

Certificate of Need Application Form
Version 12.2012

Name of Applicant	Endoscopy Associates, Inc.
Title of Application	Transition to Freestanding Ambulatory Surgery Center
Date of Submission	January 10, 2013; Re-submitted February 4, 2013
Type of review	<input checked="" type="checkbox"/> Regular Review <input type="checkbox"/> Accelerated Review (provide letter from the state agency) <input type="checkbox"/> Expeditious Review (complete Appendix A)
Tax Status of Applicant	<input type="checkbox"/> Non-Profit <input checked="" type="checkbox"/> For-Profit

Pursuant to Chapter 15, Title 23 of The General Laws of Rhode Island, 1956, as amended, and Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15- CON).

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

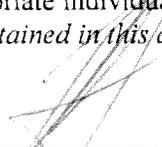
<p>Please have the appropriate individual attest to the following: <i>"I hereby certify that the information contained in this application is complete, accurate and true."</i></p>  <p>_____</p> <p>signed and dated by the President or Chief Executive Officer</p>

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PROJECT DESCRIPTION AND CONTACT INFORMATION

1.) Please provide below an Executive Summary of the proposal.

Endoscopy Associates, Inc. (the “Applicant”) is owned by the physician owners of Gastroenterology Associates, Inc., a Rhode Island professional corporation that provides gastroenterology services to patients. The Applicant provides gastroenterological endoscopy services to patients and currently holds a license to operate as a physician ambulatory surgery center. The Applicant proposes to transition to and obtain a license to operate as a freestanding ambulatory surgery center in order to increase its options with respect to its ownership structure. The Applicant currently does not have any plans to change its ownership structure, however, as a physician ambulatory surgery center the Applicant can only be owned by physicians and allow owners to utilize the facility. Upon approval of this CON application, the Applicant would have the option, if ultimately desired, to (i) allow a non-physician to purchase an ownership interest in the Applicant; and (ii) allow non-owner physicians to utilize the facility.

The Applicant currently operates from the surgery center located at 44 West River Street, 1st Floor, Providence, RI (the “Facility”). The Facility is owned by Nob Creek, LLC, a Rhode Island limited liability company. All of the owners of the Applicant are owners of Nob Creek, LLC. As set forth in response to Question 7(D), the Applicant’s hours of operation are typically 7:30 a.m. to 3:00 p.m. Monday through Friday. The Applicant generally serves patients from Rhode Island, southeastern Massachusetts, and eastern Connecticut.

The Applicant is currently Medicare certified and accredited by the Accreditation Association for Ambulatory Health Care (“AAAHHC”) and does not currently plan to seek accreditation from any other accreditation agency.

A consulting Architect has reviewed the facility plans and has made recommended changes (see Exhibit D2). The estimated total cost of the proposed renovations and new equipment is \$11,001.14 (see Exhibit 1). As shown in Exhibit 1, the total renovation costs are estimated at \$8,988. Additionally, new equipment costs are estimated at \$1,289 total for two wardrobe lockers and \$724.14 total for three Mckesson schuco pumps. Some changes are already underway. The Applicant anticipates that all of the recommended changes will be completed within one week of obtaining a license as an Freestanding Ambulatory Surgery Center.

2.)

Capital Cost	\$11,001.14	From responses to Questions 10 and 11
Operating Cost	\$1,427,000.00	For the first full year after implementation, from response to Question 18
Date of Proposal Implementation	August 2013	Month and year

3.) Please provide the following information:

Information of the applicant:

Name:	Endoscopy Associates, Inc.	Telephone #:	401-274-4800
Address:	44 West River Street, 1 st Floor, Providence, RI	Zip Code:	02904

Information of the facility (if different from applicant):

Name:	Same as above	Telephone #:	
Address:		Zip Code:	

Information of the Chief Executive Officer:

Name:	Neil Greenspan, M.D.	Telephone #:	401-274-4800
Address:	44 West River Street, 1 st Floor, Providence, RI	Zip Code:	02904
E-Mail:	neilgreenspan@yahoo.com	Fax #:	401-454-0410

Information for the person to contact regarding this proposal:

Name:	Stephen D. Zubiago, Esq.	Telephone #:	401-454-1017
Address:	One Citizens Plaza, Suite 500, Providence, RI	Zip Code:	02903
E-Mail:	SZubiago@Nixonpeabody.com	Fax #:	401-454-1030

4.) Select the category that best describes the facility named in Question 3.

- Freestanding ambulatory surgical center Home Care Provider
 Home Nursing Care Provider Hospital
 Hospice Provider
 Inpatient rehabilitation center (including drug/alcohol treatment centers)
 Multi-practice physician ambulatory surgery center
 Multi-practice podiatry ambulatory surgery center
 Nursing facility Other (specify): _____

5.) Please select each and every category that describes this proposal.

- A. construction, development or establishment of a new healthcare facility;
- B. a capital expenditure for:
 - 1. health care equipment in excess of \$2,250,000;
 - 2. construction or renovation of a health care facility in excess of \$5,250,000;
 - 3. an acquisition by or on behalf of a health care facility or HMO by lease or donation;
 - 4. acquisition of an existing health care facility, if the services or the bed capacity of the facility will be changed;
- C. any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers);
- D. any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, whichever is greater, and for which the related capital expenditures do not exceed \$2,000,000
- E. the offering of a new health service with annualized costs in excess of \$1,500,000;
- F. predevelopment activities not part of a proposal, but which cost in excess of \$5,250,000;
- G. establishment of an additional inpatient premise of an existing inpatient health care facility;
- H. tertiary or specialty care services: full body MRI, CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services. Or, expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities;

HEALTH PLANNING AND PUBLIC NEED

- 6.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency, including the Health Care Planning and Accountability Advisory Council, and any state plans for categorically defined programs. In your response, please identify all such priorities and how the proposal supports these priorities.

Response: The applicant is not aware of any state health plans that apply to outpatient endoscopy or colon cancer. However, the applicant is aware of the Rhode Island Comprehensive Cancer Control Plan (2007) (the “Plan”) and notes that with respect to detection and screening for colon cancer, the Plan recommends increasing the rate of endoscopic screening for colorectal cancer among adults age 50 and over by at least 10% by 2012. Applicant provides such screening endoscopies and will continue to help the state meet these important goals. The following table shows the expected impact of the subject proposal on and how the proposal will support each of the 10 goals of the Plan.

Goal	Description	Explanation	Impact of the Proposal
1	Reduce cancer risk through changes in behavior, policies and environment that promote healthy lifestyles	The priorities are to focus on reduction of tobacco, obesity, and sun exposure as well as an increase in the rates of physical activity, the HPV vaccine coverage, breastfeeding and physical activity as prevention measures	The proposal does not support this goal.
2	Increase proven, science- based cancer screening rates among all segments of the population in Rhode Island	Increase colorectal cancer screening rates through increased access and affordability is the priority for screening in RI. Breast, cervical, prostate and skin cancer screening are also important in reducing the burden of cancer through early detection .	Colorectal cancer, with 150,000 new cases annually and 50,000 deaths is the second most common cause of cancer deaths in the US. In Rhode Island in 2012 there were 540 new cases and 170 deaths attributed to colon cancer (American Cancer Society). Screening for colon cancer is a national and state priority in an attempt to reduce the incidence of colon cancer. Colonoscopy has been shown to reduce the risk of colon cancer via removal of precancerous lesions (polyps). More importantly, a recent study has proven that colonoscopy reduces the death rate due to colon cancer by 53%. (Zauber AG et al NEJM;366:689-96) . A

Goal	Description	Explanation	Impact of the Proposal
			copy of this article is included as <u>Exhibit 6</u> . Colonoscopy performed for screening or surveillance purposes is the most common procedure performed at West River Endoscopy providing access to this lifesaving procedure for 3,449 patients in 2012. Medicare and private insurance facility reimbursement at West River Endoscopy is a fraction of that provided to hospitals in the state. With the exception of hospitals that have a special arrangement with their insurance companies, out of pocket costs for patients is also lower for procedures performed at West River Endoscopy when compared with the hospital.
3	Ensure access to cancer care for all residents of Rhode Island	Increased access to healthcare and cancer treatment for all Rhode Islanders is essential for decreasing cancer mortality and disparities	The Applicant improves access to diagnostic and screening endoscopy services by providing these essential services to more than 5,500 patients annually. The lower cost when compared with the hospitals also improves access. Once a facility license is obtained, it is anticipated that each year 55 additional indigent patients will be served, further improving access to care.
4	Improve the quality of cancer treatment provided in Rhode Island	RI is working to have 100% of the acute care at RI hospitals approved by the American College of Surgeons Commission on Cancer (ACoS CoC) approved.	The proposal does not support this goal.
5	Enhance the treatment experience for cancer patients	The treatment experience for cancer patients can be enhanced through linguistically and culturally appropriate	The proposal does not support this goal.

Goal	Description	Explanation	Impact of the Proposal
		educational and supportive services	
6	Reduce workforce gaps and ensure an adequate supply of diverse and highly trained professionals in all aspects of cancer care and control	A diverse and well-trained workforce is essential for providing cancer prevention, early detection, treatment and support services	The Applicant hires and trains nurses and nursing assistants in the particular skills required to provide high quality endoscopic services, including, without limitation, cancer prevention, early detection, treatment and support services.
7	Increase awareness, access, and participation in cancer clinical trials by Rhode Island residents	In order to improve participation in clinical trials, this plan proposes a baseline assessment of cancer clinical trials, and activities that will increase public and provider awareness of clinical trials in RI.	The majority of patients diagnosed with cancer at the Applicant are referred for further care to oncologists at the Miriam Hospital and Memorial Hospital many of whom participate in clinical trials of cancer treatments.
8	Improve access to palliative care for all patients seeking end-of-life care due to cancer in Rhode Island	Cancer patients seeking end-of-life care should be informed about and have access to a palliative care team and hospital care if desired	The proposal does not support this goal.
9	Promote the well-being and quality of life of Rhode Islanders who are living with, through and beyond cancer	A new recognition of the importance of survivorship services focuses on assessing the current services, gaps, and a plan for improvement for the growing number of cancer survivors and their caretakers.	Patients who survive colon cancer are at increased risk for metachronous cancers. Patients diagnosed with colon cancer at the Applicant are entered into a surveillance program as recommended by National GI societies.
10	Assure the use of timely, complete, and accurate cancer surveillance data in the planning, management and evaluation of cancer control	In order to make informed decisions, track progress, and evaluate success, it is essential to maintain the integrity of the data surveillance systems in the state	The proposal does not support this goal. As stated in the RIDOH Rules and Regulations Pertaining to the Rhode Island Cancer Registry. Cancer reporting is the responsibility of the treating physician. In most cases this would be the surgeon or

Goal	Description	Explanation	Impact of the Proposal
	programs		oncologist to whom we refer the patient.

- 7.) On a separate sheet of paper, please discuss the proposal and present the demonstration of the public need for this proposal. Description of the public need must include at least the following elements:
- A. Please identify the documented availability and accessibility problems, if any, of all existing facilities, equipment and services available in the state similar to the one proposed herein:

[Please See Chart on Following Page]

Name of Facility/Service Provider	List similar type of Service/Equipment	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)
Ocean State Endoscopy	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	0.25
RIH Surgery Center at Wayland Square	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	2.5
Bayside Endoscopy	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	3.75
East Bay Endoscopy Center	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	31.5
Blackstone Valley Surgicare	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	7.25
East Greenwich Endoscopy Center	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	15.5
Landmark Medical Center	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	13.2
Memorial Hospital of RI	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	6.6
The Miriam Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	4.2
Rhode Island Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	5.3
Roger Williams Medical Center	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	3.1
St. Joseph Health Services	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	1.4
Women and Infants Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	5.3
Kent Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	15.5
Newport Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	37.5
South County Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	21.9
Westerly Hospital	Colonoscopy, EGD, flexible sigmoidoscopy	We are not aware of any documented availability problems	We are not aware of any documented accessibility problems	49.2

- B. Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in (A) above.

Response: This proposal will not result in any unnecessary duplication of similar existing services or equipment. First, it is important to note that this proposal does not contemplate the creation of a new endoscopy provider in the state. Rather, as this Certificate of Need is required as a result of the request for Freestanding Ambulatory Surgery Center (“FASC”) licensing, the facility will continue to provide the same services to the same patient population albeit under a different license, as it has for many years. If approved, this proposal will not increase the number of endoscopy rooms in the state.

Further, consultant reports analyzing the need for endoscopy rooms in Rhode Island and the Applicant’s historic, current, and projected utilization rates support the Applicant’s position that approval of this proposal will not result in unnecessary duplication of health care services in the state. The report prepared for the RIDOH in 2009 by Harvey Zimmerman at Spectrum Research Services, Inc. entitled, “Assessment of Need for Ambulatory Surgery Capacity in Rhode Island: 2009” (the “Zimmerman Report”) shows a projected oversupply (by 9 rooms) for operating and endoscopy rooms in Rhode Island through 2013 (See Table 3 of the Zimmerman Report). However, the Zimmerman Report shows that there is a projected undersupply (by 4 rooms) of endoscopy rooms in Rhode Island through 2013 (See Table 3 of the Zimmerman Report). To the Applicant’s knowledge, the Zimmerman Report is the most recent report available that analyzes the need for ambulatory surgery rooms in Rhode Island.

Moreover, as set forth in response to subsection D below, Applicant has operated at a utilization rate between 84% and 91% annually since 2010 and projects a 92% utilization through 2015. The state agency consultant report and the Applicant’s current and historical utilization rates clearly demonstrate that the Applicant provides necessary health care services in Rhode Island and that continuing to do so, even under a new license, will not result in any unnecessary duplication of similar existing services or equipment.

- C. Please identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.

Response: The primary service area is Providence, North Providence, Cranston, Johnston, Pawtucket and East Providence. Secondary Service area includes Warwick, Lincoln, Barrington, Smithfield and West Warwick.

Please identify the health needs of the population in (C) relative to this proposal.

Response: This population requires screening colonoscopies for individuals aged 50 and older and as needed for gastroenterological disease.

- D. Please identify utilization data for the past three years (if existing service) and as projected through the next three years, after implementation, for each separate area of service affected by this proposal. Please identify the units of service used.

Actual (last 3 years)	FY 2010	FY 2011	FY 2012
Hours of Operation	7:30A-3:00P	7:30A-3:00P	7:30A-3:00P
Utilization (#)	6104	6060	6579
Throughput Possible (#)	7300	7300	7300
Utilization Rate (%)	84%	83%	91%

Projected	FY 2013	FY 2014	FY 2015
Hours of Operation	7:30A-3:00P	7:30A-3:00P	7:30A-3:00P
Utilization	6700	6700	6700
Throughput Possible	7300	7300	7300
Utilization Rate (%)	92%	92%	92%

- E. Please identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.

Response: Again, this CON application is unique because it simply involves a request for a new license category. Thus the facility is presently satisfying existing need and it will continue to meet the same need if the CON is granted. The best evidence of the Applicant's ability to satisfy existing need for endoscopy services is its historical, current, and projected utilization rates. As set forth in response to subsection D above, Applicant has operated at a utilization rate between 84% and 91% annually since 2010 and projects a 92% utilization through 2015.

- F. Please identify and evaluate alternative proposals to satisfy the unmet need identified in (F) above, including developing a collaborative approach with existing providers of similar services.

Response: This is a unique CON filing in that the Applicant is currently operating and meeting existing need (at near capacity levels). Alternative proposals such as collaborative approaches with existing licensed and non-licensed providers to promote colonoscopy screenings instead of the establishment of a new licensed provider do not make sense in the context of this proposal because the Applicant's track record indicates that numerous patients seek services from the Applicant and it does not appear that other area centers could meet this capacity. Regardless, if this CON is not granted, the Applicant will continue to meet the need and provide the services. The Applicant is not seeking to establish a new licensed provider, it is an existing licensed provider. The Applicant has been a licensed endoscopy provider in Rhode Island for many years. Since its inception, the Applicant has worked to promote colonoscopy screenings and increase colonoscopy utilization in the state. The Applicant will continue to do so.

- G. Please provide a justification for the instant proposal and the scope thereof as opposed to the alternative proposals identified in (G) above.

Response: The justification for the instant proposal is the owners of the facility are seeking a higher license category for the facility and in order to do that Rhode Island law requires that they obtain a CON and demonstrate need and affordability. There is obvious need as the facility is currently utilized to near capacity. Next, we believe the CON is affordable because the license change will not increase either cost to patients or the amount that the facility is reimbursed by Medicare, Medicaid, or any third party payor. Alternative proposals such as collaborative approaches with existing licensed and non-licensed providers to promote colonoscopy screenings instead of the establishment of a new licensed provider do not make sense in the context of this proposal. The Applicant is not seeking to establish a new licensed provider, it is an existing licensed provider. The Applicant has been a licensed endoscopy provider in Rhode Island for many years. Since its inception, the Applicant has worked to promote colonoscopy screenings and increase colonoscopy utilization in the state. The Applicant will continue to do so.

HEALTH DISPARITIES AND CHARITY CARE

- 8.) The RI Department of Health defines health disparities as inequalities in health status, disease incidence, disease prevalence, morbidity, or mortality rates between populations as impacted by access to services, quality of services, and environmental triggers. Disparately affected populations may be described by race & ethnicity, age, disability status, level of education, gender, geographic location, income, or sexual orientation.

- A. Please describe all health disparities in the applicant's service area. Provide all appropriate documentation to substantiate your response including any assessments and data that describe the health disparities.

Response: The Plan notes that cancer is not equally distributed among the population and that women, the elderly, and African-Americans bear the highest burdens of cancer. Page 8 of the Plan. The Plan also indicates that individuals of low socio-economic status receive less health care services meaning often they receive cancer treatment when the disease is more advanced and accordingly have higher death rates. Page 10 of the Plan.

- B. Discuss the impact of the proposal on reducing and/or eliminating health disparities in the applicant's service area.

Response: The applicant will provide care to patients without regard to health disparities. The applicant's Providence location is a short distance from diverse socio-economic neighborhoods and applicant makes its services available to such residents. In addition, applicant's services are more cost effective than similar services provided at a hospital.

- 9.) Please provide a copy of the applicant's charity care policies and procedures and charity care application form.

Response: Attached hereto as Exhibit 9 is a copy of applicant's charity care policy and application form.

FINANCIAL ANALYSIS

- 10.) A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., \$112,527=\$113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES		
	Amount	Percent of Total
Survey/Studies	\$0	0%
Fees/Permits	\$0	0%
Architect	\$0	0%
“Soft” Construction Costs	\$0	0%
Site Preparation	\$193.00	1.8%
Demolition	\$224.00	2.0%
Renovation	\$8,571.00	78.0%
New Construction	\$0	0%
Contingency	\$0	0%
“Hard” Construction Costs	\$8,988.00	81.8%
Furnishings	\$0	0%
Movable Equipment	\$724.14	6.5%
Fixed Equipment	\$1,289.00	11.7%
“Equipment” Costs	\$2,013.14	18.2%
Capitalized Interest	\$0	0%
Bond Costs/Insurance	\$0	0%
Debt Services Reserve ¹	\$0	0%
Accounting/Legal	\$0	0%
Financing Fees	\$0	0%
“Financing” Costs	\$0	0%
Land	\$0	0%
Other (specify _____)	\$0	0%
“Other” Costs	\$0	0%
TOTAL CAPITAL COSTS	\$11,001.14	100%

¹ Should not exceed the first full year’s annual debt payment.

- B.) Please provide a detailed description of how the contingency cost in (A) above was determined.

Response: Not applicable.

C.) Given the above projection of the total capital expenditure of the proposal, please provide an analysis of this proposed cost. This analysis must address the following considerations:

- i. The financial plan for acquiring the necessary funds for all capital and operating expenses and income associated with the full implementation of this proposal, for the period of 6 months prior to, during and for three (3) years after this proposal is fully implemented, assuming approval.

Response: The Applicant can easily afford the estimated capital and operating costs of the proposal from its existing cash reserves and current operations at all applicable times, including 6 months prior to, during, and for 3 years after this proposal is fully implemented, assuming approval, as demonstrated by the Applicant's financial information set forth in response to Question 20(A) of this Application.

- ii. The relationship of the cost of this proposal to the total value of your facility's physical plant, equipment and health care services for capital and operating costs.

Response: The cost of this proposal represents a de minimus percentage of the total value of the Applicant's business, including its equipment and health care services.

- iii. A forecast for inflation of the estimated total capital cost of the proposal for the time period between initial submission of the application and full implementation of the proposal, assuming approval, including an assessment of how such inflation would impact the implementation of this proposal.

Response: The proposed renovations will be relatively inexpensive and quickly completed. Consequently, inflation will not impact the implementation of this proposal.

11.) Please indicate the financing mix for the capital cost of this proposal. NOTE: the Health Services Council's policy requires a minimum 20% equity investment in CON projects (33% equity minimum for equipment-related proposals).

Source	Amount	Percent	Interest Rate	Terms (Yrs.)	List source(s) of funds (and amount if multiple sources)
Equity*	\$11,001.14	100%			Applicant's cash on hand.
Debt**	\$0	0%	N/A%	N/A	N/A
Lease**	\$0	0%	N/A%	N/A	N/A
TOTAL	\$0	100%			

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (R23-15-CON).

** If debt and/or lease financing is indicated, please complete **Appendix F**.

12.) Will a fundraising drive be conducted to help finance this approval? Yes ___ No X

13.) Has a feasibility study been conducted of fundraising potential? Yes ___ No X

- If the response to Question 13 is 'Yes', please provide a copy of the feasibility study.

14.) Will the applicant apply for state and/or federal capital funding? Yes ___ No X

- If the response to Question 14 is 'Yes', please provide the source: _____, amount: _____, and the expected date of receipt of those monies: _____.

Response: As response to Question 14 is "No", no response is provided.

15.) Please calculate the yearly amount of depreciation and amortization to be expensed.

Response: All equipment used at the facility has already been fully depreciated. As noted elsewhere in this application, Applicant does not need to purchase new equipment. Therefore, there is no yearly depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
	Improvements	Equipment		Amortization	Total
		Fixed	Movable		
Total Cost	\$	\$	\$	\$	\$ *1*
(-) Salvage Value	\$	\$	\$	\$	\$
(=) Amount Expensed	\$	\$	\$	\$	\$
(/) Average Life (Yrs.)					
(=) Annual Depreciation	\$	\$	\$	\$	\$ *2*

1 Must equal the total capital cost (Question 10 above) less the cost of land and less the cost of any assets to be acquired through lease financing

2 Must equal the incremental "depreciation/amortization" expense, column -5-, in Question 18 (below).

- 16.) For the first full operating year of the proposal (identified in Question 18 below), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., \$42,575=\$43).

Response: Both the Medical Director and physicians are not compensated as employees of Endoscopy Associates, Inc. They are owners/shareholders and received distributions of the profits. Additionally, this proposal will not impact the number of FTEs needed to operate the facility.

Personnel	Existing		Additions/(Reductions)		New Totals	
	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes
Medical Director	0.1	\$0	0	\$0	0.1	\$0
Physicians	8	\$0	0	\$0	8	\$0
Administrator	1	\$123	0	\$0	1	\$123
RNs	4.5	\$241	0	\$0	4.5	\$241
LPNs	1	\$46	0	\$0	1	\$46
Nursing Aides	3	\$95	0	\$0	3	\$95
PTs	0	\$0	0	\$0	0	\$0
OTs	0	\$0	0	\$0	0	\$0
Speech Therapists	0	\$0	0	\$0	0	\$0
Clerical	3	\$132	0	\$0	3	\$132
Housekeeping	0	\$0	0	\$0	0	\$0
Other: (specify)	0	\$0	0	\$0	0	\$0
TOTAL	20.6	\$637	0	\$0	20.6	\$637

1 Must equal the incremental “payroll w/fringes” expense in column -5-, Question 18 (below).

INSTRUCTIONS:

- “FTEs” Full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
- “Additions” are NEW hires;
- “Reductions” are staffing economies achieved through attrition, layoffs, etc. It does **NOT** report the reallocation of personnel to other departments.

- 17.) Please describe the plan for the recruitment and training of personnel.

Response: The applicant plans on retaining all of its existing persons many of whom are long tenured employees.

[Remainder of Page Intentionally Left Blank]

18.) Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., \$112,527=\$113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., “depreciation” from Question 15 above, “payroll” from Question 16 above). If this proposal involved more than two separate “units of service” (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

CON approval or denial is not expected to impact budgeted pro-forma P&L statement.

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY					
	Actual Previous Year 2011 (1)	Budgeted Current Year 2012 (2)	<-- FIRST FULL OPERATING YEAR 2013 -->		
			CON Denied (3)	CON Approved (4)	Incremental Difference *1* (5)
REVENUES:					
Net Patient Revenue	\$3,035	\$3,275	\$3,335	\$3,335	\$ 0
Other:	\$0	\$0	\$0	\$0	\$ 0
Total Revenue	\$3,035	\$3,275	\$3,335	\$3,335	\$ 0
EXPENSES:	\$	\$	\$	\$	\$
Payroll w/Fringes	\$626	\$630	\$637	\$637	\$ 0
Bad Debt	\$0	\$0	\$0	\$0	\$ 0
Supplies	\$214	\$220	\$224	\$224	\$ 0
Office Expenses	\$206	\$213	\$217	\$217	\$ 0
Utilities	\$26	\$28	\$29	\$29	\$ 0
Insurance	\$5	\$6	\$7	\$7	\$ 0
Interest	\$0	\$0	\$0	\$0	\$ 0
Depreciation/Amortization	\$0	\$0	\$0	\$0	\$ 0
Leasehold Expenses	\$307	\$310	\$313	\$313	\$ 0
Other: (specify _____)	\$0	\$0	\$0	\$0	\$ 0
Total Expenses	\$1,384	\$1,407	\$1,427	\$1,427	\$ 0
OPERATING PROFIT:	\$1,651	\$1,868	\$1,908	\$1,908	\$ 0

For each service to be affected by this proposal, please identify each service and provide: the utilization, average net revenue per unit of services and the average expense per unit of service.

Service Type:	COLON				
Service (#s):	4205	4589	4675	4675	0
Net Revenue Per Unit *8*	\$519	\$515	\$515	\$515	\$0
Expense Per Unit	\$237	\$222.5	\$222	\$222	\$0
Service Type:	EGD				

Service (#s):	1737	1871	1900	1900	0
Net Revenue Per Unit *8*	\$473	\$470	\$470	\$470	\$0
Expense Per Unit	\$213	\$197	\$196	\$196	\$0
Service Type:	SIG				
Service (#s):	115	119	125	125	0
Net Revenue Per Unit *8*	\$276	\$275	\$275	\$275	\$0
Expense Per Unit	\$150	\$146	\$145	\$145	\$0

INSTRUCTIONS: Present all dollar amounts (except unit revenue and expense) in thousands.

- *1* The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column -3-.
- *2* Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.
- *3* Payroll with fringe benefits (column -5-) equals that identified in Question 16 above.
- *4* Bad Debt is the same as that identified in column -4-.
- *5* Interest Expense equals the first full year's interest paid on debt.
- *6* Depreciation equals a full year's depreciation (Question 15 above), not the half year booked in the year of purchase.
- *7* Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service;
- *8* Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.

19.) Please provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

Response: If the CON is approved the license category for the facility will change from physician ambulatory care facility ("PASC") to freestanding ambulatory care facility ("FASC"). The applicant is not aware that this license category change will impact reimbursement for the services provided. The facility will maintain the same name and tax identification number and provide the same services. There will be a facility fee associated with services provided in a licensed facility.

Projected First Full Operating Year: FY 2013									
Payor Mix	Implemented			Not Implemented			Difference		
	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue
	#	%	\$	#	%	\$	#	%	\$
Medicare	2,170	32.35%	\$828,000	2,170	32.35%	\$828,000	0	0%	\$0
RI Medicaid	15	0.35%	\$7,000	15	0.35%	\$7,000			
Non-RI Medicaid	0	0%	\$0	0	0%	\$0	PROJECTED UTILIZATION AND REVENUE WILL NOT CHANGE WITH CON.		
RIteCare	165	2.50%	\$67,000	165	2.50%	\$67,000	0	0%	\$0
Blue Cross	2,780	41.50%	\$1,600,000	2,780	41.50%	\$1,600,000	0	0%	\$0
Commercial	1,025	15.25%	\$505,000	1,025	15.25%	\$505,000	0	0%	\$0
HMO's	535	8.00%	\$325,000	535	8.00%	\$325,000	0	0%	\$0
Self Pay	5	0.05%	\$3,000	5	0.05%	\$3,000	0	0%	\$0
Charity Care	55	0%	\$0	55	0%	\$0	0	0%	\$0
Other: _____	0	0%	\$0	0	0%	\$0			
TOTAL	6,750	100%	\$3,335,000	6,750	100%	\$3,335,000	0	0%	\$0

20.) Please provide the following:

- A. Please provide audited financial statements for the most recent year available.

Response: Attached hereto as Exhibit 20(A) are audited financial statements for most recent fiscal year.

- B. Please discuss the impact of approval or denial of the proposal on the future viability of the (1) applicant and (2) providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

Response: The denial of the proposal may impact the applicant because it would not be able to joint venture with health care providers who are not physician owned which may be detrimental in the fast changing health care environment. The approval or denial of the proposal will not impact the viability of providers of health care services to a significant proportion of the population served.

21.) Please identify the derivable operating efficiencies, if any, (i.e., economies of scale or substitution of capital for personnel) which may result in lower total or unit costs as a result of this proposal.

Response: This proposal does not result in any derivable operating efficiencies which may result in lower total unit costs.

- 22.) Please describe on a separate sheet of paper all energy considerations incorporated in this proposal.

Response: As the services will be provided in the same facility, by the same personnel using the same methods if the CON is granted, there are no energy considerations.

- 23.) Please comment on the affordability of the proposal, specifically addressing the relative ability of the people of the state to pay for or incur the cost of the proposal, at the time, place and under the circumstances proposed. Additionally, please include in your discussion the consideration of the state's economy.

Response: We believe the proposal is affordable because it does not increase the cost of services received from it by the general population. As discussed in response to other questions, this CON proposal is required because the applicant wishes to change the license status of the facility. The facility will provide the same services in exchange for the same charges if the CON is approved.

With regard to the relative ability of the people of the state to pay for the proposal, the applicant acknowledges that the Rhode Island economy is struggling and that patients without health insurance often lack funds to pay for health services. We have already noted that this proposal does not increase the cost of services patients will receive from the facility. Accordingly, even given the struggling economy and the challenges of individuals without health insurance, applicant believes this proposal is affordable. Finally, applicant has a charity care policy and provides charity care.

- 24.) Please address how the proposal will support optimizing health system performance with regards to the following three dimensions:

Response:

- a. Improving the patient experience of care (including quality and satisfaction)

The Applicant has, since its inception continually collected data to assess patient satisfaction and the quality of care provided. The data is reviewed at least quarterly by the Applicant's Quality Committee and recommendations for improvement are referred to the Governing Board.

A copy of our patient satisfaction form is attached as Exhibit 24(a). The data speaks for itself.

All of the measures outlined by the American College of Gastroenterology and American Society of Gastrointestinal Endoscopy joint task force on endoscopic quality are tracked by the Applicant and include the following.

1. History and physical documentation on chart
2. Informed consent, including risks

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value.

Further evidence is documented in the following which concluded: Colonoscopy represents a cost-effective means of screening for colorectal cancer because it reduces mortality at relatively low incremental costs.

Cost-effectiveness of colonoscopy in screening for colorectal cancer. Sonnenberg, A et al *Annals of Internal Medicine*[2000, 133(8):573-584] PMID:11033584. A copy of this article is attached as Exhibit 24(c).

25.) Please identify any planned actions of the applicant to reduce, limit, or contain health care costs and improve the efficiency with which health care services are delivered to the citizens of this state.

