PHYSICIANS SURGER CENTER OF FREDERICK: DOCKET #21-10-2451

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Introduction: Response to Comments from Interested Party Re: Docket # 21-10-2451

On July 9, 2021, Physicians Surgery Center of Frederick (PSCF) submitted application to the MHCC to add two additional operating rooms 81 Thomas Johnson Court, Suite B Frederick Maryland to support current caseloads and rapid growth of Orthopedic Surgical and other case volume. It is expected that expansion will comprise additional square footage as described in this application onto the adjacent lot so that the approved OR's and Procedure Room can be combined in one building on ground floor level. PSCF submitted application with information it believed answered the questions sufficiently in good faith to the best of its knowledge and abilities.

PSCF received a letter from FHH, as an Interested Party letter referencing specific areas of the application they felt required additional clarification. Based upon on our interpretation of the questions and objections in Document "interested Party Comments of Frederick Health Hospital, Inc. in opposition to Andochick Surgical Center LLC'S Application for Certificate of Need to increase Outpatient Operating Room Capacity in Frederick County, MD." PSCF submits it' response below.

PSCF goal is to provide the most outstanding surgical service to the community it serves, and all who enter here well into the future in a safe, convenient and comfortable setting. This does not exclude our respect and support of the FHH system to insure all in the community have access to affordable, high quality care in the safest settings possible. This has evolved from within our organization due to the surgeons and patient desire to have cases performed at our facility in a convenient location, an environment they enjoy and trust will provide the most efficient and safe outpatient surgical care to their patients. PSCF is proud of its positive patient outcomes and has enabled it to form a solid reputation of excellence within the community. In an effort to achieve its goal of providing the community with a modern state of the art facility deemed an Orthopedic Surgical Facility of Excellence for general/specialized orthopedic surgery, Upper Extremity/Hand Surgical Specialty in addition to Breast Cancer Surgical Care and Ophthalmic surgical services option all under one roof, additional space is needed to do so. We ask that you consider our petition for additional space (2 Operating Room) to make this possible, as growth cannot be sustained without expansion. We will

then be enabled to continue to provide highest quality, safe outpatient only care to those who require surgical services noted above with sufficient space to do so regardless of ability to pay.

PSCF would like to start with informing Interested Parties that PSCF believes it's relationship with FHH in the community, for many years, has been a collaborative, well established one that has supported the FHH healthcare system within a commons service area. It is not the intent of PSCF to change this relationship or create a negative impact on FHH and its surgical case volume. PSCF is simply experiencing significant independent growth of the services is provides. Cases not appropriate to the outpatient setting, or on the CMS Inpatient Only list are referred to the FHH by the same surgeons. Only outpatient cases will be scheduled and accepted at PSCF as determined through the PSCF preoperative screening process. PSCF has enjoyed a good relationship with FHH, and do not wish to make any changes that will negatively affect that relationship or the FHH caseload. The increase in volume at PSCF is physician driven due to their satisfaction with the environment, ease in scheduling, location, excellence in anesthesia services and clinical staff resulting in high quality surgical services to their patients. This has resulted in very high safety and satisfaction rates reflecting well upon the surgeons and their professional practices, which is of great value to them. We respectfully ask for your approval to do what PSCF does best in a more spacious environment and to meet the surgeons and patients' needs into the future.

Please see Exhibit 10: Letter to Mr. Chan from Scott E. Andochick, MD

Response to Comments from Interested Party Re: Docket # 21-10-2451

A. Interested Party Comments

I. Standard 05(a)(2)-Information Regarding Procedure Volume

PSCF Response:

This attachment regarding Approved procedures HST report CT6003 has been submitted to the MHCC with the initial application on July 9, 2021. I have attached the copy submitted at that time for review within the original application. PSCF is unsure why FHH could not view this document.

See Exhibit 1: HST Report CT 6300: Procedures

II. Standard 05(A)(3)-Charity Care

PSCF Response:

Please see attached summary of Charity Care for 2020 and 2021 demonstrating that PSCF has met and exceeded its commitment goal. PSCF takes pride in and remains committed to the continuance of this method of providing service to the underserved in the Frederick Community regardless of their ability to pay, well into the future on a continual basis. Sharing this mutual goal will benefit all, and the underserved with an alternative and more extensive outreach into the community we both serve.

See Exhibit 2: HST report ME 9006: Transaction Information for year 2020 and 2021: Charity Care.

III. Standard .05B(3) Need-Expansion of an Existing Facility

Interested Party Concern #1: Insufficiency of Volume Projections and basis for revenue projections: "Applicant does not provide any documentation to support 1143 cases per year in each new operating room. The Applicant does not provide any documentation to support these Projections:

PSCF Response:

See Exhibit 8: Addendum B adjusted for Dr. Steinberg move out of state.

Interested Party Concern #2:

There is no explanation of utilization hours or the nature of the case mix, which would aid in interpreting the true case utilization. (app. 29)

PSCF Response:

Current and projected case mix by surgeon is revealed on Page 30 of application and Addendum B documents. See attached updated attached document with specially demonstrating the "nature of case mix for each specialty on Exhibit 3a and b. as revealed as a percent of total cases per year.

See Exhibit 3a. and b.: Percent of cases by specialty as a part of total case volume by year.

See Exhibit 9: Additional Statistical History and Specialty

Interested Party Concern 3:

Table 1-2 however, does not indicated that current utilization is at optimal capacity, which is 2.0. Rather, it indicates that current utilization for the past two years has been less than 2.0 (2019 at 1.89 and 2020 at 1.63). the applicant provides a caseload number per surgeon from 2020-2025, but does not indicated specifically how the existing operating rooms, or the two proposed operating rooms, have been and will be utilized.

PSCF Response:

Case load for 2020 due to the center being closed a total of 60 days to insure patient and community safety when HVAC replaced (10 surgical days) and as mandated by the Governor of Maryland suspending Elective Surgery (50 surgical days). Estimated total case lost in 2020 is 529-summarized below. This resulted in a spike in growth of approximately 39% (artificial spike) compared to 2021 once the center was resumed to normal after the COVID closure and functioning five days a week, eight or more hours per day. Had those cases not been lost the comparison would be as follows:

Year 2020 Volume	**Year 2021 Volume**	**Percent Increase Adjusted**
2060	2865	
+529 lost		
	(Adjusted Incremental Cases 276)	
2589 cases	2865 cases	9.6% increase

(2019 historic numbers are more reflective of caseload increases compared to 2020, as there were no unplanned closures. This should be considered in reviewing caseload increases as 2020 incurred closures outside of its control and 1.6%. Utilization would have been on target for **2.0 Optimal Capacity or: 1.7 full** prior to closures and adjusted turn around time as requested by FHH which will be addressed below.

The hospital recently closed its operating rooms for elective surgery once again in 2022 due to COVID. PSCF is seeing an increase in case load to assist in accommodating outpatient appropriate only patients' needs that the surgeon had to place at FHH due to lack of room at PSCF. PSCF will extend its hours to insure patients do not incur long wait times to have their issues surgically resolved. Therefore, this supports the premise that the PSCF projections are conservative due to surges in case load for various reasons paired with steady ongoing growth unrelated to any surge. The COVID surge of cases from FHH are patients that would have been scheduled at PSCF if there had originally been room available. Due to FHH closures, additional OR time through extended days has made it possible for PSCF to perform some those cases. This is one way PSCF "draws cases from FHH", but had there been room at PSCF, they would not have been scheduled there in the first place and not considered a draw.

FHH refers to page 53 of the PSCF CON application stating the facility projects that it will experience an increase in total joint replacements of up to 200 per year by 2025 and expresses concern. It failed to mention that if PSCF had the OR availability, these cases would have been posted at PSCF in the first place as the surgeons performing them want to bring them to this facility, not FHH. Individual surgeons can attest to this fact upon request. FHH has been moving in a direction that pushes many cases to the ASC setting (example: Cataract Ophth/Oral Surgery), and the ones that the PSCF surgeons have seen in their offices typically bring them to PSCF. They work diligently to fill their OR time at PSCF with their outpatient appropriate patients. As their own patient volume increases, so will the number of their outpatient cases. Some will be sent to FHH because there is not enough OR time at PSCF. With FHH pushing cases to ASC's, our surgeons are finding it more difficult to schedule cases at either location, or wait times are extending. The cases belong to the surgeon and their patient, and not a facility. It is their decision to direct their

care. Therefore, those cases should not be considered "being drawn from FHH" if the surgeon is unable to fit them on the PSCF schedule, their original choice. It is actually FHH that has benefited and not PSCF. It must also account for when there is open OR time, many are not suitable for outpatient surgery, and those cases will be sent to FHH by the same surgeons. The PSCF surgeons simply want freedom to pick their site of choice along with their patients for convenience and safety. They have maintained their first choice is PSCF if patient is a candidate for outpatient services, and can attest to that statement upon request. Patients experience less wait time, turn over time is efficient, surgical schedule runs on time, more cases can be performed on a daily basis in less time than at FHH, and it is a physician friendly and patient centric environment with pleasant high quality staff resulting in excellent outcomes. Therefore, through extended hours, or when PSCF has additional OR space it will continue to grow its case volume. Those patients will not be drawn from FHH because they were scheduled at the point of care originally planned for. PSCF believes that 200 joint replacements per year among the number of surgeons performing those procedures at PSCF is small compared to the number that will be referred to and performed at FHH by the same surgeons. Some of those total joints will be performed by the Montgomery County surgeons that will not affect FHH, except potentially in a positive manner. PSCF surgeons are not employees of FHH yet are a strong patient referral system to FHH. Again, these cases will be scheduled at PSCF if appropriate candidates first, and then to FHH if no space is available or are inpatient only. This is exclusively for the benefit of the patient and has no reflection on the site of care as long as the patient is well taken care of. PSCF continues to believe the impact will be minimal or positive for FHH keeping in mind they have other hospitals to refer to.

See Exhibit 4: Table 1-2 (Original Table)

Definition Clarification: Based upon PSCF understanding of this assessment Cases performed in Exhibit 4 **are** at **Optimal Capacity as defined in COMAR 10.24.11** which **is** revealed for this year and, in good faith has been reported it meets the description as defined in COMAR 10.24.11 (iii) (see below) for the current two operating rooms at PSCF.

"Definition: COMAR 10.24.11

(a) A dedicated **inpatient** general-purpose operating room or mixed-use general-purpose operating room:
(i) Has full capacity use of **2,375** hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases; and

(ii) Has an optimal capacity of 80 percent of full capacity, which is **1,900** hours per year and includes the time during which surgical procedures are being performed and room turnaround time between surgical cases.

(b) A dedicated **outpatient** general-purpose operating room: (i) Is expected to be used for a minimum 255 days per year, eight hours per day;
(ii) **Has full capacity use of 2,040** hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases; and
(iii) **Has optimal capacity of 80 percent of full capacity, which is 1,632** hours per year and includes the time during which surgical procedures are being performed and room turnaround time between surgical cases, unless an applicant demonstrates that a different optimal capacity standard is applicable based on:
1. The ability of the ambulatory surgical facility or the hospital to maintain patient safety and quality of care at the proposed optimal capacity standard; and
2. An analysis of the cost-per-case of operating at a range of utilization levels that includes the applicant's proposed optimal capacity standard, the standard described in §A(1)(b)(iii) of this regulation, and utilization levels between these two standards, and that explains the basis of each assumption used in the analysis; or
3. An analysis of the benefits and costs for patients served by each surgeon operating at a proposed ambulatory surgical facility and the benefits and costs for each surgeon when the ambulatory surgical facility operates at the utilization level described in §A(1)(b)(iii) of this regulation and at the applicant's proposed optimal capacity standard; and the cost per case at both the applicant's proposed optimal capacity standard and the standard described in §A(1)(b)(iii) of this regulation, as well as the cost per case at utilization levels between these two standards; all assumptions used in these analyses shall be explained. "

PSCF Response continued:

As previously addressed, the facility was closed the last two weeks of February 2020 for installation of a new updated HVAC system, cases did not commence until all testing, and approvals were acquired. All were rescheduled or sent to FHH. FHH benefited. Additionally, the COVID 19 pandemic became an issue for the ASC industry and state directives by Governor Hogan regarding elective surgeries significantly influenced case volume until they were approved for reinstatement in June of 2020. All state recommendations were followed and patient/community safety insured. Respectively, the center estimates a total number of cases lost due to the HVAC replacement and COVID 19 closures was 529. The center was closed for 60 days in 2020 through no fault of its own due to unanticipated events:

*February two week closure: case loss for HVAC Replacement: 126 cases lost

*COVID Closure for elective cases due to state of Emergency Directives. All cases that were on the schedule and cancelled from March 23, 2020 to June 1, 2020. This must be taken into consideration when evaluating the transient decline in cases for 2020 due to reasons out of the

organizations control and in compliance with all regulatory bodies and the law. This resulted in a significant increase in total cases per year between 2020 and 2021. The actual increase would likely have been approximately 9.6% and not the 39% due to uncontrollable external events.

March case volume loss: 54

April case volume loss: 200

May Case volume loss: 149

Total estimated case volume loss for 2020: **529 cases** (estimated case volume for 2020: 2589)

Had these events not occurred the estimated case load for 2020 is 2589, utilizing 3667 hours of OR time. Thus, requiring 1.79 OR's for full capacity or 2.2 OR's for Optimal capacity to meet caseload need in a safe environment. This demonstrates the current two operating rooms are **"optimally"** utilized and can be considered at **"full capacity"** depending on the actual cases that would have been performed should the closures not have taken place. These figures are based upon the 25-minute turn around time included before the first case and after the last. Exhibit 5 demonstrates figures after turn around time before and after is removed.

Interested Party Concern 4:

"This needs assessment includes historic and projected trends in the demand for specific types of surgery among the population in the proposed service area. There is no specific data or discussion of historic or projected trends for specific types of surgery in Frederick County."

PSCF Response:

PSCF has revealed its historic trends and future projections in Exhibit 3 a. & b. attached.

EXHIBIT 3a & b.: Updated information table of case mix by specialty as a percentage of overall volume per year.

PSCF is projecting its own anticipated utilization and presented in the application p. 30. While it is helpful to see trends for Frederick County, a significant portion of our growth will be from Montgomery County as three new surgeons from that area join the PSCF partnership in an

effort to meet the needs of their growing patient population close to the Frederick County line. Therefore, PSCF chose to work with the information provided by the new surgeons and current ones. PSCF growth is from within, independent of Frederick community growth and considered "home grown". PSCF would like to keep surgeons in Frederick County. Should additional more specific information is needed it can be provided upon request. PSCF requests additional clarification on this request.

Exhibit 6: National and Regional Projections of Supply and Demand for Surgical Specialty Practitioners 2013-2025.

Interested Party Concern 5:

Standard .05B(3)(c)(ii): requires need assessment address time for surgical cases historically by specialty or operating category. (App. P. 30, Table 1-2). Not only is it impossible to determine how the Applicant has been utilizing its existing two operating rooms, it is impossible to know how the applicant plans on utilizing the two additional operating rooms it requests because there is insufficient data in the application regarding the quantity of types of procedures in their projections.

PSCF Response:

***Please see Exhibit 3a. & b.*: Historic percent case mix as a percent of total cases historic and projected up through year 2025.**

Interested Party Concern 6:

Standard .05B(3)(c)(iii) requires data on projected cases to be performed in each proposed additional operating room. Neither table 1-2, nor its vague accompanying description, adequately address the standard. There is insufficient data on the types of projected cases performed in each of the additional operating rooms requested, and virtually nothing to substantiate the projections.

PSCF Response:

PSCF has provided multiple explanations of the main specialty of increased case load, specifically orthopedic surgery. There will be growth in orthopedic hand and upper extremity

surgical procedures due to new surgeon increasing case load, general orthopedic surgery due to recruitment of three prolific orthopedic surgeons from Montgomery County who will perform shoulder, knee and hip surgery to include joint replacements at PSCF. Additional growth will be from increasing caseload by orthopedic surgeons who are current partners, and the addition of two additional surgeons credentialed at the facility. All of who will absorb Dr. Steinberg's cases when he moves out of the state as directed by the MMI Exit plan.

