8/4/2022 Received

Washington State Department of Health

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Certificate of Need Application
Ambulatory Surgical Facilities
Ambulatory Surgery Centers

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Name, Title, and Signature of Responsible Officer: Eric Chandler, Regional VP Operations, Surgery Partners Signature: E. Chandler Dated: 8/3/22	Phone Number: (615) 234-8905 Email Address: echandler@surgerypartners.com
Legal Name of Applicant: NeoSpine Puyallup Spine Center, LLC dba Microsurgical Spine Center Address of Applicant: Microsurgical Spine Center 1519 3rd Street SE, Suite 102 Puyallup, WA 98372	Number of Operating Rooms requested – include procedure rooms: NeoSpine is CN Approved to operate 2 surgical suites. It is requesting approval to add 1 Procedure room and additional specialty cases. Estimated Capital Expenditure: There are no capital expenditures associated with the proposed project. Estimated expenditures include: Not applicable

Identify the Planning Area for this project as defined in WAC 246-310-270(3):

East Pierce County Secondary Health Services Planning Area ("East Pierce Planning Area")

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1. Introduction and Rationale

NeoSpine Puyallup Spine Center LLC Doing Business As (DBA) Microsurgical Spine Center, located at 1519 3rd Street SE, Suite 102, Puyallup WA 98372, is a certificate of need ("CN") approved ambulatory surgical facility ("ASF") (CN #1317). It was approved on August 22, 2005, to operate two operating suites and provide spine and pain management cases. This current CN application requests approval to add one Procedure Room and Orthopedics, Interventional Radiology, Cardiology and Podiatry specialties to its CN-approved ASF.

Background and History of Ownership Changes

In 2004, two entities, South Sound Neurosurgery PLC, dba Microsurgical Spine Center, which was a group surgical practice, owned by Doctors Peter Shin and Richard N.W. Wohns, and NeoSpine Surgery LLC[1] were approved to jointly establish, own, and operate NeoSpine Puyallup Spine Center LLC dba Microsurgical Spine Center.[2] Since that time, there have been multiple consolidations, entity sales, and purchases such that currently Microsurgical Spine Center is wholly owned by South Sound Neurosurgery PLLC, which is in turn wholly owned by Dr. Wohns. In this regard, in addition to Microsurgical Spine Center being the applicant we would also consider Dr. Wohns and possibly South Sound Neurosurgery as applicants, since Dr. Wohns owns 100% of South Sound Neurosurgery PLLC, which, in turn owns 100% of Microsurgical Spine Center.

Background of Operating Room Changes/Additions

The single line drawing included with this application shows there are two operating rooms and a procedure room used exclusively for pain management cases. As stated above, however, the CN approval (CN #1317) in 2005, approved two ORs. Review of that earlier application shows there were only two ORs. In 2012, the procedure room was added. While the construction was approved by CRS (CRS# 60274723), there apparently was no CN request to add that procedure room. Other than the CRS approval, which we have attached in Exhibit 1, there are no records of its build-out. Since that time, only the larger OR and the procedure room have been used. The smaller OR is not in use. Should this CN request be approved, we anticipate use of the smaller OR for cases of lower complexity than the current neurosurgery cases performed in the larger OR suite.

Rationale for this CN Request

With this additional CON approval, Microsurgical Spine Center will add one Procedure Room and Orthopedics, Interventional Radiology, Cardiology, and Podiatry specialties to its currently CN-approved, two operating room ASF, where neurosurgery and pain management procedures are performed. Additional capacity is needed to best meet planning area population growth and increased demand for ambulatory surgery. At present, we estimate that about half to two-thirds

[1] NeoSpine Surgery LLC purchased a 50% ownership share in Microsurgical Spine Center for $1.5 million in 2004. It was established in 2002 to "partner with accomplished spine surgeons and develop and manage ambulatory surgery centers." At the time of the 2004 CN application, NeoSpine Surgery LLC operated Microsurgical Spine Center under a management agreement (2004 Application, p. 2).
[2] NeoSpine Puyallup Spine Center LLC was specifically established for the 2005 purchase by NeoSpine Surgery LLC for a 50% share of Microsurgical Spine Center, the CN request and its subsequent joint venture operation of its dba, Microsurgical Spine Center, post CN approval.

of East Pierce residents in need of outpatient surgical services outmigrate to other planning areas.[3] Without increases in planning area provider capacity, significant numbers of planning area residents must continue to receive care at out-of-area providers, thereby impacting patient access to outpatient surgical services and causing residents to pay higher costs at less convenient settings or wait for surgical availability at an area outpatient facility. Furthermore, geography and regional traffic patterns may restrict access to neighboring areas, a concern for East Pierce residents given the abnormally high rate of calculated resident outmigration for ambulatory surgery.

[3] The calculated outmigration rate is dependent on the surgical use rate of the reference population. Based on a surgical use rate of 1,560.3 per 10,000 persons, as calculated in the National Hospital Ambulatory Medical Care Survey, and an East Pierce population of 327,507, we estimate that East Pierce residents had about 51,099 surgical procedures in 2020. The number of surgical procedures at planning area providers this same year was 19,224, indicating expected net outmigration of 31,875 cases, or about 62%. Alternatively, a survey of 19 planning areas accounting for over 80 percent of Washington population indicates an overall Washington State surgical use rate of 106.3 cases per 1,000 residents. The difference in use rates between Pierce East and the overall Washington use rate suggests that residents of Pierce East account for 16,773 cases in other Washington planning areas. This corresponds to about a 47% outmigration rate.

2. Applicant Description

Answers to the following questions will help the department fully understand the role of applicants. Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. **Provide the legal name(s) and address(es) of the applicant(s)**
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity. WAC 246-310-010(6)

   NeoSpine Puyallup Spine Center, LLC dba Microsurgical Spine Center is the legal name of the applicant.

   The applicant's address is:

   Microsurgical Spine Center
   1519 3rd Street SE, Suite 102
   Puyallup, WA 98372

   The address of Microsurgical Spine Center is the same as the applicant.

   As stated above, Microsurgical Spine Center is wholly owned by South Sound Neurosurgery PLLC, which in turn is wholly owned by Dr. Richard Wohns.

2. **Identify the legal structure of the applicant (LLC, PLLC, etc.) and if known, provide the UBI number.**

   Microsurgical Spine Center is a privately held, for-profit entity.

   The UBI number of Microsurgical Spine Center is 602-419-505.

3. **Provide the name, title, address, telephone number, and email address of the contact person for this application.**

   Eric Chandler,
   Regional VP Operations
   Surgery Partners
   310 Seven Springs Way, Suite 500
   Brentwood, TN 37027
   (615) 234-8905
   echandler@surgerypartners.com

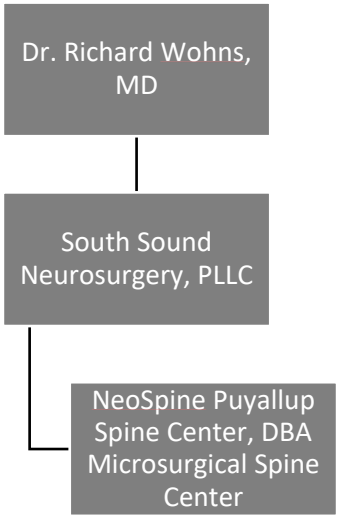
4. **Provide the name, title, address, telephone number, and email address of any other representatives authorized to speak on your behalf related to the screening of this application (if any).**

   Frank Fox, PhD.

Health Trends
511 NW 162nd St,
Shoreline, WA 98177
206.366.1550
frankgfox@comcast.net

5. **Provide an organizational chart that clearly identifies the business structure of the applicant(s) and the role of the facility in this application.**

The business and ownership structure are very simple: Microsurgical Spine Center is wholly owned by South Sound Neurosurgery PLLC, which in turn is wholly owned by Dr. Richard Wohns.



3. Project description

Answers to the following questions will help the department fully understand the type of facility you are proposing as well as the type of services to be provided. Your answers in this section will provide context for the reviews under Need (WAC 246-310-210) and Structure and Process of Care (WAC 246-310-230)

1. **Provide the name and address of the existing facility.**

   Microsurgical Spine Center
   1519 3rd Street SE, Suite 102
   Puyallup, WA 98372

2. **Provide the name and address of the proposed facility. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.**

   This question is not applicable.

3. **Provide a detailed description of proposed project.**

   Microsurgical Spine Center was approved in 2005 to operate two (2) operating suites for services related to neurosurgery and pain management (CN#1317). The proposed project requests CN approval to add one (1) Procedure Room and the specialties of Orthopedics, Interventional Radiology, Cardiology, and Podiatry to its CN-Approved ambulatory surgical facility ("ASF").

   Microsurgical Spine Center currently provides care to patients over the age of 18 who are appropriate candidates for ambulatory surgery. With approval of the proposed project, it would expand to provide care to patients aged 16 and over.

4. **With the understanding that the review of a Certificate of Need application typically takes at least 6-9 months, provide an estimated timeline for project implementation, below:**

Event	Anticipated Month/Year
CN Approval	March, 2023
Design Complete	March, 2023
Construction Commenced	N/A
Construction Completed	N/A
Facility Prepared for Survey	N/A
Project Completion	March, 2023

5. **Identify the surgical specialties to be offered at this facility by checking the applicable boxes below. Also attach a list of typical procedures included within each category.**

   ☐ Ear, Nose, & Throat ☐ Maxillofacial ☒ Pain Management
   ☐ Gastroenterology ☐ Ophthalmology ☐ Plastic Surgery

☐ General Surgery ☐ Oral Surgery ☒ Podiatry
☐ Gynecology ☒ Orthopedics ☐ Urology

☒Other? Describe in detail:

Microsurgical Center currently performs cases within the specialties of neurosurgery and pain management. A list of typical procedures within each of these specialties is presented in Table 1.

Table 1: Typical Procedures at Microsurgical Spine Center

CPT	CPT Description
Neurosurgery	
63047	Laminectomy, facetectomy and foraminotomy, single vertebral segment; lumbar
63030	Laminotomy with decompression of nerve root(s)
63048	Laminectomy, facetectomy and foraminotomy, single vertebral segment; lumbar; each additional segment
22551	Arthrodesis, anterior interbody
20936	Autograft for spine surgery
Pain Management	
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet joint with image guidance, lumbar or sacral; single level
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet joint with image guidance, lumbar or sacral; second level
62323	Injection(s), of diagnostic or therapeutic substance(s), lumbar or sacral; with imaging guidance

Source: Applicant

Furthermore, given CN approval, Microsurgical Spine Center will add the specialties of Orthopedics, Interventional Radiology, Cardiology, and Podiatry.

Typical Orthopedics procedures are expected to include:

- Tenodesis of long tendon of biceps (CPT 23430)
- Arthroscopy, shoulder, surgical; repair of SLAP lesion (CPT 29807)
- Arthroscopy, shoulder, surgical; debridement, extensive (CPT 29823)
- Arthroscopy, knee, surgical; abrasion arthroplasty or multiple drilling or microfracture (CPT 29879)
- Arthroscopy, knee, surgical; with meniscectomy including debridement/shaving of articular cartilage (CPT 29881)

Typical Interventional Radiology procedures are expected to include:

- Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography (CPT 27369)
- Fine needle aspiration biopsy, including ultrasound guidance; first lesion (CPT 10005)
- Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion (CPT 10007)
- Radiologic examination, knee, arthrography, radiological supervision and interpretation (CPT 73580)
- Radiologic examination, spine, single view, specify level (CPT 72020)

Typical Cardiology procedures are expected to include:

- Insertion of new or replacement of permanent pacemaker with transvenous electrode(s) (CPT 33206, 33207, or 33208)
- Repositioning of previously implanted transvenous pacemaker or implantable defibrillator electrode (CPT 33215)
- Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator (CPT 33216)
- Relocation of skin pocket for implantable defibrillator (CPT 33223)
- Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator (CPT 33227, 33228, or 33229)
- Removal of implantable defibrillator pulse generator only (CPT 33241)
- Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber (CPT 33249)
- Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator (CPT 33262, 33263, or 33264)
- Insertion, subcutaneous cardiac rhythm monitor, including programming (CPT 33285)
- Removal, subcutaneous cardiac rhythm monitor (CPT 33286)

Typical Podiatry procedures are expected to include:

- Removal of implant; deep (CPT 20680)
- Partial excision bone; talus or calcaneus (CPT 28120)
- Correction, hammertoe (CPT 28285)
- Bunionectomy (CPT 28296)
- Open treatment of metatarsal fracture (CPT 28485)

6. If you checked gastroenterology, above, please clarify whether this includes the full spectrum of gastroenterological procedures, or if this represents a specific sub-specialty:

☐ Endoscopy ☐ Bariatric Surgery ☐ Other:_____

This question is not applicable.

7. **For existing facilities, provide a discussion of existing specialties and how these would or would not change as a result of the project.**

   Microsurgical Spine Center currently offers surgical services related to spinal surgery and pain management. With the proposed project, Microsurgical Spine Center anticipates providing surgical services across the aforementioned specialties as well as services related to Orthopedics, Interventional Radiology, Cardiology, and Podiatry.

8. **Identify how many operating rooms will be at this facility at project completion. Note, for certificate of need and credentialing purposes, "operating rooms" and "procedure rooms" are one and the same.**

   Given approval of the proposed project, Microsurgical Spine Center will have a total of two (2) operating rooms and one (1) procedure room.

9. **Identify if any of the operating rooms at this facility would be exclusively dedicated to endoscopy, cystoscopy, or pain management services. WAC 246-310-270(9)**

   None of the rooms at this facility will be exclusively dedicated to endoscopy, cystoscopy, or pain management.

10. **Provide a general description of the types of patients to be served by the facility at project completion (e.g., age range, etc.).**

    Microsurgical Spine Center will serve patients aged 16 and older who require Spinal, Pain Management, Orthopedics, Podiatry, Cardiology, and Interventional Cardiology surgical procedures that can be provided appropriately in an outpatient setting.

11. **If you submitted more than one letter of intent for this project, provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.**

    Microsurgical Spine Center submitted its Letter of Intent on February 3, 2022; it expires August 3, 2022. We include the original Letter of Intent in Exhibit 2, but with the understanding that the review will begin 30 days following receipt of this application, and request the application serve as the Letter of Intent, as necessary.

12. **Provide single-line drawings (approximately to scale) of the facility, both before and after project completion.**

    Please see Exhibit 3 for a floorplan of the Microsurgical Spine Center facility.

13. **Confirm that the facility will be licensed and certified by Medicare and Medicaid, which is a requirement for CN approval. If this application proposes the expansion of an existing facility, provide the existing facility's identification numbers.**

This facility is currently and will continue to be licensed and certified by Medicare and Medicaid.

License #: ASF.FS.60101867

Medicare #: 50C0001213

Medicaid #: 1006484

14. Identify whether this facility will seek accreditation. If yes, identify the accrediting body.

This facility is and will continue to be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC).

15. OPTIONAL – The Certificate of Need program highly recommends that applicants consult with the office of Construction Review Services (CRS) early in the planning process. CRS review is required prior to construction and licensure (WAC 246-330-500, 246-330-505, and 246-330-510). Consultation with CRS can help an applicant reliably predict the scope of work required for licensure and certification. Knowing the required construction standards can help the applicant to more accurately estimate the capital expenditure associated with a project.

No construction is required for the proposed project. However, the additional procedure room was reviewed by CRS when it was constructed in 2012 (CRS# 60274723). We have included a copy of the CRS review in Exhibit 1.

4. Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-270 provides specific criteria for ambulatory surgery applications. Documentation provided in this section must demonstrate that the proposed facility will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing facilities proposing to expand. For any questions that are not applicable to your project, explain why.

Some of the questions below require you to access facility data in the planning area. Please contact the Certificate of Need Program for any planning area definitions, facility lists, and applicable survey responses with utilization data.

1. **List all surgical facilities operating in the planning area – to include hospitals, ASFs, and ASCs.**

   Please see Table 2 below for a complete list of hospitals and ambulatory surgery facilities in the East Pierce Planning Area.

2. **Identify which, if any, of the facilities listed above provide similar services to those proposed in this application.**

   Microsurgical Spine Center currently performs spine surgery and pain management procedures, and with project approval, would also provide outpatient surgical services across the additional specialties of cardiology, interventional radiology, orthopedics, and podiatry.

   Outpatient ambulatory surgery centers which provide pain management, orthopedics, and podiatry services include Puyallup Ambulatory Surgery Center, The Surgery Center at Rainier and Meridian Surgery Center. We are not aware of any other planning area providers which provide surgical services related to spinal surgery, cardiology, or interventional radiology, although there may be a small number of cases within the specialty of General Surgery which overlap with these specialties.

3. **Provide a detailed discussion outlining how the proposed project will not represent an unnecessary duplication of services.**

   As described below, we believe there exists need for additional outpatient services in East Pierce to absorb the future increases in utilization driven by an aging planning area population as well as reduce the apparent high rates of planning area outmigration. Furthermore, Microsurgical Spine Center expects to perform a mix of procedures which differs from other planning area providers. Therefore, there would not be an unnecessary duplication of services.

4. **Complete the methodology outlined in WAC 246-310-270, unless your facility will be exclusively dedicated to endoscopy, cystoscopy, or pain management. If your facility will be exclusively dedicated to endoscopy, cystoscopy, or pain**

management, so state. If you would like a copy of the methodology template used by the department, please contact the Certificate of Need Program.

Estimation of numeric need as defined in WAC 246-310-270 requires calculation of current surgical capacity (exclusive of capacity dedicated to endoscopy and pain management).[4] Hospitals and ASCs voluntarily report OR utilization through an annual utilization survey distributed by the Washington Department of Health. As of February 2022, OR utilization data for 2020 was available for the single planning area hospital and all seven of the planning area ASCs not dedicated to pain management or endoscopy services. Table 2 lists the current supply of operating rooms in the East Pierce County Planning Area not dedicated to endoscopy or pain management.

Table 2: Supply of Outpatient and Inpatient ORs in the East Pierce County Planning Area

Hospitals, CN-Approved	Mixed Use ORs	Outpatient ORs
MultiCare Good Samaritan Hospital	10	
ASCs, CN- Approved		
Meridian Surgery Center		2
Microsurgical Spine Center		2
The Surgery Center at Rainier		4
Puyallup Ambulatory Surgery Center		3
ASCs, CN-Exempt		
Cascade Eye and Skin Centers		4
Hillside Surgery Center		1
Philip C. Kierney MD		1
Total CN-Approved ORs	**10**	**11**

Sources: 2021 Department of Health ASC Survey

From Table 2, there are 22 CN-approved Operating Rooms in the East Pierce County Planning Area, including 10 inpatient/mixed use ORs and 11 CN-approved outpatient ORs. Furthermore, there are 6 licensed CN-exempt outpatient ASCs whose outpatient surgery volumes are included in the planning area surgery use rate calculations (while their ORs are excluded). Operating rooms dedicated to GI/endoscopy or pain management are neither counted in the number of planning area ORs, nor is their utilization used to determine planning area surgery use rates.[5]

The data and assumptions used in the numeric need calculations are presented in Table 3. These are generated from population forecasts by Claritas and planning area

[4] It is our understanding that the Department of Health numeric need methodology excludes these rooms. For example, see "Evaluation Dated October 9, 2018, for the certificate of need application from Virginia Mason Medical Center a subsidiary of Virginia Mason Health System proposing to construct a five operating room ambulatory surgery center in Bellevue within East King County". Department of Health, October 9, 2018, page 9.
[5] WAC 246-310-270(9)(iv).

utilization data from the 2021 Department of Health ASC Survey. For detail on the data sources, see Exhibit 4.

Table 3: Summary of data and assumptions used in numeric need methodology	
Planning area	East Pierce County
Population estimates and forecasts, all ages	Year 2020: 327,507 Year 2025 (Forecast Year): 352,372 Source: Claritas 2021
Planning area surgeries	Inpatient or Mixed Use: 8,864 Outpatient: 10,360 Total: 19,224 Sources: 2021 ASC Surveys
Planning area use rate	Surgeries/2020 Population*1,000 = 58.70 per 1,000 persons
Surgery case mix	Inpatient: 46.11% Outpatient: 53.89%
Average minutes per case	Inpatient: 93.91 Outpatient: 54.22 Sources: 2021 ASC Surveys
OR annual capacity (in minutes)	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes
Existing OR capacity (in ORs)	11 dedicated outpatient ORs,10 mixed use ORs See Table 2
Summary of need calculations	Projected 2025 Overall Surplus of 2.12 ORs.

Exhibit 5 presents a step-by-step calculation of net need using the assumptions outlined in Table 3. This methodology is described and summarized below.

WAC 246-310-270(9) — Methodology

(a) Existing Capacity

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and cleanup time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/cleanup time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a) (vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

Dedicated outpatient CN-approved ORs in the planning area = 11

Capacity = 68,850 minutes per year per OR

Total annual capacity in minutes: 11*68,850 = 757,350 minutes

Minutes per surgery = 54.22 minutes

Total annual capacity in outpatient surgeries:

757,350 / 54.22 = **13,968 annual [dedicated] outpatient surgeries**

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

Inpatient/mixed use, CN-Approved ORs in the planning area = 10

Capacity = 94,250 minutes per year per OR

Total annual capacity in minutes: 10*94,250 = 942,500 minutes **(a)(iv)**

Minutes per surgery = 93.91 minutes

Total annual capacity in inpatient/mixed use surgeries:

942,500 / 93.91 = **10,036 annual inpatient/mixed use surgeries**

(b) Future need

(i) Project the number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

Based on the forecast population in 2025 and the use rate of 58.70 per 1,000 residents, there is a projected total of 20,684 surgeries in the East Pierce County Planning area. [(b) (i)]

An estimated 46.11% of surgeries were performed as inpatient/mixed use and 53.89% as outpatient surgeries. Thus, of the 20,684 forecasted surgeries for 2025, 9,537 would be inpatient/mixed use surgeries and 11,147 outpatient surgeries [(b) (i)].

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b) (iv) of this subsection.

Outstanding demand for outpatient surgeries:

11,147 – 13,968 = -2,821 outpatient surgeries

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

Inpatient/mixed use surgery minutes = 832,400

Inpatient/mixed use cases = 8,864

Average inpatient/mixed use minutes per case = 93.91

Outpatient surgery minutes = 561,750

Outpatient cases = 10,360

Average outpatient minutes per case = 54.22

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

Inpatient minutes: 9,537 surgeries * 93.91 minutes/surgery = 895,620 minutes, or [(b)(i) * (b)(iii)]

Remaining outpatient minutes: -2,821 surgeries (b)(i) * 54.22 minutes/surgery (b)(iii) = -152,955 minutes, or [(b)(ii) * (b)(iii)]

Sum of projected inpatient operating room time needed, and projected remaining outpatient operating room time needed:

895,620 minutes + -152,955 minutes = 742,665 minutes (b)(iv)

(c) Net Need

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

Not applicable; go to c.ii.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b) (iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

As shown above, (b)(iv) is greater than (a)(iv):

942,500 minutes > 742,665 minutes.

The model shows no numeric need overall.

5. **If the methodology does not demonstrate numeric need for additional operating rooms, WAC 246-310-270(4) gives the department flexibility. WAC 246-310-270(4) states: "Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need."**

   These circumstances could include but are not limited to: lack of CN approved operating rooms in a planning area, lack of providers performing widely utilized surgical types, or significant in-migration to the planning area. If there isn't sufficient numeric need for the approval of your project, please explain why the department should give consideration to this project under WAC 246-310-270(4). Provide all supporting data.

