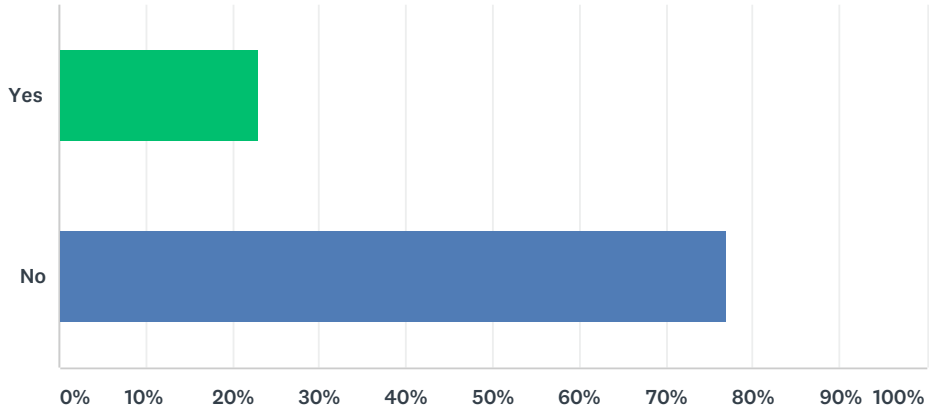
Q1 Have you closed your nonhospital center (physician office or ambulatory surgical center) due to cuts since 2017 under Medicare for vascular access services?

Answered: 65 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	23.08%	15
No	76.92%	50
TOTAL		65

Q2 For Medicare patients that have lost access to coverage at your center, what would you estimate would be the average increased drive time for these patients to receive vascular access coverage at another site-of-service?

Answered: 33 Skipped: 32

#	RESPONSES	DATE
1	60-90 minutes	8/6/2018 11:07 AM
2	30 min	8/6/2018 11:03 AM
3	1 hour	8/6/2018 6:22 AM
4	30 miles	8/2/2018 7:49 PM
5	20 min	8/1/2018 2:46 PM
6	No loss of access	8/1/2018 10:21 AM
7	2 days	7/31/2018 6:15 PM
8	Two hours	7/31/2018 5:19 PM
9	45 min -1.5 hrs	7/31/2018 2:54 PM
10	30 to 60 minutes	7/31/2018 12:30 PM
11	20 min	7/31/2018 7:10 AM
12	1-2 hours	7/31/2018 4:16 AM
13	5 miles	7/30/2018 5:47 PM
14	45 min	7/30/2018 4:51 PM
15	No Medicare patients lost coverage at my centers	7/30/2018 3:52 PM
16	30 minutes	7/30/2018 3:20 PM
17	4 to 5 hours	7/30/2018 3:10 PM
18	No increase	7/30/2018 2:21 PM
19	1 hour to 1.5 hours	7/30/2018 2:15 PM
20	na	7/30/2018 1:48 PM
21	No difference	7/30/2018 1:16 PM
22	One hour	7/30/2018 1:11 PM
23	30 to 40 mins	7/30/2018 1:03 PM
24	No significant increase	7/30/2018 1:02 PM
25	60 min	7/30/2018 12:56 PM
26	1 hour	7/30/2018 12:40 PM
27	30 minutes	7/30/2018 12:31 PM
28	3 hours	7/30/2018 12:31 PM
29	10 minutes	7/30/2018 12:24 PM
30	2 Hours	7/30/2018 12:22 PM
31	45 minutes	7/30/2018 12:21 PM
32	45 miles.	7/30/2018 12:21 PM

33	Up to 30 miles	7/30/2018 12:20 PM

Q3 Comments:

Answered: 21 Skipped: 44

#	RESPONSES	DATE
1	- CMS Needs to understand the need to provide dialysis access services ESRD patients, in an outpatient care setting. - As an interventional nephrologist for last years, I believe that the work I do achieves following objectives: 1st: improves quality of life of our ESRD patients 2nd: Improve access to high quality care in "non-hospital setting". 3rd: Avoid hospital / ER visits and / or admissions with issues related to dialysis access. - I am not aware of ANY health care model (including hospitals and other health systems) or any other business for that matter, that could survive such drastic cuts in payment over such a short time and still be able to "survive" -- especially when the goal and mission is to provide high quality affordable health care with aimed to reduce patient morbidity, mortality and improve patient centered care outcomes!! Given the drastic volatility in rates we projected no longer affording to run our office based facility. To continue service, we have incurred $400,000 of debt just to convert to an ASC and were just about to open doors. If these cuts go through, the ASC will close, we will be stuck with this debt, and patients will go to the hospital for procedures (many people with access issues were admitted as inpatients in our city before an outpatient access center opened). In addition to drive time I suggest you also discuss with CMS the delays in access care, hospitalizations, and ultimately lost vascular accesses for this vulnerable population.	8/6/2018 11:07 AM
2	We are currently trying to survive due to the deep cuts in 2016. As we prepare to convert to an ASC at great expensive we are hit with this change. We are currently trying to determine if we will be able to continue operating our center under the proposed changes. We have not closed yet, however may be pending as my physicians have incurred over a 6 figure debt to convert to ASC this year based on cuts and have taken the 25% cut in reimbursement for EOP while doing so.	8/6/2018 11:03 AM
3	The proposed Medicare cuts with will be crippling for our dialysis access center. We would project to be operating at a deficit. Hospitals in our area are ill-equipped to compensate for the volume that we currently provide, and patients will suffer due to increased risk of loss of their vascular access and its related morbidities.	8/6/2018 8:08 AM
4	We converted 2 offices to ambulatory surgery centers because we would not have been able to stay open as offices. The cuts in reimbursement resulted in us taking a loss at both centers in 2017.	8/3/2018 12:40 PM
5	If the goal is to reduce costs this will have the opposite effect. It has been shown time and again that outcomes and cost are less for outpatient procedures. This change will cause many centers to shut down. This will limit access to outpatient facilities and lead to more hospitalizations for ESRD patients due issues with vascular access. This will drive up cost and TDC use.	8/3/2018 10:48 AM
6	The great majority of patients will go to the hospital, not another vascular access center.	8/2/2018 7:49 PM
7	Missed treatment increased Length of stay in hospital increased Increased hospitalization rate	7/31/2018 5:19 PM
8	we didn't close, but are barely surviving by adding arterial procedure with a Vascular MD. We are trying to keep our center open because our patients will tremendously suffer from closure as there are NO other practical our not overly costly options for them.	7/31/2018 11:00 AM
9	We operated 2017 at a significant lose while we converted from EOP to ASC. We are just getting payor contracts in place. If ASC rates are reduced to the current EOP rates are center will not be sustainable and we will need to close. This will result in many patients being hospitalized in order to get access care, as our local hospital networks are not well equipped to offer urgent care to outpatients.	7/30/2018 8:11 PM
10	Trying to keep it open but any more cuts will likely require closure and undoubtedly lead to increased admissions and emergent surgical needs for these patients.	7/30/2018 4:53 PM
11	We have decided as a group not to pursue developing an ASC/VAC due to possible impending further reimbursement cuts	7/30/2018 4:51 PM
12	Patients now are referred to the hospital setting. Drive time is the same, but they are admitted to hospital and Interventional Radiology works on the access the following day or two and then they get dialysis and at discharged home.	7/30/2018 2:21 PM

13	With the new cuts, our center is facing the decision as to whether it will continue to be viable to operate beyond 2018. We are the only OP center in Central ohio servicing columbus and surrounding cities. The only other center in the city closed after the 2017 reimbursement cuts. 100% of Ckd/esrd patients in columbus will return to the hospital for all access related services should our center close.	7/30/2018 1:20 PM
14	However, going to the hospital for these procedures is much more inconvenient for the patients. They end up waiting in the waiting room for hours. Also, scheduling an emergent procedure is much more difficult and requires a lot of time and effort	7/30/2018 1:16 PM
15	We have not closed however we continue to face extreme hardship due to reimbursement cuts. If they are cut any more we will need to discuss other options. This patient populations should be advised under the transparency rules how hospitals are raking in unbelievable charges for the exact same procedure, hospitals do not have to be cost effective or negotiate pricing with vendors just to stay in business. We provide excellent service, zero infection rate, care for and about our patients. We are fully accredited and if anyone with any medical and financial sense looked at the rate differences for hospitals no one would wonder why Medicare is going broke, it is because they clearly favor hospitals. There are times when hospital care is necessary however for these procedures (that are safer and cost effective in office setting even at a much higher rate) they should reimburse us a fair rate and save the big payouts to hospitals for urgent cases that can only be done in that setting	7/30/2018 1:07 PM
16	We operate 3 centers and just converted to ASCs within the last 12 months to avoid closing. Based upon the proposed 2019 fee schedule, I am not sure whether we will be able to continue to operate our centers and may have to close them if these become the final rule	7/30/2018 12:57 PM