Response: The ability of the Applicant to provide endoscopic services at a markedly reduced cost compared with hospital facilities will result in lower overall costs to the health care system. By expanding access to high quality screening colonoscopy services, Applicant will reduce the rate of colon cancer and the associated costs of treatment and lost productivity due to illness and premature death in patients affected by this disease.

QUALITY, TRACK RECORD, CONTINUITY OF CARE, AND RELATIONSHIP TO THE HEALTH CARE SYSTEM

26.) **A) If the applicant is an existing facility:**

Please identify and describe any outstanding cited health care facility licensure or certification deficiencies, citations or accreditation problems as may have been cited by appropriate authority. Please describe when and in what manner this licensure deficiency, citation or accreditation problem will be corrected.

Response: None.

B) If the applicant is a proposed new health care facility:

Please describe the quality assurance programs and/or activities which will relate to this proposal including both inter and intra-facility programs and/or activities and patient health outcomes analysis whether mandated by state or federal government or voluntarily assumed. In the absence of such programs and/or activities, please provide a full explanation of the reasons for such absence.

Response: Attached hereto as Exhibit 26(B) (originally submitted as Exhibit 24(B)) are the facility's Performance Improvement Plan relating to Peer Review, Performance Improvement, Quality Improvement and Benchmarking, and Medical Records. As indicated from the policies, the facility requires peer review of approximately 10% of the patient

charts. In addition, the Performance Improvement Committee oversees a range of quality improvement activities.

C) If this proposal involves construction or renovation:

Please describe your facility's plan for any temporary move of a facility or service necessitated by the proposed construction or renovation. Please describe your plans for ensuring, to the extent possible, continuation of services while the construction and renovation take place. Please include in this description your facility's plan for ensuring that patients will be protected from the noise, dust, etc. of construction.

Response: The planned renovations will not require a temporary move of the facility or service. The renovations are relatively simple, low-impact, and will be quickly completed over weekends and/or off hours. As such the renovations will not disrupt continuity of services and will not subject patients to noise, dust, or other adverse aspects typically associated with construction.

27.) Please discuss the impact of the proposal on the community to be served and the people of the neighborhoods close to the health care facility who are impacted by the proposal.

Response: From a healthcare perspective, this proposal allows the applicant to be positioned to meet the challenges of changing healthcare market by allowing the option of minority ownership by a healthcare company that is not physician owned. The facility has been located in a community area for seven (7) years and does not impact its neighborhood negatively.

28.) Please discuss the impact of the proposal on service linkages with other health care facilities/providers and on achieving continuity of patient care.

Response: The facility enjoys excellence service linkages with the primary care physicians who refer to the facility as well as the Gastroenterology Associates, the physicians who refer patients to the facility. These longstanding linkages allows for continuity of care.

29.) Please address the following:

- A. How the applicant will ensure full and open communication with their patients' primary care providers for the purposes of coordination of care;

Response: Once the patient has been seen and their procedure has been performed, an electronic report is generated by the providing physician. These reports are faxed to the patient's primary care physician within 48 hours. The reports that are faxed include the test result, changes recommended by the consulting physician, new prescriptions given to the patient upon discharge and the recommendations for follow-up care. If an abnormal result is discovered on exam that requires immediate intervention, the physician performing the procedure calls the patients' primary care physician directly to discuss recommendations and treatment options. If there are specimens obtained during the patient's procedure, they are sent to the pathology lab, which in turn processes the specimens and sends a report to the

physician that performed the procedure and a duplicate copy to the patients' primary care physician.

Standard operating procedure for filing and sending reports to the primary care physician from our facility is as follows: The secretary who faxes the reports verifies that the report has been sent successfully to the patients' PCP the next business day. The pathology results are reconciled monthly to ensure that all pathology reports have been successfully entered into the electronic medical record and reviewed by the physician that performed the procedure.

- B. Discuss the extent to which preventive services delivered in a primary care setting could prevent overuse of the proposed facility, medical equipment, or service and identify all such preventative services;

Response: The majorities of cases are performed for colorectal cancer screening purposes and are key to preventing colorectal cancer. Referrals are initiated by the patient's primary care physician. Once the procedure is completed, primary care physicians are notified of the results along with the recommended interval for follow-up exam. Recommendations are based on guidelines published by the American College of Gastroenterology (ACG) and American Gastroenterological Association (AGA). Initial screening guideline and post polypectomy guidelines are well published and known within the primary care setting which prevents overuse of services. In addition, Applicant has previously distributed laminated copies of nationally recognized screening and surveillance guidelines to all primary care providers in Rhode Island. A copy of the laminate is attached as Exhibit 29(B).

- C. Describe how the applicant will make investments, parallel to the proposal, to expand supportive primary care in the applicant's service area.

Response: As discussed above, the Applicant invests in primary care by establishing clinical and professional relationships that allow the facility and its physicians to support the services provided by the primary care physician.

- D. Describe how the applicant will use capitalization, collaboration and partnerships with community health centers and private primary care practices to reduce inappropriate Emergency Room use.

Response: Applicant's services do not result in patients utilizing an emergency room so applicant cannot influence inappropriate emergency room use.

- E. Identify unmet primary care needs in your service area, including "health professionals shortages", if any (information available at Office of Primary Care and Rural Health at <http://www.health.ri.gov/disease/primarycare/hpsa-professionals.php>).

Response: The Applicant does not provide primary care services so it does not have an understanding of the extent of unmet primary care need in its service area. However, the Health Resources and Services Administration within the U.S. Department of Health and Human Services designates Pawtucket, Central Falls, Providence, Newport, Middletown,

and Woonsocket areas as low-income primary care health professional shortages areas and it designates Block Island as a geographic primary care health professional shortages area. The Applicant is not aware of health professionals shortages in Providence.

30.) Please discuss the relationship of the services proposed to be provided to the existing health care system of the state.

Response: Applicant believes the services it provides fit well in the existing health care system. The physician owner's utilize Miriam Hospital and Memorial Hospital for their patients who require hospital care. Then the facility, which is out-patient and conveniently located, allows easy access for the ambulatory services which are provided.

31.) Please identify any state or federal licensure or certification citations and/or enforcement actions taken against the applicant and their affiliates within the past 3 years and the status or disposition of each.

Response: None.

32.) Please provide a list of pending or adjudicated citations, violations or charges against the applicant and their affiliates brought by any governmental agency or accrediting agency within the past 3 years and the status or disposition of each.

Response: None.

33.) Please provide a list of any investigations by federal, state or municipal agencies against the applicant and their affiliates within the past 3 years and the status or disposition of each.

Response: None.

Select and complete the Appendixes applicable to this application:

Appendix	Check off:	Required for:
A		Accelerated review applications
B		Applications involving provision of services to inpatients
C		Nursing Home applications
D	X	All applications
E		Applications with healthcare equipment costs in excess of \$2,596,709 and any tertiary/specialty care equipment
F		Applications with debt or lease financing
G	X	All applications

D

Appendix D

All applications must be accompanied by responses to the questions posed herein.

1. Provide a description and schematic drawing of the contemplated construction or renovation or new use of an existing structure and complete the Change in Space Form.

Response: Please see Exhibit D(1)(facility schematic) and Exhibit D(2)(description of renovations)

2. Please provide a letter stating that a preliminary review by a licensed architect indicates that the proposal is in full compliance with the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number.

Response: See letter from Vision 3 Architects dated January 9, 2013 attached hereto as Exhibit (D)(2). Please see timing and cost of implementing the necessary changes set forth in response to Question , Exhibit 1, and throughout this Application.

3. Provide assurance and/or evidence of compliance with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

Response: To its knowledge, applicant is in compliance with all applicable legal requirements.

4. Does the construction, renovation or use of space described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems: Yes X No _____

- o If Yes, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances or equivalencies.

Response: Please see Exhibit D(2) for a list of each specific code and the proposed corrective action. The Applicant will not seek any waiver, variance, or equivalency with respect to the deficiencies set forth in response to this question. The Applicant plans to take each corrective action regardless of the ultimate disposition of this application.

5. Describe all the alternatives to construction or renovation which were considered in planning this proposal and explain why these alternatives were rejected.

Response: As this proposal involves only minor renovation to address specific needs, alternatives were not examined.

6. Attach evidence of site control, a fee simple, or such other estate or interest in the site including necessary easements and rights of way sufficient to assure use and possession for the purpose of the construction of the project.

Response: Applicant leases the space that comprises the facility from NOB CREEK, LLC. A copy of the lease is attached hereto as Exhibit D(6).

7. If zoning approval is required, attach evidence of application for zoning approval.

Response: Zoning approval not required.

8. If this proposal involves new construction or expansion of patient occupancy, attach evidence from the appropriate state and/or municipal authority of an approved plan for water supply and sewage disposal.

Response: Proposal does not involve construction or expansion of patient occupancy.

9. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle.

Response: No construction required.

10. Assuming this proposal is approved, provide an estimated date (month/year) that the service will be actually offered or a change in service will be implemented. If this service will be phased in, describe what will be done in each phase.

Response: August 2013.

Change in Space Form Instructions

The purpose of this form is to identify the major effects of your proposal on the amount, configuration and use of space in your facility.

Column 1

Column 1 is used to identifying discrete units of space within your facility, which will be affected by this proposal. Enter in Column 1 each discrete service (or type of bed) or department, which as a result of this proposal is:

- a.) to utilize newly constructed space
- b.) to utilize renovated or modernized space
- c.) to vacate space scheduled for demolition

In each of the Columns 3, 4, and 5, you are requested to disaggregate the construction, renovation and demolition components of this proposal by service or department. In each instance, it is essential that the total amount of space involved in new construction, renovation or demolition be totally allocated to these discrete services or departments listed in Column 1.

Column 2

For each service or department listed in Column 1, enter in this column the total amount of space assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 3

For each service or department, please fill in the amount of space which that service or department is to occupy in proposed new construction. The figures in Column 3 should sum to the total amount of space of new construction in this proposal.

Column 4

For each service or department, please fill in the amount of space, which that service or department is to occupy in space to be modernized or renovated. The figures in column 4 should sum to the total amount of space of renovation and modernization in this proposal.

Column 5

For each service or department fill in the amount of currently occupied space which is proposed to be demolished. The figures in Column 5 should sum to the total amount of space of demolition specified in this proposal.

Column 6

For each service or department entered in Column 1, enter in this column the total amount of space which will, upon completion of this project, be assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 7

Subtract from the amount of space shown in Column 6 the amount shown in Column 2. Show an increase or decrease in the amount of space.

Change in Space Form

Please identify and provide a definition for the method used for measuring the space (i.e. gross square footage, net square footage, etc.):

Gross square footage

1. Service or Department Name	2. Current Space Amount	3. New Construction Space Amount	4. Renovation Space Amount	5. Amount of Space Currently Occupied to be Demolished	6. Proposed Space Amount	7. Change [(6)-(2)]
Endoscopy facility	3,911	0	3,911	0	3,911	0
TOTAL:	3,911	0	3,911	0	3,911	0

G



Appendix G

Ownership Information

All applications must be accompanied by responses to the questions posed herein.

- List all officers, members of the board of directors, trustees, stockholders, partners and other individuals who have an equity or otherwise controlling interest in the applicant. For each individual, provide their home and business address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

Response:

	Home Address	Business Address	Occupation	Position	% of Stock	Share of Partnership
Alyn Adrain, M.D.	64 Leroy Avenue Warwick, RI	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	14.93%	100
Evan Cohen, M.D.	29 Great Road Barrington, RI	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	14.93%	100
Neil Greenspan, M.D.	12 Nathaniel Road Barrington, RI	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	14.93%	100
Brett Kalmowitz, M.D.	40 Horizons Road Sharon, MA	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	10.45%	70
David Schreiber, M.D.	53 Ashcroft Road Sharon, MA	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	14.93%	100
Samir Shah, M.D.	5 Wadsworth Way Sharon, MA	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	14.93%	100
Jeremy Spector, M.D.	7 Chachapacassett Rd. Barrington, RI	44 West River Street Providence, RI	Physician	Shareholder, Owner, Partner, Director, Officer	14.93%	100

- For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

Response: None other than the ownership disclosed above in Endoscopy Associates, Inc.

- If any individual listed in response to Question 1 above, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending

institution, insurance or professional services, please identify each such individual and the nature of each relationship.

Response: The individuals listed in response to Question 1 above are owners of Endoscopy Associates, Inc. They have no other business relationship with the applicant.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes ___ No X.

- If response is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

Response: None

5. Please provide organization chart for the applicant, identifying all "parent" entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all subsidiary entities owned by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.

Response: See Exhibit G(5) attached hereto.

6. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 5 above (applicant and/or its principals). For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

Response: None.

7. Have any of the facilities identified in Question 5 or 6 above had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license? Yes ___ No X

- If response is 'Yes', please identify the facility involved, the nature of each incident, and the resolution of each incident.

8. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 or 6 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes ___ No X

- If response is 'Yes', please identify the facility and its current status.

9. For applications involving establishment of a new entity or involving out of state entities, please provide the following documents: Not applicable as no new entity or out of state entity involved in this project.
- Certificate and Articles of Incorporation and By-Laws (for corporations)
 - Certificate of Partnership and Partnership Agreement (for partnerships)
 - Certificate of Organization and Operating Agreement (for limited liability corporations)

Response: See Exhibit G(9) attached hereto containing the Endoscopy Associates, Inc. Certificate of Incorporation and bylaws.

1

E W BURMAN

GENERAL CONTRACTORS

January 31, 2013

Neil R. Greenspan MD, FACG
Chief Executive Officer
Endoscopy Associates
44 West River Street
Providence, RI 02904

Re: CON Compliance – Proposal

Dear Neil:

We are pleased to provide you with this proposal to furnish the labor and materials to complete item #'s 3 & 4 of the remedial work as per Vision 3 Architects letter dated January 9, 2013.

Our price to complete this work is **\$8,988**.

Our proposal includes the following:

Item 3: Toilet Room Doors

- Work to include reworking the door openings at Toilet Rooms 114 & 121 so that the doors swing outward
- Erect temporary poly dust containment barriers
- Remove and salvage the existing wood doors and hardware
- Remove and dispose of the existing welded hollow metal door frames
- Patch the existing adjacent drywall
- Furnish and install two new hollow metal knock down door frames
- Paint the new door frames and the patched drywall partitions
- Reinstall the salvaged wood doors and hardware
- Lead time on the door frames is approximately 2 weeks and installation to take around 4 days

Item 4: Finishes, Floors

- Work to include the following rooms; Clean 134, Hold 135, Soiled 136
- Remove the existing vinyl composition tile and vinyl base
- Prepare the subfloor to provide a smooth, bondable surface
- Furnish and install Mannington's Biospec MD vinyl flooring with integral flash cove base and heat welded seams
- If no work is required in room Hold 135, please deduct \$950
- Lead time on the flooring material is 2 to 3 weeks and will take around 5 days to install

Thank you for the opportunity to quote this work and should you have any questions, please let me know.

Very truly yours,

Andrew Burman
Project Manager

cc: File

Spreadsheet Level	Takeoff Quantity	Labor Amount	Material Amount	Sub Amount	Total Amount
01 Overhead					
1350 Temporary Partitions					
6 Mil Poly Dust Barrier	150.00 sqft	163	30	-	193
Temporary Partitions		163	30		193
1725 Cleanup					
Final Cleanup	1.00 lsum	-	-	200	200
Cleanup				200	200
01 Overhead		163	30	200	393
02 Demolition					
2008 Remove Doors & Windows					
Wood Door	2.00 each	71	20	-	91
Hollow Metal Frame single	2.00 each	123	10	-	133
Remove Doors & Windows		194	30		224
02 Demolition		194	30		224
08 Doors					
8120 Hollow Metal Frames					
Install Hollow Metal Door Frame	2.00 each	331	2	-	333
Hollow Metal Door Frame	2.00 each	-	390	-	390
Hollow Metal Frames		331	392		723
8200 Wood Doors					
Install Wood Door	2.00 each	331	2	-	333
Wood Doors		331	2		333
08 Doors		663	394		1,057
09 Drywall					
9259 Taping & Patching					
Patch DW @ Door/Window Opening	120.00 sqft	300	145	-	445
Taping & Patching		300	145		445
09 Drywall		300	145		445
09 Flooring					
9665 Resilient Sheet					
Resilient Sheet Floor Sub	1.00 lsum	-	-	5,700	5,700
Resilient Sheet				5,700	5,700
09 Flooring				5,700	5,700
09 Painting					
9920 Painting					
Touch Up Painting	200.00 sqft	-	-	660	660
Painting				660	660
09 Painting				660	660

Estimate Totals

Description	Amount	Totals	Hours	Rate
Labor	1,320		16.336 ch	
Material	599			
Subcontract	6,560			
	<hr/>			
	8,479	8,479		
Fee	509			6.000 %
	<hr/>			
	509	8,988		
Total		8,988		

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Colonoscopic Polypectomy and Long-Term Prevention of Colorectal-Cancer Deaths

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ABSTRACT

BACKGROUND

In the National Polyp Study (NPS), colorectal cancer was prevented by colonoscopic removal of adenomatous polyps. We evaluated the long-term effect of colonoscopic polypectomy in a study on mortality from colorectal cancer.

METHODS

We included in this analysis all patients prospectively referred for initial colonoscopy (between 1980 and 1990) at NPS clinical centers who had polyps (adenomas and nonadenomas). The National Death Index was used to identify deaths and to determine the cause of death; follow-up time was as long as 23 years. Mortality from colorectal cancer among patients with adenomas removed was compared with the expected incidence-based mortality from colorectal cancer in the general population, as estimated from the Surveillance Epidemiology and End Results (SEER) Program, and with the observed mortality from colorectal cancer among patients with nonadenomatous polyps (internal control group).

RESULTS

Among 2602 patients who had adenomas removed during participation in the study, after a median of 15.8 years, 1246 patients had died from any cause and 12 had died from colorectal cancer. Given an estimated 25.4 expected deaths from colorectal cancer in the general population, the standardized incidence-based mortality ratio was 0.47 (95% confidence interval [CI], 0.26 to 0.80) with colonoscopic polypectomy, suggesting a 53% reduction in mortality. Mortality from colorectal cancer was similar among patients with adenomas and those with nonadenomatous polyps during the first 10 years after polypectomy (relative risk, 1.2; 95% CI, 0.1 to 10.6).

CONCLUSIONS

These findings support the hypothesis that colonoscopic removal of adenomatous polyps prevents death from colorectal cancer. (Funded by the National Cancer Institute and others.)

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IT HAS BEEN A LONG-STANDING BELIEF THAT screening for colorectal cancer can affect mortality from the disease in two ways: by detecting cancers at an early, curable stage and by detecting and removing adenomas.¹ Detection of early-stage colorectal cancer has been shown to be associated with a reduction in mortality from colorectal cancer in screening trials.²⁻⁴ However, an adenomatous polyp is a much more common neoplastic finding on endoscopic screening. We previously reported that colonoscopic polypectomy in the National Polyp Study (NPS) cohort reduced the incidence of colorectal cancer.⁵ An important question is whether the cancers prevented by colonoscopic polypectomy in the cohort were those that had the potential to cause death. To estimate the effect of colonoscopic detection and removal of adenomatous polyps on mortality from colorectal cancer, we examined mortality in the study cohort during a surveillance period of up to 23 years after colonoscopic polypectomy.

METHODS

STUDY DESIGN

We conducted a long-term follow-up study of the NPS cohort using the National Death Index (NDI) to determine the death rate among patients with adenomatous polyps that had been removed, as compared with mortality from colorectal cancer in the general population and in an internal concurrent control group of patients with nonadenomatous polyps.⁶

The NPS was a multicenter postpolypectomy surveillance study of patients with one or more newly diagnosed adenomas; it involved seven clinical centers that represent a wide range of endoscopic practices (see the Supplementary Appendix, available with the full text of this article at [NEJM.org](http://www.nejm.org)). Patients in the randomized, controlled trial were assigned either to surveillance colonoscopy at 1 and 3 years after polypectomy or to first surveillance colonoscopy at 3 years; both groups were offered surveillance colonoscopy at 6 years. Previous reports have detailed the study design and methods.^{5,7-9}

PATIENTS

All patients referred for initial colonoscopy at the seven clinical centers between November 1980 and February 1990 who did not have a family or personal history of familial polyposis or inflamma-

tory bowel disease or a personal history of prior polypectomy or colorectal cancer were prospectively evaluated for enrollment in the randomized, controlled trial of surveillance intervals and underwent a protocol-specified colonoscopy.^{8,9} Patients had been referred for colonoscopy because of positive findings on barium enema examination (27%), sigmoidoscopy (15%), fecal occult-blood test (11%), or other tests (10%) or because of symptoms (32%) or a family history (5%) of colorectal cancer.⁸ All identified polyps were removed and centrally reviewed according to NPS pathological criteria.⁷ Patients were classified at the initial colonoscopy as having adenomatous polyps or only nonadenomatous polyps (i.e., mucosal tags or hyperplastic polyps) by pathological classification at the clinical center (Fig. 1). Patients with newly diagnosed adenomas were eligible for the randomized, controlled study if they underwent a complete colonoscopy to the cecum with removal of one or more adenomas and if all polyps detected were removed. Patients were ineligible if they had no polyps or had gross colorectal cancer, inflammatory bowel disease, malignant polyps (i.e., a polyp removed at colonoscopy that appeared to be benign on endoscopy but that was identified as invasive adenocarcinoma on pathological assessment¹⁰), or sessile polyps greater than 3 cm in diameter, or if the colonoscopy was incomplete. The current analysis of mortality from colorectal cancer included all patients with adenomas who were eligible for the randomized trial and all patients with only nonadenomatous polyps (Table 1 and Fig. 1).

COMPARISON GROUPS

General Population

To compare the observed mortality in the adenoma cohort with appropriately matched rates in the general population, we used incidence-based mortality to adjust the general-population rates for our exclusions. Incidence-based mortality, which is derived by following back deaths in the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) population-based registry program to their diagnosis (<http://surveillance.cancer.gov/statistics/ibm>), allows mortality to be partitioned by date of diagnosis.¹² We excluded deaths from colorectal cancer in the SEER database that occurred in cases that were diagnosed before the calendar year of enrollment in the NPS and those that were diagnosed within 3 years after enrollment. This 3-year time lag corresponds to the average

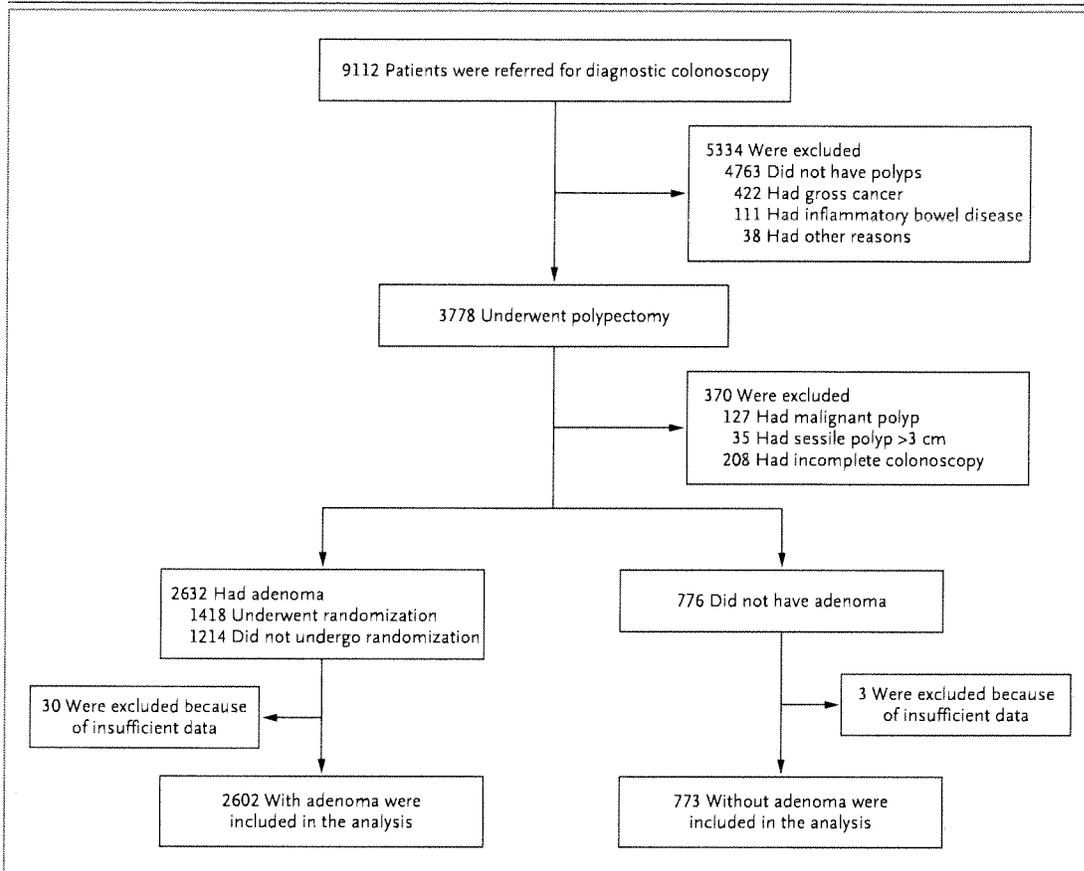


Figure 1. Study Enrollment.

Of the 9112 patients referred for this study, 2602 with adenomatous polyps and 773 with only nonadenomatous polyps were included in the analysis. Diagnosis was made according to pathological classification at the clinical center. Only patients who provided sufficient demographic information (at least first and last names and either Social Security number or the month and year of birth) were matched against data from the National Death Index. These identifiers were not retained for patients with no polyps or with gross cancer; consequently, none of these patients were included in the analysis of mortality. In addition, 30 patients with adenomas and 3 with nonadenomas did not have sufficient demographic information and were not included in the analysis.

cancer sojourn time, as estimated from screening studies that use fecal occult-blood tests. The period during which a cancer can be detected by a screening test (e.g., the fecal occult-blood test) before entering a clinical phase is defined as the cancer sojourn time.¹³ During the study-enrollment period (from 1980 through 1990), there was a small percentage of people who underwent screening for colorectal cancer, with screening performed predominantly by means of a guaiac fecal occult-blood test.^{14,15} On the basis of the available literature, we estimated an average sojourn time for colorectal cancer of 3 years (range, 2 to 5).^{13,16-18}

We used SEER*Stat with the SEER registries of nine areas (SEER9),¹⁹ which included data from

1975 forward, for the analysis of incidence-based mortality from colorectal cancer. We used the National Center for Health Statistics database for the analysis of all causes of death in the general population.²⁰

Nonadenoma Cohort as Internal Concurrent Control

Patients referred for initial colonoscopy at the participating centers from 1980 through 1990 who had only nonadenomatous polyps (including mucosal tags) were used as an internal concurrent control group for the adenoma cohort.^{6,8} All hyperplastic polyps were reviewed in 2007 and were reclassified on the basis of criteria for the serrated polyp pathway.²¹

END POINTS

To ascertain mortality from colorectal cancer, we matched the NPS patient cohorts against records in the NDI, the registry of all deaths in the United States, from 1980 through 2003.²² NPS records were matched against the NDI data on the basis of name, Social Security number, date of birth, sex, marital status, state of birth, and state of residence. Only records that included sufficient information — at least first and last names and either Social Security number or the month and year of birth — were matched against the NDI data (Fig. 1). The identifiers of date of birth and Social Security number were not collected for patients with no polyps or with gross cancer; consequently, data for these

patients could not be matched against the NDI data and are not included in this study. In addition, a small number of patients in the adenoma and nonadenoma cohorts had insufficient information to allow a match with the NDI registry and were excluded from the analysis.

STUDY OVERSIGHT

The human subjects committee of the Memorial Sloan-Kettering Cancer Center approved the NPS. Patients provided authorization to release all medical and pathological reports to the study, as well as written informed consent to participate in the trial. In addition, the committee granted a waiver of authorization to conduct the search of the NDI.

Table 1. Baseline Characteristics of the Adenoma and Nonadenoma Cohorts.*

Characteristic	Adenoma (N = 2602)	Nonadenoma (N = 773)	P Value†
Age — yr‡	62.0±11.1	57.3±12.7	<0.001
Mean			
Age group — no. (%)			
<50 yr	327 (12.6)	193 (25.0)	<0.001
50–59 yr	682 (26.2)	223 (28.8)	
60–69 yr	926 (35.6)	233 (30.1)	
≥70 yr	657 (25.3)	124 (16.0)	
Sex — no. (%)§			
Male	1722 (66.2)	466 (60.3)	0.002
Female	878 (33.7)	307 (39.7)	
Race — no. (%)¶			
White	2143 (82.4)	640 (82.8)	0.39
Black	178 (6.8)	61 (7.9)	
Other	25 (1.0)	9 (1.2)	
Unknown	256 (9.8)	63 (8.2)	
No. of first-degree relatives with colorectal cancer — no. (%)			
0	2169 (83.4)	669 (86.5)	0.08
1	376 (14.5)	87 (11.3)	
≥2	57 (2.2)	17 (2.2)	
No. of colonoscopies to clear all detected polyps — no. (%)			
1	2320 (89.2)	757 (97.9)	<0.001
2	266 (10.2)	16 (2.1)	
≥3	16 (0.6)	0	
Participation in randomized follow-up surveillance study of patients with adenomas — no. (%)		NA	
Yes	1418 (54.5)		
No	1184 (45.5)		

Characteristic	Adenoma (N=2602)	Nonadenoma (N=773)	P Value†
Most advanced adenoma — no./total no. (%)‖		NA	
Nonadvanced	1075/2517 (42.7)		
Advanced**	1442/2517 (57.3)		
No. of adenomas — no./total no. (%)‖		NA	
1	1475/2517 (58.6)		
2	555/2517 (22.1)		
≥3	487/2517 (19.3)		
Location of adenomas — no./total no. (%)‖††		NA	
Distal only	1621/2517 (64.4)		
Any proximal	896/2517 (35.6)		
Proximal only	377/2517 (15.0)		
Distal and proximal	519/2517 (20.6)		

* Plus-minus values are means \pm SD. NA denotes not applicable.

† Chi-square tests were used for the comparison of categorical variables between groups; Student's t-test was used for the comparison of mean age.

‡ Data on age were missing for 10 patients in the adenoma cohort.

§ Data on sex were missing for 2 patients in the adenoma cohort.

¶ Race was self-reported. The proportion of blacks in the NPS patient population was consistent with the U.S. Census estimate of blacks at similar ages (9%).¹¹

‖ Of the 2602 patients with adenomas, 85 (3.3%) had polyps that were originally classified as adenomatous at the clinical centers but were reclassified as nonadenomatous by NPS pathological review, so the total number of patients with adenomas in this calculation is 2517.

** Advanced adenoma was defined by a diameter of 1.0 cm or more, tubulovillous or villous histologic appearance, or high-grade dysplasia. Of the 1442 patients with advanced adenomas, 895 (62%) had only tubular adenomas that were 1.0 cm or larger.

†† Location of the adenomas was defined as proximal for lesions in the cecum, ascending colon, hepatic flexure, and transverse colon and as distal for lesions in the splenic flexure, descending colon, sigmoid colon, or rectum.

STATISTICAL ANALYSIS

Person-years at risk were calculated for each patient from the date of the initial colonoscopy until death or the last date of follow-up (December 31, 2003), according to NDI records and categorized by age (within 5-year groups), sex, race, calendar year, and calendar year of enrollment in the study. These data on person-years at risk were used in conjunction with the incidence-based mortality from colorectal cancer in the general population, according to SEER9 data, to determine the number of deaths from colorectal cancer that would be expected in the adenoma cohort if the cohort had the same rate of death as that among members of the general population with similar age, sex, race, and calendar-year characteristics and with adjustment for the same exclusions.²³

The observed number of deaths was assumed to follow a Poisson distribution. The standardized incidence-based mortality ratio was derived as the

ratio of observed to expected deaths from colorectal cancer, and the exact 95% confidence interval was calculated. A two-sided P value of 0.05 or less was considered to indicate statistical significance. The percent reduction was calculated as the complement of the standardized mortality ratio multiplied by 100. The results are presented for the entire follow-up time, for the first 10 years (0 to 9.9 years), and for 10 or more years of follow-up. The standardized mortality ratio for all causes of death was also calculated.