   The model shows no numeric need for additional operating rooms in the East Pierce County Planning Area. However, there are qualitative arguments that support approval of the proposed project. These include (1) likely significant planning area outmigration; (2) an increasing use rate; (3) significant shifting of surgical care to outpatient settings, driven by changing clinical practices, improved technology, and patient preference; and (4) lower cost of care for patients and their insurers in freestanding ASFs as compared to hospital-based providers.

   1. *Planning Area Outmigration*

      A characteristic of operating room use is significant differences in planning area use rates based on the availability of existing planning area providers. For example, in 2020, we calculate a planning area use rate of 267.9 for King Central residents, but a

use rate of 58.7 for Pierce East residents.[6] This indicates a substantial amount of migration across planning areas by Washington State residents in need of surgical services. A survey of 19 planning areas accounting for over 80 percent of Washington population indicates an overall Washington State surgical use rate of 106.3 cases per 1,000 residents.[7] The difference in use rates between Pierce East and the overall Washington use rate suggests that residents of Pierce East account for 16,773 cases in other Washington planning areas.[8] This corresponds to about a 47% outmigration rate. Thus, we estimate that nearly half of all surgical services to Pierce East residents takes place at providers outside of the East Pierce planning area.

2. *Increasing use rate*

The model as presented above and in Exhibit 5 assumes a constant use rate. However, it is likely this use rate will continue to increase over the forecast period given (1) the planning area population is aging, and (2) older persons have much higher surgical utilization rates.

High population growth rates for older persons in the East Pierce County Planning Area

Population forecasts project average annual growth rates over 4.80% for persons aged 65+ in the East Pierce County planning area. This rate reflects growth about 3 times higher than the rate of population growth for the planning area overall. Please see Table 4, which presents population statistics and associated growth factors across the different planning area age cohorts over the period 2010 to 2025.

Table 4: East Pierce County Planning Area Population Growth Rates by Age Group, 2010 to 2025

	Population Estimates			Average Annual Growth	
Age Group	2010	2020	2025	2010 to 2021	2019 to 2024
Total	278,375	326,323	351,990	1.65%	1.53%
Under 15	59,012	63,701	67,008	0.77%	1.02%
15 to 44	113,429	131,184	138,750	1.49%	1.13%

[6] Planning area use rates based on total cases of 94,402 cases and 352,378 residents in King Central and 19,224 cases and 327,507 residents in Pierce East.

[7] These planning areas include Clark, the 5 planning areas in King County, Kitsap, the 3 planning areas in Pierce County, the 4 planning areas in Snohomish County, Thurston (SWWA 10), Benton-Franklin, Spokane, Walla Walla, and Yakima counties.

[8] Multiplication of 106.3 (the average use rate across the surveyed WA planning areas) with 352,372 (2025 East Pierce population) results in 37,457 surgeries. Assuming all WA residents have the same baseline utilization of surgical services, this is then the number of surgeries for East Pierce residents. Based on the East Pierce use rate, the number of surgeries in East Pierce operating rooms is forecast to equal 20,684 in 2025. 37,457 minus 20,684 is equal to 16,773.

45 to 64	77,502	85,981	88,769	1.08%	0.64%
65+	28,432	45,456	57,463	4.93%	4.80%
65 to 74	16,719	28,158	35,889	5.35%	4.97%
75 and over	11,713	17,298	21,573	3.97%	4.52%

Source: Claritas 2021

Higher surgical use rates for older persons

Surgical utilization by major age group is published within the latest National Center for Health Statistics ("NCHS") survey study, "Ambulatory Surgery in the United States."[9] Table 5 uses this data to present use rates by age group. From Table 5, surgical utilization rates for persons 65+ year of age are about 2.5 times greater than overall population surgical utilization rates.

Table 5: ASC Utilization Rates by Age Group for the U.S. Population, 2010

Age Group	U.S. Total, 2010		
	ASC Procedures (Thousands)	Population	Utilization Rate per 10,000
Total	48,263	309,326,085	1,560.26
Under 15	2,916	61,200,686	476.47
15 to 44	10,478	125,876,000	832.41
45 to 64	18,783	81,770,617	2,297.04
65+	16,086	40,478,782	3,973.93

Sources: National Health Statistics Reports, No. 102, February 28, 2017, Table 2: Number and percent distribution of ambulatory surgery procedures, by age and sex: United States, 2010; Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2010 to July 1, 2018

In summary, the planning area population is aging, with a greater proportion of its population expected to fall within the older age group of 65+. This aging, combined with the much higher surgical utilization rates for the older age cohorts, will drive up the overall surgical utilization rate.

Aside from knowing that the surgical use rate is likely to increase, because data on historical utilization is incomplete and inconsistent across ASC providers, it is difficult to precisely forecast changes in the OR use rate over time. However, it is possible to combine the forecasted demographic changes in the planning area population with the ASC use rates by age group. Given the forecasted shift in the age distribution of the planning area population, the age-specific ASC use rates imply about a 0.76% average annual increase in planning area use rates. Applying these growth rates to the numeric need methodology indicates an increase of the surgery use rate from

[9] The report analyzed and presented summaries of data from the 2010 National Survey of Ambulatory Surgery ("NSAS").[9] This survey is included in our application as Exhibit 6.

58.7 to about 60.94 surgeries per 1,000 residents between 2020 and 2025. Allowing for this growth would increase estimates of numeric need from an overall surplus of 2.12 operating rooms to an overall surplus of 1.51 operating rooms. As such, by itself, the aging planning area population is not sufficient to turn estimates of numeric need from surplus to need, however combined with the likely high rates of planning area outmigration and other qualitative arguments, there will be an overall need for additional outpatient services for East Pierce residents in the future.

3. *Significant shift to outpatient-based surgeries*

The Department's ASF numeric need methodology was adopted nearly thirty years ago. *See* WAC 246-310-270 (effective Jan. 23, 1992). Much has changed in healthcare during the past three decades. Among those changes is a large shift of outpatient surgery from hospitals to ASCs. This shift to outpatient settings is due to at least two reasons:

- Improved clinical practices/technologies that allow surgeries to be performed on an outpatient basis. Thus, even if the use rate were not increasing, there would be increased demand for outpatient surgeries relative to inpatient surgeries.

- Patient Preference for Outpatient ORs.

Expanded ASC options is preferred by patients since ASCs are typically more convenient and easier to access compared to hospital ORs. This includes scheduling and patient care, given hospitals must also focus on inpatient surgeries, which are often much more complex. Outpatient surgery centers, on the other hand, can focus exclusively on outpatient care, increasing efficiency and care delivery.

4. *Greater efficiency and lower cost of care with outpatient, freestanding surgery centers*

Freestanding facilities are more cost-effective, i.e., lower cost in comparison to hospital outpatient surgery departments, leading to lower contractual rates for purchasers and cost savings for patients. As demand for outpatient surgeries increases over time, if hospital based ORs are expanded over freestanding ORs, then relatively higher cost care is being created. This is a less efficient option for patients and their insurers. In other words, without additional outpatient OR capacity at freestanding ASCs, more patients will be treated in higher cost, hospital-based operating rooms, which lowers planning area resource efficiency overall.

6. For existing facilities, provide the facility's historical utilization for the last three full calendar years.

Please see Table 6 for the number of surgeries by specialty between 2019 and 2021 at Microsurgical Spine Center. Cases fell substantially in 2020 due to the closure of the entire surgery center over the months of April and May.

Table 6: Microsurgical Spine Center Historical Utilization, 2019 to 2021

Cases by Specialty	2019	2020	2021
Neurosurgery	486	425	414
Pain Management	1,824	1,604	1,732
Total	**2,310**	**2,029**	**2,146**

Source: Applicant

7. **Provide projected surgical volumes at the proposed facility for the first three full years of operation, separated by surgical type. For existing facilities, also provide the intervening years between historical and projected. Include the basis for all assumptions used as the basis for these projections.**

   In Table 7, we present projected surgical volumes for the first three full years of operations given expected project approval in 2023 (2024 through 2026), as well as a 2023 split between the periods prior to and after project approval (January to March and April to December, respectively). Currently, Microsurgical Spine Center provides outpatient services for spinal surgery and pain management. Beginning in April 2023, given approval of the proposed project, it will add the specialties of Cardiology, Interventional Radiology, Orthopedics, and Podiatry.

   The specialty-specific case counts presented in Table 7 reflect a mapping of procedures by ICD-9 group presented in Table 8. Some ICD-9 groups have a straightforward correspondence to a certain specialty group, while others bridge multiple specialty groups. For this reason, we apply mapping assumptions regarding *the expected proportion of procedures within a given ICD-9 group to fall within each of the different specialties for Microsurgical Spine Center.* These mapping assumptions are based on review of CPT and ICD-9 procedural classifications, the historical utilization of Microsurgical Spine Center, and the types of cases expected within the added specialties. We emphasize that our mapping assumptions are distinct from our market share assumptions, which are outlined in Table 10. These mapping assumptions are:

   - For ICD-9 group "Operations on the Nervous System," 20% are Neurosurgery procedures and 80% Pain Management procedures, based on the historical distribution of these cases at Microsurgical Spine Center.

   - For ICD-9 group "Operations on the Cardiovascular System," 10% are Interventional Radiology procedures and 90% Cardiology/Vascular procedures. The distribution is based on the types of cases expected by Microsurgical Spine Center, described above.

   - For ICD-9 group "Operations on the Musculoskeletal System," 20% are Interventional Radiology procedures, 40% are Orthopedics procedures, and 40% are podiatry procedures. The distribution is based on the types of cases expected by Microsurgical Spine Center, described above.

- For ICD-9 group "Miscellaneous diagnostic and therapeutic procedures and new technologies," 100% are Interventional Radiology procedures. The distribution is based on the types of cases expected by Microsurgical Spine Center, described above.

Table 7: Microsurgical Spine Center Projected Case Count, 2022 to 2026

	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Digestive	-	-	-	-	-	-
Endocrine	-	-	-	-	-	-
ENT	-	-	-	-	-	-
Eye/Ophthalmology	-	-	-	-	-	-
General Surgery	-	-	-	-	-	-
Gynecological	-	-	-	-	-	-
Interventional Radiology	-	-	166	246	271	275
Neurosurgery	435	109	347	470	477	484
Orthopedics	-	-	118	191	226	229
Pain Management	1,741	435	1,390	1,880	1,906	1,934
Plastic	-	-	-	-	-	-
Podiatry	-	-	118	191	226	229
Urologic	-	-	-	-	-	-
Vascular/Cardiology	-	-	80	163	220	223
Total*	2,176	544	2,218	3,140	3,325	3,374

Sources: Applicant

The forecast model uses the following assumptions and methodologies:

1. Surgical use rates by ICD-9 procedure code group were derived from the latest National Center for Health Statistics ("NCHS") survey study, "Ambulatory Surgery in the United States." The report analyzed and presented summaries of data from the 2010 National Survey of Ambulatory Surgery ("NSAS").[10] This survey is included in our application as Exhibit 6. For utilization estimates by surgical specialty, please see Table 8, below.

[10] The estimates are found in Table 4 of the report. This report was revised on February 28, 2017.

Table 8: National Center for Health Statistics. Ambulatory Surgery Utilization Estimates

Procedure Description (ICD-9-CM Code)	ICD9 CM Code	Utilization Rate / 10,000
All Operations		1560.3
Operations on the Nervous System	01-05	136.6
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	06-07,40-41,72-75	11.3
Operations on the Eye	08-16	254.7
Operations on the Ear	18-20	34.1
Operations on the Nose, Mouth and Pharynx	21-29	77.8
Operations on the Respiratory System	30-34	9.1
Operations on the Cardiovascular System	35-39,00.50-00.51,00.53-00.55,00.61-00.66	34.7
Operations on the Digestive System	42-54	324.7
Operations on the Urinary System	55-59	43.6
Operations on the Male Genital Organs	60-64	17.0
Operations on the Female Genital Organs	65-71	57.1
Operations on the Musculoskeletal System	76-84,00.70-00.73,00.80-00.84	228.8
Operations of the Integumentary System	85-86	140.3
Miscellaneous diagnostic and therapeutic procedures and new technologies	87-99,00	190.5

Sources: "Ambulatory Surgery in the United States, 2010," US Department of Health and Human Services, National Center for Health Statistics, National Health Statistics Reports, Number 102, February 28, 2017; U.S. Census Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2010 to July 1, 2018

Notes: Utilization rates calculated by dividing specialty-specific procedure counts available in Table 3 of "Ambulatory Surgery in the United States, 2010," by 2010 U.S. census population counts and multiplying by 10,000.

In this study, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory basis in a hospital or freestanding center's general ORs, dedicated ambulatory surgery rooms, and other specialized rooms. This NCHS survey study is the principal source for published national data on the characteristics of visits to hospital based and freestanding ASFs. The report was updated and revised in 2017 and contains NCHS estimates on ambulatory surgery case counts for the year 2010.[11] Estimates of population use rates were calculated by dividing the

[11] The NCHS survey covers procedures performed in ambulatory surgery centers, both hospital-based and freestanding. Hospitals include non-institutional hospitals exclusive of federal, military, and Veteran's Affairs located in the 50 states and the District of Columbia. Only short-stay hospitals—hospitals with an average length of stay less than 30 days—or those whose specialty was general medicine or general surgery were included in the survey. Freestanding facilities included those that were regulated by CMS

procedure case counts by 2010 U.S. Census population counts and multiplying by 10,000. Please see Exhibit 6 for a copy of the NCHS survey study used in the forecast methodology.

The NCHS use rates were multiplied by 2022-2026 East Pierce County Planning Area population forecasts and divided by 10,000 to forecast Planning Area resident ambulatory surgeries by procedure type and year. Table 9 presents estimates of these case counts.

Table 9: East Pierce County Ambulatory Surgery Forecasts, 2022 to 2026

Service Area Volume of Outpatient Cases	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Number of Months	**12**	**3**	**9**	**12**	**12**	**12**
Operations on the Nervous System	4,615	1,154	3,509	4,746	4,814	4,884
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	380	95	289	391	396	402
Operations on the Eye	8,604	2,151	6,544	8,849	8,977	9,107
Operations on the Ear	1,151	288	875	1,184	1,201	1,218
Operations on the Nose, Mouth and Pharynx	2,628	657	1,999	2,703	2,742	2,782
Operations on the Respiratory System	308	77	234	317	321	326
Operations on the Cardiovascular System	1,171	293	890	1,204	1,221	1,239
Operations on the Digestive System	10,968	2,742	8,342	11,281	11,443	11,610
Operations on the Urinary System	1,473	368	1,120	1,515	1,537	1,559
Operations on the Male Genital Organs	573	143	436	590	598	607
Operations on the Female Genital Organs	1,928	482	1,467	1,983	2,012	2,041
Operations on the Musculoskeletal System	7,727	1,932	5,876	7,946	8,061	8,178
Operations of the Integumentary System	4,739	1,185	3,604	4,874	4,944	5,016
Miscellaneous diagnostic and therapeutic procedures and new technologies	6,434	1,608	4,893	6,617	6,712	6,810
Subtotal	**52,699**	**13,175**	**40,079**	**54,198**	**54,978**	**55,779**

Source: Applicant

Market share figures were applied to each procedure code group based on current and planned surgeries. These market share figures are based on the historical utilization of Microsurgical Spine Center, the expected procedures to be performed given project approval, and the types of procedures performed at existing planning area providers.

for Medicare participation. The NSAS sample of facilities was selected using a multistage probability design with facilities having varying selection probabilities.

For East Pierce County, based on a utilization rate of 1,560.3 (Table 8) and a 2020 population of 327,507, we estimate a total of 51,099 procedures for East Pierce residents in 2020. This same year, East Pierce providers performed 19,224 procedures, resulting in an estimate of resident net out-migration of 31,875 procedures. As we discuss below, this outmigration rate of about 57% indicates significant potential for expansion of planning area providers and subsequent increases in planning area efficiency and resident access.

Table 10 presents our market share assumptions. For those specialties in which Microsurgical Spine Center has not previously performed procedures, the market share figures begin with values reflective of the procedures performed at other outpatient surgery centers within East Pierce.

Market share figures for Operations on the Nervous System are based on historical case count data by specialty presented in Table 6. For Operations on the Cardiovascular System, we assume a 10% market share for the Q2-Q4 2023, increasing to a 20% market share in 2025 and 2026, based on our observation that other planning area outpatient providers do not appear to provide these types of surgical services and a ramp rate to recruit cardiology surgeons. We believe this level is reasonable given that residents in need of these services likely must either outmigration or use inpatient services. For operations on the Musculoskeletal System, we assume a 5% market share in Q2-Q4 2023, increasing to 7% over the forecast period. We believe this level is reasonable given that, while existing planning area providers provide services within this ICD-9 group, there nevertheless is likely significant excess demand and planning area outmigration based on forecast resident use rates. For Miscellaneous Diagnostic and Therapeutic Procedures and New Technologies, we assume a 2% market share over the forecast period. This small market share reflects our expectations of the pattern of procedures at existing planning area providers, as well as this being a broad category of which only those cases related to Interventional Radiology are relevant.

Table 10: Microsurgical Spine Center Market Share Assumptions, 2022-2026

MSC Market Share Calculations and Assumptions	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Market Share Growth	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Operations on the Nervous System	47.2%	47.2%	49.5%	49.5%	49.5%	49.5%
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures			0.0%	0.0%	0.0%	0.0%
Operations on the Eye			0.0%	0.0%	0.0%	0.0%
Operations on the Ear			0.0%	0.0%	0.0%	0.0%
Operations on the Nose, Mouth and Pharynx			0.0%	0.0%	0.0%	0.0%
Operations on the Respiratory System			0.0%	0.0%	0.0%	0.0%

Operations on the Cardiovascular System			10.0%	15.0%	20.0%	20.0%
Operations on the Digestive System			0.0%	0.0%	0.0%	0.0%
Operations on the Urinary System			0.0%	0.0%	0.0%	0.0%
Operations on the Male Genital Organs			0.0%	0.0%	0.0%	0.0%
Operations on the Female Genital Organs			0.0%	0.0%	0.0%	0.0%
Operations on the Musculoskeletal System			5.0%	6.0%	7.0%	7.0%
Operations of the Integumentary System			0.0%	0.0%	0.0%	0.0%
Miscellaneous diagnostic and therapeutic procedures and new technologies			2.0%	2.0%	2.0%	2.0%

Source: Applicant

Estimated planning area surgeries were then multiplied by the assumed market share figures for the ASF, yielding forecasted number of procedures, by year. These projections are included below in Table 11. Please note that CN approval is assumed to occur by March 2023, and there is no construction required, so project implementation can begin immediately thereafter. From an operations point of view, year one is 2024 since that is the first complete year after CN approval.

Microsurgical Spine Center's East Pierce County Planning Area market share equaled 4.1% of all planning area ambulatory surgeries in 2021 and is projected to increase slightly over the forecast period to 6.0% due to the expansion of specialties following approval of the proposed project.

Table 11: Microsurgical Spine Center Projected Number of Ambulatory Surgeries, by Type, 2022-2026

MSC Cases, Forecast Based on Market Share	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Operations on the Nervous System	2,176	544	1,737	2,350	2,383	2,418
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	-	-	-	-	-	-
Operations on the Eye	-	-	-	-	-	-
Operations on the Ear	-	-	-	-	-	-
Operations on the Nose, Mouth and Pharynx	-	-	-	-	-	-
Operations on the Respiratory System	-	-	-	-	-	-
Operations on the Cardiovascular System	-	-	89	181	244	248
Operations on the Digestive System	-	-	-	-	-	-
Operations on the Urinary System	-	-	-	-	-	-

Operations on the Male Genital Organs	-	-	-	-	-	-
Operations on the Female Genital Organs	-	-	-	-	-	-
Operations on the Musculoskeletal System	-	-	294	477	564	572
Operations of the Integumentary System	-	-	-	-	-	-
Miscellaneous diagnostic and therapeutic procedures and new technologies	-	-	98	132	134	136
Total Cases	**2,176**	**544**	**2,218**	**3,140**	**3,325**	**3,374**
East Pierce Planning Area Cases	52,699	13,175	40,079	54,198	54,978	55,779
MSC Market Share, East Pierce Planning Area	4.1%	4.1%	5.5%	5.8%	6.0%	6.0%
Average annual growth, cases	1.4%		26.7%	13.7%	5.9%	1.5%
Source: Applicant						

2. The forecasted number of ambulatory surgeries at Microsurgical Spine Center presented in Table 11 are mapped into the specialty groups presented in Table 9 using the methodology outlined above. Cases are translated into surgery minutes using Microsurgical Spine Center 2021 outpatient surgery case per minute figure of 100.37 minute for neurosurgery and 12.12 minutes for Pain Management. Based on WAC 246-310-270(9)(iii), the two ORs and procedure room would be efficiently utilized.

The NCHS use rates in the utilization forecast are based on a 2010 national data set, so are national estimates which do not vary over time. It is possible that local patterns vary from the survey figures and that years such as 2020 deviate from the earlier use rates. However, this methodology is a robust statistical approach to estimate expected future volumes with procedural specificity. It is arguably reasonable to increase the use rate over time, given population aging and higher ambulatory surgery use rates for older age cohorts.[12] However, we assume a constant use rate over our forecast period.

8. Identify any factors in the planning area that could restrict patient access to outpatient surgical services. WAC 246-310-210(1) and (2)

At present, we estimate that over half of East Pierce residents in need of outpatient surgical services outmigrate to other planning areas.[13] Without increases in planning area provider capacity, significant numbers of planning area residents must continue to receive care at out-of-area providers, thereby impacting patient access to outpatient surgical services and causing residents to pay higher costs at less convenient settings or wait for surgical availability at an area outpatient facility. Furthermore, geography and

[12] Please see our discussion on an increasing use rate in the section Need (WAC 246-310-210).
[13] Based on a surgical use rate of 1,560.3 per 10,000 persons, and an East Pierce population of 327,507, we estimate that East Pierce residents had about 51,099 surgical procedures in 2020. The number of surgical procedures at planning area providers this same year was 19,224, indicating expected net outmigration of 31,875 cases, or about 62%.

regional traffic patterns may restrict access to neighboring areas, a concern for East Pierce residents given the abnormally high rate of expected resident outmigration.

9. **In a CN-approved facility, WAC 246-310-210(2) requires that "all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services." Confirm your facility will meet this requirement.**

   Microsurgical Spine Center is committed to meeting community and regional health needs and will provide Charity Care consistent with its financial assistance policy, included as Exhibit 7. This policy states that necessary health care will be provided as a reduced charge to eligible patients.

   Our financial pro forma forecast provided in Exhibit 12 explicitly allocates 2.18% of total revenues to be provided for charity care, a figure equal to the East Pierce County Planning Area charity care average over 2018-2020, across hospitals located in East Pierce County.[14] Please see Table 12 below.

10. **Provide a copy of the following policies:**
    - **Admissions policy**
    - **Charity care or financial assistance policy**
    - **Patient Rights and Responsibilities policy**
    - **Non-discrimination policy**
    - **Any other policies directly related to patient access to care.**

    Please see Exhibit 7 for the Microsurgical Spine Center Financial Assistance Policy. Exhibit 8 includes the Admissions Protocol Policy, Exhibit 9 the Patient Consent for the Procedure Policy, Exhibit 10 the Patient Rights and Notice of Privacy Practices Policy, and Exhibit 11 the Nondiscrimination Policy.