PSCF did not include potential cases that will come to the facility from additional partners of the Montgomery County surgeons interested in bringing cases to the center when expansion is approved. This cannot be measured at this time but will add significantly to overall case volume.

See Exhibit 5: Revised Table 1-2

See Exhibit 3a. & b.: Surgical specialty by percent of total case volume

See Exhibit 8: Addendum B for each surgeon supporting case projections

See attachment Exhibit 6: Information regarding surgical specialty growth Montgomery and Frederick County.

IV. **Standard 0.5B(8) Financial Feasibility:**

Interested Party Concern 7:

There is no specific response by Applicant to demonstrate that the Project will be financially feasible. (App. P. 36) The applicant fails to specify that it meets the required elements outlined in Standard .05B(8)(a)(i) through (iv) or to provide a statement concerning the assumptions used to develop Applicants Projections.

PSCF Response:

See Exhibit 7: Statement by PSCF Accounting Team regarding table 3 and 4.

See Exhibit 8: Addendum B (All of Dr. Steinberg's cases will be absorbed by MMI partners and can be attested to by the Surgeons and MMI Management)

need.

EXHIBIT 5: Updated table 1-2

V. **Standard .05B(9) Impact: (App pg. 36):**

The anticipated percent of growth does not exclusively include the existing PSCF credentialed orthopedic surgeons. Three new orthopedic surgeons are in the process of becoming partners at PSCF, and will add a significant increase in our outpatient orthopedic case volume. Two additional orthopedic surgeons affiliated with PSCF have been increasing numbers of their cases at PSCF. Additionally, an Upper Extremity Orthopedic joined PSCF in 2020 and has seen a rapid increase in volume. Their overall case volume is growing and strong. Therefore, PSCF projections may be considered conservative. These cases will have no impact on FHH except a positive one. PSCF believes this growth will be sustained by present and future surgeons. (Interested Party does not address the three new orthopedic surgeons from Montgomery County in their assessment who will perform total joint replacements that will not draw from FHH).

VI. Turn Around Times:

FHH assumes that the turnaround time for the case projections is incorrect. However, PSCF takes into consideration set up time in the morning and tear down time, cleaning and preparation for the next day in the afternoon. This is time the OR's could be utilized for surgery. PSCF does not have turn around teams and each individual licensed practitioner assists in the process. Safety and quality is prioritized and the works diligently to insure compliance. One must also be aware that turn over time can be more complex and timely for more complicated cases. Turn over average is 25 minutes based on history of performed cases. Projected cases are increasing in complexity and will require additional time, but not used adjusted upward for purposes of this report. This must be taken into consideration when determining

Table A: The increase in projected cases for 2021 is 39% due to:

1. HVAC replacement: Closed last two weeks for installation, testing and approval to resume cases.

2. Closed for Elective cases due to the Governors Mandate and PSCF compliance with the guideline resulted in lost case volume. Closure Marh 23, 2020 to June 1, 2020.
3. Consistent increase in 2021 case volume

A large segment of 2020 volume was lost/deferred due to the closures related to HVAC and COVID. Projections for 2021 was established with the information provided by the surgeons, knowing that there would be an influx of cases that had been a.) Closure postponed/rescheduled, and b.) Increase in the number of surgeons bringing cases to the facility. Specifically Orthopedic cases. PSCF does not rely exclusively on Dr. Steinberg for case volume. The original projections for 2021 were only partially attributable to Dr. Steinberg, and the increase by other partner arthropods, partners and new orthopedic surgeons. Case volume was expected to increase significantly in 2021 that resulted in a 39% increase over 2020(a year impacted by closures). If cases had not been lost in 2020, the cases volume may have been 5289. Therefore, an adjusted increase in cases from 2020 through 2021 is estimated at 9.5%.

The loss of Dr. Steinberg to the Frederick community will take place in July of 2022. The President of MMI and Dr. Steinberg have attested to the fact that an exit strategy is in progress to insure all of his cases remain in the Frederick Community and are absorbed by his Colleague Peers at MMI as previously addressed. In Exhibit 5 case and time projections will are adjusted as follows: No adjustment is indicated for Dr. Steinberg caseload due to the MMI exit plan, nor because of CMS Inpatient List reversals, as previously explained. Only turnaround time adjustments will be made as requested with the understanding that time before and after first and last case is tangible OR time that could be used in an ambulatory surgery center.

Indeed, Dr. Steinberg has been established in Frederick for many years. He has nurtured, mentored, fully proctored and worked directly with all of his partners (continues to do so) to insure that he is easily replaced and that the void he will leave behind is immediately filled by his competent partners. He has committed to making the transition smooth and comprehensive to insure all cases remain within MMI of Frederick County. His intentions are to leave his practice in very good shape and includes caseloads referred to him by Dr. Grandia, which can be attested for by the two surgeons. He indicates Frederick County patients will be left in good hands. He has expressed great pride in passing the torch to his capable partners and is willing to attest to this fact. FHH is correct in stating that he will be

missed by all of the partners at PSCF, MMI and the community, but believes his shoes will be filled with like competence as mentored by himself.

In addition to the above, FHH will hire new surgeons into the community to meet their increasing demand for orthopedic services as some of their surgeons have moved on as well. That will be for them to address. Those surgeons will be new to the community and I am sure they will also find suitable replacements. In regards to MMI, the surgeons will have a team of Peers to monitor quality, safety and satisfaction moving forward. This enables MMI and PSCF to meet their Mission and Goals without disruption. PSCF does not believe that case volume will be negatively impacted by Dr. Steinberg leaving because of the redistribution of his cases to MMI partners through a well-developed exit strategy, and other new (unaffiliated) surgeons joining PSCF from Montgomery County requesting privileges when expansion has taken place. These are just a couple facts supporting PSCF future case projections. As previously addressed three orthopedic surgeons from Montgomery County entering partnership with PSCF and anticipate more in the future once OR space is expanded. This is an effort PSCF is aggressively pursuing to insure an influx of cases to Frederick County to meet their needs, and prevent cases moving out of Frederick County. We have invited them to Frederick instead! This is more convenient option for their patients and increases access to orthopedic surgery in Frederick County. These three surgeons have informed PSCF their large practice has other partners in the group planning to bring cases to PSCF when space is available adding additional volume in the future not included in the projections.

FHH assumes in this section that PSCF will lose cases because of reversals in CMS Inpatient Only list as a focus of its position on PSC not being able to perform approximately 228 procedures due to safety concerns. However, they did not specify which cases would be affected. PSCF will assume they refer to shoulder replacement, ankle reconstructions. **The only** Medicare cases that will be performed at PSCF are the ones Medicare approves for outpatient surgery. PSCF monitors and adjusts annually to comply with the CMS Inpatient Only list directives. Our application indicates that very few of these cases will be drawn from FHH for that reason. This poses no threat to the FHH case volume. PSCF does not plan to perform Medicare cases that CMS does not approve for care and reimbursement in the ASC setting due to safety concerns and dedication to compliance. PSCF agrees with CMS Inpatient Only list for 2022 and will never compromise safety of the community it serves. Only cases that are approved, and or are approved by Medicare (or other insurance companies) will be performed **after confirming they are appropriate to the outpatient setting** and their needs can be

met in the safest high quality care arena possible. Therefore, we did not include numbers for those cases in our projections. PSCF reiterates it does not include any of these CMS inpatient only cases in its case projections for Medicare patients, and will not affect volume projections already submitted to the MHCC. It will have minimal impact on FHH for the same reasons stated in their Interested Party Statement regarding CMS Inpatient Approved list. If they had been approved, PSCF still did include those projections in our volume for the future, as most are not appropriate candidates for the Outpatient setting due to many having multiple Co-morbidities and are very small in number.

PSCF is not counting on Cases that are on the CMS Inpatient Only List. PSCF will only provide services to Out Patient Appropriate population, thoroughly screened for appropriateness in the ASC. We do not perform Medicare In Patient Only CPT 23472, or Medicare Inpatient only CPT 27702 cases for many reasons. Medicare does not permit these cases in an ASC and will not reimburse. They are typically acute injuries, not healthy enough for the ASC, lack appropriate home care and needed resources for positive outcomes after discharge to home. PSCF has performed very few CPT 23472 procedures over two years. All of which were appropriate for outpatient care and screened thoroughly to confirm and approved by the patients commercial payer and reimbursed One was performed in 2020 during the hospital OR closure due to COVID. It was provided as Community Charity Care procedure due to patient having no other place to go for care in Frederick at that time and experiencing excessive pain and distress preoperatively making a long wait difficult. Patient declined care elsewhere. All of the patients experienced excellent outcomes and no complications. None drawn from FHH. This procedure is very low volume at our facility and not relied upon for case projections. Code 27702 has not been performed at PSCF. PSCF did not utilize a consulting team in formulating projections, and the application has been developed based upon knowledge of the PSCF business, historic trends, and the partners input and increasing volume, in good faith to the best of its knowledge. If further clarifications are needed regarding the CMS Inpatient Only List, they are welcomed to be submitted upon request.

FHH assumes all joint replacement will come from their facility. This is not the case. Many new cases will be performed by the Montgomery County Surgical Team of Surgeons. Only cases that are seen at the MMI office first, and deemed appropriate for the outpatient setting through patient selection by the surgeon will be scheduled directly to PSCF and not drawn from FHH. The small number that may move from FHH are those that would originally have been performed at PSCF, but due to lack of operating room space to meet the surgeons and patient's needs prohibited this

from taking place, and the case was lost to FHH (not the other way around as FHH predicts). PSCF does not perform **acute** joint replacements because of urgent fractures, falls, trauma or other injuries. These patients are unsuitable for the outpatient setting and need more comprehensive care to insure safety. Furthermore, PSCF patients recover very well in their familiar home setting, are provided extensive preoperative education and discharge planning through the PSCF Nurse Navigation team and prompt follow up at home.

VII. CMAR 10.24.01.08G(3)(b). Need

PSCF Response:

Updated Addendum B documents: submitted to the MHCC on January 7, 2021 are presented in PSCF Response below. PSCF stands by its case projections and are supported by updated Addendum B for each surgeon, Original and Updated Table 1-2 in Exhibit 4 and 5 and Statistical History per specialty noted below and in Exhibit 3a. and 3b for example of case mix by specialty.

EXHIBIT 8: See attached Addendum B Documents reported to the MHCC for each surgeon

EXHIBIT 4: Original Table 1-2

EXHIBIT 5: Updated Table 1-2 with adjusted turn around times

EXHIBIT 3a. and 3.b: Case and specialty mix

The above figures have been adjusted to remove 25 minutes prior to first case and 25 minutes after last case. However, adjustments are not made to reflect Dr. Steinberg's absence in 2022 due the comprehensive Exit Plan previously addressed and in Place. PSCF is experiencing this exit strategy now and case volume continues to rise. Total number of cases in not anticipated to decline as a result of the well thought out and executed MMI Exit plan for Dr. Stienberg.

EXHIBIT 8: Updated Addendum B submitted to MHCC January 7, 2022

PSCF did not rely on CMS Inpatient only cases when formulating caseloads as the center does to perform cases on those patients at any given time. This has been addressed multiple times. When CMS does make changes, it is not anticipated to impact projections, and caseload shifted to PSCF will be minimal. This will again, will have minimal

negative impact on FHH. When asked on Addendum B where cases may come from, PSCF answered honestly indicating "the most likely scenario may be FHH" as it is the only hospital nearby. However, that is speculative and not measurable at this time.

PSCF has adjusted the turn over time noted above in the original table 1-2 (see Exhibit 4 original table and Exhibit 5 adjusted table with Optimal and Full Capacity assessments based on conservative projections previously addressed). However, PSCF requests that MHCC takes into consideration that the facility closes after hours and must have OR time dedicated to the safe high level disinfection, set up and preparation of the OR each morning to insure high quality safe patient care. Additionally at end of day tear down, high level disinfect and prepare for next morning therefore by the clinical team resulting in the necessary use of valuable OR time and staffing resources. PSCF places the highest value on any OR time that could otherwise be used for patient care.

PSCF stands by its volume projections and is confident the fourth operating room, if granted will be at Optimal or Full Capacity on or **before** 2025. All of the surgeons credentialed at PSCF are independent practitioners and choose to bring the cases drawn to their highly respected practice primarily at PSCF. They hold credentialed status at multiple sites in Frederick and have choices. They are self-directed and able to choose the preferred point of care for their patients. This reflects the regard for high quality, safe patient centric care provided at PSCF in an environment that is welcoming and supportive of all physicians, patients and staff. This is what they seek for their patients and themselves for an enjoyable and efficient experience. This experience is a positive reflection of the care they provide, a testament to their patient care plan and their practice/reputation. It is an accomplishment PSCF is proud of and wishes to experience continued growth so the community has a center of excellence to access for outpatient surgical care. We contend that in order to do so, additional space is necessary.

VII. COMAR 10.24.01.08G(3)(c): Availability or More Cost Effective Alternatives

PSCF Response:

1. PSCF, in respect of the FHH, does not plan to draw significant cases from the hospital. This is surgeon preference and surgeon/patient driven. PSCF provides a convenient location and safe and cost effective alternative for their patient care.
2. PSCF is within the same growing demographic area as FHH, and both should see like increases in caseload.
3. PSCF will also see increase in case load that will have no impact on the Frederick Community as addressed in the new partnering surgeons from Montgomery County. Those surgeons will assist FHH in retaining many patients in Frederick Community, and support growth. Some will be also be drawn from other locations that do not negatively affect FHH. This increase is expected to promote retention and confidence in care received in Frederick County. This will benefit both PSCF and FHH healthcare system in a positive manner.
4. Ambulatory surgery centers are reputed organizations known to contain costs, and provide efficient high quality care in a safe setting. PSCF utilizes the same Anesthesia group FHH uses to administer high quality anesthesia services, and several of the same surgeons at a reduced cost to the community. PSCF surgeons are not employed by FHH. PSCF has an outreach plan/program in place to continue offering Charity Care to persons in need to promote access to all. The decision to have a patient receive care at PSCF is between the surgeon, patient and their insurance carrier. PSCF provides the location, safe environment, quality staffing and anesthesia services for all who wish to be treated by our organization. It has developed into an attractive choice located in Frederick with a very strong reputation of excellence.
5. PSCF works with vendors and Insurance carriers to promote the most productive, safe and cost effective surgical care without compromise to quality. This is done on a continual basis.

   This enables PSCF to keep overhead down, equipment/supply costs streamlined and physician buy in strong to contain waste. Flexible and intelligent scheduling of services assists in minimizing duplication of supplies, equipment and staff to work most efficiently on a daily basis. Consistent staffing minimizes the cost of turn over and promotes smooth surgical schedule flow, physician and patient satisfaction. The ongoing education and training program is strong and well-developed promoting staff excellence among all of the care providers. High quality care minimizes complications and infections thus assisting the overall healthcare industry in cost

containment through excellent patient outcomes. PSCF manages cost, promotes quality and with surgeons assisting in the process insures the highest quality care possible at a reasonable cost.

6. PSCF stands by its projections and with the current growth, expressed interest by other surgical providers, and increasing complexity of cases feels confident it will meet Optimal to Full Capacity on or before 2025. We do not believe the projections are calculated on incorrect assumptions as FHH stipulates and a plan is in place to maintain the volume. FHH is not fully aware of PSCF relationships and surgeon commitments being anything other than what we have stated in good faith. Anything to the contrary is speculation by FHH.

All projections submitted are in good faith and concluded to the best of our knowledge and abilities at this time. PSCF respectfully requests the MHCC consider granting the CON for two additional operating rooms to provide the community a more spacious environment, and an Orthopedic Surgical Center of Excellence well into the future to benefit all who reside in our service area. We would also like to continue a mutually strong and supportive relationship with FHH to the benefit of all patients at both facilities.

Regarding COMAR 10.24.11. 08G(3)(b)

FHH did not contact PSCF to inquire if existing capacity at PSCF existed to support its growth future needs. FHH does not communicate directly with PSCF unless initiated. PSCF did evaluate FHH via the MHCC and public state reporting web sites assuming they hold accurately reported information.