Fisher's exact test was used to compare the observed mortality in the adenoma and nonadenoma cohorts in the first 10 years of follow-up. The net cumulative mortality curves specific for colorectal cancer were derived as the complement of the Kaplan-Meier cumulative survival curve. SAS software, version 9.2 (SAS Institute), was used for analyses.

The accuracy of the NDI match to the NPS co-

Table 2. Characteristics of the 12 Patients with Adenomas Who Died of Colorectal Cancer, According to Interval from Baseline Colonoscopy to Death.*

Patient No.	Sex	Race†	At Baseline Colonoscopy						At Time of Death		
			Age	Year Enrolled	Adenomas	Most Advanced Histologic Type	Largest Adenoma	Location of Adenoma	First-Degree Relatives with Colorectal Cancer	Age	Interval from Baseline Colonoscopy to Death
1	M	Black	50	1989	2	Tubular	0.6	Splenic flexure, ascending	0	56	6
2	M	Other	49	1982	1	Tubular‡	1.0	Sigmoid	0	56	7
3	M	White	50	1981	1	Tubulovillous	1.5	Sigmoid	0	59	9
4	F	Other	56	1988	1	Tubular	0.2	Sigmoid	0	65	9
5	F	White	66	1982	1	Tubular	0.6	Descending	2	76	10
6	F	White	34	1982	1	Villous	1.0	Rectum	0	44	10
7	F	White	75	1989	2	Tubular	1.0	Sigmoid, ascending	0	86	11
8	M	White	58	1987	6	Tubular	2.0	Splenic flexure (1), ascending (5)	1	70	12
9	F	Other	62	1982	1	Villous	1.2	Sigmoid	0	75	13
10	M	White	50	1982	2	Tubular	2.0	Sigmoid	0	67	17
11	F	White	52	1981	1	Tubular	0.5	Sigmoid	0	72	20
12	M	White	63	1981	1	Tubular	0.8	Hepatic flexure	0	85	22

* For patients with deaths matched to the National Death Index (NDI) who died during the period from 1980 through 1998, the deaths from colorectal cancer were those with cause of death coded by NDI-Plus as 1530–1539, 1540, 1541, or 1590, based on codes from the *International Classification of Diseases, 8th Revision and 9th Revision* (ICD-8 and ICD-9); if they died during the period from 1999 through 2003, the cause of death was coded as C18.0–C18.9, C19.0–C19.9, C20.0–C20.9, or C26.0, based on codes from the *International Classification of Diseases, 10th Revision* (ICD-10). Five cases of colorectal cancer were diagnosed in the patients with adenomas during active surveillance⁵; none of these patients died of colorectal cancer.

† Race was self-reported.

‡ The diagnosis was made on the basis of pathological classification at a clinical center. Diagnoses for the other 11 patients were made on the basis of NPS pathological review.

hort was determined by evaluating the sensitivity and specificity of the match in the group of 1418 patients with adenomatous polyps who were enrolled and followed directly in the randomized trial of surveillance intervals.⁹ Deaths were closely monitored among these patients from 1980 through 1990. Analysis of these deaths served as an assessment of the completeness of the overall cohort match to the NDI for all deaths.²⁴

RESULTS

MORTALITY IN THE ADENOMA COHORT

The characteristics of the 2602 patients with adenomatous polyps are shown in Table 1. In the randomized adenoma cohort, 81% of patients underwent one or more surveillance colonoscopies.⁹ There were 37,073 person-years at risk in the ad-

enoma cohort. The median follow-up period was 15.8 years, with a maximum of 23 years. On the basis of the NDI match, there were 1246 deaths among the 2602 patients (48%). All-cause mortality was lower in the adenoma cohort than in the general population, matched by age, sex, race, and calendar year on the basis of SEER data (standardized mortality ratio, 0.85; 95% confidence interval [CI], 0.81 to 0.90). The NDI match for the 1418 patients in the randomized, controlled trial had 97.5% sensitivity, 99.7% specificity, and 99.4% overall accuracy in classifying deaths.

There were 12 deaths from colorectal cancer in the adenoma cohort (Table 2), as compared with 25.4 expected deaths from the disease in the general population (standardized incidence-based mortality ratio, 0.47; 95% CI, 0.26 to 0.80) (Table 3), corresponding to an estimated 53% reduction

Table 3. Deaths from Colorectal Cancer in the Adenoma Cohort, as Compared with Incidence-Based Mortality from Colorectal Cancer in the General Population.*

Follow-up Time	Adenoma Cohort			General Population			P Value
	No.	Person-Years at Risk	Observed Deaths <i>no.</i>	Expected Deaths <i>no.</i>	SMR (95% CI)	Reduction %	
All	2602	37,073	12	25.4	0.47 (0.26–0.80)	53	0.008
<10 yr	2602	22,903	4	9.1	0.44 (0.14–1.06)	56	0.09
≥10 yr	2031	14,170	8	16.3	0.49 (0.23–0.93)	51	0.04

* Data on the general population are from the Surveillance, Epidemiology, and End Results registries of nine areas (SEER9). The standardized mortality ratio (SMR) and percent reduction in mortality are for the adenoma cohort as compared with the general population.

in mortality from colorectal cancer. The reduction in mortality for the first 10 years of follow-up (0 to 9.9 years) was similar to that for 10 or more years of follow-up (Table 3). The cumulative mortality rate in the adenoma cohort at 20 years was 0.8%, as compared with an estimated 1.5% in the general population (on the basis of SEER9 data) (Fig. 2).

Sensitivity analyses of 2-year and 5-year cancer sojourn times showed a reduction in mortality from colorectal cancer of 56% (P=0.003) and 44% (P=0.04), respectively, for the entire 23 years of follow-up. The 51% reduction in mortality for the follow-up period of 10 or more years was not affected by varying the sojourn time.

MORTALITY IN THE NONADENOMA COHORT

Of the 773 patients in the NPS with nonadenomatous polyps, 278 (36%) had hyperplastic polyps; there were no serrated polyps with adenomatous change or dysplasia in this cohort. These patients were followed for a total of 12,090 person-years, with a median follow-up period of 16.5 years. Patients with nonadenomatous polyps were similar to those with adenomatous polyps with respect to race and number of first-degree relatives with colorectal cancer. However, they were younger than the adenoma cohort (57 years vs. 62 years, P<0.001) and more likely to be women (40% vs. 34%, P=0.002) and accordingly at lower risk for colorectal cancer (Table 1). There was one death from colorectal cancer at 7.7 years. In the first 10 years after the initial colonoscopy, the observed mortality for colorectal cancer in the adenoma cohort was similar to that in the nonadenoma cohort (0.19% and 0.15%, respectively; relative risk for the adenoma cohort, 1.2; 95% CI, 0.1 to 10.6; P=1.0) (Table 4).

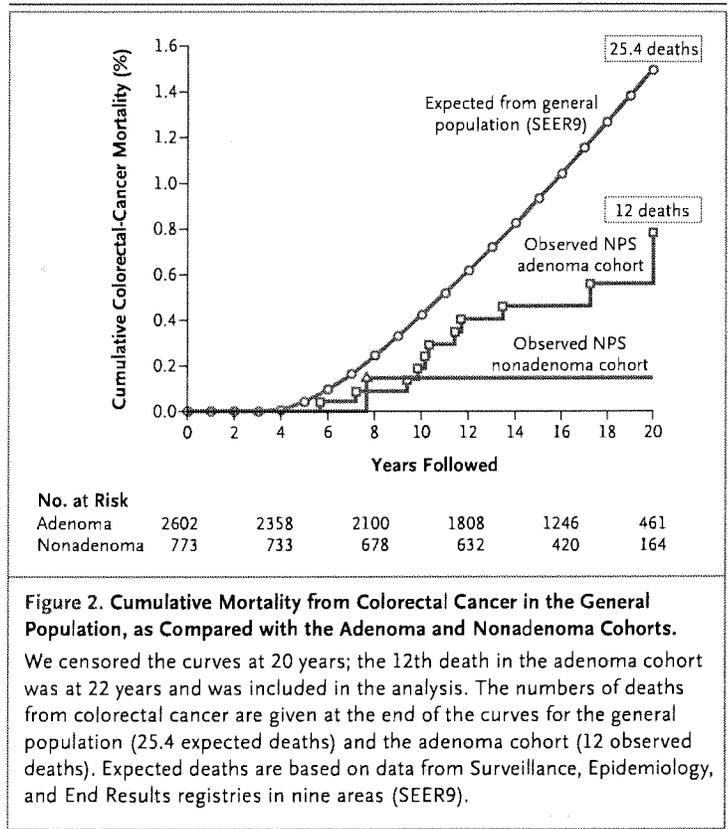


Figure 2. Cumulative Mortality from Colorectal Cancer in the General Population, as Compared with the Adenoma and Nonadenoma Cohorts. We censored the curves at 20 years; the 12th death in the adenoma cohort was at 22 years and was included in the analysis. The numbers of deaths from colorectal cancer are given at the end of the curves for the general population (25.4 expected deaths) and the adenoma cohort (12 observed deaths). Expected deaths are based on data from Surveillance, Epidemiology, and End Results registries in nine areas (SEER9).

DISCUSSION

We previously found that polypectomy reduced the incidence of colorectal cancer in the NPS cohort.⁵ The present study suggests that adenoma removal significantly reduced the risk of death from colorectal cancer, as compared with that in the general population, and in the first 10 years after polypectomy, reduced the risk to a level similar to that in

Table 4. Comparison of Adenoma and Nonadenoma Cohorts in the First 10 Years after Initial Colonoscopy.*

Cohort	No. of Patients	Person-Years at Risk	Observed Deaths	Relative Risk (95% CI)	P Value†
Adenoma	2602	22,903	4	1.2 (0.1–10.6)	1.00
Nonadenoma	773	7,178	1	1.0	

* The mean follow-up time within the first 10 years was 9 years for both the adenoma and nonadenoma cohorts.

† Fisher's exact test was used to compare the observed mortality in the two cohorts.

an internal concurrent control group of patients with no adenomas.

Our comparison of observed deaths in the adenoma cohort with expected deaths in the general population, based on SEER data that were specific for age, sex, race, and calendar year, may have underestimated the reduction in mortality that may be achieved with colonoscopic polypectomy in screening populations. Because all the patients in the adenoma cohort had adenomas, including 57.3% with advanced adenomas, they represented a higher-risk group than the general population.²⁵⁻²⁷

The comparison of mortality in the adenoma cohort with that in a concurrent control group of patients in the NPS who did not have adenomatous polyps supported the results of the comparison with estimated mortality in the general population.⁶ The patients without adenomas were similar to those with adenomas, except for the findings at initial colonoscopy. The group without a precursor adenoma would be expected to have low mortality from colorectal cancer, and several studies have also shown that patients with no polyps or with nonadenomatous polyps have low rates of colorectal neoplasia after colonoscopy.²⁸⁻³¹

A cohort of patients with adenomas in whom polypectomy was not performed would, of course, be a more meaningful comparison group for the patients in the NPS with adenomas, all of whom underwent polypectomy, but such a comparison group would not be an option on either ethical or clinical grounds because of the known potential for adenomas to progress to carcinoma. We addressed this comparison using a microsimulation model of the mortality effect had the adenomas not been removed and the natural history of the adenoma–carcinoma sequence had proceeded without intervention. This model, the MISCAN-Colon model of the Cancer Intervention and Surveillance Modeling Network (CISNET) ([.cancer.gov/colorectal\), showed an even larger reduction in mortality from polypectomy than the comparison with the SEER incidence-based mortality rates \(see the Supplementary Appendix\).](http://cisnet</p>
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Although the NPS does not address the effectiveness of screening colonoscopy in the general population, our findings provide an indirect estimate of the effect of removing adenomas, which is the primary interventional measure in screening colonoscopy. Studies and commentaries have raised issues regarding the magnitude of the effect of colonoscopy on the incidence of and mortality from colorectal cancer.³²⁻³⁸ A recent study from Germany showed a large effect of colonoscopy on the incidence of colorectal cancer.³⁹ In two Canadian studies,^{32,34} the mortality reduction from colonoscopy in community practice was largest when the colonoscopy was performed by a gastroenterologist³⁴ and when the examination was complete.³² The magnitude of the reduction in mortality among the patients in the NPS after polypectomy is probably due to high-quality colonoscopy performed by well-trained gastroenterologists.⁴⁰⁻⁴⁵ These issues will be more precisely understood after completion of long-term randomized, controlled trials of screening colonoscopy in the general population that have recently been initiated in northern Europe (Nordic-European Initiative on Colorectal Cancer; ClinicalTrials.gov number, NCT00883792),⁴⁶ in Spain (ClinicalTrials.gov number, NCT00906997), and by the Veterans Administration in the United States (ClinicalTrials.gov number, NCT01239082); the incidence and mortality end points will not be available for at least 10 or more years.

This prospective study has some limitations. First, a small number of trained endoscopists performed the colonoscopies according to a study protocol that required examination to the cecum, adequate preparation, careful inspection of the colon, and removal of all identified polyps, features that are consistent with reports of high-quality performance.⁴⁰⁻⁴² Consequently, the NPS observations may not be generalizable to present community practice, for which reported incidence rates of colorectal cancer after polypectomy are higher than those reported in the NPS.^{47,48}

Comparisons with mortality from colorectal cancer in the general population, based on the SEER data, were limited by our inability to adjust for differences between the NPS cohort and the general population in risk factors, behaviors, ac-

cess to health care, or quality of health care. All-cause mortality was lower for the patients enrolled in the NPS than for the general population; the difference may be attributable to better access to medical care (which included colonoscopy) in the NPS study and the fact that the study patients were in sufficiently good health (especially with respect to cardiovascular disease)⁴⁹ to have been referred for colonoscopy during the period from November 1980 through February 1990.

Our comparison of the two NPS cohorts (patients with and those without adenomas) was limited by the very small number of deaths from colorectal cancer, as reflected by the wide confidence intervals, indicating either a large decrease or a large increase in the relative risk of death from colorectal cancer for the patients with adenomas, as compared with those with only nonadenomas.

An additional limitation of the study is that it did not take account of potential changes in lifestyle over time. After detection and removal of an adenoma, patients may stop smoking, modify their diet, control their weight, increase their physical activity, and take multivitamins and nonsteroidal antiinflammatory drugs^{15,50-53} to prevent recurrence of adenomas and prevent colorectal cancer.

Deaths that occurred during the study were ascertained with the use of data from the NDI. These data are based on information from death certificates, which do not include the site in the colorectum of the original cancer. Consequently, mortality rates associated with proximal and distal cancers could not be compared in this study.²⁴

Finally, 81% of the patients in the randomized adenoma cohort underwent surveillance colonoscopies after polypectomy.⁹ Consequently, the polypectomy effect for these patients would include the effect of surveillance colonoscopies as well.⁵⁴

In conclusion, we previously reported a lower-than-expected incidence of colorectal cancer in patients after the removal of adenomatous polyps,⁵ and this study shows that polypectomy results in reduced mortality from colorectal cancer. These combined findings indicate that adenomas identified and removed at colonoscopy include those that are clinically important, with the potential to progress to cancer and cause death. A demonstrated reduction in mortality with colonoscopic polypectomy is a critical prerequisite for continued recommendations of screening colonoscopy in clinical practice while we wait for the results of randomized, controlled trials of screening colonoscopy.

The views expressed in this article are those of the authors and do not necessarily represent the official views of the National Cancer Institute or the National Institutes of Health.

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No potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Exhibit 9

Endoscopy Associates, Inc.
44 West River Street
1st Floor
Providence, Rhode Island

Outreach and Charity Care Policy

January 1, 2013

1. Purpose. It shall be the policy of Endoscopy Associates, Inc. located at 44 West River Street, Providence, RI (the "Center") to provide free care to patients consistent with the charity care obligations under Rhode Island law.

2. Qualifying Patients. The Center will provide free care to those patients (a "Qualifying Patient") who meet the charity care guidelines as issued and periodically revised by Rhode Island Hospital ("RIH") as listed on Exhibit A attached hereto. Accordingly, Qualifying Patients will be those uninsured or underinsured patients with incomes up to 200% of the Federal Poverty Limits and with limited assets. Asset limits shall be \$8,000 for an individual and \$12,000 for a family. Because of the nature of the Center's services, all patients must be referred to the Center from one of the following appropriate screening institutions:
 - a) RIH, The Miriam Hospital ("TMH"), Roger Williams Hospital, or St. Joseph's Hospital;
 - b) The Community Health Centers listed on Exhibit B attached hereto;
 - c) Rhode Island Primary Care Physician Advisory Committee; or
 - d) Another health care provider.

3. Charity Care Policy. The Center agrees it will neither bill Qualifying Patients for endoscopy or colonoscopy services nor collect any fees for provision of such services in order to satisfy its charity care obligations.

4. Outreach. The Center shall establish an Outreach Program as follows.
 - 4.1 Outreach Coordinator. The Center shall designate an Outreach Coordinator who shall be responsible for outreach efforts on behalf of the Center. The Outreach Coordinator shall be Alice Micklich.

 - 4.2 Written Outreach Materials. The Center will send out a written communication annually to the Community Health Centers listed in Exhibit B to make them aware of the Center's Charity Care Policy. The written communication will be substantially similar to the letter attached hereto as Exhibit C. In addition, annually, the Center will send out information about the existence of its Charity Care Policy to the Rhode Island Primary Care Physician Advisory Committee ("RIPCPAC") in order to facilitate the dissemination of the Center's Charity Care Policy to primary care physicians. An initial letter to RIPCPAC is attached hereto as Exhibit D. The Center will also forward

information about the Charity Care Policy upon request of any patient or physician. A draft of such letter is attached hereto as Exhibit E. This same letter will also be sent to all physicians listed as having privileges at TMH.

4.3 Review of Outreach. The Outreach Coordinator shall review the effectiveness of the outreach efforts of the Center, at a minimum, on an annual basis. The Outreach Coordinator shall report to the Center's Board of Managers upon completion of any review. If the Center's charity care goal is not being met, the Outreach Coordinator will suggest alternative outreach methods for consideration and implementation. The Center shall take all reasonable efforts suggested by the Outreach Coordinator to reach its charity care goal and create an effective Outreach Program.

5. Monitoring.

5.1 The Center Front Desk and Staff will keep a log of patients and calls received regarding the Center's Charity Care Policy. The Log Form is attached hereto as Exhibit F.

5.2 Annually a questionnaire will be sent to the entities listed in Section 2(a)-(d) of this Policy as well as all physicians that were sent charity care information. The questionnaire is attached hereto as Exhibit G. The Outreach Coordinator will review the results captured on this Questionnaire and make follow up calls to any physician or entity who rated our program less than an average of a score of 3 overall. Feedback provided by the physicians and entities will be utilized to make necessary changes to the provision of charity care at the Center, including the charity care process and the charity care materials or presentations utilized by the Center.

5.3 The Log Form and Quarterly Questionnaires will be presented at the Center's Board of Managers meetings for consideration and review.

5.4 An Outreach Calendar will be maintained and updated by the Outreach Coordinator and will include the event, date, and attendance at the outreach event. At each Board of Managers meeting, the outreach calendar will be presented and discussed, and concerns or changes will be implemented as determined appropriate.

5.5 An Annual Summary of Outreach activity based on the Outreach Calendar and Board of Managers meetings will be drafted and provided to the Board of Managers on an annual basis.

Exhibit A

Rhode Island Hospital Charity Care Policy

Exhibit B

Community Health Centers

Bayside Family Healthcare
308 Callahan Road
North Kingstown, RI 02852

Blackstone Valley Community Health Care
Pawtucket
42 Park Place
Pawtucket, RI 02860

Blackstone Valley Community Health Center
Central Falls
9 Chestnut Street
Central Falls, RI 02863

Block Island Health Services
Box 919
Block Island, RI 02807

Chad Brown Health Center
285 A Chad Brown Street
Providence, RI 02908

East Bay Family Health Care
100 Bullocks Point Avenue
Riverside, RI 02915

Family Health Services
Cranston
1090 Cranston Street
Cranston, RI 02920

Family Health Services
Coventry
191 McArthur Blvd.
Coventry, RI 02816

New Visions for Newport County
Newport
19 Broadway
Newport, RI 02840

New Visions for Newport County
Tiverton
1048 Stafford Road
Tiverton, RI 02878

Northwest Health Center
36 Bridgeway
Pascoag, RI 02859

Providence Community Health Centers
Administrative Offices
375 Allens Avenue
Providence, RI 02905-5010

Providence Community Health Centers
Allen Berry Health Center
202 Prarie Avenue
Providence, RI 02905

Providence Community Health Centers
Capitol Hill Health Center
40 Candace Street
Providence, RI 02908

Providence Community Health Centers
Central Health Center
239 Caranston Street
Providence, RI 02907

Providence Community Health Centers
Fox Point Health Center
550 Wickenden Street
Providence, RI 02903

Providence Community Health Centers
Olneyville Health Center
100 Curtis Street
Providence, RI 02909

Thundermist Health Center
Administration, Dental, WIC Offices
191 Social Street 9th Floor
Woonsocket, RI 02895

Thundermist Health Center of Woonsocket
383 Arnold Street
Woonsocket, RI 02895

Thundermist Health Center For Women and Children
206 Cass Avenue
Woonsocket, RI 02895

Thundermist Health Center of South Country
1 River Street
Wakefield, RI 02879

Traveler's Aid Society of RI
Health Care for the Homeless
177 Union Street
Providence, RI 02903

Tri-Town Health Center
1126 Hartford Avenue
Johnston, RI 02919

Wood River Health Services
823 Main Street
Hope Valley, RI 02832

Rhode Island Health Center Association
235 Promenade Street, Suite 104
Providence, RI 02908

Exhibit C

Letter to Community Health Centers

***Re: Endoscopy Associates, Inc.
Charity Care Policy***

Dear [Community Health Center]:

Endoscopy Associates, Inc. currently provides endoscopy and colonoscopy services at its location at 44 West River Street, Providence, RI (the "Center"). We are pleased to announce the commencement of our Outreach Program to fulfill our mission of providing high quality care to the people of Rhode Island who may be uninsured or underinsured. Accordingly, the Center will provide endoscopy and colonoscopy services free of charge to any patient who qualifies for charity care. Qualifying patients will be those uninsured or underinsured patients with incomes up to 200% of the Federal Poverty Limits and with limited assets. Asset limits shall be \$8,000 for an individual and \$12,000 for a family.

If you have any questions regarding the Center's provision of free care to the uninsured or underinsured or you would like to refer a patient that may qualify for free care, please contact our Assistant Outreach Program Coordinator, Alice Micklich at (401) 274-4800 ext 201. The Assistant Outreach Program Coordinator can also receive a fax at (401) 454-0410 or mail at Assistant Outreach Program Coordinator, Endoscopy Associates, Inc., 44 West River Street, Providence, RI 02904.

We look forward to working with you in the future and hope that our charity care policy will allow your patients to receive necessary endoscopy and colonoscopy services without regard to their ability to pay.

Sincerely,

Alice Micklich
Assistant Outreach Coordinator
Endoscopy Associates, Inc.

Exhibit D

Letter to Rhode Island Primary Care Physician Advisory Committee

Jeffrey Borkan, M.D., PhD
Rhode Island Primary Care Physician Advisory Committee
111 Brewster Street
Pawtucket, RI 02860

***Re: Endoscopy Associates, Inc.
Charity Care Policy***

Dear Dr. Borkan:

We are writing to inform you that Endoscopy Associates, Inc. currently provides endoscopy and colonoscopy services at its location at 44 West River Street, Providence, RI (the "Center"). We are pleased to announce the commencement of our Outreach Program to fulfill our mission of providing high quality care to the people of Rhode Island who may be uninsured or underinsured. Accordingly, the Center will provide endoscopy and colonoscopy services free of charge to any patient who qualify for charity care. Qualifying patients will be those uninsured or underinsured patients with incomes up to 200% of the Federal Poverty Limits and with limited assets. Asset limits shall be \$8,000 for an individual and \$12,000 for a family.

If you have any questions regarding the Center's provision of free care to the uninsured or underinsured or you would like to refer a patient that may qualify for free care, please contact our Assistant Outreach Program Coordinator, Alice Micklich at (401) 274-4800 ext 201. The Assistant Outreach Program Coordinator can also receive a fax at (401) 454-0410 or mail at Assistant Outreach Program Coordinator, Endoscopy Associates, Inc., 44 West River Street, Providence, RI 02904.

We look forward to working with you in the future and hope that our charity care policy will allow your patients to receive necessary endoscopy and colonoscopy services without regard to their ability to pay.

Sincerely,

Alice Micklich
Assistant Outreach Coordinator
Endoscopy Associates, Inc.

Exhibit E

Letter to Interested Patient or Physician

***Re: Endoscopy Associates, Inc.
Charity Care Policy***

Dear Interested Patient/Physician:

Endoscopy Associates, Inc. currently provides endoscopy and colonoscopy services at its location at 44 West River Street, Providence, Rhode Island (the "Center"). We are pleased to announce the commencement of our Outreach Program to fulfill our mission of providing high quality care to the people of Rhode Island who may be uninsured or underinsured. Accordingly, the Center will provide care free of charge to any patient who qualifies for charity care.

Qualifying patients will be those uninsured or underinsured patients with incomes up to 200% of the Federal Poverty Limits and with limited assets. Asset limits shall be \$8,000 for an individual and \$12,000 for a family. Please note, that due to the nature of the Center's services, all patients must be referred to the Center by a health care provider.

If you have any questions regarding the Center's provision of free care to the uninsured or underinsured or you would like to refer a patient that may qualify for free care, please contact our Assistant Outreach Program Coordinator, Alice Micklich at (401) 274-4800 ext 201. The Assistant Outreach Program Coordinator can also receive a fax at (401) 454-0410 or mail at Assistant Outreach Program Coordinator, Endoscopy Associates, Inc., 44 West River Street, Providence, RI 02904.

We look forward to working with you in the future and hope that our charity care policy will allow your patients to receive necessary endoscopy and colonoscopy services without regard to their ability to pay.

Sincerely,

Alice Micklich
Assistant Outreach Coordinator
Endoscopy Associates, Inc.

Exhibit F

Log Form

Number	Name of Referring Physician or Healthcare Entity	Patient Name	Date of Initial Contact	Result
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Exhibit G

Endoscopy Associates, Inc.
Charity Care Outreach Program Questionnaire

Endoscopy Associates, Inc.(the “Center”) provides the following questionnaire to obtain your input regarding the effectiveness of our Outreach Program and the materials we provide to interested parties regarding our Charity Care Policy. Your input will be considered for the effectiveness of our Outreach Program and for changes to our future outreach activities. Thank you for your time.

Name: _____ **Phone Number:** _____

Please rate the following aspects of charity care material on a scale of 1 to 5 (1 being the lowest and 5 being the highest).

Written Materials

Material is easy to understand	1	2	3	4	5
Material is useful	1	2	3	4	5
Material adequately explains terms of free care	1	2	3	4	5

Referral Process

Referral Process was easy	1	2	3	4	5
Response from Center Staff was adequate	1	2	3	4	5
Response from Center Staff was timely	1	2	3	4	5
Center accepted patients that qualified for charity care	1	2	3	4	5

Patient Care

Patients referred to the Center received a timely appointment	1	2	3	4	5
Patients referred to the Center appeared satisfied with the Center’s provision of free care	1	2	3	4	5

Comments/Suggestions

**Endoscopy Associates, Inc.
Charity Care Application**

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: (c) _____ (h) _____ (w) _____

Previous Year Income: _____ * Please provide documentation such as a W-2 form, tax return, pay stub, or other similar documentation.

Size of Family Unit: _____

I hereby attest and affirm that the information provided in this Charity Care Application is true and accurate to the best of my knowledge.

Signature: _____ Date: _____



20A

Exhibit 20(A)

ENDOSCOPY ASSOCIATES, INC.

**Financial Statements
and Supplementary Information
– Income Tax Basis**

Years Ended December 31, 2011 and 2010

(With Independent Accountants' Review Report Thereon)



ENDOSCOPY ASSOCIATES, INC.
**FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION –
INCOME TAX BASIS**

Years Ended December 31, 2011 and 2010

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INDEPENDENT ACCOUNTANTS' REVIEW REPORT

To the Board of Directors of
Endoscopy Associates, Inc.:

We have reviewed the accompanying statements of assets, liabilities and stockholders' equity - income tax basis of Endoscopy Associates, Inc. (the Company) as of December 31, 2011 and 2010 and the related statements of revenue, expenses and retained earnings - income tax basis and cash flows - income tax basis for the years then ended. A review includes primarily applying analytical procedures to management's financial data and making inquiries of Company management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the income tax basis of accounting and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the reviews in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. Those standards require us to perform procedures to obtain limited assurance that there are no material modifications that should be made to the financial statements. We believe that the results of our procedures provide a reasonable basis for our report.

Based on our reviews, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with the income tax basis of accounting, as described in Note 2.

Our reviews were made for the purpose of expressing a conclusion that there are no material modifications that should be made to the financial statements in order for them to be in conformity with the income tax basis of accounting, as described in Note 2. The information included in the accompanying schedule is presented only for purposes of additional analysis and has been subjected to the inquiry and analytical procedures applied in the reviews of the basic financial statements, and we are not aware of any material modifications that should be made thereto.

Kahn, Litwin, Renza & Co., Ltd.

March 24, 2012

ENDOSCOPY ASSOCIATES, INC.
STATEMENTS OF ASSETS, LIABILITIES AND STOCKHOLDERS' EQUITY -
INCOME TAX BASIS
December 31, 2011 and 2010

KLR

	2011	2010
Assets		
Current Assets:		
Cash and cash equivalents	\$ 89,163	\$ 66,584
Total current assets	89,163	66,584
Property and Equipment	299,952	299,952
Less accumulated depreciation	299,734	294,196
Net property and equipment	218	5,756
Other Assets:		
Due from related parties	-	108,377
Intangible assets, net	24,420	26,991
Total other assets	24,420	135,368
Total Assets	\$ 113,801	\$ 207,708
Liabilities and Stockholders' Equity		
Current Liabilities:		
Due to affiliate	\$ 10,991	\$ 34,187
Accrued profit sharing expense	24,226	22,559
Total current liabilities	35,217	56,746
Stockholders' Equity:		
Common stock, no par value; 8,000 shares authorized, 660 and 640 shares issued and outstanding as of December 31, 2011 and 2010, respectively	1	1
Retained earnings	78,583	150,961
Total stockholders' equity	78,584	150,962
Total Liabilities and Stockholders' Equity	\$ 113,801	\$ 207,708

See accompanying notes to financial statements and independent accountants' review report.

ENDOSCOPY ASSOCIATES, INC.
STATEMENTS OF REVENUE, EXPENSES AND
RETAINED EARNINGS - INCOME TAX BASIS
Years Ended December 31, 2011 and 2010



	2011		2010	
Net revenue	\$ 3,034,815	100.0 %	\$ 3,056,989	100.0 %
Operating expenses	1,392,811	45.9	1,408,128	46.1
Operating income	1,642,004	54.1	1,648,861	53.9
Other income (expense):				
Interest income	1,618	0.1	2,898	0.1
Interest expense	-	-	(1,900)	(0.1)
	1,618	0.1	998	0.0
Net income	1,643,622	<u>54.2</u> %	1,649,859	<u>53.9</u> %
Retained earnings, beginning of year	150,961		55,102	
Stockholder distributions	(1,716,000)		(1,554,000)	
Retained earnings, end of year	\$ 78,583		\$ 150,961	

See accompanying notes to financial statements and independent accountants' review report.