17	Eastern Nephrology Associates is the largest nephrology practice in Eastern North Carolina, and has focused on caring for chronic kidney disease (CKD) and end-stage renal disease (ESRD) patients since 1975. We have 18 nephrologists, including 3 interventional nephrologists, 3 main offices in Greenville, New Bern, and Kinston along with 8 satellite offices throughout the region. Currently we have over 1300 ESRD patients at 22 dialysis units who rely on dialysis to preserve and prolong their lives. Many of you already know that ESRD patients require a disproportionately expensive amount of medical treatment. Collectively, they are less than 1% of Medicare beneficiaries but they represent more than 7% of total Medicare expenditures. People with ESRD are medically complex with lots of co-morbidities, and their survival requires them to undergo hemodialysis three times per week. Eastern Nephrology is on the cutting edge of caring for this difficult and vulnerable population. We participate in CMS's "Comprehensive ESRD Care Model" through our participation in an ESRD Seamless Care Organization or "ESCO," which is an Accountable Care Organization specifically focused on ESRD patients. ESCOs are accountable for clinical quality outcomes and financial outcomes for ESRD patients, including all Medicare spending for those patients. CMS recognizes importance of coordination and quality of care, and ENA partners with other nephrologists and dialysis facilities through the ESCO to provide best quality care while reducing expenditures for the Medicare program. One critical factor in caring for a dialysis patient is their vascular access (usually an arteriovenous fistula or graft, and sometimes a catheter), through which the patient's blood is filtered using a dialysis machine. Dialysis accesses are essential for their survival, but they are prone to dysfunction, infection, stenosis and thrombosis that frequently need interventions to maintain their patency and function to provide life saving dialysis treatment. The need for an intervention is usually unexpected, and interventions must happen very quickly, or the patient deteriorates rapidly since they are unable to dialyze until their vascular access is restored. We know from our years of experience that ESRD patients benefit enormously from a specialized, coordinated team providing care in a dedicated ambulatory setting, as opposed to receiving their care in a hospital for their dialysis access care. Our community hospitals provide incredible care every day to all types of patients, but when it comes to the specific challenges of the dialysis population, numerous studies have shown that patients have better outcomes, better patient satisfaction, and fewer hospitalizations, and all at lower cost to the healthcare system, if their care can be provided outside the hospital. Eastern Nephrology provides interventions to correct vascular access dysfunction in the office setting, but providing this care in the office setting is not enough. First, CMS does not allow dialysis access creation procedures in office setting. Access creation procedures are currently done in a hospital setting but having them placed in an outpatient setting such as an ambulatory surgical center (ASC) can markedly decrease the cost to the healthcare system. Also, since 2017, drastic reimbursement cuts between 30%-40% by CMS threaten our ability to do vascular access procedures in the office at all. These cuts have drastically affected our ability to practice medicine in this office setting since the financial constants have severely restricted our ability to perform certain vital procedures due to negative profit margin. CMS's reimbursement changes were certainly intended to control cost, but cuts will ultimately have the opposite effect, as vascular access centers (VACs) must close or cut back on vascular access services to stay afloat. Either way, care for dialysis patients will be forced back to hospitals. That will result in much higher costs and worse outcomes, with more complications and admissions, which will hurt patient outcomes and drive up total care costs for ESRD patients even further. This will increase the likelihood that the ESCO model will fail to provide cost savings to the healthcare system for dialysis patients. Ambulatory surgery centers would seem to be the logical choice to perform creation and maintenance of dialysis access. CMS reimburses dialysis access interventions at a sustainable level in an ambulatory surgical center. ASC's can perform dialysis access creation procedures, and ASC reimbursement costs the healthcare system far less than doing the same procedures in a hospital.	7/30/2018 12:56 PM
18	We spent 1.5 years planning and constructing a freestanding ambulatory surgical center to better serve our patients. We were about to start our first cases in the center after a significant investment of personal resources, time, effort, and an outside loan. Now with the cuts, we will not be able to support the center. Patients will continue to suffer delayed interventions, delayed access placements, and missed dialysis due to these changes. Numerous staff members will lose jobs, and I fear patient outcomes will continue to suffer. CMS did not allow adequate time or notice for these decreases in reimbursement at such short intervals.	7/30/2018 12:40 PM
19	We have moved our practice to an ASC.	7/30/2018 12:24 PM
20	Our access center is an extension of practice and we started the process of conversion into an ambulatory surgery center but at this point, we are considering closure of the center. We have been providing dialysis access care for dialysis patients for 10 years	7/30/2018 12:23 PM

