349	39	3,198	40	3,360	42	3,528	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
67311-Strabismus Surg 1 Horiz Muscle	53	74
67314-Strabismus Surg, 1 Vertical Mus	6	13
67808=Exc of Chalazion;Under Gen Anes	7	6
67332-Strasbismus Surg-Pt w/Scar EO M	5	4
68811-Nasolacr Duct Probe Req Gen Anes	1	7

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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

Signature S Collicott

Print Name: S Collicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Emily Niu	N/A	N/A	143	19,747	30	3,750	31	4,278	32	4,000	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
29888ArthroscAnt Cruci Lig Rep/Aug	N/A	24
24528Perc Fix SC/TC Humerus FX	N/A	20
29882ArthroscKnee w/Men RepMed&LA	N/A	15
29881ArthroscKneew/Medisc-Med/LAT	N/A	8
27502 CL TX Femoral Shaft FX,w/Manip	N/A	5

* List in descending order based on the cumulative 2 year volume

notes:
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Signature SCallicott

Print Name: Susan Callicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Gary Rogers	159	10,702	168	12,629	84	6,132	100	7,300	120	8,760	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
12051-Int Rep f/e/n/l/mm; 2.5cm/<	28	26
11442Removal of skin lesion	16	19
11200 Removal of skin tags	14	11
26587 Recons extra finger	7	14
19318Reduction Mammaplasty	8	11

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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Signature SCallicott

Print Name: Susan Callicott

	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Nadia Kalloo	213	17,713	156	15,288	117	9,711	122	10,126	137	11,371	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
54640 Orchiopexy, Inguinal approach	102	69
49500 RPR Ing Herninit, Reduce 6M<5Y	47	51
54161 Circum 28 days or older	42	34
54300 Penis OP-Straighten Chordee	23	17
54162 Lysis Penil Circumcis Adhes	22	16

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up & turnover

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

Signature S Callicott
Print Name: Susan Callicott

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Sally Evans	166	4,131	205	4,752	58	1,334	60	1,380	139	3,197	Main campus/Sheikh Zayed

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
64643-Each add'l extremity 1-4 Musc	312	317
64642-Chemodenervation of 1 extrem	226	276
64640Destr w/Neuroly oth periph nrv	218	261
64644 Chemodenervation of 1 extr; 5+	208	171

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up and turnover

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

Signature SCallicott
Print Name: Susan Callicott

The only sedated procedure she brings to the OR as a non-surgeon is botox injection, but other data as below -

Exhibit 25

Completeness Questions, Table 2

Table 2 - Historical and Projected Surgical Volumes Related to Ambulatory Surgical Facility CON Application, by Physician