PSCF did not contact FHH regarding their opinion on capacity estimations because the organization is able to do so in collaboration with its own providers, growth in the community and volume growth PSCF is experiencing from Montgomery County. PSF did review published in formation regarding the FHH capacity, but it is inconsistent due to recent trends in the Pandemic and closures of their Operating rooms etc. Additionally FHH reimbursement process does not align with PSCF as an independent organization, and could not be equally compared without prejudice. PSCF utilizes global billing process and accepts whatever the payer reimburses regardless of how much is paid. Consistency in surgical cases enables group purchasing that is streamlined to meet practitioner's needs without waste, and staffing stability assists in the same manner due to frequency of

cases and staff familiarity. Overhead is less costly due to hours of operation and add to the overall ability to contain cost among many other factors.

PSCF does not provide the "cheapest care" and does not claim to be the cheapest provider. It is committed to providing excellent surgical care to the entire community regardless of ability to pay in a comfortable environment while committing to and evaluating cost containment on a continuum. PSCF claims it provides a cost effective alternative for outpatient surgery services that meets all Medicare and AAAHC criteria. It possesses a very solid record of quality, safety and satisfaction (patient, surgeon and staff). It prides itself in being a benefit to the community as reflected in patient satisfaction questionnaires, and is often preferred to the inpatient setting by many of the patients, especially during the time of the Pandemic. PSCF enjoys a very low infection and complication rate, and works diligently to maintain that record. Offering this alternative does not mean these patients will never use the hospital again. There is no evidence indicating they have been lost to the Hospital service throughout their lifetime. PSCF maintains a hospital transfer agreement on a continual basis insuring that any **rare** transfer is sent to their FHH facility exclusively.

PSCF employs a Patient Care Coordinator who exclusively provides pre-surgical screening and education. The PSCF Nurse Navigator provides discharge planning education and training to insure safety and positive outcome at home postoperatively. Discharge planning is documented in the patient's record, and patients are followed up with postoperatively to insure compliance and to mitigate unanticipated patient concerns. Therefore, PSCF will continue to collaborate with FHH without reservation to provide the highest quality care Frederick County has to offer.

PSCF possesses dedicated and high quality staff in ample numbers to provide safe, secure and quality care on a continual basis. All are Registered Nurses with the state of Maryland, Surgical Technicians, MA's and a solid base in the business office. They are highly trained and long term employees. Perpetual training requirements are in place and maintained on a continual basis. Competencies are evaluated annually and as needed. Staffing to patient ratio is primarily 1:1 and 1:2 depending on case mix and location of the patient within the facility during their visit (ex. Pre-Op) to meet the needs of patients and their families. Our staff are well experienced in the outpatient setting and perform at a very "high caliber". All are trained in emergency response

care/mitigation, Malignant Hyperthermia, Difficult Airway Management, Arrhythmia and EKG interpretation and safe transfer of patient should the rare event occur. RN's are ACLS, BLS and PALS certified and technicians are BLS certified. Many are originally hospital trained but not exclusively by FHH. Staff originated in various locations throughout the country,

PSCF possesses high quality patient outcomes as reflected in its consistently very low infection rate, complication and transfer rate. PSCF acknowledges FHH ability to manage higher complexity cases, those of which are not candidates for the outpatient setting, and screens them pre-operatively so they do not become patients at PSCF. This is a first line of safety activity at PSCF in the best interest of every patient. Therefore, patients are placed at the facility that will meet their individual needs and competition with FHH for patients is ultimately nonexistent. All patients determined not to meet outpatient medical assessment screening criteria are referred back to the surgeon to be scheduled at FHH.

VIII. COMAR 10.24.01G(3)(d): Viability of the Proposal

FHH states that an integrated hospital owned ASC could be part of an integrated care delivery model. This may be true, but PSCF believes this should already be in place presently with Frederick Surgical Center, which is affiliated with FHH. PSCF surgeons have access to FHH at their choosing. PSCF surgeons value their relationship with FHH for their inpatient care and plan to continue this relationship. However, a partnership is exclusively the Physician Partner/Owner decision if it becomes of interest in the future. This was not a topic discussed with PSCF when the planning was initiated, it came much later from FHH. The current model remains their preference. PSCF's Management and Governance model is hands on with every partner contributing, efficient and inclusive in decision making, problem solving, strategizing and developing long-term goals for the organizations best interest. One of the qualities PSCF utilizes to maintain its quality and continued success is to always remain open to assessing value of suggestion/recommendations for improvement that will best meet their patient's needs. That can include alternative directions/strategies to be evaluated, including an alignment strategy. If that were the case, patients theoretically shifted from FHH to PSCF as a result, the need for two additional rooms will be further justified to meet those needs of increased patient volume. It cannot be confirmed a union of some form will reduce costs to the community without a comparative analysis. PSCF

contends it can provide the safest high quality care possible in a pleasant, efficient and patient centric environment at a reduced cost until it can be otherwise proven by FHH.

FHH states that there may be a question regarding community support of its expansion. This has been observed through patient satisfaction reports, surgeon testimonials, and extensive spread of our sound reputation, increased charity care and outreach among others. It is acknowledged that FHH is a strong support system along with PSCF. This is most recently exemplified in the activities regarding the Pandemic and PSCF involvement with Central Command offering any assistance needed. PSCF is ready and willing to contribute. PSCF submits notice annually to inform the county that it is available to them, for any issue they may need assistance with (staff, equipment, medications etc.) to assist in maintaining a strong healthcare safety net for all. This will minimize any hardship or strain on the system at any time.

PSCF is not aware it must obtain a letter of support from FHH. We have always assumed that as a key stakeholder in the community's healthcare net, FHH would never turn its back to any component/member of that community plan. This includes PSCF. PSCF will maintain its readiness and support of the community in any fashion that will support FHH and the community at large. PSCF does not object to submitting a request for a letter of support upon request of the MHCC.

VIV: COMAR 10.24.01G(3)(f): Impact on Existing Providers and Health Care Delivery Systems:

Patient Shift:

PSCF Response:

From FHH to PSCF: Unable to measure: PSCF case volume is patient/surgeon driven choice. Its impact on caseload at FHH in good faith is Minimal. We do not feel we pose a threat to FHH, but prefer to meet the needs of our surgeons and patients as the priority. All surgeons and patients have the right to choose where they go for their healthcare in a free market. PSCF does not target FHH case load to be deferred to our surgery center. We emphasize patient choice when pre-operatively screen our patients, and at time of admission to the facility. We inform them they have alternate sites of care to choose from, including FHH as their surgeon is credentialed there also. We inform patients they have the right to self-direct their healthcare at all times and can discuss these options at any time prior to commencement of their surgery. Our goal is to provide ample space for

outstanding Orthopedic, Ophthalmic and Breast Cancer surgical care well into the future It is not our goal to negatively impact the simultaneously growing FHH community health system. Therefore, a patient volume count that may be drawn from FHH is not predictable at this time, and we choose not to speculate on something that cannot yet be measured and provide an artificial figure.

EXHIBIT 8: ADDENDUM B For projected case counts

Case Mix:

PSCF Response:

FHH assumes that the PSCF surgeon partners wish to take many of their outpatient appropriate cases to FHH. While this may be the case for their inpatient care, their primary preference is PSCF due to the ease in scheduling, ability to be more productive, staff quality, familiarity, and access to resources, safety and satisfaction in a pleasant setting. The specific patients referred to as being more complex and less reimbursable is a little misleading as those patients are **not candidates** for an outpatient setting. PSCF provides care to any patient regardless of their ability to pay and is committed to continuing that focus on the community it serves. The organizations partners support this process. Many of the patients (complex and less reimbursable) may have comorbidities warranting inpatient care and, are scheduled at FHH for their safety. They will be no shift to PSCF. Some of the surgeons outpatient candidates are scheduled at FHH when there is NO room at PSCF during their block time resulting in the patient experiencing a long waiting period. These patients are originally planned to be performed at PSCF, but could not get on the schedule due to lack of OR time. They should not be considered drawn from FHH as they are deferred from PSCF and sent to FHH. The patient and surgeon wish to come to PSCF for the reasons noted above in addition to customized care, short wait times, convenience, prompt return to their homes to recover. This will be minimized with more space. Patient inconvenience, exposure to the hospital setting, and wait time will decrease if the PSCF request for additional OR space be granted. PSCF offers an increase in quality of care for the community.

PSCF is forming partnership with three surgeons from Montgomery County. FHH did not seem to account for their case volume in projections when assuming the PSCF concluded them on incorrect assumptions. The

main focus was Dr. Steinberg leaving and unaware of a solid exit strategy being put into place. PSCF contends the total volume may be conservative as these surgeons have additional partners interested in bringing cases to the facility when enlarged and more operating room time is available. This supports our assumption of Optimal to Full capacity on or before 2025. Should our request for two additional operating rooms be blocked by FHH, it cannot be predicted if the new surgeons will continue to assist in keeping patients in Frederick County, but let them receive care elsewhere in Maryland in a more inconvenient location outside of Frederick.

The impact on FHH will be positive as these surgeons may bring cases to their facility also. It will assist in keeping orthopedic patients within Frederick County and in the fold of the FHH healthcare system. That is one goal PSCF has to offer and believes it can be mutually beneficial with FHH. There will be no negative impact to FHH by these surgeons, only a positive impact is additional space is made possible. The Montgomery County Surgeons may play a role that will benefit FHH as an additional source of inpatient referrals.

Case Mix:

PSCF Response:

PSCF case mix is consistently 67-70% orthopedic surgery. These procedures have the potential to increase significantly once additional OR space is obtained. PSCF will continue to serve all patients regardless of their ability to pay. Percent case mix will not change with the exception of orthopedic services due to continued increasing number of orthopedic surgeons joining the partnership. It will be helpful for FHH to be more specific on the cases they believe PSCF will reject, and further clarification can be provided as indicated.

Staffing:

PSCF actively recruits staff on a continual basis through word of mouth referrals, advertisements, Maryland Ambulatory Surgery Association, Baltimore Nurse Group, Surgeon Recommendation, and distance recruiting. PSCF is not currently experiencing a staffing shortage in spite of the COVID pandemic. PSCF possesses a large base of full time seasoned, highly skilled nurses. The daily schedule and patient safety needs has not been negatively impacted due to the number of staff on payroll, PRN and part time staff to support the full time team. Many FHH staff have reached out to PSCF for employment; unfortunately, most were not hired due to non-match qualifications and stability of our current workforce (no vacancies). We have experienced small number

resignations for those staff wishing to gain temporary financial benefits in areas that are paying very high wages in COVID dominant facilities. This is minor compared to other local organizations. Others, have left those same facilities seeking work in ASC's like PSCF. Many staff that have left PSCF have consistently returned later. PSCF has benefited from this and has a very stable staff base at this time. PSCF does not have problem recruiting high quality staff. PSCF turnover is low.

Retirement age: All but one of the PSCF staff are well under retirement age. The one individual nearing retirement has indicated she will continue to work, that she loves her job, and has no plans to retire at this time. She is a stellar employee and welcome to stay. PSCF has recruited a very few staff from FHH. Currently, only two of PSCF staff have come from FHH. They stated they were dissatisfied and wanted to enter the ASC environment. This was 3 years ago. Most staff have been with PSCF greater than three years (most 5-10 years), have come from PA, Washington County, Carroll County and Montgomery county. We do not believe a significant number will leave FHH and join PSCF at this time. PSCF also provides a strong orientation, education and training program to insure quality care to all. PSCF cannot be responsible for FHH employees entering the workforce seeking new employment. PSCF will only hire those that qualify. We believe it is our pleasant environment, employee support, comradery and highly skilled team that makes them stay long term.

IX. Conclusion:

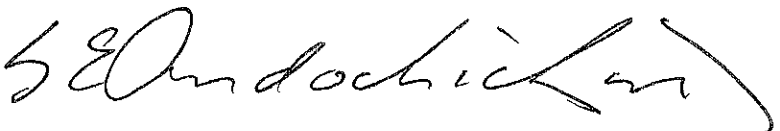
PSCF requests to maintain their application for two additional operating rooms as submitted in good faith with information provided as accurate as possible to the best or our knowledge and abilities. PSCF will always provide the highest quality care to the citizens of the Frederick County and surrounding communities without compromise. PSCF moves forward with the understanding it will collaborate in a positive manner with FHH and any other facility to promote quality care on a continuum to what is most important. The patient and the community.

We wish to extend a warm thank you to FHH for their input, and hope that we have made clarifications that are of assistance. We would like all to know that PSCF has grown exponentially in an independent fashion over many years in the community. PSCF intent is to support surrounding business and care providers, not harm. It is humbling to know that the surgeons/patients are drawn to our facility, and promise to provide them

with continued excellence in surgical care to their patients, and as a reflection of what they do for others. Our position has always been patient and physician driven. It works, promotes excellence, growth, patient quality care and we will maintain this business plan/culture as a signature of our organization without compromise. It has never been to create unfair competition, conflict of any kind or animus. PSCF hopes to continue a strong and healthy community relationship with FHH well into the future for the benefit of those we mutually care for. PSCF believes it has evolved into something very special for the community and can play a supportive and contributory role along with the FHH healthcare system for Frederick County. A place where surgeons, patients and staff want to come. A place where all are motivated to achieve the highest quality of care, safety, positive outcomes and satisfaction. A place that offers free choice to all who are involved and who seek care with the organization. PSCF and its partners believe is will continue to serve as a strong referral source to benefit FHH. It is an honor to serve this community. PSCF is pleasantly surprised on its growth trajectory and welcomes it to continue. It is pleased to provide a stellar service as an option to the citizens of Frederick County. Our operating rooms will not see idle time!

PSCF is hopeful its request for the proposed expansion to enable it to provide improved timely surgical care in our community by approving two additional operating rooms. Upon approval, patients will enjoy decreased delays in access to highest quality care in a spacious, state of the art surgical specialty environment. The "right" all in our community deserve regardless of ability to pay. If additional information if needed, feel free to contact us at your convenience.

Respectfully submitted,



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

Scott E. Andochick, MD
Physicians Surgery Center of Frederick
81 Thomas Johnson Court
Suite B
Frederick, MD 21702

Procedure	Description	Primary CPT	Specialty	Duration	Require Laser
27130	Total Hip	27130		0	N
2nd IOL	2nd IOL - Cataract Repair	66820	OPH	0	N
A&PRPR	Anterior & Posterior Repair		URO	0	N
ABDOMIN	Abdominoplasty		PLS	0	N
ACDF	Anterior Cervical Discectomy & Fusion		NEU	0	N
ACL	Anterior Cruciate Ligament Reconstruction w/ Allograft/Autograft		ORT	0	N
ACRES	Acromioclavicular Resection		ORT	0	N
ACROM	Acromioplasty		ORT	0	N
AMPFINHA	Amputation Finger/Hand		HND	0	N
AMPPENIS	Amputation Penis			0	N
AMPTOEFT	Amputation Toe/Foot		ORT	0	N
AMPUPEX	Partial Amputation Upper Extremity			0	N
ANALEUA	Exam Under Anesthesia Anus		GEN	0	N
ANALFISS	Anal Fissurectomy		GEN	0	N
ANALOTH	Anal Procedure Other		GEN	0	N
ANESGEN	Anesthesia General			0	N
APPENDIX	Appendectomy		GEN	0	N
ARCNTSIS	Arthrocentesis Various Locations			0	N
ARDSUPEX	Arthrodesis Upper Extremity	26860	ORT	0	N
ARTDISC	Artificial Disc Placement		NEU	0	N
ARTH CAP	Capsulorraphy / Bankart Repair		ORT	0	N
ARTH LEX	Arthrodesis Lower Extremitiy		ORT	0	N
ARTH RCR	Arthroscopy Shoulder with Rotator Cuff Repair		ORT	0	N
ARTH SAD	Subacromial Decompression		ORT	0	N
ARTHANKL	Arthroscopy Ankle		ORT	0	N
ARTHCHE	Chilectomy / Hallus Rigidus Correction		POD	0	N
ARTHELB	Arthroscopy Elbow		ORT	0	N
ARTHKEL	Keller Procedure With Toe Implant		POD	0	N
ARTHKN	Arthroscopy Knee		ORT	0	N
ARTHMEN	Arthroscopy Knee with Meniscectomy		ORT	0	N
ARTHOAT	Osteochondral Autograft Transfer (OATS)		ORT	0	N
ARTHPTH	Arthroplasty Thumb	25447	ORT	0	N
ARTHRTLE	Arthrotomy Lower Extremity		ORT	0	N
ARTHRTUP	Arthrotomy Upper Extremity		ORT	0	N
ARTHSH	Arthroscopy Shoulder		ORT	0	N
ARTHTFCC	Triangular Fibrocartilage Complex (TFCC) Repair		HND	0	N
ARTHWRST	Arthroscopy Wrist	29846	ORT	0	N
ARTPLSTY	Arthroplasty		ORT	0	N
ATDF	Anterior Thoracic Discectomy and Fusion		NEU	0	N
BALANCE	Balance Forward from Previous System			0	N
BARTHOL	Bartholin's Cyst Excision		GYN	0	N
BATREP	Epidural Spinal Cord Stimulator, Replacement		NEU	0	N
BATXCHNG	DBS Battery Exchange		NEU	0	N
BFSIS	Balance Forward / SIS			0	N
BICEPS	Tendon Repair Biceps		ORT	0	N

