Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☑ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 12-31799 **Check No.:** 3242
OHCA Verified by: SL **Date:** 10/31/12

☑ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☑ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☑ **Attached are completed Financial Attachments I and II.**

☑ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☐ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

AFFIDAVIT

Applicant: Greenwich Plastic Surgery Center

Project Title: Formation of Operating Facility

I, Sandra L. Margules MD and Elsa M Rasin, MD Owner
(Individual's Name) (Position Title – CEO or CFO)

of Greenwich Hospital being duly sworn, depose and state that
(Hospital or Facility Name)

Greenwich Hospital 's information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

Signature Elsa Rasin MD Date 10/26/2012

Subscribed and sworn to before me on 10/26/2012

Notary Public/Commissioner of Superior Court

My commission expires:

VALBONA ULAJ
State of Connecticut
My Comm. Expires Aug. 31, 2017

CERTIFICATE OF NEED APPLICATION

Docket Number:

Applicant: Elsa M. Raskin, MD and Sandra L. Margoles, MD
Greenwich Plastic Surgery Center

Contact Person: Sandra L. Margoles, MD

Contact Person's Title: physician

Contact Persons's Address: 2 ½ Dearfield Dr., Greenwich, CT 06831

Contact Person's Phone Number: (203) 769-1200

Contact Person's Fax Number: (203) 861-6621

Contact Person's Email: slmargoles@aol.com

Project Town: Greenwich CT

Project Name: Certificate of Need for Greenwich Plastic Surgery Center

Statue Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: $32,000

Greenwich Plastic Surgery Center
Raskin and Margoles

1. Project Description: Outpatient Surgical Center

a. Greenwich Smartlipo d/b/a Greenwich Plastic Surgery Center, proposes to (establish) upgrade our existing procedure room to a freestanding operating facility at 2 ½ Dearfield Dr., Suite 102, Greenwich, CT 06870 at a total capital cost of $32,000.

b. See Attached Letters of Support

c. We previously established Greenwich Smartlipo in 2010 to provide cosmetic procedures under local anesthesia to our patients at the 2 ½ Dearfield Dr. location. We now wish to upgrade to a single operating room to provide IV, general sedation to make our patients more comfortable.

2. Clear Public Need

a. The Greenwich Plastic Surgery Center will provide for its existing patients over the age of 18 to provide anesthesia to make them more comfortable. We provide state of the art laser liposuction treatment that is not available at the hospital. This new technology is less painful and traumatic to the tissues than traditional liposuction and is now done under local anesthesia, however, our patients will still benefit from a deeper form of sedation. In addition, The Greenwich Hospital does not provide block time to the plastic surgeons to accommodate scheduling needs of our other cosmetic patients.

b.

Retrospective Volume Per Year

Procedures	Operating Room 1	2009	2010	2011
Abdominoplasty	1	1	16	5
Blepharoplasty	1	10	7	5
Breast augmentation	1	9	6	7
Breast lift	1	7	13	5
Breast reduction	1	34	37	10
Facelift	1	2	3	3
Liposuction	1	5	20	30
Rhinoplasty	1	1	1	2
Subtotal	1	69	90	42

c. Location

i. The proposed location is our current office and procedure room and will take less cost to upgrade than moving to another location. We will be able to perform the surgeries for patients with lower fees and lower expenses for the physicians and thefore result in lower cost to the patients. There will be reduced costs for in-house staffing, lower infection rates and lower anesthesia costs (see attached journal article).

ii. The direct service area is the town of Greenwich, CT and its surrounding towns including Stamford, Darien, New Canaan and other towns of Fairfield County.

iii. The center will provide services to existing cosmetic patients as well as new patients over the age of 18. Drs. Raskin and Margoles have been in practice for over 12 years with most patients coming from referrals from previous patients. Insurance cases and large procedures will still be performed at the Greenwich Hospital. The applicant will offer low interest rate patient financing for those unable to afford the total fee prior to surgery. This is not provided by the local hospital.

iv. Currently, cosmetic patients will seek other plastic surgeons in NY or Conn to have their procedures because they expect their surgeries to be performed in an OR in a plastic surgeons office and not in the acute hospital setting. Most of our competitors have a freestanding facility and we are losing patients to those surgeons. The proposed center will improve the quality and accessibility of the ambulatory surgical services for patients seeking cosmetic surgery.

v. **Table 1. Utilization and Capacity of Existing Providers**

Provider Name	# Operating Rms Available	Utilized*	Not Utilized	Equipped	Est. Capacity	Utilization
Greenwich Hospital 5 Perryridge Road Greenwich, Ct 06831	0 Rooms	7 Rooms	7 Rooms	1 Room	1 Room	**
Hemsley Ambulatory Center Greenwich, Ct 06831	0 Rooms	4 Rooms	4 Rooms	1 Room	1 Room	***

*Utilized by other surgeons

**Our cases are only available on a last minute standby basis

***Partly utilized and owned exclusively by Orthopedics and Neurosurgical Associates since 2009

vi. There is no impact on the other surgical providers in the hospital; they have scheduled, protected block time.

d. There will not be any duplication of existing or approved health care services. The hospitals have not provided the state of the art plastic surgical techniques we provide in the office and do not provide the financing required by some of the cosmetic patients. More importantly, the hospital does not provide operating room surgical assistants or scrub nurses for the cosmetic cases.

d. See Attached for copies of article:

Analysis of Outpatient Surgery Center Safety Using an Internet-Based Quality Improvement and Peer Review Program; Plas. Recontr. Surg 113: 1760, 2004

This study documents a comparison of between hospitals and accredited office surgery centers on measures of safety. The Greenwich Plastic Surgery Center has been accredited by AAASF from 2010-12 and we propose to utilize the Standard of Practice Guidelines of The American Association for Accreditation of Ambulatory Surgery Facilities. (AAAASF).

Greenwich Plastic Surgery Center
Raskin and Margoles

3. Projected Volume

Projected outpatient Surgical Volume by Procedure Type and Operating Room * single room

Projected Volume	**Retrospective**	**Per Year**		
Greenwich Plastic Surgery Center				
	Operating Room 1	2012	2013	2014
Abdominoplasty		12	18	25
Blepharoplasty	1	8	14	20
Breast augmentation	1	12	20	30
Breast lift	1	8	13	20
Breast reduction	1	28	30	30
Facelift	1	2	6	10
Liposuction	1	2	8	12
Rhinoplasty	1	2	4	6
Smartlipo	1	45	65	80
Greenwich Hospital				
Abdominoplasty		12	5	5
Breast Reduction		28	24	20
Breast Reconstruction		16	20	30

4. Quality Measures

a. Attached Copies of CV
Elsa Raskin. MD., Sandra Margoles, MD, Christina Zarb, RN
b. As outlined in our attached journal article in Section 2d the quality for cosmetic, self pay patients will have improved access and costs.
c. The Greenwich Plastic Surgery Center has been accreditated by AAASF from 2010-12 and we propose to utilize the Standard of Practice Guidelines of The American Association for Accreditation of Ambulatory Surgery Facilities. (AAAASF).
d. see attached

Greenwich Plastic Surgery Center
Raskin and Margoles

5. **Organizational and Financial Information**
   a. Greenwich Plastic Surgery Center d/b/a Greenwich Smartlipo, LLP
   b. Dr. Raskin and Dr. Margoles are equal partners in the ownership of Greenwich Smartlipo, LLP
   c. Articles of Organization, included
   d. We do not have a non-profit status
   e. N/A
   f. See Attached:
   g. Final Version of Capital Expenditures/Costs

Table 3. Proposed Capital Expenditures/Costs

Medical Equipment Purchase	26,000
Construction Renovation	$1000
Non medical Equipment	$5000
Total Capital Expenditure	**$32,000**

   h. The capital expenditure will be funded by the cash accounts of Greenwich Smartlipo, LLP. There will be no loans from a lending institution.
   i. The Center will not accept insurance. We offer patient financing for those unable to afford procedures.

6. **Patient Population Mix: Current and Projected**
   a. N/A This proposal is for cosmetic, self pay operating room. We will not take any cases covered by insurance.
   b. N/A

7. **Financial Attachments**

Projected Incremental Revenues and Expenses

Description	FY 2012	FY 2013	FY 2014
Revenue from operations	$250,000	$550,000	$625,000
Non-operative revenue	$20,000	$25,000	$30,000
Total revenue	$270,000	$575,000	$655,000
Total operating expenses	$216,000	$240,000	$260,000

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classified@scni.com
Hours: 8:30 a.m. – 5:30 p.m., M-F
Major Credit Cards Accepted

PUBLIC NOTICES

CLASSIFIED AD

Gateway Preschool Flooring Replacement,
2 Chapel Street, Greenwich, CT

Invitation to Bid

aled bids will be received by Family Centers Inc., Greenwich, CT for a ntract to replace the flooring (carpet and sheet vinyl) at Family Centers' teway Preschool at 2 Chapel Street, Greenwich, CT. Bids to include re- val of existing flooring and installation new carpet and sheet vinyl floor- . Work is expected to begin on or about the 20th of August 2012. ds will be received until 1:00 p.m., Tuesday, August 7, 2012 at the of- e of Family Centers Inc., 40 Arch Street, Greenwich, CT 06830. Bids l be opened publicly by the owner at 1:00 p.m., Tuesday, August 7, 12.

pre-bid meeting and site visit is scheduled for prospective bidders at mily Centers Gateway Preschool, 2 Chapel Street, Greenwich CT on follow dates: 1) July 30, 2012, Monday, at 11:00 am; 2) July 31, 2012, esday, at 11:00 am; 3) August 1, 2012, Wednesday, at 3:00 pm. Other es may be scheduled with the owner.

g and Contract Documents may be obtained upon request at Family nters Inc., 40 Arch St., Greenwich, CT 06830, Attn: Robert Short, tele- one 203-869-4848. Copies of the bidding documents may also be ex- ined at Family Centers Inc., the same address, by appointment.

ch bid must be accompanied by a completely filled in and properly exe- ted copy of the Contract Documents from Bid Package, including all ms, i.e. Bidder's Qualification Statement, and Non-Collusion Affidavit.

ork to be performed under this contract is funded by Federal monies rough Community Development Block Grant program of the Town of eenwich, and is subject to the Davis-Bacon Act in compliance with cer- in local and federal requirements.

rsuant to Connecticut General Statutes § 12-403, An Act Concerning es Tax-Bond Requirements For Nonresident Contractors, a nonresi- nt contractor shall furnish the Department of Revenue Services (DRS) guarantee bond for 5% of the total contract price using Form AU-766.

ntact Robert Short at Family Centers Inc., Phone: 203-869-4848, for ad- tional information.

Bidder may withdraw his Bid within 60 days after the actual date of d receipt.

mily Centers reserves the right to re-bid the project should all bids ex- ed the projected budget by more than 10%.

LEGAL NOTICE

his is a notification of a pending pplication for a Certificate of ed for the establishment of an mbulatory surgical facility for the reenwich Plastic Surgery Center, the town of Greenwich CT.

GENERAL HELP WANTED

AUTO BODY TECHNICIAN n Wilton. Must have at least 5 yrs p & own tools. Call 203-762-5222.

GENERAL HELP WANTED

ESTATE MANAGER
Experienced Caretaker sought for 18 acre multi-building estate in Greenfield Hills section of Fairfield, CT. Must have extensive knowledge and experience in the care of Gardens and Grasses. You will also need excellent mechanical and handy-man skills to be able to handle a wide variety of daily projects.
Fax resume and salary history to 914-345-7134 or email to Jobs@amcaonline.com

EXPERIENCED TREE CLIMBER

GENERAL HELP WANTED

SECURTIY GUARD-PART TIME
Sat. & Sun. 7:00-3:00
Gated Community-Greenwich Area
Fax Resume to: McGrath Mgmt
(914) 234-0889

TREE CLIMBER: Growing Fairfield County based tree Care Company needs a qualified tree climber for pruning and removals. Ability to drive a truck. Salary base on experience. Call Bruce S. Pauley Tree Care, Inc. at 203-966-0869.

SITUATIONS WANTED

2 HARDWORKING women looking for housecleaning, commencal, windows in/out work. Legal. Excellent refs. 203-554-2216.

AMANDA SEEKING full time Nanny position at $12 per hour. Call 203-434-0462.

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The advertisers in this classification are providing a service.

EASTERN EUROPEAN Lady will clean your house to perfection. English speaking, Legal, own car and license. PT/FT. Live In/ Out. Please Call 203-520-5608.

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EXPERIENCED NURSING ASSISTANT with references and drivers license seeks evenings, overnights & weekend position. Call 203-536-0476.

HOUSEMAN PROPERTY caretaker, estate experienced, I am looking for FT/PT work. call Joseph 203-912-2609.

HOUSEKEEPER W/ 9 yrs of exp. looking for FT/PT work. Very honest, reliable, own tran, spk basic Eng, great ref. Call anytime, 203-359-1089.

IRISH LADY available to clean your house or apartment. References available. Call Kathleen at 917-459-3680.

POLISH RELIABLE Young Woman. Looking for FT/PT housekeeping/ babysitting job. Great ref & exp. Call Eva 203-536-4668.

RETIRED gentlemen seeking job helping handicap.

rts

lo Jr. grabs early lead

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s and it was
lt," Bensel said.
were running
nd the rough
was riding high, so you had to keep it in the fairways. Anything under par is good around here."

Like Balin, Bensel will compete in the PGA Championship.

"I'm looking forward to that and feel as though I'm prepared for it," Bensel said. "Playing in events like this where we walk the course gets my walking legs ready."

Andrew Gruss from Trumbull, Dustin Toner (Jupiter, Fla.), Jason Caron of Greenwich, Bobby Gage (Torrington), Tom McCarthy (New York), Sean Gaudette (Hadley, Mass.) and Jeffrey Hatten (Farmington) each shot a 1-over-par 73.

"I started out great out of the box with pars on the first four holes," Gruss said. "Then I had a couple of bogeys and things became a little difficult between the ears."

Gruss regrouped though, sinking birdie putts on Nos. 10, 17 and 18.

"It's not difficult to make bogeys on this course, but it's scoreable if you keep it out of the rough," Gruss said. "I feel good about my round, I just didn't execute a couple of shots. I could have shot a 70 or I could have shot a 76, so I'm happy with a 73."

Ryan Kalista, an Old Greenwich resident and pro at Innis Arden, birdied the first two holes en route to carding a 3-over 75.

"It could have been a spectacular round for me," Kalista said. "I thought I hit a lot of good shots, but a couple of holes were tough for me. This course is in spectacular condition. Every hole is a real good golf hole."

Peter Ballo, Mike's younger brother, is eager to improve upon his first-round score of 76.

"I've played this course enough to put up a good score; so hopefully I'll play well tomorrow," said Ballo, who will play golf at Sacred Heart in the fall.

"I'm hitting the ball well, I just need to find my stroke on the putting green and drop a couple of more putts in."

Greenwich High graduate Tomas Agrest also intends to make a strong showing Tuesday after carding an 82.

"I don't expect to win at this point, but my goal is to shoot the lowest score possible," Agrest said. "I only got to play at Wee Burn once in high school, so to get another free round at this course is great."

david.fierro@scni.com

ld times at Olympics

B1

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The other scandal: Empty seats! Games chief Sir Sebastian Coe promised not to repeat the embarrassment of past Olympics when thousands of seats went unfannied (my word, not Sir Coe's). And yet, on tallies all over Sunday, after Lord LeBron and his knaves destroyed France, a few of the U.S. players mention (not complained) that the rims are very tight, much stiffer and less forgiving than NBA rims. It's easy to see the

Scoreboard

On the air

MAJOR LEAGUE BASEBALL

- Baltimore Orioles at New York Yankees (YES) (WCBS-AM 880, WICC-AM 600, WLAD-AM 1300, WAVZ-AM 1300) 1 p.m.
- Chicago White Sox at Minnesota Twins (MLB) 1 p.m.
- Pittsburgh Pirates at Chicago Cubs (WGN) 2:10 p.m.
- Detroit Tigers at Boston Red Sox (ESPN, NESN) (WTIC-AM 1080, WGCH-AM 1080, WQUN-AM 1220) 7 p.m.
- New York Mets at San Francisco Giants (SNY) (WFAN-AM 660) 10 p.m.

BIG LEAGUE BASEBALL

World Series championship (ESPN2) 8 p.m.

Listings subject to change by stations and networks. Check cable and satellite companies for availability.

GOLF

THIS WEEK ON TOUR

WORLD GOLF CHAMPIONSHIPS

BRIDGESTONE INVITATIONAL

WHEN: Thursday-Sunday

WHERE: Firestone Country Club, South Course (7,400 yards, par 70), Akron, Ohio

PURSE: $8.5 million. Winner's share: $1.4 million

TELEVISION: Golf Channel (Thursday-Friday 2-6 p.m., 8:30 p.m.-12:30 a.m.; Saturday-Sunday, noon-1:30 p.m., 9 p.m.-12:30 a.m.) and CBS (Saturday-Sunday 2-6 p.m.)

UP NEXT: The PGA Championship is next week at Kiawah Island in South Carolina.

PGA TOUR

RENO-TAHOE OPEN

WHEN: Thursday-Sunday

WHERE: Montreux Golf and Country Club (7,472 yards, par 72), Reno, Nev.

PURSE: $3 million. Winner's share: $540,000

TELEVISION: Golf Channel (Thursday, 6:30-8:30 p.m., Friday, 1:30-3:30 a.m., 6:30-8:30 p.m., Saturday, 1:30-3:30 a.m., 6:30-9 p.m., Sunday, 1:3 a.m., 7-9 p.m., Monday, 1:3 a.m.)

UP NEXT: The PGA Championship is next week at Kiawah Island in South Carolina, followed by the Wyndham Greensboro, N.C.

OLYMPICS

RESULTS

BASKETBALL
Men
Group A

Lithuania 72, Nigeria 53
France 71, Argentina 64
United States 110, Tunisia 63

Group B

Russia 73, China 54
Spain 82, Australia 70
Brazil 67, Britain 62

SOCCER
Women
Group E

New Zealand 3, Cameroon 1
Britain 1, Brazil 0

Group F

Japan 0, South Africa 0
Canada 2, Sweden 2

Group G

United States 1, North Korea 0
France 1, Colombia 0

HANDBALL
Men
Group A

Iceland 32, Tunisia 22
Sweden 41, Britain 19
France 32, Argentina 20

Group B

Hungary 27, South Korea 19
Croatia 31, Serbia 23
Denmark 24, Spain 23

HOCKEY
Women
Pool A

Netherlands 3, Japan 2
Belgium 0, China 0
Britain 5, South Korea 3

Pool B

New Zealand 4, South Africa 1
United States 1, Argentina 0
Australia 2, Germany 1

VOLLEYBALL
Men
Pool A

Bulgaria 3, Poland 1 (25-22, 25-27, 28-26, 25-23)
Italy 3, Argentina 1 (25-17, 23-25, 25-17, 25-23)
Australia 3, Britain 0 (25-15, 25-18, 25-20)

Pool B

Serbia 3, Tunisia 1 (25-15, 25-21, 20-25, 25-18)
United States 3, Germany 0 (25-23, 25-16, 25-20)
Brazil 3, Russia 0 (25-21, 25-23, 25-21)

WATER POLO
Men
Group A

Croatia 8, Spain 7
Australia 7, Kazakhstan 4
Greece 7, Italy 7

Group B

Serbia 21, Britain 7
United States 10, Romania 8
Montenegro 11, Hungary 10

USA 110, TUNISIA 63

Tunisia
H-Sumiane 0-0-0-0, M.Laghnej 0-1-0-0, M.El Mabrouk 1-3-2-5, M.Kechrid 3-11-0-9, M.Haddiane 4-9-1-11, M.Hafsi 2-5-1-6, M.Ghayaza 0-1-0-0, M.Ben Romdhane 9-18-3-22, A.Riahi 2-8-1-6, S.Mejri 2-9-0-4. Totals 23-65 8-21 63

United States
T.Chandler 2-3-0-1 6, K.Durant 4-10 4-4 13, L.James 7-14 0-0 15, R.Westbrook 4-8 3-5 11, D.Williams 3-5 2-2 8, A.Iguodala 3-4 0-0 6, K.Bryant 2-5 0-0 4, K.Love 6-9 2-2 16, J.Harden 4-7 0-0 10, C.Paul 1-4 0-0 2, A.Davis 0-1 2-2 2, C.Anthony 0-3 2-2 2. Totals 43-70 14-18 110

Halftime—United States 46, Tunisia 33. 3-Point Goals—Tunisia 2-26 (M.Laghnej 0-1, M.El Mabrouk 1-2, M.Haddiane 2-6, M.Hafsi 1-1, M.Ben M.Kechrid 1-8, M.Haddiane 2-6, M.Hafsi 1-1, M.Ben Romdhane 1-3, A.Riahi 1-4, S.Mejri 1-2), United States 10-25 (K.Durant 1-4, L.James 1-2, R.Westbrook 0-1, D.Williams 1-2, A.Iguodala 0-1, K.Bryant 0-2, K.Love 3-5, J.Harden 2-4, C.Paul 0-2, C.Anthony 2-2). Fouled Out—None. Rebounds—Tunisia 31 (M.Ben Romdhane 10), United States 44 (K.Durant 10). Assists—Tunisia 12 (M.Ben Romdhane 4), United States 28 (C.Paul 7). Total Fouls—Tunisia 21, United States 19.

AMERICA'S LINE

BASEBALL

Giants notebook

SASH SUSPENDED: Safety **Tyler Sash** was suspended four games for violation of the league's performance-enhancing drug policy.

Sash, a rookie last season after being selected out of Iowa in the 2011 draft, is eligible to participate in all preseason practices and games, according to an NFL statement, and will be eligible to return to the Giants' active roster on Oct. 1, following the Sept. 30 game vs. the Eagles.

BOLEY OK: The MRI on linebacker **Michael Boley**'s injured hamstring showed no significant damage. He is not expected to miss any significant time but the Giants are sure to be cautious with the injury.

—WIRE REPORTS

Jets notebook

NAME RECOGNITION: The team announced that it will retire the jerseys of running back **Curtis Martin** and defensive end **Dennis Byrd**. Martin will be inducted into the Pro Football Hall of Fame this weekend. His No. 28 jersey will be retired during a ceremony at halftime of the regular-season opener against Buffalo on Sept. 9.

Byrd's No. 90 will be retired Oct. 28 against Miami. It hasn't been worn since his career-ending injury in 1992.

TRADE RESCINDED: **Jeff Otah** failed his physical again, meaning New York's trade with Carolina is off and the offensive tackle is headed back to the Panthers.

Otah was acquired by the Jets last Monday, but failed his physical and was placed on the active/physically unable to perform list. He had seven days — until Tuesday — to pass.

—ASSOCIATED PRESS

October 24, 2012

To Whom It May Concern:

This letter is written in support of Dr. Elsa Raskin and Dr. Sandra Margoles to achieve a Certificate Of Need for an operating room at their office.

As a patient of theirs, I had surgery at Stamford Hospital. Although the outcome was a success, the journey getting there was not.

The morning of the surgery, my case was delayed due to unforeseen emergencies. After waiting 2 hours in a crowded waiting room, it was finally my time. Even though this was an elective procedure, I felt there were unnecessary hurdles to jump. It would have been a better experience if I could have had this done at their office. The lack of privacy and one-on-one attention that I received at the hospital could have been averted, had I been able to have the procedure done at their office.

Please strongly consider their application so that future patients can reap the rewards of a convenient, comfortable elective procedure.

Thank you,

Jana Hickman

October 26, 2012

To Whom it May Concern:

I am writing in support of Drs. Elsa Raskin and Sandra Margoles to obtain a Certificate of Need for an operating room in their medical office at 2 ½ Dearfield Drive, Greenwich, CT.

On 9/10/ 2010 I underwent SmartLipo of the abdomen and neck. While I am very pleased with the results, there is no doubt that it would have been a much better experience if I had been under some form of general anesthesia. The oral medications simply were not effective for the level of discomfort involved.

I strongly believe that future patients will be better served if they have choices for pain control.

Yours truly,

Barbara Asciutto

Barbara Asciutto
32 Harkim Road
Greenwich, CT 06831

Special Topic

Analysis of Outpatient Surgery Center Safety Using an Internet-Based Quality Improvement and Peer Review Program

Geoffrey R. Keyes, M.D., Robert Singer, M.D., Ronald E. Iverson, M.D., Michael McGuire, M.D., James Yates, M.D., Alan Gold, M.D., and Dennis Thompson, M.D.

Assessing the quality of care delivered in office-based outpatient surgery centers is difficult because formerly there was no central data collection system. The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), in its ongoing effort to assess and improve patient care, has developed an Internet-based quality improvement and peer review program to analyze outcomes for surgery centers it accredits. Reporting is mandatory for all surgeons operating in AAAASF-accredited facilities. Each surgeon must report all unanticipated sequelae and at least six random cases reviewed by an accepted peer review group biannually. A total of 411,670 procedures were analyzed during a 2-year period (from 2001 to 2002). There were 2597 sequelae reported during this period. The most common sequela was hematoma formation following breast augmentation. Infection occurred in 388 cases. Deep vein thrombosis, pulmonary embolism, and intraoperative cardiac arrhythmias were found to occur in a frequency consistent with previous reports. Significant complications (hematoma, hypertensive episode, wound infection, sepsis, and hypotension) were infrequent. A total of 1378 significant sequelae were reported for 411,670 procedures. This calculates to one unanticipated sequela in 299 procedures (an incidence of 0.33 percent). Seven deaths were reported. A death occurred in one in 58,810 procedures (0.0017 percent). The overall risk of death was comparable whether the procedure was performed in an AAAASF-accredited office surgery facility or a hospital surgery facility.

This study documents an excellent safety record for surgical procedures performed in accredited office surgery facilities by *board-certified surgeons*. (*Plast. Reconstr. Surg.* 113: 1760, 2004.)

The number of outpatient surgery centers and physician office–based surgery facilities is escalating dramatically.[1,2] This phenomenon is in direct response to the demand for safe, cost-effective surgical care for procedures that can be performed in an outpatient setting. There are advantages to performing operations in an outpatient setting for both patients and surgeons, including convenience, patient privacy and comfort, consistency in nursing and support staff, and increased efficiency.[3]

The American Society of Anesthesiologists predicts that by the year 2005, an estimated 10 million procedures will be performed annually in doctors' offices—twice the number of office-based operations performed in 1995.[4] This dramatic increase in the number of procedures performed in outpatient surgery centers has focused attention on the need for accreditation as a means of ensuring compliance with standards for their safe operation.[5,6]

Currently, only 14 states have mandated accreditation of surgery centers. The number of states requiring accreditation or licensure to perform surgery in an outpatient setting will, and should, continue to increase, until accreditation becomes the national standard.

In the spring of 1999, recognizing the importance of accreditation, the American Society of Plastic Surgeons and The American Society for Aesthetic Plastic Surgery passed a joint mandate for all of their members stipulating that members who perform outpatient operations under sedation or general anesthesia do so in an accredited or state-licensed facility.[7] Accredited or licensed outpatient surgical facilities must meet at least one of the following criteria[7]:

- Be accredited by a nationally recognized or state-recognized accrediting agency or organization, such as the American

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Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), Accreditation Association for Ambulatory Health Care, or the Joint Commission on the Accreditation of Healthcare Organizations.
- Be certified to participate in the Medicare program under Title XVII.
- Be licensed by the state in which the facility is located.

Monitoring Surgery Center Management

Design and management of a surgery center require compliance with nationally recognized standards to safeguard patient care. Ongoing monitoring of care delivery is vital to ensure patient safety. However, it is difficult to compile and compare the data documenting care delivery. This difficulty is a consequence of lack of centralization of data collection from the multiple accrediting, licensing, and managing entities of outpatient surgical facilities. As a result, there is little available coordinated information concerning ultimate outcomes of outpatient surgery in nonhospital settings.

Since 1982, AAAASF, the largest organization in the United States that accredits single or multispecialty office-based surgery centers, has been at the forefront of developing safety standards for the operation of outpatient surgery centers and coordinating relevant data. In 1996, AAAASF conducted a voluntary survey of all of their accredited surgery centers to assess outcomes of surgical care. The directors of all the surgery centers were asked to fill out questionnaires about unanticipated sequelae that occurred in their facilities. Of the 418 facilities accredited at that time, 241 (57.7 percent) returned the anonymous questionnaires, a very high response rate. In 1997, Morello, Colon, Fredricks, Iverson, and Singer published a review of this survey, entitled "Patient Safety in Accredited Office Surgical Facilities."[8]

The following findings were of interest:
- 400,675 operative procedures were reported during a 5-year period from January 1, 1989, to December 31, 1993.
- Significant complications (hematoma, hypertensive episode, wound infection, sepsis, and hypotension) were infrequent, numbering 1877, for an occurrence of one in every 213 cases, or 0.47 percent.
- Return to the operating room within 24 hours and precautionary hospitalization were less frequent.
- Seven deaths were reported. A death occurred in one in 58,810 procedures (0.0017 percent). The overall risk of death was comparable whether the procedure was performed in an AAAASF-accredited office-based surgery facility or a hospital surgery facility.[8,9]

This study documented an excellent safety record for surgical procedures performed in accredited office-based surgery facilities by board-certified surgeons.

Quality Improvement and Peer Review

The goal of a surgery facility is to provide the highest level of care delivery. The facility, whether office-based, free-standing, or in a hospital, should provide care with positive outcomes and a reduced incidence of unanticipated sequelae. In an effort to improve quality of patient care, AAAASF designed and adopted the first Internet-based reporting system for quality improvement and peer review. The purpose of the Internet system was twofold: to improve monitoring of random case review and unanticipated sequelae and to facilitate collation and analysis of the data acquired. This system has provided AAAASF with the ability to more precisely evaluate outcomes.

The guidelines for using this new reporting system follow AAAASF standards,[9] which require facilities to institute an ongoing quality improvement program that (1) monitors and evaluates the quality of patient care, (2) evaluates methods to improve patient care, (3) identifies and corrects deficiencies within the facility, and (4) alerts the medical director to identify and resolve recurring problems.

Peer review must be performed every 6 months and must include reviews of both random cases and unanticipated operative sequelae. If peer review sources external to the facility are used to evaluate delivery of surgical care, the patient consent form is so written as to protect confidentiality of the medical records, consistent with current legal standards. Peer review is performed either by a recognized peer review organization or by a physician other than the operating surgeon.

A minimum of six random cases per surgeon utilizing the facility must be reviewed, and for group practices, 2 percent of all cases performed must be reviewed every 6 months. These random case reviews must include assessment of the following: (1) thoroughness and legibility of the history and physical exam-

ination; (2) adequacy and appropriateness of the surgical consent form; (3) presence of appropriate laboratory, electrocardiographic, and radiographic reports; (4) presence of a dictated operative report or its equivalent; (5) anesthesia record for operations performed with intravenous sedation or general anesthesia; (6) presence of instructions for postoperative and follow-up care; (7) and documentation of unanticipated sequelae.

All unanticipated operative sequelae are reviewed, including, but not limited to the following: (1) unplanned hospital admission; (2) unscheduled return to the operating room for complication of a previous procedure; (3) untoward result of a procedure, such as infection, bleeding, wound dehiscence, or inadvertent injury to another body structure; (4) cardiac or respiratory problems during stay at the facility or within 48 hours of discharge; (5) allergic reaction to medication; (6) incorrect needle or sponge count; (7) patient or family complaint; (8) equipment malfunction leading to injury or potential injury to patient; and (9) death.

Each unanticipated operative sequela chart review includes the following information, in addition to the operative procedure performed: (1) identification of the problem; (2) immediate treatment or disposition of the case; (3) outcome; (4) analysis of reason for problem; and (5) assessment of efficacy of treatment.

The data obtained through the individual surgery center peer review meetings are then entered into the Internet quality improvement and peer review program.

Data obtained from 621 surgery centers from 2001 through 2002 were statistically analyzed. The AAAASF standards require a bound surgical log book be kept that records sequentially all operations performed. The first and last surgical log numbers of all reviewed random cases and unanticipated sequelae from a reporting period are entered into the Internet program with the reported data. This allows for the computation of the total number of cases performed per surgeon per period. In this study, 73 percent of reporting surgeons correctly entered their surgical log numbers. The average number of cases for those surgeons was assigned to the surgeons whose numbers were not correctly entered. The average case consisted of 1.37 procedures. Using this multiple, the total number of procedures reported for this study was 411,670.

A total of 2597 sequelae in 411,670 procedures were reported. The standards for AAAASF require *all* unanticipated sequelae to be reported, including patient complaints, surgery cancellations, and a variety of sequelae deemed less significant than those reported by Morello et al.[8]

When analyzing data in this report comparable to data in the aforementioned article, a total of 1378 significant sequelae were reported in 411,670 procedures over a 2-year period (from 2001 to 2002). This calculates to one unanticipated sequelae in 299 procedures (an incidence of 0.33 percent) compared with one in every 213 cases, or 0.47 percent, for the Morello et al.[8] article.

Recently, Byrd et al.[2] reported 35 unanticipated sequelae in 5316 cases. The 0.7 percent incidence of unanticipated sequelae in their study, conducted over a 6-year period, supports the incidence found in the current study.

Analysis of Sequelae

Table I lists the 1378 reported sequelae by type in descending order of frequency.

Hematoma

Hematoma was the most common unanticipated sequela reported in the study. There were a total of 740 hematomas reported, representing 28 percent of all sequelae or 0.18 percent of all procedures. The majority of hematomas ($n = 676$) were managed on an outpatient basis (Fig. 1). Sixty-four patients with hematoma required hospitalization

TABLE I
Sequelae*

Sequelae	No.
Hematoma	740
Infection	388
Necrosis	76
Cardiac events	29
Respiratory distress	20
Pneumothorax	19
Burn	19
Pulmonary embolism	17
Deep vein thrombosis	14
Hypotension/hypertension	16
Pulmonary edema	11
Allergic reaction	6
Cellulitis	6
Death	6
Hypoxia	5
Cardiac arrest	2
Chest pain	2
Hyperthermia	2

*Total number of sequelae = 1378.

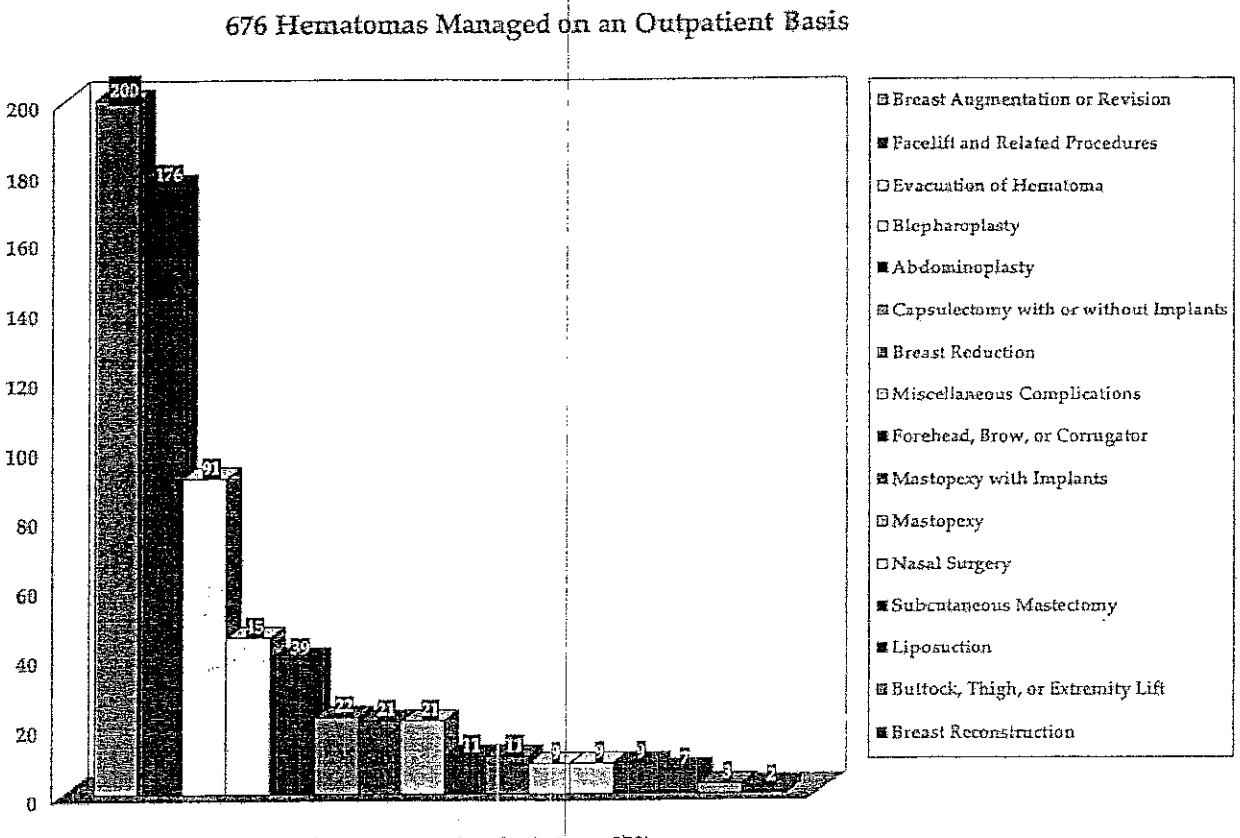

FIG. 1. Hematomas managed on an outpatient basis (n = 676).

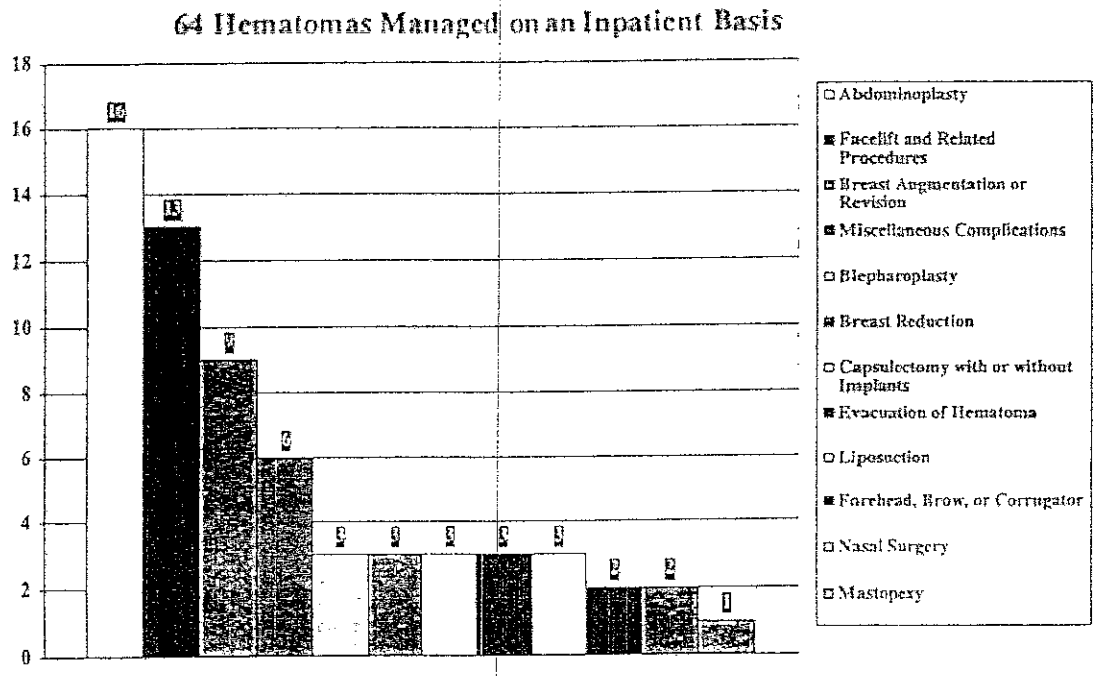

FIG. 2. Hematomas managed on an inpatient basis (n = 64).

(Fig. 2). Of those patients hospitalized, three patients were hospitalized for observation and had no surgical intervention. The average hospital stay for these patients was 1.38 days (range, 1 to 6 days).

Breast augmentation resulted in the largest

number of hematomas managed as outpatient cases ($n = 200$). Abdominoplasty accounted for the largest number of patients hospitalized with hematomas ($n = 16$). All hematomas were managed successfully without residual sequelae. No deaths were reported as the result of hematomas.

Morello et al.[8] reported hematoma or bleeding episodes in 965 of the 400,675 operative procedures, or one in every 415 procedures (an incidence of 0.24 percent). Byrd et al.[2] reported that 77 percent of sequelae were hematomas, an incidence of 0.5 percent or one in 200 procedures. Natof[10] performed a prospective study on 13,433 procedures with a follow-up of 14 days. Bleeding occurred in 74 patients, or one in 182 procedures (0.55 percent).

Infection

There were 388 infections reported, representing an incidence of 0.09 percent or one in 1061 procedures. A total of 348 patients had infections that were managed on an outpatient basis (Fig. 3). Forty of the patients who had infections required hospitalization (Fig. 4). The average hospital stay for these patients was 5.1 days. The length of stay varied from 1 day to 21 days. All infections resolved with local wound care or a combination of antibiotics and local wound care.

Forty-eight patients had an infection associated with an implant that was eventually removed. Forty-three patients had breast implants removed, and five patients had chin or other facial implants removed. There were no deaths attributable to infection.

Interestingly, Morello et al.[8] reported the same incidence of infection, 0.09 percent, for a frequency of one in 1145 procedures. Byrd et al.[2] reported six infections, an incidence of one in 886 procedures, or 0.11 percent. Natof's[10] study reported 10 patients with postoperative infections for an incidence of one in 1343 procedures or 0.074 percent.

Cardiac-Related Sequelae

Cardiac events occurred in 29 patients (incidence of one in 14,196 cases, or 0.007 per-

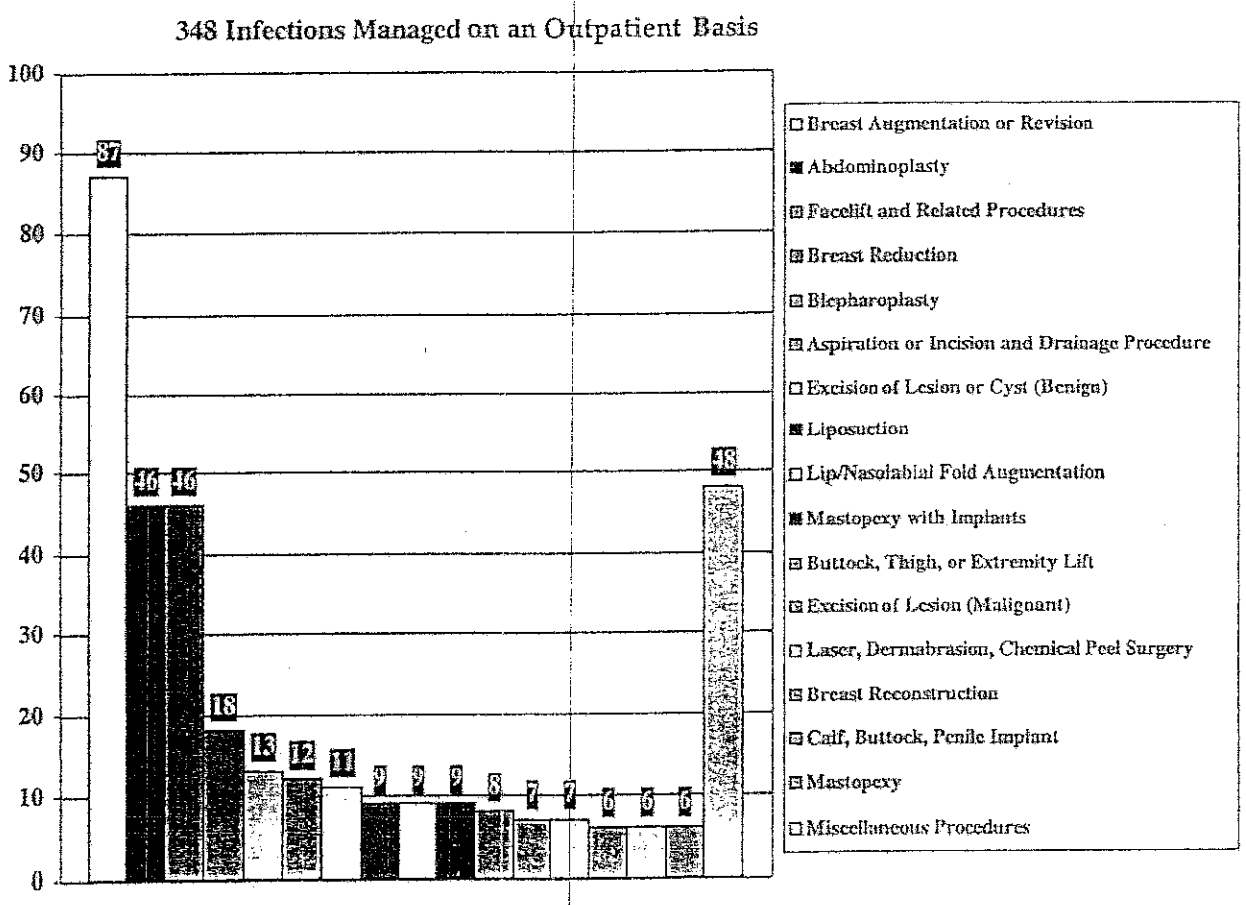

FIG. 3. Infections managed on an outpatient basis ($n = 348$).

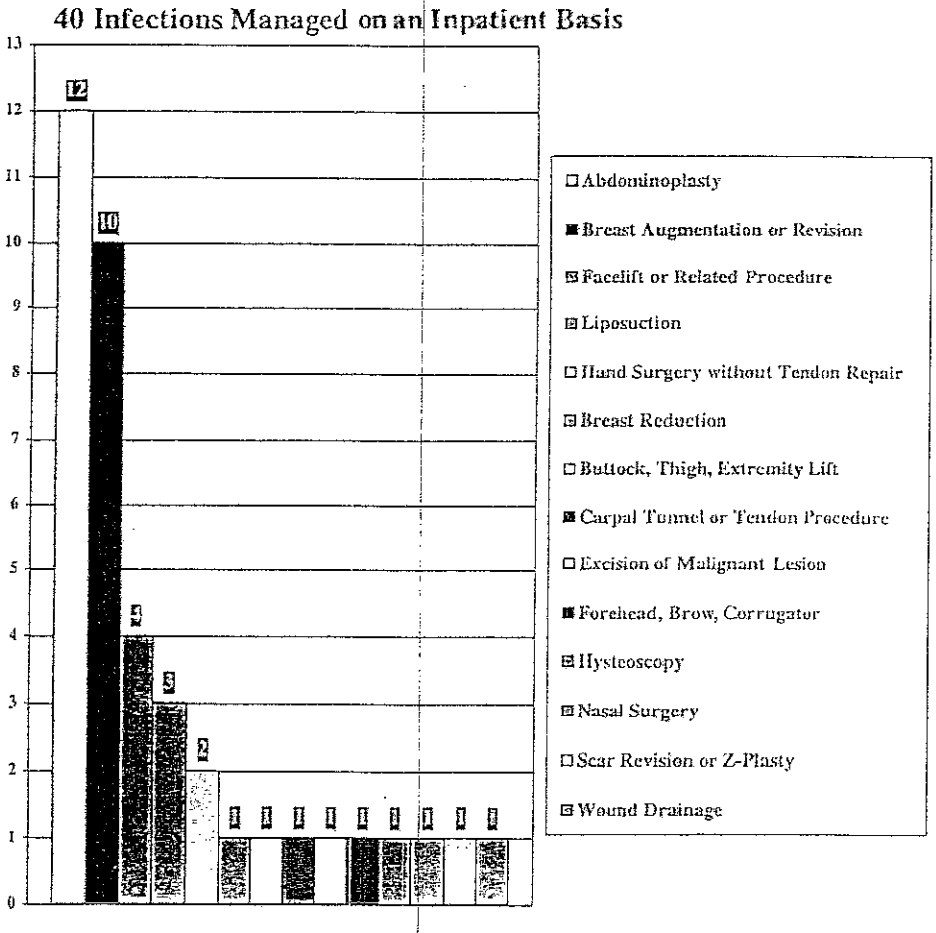

FIG. 4. Infections managed on and inpatient basis (n = 40).

cent). Twenty-seven patients had arrhythmias and two patients had cardiac arrests.

Of the two cardiac arrests, one patient became bradycardic, hypotensive, and unresponsive in the postoperative recovery room. A code was called and cardiopulmonary resuscitation, atropine, and epinephrine were administered. The patient was transferred to a hospital and admitted. Unresponsive and without spontaneous respiration, she was admitted to the cardiac care unit and placed on a respirator. After a 34-day hospital stay, the patient was discharged with some neurologic deficit.