ENDOSCOPY ASSOCIATES, INC.
STATEMENTS OF CASH FLOWS - INCOME TAX BASIS
Years Ended December 31, 2011 and 2010



	<u>2011</u>	<u>2010</u>
Cash Flows from Operating Activities:		
Net income	\$ 1,643,622	\$ 1,649,859
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	5,538	24,068
Amortization	2,571	2,571
Change in operating liabilities:		
Accrued profit sharing expense	1,667	510
Net cash provided by operating activities	<u>1,653,398</u>	<u>1,677,008</u>
Cash Flows from Investing Activities:		
Capital expenditures	-	(13,136)
Due from related parties	108,377	(88,377)
Net cash provided (used) by investing activities	<u>108,377</u>	<u>(101,513)</u>
Cash Flows from Financing Activities:		
Principal payments on long-term debt	-	(51,315)
Due to affiliate	(23,196)	17,355
Stockholder distributions	(1,716,000)	(1,554,000)
Net cash used by financing activities	<u>(1,739,196)</u>	<u>(1,587,960)</u>
Net Increase (Decrease) in Cash and Cash Equivalents	22,579	(12,465)
Cash and Cash Equivalents, beginning of year	<u>66,584</u>	<u>79,049</u>
Cash and Cash Equivalents, end of year	<u><u>\$ 89,163</u></u>	<u><u>\$ 66,584</u></u>

See accompanying notes to financial statements and independent accountants' review report.

ENDOSCOPY ASSOCIATES, INC.
NOTES TO FINANCIAL STATEMENTS
Years Ended December 31, 2011 and 2010

1. Nature of Operations

Endoscopy Associates, Inc. (the Company) operates a medical practice specializing in endoscopy with an office located in Providence, Rhode Island.

2. Summary of Significant Accounting Policies

This summary of significant accounting policies of the Company is presented to assist in understanding the Company's financial statements. The financial statements and notes are representations of the Company's management who are responsible for their integrity and objectivity. These accounting policies conform to accounting principles adhered to in connection with the income tax basis of accounting followed in the United States of America and have been consistently applied in the preparation of the financial statements.

Basis of Accounting

The Company's policy is to prepare its financial statements on the basis of accounting used for income tax reporting. Under this basis of accounting, revenues are recognized when collected rather than when earned, and expenses are generally recognized when paid rather than when the obligation is incurred. Consequently, accounts receivable due from patients and accounts payable are not included in the financial statements. Also, depreciation is provided for using accelerated methods. While under accounting principles generally accepted in the United States of America, depreciation is provided for over the estimated useful lives of the respective assets on the straight-line basis.

Although income tax rules are used to determine the timing of the reporting of revenues and expenses, nondeductible expenses are included in the determination of net income. These statements are not intended to show financial position and results of operations in accordance with accounting principles generally accepted in the United States of America.

Revenue Recognition

The Company recognizes revenue upon rendering of services.

Cash Equivalents

The Company considers all highly liquid investments with original maturities of three months or less when purchased to be cash equivalents.

Property and Equipment

Property and equipment are stated at cost. Expenditures for repairs and maintenance are expensed as incurred. Renewals and betterments that materially extend the life of the assets are capitalized. Depreciation is computed using accelerated methods of depreciation over the respective useful lives of the assets for book and income tax purposes. Estimated useful lives of the property and equipment range from five to seven years.

Intangible Assets

Intangible assets consist of start-up costs and are amortized using the straight-line basis as permitted under current tax law.

ENDOSCOPY ASSOCIATES, INC.
NOTES TO FINANCIAL STATEMENTS
Years Ended December 31, 2011 and 2010

KLR

Income Taxes

The Company, with the consent of its stockholders, has elected to have its income taxed under the provisions of Subchapter S of the Internal Revenue Code. Subchapter S provides that the individual stockholders be taxed on their proportionate share of the Company's taxable income in lieu of the corporation paying income taxes. Therefore, no provision or liability for income taxes is reflected in these financial statements. The Company's income tax returns for 2008, 2009 and 2010 are subject to examination by the Internal Revenue Service, generally for three years after they were filed.

Concentration of Credit Risk

The financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash and cash equivalents.

The Company maintains its operating accounts in one financial institution. The balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to specified limits. From time to time, the Company had bank balances in excess of federally insured limits.

Use of Estimates

The preparation of financial statements in conformity with the income tax basis of accounting requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Subsequent Events

Management has evaluated subsequent events through March 24, 2012, which is the date these financial statements were available to be issued.

3. Property and Equipment

Property and equipment consisted of the following:

	<u>2011</u>	<u>2010</u>
Medical equipment	\$ 220,648	\$ 220,648
Office equipment	53,919	53,919
Leasehold improvements	9,678	9,678
Furniture and fixtures	<u>15,707</u>	<u>15,707</u>
Property and equipment	<u>\$ 299,952</u>	<u>\$ 299,952</u>

Depreciation expense for the years ended December 31, 2011 and 2010 amounted to approximately \$5,500 and \$24,100, respectively.

ENDOSCOPY ASSOCIATES, INC.
NOTES TO FINANCIAL STATEMENTS
Years Ended December 31, 2011 and 2010

NLR

4. Intangible Assets

The Company had the following intangible assets:

	<u>2011</u>	<u>2010</u>
Start up costs	\$ 38,559	\$ 38,559
Accumulated amortization	<u>(14,139)</u>	<u>(11,568)</u>
Intangible assets, net	<u>\$ 24,420</u>	<u>\$ 26,991</u>

Amortization is computed on a straight-line basis over a period of fifteen years. Amortization expense for each of the years ended December 31, 2011 and 2010 amounted to \$2,571.

5. Profit Sharing Plan

The Company maintains a "safe harbor" 401(k) profit sharing plan (the Plan). The Plan is available to all employees, age 21 and over, who have completed one year of service and work a minimum of 1,000 hours per year. Participants may contribute a portion of their salary to the Plan in accordance with limits established by the Internal Revenue Code. The Company will make "safe harbor" contributions to the Plan that is equivalent to 3% of a participant's eligible compensation.

The Company may also make discretionary matching contributions based on participant's deferral amounts, up to a maximum of 4% of eligible compensation contributed by the participant to the Plan. In addition, the Company may also make an annual discretionary profit sharing contribution in an amount to be determined at year-end. Total contributions to the Plan for the years ended December 31, 2011 and 2010 were approximately \$24,200 and \$22,600, respectively.

6. Stock Transactions

During the years ended December 31, 2011 and 2010, the Company issued 20 shares and 10 shares of common stock, respectively, to one doctor, according to a schedule set forth in the Shareholders' Agreement. Consideration for the transaction is the stockholder's time and effort that he expends on behalf of the Company and its related entities.

7. Economic Dependency

The Company received approximately 85% and 86% of its revenues from insurance reimbursements collected from three insurers during the years ended December 31, 2011 and 2010, respectively.

ENDOSCOPY ASSOCIATES, INC.
NOTES TO FINANCIAL STATEMENTS
Years Ended December 31, 2011 and 2010

KLR

8. Commitments and Contingencies

Lease Commitments - Related Party

The Company rents its office space from Nob Creek, LLC, a company related through common ownership. The lease requires monthly payments of \$24,500 with potential annual increases in the rental amount based on certain cost of living adjustment calculations not to exceed an annual increase of 5%. The Company is also responsible for payment of its proportionate share of certain operating and administrative expenses, taxes and utilities during the lease term.

The initial term ran through April, 2011 and the lease agreement contains three five-year options to extend the term of the lease under the same terms. Rent expense paid by the Company under this lease for each of the years ended December 31, 2011 and 2010 was \$294,000.

Approximate annual future minimum lease payments required under this lease, without consideration of any annual increases, are as follows:

<u>Year Ending</u>	
December 31, 2012	\$ 294,000
December 31, 2013	294,000
December 31, 2014	294,000
December 31, 2015	294,000
December 31, 2016	<u>98,000</u>
Total	<u>\$ 1,274,000</u>

Guarantees

The Company is contingently liable as a guarantor on two loans made by a bank to Nob Creek, LLC. The Company's guarantees are expected to continue through the terms of these loans (August, 2020 and June, 2026) or until an amendment to the guarantees occurs. In the event that Nob Creek, LLC defaults on either loan, the Company could be responsible for the repayment of the outstanding loan balance and any interest due. As of December 31, 2011 and 2010, the total outstanding balances on the Nob Creek, LLC's loans were approximately \$2,779,000 and \$2,941,000, respectively. Both loans are secured by a building.

9. Supplemental Cash Flow Information

Cash paid for interest for the year ended December 31, 2010 was \$1,900. There was no interest paid during the year ended December 31, 2011.

ENDOSCOPY ASSOCIATES, INC.
SCHEDULE OF OPERATING EXPENSES - INCOME TAX BASIS
Years Ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Salaries and wages	\$ 545,195	\$ 540,029
Payroll taxes	45,577	46,385
Amortization	2,571	2,571
Bank fees	4,686	4,041
Depreciation	5,538	24,068
Insurance	61,682	53,187
Laundry and cleaning	30,484	26,921
Licenses	5,857	7,827
Medical supplies	202,566	192,307
Miscellaneous	386	499
Office supplies and expense	30,146	28,195
Outside services	9,036	12,325
Profit sharing expense	24,226	22,559
Professional fees	12,192	16,257
Property and other taxes	70,248	74,378
Rent	306,760	309,803
Repairs and maintenance	7,204	17,483
Telephone	2,156	1,807
Utilities	26,301	27,486
	<u> </u>	<u> </u>
Total operating expenses	<u><u>\$ 1,392,811</u></u>	<u><u>\$ 1,408,128</u></u>

See accompanying independent accountants' review report.

24A

Total # of surveys received	889
How long patients waited to schedule procedures with office	
Excellent	640
Very Good	196
Good	38
Fair	6
Poor	0
How long patients waited at WRE before procedure	
Excellent	632
Very Good	179
Good	55
Fair	17
Poor	4
Personal manner of physician	
Excellent	828
Very Good	51
Good	6
Fair	0
Poor	0
Personal manner of secretary	
Excellent	765
Very Good	95
Good	24
Fair	3
Poor	0
Personal manner of nurses and support staff	
Excellent	822
Very Good	58
Good	4
Fair	1
Poor	0
Technical skills of prep nurses	
Excellent	817
Very Good	60
Good	6
Fair	1
Poor	2
Adequacy of explanations	
Excellent	783
Very Good	85
Good	14

Fair	3
Poor	0

Pain level	
No pain	778
Mild pain	91
Moderate pain	18
Severe pain	5

Visit Rating	
Excellent	796
Very Good	78
Good	4
Fair	3
Poor	1

Would you use this physician again	
Yes	882
No	3

Would you use this facility again	
Yes	881
No	3

Parking convenient	
Yes	883
No	1

Would you recommend this facility to family/friends	
Yes	880
No	1

Cost-Effectiveness of Colonoscopy in Screening for Colorectal Cancer

Amnon Sonnenberg, MD, MSc; Fabiola Delcò, MD, MPH; and John M. Inadomi, MD

Background: Fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy are used to screen patients for colorectal cancer.

Objective: To compare the cost-effectiveness of fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy.

Design: The cost-effectiveness of the three screening strategies was compared by using computer models of a Markov process. In the model, a hypothetical population of 100 000 persons 50 years of age undergoes annual fecal occult blood testing, sigmoidoscopy every 5 years, or colonoscopy every 10 years. Positive results on fecal occult blood testing or adenomatous polyps found during sigmoidoscopy are worked up by using colonoscopy. After polypectomy, colonoscopy is repeated every 3 years until no polyps are found.

Data Sources: Transition rates were estimated from U.S. vital statistics and cancer statistics and from published data on the sensitivity, specificity, and efficacy of various screening techniques. Costs of screening and cancer care were estimated from Medicare reimbursement data.

Target Population: Persons 50 years of age in the general population.

Time Horizon: The study population was followed annually until death.

Perspective: Third-party payer.

Outcome Measure: Incremental cost-effectiveness ratio.

Results of Base-Case Analysis: Compared with colonoscopy, annual screening with fecal occult blood testing costs less but saves fewer life-years. A screening strategy based on flexible sigmoidoscopy every 5 or 10 years is less cost-effective than the other two screening methods.

Results of Sensitivity Analysis: Screening with fecal occult blood testing is more sensitive to changes in compliance rates, and it becomes easily dominated by colonoscopy under most conditions assuming less than perfect compliance. Other assumptions about the sensitivity and specificity of fecal occult blood testing, screening frequency, efficacy of colonoscopy in preventing cancer, and polyp incidence have a lesser influence on the differences in cost-effectiveness between colonoscopy and fecal occult blood testing.

Conclusions: Colonoscopy represents a cost-effective means of screening for colorectal cancer because it reduces mortality at relatively low incremental costs. Low compliance rates render colonoscopy every 10 years the most cost-effective primary screening strategy for colorectal cancer.

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www.annals.org

For author affiliations, current addresses, and contributions, see end of text.

See editorial comment on pp 647-649.

With its high incidence and mortality, colorectal cancer constitutes a public health burden in most industrialized countries. In the United States, colorectal cancer is the second leading cause of death among cancers from all sites, exceeded only by lung cancer (1). Because of its high prevalence, its long asymptomatic phase, and the presence of a treatable precancerous lesion, colorectal cancer ideally meets the criteria for screening.

Fecal occult blood testing and colonoscopy represent the extremes of a wide spectrum of potential screening strategies. The first method is characterized by simplicity and low price, the second by efficacy and thoroughness. Previous studies of the cost-effectiveness of colorectal cancer screening have shown colonoscopy, flexible sigmoidoscopy, and fecal occult blood testing to be cost-effective screening alternatives (2-7). Since the publication of these analyses, new studies have become available to assess the

protective influence of endoscopic procedures against future development of colorectal cancer (8-11).

The cost structure for reimbursement of gastrointestinal procedures has undergone several changes. The guidelines for screening have been revised to recommend colonoscopy every 10 years instead of 5 years (7). We sought to take these recent changes into account and reassess the cost-effectiveness of screening programs for colorectal cancer based on fecal occult blood testing, flexible sigmoidoscopy, or colonoscopy as the primary screening method. In contrast to most previous studies, our decision analysis tests the influence of different compliance rates with the three screening methods. Fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy are compared with respect to the number of prevented cases of colorectal cancer and the costs spent per 1 life-year saved from cancer-related mortality.

METHODS

General Assumptions of the Markov Model

The cost-effectiveness of fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy were compared by using computer models based on a Markov process (12). Medical events are modeled as transitions of patients among a predefined set of health states; the occurrence of each transition is governed by a probability value (**Appendix Figure**). The time frame of the analysis is divided into equal increments of 1 year, during which patients may cycle from one state to another. Only the gray and black ovals of the **Appendix Figure** show states in the true sense of a Markov process, because patients remain in these states for at least a full 1-year cycle. The white ovals represent the intermediate states of screening procedures. Patients can enter and leave these intermediate states during one cycle before settling in a true Markov state.

In the first model of screening by fecal occult blood testing, the initial population comprises 100 000 patients 50 years of age who are offered the test. Depending on the initial compliance rate and the outcome of the test (positive or negative), patients then undergo colonoscopy or enter the pool of patients waiting for their next fecal occult blood test in 1 year's time. In the case of normal results on colonoscopy (no adenomatous polyp), annual fecal occult blood testing is resumed 10 years after colonoscopy. If an adenomatous polyp is found, surveillance colonoscopy is repeated every 3 years until adenomatous polyps are no longer found. Patients with a positive result on fecal occult blood testing who decline colonoscopy or those who decline to have repeated fecal occult blood testing after 1 year enter the state of noncompliance.

Patients in any Markov state can develop colorectal cancer; the probability stems from the age-specific incidence rate. The likelihood of developing cancer is reduced in patients after colonoscopy plus polypectomy, depending on the rate of preventive efficacy assigned to the procedure. The length of time for which colonoscopy plus polypectomy protects against colorectal cancer is equal to the screening interval. In addition to the states shown in the **Appendix Figure**, the population in each state is also subjected to natural attrition by the annual age-specific death rate of the U.S. population (13).

Screening with flexible sigmoidoscopy is modeled similarly to fecal occult blood testing (**Appendix Figure**). The simulation is started with 100 000 patients being offered screening with flexible sigmoidoscopy. The transitions out

of this intermediate state depend on whether a polyp is found during sigmoidoscopy. After normal flexible sigmoidoscopy without adenomatous polyps, patients stay in the pool waiting for the next screening sigmoidoscopy in 5 years. The remainder of the model is similar to that of fecal occult blood testing.

Screening with colonoscopy is modeled by using a Markov process similar to that used for the two previous strategies, except that all states associated with a different screening test other than colonoscopy are eliminated (**Appendix Figure**).

All three models were simulated by using Excel spreadsheets (Microsoft Corp., Redmond, Washington).

Transition Probabilities

The transition probabilities built into the model and the ranges tested in the sensitivity analyses are shown in the **Appendix Table**. Most large prospective trials of fecal occult blood testing used nonhydrated slides. The sensitivity and specificity of testing for colorectal cancer varied from 30% to 50% and 90% to 99%, respectively (14, 15, 24–28). Estimates of 40% and 97.5% for the two parameters are supported by data from a recent large prospective trial comprising more than 8000 participants (15). The rate of positive results on fecal occult blood testing was calculated as the sum of true-positive and false-positive results. Screening intervals were chosen to agree with the most recent set of recommendations (7).

Three types of compliance rates are built into the model; screened patients must be compliant with the initial screening procedure, each repeated screening, and colonoscopy after a positive result on fecal occult blood testing or flexible sigmoidoscopy. Under baseline conditions, all compliance rates were assumed to be 100%. In the sensitivity analysis, the rates of initial, repeated, and follow-up compliance were varied according to estimates published for the three screening methods (9, 24, 29–34).

The prevalence of adenoma per 10-year age group was available from autopsy studies (16, 17). An annual incidence of 1% was calculated as the average difference between the prevalence rates of two consecutive age groups. In the sensitivity analysis, the annual incidence of adenomatous polyps was varied from 1% to 6%. The Markov model uses the polyp rate to calculate the number of polypectomies and repeated colonoscopies after polypectomy. The number of cases of cancer prevented was calcu-

lated from the age-specific incidence rates of colorectal cancer. About 45% of all polyps are within the reach of flexible sigmoidoscopy (18, 22, 35). The annual age-specific incidence rate of colorectal cancer is taken from published statistics of the Surveillance, Epidemiology, and End Results Program (36). Depending on the type of historical control group chosen, the National Polyp Study showed an efficacy of colonoscopy in reducing the incidence of colorectal cancer ranging from 76% to 90% (9). Because other studies have suggested an efficacy of only 49% to 59% (8, 10, 11), we chose a median value of 75% as the baseline rate.

Effectiveness and Costs

Effectiveness of screening is measured in terms of life-years saved through prevention of colorectal cancer and improved survival of earlier cancer stages. Without screening, 40% of all colorectal cancers were assumed to result in death within 5 years (36). Because detection of colorectal cancer at earlier stages improves the overall 5-year survival rate, survival after annual screening was adjusted to reduce mortality from colorectal cancer by 18% (37). The life-years lost by the age-dependent proportions of patients dying prematurely of colorectal cancer are accumulated for each cycle during the entire expected lifetime. The number of life-years saved because of screening corresponds to the difference in life-years lost from cancer-related deaths between a Markov model with and one without screening.

Medical, surgical, and diagnostic services were assigned Current Procedural Terminology or diagnosis-related group codes to identify the health care resources utilized for each patient (19, 20). These codes were converted into costs for each health care resource utilization (Table 1). The costs represent the average payments allowed for each coded procedure by the U.S. Health Care Finance Administration during fiscal year 1998. The costs also include the possibility of hospitalization for bleeding or perforation after endoscopy with or without polypectomy (21, 38–43). Published cost estimates for the medical care of patients with colorectal cancer range from \$25 000 to \$45 000 (4, 7, 23, 44). We used the most recent data available from a study by Lee and colleagues (44). All future costs arising from screening or care of colorectal cancer and all future life-years saved through screening are discounted at an annual rate of 3% (45).

Table 1. Costs Based on Medicare Payments in 2000*

CPT Code (DRG Code)	Cost Item	Cost, \$
82270	Fecal occult blood testing	3.50†
45330	Flexible sigmoidoscopy‡	400.56†
	Colonoscopy	695.95†
85610	Prothrombin time	5.61
85027	Complete blood count	8.95
45378	Procedure‡	681.39
	Polypectomy	1003.76†
85610	Prothrombin time	5.61
85027	Complete blood count	8.95
45385	Procedure‡	808.42
88305	Surgical pathology‡	180.78
	Bleeding§	4360.23†
99283	Visit to the emergency room	57.98
99222	Initial care, moderate complexity	108.19
99232	Daily care, moderate complexity	267.38
99238	Discharge, moderate complexity	61.54
45382	Colonoscopy with bleeding control	398.26
(174)	Hospitalization	3466.88
	Perforation§	13 000.32†
99222	Initial care, moderate complexity	108.19
74000	Radiologic examination of the abdomen	26.50
93010	Electrocardiography	10.50
44604	Suture of the colon	777.32
840	Anesthesia	167.60
(148)	Hospitalization	11 910.21
	Total cost of care for colorectal cancer	45 228.00†

* CPT = Current Procedural Terminology; DRG = diagnosis-related group.
 † Sum of all included costs.
 ‡ Costs include professional fees and facility costs.
 § Facility costs among inpatients are covered by payment for the corresponding DRG code; all other costs arise from professional fees.

Role of the Funding Sources

Dr. Delcò's salary was supported by a grant from the Swiss Foundation for Grants in Medicine and Biology. Drs. Inadomi and Sonnenberg were full-time employees of the Department of Veterans Affairs. The funding sources had no role in the collection, analysis, or interpretation of the data or in the decision to submit the paper for publication.

RESULTS

Baseline Assumptions

Table 2 shows the outcomes of modeling four programs to prevent colorectal cancer. Future life-years saved and the costs associated with various items reflect the effect of an annual discount rate of 3%. Without screening, the cohort of 50-year-old persons will experience 5904 cases of colorectal cancer and a loss of 10 602 cancer-related life-years. Screening with fecal occult blood testing prevents 16% of all colorectal cancers compared with prevention rates of 34% or 75% with flexible sigmoidoscopy or

Table 2. Outcome of Screening Programs To Prevent Colorectal Cancer*

Variable	Screening Method			
	None	FOBT	Sigmoidoscopy	Colonoscopy
Cases of CRC prevented, <i>n</i>	0	926	2027	4428
Prevented cases of CRC/total cases of CRC, %	0	16	34	75
Life-years saved	0	1896	3636	7952
Reduction in mortality, %	0	18	34	75
Procedures, <i>n</i>				
FOBT	0	2 464 606	0	0
Sigmoidoscopies	0	0	623 597	0
Colonoscopies	0	69 794	27 319	365 456
Diagnostic (without polypectomy)	0	62 815	12 624	328 911
Therapeutic (with polypectomy)	0	6979	14 695	36 546
Complications, <i>n</i>				
Bleeding events	0	234	313	1224
Screening-related perforations	0	152	81	797
Screening-related deaths	0	7	3	37
Costs, \$				
FOBT	0	5 497 809	–	0
Sigmoidoscopy	0	–	163 313 218	–
Colonoscopy	0	33 640 016	16 281 508	189 667 598
Care for CRC	136 452 922	115 715 753	89 619 575	34 113 230
Total	136 452 922	154 853 577	269 214 301	223 780 829
Total costs per life-years saved†	∞	81 678	74 032	28 143

* Values pertain to a cohort of 100 000 persons 50 years of age who were followed for an average of 28.5 years until death. Future life-years saved and future costs were discounted by using an annual rate of 3%. CRC = colorectal cancer; FOBT = fecal occult blood testing.

† Average cost-effectiveness ratio.

colonoscopy, respectively. Screening with colonoscopy results in more life-years saved; that is, it offers a greater reduction in mortality than the two other screening methods. In screening with fecal occult blood testing, the detection of cancer at earlier stages leads to a reduction in mortality beyond cancer prevention alone (18% vs. 16%). Because flexible sigmoidoscopy and colonoscopy are done less frequently, this added benefit of screening is far less pronounced in these two screening strategies.

Table 2 also shows the number of tests done for prevention in each program. The investments in screening with fecal occult blood testing or flexible sigmoidoscopy lead to performance of many fewer colonoscopies in each of the two strategies. Fewer colonoscopies translate into fewer complications. On the basis of the rates shown in the Appendix Table and a mortality rate of 1 per 10 000 colonoscopies (7), one can estimate that in the colonoscopy screening program, an appreciably higher proportion of patients will experience procedure-related bleeding, perforation, or even death compared with those undergoing other screening strategies. Without screening or use of fecal occult blood testing, the largest proportion of costs stems from care of unprevented cancer. In the other two screening programs, endoscopic procedures account for most

costs. Although 85% of the total costs in the colonoscopy program arise from the endoscopic procedure itself, colonoscopy contributes 22% and 6% to the total costs of the fecal occult blood testing and sigmoidoscopy screening programs, respectively.

The total costs of managing colorectal cancer increase going from no screening to fecal occult blood testing, colonoscopy, and flexible sigmoidoscopy. At the same time, the effectiveness of screening, as evidenced by the number of life-years saved, increases from no screening to fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy. Table 2 shows the average cost-effectiveness ratios of the screening strategies. Fecal occult blood testing and flexible sigmoidoscopy are relatively expensive strategies compared with colonoscopy. The strategy of no screening results in an infinitely large ratio of costs to life-years saved because costs are positive (from the care of colorectal cancer) but life-years are zero.

The incremental cost-effectiveness ratio shown in Table 3 is more informative than the average cost-effectiveness ratio. It compares each screening strategy with the preceding less effective option, including a strategy of no screening. The incremental cost-effectiveness ratio is calculated as the difference in costs divided by the corre-

sponding difference in effectiveness (46, 47). The results of baseline conditions suggest the following interpretation. Fecal occult blood testing represents a cost-effective option compared with no screening. Flexible sigmoidoscopy is an expensive alternative to fecal occult blood testing. Colonoscopy is associated with relatively modest incremental cost-effectiveness compared with fecal occult blood testing and no screening.

Sensitivity Analysis

The base-case analysis indicates that fecal occult blood testing is a cost-effective screening method to prevent colorectal cancer. At a higher total cost of screening, colonoscopy represents a cost-effective alternative because additional life-years are saved to justify additional costs. All measures that make colonoscopy particularly expensive increase its incremental cost-effectiveness ratio compared with fecal occult blood testing.

In the first set of sensitivity analyses, the frequency of colonoscopy is increased to once every 5 years, its efficacy is reduced to 50%, and compliance with repeated colonoscopy is reduced to 80%. Under these conditions, the incremental cost-effectiveness of colonoscopy compared with fecal occult blood testing increases from a baseline value of \$11 382 to \$27 529, \$24 689, and \$12 695, respectively. Assuming that all unfavorable conditions apply simultaneously, the incremental cost-effectiveness ratio increases to \$54 561. These results suggest that even when some unfavorable assumptions about frequency and compliance are made, colonoscopy remains a relatively cost-effective screening option compared with other health care interventions that are currently standard practice (47).

Variations of Compliance Rates

Under base-case conditions, the incremental cost-effectiveness ratio of colonoscopy compared with no screening is only slightly greater than that of fecal occult blood testing compared with no screening (\$10 983 vs. \$9705). In subsequent one-way sensitivity analyses, the incremental cost-effectiveness ratios of fecal occult blood testing and colonoscopy (compared with no screening) were assessed by systematically varying all assumptions built into the model. Since flexible sigmoidoscopy is dominated by colonoscopy, only changes in test frequency are considered to reduce its incremental cost-effectiveness ratio.

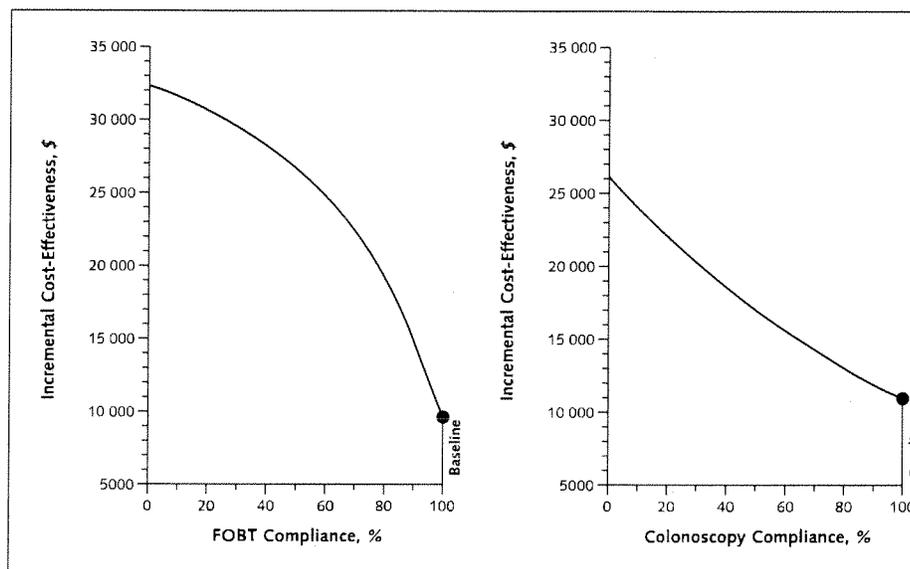
Because initial compliance determines how many persons enter the screening program, it influences the overall number of cancers prevented and the total costs in a linear fashion. However, the initial compliance rate does not affect the cost-effectiveness of any individual program. A decrease in compliance rate associated with test repetition results in higher costs per life-year saved (Figure 1). Fecal occult blood testing is particularly sensitive to changes in the compliance rate of repeated testing because it is done more frequently than colonoscopy. For instance, a decrease of compliance with annual test repetition to 90% increases the incremental cost-effectiveness ratio of fecal occult blood testing to \$14 788. In the case of colonoscopy screening, the same incremental cost-effectiveness ratio is achieved with a decrease in compliance with repeated 10-year colonoscopy to 66% (Figure 1). Similarly, a decrease in compliance with repeated fecal occult blood testing to 80% matches a decrease in compliance with repeated colonoscopy to 37%. Low compliance with colonoscopy after a positive result on fecal occult blood testing also renders the initial screening technique less efficacious and increases its associated costs per saved life-year. If only 75%

Table 3. Incremental Cost-Effectiveness Ratios*

Strategy 1	Strategy 2			
	No Screening	Fecal Occult Blood Testing	Sigmoidoscopy	Colonoscopy
No screening	0	9705	36 509	10 983
Fecal occult blood testing	-	0	65 704	11 382
Sigmoidoscopy	-	-	0	Dominates†
Colonoscopy	-	-	-	0

* The difference between total costs of strategy 2 and strategy 1 was divided by the difference between life-years saved by strategy 2 and strategy 1.
 † Strategy 2 is less costly and more effective than strategy 1.

Figure 1. Influence of compliance with repeated fecal occult blood testing (FOBT) once per year (left) and repeated colonoscopy (right) once per decade on the incremental cost-effectiveness ratio compared with no screening.



of positive fecal occult blood tests were followed by colonoscopy, the incremental cost-effectiveness ratio of fecal occult blood testing would increase to \$10 281.

Because it depends on several types of patient compliance, screening by fecal occult blood testing is generally more sensitive to changes in compliance rates. For instance, 93% compliance with repeated fecal occult blood testing has been reported (29). On the basis of compliance rates reported for repeated sigmoidoscopy and surveillance colonoscopy after polypectomy, an 80% compliance rate appears reasonable to expect for repeated colonoscopy (9, 33). We also estimated compliance rates of 75% for colonoscopy after a positive result on fecal occult blood testing or after sigmoidoscopy that is positive for polyps (34). Under these conditions, the incremental cost-effectiveness ratios of screening with fecal occult blood testing and colonoscopy (compared with no screening) change to \$14 071 and \$13 081, respectively.