Procedure	Description	Primary CPT	Specialty	Duration	Req Laser
BLEB	Blepharoplasty Revision		OPH	0	N
BLEPH	Blepharoplasty		OPH	0	N
BLOOD	Pain Blood Patch		PM	0	N
BONEGR	Bone Graft		ORT	0	N
BRACHIO	Brachioplasty		PLS	0	N
BREASTBX	Breast Biopsy		GEN	0	N
BROWLFT	Brow Lift		PLS	0	N
BRSTAUG	Breast Augmentation		PLS	0	N
BRSTMASS	Breast Mass Excision		GEN	0	N
BRSTREC	Breast Reconstruction		PLS	0	N
BRSTRED	Breast Reduction		PLS	0	N
BUNION	Bunionectomy		POD	0	N
BURSAEX	Excision Bursa / Bursectomy		ORT	0	N
BURSALWE	Bursectomy Lower Extremity			0	N
BURSAUPE	Bursectomy Upper Extremity			0	N
BXEXC	Biopsy Excisional		GEN	0	N
BXTESTES	Testicular Biopsy			0	N
Canal	Canaloplasty		ENT	0	N
CANICREP	Canicular Repair		OPH	0	N
CANTHO	Canthoplasty		OPH	0	N
CARP	Carpectomy	25215	HND	0	N
CAST	Casting of Extremity, Post Surgical		ORT	0	N
CATHPORT	Catheter/Port Insertion/Removal		GEN	0	N
CATIOL	Cataract Extraction with Intraocular Lens	66984	OPH	0	N
CATIOLCP	Cataract Extraction with Complications		OPH	0	N
CAUT	Nasal Cauterization Procedure		ENT	0	N
CERVLAMI	Cervical Laminectomy		NEU	0	N
CERVPOST	Posterior Cervical Discetomy		NEU	0	N
CHALA	Chalazion		OPH	0	N
CHGEANES	Anesthesia Charges			0	N
CHGEPRP	Pre-op Charges			0	N
CHILECT	Chilectomy Exostectomy		POD	0	N
CHINAUG	Chin Augmentation Mentoplasty		PLS	0	N
CIRCUM	Circumcision		URO	0	N
CLAVRES	Clavicle Resection		ORT	0	N
COLDCON	Cold Knife Conization		GYN	0	N
COLON	Colonoscopy with Possible Biopsy		GI	0	N
COLONDX	Colonoscopy Diagnostic, with Biopsy		GEN	0	N
CONJUN	Conjunctivoplasty		OPH	0	N
CORNEA	Corneal Transplant		OPH	0	N
COVID	Pre-operative Covid screening		RN	0	N
CRFXLWEX	Closed Reduction Lower Extremity Fracture		ORT	0	N
CRFXUPEX	Closed Reduction Upper Extremity Fracture		ORT	0	N

Procedure	Description	Primary CPT	Specialty	Duration	Require Laser
CRNF	Closed Reduction Nasal / Septal Fracture		ENT	0	N
CTR	Open Carpal Tunnel Release	64721	ORT	0	N
CTRENDO	Carpal Tunnel Release Endoscopic	29848	ORT	0	N
CUBITTUN	Cubital Tunnel Release / Ulnar Nerve Decompression		ORT	0	N
CYSTEC	Cystectomy	26160	ORT	0	N
CYSTO	Cystoscopy		URO	0	N
CYSTSTMY	Cystostomy/Suprapubic Catheter Placement			0	N
D&C	Dilation and Curettage		GYN	0	N
DACPLS	Dacryoplasty		OPH	0	N
DACRYO	Dacryocystorhinostomy		OPH	0	N
DARPRO	Ulna Excision (Darrach Procedure)		ORT	0	N
DCR	Lacrimal Duct Probing w/wo Lacrimal Tube Insertion or Removal		OPH	0	N
DEBRID	Debridement		ORT	0	N
DENTAL	Extraction tooth		PLS	0	N
DEQREL	Dequervain's Release / Extensor Tendon		HND	0	N
DIODE	Diode Laser, Eye		OPH	0	N
DISC	Discectomy		NEU	0	N
DISTCLA	Clavicle Excision Distal		ORT	0	N
DSEK	Descemets Stripping Endothelial Keratoplasty	65756	OPH	0	N
CTOPL	Ductoplasty			0	N
Dupyperc	Dupuytren's Release Percutaneous		ORT	0	N
DUPYTRNS	Dupuytren's Release / Palmar and Digital Fasciectomy		HND	0	N
ECTROPIA	Ectropion Repair		OPH	0	N
elbow ex	Tendon Repair/Revision Extensor		ORT	0	N
ELECT	Neuroelectrode Lead Insertion		PM	0	N
ELR	External Levator Resection		OPH	0	N
ENTROP	Entropion Repair		OPH	0	N
ENUCL	Enucleation with or without Implant		OPH	0	N
EPIHERN	Hernia Repair Epigastric		GEN	0	N
EXBONEFT	Bone Spur Excision Foot		POD	0	N
EXBONELW	Bone Spur Excision Lower Extremity		ORT	0	N
EXBONEUP	Bone Spur Excision Upper Extremity		ORT	0	N
EXCGRWTH	Excision Pterygium		OPH	0	N
EXCGYNE	Excision of Gynecomastia			0	N
EXCNAIL	Excision Nail		ORT	0	N
EXCRAD	Radial Head Excision		HND	0	N
EXNODEHN	Lymph Node Excision Head & Neck		ENT	0	N
EYEEUA	Exam Under Anesthesia Eye		OPH	0	N
EYEMUSCL	Eye Muscle Surgery		OPH	0	N
EYEOTHER	Eye Procedure Other		OPH	0	N
FACELIFT	Facelift		PLS	0	N
FACLFT	Face Lift		PLS	0	N
FASCEO	Fasciotomy with Extensor Origin Detached		ORT	0	N

Procedure	Description	Primary CPT	Specialty	Duration	Req. Laser
FBEAR	Foreign Body Removal Ear		ENT	0	N
FBEYE	Foreign Body Removal Eye		OPH	0	N
FBH&N	Foreign Body Removal Head & Neck		PLS	0	N
FBLWEX	Foreign Body Removal Lower Extremity		POD	0	N
FBTRUNK	Foreign Body Removal Trunk		PLS	0	N
FBUPEX	Foreign Body Removal Upper Extremity		ORT	0	N
FEMHERN	Hernia Repair Femoral With Possible Mesh		GEN	0	N
FISTUL	Fistulectomy Perianal			0	N
FLAPH&N	Flap Reconstruction Head & Neck		PLS	0	N
FLUOR	Fluoroscopy		PM	0	N
FORAM	Foraminotomy		NEU	0	N
FRENO	Frenoplasty			0	N
FRENUL	Frenulectomy		ENT	0	N
FTSGEAR	Skin Graft Full Thickness Ear		PLS	0	N
FTSGH&N	Skin Graft Full Thickness Head & Neck		PLS	0	N
FTSGLWEX	Skin Graft Full Thickness Lower Extremity		PLS	0	N
FTSGTRNK	Skin Graft Full Thickness Trunk			0	N
FTSGUPEX	Skin Graft Full Thickness Upper Extremity		PLS	0	N
FULGRAT	Fulguration			0	N
FUSION	Fusion of Joint	26850	HND	0	N
GANGLION	Ganglion Cystectomy		ORT	0	N
GMKP	Thumb Fracture Repair (Gamekeeper Thumb)			0	N
HAMMER	Hammer Toe Repair / Hallux Valgus		POD	0	N
HardFc	Hardware Removal Face		PLS	0	N
HEMAEVAC	Hematoma Evacuation		PLS	0	N
HEMRHOID	Hemorrhoidectomy		GEN	0	N
HWREMLE	Hardware Removal Lower Extremity		ORT	0	N
HWREMUE	Hardware Removal Upper Extremity		ORT	0	N
HYDRAD	Hydradenitis Excision		GEN	0	N
HYDROCEL	Hydrocelectomy			0	N
HYSTER	Hysteroscopy		GYN	0	N
I&DGROIN	Incision and Drainage Abscess Groin		GEN	0	N
I&DH&N	Incision and Drainage Abscess Head and Neck		GEN	0	N
I&DLWEX	Incision and Drainage Abscess Lower Extremity		ORT	0	N
I&DTRUNK	Incision and Drainage Abscess Trunk		GEN	0	N
I&DUPEX	Incision and Drainage Abscess Upper Extremity		GEN	0	N
IDET	Percutaneous Intradiscal Electrothermal Annuloplasty (IDET)		PM	0	N
INCHERN	Hernia Repair Incisional With Possible Mesh		GEN	0	N
INGHERN	Hernia Repair Inguinal With Possible Mesh		GEN	0	N
INTFUS	Posterior Lumbar Interbody Fusion (PLIF)		NEU	0	N

Procedure	Description	Primary CPT	Specialty	Duration	Require Laser
INTSTIM	Interstim Electrode Insertion		URO	0	N
IOLrepos	Repositioning of IOL		OPH	0	N
IPGREM	Spinal Cord Stimulator Removal		NEU	0	N
IRIDOT	Iridotomy		OPH	0	N
KYPHO	Vertebroplasty / Kyphoplasty, Percutaneous		NEU	0	N
L8699	Implant		ORT	0	N
LAMINECT	Lumbar Laminectomy		NEU	0	N
LAPAPPY	Laparoscopic Appendectomy		GEN	0	N
LAPARSCP	Laparoscopy			0	N
LAPCHOLE	Laparoscopic Cholecystectomy With Possible Cholangiogram		GEN	0	N
LAPHERN	Hernia Repair Laparoscopic		GEN	0	N
LAPNISS	Laparoscopic Nissen Fundoplasty		GEN	0	N
LIDLESIO	Lesion Excision Eyelid		OPH	0	N
LIDRECON	Lid Reconstruction		OPH	0	N
LIGMNT	Ligament Repair / Reconstruction		ORT	0	N
LIPOSUCT	Liposuction Various Locations		PLS	0	N
LSNGEN	Lesion Excision Genitalia		GYN	0	N
LSNH&N	Lesion Excision Head & Neck		ENT	0	N
[illegible]WEX	Lesion Excision Lower Extremity		PLS	0	N
[illegible]NASAL	Lesion Excision Nose		ENT	0	N
[illegible]NORAL	Lesion Excision Oral/Nose/Throat		ENT	0	N
LSNRECT	Lesion Excision Rectum			0	N
LSNTRUNK	Lesion Excision Trunk		PLS	0	N
LSNUPEX	Lesion Excision Upper Extremity		PLS	0	N
LYMPHNOD	Lymph Node Excision			0	N
MAJOREAR	Ear Procedure Major		ENT	0	N
MANDIBLE	Reconstruction of Mandible or Maxilla / endosteal implant		PLS	0	N
MANIPAK	Manipulation Ankle		ORT	0	N
MANIPELB	Manipulation Elbow		ORT	0	N
MANIPKNE	Manipulation Knee		ORT	0	N
MANIPSHL	Manipulation Shoulder Under Anesthesia		ORT	0	N
MASSAXIL	Mass Excision Axilla			0	N
MASSGEN	Mass Excision Genitalia			0	N
MASSH&N	Mass Excision Head & Neck		PLS	0	N
MASSLWEX	Mass Excision Lower Extremity		ORT	0	N
MASSTRNK	Mass Excision Trunk		PLS	0	N
MASSUPEX	Mass Excision Upper Extremity		GEN	0	N
MASTECTO	Mastectomy			0	N
MASTOID	Tympanomastoidectomy		ENT	0	N
[illegible]TPXY	Mastopexy Breast		PLS	0	N
[illegible]TOT	Meatotomy		URO	0	N
MENING	Meningocele Repair		NEU	0	N
MICRODIR	Laryngoscopy Micro Direct with Possible Biopsy		ENT	0	N

Procedure	Description	Primary CPT	Specialty	Duration	Requ Lase
MISC	Misc Procedure		NEU	0	N
NERVTRAN	Nerve Transposition			0	N
NEURECT	Neurectomy		NEU	0	N
NEUROMLE	Neuroma Excision Lower Extremities			0	N
NEUROMUE	Neuroma Excision Upper Extremities		ORT	0	N
NEURSTIM	Neurostimulator Percutaneous Implantaion of Trial		NEU	0	N
Nipple	Nipple Reconstruction		PLS	0	N
nirschel	Nirschel Procedure (Tennis Elbow Repair)		ORT	0	N
NRVRPUE	Nerve Repair Upper Extremity			0	N
NSR	Nasal Septal Reconstruction		ENT	0	N
OPENANK	Open Ankle Procedure		ORT	0	N
OPENELB	Open Elbow Procedure		ORT	0	N
OPENHND	Open Hand Procedure		ORT	0	N
OPENKNE	Open Knee Procedure		ORT	0	N
OPENRELE	Open Release Lower Extremity		ORT	0	N
OPNRELUP	Open Release Upper Extremity	25000	HND	0	N
Orbit	Anterior Orbitotomy		OPH	0	N
ORBITFX	Orbital Fracture repair		PLS	0	N
ORCHIECT	Orchiectomy			0	N
ORCHIPEX	Orchiopexy			0	N
ORDALL	Order Sheet For All Areas			0	N
ORDANES	Order Anesthesia Supplies			0	N
ORDCAST	Order Cast Cart			0	N
ORDDRP	Order Drapes and Packs			0	N
ORDGENSU	Order General Surgery			0	N
ORDGLV	Order Gloves			0	N
ORDOPHTH	Order Ophthalmology			0	N
ORDORTHO	Order Orthopaedics			0	N
ORDPAIN	Order Pain Management			0	N
ORDPREOP	Order Pre-op/PACU Supplies			0	N
ORDRXANS	Order Medications Anesthesia			0	N
ORDRXOR	Order Medications OR			0	N
ORDRXPRP	Order Medications Pre-op/PACU			0	N
ORDSOL	Order Solutions			0	N
ORDSPD	Order SPD			0	N
ORDSTER	Order Sterile Supplies			0	N
ORDSUT	Order Suture			0	N
ORDSYRND	Order Syringes and Needles			0	N
ORDUNST	Order Unsterile Supplies			0	N
ORIF Nas	Open Reduction w/ Fixation Nasal/Septum		ENT	0	N
ORIFCLAV	Open Reduction Internal Fixation, Clavicle	23500	ORT	240	N