The second patient was undergoing a face lift under intravenous sedation. It is believed that the patient had a myocardial infarction after becoming hypotensive intraoperatively. The patient was resuscitated, but immediately became bradycardic and was admitted to a hospital. She died after a 2-week hospital stay.

Fourteen of the patients with cardiac arrhythmias were hospitalized, with an average length of stay of 4 days (range, 0 to 34 days). Two patients were reported to have had chest pain in the early postoperative period that was determined to be due to anxiety (Fig. 5).

Blood Pressure Alteration

The current study showed that nine patients developed notable hypertension intraoperatively. All of these patients responded to medical management. Hypertensive episodes occurred in 0.002 percent of cases. One of these patients had their surgery canceled and was referred for medical evaluation.

Seven patients, or 0.002 percent of all cases performed, had notable hypotensive episodes. Five of these patients were hospitalized for an average period of 2.1 days. Two patients received a blood transfusion. All patients recovered without residual sequelae (Fig. 6). In the Morello et al.[8] article, hypertensive episodes represented 414 cases, or one in 968 procedures (an incidence of 0.1 percent). Intraoperative and postoperative hypotension occurred in 148 cases, or one in

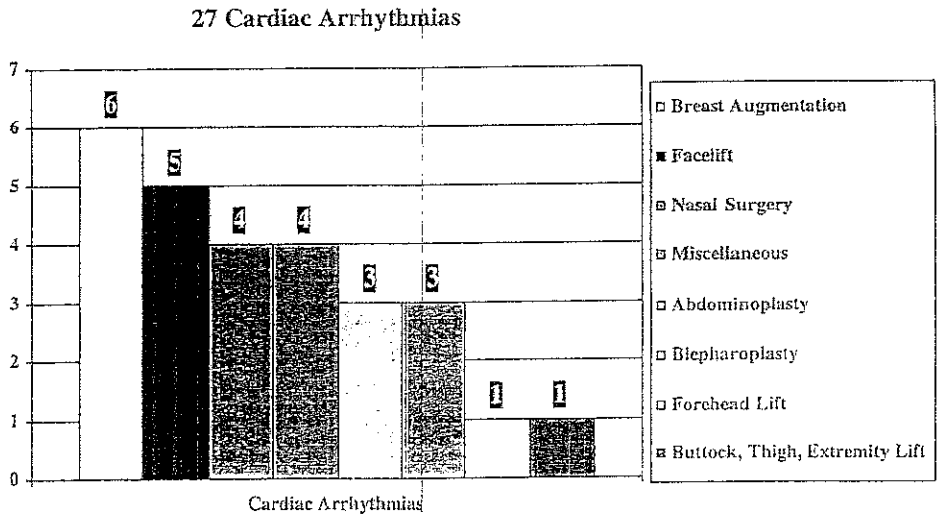

FIG. 5. Cardiac arrhythmias (n = 27). There were also two occurences of cardiac arrest.

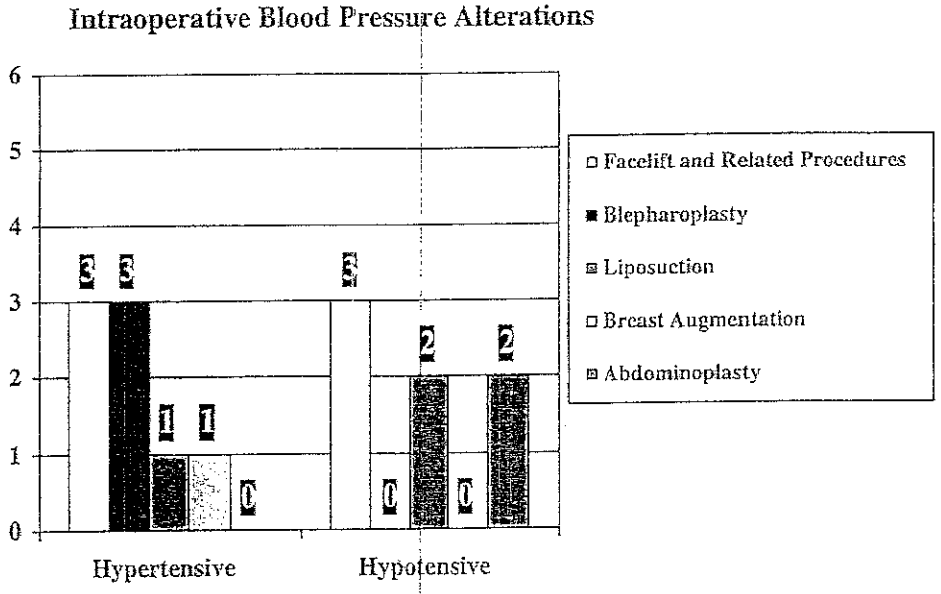

FIG. 6. Intraoperative blood pressure alterations (n = 15). One other patient experienced hypertension, but the operation was cancelled.

2707 procedures, an incidence of 0.04 percent.

Deep Vein Thrombosis or Pulmonary Embolism

All surgical patients are at some risk for the development of deep vein thrombosis in the lower extremities. The risk is increased for patients with a previous history of that condition, pulmonary embolism, or chronic venous insufficiency and for those with a family history of thrombotic syndromes. Other contributing factors include obesity, trauma, severe infection, polycythemia, central nervous system disease, malignancy, homocystinemia, history of radiation therapy, especially for pelvic neoplasms, and the use of birth control pills.[11,12]

There have been few reported studies on the frequency of deep vein thrombosis and pulmonary embolism associated with outpatient surgery. In the 2-year period monitored by the AAAASF quality improvement and peer review program, 31 patients developed deep vein thromboses or pulmonary emboli in 411,670 procedures (Fig. 7). This represents 0.01 percent of procedures performed, consistent with the report by Reinish et al.[13] As with the study by Morello et al., the Reinish group's study was conducted through a voluntary survey. The

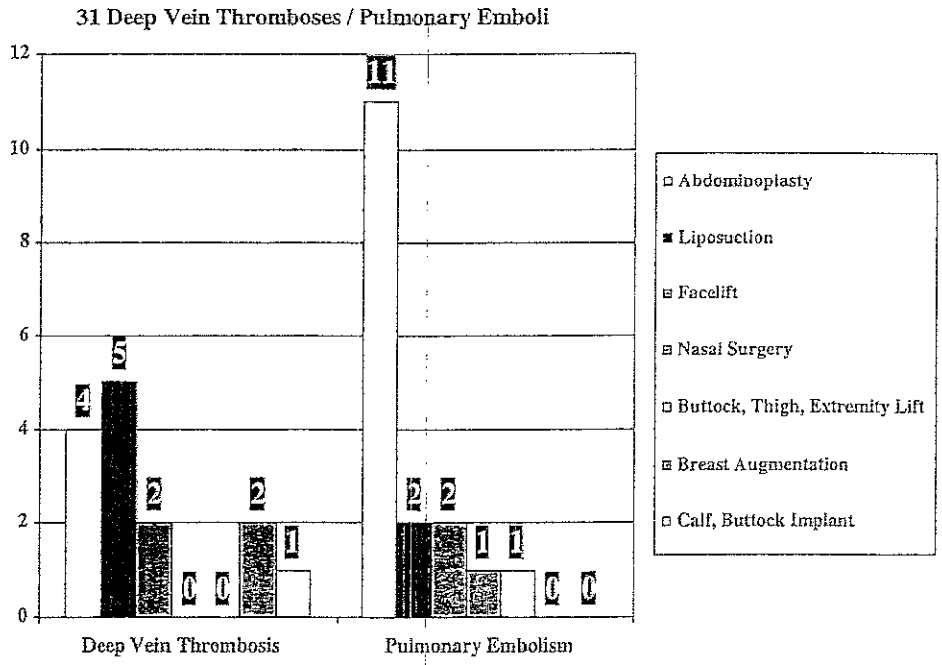

FIG. 7. Deep vein thromboses/pulmonary emboli (n = 31).

correlation of statistics with the mandatory AAAASF quality improvement and peer review Internet-based reporting system is significant.

Of these 31 patients with deep vein thromboses or pulmonary emboli, 14 patients had deep vein thromboses, of whom eight were hospitalized for management; six patients were treated on an outpatient basis. The average length of stay for those hospitalized for deep vein thromboses was 5.38 days (range, 2 to 12 days). There were no deaths associated with deep vein thromboses that did not eventuate in pulmonary emboli. All thromboses that did not result in pulmonary embolism resolved without additional sequelae.

The 17 patients who developed pulmonary emboli were hospitalized. The incidence of pulmonary embolism was one in 24,216 procedures, or 0.004 percent. The average length of stay for pulmonary emboli patients was 6.2 days (range, 1 to 11 days). Six deaths were reportedly due to pulmonary embolism. Four of the patients who died of pulmonary embolism had undergone an abdominoplasty. One of the aforementioned patients had undergone multiple procedures. The fifth patient who died had a pulmonary embolus 2 weeks after rhinoplasty. The procedure for the sixth patient who died was suction lipectomy of the abdomen using epidural anesthesia. The total amount of fat removed for the liposuction case was 3700 cc. All fatal pulmonary emboli occurred between postoperative days 2 and 14. In the remaining 11 patients, the pulmonary emboli resolved without residual sequelae.

The incidence of deep vein thrombosis was reported to be 0.3 percent in one large series of patients undergoing hip replacement.[14] Fatal pulmonary emboli occur in 0.1 to 0.8 percent of general surgery patients, 2 to 3 percent of patients undergoing elective hip replacement, and 4 to 7 percent of patients undergoing operative reduction of hip fracture.[14]

In a study of patients undergoing face lift surgery, Reinisch et al.[13] reported an incidence of thrombosis of 0.1 percent based on a survey of selected surgeons from the American Society of Plastic and Reconstructive Surgeons. In that study, 37 of 9493 face lift patients developed deep vein thrombosis (0.39 percent) and 15 patients developed pulmonary embolism (0.16 percent). Byrd et al.[2] reported no pulmonary emboli in their 5316 elective plastic surgery cases performed in an accredited outpatient plastic surgery facility.

Pneumothorax

Intraoperative pneumothorax has been reported as a complication in major surgical procedures about the chest wall when obtaining rib grafts, mobilizing chest muscle flaps, and performing chest wall reconstruction. In a re-

cent study, Osborn and Stevenson[15] surveyed 363 members of the California Society of Plastic Surgeons, requesting demographic data on each participant regarding the number of years that they were in practice and the number of breast operations performed per year. The remainder of the questions dealt with the incidence of pneumothorax encountered by surgeons when performing breast augmentation. Fifty percent of the surgeons responded (n = 181); their responses indicated that a total of 83 cases of pneumothorax had been encountered during breast augmentation in their practices.[15]

This study reports 19 cases of pneumothorax (Fig. 8). The incidence of pneumothorax was greatest for breast augmentation and augmentation-related procedures (n = 17). The other two cases of pneumothorax were diagnosed during an abdominoplasty and a breast reduction. In 17 patients, the pneumothorax was noted intraoperatively, and in two patients, it was diagnosed between postoperative days 1 and 4. Puncture of the pleura at the time of rib block occurred in seven patients, and an intraoperative pleural tear while cauterizing bleeders was the cause of pneumothorax for 11 patients. In one patient, pneumothorax was attributed to preexisting pulmonary blebs.

Osborn and Stevenson[15] discuss the potential for the occurrence of catamenial pneumothorax caused by endometrial implants on the lungs. They usually occur between 48 to 72 hours after the onset of menstruation and have been reported to account for 2.8 percent to 5.6 percent of all episodes of spontaneous pneumothorax in women.[15–21] There were no cases of catamenial pneumothorax reported in this study.

Twelve patients required chest tubes and were hospitalized. The average length of stay was 1.83 days (range, 1 to 7 days). The patient hospitalized for 7 days had bilateral pneumothorax with pulmonary edema that resolved. There were no deaths from pneumothorax in the 411,670 procedures performed.

Hyperthermia

Two cases of hyperthermia were reported. One case was managed with aspirin. The other case was a true malignant hyperthermia; the patient was managed with dantrolene sodium in the surgery center and transported to a hospital. The hospital stay lasted 1 day, and the patient was discharged without residual sequelae.

Deaths

In addition to the six deaths related to pulmonary embolism and the one death related to intraoperative hypoxia, another patient died on the first postoperative day, presumably from hypoxia related to sleep apnea. The patient was obese and had undergone a face lift. She died

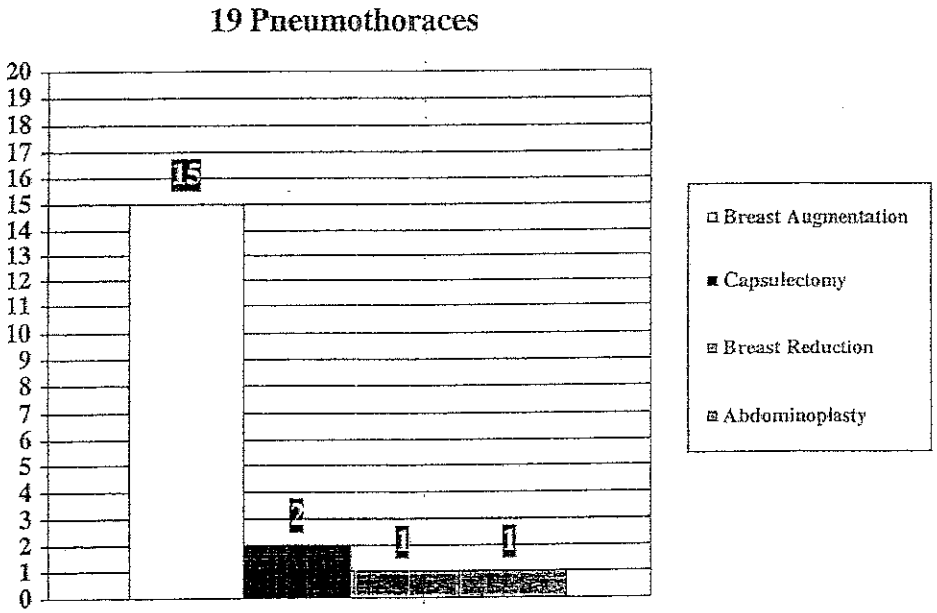

FIG. 8. Pneumothorax (n = 19).

in her sleep at home the evening after the operation.

The incidence of a patient dying after having an outpatient procedure was 0.002 percent, or one in 51,459 procedures. This compares favorably to the incidence in Morello et al.'s study,[8] which reported seven deaths in 400,675 procedures for an incidence of 0.0017 percent, or less than one in 57,000 procedures.

Discussion

Comparison of data obtained through voluntary and mandatory reporting programs demonstrates close correlation in overall incidence of unanticipated sequelae, their occurrence by type, and postoperative deaths. It is important to note that of the eight deaths reported through the Internet reporting program, only two occurred in the intraoperative or immediate postoperative period. Most of the deaths were secondary to the development of pulmonary embolism, which can occur as the result of any surgical procedure, whether it is performed in a multispecialty free-standing outpatient facility, an office-based outpatient facility, or a hospital.

All patients with unanticipated sequelae who required hospitalization as the result of bleeding or infection were managed and discharged from the hospital with the sequelae resolved.

The AAAASF standards for accreditation of a surgery center require all surgeons to be certified by an American Board of Medical Specialties surgical board and to have core credentials in a hospital for all procedures that they perform in their surgery centers. It may be assumed that the surgical technique for any given procedure performed by a certified surgeon would be the same whether the procedure is performed in a hospital or a surgery center. The low incidence of intraoperative sequelae in this report demonstrates conclusively the safety of operation of outpatient surgery centers that are accredited by a recognized accrediting organization and staffed by American Board of Medical Specialties board-certified surgeons.

Additional broad based studies are being designed to identify areas to improve the delivery of outpatient surgical care. The first Internet model for collecting data on outpatient surgical outcomes, designed by the AAAASF, has added a new dimension to monitoring and evaluating patient care. Its current use and expansion will provide the needed data for further analysis of surgical outcomes. It is important to note that the analysis of outcomes will be more meaningful when reviewed in conjunction with a surgery center's compliance with accepted standards for operation.[22–24]

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PUBLICATIONS AND PRESENTATIONS

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Margoles, S.L., Bookheimer, S., Sass, K., Novelly, R., Spencer, D., Partington, J., and J.Kim.:Prediction of hippocampal pathology from neuropsychological tests of memory. J. Clinic. Expt.Neuropsych, 10; p. 82, 1988.

Bookheimer, S., Margoles, S.L., Sass, K., Novelly, R., Spencer, D., Kim, J., Robbins, R., and J.Partington.: Absence of memory dysfunction in the presence of hippocampal pathology. J. Clinic.Expt. Neuropsych, 10; p. 83, 1988.

Rubin, J.P., Margoles, S.L., McKee, May,: Skeletal Muscle Flap Metabolism and Function Following Normothermic Ischemia. Presented at Plastic Surgery Research Council, May 1995, NYC.

Rubin, J.P., Margoles, S.L., McKee, May, J.: Skeletal Muscle Flap Metabolism and Function Following Normothermic Ischemia. Presented at Northeastern Society of Plastic Surgeons, Nov 1995, Boston, MA.

Butler, P.E. and S.L. Margoles Co-Investigators Sunlight and Smoking: A Study of their Cumulative Effects on the Aging of Human Skin Asthetic Society Grant, 1995.

Rubin, J.P., Margoles, S.L., McKee, May, J.: Skeletal Muscle Flap Metabolism and Function Following Normothermic Ischemia. Presented at Am Assoc Hand Surgery, January 1996, Palm Springs, CA.

Margoles, S.L. The Quantitative Dermal Effects of the CO2 Laser in Skin Resurfacing of Facial Wrinkles, Invited Faculty, ìInterdisciplinary Perspective on Facial Ageingî, presented at Vail, Colorodo, March, 1996.

Margoles, S.L. The MRI and Facial Ageing, Invited Faculty , iInterdisciplinary Perspective on Facial Ageingî, presented at Vail, Colorodo, March, 1996.

Margoles, S.L., Chowanski, Z., Randolph. M., Concannon, M., Birk, D.E., Lee, W.P.A., Neotendon Formation using Human Dermal Fibroblasts, Presented to Northeastern Society Meeting, Maine, May, 1996.

Margoles, S.L., Butler, P.E.M., Zimmerman, D., Randolph, M.A., Grevelink, J., Kochevar, I., Yaremcuk, M.J., Quantitative Comparison of the C02 Laser and Chemical Peel in Skin Resurfacing. Presented to Northeastern Society Meeting, Maine, May, 1996.

Margoles, S.L., Butler, P.E.M., Zimmerman, D., Randolph, M.A., Grevelink, J., Kochevar, I., Yaremcuk, M.J., Quantitative Comparison of the C02 Laser, Dermabrasion and Chemical Peel in Skin Resurfacing. Presented at Plastic Surgery Research Council, St. Louis, MO, June, 1996.

Margoles, S.L., Chowanski, Z., Randolph. M., Concannon, M., Birk, D.E., Lee, W.P.A., Neotendon Formation using Human Dermal Fibroblasts, Presented to Plastic Surgery Research Council, St. Louis, June, 1996.

Margoles, S.L Quantitative Comparison of the C02 Laser, Dermabrasion and Chemical Peel in Skin Resurfacing Investigator, Aesthetic Society Grant, 1996.

Margoles, S.L., Chowanski, Z., Randolph. M., Concannon, M., Birk, D.E., Lee, W.P.A., Neotendon Formation using Human Dermal Fibroblasts, Am. Society Surg. Hand, Sept., 1996.

Margoles, S.L., Butler, P.E.M., Zimmerman, D., Randolph, M.A., Grevelink, J., Kochevar, I., Yaremcuk, M.J., Quantitative Comparison of the C02 Laser, Dermabrasion and Chemical Peel in Skin Resurfacing, presented at New England Society, 1996

Chun, J.K., Sterry, T.P., Margoles, S.L., Silver, L.: Salvage of Ear Replantation Using the Temporoparietal Fascia Flap, accepted, Ann of Plastic Surgery, 1999

CURRICULUM VITAE

ELSA M. RASKIN, M.D.

Personal Information

Nationality:	Swiss- American
Phy. Condition:	Excellent, no disabilities
Marital status:	Married- Keith B. Raskin, M.D
Children:	Vanessa Brooke Alexis Paige Lucas Adam
Social Security Number	[redacted]
Home Address	230 Taconic Road Greenwich, Ct 06831
Office Address	21/2 Dearfield Drive Greenwich, Ct 06831 (203) 861-6620 317 East 34th Street, 3rd floor New York, NY 10016 (212) 889-8600
E-mail Address	ERASKINMD @ AOL.COM
Languages	English, French, Spanish, Portuguese

Postgraduate Training

Residency:	7/99- 6/01	Plastic and Reconstructive Surgery Cornell Medical Center New York Presbyterian Hospital New York, New York Lloyd Hoffman, MD-Director
Residency:	1/97 - 2/99	General Surgery New York University Medical Center/ Bellevue Hospital New York, New York Thomas Gouge, MD- Director
Residency:	1/96-12/96	Plastic and Reconstructive Surgery University of Pittsburgh Medical Center

		Pittsburgh, Pennsylvalnia J. William Futrell, MD-Director
Fellowship:	7/95 - 12/95	Oculoplastic and Reconstructive Surgery The Children's Hospital of Philadelphia University of Pennsylvania Philadelphia, Pennsylvania James A. Katowitz, MD-Director
Residency:	7/92 - 6/95	Ophthalmology The New York Eye and Ear Infirmary New York, New York Joseph Walsh, MD-Director
Fellowship:	7/91 - 6/92	Ophthalmic Pathology The New York Eye and Ear Infirmary New York, New York
Research Fellowship:	7/90-6/92	Fight for Sight Fellowship Recipient The New York Eye and Ear Infirmary New York, New York
Residency:	7/89 - 6/90	General Surgery New York University Medical Center/ Bellevue Hospital New York, New York Thomas Gouge, MD-Director
	10/87 - 9/88	General Surgery Hospital de Montreux Montreux, Switzerland

Education

Medical School:	10/80 - 9/ 86	Faculty of Medicine University of Geneva Geneva, Switzerland *Accelerated Program
Pre-Medical: Training	10/77 - 9/80	LeGymnase Cantonal de La Chaux-de-Fonds Neuchatel, Switzerland* B.S. Physics

Licensure and Certifications

9/14/02	Diplomate American Board of Plastic Surgery
9/30/05	State of Connecticut Licensure (#041001)
9/02	New Jersey Licensure (#25MA07471700)
6/96	DEA# BR 4467014
6/95	Commonwealth of Pennsylvania Licensure (#55265)
9/92	New-York State Licensure (# 190500)
2/89	FLEX Examination
5/88	Educational Commission for Foreign Medical Graduates
9/87	Swiss Confederation Diploma-Physician

Professional Affiliations:

American Society of Plastic Surgery, 2002 Member
North Eastern Association of Plastic Surgeons, 2002 Member
New York Regional Society of Plastic Surgeons, 2002 Member

Hospital Affiliations:

Greenwich Hospital, Greenwich CT
Lenox Hill Hospital, New York, NY
Manhattan Eye, Ear and Throat Hospital, New York, NY
Center for Specialty Care

Research Grants

Fight for Sight, the Research Division of the National Society to Prevent Blindness: Pathogenesis and Prophylaxis of Postoperative Endophthalmitis.

Publications (in peer-reviewed journals)

Molecular Biology of Circulatory Shock. Buchman TG, Cabin DE, Raskin EM, et al. Surgery; Sept. 1990, 559-566.

The Effect of Rigid Gas Permeable Contact Lens Wear on the Corneal Endothelium Post-Keratoplasty. Speaker MG, Cohen EJ, Edelhauser HF, Clemons CS, Arentsen JJ, Laibson PR, Raskin EM. Ophthalmology 1991; 109: 1703-1706.

A Case-Control Study of Risk Factors for Postoperative Endophthalmitis. Menikoff JA, Speaker MG, Raskin Ophthalmology 1991; 98: 1761-1768.

Blepharitis. Raskin EM, Speaker MG, Laibson PR. (1992) Infectious Disease Clinics of North America: Ocular Infections. J. Baum and M. Barza (ed) W. B. Saunders.

Polypropylene Haptics Increase Bacterial Adherence to Intraocular Lenses. Raskin EM, Speaker MG, McCormick, SA Wong DS, Menikoff JA. Pelton-Henrion K. Archives of Ophthalmology. 1993; 111:250-253.

Non-infectious Granulomatous Idiopathic Orbital Inflammation. Raskin EM, McCormick SA, Maher EA and Della Rocca RC. Ophthalmic Plastic and Reconstructive Surgery 1995; 11,2:131-135.

Reducing Eyelid Retraction Following Subperiosteal Facelift. Hurwitz DJ. Raskin EM. Aesthetic Surgery Journal.1997;17,3:149-156.

Prediction of Late Enophthalmos by Volumetric Analysis of Orbital Fractures. Raskin EM, Millman AL, Lubkin V, Della Rocca RC, Lisman RD, Maher EA. Ophthalmic Plastic and Reconstructive Surgery. 14:19,1998.

A Long Road. Raskin EM.
This Side of Doctoring; Reflections from Women in Medicine.
Eliza Lo Chin. Sage Publications, 2002.

"Why do we age in our cheeks?" Raskin, E.M. LaTrenta, G.S., Plastic and Reconstructive Surgery Journal. Aesthetic Surgery Journal.2007;27,1:19-28.

Presentations and Published Abstracts

Decentration and Tilting of Posterior Chamber Intraocular Lenses After Trans-scleral Suture Fixation. American Society for Cataract and Refractive Surgery, Boston, April, 1991.

Phenotypic and Genetic Evaluation of Pathogenic Staphylococci Causing Postoperative Endophthalmitis. Raskin EM, Menikoff JA, Speaker, MG, Kreiswirth, BN, Shah, MK. Association for Research in Vision and Ophthalmology, May, 1991.

Systemic Ciprofloxacin and Ceftriaxone in the Treatment of Postoperataive Endophthalmitis. Menikoff, JA, Raskin, EM, Speaker, MG. Association for Research in Vision and Ophthalmology, May 1991.

Decentration and Tilting of Posterior Chamber Intra-Ocular Lenses After Trans-Scleral Suture Fixation. Speaker, MG, Raskin, EM, Menikoff, JA. Association for Research in Vision and Ophthalmology, May, 1991.

Phenotypic and Genetic Evaluation of Pathogenic Staphylococci Causing Postoperataive Endophthalmitis. Raskin, EM, Menikoff, JA, Speaker, MG, Kreiswirth, BN, Shah, MK. Ocular Microbiology and Immunology Group, Anaheim, CA., October 12, 1991.

Decentration and Tilting of Posterior Chamber Intra-Ocular Lenses After Trans-Scleral Suture Fixation. Speaker, MG, Raskin, EM, Menikoff, JA. Castroviejo Society, Anaheim, CA., October 12, 1991.

Polypropylene Haptics Increase Bacterial Adherence to Intraocular Lenses. Raskin EM, Speaker MG, Pelton-Henrion V, Shah MK, Wong DS McCormick, SA. Association for Research in Vision and Ophthalmology, May, 1992.

Orbital Traumatic Neuroma: Pathologic and Tissue Culture Observations of an Under-Recognized Clinico-pathologic Entity. McCormick SA, Maher EA, Hu DN, Della Rocca RC, Millman AL, Raskin EM. Association for Research in Vision and Ophthalmology, May, 1992.

A Microbial Evaluation of Pre-Operative Prophylaxis with Topical Ciprofloxacin and Povidine-Iodine. Raskin EM, Speaker MG, Shah MK, Mermelstein JM, Preschel N, McCormick SA. American Academy of Ophthalmology, Dallas, Tx, November, 1992.

Non-infectious Granulomatous Idiopathic Orbital Inflammation ("Inflammatory Pseudotumor"): Analysis of Five Patients.Raskin EM, McCormick SA, Maher EA and Della Rocca RC. Association for Research in Vision and Ophthalmology, May, 1993.

Microbiologic Evaluation of Pre-Operative Prophylaxis And Bacterial Contamination of Intraocular Fluids. Preschel N, Speaker MG, Raskin EM, McCormick SA, Shah MK, and Mermelstein JR. Association for Research in Vision and Ophthalmology, May, 1993.

Non-infectious Granulomatous Idiopathic Orbital Inflammation ("Inflammatory Pseudotumor"): Analysis of Five Patients. Raskin EM, McCormick SA, Maher EA and Della Rocca RC. American Society of Ophthalmic Plastic and Reconstructive Surgery, Chicago, IL, November 1993.

Early Surgical Intervention for Orbital Cellulitis. Maher EA, Weiner, MH, Raskin EM and Della Rocca RC. American Society of Ophthalmic Plastic and Reconstructive Surgery, Chicago, IL, November 1993.

Volumetric Analysis of Enophthalmos in Orbital Fractures
Elsa M. Raskin, Arthur L. Millman, V. Lubkin,
Robert C. Della Rocca, Richard D. Lisman, Elizabeth A.
Maher, American Academy of Ophthalmology, San Francisco, CA,
November, 1994.

Orbital Anatomy. Elsa M Raskin. Scheie Eye Institute. Annual Board Review Course. Philadelphia, PA, September, 1995.

Enucleation, Evisceration and Socket Reconstruction. Elsa M Raskin. Scheie Eye Institute. Annual Board Review Course. Philadelphia, PA, November, 1995.

Lacrimal Problems in the Pediatric Age Group. James A. Katowitz, Katrinka Heher, Elsa M.Raskin. Course, American Academy of Ophthalmology, Atlanta, GA,November, 1995.

Orbital Decompression in Thyroid Related Ophthalmopathy.
Elsa M.Raskin. Plastic Surgery Grand Rounds. Pittsburgh, PA.
February, 1996.

Prediction of Late Enophthalmos by Volumetric Analysis of Orbital Fractures. Elsa M. Raskin, Arthur L. Millman. Ivy Society Annual Meeting. Pittsburgh, PA, March, 1996.

Prevention of Post-Operative Lower Lid Retraction in the Deep Plane Face Lift - A Series of Fifty Patients" Elsa M. Raskin Dennis J. Hurwitz. Ohio Society. Cleveland, OH, June, 1996.

Periocular Reconstruction. Elsa M.Raskin. Plastic Surgery Grand Rounds. Pittsburgh, PA. June, 1996.

Orbital Fractures. Elsa M. Raskin. Plastic Surgery Grand Rounds. Pittsburgh, PA. August, 1996.

Vascularized Cranial Bone Grafts. Elsa M. Raskin. Plastic Surgery Grand Rounds. Pittsburgh, PA. September, 1996.

Reducing Eyelid Retraction Following Subperiosteal Facelift. Dennis J. Hurwitz, Elsa M. Raskin. The American Society for Aesthetic Plastic Surgery. New York, NY. May, 1997.

Surgical Flaps. Elsa M. Raskin. Plastic Surgery Grand Rounds. New York Presbyterian Hospital, NY. November 1999.

Breast Reduction and Mastopexy. Elsa M. Raskin. Plastic Surgery Grand Rounds. New York Presbyterian Hospital, NY.May 2000.

Periorbital Reconstruction. Elsa M. Raskin. Plastic Surgery Grand Rounds. New York Presbyterian Hospital, NY.January 2001.

Fat distribution within the layers of the human face: A cadaveric study. Elsa M. Raskin, Gregory S. LaTrenta, Lloyd Hoffman. Senior Residents Conference. Providence, Rhodes Island, March 2001.

Fat distribution within the layers of the human face: A cadaveric study. Elsa M. Raskin, Gregory S. LaTrenta, Lloyd Hoffman. ASAPS. New York, NY, May 2001.

"Why do we age in our cheeks?" Gregory S. LaTrenta, Elsa M. Raskin. ASAPS, Las Vegas, April 2002.

PSEF in service writing questions task force. Philadelphia, May 21st 2004.

"Why do we age in our cheeks?" Gregory S. LaTrenta, Elsa M. Raskin. Submitted to PRS, October 2004.

PSEF in service writing questions task force. Philadelphia, May 6th[t] 2005.

PSEF in service writing questions task force. Philadelphia, May 5th[t] 2006.

PSEF in service writing questions task force. Philadelphia,June 15, 2007.

PSEF in service writing questions task force. Philadelphia, May 9, 2008.

PSEF in service writing questions task force. Philadelphia, May 29, 2009.

PSEF in service writing questions task force. Philadelphia,June 4, 2010.

Christine N. Zarb
60 Wilton Crest
Wilton, CT 06897
Cell Phone (917) 859-4936
Email: czarbo@optonline.net

VISITING NURSE SERVICE OF NEW YORK
Nurse consultant, VNS Choice – Medicaid Managed Long Term Care Program – 1997-2001

NEW YORK UNIVERSITY MEDICAL CENTER – TISCH HOPITAL
Staff Nurse – 1996-1997

AC&R ADVERTISING
Senior Media Planner – 1992-1994

BOZELL WORLDWIDE ADVERTISING
Media Planner – 1989-1992

EDUCATION

MASTER OF PUBLIC HEALTH – 2002
Columbia University School of Public Health

MASTER OF SCIENCE, GERIATRIC/ADULT NURSE PRACTITIONER – 2001
Columbia University School of Nursing

BACCALAUREATE OF NURSING SCIENCE - 1996
New York University School of Education

BACHELOR OF BUSINESS ADMINISTRATION - 1989
Hofstra University School of Business

LICENSING & PROFESSIONAL ASSOCIATIONS

- Connecticut, New York and Florida APRN Licenses
- American Nurses Credentialing Center Board Certified for Adult and Gerontology NP
- Member of the American Academy of Nurse Practitioners.
- Member of Dermatology Nurses Association

LASER EXPERIENCE

- Candela Gentlelase
- Cutera Xeo Platform with Coolglide, Limelight, Titan XL, Pearl Fractional
- Sciton 1064
- Palomar Starlux
- Lumenis Quantum IPL
- Completed Laser and Light Technologies 16 hour course in theory, operation and regulation of lasers and pulsed light devices December 2005

Christine N. Zarb
60 Wilton Crest
Wilton, CT 06897
Cell Phone (917) 859-4936
Email: czarbo@optonline.net

PROFESSIONAL EXPERIENCE

ELSA RASKIN, MD (PRIVATE PRACTICE)
Plastic and Cosmetic Surgery
Independent Contractor – 2012-present

- Provide cosmetic medical services including Laser Hair Reduction, Photofacials, and injectables.

LONG RIDGE DERMATOLOGY
Nurse Practitioner – 2007-2012

- Provide cosmetic dermatology services including Botox, Dysport, Dermal fillers, Sculptra, Chemical Peels, Microdermabrasion, Laser Hair Reduction, IPL, Fraxel, Titan, Pearl Fractional.
- Provide medical services including diagnosis and treatment of various skin conditions, cancer screening, biopsies, photodynamic therapy.
- Preceptored an FNP Student.
- Trained Medical Assistants on Laser treatments and safety

KLINGER ADVANCED AESTHETICS
Cosmetic Nurse Practitioner Consultant – 2005-2007

- Completed an 11-week intensive training program on cosmetic services developed by Johns Hopkins School of Medicine.
- Set up a new office for a start-up medical spa in Manhasset, NY.
- Provided Botox Cosmetic, dermal fillers, photorejuvenation, laser hair reduction, and chemical peels.
- Developed and delivered medical in-service seminars on cosmetic procedures and acne management for spa staff.

SKINKLINIC
Nurse Practitioner – 2004-2005

- Provided skin consultations to identify client goals for healthier skin.
- Administered cosmetic dermatology services including Botox Cosmetic and dermal fillers, chemical peels, microdermabrasion, IPL, and laser hair reduction.

NORTHERN WESTCHESTER HOSPITAL CENTER
Geriatric Nurse Practitioner – Community Outreach –2002-2004

- Collaborated with physicians to provide care to geriatric patients with complex case loads to improve quality of care and decrease length of stay.
- Corresponded with area nursing homes to enhance relationships, streamline referral process, and provide staff education.
- Participated in staff education and orientation.
- Developed a 12-bed Geriatric Unit to provide specialized care to frail elderly patients.

EVERCARE
Nurse Practitioner- Medicare Managed Care Program – 2001-2002

- Delivered on-going medical care for nursing home residents.
- Managed chronic and sub-acute conditions in the nursing home setting.
- Assessed the medical necessity and appropriateness of ancillary services and interfaced directly with the provider and case managers.

WALTER LAMPETER CSA, RNFA, CST

4 Lewis Street Apartment C, Greenwich, CT 06830 ● (917) 837-9908

PROFESSIONAL EXPERIENCE:

Surgical Assistant December 2009 - Present
Greenwich Hospital – Yale New Haven Health, Connecticut
Supervisor: Steven Fern, M.D. – Attending Surgeon

Surgical Assistant January 2004 – Present
Lenox Hill / Manhattan Eye Ear & Throat Hospital, New York
Supervisor: Sherrell Aston, M.D. – Chairman of Plastic Surgery

Surgical Assistant October 2000 – Present
Walter Lampeter CSA, RNFA, New York / Connecticut
Private Practice

Surgical Technologist July 2001 – December 2003
Manhattan Eye Ear & Throat Hospital, New York
Supervisor: Peggy Rivers, ADN – Surgical Services

Surgical Assistant February 1998 – September 2000
Andrew Kornstein, M.D., F.A.C.S. Plastic Surgery, New York
Supervisor: Andrew Kornstein, M.D. – Medical Director

RN First Assistant Intern September 1997 – December 1997
North Shore University Hospital at Glen Cove, New York
Supervisor: Michael Grieco, M.D. – Chief of Surgery

CREDENTIALS:

Certified Surgical Assistant **(CSA)**
Registered Nurse First Assistant **(RNFA)**
Certified Surgical Technologist **(CST)**
Licensed Cosmetologist

AFFILIATIONS:

American College of Surgeons - Affiliate Member
National Surgical Assistant Association
Board of Directors / Educational Liaison

PUBLICATIONS:

Technical Editor - Aston, S.J., Steinbrech, D.S., Walden, J.L. eds, ***Aesthetic Plastic Surgery***. London: Elsevier, 2009.

Walden, J.L., Lampeter, W. **Hyaluronic Acid Injectable Filler**. In Aston, S.J., Steinbrech, D.S., Walden, J.L. eds, ***Aesthetic Plastic Surgery***. London: Elsevier, 2009, pp. 865-874.

Variability of Educational Standards in Surgical Assisting: "Selecting Your Program Wisely", *CSA Node*, Volume 26 Number 2, 2009.

Adjuvant Therapies in Reconstructive Surgery, *CSA Node*, Volume 25 Number 1, 2008.

EDUCATION:

Delaware County Community College Media, Pennsylvania
January 1997 – December 1997
Certificate: RN First Assistant

Nassau Community College Garden City, New York
September 1992 – May 1994
Degree: Associate of Science – Nursing

Queens College – City University of New York
September 1981 – June 1986
Degree: Bachelor of Arts – Communications

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

August 16, 2012

To Whom It May Concern:

This is to certify that Sandra Margoles, M.D. has been a member of the Greenwich Hospital Medical Staff in the Department of Surgery, Section of Plastic Surgery since September 28, 1999.

She is a member of the Active Attending Staff has operating and admitting privileges and is in good standing. In the event of emergency, Dr. Margoles may transfer patients to Greenwich Hospital from her office.

Sincerely,

Brian J. Doran, M.D.
Senior Vice President, Medical Services &
Chief Medical Officer

5 Perryridge Road
Greenwich, CT 06830-4697
(203) 863-3000

SECRETARY OF THE STATE
30 TRINITY STREET
P.O. BOX 150470
HARTFORD, CT 06115-0470

JULY 1,2010

CSC THE UNITED STATES CORPORATION
59 DOGWOOD ROAD
WETHERSFIELD, CT 06109

RE: Acceptance of Business Filing

This letter is to confirm the acceptance of a filing for the following business:

GREENWICH SMARTLIPO LLP

Work Order Number: 20101632 38-001
Business Filing Number: 0004191290
Type of Request: CERTIFICATE OF LIMITED LIABILITY PARTNERSHIP
File Date/Time: JUL 01 2010 12:06 PM
Effective Date/Time:
Work Order Payment Received: 1070.00
Payment Received: 170.00

Business Id: 1008957

PATRICIA SHANAHAN
Commercial Recording Division
860-509-6037
WWW.CONCORD.SOTS.CT.GOV

BUSINESS FILING REPORT

WORK ORDER NUMBER:2010163238-001
BUSINESS FILING NUMBER: 0004191290

BUSINESS NAME:

GREENWICH SMARTLIPO LLP

BUSINESS LOCATION:

2 1/2 DEARFIELD DRIVE, SUITE 102
GREENWICH,CT 06831

** END OF REPORT **

SECRETARY OF THE STATE
30 TRINITY STREET
P.O. BOX 150470
HARTFORD, CT 06115-0470

JULY 1,2010

CSC THE UNITED STATES CORPORATION
59 DOGWOOD ROAD
WETHERSFIELD, CT 06109

RE: Acceptance of Business Filing

This letter is to confirm the acceptance of a filing for the following business:

GREENWICH SMARTLIPO LLP

Work Order Number: 2010163238-001
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Type of Request: CERTIFICATE OF LIMITED LIABILITY PARTNERSHIP
File Date/Time: JUL 01 2010 12:06 PM
Effective Date/Time:
Work Order Payment Received: 1070.00
Payment Received: 170.00

Business Id: 1008957

PATRICIA SHAMAHAN
Commercial Recording Division
860-509-6037
WWW.CONCORD.SOTS.CT.GOV

BUSINESS FILING REPORT

WORK ORDER NUMBER:2010163238-001
BUSINESS FILING NUMBER: 0004191290

BUSINESS NAME:

GREENWICH SMARTLIPO LLP

BUSINESS LOCATION:

2 1/2 DEARFIELD DRIVE, SUITE 102
GREENWICH,CT 06831

** END OF REPORT **

PARTNERSHIP AGREEMENT FOR
GREENWICH SMARTLIPO LLP

a Connecticut Limited Liability Partnership

This PARTNERSHIP AGREEMENT (together with the schedules and exhibits attached hereto, the "Agreement"), dated as of _____, 2010, by and among Greenwich Smartlipo LLP (the "Company"), and each of the undersigned members (individually, a "Member," and collectively, the "Members"). Capitalized terms used in this Agreement and not otherwise defined shall have the meanings ascribed to such terms in Article I.

Preliminary Statement

WHEREAS, the Company was formed as a limited liability partnership under the laws of the State of Connecticut by the filing of its Certificate of Limited Liability Partnership on July 1, 2010, (as amended, modified, restated or supplemented from time to time, the "Articles") with the Secretary of State of the State of Connecticut, and the Members hereby adopt and ratify the Articles and all acts taken by the sole organizer in connection therewith; and

WHEREAS, the parties hereto wish to set forth their respective rights and obligations to and among each other with respect to the operation of the Company.

NOW, THEREFORE, for and in consideration of the mutual covenants set forth herein and for other good and valuable consideration, the adequacy, receipt and sufficiency of which is hereby acknowledged, the parties hereto hereby agree as follows.

ARTICLE I
DEFINITIONS

As used in this Agreement, the following terms shall have the meanings set forth below:

"AAA" has the meaning ascribed to such term in Section 15.17.

"Act" means the Connecticut Uniform Partnership Act, as amended from time to time (or any corresponding provisions of succeeding law).

"Affiliate" of a Person means any other Person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with such Person.

"Agreement" means this Partnership Agreement of the Company, as hereafter amended, modified, restated or supplemented from time to time, and the terms "hereof," "hereto," "hereby," and "hereunder," when used with reference to this Agreement, refer to this Agreement as a whole, unless the context otherwise requires.

"Articles" has the meaning ascribed to such term in the preamble to this Agreement.

"Bankrupt" or "Bankruptcy" means: (i) the entry of a decree or order for relief against a Member by a court of competent jurisdiction in any involuntary case brought against the Member under any bankruptcy, insolvency or other similar law (collectively, "Debtor Relief Laws") generally affecting the rights of creditors and relief of debtors now or hereafter in effect; (ii) the appointment of a receiver, liquidator, assignee, custodian, trustee, sequestrator or other similar agent under applicable Debtor Relief Laws for the Member or for any substantial part of such Member's assets or property; (iii) the ordering of the winding up or liquidation of the Member; (iv) the filing of a petition in an involuntary bankruptcy case, which petition remains undismissed or suspended for a period of sixty (60) days or for which is not dismissed or suspended pursuant to Section 305 of the Federal Bankruptcy Code (or any corresponding provision of any future United States bankruptcy law); (v) the commencement by the Member of a voluntary case under any applicable Debtor Relief Law now or hereafter in effect; (vi) the consent by the Member to the entry of an order for relief in an involuntary case under any such law or to the appointment of or the taking of possession by a receiver, liquidator, assignee, trustee, custodian, sequestrator or other similar agent under any applicable Debtor Relief Laws for the Member or for any substantial part of such Member's assets or property; or (vii) the making by a Member of any assignment for the benefit of such Member's creditors.

"Capital Account" means, with respect to any Member, the capital account which the Company establishes and maintains for such Member pursuant to Section 3.4.

"Capital Contribution" means the total value of cash and fair market value of property, services or other consideration contributed to the Company by Members as reflected on Schedule A hereto.

"Code" means the Internal Revenue Code of 1986, as amended from time to time, the provisions of succeeding law, and to the extent applicable, the Regulations.

"Company" has the meaning ascribed to such term in the preamble to this Agreement.

"Company Minimum Gain" has the meaning ascribed to the term "Partnership Minimum Gain" in the Regulations Section 1.704-2(d).

"Confidential Information" means any information, whether oral, written or otherwise, concerning or relating to the Company, that is not generally known to the public and that constitutes confidential or proprietary information or trade secrets, including, without limiting the generality of the foregoing: information regarding the Company's business, intellectual property, products, designs, manufacturing arrangements, processes, financing, financial information, projections and forecasts, market plans, expansion plans, personnel related plans, systems, methods of operation, sales and marketing information and methods, revenues, costs, expenses, operating data, contracts, plans, prospects, records and similar data, mailing lists, vendor/vendee information, customer information, and promotional information. The term "Confidential Information" does not include any information which: (a) is or becomes available to the public other than by disclosure by the party receiving such Confidential Information or his, her or its representatives in violation of this Agreement; (b) was demonstrably known to the party receiving such Confidential Information previously with no obligation to hold it in

confidence; (c) is independently developed by the party receiving such Confidential Information without recourse to the Confidential Information; or (d) is approved for release by written authorization of the Company, but only to the extent and subject to such conditions as may be imposed in such written authorization.

"Covered Person" and "Covered Persons" have the meanings ascribed to such terms in Section 11.1.

"Disability" means a physical or mental impairment continuing for a consecutive period of six (6) months that substantially limits a Member's ability to engage in the business of the Company.

"Disputes" has the meaning ascribed to such term in Section 15.17.

"Distributable Cash" means the amount of cash which the Managers deem available for distribution to the Members, taking into account (i) payment of all Company debts, liabilities, expenses and obligations then incurred, including debts, liabilities, expenses, fees, guaranteed payments and obligations to the Members, and (ii) amounts which the Managers, in their sole and absolute discretion, deems necessary for reserves for the Company's future needs, but excluding Net Sale Proceeds (which shall be distributed in accordance with Section 10.5).

"Fiscal Year" means the Company's fiscal year, which shall be the calendar year.

"Indemnified Person" and "Indemnified Persons" have the meanings ascribed to such terms in Section 11.2.

"Managers" means the individuals selected to manage the affairs of the Company as provided under Article V.

"Margoles" means Sandra Margoles.

"Member" means each Person who (a) is an initial signatory to this Agreement, has been admitted to the Company as a Member in accordance with the Articles or this Agreement or is an assignee who has become a Member in accordance with Article VII, and (b) has not resigned, withdrawn, been expelled or, if other than an individual, dissolved.

"Member Nonrecourse Debt" has the meaning ascribed to the term "Partner Nonrecourse Debt" in Regulations Section 1.704-2(b)(4).

"Member Nonrecourse Deductions" means items of the Company loss, deduction, or Code Section 705(a)(2)(B) expenditures which are attributable to Member Nonrecourse Debt.

"Membership Interest" and "Membership Interests" have the meaning ascribed to such term in Section 3.2.

"Member Material" has the meaning ascribed to such term in Section 14.2.

"MSF" has the meaning ascribed to such term in Section 15.1.

"Net Profits" and "Net Losses" means the income, gain, loss, deductions, and credits of the Company in the aggregate or separately stated, as appropriate, under the method of accounting at the close of each fiscal year on the Company's information tax return filed for federal income tax purposes. Net Profits and Net Losses are to be allocated as provided in Article VI.

"Net Sale Proceeds" means the net proceeds of sale (after payments of all expenses attributable thereto) of all or substantially all of the Company's assets.

"Percentage Interest" has the meaning ascribed to such term in Section 3.2.