[14] Only Good Samaritan Hospital was operational in East Pierce.

B. Financial Feasibility (WAC 246-310-220)

Financial feasibility of a project is based on the criteria in WAC 246-310-220.

1. **Provide documentation that demonstrates that the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under "Need" in section A. Include the basis for all assumptions.**
   - **Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include the basis for all assumptions.**
   - **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include the basis for all assumptions.**
   - **For existing facilities, provide three years of historical revenue and expense statements, including the current year. Ensure these are in the same format as the pro forma projections. For incomplete years, identify whether the data is annualized.**

   Please see Exhibit 12 for historical financial statements and the Pro Forma financial forecast for the first three full years of operations.

2. **Provide the following applicable agreements/contracts:**

   - **Management agreement**
   - **Operating agreement**
   - **Medical director agreement**
   - **Development agreement**
   - **Joint Venture agreement**

   Note that all agreements above must be valid through at least the first three full years following completion of the project or have a clause with automatic renewals. <u>Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.</u>

   Please see Exhibit 13 for a copy of the Microsurgical Spine Center Management Agreement and Exhibit 14 for a copy of the Medical Director Agreement.

3. **Certificate of Need approved ASFs must provide charity care at levels comparable to those at the hospitals in the ASF planning area. You can access charity care statistics from the Hospital Charity Care and Financial Data (HCCFD) website. Identify the amount of charity care projected to be provided at this facility, captured as a percentage of gross revenue, as well as charity care information for the planning area hospitals. The table below is for your convenience but is not required. WAC 246-310-270(7)**

Microsurgical Spine Center, in its financial projections for the proposed project, assumes charity care to be 2.18% of total or gross revenue. This figure is consistent with the East Pierce County Planning Area Charity Care average of 2.18% over the 2018 to 2020 period (Table 12).

Table 12: Planning Area Charity Care Statistics, 2018-2020

Hospitals	2018	2019	2020	2017 to 2019 Average
East Pierce County PA				
% Total Patient Service Revenue	2.22%	2.19%	2.14%	2.18%
% Adjusted Patient Service Revenue	6.30%	6.19%	5.79%	6.10%

Source: DOH Charity Care Reports, 2018-2020

Notes:
Total patient service revenue includes revenue across all sources. Adjusted patient service revenue reflects total patient service revenue, less revenue from Medicare and Medicaid. Hospitals within the East Pierce County Planning Area reporting charity care amounts include MultiCare Good Samaritan Hospital.

4. **Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site. If a lease agreement is provided, the terms must be for at least five years following project completion. The costs identified in these documents should be consistent with the Pro Forma provided in response to question 1.**

   Please see Exhibit 15 for a copy of the parcel information documenting ownership of the proposed site by Tres Amigos I, LLC, a copy of the original lease agreement and January 2002 extension between Tres Amigos and Neospine, and a signed letter of intent for an additional 10-year extension starting on October 1, 2024.

5. **For new facilities, confirm that the zoning for your site is consistent with the project.**

   Microsurgical Spine Center has been operational as a CN Approved facility at its current location since 2005. Thus, this question is not applicable.

6. **Complete the table below with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed below, please include the items with a definition of the line item. Include all assumptions used as the basis the capital expenditure estimate.**

   There are no capital expenditures associated with the proposed project.

7. **Identify the entity or entities responsible for funding the capital expenditure identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for all.**

   There are no capital expenditures associated with the proposed project. Thus, this question is not applicable.

8. **Please identify the amount of start-up costs expected for this project. Include any assumptions that went into determining the start-up costs. If no start-up costs are needed, explain why.**

   Microsurgical Spine Center is fully operational, and so does not anticipate any start-up costs associated with the proposed project. Thus, this question is not applicable.

9. **Provide a non-binding contractor's estimate for the construction costs for the project.**

   There are no construction costs associated with the proposed project. Thus, this question is not applicable.

10. **Explain how the proposed project would or would not impact costs and charges to patients for health services. WAC 246-310-220**

    There are no construction or capital costs associated with the proposed project, thus it is not expected to increase any fixed operating expenses. Therefore, it would not be expected to affect costs and charges. Furthermore, Microsurgical Spine Center does not set its rates. Rather, they are based on fee schedules with CMS and principal payers.

11. **Provide documentation that the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges to patients for health services in the planning area. WAC 246-310-220**

    Please see our response to Question 10 above.

12. **Provide the projected payer mix by gross revenue and by patients using the example table below. If "other" is a category, define what is included in "other."**

    Since Microsurgical Spine Center is a cash-based business, we present the payer mix by patient and Net Revenue below.

Projected Payer Mix	Percentage by Revenue WAC 246-310-220(1)	Percentage by Patient WAC 246-310-210(2)

Medicare	31.8%	40.4%
Medicaid	1.0%	5.8%
Commercial/HMO	53.4%	40.8%
Other Government	1.3%	3.5%
Other/Misc.	12.1%	9.0%
Self-Pay	0.5%	0.5%
Total	100.0%	100.0%

Those cases and charges part of the "Other/Misc." category include cases to persons with Workers' Comp or Auto/Liability payers.

The projected payer mix is based on Microsurgical Spine Center's 2021 payer mix, adjusting for a relative shift towards more Medicaid patients and Medicaid revenue as a result of the expansion of specialties.

13. If this project proposes CN approval of an existing facility, provide the historical payer mix by revenue and patients for the existing facility for the most recent year. The table format should be consistent with the table shown above.

Microsurgical Spine Center Payer Mix, 2021	Percentage by Revenue WAC 246-310-220(1)	Percentage by Patient WAC 246-310-210(2)
Medicare	32.1%	42.9%
Medicaid	0.0%	0.0%
Commercial/HMO	53.9%	43.3%
Other Government	1.3%	3.7%
Other/Misc.	12.2%	9.6%
Self-Pay	0.5%	0.5%
Total	100.0%	100.0%

14. Provide a listing of new equipment proposed for this project. The list should include estimated costs for the equipment. If no new equipment is required, explain.

Microsurgical Spine Center does not anticipate the need to purchase any equipment because of the proposed project. Thus, this question is not applicable.

15. Provide a letter of financial commitment or draft agreement for each source of financing (e.g., cash reserves, debt financing/loan, grant, philanthropy, etc.). WAC 246-310-220.

There are no capital expenditures or start-up costs associated with the proposed project. Thus, this question is not applicable.

16. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized. WAC 246-310-220

This question is not applicable.

17. Provide the applicant's audited financial statements covering the most recent three years. WAC 246-310-220

Please see Exhibit 16 for the historical financial statements of Microsurgical Spine Center for the period 2018 to 2021. It does not have audited financial statements, nor does its parent. As part of its Management Agreement, Surgery Partners has external audit testing throughout the year, but the overall audit process is consolidated up through the entire enterprise; Deloitte, the audit firm for Surgery Partners, does not provide an opinion on each individual center.

C. Structure and Process of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220 and will be marked as such.

1. **Identify all licensed healthcare facilities owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities and should identify the license/accreditation status of each facility.**

   Neither Microsurgical Spine Center nor its parent South Sound Neurosurgery own any other facilities, thus this question is not applicable.

2. **Provide a table that shows FTEs [full time equivalents] by classification (e.g., RN, LPN, Manager, Scheduler, etc.) for the proposed facility. If the facility is currently in operation, include at least the last three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff classifications should be defined.**

   Please see Table 13 below for the historical number of FTEs, current, and projected FTEs.

Table 13: Microsurgical Spine Surgery Center Productive and Non-Productive FTEs by Type and Year

	2019	2020	2021	2022	2023	2024	2025	2026
Facility Administrator	0.56	0.56	0.56	0.56	0.56	0.56	0.56	0.56
Business Office Manager	1.12	1.12	1.12	1.12	1.12	1.12	1.12	1.12
Registered Nurses	3.92	3.92	3.92	4.48	4.48	5.04	5.60	5.60
Scrub Tech	1.68	1.68	1.68	2.24	2.24	2.80	2.80	2.80
X-Ray Tech	1.12	1.12	1.12	1.68	1.68	2.24	2.24	2.24
Sterile Processing Tech	1.12	1.12	1.12	1.12	1.12	1.68	1.68	1.68
Office/Front Desk	1.12	1.12	1.12	1.68	1.68	1.90	1.90	1.90
TOTAL	**10.64**	**10.64**	**10.64**	**12.88**	**12.88**	**15.34**	**15.90**	**15.90**

Source: Applicant

Notes: FTE counts include both productive and non-productive work hours, where non-productive work hours are those allocated to vacation time and sick leave.

3. **Provide the basis for the assumptions used to project the number and types of FTEs identified for this project.**

Prior to the project start, in 2022 Microsurgical Spine Center expects to add 1 RN FTEs, 0.5 Scrub Tech FTEs, 0.5 X-Ray Tech FTEs, 0.5 Sterile Processing Tech FTEs, and 0.2 Office/Front Desk FTEs. Following approval of the proposed project, to project staffing increases commensurate with the projected increases in utilization, we added a 25% staffing increase for RNs between 2022 and 2026. Likewise, Scrub Tech, X-Ray Tech, and Sterile Processing Tech FTEs are assumed to increase by 25%, 33%, and 50%, respectively. We also anticipate adding 0.20 Office/Front Desk FTEs to handle the additional patient and scheduling load. Furthermore, all productive FTEs are adjusted by a 12% non-productive multiplier to account for expected vacation time and sick leave. We anticipate the other ASC administrative staff able to handle the increased utilization with their current FTE levels.

4. **Provide the name and professional license number of the current or proposed medical director. If not already disclosed under WAC 246-310-220(1) above, identify if the medical director is an employee or under contract.**

   Microsurgical Spine Center's Medical Director is Dr. Richard Wohns (MD00018307). Please see Exhibit 14 for a copy of the Medical Director Agreement.

5. **If the medical director is/will be an employee rather than under contract, provide the medical director's job description.**

   This question is not applicable.

6. **Identify key staff by name, if known (e.g., nurse manager, clinical director, etc.)**

Table 14: Microsurgical Spine Center, List of Key ASC Staff

Key Staff	Position	License #
Caroline Holden	Facility Admin/ Clinical Manager	RN00096196
Trudy Zarella	Charge Nurse	RN60221144
Caroline Tederman	Materials Manager	ST00001679

Source: Applicant

7. **Provide a list of physicians who would use this surgery center, including their names, license numbers, and specialties. WAC 246-310-230(3) and (5).**

Table 15: Microsurgical Spine Center Medical Roster

Physician Name	License #	Specialty
Dr Richard Wohns	MD00018307	Neurosurgery
Dr A. Alex Mohit	MD00048393	Neurosurgery
Dr Kenneth Nwosu	MD60759285	Ortho spine
Dr Kathy Wang	OP0002056	Interventional pain
Dr Neil Batta	MD61159582	Interventional pain
Dr David Paly	MD00020325	Anesthesia
Dr Asher Gold	MD00035662	Anesthesia

Dr R Lawrence Vercio	MD00025731	Anesthesia

Source: Applicant

8. **For existing facilities, provide names and professional license numbers for current credentialed staff. WAC 246-310-230(3) and (5).**

Table 16: Microsurgical Spine Center, List of Current Credentialed Staff

Name	License #	Position
Heather Bourne	RN61010859	RN
Nicole Grobins	RN60964469	RN
Caroline Holden	RN00096196	RN/FA
Tonya Koskovich	RN000133673	RN
Heather (Mobley) Green	RN00044230	RN
Lauren Patterson	RN60939210	RN
Trudy Zarella	RN60221144	RN
Josephine Perez	ST60311117	ORT
Caroline Tederman	ST00001679	ORT
Robert Filimaua	XT00005134	RAD TECH
Brandy Hawes	MR61152314	MA

Source: Applicant

9. **Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project. WAC 246-310-230(1)**

Microsurgical Spine Center utilizes Ultipro and Indeed for recruitment as well as relying on local leads in the community. We have an attractive work routine with no weekends, holidays, or on-call, as well as competitive pay scale in the community.

10. **For existing facilities, provide a listing of ancillary and support services already in place. WAC 246-310-230(2)**

Table 17: Microsurgical Spine Center, Ancillary and Support Services

Organization Name	Services Provided
AES	Anesthesia machine
Iron Mountain	archiving records
Omega medical	biomed testing; autoclave/ washer
Corwin	C-Arm physio

Prescotts inc	Microscope
GE_OEC	C-arm maintanence
Medx services	Coding
Audit and Adjustment	Collections
Pacific Office Automation	Copiers
Prognocis	EMR
Cummings Northwest	Generator
NW Family Affair	Janitorial
Alarm Center Inc	Fire/smoke protection
Seatac Fire Protection	Sprinkler system
Medgas Services	Medical gas system inspection
Comfort Systems NW	HVAC
NW neuromonitoring	Neuromonitoring
ImageFirst	Linen Services
Richard Wohns MD	Medical Director
Airgas	Medical Gases
Stericycle	Medical Waste
SPH Analytics	Patient Satisfaction
Good Samaritan Hospital	Patient Transfer
Lemay	Document shredding
Performance Systems	Fire Extinguisher

Source: Applicant

11. For new facilities, provide a listing of ancillary and support services that will be established. WAC 246-310-230(2)

This question is not applicable.

12. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project. WAC 246-310-230(2)

Microsurgical Spine Center does not expect any of the agreements with the organizations listed in Table 17 to change.

13. If the ASF is currently operating, provide a listing of healthcare facilities with which the ASF has working relationships. WAC 246-310-230(4)

Microsurgical Spine Center currently has a working relationship with MultiCare Good Samaritan Hospital. Please see Exhibit 18 for a copy of the transfer agreement between Microsurgical Spine Center and MultiCare Health System.

14. Identify whether any of the existing working relationships with healthcare facilities listed above would change as a result of this project. WAC 246-310-230(4)

Microsurgical Spine Center does not expect any of the existing working relationships to change as a result of this project.

15. For a new facility, provide a listing of healthcare facilities with which the ASF would establish working relationships. WAC 246-310-230(4)

This question is not applicable.

16. Provide a copy of the existing or proposed transfer agreement with a local hospital. WAC 246-310-230(4)

Please see Exhibit 18 for a copy of the transfer agreement between Microsurgical Spine Center and MultiCare Good Samaritan Hospital.

17. Provide an explanation of how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230(4)

Microsurgical Spine Center promotes continuity of care now, since it offers all elements of outpatient spinal surgery and pain management care, including diagnoses, treatment, and outpatient surgery, if needed. Expansion of the set of specialties to also include cardiology, interventional radiology, orthopedics, and podiatry will allow affiliated and non-organizational physicians across all these specialties to perform surgical procedures at the ASC. CN approval of the proposed project will allow Microsurgical Spine Center to help meet the increased Planning Area demand for surgical procedures and continue to support continuity of care in its local market. Without further increases in supply, patients in search of surgical procedures must continue to commute outside the East Pierce planning area, perpetuating and amplifying unwarranted fragmentation of services in the future.

18. Provide an explanation of how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230(4).

Microsurgical Spine Center cooperates with the only East Pierce inpatient provider, MultiCare Good Samaritan Hospital. Please see Exhibit 18 for a copy of the transfer agreement with between Microsurgical Spine Center and MultiCare Health System.

19. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)

a. **A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or**
b. **A revocation of a license to operate a healthcare facility; or**
c. **A revocation of a license to practice as a health profession; or**
d. **Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.**

Microsurgical Spine Center does not have a history of any of the actions listed above. Thus, this question is not applicable.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project.

In deciding to submit this application, Microsurgical Spine Center explored the following options: (1) no project—continuing as a CN-Approved, two OR facility, and (2) request CN approval for one additional Procedure Room and an expansion of specialties including Orthopedics, Podiatry, Interventional Radiology, and Cardiology.

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

We evaluate the options above using the following decision criteria: improving access; improving quality of care; capital and operating costs (efficiency); and legal restrictions:

Table 18: Alternatives Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:
No project - remain CN-Approved with 2 ORs	• There is no advantage to continuing as is in terms of improving access. (Disadvantage ("D")) • Capacity constraints at Microsurgical Spine Center prevent the potential for further growth in surgical procedures, leading to reduced access to outpatient surgery services for planning area residents. Without the project, these constraints may cause patients to continue to out-migrate to non-Planning Area facilities, which harms access. (D)
CN Approval for 1 additional Procedure Room and expansion of specialties (Requested project)	• Allows an expansion of specialties at Microsurgical Spine Center, open to all physicians in the community who are credentialed, leading to improved access to planning area residents in need of procedures across the additional specialties (Advantage ("A")) • Allows an additional procedure room, alleviating capacity constraints and preventing "crowding out" of surgical procedures. (A)

Table 19: Alternatives Analysis: Promoting Quality of Care	
Option:	**Advantages/Disadvantages:**
No project - remain CN-Approved with 2 ORs	• There are no current quality of care issues, so there are no advantages or disadvantages from a quality-of-care perspective. (Neutral ("N"))
CN Approval for 1 additional Procedure Room and expansion of specialties (Requested project)	• The requested project allows expansion of both the array of specialties and capacity. This improves access, and thus quality of care. (A) • From a quality-of-care perspective, there are only advantages. (A)

Table 20: Alternatives Analysis: Promoting Cost and Operating Efficiency	
Option:	**Advantages/Disadvantages:**
No project - remain CN-Approved with 2 ORs	• Under this option, there would be no impacts on costs or efficiency of Microsurgical Spine Center—the surgery center would continue as present. (N) • However, as stated above, without the project, some residents in need of outpatient surgical procedures would likely need to out-migrate or visit inpatient providers due to planning area capacity constraints. This requires otherwise unnecessary travel or usage of relatively expensive inpatient care. (D)
CN Approval for 1 additional Procedure Room and expansion of specialties (Requested project)	• An expansion of services and ability of outside physicians to use the facility would increase access within the planning area for persons needing Orthopedics, Interventional Radiology, Cardiology, and Podiatry procedures, and reduce the need for outmigration across these specialties. (A) • An additional procedure room will provide greater accessibility to planning area residents for outpatient surgical services. Adding capacity to a local ASF reduces travel time and costs, patient inconvenience and anxiety, and is a cost-effective alternative to increased utilization of hospital outpatient surgery departments. (A)

Table 21: Alternatives Analysis: Legal Restrictions.	
Option:	**Advantages/Disadvantages:**
No project - remain CN-Approved with 2 ORs	• There are no legal restrictions to continuing operations as presently. (A)
CN Approval for 1 additional Procedure Room and expansion of specialties (Requested project)	• Requires certificate of need approval. This requires time and expense. (D)

3. Identify any aspects of the facility's design that lead to operational efficiency. This could include but is not limited to LEED building, water filtration, or the methods for construction, etc. WAC 246-310-240(2) and (3).

The ASC physical design allows for efficient pattern of patient movement within a single floor. Operating rooms, imaging instruments, sterile processing, instruments, implants, and central supply are all located within the ASC space. Please see Exhibit 3 for a floorplan of the ASC.

Exhibit 1

CRS Treatment Room Remodel

Letter of Transmittal

May 6, 2014

Washington State Department of Health

Construction Review Services
310 Israel Rd. SE
Tumwater, WA 98501

PO Box 47852
Olympia, Washington 98504-7852

www.doh.wa.gov/crs
tel. 360-236-2944
fax. 360-236-2901

Project Info:

CRS# 60274723
Microsurgical Spine Center
NFPA 101, 2000 Version ASC
Treatment Room Renovation

Project location: 1519 3rd St SE Ste 102 Puyallup, WA 98372

Local Permit #:

Key People:

Assigned DOH Reviewer:	Steve Pennington steve.pennington@doh.wa.gov
Facility Administrator:	Microsurgical Spine Center Carol Holden 1519 3rd St SE Ste 102 Puyallup, WA 98372 (253) 604-1422 x. cholden@symbion.com
Architect / Engineer:	The CFP Group, LLC Bill Lester 1305 Clinton St, Ste 300 Nashville, TN 37206 (615) 846-0222 x. wlester@CFP-group.com
Consultant:	Envision Advantage, LLC Richard Graham 320 Seven Springs Way, Ste 230 Bremerton, TN 37027 (615) 661-6211 x. RGraham@envision-eng.com
Contact:	N/A

x.

Facility Contact:	Same As Administrator
	x.
Local AHJ:	City of Puyallup Ray Cockerham 333 S Meridian Puyallup, WA 98371-5904 (253) 841-5585 x. rayc@ci.puyallup.wa.us
Consultant:	N/A
	x.
Contact:	N/A

x.

Copies To:

- ☒ Local AHJ: City of Puyallup
- ☒ Architect / Engineer: The CFP Group, LLC
- ☒ Consultant: Envision Advantage, LLC
- ☐ Consultant: N/A
- ☐ Contact: N/A
- ☐ Contact: N/A
- ☒ CRS File
- ☐ DOH Child Birth Center Licensing
- ☐ DOH Office of Accommodations & Res. Care Survey
- ☒ DOH Office of Investigations & Inspections
- ☐ DSHS, , Div. Of Alcohol & Substance Abuse
- ☐ DSHS, , Aging & Adult Services Admin.
- ☒ L&I, Bill Eckroth, Electrical Section
- ☐ L&I, John Harvey, Factory Assembled Structures

Facility Data Certificate:

Facility Name:	**Microsurgical Spine Center**	**Licensee UBI#:**	**602419505**
Site Address:	**1519 3rd St SE Ste 102 Puyallup, WA 98372**	**Critical Access Facility:**	☐ Yes ☒ No
Estimated Date of Occupancy: Occupied			

ALL FACILITY TYPES

Occupancy Group:	**B**	Construction Type:	**5-A**	Applicable Code:	**2000 NFPA 101**
Number of Beds:	Current: N/A	Added:		Removed:	Total:
Automatic Fire Sprinkler System:	☒ Yes ☐ No	Type 13			
Automatic Fire Alarm System:	☒ Yes ☐ No				
Compartmentation req'd:	☐ Yes ☒ No	Smoke Control System Provided:	☐ Yes ☒ No		
Special Delayed Egress Control:	☐ Yes ☒ No	Location:			
Certificate of Need Required:	☐ Yes ☒ No	CON Approval Granted: ☐ Yes ☐ No CON Number :			

RESIDENTIAL CARE FACILITIES ONLY

Number of units:	Private occupancy:	Two person occupancy:
Based on size of rooms used for sleeping	Residents	
Based on size of common rooms	Residents	
Maximum allowable licensable beds: ____		
Qualifies for Assisted Living Funding Program	☐ Yes ☐ No	Number of qualifying units:

NOTES

Conversion of recovery space into a treatment room.

The data above is based on the information presented to CRS. Any change in the facility or facility program that causes the above information to be incorrect is subject to review by CRS. Approval for construction is not approval for licensure. A copy of the facility data certificate will be sent to the licensing agency.