21	These vital services to patients prevents hospitalizations and reduces total medicare spend per dialysis beneficiaries. CMS is effectively driving patients to the hospitals where cost of care is higher and prevalent catheter rates will surely increase.	7/30/2018 12:21 PM

Q4 Your Location (City/State):

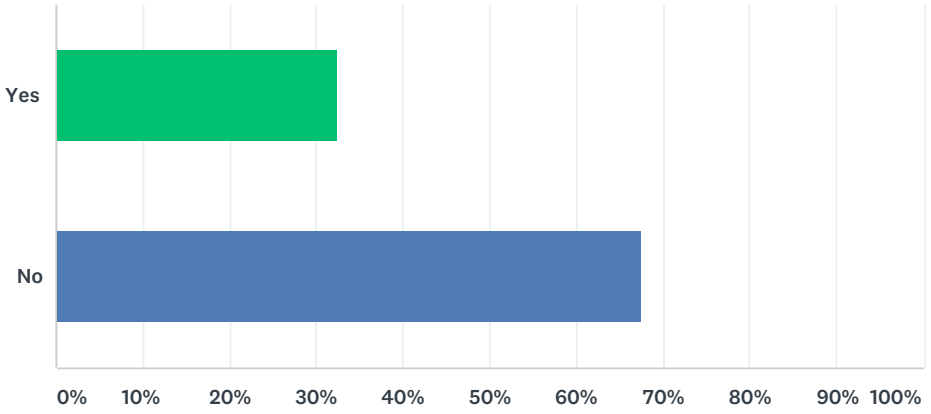
Answered: 52 Skipped: 13

#	RESPONSES	DATE
1	Columbus Ohio	8/6/2018 11:07 AM
2	Kansas city/Kansas	8/6/2018 11:03 AM
3	Philadelphia, PA	8/6/2018 8:08 AM
4	Cincinnati, OH	8/6/2018 6:22 AM
5	Baltimore, Maryland	8/3/2018 12:40 PM
6	Cincinnati Ohio	8/3/2018 10:48 AM
7	Houston, Texas	8/2/2018 7:49 PM
8	Landover, MD	8/1/2018 2:46 PM
9	Newington, CT	8/1/2018 10:21 AM
10	Brooklyn NY	7/31/2018 6:15 PM
11	Allen park	7/31/2018 5:19 PM
12	bronx, NY	7/31/2018 2:54 PM
13	Saint Louis Missouri	7/31/2018 12:30 PM
14	Wichita, KS	7/31/2018 11:00 AM
15	NY/NJ	7/31/2018 7:10 AM
16	AZ	7/31/2018 4:16 AM
17	FresnoCA	7/30/2018 11:55 PM
18	Cincinnati, Oh	7/30/2018 8:28 PM
19	Bethlehem, PA	7/30/2018 8:11 PM
20	long beach/ california	7/30/2018 5:47 PM
21	Alabama	7/30/2018 4:53 PM
22	Gainesville FL. Leesburg FL	7/30/2018 4:51 PM
23	new york new york	7/30/2018 4:01 PM
24	Memphis, TN	7/30/2018 3:52 PM
25	San Diego, CA	7/30/2018 3:20 PM
26	Phoenix, AZ	7/30/2018 3:10 PM
27	Detroit, mi	7/30/2018 2:48 PM
28	Roanoke, VA	7/30/2018 2:21 PM
29	Ottawa, IL	7/30/2018 2:15 PM
30	va	7/30/2018 1:48 PM
31	Columbus/ Ohio.	7/30/2018 1:20 PM
32	Naperville , IL	7/30/2018 1:16 PM
33	Huston, Texas	7/30/2018 1:11 PM
34	Great Neck, NY	7/30/2018 1:07 PM
35	michigan,Ypsilanti	7/30/2018 1:03 PM