"Permitted Transferee" means, with respect to any Member, any one of the following Persons who may receive Units Transferred pursuant to this Agreement: (a) a spouse, child, step child, descendants or the lineal ancestors of such Member or such Member's spouse; (b) the custodian, executor, heirs, receiver, liquidator or trustee of any Member or such Member's estate upon (i) the death of such Member for purposes of administration of such Member's estate, or (ii) upon the incompetence of such Member for purposes of the protection and management of such Member's assets; (c) a family limited partnership or limited liability company in which all interests are held by the Member, the Member's spouse, and/or the lineal ancestors, step children, siblings, nieces, nephews or descendants of such Member or such Member's spouse; provided, that control of such partnership or limited liability company by virtue of voting power resides with such Member, his spouse, or a combination of both; (d) a trust, all of the beneficiaries of which are a Member, the Member's spouse and/or the lineal ancestors, step children, siblings, nieces, nephews or descendants of such Member or such Member's spouse; provided, that control of such partnership or limited liability company by virtue of voting power resides with such Member, his spouse, or a combination of both; (e) a limited liability company or other entity provided that the majority interest in such entity is and continues to be owned or controlled by the Member; or (f) with respect to any Member that is a trust, all of the beneficiaries of such trust, and the spouse, children, step children, descendants or the lineal ancestors of such beneficiaries. In each case, the Permitted Transferee shall take such Units subject to, and otherwise be bound by, the provisions of this Agreement.

"Person" means an individual, general partnership, limited partnership, limited liability company, corporation, trust, estate, real estate investment trust, association or any other entity.

"Purchase Price" has the meaning ascribed to such term in Section 3.5.

"Raskin" means Elsa Raskin.

"Regulations" means, unless the context clearly indicates otherwise, the regulations currently in force as final or temporary that have been issued by the U.S. Department of Treasury pursuant to its authority under the Code.

"Securities Act" means the Securities Act of 1933, as amended.

"Tax Distribution" has the meaning ascribed to such term in Section 6.4.

"Transfer" has the meaning ascribed to such term in Section 7.1.

"Unit" shall have the meaning ascribed to such term in Section 3.2.

"Unreturned Capital Contributions Account" means, with respect to any Member that has made a Capital Contribution in accordance with Section 3.1 consisting of cash or other immediately available funds, a bookkeeping account which shall at all times be equal to the Capital Contributions, if any, made by such Member in accordance with Section 3.1, reduced by the distributions, if any, made to such Member pursuant to Section 6.5(i).

ARTICLE II
ORGANIZATIONAL MATTERS

2.1 Formation. Pursuant to the Act, the Managers have formed a limited liability partnership under the laws of the State of Connecticut by filing the Articles with the Secretary of State of the State of Connecticut and entering into this Agreement. The rights and liabilities of the Members shall be determined pursuant to the Act and this Agreement. To the extent that the rights or obligations of any Member are different by reason of any provision of this Agreement than they would be in the absence of such provision, this Agreement shall, to the extent permitted by the Act, control.

2.2 Name. The name of the Company is "Greenwich Smartlipo LLP." The business of the Company may be conducted under that name or, upon compliance with applicable laws, any other name that the Managers deem appropriate or advisable. The Managers shall cause to be filed any fictitious name certificates and similar filings, and any amendments thereto, that the Managers considers appropriate or advisable.

2.3 Term. The term of the Company commenced on the filing of the Articles with the Secretary of State of the State of Connecticut and shall continue in existence in perpetuity until the Company shall be sooner dissolved and its affairs wound up in accordance with the Act or this Agreement. The Managers are hereby authorized to execute and file such documents as the Managers determine are necessary or appropriate, including an amendment to the Articles, to effectuate the foregoing.

2.4 Purpose of Company. The purpose and business of the Company shall be to engage in a medical practice or any lawful act or activity for which a limited liability partnership may be organized under the Act. The Company shall be permitted to engage in any lawful activities in furtherance of the foregoing as may be necessary, desirable, expedient, convenient or incidental to carry out the purpose and business of the Company and for the protection and benefit of the Company.

2.5 Office and Agent. The Company shall continuously maintain a registered agent

in the State of Connecticut. The principal office of the Company shall be at 2 ½ Dearfield Drive, Suite 102, Greenwich, Connecticut 06831 or at such other location as the Managers may determine. The Company also may have such offices as the Managers from time to time may determine, or the business of the Company may require. The registered agent shall be as stated in the Articles or as otherwise determined by the Managers. The Managers shall cause the Company to be qualified to do business in all jurisdictions where the Company is required to so qualify.

2.6 Addresses of the Members. The respective addresses of the Members for notice purposes are set forth on Schedule A. The address for any Member shall be changed upon the request of such Member, and, upon such request, the Managers shall update Schedule A accordingly.

2.7 Reservation of Other Business Opportunities. Subject to any other agreement between a Member and the Company, no business opportunities other than those actually exploited by the Company shall be deemed to be the property of the Company, and any Member (or Manager) may, subject to the express terms hereof, engage in or possess an interest in any other business venture (including those which may be competitive with the Company), independently or with others of any nature and description, and neither any other Member nor the Company shall have any rights by virtue hereof in and to such other business ventures, or to the income or profits derived therefrom.

ARTICLE III
CAPITAL CONTRIBUTIONS AND CAPITAL STRUCTURE

3.1 Capital Contributions. The Capital Contribution of each Member is as set forth on Schedule A. Schedule A shall be revised by the Managers to reflect any additional contributions or other changes in the membership of the Company. Members shall not be entitled to a return of their Capital Contribution or to receive any interest on such Capital Contributions except as otherwise expressly set forth herein. A Member shall not be entitled to withdraw any part of such Member's Capital Account or to receive any distributions from the Company, except as specifically provided in this Agreement.

3.2 Units; Membership Interest; Percentage Interest. Each Member's interest in the Company, including, without limitation, (a) the right of a Member to receive distributions of revenues, allocations of income and loss and distributions of liquidation proceeds under this Agreement, and (b) any management rights, voting rights, rights to consent, and the right to information concerning the business and affairs of the Company, as provided in this Agreement and under the Act are referred to herein individually as a "Membership Interest," and collectively as "Membership Interests." Each Member's Membership Interest shall be represented by units of limited liability company interest (each, a "Unit"). The ownership by a Member of Units shall entitle such Member to allocations of Net Profits and Net Losses and other items and distributions of cash and other property as set forth in this Agreement. The Company shall have one class of Units and is authorized to issue an unlimited number of Units. Units shall be issued in non-certificate form. The percentage of each Member's Membership Interest at any time shall be determined by dividing the number of Units owned by such Member at such time by the total

number of Units then issued and outstanding, and shall be referred to as a Member's "Percentage Interest." The number of Units held by each Member and the Percentage Interest of each Member shall be as set forth on Schedule A, which shall be amended from time to time by the Managers as required to reflect the issuance of additional Units, the reduction in any Member's Units, the Transfer or redemption of Units, the applicable Percentage Interests of the Members, and the addition or withdrawal of Members.

3.3 Additional Capital Contributions. No Member shall be required to make any additional Capital Contribution to the Company.

3.4 Capital Accounts. The Company shall establish an individual Capital Account for each Member. The Company shall determine and maintain each Capital Account in accordance with Regulations Section 1.704-(1)(b)(2)(iv). If a Member transfers all or a part of such Member's Units in accordance with this Agreement, such Member's Capital Account attributable to the transferred Units shall carry over to the new owner of such Units pursuant to Regulations Section 1.704-1(b)(2)(iv)(1).

3.6 Dilution. In the event that the Company issues additional Units to an existing Member or Members, or admits an additional Member or Members, then the respective Percentage Interest of each Member who does not participate in her pro rata amount of any such issuance shall be diluted by the issuance of such additional Units, and Schedule A shall be amended by the Managers accordingly.

ARTICLE IV
MEMBERS

4.1 Limited Liability. Except as required under the Act or as expressly set forth in this Agreement, no Member or Manager shall be personally liable for any debt, obligation, or liability of the Company, whether that liability or obligation arises in contract, tort, or otherwise by reason of being a Member.

4.2 Admission of Additional Members. The issuance of additional Units and/or the admittance of additional Members, for such consideration (including services) and on such terms and conditions as shall be determined by the Managers, shall be permitted upon the election of the Managers. Any such additional Member or Members shall obtain Units and will participate in the management, Net Profits, Net Losses, and Distributable Cash of the Company as determined by the Managers.

4.3 Power to Bind the Company. No Member (other than a Manager) shall have any authority to bind the Company with respect to any matter except pursuant to a resolution expressly authorizing such action, which resolution is duly adopted by the Managers.

4.4 Meetings of and Voting by Members. No annual or regular meetings of the Members shall be required. A meeting of the Members may be called at any time by any Manager or Members holding a Percentage Interest equal to or greater than twenty-five percent (25%). Meetings of Members shall be held at the Company's principal place of business or at

any other place within the State of Connecticut selected by the Manager or the Members calling the meeting. Not less than five (5) nor more than thirty (30) days before each meeting, the Person calling the meeting shall give written notice of the meeting to each Member entitled to vote at the meeting. The notice shall state the place, date, hour, and purpose of the meeting. Notwithstanding the foregoing provisions, each Member who is entitled to notice waives notice if before or after the meeting the Member signs a waiver of the notice which is filed with the records of Members' meetings, or is present at the meeting in person or by proxy without objecting to the lack of notice. Unless this Agreement provides otherwise, at a meeting of Members, the presence in person or by proxy of Members holding at least a majority of the Units constitutes a quorum. A Member may vote either in person or by written proxy signed by the Member or by the Member's duly authorized attorney in fact. A Member may also participate in any meeting telephonically so long as all Members can hear each other at the same time. Any action that may be taken at a meeting of Members may be taken without a meeting, if a consent in writing setting forth the action so taken, is signed and delivered to the Company by Members having not less than the minimum number of votes that would be necessary to authorize or take that action at a meeting at which all Members entitled to vote on that action at a meeting were present and voted. All such consents shall be filed with the Company and, in any event, shall be maintained in the Company records. If an action is authorized by written consent, no meeting of the Members need be called or notice be given. A copy of any action taken by written consent shall be sent promptly to all Members.

4.5 Member Loans. In the event that the Managers determine in good faith that the Company requires additional funds, the Managers may, or may permit the Members to, lend funds to the Company at interest rates and upon such other terms as determined by the Managers. Unless otherwise determined by the Managers, any such Manager or Member loans shall be repaid by the Company on a pari passu basis prior to the distribution of Distributable Cash. Loans by a Member to the Company shall not be considered Capital Contributions.

ARTICLE
MANAGEMENT AND CONTROL OF THE COMPANY

5.1 Management of the Company by the Managers. Subject to the express limitations set forth herein, the right to manage, control and conduct the business and affairs of the Company and to take any and all actions on behalf of the Company shall be vested exclusively in the Managers, who shall manage the Company solely in their capacity as the Managers of the Company, and who shall jointly have all necessary powers to manage and carry out the purposes, business, property and affairs of the Company, including, without limitation, the power to exercise on behalf and in the name of the Company all of the powers described in the Act. There shall initially be two (2) Managers. The Members hereby designate Raskin and Margoles as the Managers, and should either Raskin or Margoles resign, become Bankrupt (in which event such Manager shall be deemed to have resigned as a Manager) or is otherwise unable to serve as a Manager, the number of Managers shall be one and the other of Raskin and Margoles shall be the sole Manager, with all of the rights and powers of the Managers, and all references in this Agreement to Managers shall be deemed amended to reflect that there is only one Manager. A Manager is not required to be a Member of the Company. Any action, approval, or determination taken or made on behalf of the Company shall require the unanimous vote or written consent of

the Managers. Subject to such vote or consent, each Manager shall have full and complete authority, power and discretion to manage and control the business, property and affairs of the Company, to make all decisions regarding those matters and to perform any and all other acts or activities customary or incident to the management of the Company's business, property and affairs. Decisions made by the Managers in accordance with the terms and conditions of this Agreement may be implemented through any Person selected by the Managers.

5.2 Powers of the Managers. Subject to the express limitations set forth herein, the Managers shall have all necessary powers to manage and carry out the purposes, business, property, and affairs of the Company, including, without limitation, the power to exercise on behalf and in the name of the Company all of the powers described in the Act. Without in any way limiting the foregoing, or the provisions of Section 5.1, the Managers shall have the authority, without the need to obtain the consent of any Member, to: (i) consummate any sale, reorganization, merger or consolidation of the Company with or into any other Person or any other business combination; (ii) sell all or any portion of the assets of the Company; (iii) acquire all or substantially all or any of the assets or equity of any other company or business; (iv) incur indebtedness; (v) grant a lien on any of the Company's assets; (vi) issue additional Units (or options or rights to acquire Units) to new or existing Members and admit additional Members; and (vii) file a petition for the voluntary bankruptcy, dissolution or liquidation of the Company.

5.3 Performance of Duties; Liability of Managers.

(a) Each Manager shall only be required to devote such time, attention, skill and energy to the business and affairs of the Company in her capacity as Manager as she believes is reasonably necessary for her to properly perform her obligations as Manager.

(b) The Managers shall not be liable to the Company or to any Member for any loss or damage sustained by the Company or any Member, unless the loss or damage shall have been determined by a court of law not subject to further appeal to have been the result of such Manager's fraud, bad faith, or willful misconduct. In exercising the rights of a Manager, each Manager shall be entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, provided by the officers, employees or other agents of the Company or any attorney, independent accountant or other professional.

5.4 Acts of Managers as Conclusive Evidence of Authority. Third parties shall be permitted to rely on any note, mortgage, evidence of indebtedness, contract, certificate, statement, conveyance, instrument or other document in writing, and any assignment or endorsement thereof, executed or entered into between the Company and any other Person, when signed by a single Manager.

5.5 Officers and Employees. The Managers may appoint such Persons as the Managers shall determine as officers or employees of the Company and such officers and employees shall have such duties as may be approved by the Managers. The officers and employees of the Company shall serve subject to the direction of the Managers. The Managers shall determine the compensation (including base salary, bonus, and benefits) payable to each officer and employee of the Company; such compensation shall be reasonably commensurate with the duties and

responsibilities of such officers and employees in the reasonable discretion of the Managers. The Managers may remove, at their discretion, any officer or employee appointed or engaged by the Managers at any time.

5.6 Limited Liability. Neither the Managers, nor any Person who is an officer or employee of the Company, shall be personally liable under any judgment of a court, or in any other manner, for any debt, obligation, or liability of the Company, whether the liability or obligation arises in contract, tort, or otherwise, solely by reason of being Managers, an officer or employee of the Company.

5.7 Reimbursement of Managers. The Managers shall be reimbursed for all reasonable out-of-pocket expenses, disbursements and advances incurred or made by such Manager in connection with the management, operation or business of the Company, including, without limitation, fees for outside services, accounting expenses, reasonable travel and entertainment expenses, insurance premiums, legal fees, taxes or other governmental charges, expenses relating to the business of the Company, and other direct or indirect costs upon submission to the Company of reasonably detailed evidence of such expenditures. Any out-of-pocket expenditure made by a Manager and eligible for reimbursement pursuant to this Section 5.7 shall not be treated as a Capital Contribution and any reimbursement of such expenditure shall not be treated as a distribution to such Manager.

ARTICLE VI
ALLOCATIONS OF NET PROFITS AND NET LOSSES AND DISTRIBUTIONS

6.1 Allocations of Net Profit and Net Loss. (a) Net Loss, other than Net Loss in connection with the liquidation of the Company or the sale of all or substantially all of the Company's assets, shall be allocated to the Members in proportion to their positive Capital Account balances until their respective Capital Account balances equal Zero Dollars ($0), and then in accordance with their respective Percentage Interests. Notwithstanding the previous sentence, loss allocations to a Member shall be made only to the extent that such loss allocations will not create a deficit Capital Account balance for that Member in excess of an amount, if any, equal to such Member's share of Company Minimum Gain that would be realized on a foreclosure of the Company's property. Any loss not allocated to a Member because of the foregoing provision shall be allocated to the other Members (to the extent the other Members are not limited in respect of the allocation of losses under this Section 6.1(a)). Any loss reallocated under this Section 6.1(a) shall be taken into account in computing subsequent allocations of income and losses pursuant to this Article VI, so that the net amount of any item so allocated and the income and losses allocated to each Member pursuant to this Article VI, to the extent possible, shall be equal to the net amount that would have been allocated to each such Member pursuant to this Article VI if no reallocation of losses had occurred under this Section 6.1(a).

(b) Net Profit, other than Net Profit in connection with the liquidation of the Company or the sale of all or substantially all of the Company's assets, shall be allocated (i) first, to the Members in proportion to any losses previously allocated to the Members to the extent of

such allocations (less any Net Profit heretofore allocated under this Section 6.1(b)(i)); and (ii) second, if the Capital Account of any one or more Members is negative, to the Members in proportion to their relative negative capital account balances, if any, until all Capital Account balances equal or exceed zero after taking into account Net Profits allocated under Section 6.1(b)(i); and (iii) third, to the Members in accordance with their respective Percentage Interests.

(c) Subject to Sections 6.2 and 6.3, but notwithstanding any of the other provisions contained in this Article VI, any Net Profit recognized on the sale of all or substantially all of the Company's assets or otherwise in connection with the liquidation of the Company shall be allocated to and among the Members as follows: (i) first, to any Member with a negative Capital Account to the extent of such Member's negative Capital Account balance, and (ii) second, any additional Net Profit, in accordance with Members' respective Percentage Interests. Subject to Section 6.3, but notwithstanding any of the other provisions contained in this Article VI, any Net Loss recognized on the sale of all or substantially all of the Company's assets or otherwise in connection with the liquidation of the Company shall be allocated to and among the Members in the reverse order set forth in the preceding sentence.

6.2 Special Allocations. (a) Notwithstanding Section 6.1, if there is a net decrease in Company Minimum Gain during any Fiscal Year, each Member shall be specially allocated items of Company income and gain for such Fiscal Year (and, if necessary, in subsequent fiscal years), in an amount equal to the portion of such Member's share of the net decrease in Company Minimum Gain that is allocable to the disposition of Company property subject to a Nonrecourse Liability, which share of such net decrease shall be determined in accordance with Regulations Section 1.704-2(g)(2). Allocations pursuant to this Section 6.2(a) shall be made in proportion to the amounts required to be allocated to each Member under this Section 6.2(a). The items to be so allocated shall be determined in accordance with Regulations Section 1.704-2(f). This Section 6.2(a) is intended to comply with the minimum gain chargeback requirement contained in Regulations Section 1.704-2(f) and shall be interpreted consistently therewith.

(b) Notwithstanding Section 6.1 of this Agreement, if there is a net decrease in Company Minimum Gain attributable to a Member Nonrecourse Debt, during any Fiscal Year, each Member who has a share of the Company Minimum Gain attributable to such Member Nonrecourse Debt (which share shall be determined in accordance with Regulations Section 1.704-2(i)(5)) shall be specially allocated items of Company income and gain for such Fiscal Year (and, if necessary, in subsequent Fiscal Years) in an amount equal to that portion of such Member's share of the net decrease in Company Minimum Gain attributable to such Member Nonrecourse Debt that is allocable to the disposition of Company property subject to such Member Nonrecourse Debt (which share of such net decrease shall be determined in accordance with Regulations Section 1.704-2(i)(5)). Allocations pursuant to this Section 6.2(b) shall be made in proportion to the amounts required to be allocated to each Member under this Section 6.2(b). The items to be so allocated shall be determined in accordance with Regulations Section 1.704-2(i)(4). This Section 6.2(b) is intended to comply with the minimum gain charge-back requirement contained in Regulations Section 1.704-2(i)(4) and shall be interpreted consistently therewith.

(c) Notwithstanding Section 6.1, any nonrecourse deductions (as defined in

Regulations Section 1.704-2(b)(1)) for any Fiscal Year or other period shall be specially allocated to the Members in proportion to their Percentage Interests.

(d) Notwithstanding Section 6.1, those items of Company loss, deduction, or Code Section 705(a)(2)(B) expenditures which are attributable to Member Nonrecourse Debt for any Fiscal Year or other period shall be specially allocated to the Member who bears the economic risk of loss with respect to the Member Nonrecourse Debt to which such items are attributable in accordance with Regulations Section 1.704-2(i).

(e) Notwithstanding Section 6.1, if a Member unexpectedly receives any adjustments, allocations, or distributions described in Regulations Section 1.704-1(b)(2)(ii)(d)(4), (5) or (b), or any other event creates a deficit balance in such Member's Capital Account in excess of such Member's share of Company Minimum Gain, items of Company income and gain shall be specially allocated to such Member in an amount and manner sufficient to eliminate such excess deficit balance as quickly as possible. Any special allocations of items of income and gain pursuant to this Section 6.2(e) shall be taken into account in computing subsequent allocations of income and gain pursuant to this Article VI so that the net amount of any item so allocated and the income, gain, and losses allocated to each Member pursuant to this Article VI to the extent possible, shall be equal to the net amount that would have been allocated to each such Member pursuant to the provisions of this Section 6.2(e) if such unexpected adjustments, allocations, or distributions had not occurred.

6.3 Code Section 704(c) Allocations. Notwithstanding any other provision in this Article VI, in accordance with Code Section 704(c) and the Regulations promulgated thereunder, income, gain, loss, and deduction with respect to any property contributed to the capital of the Company shall, solely for tax purposes, be allocated among the Members so as to take account of any variation between the adjusted basis of such property to the Company for federal income tax purposes and its fair market value on the date of contribution. Allocations pursuant to this Section 6.3 are solely for purposes of federal, state and local taxes. As such, they shall not affect or in any way be taken into account in computing a Member's Capital Account or share of profits, losses, or other items of distributions pursuant to any provision of this Agreement.

6.4 Tax Distributions. With respect to each taxable year and portion thereof in which the Company is taxed as a partnership for U.S. federal income tax purposes, the Managers shall cause the Company, within ninety (90) days of the end of each fiscal year other than the year in which the Company liquidates, to distribute to the Members in proportion to their Percentage Interests an aggregate amount (a "Tax Distribution") that will provide to each Member an amount equal to at least forty percent (40%) of the Net Profits allocated to that Member ("Tax Distribution"). Distributions under this Section 6.4 shall only be made to the extent funds are legally available therefor and would not result in the Company's breach of any obligation. All distributions to a Member under this Section 6.4 shall take priority over and shall reduce the amount of any future distributions to that Member under Section 6.5 by the same amount.

6.5 Distributions of Distributable Cash by the Company. Subject to applicable law and the provisions of Section 6.4 and Section 10.5, the Managers shall determine, in their sole and absolute discretion, the amount of Distributable Cash and, from time to time upon such

determination, but in no event less than semi-annually, the Company shall distribute to the Members the amount of Distributable Cash so determined to all Members pro rata in accordance with each Member's respective Percentage Interest. Neither the Company nor any Member shall incur any liability for making distributions in accordance with this Section 6.5. Net Sale Proceeds shall be distributed in accordance with Section 10.5.

6.6 Form of Distribution. A Member, regardless of the nature of the Member's Capital Contribution, has no right to demand or receive any distribution from the Company in any form other than money except upon the liquidation of the Company in accordance with Article X. No Member may be compelled to accept from the Company a distribution of any asset in kind in lieu of a proportionate distribution of money being made to other Members.

6.7 Withholding Taxes. The Company is authorized to withhold from distributions to a Member, or with respect to allocations to a Member, and to pay over to a federal, state, local or foreign government, any amounts required to be withheld pursuant to the Code, or any provisions of any other federal, state, local or foreign law. Any amounts so withheld shall be treated as having been distributed to such Member pursuant to this Article VI for all purposes of this Agreement, and shall be offset against the amounts otherwise distributable to such Member.

6.8 Obligations of Members to Report Allocations. The Members are aware of the income tax consequences of the allocations made by this Article VI and hereby agree to be bound by the provisions of this Article VI in reporting their shares of Company income and loss for income tax purposes.

6.9 Negative Capital Account Balances. No Member shall be required to restore any negative balances in such Member's Capital Account.

ARTICLE
TRANSFER AND ASSIGNMENT

7.1 General. No Member shall gift, sell, assign, pledge, hypothecate, exchange, dispose or otherwise transfer (collectively, a "Transfer") any Units to another Person without the prior written consent of the Managers; *provided, however,* that a Member may Transfer all or a portion of such Member's Units to a Permitted Transferee or another Member only upon such Member's death or Disability. Notwithstanding the foregoing, no Transfer of Units may be made: (i) if such Transfer, alone or when combined with other transactions, would result in a termination of the Company within the meaning of Section 708 of the Code; (ii) without an opinion of counsel satisfactory to the Managers that such Transfer is subject to an effective registration under, or exempt from the registration requirements of, the applicable state and federal securities laws (which opinion may be waived by the Managers in their sole discretion) and containing such other opinions of counsel as reasonably required by the Managers; (iii) unless and until the Company receives from the transferee the information and agreements that the Managers may reasonably require, including, but not limited to, an agreement of the transferee to be bound by all the terms and conditions of this Agreement; (iv) unless and until the Company receives from the transferring Member all expenses of the Company (including reasonable attorneys' fees) incurred in connection with such Transfer; and (v) unless the

Company has received a signed spousal consent form from the spouse of the Person receiving the Units from such transferring Member, if applicable.

7.2 Admission of Transferee as Member. A transferee shall be admitted as a substitute or additional Member having the rights in whole or in part of the transferring Member in and to such Member's Membership Interest upon compliance with the provisions of this Article VII. If so admitted, the substitute or additional Member shall have all the rights and powers and shall be subject to all the restrictions and liabilities of the Member originally transferring the Membership Interest; provided, that Permitted Transferees shall not have the right to vote on or consent to any matter required to be approved by the vote or consent of the Members. The admission of a substitute or additional Member, without more, shall not release the Member originally transferring the Membership Interest from any liability to the Company that may have existed prior to approval of the Transfer.

7.3 Transfers Not in Compliance Void. Any attempted Transfer of Units by a Member not in compliance with this Article VII shall be null and void *ab initio* and of no force whatsoever.

ARTICLE VIII
CONSEQUENCES OF BANKRUPTCY OR DEATH OF A MEMBER

8.1 Bankruptcy and Death or Disability: Transfer Procedures. Upon the happening of the Bankruptcy or death or Disability of a Member, the applicable Member and/or such Member's Permitted Transferees shall be deemed to have offered all of such Member's Units and/or such Member's Permitted Transferees' Units to the Company, and the Company shall purchase all of such Units, for the purchase price of One Dollar ($1.00). Upon the Bankruptcy or death or Disability of a Member, the Company shall give written notice to the applicable Member or such Member's legal representative and her Permitted Transferees, if any, within twenty (20) days of the date the applicable Member became Bankrupt or died or became Disabled that such Member's Units and the Units held by such Member's Permitted Transferees, if any, will be purchased by the Company in accordance with this Section 8.1. Any Transfer from such Member, trustee in bankruptcy or legal representative shall be subject to the provisions of this Agreement.

8.2 Tax Allocations Regarding Former Member's Units. For federal income tax purposes, any gains or losses realized by the Company on the sale of assets in connection with the liquidation or redemption of a former Member's Units shall be allocated to the former Member in such amounts and character that would equal the amounts that would be allocated to the former Member had the Company sold all of its assets on the valuation date and distributed all proceeds in liquidation to each Member in accordance with each Member's Percentage Interest.

8.3 Closing of Purchase of Former Member's Interest. The closing for the sale of a former Member's (and such Member's Permitted Transferees, if applicable) Units pursuant to this Article VIII shall be held as soon as practicable, and in any event within thirty (30) days of

the date the applicable Member became Bankrupt or died or became Disabled. The closing shall occur at the principal office of the Company. At the closing, the former Member or such Member's Permitted Transferees, if applicable and/or such Member's or such Member's Permitted Transferees' legal representative(s) shall deliver to the Managers or the Company an instrument of transfer (containing warranties of title and no encumbrances) conveying the former Member's Units (and the Units held by such former Member's Permitted Transferees, if applicable). The former Member, the former Member's legal representative, each Member, the Managers and the Company shall do all things and execute and deliver all papers as may be necessary fully to consummate such sale and purchase in accordance with the terms and provisions of this Agreement.

ARTICLE IX
BOOKS, REPORTS AND REPORTING

9.1 Books. The Managers shall cause to be maintained complete and accurate books of account of the Company's affairs at the Company's principal place of business, which shall be available for the review of the Members at the offices of the Company during normal business hours and upon reasonable advanced notice, and subject to such other restrictions and requirements as may be imposed by the Managers in accordance with the Act. Such books shall be kept on such method of accounting as the Managers shall select.

9.2 Reports. The books of account of the Company shall be closed after the close of each Fiscal Year, and there shall be prepared and sent to each Member a Form K-1 for that period.

9.3 Filings. The Managers, at the Company's expense, shall cause the income tax returns for the Company to be prepared and timely filed with the appropriate authorities. The Managers, at the Company's expense, shall also cause to be prepared and timely filed, with appropriate federal and state regulatory and administrative bodies, amendments to, or restatements of, the Articles and all reports required to be filed by the Company with those entities under the Act or other then current applicable laws, rules and regulations. If a Member required by the Act to execute or file any document fails, after demand, to do so within a reasonable period of time or refuses to do so, the Managers may prepare, execute and file such document.

9.4 Tax Matters for the Company Handled by Tax Matters Partner. The Tax Matter Partner (as defined below) shall from time to time cause the Company to make such tax elections as it deems to be in the best interests of the Company and the Members. The Tax Matters Partner, as defined in Code Section 6231, shall represent the Company (at the Company's expense) in connection with all examinations of the Company's affairs by tax authorities, including resulting judicial and administrative proceedings, and shall expend the Company funds for professional services and costs associated therewith. The Tax Matters Partner shall oversee the Company tax affairs in the overall best interest of the Company. If for any reason the Tax Matters Partner can no longer serve in that capacity or ceases to be a Member, as the case may be, the Members holding a majority of the Units may designate another Member to be Tax Matters Partner. The Tax Matter Partner shall initially be [Margoles and Raskin].

ARTICLE
DISSOLUTION AND WINDING UP

10.1 Dissolution. The Company shall be dissolved, its assets shall be disposed of, and its affairs wound up on the first to occur of the following: (i) upon the happening of any event of dissolution specified in the Articles; (ii) upon the entry of a decree of judicial dissolution; (iii) the sale of all or substantially all of the assets of Company; or (iv) otherwise upon the consent of the Managers.

10.2 Filings. As soon as possible following the occurrence of any of the events specified in Section 10.1, the Company shall execute, acknowledge and cause to be filed such certificates and other instruments in such form as shall be necessary or appropriate to evidence the dissolution of the Company.

10.3 Winding Up. Upon the occurrence of any event specified in Section 10.1, the Company shall continue solely for the purpose of winding up its affairs in an orderly manner, liquidating its assets, and satisfying the claims of its creditors. The Managers shall be responsible for overseeing the winding up and liquidation of the Company, shall take full account of the liabilities of the Company and its assets, shall either cause its assets to be sold or distributed, and if sold as promptly as is consistent with obtaining the fair market value thereof, shall cause the proceeds therefrom, to the extent sufficient therefore, to be applied and distributed as provided in Section 10.5.

10.4 Distributions in Kind. Any non-cash asset distributed to one or more Members shall first be valued at its fair market value to determine the Net Profit or Net Loss that would have resulted if such asset were sold for such value, such Net Profit or Net Loss shall then be allocated pursuant to Article VI, and the Members' Capital Accounts shall be adjusted to reflect such allocations. The amount distributed and charged to the Capital Account of each Member receiving an interest in such distributed asset shall be the fair market value of each interest (net of any liability secured by such asset that such Member assumes or takes subject to). The fair market value of such asset shall be determined in good faith by the Managers.

10.5 Order of Payment of Liabilities and Distributions Upon Dissolution or Liquidation. The Net Sale Proceeds and all other assets of the Company upon its liquidation shall be applied and distributed in the following order of priority: (a) first, to the payment of the expenses of liquidation and the debts and liabilities of the Company, including, without limitation, debts and liabilities owing to the Members; (b) second, to the setting up of any reserves which the Managers may deem necessary or desirable for any contingent or unforeseen liabilities or obligations of the Company, which reserves shall be paid over to a title company or an attorney-at-law admitted to practice in the State of Connecticut or New York as escrow agent, to be held for a period to be determined by the Managers for the purpose of payment of the aforesaid liabilities and obligations, at the expiration of which period the balance of such reserves shall be distributed as hereinafter provided; (c) third, to the Members in proportion to their respective Capital Accounts until each Member has received cash distribution equal to any

positive balance in his Capital Account, in accordance with the rules and requirements of Regulations Section 1.704-1(b)(2)(ii)(b) and after taking into account the allocation of Net Profits, Net Losses, gains or losses pursuant to Article VI; and (d) finally, to the Members in proportion to the Members' Percentage Interests. If the Managers determine that it is not practicable to liquidate all of the assets of the Company, the Managers may retain assets having a fair market value equal to the amount by which the net proceeds of liquidated assets are insufficient to satisfy the debts and liabilities referred to above. If, in the absolute judgment of the Managers, it is not feasible to distribute to each Member his proportionate share of each asset, the Managers may allocate and distribute specific assets to one or more Members in such manner as the Managers shall determine to be fair and equitable, taking into consideration the basis for tax purposes of each asset.

10.6 Limitations on Payments Made in Dissolution. Except as otherwise specifically provided in this Agreement, each Member shall only be entitled to look solely at the assets of Company for the return of his positive Capital Account balance and shall have no recourse for his Capital Contribution and/or share of Net Profits (upon dissolution or otherwise) against any Manager or any other Member except as provided in Article XI.

10.7 Termination. Upon completion of the dissolution, winding up, liquidation and distribution of the assets of the Company, the Company shall be deemed terminated.

ARTICLE XI
EXCULPATION, INDEMNIFICATION AND INSURANCE

11.1 Exculpation. Notwithstanding any other provisions of this Agreement, whether express or implied, or obligation or duty at law or in equity, neither the Managers nor any of the Members, or any officers, directors, stockholders, partners, employees, representatives, consultants or agents of either of the foregoing, nor any officer, employee, representative, consultant or agent of the Company or any of its Affiliates (individually, a "Covered Person" and, collectively, the "Covered Persons") shall be liable to the Company or any other Person for any act or omission (in relation to the Company and the conduct of its business, the Agreement, any related document or any transaction contemplated hereby or thereby) taken or omitted in good faith by a Covered Person and in the reasonable belief that such act or omission was in or was not contrary to the best interests of the Company; *provided* that such act or omission does not constitute fraud, willful misconduct or bad faith.

11.2 Indemnification. To the fullest extent permitted by applicable law, in the event that any Member or Manager or any of their heirs, legal representatives, partners, members, trustees, directors, officers, shareholders, employees, incorporators, agents, Affiliates or controlling persons, successors or assigns (collectively, "Indemnified Persons" and each, including the applicable Member, an "Indemnified Person"), becomes involved, in any capacity, in any threatened, pending or completed action, proceeding or investigation, in connection with any matter arising out of or relating to the Company's business or affairs, the Company will periodically reimburse such Indemnified Person for its legal and other related expenses incurred in connection therewith, provided, that such Indemnified Person shall promptly repay to the Company the amount of any such reimbursed expenses paid to such Indemnified Person if it

shall ultimately be determined that such Indemnified Person is not entitled to be indemnified by the Company in connection with such action, proceeding or investigation as provided in the exception contained in the next sentence. To the fullest extent permitted under the law of the State of Connecticut as the same exists or may hereafter be amended (but, in the case of any such amendment, only to the extent that such amendment permits the Company to provide broader indemnification rights than said law permitted the Company to provide prior to such amendment), the Company also will indemnify and hold harmless each Indemnified Person against losses, claims, damages, liabilities, obligations, penalties, actions, judgments, suits, proceedings, costs, expenses and disbursements of any kind or nature whatsoever (collectively, "Damages"), to which such Indemnified Person may become subject in connection with any matter arising out of or in connection with the Company's business or affairs, except to the extent any such Damages result solely from the fraud, willful misfeasance, gross negligence or bad faith of such Indemnified Person. The reimbursement and indemnity obligations of the Company under this Section 11.2 shall be in addition to any liability which the Company may otherwise have to any Indemnified Person and shall be binding upon and inure to the benefit of any successors, assigns, heir and personal representative of the Company and any Indemnified Person. The reimbursement and indemnity obligations of the Company under this Section 11.2 shall be limited to the Company's assets, and no Member or Manager shall have any personal liability on account thereof. Any amendment or repeal of this Section 11.2 shall not adversely affect any right or protection existing hereunder immediately prior to such amendment or repeal.

11.3 Insurance. The Company shall maintain professional liability insurance in an amount not less than the amount required by the Act. The Company shall have the power to purchase and maintain insurance on behalf of any Person who is or was an agent, officer, employee, Member or Manager of the Company against any liability asserted against such Person and incurred by such Person in any such capacity, whether or not the Company would have the power to indemnify such Person against such liability under the provisions of Section 11.2 or under applicable law.

ARTICLE XII
AMENDMENTS

12.1 Amendments. Except as otherwise explicitly set forth herein, amendments, modifications, restatements or supplements to this Agreement shall require only the written consent of the Managers; provided, however, that any amendment, modification, restatement or supplement which adversely affects any Member and is prejudicial to such Member relative to all other Members cannot be effected without consent of such Member. For the avoidance of doubt, the issuance (including, without limitation, with respect to the consideration to be received and/or the rights, preferences or privileges of any interest in the Company so issued) or Transfer of Units to any Member (new or existing) pursuant to the terms of this Agreement, and the appropriate amendments to this Agreement or Schedule A hereto to reflect such issuance shall be deemed not to have an adverse effect on the rights of a Member.

ARTICLE XIII
TRANSACTIONS WITH THE COMPANY; OTHER AGREEMENTS

13.1 Business Transactions with the Company. The Members, including the Managers, or an Affiliate of any Member or Manager may lend money to, act as surety, guarantor or endorser for, guaranty or assume one or more obligations of, provide collateral for the Company upon the consent of the Managers. In addition, the Company may transact business with any Member, Manager or Affiliate of any Member or Manager and such Member, Manager or Affiliate thereof may receive compensation and remuneration therefor, as determined by the Managers; provided, however, that such services are provided on arms-length terms. No transaction with the Company shall be voidable solely because a Member, Manager or Affiliate of a Member or Manager has a direct or indirect interest in the transaction. Subject to applicable law, any Member, including a Manager, transacting business with the Company shall have the same rights and obligations with respect to any such matter as a Person who is not a Member.

ARTICLE XIV
CONFIDENTIALITY

14.1 Confidentiality. The Members acknowledge and agree that, as a result of their relationship with the Company, each Member will have access to confidential and proprietary information relating to the business and operations of the Company, provided however, that the personal information of any patient of the Company shall be subject the rights of the individual to which such personal information relates and the applicable privacy laws. The Members acknowledge that such Confidential Information is of critical importance to the Company and that disclosure of it or its use by the Members or others could cause substantial loss to the Company. The Members and the Company also recognize that an important part of each Member's duties will be to develop goodwill for the Company through her personal contact with Persons having business relationships with the Company, and that such goodwill developed for the benefit of the Company will become the exclusive proprietary asset of the Company. Accordingly, each Member covenants and agrees that such Member shall not (a) at any time while a Member use any Confidential Information for any purpose other than for the benefit of the Company, (b) during or after a Member's membership in the Company, directly or indirectly, disclose to others, or permit the disclosure of, any Confidential Information of the Company except as required by applicable law, regulation or court order, or (c) after all of a Member's Units have been Transferred or a Member is otherwise no longer a Member of the Company, use or disclose any Confidential Information for any purpose without the prior written consent of the Managers. Upon a Member ceasing to be a Member or the earlier demand by the Managers, the applicable Member will promptly return to the Company all Confidential Information available to them in any form whatsoever and any copies thereof, along with a list of all Persons that Member knows, or should reasonably know, have had access to such Confidential Information. In the event that a Member becomes legally compelled (by deposition, interrogatory, request for documents, subpoena, civil investigative demand or similar process) to disclose any Confidential Information, it shall provide the Company with prompt prior written notice of such requirement so that the Company may seek a protective order or other appropriate remedy and/or waive compliance with the terms of this Agreement. In the event that such protective order or other

remedy is not obtained, or that the Company waives compliance with the provisions hereof, the applicable Member agrees to furnish only that portion of the Confidential Information which it is advised by written opinion of counsel is legally required and to exercise best efforts to obtain assurance that confidential treatment will be accorded such information. In no event will a Member oppose action by the Company or any other Member to obtain an appropriate protective order or other reliable assurance that confidential treatment will be accorded the Confidential Information.

ARTICLE XV
MISCELLANEOUS

15.1 Counsel to the Company. Each Member acknowledges that Meister Seelig & Fein LLP ("MSF") (i) is counsel to the Company; (ii) does not represent any Member, specifically, in connection with the preparation of this Agreement and generally, in any other manner, in the absence of a clear and explicit written agreement to the contrary; and (iii) MSF may also be counsel to any Member, Manager or any Affiliate of a Member or Manager. In the absence of any such agreement as referred to in clause (ii) of the preceding sentence, MSF shall owe no duties directly to a Member. The Company and the Members hereby waive any conflict of interest to the fullest extent permitted under applicable law with regard to MSF representing any Member in matters unrelated to the Company and the Company. The Company and the Members hereby freely and willingly waive any conflict of interest to the fullest extent permitted under applicable law with regard to MSF representing the Company against any Member in the event of a default and/or if proceedings are commenced by the Company. Each Member represents that he, she or it has been advised to retain independent counsel of such Person's own choice and has had the opportunity to review this Agreement with such counsel.

15.2 Complete Agreement. This Agreement constitutes the entire agreement among the Members hereto relating to the subject matter hereof and supersedes all prior contracts, agreements and understandings between them. No course of prior dealings among the Members shall be relevant to supplement or explain any term used in this Agreement. Acceptance or acquiescence in a course of performance rendered under this Agreement shall not be relevant to determine the meaning of this Agreement even though the accepting or the acquiescing party has knowledge of the nature of the performance and an opportunity for objection. No provisions of this Agreement may be waived orally, but only by an instrument in writing executed by the waiving party. No waiver of any terms or conditions of this Agreement in one instance shall operate as a waiver of any other term or condition or as a waiver in any other instance. No representation, statement, condition or warranty not contained in this Agreement or the Articles will be binding on the Members or have any force or effect whatsoever.

15.3 Binding Effect. Subject to the provisions of this Agreement relating to transferability, this Agreement will be binding upon and inure to the benefit of the Members, and their respective successors and assigns.

15.4 Parties in Interest. Except as set forth in Article XI, nothing in this Agreement shall confer any rights or remedies under or by reason of this Agreement on any Persons other than the Members and their respective, heirs, administrators, successors and assigns nor shall

anything in this Agreement relieve or discharge the obligation or liability of any third person to any party to this Agreement, nor shall any provision give any third person any right of subrogation or action over or against any party to this Agreement.

15.5 Pronouns; Statutory References. All pronouns and all variations thereof shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the context in which they are used may require. Any reference to the Code, the Regulations, the Act, or other statutes or laws will include all amendments, modifications, or replacements of the specific sections and provisions concerned.

15.6 Headings. All headings herein are inserted only for convenience and ease of reference and are not to be considered in the construction or interpretation of any provision of this Agreement.

15.7 Interpretation. In the event any claim is made by any Member relating to any conflict, omission or ambiguity in this Agreement, no presumption or burden of proof or persuasion shall be implied by virtue of the fact that this Agreement was prepared by or at the request of a particular Member or his or her counsel.

15.8 References to this Agreement. Numbered or lettered articles, sections and subsections herein contained refer to articles, sections and subsections of this Agreement unless otherwise expressly stated.

15.9 GOVERNING LAW. THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF CONNECTICUT WITHOUT REGARD TO THE PRINCIPLES OF CONFLICTS OF LAWS THEREOF.

15.10 JURISDICTION. SUBJECT SO SECTION 15.17, THE COMPANY AND EACH MEMBER HEREBY CONSENTS AND SUBMITS TO THE EXCLUSIVE VENUE AND JURISDICTION OF THE STATE AND FEDERAL COURTS SITTING IN FAIRFIELD COUNTY, CONNECTICUT, IN ANY ACTION ON A CLAIM ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT. THE COMPANY AND EACH MEMBER FURTHER AGREES THAT PERSONAL JURISDICTION OVER HIM OR IT MAY BE EFFECTUATED BY SERVICE OF PROCESS BY REGISTERED OR CERTIFIED MAIL ADDRESSED AS PROVIDED IN SECTION 15.14 OF THIS AGREEMENT.

15.11 Schedules. All schedules and exhibits attached to this Agreement are incorporated and shall be treated as if set forth herein.

15.12 Severability. If any provision of this Agreement or the application of such provision to any person or circumstance shall be held invalid, the remainder of this Agreement or the application of such provision to persons or circumstances other than those to which it is held invalid shall not be affected thereby and will continue in full force without being impaired or invalidated in any way. The Members agree to replace any invalid or unenforceable provision with a valid provision that most closely approximates the intent and economic effect of the

invalid or unenforceable provision.

15.13 Additional Documents and Acts. Each Member agrees to execute and deliver such additional documents and instruments and to perform such additional acts as may be necessary or appropriate to effectuate, carry out and perform all of the terms, provisions, and conditions of this Agreement and the transactions contemplated hereby.

15.14 Notices. Unless otherwise specifically provided in this Agreement, all notices and other communications required or permitted to be given hereunder shall be in writing and shall be (i) delivered by hand, (ii) delivered by a nationally recognized commercial overnight delivery service, (iii) mailed postage prepaid by first class mail, (iv) by telecopier, or (v) by electronic mail, in any such case directed or addressed to each Member at the address or telecopy number set forth on Schedule A hereto or the facsimile number or electronic mail address provided by such Member to the Company. Such notices shall be effective: (a) in the case of hand deliveries when received; (b) in the case of an overnight delivery service, on the next business day after being placed in the possession of such delivery service, with delivery charges prepaid; (c) in the case of mail, five (5) days after deposit in the postal system, first class mail, postage prepaid, (d) in the case of facsimile notices, when electronic indication of receipt is received, and (e) in the case of electronic mail, when sent. Any Member may change its address and telecopy number by written notice to the Company; upon the receipt of any such notice the Managers shall amend Schedule A consistent with such notice and shall promptly provide such amended Schedule A to the Members in accordance with this Section 15.14.

15.15 No Interest in Company Property; Waiver of Action for Partition. No Member has any interest in specific property of the Company. Without limiting the foregoing, each Member irrevocably waives during the term of the Company any right that he or she may have to maintain any action to dissolve the Company or for partition with respect to the property of the Company.

15.16 Representations and Warranties of the Members. Each Member represents and warrants to the Company as follows:

(a) This Agreement constitutes the legal, valid and binding obligation of such Member enforceable in accordance with its terms.

(b) No consents or approvals are required from any governmental authority or other Person for such Member to enter into this Agreement and all action on the part of such Member necessary for the authorization, execution and delivery of this Agreement, and the consummation of the transactions contemplated hereby, have been duly taken.

(c) The execution and delivery of this Agreement by such Member, and the consummation of the transactions contemplated hereby, does not conflict with or contravene the provisions of such Member's organizational documents, if any, or any agreement or instrument by which such Member or her properties are bound or any law, rule, regulation, order or decree to which such Member or her properties are subject.

(d) Such Member is an "accredited investor" (as defined in Regulation D under the Securities Act of 1933, as amended (the "Securities Act")) and understands and agrees that (i) such Member is acquiring Units for such Member's own account for investment only, and not with a view to, or for sale in connection with, any distribution thereof in violation of the Securities Act; (ii) an investment in the Company involves substantial and a high degree of risk, (iii) no federal or state agency has passed on the offer and sale of Units in the Company to any Person, (iv) such Member must bear the economic risk of such Member's investment in the Company for an indefinite period of time, since such Member's Units have not been registered for sale under the Securities Act, and, therefore, cannot be sold or otherwise transferred unless subsequently registered under the Securities Act or an exemption from such registration is available, and such Member's Units cannot be sold or otherwise Transferred unless registered under applicable state securities or blue sky laws or an exemption from such registration is available and that the Transfer of Units is restricted in accordance with the terms of this Agreement, (v) there is no established market for such Member's Units and it is not currently anticipated that a public market will develop, and (vi) such Member has such knowledge and experience in business related to the business of the Company and other financial and business matters that he is capable of evaluating the merits and risks of an investment in the Company.

(e) Such Member has been given the opportunity to (i) ask questions of, and receive answers from, the Company concerning the terms and conditions this Agreement, and (ii) obtain any additional information from the Company that was relevant to permit such Member to make a free and knowledgeable decision to execute this Agreement. Such Member has not relied upon any representations made by, or other information (whether oral or written) furnished by or on behalf of, the Company, any Manager, or any director, officer, Member, partner, employee, agent, counsel, representative or affiliate of such persons, other than as set forth in this Agreement.