Project Status:

- Authorized to Begin Construction –

-All Comments Approved-

The construction documents have been reviewed per Chapter 246-330 WAC Ambulatory surgery facility and found acceptable. The stamped approved copy of the documents shall be kept and available for the licensing staff on site. Please note the following:
Any changes/deviations (incl. change orders or addenda) from the approved documents must be submitted to the Department for review and approval. Please include your CRS number on all communications to Construction Review Services.
You must notify the department when construction is complete, either by the included notification of construction complete or by completing the form on the CRS website. Additional instructions may be printed on the notice of completion.
When we receive notification, we will notify DOH Office of Health Care Survey that you have completed the review process and are ready for licensing.
Ambulatory surgery facility licensing regulations do not allow use of the completed project area until the Office of Health Care Survey has been notified by CRS that the project has been completed.
The local building official is responsible for building construction permitting and occupancy.
Final licensing approval may be subject to a site inspection by DOH Office of Health Care Survey to verify compliance with Ambulatory surgery facility licensing regulations.
If you have any questions please feel free to contact Construction Review Services. You can monitor project status and fill out our online survey at www.doh.wa.gov/crs.

PROJECT CLOSE-OUT REQUIREMENTS You must notify the department when construction is complete by completing the following steps:

- ✓ Verify that you have resolved all of the comments on this form and have submitted any revisions
- ✓ Complete the Online Notification of Construction Completed at: **http://static.doh.wa.gov/hsqa/fsl/CRS/pink_card.htm**
- ✓ Email or fax a copy of the approval from the local building department (final permit approval or certificate of occupancy); and
- ✓ Email or fax a floor plan showing the scope of work.
- ✓ Email: fslcrs@doh.wa.gov Fax: 360-236-2901, Attn: Construction Review

Once your construction project is complete, you may contact the DOH Office of Customer Service for help with adjusting or amending your license to add this project. Their telephone number is 360-236-4700.

You can monitor project status at www.doh.wa.gov/crs.

Plan Review Comments:

Comment ID #	Approved	Not Approved	
1	☒		Two complete plans and specifications for the fire alarm system installation or modification shall be submitted for review and approval **prior** to system installation. The department reserves the right to defer plan review and inspections to the local authority having jurisdiction (AHJ). Plans and specifications shall include, but not be limited to, a floor plan; location of all alarm-initiating and alarm-signaling devices; alarm-control and trouble-signaling equipment; annunciation; power connection; battery calculations; conductor type and sizes; voltage drop calculations; name, address, and phone number of the agency receiving off-premises transmission of alarm; and the manufacturer, model numbers, and listing information for all equipment, devices, and materials. **Incomplete plans and specifications will be returned without review**. Plans and specifications may be submitted separately from construction documents during the construction of the project. For small renovation projects in which devices are only to be relocated or very few devices are to be added, provide two plans that shows the relocation of devices which may be submitted for review in lieu of the above requirements. This information can be included on the electrical or architectural plans. Verify with Department staff to determine if the scope of your project meets this criteria. Section 907.1, International Fire Code **Approved 4/26/12 – Based on L/1.01 received with F/A and F/S shown.**
2	☒		Two sets of sprinkler system working plans shall be submitted for review and approval before any equipment is installed or remodeled. The department reserves the right to defer plan review and inspections to the local authority having jurisdiction (AHJ). Deviation from approved plans will require permission. Plans and specifications, including hydraulic calculations, that are incomplete or are not stamped by a Washington State Licensed Fire Sprinkler Contractor, will be returned without review. Plans and specifications may be submitted separately from construction documents during the construction of the project. For small renovation projects in which heads are only to be relocated, a plan that shows the relocation of devices can be submitted for review in lieu of the above requirements. Section 903.1, International Fire Code **Approved 4/26/12 – Based on L/1.01 received with F/A and F/S shown.**
3	☒		Provide a general list of the types of procedures planned to be used for the new Class "A" surgery suite and the levels of anesthesia to be used. WAC 246-330-510 **Approved 4/26/12 – Based on procedure list received.**

4 ☒ Provide clarification on whether the new procedure room is a Class "A" or a treatment room per the 2006 FGI. A surgery suite will bring in all the medical gas and HVAC of a surgery suite and a treatment room has lesser requirements. The drawings and functional program describe both and based on what types of procedures are being performed, will determine what type of space standard will be applied. WAC 246-330-510

Approved 4/26/12 – Based on clarification in comment response that this is a treatment room only.

5 ☒ Provide updated life safety plan showing all rated walls in addition to the information provided on submitted sheet # LS1.01 WAC 246-330-510

Approved 4/26/12 – Based on complete life safety plan received.

6 ☒ Provide scale able drawings per WAC 246-330-510.

Approved 4/26/12 – Based on scale able set received.

7 ☒ Provide air exchange rates in new room per WAC 246-330-510

Approved 4/26/12 – Based on sheet M100 that meets the minimum requirements.

8 ☒ Provide complete electrical plan showing outlet locations types and power sources. WAC 246-330-510

Approved 4/26/12 – Based on sheet E100 received that shows the electrical meeting the minimum requirements.

9 ☒ Provide drawing showing how the new three recovery spaces will be accommodated in room # 162 meeting the clearance and square footage for each per 2006 FGI Chapter 3.7

Approved 4/26/12 – Based on plan changing to two level 2 recovery bays.

Compliance with the comments above provided by the Department of Health, Construction Review Services are necessary for this facility to meet the requirements of the applicable licensing regulations found in the Washington State Administrative Code and associated references. These comments do not relieve the facility from the responsibility to meet the requirements of any other applicable federal, state or local regulations. In the event of conflicts between other jurisdictions and these written comments, the most stringent shall apply.

Exhibit 2

Letter of Intent

Microsurgical Spine Center
OUTPATIENT SPINE SURGERY CENTER

February 3, 2022

Received 02/03/22-KN

Eric Hernandez, Manager
Washington State Department of Health
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

Re: Letter of Intent requesting certificate of need approval to add one procedure room and the specialties of Orthopedics, Interventional Radiology, Cardiology and Podiatry to Neospine Center, LLC DBA Microsurgical Spine Center.

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, Neospine Center, LLC DBA Microsurgical Spine Center submits this Letter of Intent ("LOI") for certificate of need ("CN") approval to add one (1) Procedure Room and the specialties of Orthopedics, Interventional Radiology, Cardiology and Podiatry to its CN-approved ambulatory surgical facility ("ASF"). Microsurgical Spine Center, located at 1519 3rd Street SE, Suite 102, Puyallup WA 98372, is a certificate of need approved ASF (CN #1317), approved on August 22, 2005. It was approved to operate two operating suites for spine and pain management cases.

1. Description of proposed service
   We are requesting CN approval to add one procedure room and the specialties of Orthopedics, Interventional Radiology, Cardiology and Podiatry to Microsurgical Spine Center.
2. Estimated cost of the project
   There are no anticipated capital expenditures.
3. Identification of the service area
   The service area is East Pierce Secondary Hospital Planning Area.

Please submit any notices, correspondence, communications or documents to: Eric Chandler, 615.234.8905 or at echandler@surgerypartners.com

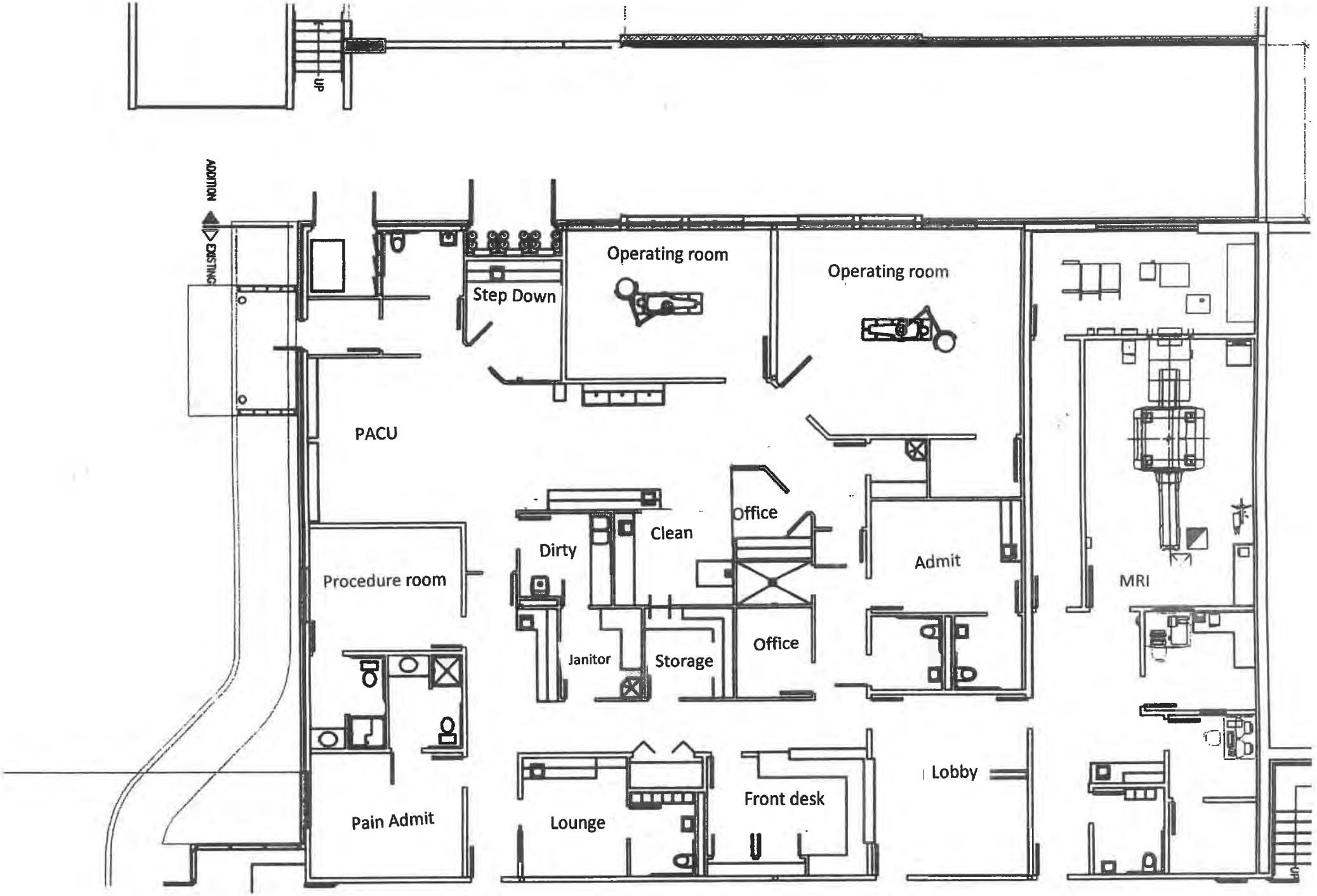
Thank you for your support. Please contact me if you have any questions.

Sincerely,

Eric Chandler, Regional VP Operations
Surgery Partners
310 Seven Springs Way, Suite 500
Brentwood TN 37027

Exhibit 3

Microsurgical Spine Center Floorplan


UP
ADDITION
EXISTING
Step Down
Operating room
Operating room
PACU
Procedure room
Dirty
Clean
Office
Admit
MRI
Janitor
Storage
Office
Pain Admit
Lounge
Front desk
Lobby

4372 SQ FT

Exhibit 4

Planning Area Supply with Sources

Planning Area Supply
Pierce East Planning Area

Facility Name	Exempt/ Approved	Nbr of ORs			Number of surgeries		Number of Minutes		Minutes/Case		Source
		IP	OP	Mixed	Op	Mixed	Op	Mixed	Op	Mixed	
Inpatient											
MultiCare Good Samaritan Hospital	Approved			10		8,864		832,400		93.91	2021 ASC Survey (CY 2020)
ASF - CN Approved											
Meridian Surgery Center	Approved		2		400		20,000		50.00		2021 ASC Survey (CY 2020); Default minutes
Microsurgical Spine Center	Approved		2		2,029		219,778		108.32		2021 ASC Survey (CY 2020)
The Surgery Center at Rainier	Approved		4		1,941		110,444		56.90		2021 ASC Survey (CY 2020)
Puyallup Ambulatory Surgery Center	Approved		3		1,355		78,845		58.19		2021 ASC Survey (CY 2020)
ASF - CN Exempt											
Cascade Eye and Skin Centers	Exempt		4		3,229		65,804		20.38		2021 ASC Survey (CY 2020)
Hillside Surgery Center	Exempt		1		1,098		30,404		27.69		2021 ASC Survey (CY 2020)
Philip C. Kierney MD	Exempt		1		308		36,475		118.43		2021 ASC Survey (CY 2020)
Puyallup Endoscopy Center	Exempt	Excluded (Endoscopy Only)									
Sunrise Endoscopy Center	Exempt	Excluded (Endoscopy Only)									

Exhibit 5

East Pierce County Numeric Need Methodology

Ambulatory Surgery Operating Suite Need Methodology, All Ages
Pierce East Planning Area

Service Area Population, 2025			352,372		Source: Claritas 2021			
Surgeries per, 1,000 residents, 2025 @	58.70		20,684					
a.i.	94,250	minutes per year, mixed use OR						
a.ii.	68,850	minutes per year, outpatient OR						
a.iii.	11	dedicated OP ORs x 68,850 minutes =		757,350	minutes, dedicated OR capacity.		13,968	Outpatient surgeries
a.iv.	10	dedicated mixed use ORs x 94,250 minutes =		942,500	minutes, mixed use OR capacity.		10,036	Mixed use surgeries
b.i.	Projected inpatient surgeries =		9,537	=	895,620	minutes, mixed use surgeries		
	Projectedoutpatient surgeries =		11,147	=	(152,955)	minutes, outpatient surgeries		
b. ii.	Forecast # of OP surgeries - capacity,of dedicated OP ORs							
			11,147	minus	13,968	=	(2,821)	
b.iii.	Average time of mixed use surgeries			=	93.91	minutes		
	Average time of outpatient surgeries			=	54.22	minutes		
b.iv.	mixed use surgeries, 2025 * average minutes/case			=	895,620	minutes		
	remianing OP surgeries (b.ii.) * average minutes/case			=	(152,955)	minutes		
					742,665	minutes		
c.i.	if b.iv. < a.iv., divide by (a.iv. - b.iv.) 94,250 to determine surplus of mixed use ORs							
	942,500							
	(742,665)							
	199,835	divided by	94,250	=	2.12	**Surplus**		
c.ii.	if b.iv. > a.iv., divide (mixed use part of b.iv. - a.iv) by 94,350 to determine shortage of mixed use ORs							
	Not Applicable							
	895,620							
	(942,500)							
	(46,880)	divided by	94,250	=	(0.50)	**Surplus**		
	Divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated OP ORs							
	(152,955)	divided by	68,850	=	(2.22)	**Surplus**		

Exhibit 6

National Health Statistics Reports No. 102

National Health Statistics Reports

Number 102 ■ February 28, 2017

Ambulatory Surgery Data From Hospitals and Ambulatory Surgery Centers: United States, 2010

by Margaret J. Hall, Ph.D., Alexander Schwartzman, Jin Zhang, and Xiang Liu, Division of Health Care Statistics

Abstract

Objectives—This report presents national estimates of surgical and nonsurgical ambulatory procedures performed in hospitals and ambulatory surgery centers (ASCs) in the United States during 2010. Patient characteristics, including age, sex, expected payment source, duration of surgery, and discharge disposition are presented, as well as the number and types of procedures performed in these settings.

Methods—Estimates in this report are based on ambulatory surgery data collected in the 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). NHAMCS has collected outpatient department and emergency department data since 1992 and began gathering ambulatory surgery data from both hospitals and ASCs in 2010. Sample data were weighted to produce annual national estimates.

Results—In 2010, 48.3 million surgical and nonsurgical procedures were performed during 28.6 million ambulatory surgery visits to hospitals and ASCs combined. For both males and females, 39% of procedures were performed on those aged 45–64. For females, about 24% of procedures were performed on those aged 15–44 compared with 18% for males, whereas the percentage of procedures performed on those under 15 was lower for females than for males (4% compared with 9%). About 19% of procedures were performed on those aged 65–74, while about 14% were performed on those aged 75 and over. Private insurance was listed as the principal expected source of payment for 51% of ambulatory surgery visits, Medicare for 31% of visits, and Medicaid for 8% of visits. The most frequently performed procedures included endoscopy of large intestine (4.0 million), endoscopy of small intestine (2.2 million), extraction of lens (2.9 million), insertion of prosthetic lens (2.6 million), and injection of agent into spinal canal (2.9 million). Only 2% of visits with a discharge status were admitted to the hospital as an inpatient.

Keywords: outpatient surgery • procedures • ICD–9–CM • National Hospital Ambulatory Medical Care Survey (NHAMCS)

Introduction

This report presents nationally representative estimates of ambulatory surgery performed in hospitals and ambulatory surgery centers (ASCs) gathered by the 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). Ambulatory surgery, also called outpatient surgery, refers to surgical and nonsurgical procedures that are nonemergency, scheduled in advance, and generally do not result in an overnight hospital stay.

Ambulatory surgery has increased in the United States since the early 1980s (1,2). Two factors that contributed to this increase were medical and technological advancements, including improvements in anesthesia and in analgesics for the relief of pain, and the development and expansion of minimally invasive and noninvasive procedures (such as laser surgery, laparoscopy, and endoscopy) (3–6). Before these advances, almost all surgery was performed in inpatient settings. Any outpatient surgery was likely to have been minor, performed in physicians' offices, and paid for by Medicare and insurers as part of the physician's office visit reimbursement.

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National Center for Health Statistics

The above advances and concerns about rising health care costs led to changes in the Medicare program in the early 1980s that encouraged growth in ambulatory surgery. Medicare expanded coverage to include surgery performed in ASCs (both hospital-based and freestanding). In addition, a prospective payment system for hospitals based on diagnosis-related groups was adopted, and that created strong financial incentives for hospitals to shift some surgery out of the hospital (1–5). Ambulatory surgery proved to be popular among both physicians and patients (3,4,7,8), and the number of Medicare-certified ASCs increased steadily, from 239 in 1983 to 5,316 in 2010 (9,10).

This report covers ambulatory surgery performed in hospitals and ASCs that are independent of hospitals. Ambulatory surgery procedures performed in physicians' offices and independent screening or diagnostic centers were not included in this report.

Methods

Data source and sampling design

Data for this analysis are from the ambulatory surgery component of the 2010 NHAMCS, a nationally representative survey of hospitals and ASCs conducted by the National Center for Health Statistics (NCHS). This survey has provided data on ambulatory medical care services provided in hospital emergency and outpatient departments since 1992. From 2010 through 2012, NHAMCS gathered data on ambulatory surgery procedures in both hospitals and ASCs. In 2013, data collection in ASCs was suspended so a new sampling frame could be developed. Previously, during 1994–1996 and in 2006, the National Survey of Ambulatory Surgery (NSAS) gathered data from hospital-based ASCs (HBASCs) and from facilities independent of hospitals [then called freestanding ASCs (FSASCs)] (2). The terms HBASC and FSASC are no longer in use because Medicare, and other insurers following Medicare's lead, changed the name and nature of the reimbursement categories for these services. Ambulatory surgery performed in hospitals is now called hospital outpatient department surgery. Facilities independent of hospitals that specialize in ambulatory surgery are now known as ASCs.

Independent samples of hospitals and ASCs were drawn for the NHAMCS ambulatory surgery component. The NHAMCS hospital sample (11) was selected using a multistage probability design, first sampling geographic units and then hospitals. Locations within the hospital where the services of interest were provided, in this case ambulatory surgery, were sampled next. Lastly, patient visits within these locations were sampled.

The hospitals that qualify for inclusion in this survey (the universe) include noninstitutional hospitals (excluding federal, military, and Department of Veterans Affairs hospitals) located in the 50 states and the District of Columbia. Only short-stay hospitals (hospitals with an average length of stay for all patients of fewer than 30 days), those with a general specialty (medical or surgical), and children's general were included in the survey. These hospitals must also have six or more beds staffed for patient use. The 2010 NHAMCS hospital sample frame was constructed from the products of SDI Health's "Healthcare Market Index," which was updated July 15, 2006, and its "Hospital Market Profiling Solution, Second Quarter, 2006" (12). These products were formerly known as the SMG Hospital Market Database.

In 2010, the sample consisted of 488 hospitals, of which 74 were out-of-scope (ineligible) because they went out of business or otherwise failed to meet the criteria for the NHAMCS universe. Of the 414 in-scope (eligible) hospitals, 275 had eligible ambulatory surgery locations. Of these, 227 participated, yielding an unweighted hospital ambulatory surgery response rate of 82.6% and a weighted response rate of 90.9%. All of the 321 ambulatory surgery locations within the 227 participating hospitals were selected for sampling, and 281 of these fully or adequately responded [at least one-half of the number of expected patient record forms (PRFs) were completed]. The resulting hospital ambulatory surgery location sample response rate was 87.5% unweighted, and 86.9% weighted. The overall hospital response rate was 72.2% unweighted and 79.0% weighted. In all, 18,469 PRFs for ambulatory surgery visits were submitted by hospitals.

The ASCs that qualified for inclusion in the 2010 NHAMCS (the universe) only included facilities in the 2006 NSAS sample. This sample was drawn in 2005 from a universe consisting of facilities listed in the 2005 Verispan (later called SDI Health and then IMS Health) Freestanding Outpatient Surgery Center Database (13) or the Centers for Medicare & Medicaid Services' (CMS) Medicare Provider of Services file (14). Using both of these sources resulted in a list of facilities that were regulated or licensed by the states and those certified by CMS for Medicare participation. More details about the 2006 NSAS sample have been published elsewhere (2). Selection of the 2010 ASC sample began with the NSAS 2006 stratified list sample of 472 FSASCs, which had strata defined by four geographic regions and 17 facility specialty groups. Seventy-four facilities were out-of-scope, leaving 398 facilities from which to select the 2010 NHAMCS ASC sample. To the extent possible, the ASC sample was selected from the NHAMCS geographic sampling units. The 17 specialty group strata used in the 2006 NSAS sample were collapsed into 5 strata (ophthalmic, gastrointestinal, multispecialty, general, and other).

All of the in-scope 2006 NSAS sample facilities located within the NHAMCS geographic sampling units were selected, yielding 216 facilities. To achieve the desired 246 facilities, a stratified list sample of 30 facilities was drawn from the remaining in-scope 2006 NSAS sample facilities that were located outside of the NHAMCS geographic sampling units. Strata were defined by the four regions and the five collapsed surgery specialty groups.

There were 149 in-scope (eligible) ASCs and, of this number, 109 responded to the survey for an unweighted response rate of 73.2% and a weighted response rate of 70.2%. In all, 8,492 PRFs were submitted for ASCs.

The overall response rate for hospitals combined with ASCs was 72.2% unweighted and 79.0% weighted.

The combined number of PRFs from both of these settings was 26,961.

Facilities were selected using a multistage probability design, with facilities having varying selection probabilities. Patient visits to ASCs and to locations in the hospital where ambulatory surgery was provided were selected using systematic random sampling procedures.

Within each sampled hospital, a sample of ambulatory surgery visits was selected from all of the ambulatory surgery locations identified by hospital staff. These locations included main or general operating rooms; dedicated ambulatory surgery units; cardiac catheterization laboratories; and rooms for endoscopy, laparoscopy, laser procedures, and pain block. Locations within hospitals dedicated exclusively to abortion, dentistry, podiatry, family planning, birthing, or small procedures were excluded, but these procedures were included if performed at in-scope locations. In ASCs with in-scope specialties, all visits were sampled. Facilities specializing in abortion, dentistry, podiatry, family planning, birthing, or small procedures were excluded, but these procedures were included if performed at in-scope ASCs.