Physician Data, Aggregated											
Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Alexandra Espinel*	n/a	n/a	533	20,029	121	4,547	128	4,810	140	5,261	Main campus/Sheikh Zayed
Dr. Pamela Mudd	501	23,547	592	29,090	107	5,136	112	5,376	130	6,240	Main campus/Sheikh Zayed
Dr. Maria Pena	488	20,556	564	23,821	119	5,026	123	5,116	125	5,250	Main campus/Sheikh Zayed
Dr. Diego Preciado	416	19,865	479	25,387	73	3,869	73	3,869	125	6,625	Main campus/Sheikh Zayed
New ENT MD's-Drs. Gittman & Lawlor	-	-	-	-	-	-	85	4,505	280	14,840	Main campus/Sheikh Zayed
Dr. Mikael Petrosyan	649	35,501	672	47,712	334	21,710	344	22,360	385	25,025	Main campus/Sheikh Zayed
Gen Surgery Physician(s) to be recruited	-	-	-	-	-	-	-	-	303	19,695	Main campus/Sheikh Zayed
Dr. Sravan Matta	-	-	83	3,320	84	3,360	86	3,440	172	8,428	Main campus/Sheikh Zayed
Hem Onc-Drs. S. Jacobs & E. Perez	35	3,360	50	4,500	25	2,250	26	2,340	52	4,680	Main campus/Sheikh Zayed
Dr. Marlet Bazemore	97	7,828	63	5,696	38	3,116	39	3,159	40	3,240	Main campus/Sheikh Zayed
Dr. Heather deBeaufort	46	3,548	75	6,349	39	3,198	40	3,360	42	3,528	Main campus/Sheikh Zayed
Dr. Emily Niu	-	-	143	19,747	30	3,750	31	4,278	32	4,000	Main campus/Sheikh Zayed
Orthopedic Surgery Physician(s) to be recruit	-	-	-	-	-	-	-	-	50	6,250	Main campus/Sheikh Zayed
Dr. Gary Rogers	159	10,702	168	12,629	84	6,132	100	7,300	120	8,760	Main campus/Sheikh Zayed
Dr. Nadia Kalloo	213	17,713	156	15,288	117	9,711	122	10,126	137	11,371	Main campus/Sheikh Zayed
Urology Physician(s) to be recruited	-	-	-	-	62	5,146	62	5,146	128	10,624	Main campus/Sheikh Zayed
Dr. Sarah Evans	166	4,131	205	4,752	58	1,334	60	1,380	139	3,197	Main campus/Sheikh Zayed
All Community physicians					-	-	-	-	155	16,895	Main campus/Sheikh Zayed
Total	2,770	146,751	3,783	218,320	1,291	78,285	1,431	86,565	2,555	163,909	
turnover time per case		69,250		94,575		32,275		35,775		63,875	
total minutes w/turnover		216,001		312,895		110,560		122,340		227,784	

notes:

*n/a means that this surgeon did not start until fiscal year where volume listed

These projections have been supplied to me by surgeons who have expressed interest in providing services at our proposed Ambulatory Surgical Facility (and whose individual data is included herein).

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

Signature S Callicott

Print Name and Title: Susan Callicott, Director

Exhibit 26

Truven Health Analytics Methodology

DOWNLOAD OF METHODOLOGY FROM TRUVEN HEALTH ANALYSTICS – MARKET EXPERT (planning tool)

Outpatient Procedure Estimates

About Outpatient Procedure Estimates

Truven Health Outpatient Procedure Estimates (OPE) predicts the total annual volume of ambulatory procedures performed by ZIP Code, age group, sex, site of service, and payor for every market in the United States. Procedures are defined and reported by 674 categories of CPT® codes and Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) codes, which are further grouped into clinical service lines as well as broad technical groups. To construct population-based use rates for all payors and all ambulatory care settings, Truven Health used proprietary and public claims, as well as federal surveys.

Outpatient procedure estimates includes three sets of projections for the current through projected years:

- Reform Baseline: Assumes full impact of the ACA. It reflects changes in inpatient utilization due to demographics shifts, as well as the impact of healthcare reform on payor mix.
- Reform Trended: Assumes full impact of the ACA. In addition to the impact of demographics shifts and payor mix, trended forecasts also incorporate projections of long-term and short-term changes in inpatient utilization due to diagnosis and treatment patterns, including site-of-service shifts.
- Repeal Trended: Assumes full repeal of the ACA. Enrollment numbers reflect pre-2013 reform totals. Trended forecasts also incorporate projections of long-term and short-term changes in inpatient utilization due to diagnosis and treatment patterns, including site-of-service shifts.

Payor Type: Medicaid Expansion

Truven Health includes the payor type, "Medicaid Expansion Population," to allow users to track the utilization of the newly-eligible Medicaid beneficiaries. Extensive studies of the health and behavior of this new segment permit more precise estimates of the impact of Healthcare Reform in expansion states.

The ACA included provisions to add low-income adults to the Medicaid program. After the 2012 Supreme Court decision, allowing states to choose whether to opt in or opt out of these provisions, about half the states elected to expand their Medicaid program to include these adults. We made the assumption that states that were

expanding Medicaid would begin no later than 2014. Since the creation of these estimates, it was noted that Pennsylvania will not begin expansion until 2015.