5.17 Dispute Resolution. Subject to seeking equitable relief in a court of competent jurisdiction to enforce this Agreement or as necessary to preserve the status quo during the pendency of final resolution of a Dispute in accordance with this Section 5.17, the Members will first attempt to settle each and every dispute, controversy or claim arising out of or relating to this Agreement ("Disputes") through good faith negotiations. Any Dispute not thus resolved within thirty (30) days or such other period as the parties shall mutually agree in writing shall be then settled by final and binding arbitration conducted in a mutually agreed location in Fairfield County, Connecticut by one neutral arbitrator, in accordance with this Section 5.17 and the then current Commercial Arbitration Rules of the American Arbitration Association (the "AAA"). Each party shall bear its own expenses and the parties shall equally share the filing and other administrative fees of the AAA and the expenses of the arbitrator. Judgment upon an award may be entered in any court having competent jurisdiction. The arbitrator shall not have the power to award any consequential or punitive damages. The arbitrator shall have the power to order prehearing discovery of documents and the taking of depositions, and may compel attendance of witnesses and the production of documents at the hearing. The arbitrability of any Dispute, including those as to the enforceability of this Section 5.17, shall be determined solely by the arbitrator. The Federal Arbitration Act, 9 U.S.C. Section 1 to 16 shall govern the interpretation and enforcement of this Section 5.17. The statute(s) of limitation applicable to any Dispute shall be tolled upon initiation of the Dispute resolution procedures under this Section 5.17 and shall

remain tolled until the Dispute is resolved under this Section 5.17. However, tolling shall cease if the aggrieved party does not file a demand for arbitration of the Dispute with the AAA within sixty (60) days after good faith negotiations have been terminated by either party. The parties, their representatives and participants and the arbitrator shall hold the existence, content and result of the arbitration in confidence, except to the limited extent necessary to enforce a final settlement agreement or to obtain or enforce a judgment on an arbitration decision and award.

5.18 Attorneys' Fees and Costs. Except as otherwise expressly provided herein, in any action, proceeding or dispute resolution process arising from, out of or in connection with this Agreement, or the transactions contemplated hereby, the prevailing party therein shall be entitled to recover from the other party(ies) thereto the costs, expenses and reasonable attorneys' fees incurred by the prevailing party in connection therewith.

15.19 Multiple Counterparts; Facsimile. This Agreement may be executed in two or more counterparts and by facsimile, each of which shall be deemed an original, but all of which shall constitute one and the same instrument.

15.19 Failure of Member to Comply; Remedies Cumulative. If any Member fails to perform in accordance with, or to comply with the terms and conditions of this Agreement, then the Members acknowledge that the Company and all other Members bound by this Agreement will have no adequate remedy at law and shall be entitled to such equitable and injunctive relief as may be available to restrain a violation or threatened violation of this Agreement or to specifically enforce the provisions thereof without the necessity of posting a bond or proving actual damages. The remedies under this Agreement are cumulative and shall not exclude any other remedies to which any person may be lawfully entitled.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the Company and all of the Members of Greenwich Smartlipo LLP, a Connecticut limited liability partnership, have executed this Partnership Agreement, effective as of the date written above.

GREENWICH SMARTLIPO LLP

By: ELSA RASKIN. MD
Name:
Title:

By:_____
Name:
Title:

MANAGERS:

_____
ELSA RASKIN

_____
SANDRA MARGOLES

MEMBERS:

_____
ELSA RASKIN

_____
SANDRA MARGOLES

SCHEDULE A

Member Name and Address, Capital Contributions, Units and Percentage Interest

Member's Name and Address	Capital Contributions	Number of Units	Percentage Interest
Elsa Raskin		100	50%
Sandra Margoles		100	50%
TOTAL		200	100%

Greenwich SmartLipo LLP
Profit & Loss
January through December 2011

	Jan - Dec 11
Ordinary Income/Expense	
Income	
Fee for Service Income	205,365.67
Refunds	-4,650.00
Total Income	200,715.67
Expense	
Advertising and Promotion	34,260.40
Bank Service Charges	41.00
Computer and Internet Expenses	1,867.23
Contract Labor	23,285.05
Credit card fees	5,078.27
Depreciation Expense	31,882.00
Donations	350.00
Insurance Expense	9,927.28
Interest Expense	8,071.14
Janitorial Expense	3,006.66
Licensing & Permits	120.00
Meals and Entertainment	521.55
Medical Records and Supplies	175.60
Medical Supplies	29,802.61
Office Supplies	2,734.56
Practice Expenses	250.56
Professional Fees	
Accounting Fees	3,430.00
Total Professional Fees	3,430.00
Repairs and Maintenance	1,619.93
Taxes - Business	250.00
Taxes - Property	1,535.86
Telephone Expense	904.05
Utilities	20.00
Total Expense	159,133.75
Net Ordinary Income	41,581.92
Net Income	**41,581.92**

Greenwich SmartLipo LLP
Balance Sheet
As of December 31, 2011

	Dec 31, 11
ASSETS	
Current Assets	
Checking/Savings	
Chase Checking xx25119	1,945.40
Total Checking/Savings	1,945.40
Total Current Assets	1,945.40
Fixed Assets	
Accumulated Depreciation	-128,369.00
Furniture and Equipment	177,255.22
Leasehold Improvements	3,409.78
Total Fixed Assets	52,296.00
TOTAL ASSETS	**54,241.40**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Commercial Loan - JP Morgan	132,455.00
Partner 2 Loan - SM	-5,847.71
Partners Loan - EMR	-5,847.71
Total Other Current Liabilities	120,759.58
Total Current Liabilities	120,759.58
Total Liabilities	120,759.58
Equity	
Partner 1 Draws	-22,000.00
Partner 2 Draws	-22,000.00
Partner Equity - E. Raskin	1,000.00
Partner Equity - S. Magoles	1,000.00
Retained Earnings	-66,100.10
Net Income	41,581.92
Total Equity	-66,518.18
TOTAL LIABILITIES & EQUITY	**54,241.40**

COPY

Form **1065**

Department of the Treasury
Internal Revenue Service

U.S. Return of Partnership Income

For calendar year 2011, or tax year beginning _____, 2011,
ending _____, 20 ____.
► See separate instructions.

OMB No. 1545-0099

2011

A Principal business activity: Medical services	Print or type.	Name of partnership: GREENWICH SMARTLIPO LLP	D Employer identification number: 27-2994781
B Principal product or service: MEDICAL SERVICES		Number, street, and room or suite number. If a P.O. box, see the instructions.: 2 1/2 DEARFIELD DRIVE, SUITE 102	E Date business started: 07/01/10
C Business code number: 621111		City or town: GREENWICH State: CT ZIP code: 06830	F Total assets (see instrs): $ 54,241.

G Check applicable boxes: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change (5) ☐ Amended return
(6) ☐ Technical termination — also check (1) or (2)

H Check accounting method: (1) ☒ Cash (2) ☐ Accrual (3) ☐ Other (specify) ►

I Number of Schedules K-1. Attach one for each person who was a partner at any time during the tax year . . . ► 2

J Check if Schedules C and M-3 are attached . . . ☐

Caution. *Include **only** trade or business income and expenses on lines 1a through 22 below. See the instructions for more information.*

INCOME	1a	Merchant card and third-party payments (including amounts reported on Form(s) 1099-K). For 2011, enter -0-	1a	0.	
	b	Gross receipts or sales not reported on line 1a (see instructions)	1b	200,716.	
	c	Total. Add lines 1a and 1b	1c	200,716.	
	d	Returns and allowances plus any other adjustments to line 1a (see inst)	1d		
	e	Subtract line 1d from line 1c	1e	200,716.	
	2	Cost of goods sold (attach Form 1125-A)	2		
	3	Gross profit. Subtract line 2 from line 1e			3 200,716.
	4	Ordinary income (loss) from other partnerships, estates, and trusts (attach statement)			4
	5	Net farm profit (loss) (attach Schedule F (Form 1040))			5
	6	Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797)			6
	7	Other income (loss) (attach statement)			7
	8	**Total income (loss).** Combine lines 3 through 7			8 200,716.
DEDUCTIONS (SEE INSTRS FOR LIMITATIONS)	9	Salaries and wages (other than to partners) (less employment credits)			9
	10	Guaranteed payments to partners			10 0.
	11	Repairs and maintenance			11 1,620.
	12	Bad debts			12
	13	Rent			13
	14	Taxes and licenses			14 1,906.
	15	Interest			15 8,071.
	16a	Depreciation (if required, attach Form 4562)	16a	31,882.	
	b	Less depreciation reported on Form 1125-A and elsewhere on return	16b		16c 31,882.
	17	Depletion **(Do not deduct oil and gas depletion.)**			17
	18	Retirement plans, etc.			18
	19	Employee benefit programs			19
	20	Other deductions (attach statement) * STMT			20 115,045.
	21	**Total deductions.** Add the amounts shown in the far right column for lines 9 through 20			21 158,524.
	22	**Ordinary business income (loss).** Subtract line 21 from line 8			22 42,192.

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than general partner or limited liability company member manager) is based on all information of which preparer has any knowledge.

COPY

► Signature of general partner or limited liability company member manager — ► 03/30/12 Date

May the IRS discuss this return with the preparer shown below (see instrs)? ☐ Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN

Firm's name ► Self-Prepared — Firm's EIN ►

Firm's address ► — Phone no.

Schedule B Other Information

		Yes	No
1	What type of entity is filing this return? Check the applicable box: a [ ] Domestic general partnership b [ ] Domestic limited partnership c [ ] Domestic limited liability company d [X] Domestic limited liability partnership e [ ] Foreign partnership f [ ] Other ►		
2	At any time during the tax year, was any partner in the partnership a disregarded entity, a partnership (including an entity treated as a partnership), a trust, an S corporation, an estate (other than an estate of a deceased partner), or a nominee or similar person?		X
3	At the end of the tax year: a Did any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, or tax-exempt organization, or any foreign government own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership? For rules of constructive ownership, see instructions. If 'Yes,' attach Schedule B-1, Information on Partners Owning 50% or More of the Partnership		X
	b Did any individual or estate own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership? For rules of constructive ownership, see instructions. If 'Yes,' attach Schedule B-1, Information on Partners Owning 50% or More of the Partnership	X	
4	At the end of the tax year, did the partnership: a Own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of stock entitled to vote of any foreign or domestic corporation? For rules of constructive ownership, see instructions. If 'Yes,' complete (i) through (iv) below		X

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage Owned in Voting Stock

b Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If 'Yes,' complete (i) through (v) below			X

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Maximum Percentage Owned in Profit, Loss, or Capital

	Yes	No
5 Did the partnership file Form 8893, Election of Partnership Level Tax Treatment, or an election statement under section 6231(a)(1)(B)(ii) for partnership-level tax treatment, that is in effect for this tax year? See Form 8893 for more details		X
6 Does this partnership satisfy **all four** of the following conditions?		
a The partnership's total receipts for the tax year were less than $250,000.		
b The partnership's total assets at the end of the tax year were less than $1 million.		
c Schedules K-1 are filed with the return and furnished to the partners on or before the due date (including extensions) for the partnership return.		
d The partnership is not filing and is not required to file Schedule M-3	X	
If 'Yes,' the partnership is not required to complete Schedules L, M-1, and M-2; Item F on page 1 of Form 1065; or Item L on Schedule K-1.		
7 Is this partnership a publicly traded partnership as defined in section 469(k)(2)?		X
8 During the tax year, did the partnership have any debt that was cancelled, was forgiven, or had the terms modified so as to reduce the principal amount of the debt?		X
9 Has this partnership filed, or is it required to file, Form 8918, Material Advisor Disclosure Statement, to provide information on any reportable transaction?		X
10 At any time during calendar year 2011, did the partnership have an interest in or a signature or other authority over a financial account in a foreign country (such as a bank account, securities account, or other financial account)? See the instructions for exceptions and filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If 'Yes,' enter the name of the foreign country. ►		X
11 At any time during the tax year, did the partnership receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If 'Yes,' the partnership may have to file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts. See instructions.		X
12a Is the partnership making, or had it previously made (and not revoked), a section 754 election? See instructions for details regarding section 754 election.		X
b Did the partnership make for this tax year an optional basis adjustment under section 743(b) or 734(b)? If 'Yes,' attach a statement showing the computation and allocation of the basis adjustment. See instructions		X
c Is the partnership required to adjust the basis of partnership assets under section 743(b) or 734(b) because of a substantial built-in loss (as defined under section 743(d)) or substantial basis reduction (as defined under section 734(d))? If 'Yes,' attach a statement showing the computation and allocation of the basis adjustment. See instructions		X
13 Check this box if, during the current or prior tax year, the partnership distributed any property received in a like-kind exchange or contributed such property to another entity (other than disregarded entities wholly-owned by the partnership throughout the tax year) ► ☐		
14 At any time during the tax year, did the partnership distribute to any partner a tenancy-in-common or other undivided interest in a partnership property?		X
15 If the partnership is required to file Form 8858, Information Return of U.S. Persons With Respect To Foreign Disregarded Entities, enter the number of Forms 8858 attached. See instructions ►		
16 Does the partnership have any foreign partners? If 'Yes,' enter the number of Forms 8805, Foreign Partner's Information Statement of Section 1446 Withholding Tax, filed for this partnership. ►		X
17 Enter the number of Forms 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships, attached to this return ►		
18a Did you make any payments in 2011 that would require you to file Form(s) 1099? See instructions	X	
b If 'Yes,' did you or will you file all required Form(s) 1099?	X	
19 Enter the number of Form(s) 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations, attached to this return ►		

Designation of Tax Matters Partner (see the instructions)
Enter below the general partner designated as the tax matters partner (TMP) for the tax year of this return:

Name of designated TMP ►

Identifying number of TMP ►

If the TMP is an entity, name of TMP representative ►

Phone number of TMP ►

Address of designated TMP ►

Schedule K	Partners' Distributive Share Items		Total amount
Income (Loss)	1 Ordinary business income (loss) (page 1, line 22)	1	42,192.
	2 Net rental real estate income (loss) (attach Form 8825)	2	
	3a Other gross rental income (loss) 3a		
	b Expenses from other rental activities (attach stmt) 3b		
	c Other net rental income (loss). Subtract line 3b from line 3a	3c	
	4 Guaranteed payments	4	0.
	5 Interest income	5	
	6 Dividends: a Ordinary dividends	6a	
	b Qualified dividends 6b		
	7 Royalties	7	
	8 Net short-term capital gain (loss) (attach Schedule D (Form 1065))	8	
	9a Net long-term capital gain (loss) (attach Schedule D (Form 1065))	9a	
	b Collectibles (28%) gain (loss) 9b		
	c Unrecaptured section 1250 gain (attach statement) 9c		
	10 Net section 1231 gain (loss) (attach Form 4797)	10	
	11 Other income (loss) (see instructions) Type ►	11	
Deductions	12 Section 179 deduction (attach Form 4562)	12	1,000.
	13a Contributions Donations	13a	350.
	b Investment interest expense	13b	
	c Section 59(e)(2) expenditures: (1) Type ► (2) Amount ►	13c (2)	
	d Other deductions (see instructions) Type ► MEDICAL INSURANCE PAYMENTS FOR PARTNERS	13d	0.
Self-Employment	14a Net earnings (loss) from self-employment	14a	42,192.
	b Gross farming or fishing income	14b	
	c Gross nonfarm income	14c	200,716.
Credits	15a Low-income housing credit (section 42(j)(5))	15a	
	b Low-income housing credit (other)	15b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468)	15c	
	d Other rental real estate credits (see instructions) Type ►	15d	
	e Other rental credits (see instructions) Type ►	15e	
	f Other credits (see instructions) Type ►	15f	
Foreign Transactions	16a Name of country or U.S. possession ►		
	b Gross income from all sources	16b	
	c Gross income sourced at partner level	16c	
	Foreign gross income sourced at partnership level		
	d Passive category ► e General category ► f Other ►	16f	
	Deductions allocated and apportioned at partner level		
	g Interest expense ► h Other ►	16h	
	Deductions allocated and apportioned at partnership level to foreign source income		
	i Passive category ► j General category ► k Other ►	16k	
	l Total foreign taxes (check one): ► Paid ☐ Accrued ☐	16l	
	m Reduction in taxes available for credit (attach statement)	16m	
	n Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	17a Post-1986 depreciation adjustment	17a	40.
	b Adjusted gain or loss	17b	
	c Depletion (other than oil and gas)	17c	
	d Oil, gas, and geothermal properties – gross income	17d	
	e Oil, gas, and geothermal properties – deductions	17e	
	f Other AMT items (attach stmt)	17f	
Other Information	18a Tax-exempt interest income	18a	
	b Other tax-exempt income	18b	
	c Nondeductible expenses	18c	261.
	19a Distributions of cash and marketable securities	19a	44,000.
	b Distributions of other property	19b	
	20a Investment income	20a	
	b Investment expenses	20b	
	c Other items and amounts (attach stmt)		

Analysis of Net Income (Loss)

1	Net income (loss). Combine Schedule K, lines 1 through 11. From the result, subtract the sum of Schedule K, lines 12 through 13d, and 16l	1 40,842.

2 Analysis by partner type:	(i) Corporate	(ii) Individual (active)	(iii) Individual (passive)	(iv) Partnership	(v) Exempt organization	(vi) Nominee/Other
a General partners		40,842.				
b Limited partners						

Schedule L Balance Sheets per Books

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
1 Cash		5,726.		1,945.
2a Trade notes and accounts receivable				
b Less allowance for bad debts				
3 Inventories				
4 U.S. government obligations				
5 Tax-exempt securities				
6 Other current assets (attach stmt)				
7a Loans to partners (or persons related to partners)				
b Mortgage and real estate loans				
8 Other investments (attach stmt)				
9a Buildings and other depreciable assets	175,430.		83,873.	
b Less accumulated depreciation	96,487.	78,943.	31,577.	52,296.
10a Depletable assets				
b Less accumulated depletion				
11 Land (net of any amortization)				
12a Intangible assets (amortizable only)				
b Less accumulated amortization				
13 Other assets (attach stmt)				
14 Total assets		84,669.		54,241.
Liabilities and Capital				
15 Accounts payable				
16 Mortgages, notes, bonds payable in less than 1 year		0.		0.
17 Other current liabilities (attach stmt)				
18 All nonrecourse loans				
19a Loans from partners (or persons related to partners)				
b Mortgages, notes, bonds payable in 1 year or more		160,769.		132,455.
20 Other liabilities (attach stmt)				
21 Partners' capital accounts		-76,100.		-78,214.
22 Total liabilities and capital		84,669.		54,241.

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note. Schedule M-3 may be required instead of Schedule M-1 (see instructions).

1	Net income (loss) per books	41,886.	
2	Income included on Schedule K, lines 1, 2, 3c, 5, 6a, 7, 8, 9a, 10, and 11, not recorded on books this year (itemize):		
3	Guaranteed pmts (other than health insurance)		
4	Expenses recorded on books this year not included on Schedule K, lines 1 through 13d, and 16l (itemize):		
	a Depreciation $		
	b Travel and entertainment $ 261.	261.	
5	Add lines 1 through 4	42,147.	
6	Income recorded on books this year not included on Schedule K, lines 1 through 11 (itemize):		
	a Tax-exempt interest $		
7	Deductions included on Schedule K, lines 1 through 13d, and 16l, not charged against book income this year (itemize):		
	a Depreciation $ 1,305.		1,305.
8	Add lines 6 and 7		1,305.
9	Income (loss) (Analysis of Net Income (Loss), line 1). Subtract line 8 from line 5		40,842.

Schedule M-2 Analysis of Partners' Capital Accounts

1	Balance at beginning of year	-76,100.	6	Distributions: a Cash	44,000.
2	Capital contributed: a Cash			b Property	
	b Property		7	Other decreases (itemize):	
3	Net income (loss) per books	41,886.			
4	Other increases (itemize):		8	Add lines 6 and 7	44,000.
5	Add lines 1 through 4	-34,214.	9	Balance at end of year. Subtract line 8 from line 5	-78,214.

SCHEDULE B-1
(Form 1065)
(December 2011)
Department of the Treasury
Internal Revenue Service

Information on Partners Owning 50% or More of the Partnership

► Attach to Form 1065. See instructions.

OMB No. 1545-0099

Name of partnership

GREENWICH SMARTLIPO LLP

Employer identification number (EIN)

27-2994781

Part I Entities Owning 50% or More of the Partnership (Form 1065, Schedule B, Question 3a)

Complete columns (i) through (v) below for any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, tax-exempt organization, or any foreign government that owns, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership (see instructions).

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Maximum Percentage Owned in Profit, Loss, or Capital

Part II Individuals or Estates Owning 50% or More of the Partnership (Form 1065, Schedule B, Question 3b)

Complete columns (i) through (iv) below for any individual or estate that owns, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership (see instructions).

(i) Name of Individual or Estate	(ii) Identifying Number (if any)	(iii) Country of Citizenship (see instructions)	(iv) Maximum Percentage Owned in Profit, Loss, or Capital
DR. ELSA RASKIN	[redacted]	US	50.0000
DR SANDRA L. MARGOLES	[redacted]	US	50.0000

Form **4562**

Department of the Treasury
Internal Revenue Service (99)

Depreciation and Amortization
(Including Information on Listed Property)

► See separate instructions. ► Attach to your tax return.

OMB No. 1545-0172

2011

Attachment Sequence No. **179**

Name(s) shown on return: GREENWICH SMARTLIPO LLP

Identifying number: 27-2994781

Business or activity to which this form relates: Form 1065 Line 22

Part I Election To Expense Certain Property Under Section 179

Note: *If you have any listed property, complete Part V before you complete Part I.*

1	Maximum amount (see instructions)	1	500,000.
2	Total cost of section 179 property placed in service (see instructions)	2	4,132.
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	2,000,000.
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	0.
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	500,000.

6	(a) Description of property	(b) Cost (business use only)	(c) Elected cost
	Bovie 1250 Electrosung Unit	2,495.	500.
	Defibulator	1,637.	500.

7	Listed property. Enter the amount from line 29	7	
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	8	1,000.
9	Tentative deduction. Enter the **smaller** of line 5 or line 8	9	1,000.
10	Carryover of disallowed deduction from line 13 of your 2010 Form 4562	10	
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instrs)	11	42,192.
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11	12	1,000.
13	Carryover of disallowed deduction to 2012. Add lines 9 and 10, less line 12 ►	13	0.

Note: *Do not use Part II or Part III below for listed property. Instead, use Part V.*

Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	

Part III MACRS Depreciation (Do not include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2011	17	31,577.
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ► ☐		

Section B — Assets Placed in Service During 2011 Tax Year Using the General Depreciation System

	(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only — see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19a	3-year property						
b	5-year property						
c	7-year property		3,132.	7.0 yrs	HY	Various	305.
d	10-year property						
e	15-year property						
f	20-year property						
g	25-year property			25 yrs		S/L	
h	Residential rental property			27.5 yrs	MM	S/L	
				27.5 yrs	MM	S/L	
i	Nonresidential real property			39 yrs	MM	S/L	
					MM	S/L	

Section C — Assets Placed in Service During 2011 Tax Year Using the Alternative Depreciation System

20a	Class life					S/L	
b	12-year			12 yrs		S/L	
c	40-year			40 yrs	MM	S/L	

Part IV Summary (See instructions.)

21	Listed property. Enter amount from line 28	21	
22	**Total.** Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations — see instructions	22	31,882.
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	

Part V Listed Property (Include automobiles, certain other vehicles, certain computers, and property used for entertainment, recreation, or amusement.)

Note: *For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete* **only** *24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.*

Section A – Depreciation and Other Information (Caution: *See the instructions for limits for passenger automobiles.*)

24a Do you have evidence to support the business/investment use claimed? [X] Yes [ ] No **24b** If 'Yes,' is the evidence written? [X] Yes [ ] No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use (see instructions)						25		
26 Property used more than 50% in a qualified business use:								
27 Property used 50% or less in a qualified business use:								
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1						28		
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1							29	

Section B – Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other 'more than 5% owner,' or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
30 Total business/investment miles driven during the year (**do not** include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
33 Total miles driven during the year. Add lines 30 through 32												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
34 Was the vehicle available for personal use during off-duty hours?												
35 Was the vehicle used primarily by a more than 5% owner or related person?												
36 Is another vehicle available for personal use?												

Section C – Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who **are not** more than 5% owners or related persons (see instructions).

	Yes	No
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners		
39 Do you treat all use of vehicles by employees as personal use?		
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?		
41 Do you meet the requirements concerning qualified automobile demonstration use? (See instructions.)		

Note: *If your answer to 37, 38, 39, 40, or 41 is 'Yes,' do not complete Section B for the covered vehicles.*

Part VI Amortization

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2011 tax year (see instructions):					
43 Amortization of costs that began before your 2011 tax year				43	
44 **Total.** Add amounts in column (f). See the instructions for where to report				44	

Form 1065, Line 20
Other deductions

ACCOUNTING	3,430.
ADVERTISING	34,260.
BANK CHARGES	41.
INSURANCE	9,927.
JANITORIAL	3,007.
MEALS AND ENTERTAINMENT (50%)	261.
OFFICE EXPENSE	2,986.
OUTSIDE SERVICES/INDEPENDENT CONTRACTORS	23,285.
TELEPHONE	904.
UTILITIES	20.
INTERNET/ COMPUTER SUPPORT EXPENSE	1,867.
CREDIT CARD MERCHANT FEES	5,078.
MEDICAL SUPPLIES	29,979.
Total	115,045.

Supporting Statement of:

Form 1065 p1-3/Line 1b

Description	Amount
Fee for Service Income	205,366.
Refunds	-4,650.
Total	200,716.

Supporting Statement of:

Form 1065 p1-3/Line 14b

Description	Amount
Taxes - Business	0.
Taxes - Property	1,536.
Total	1,536.

Supporting Statement of:

Form 1065 p1-3/Line 14e

Description	Amount
Licensing & Permits	120.
Taxes - Business	0.
Total	120.

Supporting Statement of:

Form 1065 p4-5/Sch L, Line 19b(d)

Description	Amount
5	132,455.
Total	132,455.

Supporting Statement of:

Form 1065 p4-5/Qual nonrecourse liab

Description	Amount
	132,455.
Total	132,455.

This list identifies the codes used on Schedule K-1 for all partners and provides summarized reporting information for partners who file Form 1040. For detailed reporting and filing information, see the separate Partner's Instructions for Schedule K-1 and the instructions for your income tax return.

		Report on
1	**Ordinary business income (loss).** Determine whether the income (loss) is passive or nonpassive and enter on your return as follows.	
	Passive loss	See the Partner's Instructions
	Passive income	Schedule E, line 28, column (g)
	Nonpassive loss	Schedule E, line 28, column (h)
	Nonpassive income	Schedule E, line 28, column (j)
2	**Net rental real estate income (loss)**	See the Partner's Instructions
3	**Other net rental income (loss)**	
	Net income	Schedule E, line 28, column (g)
	Net loss	See the Partner's Instructions
4	**Guaranteed payments**	Schedule E, line 28, column (j)
5	**Interest income**	Form 1040, line 8a
6 a	**Ordinary dividends**	Form 1040, line 9a
6 b	**Qualified dividends**	Form 1040, line 9b
7	**Royalties**	Schedule E, line 3b
8	**Net short-term capital gain (loss)**	Schedule D, line 5
9 a	**Net long-term capital gain (loss)**	Schedule D, line 12
9 b	**Collectibles (28%) gain (loss)**	28% Rate Gain Worksheet, line 4 (Schedule D instructions)
9 c	**Unrecaptured section 1250 gain**	See the Partner's Instructions
10	**Net section 1231 gain (loss)**	See the Partner's Instructions
11	**Other income (loss)**	
	Code	
	A Other portfolio income (loss)	See the Partner's Instructions
	B Involuntary conversions	See the Partner's Instructions
	C Section 1256 contracts and straddles	Form 6781, line 1
	D Mining exploration costs recapture	See Pub 535
	E Cancellation of debt	Form 1040, line 21 or Form 982
	F Other income (loss)	See the Partner's Instructions
12	**Section 179 deduction**	See the Partner's Instructions
13	**Other deductions**	
	A Cash contributions (50%)	See the Partner's Instructions
	B Cash contributions (30%)	
	C Noncash contributions (50%)	
	D Noncash contributions (30%)	
	E Capital gain property to a 50% organization (30%)	
	F Capital gain property (20%)	
	G Contributions (100%)	
	H Investment interest expense	Form 4952, line 1
	I Deductions — royalty income	Schedule E, line 19
	J Section 59(e)(2) expenditures	See the Partner's Instructions
	K Deductions — portfolio (2% floor)	Schedule A, line 23
	L Deductions — portfolio (other)	Schedule A, line 28
	M Amounts paid for medical insurance	Schedule A, line 1 or Form 1040, line 29
	N Educational assistance benefits	See the Partner's Instructions
	O Dependent care benefits	Form 2441, line 12
	P Preproductive period expenses	See the Partner's Instructions
	Q Commercial revitalization deduction from rental real estate activities	See Form 8582 Instructions
	R Pensions and IRAs	See the Partner's Instructions
	S Reforestation expense deduction	See the Partner's Instructions
	T Domestic production activities information	See Form 8903 Instructions
	U Qualified production activities income	Form 8903, line 7b
	V Employer's Form W-2 wages	Form 8903, line 17
	W Other deductions	See the Partner's Instructions
14	**Self-employment earnings (loss)**	

Note. *If you have a section 179 deduction or any partner-level deductions, see the Partner's Instructions before completing Schedule SE.*

	A Net earnings (loss) from self-employment	Schedule SE, Section A or B
	B Gross farming or fishing income	See the Partner's Instructions
	C Gross non-farm income	See the Partner's Instructions
15	**Credits**	
	A Low-income housing credit (section 42(j)(5)) from pre-2008 buildings	See the Partner's Instructions
	B Low-income housing credit (other) from pre-2008 buildings	
	C Low-income housing credit (section 42(j)(5)) from post-2007 buildings	
	D Low-income housing credit (other) from post-2007 buildings	
	E Qualified rehabilitation expenditures (rental real estate)	
	F Other rental real estate credits	
	G Other rental credits	
	H Undistributed capital gains credit	Form 1040, line 71; check box a
	I Alcohol and cellulosic biofuel fuels credit	See the Partner's Instructions
	J Work opportunity credit	See the Partner's Instructions
	K Disabled access credit	
	L Empowerment zone and renewal community employment credit	
	M Credit for increasing research activities	
	N Credit for employer social security and Medicare taxes	
	O Backup withholding	Form 1040, line 62
	P Other credits	See the Partner's Instructions
16	**Foreign transactions**	
	A Name of country or U.S. possession	Form 1116, Part I
	B Gross income from all sources	
	C Gross income sourced at partner level	
	Foreign gross income sourced at partnership level	
	D Passive category	Form 1116, Part I
	E General category	
	F Other	
	Deductions allocated and apportioned at partner level	
	G Interest expense	Form 1116, Part I
	H Other	Form 1116, Part I
	Deductions allocated and apportioned at partnership level to foreign source income	
	I Passive category	Form 1116, Part I
	J General category	
	K Other	
	Other information	
	L Total foreign taxes paid	Form 1116, Part II
	M Total foreign taxes accrued	Form 1116, Part II
	N Reduction in taxes available for credit	Form 1116, line 12
	O Foreign trading gross receipts	Form 8873
	P Extraterritorial income exclusion	Form 8873
	Q Other foreign transactions	See the Partner's Instructions
17	**Alternative minimum tax (AMT) items**	
	A Post-1986 depreciation adjustment	See the Partner's Instructions and the Instructions for Form 6251
	B Adjusted gain or loss	
	C Depletion (other than oil & gas)	
	D Oil, gas, & geothermal — gross income	
	E Oil, gas, & geothermal — deductions	
	F Other AMT items	
18	**Tax-exempt income and nondeductible expenses**	
	A Tax-exempt interest income	Form 1040, line 8b
	B Other tax-exempt income	See the Partner's Instructions
	C Nondeductible expenses	See the Partner's Instructions
19	**Distributions**	
	A Cash and marketable securities	See the Partner's Instructions
	B Distribution subject to section 737	
	C Other property	
20	**Other information**	
	A Investment income	Form 4952, line 4a
	B Investment expenses	Form 4952, line 5
	C Fuel tax credit information	Form 4136
	D Qualified rehabilitation expenditures (other than rental real estate)	See the Partner's Instructions
	E Basis of energy property	See the Partner's Instructions
	F Recapture of low-income housing credit (section 42(j)(5))	Form 8611, line 8
	G Recapture of low-income housing credit (other)	Form 8611, line 8
	H Recapture of investment credit	Form 4255
	I Recapture of other credits	See the Partner's Instructions
	J Look-back interest — completed long-term contracts	See Form 8697
	K Look-back interest — income forecast method	See Form 8866
	L Dispositions of property with section 179 deductions	See the Partner's Instructions
	M Recapture of section 179 deduction	
	N Interest expense for corporate partners	
	O Section 453(l)(3) information	
	P Section 453A(c) information	
	Q Section 1260(b) information	
	R Interest allocable to production expenditures	
	S CCF nonqualified withdrawals	
	T Depletion information — oil and gas	
	U Amortization of reforestation costs	
	V Unrelated business taxable income	
	W Precontribution gain (loss)	
	X Section 108(i) information	
	Y Other information	

651111

Schedule K-1 (Form 1065)

Department of the Treasury Internal Revenue Service

2011

For calendar year 2011, or tax year beginning _____, 2011 ending _____.

☐ Final K-1 ☐ Amended K-1 OMB No. 1545-0099

Partner's Share of Income, Deductions, Credits, etc.

► See separate instructions.

Part I Information About the Partnership

A Partnership's employer identification number
27-2994781

B Partnership's name, address, city, state, and ZIP code
GREENWICH SMARTLIPO LLP
2 1/2 DEARFIELD DRIVE, SUITE 102
GREENWICH, CT 06830

C IRS Center where partnership filed return
CINCINNATI, OH

D ☐ Check if this is a publicly traded partnership (PTP)

Part II Information About the Partner

E Partner's identifying number
[redacted]

F Partner's name, address, city, state, and ZIP code
DR. ELSA RASKIN
230 TACONIC ROAD
GREENWICH, CT 06831

G ☒ General partner or LLC member-manager ☐ Limited partner or other LLC member

H ☒ Domestic partner ☐ Foreign partner

I What type of entity is this partner? INDIVIDUAL

J Partner's share of profit, loss, and capital (see instructions):

	Beginning	Ending
Profit	50.00000 %	50.00000 %
Loss	50.00000 %	50.00000 %
Capital	50.00000 %	50.00000 %

K Partner's share of liabilities at year end:

Nonrecourse	$
Qualified nonrecourse financing	$ 66,227.
Recourse	$

L Partner's capital account analysis:

Beginning capital account	$ -38,050.
Capital contributed during the year	$
Current year increase (decrease)	$ 20,943.
Withdrawals and distributions	$ 22,000.
Ending capital account	$ -39,107.

☒ Tax basis ☐ GAAP ☐ Section 704(b) book ☐ Other (explain)

M Did the partner contribute property with a built-in gain or loss?
☐ Yes ☒ No
If 'Yes', attach statement (see instructions)

Part III Partner's Share of Current Year Income, Deductions, Credits, and Other Items

1	Ordinary business income (loss) 21,096.	15	Credits
2	Net rental real estate income (loss)		
3	Other net rental income (loss)	16	Foreign transactions
4	Guaranteed payments 0.		
5	Interest income		
6a	Ordinary dividends		
6b	Qualified dividends		
7	Royalties		
8	Net short-term capital gain (loss)		
9a	Net long-term capital gain (loss)	17	Alternative minimum tax (AMT) items
		A	20.
9b	Collectibles (28%) gain (loss)		
9c	Unrecaptured section 1250 gain		
10	Net section 1231 gain (loss)	18	Tax-exempt income and nondeductible expenses
11	Other income (loss)	C	130.
12	Section 179 deduction 500.	19	Distributions
		A	22,000.
13	Other deductions	20	Other information
A	175.		
M	0.		
14	Self-employment earnings (loss)		
A	21,096.		
C	100,358.		

*See attached statement for additional information.

FOR IRS USE ONLY

BAA For Paperwork Reduction Act Notice, see Instructions for Form 1065.

Schedule K-1 (Form 1065) 2011

PTPA0312 08/18/11

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Schedule K-1 (DR SANDRA L. MARGOLES), Supplemental Information

Supplemental Information

This Schedule K-1 is from an Eligible Small Business.

651111

Schedule K-1 (Form 1065) 2011

For calendar year 2011, or tax year beginning _____, 2011 ending _____

Department of the Treasury
Internal Revenue Service

☐ Final K-1 ☐ Amended K-1 OMB No. 1545-0099

Partner's Share of Income, Deductions, Credits, etc.

► See separate instructions.

Part I Information About the Partnership

A Partnership's employer identification number
27-2994781

B Partnership's name, address, city, state, and ZIP code
GREENWICH SMARTLIPO LLP
2 1/2 DEARFIELD DRIVE, SUITE 102
GREENWICH, CT 06830

C IRS Center where partnership filed return
CINCINNATI, OH

D ☐ Check if this is a publicly traded partnership (PTP)

Part II Information About the Partner

E Partner's identifying number
[redacted]

F Partner's name, address, city, state, and ZIP code
DR SANDRA L. MARGOLES
14 RICHMOND DRIVE
OLD GREENWICH, CT 06870

G ☒ General partner or LLC member-manager ☐ Limited partner or other LLC member

H ☒ Domestic partner ☐ Foreign partner

I What type of entity is this partner? INDIVIDUAL

J Partner's share of profit, loss, and capital (see instructions):

	Beginning	Ending
Profit	50.00000 %	50.00000 %
Loss	50.00000 %	50.00000 %
Capital	50.00000 %	50.00000 %

K Partner's share of liabilities at year end:

Nonrecourse	$
Qualified nonrecourse financing	$ 66,228.
Recourse	$

L Partner's capital account analysis:

Beginning capital account	$ -38,050.
Capital contributed during the year	$
Current year increase (decrease)	$ 20,943.
Withdrawals and distributions	$ 22,000.
Ending capital account	$ -39,107.

☒ Tax basis ☐ GAAP ☐ Section 704(b) book
☐ Other (explain)

M Did the partner contribute property with a built-in gain or loss?
☐ Yes ☒ No
If 'Yes', attach statement (see instructions)

Part III Partner's Share of Current Year Income, Deductions, Credits, and Other Items

1	Ordinary business income (loss) 21,096.	15	Credits
2	Net rental real estate income (loss)		
3	Other net rental income (loss)	16	Foreign transactions
4	Guaranteed payments 0.		
5	Interest income		
6a	Ordinary dividends		
6b	Qualified dividends		
7	Royalties		
8	Net short-term capital gain (loss)		
9a	Net long-term capital gain (loss)	17 A	Alternative minimum tax (AMT) items 20.
9b	Collectibles (28%) gain (loss)		
9c	Unrecaptured section 1250 gain		
10	Net section 1231 gain (loss)	18	Tax-exempt income and nondeductible expenses
11	Other income (loss)	C	131.
		19	Distributions
12	Section 179 deduction 500.	A	22,000.
13	Other deductions	20	Other information
A	175.		
M	0.		
14	Self-employment earnings (loss)		
A	21,096.		
C	100,358.		

*See attached statement for additional information.

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This list identifies the codes used on Schedule K-1 for all partners and provides summarized reporting information for partners who file Form 1040. For detailed reporting and filing information, see the separate Partner's Instructions for Schedule K-1 and the instructions for your income tax return.

		Report on
1	**Ordinary business income (loss).** Determine whether the income (loss) is passive or nonpassive and enter on your return as follows.	
	Passive loss	See the Partner's Instructions
	Passive income	Schedule E, line 28, column (g)
	Nonpassive loss	Schedule E, line 28, column (h)
	Nonpassive income	Schedule E, line 28, column (j)
2	**Net rental real estate income (loss)**	See the Partner's Instructions
3	**Other net rental income (loss)**	
	Net income	Schedule E, line 28, column (g)
	Net loss	See the Partner's Instructions
4	**Guaranteed payments**	Schedule E, line 28, column (j)
5	**Interest income**	Form 1040, line 8a
6a	**Ordinary dividends**	Form 1040, line 9a
6b	**Qualified dividends**	Form 1040, line 9b
7	**Royalties**	Schedule E, line 3b
8	**Net short-term capital gain (loss)**	Schedule D, line 5
9a	**Net long-term capital gain (loss)**	Schedule D, line 12
9b	**Collectibles (28%) gain (loss)**	28% Rate Gain Worksheet, line 4 (Schedule D Instructions)
9c	**Unrecaptured section 1250 gain**	See the Partner's Instructions
10	**Net section 1231 gain (loss)**	See the Partner's Instructions
11	**Other income (loss)**	
	Code	
	A Other portfolio income (loss)	See the Partner's Instructions
	B Involuntary conversions	See the Partner's Instructions
	C Section 1256 contracts and straddles	Form 6781, line 1
	D Mining exploration costs recapture	See Pub 535
	E Cancellation of debt	Form 1040, line 21 or Form 982
	F Other income (loss)	See the Partner's Instructions
12	**Section 179 deduction**	See the Partner's Instructions
13	**Other deductions**	
	A Cash contributions (50%)	See the Partner's Instructions
	B Cash contributions (30%)	
	C Noncash contributions (50%)	
	D Noncash contributions (30%)	
	E Capital gain property to a 50% organization (30%)	
	F Capital gain property (20%)	
	G Contributions (100%)	
	H Investment interest expense	Form 4952, line 1
	I Deductions — royalty income	Schedule E, line 19
	J Section 59(e)(2) expenditures	See the Partner's Instructions
	K Deductions — portfolio (2% floor)	Schedule A, line 23
	L Deductions — portfolio (other)	Schedule A, line 28
	M Amounts paid for medical insurance	Schedule A, line 1 or Form 1040, line 29
	N Educational assistance benefits	See the Partner's Instructions
	O Dependent care benefits	Form 2441, line 12
	P Preproductive period expenses	See the Partner's Instructions
	Q Commercial revitalization deduction from rental real estate activities	See Form 8582 Instructions
	R Pensions and IRAs	See the Partner's Instructions
	S Reforestation expense deduction	See the Partner's Instructions
	T Domestic production activities information	See Form 8903 Instructions
	U Qualified production activities income	Form 8903, line 7b
	V Employer's Form W-2 wages	Form 8903, line 17
	W Other deductions	See the Partner's Instructions
14	**Self-employment earnings (loss)**	
	Note. If you have a section 179 deduction or any partner-level deductions, see the Partner's Instructions before completing Schedule SE.	
	A Net earnings (loss) from self-employment	Schedule SE, Section A or B
	B Gross farming or fishing income	See the Partner's Instructions
	C Gross non-farm income	See the Partner's Instructions
15	**Credits**	
	A Low-income housing credit (section 42(j)(5)) from pre-2008 buildings	See the Partner's Instructions
	B Low-income housing credit (other) from pre-2008 buildings	
	C Low-income housing credit (section 42(j)(5)) from post-2007 buildings	
	D Low-income housing credit (other) from post-2007 buildings	
	E Qualified rehabilitation expenditures (rental real estate)	
	F Other rental real estate credits	
	G Other rental credits	
	H Undistributed capital gains credit	Form 1040, line 71; check box a
	I Alcohol and cellulosic biofuel fuels credit	See the Partner's Instructions
	J Work opportunity credit	See the Partner's Instructions
	K Disabled access credit	
	L Empowerment zone and renewal community employment credit	
	M Credit for increasing research activities	
	N Credit for employer social security and Medicare taxes	
	O Backup withholding	Form 1040, line 62
	P Other credits	See the Partner's Instructions
16	**Foreign transactions**	
	A Name of country or U.S. possession	Form 1116, Part I
	B Gross income from all sources	
	C Gross income sourced at partner level	
	Foreign gross income sourced at partnership level	
	D Passive category	Form 1116, Part I
	E General category	
	F Other	
	Deductions allocated and apportioned at partner level	
	G Interest expense	Form 1116, Part I
	H Other	Form 1116, Part I
	Deductions allocated and apportioned at partnership level to foreign source income	
	I Passive category	Form 1116, Part I
	J General category	
	K Other	
	Other information	
	L Total foreign taxes paid	Form 1116, Part II
	M Total foreign taxes accrued	Form 1116, Part II
	N Reduction in taxes available for credit	Form 1116, line 12
	O Foreign trading gross receipts	Form 8873
	P Extraterritorial income exclusion	Form 8873
	Q Other foreign transactions	See the Partner's Instructions
17	**Alternative minimum tax (AMT) items**	
	A Post-1986 depreciation adjustment	See the Partner's Instructions and the Instructions for Form 6251
	B Adjusted gain or loss	
	C Depletion (other than oil & gas)	
	D Oil, gas, & geothermal — gross income	
	E Oil, gas, & geothermal — deductions	
	F Other AMT items	
18	**Tax-exempt income and nondeductible expenses**	
	A Tax-exempt interest income	Form 1040, line 8b
	B Other tax-exempt income	See the Partner's Instructions
	C Nondeductible expenses	See the Partner's Instructions
19	**Distributions**	
	A Cash and marketable securities	See the Partner's Instructions
	B Distribution subject to section 737	
	C Other property	
20	**Other information**	
	A Investment income	Form 4952, line 4a
	B Investment expenses	Form 4952, line 5
	C Fuel tax credit information	Form 4136
	D Qualified rehabilitation expenditures (other than rental real estate)	See the Partner's Instructions
	E Basis of energy property	See the Partner's Instructions
	F Recapture of low-income housing credit (section 42(j)(5))	Form 8611, line 8
	G Recapture of low-income housing credit (other)	Form 8611, line 8
	H Recapture of investment credit	Form 4255
	I Recapture of other credits	See the Partner's Instructions
	J Look-back interest — completed long-term contracts	See Form 8697
	K Look-back interest — income forecast method	See Form 8866
	L Dispositions of property with section 179 deductions	See the Partner's Instructions
	M Recapture of section 179 deduction	
	N Interest expense for corporate partners	
	O Section 453(l)(3) information	
	P Section 453A(c) information	
	Q Section 1260(b) information	
	R Interest allocable to production expenditures	
	S CCF nonqualified withdrawals	
	T Depletion information — oil and gas	
	U Amortization of reforestation costs	
	V Unrelated business taxable income	
	W Precontribution gain (loss)	
	X Section 108(i) information	
	Y Other information	

Schedule K-1 (DR. ELSA RASKIN), Supplemental Information

Supplemental Information

This Schedule K-1 is from an Eligible Small Business.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 28, 2012 VIA FAX & EMAIL ONLY

Sandra L. Margoles, MD
Greenwich Platic Surgery Center
2 ½ Deerfield Drive
Greenwich, CT 06831

RE: Certificate of Need Application; Docket Number: 12-31799-CON
Greenwich Smartlipo d/b/a Greenwich Plastic Surgery Center
Establish and Operate an Outpatient Surgical Facility in Greenwich

Dear Dr. Margoles:

On October 31, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of Elsa M. Raskin, MD and Sandra L. Margoles, MD of Greenwich Smartlipo, LLP, d/b/a Greenwich Plastic Surgery Center ("Applicants" or "Facility") to establish and operate an outpatient surgery center in Greenwich, Connecticut.

OHCA requests the following additional information pursuant to Connecticut General Statutes §19a-639a(c):

1) Please revise the "Retrospective Volume" table on page 3 of the application to include columns for: January – October 2012 (actual), November – December 2012 (estimated) and a 2012 total (10 months actual + 2 months estimated).

2) Provide a breakdown of the patients' town of residence based on volumes for 2010, 2011 and 2012, year-to-date.

3) Do the patient volumes listed on page 3 of the application represent procedures completed only at the Greenwich Plastic Surgery Center, or do these numbers include procedures performed at other facilities? If procedures were completed at facilities other than the Greenwich Plastic Surgery Center, please identify volumes by facility.

4) Please provide additional detail to support the statement found on page 3 of the application, which states: "We provide state of the art laser liposuction treatment that is not available at the hospital." Provide additional documentation to explain the type of liposuction that you perform, if it is available at other area providers (application states this type of liposuction is not available at Greenwich Hospital) and show evidence to support the advantages of this method of treatment.

5) On page 4 of the application you state that the approval of this proposal would enable you to "perform the surgeries for patients with lower fees and lower expenses for the physicians and thefore [sic] result in lower cost to the patients." Explain why the physician fees, expenses and overall cost to the patients would be reduced as a result of this proposal.

6) If this proposal were approved, identify the personnel responsible for administering the delivery of the general anesthesia. If not already noted, describe their qualifications for performing this service.