Variation of Test Characteristics

Although the model considers the occurrence of adenomatous polyps and the influence of polypectomy on life-years saved, the sensitivity and specificity of the fecal occult blood test used in the current analysis pertain only to colorectal cancer as the disease of interest. The outcome

of the analysis is affected more by assumptions underlying the sensitivity of the fecal occult blood test than by its specificity (Figure 2). Improvement of test sensitivity results in detection of cancers at an earlier stage and reduced mortality from colorectal cancer. The change in test specificity has a two-sided effect. On one hand, improved specificity results in fewer colonoscopies performed after false-positive results on fecal occult blood testes. This effect is responsible for the decrease in the incremental cost-effectiveness ratio as the specificity increases to 70% to 95%. On the other hand, the opportunity to prevent future colorectal cancers is partly forgone as the specificity improves, since fewer positive test results lead to fewer colonoscopies with polypectomies. This effect becomes especially dominant as the specificity increases above 98%. Within the ranges tested in the sensitivity analysis, the overall influence on the incremental cost-effectiveness ratio exerted by the sensitivity or specificity of fecal occult blood testing does not exceed \$2000 (Figure 2).

Although screening by colonoscopy is slightly more sensitive than fecal occult blood testing to changes in the incidence of polyps, the increments of costs per life-year saved and the relationship between the two screening procedures remain largely unaffected. Changes in the efficacy of colonoscopy plus polypectomy in preventing colorectal

cancer and their influence on the incremental cost-effectiveness ratio are shown in Figure 3. An increase in preventive efficacy decreases the costs of all screening methods, again with relatively little influence on the relationship between the competing methods.

Variation of Screening Frequency and Costs

In the following analyses, changes in the screening frequency are assumed to occur without influencing the efficacy of colonoscopy plus polypectomy in preventing colorectal cancer. Under baseline conditions, screening by colonoscopy is done every 10 years. Shortening the interval of repeated colonoscopy affects all three screening methods because screening with any method is resumed earlier and all screening strategies become more expensive and less cost-effective. If colonoscopy is scheduled every 5 years, for instance, the incremental cost-effectiveness ratios of fecal occult blood test or colonoscopy compared with no screening increase to \$20 746 and \$26 385, respectively. Changes in the surveillance interval after polypectomy exert only small influences in all three programs without affecting their relative difference. Scheduling one flexible sigmoidoscopy every 10 years reduces its associated costs per life-year saved but fails to abolish the dominance of colonoscopy over flexible sigmoidoscopy. Finally, reducing the frequency of screening with fecal occult

blood testing from once annually to once every 3 years increases its incremental costs per life-year saved from a baseline value of \$9705 to \$9843, as costs savings become partly negated by fewer life-years saved through early cancer detection.

DISCUSSION

The screening model in our study suggests that colonoscopy once every 10 years is a cost-effective method of screening for colorectal cancer compared with the next best alternative, fecal occult blood testing. Compared with colonoscopy, screening with annual fecal occult blood testing costs less but saves fewer life-years. Annual fecal occult blood testing may be a cost-effective screening method if high patient compliance is maintained over prolonged time periods and if tests can be applied at low costs. A screening strategy based on flexible sigmoidoscopy every 5 or 10 years is less cost-effective than the other two screening methods. Although both fecal occult blood testing and flexible sigmoidoscopy represent less expensive screening programs than does colonoscopy, this seeming cost advantage is offset in part by the subsequent costs of medical care for cancers missed by these two screening methods. The latter two programs also incur additional costs of workup of all positive findings on colonoscopy.

What would it cost to implement a uniform colorectal

Figure 2. Influence of the sensitivity and specificity of fecal occult blood testing (FOBT) on the incremental cost-effectiveness ratio compared with no screening.

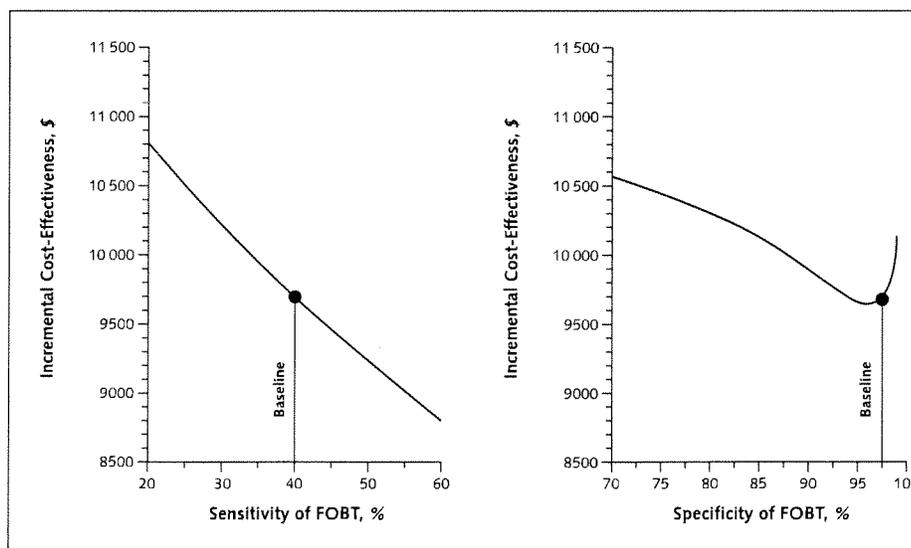
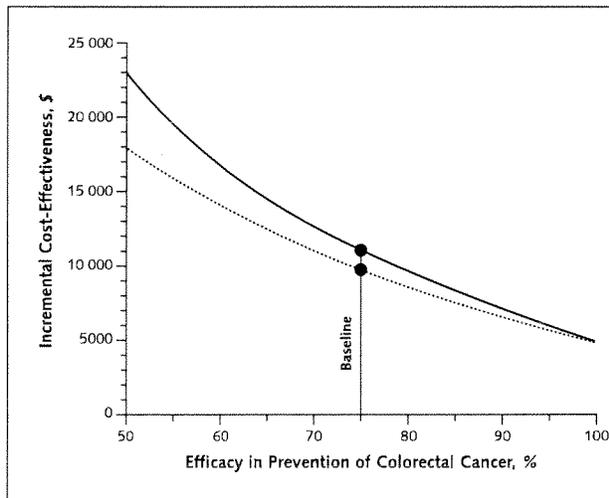


Figure 3. Efficacy of colonoscopy in preventing colorectal cancer and its influence on the incremental cost-effectiveness ratio of fecal occult blood testing (dotted line) and colonoscopy (solid line) compared with no screening.



cancer screening program in the United States? As suggested by the estimates in Table 3, for each 100 000 persons turning 50 years of age, it would cost (in current discounted dollars) \$39 million for fecal occult blood testing, \$180 million for flexible sigmoidoscopy, and \$190 million for colonoscopy until that cohort dies out. About 4 million persons annually turn 50 years of age. If everyone were screened with fecal occult blood testing, the expected annual screening cost would amount to \$1.6 billion (\$39 million \times 40). Using colonoscopy, the annual screening costs would be \$7.6 billion. Our calculation suggests a substantial increase in the cost investment for colorectal cancer screening. Some of the investment would be saved by spending less money on medical care for cancer (Table 3). These crude estimates do not consider the fact that many persons already undergo some type of screening. Moreover, only a fraction of the population may actually want to participate in a screening program for colorectal cancer.

Screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy have all been documented to be efficacious in preventing the occurrence of colorectal cancer and reducing its associated mortality (8–11, 24, 29, 49–51). Colonoscopy was shown to be the most efficacious method, and sigmoidoscopy was shown to

be more efficacious than fecal occult blood testing. The majority of recommendations for colorectal cancer screening rely on combined use of all three methods. For instance, the recent guidelines of the Health Care Finance Administration allow for reimbursement of annual fecal occult blood testing, flexible sigmoidoscopy, or contrast barium enema once every 4 years and colonoscopy once every 2 years only in high-risk persons (52). The American Cancer Society recommends annual fecal occult blood testing combined with flexible sigmoidoscopy every 5 years, double-contrast barium enema every 5 to 10 years, or colonoscopy every 10 years (1). A position paper by the American Gastroenterological Association includes a screening program comprising annual fecal occult blood testing, flexible sigmoidoscopy every 5 years, and colonoscopy once every 10 years (7).

Three published studies have compared fecal occult blood testing and colonoscopy (2–4). In a cost-effectiveness study by Lieberman (4), colonoscopy was applied only once per lifetime and no repeated colonoscopies were considered in persons without polyps. The outcome, measured as undiscounted costs per prevented deaths from colorectal cancer, showed a moderate advantage of screening with fecal occult blood testing over screening with colonoscopy. By varying the efficacy and cost assumptions in the sensitivity analyses, the difference between the two screening strategies was easily reversed. In a comprehensive analysis of multiple screening strategies, Eddy (2) compared fecal occult blood testing alone with fecal occult blood testing in combination with sigmoidoscopy or colonoscopy every 3 to 5 years. The average cost-effectiveness ratios of the three strategies were \$8400, \$19 200, and \$24 400, respectively. Wagner and coworkers (3, 6, 7), from the Office of Technology Assessment of the U.S. Congress, compared the cost-effectiveness of various screening strategies. Fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy were found to cost on average less than \$20 000 per life-year saved, and no screening strategy dominated (in economic terms) the other alternatives. The higher costs per life-year saved compared with those in our analysis stemmed primarily from more frequent screening colonoscopies performed at 5-year intervals. In addition, flexible sigmoidoscopy cost only \$80 compared with \$382 used in the present analysis.

In our study, screening with fecal occult blood testing, flexible sigmoidoscopy, or colonoscopy was modeled by using a Markov process. Besides preventing colorectal can-

cer, screening procedures were also assumed to detect already existent colorectal cancers at an earlier stage. In designing the model, we tried to reduce the complex natural history of colorectal cancer to few essential states and avoid transition assumptions for which little or no published data existed. For instance, we did not consider potential changes of the sensitivity and specificity in a long series of consecutive fecal occult blood tests. Compliance rates were not modeled as time-dependent variables, and patients who stopped complying with the screening program were assumed to remain noncompliant for the rest of their life. Finally, we omitted the impact of colorectal cancer and screening on indirect costs.

Modeling of colorectal cancer screening is insightful because it helps to quantify the complex interactions among the many variables that affect the outcome and because it reveals some unexpected and nonlinear behavior of various influences. For instance, the incidence of adenomatous polyps and the efficacy of colonoscopy in cancer prevention affect not only the screening program based on colonoscopy alone but also those based on flexible sigmoidoscopy and fecal occult blood testing. Although a low specificity of fecal occult blood test increases the test's incremental cost-effectiveness ratio, it also increases the benefit of the test with respect to the number of cancers prevented by leading to more colonoscopies and excisions of adenomatous polyps that would have otherwise progressed to cancer. Rehydration of test slides improves the test characteristics primarily by decreasing the specificity and increasing the rate of positive test results. Compliance rates exert strong nonlinear influences that can markedly alter cost-effectiveness, especially of fecal occult blood testing. A decrease in the compliance rate associated with test repetition results in loss of many patients during the initial years of the program. This exponential decline reduces the overall effectiveness of the program because the incidence of cancer increases with age and the preventive yield of all programs is higher in older age groups.

In conclusion, our findings reveal a potential advantage of one colonoscopy every 10 years as a screening strategy for colorectal cancer. Screening with colonoscopy represents a cost-effective method in addition to initial screening by fecal occult blood testing because it reduces mortality from colorectal cancer at relatively low incremental costs. Our analysis also suggests that low compliance rates are more likely to influence screening with fecal occult blood testing and that under such circumstances,

colonoscopy every 10 years may be the most cost-effective primary screening strategy for colorectal cancer.

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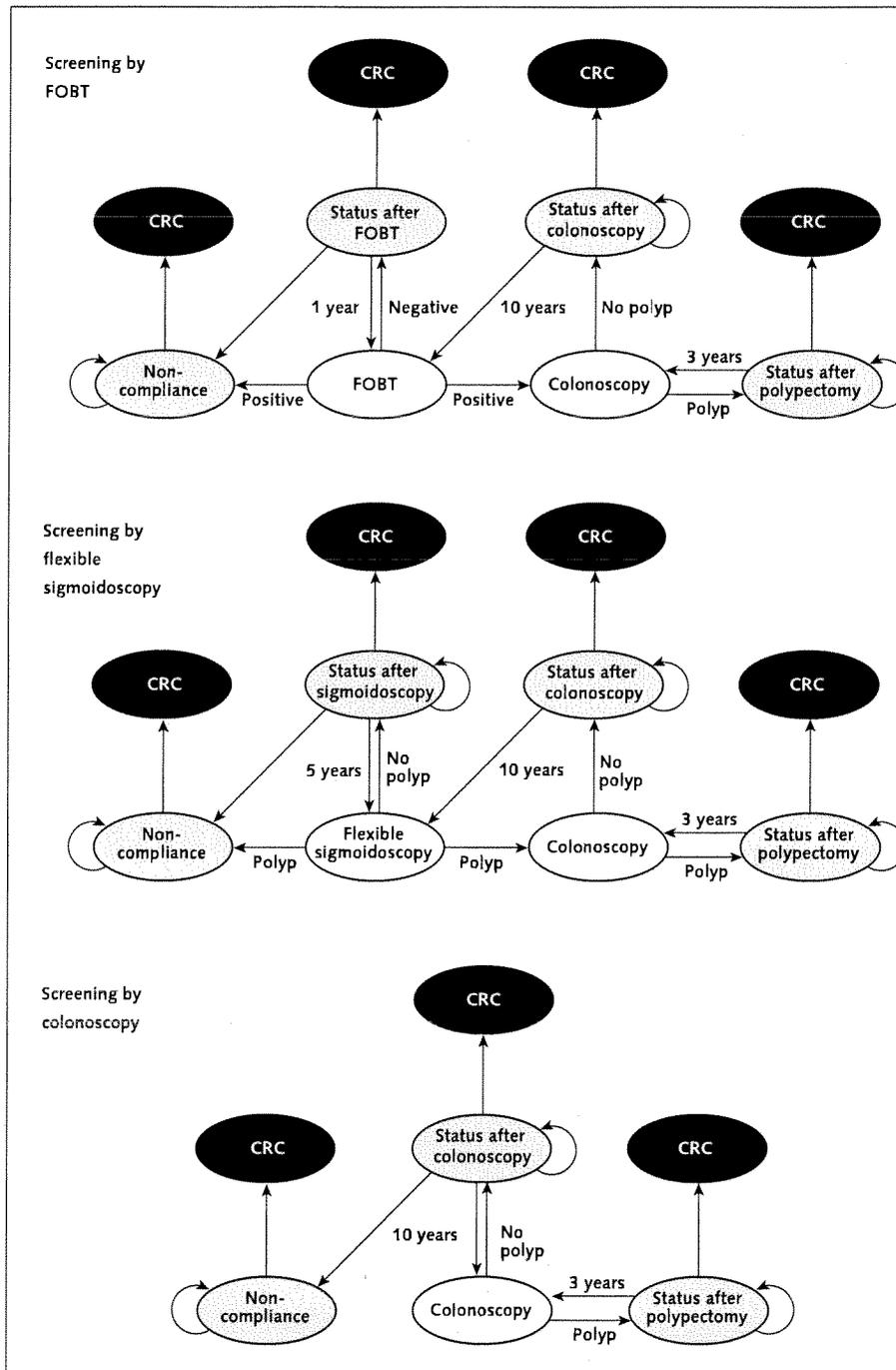
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Appendix Table. Baseline Assumptions and Ranges Tested in the Sensitivity Analysis*

Rate	Baseline Model	Sensitivity Analysis	Reference
Sensitivity of FOBT in detecting colorectal cancer, %	40	20–60	14
Specificity of FOBT in detecting colorectal cancer, %	97.50	70–99	14
Screening interval for FOBT, y	1	1–3	15
Adenomas found by sigmoidoscopy, %	45	–	16–18
Screening interval for sigmoidoscopy, y	5	3–10	15
Annual incidence of adenomas, %	1	0–6	25, 26
Screening interval for colonoscopy, y	10	3–10	15
Surveillance interval after polypectomy, y	3	1–5	15
Efficacy of colonoscopy in preventing colorectal cancer, %	75	50–100	6
Bleeding rate with colonoscopy, %	0.15	–	19
Bleeding rate with polypectomy, %	2.00	–	20
Perforation rate with colonoscopy, %	0.20	–	19
Perforation rate with polypectomy, %	0.38	–	20
Perforation rate with sigmoidoscopy, %	0.011	–	21
Mortality rate from colorectal cancer, %	40	–	22
Annual discount rate, %	3	–	23

* FOBT = fecal occult blood test.

Appendix Figure. Markov states in screening for colorectal cancer (CRC) by fecal occult blood test (FOBT) (top), flexible sigmoidoscopy (middle), and colonoscopy (bottom).



The black and gray ovals represent Markov states in which patients remain for at least a full 1-year cycle. The white ovals represent intermediate states of screening procedures, which patients may enter and leave during one cycle. The arrows represent transitions between various states.

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Analysis and interpretation of the data: A. Sonnenberg, F. Delcò, J.M. Inadomi.

Drafting of the article: A. Sonnenberg, F. Delcò.

Critical revision of the article for important intellectual content: A. Sonnenberg, F. Delcò, J.M. Inadomi.

Final approval of the article: A. Sonnenberg, F. Delcò, J.M. Inadomi.

Provision of study materials or patients: A. Sonnenberg, F. Delcò.

Statistical expertise: A. Sonnenberg, J.M. Inadomi.

Obtaining of funding: A. Sonnenberg.

Administrative, technical, or logistic support: A. Sonnenberg.

Collection and assembly of data: A. Sonnenberg, F. Delcò.

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He was pacing up and down the room as he was talking. Now he walked up to Anna Ivanovna's bed and putting his hand on her forehead said, "Go to sleep." After a few moments she began to fall asleep.

Yura quietly left the room and told Egorovna to send in the nurse. "What's come over me?" he thought. "I'm becoming a regular quack—muttering incantations, laying on the hands. . . ."

Next day Anna Ivanovna was better.

Boris Pasternak
Doctor Zhivago
New York: Pantheon Books; 1997:68-79

Submitted by:
William L. Jackson Jr., MD
Reston, VA 20194

26 B

PERFORMANCE IMPROVEMENT PLAN

PEER REVIEW

Chart reviews are done on a monthly basis by the physician's. Each physician will review 6 charts from another physician. These charts are randomly selected by the Director of Nursing who will fill out a chart review form and send it at the beginning of every month for the previous month. Approximately 400 procedures are done each month, and this number reflects about 10% of the charts being reviewed. Deficiencies are noted and will be reviewed at each physician's re-credentialing. The chart review are expected to be returned before the month is over. Problems noted during this process are to be brought to the attention of the Director of Nursing. If a physician is delinquent in his chart reviews the Director of Nursing will notify the Medical Director.

A= Adequate I = Inadequate n/a = not applicable						
The diagnosis/impression is documented and is appropriate for the findings in the current history and physical						
Treatment, diagnostic and therapeutic procedures are consistent with clinical impression or working diagnosis.						
The record documents appropriate and timely consultation and follow-up of referrals, tests and findings.						
Reports, H&Ps, progress notes and other patient information (labs, x-ray, operative reports and consultations) were reviewed and incorporated into the record in a timely manner and current within 30 days of visit.						
Documentation regarding missed and canceled appointments.						
Records of patients treated elsewhere or transferred to another health care provider are present.						
Record reflects discussion with the patient concerning the necessity, appropriateness and risks of proposed care, surgery or procedures, as well as discussion of treatment alternatives and advance directives as applicable.						
Were post-surgical needs addressed and included in the discharge notes?						
Significant medical advice given by telephone, including medical advice provided after hours and through triage services, is entered in the clinical record and appropriately signed.						
ASA Classification						
The record reflects a current review and update of meds including doses, OTC, and dietary supplements.						
Allergies are updated with each visit.						
Notes are signed off by appropriate healthcare professional (nursing and/or physicians)						

PERFORMANCE IMPROVEMENT PLAN

Patient record includes Chief complaint						
Patient record includes Clinical findings						
Patient record includes Care rendered and therapies administered						
Changes in prescription and non-prescription medications with name and dosage.						
Disposition, recommendations and instructions given to the patient.						
Informed consent.						
Clinical records for anesthesia administration.						
Signed pathology report						
Findings and techniques of a procedure are accurately and completely documented and signed by performing physician.						
Adverse reactions reported to the physician responsible for the patient and documented in the record.						
Physician examined the patient immediately before surgery and evaluated risk of anesthesia and of the procedure to be performed and pre-surgical assessment performed, i.e. Mallampati						
Documentation of physician evaluating patient for recovery from anesthesia prior to discharge?						
Post procedure assessment documented by recovery nurse or physician?						
Discharge order signed by physician?						
Significant medical advice given by telephone, including medical advice provided after hours and through triage services, is entered in the clinical record and appropriately signed or initialed.						
Pathology results are present and signed by the pathologist						
Procedure note is signed by the physician						

PERFORMANCE IMPROVEMENT PLAN

If there is a procedural complication and a patient gets transferred to a hospital, the patient's name is entered into the Transfer Log. A Peer review worksheet is filled out and reviewed. The peer review worksheet is put into the physician's folder and used in re-credentialing.

Peer Review Worksheet

Patient Name _____ Account # _____

Physician _____ Admission Date _____

Hospital Admitted to _____

Procedure Performed _____

Reason for Review:

- Unexpected clinical finding requiring hospital admission
- Procedure more extensive than originally planned
- Complication
- Unplanned admission
- Other _____

Findings (Investigation and Analysis):

Conclusion:

Action Taken (if any):

Follow-Up on Actions Taken:

Reviewer: _____

PERFORMANCE IMPROVEMENT PLAN

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PERFORMANCE IMPROVEMENT PLAN

EQUIPMENT MONITORING AND SAFETY

Environmental rounds will be performed by one of the staff members on a monthly basis. Problems are to be brought to the attention of the Director of Nursing.

				Page 1
I/C	Yes	No	N/A	STANDARDS AND INDICATORS
				A. Physical environment.
				All areas inspected monthly for environmental hazards.
				Facility Grounds
				<ul style="list-style-type: none"> • Parking area/driveway free of obstructions and hazards, free of litter. • Grounds free of environmental hazards. • Landscape plants appear healthy and groomed. • Doors operate quietly and fully, hardware secure, locks operable. • Wheel chair is available. • All exits fully lighted and designated. • Exit doors fully accessible.
				Comments:
				Reception / Waiting Area
				1. All unnecessary equipment out of hallways.
				2. All areas appear clean, neat, dust and clutter free and sanitary.
				3. Cabinets, shelves clean free of dust, neat, doors shut if not in use.
				4. Lighting in good working order
				5. Ventilation adequate.
				6. Air vents clean, dust free filters changed/schedule.
				7. Walls clean free of gouges in good repair
				8. All floors dry, free from indications of water leaks, and in good state of repair.
				9. Carpet clean free of stains/tears.
				10. Ceiling clean, free of holes/stains
				11. Furniture & equipment undamaged, in good working order, clean, hazard free.
				12. Bathroom clean and supplied.
				Comments:
				Nurses Station
				<ul style="list-style-type: none"> • Eye Wash Station operational, • All unnecessary equipment out of hallways. • All areas appear clean, neat, dust and clutter free and sanitary. • Cabinets, shelves clean free of dust, neat, doors shut if not in use. • Cabinet doors, drawers and doors open smoothly. • Doors/cabinets locked and locking mechanism working.

PERFORMANCE IMPROVEMENT PLAN

				<ul style="list-style-type: none"> • Adequate inventory available.
				<ul style="list-style-type: none"> • Lighting in good working order
				<ul style="list-style-type: none"> • Ventilation adequate.
				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains
				<ul style="list-style-type: none"> • Furniture & equipment undamaged, in good working order, clean, hazard free
				<ul style="list-style-type: none"> • Sinks and faucets free of marks, leaks, drains flow freely.
				<ul style="list-style-type: none"> • Hand soap and towels at all sinks
				<ul style="list-style-type: none"> • Water temperature warm.
				<ul style="list-style-type: none"> • Appropriate waste receptacle.
				<ul style="list-style-type: none"> • Nurse call system operational
				<ul style="list-style-type: none"> • Spill- kit available.
				Comments
				Page 2
I/C	Yes	No	N/A	STANDARDS AND INDICATORS
				Pre-op
				<ul style="list-style-type: none"> • Suction operative, canisters clean, catheters, tubing present
				<ul style="list-style-type: none"> • O2 operating, clean, cannulas present.
				<ul style="list-style-type: none"> • Stretchers clean, locked, side rails & wheel locks operating.
				<ul style="list-style-type: none"> • All unnecessary equipment out of hallways.
				<ul style="list-style-type: none"> • All areas appear clean, neat, dust and clutter free and sanitary.
				<ul style="list-style-type: none"> • Cabinets, shelves clean free of dust, neat, doors shut if not in use.
				<ul style="list-style-type: none"> • Cabinet doors, drawers and doors open smoothly.
				<ul style="list-style-type: none"> • Storage has 2 feet clearance from ceiling.
				<ul style="list-style-type: none"> • Lighting in good working order
				<ul style="list-style-type: none"> • Ventilation adequate.
				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains
				<ul style="list-style-type: none"> • Furniture & equipment undamaged, in good working order, clean, hazard free.
				<ul style="list-style-type: none"> • Appropriate waste receptacle.
				<ul style="list-style-type: none"> • Hazardous material labeled, stored properly
				<ul style="list-style-type: none"> • Nurse call system operational
				<ul style="list-style-type: none"> • Bathroom cleaned and supplied
				Comments
				Recovery
				<ul style="list-style-type: none"> • Suction operative, canisters clean, catheters, tubing present
				<ul style="list-style-type: none"> • O2 operating, clean, cannulas present.

PERFORMANCE IMPROVEMENT PLAN

				<ul style="list-style-type: none"> • Stretchers clean, locked, side rails & wheel locks operating.
				<ul style="list-style-type: none"> • All unnecessary equipment out of hallways.
				<ul style="list-style-type: none"> • All areas appear clean, neat, dust and clutter free and sanitary.
				<ul style="list-style-type: none"> • Cabinets, shelves clean free of dust, neat, doors shut if not in use.
				<ul style="list-style-type: none"> • Cabinet doors, drawers and doors open smoothly.
				<ul style="list-style-type: none"> • Storage has 2 feet clearance from ceiling.
				<ul style="list-style-type: none"> • Lighting in good working order
				<ul style="list-style-type: none"> • Ventilation adequate.
				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains
				<ul style="list-style-type: none"> • Furniture & equipment undamaged, in good working order, clean, hazard free.
				<ul style="list-style-type: none"> • Appropriate waste receptacle
				<ul style="list-style-type: none"> • Hazardous material labeled, stored properly
				<ul style="list-style-type: none"> • Nurse call system operational
				<ul style="list-style-type: none"> • Refrigerator cleaned and log maintained
				Comments
				Procedure Room
				1. Suction operative, canisters clean, catheters, tubing present
				2. O2 operating, clean, cannulas present.
				3. All unnecessary equipment out of hallways.
				4. All areas appear clean, neat, dust and clutter free and sanitary.
				5. Cabinets, shelves clean free of dust, neat, doors shut if not in use.
				6. Cabinet doors, drawers and doors open smoothly.
				7. Doors/cabinets locked and locking mechanism working.
I/C	Yes	No	N/A	STANDARDS AND INDICATORS
				8. Adequate inventory available.
				9. Lighting in good working order
				10. Ventilation adequate.
				11. Air vents clean, dust free filters changed/schedule.
				12. Walls clean free of gouges in good repair
				13. All floors dry, free from indications of water leaks, and in good state of repair.
				14. Ceiling clean, free of holes/stains
				15. Furniture & equipment undamaged, in good working order, clean, hazard free.
				16. Sinks and faucets free of marks, leaks, drains flow freely.
				17. Hand soap and towels at all sinks
				18. Water temperature warm.
				19. Appropriate waste receptacle.
				20. Hazardous material labeled, stored properly
				21. Nurse call system operational
				22. Emergency call system operational

PERFORMANCE IMPROVEMENT PLAN

				Comments
				Staff Changing/Locker Room
				<ul style="list-style-type: none"> All areas appear clean, neat, dust and clutter free and sanitary. Cabinets, shelves clean free of dust, neat, doors shut if not in use. Doors/cabinets locked and locking mechanism working. Lighting in good working order Ventilation adequate. Air vents clean, dust free filters changed/schedule. Walls clean free of gouges in good repair All floors dry, free from indications of water leaks, & in good state of repair. Ceiling clean, free of holes/stains Furniture & equipment undamaged, in good working order, clean, hazard free. Sinks and faucets free of marks, leaks, drains flow freely. Hand soap and towels at all sinks Water temperature warm. Appropriate waste receptacle.
				Comments
				Clean Utility
				<ul style="list-style-type: none"> All areas appear clean, neat, dust and clutter free and sanitary. Cabinets, shelves clean free of dust, neat, doors shut if not in use. Cabinet doors, drawers and doors open smoothly. Lighting in good working order Storage has 2 feet clearance from ceiling. Ventilation adequate. Air vents clean, dust free filters changed/schedule. Walls clean free of gouges in good repair All floors dry, free from indications of water leaks, & in good state of repair. Ceiling clean, free of holes/stains Furniture & equipment undamaged, in good working order, clean, hazard free.
				Comments
				Soiled Utility
				<ul style="list-style-type: none"> Protective eye wear available. All areas appear clean, neat, dust and clutter free and sanitary. Cabinets, shelves clean free of dust, neat, doors shut if not in use.
I/C	Yes	No	N/A	STANDARDS AND INDICATORS
				<ul style="list-style-type: none"> Cabinet doors, drawers and doors open smoothly. Lighting in good working order Ventilation adequate.

PERFORMANCE IMPROVEMENT PLAN

				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains
				<ul style="list-style-type: none"> • Furniture & equipment undamaged, in good working order, clean, hazard free.
				<ul style="list-style-type: none"> • Sinks and faucets free of marks, leaks, drains flow freely.
				<ul style="list-style-type: none"> • Hand soap and towels at all sinks
				<ul style="list-style-type: none"> • Water temperature warm.
				<ul style="list-style-type: none"> • Appropriate waste receptacle.
				<ul style="list-style-type: none"> • Hazardous material labeled, stored properly
				<ul style="list-style-type: none"> • Clean and soiled supplies stored separately
				<ul style="list-style-type: none"> • Hopper clean and operational
				Comments
				Janitor
				<ul style="list-style-type: none"> • All movable equipment in good working order.
				<ul style="list-style-type: none"> • All areas appear clean, neat, dust and clutter free and sanitary.
				<ul style="list-style-type: none"> • Lighting in good working order
				<ul style="list-style-type: none"> • Ventilation adequate.
				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains
				<ul style="list-style-type: none"> • Furniture & equipment undamaged, in good working order, clean, hazard free.
				<ul style="list-style-type: none"> • Sinks and faucets free of marks, leaks, drains flow freely.
				<ul style="list-style-type: none"> • Hand soap and towels at all sinks
				<ul style="list-style-type: none"> • Water temperature warm.
				<ul style="list-style-type: none"> • Appropriate waste receptacle.
				<ul style="list-style-type: none"> • Hazardous material labeled, stored properly
				Comments
				Patient/Staff Bathrooms
				<ul style="list-style-type: none"> • All areas appear clean, neat, dust and clutter free and sanitary.
				<ul style="list-style-type: none"> • Lighting in good working order.
				<ul style="list-style-type: none"> • Ventilation adequate.
				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair.
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains.
				<ul style="list-style-type: none"> • Sinks and faucets free of marks, leaks, drains flow freely.
				<ul style="list-style-type: none"> • Hand soap and towels at all sinks
				<ul style="list-style-type: none"> • Water temperature warm.