The Medicaid Expansion population is comprised of all newly-enrolled individuals with incomes below 138 percent of the Federal Poverty Level. These individuals have transitioned into Medicaid either from Uninsured status or from private insurance.

Generally, our findings suggest somewhat lower costs for care of the future Medicaid-eligible adults (FMEAs) in comparison to currently-enrolled Medicaid adults. Use of healthcare services is reported at much lower rates than for those currently covered.

Nationwide Emergency Department Sample (NEDS)

The Nationwide Emergency Department Sample (NEDS) is the largest, all-payor emergency department database in the United States, yielding national estimates of hospital-based ED visits. Unweighted, it contains data from approximately 30 million discharges each year. Weighted, it estimates roughly 130 million ED visits. ED visits resulting in an inpatient admission are not included in Outpatient Estimates.

Impact of Medicaid Expansion on Emergency Department Use

Our research revealed that the newly-eligible adults use the emergency room less frequently than adults that were eligible for Medicaid prior to the ACA. To accurately reflect the different utilization rates, we broke out the utilization estimates of the newly Medicaid eligible from the traditionally Medicaid eligible. For the states that did not expand their Medicaid programs, these adults remain largely in the uninsured category, and our estimates are based on the uninsured utilization rates.

Procedures for Outpatient Procedure Estimates

Procedure groupings have been enhanced to be more clinically homogeneous, and to make it easier to focus on codes that are relevant to your market-level planning. New Procedure Groups, Clinical Service Categories, and Ambulatory Technical Groups have been created, and underlying procedures have shifted as well.

Changes include the following:

- Procedure groups were refined to ensure each procedure group was clinically homogeneous
- CPT codes that were ancillary were moved from a main procedure group into an ancillary procedure group that included the word "additional" in its title

Because of these enhancements, you may expect significant differences between last year's estimates compared to this new release. Those differences are not the result of any market or industry trend, but rather, the result of this improved grouping methodology. You can find a detailed listing of procedures added for 2015 in the appendix section *Groupings in Outpatient Planning*.

Changes from Previous Years

Each year, the estimates are created “from scratch.” Year-to-year comparisons are not recommended since they can be driven by many changes. For example, a year-to-year difference may be driven by changes observed in national utilization data, but it also may be driven by changes in procedure group definitions, local payor mix, local demographic constituency, or local utilization data.

Methodology

Truven Health created estimates as follows:

- **Outpatient procedure estimates** by constructing ambulatory utilization rates by payor, age, sex, site, and CPT®/HCPCS code
- **Ambulatory procedure estimates** by constructing ambulatory utilization rates by payor, age, sex, and CCS Category

Then, we multiplied these rates by their appropriate populations to yield procedure volume estimates at the ZIP Code level.

The majority of the utilization rates are built directly from public and private claims streams that Truven Health processes. National Federal survey data also are used to create some use rates. When the local Medicare sample is below 50 procedures, local adjustments are calculated at the state level.

With outpatient procedure estimates, in general, facility claims from the 100% Medicare database are used to estimate local variation in hospital sites of service. Physician claims from the Medicare 5% sample are used for non-hospital sites of service. The size of both of these sources determines how local variation factors are calculated. In situations where a procedure group's local Medicare samples are large enough, these adjustments are applied at the county level. Otherwise, we follow a hierarchy of aggregations to achieve sufficient sample sizes. When the total, local Medicare sample is below 50 procedures, all the samples in the same clinical service line and/or technical group are aggregated and the local adjustments are calculated at that level. If the combined Medicare samples are still below 50 procedures, the samples are aggregated at the state level. When the local Medicare facility sample is above 50 procedures but the physician claims sample is insufficient, local adjustments for the Office and Independent Ambulatory Surgery sites are predicted using a complex regression model.

Claims Analysis

Use rates created from payor claims streams are very accurate and complete; this is because all claims utilization is captured for a group of covered lives, regardless of the provider or the site of care. Truven Health carefully scrutinizes all of the claims streams used to create rates to ensure they are clean and accurate. Claims sources that are either incomplete or poorly-coded are discarded and not used in the product. Every effort is made to account for each service once and only once. For example, surgical claims submitted by assistant surgeons are excluded to avoid double counting of major surgeries.