To minimize response burden for hospitals and ASCs, the samples were divided into 16 nationally representative panels, and those panels were randomly ordered for rotation over reporting periods of 4 weeks each. Within the reporting periods, patient visits were systematically selected. The visit lists could be sign-in sheets or appointment lists. The total targeted number of ambulatory surgery visit forms to be completed in each hospital and in each ASC was 100. In facilities or hospitals with volumes higher than these desired figures, visits were sampled by a systematic procedure that selects every *n*th visit after a random start. Visit sampling rates were determined from the expected number of patients to be seen during the reporting period and the desired number of completed PRFs.

Data collection

Medical record abstraction was performed by facility staff or U.S. Census Bureau personnel acting on behalf of NCHS. A PRF for each sampled visit was completed. A visit is defined as a direct personal exchange between a physician or a staff member operating under a physician's direction, for the purpose of seeking ambulatory surgery. Visits solely for administrative purposes and visits in which no medical care was provided are out-of-scope.

The PRF contains items relating to the personal characteristics of the patients, such as age, sex, race and ethnicity, and administrative items, such as the date of the procedure, expected source(s) of payment, and discharge disposition. Medical information collected includes provider of anesthesia and type of anesthesia, length of time in both the operating room and in surgery, symptoms present during or after the procedure, and up to five diagnoses and seven procedures, which were coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) (15). Information on up to 12 new or continuing prescription and over-the-counter drugs ordered, supplied, or administered during the visit or at discharge was also collected, and these drugs were coded using Multum Lexicon (16), a proprietary drug classification system used by NCHS.

Limitations of NHAMCS Ambulatory Surgery Data

Limited resources did not permit updating the ASC frame for the 2010 NHAMCS, so the NSAS 2006 sample, based on ASCs in existence in 2005, was used. Based on annual data on the number of Medicare-certified ASCs from CMS, the increase in the number of these facilities was taken into account in the calculation of NHAMCS ASC survey weights. The visit total related to the increase in the number of ASCs was also accounted for in the weights, but any possible change in the number of visits per ASC was not accounted for because no data were available on the number of visits to ASCs over time. Final weighting is described in more detail elsewhere (11).

Based on the assumption that the characteristics of ambulatory surgery visits probably do not vary with facility age, the sample should enable the measurement of 2010 characteristics (if not numbers) of ambulatory visits. To the extent that the ASCs that existed in 2005 were different from those in existence in 2010, these differences would not have been fully captured by the 2010 NHAMCS (17).

Due to limited resources, the sample sizes for hospitals and for ASCs for the NHAMCS ambulatory surgery component were only about one-half of what they were for the 2006 NSAS, so the most recent estimates have larger standard errors. This makes it more difficult for differences to achieve statistical significance.

Until 2008, hospital ambulatory surgery was included under Medicare's HBASC payment category. Beginning in 2008, Medicare discontinued its use of this category and instead began paying for hospital ambulatory surgery as part of hospital outpatient department services. Hospitals also dropped the HBASC designation and, in some hospitals, this change led to a greater dispersion of ambulatory surgery procedures throughout the hospitals, including to various parts of the outpatient departments and locations within medical clinics.

Some hospitals had difficulty identifying all of the locations in the hospital where in-scope procedures were performed, especially in the first year of NHAMCS ambulatory surgery data collection (2009). This same year, after the problems became apparent, U.S. Census Bureau and NCHS staff provided additional information to field staff about how to identify locations in the hospital that were in-scope and out-of-scope for the ambulatory surgery component of NHAMCS. More formal training material on this point was provided in a 2010 training CD that was sent to all field staff. These efforts are believed to have corrected this problem. However, due to these issues, it is likely that some in-scope procedures were undercounted in 2009 and 2010.

A number of changes occurred in the health care system during 2008–2010 that could have affected the amount

of ambulatory surgery care that was provided in settings covered by this report and the amount provided in out-of-scope settings (e.g., physicians' offices). More information about the difficulties of gathering and comparing data on ambulatory surgery from these two time periods and surveys is available (18).

Results

Ambulatory surgery procedure and visit overview

- In 2010, 28.6 million ambulatory surgery visits to hospitals and ASCs occurred (Table 1). During these visits, an estimated 48.3 million surgical and nonsurgical procedures were performed (Table 2).
- An estimated 25.7 million (53%) ambulatory surgery procedures were performed in hospitals and 22.5 million (47%) were performed in ASCs (Table A).
- Private insurance was the expected payment source for 51% of the visits for ambulatory surgery, Medicare payment was expected for 31%, and Medicaid for 8%. Only 4% were self-pay (Figure 1).
- Ninety-five percent of the visits with a specified discharge disposition had a routine discharge, generally to the patient's home. Patients were admitted to the hospital as inpatients during only 2% of these visits (Table B).

Ambulatory surgery procedures, by sex and age

- For both males and females, 39% of procedures were performed on those aged 45–64 (Figure 2).
- For females, about 24% of procedures were performed on those aged 15–44 compared with 18% for males, whereas the percentage of procedures performed on those under 15 was lower for females than for males (4% compared with 9%).
- About 19% of procedures were performed on those aged 65–74, with about 14% performed on those aged 75 and over.

Table A. Ambulatory surgery procedures and visits to hospitals and ambulatory surgery centers: United States, 2010

Ambulatory surgery utilization	Estimate	Standard error
Procedures (millions)	48.3	4.3
in hospitals	25.7	2.6
in ASCs	22.5	3.3
Visits (millions)	28.6	2.4
in hospitals	15.7	1.6
in ASCs	12.9	1.8

NOTE: ASC is ambulatory surgery center.

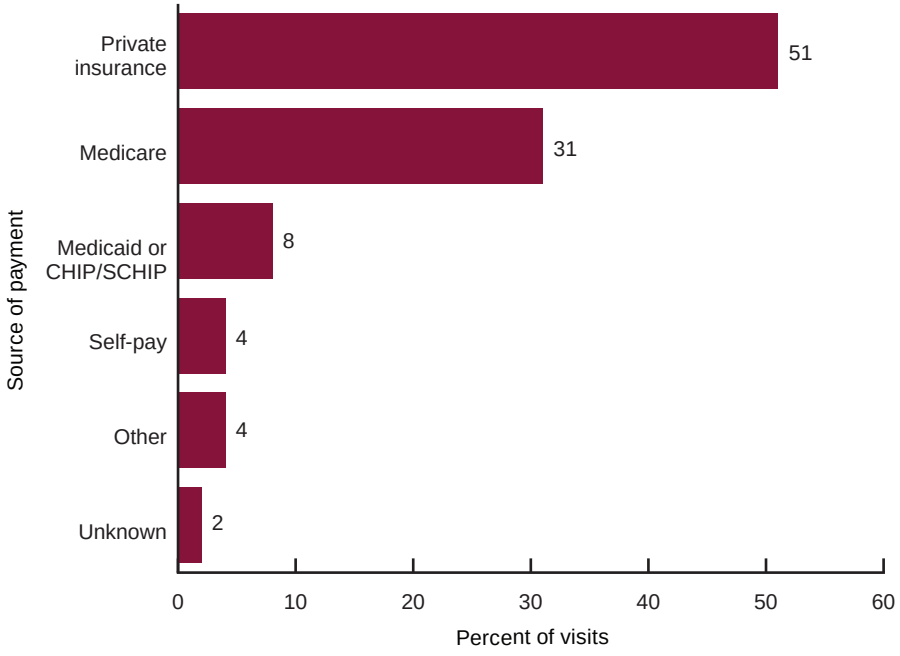
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table B. Percent distribution of ambulatory surgery visits in hospitals and ambulatory surgery centers, by discharge disposition: United States, 2010

Discharge disposition	Percent of visits
Routine discharge[1]	95
Observation status[2]	2
Admission to hospital as inpatient	2
Other[3]	1
Total[4]	100

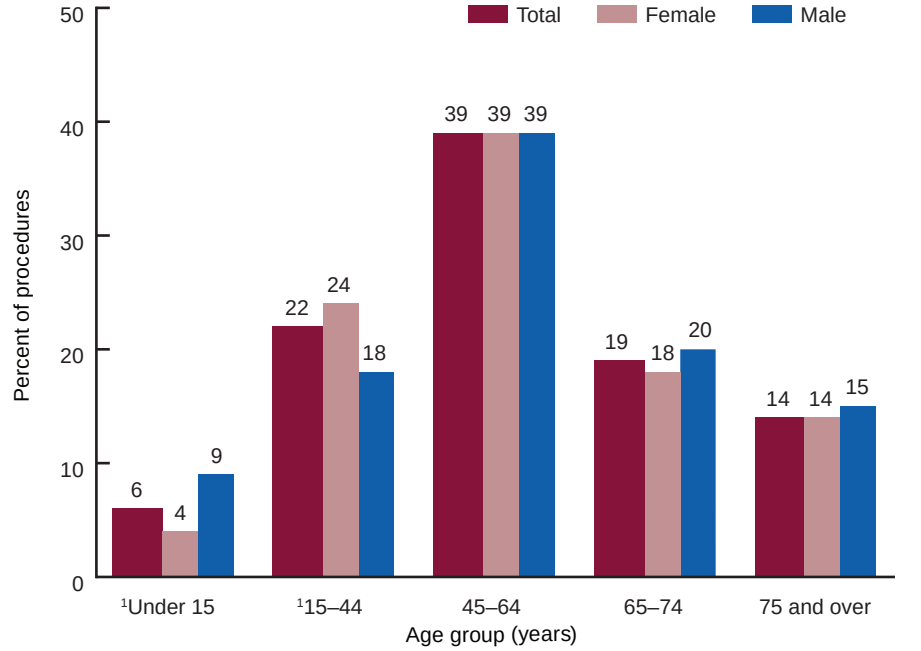
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6 million total visits with an unknown discharge disposition.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.



NOTE: CHIP is Children's Health Insurance Program and SCHIP is State Children's Health Insurance Program.
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Figure 1. Percent distribution of ambulatory surgery visits in hospitals and ambulatory surgery centers, by principal expected source of payment: United States, 2010



[1]Differences between females and males in these age groups are statistically significant.
NOTES: Numbers may not add to totals because of rounding. See Table 2 in this report (NHSR 102, "Ambulatory Surgery Data From Hospitals and Ambulatory Surgery Centers: United States, 2010") for standard errors.
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Figure 2. Percent distribution of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by age and sex: United States, 2010

Types of procedures

Seventy percent of the 48.3 million ambulatory surgery procedures were included in the following clinical categories: operations on the digestive system (10 million or 21%), operations on the eye (7.9 million or 16%), operations on the musculoskeletal system (7.1 million or 15%), operations on the integumentary system (4.3 million or 9%), and operations on the nervous system (4.2 million or 9%) (Table 3). These procedure categories made up 72% of procedures performed on females and 67% of those performed on males. Within the above-mentioned categories, data on procedures performed more than 1 million times are presented below.

Under operations on the digestive system, endoscopy of large intestine—which included colonoscopies—was performed 4.0 million times, and endoscopy of small intestine was performed 2.2 million times. Endoscopic polypectomy of large intestine was performed an estimated 1.1 million times.

Eye operations included extraction of lens, performed 2.9 million times; insertion of lens, performed 2.6 million times for cataracts; and operations on eyelids, performed 1.0 million times.

Musculoskeletal procedures included operations on muscle, tendon, fascia, and bursa (1.3 million).

Operations on the integumentary system included excision or destruction of lesion or tissue of skin and subcutaneous tissue (1.2 million).

Operations on the nervous system included injection of agent into spinal canal (2.9 million), including injections for pain relief.

Duration of surgery

The average time in the operating room for ambulatory surgery was almost 1 hour (57 minutes). On average, about one-half of this time (33 minutes) was spent in surgery. Postoperative care averaged 70 minutes. Time spent in the operating room, surgery, and receiving postoperative care were all significantly longer for ambulatory surgery performed in hospitals compared with ASCs (Table C).

The average surgical times for selected ambulatory surgery procedures are shown in Table D. Endoscopies averaged 14 minutes, while endoscopic polypectomy of the large intestine averaged 21 minutes. For cataract surgery, extraction or insertion of lens (often done together) averaged 10 minutes, and operations on the eyelids averaged 23 minutes. Arthroscopy of the knee averaged 32 minutes.

Discussion

Keeping in mind the limitations that should be taken into account when comparing 2006 NSAS data and 2010 NHAMCS ambulatory surgery data, the 53.3 million ambulatory surgery procedures estimated using 2006 NSAS data were compared with the 48.3 million ambulatory surgery procedures estimated using 2010 NHAMCS data. The difference between these two figures was not statistically significant. A significant decrease of 18% (from 34.7 to 28.6 million) was seen in the number of ambulatory surgery visits during this same time period. It had been expected based upon the limited data that were available and on projections from past trends, that there would have been an increase in the numbers of both ambulatory surgery visits and procedures (9,10,19).

One reason for these findings could be an undercount in NHAMCS in 2010. Another reason that ambulatory surgery visit estimates could have decreased and ambulatory surgery procedures remained steady, could be the deep economic recession that began in 2007. By 2010, when NHAMCS began gathering ambulatory surgery data in both hospitals and ASCs, the economy had not fully recovered. The rate of unemployment and the number of people who did not have health insurance were higher in 2010 compared with 2006, and both of these factors could have affected patients' use of ambulatory surgery (20,21). Even for those who continued to have health insurance, increased out-of-pocket costs (higher deductibles and coinsurance payments) may have contributed to a decrease in the number of visits for ambulatory surgery (22).

An examination of various data sources, including Medicare, the American Hospital Association, and NHAMCS, was undertaken to evaluate if other national

Table C. Distribution of times for surgical visits, by ambulatory surgery facility type: United States, 2010

Calculated time of ambulatory surgical visit	Hospital		Ambulatory surgery center		All facilities	
	Average time (minutes)	Standard error	Average time (minutes)	Standard error	Average time (minutes)	Standard error
Operating room[1]	63	1.9	50	3.7	57	2.2
Surgical[2]	37	1.5	29	3.2	33	1.7
Postoperative care[3]	89	2.9	51	3.8	70	2.6

[1]Calculated by subtracting the time when the patient entered the operating room from the time the patient left the operating room.
[2]Calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.
[3]Calculated by subtracting the time when the patient entered postoperative care from the time the patient left postoperative care.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

data sources reached similar conclusions about trends in ambulatory surgery during 2006–2010 (19). This analysis revealed that the only nationally representative data during this time period were from the 2006 NSAS and the 2010 NHAMCS ambulatory surgery component. Medicare data on the number of certified ASCs over time existed, but only limited Medicare ambulatory surgery utilization and expenditure data were available, and almost all of it was from ASCs only and did not include data on ambulatory surgery in hospitals. Even so, Medicare utilization and expenditure data could not have been used to generalize to the entire population because Medicare only covers those aged 65 and over and people with disabilities. Close to 70% of ambulatory surgery procedures were paid for by sources other than Medicare.

Ambulatory Surgery Data

The 2010 NHAMCS ambulatory surgery data used for this report have been released in a public-use file available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHAMCS. The data base documentation for this file is available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS.

Among the options being explored for future data collection are the use of both claims data and electronic health record data.

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Table D. Average surgical duration for selected procedures: United States, 2010

Selected procedure[1]	ICD–9–CM codes	Average surgical time (minutes)[2]	Standard error
Endoscopy (including colonoscopy)	45.11–45.14, 45.16, 45.21–45.25	14	0.87
Endoscopic polypectomy of large intestine	45.42	21	0.97
Extraction or insertion of lens (cataracts)	13.1–13.7	10	1.20
Operations on eyelids	08	23	3.56
Arthroscopy of knee	80.26	32	2.69

[1]Times were counted only for patients who had each of these selected procedures and no others during their ambulatory surgery visit.
[2]Calculated by subtracting the time surgery began from the time surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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Table 1. Number and percent distribution of ambulatory surgery visits, by age and sex: United States, 2010

Age group (years)	Both sexes		Female		Male	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
			Number (thousands)			
Total	28,588	2424	16,481	1,365	12,108	1,084
Under 15	1,812	302	712	122	1,100	184
15–44	6,426	619	4,201	411	2,225	223
45–64	10,911	1,010	6,256	555	4,659	474
65–74	5,301	446	2,951	242	2,350	213
75 and over	4,139	360	2,365	205	1,774	167
			Percent distribution			
Total	100	...	100	...	100	...
Under 15	6	0.86	4	0.62	9	1.21
15–44	23	0.94	26	1.06	18	0.91
45–64	38	0.89	38	0.84	39	1.16
65–74	19	0.67	18	0.69	19	0.84
75 and over	14	0.69	14	0.72	15	0.83

... Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table 2. Number and percent distribution of ambulatory surgery procedures, by age and sex: United States, 2010

Age group (years)	Both sexes		Female		Male	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
			Number (thousands)			
Total	48,263	4,253	27,595	2,373	20,669	1,932
Under 15	2,916	500	1,118	199	1,798	310
15–44	10,478	1,014	6,708	631	3,770	418
45–64	18,783	1,876	10,789	1,060	7,994	857
65–74	9,153	802	5,053	423	4,100	403
75 and over	6,933	619	3,926	356	3,007	285
			Percent distribution			
Total	100	...	100	...	100	...
Under 15	6	0.82	4	0.57	9	1.20
15–44	22	0.89	24	0.92	18	1.10
45–64	39	1.02	39	1.05	39	1.23
65–74	19	0.79	18	0.78	20	1.00
75 and over	14	0.80	14	0.84	15	0.89

... Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table 3. Number of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Number (thousands)							
All procedures	48,263	27,595	20,669	2,916	10,478	18,783	9,153	6,933
Operations on the nervous system (01–05,17.61)	4,226	2,385	1,841	*	1,002	1,981	631	590
Injection of agent into spinal canal (03.91–03.92)	2,918	1,588	1,330	*	712	1,313	437	453
Release of carpal tunnel (04.43)	444	266	178	–	66	240	80	*58
Operations on the eye (08–16)	7,880	4,622	3,258	93	321	2,122	2,697	2,646
Operations on eyelids (08)	1,021	651	371	*	*	482	276	*
Extraction of lens (13.1–13.6)	2,861	1,705	1,156	*	*	584	1,081	1,173
Insertion of prosthetic lens (pseudophakos) (13.7)	2,553	1,526	1,027	*	*	511	951	1,043
Operations on the ear (18–20)	1,054	442	612	847	72	58	*	*
Myringotomy with insertion of tube (20.01)	754	323	431	699	*	*	*	*
Operations on the nose, mouth, and pharynx (21–29)	2,407	1,117	1,290	903	689	575	166	*75
Incision, excision and destruction of nose and lesion of nose (21.1,21.3–21.4,21.6)	302	152	*	*	126	*	*	*
Turbinectomy (21.6)	190	78	112	*	106	*40	*	*
Repair and plastic operations on the nose (21.8)	393	179	214	*	175	135	*	*
Operations on nasal sinuses (22)	433	192	241	*	164	*	*	*
Tonsillectomy with or without adenoidectomy (28.2–28.3)	399	205	193	289	102	*	*	*
Adenoidectomy without tonsillectomy (28.6)	72	*32	*40	69	*	*	–	–
Operations on the respiratory system (30–34)	282	141	141	*	*40	86	81	*37
Bronchoscopy with or without biopsy (33.21–33.24,33.27,33.71–33.73,33.78–33.79)	106	*55	51	*	*	*30	*	*
Operations on the cardiovascular system (35–39,00.40–00.49,00.50–00.55,00.57,00.61–00.66,17.51–17.52,17.71)	1,072	519	553	*	88	369	356	245
Cardiac catheterization (37.21–37.23)	339	136	203	*	*	126	113	*
Operations on the digestive system (42–54,17.1–17.3,17.63)	10,045	5,418	4,627	*	1,826	4,759	2,044	1,198
Dilation of esophagus (42.92)	172	106	66	*	*	72	36	*38
Endoscopy of small intestine with or without biopsy (45.11–45.14,45.16)	2,172	1,312	861	*	468	936	387	325
Endoscopy of large intestine with or without biopsy (45.21–45.25)	3,987	2,202	1,785	*	474	2,132	916	431
Endoscopic polypectomy of large intestine (45.42)	1,060	485	575	*	*	520	354	158
Laparoscopic cholecystectomy (51.23)	436	325	111	*	196	162	*	*
Hernia repair (53.0–53.9,17.1–17.2)	777	196	581	*	178	355	83	88
Repair of inguinal hernia (53.0–53.1,17.1–17.2)	449	*52	*	*	82	198	54	66
Operations on the urinary system (55–59)	1,349	590	759	*67	311	456	294	220
Cystoscopy with or without biopsy (57.31–57.33)	479	219	260	*	128	155	104	82
Operations on the male genital organs (60–64)	525	–	525	*	98	131	89	*54
Operations on the female genital organs (65–71)	1,766	1,766	–	*	1,093	527	91	*
Hysteroscopy (68.12)	198	198	–	*	83	83	*	*
Dilation and curettage of uterus (69.0)	328	328	–	–	172	116	*	*

See footnotes at end of table.