PERFORMANCE IMPROVEMENT PLAN

				<ul style="list-style-type: none"> • Appropriate waste receptacle.
				<ul style="list-style-type: none"> • Nurse call system operational.
				<ul style="list-style-type: none"> • Toilets flush, adequate paper supply.
				<ul style="list-style-type: none"> • Nurse call system operational.
				Comments
				Staff Lounge
I/C	Yes	No	N/A	STANDARDS AND INDICATORS
				<ul style="list-style-type: none"> • All unnecessary equipment out of hallways.
				<ul style="list-style-type: none"> • All areas appear clean, neat, dust and clutter free and sanitary.
				<ul style="list-style-type: none"> • Cabinets, shelves clean free of dust, neat, doors shut if not in use.
				<ul style="list-style-type: none"> • Cabinet doors, drawers and doors open smoothly.
				<ul style="list-style-type: none"> • Lighting in good working order.
				<ul style="list-style-type: none"> • Ventilation adequate.
				<ul style="list-style-type: none"> • Air vents clean, dust free filters changed/schedule.
				<ul style="list-style-type: none"> • Walls clean free of gouges in good repair.
				<ul style="list-style-type: none"> • All floors dry, free from indications of water leaks, & in good state of repair.
				<ul style="list-style-type: none"> • Ceiling clean, free of holes/stains.
				<ul style="list-style-type: none"> • Furniture & equipment undamaged, in good working order, clean, hazard free.
				<ul style="list-style-type: none"> • Sinks and faucets free of marks, leaks, drains flow freely.
				<ul style="list-style-type: none"> • Hand soap and towels at all sinks.
				<ul style="list-style-type: none"> • Water temperature warm.
				<ul style="list-style-type: none"> • Appropriate waste receptacle.
				Comments
				Emergency equipment
				<ul style="list-style-type: none"> • Crash cart checked daily when center has admissions.
				<ul style="list-style-type: none"> • Call bells, emergency bells checked monthly.
				<ul style="list-style-type: none"> • Auxiliary power generator exercised weekly.
				<ul style="list-style-type: none"> • Auxiliary power generator exercised under load monthly.
				<ul style="list-style-type: none"> • Auxiliary power enunciator panels checked annually.
				<ul style="list-style-type: none"> • Fire extinguishers inspected and tagged annually and recharged immediately
				<ul style="list-style-type: none"> • Fire plan located in all areas of the center.
				<ul style="list-style-type: none"> • Smoke detectors tested annually.
				Comments:
				Electrical Safety
				<ul style="list-style-type: none"> • Wires or plugs in tact, not bare/frayed.
				<ul style="list-style-type: none"> • Outlets and switch covers intact and secure.
				<ul style="list-style-type: none"> • Electrical cords/ wiring secured to reduce potential of falls.
				<ul style="list-style-type: none"> • All three wire cords equipped as such.

PERFORMANCE IMPROVEMENT PLAN

				<ul style="list-style-type: none"> • Lighting in good working order.
				<ul style="list-style-type: none"> • Flashlights in all pt. areas, labeled w/batteries replaced Q 3 months
				<ul style="list-style-type: none"> • Grounding is appropriate.
				<ul style="list-style-type: none"> • Tension is appropriate.
				<ul style="list-style-type: none"> • Electrical equipment tested and tagged by biomedical engineer.
				Comments:

Signature of Reviewer _____ Date _____

PERFORMANCE IMPROVEMENT PLAN

Temperature logs are filled out daily by the Recovery Room staff and documented in the log. If a temperature outside the parameters exists, the Director of Nursing is notified.

Refrigerator Temperature

Month / Day	Temperature °F	Signature
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		

PERFORMANCE IMPROVEMENT PLAN

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31		

If temperature >45°F and <35°F notify Director of Nursing.

PERFORMANCE IMPROVEMENT PLAN

Call lights are tested on a weekly basis and documented in the log. Malfunctions are reported to the Director of Nursing.

Week	January	February	March	April	May	June
	Date & Initials					
Week 1						
Week 2						
Week 3						
Week 4						
	July	August	September	October	November	December
	Date & Initials					
Week 1						
Week 2						
Week 3						
Week 4						

Name _____ Signature _____ Initials _____

Name _____ Signature _____ Initials _____

Name _____ Signature _____ Initials _____

PERFORMANCE IMPROVEMENT PLAN

Generator testing is done weekly for 30 minutes under load and documented in the log. Bi-annual testing is done by New England Medical Gas.

Year _____

Generator Testing Log

Month	Week	Oil Level OK	Battery OK	Water OK	Tested under full load 30 minutes	Area around generator clean	Generator Locked	Bi-Annual Testing	Initials	Signature
January	1									
	2									
	3									
	4									
February	1									
	2									
	3									
	4									
March	1									
	2									
	3									
	4									
April	1									
	2									
	3									
	4									
May	1							NE Gas		
	2									
	3									
	4									
June	1									
	2									
	3									
	4									
July	1									
	2									
	3									
	4									

PERFORMANCE IMPROVEMENT PLAN

August	1									
	2									
	3									
	4									
September	1									
	2									
	3									
	4									
October	1									
	2									
	3									
	4									
November	1									
	2									
	3									
	4									
December	1									
	2									
	3									
	4									

PERFORMANCE IMPROVEMENT PLAN

Fire extinguishers are checked monthly for use. Annual testing is done and the extinguishers are tagged.

Monthly Fire Extinguishers Log _____ Year

	Jan	Feb	March	April	May	June	July	August	Sept	October	Nov.	Dec.
Lobby												
Pre												
Post												
Procedure												
Hallway												

Name _____ Signature _____ Initials _____

Name _____ Signature _____ Initials _____

Name _____ Signature _____ Initials _____

PERFORMANCE IMPROVEMENT PLAN

Annual Testing is done on all electrical equipment used in patient care by Claflin Medical. All equipment is tagged appropriately.

Vacuum system is tested and preventive maintenance done annually.

PERFORMANCE IMPROVEMENT PLAN

INFECTION CONTROL

The medical staff and EC personnel promote and maintain a safe environment with minimal risk for infection to the patient, personnel and visitors.

Infections are to be reported to the Director of Nursing. Annual training is done regarding Universal Precautions, Hazardous Waste disposal, and Infection Control.

Equipment is cleaned after each patient use. The unit is cleaned nightly by a professional cleaning service. Floors are washed nightly.

Protocols are followed for the monitoring, maintenance and testing of cleaning equipment. Daily gluteraldehyde testing prior to first use of the day. Filters changed per manufacturer's recommendations. Daily Autoclave testing for steam and monthly spore testing. If a piece of equipment fails testing the solution is changed or the machine is taken out of service until repaired.

Filter Change

Silver Case 0.2 micron internal water filter -- 6 months

**Blue on the wall – variable depending on how hard the water is
1 micron and 0.4 micron external water filters**

Shut off yellow handle on pipe behind washer

Open gray valve to release pressure (into basin)

Close gray valve (inside front left of silver water filter case)

Gauges should be even across the board

Should be no more than 10 lb difference from one filter to the next. If more than 10lb difference, change filter.

If there is a low reservoir alarm during the rinse cycle to both tanks – it means that internal water filter (silver case) needs to be changed.

Red/Silver Disinfectant Filter

Changes with Rapicide

Silver/White Air Filter – 3 months

(Inlet should be toward pump)

PERFORMANCE IMPROVEMENT PLAN

Gluteraldehyde Monitor Log

	Date	Reading	Change Solution Every 28 Days	Initials
1		<input type="checkbox"/> pass <input type="checkbox"/> fail		
2		<input type="checkbox"/> pass <input type="checkbox"/> fail		
3		<input type="checkbox"/> pass <input type="checkbox"/> fail		
4		<input type="checkbox"/> pass <input type="checkbox"/> fail		
5		<input type="checkbox"/> pass <input type="checkbox"/> fail		
6		<input type="checkbox"/> pass <input type="checkbox"/> fail		
7		<input type="checkbox"/> pass <input type="checkbox"/> fail		
8		<input type="checkbox"/> pass <input type="checkbox"/> fail		
9		<input type="checkbox"/> pass <input type="checkbox"/> fail		
10		<input type="checkbox"/> pass <input type="checkbox"/> fail		
11		<input type="checkbox"/> pass <input type="checkbox"/> fail		
12		<input type="checkbox"/> pass <input type="checkbox"/> fail		
13		<input type="checkbox"/> pass <input type="checkbox"/> fail		
14		<input type="checkbox"/> pass <input type="checkbox"/> fail		
15		<input type="checkbox"/> pass <input type="checkbox"/> fail		
16		<input type="checkbox"/> pass <input type="checkbox"/> fail		
17		<input type="checkbox"/> pass <input type="checkbox"/> fail		

PERFORMANCE IMPROVEMENT PLAN

18		<input type="checkbox"/> pass <input type="checkbox"/> fail		
19		<input type="checkbox"/> pass <input type="checkbox"/> fail		
20		<input type="checkbox"/> pass <input type="checkbox"/> fail		
21		<input type="checkbox"/> pass <input type="checkbox"/> fail		
22		<input type="checkbox"/> pass <input type="checkbox"/> fail		
23		<input type="checkbox"/> pass <input type="checkbox"/> fail		
24		<input type="checkbox"/> pass <input type="checkbox"/> fail		
25		<input type="checkbox"/> pass <input type="checkbox"/> fail		
26		<input type="checkbox"/> pass <input type="checkbox"/> fail		
27		<input type="checkbox"/> pass <input type="checkbox"/> fail		
28		<input type="checkbox"/> pass <input type="checkbox"/> fail		

Initials	Signature	Initials	Signature

PERFORMANCE IMPROVEMENT PLAN

Temperature and Humidity are checked daily in procedure rooms. Abnormalities are reported to the Director of Nursing immediately.

Procedure Room – Temperature/Humidity ROOM _____

Month	Day	Temperature °F	Humidity	Signature
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			
	12			
	13			
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PERFORMANCE IMPROVEMENT PLAN

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If temperature >86°F and <59°F or if humidity >60% and <30% notify Director of Nurses.

PERFORMANCE IMPROVEMENT PLAN

Sharps containers are not allowed to be higher than the fill line. Changed immediately when reach the line. Linen bags are changed when full and removed to the dirty utility room. Hazardous waste is disposed of in red lined bins and removed when near full.

MEDICAL RECORDS MANUAL

POLICY: TELEPHONE ADVICE

A record of telephone calls from patients requiring consultative information will be documented and kept in the medical record.

PROCEDURE:

1. Patient calls for advice will be referred to a member of the nursing staff.
2. The call may be referred to the physician for further instructions.
3. The physician may return the call or give instructions to the staff to contact the patient.
4. Significant telephone advice given during hours of operation are documented and signed by the person giving the advice.
5. Medical advice provided by after hours telephone information or triage telephone services shall be entered on the patient's record and appropriately signed and initialed.
 - a. The Director of Nursing shall initial such advice and report to the physician or medical director if follow up is needed.

PROCEDURE FOR FILING DICTATED NOTE AND PATHOLOGY OR LAB RESULTS:

The physician will be notified of all pathology reports received in a timely manner to provide plan of care.

1. When dictation and pathology or lab results are received, they are to be sent to the EMR.
2. The Physician is responsible to review all results and in the event of an adverse pathology or lab report the physician will be verbally notified immediately and the notification documented on the patient's record by the RN.
3. The referring physician and/or primary care physician will be verbally notified by the Center's physician of an adverse report.
4. The chart will be placed in the physician's in-file to be reviewed.
5. The pathology or lab report is to be initialed by the physician and the dictation is to be electronically signed by the physician in the EMR.
6. Copies will be sent to:
 - a. Referring and/or primary care physicians via fax within 3 work days.
 - b. The original will be kept for the patient chart.
7. Once this has been done and paperwork is filed in the chart, the chart will be considered complete and filed in the file cabinet.
8. The secretary will reconcile all procedure notes and pathology at the end of every day to verify that it has been properly placed in the EMR.

POLICY: PERFORMANCE IMPROVEMENT

The Center will assess the quality of care by means of an effective performance improvement plan. The plan will be administered by The Performance Improvement Committee and will monitor patient care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, patient care statistics, and discharge planning services.

The Performance Improvement process will incorporate periodic review of patient medical records and will include evaluation by patients of care and services provided by the facility. Evaluation of patient care throughout the facility shall be criteria-based, so that certain review actions are taken or triggered when specific quantified, pre-determined levels of outcomes or potential problems are identified.

The Administrator will follow-up on the findings of quality assurance program to ensure that effective corrective actions have been taken, including at least policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

The quality assurance program will identify and establish indicators of quality care specific to the facility, which shall be monitored and evaluated.

The results of the quality assurance program will be submitted to the governing authority at least annually and shall include at least deficiencies found and recommendations for corrections or improvements. Deficiencies which jeopardize patient safety will be reported to the governing authority immediately.

Performance Improvement is the monitoring and evaluation process designed to help healthcare organizations to effectively use their resources to manage the performance of care in the service they provide.

Monitoring and evaluation activities involve the ongoing examination of care provided, identification of deficiencies in that care, and improvement, as necessary. Appropriate monitoring and evaluation activities are ongoing and integrated with other monitoring and evaluation activities throughout the organization.

The monitoring and evaluation process assists both in identifying patterns of care that may not be evident when only case by case review is performed and in identifying situations in which review is likely to be most useful in identifying correctable deficiencies in care and opportunities to improve care. Although this process will not identify every case of substandard care, monitoring and evaluation does help the Center identify situations on which its attention could be most productively focused.

POLICY: PERFORMANCE IMPROVEMENT COMMITTEE

The Performance Improvement Committee shall coordinate with the Medical Director a formal program of Performance Improvement and reporting of incidents as set forth in the facility's Performance Improvement Plan and as required by regulatory agencies. It's responsibilities will be to review and analyze all elements of the PI program, coordinate with the Medical Director and Insurance Carrier the functions of Risk Management and report to the Medical Advisory Committee and The Board of Directors activities of the PI Program.

PROCEDURE:

1. Responsibilities;
 - a. Identify standards for Performance Improvement.
 - b. Establish criteria.
 1. Meets with a representative of each area to review and assist in establishing ongoing monitors and developing criteria.
 2. Determines that each area understands the criteria used in assessment.
 - c. Implements systems for monitoring care.
 - d. Ensures that all nursing and medical staff members are in-serviced as to the use of PI tools.
 - e. Assists personnel in identifying problem areas.
 - f. Reviews data.
 1. Determines priority for discussion and exploration at the PI meeting.
 2. Identifies problem areas that require additional information and research.
 3. Sets PI agenda based on data collection and review.
 - g. Disseminates information to proper areas.
 - h. Follows procedure for notifying appropriate persons, identifying problems and the implementation of measures to resolve the problem.
 - i. Advises all staff of PI assessments or evaluations.
 - j. Reviews the initial outcome of measures taken to resolve problems.
 - k. Prepares and submits reports to the Medical Advisory Committee and The Board of Directors annually and more frequently if the need arises.
2. The Performance Improvement Committee shall meet annually and more frequently if necessary.
3. The Chairperson of this committee will be responsible for the Performance Improvement Program.

QUALITY IMPROVEMENT AND BENCHMARKING STUDIES

On an annual basis, the Center will review existing quality improvement measures and end or add newly identified study interests or concerns.

Each study or benchmarking project will include:

1. **Problem or Concern.** An identified internal or external quality issue that will be monitored.
2. **Source:** Who or what information supports the study. (I.e. ASGE guidelines, national benchmark)
Team: Who is going to supply information (I.e. nursing, administration, physicians)
Frequency: How often does issue occur
Severity: Mild, Moderate or Severe
3. **Corrective Measures:** What is being done or will be done to correct the issue.
4. **Re-measurement:** When will issue be re-measured and what is the goal of compliance.

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Gastroenterology Associates, Inc.

ALYN L. ADRAIN, M.D.
EVAN B. COHEN, M.D.
NEIL R. GREENSPAN, M.D.
BRETT D. KALMOWITZ, M.D.

DAVID SCHREIBER, M.D.
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JEREMY SPECTOR, M.D.



Summary of Post Polypectomy Guidelines from the ACG and AGA

POLYP CHARACTERISTICS

RECOMMENDED INTERVAL

1 or 2 tubular adenomas < 1 cm → 5 years

> 2 adenomas, high-grade dysplasia,
> 1 cm, or villous elements → 3 years

Negative follow-up exam
for history of adenoma → 5 years

Large sessile polyp → 3 to 6 months

Malignant polyp
(with favorable criteria) → 3 months

Hyperplastic polyp → 10 years (routine screening)

ACG, American College of Gastroenterology

AGA, American Gastroenterological Association

**These are general guidelines and other factors such as quality of the preparation, family history of colon cancer, etc. may alter the recommended interval for follow up colonoscopy.*

RHODE ISLAND

44 West River Street ■ Providence, RI 02904
333 School Street ■ Pawtucket, RI 02860
905 Pontiac Avenue ■ Cranston, RI 02920
One Commerce Street ■ Lincoln, RI 02865
TEL: 401-274-4800 FAX: 401-454-0410

MASSACHUSETTS

500 East Washington Street
North Attleboro, MA 02760
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www.NewEnglandGastro.com

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Initial Screening Guidelines

CATEGORY	AGE AT ONSET OF SCREENING	FREQUENCY
Asymptomatic and NO family history of colorectal cancer or polyps	50 years (African-American 45 years)	■ If NO abnormalities are found then 10 years ■ If abnormalities are found see reverse
Early onset of colorectal cancer or adenomatous polyps in a first degree relative	Age 40 years or 10 years before age at diagnosis, whichever is first	Every 5 years

**Patients with very high risk for Colon Cancer may include those with Long Standing Inflammatory Bowel Disease or possibility of Hereditary Colon Cancer Syndrome (may account for 4-5% of all colon cancers — clues include disease affecting multiple relatives, multiple generations, and early onset of cancer of colon, endometrium, stomach, ovary, pancreas, ureter and renal pelvis, biliary tract, small bowel or brain).*

Consider referral for specialty consultation.

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D 1

D2

Exhibit D(2)



January 9, 2013

Neil R. Greenspan MD, FACG
Chief Executive Officer
Endoscopy Associates, Inc.
44 West River Street
Providence, RI 02904

**RE: AIA/FGI 2006 Guidelines Compliance Assessment
Endoscopy Associates, Inc.
44 West River Street, Providence, RI 02904
Vision 3 Architects No. 12115a**

Dear Dr. Greenspan:

As directed, Vision 3 Architects has performed an assessment of the gastrointestinal endoscopy facilities of Endoscopy Associates, Inc. located at 44 West River Street, Providence, RI for compliance with the AIA/FGI 2006 Guidelines for Design and Construction of Health Care Facilities. Sections 3.1, Outpatient Facilities, Section 3.7 Outpatient Surgical Facilities (as referenced in 3.9) and 3.9, Gastrointestinal Endoscopy Facilities, were used for this review.

With the following remedial actions, which you have stated in prior conversations that you plan on implementing once you obtain a Certificate of Need, the existing facility will be in compliance with the Guidelines:

ITEM 1:

3.9-2.3.1.3 and Table 3.1-2 Procedure Room(s) Medical Gases. – The existing three (3) Procedure Rooms each have two (2) oxygen outlets and two (2) vacuum outlets.

Action 1:

To bring them into compliance with the Guideline's requirement for three (3) vacuum outlets, one portable vacuum source (a Schuco S330A unit) will be provided in each room.

ITEM 2:

3.9-2.5.1 Patient Changing Area - The present suite's layout does not include a dedicated patient changing area, as required by the Guidelines.

Action 2:

The existing Recovery Area consists of 10 recovery cubicles, more than is required by the practice program. Two of the bays will be repurposed. One will be used for general storage and the other will be converted into a dedicated patient dressing area. This space is convenient to an existing patient toilet and will be outfitted with an ADA compliant bench and twelve (12) secure lockers.

ITEM 3:

3.9-5.2.1.2(2) Toilet room doors – The existing toilet rooms serving the Procedure Rooms and Recovery Area, though they are equipped with hardware that allows for access from the outside in an emergency, do not include doors that swing outward .

Action 3:

The doors will be modified or replace to allow for outward swings so that in an emergency they can be safely opened without pressing against a patient who may have collapsed within the room.

ITEM 4:

3.9-5.2.2.1(3) Finishes, Floors – The existing decontamination facilities floors are finished with vinyl composition tile and separately applied vinyl base, which do not conform to the Guidelines requirement for a monolithic finish in this area.

Action 4:

The exiting vinyl composition tile floor finish will be replace with a monolithic sheet vinyl finish with welded seams and an integral cove base which will extent 6" above the finished floor.

If you have any questions, please don't hesitate to contact this office.

Sincerely,

VISION 3 ARCHITECTS



Keith R. Davignon, AIA
Principal

D 6

Exhibit D(6)



NOB CREEK, LLC.

Alyn L. Adrain, M.D.
Evan B. Cohen, M.D.
Valley C. Dreisbach, M.D.
Neil R. Greenspan, M.D.
Brett D. Kalmowitz, M.D.
David Schreiber, M.D.
Samir A. Shah, M.D.
Jeremy Spector, M.D.

December 31, 2010

Neil R. Greenspan, M.D., Manager
Nob Creek, LLC
44 West River Street, 2nd Floor
Providence, RI 02904

Re: Nob Creek, LLC

Dear Dr. Greenspan:

Notice is hereby made that Endoscopy Associates, Inc. (the "Practice") wishes to exercise its first of three options under the lease between Nob Creek, LLC and the Practice, dated April 26, 2006, to extend the term from May 1, 2011 through April 30, 2016.

Sincerely,

Jeremy Spector, M.D., Vice President

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44 West River Street, Providence, RI 02904
Telephone 401-274-4800 FAX 401-454-0410

LEASE

This Lease (this "Lease") is entered into this ____ day of April, 2006 (the "Effective Date"), by and between **Nob Creek, LLC**, a Rhode Island limited liability company, with a place of business at 44 West River Street, Providence, Rhode Island 02904 (the "Lessor") and **Endoscopy Associates, Inc.**, a Rhode Island professional services corporation, with a place of business at 44 West River Street, Providence, Rhode Island 02904 (the "Lessee").

WITNESSETH:

1. PREMISES

The Lessor does hereby demise and lease unto the Lessee a portion of the building (the "Building") located at 44 West River Street, Providence, Rhode Island (the Building and the surrounding land are hereinafter referred to as the "Property"), said portion constituting the first floor of the Building consisting of approximately Eight Thousand Nine Hundred Twenty (8,920) square feet, as more completely set forth in the plan attached hereto as Attachment A. Said portion of the Building being leased to Lessee is hereinafter referred to as the "Premises" and constitutes approximately Forty-Three and 85/100 percent (43.85%) of the Building. All references to Lessee's "Proportionate Share" shall mean Forty-Three and 85/100 percent (43.85%). The use and occupation by the Lessee of the Premises shall include a right to use in common with the others entitled thereto, the common areas, including parking lots, as may be designated from time to time by the Lessor, subject however the terms and conditions of this Lease and to rules and regulations for the use thereof as prescribed from time to time by the Lessor, which rules and regulations shall not materially interfere with Lessee's use of such common areas.

2. TERM

TO HAVE AND TO HOLD the same with appurtenances thereto unto the Lessee for and during the term of five (5) years from the Commencement Date and terminating at midnight on the 30th day of April, 2011, subject to the options to renew herein granted.

3. BASE RENT; ADDITIONAL RENT

Yielding and paying therefore the following stipulated annual base rent for each and every year during the term of this Lease, and in the same proportion for any portion of a year in equal monthly payments as stated below, each on the first (1st) day of each month in advance and every month succeeding the date hereof for the term of this Lease or until such earlier termination and pro-rata for any first or last fractional month:

a. The annual base rent of \$282,318 from the Commencement Date through April 30, 2007, is payable in equal monthly installments of \$23,526.50.

b. The annual base rent for the period commencing on May 1, 2007, and for each subsequent period commencing on May 1 thereafter, shall be subject to increase upon the commencement of each such term based upon a cost-of-living adjustment. The determination based upon the cost of living index for the year commencing May 1, 2007 ("Lease Year Two") shall be made as follows:

The Consumer Price Index ("CPI") as it shall exist on April 1, 2007 shall be divided by the CPI as it existed as of April 1, 2006. From the quotient thereof, the integer one (1) shall be subtracted. The resulting positive number multiplied by 100 shall be deemed to be the percentage of increase. In no event shall the percentage increase be more than five percent (5%) over the prior year's rent irrespective of the CPI Indicator. This percentage of increase multiplied by \$282,318 ("Lease Year One Base Rent") shall be the additional amount required to supplement and add to Lease Year One Base Rent for Lease Year Two to comply with the provisions of this section ("Lease Year Two Base Rent"). Lease Year Two Base Rent shall be divided and paid in equal amounts as additional rent, together with all other monthly installment payments or other additional rents required under this Lease. Similar annual adjustments shall be made for each subsequent annual period utilizing the methodology set forth in this paragraph.

The CPI shall be that for Urban Wage Earners and Clerical Workers according to the Boston Index published by the Bureau of Labor Statistics of the US Department of Labor.

c. As additional rent, the Lessee shall pay the Lessor, at least thirty (30) days before due, its Proportionate Share of the real property taxes and current assessments levied against the Property is located, provided that such real property taxes and current assessments are due and owing during the term of this Lease and provided further that the Lessor sends the Lessee a photocopy of each tax bill and assessment from the City of Providence or other government agency issuing the bill. Taxes and assessments for the first year of the term of this Lease shall be pro-rated as of the commencement date of this Lease, and for the last year or any extension hereof, as of the last day of said last year. Real property taxes shall include all real estate taxes, assessments (including without limitations all assessments for schools, public improvements, or benefits) whether general or special, foreseen or unforeseen, which at any time during the term of this Lease may be levied, assessed, imposed, become due and payable or liens upon, or arise in connection with the use, occupancy or possession of the Property. Lease Year One Base Rent includes Lessee's Proportionate Share of real property taxes for calendar year 2006. The Lessee's Proportionate Share of any increase in such property taxes over the year 2006 taxes (assessed,

December 31, 2005) shall be additional rent for the balance of the Term of this Lease.

d. As additional rent, the Lessee shall pay its Proportionate Share of all Narragansett Bay Commission, water and sewer usage and any other water/sewer assessments, and other governmental impositions and charges of every kind and nature whatsoever, whether general or special, foreseen or unforeseen, which at any time during the term of this Lease may be levied, assessed, imposed, become due and payable or liens upon, or arise in connection with the use, occupancy or possession of the Property. A tax or assessment bill or copy thereof submitted by the Lessor to the Lessee shall be conclusive evidence of the amount of the Narragansett Bay Commission, water and sewer usage and other water/sewer assessments, use or installments thereof to be paid.

e. As additional rent, Lessee shall pay with its monthly installments of base rent and without demand, deduction or setoff, Lessee's Proportionate Share of all costs incurred by Lessor in maintaining, repairing, improving, operating, administering and insuring all portions of the Property which are the responsibility of Lessor hereunder (herein sometimes referred to as the "Operating Costs"), including, without limitation, the total costs of operating, repairing, replacing (should such replacement constitute a capital expense, then the total cost of such capital expenditure shall be amortized over its useful life in accordance with Generally Accepted Accounting Principles (GAAP), lighting, cleaning, landscaping, maintaining, painting, securing and insuring the Property, costs incurred in complying with governmental laws, ordinances, rules and regulations, plus an administrative cost equal to fifteen percent (15%) of the foregoing costs. Lessee shall pay its proportionate share of Operating Costs in advance based on estimates made by Lessor from time to time. Estimates shall be revised annually on the basis of actual Operating Costs for the preceding year of operations. Should Operating Costs be underestimated, Lessee shall pay any deficiency along with the payment of Rent next due and thereafter pay its adjusted proportionate share of Operating Costs in equal monthly installments as herein provided. Any excess payments shall be credited against the payment of Operating Costs next due.

4. OPTION TO RENEW

The Lessee, keeping and performing all of the terms, conditions, and covenants of the within Lease to be kept and performed on the part of the Lessee, shall have three (3) options to renew this Lease on additional periods of five (5) years each commencing on May 1, 2011, upon the same terms and conditions as this Lease, including, without limitation, the annual base rent and additional rent adjustments set forth in Section 3, provided, however, there shall be no additional options to renew should the Lessee exercise the third five (5) year option.

In the event the Lessee shall exercise these options to renew as provided in the paragraph above, it shall give notice of the intent to exercise said option by certified mail, return receipt requested, addressed to the Lessor at the address set forth no later than December 31, 2010, December 31, 2015 and December 31, 2020, respectively. A condition to exercise any one of such options shall be that a Lessee is not in default of any of its obligations under this Lease at the option exercise date or at the renewal date.

5. USE AND CONDITION OF PREMISES

a. The Premises are let for use solely by the Lessee for the purpose of providing medical services by physicians specializing in gastroenterology and no other use or purpose without the prior written consent of the Lessor.

b. The Lessee takes the Premises "as is, where is". The Lessee has inspected the Premises and is satisfied as to the condition thereof.

6. PARTIES' RESPONSIBILITIES WITH RESPECT TO MAINTENANCE, REPLACEMENT AND REPAIR

a. It shall be the Lessor's responsibility to maintain the foundation, roof and exterior walls of the Building, all common areas of the Building, the land surrounding the Building, and any utility connections which affect the Building in general. Lessor shall have the right to install, maintain, use, repair and replace pipes, ductwork, conduits, utility lines, and wires in the Premises. Lessor agrees that where possible all work in the Premises shall be performed in a manner which shall not unreasonably interfere with the normal business operations of Lessee.

b. Except as provided in Section 6(a), Lessee shall, at Lessee's expense, at all times keep the Premises and appurtenances thereto in good order, condition, and repair, clean, sanitary and safe including the replacement of equipment, fixtures, and all broken glass (with glass of the same size and quality), and shall, in a manner satisfactory to Lessor, decorate and paint the Premises when necessary to maintain at all times a clean and sightly appearance. In the event Lessee fails to perform any of its obligations as required hereunder, Lessor may, but shall not be required to, perform and satisfy same with Lessee hereby agreeing to reimburse Lessor, as additional rent, for the cost thereof promptly upon demand.

c. Without limiting the generality of Section 6(b), in order to maintain the Premises in good order and condition, Lessee shall make any and all additions, improvements, alterations, and repairs to or on the Premises (including, without limitation, all electrical, mechanical, heating and ventilation and/or plumbing systems located within the Premises), including any such action which may at any time during the Lease Term be required or recommend by any

lawful authorities, insurance underwriters, inspection rating bureaus, or insurance inspectors designated by Lessor, other than those which are the Lessor's responsibility for the structural repair and maintenance of the foundation, roof, exterior walls or any utility connections which affect the Building in general. All such work shall be performed in a good and workmanlike manner in accordance with the requirements set forth in Section 5.

7. UTILITIES AND SERVICES

The Lessee covenants and agrees that it shall pay for all fuel, gas, oil, heat, ventilation, air conditioning, electricity, power, and telephone services which may be furnished to or used in or about the Premises and shall keep the Premises free and clear of any lien or encumbrance of any kind whatsoever created by the Lessee's act or omission. To the extent that such services are separately metered, the Lessee shall pay for the cost of the services directly to the provider of such services.

8. LESSOR INSURANCE COVERAGE

The Lessor agrees to maintain in full force at all times during the term hereof (including any extension or renewal hereof) policies of fire and extended coverage insurance, for the full insurable value of the Building, public liability and property damage under which the insurer agrees to indemnify and hold the Lessor and the Lessee harmless from and against all cost, expense, and/or liability arising out of or based upon any and all claims, accidents, injuries, and damages arising out of occurrences in or about the Premises up to the policy limits set forth below. The Lessee agrees to reimburse the Lessor for its Proportionate Share of the cost of said insurance policies to be maintained by the Lessor on the Building. The Lessee covenants that the cost of said policy shall be paid not later than fifteen (15) days after receipt of copies of the bills therefor. Each such policy shall be with companies authorized to do business in Rhode Island, and having a rating of A or A+ and a Financial Size Category Class X or larger in the latest edition of Best's Insurance Reports. The minimum limits of liability of such insurance shall be the full insurable value of the Building for fire and extended coverage insurance. One Million and 00/100 (\$1,000,000) Dollars for any single occurrence and Two Million and 00/100 (\$2,000,000) Dollars aggregate during the policy period. The Lessor, upon request, shall provide the Lessee with certificates or copies of the policies evidencing that such insurance is in full force and effect, stating the terms thereof, naming the Lessee as an additional insured and providing that the Lessee will receive not less than thirty (30) days' notice prior to cancellation of such insurance, excepting ten (10) days for non-payment. Lease Year One Base Rent includes Lessee's Proportionate Share of insurance premium expenses for calendar year 2006. The Lessee's Proportionate Share of any increase in such insurance premiums over the year 2006 premiums shall be additional rent for the balance of the Term of this Lease.