Use Rate Construction

Healthcare utilization differs dramatically by age, sex, payor, and county of residence. Truven Health builds rates that reflect all of these variables so that final estimates are very precise and specific. Truven Health uses claims data to directly track outpatient care for the Medicare and commercially-insured populations. Since accurate claims are not available for the Medicaid and uninsured populations, Truven Health uses Federal surveys in conjunction with claims in order to construct appropriate use rates for these populations.

Because Truven Health analyzes claims from every U.S. County, rates have been carefully calibrated to take into account local differences in outpatient utilization. Rates are thus adjusted for each county based on its unique epidemiology, patterns of access, and healthcare practices.

Population Data

The use rates described above are applied to demographic data at the ZIP Code level to yield estimates of procedures through the ten-year estimates. Truven Health factors in the age, sex, and insurance mix of each population to ensure that estimates reflect local variation. Age and sex statistics at the ZIP Code level are obtained from Claritas Demographics data. Insurance mix for the population comes from the Truven Health Insurance Coverage Estimates database, which estimates the number of people covered by various health insurance arrangements at the ZIP Code level. Truven Health has done extensive research to forecast the year-by-year impact of Healthcare Reform on insurance enrollment. To forecast the impact of expanded coverage at a ZIP Code level, local employer-based coverage, household income statistics, Medicaid eligibility rules, and other local factors are used.

Impact of Healthcare Reform and Repeal

The Affordable Care Act (ACA) is a broad collection of reform initiatives and requirements. Most of them impact insurance coverage, especially the enrollment of currently uninsured adults into Medicaid or insurance exchanges. The "Reform Baseline" and "Reform Trended" projections include the impact of the ACA on Truven Health estimates of insurance coverage for the estimated years. They assume full coverage of the ACA with continued enrollment numbers. In addition, with the impact of the ACA on insurance coverage and on utilization. The "Reform Baseline" projections include only the minimum impact of reform on payor mix.

The "Repeal Trended" estimates assumes full repeal of the existing Affordable Care Act (ACA), reflecting enrollment numbers that show pre-2013 reform totals. In addition, these estimates incorporate projects of long-term and recent changes in diagnosis and treatment patterns, including site of service shifts.

Procedure Estimates - Site of Service Categories

To identify the sites of care at which procedures are being performed in the market, Truven Health has created Site of Service categories. These site categories include private physician offices, hospital emergency departments, hospital outpatient facilities, non-hospital outpatient facilities, independent ambulatory surgery centers, and independent laboratories. The following describes each Site of Service category, including a list of the services that can be performed in each.

Private Office

This setting includes offices that are owned and run by physicians, and financially independent from any hospital or independent ambulatory surgery center. The private office may be physically attached to a hospital campus or surgery center, but uses an independent provider ID and is financially separate from any other healthcare facility. Site of service is self-reported on physician claims. A Truven Health analysis of that self-reported coding shows a 96 percent accuracy rate for coding site of service.

Emergency Department

This setting is always owned by and physically located in a hospital. In reviewing facility claims, Truven Health assigned all procedures on each claim to the ED site of service if an Emergency Department Revenue code appeared anywhere on the claim. Therefore, procedures that may physically take place outside of the ED — for example, MRI — are included in the ED site of service if the procedure was performed in the context of an ED visit. For physician claims, we relied on the site of service code reported by the physician. Although physician claims are generally accurate as a source of site of service information, miscodes can occur. We make no attempt to clean or correct site information on these claims.

Hospital Outpatient

This setting comprises hospital-operated outpatient facilities. This setting may either be physically located in a hospital, or be an off-campus or freestanding facility. All types of procedures can occur in this setting. As with the Emergency Department site, we rely on the accuracy of the reported site of service where physician claims were used to estimate volume.