Table 3. Number of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Number (thousands)							
Operations on the musculoskeletal system (76–84,00.70–00.77,00.80–00.87)	7,076	3,802	3,275	173	2,114	3,456	885	448
Partial excision of bone (76.2–76.3,77.6–77.8)	241	132	109	*	49	141	*29	*
Reduction of fracture (76.7,79.0–79.3)	380	153	227	*52	160	111	*	*
Injection of therapeutic substance into joint or ligament (76.96,81.92)	267	183	84	*	*	127	*48	*
Removal of implanted devices from bone (76.97,78.6)	195	111	83	*	64	87	*	*
Excision and repair of bunion and other toe deformities (77.5)	379	327	*52	*	120	165	*55	*
Arthroscopy of knee (80.26)	692	332	359	*	254	333	80	*
Excision of semilunar cartilage of knee (80.6)	759	374	385	*	196	435	105	*
Replacement or other repair of knee (81.42–81.47,81.54–81.55,00.80–00.84)	571	285	286	*	201	*	*	*
Operations on muscle, tendon, fascia and bursa (82–83)	1,274	636	637	*	319	635	196	88
Operations on the integumentary system (85–86)	4,340	3,405	935	131	1,497	1,767	566	380
Biopsy of breast (85.11–85.12)	*	*	*	–	*	86	*	*
Local excision of lesion of breast (lumpectomy) (85.21)	268	*	*	*	64	151	*40	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue (86.2–86.4)	1,219	734	485	*	323	449	182	171
Miscellaneous diagnostic and therapeutic procedures and new technologies (87–99,00.01–00.03,00.09–00.19,00.21–00.25,00.28–00.29,00.31–00.35,00.39, 00.56, 00.58–00.59, 00.67–00.69,17.62,17.69,17.70,38.24,38.25,00.91–00.94,17.4)	5,892	3,102	2,790	228	1,225	2,358	1,158	923
Operations on the endocrine system, on the hemic and lymphatic system, and obstetrical procedures (06–07,40–41,72–75)	348	285	63	*	104	135	*62	32

* Figure does not meet standards of reliability or precision. An asterisk with a number indicates that the estimate is based on a relatively small number of cases, and while reliable, should be used with caution.
– Quantity zero.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Table 4. Standard errors of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Standard error							
All procedures	4,040	2,250	1,844	492	972	1,806	765	591
Operations on the nervous system (01–05,17.61)	703	398	316	*	240	377	90	92
Injection of agent into spinal canal (03.91–03.92)	557	305	265	*	208	297	74	82
Release of carpal tunnel (04.43)	102	61	45	–	14	61	24	*16
Operations on the eye (08–16)	1,005	569	454	21	80	318	322	392
Operations on eyelids (08)	203	130	100	*	*	106	69	*
Extraction of lens (13.1–13.6)	370	217	159	*	*	77	133	179
Insertion of prosthetic lens (pseudophakos) (13.7)	356	213	147	*	*	76	124	163
Operations on the ear (18–20)	188	107	94	184	12	16	*	*
Myringotomy with insertion of tube (20.01)	161	91	83	152	*	*	*	*
Operations on the nose, mouth, and pharynx (21–29)	312	155	173	194	88	101	35	*17
Incision, excision and destruction of nose and lesion of nose (21.1,21.3–21.4,21.6)	68	*	25	*	22	*	*	*
Turbinectomy (21.6)	31	18	20	*	19	*11	*	*
Repair and plastic operations on the nose (21.8)	78	*	32	*	35	29	*	*
Operations on nasal sinuses (22)	92	48	59	*	35	*	*	*
Tonsillectomy with or without adenoidectomy (28.2–28.3)	65	36	38	53	16	*	*	*
Adenoidectomy without tonsillectomy (28.6)	15	*8	*10	14	*	*	–	*
Operations on the respiratory system (30–34)	38	22	24	*	*11	17	17	*9
Bronchoscopy with or without biopsy (33.21–33.24,33.27,33.71–33.73,33.78–33.79)	18	*12	11	*	*	*8	*	*
Operations on the cardiovascular system (35–39,00.40–00.49,00.50–00.55,00.57,00.61–00.66,17.51–17.52,17.71)	197	98	109	*	18	62	105	53
Cardiac catheterization (37.21–37.23)	88	37	54	*	*	27	*	*
Operations on the digestive system (42–54,17.1–17.3,17.63)	1,148	608	555	*	196	599	278	144
Dilation of esophagus (42.92)	32	23	14	*	*	15	*9	*11
Endoscopy of small intestine with or without biopsy (45.11–45.14,45.16)	290	171	128	*	69	144	60	47
Endoscopy of large intestine with or without biopsy (45.21–45.25)	560	292	280	*	82	319	132	83
Endoscopic polypectomy of large intestine (45.42)	195	93	108	*	*	106	77	35
Laparoscopic cholecystectomy (51.23)	64	48	20	*	27	31	*	*
Hernia repair (53.0–53.9,17.1–17.2)	113	31	89	*	30	63	14	18
Repair of inguinal hernia (53.0–53.1,17.1–17.2)	72	*	61	*	19	37	11	16
Operations on the urinary system (55–59)	184	79	114	*20	61	67	49	33
Cystoscopy with or without biopsy (57.31–57.33)	75	38	44	*	31	25	21	15
Operations on the male genital organs (60–64)	106	–	106	*	16	*	*	*15
Operations on the female genital organs (65–71)	223	223	–	*	145	81	19	*
Hysteroscopy (68.12)	33	33	–	*	17	17	*	*
Dilation and curettage of uterus (69.0)	42	42	–	–	23	21	*	*

See footnotes at end of table.

Table 4. Standard errors of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010—Con.

Procedure category and ICD–9–CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15–44	45–64	65–74	75 and over
	Standard error							
Operations on the musculoskeletal system (76–84,00.70–00.77,00.80–00.87)	1,156	667	501	36	305	685	144	77
Partial excision of bone (76.2–76.3,77.6–77.8)	35	27	18	*	9	26	*7	*
Reduction of fracture (76.7,79.0–79.3)	50	19	36	*10	24	16	*	*
Injection of therapeutic substance into joint or ligament (76.96,81.92)	58	43	20	*	*	32	*14	*
Removal of implanted devices from bone (76.97,78.6)	37	27	15	*	16	22	*	*
Excision and repair of bunion and other toe deformities (77.5)	72	69	*13	*	28	41	*15	*
Arthroscopy of knee (80.26)	168	80	91	*	47	100	22	*
Excision of semilunar cartilage of knee (80.6)	177	79	103	*	39	124	26	*
Replacement or other repair of knee (81.42–81.47,81.54–81.55,00.80–00.84)	141	80	66	*	36	*	*	*
Operations on muscle, tendon, fascia and bursa (82–83)	201	113	96	*	62	102	44	19
Operations on the integumentary system (85–86)	496	423	111	32	217	254	65	51
Biopsy of breast (85.11–85.12)	*	*	*	–	*	21	*	*
Local excision of lesion of breast (lumpectomy) (85.21)	39	39	*	*	15	26	*10	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue (86.2–86.4)	129	103	56	*	58	66	37	48
Miscellaneous diagnostic and therapeutic procedures and new technologies (87–99,00.01–00.03,00.09–00.19,00.21–00.25, 00.28–00.29,00.31–00.35,00.39,00.56, 00.58–00.59, 00.67–00.69,17.62,17.69,17.70,38.24,38.25,00.91–00.94,17.4)	750	376	385	50	186	327	183	123
Operations on the endocrine system, on the hemic and lymphatic system, and obstetrical procedures (06–07,40–41,72–75)	50	45	14	*	21	25	*13	*9

* Figure does not meet standards of reliability or precision. An asterisk with a number indicates that the estimate is based on a relatively small number of cases, and while reliable, should be used with caution.
– Quantity zero.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

Technical Notes

Data processing and medical coding were performed by SRA International, Inc., Durham, N.C. Editing and estimation were completed by the National Center for Health Statistics.

Estimation

Because of the complex multistage design of the National Hospital Ambulatory Medical Care Survey (NHAMCS), the survey data must be inflated or weighted to produce national estimates. The estimation procedure produces essentially unbiased national estimates and has three basic components: (a) inflation by reciprocals of the probabilities of sample selection, (b) adjustment for nonresponse, and (c) population weighting ratio adjustments. These three components of the final weight are described in more detail elsewhere (11).

Because NHAMCS ambulatory surgery data are collected from a sample of visits, persons with multiple visits during the year may be sampled more than once. Therefore, estimates are of the number of visits to, or procedures performed in, hospital ambulatory surgery locations and ASCs, and not the number of persons served by these facilities.

Standard errors

The standard error is primarily a measure of sampling variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. Estimates of the sampling variability for this report were calculated using Taylor approximations in SUDAAN, which take into account the complex sample design of NHAMCS. A description of the software and the approach it uses has been published elsewhere (23). The standard errors of estimates presented in the tables of this report are included, either as part of the table or, in the case of Table 3, in a separate table (Table 4).

Data analyses were performed using the statistical packages SAS, version 9.3 (SAS Institute, Cary, N.C.) and SAS-callable SUDAAN, version 10.0 (RTI International, Research Triangle Park, N.C.).

Testing of significance and rounding

Differences in the estimates were evaluated using a two-tailed *t* test ($p < 0.05$). Terms such as "higher than" and "less than" indicate that differences are statistically significant. Terms such as "similar" or "no difference" indicate that no statistically significant difference exists between the estimates being compared. A lack of comment on the difference between any two estimates does not mean that the difference was tested and found not to be significant.

Estimates of counts in the tables have been rounded to the nearest thousand. Therefore, estimates within tables do not always add to the totals. Rates and percentages were calculated from unrounded figures and may not precisely agree with rates and percentages calculated from rounded data.

Nonsampling errors

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include reporting and processing errors as well as biases due to nonresponse and incomplete response. The magnitude of the nonsampling errors cannot be computed. However, efforts were made to keep these errors to a minimum by building procedures into the operation of the survey. To eliminate ambiguities and encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions.

Quality control procedures and consistency and edit checks reduced errors in data coding and processing. A 5% quality control sample of survey records was independently keyed and coded. Item nonresponse rates were generally low, but levels of nonresponse did vary among different variables. The data shown in this report are based upon items with low nonresponse.

Use of tables

The estimates presented in this report are based on a sample, and therefore may differ from the number that would be obtained if a complete census had been taken. The estimates shown in this report include surgical procedures, such as tonsillectomy; diagnostic procedures, such as ultrasound; and other therapeutic procedures, such as injection or infusion of cancer chemotherapeutic substance.

In 2010, up to seven procedures were coded for each visit. All listed procedures include all occurrences of the procedure coded regardless of the order on the medical record.

The procedure data in this report are presented by chapter of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM). In the Results section, selected chapters with large numbers of procedures are discussed along with specific categories of procedures performed 1 million or more times. The latter categories are included to give some examples of what was included under the chapters.

Table 3 presents data using ICD–9–CM codes for chapters of procedures as well as selected procedures within these chapters. The procedures selected for inclusion in Table 3 were those with relatively large frequencies, or because there was a clinical, epidemiological, or health services interest in them.

Data from the 2010 NHAMCS showed that an estimated 479,000 ambulatory surgery visits ended with an admission to the hospital as an inpatient. The visits made by these patients were included in this report [as they were in the 2006 National Survey of Ambulatory Surgery (NSAS) Report] (2), and the ambulatory surgery procedures they received were included in the estimates for all listed procedures.

Estimates were not presented in this report if they were based on fewer than 30 cases in the sample data or if the relative standard error (RSE) was greater than 30%. In these cases, only an asterisk (*) appears in the tables. The RSE of an estimate is obtained by dividing the standard error by the estimate itself. The result is then expressed as a percentage of the estimate. Estimates based on 30 to 59 cases include an asterisk because, while their RSE is less than 30%, these estimates are based on a relatively small number of cases and should be used with caution.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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DHHS Publication No. 2017–1250 • CS273765

Exhibit 7

Financial Assistance Policy

SURGERY PARTNERS

DEPARTMENT: Accounts Receivable	**POLICY DESCRIPTION:** Charity/Indigent Care Discounts/Financial Hardship
PAGE: 1 of 1	**POLICY NUMBER:** 02-0306
EFFECTIVE DATE: August 1, 2015	**REPLACES POLICY DATED:**
APPROVED BY: Policy Committee	**APPROVED DATE:**

SCOPE: All Company-affiliated facilities including, but not limited to, hospitals, ambulatory surgery centers, imaging and oncology centers, physician practices, and centralized business offices, etc.

PURPOSE: To ensure indigent care or financial hardship forms are appropriately completed and reviewed, and the discounts are recorded timely.

POLICY: Facilities may provide necessary health care at a reduced charge to those who meet the financial need requirements or state mandated requirements. This may be requested by the patient or by the physician scheduling the case at the facility.

1. Indigent care is generally for people who do not have other financial resources available, such as insurance, government programs or regular income. The application for indigent care is to be kept strictly confidential.
2. The facility's decision to provide indigent care does not affect the patient's financial obligation to the physician or other health care providers.
3. A sample Indigent Care Form is included as 02-0306 Exhibit A to this policy. Additionally, there is an example FAQ to provide to the patient's included as 02-0306 Exhibit B to this policy. The Business Office Manager/the ASC Director, the Facility Administrator, and/or the Regional Vice President should review the application for indigent care. Approval or disapproval of the application should take place and the patient notified before the case is scheduled.
4. Written notice including the level of discount allowed should be sent to the patient. Denial notices will include the reason for denial.

If the outstanding balance is not paid within the payment terms, the facility has the right to cancel any indigent care discount and assign unpaid balances to collections.

Financial Verification Form

Patients to fax completed form and proof of income to XXX-XXX-XXXX

Name: _____ Phone: _____

Address: _____ Age: _____

_____ Surgery Date(s): _____

Procedure description: _____

Are You?	**Are You?**	**Are You?**
☐ Married	☐ Homeowner	☐ Retired
☐ Widowed / Single	☐ Renter	☐ Employed
☐ Separated	☐ Boarder	☐ Unemployed
☐ Divorced	☐ Assisted Living	

Number of dependents, including yourself? _____

Monthly Household Income

Earnings from Employment	$
Earnings from Unemployment Compensation	$
Earnings from Workers' Compensation	$
Earnings from Social Security Administration	$
Earnings from Child Support/Alimony	$
Earnings from Pension or Retirement	$
Earnings from Rental Real Estate	$
Earnings from spouse or other household members	$
Earnings from other income not listed above _____	$
Total Monthly Income	**$**
	X 12 months
Total Annual Income	**$**

List Primary Insurance Coverage / Comments below:

_____

- **I certify that everything I have stated on this financial verification form and any attachments are correct.**
- **I certify that I am a US citizen and resident in the state in which the ASC resides.**
- **I understand that I must update this information if any financial condition changes.**
- **The falsification of data may result in the reversal of any adjustments.**
- **This agreement is good for 90 days and is applicable for all dates of service within 90 days of the original date of service.**

_____ _____

Patient or Authorized Party Signature **Date**

Please note: In order to qualify for a Financial Hardship adjustment, you must provide proof of last three (3) months household income (pay stubs, tax returns, social security pay stubs, etc) and any valid insurance information.

Center staff to fax completed form along with proof of income to (XXX) XXX-XXXX

Facility Use Only

Approved _____ Discount % _____

Denied _____ Reason for Denial

_____

Appealed ( ) Yes ( ) No

Approved after Appeal _____

Denied after Appeal _____

Regional Vice President _____
(Signature)

Facility Administrator/ ASC Director _____
(Signature)

Business Manager _____
(Signature)

Exhibit 8

Admission Protocol Policy

SURGERY PARTNERS

SUBJECT: ADMISSION PROTOCOL

1. Patients will be processed in the admitting area where an initial evaluation is made and necessary papers are signed.

2. Patients will be taken to the pre-op/holding area by a staff member.

3. The pre-procedure nurse will familiarize the patient and family (when present) to the area and to the procedures which will occur.

4. After assisting the patient with attire appropriate for the type of procedure to be performed, the patient will be placed on a stretcher or in a chair. Children may be held by their parents until going to the room.

5. A physical assessment including temperature, pulse, respiration, and blood pressure will be noted on the chart. Height and weight, when applicable, will also be noted. Family may assist with any other necessary information.

6. If a discussion with the patient has occurred regarding advance directives, notation regarding that discussion will be made in the medical record. If the patient provides a copy of his/her advance directive, a copy will be placed in the medical record and it will be noted on the record to alert others of its presence.

7. The patient's chart will be checked for appropriate consents, anesthetic history, doctor's orders and any other necessary reports and forms. The Anesthesia provider and/or attending physician will be informed of any lab values not within normal limits and will determine what appropriate action should be taken. It is the attending physician's responsibility to discuss the lab results with the patient.

8. Any pre- procedure preparations, such as pre-procedure medications, IV's and/or preps will be carried out according to the orders.

9. Patients will be taken to the room when the attending physician and the clinical team are ready.

10. The patient will be transported or accompanied to the room.

11. Depending upon the space and physical layout of the Center, families may wait with patients until the patient goes into the room. The number of family members and/or friends may be limited.

Exhibit 9

Patient Consent for the Procedure Policy

SURGERY PARTNERS

SUBJECT: CONSENT FOR THE PROCEDURE

PURPOSE:

It is required that patients and/or legal guardians, patient representative or surrogate be informed of the procedure that will be performed, the expected outcome, and possible complications and/or discomfort associated with the procedure and the physician performing the procedure. The patient and/or legal guardian, patient representative or surrogate should agree to the above and the document may be witnessed by an employee of the Center.

POLICY:

1. The informed consent is a process, not one piece of paper. In most situations, physicians initiate the discussion in the physician's office, explaining the patient's diagnosis and treatment options. During that discussion, the information such as a description of the potential procedure, along with its risks, benefits, and alternative therapies are covered with the patient and, if appropriate, the person who would grant the consent for the patient, such as a patient representative, surrogate, guardian or parent of a minor. The discussion may also include the need during the procedure for anesthesia or sedation and the pain control, if any, that may be required after the procedure.

2. The Center's responsibility is to confirm that the informed consent obtained by physicians outside the Center setting provided the information the patient needed and the patient knows the procedure which will be performed and the patient has the opportunity to ask any questions prior to the procedure. Should the patient have further questions or seem confused about the procedure to be performed, the Center staff will summon the physician scheduled to perform the procedure to discuss the procedure with the patient until the patient's questions have been answered and there is no indication of confusion about the procedure to be performed. The patient will not receive any preoperative medication until this process has been completed.

3. Who consents:

    a. Spouses and other family members do not have the right to consent or refuse consent for most patients when the patient is competent and the procedure is not a medical emergency.

    b. Adults – Any mentally competent adult (a person 18 years of age or older) may consent to the performances of a medical procedure upon his or her own body.

    c. Mentally Incompetent Patients – In non-emergency cases, when it is apparent that a patient is not able to make a rational decision or does not understand the requested consent, special arrangements should be considered. Consent of the guardian or legally responsible person should be obtained. This person is required to provide a copy of the court order authorizing guardianship.

d. Minors – The law prohibits surgical procedures on minors unless a parent or guardian consents (except in emergencies). A parent includes (i) biological parents whose parents rights have not been terminated or otherwise restricted by court order, and (ii) parents resulting from stepparent, second parent, and co-parent adoptions.

e. Emancipated Minors – An emancipated minor may consent to the performance of medical or surgical care upon himself or herself. An emancipated minor is a minor who lives away from his or her parents, and supports himself or herself or is otherwise free of parental custody and control.

f. Married Minor – A minor who is or has been married may consent to the performance of a medical or surgical procedure upon himself or herself.

g. Adopted Minors – If a minor has been legally adopted by a stepparent, second parent, or co-parents, any of the stepparents, second parents, or co-parents may consent to the performance of medical or surgical care upon the minor.

h. Minors Under Guardianship – If a minor is in the care or custody of a legal guardian, the guardian may consent. The consenting individual is required to furnish proof of guardianship. A certified copy of the court order establishing the guardianship should be attached to the signed consent form.

i. Abandonment of Minor – When an unemancipated and otherwise incompetent minor has been abandoned, the Protective Services Division of the State Department of Economic Security customarily intervenes in these cases.

j. Foster Home Children – The facilities of any healthcare institution within the state, public or private, may be employed by the foster parent, agency or division having responsibility for the care of the child. It is important to verify a foster parent's legal standing in every non-emergency case.

k. Spouses – The consent of a spouse to medical or surgical procedures is not a necessity. Spousal consent may be used when the patient is incapacitated. The reasons for the patient's inability to consent should be documented.

l. Durable Power of Attorney and Healthcare Surrogate – The person designated by the patient to hold a durable power of attorney and be the patient's healthcare surrogate may sign if the patient is incapacitated.

4. If a telephone consent is needed, the appropriate identification of the person on the phone must be obtained, such as the full name, relationship to the patient, and date of birth. The physician is required to obtain the telephone consent and it must be witnessed by two registered nurses. The signature and printed names of the witnesses will be noted on the record. Admission forms such as the clinical admission, business admission, and permission to discuss health information must also be covered by a registered nurse and witnessed by another registered nurse.

5. The physician may provide a written consent that was executed in the physician's office setting.

6. The Center will provide the patient the Clinical Admission form. The physician(s) performing the procedure will be named. The procedure without the use of any abbreviations will be written on the document. The form will be signed by the patient, patient representative or surrogate, dated and witnessed. The form will be checked by the pre-procedure and the circulating nurse prior to the patient's transport to the operating or procedure room to assure the form is properly and thoroughly completed.

7. If the patient is unable to read the forms, they must be read to the patient.

8. If the patient cannot write, an X mark must be witnessed by two persons, one of whom is a registered nurse.

9. Medications to provide relief from pain or emotional distress may be given to the extent that the patient's ability to participate in the informed consent process is not impaired and the patient can remain able to listen, understand his/her situation, the need for care, the risks and alternatives, to communicate a decision, and sign the form(s).

10. When a patient cannot give consent due to their physical or mental condition, the (1) next of kin, (2) legal guardian, (3) a person with the durable healthcare power of attorney or (4) the Health Care Surrogate will be contacted to request a consent. This issue may arise when a nursing home resident is the patient. The contact to a person who can give consent may be made in person, by telephone, or by fax.

    a. The person giving consent must have received certain elements of disclosure in order for a consent to be an informed consent. The person must have been informed of the nature of the procedure, reason, benefits, risks, side effects and complications of the procedure, any alternatives to the procedure, and possible consequences if advise is not followed.

    b. The surgery center staff member making the contact will ask the person giving consent if they received this disclosure from the physician.

        i. If the person giving consent has not heard the disclosure information from the physician, have the physician contact the person who can give consent.

        ii. If the person giving consent has heard the disclosure information from the physician, the nurse can proceed to request the consent.

    c. If the person giving consent has immediate access to a fax machine, fax the consent to the person and request an immediate return of the signed consent.

    d. If the person giving consent does not have immediate access to a fax machine, verbal consent should be witnessed by two staff members, each documenting on the consent form that they heard the verbal consent.

11. If the patient refuses to sign the consent, the surgery will be cancelled. Under no circumstances will another person override the wishes of a patient who is competent and who refuses to sign the consent.

Exhibit 10

Patient Rights and Notice of Privacy Practices Policy

SURGERY PARTNERS

SUBJECT: PATIENT RIGHTS AND NOTICE OF PRIVACY PRACTICES

POLICY:

An individual must be informed of the privacy practices and the privacy rights regarding personal health information. The notice must provide a clear explanation of the privacy practices and privacy rights. The individual will be informed through the distribution of a Privacy Notice. The Privacy Notice will be posted and a copy will be offered to the patient.
A copy of the Privacy Notice does not have to be placed in the patient's record. Instead, the edition of the privacy notice should be assigned a form or edition number. The number is placed on the patient's acknowledgment that he / she received the notice or a data field in the registration screen on the computer system will be used to record the privacy notice edition given to the patient.

1. Content of the Privacy Notice

   a. Must be in plain language

   b. Must contain the following statement as a header or otherwise prominently displayed:

      "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

   c. Describe
      i. How protected health information may be used and disclosed with sufficient detail
         (1) A description, including at least one example, of the types or uses and disclosures that the organization is permitted to make for each of the following purposes: treatment, payment, and health care operations.
         (2) A description of each of the other purposes for which the organization is permitted or required to use or disclose protected health information without the individual's written authorization.
         (3) A description of uses and disclosures required by State Laws, if any, that are more stringent than HIPAA regulations.
      ii. The individual's rights and how the individual may exercise these right
         (1) How the individual may complain,
         (2) The right to request restrictions on certain uses and disclosures,
         (3) The right to receive confidential communications,
         (4) The right to inspect and copy protected health information,
         (5) The right to amend protected health information,

(6) The right to receive an accounting of disclosures of protected health information, and

(7) The right to obtain a paper copy of the Privacy Notice.

iii. Include statements on

(1) Legal duties, including

(A) Requirement to maintain the privacy of protected health information; and to abide by the terms of the Privacy Notice currently in effect;

(B) The right to change the terms of its Privacy Notice and to make the new Privacy Notice provisions effective for all protected health information that the organization maintains; and how the organization will provide individuals with a revised notice.

(C) Other uses and disclosures made only with the individual's written authorization and that the individual may revoke such authorization

(2) Any intention of the organization to contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

(3) The right to complain, a brief description of how a compliant can be filed, and that the individual will not be retaliated against for filing a complaint.