9. LESSEE INSURANCE COVERAGE

The Lessee agrees to maintain in full force at all times during the term hereof (including any extension or renewal hereof) a public liability policy under which the Lessor is named as an additional insured, as its interest may appear. Such policy shall be with companies authorized to do business in Rhode Island, and having a rating of A or A+ and a Financial Size Category Class X or larger in the latest edition of Best's Insurance Reports. The minimum limits of liability of such insurance shall be One Million and 00/100 (\$1,000,000) Dollars any single occurrence and Two Million and 00/100 (\$2,000,000) Dollars aggregate during the policy period. The Lessee shall provide the Lessor with a certificate or copies of the policies evidencing that such insurance is in full force and effect and stating the terms thereof. In addition to the coverage required to be maintained, the Lessee covenants that it will indemnify and keep the Lessor harmless at all times against all loss, cost, expenses, and damages, for which the Lessor shall not be reimbursed by insurance, arising as a result of any loss by Lessor or claim by any persons or entities based on, or in any way growing out of the Lessee's use, maintenance, control or occupation of the Premises or the improvements or equipment of the Lessee located thereon. The Lessee further covenants and agrees to indemnify and keep harmless the Lessor against any liens, fines, losses, costs, damages, and expenses caused by any refusal or neglect on the part of the Lessee to comply with any governmental decree, regulation, order, statute or ordinance, present or future, in any way affecting the Lessee's use, maintenance, control, or occupation of the Premises or appurtenances thereto, provided however, that Lessee shall not indemnify the Lessor for the consequence of Lessor's gross negligence or willful misconduct.

10. INSURANCE COVERAGE WAIVER

The Lessor and the Lessee shall use reasonable efforts to cause each insurance policy required to be carried by them under this Lease to be written in a manner so as to provide that the insurance company waives all right of recovery by way of subrogation against the Lessor or the Lessee in connection with any loss or damage covered by any such policies. Neither party shall be liable to the other for any loss or damage caused by fire or any of the risks enumerated in its policies, provided such waiver was obtained before the time of such loss or damage. However, if such waiver cannot be obtained, or is obtainable only by the payment of an additional premium charge above, that charged by companies carrying such insurance without such waiver, the party undertaking to carry such insurance shall notify the other party of such fact, and such other party shall have a period of ten (10) days after the giving of such notice either to: (a) place such insurance in companies which are reasonably satisfactory to the other party and will carry such insurance with waiver of such subrogation, or (b) agree to pay such additional premium if such policy is obtainable at additional cost. If the release of either the Lessor or the Lessee, as set forth herein shall contravene any law with respect to exculpatory agreements,

the liability of the party in question shall be deemed not released, but no actions or rights shall be sought or enforced against such party unless and until all rights and remedies against the latter's insurer are exhausted and the latter party shall be unable to collect such insurance proceeds.

11. PROHIBITED ACTS

The Lessee covenants with the Lessor and other tenants of the Lessor occupying the Property, if any, that during the term of this Lease, or any extension thereof, no act or thing shall be done by the Lessee or by those claiming by, through or under the Lessee, upon the Premises which may make void or voidable any insurance against fire, or other casualty, or may render any increase or extra premiums payable for such insurance and that the Lessee shall be liable to the Lessor and other tenants of the Lessor occupying the Property for any increase in insurance rate whatsoever, whether for the Premises or the entire Building, resulting from the Lessee's occupation of the Premises, which increase or extra premiums shall be paid to the Lessor, as additional rent, not later than fifteen (15) days from the receipt by the Lessee or written notice of such amount accompanied by reasonable written evidence.

12. WASTE AND SIGNS

The Lessee further covenants that it will not commit any waste or injury in or to the Premises and further, that it will not place, install, or attach any signs, awning or structure upon the outside walls of the Premises or in front of the Premises, without the written consent of the Lessor, which consent will not be unreasonably withheld or delayed.

13. LESSEE COVENANTS OF NO LIEN

The Lessee further covenants that it will not permit any mechanic's liens to be placed upon the Premises as a result of its occupancy, and if such lien is filed, the Lessee will cause the lien to be discharged and released within thirty (30) days of the filing of such lien. Notwithstanding the foregoing provision, the Lessee has the right to contest any lien placed upon the Premises as a result of its occupancy, in conformity with law, provided, however, that if a mechanic's lien is placed on the Premises and contested by the Lessee and final judgment is in favor of the lien claimant, then said lien shall be paid and discharged by the Lessee within fifteen (15) days after said judgment has become final.

14. RULES AND REGULATIONS; PARKING

The Lessee further covenants that it and its employees shall abide by all reasonable rules and regulations promulgated by the Lessor from time to time, which regulations shall not materially interfere with Lessee's use of such common areas. The Lessee agrees and understands that parking spaces for its

employees and/or clients/customers at 44 West River Street, Providence, Rhode Island, are to be used in common with other tenants of the Building and no tenants, including the Lessee, shall have assigned parking.

15. SNOW REMOVAL

The Lessor shall provide and pay for the removal of snow from the Property. The Lessee, as additional rent, shall be responsible for its Proportionate Share of the snow removal bill. The Lessee covenants that its share of the cost of such snow removal shall be paid as additional rent not later than ten (10) days after receipt of copies of the paid bills therefor.

16. ELECTRICAL USE

The Lessor reserves the right to prohibit the use of electrical equipment which will overload circuits or other electrical outlets unless proper electrical conductors are installed by the Lessee at the Lessee's expense.

17. ALTERATIONS, CHANGES AND IMPROVEMENTS

Lessee shall have the right, with the prior written consent of Lessor, not to be unreasonably withheld or delayed, to make alterations, changes or improvements to the Premises; provided, the same shall be made at Lessee's sole cost and expense. All alterations, changes or improvements constituting leasehold improvements made or constructed shall be and become the property of Lessor absolutely as soon as made or installed and shall be subject to this Lease. Lessee shall not, without the written consent of Lessor, not to be unreasonably withheld or delayed, sell or dispose of any or all of the property, real or personal, subject to this Lease or remove the same or any part thereof from the Premises unless same is immediately replaced with the prior written approval of Lessor by unencumbered property or unencumbered leasehold improvements of substantially similar value and utility, which property shall be and become the property of the Lessor absolutely as soon as made or installed.

18. LESSEE COVENANTS

Without limiting the generality of Lessee's other obligations as set forth in this Lease, the Lessee covenants and agrees with the Lessor:

a. To pay the annual base rent, any additional rent, and all other charges herein agreed to be paid hereunder, at the times and in the manner aforesaid, and that no demand of rent shall be required.

b. To keep the interior of the Premises in as good order, condition, and repair as the same are, at the commencement of this Lease or may be put during the continuation hereof, ordinary wear and tear excepted.

c. To use and occupy the Premises in a lawful manner only for the uses and purposes herein before specified and not to make any improper or offensive use thereof or such use as shall unreasonably disturb or annoy other tenants of the Lessor in the Building, if any, or other tenants of the Lessor on the Premises. The Lessee hereby agrees that any use of the Premises in violation of this Lease, may be enjoined upon application of the Lessor without prejudice to any other remedy therefor.

d. The Lessee shall not assign nor sublet this Lease, in whole or in part, at any time during the term hereof without the prior written consent of the Lessor, which consent shall not be unreasonably withheld or delayed.

e. To quietly and peacefully surrender to the Lessor at the expiration or sooner termination of this Lease, the Premises including (unless otherwise required by Lessor) all erections and additions made upon or to the Premises other than equipment, inventory, and office furnishings placed therein. The Lessee further agrees to leave the Premises in good repair, order, and condition in all respects, reasonable wear and tear excepted.

19. PERSONALTY AND RISK OF LOSS

All merchandise, furniture, and property of any kind, nature, and description belong to the Lessee or any person claiming by, through, or under it, which may be in, or on or about the Premises during the continuance of this Lease is to be at the sole risk and hazard of the Lessee. If the whole or any part thereof shall be destroyed by fire, water, steam, smoke, by the leakage or bursting of water pipes, or in any other way or manner, no part of said loss or damage is to be charged to or be borne by the Lessor in any case whatsoever.

20. INDEMNIFICATION OF LESSOR

Lessee shall indemnify and save harmless Lessor (regardless of Lessee's covenant to insure) against and from any and all claims by or on behalf of any person or persons, firm or firms, corporation or corporations, arising from the use, occupancy, conduct or management of or from any work or thing whatsoever done in or about the Premises, unless done by Lessor, any of its agents, contractors, servants, employees or licensees, and shall further indemnify and save Lessor harmless against and from any and all claims arising during the term hereof from any condition of the Premises, or arising from any breach or default on the part of Lessee in the performance of any covenant or agreement on the part of Lessee in the performance of any covenant or agreement on the part of Lessee to be performed pursuant to the terms of this Lease, or arising from any act of Lessee or any of its agents, contractors, servants, employees or licensees, to any person, firm or corporation occurring during the term hereof in or about the Premises or upon or under said areas, and

from and against all costs, counsel fees, expenses or liabilities incurred in or about any such claim or action or proceeding brought thereon.

21. LESSOR RIGHT OF INSPECTION AND ENTRY

The Lessor and its servants, agents, contractors, or invitees shall have the right to enter upon the Premises or any part thereof, without charge, at all reasonable times to inspect the same. The Lessor shall give the Lessee at least one business day's advance notice of any requirement of access to the Premises and said inspections shall be made as long as a representative of Lessee is present, except in emergency situations. The Lessor will take reasonable measures to protect the Lessee's property and personnel from loss and injury and to avoid disrupting the Lessee's regular business routine.

22. DEFAULT

In case of failure on the part of the Lessee to pay the annual base rent, the additional rent and all other charges herein provided subsequent to the time when the same shall become due and payable (and it shall not be required that any demand be made for the same); or in case the Lessee shall neglect or fail to perform or observe any of the other covenants, terms or conditions imposed upon the Lessee by this Lease and fail to remedy and/or remove said breach, within fifteen (15) days of the receipt of notice thereof from the Lessor (or if said default or omission complained of shall be of such nature that the same cannot be completely cured or remedied within said fifteen (15) day period and shall not thereafter with reasonable diligence and good faith proceed to remedy or cure such default and in any event shall fail to cure such default within sixty (60) days); or in the event that the Lessee makes an assignment for the benefit of creditors; or a petition is filed by or against the lessee to adjudicate it a bankrupt; or a reorganization or similar petition or proceeding be filed by the Lessee under any provision of any bankruptcy or receivership act; or in the event a receiver is appointed over the assets of the Lessee or the Lessee's leasehold interest and/or the Lessee's property shall be levied upon, and such levy is not vacated and/or removed within ten (10) days thereafter; or if the Premises shall be deserted or vacated for a period of fifteen (15) days or more; then in any of the above cases it shall be lawful for the Lessor thereupon, or at any time thereafter at its option and notwithstanding any waiver of any prior breach of any covenant, term or condition, to enter into and upon the Premises or any part thereof in the name of the whole and repossess the same as of its former estate, and to expel the Lessee and those claiming by, through or under it, and remove its effects (as provided for by applicable law) without being deemed guilty of any manner of trespass (or the Lessor may send written notice to the Lessee of the termination of this Lease), and upon entry as aforesaid (or in the event that the Lessor shall send to the Lessee notice of termination as provided above, on the third day next following the date of the sending of the notice) the term of this Lease shall terminate, provided, that the Lessor shall not be deemed to have accepted a

surrender thereof. In any such event, the Lessee shall indemnify and hold harmless the Lessor against all loss of rent or other payments due hereunder or which the Lessor may suffer by reason of such termination. At the time of the termination or at any time thereafter, the Lessor may rent the Premises for a term which may expire after the expiration of the term of this Lease without releasing the Lessee from any liability for the defaulted term, and the Lessee shall be liable for any reasonable expenses incurred by the Lessor in connection with the collection from the Lessee of any sums due, including reasonable attorney's fees for obtaining possession of the Premises, for removing from the Premises property of the Lessee and persons claiming under it (including warehouse charges), for putting the Premises in good condition for reletting and any reletting, including but without limitation, any differences in the rent to be paid, and any monies collected from the reletting shall be applied first to the foregoing expenses and then to the payment of rent and all other payments due by the Lessee to the Lessor. The Lessor shall use commercially reasonable best efforts to mitigate its damages. This Lease shall not continue for the benefit of any assignee for the benefit of creditors, receivers, trustee(s) in bankruptcy, debtor in possession or attaching creditors.

23. DAMAGE/LOSS TO PREMISES BY FIRE OR CASULTY

The Lessor and the Lessee further covenant and agree that in case the whole or any substantial part of the Premises be destroyed or damaged by fire or other casualty so as to render the same unfit for use and occupancy, the Lessor shall repair and restore the Premises as soon as practicable; provided, however, that in the event the damage is not reasonably susceptible of repair within ninety (90) days of the occurrence, either the Lessor or the Lessee may terminate this Lease within thirty (30) days of the damage or casualty. If the Premises are rendered wholly or partly untenable by such destruction or damage a just abatement of the rent shall be made until the Premises shall be restored to tenable condition or until such termination of this Lease. The Lessor agrees, that in the event the Premises are damaged as set forth herein, to commence and complete repairs as soon as practicable after said damage, if the Lessor is to make such repairs hereunder. The Lessor shall notify the Lessee of its election to repair damage within ten (10) days after the occurrence of such damage.

24. CONDEMNATION OF PREMISES

If the whole or any substantial part of the Premises, or any interest therein shall be taken or condemned by any competent authority for any public or quasi-public use or purpose, then and in that event, the term of this Lease shall cease and terminate on the date when the possession of the part or interest so taken shall be required for such use or purpose and without apportionment of the award, it being agreed that the Lessor shall be entitled to the entire amount of the award for any such taking, other than the portion of the award specifically awarded for property of the Lessee, and the Lessee further reserves the right to

recover from the condemning authority for its moving expenses. If the Lessee can, without the necessity of any repairing or alteration by the Lessor, carry on its business in the part of the Premises not so taken or condemned, this Lease shall continue as to the part not so taken, if any, and there shall be a proportionate adjustment of the rent; provided, however, that in the event of such partial taking, the Lessee may elect to terminate this Lease on the date that actual possession is taken by the condemning authority by first giving notice by certified mail to the Lessor of its intention to terminate.

25. NOTICE

Any notice required or desired to be given under this Lease shall be in writing with copies directed as indicated below and shall be personally served, sent by recognized national courier service or given by mail. Any notice given hereunder shall be deemed to have been given when served or, if mailed, as of seventy-two (72) hours from the time when such notice was deposited in the United States mails (certified or registered, return receipt requested, postage prepaid), addressed to the party to be served with a copy as indicated below. The Lessor and the Lessee will furnish to the other an address to which all notices or other communications required or permitted hereunder are to be sent. Until such change of address shall be given in writing, said notices or other communications may be delivered.

To Lessor: Nob Creek, LLC
 44 West River Street
 Providence, RI 02904
 Attention: Manager

To Lessee: Endoscopy Associates, Inc.
 44 West River Street
 Providence, RI 02904
 Attention: President

26. WAIVER OF BREACH

The failure of the Lessor to seek redress for violation of or to insist upon the strict performance of, any covenant, term or condition, of this Lease, shall not prevent a subsequent act, which would have originally constituted a violation, from having all the force and effect of an original violation. The receipt by the Lessor of rent, with knowledge of the breach of any such covenant, term, or condition shall not be deemed to have been waived by the Lessor unless said waiver be in writing signed by the Lessor. The various rights, powers, and remedies of the Lessor herein contained shall not be considered as exclusive of

but shall be considered cumulative to any of the rights, powers, and remedies now or hereafter existing at law, in equity, by statute or by contract between said parties.

27. SUBORDINATION OF LEASE

This Lease shall be subject and subordinate at all times to the lien of existing mortgages and of mortgages which hereafter may be a lien on the Premises. Except as provided below, although no instrument or act on the part of the Lessee shall be necessary to effectuate such subordination, the Lessee will, nevertheless, execute and deliver such further instruments subordinating this Lease to the lien of any such mortgages as may be desired by the mortgagee, provided such instrument contains a "non-disturbance" agreement in form reasonably satisfactory to the Lessee.

28. SECURITY DEPOSIT

There shall be no requirement for a security deposit under this Lease.

29. QUIET ENJOYMENT

The Lessee, upon paying the annual base rent, the additional rent, and all other charges due hereunder, maintaining the interior of the Premises in a reasonable manner and performing all of the covenants, terms, and conditions contained in this Lease and to be performed by the Lessee, may peacefully hold and enjoy the Premises during the term hereof without any let or hindrance by the Lessor or any person claiming by, through or under the Lessor.

30. OCCUPANCY BEYOND TERM

No holding over by the Lessee shall operate, except by written agreement, as a renewal of this Lease, but in such event the Lessee's continued occupancy shall be on a month-to-month basis at the same monthly rental as the rental for the last month of the term, unless otherwise agreed to in writing and signed by the parties hereto, subject to adjustment as set forth in Section 3.

31. TERMS AND HEADINGS

This Lease shall be binding upon the Lessee and its successors and assigns and shall inure to the benefit of the Lessor and their heirs, executors, administrators, and assigns. The terms "Lessee" and "Lessor" and any pronouns referring thereto as used herein shall be construed in the masculine, feminine, neuter, singular, or plural as the context may require. The headings of the sections hereof are for convenience only and shall not be considered in construing the contents of such sections.

32. APPLICABLE LAW

The terms, conditions, and provisions of this Lease or portion of such terms, conditions, and provisions are set forth to comply with the requirements and provisions of section 34-18.1-1 et seq. of the General Laws of the State of Rhode, as amended (the "Act"). In the event that any of the terms, conditions, and provisions contained herein or any portion thereof, or the application thereof to any person or circumstance violate any provisions of the Act, or for any reason shall be held invalid, then and in that case, the provisions of the Act shall apply, and the remainder of the Lease or the remainder of such provision and the application thereof to other persons or circumstances shall not be affected thereby.

33. SEPARABILITY OF CLAUSES

If any provision of this Lease or portion of such provision or the application thereof to any person or circumstance is held invalid, the remainder of the Lease or the remainder of such provision and the application thereof to other persons or circumstances shall not be affected thereby.

34. AGREEMENT OF JURISDICTION

This Lease is and shall be deemed to be entered into and made pursuant to the laws of the State of Rhode Island and shall in all respects be governed, construed, applied, and enforced in accordance with the laws of said state. The Lessee hereby expressly submits to the exclusive jurisdiction of all Federal and State courts sitting in the State of Rhode Island, and agrees that any process or notice of motion or other application to any of said courts or a judge thereof may be served upon the Lessee by registered mail or by personal service, at the address of the Lessee specified herein, or at such other address as the Lessee shall specify by a prior notice in writing to the Lessor, provided a reasonable time for the appearance is allowed. The Lessee hereby irrevocably waives any objection which it may now or hereafter have to the laying of the venue of any suit, action, or proceeding arising out of or relating to this Lease brought in any Federal or State court sitting in the State of Rhode Island and hereby further irrevocably waives any claims that any such suit, action, or proceeding brought in any such court has been brought in an inconvenient forum.

35. HAZARDOUS MATERIALS

For the purposes of this Lease, the term hazardous materials ("Hazardous Materials") shall include, without limitation, substances defined as hazardous substances, hazardous materials, or toxic substances in any applicable federal law, any applicable state law, and/or any rules or regulations adopted or promulgated pursuant to any of said law. The Lessee represents and warrants that, except as set forth herein, it will not use or dispose of any Hazardous

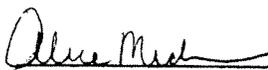
Materials in the Premises. The Lessor acknowledges and agrees that the Lessee may store material in the normal course of its business and may use cleaners and chemicals to maintain the Premises. The Lessor and the Lessee acknowledge that any or all of the stored materials, cleaners, and chemicals described in this paragraph may constitute Hazardous Materials. However, the Lessee may store, use, and dispose of same as herein set forth, provided that in doing so, the Lessee complies with all applicable laws. Lessee agrees to defend, indemnify, and hold the Lessor harmless from and against any and all costs, damages, expenses, and/or liabilities (including reasonable attorneys' fees) which the Lessor may suffer as a result of any claim, suit, or action regarding any such Hazardous Materials (whether alleged or real), and/or regarding the removal and clean-up of same. Lessee's obligations pursuant to this paragraph shall survive any expiration and/or termination of this Lease.

36. NO BROKERS

The parties hereto acknowledge that they have not employed a real estate broker in this transaction who would be entitled to a commission on the leasing of the Premises. In the event that a claim is made or submitted by any broker, person, entity, or any person claiming on behalf of any broker, person, or entity not in accordance with the terms of this Lease, then the party whose actions are the basis for such claim shall be solely responsible for undertaking the defense of any legal action based thereon, and, if unsuccessful in such defense, for paying the claim.

IN WITNESS WHEREOF, the parties hereto have signed or by their duly authorized agents caused to be signed these presents and caused to be affixed hereto their seals as of the date first written above.

WITNESS:



LESSOR:

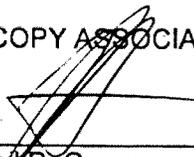
NOB CREEK, LLC

By: 

Manager

LESSEE:

ENDOSCOPY ASSOCIATES, INC.

By: 

Neil R. Greenspan, M.D.
President

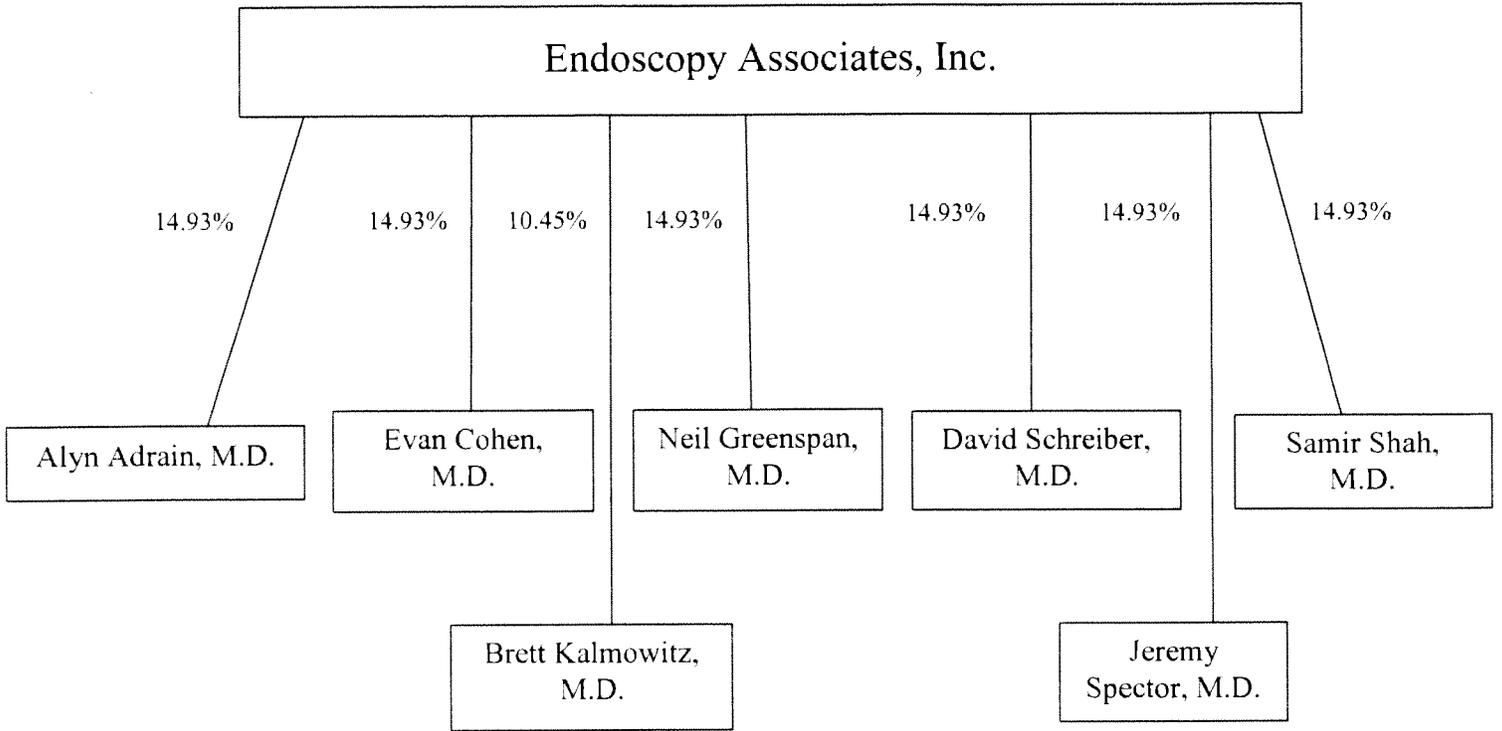
ATTACHMENT A

Floor Plan

G 5

Exhibit G(5)

Exhibit G(5)



G 9

Exhibit G(9)



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Office of the Secretary of State
Matthew A. Brown
Secretary of State

**CERTIFICATE OF INCORPORATION
OF**

Endoscopy Associates, Inc.

I, MATTHEW BROWN, Secretary of State of the State of Rhode Island and Providence Plantations, hereby certify that duplicate originals of Articles of Incorporation for the incorporation of

Endoscopy Associates, Inc.

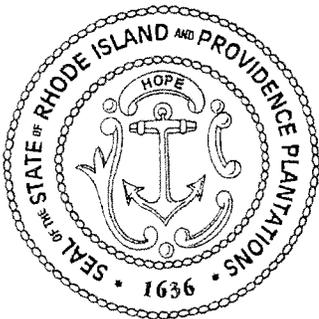
duly signed and verified pursuant to the provisions of Chapter 7-1.1 of the General Laws, 1956, as amended, have been received in this office and are found to conform to law. The affixed is a duplicate original of the Articles of Incorporation.

WITNESS my hand and the seal of the State of Rhode Island and Providence Plantations this 4th day of November, 2003.

Matthew Brown

Secretary of State

By *Cathryn J. Moser*



Filing and License Fee: \$230.00 minimum

ID Number: _____



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Office of the Secretary of State Matthew A. Brown
Corporations Division
100 North Main Street
Providence, Rhode Island 02903-1335

BUSINESS CORPORATION

ARTICLES OF INCORPORATION

(To Be Filed In Duplicate Original)

The undersigned acting as incorporator(s) of a corporation under Chapter 7-1.1 of the General Laws, 1956, as amended, adopt(s) the following Articles of Incorporation for such corporation:

1. The name of the corporation is Endoscopy Associates, Inc.

(This is a close corporation pursuant to § 7-1.1-51 of the General Laws, 1956, as amended.) (Strike if inapplicable.)

2. The period of its duration is (if perpetual, so state) Perpetual

3. The specific purpose or purposes for which the corporation is organized are:

To provide health care to patients by licensed physicians and other health care

professionals, and to engage in any and all other activities for which a corporation

may be organized under the laws of the State of Rhode Island and pursuant to the

Professional Services Corporation Law and the Rhode Island Business Corporation

Act as incorporated therein.

4. The aggregate number of shares which the corporation shall have authority to issue is:

(a) *If only one class:* Total number of shares 8,000 (If the authorized shares are to consist of one class only the par value of such shares or a statement that all of such shares are to be without par value.):

No par value

or

(b) *If more than one class:* Total number of shares _____ (State (A) the number of shares of each class thereof that are to have a par value and the par value of each share of each such class, and/or (B) the number of such shares that are to be without par value, and (C) a statement of all or any of the designations and the powers, preferences and rights, including voting rights, and the qualifications, limitations or restrictions thereof, which are permitted by the provisions of Chapter 7-1.1 of the General Laws, 1956, as amended, in respect of any class or classes of stock of the corporation and the fixing of which by the articles of association is desired, and an express grant of such authority as it may then be desired to grant to the board of directors to fix by vote or votes any thereof that may be desired but which shall not be fixed by the articles.):

5. Provisions, if any, dealing with the preemptive right of shareholders pursuant to § 7-1.1-24 of the General Laws, 1956, as amended:

The preemptive right set forth in Section 7-1.1-24 of the Rhode Island General Laws

is expressly denied to Shareholders.

FILED

NOV 04 2003

NOV 04 2003

By C10785

RECEIVED
SECRETARY OF STATE
CORPORATIONS DIV.
NOV 04 2003

6. Provisions, if any, for the regulation of the internal affairs of the corporation:

See Attachment A attached hereto.

7. The address of the initial registered office of the corporation is 56 Exchange Terrace
(Street Address, not P.O. Box)
Providence, RI 02903 and the name of its initial registered agent
(City/Town) (Zip Code)
at such address is E. Colby Cameron
(Name of Agent)

8. The number of directors constituting the initial board of directors of the corporation is 5 and the names and addresses of the persons who are to serve as directors until the first annual meeting of shareholders or until their successors are elected and shall qualify are: (If this is a close corporation pursuant to Section 7-1.1-51 of the General Laws, 1956, as amended, and there shall be no board of directors, state the titles of the initial officers of the corporation and the names and addresses of the persons who are to serve as officers until the first annual meeting of shareholders or until their successors be elected and qualify.)

<u>Title</u>	<u>Name</u>	<u>Address</u>
Director	Evan B. Cohen, M.D.	One Randall Square, Providence, RI 02904
Director	Neil R. Greenspan, M.D.	One Randall Square, Providence, RI 02904
Director	Samir Ashok Shah, M.D.	One Randall Square, Providence, RI 02904
	- See Attachment B -	

9. The name and address of each incorporator is:

<u>Name</u>	<u>Address</u>
Neil R. Greenspan, M.D.	One Randall Square, Providence, RI 02904

10. Date when corporate existence is to begin Upon filing
(not prior to, nor more than 30 days after, the filing of these articles of incorporation)

Date: 10/17/03


Signature of each Incorporator

STATE OF Rhode Island
COUNTY OF Providence

In October, on this 17 day of 2003, Neil R. Greenspan, personally appeared before me [Signature], each and all known to me and known by me to be the parties executing the foregoing instrument, and they severally acknowledged said instrument by them subscribed to be their free act and deed.

[Signature]
Notary Public
My Commission Expires: 10/3/04

**ATTACHMENT A
TO
ARTICLES OF INCORPORATION
OF
ENDOSCOPY ASSOCIATES, INC.**

6. Provisions for the regulation of the internal affairs of the Corporation:
- I. Except as otherwise provided by the Rhode Island Business Corporation Act, as has been or may hereafter be amended (the "Act"), any action required or permitted to be taken at a meeting of shareholders by the Act, by these articles of incorporation or by the by-laws of the Corporation may be taken without a meeting upon the written consent of less than all of the shareholders entitled to vote thereon if the shareholders who so consent would be entitled to cast at least the minimum number of votes which would be required to take such action at a meeting at which all shareholders entitled to vote thereon are present.
 - II. The Board of Directors of the Corporation shall have the authority to distribute to its shareholders, directly or by the purchase of its own shares, a portion of its assets, in cash or property, out of the unreserved and unrestricted capital surplus of the Corporation, without the affirmative vote of the shareholders of any class of the capital stock of the Corporation.
 - III. (A) A Director of the Corporation shall not be personally liable to the Corporation or its shareholders for monetary damages for breach of the Director's duty as a Director, except for (i) liability for any breach of the Director's duty of loyalty to the Corporation or its shareholders, (ii) liability for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, (iii) liability imposed pursuant to the provisions of Section 43 of the Act, or (iv) liability for any transaction (other than transactions approved in accordance with Section 37.1 of the Act) from which the Director derived an improper personal benefit. If the Act is amended to authorize corporate action further eliminating or limiting the personal liability of Directors, then the liability of a Director of the Corporation shall be eliminated or limited to the fullest extent so permitted. Any repeal or modification of this provision by the Corporation shall not adversely affect any right or protection of a Director of the Corporation existing prior to such repeal or modification.