7) Provide copies of any transfer agreements that the Applicants have in place with the area's acute care hospitals.

8) Provide documentation to verify your current accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) as stated on page 5 of the application.

9) Please revise the projected volumes on page 6 of the application to include FY 2015. Provide additional detail on how these estimates were calculated, and include subtotal and total rows.

10) Based on the historical data you provided on page 3 of the application, the average number of surgical procedures from 2009 to 2011 is 67. The surgical volumes projected on page 6 of the application anticipate surgical volumes to increase to 119 in 2012, 178 in 2013 and 233 in 2014. Please provide the assumptions used to determine the projected surgical volumes.

11) Revise the financial estimates found on page 7 to reflect Financial Attachment 1, Version B (see OHCA Website) adding additional row detail and columns that include: Projected w/out CON, Projected Incremental, and Projected with CON. Add FY 2015 to the projections and provide all assumptions used to prepare these projections. Also, identify the starting and ending months of your fiscal year.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 90 and reference "Docket Number: 12-31799-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact Brian Carney at (860) 418-7014.

Sincerely,

Brian A. Carney

Brian A. Carney
Associate Research Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

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RECIPIENT ADDRESS	912038616621
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PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DR. SANDRA L. MARGOLES

FAX: (203) 861-6621

AGENCY: GREENWICH PLASTIC SURGERY CENTER

FROM: BRIAN A. CARNEY - DPH/OHCA

DATE: 11/28/12 TIME: 1:32 PM

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: PLEASE SEE ATTACHED COMPLETENESS LETTER.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Carney, Brian
Sent: Wednesday, November 28, 2012 1:52 PM
To: 'slmargoles@aol.com'
Cc: Riggott, Kaila; Greer, Leslie
Subject: 12-31799-CON Greenwich Plastic Surgery Center
Attachments: 12-31799 Completeness letter.docx

Dear Dr. Margoles,

Please see the attached completeness letter in response to your Certificate of Need application. I faxed you the signed copy earlier, but am providing this attachment for your convenience (ability to copy and paste questions into your response letter). Also, please note that we repaginated your original application; please begin numbering your response letter with page 90.

Sincerely,
Brian Carney

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 28, 2012 VIA FAX & EMAIL ONLY

Sandra L. Margoles, MD
Greenwich Platic Surgery Center
2 ½ Deerfield Drive
Greenwich, CT 06831

RE: Certificate of Need Application; Docket Number: 12-31799-CON
Greenwich Smartlipo d/b/a Greenwich Plastic Surgery Center
Establish and Operate an Outpatient Surgical Facility in Greenwich

Dear Dr. Margoles:

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OHCA requests the following additional information pursuant to Connecticut General Statutes §19a-639a(c):

1) Please revise the "Retrospective Volume" table on page 3 of the application to include columns for: January – October 2012 (actual), November – December 2012 (estimated) and a 2012 total (10 months actual + 2 months estimated).

2) Provide a breakdown of the patients' town of residence based on volumes for 2010, 2011 and 2012, year-to-date.

3) Do the patient volumes listed on page 3 of the application represent procedures completed only at the Greenwich Plastic Surgery Center, or do these numbers include procedures performed at other facilities? If procedures were completed at facilities other than the Greenwich Plastic Surgery Center, please identify volumes by facility.

4) Please provide additional detail to support the statement found on page 3 of the application, which states: "We provide state of the art laser liposuction treatment that is not available at the hospital." Provide additional documentation to explain the type of liposuction that you perform, if it is available at other area providers (application states this type of liposuction is not available at Greenwich Hospital) and show evidence to support the advantages of this method of treatment.

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6) If this proposal were approved, identify the personnel responsible for administering the delivery of the general anesthesia. If not already noted, describe their qualifications for performing this service.

7) Provide copies of any transfer agreements that the Applicants have in place with the area's acute care hospitals.

8) Provide documentation to verify your current accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) as stated on page 5 of the application.

9) Please revise the projected volumes on page 6 of the application to include FY 2015. Provide additional detail on how these estimates were calculated, and include subtotal and total rows.

10) Based on the historical data you provided on page 3 of the application, the average number of surgical procedures from 2009 to 2011 is 67. The surgical volumes projected on page 6 of the application anticipate surgical volumes to increase to 119 in 2012, 178 in 2013 and 233 in 2014. Please provide the assumptions used to determine the projected surgical volumes.

11) Revise the financial estimates found on page 7 to reflect Financial Attachment 1, Version B (see OHCA Website) adding additional row detail and columns that include: Projected w/out CON, Projected Incremental, and Projected with CON. Add FY 2015 to the projections and provide all assumptions used to prepare these projections. Also, identify the starting and ending months of your fiscal year.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 90 and reference "Docket Number: 12-31799-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact Brian Carney at (860) 418-7014.

Sincerely,

Brian A. Carney

Brian A. Carney
Associate Research Analyst

Greer, Leslie

From: Carney, Brian
Sent: Thursday, December 06, 2012 1:12 PM
To: 'slmargoles@aol.com'
Cc: Riggott, Kaila; Greer, Leslie
Subject: FW: CON questions

Dear Dr. Margoles,

Steve forwarded your email to me for response. In answer to your question, please submit your volumes by town; adding the broad region the town belongs to (e.g., Westchester County, NY) would also be appreciated. You do not need to list zip codes. If you have any additional questions, please contact me at Brian.Carney@ct.gov or (860) 418 -7014.

Sincerely,
Brian Carney

From: Lazarus, Steven
Sent: Thursday, December 06, 2012 12:10 PM
To: Carney, Brian
Cc: Sandra Margoles (slmargoles@aol.com)
Subject: FW: CON questions

Brian,

Here is the email I had mentioned to you. Can you please follow up with Dr. Margoles.

Thank you,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone (Direct): 860.418.7012
Fax (Main): 860.418.7053

From: slmargoles@aol.com [mailto:slmargoles@aol.com]
Sent: Wednesday, December 05, 2012 3:44 PM
To: Lazarus, Steven
Subject: CON questions

Steve- we have submitted our CON application and are now responding to further questions. They wish to know the breakdown per volume for place of residence per year. Should we list zip codes and town names or just broad regions; towns?

Sandra L. Margoles, MD
Associate Plastic Surgeon
Dept. of Plastic Surgery

Greenwich Hospital/Stamford Hospital
203-869-2939

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 28, 2012

VIA FAX & EMAIL ONLY

Sandra L. Margoles, MD
Greenwich Platic Surgery Center
2 ½ Deerfield Drive
Greenwich, CT 06831

RE: Certificate of Need Application; Docket Number: 12-31799-CON
Greenwich Smartlipo d/b/a Greenwich Plastic Surgery Center
Establish and Operate an Outpatient Surgical Facility in Greenwich

Dear Dr. Margoles:

On October 31, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of Elsa M. Raskin, MD and Sandra L. Margoles, MD of Greenwich Smartlipo, LLP, d/b/a Greenwich Plastic Surgery Center ("Applicants" or "Facility") to establish and operate an outpatient surgery center in Greenwich, Connecticut.

OHCA requests the following additional information pursuant to Connecticut General Statutes §19a-639a(c):

1) Please revise the "Retrospective Volume" table on page 3 of the application to include columns for: January – October 2012 (actual), November – December 2012 (estimated) and a 2012 total (10 months actual + 2 months estimated).

2) Provide a breakdown of the patients' town of residence based on volumes for 2010, 2011 and 2012, year-to-date.

3) Do the patient volumes listed on page 3 of the application represent procedures completed only at the Greenwich Plastic Surgery Center, or do these numbers include procedures performed at other facilities? If procedures were completed at facilities other than the Greenwich Plastic Surgery Center, please identify volumes by facility.

4) Please provide additional detail to support the statement found on page 3 of the application, which states: "We provide state of the art laser liposuction treatment that is not available at the hospital." Provide additional documentation to explain the type of liposuction that you perform, if it is available at other area providers (application states this type of liposuction is not available at Greenwich Hospital) and show evidence to support the advantages of this method of treatment.

5) On page 4 of the application you state that the approval of this proposal would enable you to "perform the surgeries for patients with lower fees and lower expenses for the physicians and thefore [sic] result in lower cost to the patients." Explain why the physician fees, expenses and overall cost to the patients would be reduced as a result of this proposal.

6) If this proposal were approved, identify the personnel responsible for administering the delivery of the general anesthesia. If not already noted, describe their qualifications for performing this service.

7) Provide copies of any transfer agreements that the Applicants have in place with the area's acute care hospitals.

8) Provide documentation to verify your current accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) as stated on page 5 of the application.

9) Please revise the projected volumes on page 6 of the application to include FY 2015. Provide additional detail on how these estimates were calculated, and include subtotal and total rows.

10) Based on the historical data you provided on page 3 of the application, the average number of surgical procedures from 2009 to 2011 is 67. The surgical volumes projected on page 6 of the application anticipate surgical volumes to increase to 119 in 2012, 178 in 2013 and 233 in 2014. Please provide the assumptions used to determine the projected surgical volumes.

11) Revise the financial estimates found on page 7 to reflect Financial Attachment 1, Version B (see OHCA Website) adding additional row detail and columns that include: Projected w/out CON, Projected Incremental, and Projected with CON. Add FY 2015 to the projections and provide all assumptions used to prepare these projections. Also, identify the starting and ending months of your fiscal year.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 90 and reference "Docket Number: 12-31799-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact Brian Carney at (860) 418-7014.

Sincerely,

Brian A. Carney
Associate Research Analyst

1) Please revise the "Retrospective Volume" table on page 3 of the application to include columns for:
January – October 2012 (actual), November – December 2012 (estimated) and a 2012 total (10 months actual + 2 months estimated).

RETROSPECTIVE

		YEAR						LOCATION
		2009	2010	2011	2012	2012	2012 total	
PROCEDURE	Room 1	Jan-Dec	Jan-Dec	Jan-Dec	Jan-Oct	Nov-Dec	2012	Location
Abdominoplasty	1	1	16	5	5	2	7	GH
Blepharoplasty	1	10	7	5	6	1	7	GH
Breast augmentation	1	9	6	7	7	2	9	GH
Breast lift	1	7	13	5	3	1	4	GH
Breast reduction	1	34	37	10	15	2	17	GH
Facelift	1	2	3	3	1	0	1	GH
Liposuction	1	5	**20**	**30**	**38**	**5**	**43**	**GPSC**
Rhinoplasty	1	1	1	2	0	0	0	GH
Subtotal	1	69	103	67	75	13	88	

Greenwich Plastic Surgery Center since 2010 (GPSC)
Greenwich Hospital (GH)

2) Provide a breakdown of the patients' town of residence based on volumes for 2010, 2011 and 2012, year-to-date.

	Volume		
Town of Residence	**2010**	**2011**	**2012**
Darien	5%	5%	5%
Greenwich	36%	34%	33%
New Canaan	6%	8%	8%
Norwalk	6%	5%	5%
Stamford	13%	15%	15%
Other	2%	3%	2%
NY State	32%	30%	32%

3) Do the patient volumes listed on page 3 of the application represent procedures completed only at the Greenwich Plastic Surgery Center, or do these numbers include procedures performed at other facilities? If procedures were completed at facilities other than the Greenwich Plastic Surgery Center, please identify volumes by facility

The initial patient volumes listed on page 3 of the application include procedures performed at the Greenwich Hospital. As of 2010, Greenwich Plastic Surgery Center began doing liposuction in the office based operating room under local anesthesia . All liposuction cases since 2010 have been done solely at the Greenwich Plastic Surgery Center. Insurance paid cases such as some breast reductions, breast reconstructions, or cosmetic, self pay patients who require or request an overnight stay will be performed at the Greenwich Hospital.

In summary:

Total Volumes by Facility

	Greenwich Hospital	Greenwich Plastic Surgery Center
2009	69	0
2010	83	20
2011	37	30
2012	45	43

4) Please provide additional detail to support the statement found on page 3 of the application, which states: "We provide state of the art laser liposuction treatment that is not available at the hospital." Provide additional documentation to explain the type of liposuction that you perform, if it is available at other area providers (application states this type of liposuction is not available at Greenwich Hospital) and show evidence to support the advantages of this method of treatment.

Laser assisted liposuction is not available at either Greenwich Hospital, or Stamford hospital, and there are no plastic surgeons in Fairfield County with this state of the art laser machine.

Laser assisted liposuction has been shown to facilitate fat removal, reduce procedure time, patient recovery time and postoperative pain. The most current laser liposuction machine the triplex, also has a statistically significant improvement in skin shrinkage and tightening of the skin when compared to traditional liposuction alone; the only type of liposuction offered in the hospital setting.

DiBernardo, B.E., Randomized blinded split abdomen study evaluating skin shrinkage and skin tightening in laser-assisted liposuction versus liposuction control *Aesthetic Surgery Journal*, 30(4), 2010 p. 593-602

Aesthetic Surgery Journal
http://aes.sagepub.com/

Randomized, Blinded Split Abdomen Study Evaluating Skin Shrinkage and Skin Tightening in Laser-Assisted Liposuction Versus Liposuction Control

Barry E. DiBernardo

Aesthetic Surgery Journal 2010 30: 593
DOI: 10.1177/1090820X10380707

The online version of this article can be found at:
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www.aestheticsurgeryjournal.com
SAGE

Randomized, Blinded Split Abdomen Study Evaluating Skin Shrinkage and Skin Tightening in Laser-Assisted Liposuction Versus Liposuction Control

Barry E. DiBernardo, MD

Abstract

Background: Laser-assisted liposuction has shown great potential in facilitating fat removal, improving patient recovery time, and decreasing postoperative side effects. Clinical experience has indicated superior skin tightening after laser-assisted liposuction than with liposuction alone.

Objectives: The aim of the present study was to obtain quantitative, objective data for comparing tissue shrinkage and skin tightening achieved by laser-assisted liposuction versus liposuction alone.

Methods: Ten female subjects from the author's private practice with unwanted abdominal adiposity and mild to moderate skin laxity were enrolled. On the abdominal skin of each patient, the corners of four rectangular regions (approximately 5 × 5 cm each) were tattooed with India ink and randomly assigned to treatment with laser-assisted liposuction (Smartly MPX laser, Cynosure, Inc., Westford, Massachusetts) or with liposuction alone. The laser system permits individual as well as sequential emission of 1064-nm and 1320-nm wavelengths. Skin shrinkage was quantified by calculating the changes in surface area of the regions. Skin tightening was quantified by changes in the skin stiffness index measured in the treated regions.

Results: One month and three months after treatment, the mean skin shrinkage ratios were significantly higher on the laser-treated side than on the suction side. One month after treatment with or without laser, the mean skin stiffness and skin tightening showed no statistically significant difference from baseline. Three months after treatment, the mean skin stiffness and skin tightening were significantly higher on the laser-treated side.

Conclusions: Laser-assisted liposuction has a statistically significant effect on skin shrinkage and tightening of the skin in the abdominal area when compared to liposuction alone.

Keywords

liposuction, laser, laser-assisted liposuction, skin tightening, skin shrinkage

Accepted for publication December 28, 2009.

Liposuction is considered the gold-standard procedure for body sculpting and contouring.[1] The introduction of the tumescent technique has reduced the risk of bleeding, which has thereby reduced the need for general anesthesia and hospitalization and diminished postoperative ecchymoses associated with liposuction.[1-5] Other advances include the refinement of body site–specific cannulas and the manual syringe suction for autologous fat transfer and fine contouring.[6,7] More recently, ultrasound-assisted liposuction (UAL), power-assisted liposuction (PAL), vibroliposuction,[8] and laser-assisted liposuction (LAL) have shown promise in facilitating fat removal and in reducing procedure duration, surgeon strain, patient recovery time, and postoperative pain.[1,4-6,9]

Described first in a multicenter study with a Nd:YAG laser,[10] LAL was designed to enhance outcomes of standard liposuction.[1] An updated technique with a 1064-nm Nd:YAG laser was described in detail by Goldman and colleagues,[11] showing histological evidence of coagulation of small blood vessels, rupture of adipocytes, reorganization of the reticular dermis, and coagulation of collagen in fat tissue. In this and in a later study,[12] Goldman and colleagues delivered the laser energy directly to the adipose tissue transcutaneously through a 300-µm-diameter fiber, with its distal end extending 2 to 3 mm beyond the distal end of a 1-mm stainless steel cannula. Badin et al,[13,14] with a technique and laser similar to that of Goldman et al,[11,12]

Dr. DiBernardo is a surgeon in private practice in Montclair, New Jersey.

Corresponding Author:
Dr. Barry DiBernardo, 29 Park Street, Montclair, NJ 07042, USA.
E-mail: DrD@NJPS1.com

showed rupture of adipocyte cell membranes, coagulation of small blood vessels in fat tissue, coagulation of collagen in adipose and dermal tissue, and reticular dermal reorganization. Subsequent histological studies[15] showed that irradiation of freshly excised human skin and subcutaneous fat with 1064-nm laser energy resulted in greater vaporization, liquefaction, and cell membrane destruction than in nonirradiated controls. The authors also presented evidence of laser-induced coagulation of collagen fibers, which should stimulate collagen remodeling and tissue tightening.[1] The effects on adipocytes and collagen fibers were dose dependent. Kim and Geronemus[16] showed that LAL with the Nd:YAG laser was well tolerated and associated with dermal tightening, rapid recovery, and magnetic resonance imaging (MRI)-proven reduction in fat volume.

A detailed study[17] described the physics, quantification, and safety of subdermal laser heat treatment. Later, the same authors presented a preliminary report on skin shrinkage and increased elasticity as a result of multiwavelength laser application.[18] Although the aforementioned study showed promising results, it did not directly compare the effects of the LAL to those of an internally controlled traditional liposuction alone. The aim of the present study was to obtain quantitative, objective data for comparing tissue shrinkage and skin tightening achieved by LAL versus liposuction alone. Skin shrinkage was quantified by changes in surface area and skin tightening was quantified by changes in the skin stiffness index.

METHODS

Ten female subjects ages 31 to 57 years (median, 38) with unwanted abdominal adiposity and mild to moderate skin laxity without structural ptosis enrolled in the study through the author's private clinic. Pregnancy, recent abdominal surgery, disorders of the lower abdomen, thrombophlebitis, acute infection, heart failure, and previous liposuction or liposculpture in the study area were grounds for exclusion. The study was approved by the independent institutional review board in Plantation, Florida, and all subjects provided signed informed consent prior to participation.

The study was designed as a "split abdomen" study, in which one side of each subject was treated with LAL (Smartlipo MPX, Cynosure, Inc., Westford, Massachusetts) followed by aspiration and the contralateral side was treated with the laser cannula and fiber without delivery of laser energy followed by liposuction. Subjects and staff were required to wear laser eye protection during the laser portion of the procedure. The selection of treatment for each side was randomized. Prior to treatment, the entire treatment area was divided into 5 × 5-cm squares drawn with a surgical marker. The corners of each square were tattooed with India ink, delivered by dermal puncture with a 20-gauge needle. Subsequent to marking the area with tattoos, the subjects were photographed with the Vectra system (Canfield Scientific, Fairfield, New Jersey) to establish a surface topography measurement baseline. Skin laxity baseline was measured with a suction cup probe (Derma Lab Suction Cup, CyberDerm, Media, Pennsylvania) positioned at the center of each tattooed region.

Subjects were given tumescent anesthesia as per the Hunstad formula[19] (lidocaine, 1 g per L of ringer's lactate; epinephrine, 1 mg per L of ringer's lactate; and sodium bicarbonate, 10 meq/L in normal saline) five to 20 minutes before laser treatment by infiltration via a cannula into the subcutaneous fat of the premarked areas. This tumescent fluid was given to both the LAL and liposuction-alone sides in a similar fashion, approximately 50 to 100 mL per 5 × 5-cm^2 sector. In addition, patients were given two oral diazepam (10 mg each) and two acetaminophen/oxycodone (325 mg/5 mg) approximately 20 to 30 minutes before tumescent fluid application.

The laser system employed in this study permits individual as well as sequential emission of 1064-nm and 1320-nm wavelengths. Energy is delivered to the subdermal tissue through a 600-µm fiber threaded through a 1-mm microcannula and extending 2 to 3 mm beyond the distal end of the microcannula. When the microcannula is inserted in tissue, the laser is activated, and the microcannula is moved slowly and evenly through the deep or superficial subdermal layer.

Sequential emission of both wavelengths provides a spatially uniform laser energy profile for treating both superficial and deep subdermal layers. An accelerometer delivery system (SmartSense, Cynosure, Inc., Westford, Massachusetts) attached to the laser handpiece helped to minimize the occurrence of localized thermal damage during treatment. If, during treatment, the surgeon slowed the motion of the handpiece, the delivered laser power dropped accordingly. If the handpiece stopped, energy delivery ceased within 0.2 seconds.

The tissue was treated with a two-layer/two-step technique. The first step on the laser-treated side was to address the deep fat layers (1-3 cm below the epidermis) within the premarked squares. Two to four incisions of 1 mm each were made with a number 11 blade in each treated area for insertion of the microcannula. The deep fat areas were treated with Multiplex Mode 1 (20 W of 1064-nm wavelength source and 10 W of 1320-nm wavelength source). Subsequently, in the second step, the superficial subdermal layer (0.5 cm below the epidermis) was treated with Multiplex Mode 3 (8 W of 1064-nm wavelength source and 8 W of 1320-nm wavelength source). Epidermal temperature was monitored during treatment with a handheld infrared thermal camera (FLIR ThermaCAM E45, Niceville, Florida). The fiber was moved back and forth in a fan-like pattern, moving deeper into the 5 × 5-cm^2 region and generating lipolysis in the medium and deep layers of adipose tissue until sufficient energy was supplied to cause cell wall disruption and coagulation of small vessels. (This amount of energy is believed to be in the range of 1000 to 2000 joules per 5 × 5-cm^2 region for every centimeter of pinched skin thickness in the overlying area.) In the superficial layer, the microcannula was moved continually in a fan-like pattern within each premarked square, and energy delivery was

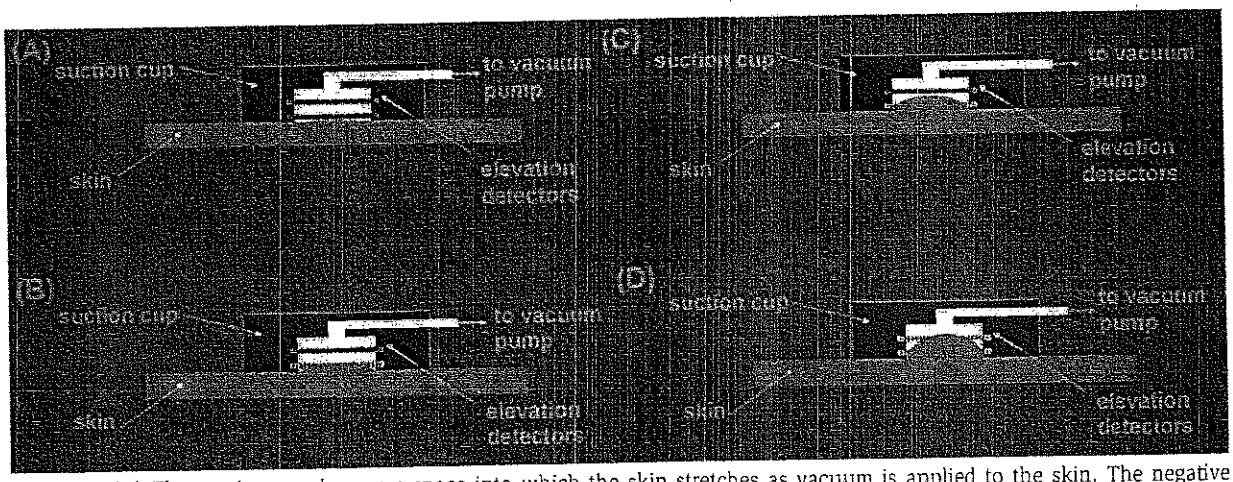

Figure 1. (A) The suction cup houses a space into which the skin stretches as vacuum is applied to the skin. The negative pressure (vacuum) exerts a force per unit area (stress) on the skin. This stretching is an elastic deformation of the skin. Elevation detectors with light beams are positioned at two heights within the space. As vacuum is applied, the skin stretches into the space. (B) When the skin reaches the lower detector, it obstructs the light beam at this lower level, and the (negative) pressure is recorded. As the vacuum (negative pressure) increases, the skin continues to stretch (C) and eventually reaches the upper detector where it obstructs the light beam (D). The negative pressure at this upper level is also recorded. Since the positions of the light beams are fixed, the strain on the skin (the magnitude of the deformation [Δx in Equation (2) caused by the vacuum) at each of the two levels is known. The (negative) pressure that lifted the skin to the lower level is a measure of the stress at that level. The same relationship holds as the skin stretches to the upper level. The greater the negative pressure (Δp in Equation (2)) required to stretch the skin to a given level, the lesser the elasticity of the skin. Reproduced with permission from Grove GL, Damia J, Grove MJ, Zerweck C. Suction chamber method for measurement of skin mechanics: the DermaLab. In: Serup J, Jemec GBE, Grove GL, editors. *Handbook of Non-Invasive Methods and the Skin*. 2nd ed. Boca Raton, FL: CRC Press; 2006. p. 594.

stopped when the epidermal temperature observed with the thermal camera reached a nearly uniform 40°C to 42°C. This temperature range was shown in previous studies to be safe to induce skin tightening and shrinkage.[17] A red aiming beam from a HeNe laser source, better seen with most of the room lights out, permitted the surgeon to visualize the tip of the fiber during treatment. For the control liposuction-alone side, a similar microcannula was inserted into the same depths as described above and moved about for a similar duration to mechanically disrupt the fat at the same depths. This was done to eliminate the possibility that skin shrinkage and tightening on the LAL side were caused by mechanical damage alone. The entire abdomen was then aspirated with a standard 3-mm suction cannula to remove any remaining fat, disrupted cells, and free fat oils.

When aspiration was complete, standard firm-pressure dressings were applied to the wounds and subjects were instructed to wear a compression garment for the following three to four weeks. Oral antibiotic prophylaxis began one day before treatment and continued for seven days after treatment. Subjects were evaluated for skin shrinkage and skin tightening one month and three months after treatment. Skin shrinkage was evaluated by measuring changes in the dimensions of the regions marked with tattoos for each subject. Tattooed regions were photographed at baseline, one month, and three months with the same camera under standardized conditions of lighting, magnification, and background. Dimensions (horizontal, vertical, and diagonal) and the perimeter of each tattoo were measured with the Vectra System at each time point and formed a basis for calculating surface areas. All measurements were reviewed and calculated by an unrelated third party blinded with respect to the treatment modality.

Shrinkage and tightening on the laser-assisted side versus the liposuction-alone side were compared at one month and three months. Differences were tested for significance through a paired t test, with $P < .05$ as the cutoff value. Skin shrinkage was evaluated by calculating the surface area shrinkage ratio (Equation (1)) for each region on each subject.

$$R_{SkinShrinkage} = \frac{SA_{postTx} - SA_{preTx}}{SA_{preTx}}, \qquad (1)$$

where

$R_{SkinShrinkage}$ is the skin area shrinkage ratio,
Tx indicates treatment, and
SA indicates surface area (mm^2).

The tattooed regions were also assessed for skin tightening with an elasticity device. A suction cup probe (Derma Lab Suction Cup, cyberDerm, Media, Pennsylvania)[20,21]

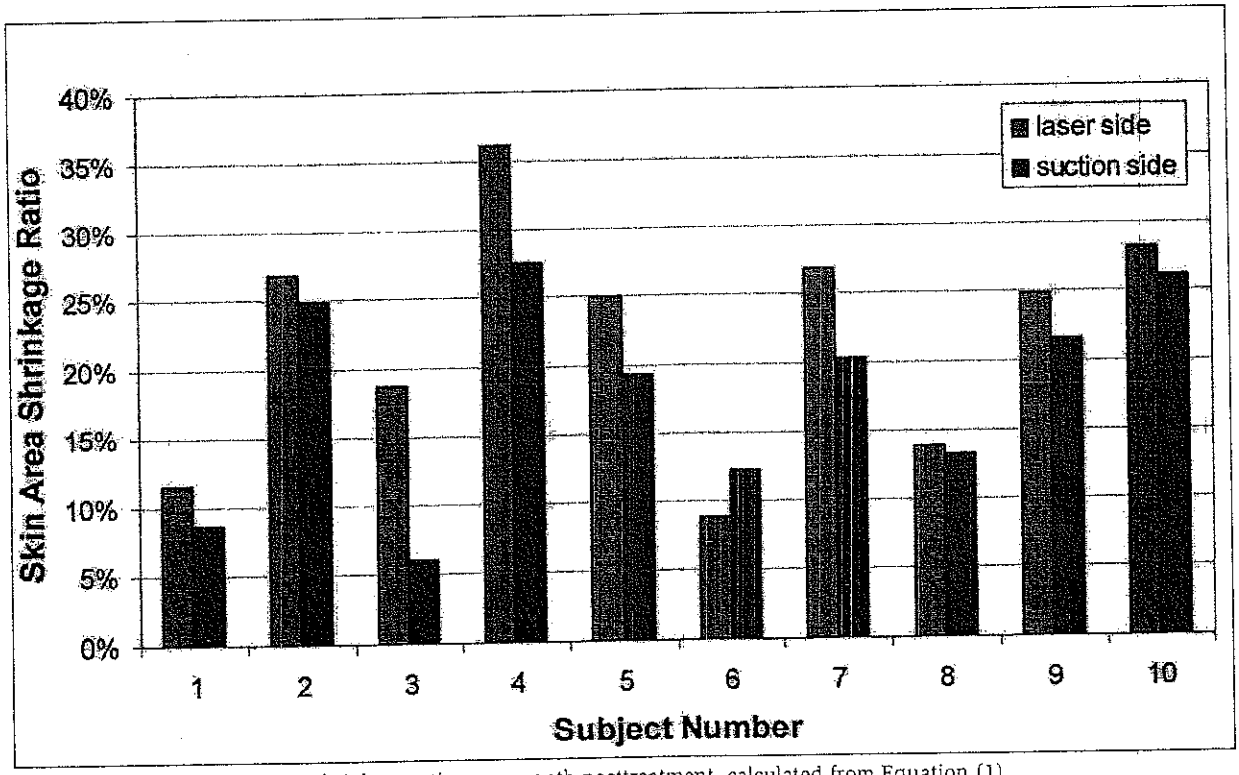

Figure 2. Individual skin area shrinkage ratios one month posttreatment, calculated from Equation (1).

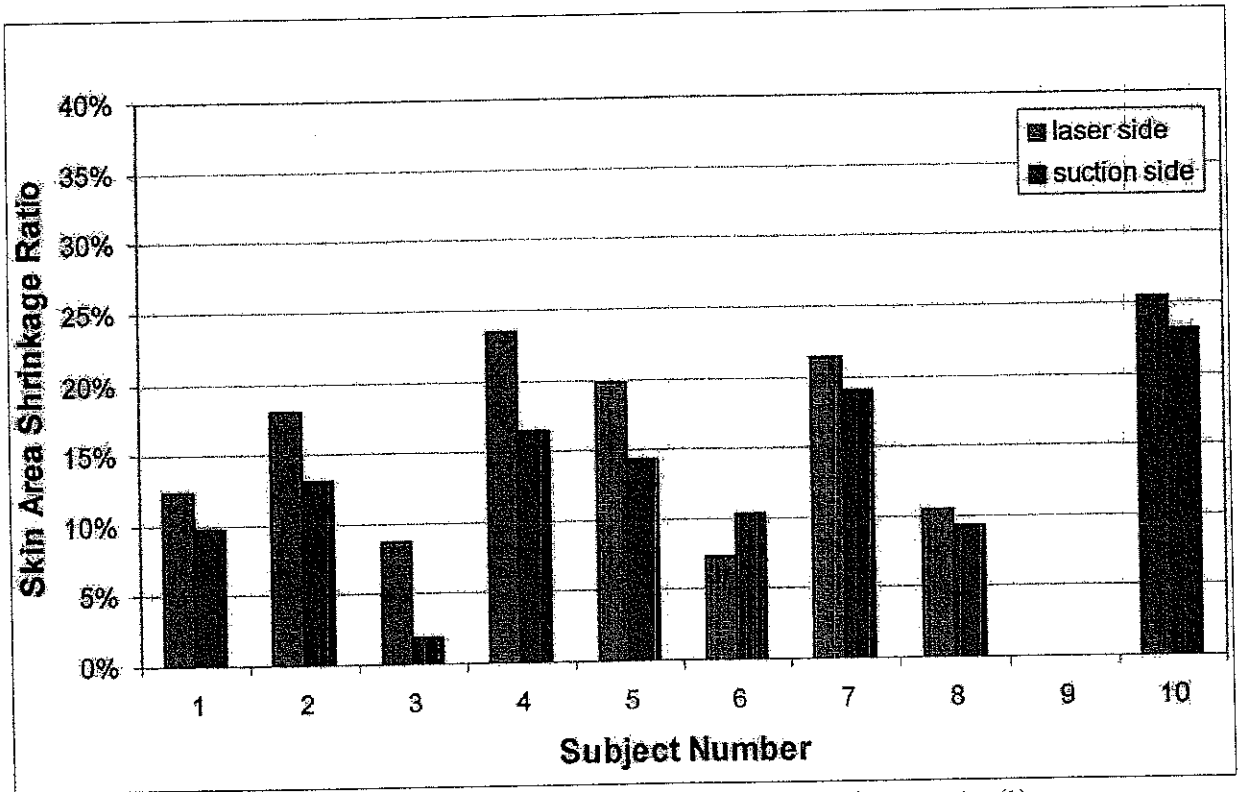

Figure 3. Individual skin area shrinkage ratios three months posttreatment, calculated from Equation (1).

Table 1. Reduction in Tattooed Region Surface Areas From Baseline for Laser-Treated Side and Suction Side

Subject	One Month (%)		Three Months (%)	
	Laser	Suction	Laser	Suction
1	12	9	12	10
2	27	25	18	13
3	19	6	9	2
4	36	27	23	17
5	25	19	20	14
6	9	12	7	10
7	27	20	21	19
8	14	13	10	9
9	25	22	—	—
10	28	26	25	23
Ave	22	18	16	13

Percentage shrinkage calculation based on Equation (1).

was positioned at the center of each tattooed region. When suction was applied, the skin was drawn up to a lower level first and then to an upper level (Figure 1). As the skin was pulled toward each level, it was subjected to tensile mechanical stress. The (negative) pressure difference between the upper and lower levels at each time point was a measure of skin elasticity at that time point.

In the present study, skin tightening was determined by measuring the skin stiffness index at baseline, one month, and three months and then comparing the stiffness index at one month and three months with the stiffness index at baseline. If the skin had a higher stiffness index at one month or three months than at baseline, the skin had been tightened. The skin stiffness indexes were calculated from a stress-strain relationship (Equation (2)).

$$Y_{SkinStiffness} = \alpha \frac{\Delta p}{\Delta x}, \quad (2)$$

where

$Y_{SkinStiffness}$ is the skin stiffness index,
$\alpha = 0.3125$ is a fixed system constant based on the geometry of the detecting suction probe,
Δp is the difference in negative pressure (mm Hg) between the upper and lower level, and
Δx is the distance between the upper and lower detectors (mm).

The Δx value is fixed by the geometry of the probe, so Δp is a direct measurement of the skin stiffness index. If the skin stiffness index was greater at three months than at baseline, the skin had tightened during the three-month period.

RESULTS

All subjects tolerated the procedure well. Adverse events were limited to minor swelling and bruising in the treated areas. The average volume of the aspirate was 936 mL.

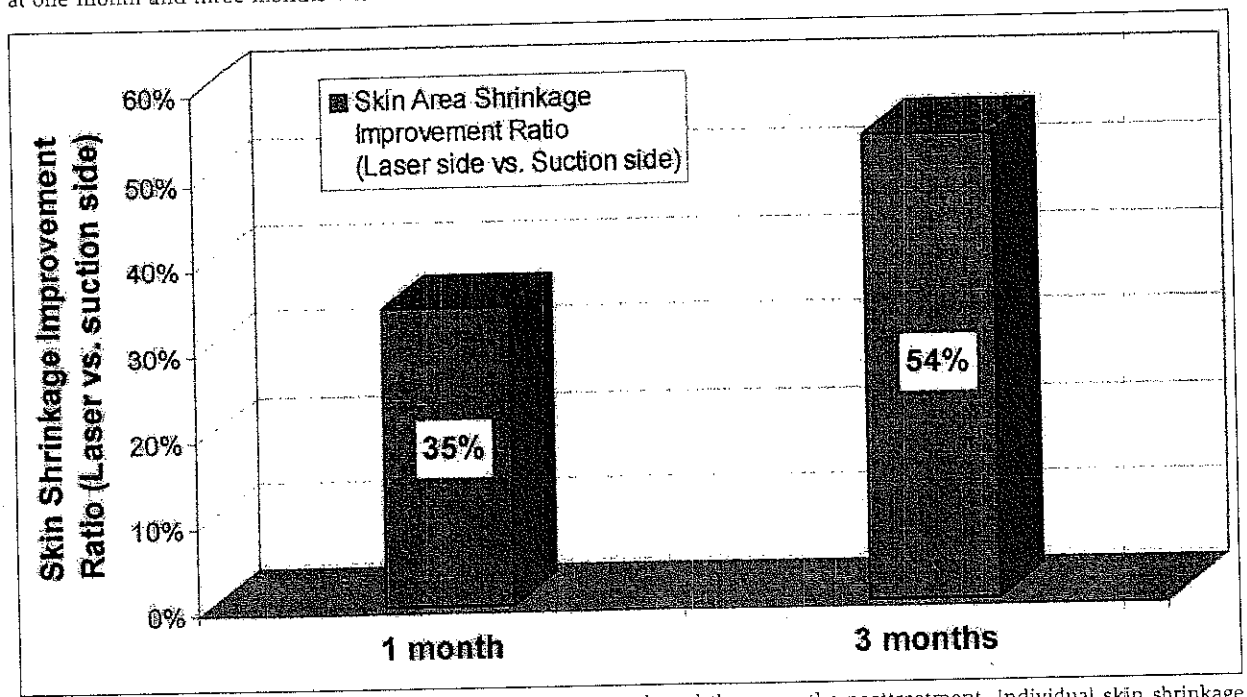

Figure 4. Mean skin shrinkage improvement ratio at one month and three months posttreatment. Individual skin shrinkage improvement ratios, calculated from Equation (3).

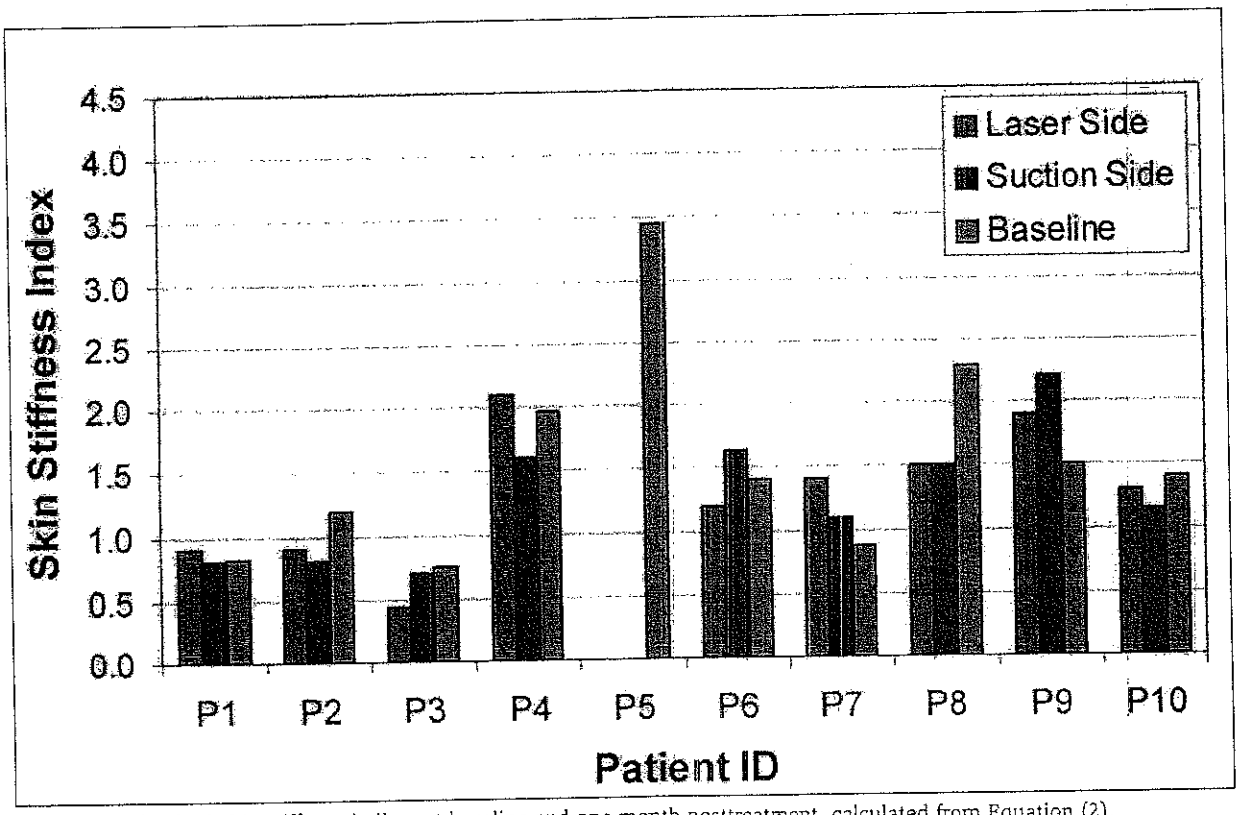

Figure 5. Individual skin stiffness indices at baseline and one month posttreatment, calculated from Equation (2).

Skin shrinkage data are tabulated in Table 1. At one month, the reduction in surface areas was greater in the laser side than in the suction side for nine of the 10 subjects. After that time, one subject, Patient 9, was lost to follow-up due to pregnancy. At three months, the same was true for eight of the nine remaining subjects. Patient 6 had a weight gain of over 15 pounds through the course of the study, contributing to results that were not consistent with the other patients.

Area shrinkage ratios at one month and three months are shown in Figures 2 and 3, respectively. A two-tailed paired *t* test showed that the mean shrinkage ratios were significantly higher ($P = .018$) on the laser side than on the suction side in nine of 10 subjects at one month and in eight of nine subjects at three months ($P = .014$). (Again, one subject was lost to follow-up at three months.) Among subjects with excess flaccidity, improvement was greater on the laser-treated side.

The variable skin shrinkage response in individual patients was accounted for by calculating for each patient a skin shrinkage improvement ratio defined in Equation (3).

$$I_{SkinShrinkage} = \frac{R_{SkinShrinkage\_Laser}}{R_{SkinShrinkage\_Suction}} - 1, \qquad (3)$$

where

$I_{SkinShrinkage}$ is the skin shrinkage improvement ratio,

$R_{SkinShrinkage\_Laser}$ is the skin shrinkage ratio using the laser, and

$R_{SkinShrinkage\_Suction}$ is the skin shrinkage ratio using suction alone.

Improvement in shrinkage ratios on the laser side over the suction side at one month and three months was quantified by Equation (3). The mean of the individual skin shrinkage improvement ratios showed 35% greater shrinkage on the laser side at one month and 54% greater shrinkage at three months. These results are presented graphically in Figure 4.

To assess improvement in skin tightening, suction cup probe measurements were taken and the skin stiffness indexes were calculated from Equation (2) for both sides of the abdomen at baseline, one month, and three months. The skin stiffness indexes for each subject at baseline, one month, and three months are shown in Figures 5 and 6, respectively.

The variable skin stiffness index at baseline and skin-tightening response in individual patients were accounted for by calculating for each side of the abdomen of each patient a skin-tightening index defined in Equation (4).

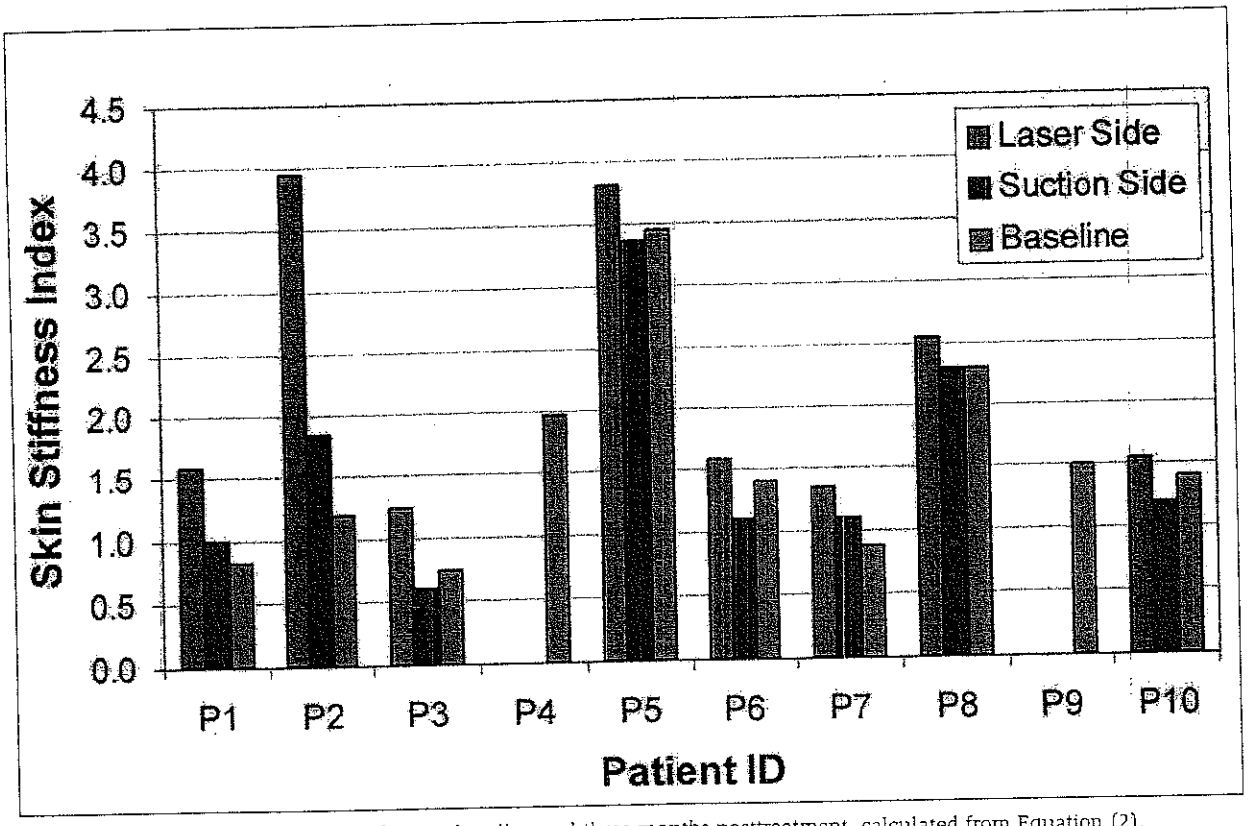

Figure 6. Individual skin stiffness indices at baseline and three months posttreatment, calculated from Equation (2).

$$T_{SkinTightening\_Laser\_or\_Suction} = \frac{Y_{SkinStiffness\_Laser\_or\_Suction}}{Y_{SkinStiffness\_Baseline}} - 1, \quad (4)$$

where

$T_{SkinTightening}$ is the skin-tightening index calculated separately for the laser or the suction side, and
$Y_{SkinStiffness}$ is the skin stiffness index at baseline and posttreatment on the laser or suction side.

At one month (n = 9), the mean skin-tightening indexes of the laser side versus suction side did not differ significantly. Mean improvements in skin stiffness from baseline were −2% for the laser side and −3% for the suction side (Table 2). Based on a paired two-tailed *t* test at one month, the difference between the mean skin stiffness after treatment (laser or suction) and baseline was not statistically significant.

At three months (n = 8), all patients had higher skin stiffness on the laser side than on the suction side. Mean skin-tightening improvements were 62% for the laser side and 5% for the suction side (Table 2). One subject was lost to follow-up. Based on a paired two-tailed *t* test, the mean skin stiffness index was significantly higher (P = .02) on the laser than on the suction side. The difference between the mean skin stiffness after treatment with suction alone and baseline was not statistically significant. On the laser side, the difference between the mean skin stiffness index at three months and baseline was of borderline significance (P = .06). Due to the small sample size and large variance over patients, Wilcoxon signed rank tests were used to check for significance. The test showed that the median skin stiffness index at three months was significantly higher on the laser side versus baseline (P = .011).

The mean skin-tightening indices for the laser-assisted and the suction side, calculated from Equation (4), are plotted on the graph in Figure 7. A clinical example is shown in Figures 8 and 9.