Non-Hospital Outpatient Facility

This setting includes all institutional providers that are not owned or operated by a hospital. This setting comprises community mental health centers, comprehensive outpatient rehabilitation centers, end-stage renal disease (ESRD) facilities, federally-qualified health centers, outpatient physical therapy/speech pathology facilities, and rural health clinics. These sites of service were identified using the Medicare ID of the facility submitting each claim. Utilization in these types of facilities is very specialized and generally consists of a handful of procedures specific to the facility type.

Independent Ambulatory Surgery Center

This setting is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. These facilities are organizationally independent and physically separate from any hospital or private physician office. By CMS regulations, such facilities are not considered to be institutional providers.

Independent Laboratory

This setting includes laboratories certified to perform diagnostic and/or clinical tests independent of either an institution or a physician’s office.

Urgent Care

This site was previously included in the "Office" setting. In 2016 this was broken out into its own individual site of service.

Procedure Groupings

There are over 13,000 valid CPT® and HCPCS codes present in the underlying claims. In order to make the estimates both statistically valid and relevant to the needs of ambulatory planners, Truven Health consolidated those codes that were appropriate and usable for outpatient analysis into procedure groups. These procedure groups, which are proprietary to Truven Health, aggregate similar CPT® and HCPCS codes into relatively homogeneous categories based on the type of procedure performed and/or the equipment used for each procedure. Each of these procedures is further grouped into a Clinical Service Category (CSC) and an Ambulatory Technical Group (ATG). For lists of CSCs and ATGs, see the appendix section *Groupings in Outpatient Planning*.

Clinical Classifications Software

In 2016 we released a process to roll up CPT volumes at the CCS level. CPT-to-CCS mapping is provided by AHRQ. CPT/HCPCS codes are collapsed into clinically meaningful categories with over 10,000 CPT codes. We take the Outpatient Procedure Estimates volume and map the CPT to CSS, and then roll the volume up to the CCS level for more comparable reporting with the inpatient setting.

Frequently Asked Questions

This section includes frequently asked questions about this module and its content sets.

How do these estimates compare to actual values in my market?

These data represent estimates of utilization and are not a perfect accounting of every single procedure visit that did occur. While Truven Health uses a vast amount of claims at a local level, these estimates may vary from actual experience.

I see that the estimates for my market have changed since last year. What is causing this change?

Apart from methodology changes, national rates vary widely from year to year for some procedures. The reasons for such changes include variability of billing practices, changes in reimbursement, and changes in practice patterns.

Are the estimates accurate to a ZIP Code level?

County level data are used to calculate local variation. ZIP Code level utilization is extrapolated from the county level using population data. Because estimates for smaller geographies have a greater standard error than those for larger geographies, *analysis should be performed at a market level rather than at the ZIP Code level*.

Are there any geographies that need to be addressed differently that I should be aware of?

The following counties do not contain the majority of population for any ZIP Code. As such, their volume is represented in neighboring counties. This is consistent with the previous releases:

Bedford City, Virginia (SCFIPS 51515) included in Bedford County, Virginia (51019)

Covington City, Virginia (SCFIPS51580) included in Alleghany County, Virginia (51005)

Emporia City, Virginia (SCFIPS 51595) included in Greensville County, Virginia (51081)

Fairfax City, Virginia (SCFIPS51600) included in Fairfax County, Virginia (51059)

Lexington City, Virginia (SCFIPS 51678) included in Rockbridge County, Virginia (51163)

Manassas Park City, Virginia (SCFIPS 51685) included in Prince William County, Virginia (51153)

Martinsville City, Virginia (SCFIPS 51690) included in Henry County, Virginia (51089)

King County, Texas (SCFIPS 48269) included in Cottle County, Texas (48101)

Cardiac catheterization can consist of several related procedures. How do you handle cardiac catheterizations in Outpatient Procedure Estimates?

For cardiac catheterization, we provide several related procedure categories. We suggest using the following three procedures for counting actual cases:

Cardiac catheterization, combined

Cardiac catheterization, left

Cardiac catheterization, right

Including any other cardiac catheterization procedures along with these three will likely double count utilization and overestimate the number of procedures performed.