Procedure	Description	Primary CPT	Specialty	Duration	Require Laser
ORIFLE	ORIF Tibial Array Fracture	27535	ORT	120	N
ORIFLWEX	Open Reduction Internal Fixation, Lower Extremity		ORT	0	N
ORIFUPEX	Open Reduction Internal Fixation, Upper Extremity		ORT	0	N
OSSPLAS	Osseoplasty		NEU	0	N
OSTEOTOM	Osteotomy		POD	0	N
OTEXAMUA	Exam Under Anesthesia Other		ORT	0	N
OTOPLSTY	Otoplasty		PLS	0	N
PAINBLK	Pain Management Block		PM	0	N
PAINCERV	Pain Management Cervical/Thoracic Epidural Steroid Injection		PM	0	N
PAINDISC	Pain Discogram		PM	0	N
PAINEPID	Pain Management Lumbar Epidural Steroid Injection		PM	0	N
PAINFAC	Pain Facet Nerve Block		PM	0	N
PAINMGMT	Pain Management Injection		PM	0	N
PAINRF	Pain Radiofrequency		PM	0	N
PAINTRIG	Pain Trigger Point Injection		PM	0	N
PALMF	Palmer Fasciectomy with Extensor Release	26123	HND	0	N
PATELLA	Patella Repair		ORT	0	N
PERMSTIM	Spinal Cord Stimulator Implant (PERMANENT SPINAL CORD STIMULATOR)		NEU	0	N
ONIDL	Pilonidal Cystectomy			0	N
CE	Placement of Gold Weight		OPH	0	N
PLANTAR	Plantar Fascia Release		POD	0	N
PLANTEND	Plantar Fascia Release Endoscopic		POD	0	N
POLYP	Polypectomy Anal/Rectal		GI	0	N
POSTLAMI	Posterior Lumbar Laminectomy			0	N
POSTOPBK	Post-Operative Pain Control Block		PM	0	N
PTERY	Pterygium Excision	65426	OPH	0	N
PTOSIS	Ptosis Repair		OPH	0	N
PUNCTO	Punctoplasty		OPH	0	N
RCR	Rotator Cuff Repair		ORT	0	N
RCROPN	Rotator Cuff Repair Open		ORT	0	N
REMNUCL	Removal of Retained Nucleus		OPH	0	N
RETROCEL	Retrocele Repair			0	N
RFN	Radio Frequency Neurotomy		NEU	0	N
RHINO	Rhinoplasty		PLS	0	N
RHTDCCN	Rhytidectomy, Cheek, Chin, Neck		PLS	0	N
RHTDFH	Rhytidectomy, Forehead		PLS	0	N
RHTDFL	Rhytidectomy, Frown Lines		PLS	0	N
RHTDN	Rhytidectomy, Neck		PLS	0	N
HTDSF	Rhytidectomy, Superficial Musculoaponeurotic System (SMAS) Flap		PLS	0	N
PLAT	Sacroplasty		PM	0	N
scar	Scar Revision Head & Neck		PLS	0	N
scarex	Scar Revision Extremity		PLS	0	N
SCARTRNK	Scar Revision Trunk			0	N

Procedure	Description	Primary CPT	Specialty	Duration	Req Laser
SCLBCKLE	Scleral Buckle			0	N
SEPTO	Septoplasty		ENT	0	N
SESMOID	Sesamoidectomy		POD	0	N
SHOULDER	Shoulder Surgery		ORT	0	N
SIGMOID	Sigmoidoscopy		GI	0	N
SKINLAC	Wound Closure Skin Laceration		ORT	0	N
SLAP	Superior Labrum Anterior to Posterior (SLAP) Lesion Repair Shoulder		ORT	0	N
SLTL	Selective Laser Trabeculoplasty		OPH	0	N
SMR	Submucous Resection		ENT	0	N
SPHENOID	Sphenoidectomy		ENT	0	N
SPINCTER	Anal Sphincter Repair/Revision		GEN	0	N
STSGHN	Split Thickness Skin Graft Head and Neck		PLS	0	N
STSGTRNK	Split Thickness Skin Graft Trunk, Arms, Legs		PLS	0	N
SUBMAND	Submandibular Gland Excision		ENT	0	N
SUPPANES	Supplies and Par Levels Anesthesia Carts			0	N
SUPPBLCK	Supplies and Par Levels Block Cart			0	N
SUPPCRSH	Supplies and Par Levels Crash Cart			0	N
SUPPDIFF	Supplies and Par Levels Difficult Airway Cart			0	N
SUPPMHCT	Supplies and Par Levels Malignant Hyperthermia Cart			0	N
SUPPORRM	Supplies and Par Levels OR Rooms			0	N
SUPPPACU	Supplies and Par Levels PACU			0	N
SUPPPAIN	Supplies and Par Levels Pain Cart			0	N
SUPPPEDS	Pediatric Cart Par Levels			0	N
SYNBX	Synovial Biopsy			0	N
TARSCTMY	Metatarsectomy Subtotal		POD	0	N
TARSLTUN	Tarsal Tunnel Release		ORT	0	N
TARSORR	Tarsorrhaphy		OPH	0	N
TEARDUCT	Tear Duct Probe			0	N
TEMPARBX	Temporal Artery Biopsy		GEN	0	N
TENDONAC	Tendon Repair Achilles		ORT	0	N
TENDONAK	Tendon Repair Ankle		ORT	0	N
TENDONLE	Tendon Repair Lower Extremity		ORT	0	N
TENDONRP	Tendon Repair Digit/Thumb		HND	0	N
TENDONUE	Tendon Release Upper Extremity	25000	ORT	0	N
TENDONUP	Tendon Repair Upper Extremity	26370	ORT	0	N
THIPLAST	Thighplasty		PLS	0	N
TISSEX	Tissue Expander Insert / Exchange		PLS	0	N
TMJARTH	Temporalmandibular Joint (TMJ) Arthroscopy			0	N
TOTALHYS	Total Vaginal Hysterectomy		GYN	0	N
TRAB	Trabeculectomy		OPH	0	N
TRABTUBE	Trabeculectomy with Tube Shunt		OPH	0	N
TRANSFER	Transfer Tendon			0	N
TRAPEX	Trapezial Excision		ORT	0	N

Procedure	Description	Primary CPT	Specialty	Duration	Require Laser
TRIGGER	Trigger Finger Release	26055	ORT	0	N
TRIPLE	PE/IOL with Trabeculectomy w/MMC		OPH	0	N
TSHUNT	Tube Shunt w/Patch graft		OPH	0	N
TUBALLIG	Tubal Ligation		GYN	0	N
TUBLIGRV	Tubal Ligation Reversal		GYN	0	N
TUMEXC	Excision Tumor Foot		POD	0	N
TURB	Turbinoplasty			0	N
TURBRED	Turbinate Reduction		ENT	0	N
TVT	Transvaginal Tape			0	N
ULNAR	Ulnar Nerve Transposition		ORT	0	N
UMBHERN	Hernia Repair Umbilical		GEN	0	N
URETLASR	Ureterscopy w/wo Laser			0	N
VARICOCE	Varicocelectomy			0	N
VASECTMY	Vasectomy		URO	0	N
VENTHERN	Hernia Repair Ventral With Possible Mesh		GEN	0	N
VITRECT	Vitrectomy		OPH	0	N
VULVCTMY	Vulvectomy		GYN	0	N
WOUNDHN	Wound Closure Head & Neck		PLS	0	N
NDLE	Wound Closure Lower Extremity		PLS	0	N
WOUNDUE	Wound Closure Upper Extremity		HND	0	N
YAGCAPS	Yag Laser Capsulotomy		OPH	0	N
YAGPI	Iridotomy		OPH	0	N
YAGPROC	Yag Laser Of Eye		OPH	0	N
ZYGO	Zygomatic Fracture Repair		PLS	0	N

Total Procedure Count: 365

Printing Selection: From Tran Date=1/1/2021 To Tran Date=12/31/2021 Tx Category=(AD) Hide Detail?=No

Sort By: Transaction Date

Group By: Tx Code

Tx Date	Tx Number	Post Date	Tx Status	Description	Amount	Payer ID	Account – Visit	Patient Name	Phys ID	Date of Service	Accounting Year	Accounting Period	Change By
01/22/21	286230	01/22/21	P	46 - Charity Adjustment	($300.00)	1	16490 - 2	[redacted]	116	12/22/20	2021	1	tdorsey
10/11/21	293376	10/11/21	P	46 - Charity Adjustment	($500.00)	1	24532 - 1	[redacted]	103	05/21/21	2021	10	tdorsey
10/14/21	293527	10/14/21	P	46 - Charity Adjustment	($59.33)	1	24864 - 1	[redacted]	238	08/27/21	2021	10	Klind
10/14/21	293527	10/14/21	P	46 - Charity Adjustment	($23.15)	1	24864 - 2	[redacted]	238	09/10/21	2021	10	Klind
Tx Code: 46													
Tx Category:						**(AD)**							
Totals:						**4 ($882.48)**							
06/21/21	290290	06/21/21	P	91 - Medicaid Write Off	($225.00)	2330	19183 - 7	[redacted]	103	04/02/21	2021	6	tdorsey
06/21/21	290292	06/21/21	P	91 - Medicaid Write Off	($71.82)	2330	24323 - 1	[redacted]	116	05/25/21	2021	6	tdorsey
06/21/21	290291	06/21/21	P	91 - Medicaid Write Off	($499.79)	2330	24422 - 1	[redacted]	238	05/14/21	2021	6	tdorsey
08/24/21	292060	08/24/21	P	91 - Medicaid Write Off	($361.08)	2330	24422 - 2	[redacted]	238	07/23/21	2021	8	tdorsey
08/24/21	292060	08/24/21	P	91 - Medicaid Write Off	($529.79)	2330	24778 - 1	[redacted]	112	07/15/21	2021	8	tdorsey
08/24/21	292060	08/24/21	P	91 - Medicaid Write Off	($225.00)	2330	24809 - 1	[redacted]	116	07/20/21	2021	8	tdorsey
09/23/21	292979	09/27/21	P	91 - Medicaid Write Off	($225.00)	2330	24434 - 1	[redacted]	238	06/04/21	2021	9	tdorsey
09/23/21	292980	09/27/21	P	91 - Medicaid Write Off	($225.00)	2330	24434 - 2	[redacted]	238	06/25/21	2021	9	tdorsey
Tx Code: 91													
Tx Category:						**(AD)**							
Totals:						**8 ($2,362.48)**							
08/16/21	291856	08/16/21	P	122 - COVID Community Serv/Charity	($45,000.00)	2117	22757 - 1	[redacted]	257	04/22/20	2021	8	tdorsey
Tx Code: 122													
Tx Category:						**(AD)**							
Totals:						**1 ($45,000.00)**							

TOTAL, 2021 -48244.96

EXHIBIT
2

12 - Physicians Surge enter of Frederick

Report ID: ME9006 - Transaction Information

Run Date: 1/10/2022 12:16 PM

Printing Selection: From Tran Date=1/1/2020 To Tran Date=12/31/2020 Tx Category=(AD) Hide Detail?=No

Sort By: Transaction Date

Group By: Tx Code

Tx Date	Tx Number	Post Date	Tx Status	Description	Amount	Payer ID	Account – Visit	Patient Name	Phys ID	Date of Service	Accounting Year	Accounting Period	Change By
01/27/20	278034	01/27/20	P	91 - Medicaid Write Off	($194.29)	2330	21775 - 1	[redacted]	238	09/06/19	2020	1	tdorsey
04/02/20	279818	04/01/20	P	91 - Medicaid Write Off	($52.44)	2330	17012 - 3	[redacted]	103	03/13/20	2020	4	tdorsey
09/17/20	283146	09/17/20	P	91 - Medicaid Write Off	($100.00)	1	20188 - 1	[redacted]	238	10/12/18	2020	9	tdorsey
09/17/20	283146	09/17/20	P	91 - Medicaid Write Off	($69.29)	1	20188 - 2	[redacted]	238	08/30/19	2020	9	tdorsey
09/17/20	283148	09/17/20	P	91 - Medicaid Write Off	($141.55)	1	23230 - 1	[redacted]	116	08/20/20	2020	9	tdorsey
09/22/20	283240	09/22/20	P	91 - Medicaid Write Off(Reversal)	$141.55	1	23230 - 1	[redacted]	116	08/20/20	2020	9	tdorsey
09/30/20	283515	10/02/20	P	91 - Medicaid Write Off	($845.16)	2330	22260 - 1	[redacted]	257	01/13/20	2020	9	tdorsey
10/07/20	283625	10/07/20	P	91 - Medicaid Write Off	($201.06)	2330	23284 - 1	[redacted]	238	09/18/20	2020	10	tdorsey
10/26/20	284186	11/02/20	P	91 - Medicaid Write Off	($201.06)	2330	21131 - 2	[redacted]	238	09/29/20	2020	10	tdorsey
Tx Code: 91													
Tx Category:						**(AD)**							
Totals:						**9 ($1,663.30)**							

Provide a needs assessment demonstrating what each proposed operating room is likely to be utilized for at optimal capacity or higher levels within three years of the completion of the additional operating room capacity, consistent with Regulation .07 of this chapter.

Surgeon	Specialty	2020	2021	2022	2023	2024	2025
Andochick	Cosmetic/Reconstruction	69	95	100	120	150	180
Mecinski	Cosmetic/Reconstruction	333	375	400	430	475	500
Steinberg	Orthopedic	229	290	350	365	380	400
Nesbitt	Orthopedic	643	675	725	740	780	800
Levine	Orthopedic	166	215	300	335	375	400
Thadani	Ophthalmology	513	675	700	730	800	825
Horton	Orthopedic	59	285	360	415	490	600
Walsh	Orthopedic	20	140	175	200	225	275
Henry	Oculoplastic	8	15	30	50	75	95
Gupta	Orthopedic	5	0	10	40	80	100
Other(New Surgeons) 3:orthopedic 1: ophth	Orthopedicx3 Ophthalmologyx1	15	100	225	275	345	400
	2020 Lost cases due to HVAC and COVID: 529		**2021 Increase post COVID**				
Total Cases		2060	2865	3275	3700	4175	4575

i. attached increasing percentage of orthopedic cases projected to be performed due to addition of surgeons, a draw from Montgomery County to assist in keeping the Frederick case volume in the Frederick County service area, and each surgeon's primary case contribution by specialty.

Levine: Shoulders and knees.
Nesbitt: Upper extremity and hands
Horton: Upper extremity, hands and shoulders
Walsh: Knee Replacement and Hip Replacement, knee arthroscopies
Gupta: Knee Replacement and Hip Replacement, knee arthroscopies
Petruccelli: Shoulder and Rotator Cuff Repair, Knee Arthroscopies
Sanders: Knee and Shoulder procedures, ACL repairs
Evans: Knee and Hip Replacement, knee arthroscopies
Mecinski: Breast Reduction and Reconstruction, Upper Extremity procedures
Andochick: Breast Reconstruction
Thadani: Ophthalmology
Henry: Oculoplastic
Ophthalmology: To be recruited early 2022

ii. See attached projected cases in each room

Plans for the additional two operating rooms requested will be primarily for Knee, Hip and shoulder replacement surgery in addition to complex joint surgery and Sports Medicine (ACL reconstruction, Fractures, Rotator Cuff Repairs etc. due to larger square foot per room.

The current OR's will be utilized for ophthalmology and Breast Reconstruction/Reduction and Upper Extremity Cases.

Procedure room will be utilized for procedures appropriate to the Procedure Room environment.

EXHIBIT 3.b.

		Year	Year	Year	Year	Year	
Specialty	**Surgeon**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
	Annual Case Volume	**2060**	**2865**	**3275**	**3700**	**4175**	**4575**
Ophthalmology	Henry, J. Christopher						
	Sunil Thadani						
	Pillar, Angelique						
Total Percent Ophthalmology	Percent of annual volume	25	23.5	21	20	18	20
Orthopaedics	Evans, Korboi						
Orthopaedics	Gupta, Rishi R						
Orthopaedics	Horton, Steven A						
Orthopaedics	Levine, Matthew J						
Orthopaedics	Nesbitt Silon, Kristin						
Orthopaedics	Petruccelli, Gabriel						
Orthopaedics	Sanders, Samuel						
Orthopaedics	Steinberg, James M						
Orthopaedics	Walsh, Cory T						
Orthopaedics	Petruccelli, Gabriel	xxxxx					
Orthopaedics	Evans, Korboi	xxxxx					
Orthopedics	Sanders, Samuel	xxxxx					
Total Percent Orthopedic	Percent of annual volume	60	63	68	67	67	68
Plastics/Reconstructive	Andochick, Scott E						
Plastics/Reconstructive	Mecinski, Adam M						
Total Plastic/Reconstructive	Percent of Annual Volume	15	13.4	14	14.3	15	12
Total		100%	100%	100%	100%	100%	100%

EXHIBIT 3 a.

Original Table 1-2

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.