36	Mesa, AZ	7/30/2018 1:02 PM
37	Phoenix and Tucson AZ	7/30/2018 12:57 PM
38	New Bern, NC	7/30/2018 12:56 PM
39	Houston, TX	7/30/2018 12:46 PM
40	Humble, Texas	7/30/2018 12:40 PM
41	Atlanta/Georgia	7/30/2018 12:39 PM
42	chicago, Illinois	7/30/2018 12:31 PM
43	San Antonio	7/30/2018 12:31 PM
44	Clearwater, FL	7/30/2018 12:30 PM
45	Hattiesburg, MS	7/30/2018 12:24 PM
46	Boston, MA	7/30/2018 12:24 PM
47	Boardman, Ohio	7/30/2018 12:23 PM
48	Raleigh, NC	7/30/2018 12:22 PM
49	Union, NJ	7/30/2018 12:21 PM
50	Milford Delaware	7/30/2018 12:21 PM
51	Dallas TX	7/30/2018 12:20 PM
52	San Antonio, TX	7/30/2018 12:20 PM

Q1 Do you anticipate closing your nonhospital center (physician office or ambulatory surgical center) due to cuts since 2017 under Medicare for vascular access services?

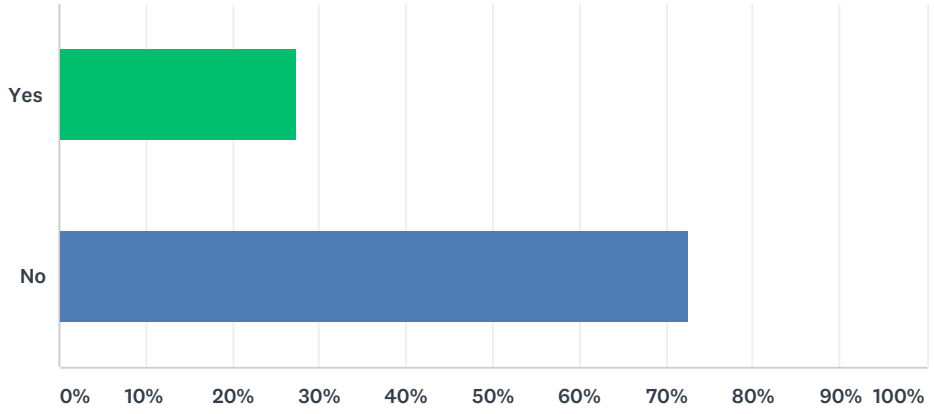
Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	32.50%	13
No	67.50%	27
TOTAL		40

Q2 Do you plan on limiting the number of Medicare patients you serve due to cuts under Medicare for vascular access services?

Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	27.50%	11
No	72.50%	29
TOTAL		40

Q3 For Medicare patients that you believe will lose access to coverage at your center, what would you estimate would be the average increased drive time for these patients to receive vascular access coverage at another site-of-service?

Answered: 21 Skipped: 19

#	RESPONSES	DATE
1	Drive time increase minimal	8/6/2018 9:06 AM
2	it would occupy their half a day at least in other site of service; instead of max 1 hour in our facility	8/5/2018 5:47 PM
3	One to 2 hours.	8/3/2018 11:20 PM
4	1 hour	8/3/2018 8:25 PM
5	60-90 minutes	8/3/2018 7:26 PM
6	60 minutes	8/3/2018 5:52 PM
7	Increased drive time of 10-30mins but the inconvenience of the hospital is the real driving factor.	8/3/2018 5:52 PM
8	1hr	8/3/2018 5:39 PM
9	20mins	8/3/2018 5:38 PM
10	10 minutes	8/2/2018 11:45 AM
11	10-15 miles	8/1/2018 11:23 PM
12	20 minutes	8/1/2018 7:08 PM
13	30 miles	8/1/2018 6:10 PM
14	30 to 60 minutes	7/31/2018 1:55 PM
15	45 minutes	7/31/2018 11:22 AM
16	Additional 10-15 miles	7/30/2018 10:12 PM
17	5 miles	7/30/2018 5:48 PM
18	None	7/30/2018 4:23 PM
19	6 hours	7/30/2018 4:09 PM
20	unclear	7/30/2018 4:03 PM
21	Same drive time	7/30/2018 3:56 PM

Q4 Comments:

Answered: 19 Skipped: 21

#	RESPONSES	DATE
1	We have few patients with true 'commercial' insurance. Medicare is our highest payer- either in 'straight' form or as a marketplace alternative. While we do not plan to close the center at this time we may well be forced to do so given out experience with revenue last year (before converting to an ASC). We do some PAD and are hoping to expand that in order to stay open so that we can provide a viable access care for our patients. I think the situation is dire.	8/6/2018 10:53 AM
2	What will happen to our patients is the following: 1. Increased hospitalization 2. Delay in Care 3. Increased Catheter rate 4. Increased wait time for a procedure 5. Reduced patient satisfaction 6. Increase in missed dialysis treatments 7. Poorer outcomes. From a Practice standpoint: 1. Major reduction in workforce, cutting staff etc. 2. Relocation of Physicians due to inadequate income based on labor 3. Increased hospital workload and Physician burn out We are expected to upgrade our practice with major expenses including EMR, increasing insurance premiums, meeting MIPS/MACRA etc., And upgrading from an OBL to an ASC Which have all been very costly, yet our procedure revenue will be cut by up to 50% for certain procedures??? Name an industry that will survive with such cuts. The federal government/CMS has been cutting the reimbursement for many "high dollar" procedures over the years, and the cost of healthcare has continued to rise. Your formulas and methodology are flawed. You have created a volume driven atmosphere in the world of medicine. To help reduce cost to the system and more outpatient facilities should be encouraged with meaningful metrics.	8/6/2018 9:06 AM
3	If cuts continue I will have no choice but to close. The proposed cut to ASC fees is inappropiate. It does not take into account the increased costs and regulatory burdens of an ASC as compared to an office setting. This needs to be pointed out to CMS. Procedures done in an ASC are more accountable due to the obligatory reporting.	8/3/2018 11:20 PM
4	In addition to increase drive time, the patients will be backlogged and delays in getting procedures done in a timely fashion. More emergency room visits and clearly more hospital admissions.	8/3/2018 8:25 PM
5	This will vastly limit access to care, increased hospital admissions, ED visits, missed dialysis ,treatment to the ESRD patients. I am shocked to learn about these disastratous changes.	8/3/2018 7:26 PM
6	Further cuts will greatly limit our practice growth. Whereas we may not close as an immediate result of further cuts there will most cerainly be changes to personel and possibly lost jobs.	8/3/2018 5:52 PM
7	Most abrupt and unthougtfu act by CMS to put Medicare patients in jeopardy	8/3/2018 5:39 PM
8	More than drive time lack of timely interventions leading to thrombosis,inadequate dialysis and increase in Catheter rates(with associated complications) and increased hospitalization	8/3/2018 5:38 PM
9	In the near term (2109) we will remain open as ambulatory surgery centers, however, we cannot operate the centers at a loss which is what we are forecasting if these proposed reimbursement cuts come to fruition. We would most likely consider closing the centers in 2020.	8/3/2018 12:45 PM
10	Acceptance of the lower reimbursement rates for vascular access procedures. Only result is lower physician earnings. No change in patient volume.	8/2/2018 10:21 AM
11	Some patient will have to be admitted to the hospital and some will have to drive extra 10-15 miles to get access work done. However, there will be loss of prompt service as well.	8/1/2018 11:23 PM
12	Many will end up going to a local hospital for care of their vascular access.	8/1/2018 6:10 PM
13	ASDIN should advocate for INs doing PAD work.	7/31/2018 3:08 PM