(4) The name or title and telephone number of a person or office to contact for further information.

iv. An effective date

2. Providing the Privacy Notice

a. Must be provided on or before the first patient encounter on or after April 14, 2003.

i. Telephone contact with the patient can occur, for example, to obtain pre-procedure information and review pre-procedure instructions prior to the patient signing an acknowledgment of the receipt of the Privacy Notice.

ii. The Privacy Notice can be provided to the patient at registration.

iii. It can be mailed to the patient. Some organizations that mail registration or pre-admission packets to patients may choose to mail the Privacy Notice in the packet.

iv. Established patients of a physician may be mailed the Privacy Notice so the physician can provide health care services over the phone on or after April 14, 2003 but before the patient appears at the physician's office.

b. May be provided via e-mail if the patient agrees to receive the Privacy Notice in this manner. A return receipt or other transmission must be obtained from the individual in response to the receipt of the Notice.

c. To anyone, whether a patient or not, who requests a copy of the organization's privacy notice.

3. Posting of Privacy Notice

a. Must be posted in a clear and prominent location where the patient would reasonably be expected to look, such as the waiting area.

b. Newest version of the Privacy Notice must be the version posted.

c. If the organization has a web site, a copy of the most current version of the Privacy Notice must be displayed on the web site.

4. Acknowledgment of Privacy Notice

a. Direct treatment providers must make a good faith effort to have the patient sign or initial an acknowledgment (a statement) that the patient received the Privacy Notice.

b. The acknowledgment is not asking the patient to acknowledge that he/she agrees with the Privacy Notice or he/she understands the notice. It is only asking the patient to acknowledge that he/she received it.

c. An acknowledgment must be clear that the patient is acknowledging he/she received the Privacy Notice. Although the acknowledgment may be located on another form, the acknowledgment statement should be signed separately from other items that appear on the form.

d. If a signed acknowledgment cannot be obtained, the organization must document the good faith efforts that were made to obtain the acknowledgment and the reason why the acknowledgment could not be obtained. If the acknowledgment cannot be obtained because of an emergency, the organization must make good faith efforts to obtain the signed acknowledgment as soon as practical after the emergency situation has ended.

e. The medical record will contain either an acknowledgment that the patient received the notice or it will contain a "good faith effort" form the employee completes to record the attempt to get the patient to sign an acknowledgment.

5. Revisions to Privacy Notice

a. A revision is required if there are material changes affecting any of the following:
   i. The organization's uses and disclosures of the patient's information
   ii. The individual's rights
   iii. The organization's duties
   iv. Any other change to the organization's privacy practice

6. Retention of Privacy Notice and Acknowledgments

   a. A copy of all versions of the Privacy Notice must be kept for at least six years.

   b. Signed acknowledgments and "Good Faith Effort" forms must also be kept for at least six years.

PROCEDURE:

1. The most current Privacy Notice will be posted in the waiting area where individuals can read the notice.

   a. The regulation does not specify how it is to be posted. Since the Privacy Notice may be several pages in length, a sign may point individuals to the Privacy Notice located in a binder or notebook located in the waiting area and easily assessable to individuals.

2. The most current Privacy Notice will also be on the organization's web site, if the organization has a web site.

3. When a patient signs in for a procedure, the registration staff is responsible for determining whether the patient has visited in the past to see if the patient has a signed acknowledgment on file and the version of the Privacy Notice the patient received.

4. If the patient does not have a signed acknowledgment on file or if the Privacy Notice has been revised since the patient signed an acknowledgment, the registration staff is responsible for giving the patient a copy of the current Privacy Notice and obtaining a signed acknowledgment.

5. The signed acknowledgment will be placed in the patient's chart.

6. When the Privacy Notice is mailed, faxed, or e-mailed, an acknowledgment form should also be sent with instructions for the patient to sign and return the acknowledgment form. The copy of the mailed, faxed, or e-mailed acknowledgment form should be placed in the chart until the signed copy is received or a "Good Faith Effort" Form is completed.

7. If an employee is unable to get a signed acknowledgment, he or she is responsible for completing a "Good Faith Effort" Form and placing a copy of that form in the patient's chart.

8. If the acknowledgment cannot be obtained because of an emergency, employees will obtain the signed acknowledgment as soon as practical after the emergency situation has ended. If the acknowledgment cannot be obtained on that date of service, a "Good Faith Effort" Form will be completed and an attempt will be made to get the acknowledgment signed on the next date of service.

9. If the Privacy Notice is revised because of a material change in the privacy practices, the newest version will be posted in the organization and on the web site.

10. All versions of the Privacy Notice, acknowledgment form and "Good Faith Effort" forms will be retained for at least six years.

Exhibit 11

Non-Discrimination Policy

SURGERY PARTNERS

SUBJECT: NONDISCRIMINATION, NOTICE OF NONDISCRIMINATION, TAGLINES AND FEDERAL NON ENGLISH LANGUAGE REQUIREMENTS

POLICY:

Under the final rule, "Nondiscrimination in Health Programs and Activities", contained in Section 1557 of the Affordable Care Act, issued by the U.S. Department of Health and Human Services, the Center makes provisions to ensure individuals are able to receive services and benefits under any of its programs and activities free from discrimination. Individuals are protected from discrimination under local, state or federal law.

The Center does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, disability and sex, including discrimination based on pregnancy, gender identity and sex stereotyping.

Centers with 15 or more employees will have a compliance officer, known as a Civil Rights Coordinator, appointed by the Governing Body. The role is in conjunction with the duties of the risk manager or risk manager designee.

All employees, providers and associated personnel are responsible to conduct themselves in ways that ensure others are able to receive care in an atmosphere free from discrimination of any kind.

Staff will receive initial and routine training regarding nondiscrimination. This will entail various forms and methods designed to heighten awareness and education on the subject.

PROCEDURE:

The Center will post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services. The Center may elect to utilize the provided resources provided by the Office of Civil Rights (OCR).
http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

The Center will post taglines (short statements) in at least the top 15 non-English languages spoken in the State in which the Center is located or does business. The following resource provides a list of the top 15 non-English languages by State.
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf

Notice of Nondiscrimination

The Center will post a Notice of Nondiscrimination that includes:

a) A statement the Center does not discriminate on the basis of race, color, national origin, sex, age or disability.
b) A statement the Center provides appropriate auxiliary aids and services, free of charge and in a timely manner, to individuals with disabilities.

c) A statement the Center provides language assistance services, free of charge and in a timely manner, to individuals with Limited English Proficiency (LEP).
d) How to obtain these aids and service.
e) Contact information for the associated compliance officer. The designated Civil Rights Coordinator.
f) The availability of the grievance policy and procedure, including how to file a grievance.
g) How to file a discrimination complaint with the Office of Civil Rights.

Significant Publications and Communications

The Center will include a "Statement of Nondiscrimination" (statement instead of the full notice) and taglines in at least the top two non-English languages spoken by individuals with limited English proficiency in the State in which the Center is located or does business, on any small-size significant publications and communications. The English version will be included as well. http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Exhibit 12

Financial Pro Forma

Microsurgical Spine Center
Revenue and Expense Statement

	2022	Jan to Mar 2023	Apr to Dec 2023	Year 1 2024	Year 2 2025	Year 3 2026
ASC Volumes						
OR Cases ("Procedures")	2,176	544	2,218	3,140	3,325	3,374
Gross Revenues	$6,264,359	$1,566,090	$6,384,983	$9,039,851	$9,573,300	$9,712,636
Deductions From Revenue						
Contractual Allowances	($15,440,124)	($3,860,031)	($15,737,431)	($22,281,035)	($23,595,858)	($23,939,287)
Charity care	($136,563)	($34,141)	($139,193)	($197,069)	($208,698)	($211,735)
Bad Debt	($36,424)	($9,106)	($37,125)	($52,562)	($55,663)	($56,474)
Total Deductions From Revenue	($15,613,111)	($3,903,278)	($15,913,749)	($22,530,666)	($23,860,220)	($24,207,497)
Net Revenue	$6,091,373	$1,522,843	$6,208,665	$8,790,220	$9,308,939	$9,444,427
Total Operating Expenses	$4,223,288	$1,057,064	$3,894,302	$5,666,393	$6,004,776	$6,004,776
Net Income from Operations	**$1,868,084**	**$465,779**	**$2,314,363**	**$3,123,827**	**$3,304,162**	**$3,439,651**
Non-Operating Expenses						
Depreciation	$182,941	$49,409	$137,599	$185,640	$186,229	$186,145
Gain/(Loss) on Disposal	$0					
Interest & Other Income	$2,565					
Interest & Other Expense	($16,033)	($4,008)	($12,024)	($16,033)	($16,033)	($16,033)
Total Non-Operating Expenses	**$169,473**	**$45,401**	**$125,575**	**$169,607**	**$170,196**	**$170,112**
Net Income (Loss) (Pre-Tax)	**$1,698,611**	**$420,378**	**$2,188,788**	**$2,954,220**	**$3,133,966**	**$3,269,539**

Revenues and Expenses per Case Forecasts						
Billed Revenues	$ 2,878.84	$ 2,878.84	$ 2,878.84	$ 2,878.84	$ 2,878.84	$ 2,878.84
Deductions From Revenue	$ (7,175.14)	$ (7,175.14)	$ (7,175.14)	$ (7,175.14)	$ (7,175.14)	$ (7,175.14)
Net Revenue	$ 2,799.34	$ 2,799.34	$ 2,799.34	$ 2,799.34	$ 2,799.34	$ 2,799.34
Total Operating Expenses	$ 1,940.85	$ 1,943.13	$ 1,755.85	$ 1,804.53	$ 1,805.73	$ 1,779.83
Total Non-Operating Expenses	$ 77.88	$ 83.46	$ 56.62	$ 54.01	$ 51.18	$ 50.42
Total Expenses	$ 2,018.73	$ 2,026.59	$ 1,812.47	$ 1,858.54	$ 1,856.91	$ 1,830.25
Net Income (Loss)	$ 858.49	$ 856.21	$ 1,043.49	$ 994.82	$ 993.61	$ 1,019.52

Revenues and Expenses per OR Minute Forecasts						
Billed Revenues	$ 96.70	$ 96.70	$ 63.86	$ 60.56	$ 57.83	$ 57.84
Deductions From Revenue	$ (241.02)	$ (241.02)	$ (159.17)	$ (150.95)	$ (144.14)	$ (144.16)
Net Revenue	$ 94.03	$ 94.03	$ 62.10	$ 58.89	$ 56.24	$ 56.24
Total Operating Expenses	$ 65.20	$ 65.27	$ 38.95	$ 37.96	$ 36.28	$ 35.76
Total Non-Operating Expenses	$ 2.62	$ 2.80	$ 1.26	$ 1.14	$ 1.03	$ 1.01
Total Expenses	$ 67.81	$ 68.08	$ 40.21	$ 39.10	$ 37.30	$ 36.77
Net Income (Loss)	$ 28.84	$ 28.76	$ 23.15	$ 20.93	$ 19.96	$ 20.48

Footnotes:

1. NeoSpine 2021 minutes per case used to estimate total minutes.
2. Need for OR suites is estimated by dividing OR minutes by OR Capacity. The capacity of a single OR equals 68,850 minutes per WAC 246-310-270.

Microsurgical Spine Center
Volume and Revenue Forecast

	--------FORECAST--------					
				Year 1	Year 2	Year 3
	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
ASC Volumes						
Total Cases	*2,176*	*544*	*2,218*	*3,140*	*3,325*	*3,374*
Total Patient Revenue	$21,703,857	$5,425,964	$22,121,776	$31,319,982	$33,168,201	$33,650,952
Contractual Adjustments (%)	*71.14%*	*71.14%*	*71.14%*	*71.14%*	*71.14%*	*71.14%*
Contractual Adjustments ($)	*($15,440,124)*	*($3,860,031)*	*($15,737,431)*	*($22,281,035)*	*($23,595,858)*	*($23,939,287)*
Total Patient Revenue, Less Contractual Adjustments	**$6,263,733**	**$1,565,933**	**$6,384,344**	**$9,038,947**	**$9,572,343**	**$9,711,665**
Payer Mix (% of Revenue Net Contractuals)						
Medicare	31.8%	31.8%	31.8%	31.8%	31.8%	31.8%
Medicaid	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Commercial/HMO	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%
Other Government	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
Other/Misc	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%
Self-Pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Revenue Net Contractuals, By Payer						
Medicare	$1,989,988	$497,497	$2,028,306	$2,871,673	$3,041,133	$3,085,396
Medicaid	$62,637	$15,659	$63,843	$90,389	$95,723	$97,117
Commercial/HMO	$3,343,581	$835,895	$3,407,963	$4,824,990	$5,109,717	$5,184,087
Other Government	$80,802	$20,201	$82,358	$116,602	$123,483	$125,280
Other/Misc	$758,538	$189,635	$773,144	$1,094,616	$1,159,211	$1,176,083
Self-Pay	$28,813	$7,203	$29,368	$41,579	$44,033	$44,674
Total Revenue Net Contractuals	***$ 6,264,359***	***$ 1,566,090***	***$ 6,384,983***	***$ 9,039,851***	***$ 9,573,300***	***$ 9,712,636***
Additional Deductions from Revenue						
Bad Debt	($36,424)	($9,106)	($37,125)	($52,562)	($55,663)	($56,474)
0.17%						
Charity Care	($136,563)	($34,141)	($139,193)	($197,069)	($208,698)	($211,735)
2.18%						
Total Additional Deductions	***$ (172,987)***	***$ (43,247)***	***$ (176,318)***	***$ (249,630)***	***$ (264,361)***	***$ (268,209)***
Total Net Revenues	***$6,091,373***	***$1,522,843***	***$6,208,665***	***$8,790,220***	***$9,308,939***	***$9,444,427***

Microsurgical Spine Center
Deductions from Revenue

				Year 1	Year 2	Year 3
	2022	**Jan to Mar 2023**	**Apr to Dec 2023**	**2024**	**2025**	**2026**
Total Contractual Allowances	$ 15,440,124	$ 3,860,031	$ 15,737,431	$ 22,281,035	$ 23,595,858	$ 23,939,287
Bad Debt	$ 36,424	$ 9,106	$ 37,125	$ 52,562	$ 55,663	$ 56,474
Charity Care	$ 136,563	$ 34,141	$ 139,193	$ 197,069	$ 208,698	$ 211,735
Total Deductions From Revenue	**$ 15,613,111**	**$ 3,903,278**	**$ 15,913,749**	**$ 22,530,666**	**$ 23,860,220**	**$ 24,207,497**

Microsurgical Spine Center
Operating and Non-Operating Expenses

	-------FORECAST-------					
				Year 1	Year 2	Year 3
	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Salaries & Wages	$ 994,157	$ 248,539	$ 745,618	$ 1,157,928	$ 1,205,102	$ 1,205,102
Employee Benefits	$ 222,691	$ 55,673	$ 167,018	$ 259,376	$ 269,943	$ 269,943
Total salaries and benefits	$ 1,216,848	$ 304,212	$ 912,636	$ 1,417,303	$ 1,475,045	$ 1,475,045
Other operating expenses						
Medical Director Fee	$ 75,000	$ 18,750	$ 56,250	$ 75,000	$ 75,000	$ 75,000
Contract Labor	$ 833	$ 208	$ 849	$ 1,202	$ 1,273	$ 1,292
Employee General & Admin	$ 1,023	$ 256	$ 1,042	$ 1,476	$ 1,563	$ 1,585
Seminars & Education	$ 279	$ 70	$ 285	$ 403	$ 427	$ 433
Dues, Fees, & Subscriptions	$ 14,952	$ 3,738	$ 15,240	$ 21,576	$ 22,850	$ 23,182
Travel & Entertainment	$ 20,411	$ 5,103	$ 20,804	$ 29,455	$ 31,193	$ 31,647
Office Supplies	$ 23,067	$ 5,767	$ 23,511	$ 33,286	$ 35,251	$ 35,764
Medical Supplies	$ 1,670,578	$ 417,644	$ 1,702,746	$ 2,410,745	$ 2,553,005	$ 2,590,163
Professional Fees	$ 85,718	$ 21,430	$ 87,369	$ 123,696	$ 130,996	$ 132,902
Medical Related Fees	$ 117,852	$ 29,463	$ 120,121	$ 170,068	$ 180,104	$ 182,725
Rent/Lease Building	$ 165,653	$ 42,656	$ 106,373	$ 143,107	$ 144,634	$ 166,490
Repairs & Maintenance	$ 107,487	$ 26,872	$ 109,557	$ 155,111	$ 164,264	$ 166,655
Utilities	$ 28,157	$ 7,039	$ 28,700	$ 40,633	$ 43,031	$ 43,657
Insurance, Taxes, & Licenses	$ 228,235	$ 57,059	$ 232,630	$ 329,357	$ 348,793	$ 353,869
Other Expenses	$ -	$ -	$ -	$ -	$ -	$ -
Business and Operating Tax	$ 91,371	$ 22,843	$ 93,130	$ 139,634	$ 141,666	$ 141,666
Management Fee	$ 375,824	$ 93,956	$ 383,061	$ 574,341	$ 582,700	$ 582,700
Total Operating Expenses	**$ 4,223,288**	**$ 1,057,064**	**$ 3,894,302**	**$ 5,666,393**	**$ 5,931,793**	**$ 6,004,776**
Non-operating Expenses						
Depreciation	$ 182,941	$ 49,409	$ 137,599	$ 185,640	$ 186,229	$ 186,145
Gain/(Loss) on Disposal	$ -	$ -	$ -	$ -	$ -	$ -
Interest & Other Income	$ 2,565	$ 641	$ 1,924	$ 2,565	$ 2,565	$ 2,565
Interest & Other Expense	$ (16,033)	$ (4,008)	$ (12,024)	$ (16,033)	$ (16,033)	$ (16,033)
Total Non-operating Expenses	**$ 169,473**	**$ 46,042**	**$ 127,499**	**$ 172,172**	**$ 172,761**	**$ 172,677**
Total Expenses	**$ 4,392,762**	**$ 1,103,106**	**$ 4,021,801**	**$ 5,838,565**	**$ 6,104,554**	**$ 6,177,453**

Microsurgical Spine Center
Cash Flow Statement

	2022	Jan to Mar 2023	Apr to Dec 2023	Year 1 2024	Year 2 2025	Year 3 2026
				----------Forecast----------		
Operating Activities						
Net Income (Loss) - Cash Flow	$ 1,698,611	$ 420,378	$ 2,188,788	$ 2,954,220	$ 3,133,966	$ 3,269,539
Depreciation	$ 182,941	$ 49,409	$ 137,599	$ 185,640	$ 186,229	$ 186,145
(Gain) loss - sale or disposal of property and equipment	$ -	$ -	$ -	$ -	$ -	$ -
Provision for bad debts	$ 36,424	$ 9,106	$ 37,125	$ 52,562	$ 55,663	$ 56,474
Accounts Receivable, Net	$ 44,205	$ -	$ (374,825)	$ (176,665)	$ (23,223)	$ -
Inventories	$ (15,531)	$ -	$ 13,492	$ (24,780)	$ (4,979)	$ (1,301)
Prepaids and other current assets	$ (2,490,634)	$ (671,045)	$ (995,000)	$ (495,917)	$ (500,000)	$ 250,000
Accounts payable	$ 110,584	$ 538	$ 89,832	$ 22,744	$ 21,591	$ 7,907
Non-current liabilities	$ (209,088)	$ (139,064)	$ (38,953)	$ (56,528)	$ -	$ -
Current liabilities	$ (185,604)	$ (96,741)	$ 30,475	$ 1,198	$ (56,528)	$ -
Cash provided by (used in) operating activities	**$ (828,091)**	**$ (427,419)**	**$ 1,088,533**	**$ 2,462,473**	**$ 2,812,719**	**$ 3,768,763**
Investing Activities						
Purchases of property and equipment	$ 30,000	$ 7,500	$ 22,500	$ 30,000	$ 30,000	$ 30,000
Cash provided by (used in) investing activities	**$ 30,000**	**$ 7,500**	**$ 22,500**	**$ 30,000**	**$ 30,000**	**$ 30,000**
Financing Activities						
Principal payments on long-term debt	$ 163,757	$ 40,939	$ 122,818	$ 163,757	$ 163,757	$ 163,757
Distributions to noncontrolling interest holders	$ -	$ -	$ -	$ -	$ -	$ -
Distributions to parent						
Proceeds from (purchases of) ownership interests in consolidated facilities	$ -	$ -	$ -	$ -	$ -	$ -
Cash provided by (used in) financing activities	**$ 163,757**	**$ 40,939**	**$ 122,818**	**$ 163,757**	**$ 163,757**	**$ 163,757**
Net Change in Cash and Cash Equivalants	**$ (634,334)**	**$ (378,979)**	**$ 1,233,851**	**$ 2,656,230**	**$ 3,006,477**	**$ 3,962,520**
Cash at beginning of the period	**$ 2,692,440**	**$ 2,058,107**	**$ 1,679,128**	**$ 2,912,979**	**$ 5,569,209**	**$ 5,569,209**
Cash Balance at end of period	**$ 2,058,107**	**$ 1,679,128**	**$ 2,912,979**	**$ 5,569,209**	**$ 8,575,685**	**$ 9,531,729**