Year	OR Cases	Surgical Procedure Time (60 minute average/case	Turn over time estimate (25 minutes per case)	Total OR time in hours utilization	ORs needed at **Optimal** Capacity	Optimal Capacity=1900 hours Additional Comments
Historical Utilization of 2 OR's						
2016	1574	95640	39350	1125	1.37	
2017	1909	106723	47725	1287	1.5	
2019	2075	106844	51875	1347	1.65	
2020	2060	108883	51500	2673	1.63	Significant decline in volume due to facilty closure to upgrade HVAC system and Government mandates suspending elective surgery due to COVID
Future Projections need Total of 4 OR's						
2021	2865	151845	71625	3724	2.3	Caseload accommodated utilizing extended hours of service.
2022	3275	196500	81875	4640	2.84	Extended hours will be required to accommodate case load
2023	3700	222000	92500	5241	3.21	Increasing cases complex requiring longer OR time.
2024	4175	250500	104375	5914	3.62	
2025	4575	274500	117375	6536	4.0	

EXHIBIT 4

Update to Table 1-2 (app. P.31)Without turn over time prior to first case and last case of the day.

Year	OR Cases	Surgical Procedure Time (ave 60 min per case)	Turn Around Time (25 minutes per case average) does not include time before first case and after last case	Total OR time in hours of utilization	OR's needed to accommodate Optimal Capacity as defined by COMAR Utilization 1632 hr/yr	OR's needed to accommodate Full Capacity as defined by COMAR Utilization 2040 hr/yr	Additional supportive documentation
Historic							
2016	1574	95640	29906	2092	1.28	1.03	
2017	1909	106723	36271	2383	1.46	1.17	
2018	2075	106844	39425	2438	1.49	1.20	
2019	2486	123343	47324	2843	1.74	1.40	
2020	2060 (2589)	108883 (155340)	39140 (49191)	2467 (3408)	1.51 (2.0)	1.21 (1.7)	HVAC and COVID Mandated closure loss of cases In Parenthesis (Case load estimates if center had not closed due to HVAC or COVID)
2021	2865	151845	54425	3438	2..1	1.7	
2022	3275	196500	62225	4312	2..64	2.1	2022- 2025: Increasing complexity and length of cases anticipated and may add OR time, but not included in this table of projections.
2023	3700	222000	70300	4872	3.0	2.4	
2024	4175	250500	78425	5482	3.3	2.7	Optimal Capacity for four OR's is anticipated to be reached this year due to increasing cases load, growth in the community and complexity of cases.
2025	4575	274500	86925	6024	3.7	3.0	Full capacity is expected to be reached for the four OR's this year due to the increasing complexity of cases and additional time that will required to perform in a safe manner. **For purposes of this exercise table the average OR time used is 60 min per case.**

EXHIBIT 5

National and Regional Projections of Supply and Demand for Surgical Specialty Practitioners: 2013-2025

December 2016

U.S. Department of Health and Human Services

Health Resources and Services Administration

Bureau of Health Workforce

National Center for Health Workforce Analysis

HRSA
Health Workforce

About the National Center for Health Workforce Analysis

EXHIBIT
6

The National Center for Health Workforce Analysis (the National Center) informs public and private-sector decision-making on the U.S. health workforce by expanding and improving health workforce data and its dissemination to the public, and by improving and updating projections of supply and demand for health workers. For more information about the National Center, please visit our website at HRSA: Health Workforce Analysis.

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National and Regional Projections of Supply and Demand for Surgical Specialty Practitioners: 2013-2025

Overview

This report presents national and regional projections of U.S. supply and demand for surgical specialty practitioners in 2025, with 2013 data serving as baseline. Projections were made using the Health Resources and Services Administration's (HRSA) Health Workforce Simulation Model (HWSM), an integrated microsimulation model that estimates supply and demand for health care workers in multiple professions and care settings.[1] Baseline demand for all surgical specialty practitioners was assumed to be equal to 2013 supply, consistent with standard workforce research methodology for analyses like these where there are no consistent national/regional data sources available to estimate base year shortages or surpluses. All estimates are reported as full time equivalents (FTEs) rounded to the nearest tenth.

Practitioners considered in this report include physicians and physician assistants (PAs), and cover ten surgical specialties: general surgery, colon/rectal surgery, neurological surgery, ophthalmology, orthopedic surgery, cardiothoracic surgery, otolaryngology, plastic surgery, urology, and vascular surgery. Obstetric and gynecologic surgery has been omitted from this report because this specialty is included in the National Center's Women's Health Fact Sheet. Nurse Practitioners are not included in this report because they typically do not practice in these specialties.

Important limitations for these workforce projections include underlying model assumptions that health care delivery in the future (projected until 2025) will not change substantially from the way care was delivered in the base year (2013) and current rates of workforce participation and retirement will continue similarly into the future. Changes in any of these factors may

[1] A detailed description of the HWSM can be found in the technical documentation available at HRSA: Health Workforce Analysis.

significantly impact both the supply and demand projections for the surgical specialty practitioners included in this report. The projections are also limited by the lack of data to adjust the baseline assumption that demand equals supply for any actual shortages or surpluses.

Key Findings

Surgical Specialty Physicians

- In 2025, the national supply of surgeons is projected to fall short of demand by 20,340 FTEs, with nine of the ten surgical specialties analyzed predicted to have national-level physician shortages. The only surgical specialty with a projected national surplus in 2025 is colon/rectal surgery (130 FTEs).
- Regionally, the South is projected to have the largest shortage of surgical specialty physicians in 2025, with a total deficit of 10,210 FTEs. The Midwest is projected to have a surgical specialty deficit of 7,040 FTE physicians in 2025, while the West is forecast to have a deficit of 5,330 FTEs. In the Northeast, the 2025 deficit equals 1,750 FTE physicians. In all four regions, the surgical specialty with the greatest shortage is ophthalmology.
- While all regions have overall deficits, there are some regions with an adequate supply of physicians in certain specialties. For example, in the Northeast, general surgeons, colon/rectal surgeons, and vascular surgeons are all expected to have surpluses in 2025, in spite of an overall regional deficit of 1,750 FTE surgical specialty physicians.

Surgical Specialty Physician Assistants

- In 2025, the national supply of surgical specialty PAs is projected to exceed demand by 13,990 FTEs with all modeled specialties projected to have national-level surpluses.
- Regional projections are congruent with national forecasts, with all four regions demonstrating overall PA surpluses in 2025 (Northeast: 3,940 FTEs; Midwest: 1,460 FTEs; South: 4,230 FTEs; and West: 4,310 FTEs). These figures suggest substantial growth in surgical specialty PA supply from baseline shortages in the Midwest (340 FTEs), South (1,070 FTEs), and West (350 FTEs).

Background

Demand for health providers,[2] including surgical specialists[3, 4, 5] is expected to increase, primarily due to population aging and growth and, to a lesser extent, increased utilization of health care following the national expansion of health insurance coverage. Surgical specialists include physicians and PAs who provide pre-operative, operative, and post-operative care to patients who may require invasive or minimally invasive procedures to treat injuries, diseases, congenital anomalies, and other conditions.[6]

To predict the extent to which future surgical specialty supply will meet demand, HRSA utilized the HWSM to examine ten surgical specialties, both nationally and regionally.[7] While the nuances of modeling supply and demand differ for individual health professions, the basic framework remains the same. The HWSM assumes that demand equals supply in the base year (2013). For supply modeling, the major prediction components (beyond common labor-market factors like unemployment) include characteristics of the existing workforce in a given occupation; new entrants to the workforce (e.g., newly trained workers); and workforce decisions (e.g., retirement and hours worked patterns). For demand modeling, the major components include population demographics, health care use patterns (including the influence of expanded insurance coverage), and staffing for health care services (translated into FTEs). Over the

[2] Dall TM, Gallo PD, Chakrabarti R, West T, Semilla AP, Storm, MV. 2013. An Aging Population and Growing Disease Burden Will Require A Large and Specialized Health Care Workforce By 2025. *Health Affairs*, 32: 2013-2020. An Aging Population And Growing Disease Burden Will Require ALarge And Specialized Health Care Workforce By 2025.

[3] Decker MR, Bronson NW, Greenberg CC, Dolan JP, Kent KC, Hunter JG. The general surgery job market: analysis of current demand for general surgeons and their specialized skills. *Journal of the American College of Surgeons*. 2013; 217(6):1133-1139. An Aging Population And Growing Disease Burden Will Require ALarge And Specialized Health Care Workforce By 2025.

[4] Etzioni DA, Beart RW, Madoff RD, Ault GT. Impact of the aging population on the demand for colorectal procedures. 2009. *Diseases of the Colon & Rectum*. 2009; 52(4): 583-590. Impact of the aging population on the demand for colorectal procedures..

[5]Growing demand for eye care services may highlight shortages of ophthalmologists. *Healio*, Ophthalmology. Ocular Surgery News, U.S. Edition. March 10, 2010. Growing demand for eye care services may highlight shortage of ophthalmologists.

[6] American College of Surgeons. 2016. A Guide to Surgical Specialists. Accessed 5/19/2016. Available from: A Guide to Surgical Specialists.

[7] This model uses a microsimulation approach where supply is projected based on the simulation of career choices of individual health workers. Demand for health care services is simulated for a representative sample of the current and future U.S. population based on each person's demographic and socioeconomic characteristics, health-related behavior, and health risk factors that affect their health care utilization patterns. For more information on data and methods, please see the technical documentation available at HRSA: Health Workforce Analysis.

projection period, the HWSM assumes that base year patterns of staffing and health care delivery remain unchanged within each demographic group.

Results

Surgical Specialty Physicians

Exhibit 1 presents national estimates for 10 physician surgical specialties. At baseline, there were an estimated 113,560 FTE surgical specialty physicians, with the greatest numbers practicing in general surgery (28,190 FTEs), orthopedic surgery (25,420 FTEs), and ophthalmology (18,470 FTEs).

In 2025, projected supply and demand for the 10 modeled surgical specialties show an overall deficit of 24,340 FTE surgeons, with 9 surgical specialties displaying shortages. The greatest deficits are predicted for ophthalmology (6,180 FTEs), orthopedic surgery (5,050), urology (3,630 FTEs) and general surgery (2,970 FTEs). Colon/rectal surgery is the only surgical specialty with an expected 2025 surplus at the national level (130 FTEs).

Exhibit 1: National Estimates of Supply and Demand of Surgical Specialty Physicians, 2013 -2025

Specialty[a]	Baseline Estimates (FTEs, 2013)	Projections (FTEs, 2025)		
	Supply = Demand[b]	Supply	Demand	Difference[c]
General Surgery	28,190	30,760	33,730	-2,970
Colon/Rectal Surgery	1,710	2,120	1,990	130
Neurological Surgery	5,160	4,930	6,130	-1,200
Ophthalmology	18,470	16,510	22,690	-6,180
Orthopedic Surgery	25,420	24,350	29,400	-5,050
Cardiothoracic Surgery	4,490	3,600	5,410	-1,810
Otolaryngology	9,440	9,190	10,810	-1,620
Plastic Surgery	7,720	7,280	8,770	-1,490
Urology	9,910	8,830	12,460	-3,630
Vascular Surgery	3,050	3,410	3,930	-520
Total	**113,560**	**110,980**	**135,320**	**-24,340**

Notes: Numbers may not sum to totals due to rounding. All estimates are rounded to the nearest 10.
[a] Specialties reflect physicians' primary reported discipline.
[b] Supply and demand for 2013 surgical specialty physicians were assumed to be in approximate equilibrium at the national level.
[c] Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Supply and demand for the 10 surgical specialties were also examined for the 4 U.S. Census Bureau regions (Appendix A, Exhibit A-1). Baseline supply and demand for regional projections are estimated independently and are not assumed to be in equilibrium. Regional

supply was determined according to the state where physicians practiced. Regional demands were estimated by prorating the national demand for health care services based on regional population characteristics (e.g., age, sex, household income, insurance status, health status, etc.) and applying the national staffing ratios. Thus regional demand projections account for variations in demographic, economic, and health risk factors between the regions, but because these do not account for regional differences in staffing and service delivery, they indicate the number of providers required by the regions to achieve a national level of care. As seen in Exhibit 2, the greatest projected surgical specialty deficits in 2025 occur in the South (10,210 FTEs) and Midwest (7,040 FTEs), with the West (5,330 FTEs), and Northeast (1,750 FTEs) also showing overall shortages. These total deficits are broken down further to assess deficits and surpluses among the 10 specialties with each region. For example, in the Northeast, general surgery (360 FTEs), colon/rectal surgery (240 FTEs), and vascular surgery (50 FTEs) all show surpluses in 2025, despite an overall deficit of surgical specialists (1,750 FTEs).

Exhibit 2: Regional Estimates of Supply and Demand of Surgical Specialty Physicians, 2013 -2025

Region[a] and Specialty[b]	Baseline Estimates (FTEs, 2013)			Projections (FTEs, 2025)		
	Supply	Demand	Difference[c]	Supply	Demand	Difference[c]
Northeast						
General Surgery	6,040	5,160	880	6,010	5,650	360
Colon/Rectal Surgery	440	300	140	560	320	240
Neurological Surgery	980	890	90	890	970	-80
Ophthalmology	4,180	3,560	620	3,400	4,010	-610
Orthopedic Surgery	5,010	4,890	120	4,420	5,210	-790
Cardiothoracic Surgery	980	860	120	760	960	-200
Otolaryngology	1,830	1,820	10	1,690	1,930	-240
Plastic Surgery	1,580	1,450	130	1,400	1,520	-120
Urology	2,150	1,820	330	1,740	2,100	-360
Vascular Surgery	760	590	170	740	690	50
Total	**23,950**	**21,340**	**2,610**	**21,610**	**23,360**	**-1,750**
Midwest						
General Surgery	5,970	6,330	-360	5,900	6,970	-1,070
Colon/Rectal Surgery	410	380	30	510	410	100
Neurological Surgery	1,090	1,160	-70	950	1,270	-320
Ophthalmology	3,700	4,200	-500	3,050	4,760	-1,710
Orthopedic Surgery	5,480	5,900	-420	4,870	6,320	-1,450
Cardiothoracic Surgery	980	960	20	750	1,060	-310
Otolaryngology	1,900	2,170	-270	1,700	2,300	-600
Plastic surgery	1,280	1,710	-430	1,110	1,810	-700
Urology	1,990	2,160	-170	1,690	2,510	-820
Vascular Surgery	630	680	-50	640	800	-160
Total	**23,430**	**25,650**	**-2,200**	**21,170**	**28,210**	**-7,040**

Region[a] and Specialty[b]	Baseline Estimates (FTEs, 2013)			Projections (FTEs, 2025)		
	Supply	Demand	Difference[c]	Supply	Demand	Difference[c]
South						
General Surgery	10,090	10,750	-660	11,390	13,140	-1,750
Colon/Rectal Surgery	570	670	-100	700	790	-90
Neurological Surgery	1,960	2,030	-70	1,900	2,460	-560
Ophthalmology	6,370	6,700	-330	5,840	8,380	-2,540
Orthopedic Surgery	8,960	9,260	-300	8,860	10,940	-2,080
Cardiothoracic Surgery	1,650	1,650	0	1,340	2,010	-670
Otolaryngology	3,520	3,330	190	3,460	3,880	-420
Plastic Surgery	2,880	2,850	30	2,770	3,270	-500
Urology	3,690	3,700	-10	3,360	4,730	-1,370
Vascular Surgery	1,070	1,170	-100	1,310	1,540	-230
Total	**40,760**	**42,110**	**-1,350**	**40,930**	**51,140**	**-10,210**
West						
General Surgery	6,090	5,950	140	7,470	7,970	-500
Colon/Rectal Surgery	290	360	-70	350	470	-120
Neurological Surgery	1,130	1,080	50	1,190	1,440	-250
Ophthalmology	4,210	4,010	200	4,220	5,530	-1,310
Orthopedic Surgery	5,970	5,360	610	6,200	6,930	730
Cardiothoracic Surgery	890	1,020	-130	750	1,380	-630
Otolaryngology	2,190	2,120	70	2,350	2,710	-360
Plastic Surgery	1,980	1,730	250	2,010	2,170	-160
Urology	2,080	2,230	-150	2,040	3,130	-1,090
Vascular Surgery	590	620	-30	720	900	-180
Total	**25,420**	**24,480**	**940**	**27,300**	**32,630**	**-5,330**

Notes: Numbers may not sum to totals due to rounding. All estimates are rounded to the nearest 10.