Managing radiation oncology may consist of several treatments per claim. How do you handle radiation oncology management in Outpatient Procedure Estimates?

Our empirical research suggests approximately five treatments per management claim. Multiplying the provided estimate by five will result in a conservative approximation of the total number of treatments.

Are there any exclusions that I should be aware of when analyzing the results of Outpatient Procedure Estimates content?

When we built our Outpatient Planning module, we found that there are several exclusions of which you might need to be aware:

A small number of procedures that are predominantly paid for out-of-pocket will have low estimates or no volume at all because such procedures are rarely found in claims streams. An example of such a procedure is cosmetic eye surgery (PRK or LASIK).

Workers' compensation ambulatory utilization is not included in Outpatient Planning.

Anesthesia procedures are excluded because of inconsistency in coding of unit values on source claims. Note that this issue does not apply to the CPT® codes in the "Neurolytic destruction" and "Injection, spinal cord" procedure groups. These procedure groups are included in the 2014 release of Outpatient Planning.

In certain cases, procedure counts from the claims data aren't as valuable as a visit estimate. How do I address this?

For planning purposes, the number of visits is often more useful than the number of "units" of treatment encoded on claims. In order to make this count more relevant to our clients, we base the estimates for the following procedure groups on the number of claims. This is a proxy for the number of visits:

Allergy testing

Observation care

Pulmonary function tests

All procedures in the following Ambulatory Technical Groups: Drugs, Injections, and Labs

All procedures in the Ophthalmology Clinical Service Category that are also in the Major Surgery Ambulatory Technical Group

For the ambulatory surgery estimates, how did you handle the various sites of service?

Both Hospital Outpatient and Independent Ambulatory Surgery Center procedures are included in the estimates. However, these procedures are not broken out separately in the reports.

What are some typical business applications for using the estimates in Outpatient Procedure Estimates?

Typical business questions addressed include:

How are volumes of key outpatient services going to change in my market?

How will changes in technologies and underlying practice patterns affect future volumes?

Where should I locate outpatient or ambulatory clinics to take advantage of current and future needs?

What is my market share for key outpatient services?

How are local utilization rates created?

Medicare data are used to adjust utilization rates for procedure groups at the local level. The methodology for estimating local utilization for a procedure is dependent upon whether the county Medicare volume is above or

below our sample size threshold. As such, the methodology applied to low volume procedure groups may vary from year to year.

Does the emergency department estimates data include special cases?

In allocating procedure volume to a site of service, site information is extracted from raw insurance claims. Truven Health relies on the accuracy of the claims and does not attempt to infer or correct site of service.

Appendix

Groupings in Outpatient Planning

Outpatient Planning includes high-level groupings, Clinical Service Categories and Ambulatory Technical Groups. In addition to being assigned to a Clinical Service Category, each procedure category is assigned to an Ambulatory Technical Group (ATG). The ATG represents a distinct type of service provided by a physician or healthcare professional.

Table 1 Groupings found in the various content sets

Outpatient procedure estimates	
Clinical Service Categories	Ambulatory Technical Groups
Allergy	Drug administration (Drug Admin)
Anesthesia	Drugs
Cardiology	Guidance for surgical/Invasive (Guidance)
Cardiothoracic (Cdthoracic)	Imaging Major
Chiropractic (Chiro)	Injections
Colorectal Surgery (Colorectal)	Invasive Major
CT Scan	Invasive Minor
Dermatology	Labs
Diagnostic Radiology (Diag Rad)	Medical Diagnostics
Emergency Medicine (Em)	Medical Therapies
Gastroenterology (Gastro)	Nuclear
General Surgery (Gen Surg)	Radiation Diagnostics
Hematology Oncology (Hemonc)	Major Surgery
Labs	Minor Surgery
Medicine	Visits/Consultations
Miscellaneous (Misc)	
Magnetic Resonance Imaging (Mri)	
Nephrology	
Neurosurgery	
Obstetrics/Gynecology (Ob/Gyn)	
Ophthalmology	
Oral Surgery	
Orthopedics (Ortho)	
Otolaryngology (Otolaryng)	
Pain Management/Interventional Pain Mgmt (Pain Mgmt)	
Pathology	
Positron Emission Tomography (Pet)	
Physical Therapy (Phys Ther)	
Plastic Surgery (Plast Surg)	
Podiatry	
Psychiatry (Psych)	
Pulmonary	
Radiation Therapy (Rad Ther)	
Single Photon Emission Computed Tomography (Spect)	
Urology	
Vascular	