DISCUSSION

Previous studies[17] covered the safety and laser physics of laser-assisted liposuction and the specific temperature ranges involved for safe and effective treatment. In addition, a preliminary report[18] indicated initial evidence for skin shrinkage and tightening with laser. The present study is the first to provide objective data showing that

Table 2. Skin-Tightening Index for Laser-Assisted Side and Suction-Only Side

Subject	One Month (%)		Three Months (%)	
	Laser	Suction	Laser	Suction
1	9	−3	94	21
2	−25	−33	229	54
3	−40	−7	67	−20
4	6	−19	—	—
5	—	—	10	−3
6	−14	18	14	−21
7	60	26	54	26
8	−35	−35	11	0
9	27	47	—	—
10	−7	−18	14	−14
Ave	−2	−3	62	5

Percentage skin-tightening indexes calculation based on Equation (4).

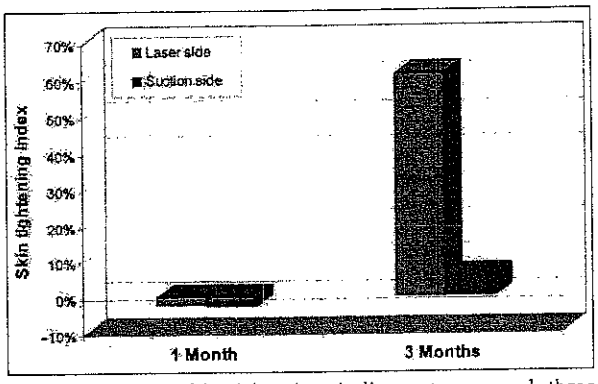

Figure 7. Mean skin-tightening indices at one and three months posttreatment. Individual skin-tightening indices calculated from Equation (4).

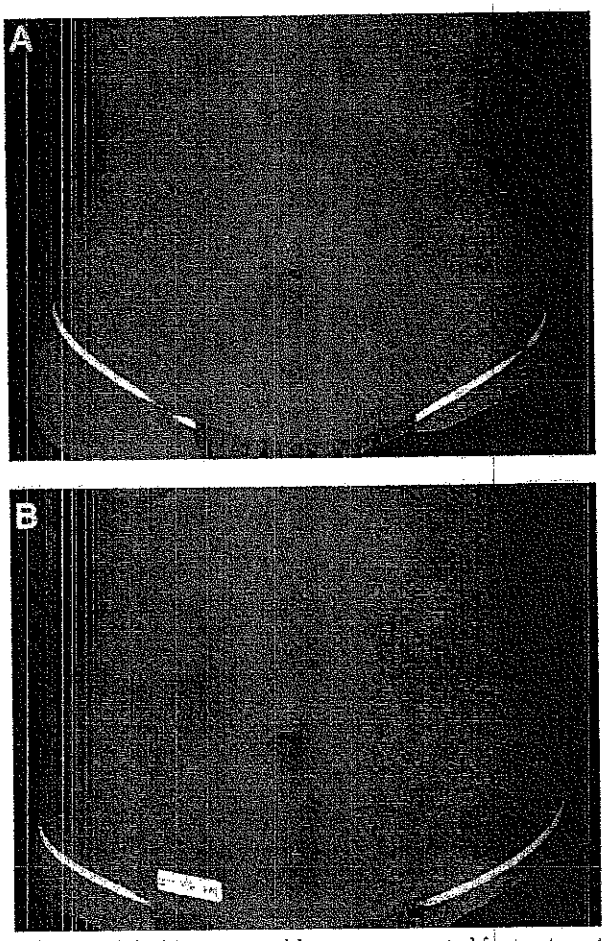

Figure 8. (A) This 40-year-old woman presented for treatment of unwanted abdominal adiposity and skin laxity. (B) Seven months after a single treatment. The right side of the abdomen was treated with the Smartlipo MPX laser (Cynosure, Inc.) and the left side by manual manipulation with the cannula and suction.

LAL with the Smartlipo MPX followed by aspiration provides greater skin shrinkage and skin tightening than liposuction alone. The results support those of earlier studies[11-16] in which a similar 1064-nm device was employed. The 600-µm fiber in the present study is larger than the 300-µm fiber in previous studies.[11,12,15,16] The larger diameter fiber would allow more energy to be delivered at a faster rate with lower probability for fiber failures. Uncontrolled large energy sources near the skin surface can cause complications if not monitored properly.

Goldman et al[11] showed that LAL and liposuction did not alter blood levels of hemoglobin, hematocrit, triglycerides, and cholesterol up to one month after treatment. Badin and colleagues[13] showed improvement in tissue flaccidity and in areas that, if treated by liposuction, would potentially become flaccid. Badin and colleagues,[14] employing adipocyte diameter as an indicator of reversible damage (tumefaction) to adipocytes, showed that LAL affected adipocytes both reversibly and irreversibly (lysis) and that the procedure resulted in better wound healing, better hemostasis, less surgical fatigue, improved postoperative recovery, more rapid return to daily activities, and an excellent aesthetic result.

To eliminate the possibility that skin shrinkage and tightening were caused by mechanical damage, the side not receiving laser energy was treated with the cannula alone, both subdermally as well as in deep fat. The manual treatment was performed for approximately the same amount of time as the laser cannula was moved manually during LAL. However, the mechanical damage did not lead to the improvement achieved on the side treated with laser energy. It is clear that laser-assisted lipolysis achieved greater skin tightening and skin shrinkage than liposuction alone.

Both the 1064-nm and 1320-nm wavelength energies in the present study are absorbed by adipose tissue and

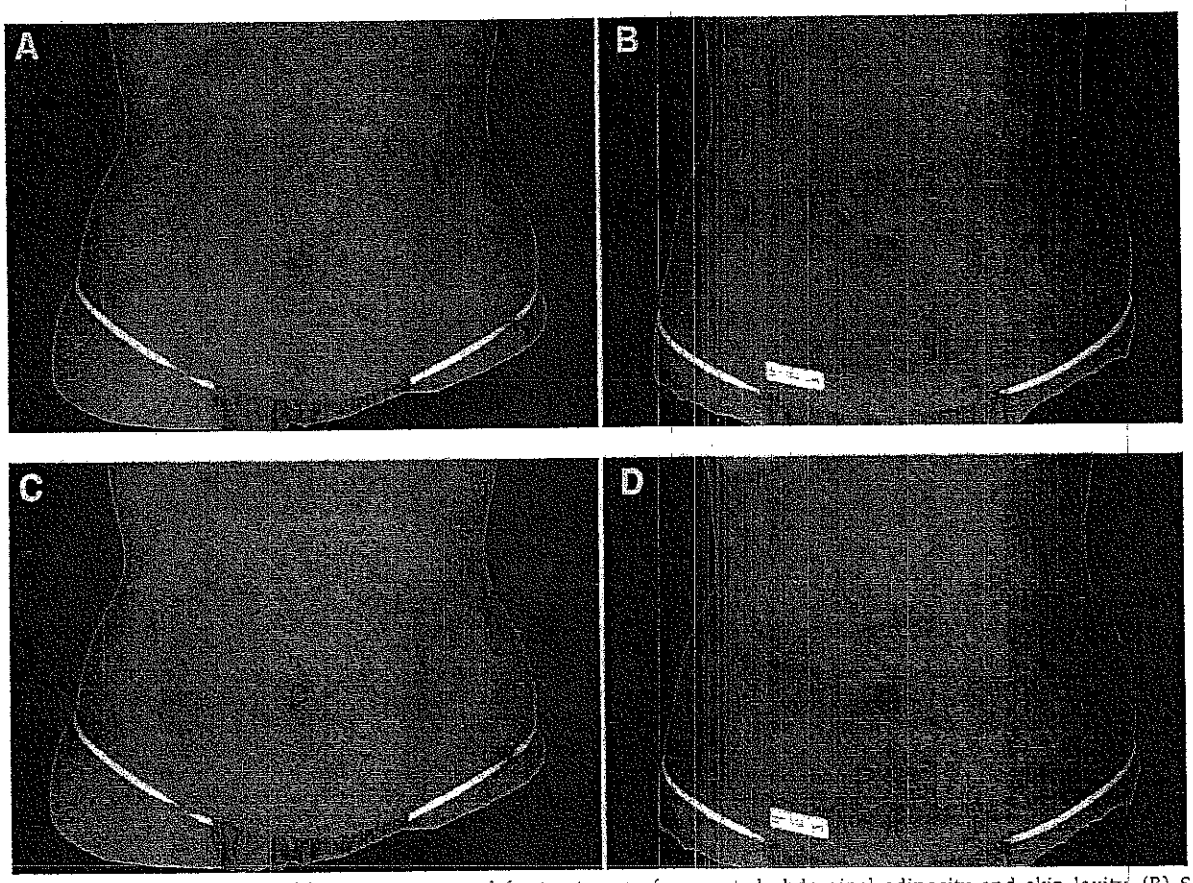

Figure 9. (A) This 42-year-old woman presented for treatment of unwanted abdominal adiposity and skin laxity. (B) Seven months after a single laser treatment (18,000 J deep and 19,681 J superficial) on the left side and manual manipulation with the cannula on the right side. (C, D) The identical before and after photos with an overlay of the 3D measured tattoo reference squares.

converted to heat that causes deformation, volume expansion, and rupture of the fat cells. The laser-induced heating also stimulates activity of dermal and fat cell collagen. The 1064-nm wavelength energy is absorbed by both oxyhemoglobin and methemoglobin, which is responsible for coagulation of small blood vessels in the fat tissue.[5] Since absorption of 1320-nm energy by hemoglobin results in methemoglobin formation and methemoglobin absorbs 1064-nm energy three to five times as strongly as it absorbs 1320-nm energy, the synergistic 1064-nm/1320-nm unit further enhances hemostasis.[22] The 1320-nm wavelength energy has a higher water absorption coefficient and is scattered less than the 1064-nm energy, so energy of this wavelength rapidly heats adipose tissue in small regions close to the tip of the optical fiber.[5] Since the 1064-nm energy from the tip of the fiber has good tissue penetration and is scattered more than its 1320-nm counterpart, it is distributed over a broader treatment area, resulting in more controlled increases in temperature, more generalized heating of adipose cells, and more widespread activity in hemoglobin. As for the 1320-nm energy, because its target is water, its effect on dermal collagen is greater than that of the 1064-nm energy and the result is greater collagen shrinkage and skin tightening.[5]

The skin-tightening indexes, plotted on the graph in Figure 7, suggest that one month after treatment, the mean skin stiffness and skin tightening showed no statistically significant difference from baseline both for the laser-assisted and the suction-alone side. That might be accounted for by the fact that at the one-month time point, skin healing is incomplete. Three months after treatment, mean skin stiffness and skin tightening were significantly higher on the laser-treated side.

In summary, the advantages of LAL with aspiration over liposuction alone are that the small-diameter cannula reduces the trauma to the patient and permits the surgeon to treat superficial areas, the face, and other areas in which it is either difficult to remove fat[11,13] or in which the trauma of a larger cannula without laser energy in the

superficial zone would cause skin irregularities after treatment. LAL provides the additional laser energy source, for those difficult-to-treat fibrous areas such as breasts in gynecomastia, upper abdomen, and back rolls.

Additional studies with more subjects would be needed to further optimize the parameters for treatment of the abdomen and other anatomical sites with unwanted fat.

CONCLUSIONS

Laser-assisted liposuction has experienced increase usage in clinical practice. Previous work has confirmed safety, efficacy, and temperature parameters to elicit skin tightening. In the present study, the sequential delivery of the 1064- and 1320-nm laser energies, as the only variable parameter in this internally controlled study, has led to data suggesting that the delivery of laser energy prior to liposuction has a statistically significant effect on skin shrinkage and tightening of the skin in the abdominal area.

Disclosures

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5) On page 4 of the application you state that the approval of this proposal would enable you to "perform the surgeries for patients with lower fees and lower expenses for the physicians and therefore [sic] result in lower cost to the patients." Explain why the physician fees, expenses and overall cost to the patients would be reduced as a result of this proposal.

A shift to an office based operating room, solely for the specialty of plastic surgery will become a more cost effective center, we are able to better control costs of supplies, only buying specifically what is needed for plastic surgery and not a large, diverse set of supplies and instruments needs for all specialties. It has been proven that doctors are more cost efficient when responsible for the costs of their own supplies.

In addition, the costs can be under direct control on a case to case basis, especially important for touch up cases and revisions.

A hospital based facility must distribute the costs and expenses for the non paying population that uses the center; and these costs have been passed on to the paying customer.

American Association for Accreditation of Ambulatory Surgery Facilites, Inc. Committee for Insurance and Reimbursement, Guide for Third Party Reimbursement, John Pitman III, MD, Chair. 1-18

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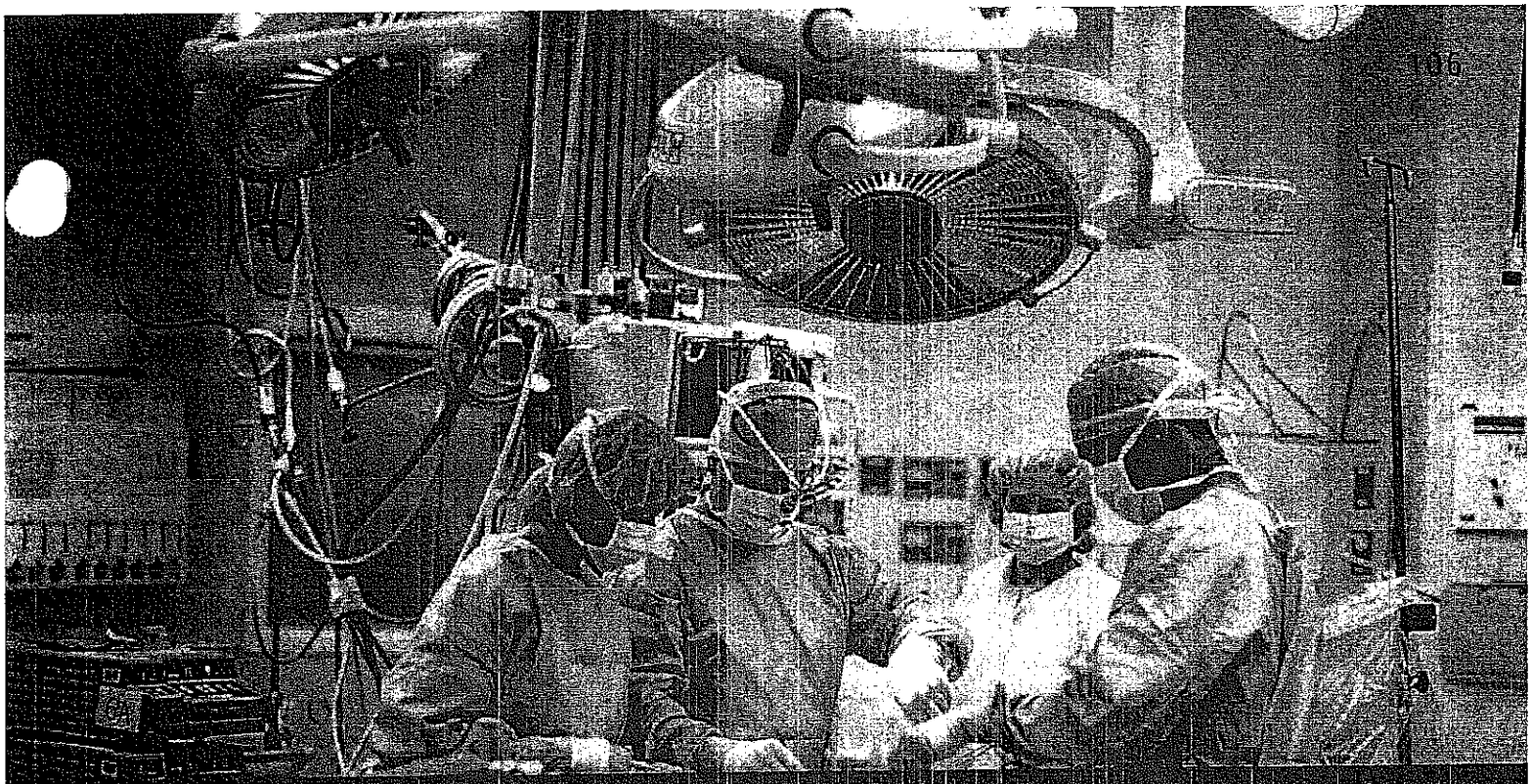
See attached articles.



Guide For Third Party Reimbusement Of Facility Fees

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.
Committee for Insurance and Reimbursement
John Pitman III, M.D. Chair

American Association for Accreditation of
Ambulatory Surgery Facilities, Inc.

GUIDE FOR THIRD PARTY REIMBURSEMENT OF FACILITY FEES

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Table of Contents:

This article contains information about reimbursement matters for ASCs. Any legal information provided in this article is not legal advice. Legal advice must be tailored to the specific circumstances of each reader. In addition, although AAAASF and the author have made every effort to ensure that the information in this article is accurate, the healthcare regulatory landscape changes daily and may vary considerably by jurisdiction. AAAASF and the author strongly recommend that investors in and users of ASCs seek individual legal counsel to review their ownership structure and billing practices for compliance.

Introduction to Insurance Reimbursement for AAAASF Accredited Ambulatory Surgical Centers

The last quarter century has seen a dramatic shift in surgical practice across all specialties. With advances in anesthesia safety, a better understanding of the physiologic response to surgery, the use of prophylactic antibiotics, and less invasive surgical techniques surgeons are now able to safely perform the majority of cases in the outpatient setting. Third party payors and the federal government are keenly aware that outcome studies continually demonstrate that outpatient surgery performed in an accredited ambulatory surgery center (ASC) leads to excellent outcomes at a cost significantly below that of hospital based facilities. In fact it is federal CMS policy to encourage case shifting to ASC care whenever possible primarily because of the lower cost. As an owner or shareholder in an ASC the prudent surgeon can take advantage of this circumstance to provide the best possible surgical experience for the patient and do so in the most efficient and reasonably profitable manner.

AAAASF accredited ASCs have taken many forms. In some cases they can be as simple as a single provider office based surgical suite. In other cases they can as complex as a large multi-specialty, multiple surgeon facility. No matter what form is taken the performance of appropriate cases reimbursed by third party payers will have a significant number of salutatory effects. First and foremost, third party payors are always looking to control costs and are increasingly supportive of shifting care to an ASC. As a general rule, they are very willing to reimburse the ASC facility fees well beyond what they pay for surgeons fees alone. Increasingly surgeons are finding that cases that pay only a surgeon's fee are barely profitable. However, when a facility fee is added these cases can return to significant profitability. In addition the practitioner is now empowered to tightly focus on control of both safety and cost. The use of the AAAASF guidelines enables the surgeon to attain a proactive stance towards safety issues and correct potential problems in a much more timely and direct fashion than the typical hospital committee structure. In addition, prudent ASC management virtually demands careful tracking of costs. Most surgeons have little knowledge of the cost factors in a typical case they perform. By being directly involved in these issues surgeons find that they are able to be very helpful in cost control measures without compromising safety. The surgeon also will typically find much greater convenience and improved time management when utilizing their own ASC. By keeping cases "in house" the ASC will allow the utilization of assistants familiar with the surgeon's needs leading much greater efficiency in case time. Struggles with scheduling and long drives to multiple hospitals as well as emergency cases "bumping" cases on the elective schedule is virtually eliminated. These efficiencies can allow the surgeon to increase his/her caseload without a significant change in work hours.

The use of a AAAASF accredited ASC is also empowering for the practitioner when it comes to negotiating with third party payers as both parties now share a mutual interest in cost control for the patients and the surgeon now has a means of providing lower cost

care for the payer. This allows even the solo practitioner to attract much more favorable third party payer contracts. Instead of having case reimbursement virtually dictated to the practitioner most third party payors are willing to discuss facility reimbursement. Charitable care also can become less financially onerous. Many practitioners and patients find that a single price to cover pre and post-operative care, operating room and anesthesia fees (an arrangement familiar to cosmetic surgeons) can be worked out reasonably and equitably in advance. In point of fact, ASC licensure by some states requires a certain percentage of charitable care to be performed in the facility. However, by providing a lower cost setting, patients lacking adequate coverage can find that their care becomes more affordable. In addition, in the setting of a profitable ASC these cases can become less financially taxing for the operating surgeon.

When taken together the surgeon owner/shareholder of an ASC will find that both gross and net income can rise substantially. This derives from several sources. Income can rise directly from facility fees. More favorable contracts can improve revenues for the surgeon's office overall. Finally, "downstream income" can improve dramatically with the typical improvement in efficiency experienced by surgeons participating in ASC ownership/use. This guide is meant to serve as a very basic introduction to facility fee reimbursement in AAAASF accredited ASCs. The opinions expressed in this guide are not definitive and cannot substitute for sound legal and professional advice (please refer to disclaimer on page 2).

Legal Matters

It cannot be stressed enough that when the provider embarks on the adventure of seeking reimbursement for an ASC there is a virtual minefield of rules and regulations unique to ambulatory surgery. This chapter cannot substitute for sound legal advice but is intended only as a very brief and general guide to some of the governing principles. The ASC owner/operator is strongly urged to seek sound and experienced legal advice ***proactively***. It is easy to make very expensive mistakes or place oneself in significant legal and financial jeopardy if these issues are not carefully addressed well in advance of any attempt at collecting facility fees. Attempting to fix damage retroactively can cost enormous amounts of time and money both in potentially lost revenues, legal defense and in possible cessation of ASC operations while these issues are being sorted out. Also it is axiomatic that ignorance of the law is not a valid legal defense. The ASC operator/owner must be aware that a whole host of state and federal laws are always involved and each state is different in how it approaches ASC regulation. Some states require licensure of an ASC and some states require a Certificate of Need (CON). It is foolhardy for the physician owner/operator/shareholder to not get sound legal advice when setting up an ASC for reimbursement and familiarize him/herself with the applicable legal concepts. A multitude of legal concepts apply to ASC reimbursement and operation and include (but are not limited to) contractual law, restraint of trade, conflict of interest, anti-kickback statutes, anti-self referral rules(e.g. Stark), state licensure, CON, reimbursement rules, contract language, dispute mediation, and "governing law" a concept where the state the ASC is operating is not the state which governs contract rules. The legal complexity and corresponding peril rises even higher if an ASC attempts to bill government providers such as Medicare, Medicaid and Tricare. Recent changes in anti-fraud legislations can attach criminal penalties to billing errors for certain government based payers. It is possible that some state rules directly conflict with federal rules, particularly healthcare fraud and abuse laws and regulations such as anti-kickback statutes and self referral laws such as Stark. These rules can be so complex that multiple interpretations of meaning and effect are common and multiple legal opinions are frequent. The ASC owner/operator is warned that these conflicts can preclude a true "safe harbor" from these so called fraud and abuse laws. It is essential that the owner/operators of an ASC understand that AAAASF certification does not in any way change the above requirements and they must be pursued as a matter separate from accreditation. On the other hand the growth in physician owned and operated ASC's is rapid and substantial so it is apparent that many physicians have been able to negotiate this legal and financial minefield and have found that this form of reimbursement is possible and very rewarding.

As a legal entity the ASC can exist in a number of forms. For example it can simply be part of a physician's office and simply integrate into the normal daily operation of the physicians practice. Billing and reimbursement would occur within the context of the daily operation of the physician practice. In some states this arrangement is considered "office based surgery" and is a separate entity from a true ASC. This is a frequently employed possible safe harbor against healthcare fraud and abuse laws. In states where

there are CON requirements this form of billing can sometimes bypass those requirements as well. In the setting of an existing CON the practitioner will typically bill on form HCFA 1500 and the third party payer will reimburse at a higher rate that includes facility fees. These arrangements are almost universally contractually based prior to performing the procedures and billing for them. This type of arrangement can also bypass separate liability for the ASC in some cases but obviously this needs to be discussed with the liability carrier and tends to vary significantly from state to state. For these and other reasons some third party payors prefer this type of arrangement. Government providers (e.g. Medicare, Medicaid, Tricare) typically do not provide for this pathway for reimbursement as they cannot negotiate with individual ASC owner/operators. This tends to be more suited to individual practitioners with an AAAASF accredited office based surgical suite.

The second possibility is that the ASC exists as a stand alone legal entity that generates its own revenue, usually under a separate provider number. Once this occurs the owner operator must be aware that the ASC is likely to incur its own liability and is very likely to fall under the same state laws that regulate hospitals and stand alone ASC's. This is also the type of entity that can more typically bill government third party payers. The size/number of providers is not necessarily relevant but the legal basis for existence is. Once a physician has a relationship with such an entity federal healthcare fraud and abuse laws and regulations almost invariably come into play. A separate contract between private payers and the ASC are almost mandatory in this case. These facilities sometimes require state licensure and concomitant state regulation. In states where a CON law exists these entities typically require obtaining such a certificate (which can be a very onerous process). It is imperative that the owner/operator addresses these issues in advance of any consideration of facility reimbursement or perhaps even construction. There have been cases in which third party payers have demanded high six figure refunds when these issues weren't properly addressed in advance. These entities typically bill on form UB92 under a unique provider number.

Medicare publishes a list of services by CPT code reimbursable to ASC's and private payers typically model the codes they will pay for after this list. The list is subject to review semiannually by the Center for Medicare and Medicaid Services (CMS). It is wise for the ASC owner/operator to become intimately familiar with this list prior to commencing facility fee reimbursement procedures. The owner/operator should realize that there are several legal issues associated with this list that most surgeons are unaware of. If a provider performs a non-listed service in an ASC the third party payor may have the legal right to deny payment depending on contract language. In the case where the third party payor is federal (e.g. Medicare) the ASC can run afoul of federal healthcare fraud and abuse laws if it can be shown that the provider intended to perform the procedure free of charge. In addition when surgeons operate in an ASC who are not owner/shareholders Stark rules can apply if there is a perceived financial inducement. So "fee splitting" arrangements in which the ASC splits facility fees with providers are strongly discouraged. The facility director is strongly encouraged to learn about the Health and Human Services (HHS) Office of Inspector General (OIG) safe harbors for ASC reimbursement.

The ASC owner/operator is also cautioned about billing practices that are overly creative and/or aggressive. Since the number of ASC's is relatively small they have a much higher likelihood of closer scrutiny by both private and government third party payors than the typical physician's office. Audits are much more likely to be triggered if billing is perceived as out of the norm. The most common cause for an audit is perceived "unbundling" of services. The physician owner/shareholder is usually familiar with correctly coding procedures but unbundling in an ASC can also involve improperly billing for ancillary services and materials (e.g. splints and medications) that are considered to be included in the basic facility fee and not eligible for additional reimbursement. To make matters worse criminal penalties can be attached under fraud and abuse statutes when government third party payors are involved. This liability can even extend to all partners in an ASC. Fortunately there are new insurance policies on the market that may provide some comfort to owner/operators. It's called "compliance insurance" and it can pay for the cost of defending yourself and even negotiate and pay for settlement with Medicare or Medicaid if you are investigated for billing improprieties.

Another legal problem arises when private carriers are billed out of network or off the ASC list. Insurance companies may have their corporate offices in another state. The ASC may find itself with little legal recourse if the plan refuses to pay even if the procedure was preauthorized. In fact, the plan can require that dispute resolution take place in the home state of the corporate headquarters. Although this doesn't in and of itself present legal problems the provider has much less protection against non-payment than if there is a contractual relationship.

Managing Overhead Expenses

The most common purpose for accepting third party reimbursement in an ASC is to enhance practitioner profitability. The most essential ingredient in a financially successful ASC is precise information on profit and loss. Since most third party payers reimburse the ASC with a flat fee per CPT code the ASC can best achieve profitability by controlling the cost of procedures. This can only be done by carefully tracking and analyzing every cost involved with performing a procedure. Although ASC failure is uncommon it does occur. The most common cause of ASC failure is non-profitability which occurs without relation to facility size or level of utilization. The cost involved in operating a facility are numerous but fortunately highly controllable and with careful attention can be made quite manageable.

There are three basic categories of expenses for the facility:

•Fixed (costs that occur irrespective of case type or volume)
•Variable (costs that vary with case type and volume)
•Personnel (these can be fixed or variable depending on how staffing is utilized and maintained).

Fixed Expenses: The calculation of these expenses depends on whether the ASC is a stand-alone facility or is physically or functionally part of a medical office. If part of an office then they should be calculated as a percentage of the overall square footage, otherwise the calculation is straightforward.

- Rent
- Utilities
- Insurance (e.g. non medical liability, property loss etc.)
- Liability insurance (if facility carries a separate policy)
- Janitorial
- Hazardous waste disposal
- Routine Equipment inspection and maintenance
- Telephone Service
- Transcription
- Equipment Lease
- Loans (e.g. build out). If facility is part of an office then loans can be apportioned by percent square footage
- Depreciation of facility and equipment
- Any service provided as a fixed monthly expense (e.g. scrubs, oxygen).

Variable Expenses: These expenses vary by the volume, length and type of case. These are also the ones most subject to control or conversely overrun.

- Anesthesia supplies and medications
- Local Anesthetics

- Suture
- IV fluids and administration supplies
- Implants (if used)
- Splints
- Plates and screws
- Electrocautery supplies
- Scalpels and drains
- Needles
- Transcription services
- Laboratory services (if not billed to the patient)
- Linen (e.g. gowns, drapes and towels)
- Hazardous waste disposal
- Stationary
- Dressings, binders and garments
- Photographic services
- Medical records
- Pre-op and recovery room medications
- Sharps
- Cleaning supplies specific to OR cleaning and maintenance
- Liquid waste disposal
- Paper cost for pre- and post-op forms

Personnel Costs: These expenses vary depending on whether or not personnel are utilized on an as needed (prn) basis for each case or are part of the overall office function. Remember to include the costs of benefit packages when calculating personnel costs. Typical personnel are as follows:

- Or director (RN or higher by AAAASF standards)
- Recovery room
- Scrub technicians
- Instrument technicians
- Circulator
- Anesthesia personnel (unless billing separately)
- Scheduling personnel

Cost Containment Strategies: Typically, the largest single area of cost for an ASC is personnel. This is the trickiest area to manage because several factors are virtually always in play and require careful monitoring. It is always in the facilities best interest to attract and retain highly qualified and highly productive personnel. It is also a fact of life that an ASC run efficiently can accommodate a higher case load leading to greater revenues. On the other hand in most cases facilities will see some variability in utilization as well as significant variability in case by case reimbursement. Successful facility directors juggle these competing factors effectively but to do so wisely takes constant analysis of actual revenues, case numbers, turn-around times, start times, and day to day profitability. The more information the facility director monitors the better. It is also helpful to use realistic growth projections and to be as realistic as possible in

looking at case numbers. It is short sighted to utilize cuts in staff as a cost control measure if that leads to a drop in efficiency. Again careful analysis of the effect of personnel numbers on case times and efficiency should be reviewed frequently. Also keep an eye on patient satisfaction as a staff stretched too thin is less able to give patients the attention they require to be satisfied with your facility. Although it seems that using the fewest personnel and paying them as little as possible is the best course from a financial perspective that frequently turns out to be a false hope and unwise course.

The area of variable cost that has the highest risk/reward ratio is ordering supplies. The cost of medical supplies varies widely depending on the source and types used. Maintaining a large inventory of supplies can leave dollars sitting on the shelf yet constantly ordering supplies piecemeal can avoid the savings that ordering volume can bring. Personnel that are ordering supplies can literally make or break an ASC in a very short period of time and this activity must be monitored closely and revisited frequently. Employees rarely have an incentive to assume the responsibility of shopping around for the best price and will generally gravitate towards comfort and convenience. Sometimes contracts with suppliers can be written with lowered cost for the most frequently used supplies. In fact hospitals will often let staff physicians "piggy back" onto their ordering at the lower cost these larger entities are able to negotiate.

Potential areas of variable cost saving: The following is a list of areas identified as more common ways to save money on variable costs.

- Reprocessing- many items that are normally single use or would be discarded because they were not used during a procedure can be safely reprocessed. Gas sterilization provides a means of sterilized unused items like sutures and paper drapes. Most facilities find that gas sterilizers pay for themselves in a very short period of time. It is the responsibility of the facility director to ensure the safety of this method, however.
- Group purchasing alliances- the prices that large hospital chains pay for medical items is a fraction of retail. Alliance with a hospital or other such entity can yield very substantial savings. There is one such plan affiliated with AAAASF. Please call the central office for more information.
- Bulk purchasing- buying in volume is a double edged sword because large inventories simply sit on the shelf and if an item is bought in bulk that is not used in bulk a facility can be stuck with expiring items. Alliance with other area ASC's or hospitals can help in that obsolescing items can be "swapped" around and used prior to expiration.
- Sharing items with other facilities- Infrequently used equipment can be shared or bulk purchases can be divided. Expensive drug requirements like Dantrolene® can be purchased with other facilities and shared.
- Equipment rental-infrequently used high cost items like c-arms, lasers, endoscopes, dermatomes can often be rented. This is another area where cost can vastly exceed revenue and facilities must be very realistic about how often "big ticket" items are used and facilities should address these procedures in advance of performing them.

- Avoiding obsolescence- frequent inventory is a must so items nearing expiration are used. This requires maintaining accurate inventory and checking it frequently and rotating stock accordingly.
- In house services vs. outsourcing- laundry is a good example. Although seemingly inexpensive, surgical scrubs can be a major expense in a busy ASC and in some cases ownership of scrubs and drapes and the use of in house laundry can yield large savings when compared to rental.
- Consignment-consignment services are a means of controlling stocking without purchase. These arrangements are really ideal for a busy ASC. Facility directors must be vigilant because these can lead to very "choppy" cash flow as items are used quickly and the bills mount quickly.
- Comparison shopping-in particular ordering personnel must be monitored closely. There is little incentive for staff to search for best price much less continue too negotiate the most favorable terms in real time. In particular be wary of a single vendor arrangement as often certain "loss leaders" will be used to entice a relationship and simply made up elsewhere. This area requires constant vigilance by the facility director.

As a general rule at least ten cases per CPT code should be audited on a regular basis for payment vs. cost. This number should be multiplied by the number of surgeons utilizing the ASC as each surgeon should be looked at separately. As physicians we are unaccustomed to having our costs looked at closely but the reality is that facility costs can vary substantially from one surgeon to another even for the same case. With time and attention most prudent facility managers find that surgeons become very adept at cost control once they know what items and their alternatives cost and the entire cost picture becomes clarified. Sometimes the cost of using a favored high expense item can be offset by savings elsewhere. The other area of cost control is ensuring that the cases are performed in the most efficient manner possible. Simply looking for lowered cost can sometimes lead to longer case and/or turn around times. Although this may yield higher profit on a single case the overall financial picture can suffer. It is sometimes better to accept lower profits per case when this allows more cases to be done in a time efficient manner. A 20% profit on five cases may be better cash flow for a facility than a 30% profit on 3 cases.

It cannot be overemphasized that constant vigilance combined with clear and frequent communication is a must. The successful facility director will ensure that staff and operating surgeons function as a team to maximize profitability, efficacy and safety.

Billing Considerations

There is probably no more important activity that affects the financial health of an ASC than effective billing. This sounds simple but most ASC managers would agree that it is the most vexing aspect of managing third party reimbursement. The prudent physician/owner is well advised to monitor this activity very closely. The fundamental problem for most ASC's is that a significant cost is accrued with each case performed in a busy facility. These costs can add up very quickly. At the same time third party payers rarely have an incentive to pay facility fees in a timely fashion. In fact it is a known "dirty little secret" that one of the business models payers utilize is "benign neglect." By delaying payment a certain percentage of claims will be ignored by the ASC in addition to the interest accrued by the carrier on cash reserves retained by delaying payment. As payments are delayed costs continue to accrue. In a short period of time a substantial operating deficit can be developed and without accurate, timely and aggressive collections an ASC can quickly become insolvent. There are several steps in the billing process of an ASC that are critical to understand.

Pre-Authorization: With the addition of ASC facility fee billing this process has several unique aspects beyond preauthorizing a surgeon's fee. Some third party payors still fail to recognize the validity of accredited ambulatory surgical centers. For this reason it is wise to per-authorize procedures for any payor with whom the facility does not have a contractual relationship. For those payors who fail to recognize AAAASF as a legitimate deeming authority but recognizes others (e.g. AAAHC) please contact the central office. It is also critical to realize that some CPT codes are *not* reimbursable in an ASC. A list of covered procedures should be obtained from each carrier. The Center for Medicare and Medicaid Services (CMS) publishes one such list applicable to the government carriers and most private payors mimic this list with some modifications. The provider *must* ensure that the carrier supports reimbursement of ASC billing for the given procedure. Even if a procedure is preauthorized carriers will typically only cover procedures on a predetermined list. Some carriers require that only a facility under contract be used. Finally, many procedures have additional fees beyond the basic facility fee associated with ASC billing such as splints, implants, radiology etc. and it is important that these costs are also pre-authorized.

Flat-Fee per CPT Code Method: Virtually all government third party payers and most HMO, IPA, and PPO payors insist on this method. Although simpler to use there is potentially greater financial pressure exerted on a facility by this method depending on the profit margin for each case. It is critical that facility managers accurately track each CPT code to ensure that payments are both accurate and timely. Frequent checks of Explanation of Benefit (EOB) forms can be done but a better method is to develop a tracking sheet that determines if facility fees were paid properly for each CPT code for every paid case.

Submission of Billing: In a busy facility cash flow becomes much more acute than a typical office as there are larger payments being tendered and much larger costs being generated. The proactive facility director will have a number of arrangements in place with his major carriers prior to submitting billing for reimbursement. These will be discussed in the section on Contracts later in this booklet. If your facility accepts payments typical for an ASC you will accept around 50-60% of hospital level reimbursement per CPT code. The ASC payment schedule published by CMS also provides a rough guide. In 1983 the Center for Medicare and Medicaid Services (CMS) published the Healthcare Common Procedure Coding System (HCPCS). There are two levels of codes. Level I is the American Medical Association Current Procedural Terminology Codes (e.g. CPT). These will cover the basic surgeon and facility fees. Level II codes classify services/supplies not covered by CPT codes. These codes cover a number of items like splints, implants and certain medications. The prudent facility director will familiarize him/herself with these codes and their use. There are two general categories of level II HCPS codes that are frequently used in the ASC setting. Codes beginning with the letter J or L are most frequently used. J codes encompass drugs administered and L codes cover Orthotic and prosthetic procedures and devices. Alloderm® (J7344) and breast implants (L8600) are examples. There are also some modifiers unique to the ASC. Coding for surgical first assistants such as a Physician Assistant uses either modifier AS or 80. In some cases coding for a facility fee requires the use of modifier TC (e.g. Technical Component). Coding for anesthesia services are billed in a number of different ways. MD providers typically bill separately for themselves but CRNA's can be billed for under separate anesthesia CPT codes if IV sedation is given under the direction of the operating surgeon. Finally, the use of certain types of equipment such as C-arm, magnification and lasers can be billed for. It is critical that the facility director have a full and complete understanding of when and how and when these types of services are billed for.

Time based and flat fee billing: These arrangements are becoming increasingly rare. In some cases these can fail to cover expenses while in others they can be very remunerative. One should seek expert advice on how to proceed if this is offered by a carrier.

Medicare Billing: All Medicare billing for ASC reimbursement is limited to the list of Medicare-covered ASC procedures. This list is available on the CMS website. It should be noted that most private payors use various modifications of the same list and it is unwise to perform procedures not on the ASC list as they are subject to exclusion from payment. CMS publishes a Correct Coding Initiative (CCI) every quarter and ASC reimbursement is subject to CCI edits. These are revised every quarter so the facility director must keep track of these. www.cms.hhs.gov/physicians/cciedits/ is the site to check these. It is critical to understand that all Medicare billing is subject to audit and that billing deemed fraudulent regardless of intent is subject to criminal penalties. Also, if a facility is out of compliance with Medicare rules it can be shut down, even to non-Medicare patients. Any facility director that considers performing procedures on Medicare patients is responsible for knowing these rules. Also, remember that the

number of facilities that bill for Medicare is limited and most likely subject to much greater scrutiny that a physician is accustomed to.

Getting Reimbursed in a Timely Fashion: This is undoubtedly the most vexing and difficult problem facing any physician's office and the problems are only multiplied in a busy ASC. Third party payors have little incentive to pay in a timely fashion and many carriers appear to reject a certain percentage of claims *a priori*. Stories of "lost claim", "sent to the wrong office", "never got the claim", "sent to the wrong person" occur so frequently that mere coincidence appears unlikely. The best way to deal with this issue is to obtain contract language that spells out timely payment with accurate ("clean") claims. Automatic payment deposit into an account owned by the ASC is even faster. Electronic tracking (typically internet) and a close working relationship with the provider representative is helpful and the ASC manager should get names, phone numbers and email addresses for the provider representative for as many carriers as possible. Most states have regulations that require carriers to pay in a timely fashion, typically 30- 45 days depending on the state. Some carriers will frequently wait till the time limit has almost expired and then deny claims for dubious reasons. The problem for the ASC is that once a claim is denied follow up phone calls or resubmission of billing only restarts the time limit clock. A better way to proceed is to develop a "warning package". A copy of the original claim with a correct quote of state rules on timely reimbursement coupled with a threat to go to the state insurance commissioner is a one such aggressive tactic. The package can also include a legal citation. In *Alsobrook v. National Travelers Life Ins. Co.* an award of $126,239 was awarded ($100,000 in punitive damages!) to the plaintiff against an insurer for unreasonable delaying payment of health insurance claims. This case specifically found the insurer liable for delaying claims when they received proper proof of loss and that bad faith applies not only to unpaid claims but also to claims whose payments are simply delayed. A citation of this case is an excellent motivator for a third party carrier when enclosed with a warning package.

Conducting Self Audits: This is a good practice as it avoids problems arising if your ASC is audited. If you find that you have been overpaid it is important that these payments are returned with an accompanying letter of explanation. By performing these maneuvers one can avoid very expensive mistakes later on if an audit is performed. There are a number of publications that explain this concept further. This practice is particularly helpful if the ASC finds itself being audited externally. As a general rule the ASC will find itself standing on much firmer ground if it has already performed internal self audits.

Acquiring Participation with Private Carriers

Probably the most important step for an ASC after accreditation is the acquisition of contracts with area PPO's, HMO's etc. This is somewhat simplified in smaller (e.g. single provider) facilities as the physician will frequently already have acquired participation with a number of these and adding the technical component (facility fee) is a simple matter of expanding services. Larger facilities will frequently have to acquire participation as a separate entity. The existence of CON laws makes this a much more complex task which will vary from state to state. Generally this type of contracting will need to be done on an individual provider basis. Most physicians find negotiating with insurance carriers to be a one-sided process and generally fruitless unless one is a member of a large group or is hospital based. The physician owner/operator of an ASC, even if he/she is a solo practitioner, can find the tables turn in his/her favor quite a bit. An ASC has several advantages for both the provider and the carrier. Following below are some guidelines for negotiating with third party payors.

Cost of Care: The first and foremost advantage of an ASC to a third party payor is cost. By limiting (or eliminating) the cost of operating on non-payers (a.k.a "self pay) the burden of finding sufficient excess profits elsewhere (known as cost shifting) by the ASC is obviated. Second, participating surgeons can be monitored closely on a case by case basis to ensure that they are functioning in a cost effective manner for the facility. Thirdly poorly reimbursing or excessively expensive procedures can be eliminated from the ASC. Finally the prudent facility director can find a multitude of ways to control variable costs as noted earlier in this manual. All of these factors combine to allow the facility to approach the carrier as an entity that has the ability to save substantial dollars by offering lower cost to the third party payor while the ASC still maintains an acceptable profit margin.

Safety: As an AAAASF accredited facility there is a certainty of safety that is unmatched among ASC's. This was elegantly demonstrated in two recent publications in Plastic and Reconstructive Surgery (113: 1760, 2004). As an entity under constant peer review AAAASF facilities have no equal in identifying and quantifying the complication rate for procedures performed in our facilities. We have demonstrated unequivocally that outpatient surgery with a very low complication rate can be performed in our facilities. No other deeming entity requires the rigorous quality assurance combined with data collection that we do. Safe surgery with minimized complications is very cost effective to the provider as the cost of a single complication generally far exceeds the cost of initial care. This should be factored in by every payor when contracts are negotiated. In addition the push for "pay for performance" has left AAAASF facilities uniquely positioned for success in this area as it becomes more prevalent.

Case Mix: The prudent facility director can look very carefully at existing levels of ASC reimbursement for different specialties and avoid poorly reimbursing ones. For example ENT, Gynecology, Plastic Surgery, Orthopedic Surgery, Hand Surgery, General Surgery, Podiatry, and Pain Management are all proven performers from an economic standpoint

nationwide. Urology, Ophthalmology, Vascular Surgery tends to perform poorly. There are of course regional differences in all of these and certain cases in all specialties tend to perform better than others. In this fashion by encouraging more profitable specialties to use the facility one can achieve a higher profit margin and perhaps accept somewhat lower facility fees overall when negotiating with carriers.

Legal Structure for ASC Reimbursement: The legal basis upon which the facility is formed can have a substantial impact on reimbursement. In states where CON rules exist the facility is faced with several options. Obtaining the CON is possible but will usually be granted only over the objection of area hospitals and competing ASC's that have deeper pockets and more political clout. CON laws were originally developed in the 1970's when Medicare reimbursed individual facilities on an annual basis. Now that Medicare pays per procedure CON laws are essentially obsolete. However 14 states have retained these laws as a means of (theoretically) controlling costs by prevention of overbuilding. The real effect this has had is the stifling of competition and allowed continued growth of politically favored entities such as hospitals at the expense of newly developing ASC's. The best advice on obtaining a CON can be obtained from other ASC's who have been successful in this venture. It tends to be a daunting process. However, in CON states there are usually a much smaller number of facilities providing ambulatory surgical services because of reduced competition. For this reason the physician owner may have much more bargaining power than he/she may realize. CON laws generally do not restrict how physicians are paid so in many CON states arrangements can be made to receive an enhanced fee for procedures performed in a physician owned ASC which bypasses the CON mandate. Usually billing is on form HCFA 1500 and the TC modifier is used. This must be set up with each individual carrier and it is critical that the provider get sound legal advice prior to embarking on this strategy. It should be noted in states where this type of arrangement has been challenged the provider, not the state, has usually prevailed. In states where there are no CON restrictions most facility directors agree that the ASC should be set up as a separate entity with it's own tax ID number, business license etc. It is felt that this improves ones negotiating position and that bargaining power is enhanced. Again good legal advice must precede any negotiation.

Potential Pitfalls in Contracts with Third Party Payors: There are a number of potential pitfalls for contracts any ASC has with third party payors and avoiding them is important. First the facility director must establish what cases will be performed in the ASC and what specialties will participate if the ASC will be a multispecialty entity. It is critical that third party payors and the facility agree on those procedures. Most payors will have a list of supported CPT codes but all participating physicians should peruse such a list very carefully. If exceptions are to be made both parties should agree on a preauthorization mechanism for "off the list" procedures in advance of their being performed. In the case of procedures that are deemed medically necessary and must be performed at the time of surgery an agreement should be reached as to how they are handled. Many payor contracts have a "hold harmless" clause that exempts the plan member from being responsible for services the plan refuses to cover even if the plan goes bankrupt. Although there are varying state laws regarding this (and federal in the

case of Medicaid/Medicare) most plans will attempt to write a much more restrictive clause than required even to the point that procedures previously authorized can be denied after the fact and the ASC cannot bill the member. Fortunately most plans are willing to negotiate this clause. Another clause called "governing law" dictates which state's law applies if there is a dispute between the plan and the provider. It is a good idea to change this to the state the ASC is located in or ask for binding arbitration. If this isn't addressed in advance the facility may be forced to legally challenge improper payment in a distant state. If an ASC is audited, particularly my Medicare or Medicaid a new insurance product called "compliance insurance" can cover the legal expenses of providers in the case of an audit or sometimes even if criminal proceedings are started. Given the higher profile that an ASC has this can be prudent if the ASC accepts Medicare facility fees. Submission of bills and late payments by payors is another frequently overlooked area. Plans that allow electronic submission to be held till required document can be submitted either on paper or electronically will speed payment considerably. Adding interest to late payments another area that plans will sometimes agree to or this can even be required by the state.