[a] Baseline supply and demand are not in equilibrium in the regions because regional demands were estimated by prorating the national demand for surgical services based on regional population characteristics (e.g., age, sex, household income, insurance status, health status, etc.).

[b] Specialties reflect the physicians' primary reported discipline.

[c] Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Surgical Specialty Physician Assistants

National provider supply and demand for the eight modeled PA surgical specialties are detailed in Exhibit 3. At baseline, over half of the estimated 20,230 FTE surgical PAs were orthopedic surgery specialists (10,440 FTEs). Again, modeling assumptions assume approximate equilibrium between provider supply and demand at baseline.

Nationally, 2025 surgical specialty PA supply is projected to be greater than demand by 13,990 FTEs. All 8 surgical specialties show a surplus of surgical specialty PAs, ranging from 30 FTEs for ophthalmology to 7,590 FTEs for orthopedic surgery.

Exhibit 3: National Estimates of Supply and Demand of Surgical Specialty Physician Assistants (PAs), 2013-2025

	Baseline Estimates (FTEs, 2013)	Projections (FTEs, 2025)		
Specialty[a]	Supply = Demand[b]	Supply	Demand	Difference[c]
General Surgery	2,960	5,660	3,540	2,120
Neurological Surgery	2,290	4,290	2,720	1,570
Ophthalmology	80	130	100	30
Orthopedic Surgery	10,440	19,660	12,070	7,590
Otolaryngology	1,020	1,890	1,170	720
Plastic Surgery	730	1,380	820	560
Urology	1,610	2,910	2,030	880
Vascular Surgery	1,100	1,930	1,410	520
Total	**20,230**	**37,850**	**23,860**	**13,990**

Notes: Numbers may not sum to totals due to rounding. All estimates are rounded to the nearest 10.
[a] Specialties reflect PAs' primary reported discipline. PAs were not modeled for cardiothoracic and colon/rectal surgical specialties due to the limited data available for these disciplines.
[b] Supply and demand for 2013 surgical specialty PAs were assumed to be in approximate equilibrium at the national level.
[c] Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Regional figures provide a different picture (Exhibit 4). Baseline estimates show shortages of PA surgical specialists in three regions: the Midwest (340 FTEs), the South (1,070 FTEs), and the West (350 FTEs). The Northeast is estimated to have equilibrium or a surplus at baseline in all modeled PA specialties, while the Midwest has no baseline surpluses of surgical PAs, and the South and West have equilibrium or surpluses at baseline in two surgical specialties (ophthalmology and vascular surgery in the South; ophthalmology and orthopedic surgery in the West).

Trending forward, in 2025 equilibrium or surpluses of surgical PAs are estimated for nearly all specialties across all regions with the exception of a small deficit in the Midwest for ophthalmology (10 FTEs). The largest projected surpluses are expected to occur in orthopedic surgery for all regions, followed by general surgery in the Northeast (990 FTEs), neurological surgery in the South (530 FTEs) and Northeast (500 FTEs), and general surgery in the West (500 FTEs).

Exhibit 4: Regional Estimates of Supply and Demand of Surgical Specialty Physician Assistants (PAs), 2013 -2025

Region[a] and Specialty[b]	Baseline Estimates (FTEs, 2013)			Projections (FTEs, 2025)		
	Supply	Demand	Difference[c]	Supply	Demand	Difference[c]
Northeast						
General Surgery	1,130	540	590	1,580	590	990
Neurological Surgery	640	400	240	930	430	500
Ophthalmology	20	20	0	20	20	0
Orthopedic Surgery	2,500	2,010	490	3,760	2,140	1,620
Otolaryngology	270	200	70	410	210	200
Plastic Surgery	210	130	80	310	140	170
Urology	490	300	190	650	340	310
Vascular Surgery	310	210	100	400	250	150
Total	**5,570**	**3,810**	**1,760**	**8,060**	**4,120**	**3,940**
Midwest						
General Surgery	620	660	-40	980	730	250
Neurological Surgery	410	510	-100	680	560	120
Ophthalmology	10	20	-10	10	20	-10
Orthopedic Surgery	2,370	2,430	-60	3,510	2,600	910
Otolaryngology	200	230	-30	300	250	50
Plastic Surgery	120	160	-40	210	170	40
Urology	340	350	-10	490	410	80
Vascular Surgery	190	240	-50	310	290	20
Total	**4,260**	**4,600**	**-340**	**6,490**	**5,030**	**1,460**
South						
General Surgery	760	1,140	-380	1,760	1,390	370
Neurological Surgery	820	900	-80	1,620	1,090	530
Ophthalmology	30	20	10	60	20	40
Orthopedic Surgery	3,340	3,810	-470	6,920	4,500	2,420
Otolaryngology	340	360	-20	660	420	240
Plastic Surgery	240	270	-30	460	300	160
Urology	500	600	-100	1,030	770	260
Vascular Surgery	430	430	0	780	570	210
Total	**6,460**	**7,530**	**-1,070**	**13,290**	**9,060**	**4,230**
West						
General Surgery	450	620	-170	1,340	840	500
Neurological Surgery	420	480	-60	1,070	640	430
Ophthalmology	20	20	0	30	20	10
Orthopedic Surgery	2,240	2,200	40	5,460	2,850	2,610
Otolaryngology	210	230	-20	520	290	230
Plastic Surgery	150	160	-10	390	200	190
Urology	280	360	-80	740	510	230
Vascular Surgery	170	220	-50	440	330	110
Total	**3,940**	**4,290**	**-350**	**9,990**	**5,680**	**4,310**

Notes: Numbers may not sum to totals due to rounding. All estimates are rounded to the nearest 10.

[a] Baseline supply and demand are not in equilibrium in the regions because regional demands were estimated by prorating the national demand for surgical services based on regional population characteristics (e.g., age, sex, household income, insurance status, health status, etc.).

[b] Specialties reflect PAs' primary reported discipline. PAs were not modeled for cardiothoracic and colon/rectal surgical specialties due to the limited data available for these disciplines.

[c] Difference = (supply – demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Strengths and Limitations

The HWSM used to develop the supply and demand projections presented in this report relies on a microsimulation approach that replaces the cohort-based workforce models used historically by HRSA and others.[8] A microsimulation approach was chosen for the HWSM because of the flexibility and granularity that this approach provides to simulate potential changes in health care delivery patterns.

HWSM is built to reflect the current patterns of health care utilization, service delivery, and labor market activities in the United States and its regions. In addition, it must be recognized that future supply and demand may be shaped by changes in a number of factors that include:

- Propensity to use health care services by demographic groups or insurance status
- Specialty care affordability
- Scope of practice regulations
- Technological advances and innovations in specialty care

As these factors change, the relationship between provider supply and demand will also change. As such, results presented in this report are to be interpreted based on the assumptions underlying HWSM.[9]

Summary

This report is one in a series of HRSA reports on the nation's health workforce. These reports are intended to help provide an understanding of the current and future workforce supply in the context of a growing and aging population, together with increased insurance coverage.

[8] Historically, supply has been modeled using a cohort approach with each cohort typically defined by age, sex, and occupation/specialty. Demand has historically been modeled by deriving provider-to-population ratios based on historical care use and delivery patterns, and then applying these ratios to subsets of the population defined by age group, sex, insurance status, and sometimes race and ethnicity.

[9] This model uses a micro-simulation approach where supply is projected based on the simulation of career choices of individual health workers. Demand for health care services is simulated for a representative sample of the current and future U.S. population based on each person's demographic and socioeconomic characteristics, health-related behavior, and health risk factors that affect their health care utilization patterns. For more information on data and methods, please see Technical Documentation for Health Resources Service Administration's Health Workforce Simulation Model

National increases in demand for the 10 surgical specialties modeled in this report are due, in part, to an aging population, as well as increased health care utilization following expanded insurance coverage. Physician supply at the national level is expected to fall short of projected demand in 2025 for all surgical specialties except colon/rectal surgery. The greatest projected national deficit is in ophthalmology (6,180 FTEs). In total, the capability to meet demands across the surgical specialties will fall short by 24,340 physician FTEs, although the national surplus of PAs practicing in surgical specialties (13,990 FTEs) may help to increase physician productivity.

Regional deficits are similar to those at the national level: across all four regions, physician supply for the majority of surgical specialties is inadequate to meet future demand. Again, although not a complete solution to the surgical specialist shortage, PAs may help address gaps in supply and demand across the United States.

It should be reiterated that these projections reflect the HWSM's underlying assumptions about baseline supply and demand, and the findings must be interpreted in the context of those assumptions. For example, the HWSM assumes national-level equilibrium at baseline between supply and demand for all PA specialties in this report. However, if baseline supply for these specialties is less than baseline demand, then the reported surplus of PA specialists may be an overestimate, and the projected 2025 supply may be closer to equilibrium with the projected demand.

In the absence of more specific data, it is not possible at this time to derive estimates of either shortages or surpluses of surgical specialty providers. However, as surgical specialty workforce data become more available, it will be possible to improve the microsimulation model to more fully characterize surgical specialty provider supply and demand.

Appendix A: U.S. Census Bureau Regions

Exhibit A-1 lists the states associated with each of the U.S. Census Bureau regions. This categorization was used in the regional projections of primary care practitioner supply and demand presented in this report.

Exhibit A-1: U.S. Census Bureau Regions and Associated States

NORTHEAST	MIDWEST	SOUTH	WEST
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	District of Columbia	Colorado
New Jersey	Michigan	Florida	Hawaii
New York	Minnesota	Georgia	Idaho
Pennsylvania	Missouri	Kentucky	Montana
Rhode Island	Nebraska	Louisiana	Nevada
Vermont	North Dakota	Maryland	New Mexico
	Ohio	Mississippi	Oregon
	South Dakota	Oklahoma	Utah
	Wisconsin	North Carolina	Washington
		South Carolina	Wyoming
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

Source: U.S. Census Bureau. 2015. Geographic Terms and Concepts: Census Divisions and Census Regions. Accessed 10/1/2015: Geographic Terms and Concepts - Census Divisions and Census Regions.

About the Model

The results included in this report come from HRSA's Health Workforce Simulation Model (HWSM), an integrated health professions projection model that estimates current and future supply and demand for health care providers.

The supply component of the HWSM simulates workforce decisions for each provider type based on each individual's demographics and profession, along with the characteristics of the local or national economy and the labor market. The starting supply plus new additions to the workforce minus attrition provide an end-of-year supply projection, which then becomes the starting supply estimate for the subsequent year. This cycle is repeated through 2025. Supply data come from multiple sources: the 2013 American Medical Association Physician Masterfile, the 2013 National Commission on Certification of Physician Assistants Masterfile, 2013 National Provider Identification data, and Florida's 2011-2013 physician survey.

Demand projections for health care services in different care settings are produced by applying regression equations for individuals' health care use on the projected population. The current staffing patterns by care setting are then applied to forecast the future demand for surgical specialty physicians and physician assistants. The population database used to estimate demand consists of records of individual characteristics of a representative sample of the entire U.S. population derived from the 2013 American Community Survey, the 2011 and 2013 Behavioral Risk Factor Surveillance System, the Bureau of Labor Statistics' Occupational Employment Statistics, and other sources. Using the Census Bureau's projected population and the Urban Institute's state-level estimates of the impact of the Affordable Care Act on insurance coverage,[10, 11] the HWSM simulates expected demographic, socioeconomic, health status, health risk and insurance status for future populations.

The HWSM makes projections at the state level which are then aggregated to regional and national levels. A detailed description of the HWSM can be found in the accompanying technical documentation available at HRSA: Health Workforce Analysis.

[10] Holahan, J. & Blumberg, L. 2010. How would states be affected by health reform? Timely analysis of immediate health policy issues. Accessed 10/1/2015: How Would States Be Affected by Health Reform?.

[11] Holahan, J. 2014. The launch of the Affordable Care Act in selected states: Coverage expansion and uninsurance. Washington, DC: The Urban Institute. Accessed 10/1/2015: The Launch of the Affordable Care Act in Selected States: Coverage Expansion and Uninsurance.

Tables 3 and 4 provide historical financial data and future financial projections based on the following assumptions:

Total cases are projected to increase over the current actual cases in the first 3 years of full utilization by 40%, 59% and 74% respectively.

Current year cases: 2,627

Projection:

2023: 3,700

2024: 4,175

2025: 4,575

Revenue is projected based on historical trend of average collections per case. The most recent 2 years average collections per case are $2,024 and $2,139. Collections assume a slight increase annually for inflation.

Current year average collection per case: $2,139

Projection:

2023: $2,150

2024: $2,175

2025: $2,200

Staffing and operating expenses are based on historical trends as a percentage of revenue. The staffing assumes sufficient head count increases for case projections.

Facility costs, including rents, debt servicing, plant and equipment depreciation are considered as additional expenses in Table 4. The projections demonstrate excess revenues over total expenses for the first three years of full utilization. The current actual trend for Net Income as percentage of revenue is 14%. Within the first five years of full utilization for the facility expansion, the projected percentage will achieve 13-14%.

Physicians Surgery Center of Frederick Accounting Team

EXHIBIT 7

TABLE 3

	Actual two most ended recent years		Current Year Projected	Projected Years (ending with first full year at full utilitzation)			
CY or FY (Circle)	2019	2020	2021	2022	2023	2024	2025
1. Revenue							
a. Inpatient services							
b. Outpatient services	4,506,517	4,170,269	6,051,543	6,943,000	7,955,000	9,080,625	10,065,000
c. Gross Patient Service Revenue	4,506,517	4,170,269	6,051,543	6,943,000	7,955,000	9,080,625	10,065,000
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue	4,506,517	4,170,269	6,051,543	6,943,000	7,955,000	9,080,625	10,065,000
h. Other Operating Revenues	20,796	11,785	15,000	15,000	15,000	15,000	15,000
i. Net Operating Revenue	4,527,313	4,182,054	6,066,543	6,958,000	7,970,000	9,095,625	10,080,000
3. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	1,251,755	1,299,693	1,815,463	2,082,900	2,386,500	2,724,188	3,019,500
b. Contractual Services							
c. Interest on Current Debt	20,295	17,217	15,003	10,030	5,013	1,610	815
d. Interest on Project Debt	0	0			42,000	41,000	36,000
e. Current Depreciation	117,802	278,758	150,000	100,000	75,000	50,000	50,000
f. Project Depreciation					351,000	251,000	126,000
g. Current Amortization	30,958	13,922	13,900	13,900	13,900	13,900	13,900
h. Project Amortization							
i. Supplies	1,728,824	1,775,345	2,420,617	2,777,200	3,182,000	3,632,250	4,026,000
j. Other Expenses (Facility Exp)	372,885	378,331	392,356	399,806	705,400	719,400	742,500
j. Other Expenses (Administrative)	282,260	254,314	363,093	416,580	477,300	544,838	603,900
j. Other Expenses (Misc)	634	126					
k. Total Operating Expenses	3,805,413	4,017,706	5,170,432	5,800,416	7,238,113	7,978,185	8,618,615
3. Income							
a. Income from Operation	721,900	164,348	896,111	1,157,584	731,887	1,117,440	1,461,385
b. Non-Operating Income	0	454,671					
c. Subtotal	721,900	619,019	896,111	1,157,584	731,887	1,117,440	1,461,385
d. Income Taxes		50,700	71,689	92,607	58,551	89,395	116,911
e. Net Income (Loss)	721,900	568,319	824,422	1,064,977	673,336	1,028,045	1,344,474

EXHIBIT 7

TABLE 4

Projected Years

(Ending with first full year at full utilization)

CY or FY (Circle)	2023	2024	2025	2026
1. Revenues				
a. Inpatient Services				
b. Outpatient Services	1,903,457	3,029,082	4,013,457	4,816,148
c. Gross Patient Services Revenue	1,903,457	3,029,082	4,013,457	4,816,148
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues	1,903,457	3,029,082	4,013,457	4,816,148
h. Total Net Operating Revenue	1,903,457	3,029,082	4,013,457	4,816,148
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	475,864	757,271	1,003,364	1,204,037
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt	42,000	41,000	36,000	30,000
e. Current Depreciation				
f. Project Depreciation	351,000	251,000	126,000	50,000
g. Current Amortization				
h. Project Amortization				
i. Supplies	666,210	1,060,179	1,404,710	1,685,652
j. Other Expenses (Facility)	447,400	461,400	484,500	506,303
j. Other Expenses (Admin)	85,656	136,309	180,606	216,727
j. Other Expenses (Misc)				
k. Total Operating Expenses	2,068,130	2,707,158	3,235,180	3,692,718
3. Income				
a. Income from Operation	-164,673	321,924	778,277	1,123,430

*2.2M @4.5% 20 yr amortization

Table 4 Cont.