Procedure added in 2017:

Disc arthroplasty

Procedures removed in 2017:

Tubal ligation/occlusion

Urological surgery

Percutaneous kyphoplasty

Pulmonary imaging

Hperthermia

Exhibit 27

Hospital CON Application, Table C

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories	1	

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement	N/A	
First Floor	N/A	
Second Floor	N/A	
Third Floor	10,700 SF	
Fourth Floor	N/A	
Average Square Feet	**10,700 SF**	
Perimeter in Linear Feet	**Linear Feet**	
Basement	N/A	
First Floor	N/A	
Second Floor	N/A	
Third Floor	492' - 3"	
Fourth Floor	N/A	
Total Linear Feet	**492' - 3"**	
Average Linear Feet	**492' - 3"**	
Wall Height (floor to eaves)	**Feet**	
Basement	N/A	
First Floor	N/A	
Second Floor	N/A	
Third Floor	16' - 6"	
Fourth Floor	N/A	
Average Wall Height	**16' - 6"**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	N/A	
Freight	N/A	
Sprinklers	**Square Feet Covered**	
Wet System	10,700 SF	
Dry System	N/A	
Other	**Describe Type**	
Type of HVAC System for proposed project	OR-AHU (CHW/HW) + Packaged RTU(DX/HW)	
Type of Exterior Walls for proposed project		

Exhibit 28

Hospital CON Application, Table E

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$ -	$ 3,210,000	$ 3,210,000
(2) Fixed Equipment	-	-	-
(3) Site and Infrastructure	-	-	-
(4) Architect/Engineering Fees	-	160,000	160,000
(5) Permits (Building, Utilities, Etc.)	-	9,630	9,630
SUBTOTAL	**$ -**	**$ 3,379,630**	**$ 3,379,630**
b. Renovations			
(1) Building	$ -	$ -	$ -
(2) Fixed Equipment (not included in construction)	-	-	-
(3) Architect/Engineering Fees	-	-	-
(4) Permits (Building, Utilities, Etc.)	-	-	-
SUBTOTAL	**$ -**	**$ -**	**$ -**
c. Other Capital Costs			
(1) Movable Equipment	$ -	$ 5,672,255	$ 5,672,255
(2) Contingency Allowance	-	283,613	283,613
(3) Gross interest during construction period	-	-	-
(4) Other (Lease buy-outs for current ROCs)	-	-	-
SUBTOTAL	**$ -**	**$ 5,955,868**	**$ 5,955,868**
TOTAL CURRENT CAPITAL COSTS	**$ -**	**$ 9,335,498**	**$ 9,335,498**
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$0**	**$9,335,498**	**$9,335,498**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$ -**	**$ -**	$ -
b. Bond Discount	-	-	-
c CON Application Assistance	-	-	
c1. Legal Fees	-	-	-
c2. Other - CON application review fee	-	57,200	57,200
d. Non-CON Consulting Fees	-	-	-
d1. Legal Fees	-	-	-
d2. Other (Specify/add rows if needed)	-	-	-
e. Debt Service Reserve Fund	-	-	-
f Other *(Specify/add rows if needed)*	-	-	-
SUBTOTAL	**$ -**	**$ 57,200**	**$ 57,200**
3. Working Capital Startup Costs			-
TOTAL USES OF FUNDS	**$ -**	**$ 9,392,698**	**$ 9,392,698**
B. Sources of Funds			
1. Cash	**$ -**	$ 9,392,698	$ 9,392,698
2. Philanthropy (to date and expected)	-	-	-
3. Authorized Bonds	-	-	-
4. Interest Income from bond proceeds listed in #3	-	-	-
5. Mortgage	-	-	-
6. Working Capital Loans	-	-	-
7. Grants or Appropriations			
a. Federal	-	-	-
b. State	-	-	-
c. Local	-	-	-
8. Other *(Specify/add rows if needed)*	-	-	-
TOTAL SOURCES OF FUNDS	**$ -**	**$ 9,392,698**	**$ 9,392,698**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land	$ -	included under building	$ -
2. Building	-	461,598	461,598
3. Major Movable Equipment	-	-	-
4. Minor Movable Equipment	-	-	-
5. Other *(Specify/add rows if needed)*	-	-	-