14	More than the driving time, these patients hates to go to the hospital to get these procedures done due to the senseless admission ordeals, hours of waiting to get the procedure done, undue emphasis/senseless NPO rules, too much of waisted interaction with the hospital staff/personal and the poor quality of the procedure performed on these patients. Many of the patients have to undergo another procedure at some other place due to the poor quality work and outcomes. If a declotting procedure fails, these patients do not get a catheter inserted for hemodialysis at the same sitting. They have to come back another day or get admitted to the hospital inpatient service and get the procedure done on another day. Patient taking anticoagulation have to go through unnecessary and meaningless ordeals before they can undergo the procedure in the hospital setting. If the patients have contrast allergy, it becomes another crazy time or days losing/waiting ordeals before they can get the procedure done. I find it crazy, meaningless and stupid for the dialysis patients to get the day-to-day procedures in an hospital setting (unless it require a very complicated intervention or needing a general anesthesia). Moreover, it is ironical to know that CMS is happy to pay higher charge to the hospitals when the same procedure can be done with efficiency/lesser complication rate/lesser infection rate at a lesser time frame and to the comforts of the patients at a lesser expense, despite which the CMD keeps on making these unmindful cuts in the payments.	7/31/2018 1:55 PM
15	7% of my patients have non-legal status in the USA and are receiving hemodialysis via an emergency medicaid program. We have up until the 2017 CMS reimbursement cuts provided access care for free in our outpatient office lab; this is no longer financially possible.	7/31/2018 11:22 AM
16	we are completely lost in terms of future planning as Extension of practice is barely breaking even after renting out our space to a vascular MD, and there is a lot of cost involved in transforming to an ASC with apparently dubious improvement. And we frankly don't know who and how decisions are made in regards to payments. We are the ONLY link that is squeezed both ways: vendors can increase their prices without consequence to them, payors can lower their payments as they please and we are left to foot the bill both ways as the patients think "we are making the big bucks". I truly feel that our voices are not heard and ignored, and the sad thing it doesn't look anything will change in the foreseeable future...	7/31/2018 11:06 AM
17	We have a second, smaller, low-volume center in less densely populated south DE. This facility is “probably” losing money, depending on how we do the accounting, as the overhead & staffing expenses are split & can be attributed variably to the center. One way or another, it is not a profitable business right now, and any further negative financial pressure could force it to close. In that case, patient travel could be as much as 80-90 miles, 1.5-2 hours to come to our north DE center. Or they would go to one of the hospitals where timeliness, quality, cost-effectiveness, and continuity would all be adversely affected	7/31/2018 7:19 AM
18	we are not sure as of yet of we are going to limit the number of patients but we are considering it if we are unable to break even with costs	7/30/2018 4:03 PM
19	The issue is not drive time. It is inconvenient to go to hospital, incur higher patient costs and use lengthier methods on non-dialysis days. So I have noticed more thrombectomies and less compliance regarding access procedures.	7/30/2018 3:56 PM

Q5 Your Location (City/State):

Answered: 35 Skipped: 5

#	RESPONSES	DATE
1	Philadelphia;PA	8/6/2018 10:53 AM
2	San Antonio, TX	8/6/2018 9:06 AM
3	Decatur, GA	8/6/2018 9:02 AM
4	Tyler, TX	8/5/2018 5:47 PM
5	Huntsville, AL	8/5/2018 10:53 AM
6	Norwood Ohio	8/4/2018 1:57 PM
7	Mobile, AL	8/4/2018 10:51 AM
8	Houston Texas	8/3/2018 11:20 PM
9	Providence/Rhode Island	8/3/2018 8:25 PM
10	Sacramento, CA	8/3/2018 7:26 PM
11	Columbus, GA	8/3/2018 6:56 PM
12	Indianapolis IN	8/3/2018 5:52 PM
13	Macon, GA	8/3/2018 5:52 PM
14	Fort Worth	8/3/2018 5:39 PM
15	Concord ,Ca	8/3/2018 5:38 PM
16	Baltimore, Maryland	8/3/2018 12:45 PM
17	Winston-Salem, NC	8/2/2018 11:45 AM
18	St. Louis, Missouri	8/2/2018 10:21 AM
19	Houston	8/1/2018 11:23 PM
20	Fairfax/VA	8/1/2018 7:08 PM
21	Houston, Texas	8/1/2018 6:10 PM
22	Metairie, LA	7/31/2018 3:08 PM
23	Dallas, TX	7/31/2018 1:55 PM
24	Raleigh, NC	7/31/2018 11:22 AM
25	Wichita, KS	7/31/2018 11:06 AM
26	DE	7/31/2018 7:19 AM
27	Chapel Hill, NC	7/30/2018 10:12 PM
28	Houston/TX	7/30/2018 8:03 PM
29	Fort Worth, TX	7/30/2018 7:50 PM
30	long beach, CA	7/30/2018 5:48 PM
31	OH	7/30/2018 4:57 PM
32	Lafayette, Louisiana	7/30/2018 4:09 PM
33	new york new york	7/30/2018 4:03 PM
34	Chattanooga/Tennessee	7/30/2018 3:56 PM
35	San Diego, CA	7/30/2018 3:39 PM