Projected Years

(Ending with first full year at full utilization)

CY or FY (Circle)	2023	2024	2025	2026
b. Non-Operating Income	15,000	15,000	15,000	15,000
c. Subtotal	-149,673	336,924	793,277	1,138,430
d. Income Taxes		26,954	63,462	91,074
e. Net Income (Loss)	-149,673	309,970	729,815	1,047,356

EXHIBIT

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Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

OR time = Current Average 68 min/case

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
James Steinberg DO					2023		2024		2025		
[redacted]	Year 21		Year 22		Year 1		Year 2		Year 3		FHH Out patient only
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Approved Hip Replacement "None YTD 2021"
	290	19,720	175	11900	0	0	0	0	0	0	

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1 2020	Yr2 2021
Knee Arthroscopy		160
Knee Replacement (Partial)		57
Shoulder Arthroscopy		43

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

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 _____

Print Name: James Steinberg DO

EXHIBIT 8

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

OR time = Current Ave 73 min/case

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023		2024		2025		Facility(s) from which these cases will be migrating
Steven Horton, MD	Year 2021		Year 2022		Year 1		Year 2		Year 3		
[redacted]	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	None
	285	20,805	370	27,010	433	31,609	509	37,157	620	45,260	

+5% Dn St

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1 2020	Yr2 2021
Hand Fracture	0	3
Distal Radius	19	58
Nerve / Tendon Repair/Lig	6	10
Trigger Finger	0	25
Carpal Tunnel	22	80

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

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 [redacted] Scott Andochick, MD

Print Name: Steven Horton, MD

MP

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

OR Time: Ave 45 min/Case

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023		2024		2025		Facility(s) from which these cases will be migrating
[redacted]	Year 2021		Year 2022		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	None
	725	32,625	728	32,760	744	33,480	784	35,280	804	36,180	

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1 2021	Yr2 2020
Carpal Tunnel Release	329	307
Trigger Finger Release	86	75
Ganglion	56	28
Distal Radius Fracture	27	18
Fracture Upper Extremety	51	56

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

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 _____

Print Name: Kristin Nesbitt-Silon MD

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

ORTime: Current Ave 105 min/case

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
Matthew Levine, MD					2023		2024		2025		
[redacted]	Year 2021		Year 2022		Year 1		Year 2		Year 3		FHH: outpatient only
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Approved Shoulder
	215	22,575	350	36,750	473	49,738	519	54,495	552	57,960	Replacement

+.38 St cases

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1 2020	Yr2 2021
Shoulder) Arthroscopy	33	38
Distal Bicep Repair, U	9	9
Rotator) Cuff Repair)	88	71
ORIF Upper Extremety	16	13

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

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 [signature] SCOTT ANDOCHICK, M.D.

Print Name: Matthew Levine, MD

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

OR time: Current Average 63 min/case

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023		2024		2025		Facility(s) from which these cases will be migrating
[redacted]	Year 21		Year 22		Year 1		Year 2		Year 3		FHA - Out Patient Only
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Approved Hip
	140	8820	212	13,356	302	19026	331	20,853	387	24,381	Arthroplasty

† ~28 of Stemlergo cases

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1 2020	Yr2 2021
ORIF Fracture Upper Extr	5	0
Knee Arthroplasty	0	5
Knee Arthroscopy	11	6

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

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 [signature] SCOTT ANDOCHICK, M.D

Print Name: Cory Walsh, MD

OR time: Current Average 72 mins/case

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
[redacted]	Year 21		Year __		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	FHH - Out Patient
Rishi Gupta MD	6	432	45	3,240	138.5	9,972	182	13,104	208	14,976	Omby Arthroplasty

+.27 DoS

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1 2020	Yr2 2021
Knee Arthroplasty	0	4
Knee Fracture Chondroplasty	2	1
Knee Arthroscopy	0	6
I+D	1	0
Manip Knee	2	0

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

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 SG Andochick SCOTT ANDOCHICK, M.D

Print Name: Rishi Gupta, MD

Mecinski

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Ave OR time/case: 47.3 min

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
Adam Mecinski, MD					2023		2024		2025		
[redacted]	Year 2021		Year 2022		Year 1		Year 2		Year 3		FHH
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Meretues
	375	17,737	*425	20,102	*450	21,285	475	22,467	500	23,650	

* Adjusted Volume by surgeon compared to projections on p. 30 of application.

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
ORIF Fingers Fracture		
Breast Reduction		
Breast Reconstruction		

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

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 Adam Mecinski

Print Name: Adam Mecinski

Thadani

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Ave OR minutes : 24

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
Sunil Thadani MD					2023		2024		2025		
[redacted]	Year 2021		Year 2022		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	NONE
	675	16,200	700	16,800	730	17520	800	19,200	825	19,800	

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Cataract Extraction		
Cornea Transplant		

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

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 _____

Print Name: Sunil Thadani

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Ave minutes: 53

Physician Name Christopher HENRY, MD	Surgical Volume Latest 2 complete years				Projections 2023 2024 2025						Facility(s) from which these cases will be migrating
[redacted]	Year 2021		Year 2022		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	None
	15	795	30	1,590	50	2,650	75	3,975	95	5,035	

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Blepharoplasty		

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

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 _____

Print Name: Scott Andochick

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Ave OR minutes = 99

Samuel Sanders, MD

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023 2024 2025						Facility(s) from which these cases will be migrating
	Year 21		Year 22		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Pinecrest Surgery Center & Montgomery County, MD
	13	1289	34	3861	100	9900	150	14850	200	19800	

99

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Shoulder Arthroscopy	4	8
Knee Arthroscopy	6	12
ORIF	5	10
Achilles Repair	1	5
Other		4

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

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 _____

Print Name: SCOTT ANDOCHICK

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Ave OR time 83min

Gabriel Petruccelli, MD

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023		2024		2025		Facility(s) from which these cases will be migrating
	Year 21		Year 22		Year 1		Year 2		Year 3		Pinnacle Surgery Center Montgomery County MD
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
	10	990	31	3069	65	6435	100	9900	150	14850	

(YTD2021 * Actual 19 1577)

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Knee Arthroscopy	2	6
Shoulder - Rotator cuff	4	12
Tendon Repair	3	9
Carpal Tunnel	1	3

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

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 [signature]

Print Name: Scott Andochick

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Kordia Evans, MD

Ave OR time 138 min

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023		2024		2025		Facility(s) from which these cases will be migrating
	Year 2021		Year 2022		Year 1		Year 2		Year 3		Piccard Surgery Center Montgomery County, MD
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
	* 5	690	30	4140	60	8280	90	12649	110	15870	

YTD 2021 Actual: 8 1,104

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Hip Replacement - Ant	2	16
Uni-Knee Replacement	1	8
Total Knee Replacement	1	10
Shoulder - Rotator Cuff	1	2

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

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 SAndochick

Print Name: SCOTT Andochick

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Pending New Ophthalmologist 2022

Estimated OR time/Case ≈ 25 min

Physician Name	Surgical Volume Latest 2 complete years				Projections 2023		2024		2025		Facility(s) from which these cases will be migrating
	Year		Year 2022		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	None
	0	0	300	7,500	500	12,500	550	13,700	600	15,000	

* Not included in projection Table 1-2

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Cataract Extraction		
Cornea Transplant		
Pterygium Repair		

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

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 _____

Print Name: Scott Andochick

Andochick
Ave 158.63 min/case

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
Scott E. Andochick, MD					2023		2024		2025		
[redacted]	Year 2021		Year 2022		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
	95	15,105	100	15,900	120	19,080	150	23,850	180	28,620	NA

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2
Breast Reconstruction		

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

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 _____

Print Name: SCOTT ANDochick MD

Statistical History and Projections per Specialty. The number of surgical cases projected for the facility and for each physician and practitioner specialty:

Surgeon	Specialty	2020	2021	2022	2023	2024	2025
Andochick	Cosmetic and Reconstruction	69	95	100	120	150	180
Mecinski	Cosmetic and Reconstruction	333	375	400	430	475	500
Steinberg	Orthopedic	229	290	350	365	380	400
Nesbitt	Orthopedic	643	675	725	740	780	800
Levine	Orthopedic	166	215	300	335	375	400
Thadani	Ophthalmic	513	675	700	730	800	825
Horton	Orthopedic	59	285	360	415	490	600
Walsh	Orthopedic	20	140	175	200	225	275
Henry	Orthopedic	8	15	30	50	75	95
Gupta	Orthopedic	5	0	10	40	80	100
Other(New Surgeons) 3:orthopedic	Orthopedic	15	100	225	275	345	400
New Opth	Ophthalmic						
		HVAC and COVID Closures	Increase post COVID				
Total Cases		2060	2865	3275	3700	4175	4575

A minimum of two years of historic surgical case volume data for each physician or practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year January through December.

Surgeon	2019	Ave. time per case min.	2020	Ave. time per case	2021	Ave. time per case
Andochick	64	240	60	160	95	259
Mecinski	440	60	323	47	375	45
Steinberg	241	90	239	67	290	68
Nesbitt	798	60	653	44.5	675	44
Levine	174	120	166	105	215	106
Thadani	658	45	516	23	675	26
Horton	0		59	73	285	70
Walsh	15	120	20	63	140	56
Henry	27	60	8	54	15	54
Gupta	7	180	5	72	0	0
Other(New Surgeons) 3: orthopedic 1: Ophth	62	60	14	60	100	60
			(COVID)			
Total Cases	2486	Ave. 103.5 min	2060	Ave. 70 min	2865	Ave. 79 min.

EXHIBIT
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PHYSICIANS
SURGERY CENTER
of Frederick

William D. Chan
Program Manager
4160 Patterson Avenue
Baltimore, MD 21215
Matter: #21-10-2451

January 14, 2022

Dear Mr. Chan,

I am responding to the objection letter written by Frederick Health in relation to our CON application for two additional operating rooms. I would summarize their objection as follows:

- Inaccurate volume projections question our current optimal capacity.
- Impossible to determine how we are utilizing two ORs.
- Insufficient data to support the utilization of two more ORs.
- We overstated five-year projected volume increases anticipating CMS releasing most total joint procedures to outpatient.
- We did not contact Frederick Health to assess existing capacity or that Frederick Health could do the outpatient expansion to create a new ASC.
- We did not discuss how we intend to hire more staff.
- Experts predict that staffing shortage could lead to higher infection rates.
- In general, obtaining two new ORs in our surgical center will hurt Frederick Health.

My first letter to the State of Maryland was in 1994 when I arrived to Frederick to start my practice. In 1998, I pursued a CON and Frederick Health fought me for much of the same reasons as they do today. I finally opened a one OR/ one Procedure room center in 2002. I slowly grew my center adding two orthopedic surgeons and another plastic surgeon. In 2005, I engaged a corporate owner to help manage and run our center. This corporate owner was purchased by a larger entity who was purchased by another large entity. With each of these three corporate owners, they received 30% of the profits and $200,000 in management fees. In 2010, I again applied for movement of a local ASC with a CON to our facility to give us 2 ORs which was also fought by Frederick Health. We were approved and created a second operating room by expanding the procedure room. We partnered with another orthopedic surgeon and an eye surgeon creating a group of six surgeons for the last 10 years. This included myself, another plastic surgeon, an ophthalmologist, a shoulder specialist, a knee specialist, and a hand specialist. In 2018,

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we were finally able to buy out our corporate owner and became completely physician owned. Over the last five years, we have managed our center independently and grown each year. Currently, we have one new hand surgeon, two new total joint specialists, and three surgeons from Montgomery County who are becoming partners. Since Dr. Steinberg is leaving, this will bring us to a total of 11 surgeon partners with 5 surgeons specializing in total Hip, total Knee, and total shoulder replacement. There is simply not enough room for all the surgeons and cases. We are considering opening a Saturday total joint day.

In summary, it is impossible for me to answer specific questions concerning OR utilization, turnover times, etc, but we have provided those estimates in table 1-2 along with other supporting documents. I can only state that Frederick Health has always fought my applications over the last 25 years and somehow, we have grown and provided state-of-the-art care to our patients. We have only partnered with surgeons who are excellent at their specialty and we have selected the best anesthesiologists for our center. We have maintained a stable force of 40 employees who are committed to providing excellent care. If you were to visit our center, you would see how well we take care of patients and provide comprehensive care whether it is a small carpal tunnel release, a breast cancer reconstruction, or a total joint replacement. You would also see that we do so in a very tight 6200 square foot space. To provide this level of care to more patients, we are in dire need of expansion.

When Frederick Memorial Hospital changed their name to Frederick Health, they apparently spent millions for their new logo. What they failed to invest in years ago prior to COVID was providing a good and healthy environment that surgeons enjoyed working in. Instead, they focused on being punitive to surgeons for minutiae that had no impact on patient care. They failed to recognize the importance of providing consistent well-trained nurses and techs. They advanced nurses to management positions that should have never been promoted. In doing so, they lost franchise player nurses who should have been promoted. Many years ago, I labeled this the "Incestuous Advancement of Mediocrity." Eventually, this led to internal employee instability resulting in the loss of over 40 OR staff because of how they were treated by nurse management and due to the failure to increase pay appropriately. With this internal collapse, surgeons started to resist performing their procedures at the hospital. This essentially has been going on for the last decade and when COVID hit, the management and running of inpatient and outpatient surgeries were already crippled.

My impression of the management of the FH OR system is shared by almost all surgeons. For this reason, many surgeons have aligned with different ASC's in the area. The Thomas Johnson Center is partnered with SCA, but their surgeons are all close to retirement age. The only younger surgeons are FH employed urologists. The Monocacy Center is partnered with Tenet Health and they do predominantly ortho and the FH employed ENT group goes there. The Frederick Surgery Center, one mile down from us, is partnered with FH 35%, another corporate owner 30%, and aging surgeons. FH employed general surgery and ortho utilize this center.

In summary, FH and their employed surgeons have all been outsourced to three different ASC's. FH has slowly allowed their own OR system to dwindle running limited rooms and they maintain minimal staff. Of course, this is related to the need to take care of the covid patient increase, but they have been moving in this direction well before Covid. For FH to now argue that PSCF should not be allowed to expand to preserve their OR system is a complete contradiction of what they have created. FH has had plenty of time to build their own ASC, but they have never been able to develop this. FH has more resources and political "power" than any of us smaller entities. They have had many years to improve their inpatient services and create a state-of-the-art ASC. This has never been a priority of FH as demonstrated by their own employed surgeons going to 3 separate ASC's, only one which has FH as a partner. This has created a large void in Frederick and those of us who work so hard to attach the best surgeons and take the best care of patients should not be penalized. Our goals have always been to take the best care of patients, their surgeons, and staff. We have proven this simply because the best surgeons from Frederick and now Montgomery County want to work here.

After 25 years, PSCF has withstood many hurdles and we had many challenging years financially. We have persevered by always placing patients first. With the out flux of total joints and now mastectomies with reconstruction to ASC's, there is no way we can provide continued care without expansion. Our new center does not just offer two new ORs if granted, but sheltered pick up and drop off, spacious waiting room, and a 4000 sq foot 14 Bed Pre and Post unit. I truly believe that PSCF will become the Premier ASC in Frederick and provide the full complement of orthopedic service and breast cancer surgery.

I appreciate all consideration given to our application. I acknowledge that I carry no hostility towards FH. I appreciate what FH means to Frederick. My 89 yo parents will most likely make their last pass thru FH. As FH moves from an older restrictive standard of thinking into a more progressive inclusive way, there may be room for a healthy partnership in the future. I have met with a new FH addition, James Sherwood, who is a free thinker and I believe he will help carry FH to a much more progressive, inclusive position that will open these doors.

Again, Thank you for your time and consideration

Respectfully,

Scott E. Andochick, M.D., D.D.S., P.A.

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EXHIBIT 10