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease. **See Application Part II - Project Budget.**

Exhibit 29

CoreLogic MVS Benchmark Report

CoreLogic - SwiftEstimator
Commercial Estimator - Summary Report

General Information

Estimate ID:	PG ROC ASC R1	**Date Created:**	-9-2018
Property Owner:		**Date Updated:**	
Property Address:	2900 North Campus Way Glenarden, MD 20706	**Date Calculated:**	03-09-2018
Local Multiplier:		**Cost Data As Of:**	03-2018
Architects Fee:		**Report Date:**	using default

Section 1

Area	10700	**Overall Depreciation %**	
Stories in Section	1	**Physical Depreciation %**	
Stories in Building	3	**Functional Depreciation %**	
Shape	manual perimeter	**External Depreciation %**	
Perimeter	492		
Effective Age			

Occupancy Details

Occupancy	%	Class	Height	Quality
431 Outpatient Surgical Center	100	A	16.6	3.0
Occupancy Total Percentage	100			

Remark / Note Details

Remark Date :	03-09-2018	**Reference Date :**	03-09-2018
Note:			

Calculation Information (All Sections)

	Units	Unit Cost	Total Cost New	Less Depreciation	Total Cost Depreciated
Basic Structure					
Base Cost	10,700	$355.14	$3,799,998		$3,799,998
Exterior Walls	10,700	$39.04	$417,728		$417,728
Heating & Cooling	10,700	$47.18	$504,826		$504,826
Basic Structure Cost	**10,700**	**$441.36**	**$4,722,552**	**$0**	**$4,722,552**

Cost data by CoreLogic, Inc.

CoreLogic - SwiftEstimator
Commercial Estimator - Summary Report

General Information

Estimate ID:	PG ROC MOB	**Date Created:**	03-09-2018
Property Owner:		**Date Updated:**	03-09-2018
Property Address:	2900 North Campus Way Glenarden, MD 20706	**Date Calculated:**	03-11-2018
Local Multiplier:		**Cost Data As Of:**	03-2018
Architects Fee:		**Report Date:**	using default

Section 1

Area	10700	**Overall Depreciation %**	
Stories in Section	1	**Physical Depreciation %**	
Stories in Building	3	**Functional Depreciation %**	
Shape	manual perimeter	**External Depreciation %**	
Perimeter	492		
Effective Age	0		

Occupancy Details

Occupancy	%	Class	Height	Quality
341 Medical Office	100	A	16.6	3.0
Occupancy Total Percentage	100			

Calculation Information (All Sections)

	Units	Unit Cost	Total Cost New	Less Depreciation	Total Cost Depreciated
Basic Structure					
Base Cost	10,700	$187.50	$2,006,250		$2,006,250
Exterior Walls	10,700	$43.17	$461,919		$461,919
Heating & Cooling	10,700	$33.49	$358,343		$358,343
Basic Structure Cost	**10,700**	**$264.16**	**$2,826,512**	**$0**	**$2,826,512**

Cost data by CoreLogic, Inc.

Except for items and costs listed under “Addition Details,” this SwiftEstimator report has been produced utilizing current cost data and is in compliance with the Marshall & Swift Licensed User Certificate. This report authenticates the user as a current Marshall & Swift user.