(B) The Directors of the Corporation may include provisions in the Corporation's by-laws, or may authorize agreements to be entered into with each Director, officer, employee or other agent of the Corporation (an "Indemnified Person"), for the purpose of indemnifying an Indemnified Person in the manner and to the extent permitted by the Act.

In addition to the authority conferred upon the Directors of the Corporation by the foregoing paragraph, the Directors of the Corporation may include provisions in its by-laws, or may authorize agreements to be entered into with each Indemnified Person, for the purpose of indemnifying such person in the manner and to the extent provided herein:

(i) The by-law provisions or agreements authorized hereby may provide that the Corporation shall, subject to the provisions of this Article, pay, on behalf of an Indemnified Person any Loss or Expenses arising from any claim or claims which are made against the Indemnified Person (whether individually or jointly with other Indemnified Persons) by reason of any Covered Act of the Indemnified Person.

(ii) For the purposes of this Article, when used herein

(1) "Directors" means any or all of the directors of the Corporation or those one or more shareholders or other persons who are exercising any powers normally vested in the board of directors.

(2) "Loss" means any amount which an Indemnified Person is legally obligated to pay for any claim for Covered Acts and shall include, without being limited to, damages, settlements, fines, penalties or, with respect to employee benefit plans, excise taxes;

(3) "Expenses" means any expenses incurred in connection with the defense against any claim for Covered Acts, including, without being limited to, legal, accounting or investigative fees and expenses or bonds necessary to pursue an appeal of an adverse judgment; and

(4) "Covered Act" means any act or omission of an Indemnified Person in the Indemnified Person's official capacity with the Corporation and while serving as such or while serving at the request of the Corporation as a member of the governing body, officer, employee or agent of another corporation, including, but not limited to corporations which are subsidiaries or affiliates of the Corporation, partnership, joint venture, trust, other enterprise or employee benefit plan.

(iii) The by-law provisions or agreements authorized hereby may cover Loss or Expenses arising from any claims made against a retired Indemnified Person, the estate, heirs or legal representatives of a deceased Indemnified Person or the legal representative of an incompetent, insolvent or bankrupt Indemnified Person, where the Indemnified Person was an Indemnified Person at the time the Covered Act upon which such claims are based occurred.

(iv) Any by-law provisions or agreements authorized hereby may provide for the advancement of Expenses to an Indemnified Person prior to the final disposition of any action, suit or proceeding, or any appeal therefrom, involving

such Indemnified Person and based on the alleged commission by such Indemnified Person of a Covered Act, subject to an undertaking by or on behalf of such Indemnified Person to repay the same to the Corporation if the Covered Act involves a claim for which indemnification is not permitted under clause (v), below, and the final disposition of such action, suit, proceeding or appeal results in an adjudication adverse to such Indemnified Person.

(v) The by-law provisions or agreements authorized hereby may not indemnify an Indemnified Person from and against any Loss, and the Corporation shall not reimburse for any Expenses, in connection with any claim or claims made against an Indemnified Person which the Corporation has determined to have resulted from: (1) any breach of the Indemnified Person's duty of loyalty to the Corporation or its stockholders; (2) acts or omissions not in good faith or which involve intentional misconduct or knowing violation of law; (3) action contravening Section 43 of the Act; or (4) a transaction (other than a transaction approved in accordance with Section 37.1 of the Act) from which the person seeking indemnification derived an improper personal benefit.

**ATTACHMENT B
TO
ARTICLES OF INCORPORATION
OF
ENDOSCOPY ASSOCIATES, INC.**

8. List of Directors (Continued)

<u>Title</u>	<u>Name</u>	<u>Address</u>
Director	David Schreiber, M.D.	One Randall Square, Providence, RI 02904
Director	Alyn Adrain, M.D.	One Randall Square, Providence, RI 02904

BYLAWS
of
ENDOSCOPY ASSOCIATES, INC.

ARTICLE I

ARTICLES OF INCORPORATION AND PROVISIONS OF LAW

These by-laws, the powers of the Corporation and of its directors and shareholders and all matters concerning the conduct and regulation of the business of the Corporation shall be subject to such provisions in regard thereto, if any, as are provided by law or set forth in the Articles of Incorporation. All references herein to the Articles of Incorporation shall be construed to mean the Articles of Incorporation of the Corporation as from time to time amended.

ARTICLE II

OFFICES

SECTION 2.01. Principal Office. The principal office of the Corporation shall be located in Providence, Rhode Island or such other place within or without the State of Rhode Island as may be determined by the Board of Directors from time to time.

SECTION 2.02. Other Offices. The Corporation may also have an office or offices at such other place or places either within or without the State of Rhode Island as the Board of Directors may from time to time determine or the business of the Corporation may require.

ARTICLE III

ELIGIBLE SHAREHOLDERS

SECTION 3.01. Eligible Shareholders. No person may be a shareholder of this Corporation unless such person is licensed to practice medicine in the State of Rhode

Island and is employed by the Corporation in such professional capacity, except that nothing contained herein shall be interpreted to prohibit the temporary exercise of incidence of ownership of shares of the Corporation by a person or corporate fiduciaries not authorized to practice medicine solely for the purposes of administering estates of shareholders deceased or under legal disability to transfer their shares.

ARTICLE IV

MEETINGS OF SHAREHOLDERS

SECTION 4.01. Place of Meetings. All meetings of the shareholders of the Corporation shall be held at the principal office of the Corporation or at such other place, within or without the State of Rhode Island, as shall be fixed by the Board of Directors and specified in the respective notices or waivers of notice of said meetings.

SECTION 4.02. Annual Meetings. The annual meeting of the shareholders for the election of directors and for the transaction of such other business as may come before the meeting shall be held at ten o'clock in the forenoon, local time, on the second in Tuesday in April in each year, if not a legal holiday, and, if a legal holiday, then on the next succeeding business day not a legal holiday. If such annual meeting is omitted by oversight or otherwise on the day herein provided therefor, a special meeting may be held in place thereof, and any business transacted or elections held at such special meeting shall have the same effect as if transacted or held at the annual meeting. The purposes for which an annual meeting is to be held, in addition to those prescribed by law or these by-laws, may be specified by a majority of the Board of Directors, the President or a

shareholder or shareholders holding of record at least ten percent (10%) in voting power of the outstanding shares of the Corporation entitled to vote at such meeting.

SECTION 4.03. Special Meetings. A special meeting of the shareholders for any purpose or purposes, unless otherwise prescribed by statute, may be called at any time by the President, by order of the Board of Directors or by a shareholder or shareholders holding of record at least ten percent (10%) in voting power of the outstanding shares of the Corporation entitled to vote at such meeting.

SECTION 4.04. Notice of Meetings. Notice of each meeting of the shareholders shall be given to each shareholder of record entitled to vote at such meeting at least ten (10) days but not more than fifty (50) days before the day on which the meeting is to be held. Such notice shall be given by delivering a written or printed notice thereof personally or by mail. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, postage prepaid, addressed to the shareholder at the post office address of such shareholder as it appears upon the stock record books of the Corporation, or at such other address as such shareholder shall have provided to the Corporation for such purpose. No publication of any notice of a meeting of shareholders shall be required. Every such notice shall state the time and place of the meeting, and, in case of a special meeting, shall state the purpose or purposes thereof. Notice of any meeting of shareholders shall not be required to be given to any shareholder who shall attend such meeting in person or by proxy or who shall waive notice thereof in the manner hereinafter provided. Notice of any adjourned meeting of the shareholders shall not be required to be given.

SECTION 4.05. Quorum. At each meeting of the shareholders, a majority of the outstanding shares of the Corporation entitled to vote, represented in person or by proxy, shall constitute a quorum for the transaction of business. In the absence of a quorum, a majority of the shares so represented at such meeting, or, in the absence of all the shareholders entitled to vote, any officer entitled to preside or to act as secretary at such meeting, may adjourn the meeting from time to time without further notice. At any such adjourned meeting at which a quorum shall be present or represented, any business may be transacted which might have been transacted at the meeting as originally noticed. The absence from any meeting of shareholders holding a sufficient number of shares required for action on any given matter shall not prevent action at such meeting upon any other matter or matters which properly come before the meeting, if shareholders holding a sufficient number of shares required for action on such other matter or matters shall be present. The shareholders present or represented at any duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal of enough shareholders to leave less than a quorum.

SECTION 4.06 Voting. Each shareholder of the Corporation shall, whether the voting is by one or more classes voting separately or by two or more classes voting as one class, be entitled to one vote in person or by proxy for each share of the Corporation registered in the name of such shareholder on the books of the Corporation. The Corporation shall not vote directly or indirectly any shares held in its own name. Any vote of shares may be given by the shareholder entitled to vote such shares in person or by proxy appointed by an instrument in writing. At all meetings of the shareholders at which a quorum is present, all matters (except where other provision is made law or by these

by-laws) shall be decided by the affirmative vote of holders of a majority of the shares present in person or represented by proxy and entitled to vote thereat.

ARTICLE V

BOARD OF DIRECTORS

SECTION 5.01. General Powers. The property, affairs and business of the Corporation shall be managed by the Board of Directors, and the Board shall have, and may exercise, all of the powers of the Corporation, except such as are conferred by these by-laws upon the shareholders.

SECTION 5.02. Number, Qualifications and Term of Office. The number of directors to constitute the Board of Directors shall be such number, not less than the minimum number allowed under the laws of the State of Rhode Island nor more than five (5) as shall be fixed from time to time by the shareholders at any annual meeting or at any special meeting called for the purpose; provided, however, that between such meetings of shareholders the number so fixed may at any time be increased or decreased, subject to the above-specified limits, by the affirmative vote of a majority of the Board of Directors. The number of directors and the names and addresses of the persons constituting the initial Board of Directors shall be as set forth in the Articles of Incorporation, except (a) any such person who shall decline such office by a writing filed with the Corporation shall not be a director, and (b) until the issuance of any capital stock of the Corporation entitled to vote upon the election of directors, the incorporators may remove any director so named and may elect new directors. Thereafter, directors shall be elected by the shareholders at each annual meeting of shareholders, or at any special meeting held in place thereof, except as provided in this Article. Each director shall hold

office until the next annual election of directors and until his successor shall have been duly elected and qualified, or until the death, resignation or removal of such directors in the manner herein provided. A director must be a shareholder and must be qualified to serve as a director in accordance with the Rhode Island Professional Service Corporation Act.

SECTION 5.03. Election of Directors. Subject to any provisions in the Articles of Incorporation providing for cumulative voting, at each meeting of the shareholders for the election of directors at which a quorum is present, the persons receiving the greatest number of votes shall be the directors, and each shareholder entitled to vote at such election shall have the right to vote, in person or by proxy, for as many nominees as the number of directors fixed as constituting the Board of Directors and to cast for each such nominee as many votes as the number of shares which such shareholder is entitled to vote, without the right to cumulate such votes.

SECTION 5.04 Quorum and Manner of Acting. A majority of the total number of directors at the time in office shall constitute a quorum for the transaction of business at any meeting, and except as otherwise provided by these by-laws, the act of a majority of the directors present at any meeting at which a quorum is present shall be the act of the Board of Directors. In the absence of a quorum, a majority of the directors present may adjourn any meeting from time to time without further notice until a quorum be had. The directors shall act only as a Board, and the individual directors shall have no power as such.

SECTION 5.05. Place of Meetings. The Board of Directors may hold its meetings at any place within or without the State of Rhode Island as it may from time to time

determine or shall be specified or fixed in the respective notices or waivers of notice thereof.

SECTION 5.06. Annual Meeting. The Board of Directors shall meet for the purpose of organization, the election of officers and the transaction of other business, as soon as practicable after each annual election of directors on the same day and at the same place at which such election of directors was held. Notice of such meeting need not be given. Such meeting may be held at any other time or place which shall be specified in a notice given as hereinafter provided for special meetings of the Board of Directors or in a consent and waiver of notice thereof signed by all the directors.

SECTION 5.07. Regular Meetings. Regular meetings of the Board of Directors shall be held at such places and at such times as the Board shall from time to time by vote determine. If any day fixed for a regular meeting shall be a legal holiday at the place where the meeting is to be held, then the meeting which would otherwise be held on that day shall be held at the same hour on the next succeeding business day not a legal holiday. Notice of regular meetings need not be given.

SECTION 5.08. Special Meetings; Notice. Special meetings of the Board of Directors shall be held whenever called by the President or by not less than twenty-five percent (25%) of the members of the Board of Directors. Notice of each such meeting shall be given by, or at the order of, the Secretary or the person calling the meeting to each director by mailing the same addressed to the director's residence or usual place of business, or personally by delivery or by telegraph, cable or telephone, at least two (2) days before the day on which the meeting is to be held. Every such notice shall state the

time and place of the meeting but need not state the purpose thereof except as otherwise in these by-laws expressly provided.

SECTION 5.09. Presumption of Assent. A director of the Corporation who is present at a meeting of the Board of Directors at which action on any corporate matter is taken shall be presumed to have assented to the action taken unless his dissent shall be entered in the minutes of the meeting or unless he shall file his written dissent to such action with the person acting as the secretary of the meeting before the adjournment thereof or shall forward such dissent by registered mail to the Secretary of the Corporation immediately after the adjournment of the meeting. Such right to dissent shall not apply to a director who voted in favor of such action.

SECTION 5.10. Telephone Meetings. Meetings of the Board of Directors, regular or special, may be held by means of a telephone conference circuit and connection to such circuit shall constitute presence at such meeting.

SECTION 5.11. Removal of Directors. Any director may be removed, either with or without cause, at any time, by the affirmative vote of the holders of record of a majority of the issued and outstanding shares entitled to vote for the election of directors of the Corporation given at a special meeting of the shareholders called and held for the purpose.

SECTION 5.12. Resignation. Any director of the Corporation may resign at any time by giving written notice to the Board of Directors or to the Chairman of the Board or to the Secretary of the Corporation. The resignation of any director shall take effect at the time specified therein; and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

SECTION 5.13. Vacancies. Subject to any provisions of the Articles of Incorporation providing for cumulative voting, any vacancy in the Board of Directors caused by death, resignation, removal, disqualification, an increase in the number of directors, or any other cause, may be filled by a majority vote of the remaining directors then in office, though less than a quorum, at any regular meeting or special meeting, including the meeting at which any such vacancy may arise, or by the shareholders of the Corporation at the meeting at which any such vacancy may arise or the next annual meeting or any special meeting, and each director so elected shall hold office until the next annual election of directors, and until a successor shall have been duly elected and qualified, or until the death or resignation or removal of such director in the manner herein provided.

ARTICLE VI

COMMITTEES

SECTION 6.01. Designation. The Board of Directors may designate one or more committees each of which shall consist of two or more Directors. The designation of such committee and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any member thereof, of any responsibility imposed by law.

SECTION 6.02. Authority. Each committee shall have and may exercise all of the authority delegated to it by the Board of Directors in the resolution that establishes such committee and appoints its membership, except that no committee shall have the authority of the Board of Directors in reference to amending the Articles of Incorporation, adopting a plan of merger or consolidation, recommending to the shareholders the sale, lease or other disposition of all or substantially all of the property and assets of the Corporation otherwise than in the usual and regular course of its business,

recommending to the shareholders a voluntary dissolution of the Corporation or a revocation thereof, increasing the number of directors constituting the Board of Directors, filling any vacancies on the Board of Directors, removing or electing any officer of the Corporation or amending the by-laws of the Corporation.

SECTION 6.03. Quorum. A majority of the members appointed to a committee shall constitute a quorum for the transaction of business at any meeting thereof, and action of any such committee shall be authorized by the affirmative vote of a majority of the members present at a meeting at which a quorum is present.

SECTION 6.04. Minutes. All committees shall keep regular minutes of their proceedings and report the same to the Board of Directors for its information at the meeting thereof held next after the proceedings shall have been taken.

ARTICLE VII

WAIVER OF NOTICE; WRITTEN CONSENT

SECTION 7.01. Waiver of Notice. Notice of the time, place and purpose of any meeting of the shareholders, Board of Directors or Executive Committee may be waived in writing by any shareholder or director either before or after such meeting. Attendance in person, or in case of a meeting of the shareholders, by proxy, at a meeting of the shareholders, Board of Directors or Executive Committee shall be deemed to constitute a waiver of notice thereof.

SECTION 7.02. Written Consent of Shareholders. (a) Any action required or permitted to be taken at a meeting of shareholders may be taken without a meeting if all of the shareholders entitled to vote thereon, or their proxies, shall consent in writing to such action.

(b) To the extent authorized by the Articles of Incorporation, any action required or permitted to be taken at a meeting of shareholders may be taken without a meeting upon the written consent of less than all of the shareholders entitled to vote thereon, or their proxies, to the extent and in the manner permitted by Section 7-1.1-30.3(2) of the Rhode Island Business Corporation Act, as amended from time to time.

SECTION 7.03. Written Consent of Directors. Unless otherwise restricted by the Articles of Incorporation or these by-laws, any action required or permitted to be taken at any meeting of the Board of Directors or Executive Committee may be taken without a meeting if a consent in writing, setting forth the action so to be taken, shall be signed before or after such action by all of the directors, or all of the members of the Executive Committee, as the case may be. Such written consent shall be filed with the records of the Corporation.

ARTICLE VIII

OFFICERS

SECTION 8.01. Number. The officers of the Corporation shall be a President, one or more Vice Presidents, a Secretary, a Treasurer, and such other officers as the Board of Directors may from time to time appoint, including a Chairman of the Board, one or more Assistant Secretaries and one or more Assistant Treasurers. One person may hold the offices and perform the duties of any two or more of said officers. In its discretion, the Board of Directors may leave unfilled for any period it may determine, any office except the offices of President, Secretary and Treasurer. All officers must be qualified to serve as an officer of the Corporation in accordance with the Rhode Island Professional Service Corporation Act.

SECTION 8.02. Election, Qualifications and Term of Office. Each officer shall be elected annually by the Board of Directors, or from time to time to fill any vacancy, and shall hold office until a successor shall have been duly elected and qualified, or until the death, resignation or removal of such officer in the manner hereinafter provided.

SECTION 8.03. Removal. Any officer may be removed by the vote of a majority of the whole Board of Directors at a special meeting called for the purpose, whenever in the judgment of the Board of Directors the best interests of the Corporation will be served thereby, but such removal shall be without prejudice to the contract rights, if any, of the officer so removed. Election or appointment of an officer or agent shall not of itself create contract rights.

SECTION 8.04. Resignation. Any officer may resign at any time by giving written notice to the Board of Directors or to the President or the Secretary. Any such resignation shall take effect at the date of receipt of such notice or at any later time specified therein; and unless otherwise specified therein the acceptance of such resignation shall not be necessary to make it effective.

SECTION 8.05. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or any other cause shall be filled for the unexpired portion of the term by the Board of Directors at any regular or special meeting.

SECTION 8.06. Chairman of the Board. The Chairman of the Board shall be a director and shall preside at all meetings of the Board of Directors and shareholders. Subject to determination by the Board of Directors, the Chairman shall have general executive powers and such specific powers and duties as from time to time may be conferred or assigned by the Board of Directors.

SECTION 8.07. The President. The President shall be the chief executive officer of the Corporation and shall have general direction of the affairs of the Corporation. In addition, the President shall perform such other duties and have such other responsibilities as the Board of Directors may from time to time determine. In the absence of a Chairman of the Board, the President shall preside at all meetings of the shareholders.

SECTION 8.08. The Vice Presidents. The Vice President, or if there shall be more than one, the Vice Presidents in the order determined by the Board of Directors, shall, in the absence or disability of the President, perform the duties and exercise the powers of the President and shall perform such other duties and have such other powers as the Board of Directors may from time to time prescribe.

SECTION 8.09. The Secretary. The Secretary shall record or cause to be recorded in books provided for the purpose all the proceedings of the meetings of the Corporation, including the shareholders, the Board of Directors, Executive Committee and all committees of which a secretary shall not have been appointed; shall see that all notices are duly given in accordance with the provisions of these by-laws and as required by law; shall be custodian of the records (other than financial) and of the seal of the Corporation; and in general, shall perform all duties incident to the office of Secretary and such other duties as may, from time to time, be assigned by the Board of Directors or the President.

SECTION 8.10. The Assistant Secretaries. At the request, or in absence or disability, of the Secretary, the Assistant Secretary designated by the Secretary or the Board of Directors shall perform all the duties of the Secretary and, when so acting, shall have all the powers of the Secretary. The Assistant Secretaries shall perform such other

duties as from time to time may be assigned to them by the Board of Directors, the President or the Secretary.

SECTION 8.11. The Treasurer. The Treasurer shall have charge and custody of, and be responsible for, all funds and securities of the Corporation, and deposit all such funds to the credit of the Corporation in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of these by-laws; disburse the funds of the Corporation under the general control of the Board of Directors, based upon proper vouchers for such disbursements; receive, and give receipts for, moneys due and payable to the corporation from any source whatsoever, render a statement of the condition of the finances of the Corporation at all regular meetings of the Board of Directors, and a full financial report at the annual meeting of the shareholders, if called upon to do so; and render such further statements to the Board of Directors and the President as they may respectively require concerning all transactions as Treasurer or the financial condition of the Corporation. The Treasurer shall also have charge of the books and records of account of the Corporation, which shall be kept at such office or offices of the Corporation as the Board of Directors shall from time to time designate; be responsible for the keeping of correct and adequate records of the assets, liabilities, business and transactions of the Corporation; at all reasonable times exhibit the books and records of account to any of the directors of the Corporation upon application at the office of the Corporation where such books and records are kept; be responsible for the preparation and filing of all reports and returns relating to or based upon the books and records of the Corporation kept under the direction of the Treasurer; and, in general,

perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned by the Board of Directors or the President.

SECTION 8.12. The Assistant Treasurers. At the request, or in the absence or disability, of the Treasurer, the Assistant Treasurer designated by the Treasurer or the Board of Directors shall perform all the duties of the Treasurer, and when so acting, shall have all the powers of the Treasurer. The Assistant Treasurers shall perform such other duties as from time to time may be assigned to them by the Board of Directors, the President or the Treasurer.

SECTION 8.13. General Powers. Each officer shall, subject to these by-laws, have, in addition to the duties and powers herein set forth, such duties and powers as are commonly incident to the respective office, and such duties and powers as the Board of Directors shall from time to time designate.

SECTION 8.14. Bonding. Any officer, employee, agent or factor shall give such bond with such surety or sureties for the faithful performance of his or her duties as the Board of Directors may, from time to time, require.

ARTICLE IX

INDEMNIFICATION OF DIRECTORS AND OFFICERS

Each person who at any time is, or shall have been, a director or officer of the Corporation, and is threatened to be or is made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative by reason of the fact that he or she is, or was, a director, officer, employee or agent of the Corporation, or is or has served at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other

enterprise, shall be indemnified against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred in connection with any such action, suit or proceeding to the full extent permitted under Section 7-1.1-4.1 of the Rhode Island Business Corporation Act, as from time to time amended. The foregoing right of indemnification shall in no way be exclusive of any other rights of indemnification to which such director, officer, employee or agent may be entitled, under any by-law, agreement, vote of shareholders or disinterested directors or otherwise, and shall continue as to a person who has ceased to be a director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person.

ARTICLE X

EXECUTION OF DOCUMENTS

SECTION 10.01. Contract, etc., How Executed. Unless the Board of Directors shall otherwise determine, the Chairman of the Board, the President, any Vice President or the Treasurer may enter into any contract or execute any contract or other instrument, the execution of which is not otherwise specifically provided for, in the name and on behalf of the Corporation. The Board of Directors, except as in these by-laws otherwise provided, may authorize any other or additional officer or officers, agent or agents, of the Corporation to enter into any contract or execute and deliver any contract or other instrument in the name and on behalf of the Corporation, and such authority may be general or confined to specific instances. Unless authorized so to do by these by-laws or by the Board of Directors, no officer, agent or employee shall have any power or authority to bind the Corporation by any contract or engagement, or to pledge its credit, or to render it liable pecuniarily for any purpose or to any amount.

SECTION 10.02. Checks, Drafts, etc. All checks, drafts, bills of exchange or other orders for the payment of money, obligations, notes, or other evidences of indebtedness, bills of lading, warehouse receipts and insurance certificates of the Corporation, shall be signed or endorsed by such officer or officers, employee or employees, of the Corporation as shall from time to time be determined by resolution of the Board of Directors.

ARTICLE XI

BOOKS AND RECORDS

SECTION 11.01. Place. The books and records of the Corporation, including the stock record books, shall be kept at such places within or without the State of Rhode Island, as may from time to time be determined by the Board of Directors.

SECTION 11.02. Addresses of Shareholders. Each shareholder shall designate to the Secretary of the Corporation an address at which notices of meetings and all other corporate notices may be served upon or mailed, and if any shareholder shall fail to designate such address, corporate notices may be served by mail directed to the shareholder's last known post office address, or by transmitting a notice thereof to such address by telegraph, cable, or telephone.

ARTICLE XII

SHARES AND THEIR TRANSFER

SECTION 12.01. Certificates for Shares. Every owner of shares of the Corporation shall be entitled to have a certificate certifying the number of shares owned by such owner in the Corporation and designating the class of shares to which such shares belong, which shall otherwise be in such form, in conformity to law, as the Board of Directors shall prescribe. Each such certificate shall be signed by such officer or officers

as the Board of Directors may prescribe, or, if not so prescribed, by the Chairman of the Board or the President or a Vice President and the Secretary or an Assistant Secretary or the Treasurer or an Assistant Treasurer of the Corporation.

SECTION 12.02. Record. A record shall be kept of the name of the person, firm or corporation owning the shares of the Corporation issued, the number of shares represented by each certificate, and the date thereof, and, in the case of cancellation, the date of cancellation. The person in whose name shares stand on the books of the Corporation shall be deemed the owner thereof for all purposes as regards the Corporation.

SECTION 12.03. Transfer of Shares. Transfers of shares of the Corporation shall be made only on the books of the Corporation by the registered holder thereof, or by such holder's attorney thereunto authorized, and on the surrender of the certificate or certificates for such shares properly endorsed or accompanied by a properly executed stock power.

SECTION 12.04. Closing of Transfer Books; Record Dates. Insofar as permitted by law, the Board of Directors may direct that the stock transfer books of the Corporation be closed for a period not exceeding fifty (50) days preceding the date of any meeting of shareholders or the date for the payment of any dividend or the date for the allotment of rights or the date when any change or conversion or exchange of shares of the Corporation shall go into effect, or for a period not exceeding fifty (50) days in connection with obtaining the consent of shareholders for any purpose; provided, however, that in lieu of closing the stock transfer books as aforesaid, the Board of Directors may, insofar as permitted by law, fix in advance a date, not exceeding fifty (50) days preceding the

date of any meeting of shareholders, or the date for the payment of any dividend, or the date for the allotment of rights, or the date when any change or conversion or exchange of shares of the Corporation shall go into effect, or a date in connection with obtaining such consent, as a record date for the determination of the shareholders entitled to notice of, and to vote at, any such meeting or any adjournment thereof, or entitled to receive payment of any such dividend, or to any such allotment of rights, or to exercise the rights in respect of any change, conversion or exchange of shares of the Corporation, or to give such consent, and in each such case shareholders and only such shareholders as shall be shareholders of record on the date so fixed shall be entitled to notice of, and to vote at, such meeting and any adjournment thereof, or to receive payment of such dividend, or to receive such allotment of rights, or to exercise such rights or to give such consent, as the case may be, notwithstanding any transfer of any shares on the books of the corporation after any such record date fixed as aforesaid.

SECTION 12.05. Lost, Destroyed or Mutilated Certificates. In case of the alleged loss or destruction or the mutilation of a certificate representing shares of the Corporation, a new certificate may be issued in place thereof, in the manner and upon such terms as the Board of Directors may prescribe.

ARTICLE XIII

SEAL

The Board of Directors may provide for a corporate seal, which shall be in the form of a circle and shall bear the name of the Corporation and the state and year of incorporation.

ARTICLE XIV

FISCAL YEAR

Except as from time to time otherwise provided by the Board of Directors, the fiscal year of the Corporation shall be the year or other fiscal period ending on the last day of December in each year.

ARTICLE XV

AMENDMENTS

All by-laws of the Corporation shall be subject to alteration or repeal, and new by-laws may be adopted either by the vote of a majority of the outstanding shares of the Corporation entitled to vote in respect thereof, or by the vote of the Board of Directors, provided that in each case notice of the proposed alteration or repeal or of the proposed new by-laws be included in the notice of the meeting at which such alteration, repeal or adoption is acted upon, and provided further that any such action by the Board of Directors may be changed by the shareholders, except that no such change shall affect the validity of any actions theretofore taken pursuant to the by-laws as altered, repealed or adopted by the Board of Directors.

ARTICLE XVI

TRANSFER RESTRICTIONS ON SHARES

SECTION 16.01. Transfer of Shares by Consent - Option in Corporation. If the Corporation has more than one shareholder, and if all of the shareholders and the Corporation have not otherwise agreed in writing, the shareholders shall not dispose of all or any part of their shares in the Corporation, now owned or hereafter acquired by them, without consent of the other shareholders, or in the absence of such written consent,

without first giving to the other shareholders and the Corporation at least thirty (30) days' written notice by certified mail of his or her intention to encumber or dispose of said shares. The notice shall contain the price at which the shareholder is willing to dispose of the shares and the name and address of the eligible person to whom the shareholder intends to transfer the shares if the offer is not accepted by the Corporation. Within the thirty (30) day period, a special meeting of the shareholders shall be called by the Corporation. At such meeting all the shares of the shareholder desiring to make any such disposition shall be offered for sale and shall be subject to an option to purchase on the part of the Corporation which option shall be exercised, if at all, at the time of such meeting. The shareholder offering the shares shall not be entitled to vote at any meeting called for the purpose of considering such offer. The purchase price by the Corporation shall be payable in cash or by certified or bank check within sixty (60) days of the exercise of the option.

SECTION 16.02. Option in Shareholders. If all of the shares of the offering shareholder are not purchased by the Corporation in accordance with the provisions of Section 16.01, then the shares not to purchased shall be offered for sale and shall be subject to an option to their holdings of the Corporation's outstanding stock, which option shall be exercised, if at all, at the time of the meeting of shareholders called pursuant to the provisions of Section 16.01. The purchase price and the payment of the purchase price shall be as provided in Section 16.01.

SECTION 16.03. Options Unexercised. If all the shares of the offering shareholder are not purchased by the Corporation or the other shareholders or by both in accordance with the provisions in Sections 16.01 and 16.02, then the options granted herein with

respect to such shares shall forthwith terminate and the offering shareholder is free to transfer said shares to the eligible person (as defined in Article III) named in the notice provided for herein for a price not less than was mentioned in said notices; provided, however, that if the offering shareholder does not dispose of his or her shares in accordance with the notice given to the Corporation and shareholders within six (6) months after the shareholders' meeting held to consider the shareholder's offer, the offering shareholder must again comply with the provisions of this Article XVI.

SECTION 16.04. Notices. Any notices required or provided for by the terms of this Article XVI shall be in writing and shall be sent by certified mail to each shareholder of record at his or her address as it appears on stock transfer books of the Corporation and to the Corporation at its principal office.

SECTION 16.05. New Shareholders-Restrictions. Any eligible person to whom shares of the Corporation are transferred in accordance with the provisions herein stated shall hold such shares subject to all the conditions and terms relating thereto as may be set forth in the Articles of Incorporation, the Bylaws and any agreements to which all the shareholders may be signatories.