Attracting Other Providers and Carriers to the Facility

The ASC that bills for facility fees can be very attractive for both surgeon and insurance carrier. By developing a cost profile the ASC can look towards expanding to other panels. In particular local employers can persuade the carrier to add your ASC to their panels when you can lower their costs. In the same way surgeons can lower their cost profile by taking their cases to a facility that costs third party payers less. The other elements that make a facility attractive to an insurance plan are patient satisfaction and safety. Since both are an integral part of AAAASF accreditation the prudent facility director can quantitatively demonstrate success in both areas. It is important that third party payors (in theory) serve their clients (your patients). One area of attracting surgeons to a facility must be addressed. The use of incentives that even have the appearance of a referral to a facility that the physician has a financial interest in brings in the possibility of Stark rules and Laws. Additionally, if there is a perceived financial benefit to the referral anti-kickback laws can come into effect. Physicians who are shareholders are less susceptible to these rules but non-owner physicians are not exempt either. It is critical to get sound legal advice on these matters. Unfortunately, there are no absolute safe harbors for Stark rules for participating physicians so the ASC facility director and shareholding physicians must have as complete an understanding of Stark as possible. It is also possible to "lease" space in the facility at fair market value and allow the surgeon to collect his own facility fee. These arrangements must be made very carefully and be able to withstand close legal scrutiny. However despite the pitfalls it can still be in the facilities' interest to make such arrangements with other providers to enhance profile and better utilize existing personnel.

Ambulatory surgery centers and physician offices less costly than hospitals

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More and more outpatient surgical procedures are being done at nonhospital-based facilities such as freestanding ambulatory surgical centers and physician offices, instead of at hospital-based outpatient departments. A new study comparing the cost to Medicare of 22 urological surgical procedures performed in each setting has found that ambulatory surgery centers and physician offices are less costly than hospitals. The results are published in the December issue of *The Journal of Urology*.

"Our findings indicate that for comparable procedures, hospitals were associated with significantly higher payments than ambulatory surgical centers and the physician office," says lead investigator John M. Hollingsworth, MD, Department of Urology, Dow Division of Health Services Research and Center for Healthcare Outcomes & Policy, University of Michigan, Ann Arbor. "In fact, offloading 50% of the procedures from hospitals to ambulatory surgery centers would save the Medicare program nearly $66 million annually."

Investigators examined national Medicare claims from 1998 to 2006, identifying elderly patients who underwent one of 22 common outpatient urological procedures. They measured all relevant payments made within 30 days of the procedure to capture any costs that may have resulted from postoperative complications and unexpected hospitalizations. They assessed the extent to which hospital payments, professional services, and facility payments vary by the ambulatory care setting where a procedure is performed.

The authors found that 88% of the procedures examined were performed at an ambulatory surgical center or physician office. Ambulatory surgical centers and physician offices were less costly than hospitals for all but two of the procedures. For instance, average adjusted total payments for urodynamic procedures performed at ambulatory surgical centers were less than a third of those done in hospitals. Compared to hospitals, office based prostate biopsies were nearly 75% less costly. While physician offices tended to be more cost-efficient than ambulatory surgical centers, the difference was not significant. Facility payments tended to be the driver of payment differences.

The average Charlson score, which measures how severely ill a patient is, was lower for patients treated in a nonhospital setting. Dr. Hollingsworth notes that low risk patients may be more likely to be treated in an ambulatory setting, and the results may reflect the lower cost of treating patients who are less seriously ill. While Medicare claims data may not be generalizable to other payers, Dr. Hollingsworth says, "the Medicare program accounts for 19% of total national spending on personal health services, making it the single largest payer in the United States. Therefore, with regard to health care financing, as Medicare goes, so goes the nation."

Dr. Hollingsworth and his colleagues observe that if the cost differences between nonhospital and hospital settings are unjustified, e.g., due to inefficiencies rather than case mix, service, or content, then Medicare might base payment in the future on costs at the least expensive setting. "Alternatively, Medicare may bundle reimbursements to facilities and physicians involved in care around a single outpatient surgical episode into a single payment. The observed variation in facilities payments suggests opportunities for improvement," they conclude.

Source: Elsevier Health Sciences

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Outpatient cholecystectomy at hospitals versus freestanding ambulatory surgical centers.

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Source

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Abstract

BACKGROUND:

Because of safety concerns, some payers do not reimburse for laparoscopic cholecystectomy performed in freestanding ambulatory surgical centers (ASCs). This policy has been controversial because of increasing competition between ASCs and hospitals for low risk surgical patients.

STUDY DESIGN:

We performed a retrospective cohort study of patients undergoing elective outpatient laparoscopic cholecystectomy in the state of Florida in 2002 and 2003 (n=40,040), using the Agency for Healthcare Research and Quality State Ambulatory Surgery Database. Patients treated in hospitals and ASCs were compared with respect to patient characteristics, charges, outcomes, and processes of care.

RESULTS:

For both hospital-based and ASC-based laparoscopic cholecystectomy patients, greater than 99% were successfully discharged home, and there were no reported deaths. Compared with those treated in hospitals, patients in ASCs had a higher rate of intraoperative cholangiogram (39% versus 36%, p=0.008). There was no difference in the proportion of procedures converted to open cholecystectomy. ASC-based patients were slightly younger (mean age 45 years versus 49 years, $p < 0.001$), were less often diagnosed with acute cholecystitis (4.8% versus 8.3%, $p < 0.001$), and had fewer comorbidities on average than hospital-based patients, but both cohorts had few comorbidities overall (99% had Charlson scores of 0 or 1). ASC patients were more likely to be Caucasian (86% versus 75%, $p < 0.001$) and were more likely to have private insurance (92% versus 67%, $p < 0.001$). For patients who had ambulatory laparoscopic cholecystectomy as the only procedure, the median charges were $6,028 at ASCs, compared with $10,876 at hospitals.

CONCLUSIONS:

In a population of slightly younger, healthier patients, laparoscopic cholecystectomy in freestanding ASCs appears to be performed safely and with substantially lower charges than in hospitals.

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Special Topic

Analysis of Outpatient Surgery Center Safety Using an Internet-Based Quality Improvement and Peer Review Program

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Assessing the quality of care delivered in office-based outpatient surgery centers is difficult because formerly there was no central data collection system. The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), in its ongoing effort to assess and improve patient care, has developed an Internet-based quality improvement and peer review program to analyze outcomes for surgery centers it accredits. Reporting is mandatory for all surgeons operating in AAAASF-accredited facilities. Each surgeon must report all unanticipated sequelae and at least six random cases reviewed by an accepted peer review group biannually. A total of 411,670 procedures were analyzed during a 2-year period (from 2001 to 2002). There were 2597 sequelae reported during this period. The most common sequela was hematoma formation following breast augmentation. Infection occurred in 388 cases. Deep vein thrombosis, pulmonary embolism, and intraoperative cardiac arrhythmias were found to occur in a frequency consistent with previous reports. Significant complications (hematoma, hypertensive episode, wound infection, sepsis, and hypotension) were infrequent. A total of 1378 significant sequelae were reported for 411,670 procedures. This calculates to one unanticipated sequela in 299 procedures (an incidence of 0.33 percent). Seven deaths were reported. A death occurred in one in 58,810 procedures (0.0017 percent). The overall risk of death was comparable whether the procedure was performed in an AAAASF-accredited office surgery facility or a hospital surgery facility.

This study documents an excellent safety record for surgical procedures performed in accredited office surgery facilities by *board-certified surgeons*. (*Plast. Reconstr. Surg.* 113: 1760, 2004.)

The number of outpatient surgery centers and physician office–based surgery facilities is escalating dramatically.[1,2] This phenomenon is in direct response to the demand for safe, cost-effective surgical care for procedures that can be performed in an outpatient setting. There are advantages to performing operations in an outpatient setting for both patients and surgeons, including convenience, patient privacy and comfort, consistency in nursing and support staff, and increased efficiency.[3]

The American Society of Anesthesiologists predicts that by the year 2005, an estimated 10 million procedures will be performed annually in doctors' offices—twice the number of office-based operations performed in 1995.[4] This dramatic increase in the number of procedures performed in outpatient surgery centers has focused attention on the need for accreditation as a means of ensuring compliance with standards for their safe operation.[5,6]

Currently, only 14 states have mandated accreditation of surgery centers. The number of states requiring accreditation or licensure to perform surgery in an outpatient setting will, and should, continue to increase, until accreditation becomes the national standard.

In the spring of 1999, recognizing the importance of accreditation, the American Society of Plastic Surgeons and The American Society for Aesthetic Plastic Surgery passed a joint mandate for all of their members stipulating that members who perform outpatient operations under sedation or general anesthesia do so in an accredited or state-licensed facility.[7] Accredited or licensed outpatient surgical facilities must meet at least one of the following criteria[7]:

- Be accredited by a nationally recognized or state-recognized accrediting agency or organization, such as the American

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Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), Accreditation Association for Ambulatory Health Care, or the Joint Commission on the Accreditation of Healthcare Organizations.
- Be certified to participate in the Medicare program under Title XVII.
- Be licensed by the state in which the facility is located.

Monitoring Surgery Center Management

Design and management of a surgery center require compliance with nationally recognized standards to safeguard patient care. Ongoing monitoring of care delivery is vital to ensure patient safety. However, it is difficult to compile and compare the data documenting care delivery. This difficulty is a consequence of lack of centralization of data collection from the multiple accrediting, licensing, and managing entities of outpatient surgical facilities. As a result, there is little available coordinated information concerning ultimate outcomes of outpatient surgery in nonhospital settings.

Since 1982, AAAASF, the largest organization in the United States that accredits single or multispecialty office-based surgery centers, has been at the forefront of developing safety standards for the operation of outpatient surgery centers and coordinating relevant data. In 1996, AAAASF conducted a voluntary survey of all of their accredited surgery centers to assess outcomes of surgical care. The directors of all the surgery centers were asked to fill out questionnaires about unanticipated sequelae that occurred in their facilities. Of the 418 facilities accredited at that time, 241 (57.7 percent) returned the anonymous questionnaires, a very high response rate. In 1997, Morello, Colon, Fredricks, Iverson, and Singer published a review of this survey, entitled "Patient Safety in Accredited Office Surgical Facilities."[8]

The following findings were of interest:
- 400,675 operative procedures were reported during a 5-year period from January 1, 1989, to December 31, 1993.
- Significant complications (hematoma, hypertensive episode, wound infection, sepsis, and hypotension) were infrequent, numbering 1877, for an occurrence of one in every 213 cases, or 0.47 percent.
- Return to the operating room within 24 hours and precautionary hospitalization were less frequent.
- Seven deaths were reported. A death occurred in one in 58,810 procedures (0.0017 percent). The overall risk of death was comparable whether the procedure was performed in an AAAASF-accredited office-based surgery facility or a hospital surgery facility.[8,9]

This study documented an excellent safety record for surgical procedures performed in accredited office-based surgery facilities by board-certified surgeons.

Quality Improvement and Peer Review

The goal of a surgery facility is to provide the highest level of care delivery. The facility, whether office-based, free-standing, or in a hospital, should provide care with positive outcomes and a reduced incidence of unanticipated sequelae. In an effort to improve quality of patient care, AAAASF designed and adopted the first Internet-based reporting system for quality improvement and peer review. The purpose of the Internet system was twofold: to improve monitoring of random case review and unanticipated sequelae and to facilitate collation and analysis of the data acquired. This system has provided AAAASF with the ability to more precisely evaluate outcomes.

The guidelines for using this new reporting system follow AAAASF standards,[9] which require facilities to institute an ongoing quality improvement program that (1) monitors and evaluates the quality of patient care, (2) evaluates methods to improve patient care, (3) identifies and corrects deficiencies within the facility, and (4) alerts the medical director to identify and resolve recurring problems.

Peer review must be performed every 6 months and must include reviews of both random cases and unanticipated operative sequelae. If peer review sources external to the facility are used to evaluate delivery of surgical care, the patient consent form is so written as to protect confidentiality of the medical records, consistent with current legal standards. Peer review is performed either by a recognized peer review organization or by a physician other than the operating surgeon.

A minimum of six random cases per surgeon utilizing the facility must be reviewed, and for group practices, 2 percent of all cases performed must be reviewed every 6 months. These random case reviews must include assessment of the following: (1) thoroughness and legibility of the history and physical exam-

ination; (2) adequacy and appropriateness of the surgical consent form; (3) presence of appropriate laboratory, electrocardiographic, and radiographic reports; (4) presence of a dictated operative report or its equivalent; (5) anesthesia record for operations performed with intravenous sedation or general anesthesia; (6) presence of instructions for postoperative and follow-up care; (7) and documentation of unanticipated sequelae.

All unanticipated operative sequelae are reviewed, including, but not limited to the following: (1) unplanned hospital admission; (2) unscheduled return to the operating room for complication of a previous procedure; (3) untoward result of a procedure, such as infection, bleeding, wound dehiscence, or inadvertent injury to another body structure; (4) cardiac or respiratory problems during stay at the facility or within 48 hours of discharge; (5) allergic reaction to medication; (6) incorrect needle or sponge count; (7) patient or family complaint; (8) equipment malfunction leading to injury or potential injury to patient; and (9) death.

Each unanticipated operative sequela chart review includes the following information, in addition to the operative procedure performed: (1) identification of the problem; (2) immediate treatment or disposition of the case; (3) outcome; (4) analysis of reason for problem; and (5) assessment of efficacy of treatment.

The data obtained through the individual surgery center peer review meetings are then entered into the Internet quality improvement and peer review program.

Data obtained from 621 surgery centers from 2001 through 2002 were statistically analyzed. The AAAASF standards require a bound surgical log book be kept that records sequentially all operations performed. The first and last surgical log numbers of all reviewed random cases and unanticipated sequelae from a reporting period are entered into the Internet program with the reported data. This allows for the computation of the total number of cases performed per surgeon per period. In this study, 73 percent of reporting surgeons correctly entered their surgical log numbers. The average number of cases for those surgeons was assigned to the surgeons whose numbers were not correctly entered. The average case consisted of 1.37 procedures. Using this multiple, the total number of procedures reported for this study was 411,670.

A total of 2597 sequelae in 411,670 procedures were reported. The standards for AAAASF require *all* unanticipated sequelae to be reported, including patient complaints, surgery cancellations, and a variety of sequelae deemed less significant than those reported by Morello et al.[8]

When analyzing data in this report comparable to data in the aforementioned article, a total of 1378 significant sequelae were reported in 411,670 procedures over a 2-year period (from 2001 to 2002). This calculates to one unanticipated sequelae in 299 procedures (an incidence of 0.33 percent) compared with one in every 213 cases, or 0.47 percent, for the Morello et al.[8] article.

Recently, Byrd et al.[2] reported 35 unanticipated sequelae in 5316 cases. The 0.7 percent incidence of unanticipated sequelae in their study, conducted over a 6-year period, supports the incidence found in the current study.

Analysis of Sequelae

Table I lists the 1378 reported sequelae by type in descending order of frequency.

Hematoma

Hematoma was the most common unanticipated sequela reported in the study. There were a total of 740 hematomas reported, representing 28 percent of all sequelae or 0.18 percent of all procedures. The majority of hematomas (n = 676) were managed on an outpatient basis (Fig. 1). Sixty-four patients with hematoma required hospitalization

TABLE I
Sequelae*

Sequelae	No.
Hematoma	740
Infection	388
Necrosis	76
Cardiac events	29
Respiratory distress	20
Pneumothorax	19
Burn	19
Pulmonary embolism	17
Deep vein thrombosis	14
Hypotension/hypertension	16
Pulmonary edema	11
Allergic reaction	6
Cellulitis	6
Death	6
Hypoxia	5
Cardiac arrest	2
Chest pain	2
Hyperthermia	2

*Total number of sequelae = 1378

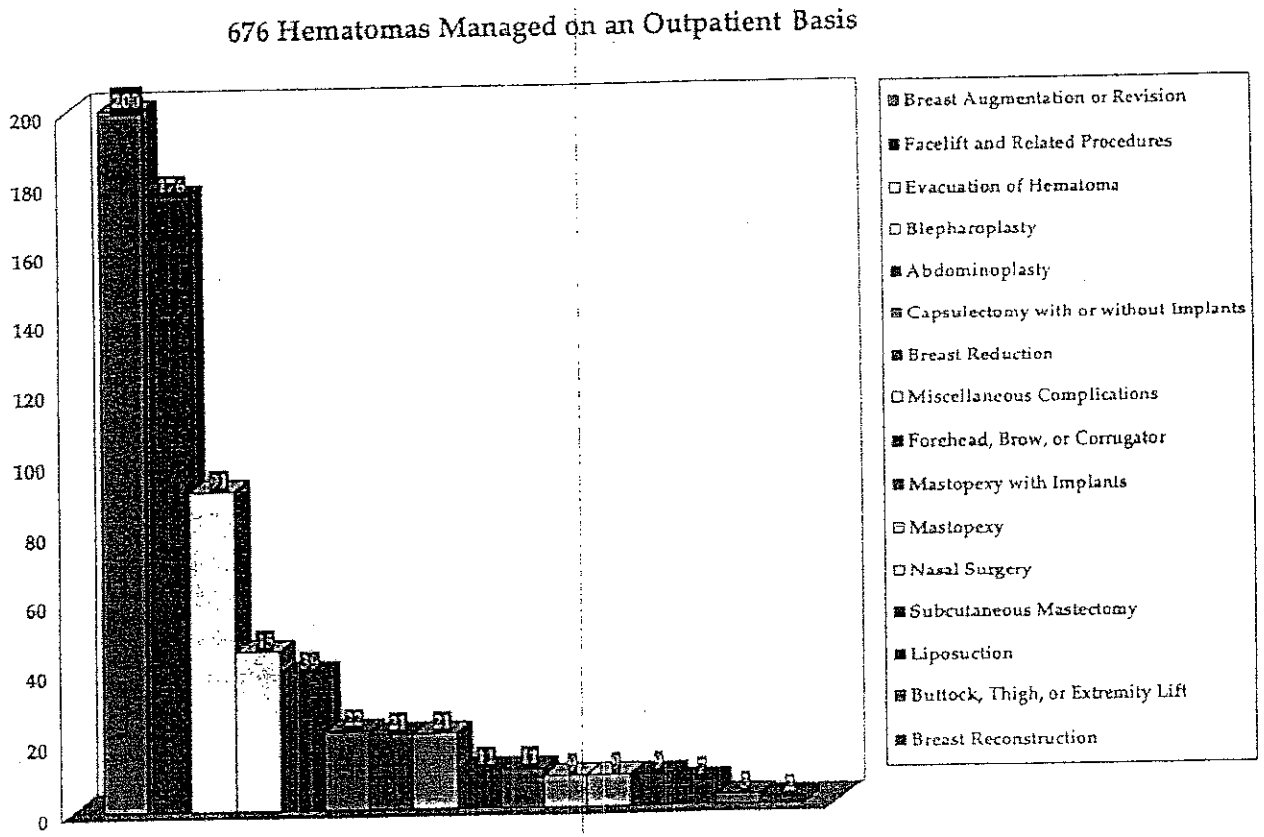

FIG. 1. Hematomas managed on an outpatient basis (n = 676).

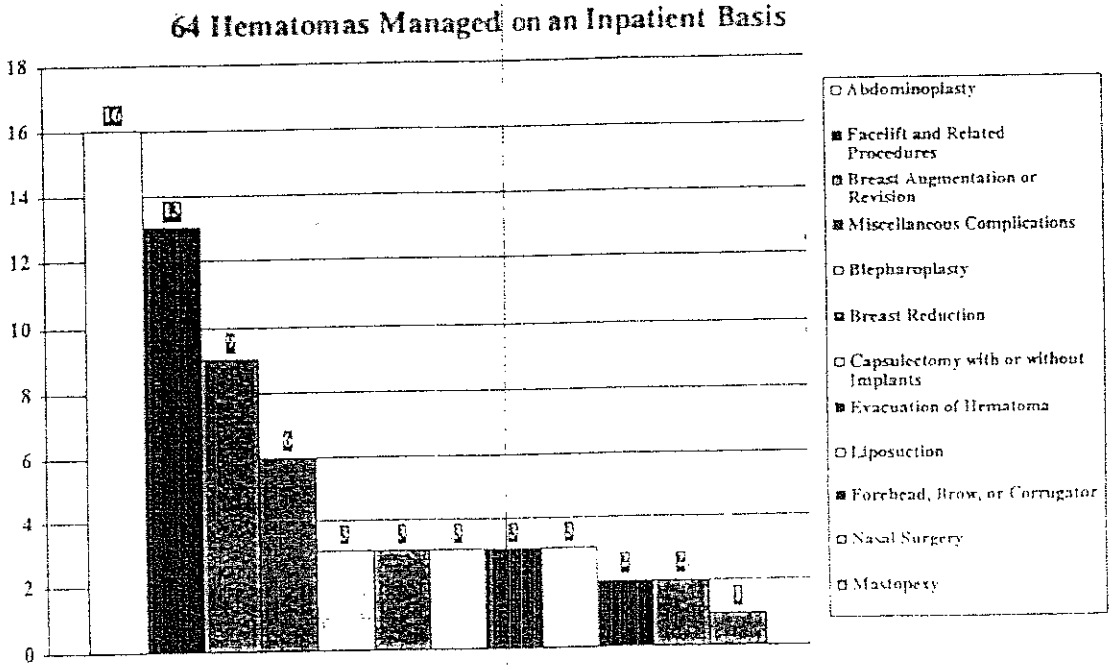

FIG. 2. Hematomas managed on an inpatient basis (n = 64).

(Fig. 2). Of those patients hospitalized, three patients were hospitalized for observation and had no surgical intervention. The average hospital stay for these patients was 1.38 days (range, 1 to 6 days).

Breast augmentation resulted in the largest

number of hematomas managed as outpatient cases (n = 200). Abdominoplasty accounted for the largest number of patients hospitalized with hematomas (n = 16). All hematomas were managed successfully without residual sequelae. No deaths were reported as the result of hematomas.

Morello et al.[8] reported hematoma or bleeding episodes in 965 of the 400,675 operative procedures, or one in every 415 procedures (an incidence of 0.24 percent). Byrd et al.[2] reported that 77 percent of sequelae were hematomas, an incidence of 0.5 percent or one in 200 procedures. Natof[10] performed a prospective study on 13,433 procedures with a follow-up of 14 days. Bleeding occurred in 74 patients, or one in 182 procedures (0.55 percent).

Infection

There were 388 infections reported, representing an incidence of 0.09 percent or one in 1061 procedures. A total of 348 patients had infections that were managed on an outpatient basis (Fig. 3). Forty of the patients who had infections required hospitalization (Fig. 4). The average hospital stay for these patients was 5.1 days. The length of stay varied from 1 day to 21 days. All infections resolved with local wound care or a combination of antibiotics and local wound care.

Forty-eight patients had an infection associated with an implant that was eventually removed. Forty-three patients had breast implants removed, and five patients had chin or other facial implants removed. There were no deaths attributable to infection.

Interestingly, Morello et al.[8] reported the same incidence of infection, 0.09 percent, for a frequency of one in 1145 procedures. Byrd et al.[2] reported six infections, an incidence of one in 886 procedures, or 0.11 percent. Natof's[10] study reported 10 patients with postoperative infections for an incidence of one in 1343 procedures or 0.074 percent.

Cardiac-Related Sequelae

Cardiac events occurred in 29 patients (incidence of one in 14,196 cases, or 0.007 per-

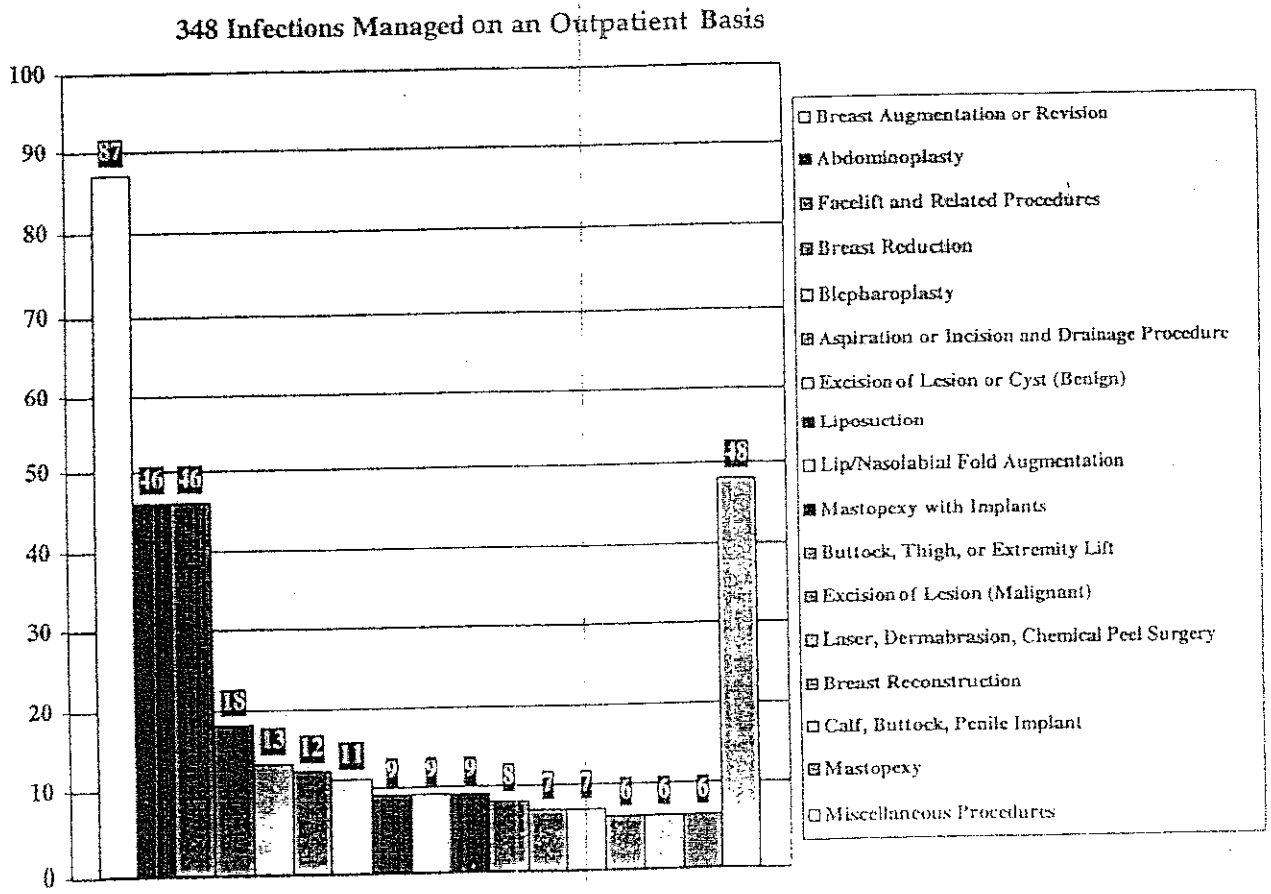

FIG. 3. Infections managed on an outpatient basis (n = 348).

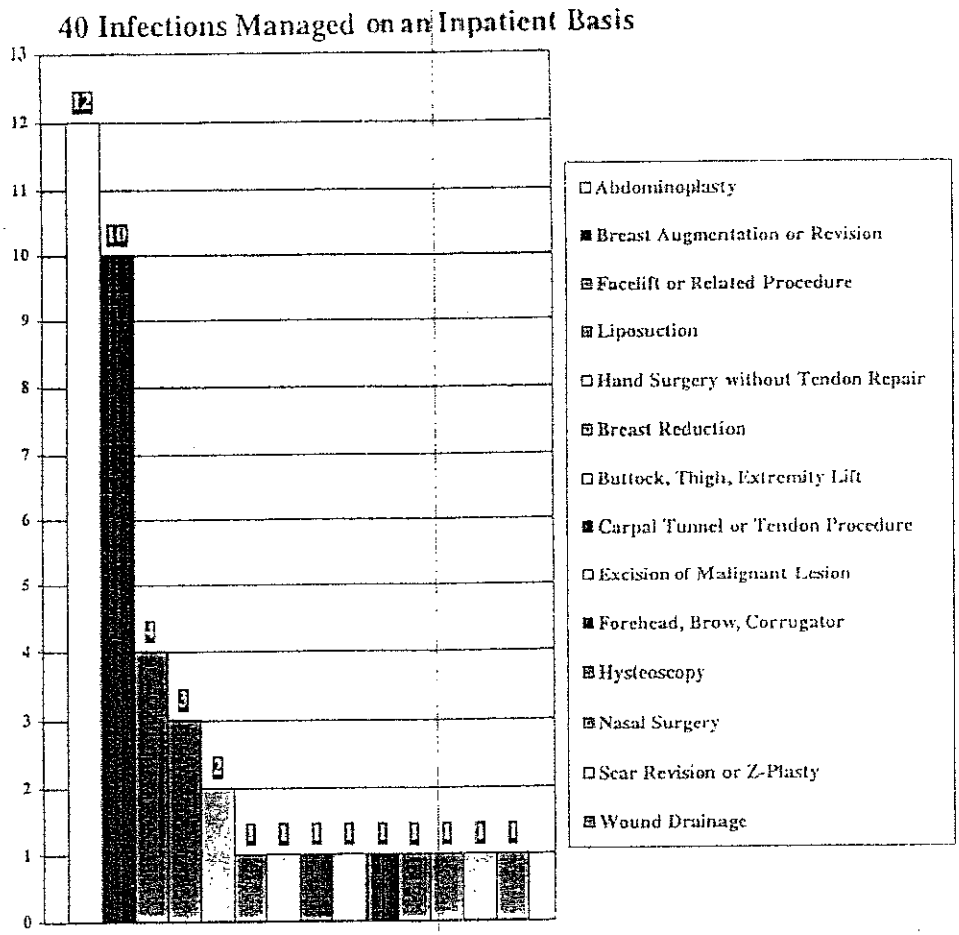

FIG. 4. Infections managed on and inpatient basis ($n = 40$).

cent). Twenty-seven patients had arrhythmias and two patients had cardiac arrests.

Of the two cardiac arrests, one patient became bradycardic, hypotensive, and unresponsive in the postoperative recovery room. A code was called and cardiopulmonary resuscitation, atropine, and epinephrine were administered. The patient was transferred to a hospital and admitted. Unresponsive and without spontaneous respiration, she was admitted to the cardiac care unit and placed on a respirator. After a 34-day hospital stay, the patient was discharged with some neurologic deficit.

The second patient was undergoing a face lift under intravenous sedation. It is believed that the patient had a myocardial infarction after becoming hypotensive intraoperatively. The patient was resuscitated, but immediately became bradycardic and was admitted to a hospital. She died after a 2-week hospital stay.

Fourteen of the patients with cardiac arrhythmias were hospitalized, with an average length of stay of 4 days (range, 0 to 34 days). Two patients were reported to have had chest pain in the early postoperative period that was determined to be due to anxiety (Fig. 5).

Blood Pressure Alteration

The current study showed that nine patients developed notable hypertension intraoperatively. All of these patients responded to medical management. Hypertensive episodes occurred in 0.002 percent of cases. One of these patients had their surgery canceled and was referred for medical evaluation.

Seven patients, or 0.002 percent of all cases performed, had notable hypotensive episodes. Five of these patients were hospitalized for an average period of 2.1 days. Two patients received a blood transfusion. All patients recovered without residual sequelae (Fig. 6). In the Morello et al.[8] article, hypertensive episodes represented 414 cases, or one in 968 procedures (an incidence of 0.1 percent). Intraoperative and postoperative hypotension occurred in 148 cases, or one in

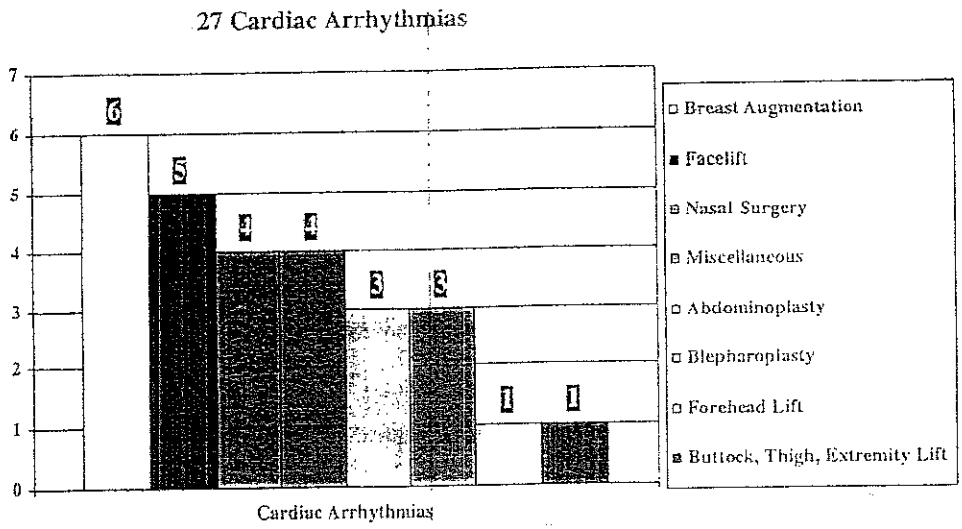

FIG. 5. Cardiac arrhythmias (n = 27). There were also two occurences of cardiac arrest.

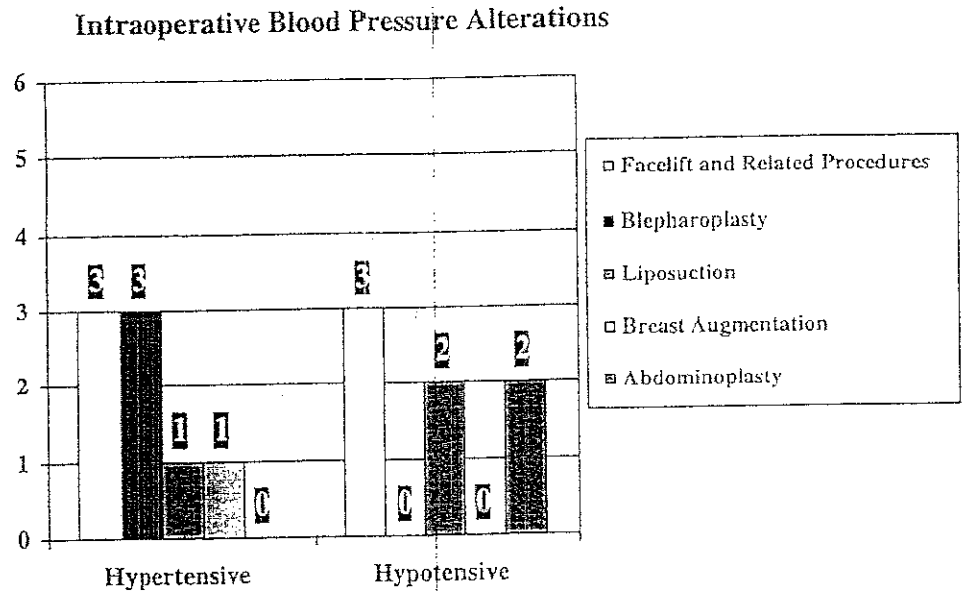

FIG. 6. Intraoperative blood pressure alterations (n = 15). One other patient experienced hypertension, but the operation was cancelled.

2707 procedures, an incidence of 0.04 percent.

Deep Vein Thrombosis or Pulmonary Embolism

All surgical patients are at some risk for the development of deep vein thrombosis in the lower extremities. The risk is increased for patients with a previous history of that condition, pulmonary embolism, or chronic venous insufficiency and for those with a family history of thrombotic syndromes. Other contributing factors include obesity, trauma, severe infection, polycythemia, central nervous system disease, malignancy, homocystinemia, history of radiation therapy, especially for pelvic neoplasms, and the use of birth control pills.[11,12]

There have been few reported studies on the frequency of deep vein thrombosis and pulmonary embolism associated with outpatient surgery. In the 2-year period monitored by the AAAASF quality improvement and peer review program, 31 patients developed deep vein thromboses or pulmonary emboli in 411,670 procedures (Fig. 7). This represents 0.01 percent of procedures performed, consistent with the report by Reinish et al.[13] As with the study by Morello et al., the Reinish group's study was conducted through a voluntary survey. The

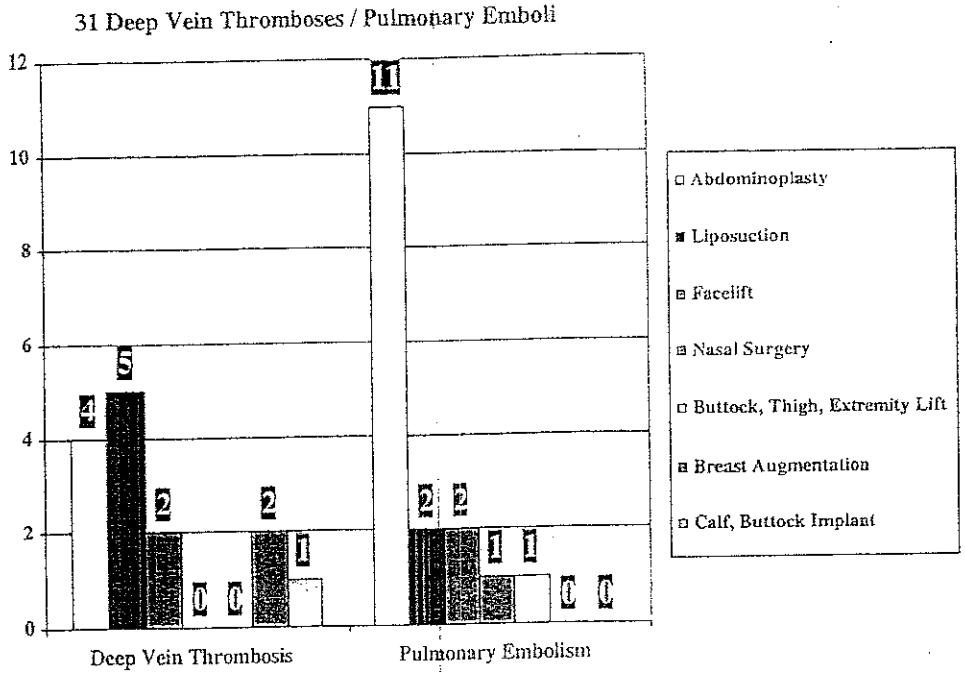

FIG. 7. Deep vein thromboses/pulmonary emboli ($n = 31$).

correlation of statistics with the mandatory AAAASF quality improvement and peer review Internet-based reporting system is significant.

Of these 31 patients with deep vein thromboses or pulmonary emboli, 14 patients had deep vein thromboses, of whom eight were hospitalized for management; six patients were treated on an outpatient basis. The average length of stay for those hospitalized for deep vein thromboses was 5.38 days (range, 2 to 12 days). There were no deaths associated with deep vein thromboses that did not eventuate in pulmonary emboli. All thromboses that did not result in pulmonary embolism resolved without additional sequelae.

The 17 patients who developed pulmonary emboli were hospitalized. The incidence of pulmonary embolism was one in 24,216 procedures, or 0.004 percent. The average length of stay for pulmonary emboli patients was 6.2 days (range, 1 to 11 days). Six deaths were reportedly due to pulmonary embolism. Four of the patients who died of pulmonary embolism had undergone an abdominoplasty. One of the aforementioned patients had undergone multiple procedures. The fifth patient who died had a pulmonary embolus 2 weeks after rhinoplasty. The procedure for the sixth patient who died was suction lipectomy of the abdomen using epidural anesthesia. The total amount of fat removed for the liposuction case was 3700 cc. All fatal pulmonary emboli occurred between postoperative days 2 and 14. In the remaining 11 patients, the pulmonary emboli resolved without residual sequelae.

The incidence of deep vein thrombosis was reported to be 0.3 percent in one large series of patients undergoing hip replacement.[14] Fatal pulmonary emboli occur in 0.1 to 0.8 percent of general surgery patients, 2 to 3 percent of patients undergoing elective hip replacement, and 4 to 7 percent of patients undergoing operative reduction of hip fracture.[14]

In a study of patients undergoing face lift surgery, Reinisch et al.[13] reported an incidence of thrombosis of 0.1 percent based on a survey of selected surgeons from the American Society of Plastic and Reconstructive Surgeons. In that study, 37 of 9493 face lift patients developed deep vein thrombosis (0.39 percent) and 15 patients developed pulmonary embolism (0.16 percent). Byrd et al.[2] reported no pulmonary emboli in their 5316 elective plastic surgery cases performed in an accredited outpatient plastic surgery facility.

Pneumothorax

Intraoperative pneumothorax has been reported as a complication in major surgical procedures about the chest wall when obtaining rib grafts, mobilizing chest muscle flaps, and performing chest wall reconstruction. In a re-

cent study, Osborn and Stevenson[15] surveyed 363 members of the California Society of Plastic Surgeons, requesting demographic data on each participant regarding the number of years that they were in practice and the number of breast operations performed per year. The remainder of the questions dealt with the incidence of pneumothorax encountered by surgeons when performing breast augmentation. Fifty percent of the surgeons responded (n = 181); their responses indicated that a total of 83 cases of pneumothorax had been encountered during breast augmentation in their practices.[15]

This study reports 19 cases of pneumothorax (Fig. 8). The incidence of pneumothorax was greatest for breast augmentation and augmentation-related procedures (n = 17). The other two cases of pneumothorax were diagnosed during an abdominoplasty and a breast reduction. In 17 patients, the pneumothorax was noted intraoperatively, and in two patients, it was diagnosed between postoperative days 1 and 4. Puncture of the pleura at the time of rib block occurred in seven patients, and an intraoperative pleural tear while cauterizing bleeders was the cause of pneumothorax for 11 patients. In one patient, pneumothorax was attributed to preexisting pulmonary blebs.

Osborn and Stevenson[15] discuss the potential for the occurrence of catamenial pneumothorax caused by endometrial implants on the lungs. They usually occur between 48 to 72 hours after the onset of menstruation and have been reported to account for 2.8 percent to 5.6 percent of all episodes of spontaneous pneumothorax in women.[15–21] There were no cases of catamenial pneumothorax reported in this study.

Twelve patients required chest tubes and were hospitalized. The average length of stay was 1.83 days (range, 1 to 7 days). The patient hospitalized for 7 days had bilateral pneumothorax with pulmonary edema that resolved. There were no deaths from pneumothorax in the 411,670 procedures performed.

Hyperthermia

Two cases of hyperthermia were reported. One case was managed with aspirin. The other case was a true malignant hyperthermia; the patient was managed with dantrolene sodium in the surgery center and transported to a hospital. The hospital stay lasted 1 day, and the patient was discharged without residual sequelae.

Deaths

In addition to the six deaths related to pulmonary embolism and the one death related to intraoperative hypoxia, another patient died on the first postoperative day, presumably from hypoxia related to sleep apnea. The patient was obese and had undergone a face lift. She died

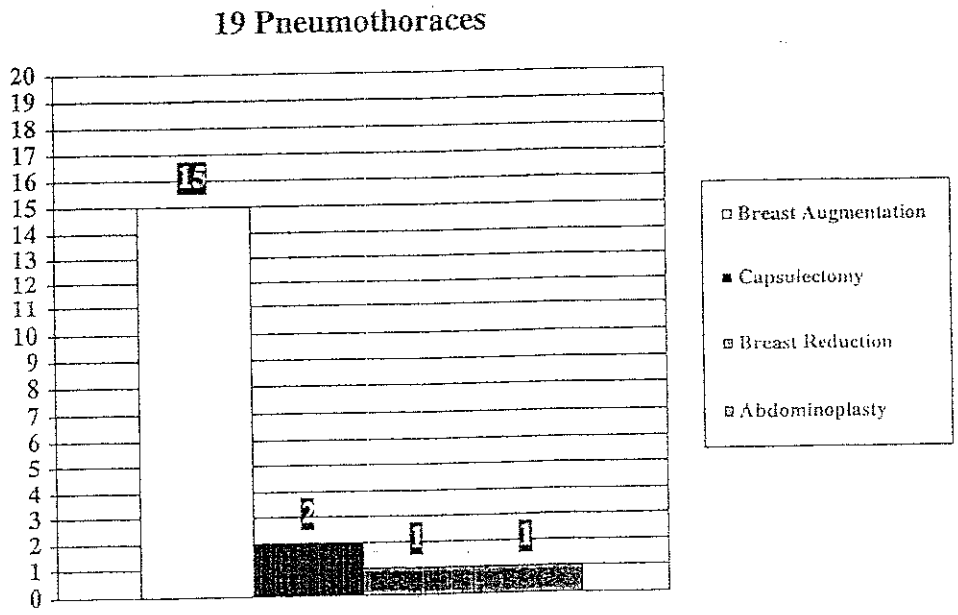

FIG. 8. Pneumothorax (n = 19).

in her sleep at home the evening after the operation.

The incidence of a patient dying after having an outpatient procedure was 0.002 percent, or one in 51,459 procedures. This compares favorably to the incidence in Morello et al.'s study,[8] which reported seven deaths in 400,675 procedures for an incidence of 0.0017 percent, or less than one in 57,000 procedures.

Discussion

Comparison of data obtained through voluntary and mandatory reporting programs demonstrates close correlation in overall incidence of unanticipated sequelae, their occurrence by type, and postoperative deaths. It is important to note that of the eight deaths reported through the Internet reporting program, only two occurred in the intraoperative or immediate postoperative period. Most of the deaths were secondary to the development of pulmonary embolism, which can occur as the result of any surgical procedure, whether it is performed in a multispecialty free-standing outpatient facility, an office-based outpatient facility, or a hospital.

All patients with unanticipated sequelae who required hospitalization as the result of bleeding or infection were managed and discharged from the hospital with the sequelae resolved.

The AAAASF standards for accreditation of a surgery center require all surgeons to be certified by an American Board of Medical Specialties surgical board and to have core credentials in a hospital for all procedures that they perform in their surgery centers. It may be assumed that the surgical technique for any given procedure performed by a certified surgeon would be the same whether the procedure is performed in a hospital or a surgery center. The low incidence of intraoperative sequelae in this report demonstrates conclusively the safety of operation of outpatient surgery centers that are accredited by a recognized accrediting organization and staffed by American Board of Medical Specialties board-certified surgeons.

Additional broad based studies are being designed to identify areas to improve the delivery of outpatient surgical care. The first Internet model for collecting data on outpatient surgical outcomes, designed by the AAAASF, has added a new dimension to monitoring and evaluating patient care. Its current use and expansion will provide the needed data for further analysis of surgical outcomes. It is important to note that the analysis of outcomes will be more meaningful when reviewed in conjunction with a surgery center's compliance with accepted standards for operation.[22–24]

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Acknowledgments

The authors thank Richard Berk, professor of statistics, Department of Statistics, University of California, Los Angeles, and Ronnie Serr, computer consultant.

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11. Moreano, E. H., Hutchinson, J. L., McCulloch, T. M., Graham, S. M., Funk, G. G., and Hoffman, H. T. Incidence of deep vein thrombosis and pulmonary

6) If this proposal were approved, identify the personnel responsible for administering the delivery of the general anesthesia. If not already noted, describe their qualifications for performing this service.

We will be contracting with The Stamford Anesthesia Services, PC a private practice anesthesia group who works primary at the Stamford Hospital, Stamford, CT.
They are a group of board certified anesthesiologists who staff the surgical services at the Stamford Hospital and The Tully Ambulatory Surgical Center of the Stamford Hospital, Stamford, CT.

7) Provide copies of any transfer agreements that the Applicants have in place with the area's acute care hospitals.

Please see attached transfer agreements for Dr. Sandra Margoles and Dr. Elsa Raskin for transfer of patients from the Greenwich Plastic Surgery Center to The Greenwich Hospital, Greenwich, CT.

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

August 16, 2012

To Whom It May Concern:

This is to certify that Sandra Margoles, M.D. has been a member of the Greenwich Hospital Medical Staff in the Department of Surgery, Section of Plastic Surgery since September 28, 1999.

She is a member of the Active Attending Staff has operating and admitting privileges and is in good standing. In the event of emergency, Dr. Margoles may transfer patients to Greenwich Hospital from her office.

Sincerely,

Brian J. Doran, M.D.
Senior Vice President, Medical Services &
Chief Medical Officer

5 Perryridge Road
Greenwich, CT 06830-4697
(203) 863-3000

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

December 6, 2012

To Whom It May Concern:

This is to certify that Elsa Raskin, M.D. has been a member of the Greenwich Hospital Medical Staff in the Department of Surgery, Section of Plastic Surgery since June 27, 2006.

She is a member of the Active Attending Staff, has operating and admitting privileges and is in good standing. In the event of an emergency, Dr. Raskin may transfer patients to Greenwich Hospital from her office.

Sincerely,

Spike Lipschutz, M.D.
Vice President, Medical Services & Chief Quality Officer

5 Perryridge Road
Greenwich, CT 06830-4697
(203) 863-3000

8) Provide documentation to verify your current accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) as stated on page 5 of the application.

Please see attached certification from the AAASF.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES, INC.

ACCREDITATION OFFICE: 5101 Washington Street, Suite 2F • P.O. Box 9500, Gurnee, Illinois 60031 • Toll Free 1-888-545-5222
Phone 847-775-1970 Fax 847-775-1985 • E-mail: info@aaaasf.org • Web Site: www.aaaasf.org

June 5, 2012

Greenwich Plastic Surgery Center
Sandra L. Margoles M.D.
2 1/2 Deerfield Drive, Suite 102
Greenwich, CT 06831

Facility ID #: 4039

Dear Dr. Margoles:

Enclosed please find the Statement of Deficiency generated by your **2012** self-evaluation, using the Standards/Checklist and Answer Sheet, for your interim year evaluation. **No Areas of Deficiency were found in the evaluation.** Enclosed is your certificate.

This self-evaluation shall not affect your status as an accredited facility, and shall not be permanently maintained in your file. The self-evaluation is to be used by you to maintain the high standards of this program, and to assist you in preparing for your next on-site re-inspection.

Thank you for your support of this voluntary program of excellence, and we look forward to your future participation.

Sincerely,

Pamela A. Baker

Pamela A. Baker, CAE
Director of Accreditation

Enclosures

PAB/jjh

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Greenwich Plastic Surgery Center

for having met the standards of a CLASS B ambulatory surgery facility in which minor or major surgical procedures are performed under intravenous or parenteral sedation (excluding Propofol), analgesia, or dissociative drugs.

ABMS or Other Specialty: Plastic Surgery

AAAASF President
Harlan Pollock, M.D.

Past President / Treasurer
Lawrence N. Reed, M.D.

Certified from 11/23/2012 to 11/23/2013

Certification Number 4038

9) Please revise the projected volumes on page 6 of the application to include FY 2015. Provide additional detail on how these estimates were calculated, and include subtotal and total rows.

The percent increase in the anticipated surgical volume is based on our own practices historical data as well as the American Society of Plastic Surgeons Plastic Surgery Statistics Report. This report provides the statistical trends in the US for the past two decades. The data base estimates a 5-9% yearly increase in surgical cases with results based on a 95 percents confidence level and with a +/- 3.16 percent margin of error.

See attached articles from www.plasticsurgery.org; the web page for the American Society of Plastic Surgeons.

9) Please revise the projected volumes on page 6 of the application to include FY 2015. Provide additional detail on how these estimates were calculated, and include subtotal and total rows.

The % increase in the anticipated surgical volume is based on our own practices historical data as well as the American Society of Plastic Surgeons Plastic Surgery Statistics Report. This report provides the statistical trends in the US for the past two decades. The data base estimates a 5-9% yearly increase in surgical cases with results based on a 95 percents confidence level and with a +/- 3.16 percent margin of error. See addendum. www.plasticsurgery.org

PROJECTED VOLUME

Greenwich Plastic Surgery Center

	2012	2013	2014	2015
Abdominoplasty	12	18	25	27
Blepharoplasty	8	14	20	22
Breast Augmentation	12	20	30	33
Breast Lift	8	13	20	22
Breast Reduction	28	30	30	33
Facelift	2	6	10	11
Liposuction	2	8	12	13
Rhinoplasty	2	4	6	6
Smartlipo	45	65	80	95
Subtotal	**119**	**178**	**233**	**262**

Greenwich Hospital

Abdominoplasty	12	5	5	5
Breast Reduction	28	24	20	15
Breast Reconstruction	16	20	30	20
Subtotal	**56**	**49**	**55**	**40**

AMERICAN SOCIETY OF PLASTIC SURGEONS®

2011 Plastic Surgery Statistics Report

*Please credit the **American Society of Plastic Surgeons** when citing statistical data or using graphics.*

ASPS Public Relations
Phone: 847-228-9900
Fax: 847-981-5482
Email: media@plasticsurgery.org
Website: www.plasticsurgery.org

2011 Plastic Surgery Statistics

Methodology and Validity

Methodology

Since 1992, the American Society of Plastic Surgeons® (ASPS®) has been the source of cosmetic and reconstructive plastic surgery statistical trends in the U.S., and this series represents nearly two decades of procedural data. ASPS has partnered with Data Harbor Solutions, a health care industry data management and technology development company, to ensure objectivity in the gathering, analysis and publication of its procedural statistics.

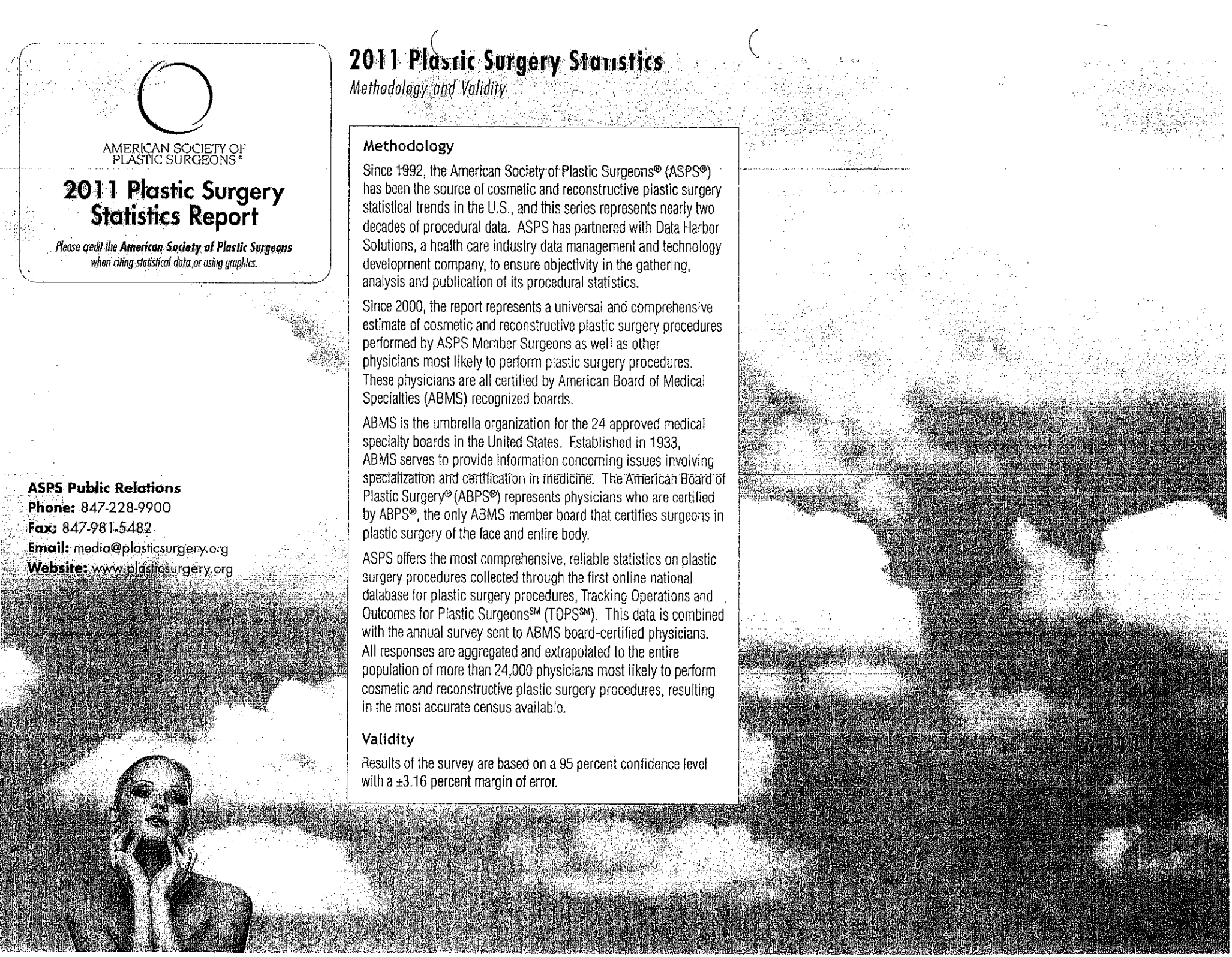
Since 2000, the report represents a universal and comprehensive estimate of cosmetic and reconstructive plastic surgery procedures performed by ASPS Member Surgeons as well as other physicians most likely to perform plastic surgery procedures. These physicians are all certified by American Board of Medical Specialties (ABMS) recognized boards.

ABMS is the umbrella organization for the 24 approved medical specialty boards in the United States. Established in 1933, ABMS serves to provide information concerning issues involving specialization and certification in medicine. The American Board of Plastic Surgery® (ABPS®) represents physicians who are certified by ABPS®, the only ABMS member board that certifies surgeons in plastic surgery of the face and entire body.

ASPS offers the most comprehensive, reliable statistics on plastic surgery procedures collected through the first online national database for plastic surgery procedures, Tracking Operations and Outcomes for Plastic Surgeons℠ (TOPS℠). This data is combined with the annual survey sent to ABMS board-certified physicians. All responses are aggregated and extrapolated to the entire population of more than 24,000 physicians most likely to perform cosmetic and reconstructive plastic surgery procedures, resulting in the most accurate census available.

Validity

Results of the survey are based on a 95 percent confidence level with a ±3.16 percent margin of error.



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Email: media@plasticsurgery.org
Website: www.plasticsurgery.org

2011 Quick Facts

Cosmetic and Reconstructive Plastic Surgery Trends

Percentage change 2011 vs. 2010

- **13.8 million cosmetic procedures** ⬆ 5%
- **1.6 million cosmetic surgical procedures** ⬆ 2%
- **12.2 million cosmetic minimally-invasive procedures** ⬆ 6%
- **5.5 million reconstructive procedures** ⬆ 5%

2011 Top 5 Cosmetic Surgical Procedures

Cosmetic Surgical	2011 vs. 2010
Breast augmentation	⬆ 4%
Nose reshaping	⬇ -3%
Liposuction	⬆ 1%
Eyelid surgery	⬇ -6%
Facelift	⬆ 5%

- Breast augmentation has been the top cosmetic surgical procedure since 2006.
- Facelifts are among the Top 5 Cosmetic Surgical procedures for the first time since 2004, replacing tummy tucks.
- Cosmetic surgical procedures not among the Top 5 that rose significantly in 2011:
  - Chin augmentation, up 71%
  - Lip augmentation, up 49%
  - Buttock implants, up 43%
  - Buttock lift, up 38%

2011 Top 5 Cosmetic Minimally-Invasive Procedures

Cosmetic Minimally-Invasive	2011 vs. 2010
Botulinum toxin type A	⬆ 5%
Soft tissue fillers	⬆ 7%
Chemical peel	⬇ -3%
Laser hair removal	⬆ 15%
Microdermabrasion	⬆ 9%

- Soft tissue fillers were among the fastest growing cosmetic minimally-invasive procedures in 2011:
  - Calcium hydroxylapatite (Radiesse®), up 36%
  - Fat injections, up 19%
  - Hylauronic acid (Restylane®, JuvedermUltra®, etc.), up 9%
- Cosmetic minimally-invasive procedures not among the Top 5 that rose significantly in 2011:
  - Cellulite treatment, up 21%
  - Laser skin resurfacing, up 9%
  - Laser treatment of leg veins, up 9%

2011 Top 5 Reconstructive Procedures

Reconstructive	2011 vs. 2010
Tumor removal	⬆ 3%
Laceration repair	⬇ -15%
Maxillofacial surgery	⬆ 125%
Scar revision	⬆ 9%
Hand surgery	⬆ 13%

- Maxillofacial surgery returns to the Top 5 Reconstructive procedures after being edged out in 2010.
- Breast reconstruction rates continue to rise, with more than 96,000 procedures performed last year, up 3%.

AMERICAN SOCIETY OF PLASTIC SURGEONS®

2011 Plastic Surgery Statistics Report

*Please credit the **American Society of Plastic Surgeons** when citing statistical data or using graphics.*

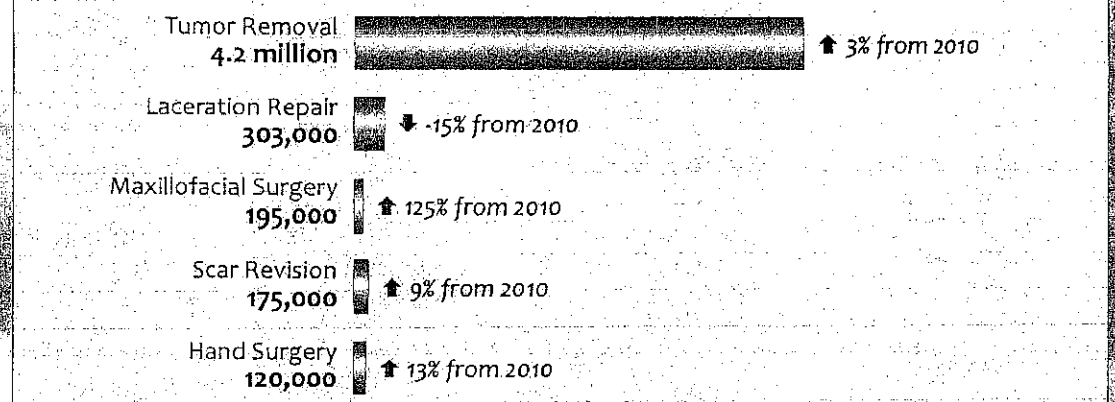
2011 Reconstructive Plastic Surgery Statistics

Reconstructive Procedure Trends

Top 5 procedures appear in bold

RECONSTRUCTIVE PROCEDURES	2011	2010	2000	% CHANGE 2011 vs. 2010	% CHANGE 2011 vs. 2000
Dog bite repair^	29,863	32,961	**43,089**	-9%	-31%
Birth defect reconstruction	39,207	34,345	40,076	14%	-2%
Breast implant removals (reconstructive patients only)^^^	15,735	14,991	16,287	5%	-3%
Breast reconstruction^^^^	96,277	**93,083**	**78,832**	3%	22%
Breast reduction (reconstructive patients only)^^	63,109	*	*	*	*
Burn care	20,456	19,369	*	6%	*
Hand surgery (excluding microsurgical)	**119,799**	**105,711**	*	13%	*
Laceration repair (other than facial)^^^	**302,800**	**356,601**	**358,666**	-15%	-16%
Maxillofacial surgery^^^^	**195,398**	87,024	**79,331**	125%	146%
Scar revision	**175,330**	**160,516**	**221,858**	9%	-21%
Tumor removal (including skin cancer)	**4,171,416**	**4,042,955**	*	3%	*
Other reconstructive procedures	301,399	259,276	376,270	16%	-20%
TOTAL RECONSTRUCTIVE PROCEDURES	**5,530,789**	*	*	*	*
TOTAL RECONSTRUCTIVE PROCEDURES *(Excluding Breast Reduction)*	**5,467,680**	**5,206,832**	*	**5%**	*

2011 TOP FIVE RECONSTRUCTIVE PROCEDURES



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2011 Quick Facts

Cosmetic Plastic Surgery Demographic Trends

Age

People age 13-19 had the least number of cosmetic procedures last year, only 2% of the total. Some of the most common procedures for teens were: nose reshaping, male breast reduction, ear surgery, laser hair removal, laser treatment of leg veins, and laser skin resurfacing.

20-29 year olds	**2011 vs. 2010**
794,000 total cosmetic procedures	⬆ 6%
253,000 surgical	*No change*
541,000 minimally-invasive	⬆ 9%

30-39 year olds	**2011 vs. 2010**
2.5 million total cosmetic procedures	⬆ 5%
364,000 surgical	⬆ 1%
2.1 million minimally-invasive	⬆ 6%

40-54 year olds	**2011 vs. 2010**
Make up the majority of cosmetic procedures – 48% of the total.	
6.4 million total cosmetic procedures	⬆ 6%
525,000 surgical	⬆ 2%
5.9 million minimally-invasive	⬆ 6%

55 and over	**2011 vs. 2010**
3.4 million total cosmetic procedures	⬆ 5%
360,000 surgical	⬆ 3%
3.1 million minimally-invasive	⬆ 5%

Gender

Female	**2011 vs. 2010**
91% of all cosmetic procedures	
12.1 million cosmetic procedures	⬆ 5%
1.4 million surgical	⬆ 2%
10.7 million minimally-invasive	⬆ 6%

Male	**2011 vs. 2010**
9% of all cosmetic procedures	
1.2 million cosmetic procedures	⬆ 6%
204,000 surgical	⬆ 1%
990,000 minimally-invasive	⬆ 8%

Ethnic	**2011 vs. 2010**
Caucasian	⬆ 4%
Hispanics	⬆ 8%
African Americans	⬆ 6%
Asian Americans	⬆ 6%

Did you know...

- Business from repeat patients up 8%
- $10.4 billion spent on cosmetic procedures in the U.S., up 2.95%
- Office-based cosmetic procedures are up 5%
- Region with the most cosmetic procedures performed in the U.S. is Mountain/Pacific – 3.9 million procedures

10) Based on the historical data you provided on page 3 of the application, the average number of surgical procedures from 2009 to 2011 is 67. The surgical volumes projected on page 6 of the application anticipate surgical volumes to increase to 119 in 2012, 178 in 2013 and 233 in 2014. Please provide the assumptions used to determine the projected surgical volumes.

In October 2010 we started providing Smartlipo ™, laser liposuction in our office procedure room, and obtained the American Association of Ambulatory Surgical Facility (AAASF) certificate in November 2012. These two factors were directly responsible for the increase in our surgical volume. The decrease in volume for 2011 was secondary to the changes in insurance payments for reconstructive elective surgical procedures; specifically breast reductions; because of an increased in patient insurance deductibles resulting in less insurance paid procedures.

The % increase in the anticipated surgical volume is based on our own practices historical data as well as the American Society of Plastic Surgeons Plastic Surgery Statistics Report. This report provides the statistical trends in the US for the past two decades. The data base estimates a 5-9% yearly increase in surgical cases with results based on a 95 percents confidence level and with a +/- 3.16 percent margin of error.

See attached articles from www.plasticsurgery.org; the web page for the American Society of Plastic Surgeons.

2008 Reconstructive Surgery Procedures

AMERICAN SOCIETY OF PLASTIC SURGEONS
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Top five procedures in bold.

	2008	RECONSTRUCTIVE PROCEDURES COMBINED % OF TOTAL	% CHANGE 2008 vs. 2000	% CHANGE 2008 vs. 2007
RECONSTRUCTIVE PROCEDURES				
Dog bite repair^	28,232	0.6%	-34%	-9%
Birth defect reconstruction†	31,950	0.6%	-20%	16%
Cleft lip and palette	18,470	0.4%	*	-2%
Breast implant removals (Reconstructive patients only)	19,939	0.4%	19%	37%
Breast reconstruction	79,458	2%	-2%	39%
Breast reduction	**88,732**	**2%**	**5%**	**-16%**
Burn care^^	19,501	0.4%	*	71%
Hand surgery^^†	**100,354**	**2%**	*	**-30%**
Carpal tunnel	37,949	1%	*	*
Arthritis	6,010	0%	*	*
Trigger finger	22,962	0%	*	*
Laceration repair	**307,485**	**6%**	**-14%**	**7%**
Maxillofacial surgery	86,301	2%	9%	7%
Microsurgery^^	12,248	0.2%	*	35%
Scar revision	**162,803**	**3%**	**-27%**	**8%**
Tumor removal^^†	**3,769,503**	**76%**	*	**-3%**
Skin cancer tumor removal	3,283,257	66%	*	*
Basal cell	1,986,227	40%	*	*
Squamous cell	961,258	19%	*	*
Melanoma	335,772	7%	*	*
Other reconstructive procedures	242,685	5%	-36%	-24%
TOTAL RECONSTRUCTIVE PROCEDURES	**4,949,191**	**100%**	**280%**	**3%**

	2008	% 2008	% 2007
RECONSTRUCTIVE PROCEDURES PERFORMED IN			
Office	2,276,628	46%	42%
Hospital	1,781,709	36%	38%
Free-standing Ambulatory Surgical Facility	890,854	18%	20%

All figures are projected.

^In 2000 figure included all animal bites.

^^The number of procedures in 2007 has been restated due to a modeling change.

**Data unavailable.*

† Represents the listed subcategories and other procedures not listed.

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2000/2007/2008 National Plastic Surgery Statistics

Cosmetic and Reconstructive Procedure Trends

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Email media@plasticsurgery.org ▪ **Website** www.plasticsurgery.org

Top five procedures in bold.

	2000	2007	2008	% CHANGE 2008 vs. 2000	% CHANGE 2008 vs. 2007
SURGICAL					
COSMETIC SURGICAL PROCEDURES					
Breast augmentation (Augmentation mammaplasty)* **	**212,500**	**347,524**	**307,230**	45%	-12%
Breast implant removals (Augmentation patients only)	40,787	26,909	20,967	-49%	-22%
Breast lift (Mastopexy)	52,836	104,176	92,461	75%	-11%
Breast reduction in men (Gynecomastia)	20,351	21,311	17,902	-12%	-16%
Buttock implants	*	1,038	853	*	-18%
Buttock lift	1,356	3,300	3,554	162%	8%
Calf augmentation	*	328	247	*	-25%
Cheek implant (Malar augmentation)	10,427	7,964	8,828	-15%	11%
Chin augmentation (Mentoplasty)	26,924	14,933	14,117	-48%	-5%
Dermabrasion	42,218	76,014	78,954	87%	13%
Ear surgery (Otoplasty)	36,295	28,571	29,434	-19%	3%
Eyelid surgery (Blepharoplasty)	**327,514**	**240,660**	**221,398**	-32%	-8%
Facelift (Rhytidectomy)	**133,856**	118,414	112,933	-16%	-5%
Forehead lift	120,971	42,895	42,063	-65%	-2%
Hair transplantation	44,694	18,346	17,580	-61%	-4%
Lip augmentation (other than injectable materials)	18,589	23,585	20,728	12%	-12%
Liposuction	**354,015**	**301,882**	**245,138**	-31%	-19%
Lower body lift	207	8,564	9,286	4386%	8%
Nose reshaping (Rhinoplasty)	**389,155**	**284,960**	**279,218**	-28%	-2%
Pectoral implants	*	440	1,335	*	203%
Thigh lift^^^	5,303	8,897	9,088	71%	2%
Tummy tuck (Abdominoplasty)	62,713	**148,410**	**121,653**	94%	-18%
Upper arm lift^^^	338	13,997	14,059	4059%	0%
TOTAL COSMETIC SURGICAL PROCEDURES	**1,901,049**	**1,837,118**	**1,669,026**	**-12%**	**-9%**
MINIMALLY-INVASIVE					
COSMETIC MINIMALLY-INVASIVE PROCEDURES					
Botox® **	**786,911**	**4,625,192**	**5,014,446**	537%	8%
Cellulite treatment	23,952	38,691	36,858	54%	-5%
Chemical peel	**1,149,457**	**1,024,788**	**1,048,577**	-9%	2%
Laser hair removal	**735,995**	**905,948**	**891,712**	21%	-2%
Laser skin resurfacing	170,961	347,255	400,262	134%	15%
Ablative			103,394	*	*
Non-ablative (Fraxel, etc.)			296,868	*	*
Laser treatment of leg veins	245,424	209,630	222,047	-10%	6%
Microdermabrasion	**868,315**	**896,505**	**841,733**	-3%	-6%
Sclerotherapy	866,555	383,717	375,328	-57%	-2%
Soft Tissue Fillers	652,885	1,523,474	1,593,632	144%	5%
Calcium hydroxylapatite (Radiesse™)	*	176,261	179,489	*	2%
Collagen	587,615	174,290	178,899	-70%	3%
Porcine/bovine-based (Evolence, Zyderm, Zyplast)			33,563	*	*
Human-based (Cosmoderm, Cosmoplast, Cymetra, Fascian)			145,336	*	*
Fat	65,270	46,690	46,218	-29%	-1%
Hyaluronic acid (Hylaform®, Hylaform Plus®, Restylane®, Juvederm™, Perlane®, Captique®)	*	**1,050,722**	**1,109,373**	*	6%
Polylactic acid (Sculptra™)	*	75,511	79,653	*	5%
TOTAL COSMETIC MINIMALLY-INVASIVE PROCEDURES	**5,500,446**	**9,955,192**	**10,424,595**	**90%**	**5%**
TOTAL COSMETIC PROCEDURES	**7,401,495**	**11,792,310**	**12,093,621**	**63%**	**3%**
RECONSTRUCTIVE					
RECONSTRUCTIVE PROCEDURES					
Dog bite repair^	43,089	31,089	28,232	*	-9%
Birth defect reconstruction	40,076	27,636	31,950	-20%	16%
Breast implant removals (Reconstructive patients only)	16,806	14,502	19,939	19%	37%
Breast reconstruction	80,908	57,102	79,458	-2%	39%
Breast reduction	**84,780**	**106,179**	**88,732**	5%	-16%
Burn care^^	*	18,141	19,501	*	7%
Hand surgery^^	*	**83,689**	**100,354**	*	13%
Laceration repair	**358,666**	**286,124**	**307,485**	-14%	7%
Maxillofacial surgery	79,331	80,331	86,301	9%	7%
Microsurgery^^	*	11,949	12,248	*	3%
Scar revision	**221,858**	**150,080**	**162,803**	-27%	8%
Tumor removal^^	*	**3,602,184**	**3,769,503**	*	5%
Other reconstructive procedures	376,270	319,871	242,685	-36%	-24%
TOTAL RECONSTRUCTIVE PROCEDURES	*	**4,793,877**	**4,949,191**	*	**3%**

All figures are projected.
** Data unavailable.*
*** Botox® numbers are of anatomic sites injected.*
****53% of total 2008 breast implants were saline; 47% were silicone.*
^In 2000 figure included all animal bites.
^^ The number of procedures in 2007 has been restated due to a modeling change.
^^^67% of total 2008 thigh and upper arm lifts were after massive weight loss.

AMERICAN SOCIETY OF PLASTIC SURGEONS

Report of the 2010 Plastic Surgery Statistics

*Please credit the **American Society of Plastic Surgeons** when citing statistical data or using graphics.*

2010 Average Surgeon Physician Fees

Cosmetic Procedures

COSMETIC SURGICAL PROCEDURES	NATIONAL AVERAGE SURGEON/PHYSICIAN FEE	TOTAL EXPENDITURE
Breast augmentation (Augmentation mammaplasty)	$3,351	$992,432,214
Breast implant removals (Augmentation patients only)	$2,288	$49,689,719
Breast lift (Mastopexy)	$4,207	$378,310,208
Breast reduction in men (Gynecomastia)	$3,013	$55,068,500
Buttock implants	$4,500	$3,627,000
Buttock lift	$4,379	$14,402,242
Calf augmentation	$3,900	$1,630,335
Cheek implant (Malar augmentation)	$2,739	$22,344,309
Chin augmentation (Mentoplasty)	$2,000	$24,154,000
Dermabrasion	$1,200	$82,363,200
Ear surgery (Otoplasty)	$3,954	$91,105,925
Eyelid surgery (Blepharoplasty)	$2,828	$590,328,829
Facelift (Rhytidectomy)	$6,231	$703,805,882
Forehead lift	$3,161	$134,114,530
Hair transplantation	$4,676	$88,819,252
Lip augmentation (other than injectable materials)	$1,683	$28,848,962
Liposuction	$2,884	$585,668,787
Lower body lift	$7,247	$69,752,647
Nose reshaping (Rhinoplasty)	$4,306	$1,086,142,208
Pectoral implants	$3,810	$845,811
Thigh lift	$4,507	$41,617,065
Tummy tuck (Abdominoplasty)	$5,130	$596,935,062
Upper arm lift	$3,729	$56,619,969

COSMETIC MINIMALLY-INVASIVE PROCEDURES	NATIONAL AVERAGE SURGEON/PHYSICIAN FEE	TOTAL EXPENDITURE
Botulinum Toxin Type A (Botox®, Dysport®)***	$375	$1,008,630,000
Cellulite treatment (e.g., Velosmooth®, Endermology)	$230	$7,182,210
Chemical peel	$706	$807,807,900
Intense Pulsed Light (IPL) treatment	$470	$216,077,809
Laser hair removal	$383	$359,148,446
Laser skin resurfacing		
Ablative	$2,040	$231,256,264
Non-ablative (e.g., Fraxel®)	$1,156	$362,235,159
Laser treatment of leg veins	$404	$88,190,141
Microdermabrasion	$146	$120,202,549
Sclerotherapy	$354	$129,459,309
Soft Tissue Fillers		
Calcium hydroxylapatite (e.g., Radiesse®)	$650	$136,482,450
Collagen		
Porcine/bovine-based (e.g., Evolence®, Zyderm®, Zyplast®)	$468	$13,055,466
Human-based (e.g., Cosmoderm®, Cosmoplast®, Cymetra®)	$475	$62,793,129
Fat	$1,700	$97,978,188
Hyaluronic acid (e.g., Juvederm Ultra®, Juvederm Ultra Plus®, Perlane®, Restylane®, Prevelle Silk®)	$547	$657,069,702
Polylactic acid (Sculptra®)	$940	$112,953,021
Polymethyl-methacrylate microspheres (Artefill®)	$1,099	$26,541,629

Total 2010 Expenditures	$10,135,689,068

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All values are projected.
Fees generally vary according to region of country and patient needs.
These fees are averages only. Fees do not include anesthesia, operating room facilities or other related expenses.

ASPS Procedural Statistics represent procedures performed by ASPS Member Surgeons certified by The American Board of Plastic Surgery® as well as other physicians certified by American Board of Medical Specialties-recognized boards.

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2011 Plastic Surgery Statistics Report

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2011 Cosmetic Plastic Surgery Statistics

Cosmetic Procedure Trends

Top 5 procedures appear in bold

COSMETIC SURGICAL PROCEDURES	2011	2010	2000	% CHANGE 2011 vs. 2010	% CHANGE 2011 vs. 2000
Breast augmentation (Augmentation mammaplasty)	**307,180**	**296,203**	**212,500**	4%	45%
Breast implant removals (Augmentation patients only)	22,271	21,714	40,787	3%	-45%
Breast lift (Mastopexy)	90,679	89,931	52,836	1%	72%
Breast reduction in men (Gynecomastia)	19,766	18,280	20,351	8%	-3%
Buttock implants	1,149	806	*	43%	*
Buttock lift	4,546	3,289	1,356	38%	235%
Calf augmentation	405	418	*	-3%	*
Cheek implant (Malar augmentation)	11,996	8,158	10,427	47%	15%
Chin augmentation (Mentoplasty)	20,680	12,077	26,924	71%	-23%
Dermabrasion	73,433	68,636	42,218	7%	74%
Ear surgery (Otoplasty)	26,433	29,828	36,295	-11%	-27%
Eyelid surgery (Blepharoplasty)	**196,286**	**208,764**	**327,514**	-6%	-40%
Facelift (Rhytidectomy)	**119,026**	112,955	**133,856**	5%	-11%
Forehead lift	46,931	42,433	120,971	11%	-61%
Hair transplantation	15,754	18,996	44,694	-17%	-65%
Lip augmentation (other than injectable materials)	25,477	17,143	18,589	49%	37%
Liposuction	**204,702**	**203,106**	**354,015**	1%	-42%
Lower body lift	7,615	9,625	207	-21%	3,579%
Nose reshaping (Rhinoplasty)	**243,772**	**252,261**	**389,155**	-3%	-37%
Pectoral implants	317	222	*	43%	*
Thigh lift	9,761	9,234	5,303	6%	84%
Tummy tuck (Abdominoplasty)	115,902	**116,352**	62,713	0%	85%
Upper arm lift	14,998	15,183	338	-1%	4,337%
TOTAL COSMETIC SURGICAL PROCEDURES	**1,579,079**	**1,555,614**	**1,901,049**	**2%**	**-17%**

COSMETIC MINIMALLY-INVASIVE PROCEDURES	2011	2010	2000	% CHANGE 2011 vs. 2010	% CHANGE 2011 vs. 2000
Botulinum Toxin Type A (Botox®, Dysport®)***	**5,670,788**	**5,379,360**	**786,911**	5%	621%
Cellulite treatment (e.g., Velosmooth®, Endermology)	37,916	31,227	23,952	21%	58%
Chemical peel	**1,110,464**	**1,144,865**	**1,149,457**	-3%	-3%
Intense Pulsed Light (IPL) treatment	501,577	459,529	*	9%	*
Laser hair removal	**1,078,612**	**937,602**	**735,996**	15%	47%
Laser skin resurfacing	466,238	426,695	170,951	9%	173%
Ablative	134,982	113,368	*	19%	*
Non-ablative (e.g., Fraxel®)	331,255	313,327	*	6%	*
Laser treatment of leg veins	237,052	218,393	245,424	9%	-3%
Microdermabrasion	**900,439**	**824,706**	**868,315**	9%	4%
Sclerotherapy	355,403	365,744	**866,555**	-3%	-59%
Soft Tissue Fillers	**1,891,158**	**1,773,326**	652,885	7%	190%
Calcium hydroxylapatite (e.g., Radiesse®)	286,179	209,973	*	36%	*
Collagen	72,300	160,000	587,615	-55%	-88%
Porcine/bovine-based (e.g., Evolence®, Zyderm®, Zyplast®)	13,734	27,919	*	-51%	*
Human-based (e.g., Cosmoderm®, Cosmoplast®, Cymetra®)	58,566	132,081	*	-56%	*
Fat	68,410	57,643	65,270	19%	5%
Hyaluronic acid (e.g., Juvederm Ultra®, Juvederm Ultra Plus®, Perlane®, Restylane®, Prevelle Silk®)	1,303,656	1,201,368	*	9%	*
Polylactic acid (Sculptra®)	143,777	120,194	*	20%	*
Polymethyl-methacrylate microspheres (Artefill®)	16,836	24,150	*	-30%	*
TOTAL COSMETIC MINIMALLY-INVASIVE PROCEDURES	**12,249,647**	**11,561,449**	**5,500,446**	**6%**	**123%**

TOTAL COSMETIC PROCEDURES	**13,828,726**	**13,117,063**	**7,401,495**	**5%**	**87%**

All values are projected.
** Data unavailable in prior year.*
****Botulinum Toxin Type A numbers are of anatomic sites injected.*

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2009 Average Surgeon/Physician Fees

Cosmetic Procedures

AMERICAN SOCIETY OF PLASTIC SURGEONS

Department of Public Relations 444 East Algonquin Road, Arlington Heights, IL 60005-4664 ▪ **Phone** 847-228-9900 ▪ **Fax** 847-228-7485
Email media@plasticsurgery.org ▪ **Website** www.plasticsurgery.org

	NATIONAL AVERAGE SURGEON/PHYSICIAN FEE	TOTAL EXPENDITURE
SURGICAL		
COSMETIC SURGICAL PROCEDURES		
Breast augmentation (Augmentation mammaplasty)	$3,331	$963,839,020
Breast implant removals (Augmentation patients only)	$2,339	$46,439,336
Breast lift (Mastopexy)	$4,185	$365,676,235
Breast reduction in men (Gynecomastia)	$3,099	$53,701,407
Buttock implants	$4,360	$3,483,530
Buttock lift	$4,165	$13,091,314
Calf augmentation	$3,649	$945,026
Cheek implant (Malar augmentation)	$2,550	$22,411,950
Chin augmentation (Mentoplasty)	$2,058	$26,978,403
Dermabrasion	$1,123	$71,606,643
Ear surgery (Otoplasty)	$3,009	$82,250,871
Eyelid surgery (Blepharoplasty)	$2,809	$571,067,160
Facelift (Rhytidectomy)	$6,396	$662,816,771
Forehead lift	$3,155	$133,659,457
Hair transplantation	$4,338	$77,168,215
Lip augmentation (other than injectable materials)	$1,736	$37,583,995
Liposuction	$2,769	$548,888,786
Lower body lift	$7,141	$63,317,460
Nose reshaping (Rhinoplasty)	$4,216	$1,079,085,702
Pectoral implants	$3,915	$900,542
Thigh lift	$4,329	$37,072,628
Tummy tuck (Abdominoplasty)	$4,936	$568,616,604
Upper arm lift	$3,568	$51,760,933
MINIMALLY-INVASIVE		
COSMETIC MINIMALLY-INVASIVE PROCEDURES		
Botulinum Toxin Type A (Botox®, Dysport®)	$405	$970,297,777
Cellulite treatment (Velosmooth®, Endermology®)	$225	$7,712,550
Chemical peel	$764	$872,969,568
Intense Pulsed Light (IPL) treatment	$491	$211,070,321
Laser hair removal	$405	$361,294,234
Laser skin resurfacing		
Ablative	$2,193	$243,237,148
Non-ablative (Fraxel®, etc.)	$1,167	$378,077,203
Laser treatment of leg veins	$400	$87,951,409
Microdermabrasion	$152	$138,770,848
Sclerotherapy	$356	$139,027,897
Soft Tissue Fillers		
Calcium hydroxylapatite (Radiesse®)	$649	$124,685,732
Collagen		
Porcine/bovine-based (Evolence®, Zyderm®, Zyplast®)	$480	$17,625,034
Human-based (Cosmoderm®, Cosmoplast®, Cymetra®)	$510	$67,609,097
Fat	$1,647	$83,343,205
Hyaluronic acid (Juvederm® Ultra, Juvederm® Ultra Plus, Perlane®, Restylane®)	$592	$716,142,669
Polylactic acid (Sculptra®)	$1,060	$91,024,374
Polymethyl-methacrylate microspheres (Artefill®)	$1,384	$20,773,287
TOTAL 2009 EXPENDITURES		**$10,013,973,541**

All figures are projected.

Fees generally vary according to region of country and patient needs.

These fees are averages only. Fees do not include anesthesia, operating room facilities or other related expenses.

AMERICAN SOCIETY OF PLASTIC SURGEONS®

2011 Plastic Surgery Statistics Report

*Please credit the **American Society of Plastic Surgeons** when citing statistical data or using graphics.*

ASPS Public Relations
Phone: 847-228-9900
Fax: 847-981-5482
Email: media@plasticsurgery.org
Website: www.plasticsurgery.org

All values are projected.
Fees generally vary according to region of country and patient needs.
These fees are averages only. Fees do not include anesthesia, operating room facilities or other related expenses.

ASPS Procedural Statistics represent procedures performed by ASPS Member Surgeons certified by The American Board of Plastic Surgery® as well as other physicians certified by American Board of Medical Specialties-recognized boards.

2011 Average Surgeon/Physician Fees

Cosmetic Procedures

COSMETIC SURGICAL PROCEDURES	NATIONAL AVERAGE SURGEON/PHYSICIAN FEE	TOTAL EXPENDITURE
Breast augmentation (Augmentation mammaplasty)	$3,388	$1,040,726,840
Breast implant removals (Augmentation patients only)	$2,292	$51,045,132
Breast lift (Mastopexy)	$4,286	$388,650,194
Breast reduction in men (Gynecomastia)	$3,051	$60,306,066
Buttock implants	$4,283	$4,921,167
Buttock lift	$4,694	$21,338,924
Calf augmentation	$3,856	$1,561,680
Cheek implant (Malar augmentation)	$2,989	$35,856,044
Chin augmentation (Mentoplasty)	$1,851	$38,278,880
Dermabrasion	$1,218	$89,441,394
Ear surgery (Otoplasty)	$3,148	$83,211,064
Eyelid surgery (Blepharoplasty)	$2,741	$538,019,926
Facelift (Rhytidectomy)	$6,426	$764,861,076
Forehead lift	$3,309	$155,294,679
Hair transplantation	$4,934	$77,730,236
Lip augmentation (other than injectable materials)	$1,650	$42,037,050
Liposuction	$2,859	$585,243,018
Lower body lift	$7,928	$60,371,720
Nose reshaping (Rhinoplasty)	$4,422	$1,077,959,784
Pectoral implants	$4,024	$1,275,608
Thigh lift	$4,657	$45,456,977
Tummy tuck (Abdominoplasty)	$5,279	$611,846,658
Upper arm lift	$3,809	$57,127,382

COSMETIC MINIMALLY-INVASIVE PROCEDURES	NATIONAL AVERAGE SURGEON/PHYSICIAN FEE	TOTAL EXPENDITURE
Botulinum Toxin Type A (Botox®, Dysport®)***	$365	$1,034,918,810
Cellulite treatment (Velosmooth®, Endermology)	$219	$8,303,604
Chemical peel	$653	$725,132,992
Intense Pulsed Light (IPL) treatment	$467	$234,236,459
Laser hair removal	$358	$386,143,096
Laser skin resurfacing		
Ablative	$2,169	$292,775,958
Non-ablative (Fraxel®, etc.)	$1,223	$405,126,088
Laser treatment of leg veins	$387	$91,739,124
Microdermabrasion	$141	$126,961,899
Sclerotherapy	$334	$118,704,602
Soft Tissue Fillers		
Calcium hydroxylapatite (Radiesse®)	$626	$179,148,054
Collagen		
Porcine/bovine-based (Evolence®, Zyderm®, Zyplast®)	$468	$6,427,512
Human-based (Cosmoderm®, Cosmoplast®, Cymetra®)	$520	$30,454,320
Fat	$1,658	$113,423,780
Hyaluronic acid (Juvederm Ultra®, Juvederm Ultra Plus®, Perlane®, Prevelle Silk®, Restylane®)	$529	$689,634,024
Polylactic acid (Sculptra®)	$987	$141,907,899
Polymethyl-methacrylate microspheres (Artefill®)	$995	$16,751,820
Total 2011 Expenditures		**$10,434,350,360**

11) Revise the financial estimates found on page 7 to reflect Financial Attachment 1, Version B (see OHCA Website) adding additional row detail and columns that include: Projected w/out CON, Projected Incremental, and Projected with CON. Add FY 2015 to the projections and provide all assumptions used to prepare these projections. Also, identify the starting and ending months of your fiscal year.

See attached table

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
NET PATIENT REVENUE										
Non-Government	$245,000	$259,700	$259,700	$519,400	$275,282	$275,282	$550,564	$297,305	$297,305	$594,609
Medicare	$25,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$270,000	$259,700	$259,700	$519,400	$275,282	$275,282	$550,564	$297,305	$297,305	$594,609
Other Operating Revenue										
Revenue from Operations	$270,000	$259,700	$259,700	$519,400	$275,282	$275,282	$550,564	$297,305	$297,305	$594,609
OPERATING EXPENSES										
Salaries and Fringe Benefits	$0	$25,000	$25,000	$50,000	$30,000	$25,000	$55,000	$30,000	$30,000	$60,000
Professional / Contracted Services	$25,000	$25,000	$25,000	$50,000	$28,000	$25,000	$53,000	$28,000	$30,000	$58,000
Supplies and Drugs	$35,780	$36,000	$12,450	$48,450	$38,000	$12,450	$50,450	$38,000	$15,000	$53,000
Bad Debts	$1,000	$1,000	$1,000	$2,000	$1,000	$1,000	$2,000	$2,000	$2,000	$4,000
Other Operating Expense	$129,089	$136,189	$0	$136,189	$142,440	$0	$142,440	$146,713	$0	$146,713
Subtotal	$190,869	$223,189	$63,450	$286,639	$239,440	$63,450	$302,890	$244,713	$77,000	$321,713
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense			$2,500	$2,500		$3,000	$3,000		$4,500	$4,500
Total Operating Expenses	$190,869	$223,189	$65,950	$289,139	$239,440	$66,450	$305,890	$244,713	$81,500	$326,213
Income (Loss) from Operations	$79,131	$36,511	$193,750	$230,261	$35,842	$208,832	$244,674	$52,591	$215,805	$268,396
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$79,131	$36,511	$193,750	$230,261	$35,842	$208,832	$244,674	$52,591	$215,805	$268,396
Provision for income taxes										
Net Income	**$79,131**	**$36,511**	**$193,750**	**$230,261**	**$35,842**	**$208,832**	**$244,674**	**$52,591**	**$215,805**	**$268,396**
Retained earnings, beginning of year		$79,131	$79,131	$79,131	$115,642	$272,881	$309,392	$151,484	$481,713	$554,066
Retained earnings, end of year	$79,131	$115,642	$272,881	$309,392	$151,484	$481,713	$554,066	$204,076	$697,518	$822,462
				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greenwich Plastic Surgery Center
2 ½ Dearfield Drive
Greenwich, CT 06831

Phone 203 861-6620 Fax 203 861-6621

FACSIMILE TRANSMITTAL SHEET

PAGES INCLUDING COVER SHEET 3 DATE 2/4/13

TO: Brian A. Carney, MBA FROM: Dr. Raskin / Dr. Margoles

FAX NUMBER:

860 - 418 - 7053

RE:

Subj: **Fw: 12-31799-CON**
Date: 2/1/2013 10:54:17 A.M. Eastern Standard Time
From: slmargoles@aol.com
To: eraskinmd@aol.com
Sent from my Verizon Wireless BlackBerry

From: "Carney, Brian" <Brian.Carney@ct.gov>
Date: Fri, 1 Feb 2013 09:51:46 -0500
To: 'slmargoles@aol.com'<slmargoles@aol.com>
Cc: Riggott, Kaila<Kaila.Riggott@ct.gov>
Subject: 12-31799-CON

Dr. Margoles,

I have received your completeness responses and started to review your responses and noticed a small omission on question 9. I had asked for you to revise the table found on page 6 (of the application) to include FY 2015 and to add subtotals/total rows, but do not see it in the responses you provided. As you have done a thorough job in your responses, I wanted to avoid sending a second completeness letter to obtain the missing table. I don't think the table will be too hard to produce, if you could submit to me by fax (860-418-7053) in the next day or so, I would appreciate it.

Call me if you have any questions.

Thanks,

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

12-31799-CON
2/4/13

Greenwich Plastic Surgery Center

9) Please revise the projected volumes on page 6 of the application to include FY 2015. Provide additional detail on how these estimates were calculated, and include subtotal and total rows.

The % increase in the anticipated surgical volume is based on our own practices historical data as well as the American Society of Plastic Surgeons Plastic Surgery Statistics Report. This report provides the statistical trends in the US for the past two decades. The data base estimates a 5-9% yearly increase in surgical cases with results based on a 95 percents confidence level and with a +/- 3.16 percent margin of error. See addendum. www.plasticsurgery.org

PROJECTED VOLUME

Greenwich Plastic Surgery Center

	2012	2013	2014	2015
Abdominoplasty	12	18	25	27
Blepharoplasty	8	14	20	22
Breast Augmentation	12	20	30	33
Breast Lift	8	13	20	22
Breast Reduction	28	30	30	33
Facelift	2	6	10	11
Liposuction	2	8	12	13
Rhinoplasty	2	4	6	6
Smartlipo	45	65	80	95
Subtotal	**119**	**178**	**233**	**262**

Greenwich Hospital

Abdominoplasty	12	5	5	5
Breast Reduction	28	24	20	15
Breast Reconstruction	16	20	30	20
Subtotal	**56**	**49**	**55**	**40**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

Via Fax and Regular Mail

February 13, 2013

Sandra L. Margoles, MD
Greenwich Plastic Surgery Center
2 ½ Dearfield Dr.
Greenwich, CT 06831

RE: Certificate of Need Application; Docket Number: 12-31799-CON
Greenwich Smartlipo d/b/a Greenwich Plastic Surgery Center
Establish an Outpatient Surgical Facility in Greenwich
Notification Deeming CON Application Complete

Dear Dr. Margoles:

This letter is to inform you that, pursuant to Section 19a-639a(d) of the Connecticut General Statutes, the Office of Health Care Access has determined that the above-referenced application has been deemed complete as of February 11, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7037.

Sincerely,

Kaila Riggott
Planning Specialist, DPH OHCA

****
*** TX REPORT ***
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TRANSMISSION OK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SANDRA MARGOLES, MD

FAX: (203) 861-6621

AGENCY: GREENWICH PLASTIC SURGERY CENTER

FROM: LESLIE GREER

DATE: 2/13/13 **TIME:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: DN: 12-31799-CON Application Deemed Complete

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

Via Fax Only

March 1, 2013

Sandra L. Margoles, MD
Greenwich Plastic Surgery Center
2 ½ Dearfield Dr.
Greenwich, CT 06831

RE: Certificate of Need Application; Docket Number: 12-31799-CON
Greenwich Smartlipo d/b/a Greenwich Plastic Surgery Center
Establish an Outpatient Surgical Facility in Greenwich
Notification Deeming CON Application Complete

Dear Dr. Margoles:

This **correcting** letter is to inform you that, pursuant to Section 19a-639a(d) of the Connecticut General Statutes, the Office of Health Care Access has determined that the above-referenced application has been deemed complete as of **February 13, 2013**.

If you have any questions regarding this matter, please feel free to contact Brian Carney at (860) 418-7014.

Sincerely,

Brian A. Carney

Brian A. Carney,
Associate Research Analyst, DPH OHCA

Copy:

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3308
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PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SANDRA L. MARGOLES, MD

FAX: (203) 861-6621

AGENCY: DPH/OHCA

FROM: BRIAN A. CARNEY

DATE: 3/1/13 TIME: 9:15 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: 12-31799 PLEASE SEE ATTACHED - DATE DEEMED COMPLETE HAS BEEN CORRECTED DUE TO A TYPO ON PREVIOUS VERSION. NO ACTION IS REQUIRED OF YOU.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.