Microsurgical Spine Center
Balance Sheet

	----------Forecast----------					
				Year 1	Year 2	Year 3
	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Months	12	3	9	12	12	12
ASSETS						
Current Assets						
Cash and Equivalents	$ 2,058,107	$ 1,679,128	$ 2,912,979	$ 5,569,209	$ 8,575,685	$ 9,531,729
Accounts Receivable (Net)	$ 1,044,060	$ 1,044,060	$ 1,418,885	$ 1,595,550	$ 1,618,773	$ 1,618,773
Other Receivables	$ -	$ -	$ -	$ -	$ -	$ -
Inventories	$ 73,088	$ 73,088	$ 59,596	$ 84,376	$ 89,355	$ 90,656
Prepaid Expenses	$ 14,538	$ 10,583	$ 5,583	$ 1,500	$ 1,500	$ 1,500
Due from Related Party	$ 7,934,376	$ 8,609,376	$ 9,609,376	$ 10,109,376	$ 10,609,376	$ 10,359,376
Total Current Assets	**$ 11,124,168**	**$ 11,416,234**	**$ 14,006,419**	**$ 17,360,011**	**$ 20,894,689**	**$ 21,602,033**
Property & Equipment						
Leasehold Improvements	$ 858,554	$ 858,554	$ 858,554	$ 858,554	$ 858,554	$ 858,554
Furniture, Fixtures, & Equipment	$ 27,253	$ 27,253	$ 27,253	$ 27,253	$ 27,253	$ 27,253
Computers & Software	$ 124,802	$ 124,802	$ 124,802	$ 124,802	$ 124,802	$ 124,802
Medical Equipment	$ 1,582,976	$ 1,590,476	$ 1,612,976	$ 1,642,976	$ 1,672,976	$ 1,672,976
Right of Use	$ 436,731	$ 436,731	$ 436,731	$ 436,731	$ 436,731	$ 436,731
Accumulated Depreciation	$ (2,448,131)	$ (2,497,540)	$ (2,635,139)	$ (2,820,779)	$ (3,007,007)	$ (3,006,923)
Total Property & Equipment	**$ 582,186**	**$ 540,277**	**$ 425,178**	**$ 269,538**	**$ 113,309**	**$ 113,393**
Other Assets						
Right of Use - Operating	$ 261,544	$ 29,478	$ 117,913	$ -	$ -	$ -
Total Assets	**$ 11,967,898**	**$ 11,985,989**	**$ 14,549,509**	**$ 17,629,548**	**$ 21,007,998**	**$ 21,715,426**
LIABILITIES AND OWNER EQUITY						
Current Liabilities						
Accounts Payable	$ 284,983	$ 285,522	$ 375,354	$ 398,098	$ 419,689	$ 427,595
Accrued Payroll	$ 75,000	$ -	$ -	$ -	$ -	$ -
Employer Liabilities	$ 56,736	$ 56,736	$ 56,736	$ 56,736	$ 56,736	$ 56,736
Capital Leases	$ 46,596	$ 12,831	$ 51,322	$ 56,528	$ -	$ -
Interest Payable	$ (16,033)	$ (4,008)	$ (12,024)	$ (16,033)	$ (16,033)	$ (16,033)
Taxes Payable	$ 12,000	$ 12,000	$ 12,000	$ 12,000	$ 12,000	$ 12,000
Other Current Liabilities	$ 151,528	$ 31,674	$ 126,694	$ -	$ -	$ -
Total Current Liabilities	**$ 447,283**	**$ 351,080**	**$ 471,388**	**$ 495,329**	**$ 460,392**	**$ 468,299**
Long Term Liabilities						
Long Term Capital Leases	$ 107,851	$ 95,481	$ 56,528	$ -	$ -	$ -
Other Long Term Liabilities	$ 126,694	$ -	$ -	$ -	$ -	$ -
Total Long Term Liabilities	**$ 234,545**	**$ 95,481**	**$ 56,528**	**$ -**	**$ -**	**$ -**
Shareholders' Equity						
Acquisition Equity	$ 1,344,208	$ 1,344,208	$ 1,344,208	$ 1,344,208	$ 1,344,208	$ 1,344,208
GP Distributions	$ (7,617,204)	$ (7,617,204)	$ (7,617,204)	$ (7,617,204)	$ (7,617,204)	$ (7,617,204)
Physicians Acquisition Equity	$ 12,709	$ 12,709	$ 12,709	$ 12,709	$ 12,709	$ 12,709
LP Distributions-Physicians	$ (6,350,937)	$ (6,350,937)	$ (6,350,937)	$ (6,350,937)	$ (6,350,937)	$ (6,350,937)
Total Additional Capital	$ (12,963)	$ (12,963)	$ (12,963)	$ (12,963)	$ (12,963)	$ (12,963)
Retained Earnings	$ 23,910,257	$ 24,163,614	$ 26,645,780	$ 29,758,406	$ 33,171,793	$ 33,871,314
Total Shareholders' Equity	**$ 11,286,070**	**$ 11,539,428**	**$ 14,021,593**	**$ 17,134,219**	**$ 20,547,606**	**$ 21,247,128**
Total Liabilities and Equity	**$ 11,967,898**	**$ 11,985,989**	**$ 14,549,509**	**$ 17,629,548**	**$ 21,007,998**	**$ 21,715,426**

Microsurgical Spine Center Center
FTE Schedule, Salaries, and Benefits

FTEs (Productive & Non-Productive)

	2022	2023	2024	2025	2026
Facility Administrator	0.56	0.56	0.56	0.56	0.56
Business Office Manager	1.12	1.12	1.12	1.12	1.12
Registered Nurses	4.48	4.48	5.04	5.60	5.60
Scrub Tech	2.24	2.24	2.80	2.80	2.80
X-Ray Tech	1.68	1.68	2.24	2.24	2.24
Sterile Processing Tech	1.12	1.12	1.68	1.68	1.68
Office/Front Desk	1.68	1.68	1.90	1.90	1.90
TOTAL	**12.88**	**12.88**	**15.34**	**15.90**	**15.90**

FTEs (Productive)

	2022	2023	2024	2025	2026
Facility Administrator	0.50	0.50	0.50	0.50	0.50
Business Office Manager	1.00	1.00	1.00	1.00	1.00
Registered Nurses	4.00	4.00	4.50	5.00	5.00
Scrub Tech	2.00	2.00	2.50	2.50	2.50
X-Ray Tech	1.50	1.50	2.00	2.00	2.00
Sterile Processing Tech	1.00	1.00	1.50	1.50	1.50
Office/Front Desk	1.50	1.50	1.70	1.70	1.70
TOTAL	**11.50**	**11.50**	**13.70**	**14.20**	**14.20**

Staffing Assumptions

	Hourly Wage	# of Hours	Benefits %
Facility Administrator	$74.50	2080	22.4%
Business Office Manager	$58.50	2080	22.4%
Registered Nurses	$40.50	2080	22.4%
Scrub Tech	$32.00	2080	22.4%
X-Ray Tech	$32.00	2080	22.4%
Sterile Processing Tech	$28.50	2080	22.4%
Office/Front Desk	$19.00	2080	22.4%
TOTAL			

	2022	2023	2024	2025	2026
Number of Months	12	12	12	12	12

Microsurgical Spine Center Center
FTE Schedule, Salaries, and Benefits

Salaries

	2022	2023	2024	2025	2026
Facility Administrator	$ 86,778	$ 86,778	$ 86,778	$ 86,778	$ 86,778
Business Office Manager	$ 136,282	$ 136,282	$ 136,282	$ 136,282	$ 136,282
Registered Nurses	$ 377,395	$ 377,395	$ 424,570	$ 471,744	$ 471,744
Scrub Tech	$ 149,094	$ 149,094	$ 186,368	$ 186,368	$ 186,368
X-Ray Tech	$ 111,821	$ 111,821	$ 149,094	$ 149,094	$ 149,094
Sterile Processing Tech	$ 66,394	$ 66,394	$ 99,590	$ 99,590	$ 99,590
Office/Front Desk	$ 66,394	$ 66,394	$ 75,246	$ 75,246	$ 75,246
TOTAL	**$ 994,157**	**$ 994,157**	**$ 1,157,928**	**$ 1,205,102**	**$ 1,205,102**

Benefits

	2022	2023	2024	2025	2026
Facility Administrator	$ 19,438	$ 19,438	$ 19,438	$ 19,438	$ 19,438
Business Office Manager	$ 30,527	$ 30,527	$ 30,527	$ 30,527	$ 30,527
Registered Nurses	$ 84,537	$ 84,537	$ 95,104	$ 105,671	$ 105,671
Scrub Tech	$ 33,397	$ 33,397	$ 41,746	$ 41,746	$ 41,746
X-Ray Tech	$ 25,048	$ 25,048	$ 33,397	$ 33,397	$ 33,397
Sterile Processing Tech	$ 14,872	$ 14,872	$ 22,308	$ 22,308	$ 22,308
Office/Front Desk	$ 14,872	$ 14,872	$ 16,855	$ 16,855	$ 16,855
TOTAL	**$ 222,691**	**$ 222,691**	**$ 259,376**	**$ 269,943**	**$ 269,943**

Salaries and Benefits

	2022	2023	2024	2025	2026
Facility Administrator	$ 106,216	$ 106,216	$ 106,216	$ 106,216	$ 106,216
Business Office Manager	$ 166,809	$ 166,809	$ 166,809	$ 166,809	$ 166,809
Registered Nurses	$ 461,932	$ 461,932	$ 519,673	$ 577,415	$ 577,415
Scrub Tech	$ 182,492	$ 182,492	$ 228,114	$ 228,114	$ 228,114
X-Ray Tech	$ 136,869	$ 136,869	$ 182,492	$ 182,492	$ 182,492
Sterile Processing Tech	$ 81,266	$ 81,266	$ 121,899	$ 121,899	$ 121,899
Office/Front Desk	$ 81,266	$ 81,266	$ 92,101	$ 92,101	$ 92,101
TOTAL	**$ 1,216,848**	**$ 1,216,848**	**$ 1,417,303**	**$ 1,475,045**	**$ 1,475,045**

Microsurgical Spine Center
Depreciation Forecast for Annual Equipment Expenditures

	2022	Jan to Mar 2023	Apr to Dec 2023	2024	2025	2026
Equipment Expenditures	$ 30,000	$ 7,500	$ 22,500	$ 30,000	$ 30,000	$ 30,000
Depreciation period (years)	7	7	7	7	7	7
Accumulated Equipment Value, Starting Period	$ 30,000	$ 33,214.29	$ 25,255.10	$ 48,892.13	$ 53,015.41	$ 52,426.37
Annual Depreciation	$ 4,285.71	$ 4,744.90	$ 3,607.87	$ 6,984.59	$ 7,573.63	$ 7,489.48

Exhibit 13

Management Agreement

MANAGEMENT SERVICES AGREEMENT

This Management Services Agreement (the "Agreement") dated October 5, 2018 is between South Sound Neurosurgery, PLLC, a Washington professional limited liability company (the "Company") and SP Practice Management, LLC, a Delaware limited liability company (the "Management Company"). The Company and the Management Company are collectively referred to herein as the "Parties".

RECITALS

A. The Company is engaged in the provision of neuromedicine services, pain management services, related surgical procedures, physical therapy services, and related ancillary services (the "Practice") and operates practice sites (the "Practice Sites") in the State of Washington (the "State");

B. The Company's Physicians and AHPs (the "Providers") hold all licenses and permits necessary to practice medicine in the State; and

C. The Company desires to engage the Management Company to provide and arrange certain management and administrative services.

AGREEMENT

The Parties hereby agree as follows:

ARTICLE I
ENGAGEMENT AND AUTHORITY

1.1 Engagement of the Management Company. On the terms and subject to the conditions contained in this Agreement, the Company hereby engages the Management Company, and the Management Company hereby accepts engagement by the Company, to provide and/or to arrange for the provision of the Management Services described in Article II and Exhibit A to the Company. The Company expressly acknowledges that the Management Company may subcontract with third parties for the performance of certain Management Services.

1.2 Relationship of Parties. In performing their respective duties and obligations under this Agreement, the Parties are independent contractors, and as such they will remain professionally and economically independent of each other. The Parties will not be deemed to be joint venturers, partners or employees of each other.

1.3 Conduct of Medical Practice. The Company will be solely and exclusively in control of the provision of professional medical services, and the Management Company will neither have nor exercise any control or discretion over the methods by which the Providers perform medical services or other professional health care services pursuant to this Agreement. Nothing in this Agreement will be construed to alter or otherwise affect the legal, ethical or professional relationships between and among the Company, the Providers and their patients, nor does anything in this Agreement abrogate any right, privilege or obligation arising from or related to the physician-patient relationship.

1.4 Company Action. Unless otherwise specified in this Agreement, when this Agreement calls for the approval, consent, direction or other action by the Company, the action of the owner, director or other duly authorized official of the Company (the "Company Designee") will constitute the action of the Company. In each instance, the Management Company may assume that all consents and approvals required by the Company's governing documents (the "Company Governing Documents") have been obtained.

ARTICLE II
MANAGEMENT SERVICES

2.1 General Authority.

(a) The Management Company will provide or arrange for the provision of the management services set forth in Exhibit A (the "Management Services") and the Management Company will be the Company's exclusive provider of the Management Services. Notwithstanding the foregoing, the Management Company will not provide any service which would constitute the clinical practice of medicine or the provision of professional medical services, and the Company Designee shall have ultimate decision making authority over all business decisions affecting the Company.

(b) The Company expressly authorizes the Management Company to perform the Management Services in the manner that the Management Company deems reasonably appropriate to meet the day-to-day business needs of the Company, including the performance of specific business office functions at locations other than the Practice Sites. The Company will not prevent the Management Company from providing, or causing to be provided, and the Management Company will provide or cause to be provided, the Management Services in a business-like manner and in compliance with all applicable Laws.

2.2 Billing and Collection.

(a) **Authorization.** The Company hereby authorizes the Management Company to bill and collect for all clinical services rendered by the Company and all other amounts payable to the Company, including all amounts due for all services furnished by or under the supervision of the Clinical Professionals acting for or on behalf of the Company. To facilitate such billing and collection services, the Company, in accordance with applicable Law, hereby grants to the Management Company an exclusive, special power of attorney and appoints the Management Company as an exclusive and lawful agent and attorney-in-fact, and the Management Company hereby accepts such special power of attorney and appointment, for the following purposes:

(i) to submit bills in the Company's name and on the Company's behalf, to patients and Third-Party Payors for payment, reimbursement, or indemnification in respect of services rendered and products provided to the Company's patients by or on behalf of the Company;

(ii) to collect and receive (and to take possession of and endorse), in the Company's name and on the Company's behalf, all receivables (including any negotiable instrument received as payment) for services rendered and products provided to the Company's patients by or on behalf of the Company and all cash received by the Company (including patient co-payments, co-insurance and deductibles and accounts receivable), for deposit into one or more bank accounts in the name of and under the sole ownership of the Company (the "Lockbox Account(s)"); provided that to facilitate the provision of the Management Services hereunder, the Company shall establish and maintain instructions with a financial institution chosen by the Parties to establish and service the Lockbox Accounts and to sweep, on a daily basis, all funds from the Lockbox Account into one or more bank accounts in the name of the Management Company and maintained for the Company's benefit (the "Operating Account(s)");

(iii) to make demand with respect to, settle, compromise and adjust any claims and to coordinate with collections agencies (approved by the Company) to commence any suit, action, or proceeding to collect upon such claims;

(iv) to transfer from the Lockbox Account and Operating Account, to an account designated by the Management Company amounts sufficient to pay all outstanding fees, expense reimbursements and other amounts due to the Management Company pursuant to this Agreement; and

(v) to sign negotiable instruments on the Company's behalf and to make withdrawals from the Lockbox Account and Operating Account to pay the Company's expenses and as otherwise requested by the Company from time to time.

(b) **Bank Documentation.** Upon request of the Management Company, the Company shall execute and deliver to the Management Company for further delivery to any financial institution at which any Lockbox Account or Operating Account is maintained, such additional documents or instruments as may be necessary to evidence the billing and collection authority granted hereunder. During the Term of this Agreement, in order to facilitate the timely and efficient provision of Management Services hereunder, the Company hereby expressly consents to, and shall not take any action to interfere with, the transfer of funds from the Lockbox Account to the Operating Account in accordance with this Section 2.2.

2.3 Practice Sites. The Management Company shall grant the Company a license to utilize all medical and administrative office space necessary for the operation of the Practice Sites pursuant to written sublease agreements (the "Sublease Agreements"). All office space and leasehold improvements utilized by the Company pursuant to this Agreement, shall at all times be and remain the sole and exclusive property of the Management Company and the Company will not have any right, title, and interest therein except as otherwise expressly set forth in this Agreement or the respective Sublease Agreement.

2.4 Services the Management Company May Not Provide. The Management Company will not provide any of the following services to the Company:

(a) assigning or designating clinical providers to treat patients;

(b) assuming responsibility for the care of patients;

(c) serving as a party to whom bills or charges are made payable on the Company's behalf;

(d) engaging in any activity that involves the practice of medicine or that would cause either Party to be subject to licensure under applicable state licensure Laws; or

(e) providing the Company with any inducement or remuneration in exchange for recommending to patients any services provided by the Management Company.

ARTICLE III
GENERAL OBLIGATIONS

3.1 Duty to Cooperate. The Parties acknowledge that mutual cooperation is critical to the performance of their respective duties and obligations under this Agreement. To ensure the communication necessary for mutual cooperation, the Company will permit a representative designated by the Management Company (the "Management Company Representative") to attend and participate (in a non-voting capacity) in all meetings of the Company Designee and all meetings of the Company's equityholders called pursuant to the Company Governing Documents or as otherwise required by applicable Law. The Company will give the Management Company at least five (5) days prior written notice of each such meeting, specifying the date, time and place of the meeting and, if the meeting is a special meeting, the purposes for which the meeting is called.

3.2 Providers. The Company will employ or engage all Providers necessary to conduct, manage and operate in a proper and efficient manner the medical practice conducted at the Practice Sites.

3.3 Business Associate Provisions. The Management Company acknowledges and agrees that: the Company is a "*covered entity*" (as defined in the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and its implementing regulations (45 C.F.R. parts 160-164) (collectively "HIPAA"); and the Management Company is a "*business associate*" (as defined under HIPAA) of the Company when the Management Company provides services to the Company involving "*protected health information*" (as defined under HIPAA) pursuant to this Agreement. The Management Company agrees to perform all services involving protected health information in accordance with the Business Associate Provisions set forth on Exhibit B, which shall serve as the business associate agreement between the Management Company and the Company.

3.4 Quantity, Service and Specialty Requirements; Standards.

(a) The Management Company will periodically review, and make recommendations to the Company regarding, the appropriate number of full and part-time Providers needed by the Company to operate the Practice Sites and treat patients presenting themselves at the Practice Sites (the "Provider Staffing Levels"). Final determinations with respect to the Provider Staffing Levels will, at all times, be the responsibility of the Company.

(b) The Company, in consultation with the Management Company, will be responsible for (i) developing and implementing utilization review and quality assurance guidelines (consistent with guidelines imposed by third parties), (ii) supervising the Providers' submission to the Company of complete, accurate and timely documentation for coding and billing services provided in the Practice, (iii) supervising the taking of corrective action by Providers when Providers do not satisfy guidelines and standards, (iv) credentialing of Providers for the performance of specific procedures, (v) handling impaired Providers, and (vi) overseeing, developing and implementing policies of a purely medical nature (including medical records documentation, clinical communications with patients and the determination of resources to be used for particular patients).

3.5 Employment and Independent Contractor Agreements.

(a) The Company will employ each Physician who is or becomes an employee of the Company pursuant to a written employment agreement substantially in a form prepared by the Management Company and approved by the Company (the "Employment Agreement").

(b) The Company will engage each Physician who is or becomes an independent contractor of the Company pursuant to a written independent contractor agreement substantially in a form prepared by the Management Company and approved by the Company (the "Independent Contractor Agreement").

3.6 Regulatory Matters.

(a) The Providers will be free, in their sole discretion, to exercise their professional judgment on behalf of patients of the Company. Nothing in this Agreement permits the Management Company to affect or influence the professional judgment of any Provider. To the extent that any act or service required or permitted of the Management Company under any provision of this Agreement is deemed to constitute the practice of medicine, the ownership or control of a medical practice or the operation of a clinic, such provision of this Agreement will be void *ab initio* and the performance of such act or service by the Management Company will be deemed waived by the Company.

(b) The Parties agree to cooperate with one another in the fulfillment of their respective obligations under this Agreement, and to comply with (i) all Laws applicable to the Company and all Orders by which the Company is bound or to which the Company is subject (including Laws and Orders relating to the practice of medicine, institutional and professional licensure, pharmacology and dispensing medicines or controlled substances, medical documentation, medical record retention, laboratory services, unprofessional conduct, fee-splitting, referrals, billing and submission of false or fraudulent claims, claims processing, quality, safety, medical necessity, medical privacy and security, patient confidentiality and informed consent and the hiring of employees or acquisition of services or supplies from Persons excluded from participation in government healthcare programs), and (ii) the requirements of any insurance company insuring the Company or the Management Company against liability for injury or accident in or on the premises of the Company or the Practice.

3.7 Books and Records. The Company will retain and provide the Management Company with full and unrestricted access to its books and records (including work papers in the possession of its accountants) with respect to all transactions and the Company's financial condition, assets, liabilities, operations and cash flows, in compliance with all applicable Laws.

ARTICLE IV
COMPENSATION OF THE MANAGEMENT COMPANY AND DEFICIT FUNDING

4.1 Management Fee. Upon the terms and subject to the conditions contained in this Agreement, the Company will pay the Management Company the fee (the "Management Fee") set forth on Exhibit C during the Term in consideration of the Management Services rendered by the Management Company pursuant to this Agreement.

(a) The Parties have determined the Management Fee to be equal to the fair market value of the Management Services, without consideration of the proximity of the Company to any referral sources or the volume or value of any referrals from the Management Company or any of its Affiliates to the Company or from the Company to the Management Company or any of its Affiliates, that is reimbursed under any governmental or private health care payment or insurance program.

(b) Payment of the Management Fee is not conditioned upon a requirement that the Company make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the Management Company or any of its Affiliates or a requirement that the Management Company or any of its Affiliates make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the Company. The Management Fee does not include any discount, rebate, kickback or other reduction in charge.

(c) The Management Fee may not be changed except by written agreement of the Parties.

(d) Remittances to the Company of monies collected will be made net of that portion of the Management Fee then due and owing to the Management Company pursuant to this Agreement.

4.2 Expense Reimbursement. In addition to the Management Fee, the Company will reimburse the Management Company for all reasonable expenses (including travel, meals and lodging expenses) incurred by the Management Company in connection with the provision of the Management Services (the "Management Expenses"); *provided that* such expenses are approved in advance by the Company or are included in the Company's budget for the applicable fiscal year (the "Budget"). Remittances to Company of monies collected will be made net of amounts for which the Management Company is then due to reimbursement from the Company pursuant to this Agreement.

4.3 Failure to Pay. The Company's failure to pay any portion of the Management Fee or reimbursable expenses when due will be a material breach of this Agreement by the Company.

4.4 Deficit Funding Loan Agreement. If the Company does not have sufficient cash to pay for its liabilities or financial obligations that are permitted to be incurred by the Company (including any portion of the Management Fee or reimbursable expenses owed to the Management Company hereunder), by that certain Deficit Funding Loan Agreement of even date herewith (the "Deficit Funding Loan Agreement"), pursuant to which the Management Company may, in its sole discretion, make "Advances" (as defined in the Deficit Funding Loan Agreement) to the Company upon request for the purpose of enabling the Company to pay such liabilities and meet such financial obligations. Such Advances will bear interest as set forth in the Deficit Funding Loan Agreement. The Company will repay such Advances in accordance with the terms of the Deficit Funding Loan Agreement.

4.5 No Recourse or Personal Liability. All amounts due and owing under this Agreement are repayable solely from the assets of the Company, and the Management Company will have no recourse against any equityholder, director, manager, officer or employee of the Company for any such amounts and under no circumstances shall any equityholder, director, manager, officer or employee of the Company have personal liability for any such amounts. For the avoidance of doubt, the Management Company acknowledges and agrees that no equityholder, director, manager, officer or employee of Company shall have personal liability for liability under or sums that may be due and owning pursuant to this Agreement.

4.6 Priority of Payments. Except as agreed from time to time in writing by the Management Company and the Company, the funds payable from the Operating Account will be applied by the Parties in the following order of priority:

(a) Payment of all Company expenses, including without limitation compensation due and payable to employed and contracted Providers;

(b) Payment of all Management Expenses;

(c) Payment of the Management Fee; and

(d) Repayment of amounts advanced to the Company under the Deficit Funding Loan Agreement.

ARTICLE V
TERM AND TERMINATION

5.1 Initial Term; Automatic Renewals. The initial term of this Agreement commences on the date of this Agreement and ends on the fifteenth (15th) anniversary of the date of this Agreement, subject to earlier termination in accordance with Section 5.2 (the "Initial Term" and, together with all Renewal Terms, the "Term"). After the Initial Term, this Agreement will automatically renew for successive five (5) year terms (each a "Renewal Term") unless this Agreement is otherwise terminated in accordance with Section 5.2.

5.2 Termination. This Agreement may be terminated during the Term:

(a) by mutual agreement of the Parties;

(b) by the Company immediately and without notice if (i) the Management Company breaches this Agreement and fails to cure such breach within forty-five (45) days after receiving written notice from the Company describing in reasonable detail the nature of the breach (*provided, however, that*

any such notice from the Company must be executed by the Company Designee to be effective), and such breach is material and has a materially adverse impact on the Company or (ii) the Management Company admits in writing its inability to pay its debts generally when due, applies for or consents to the appointment of a trustee, receiver or liquidator of all or substantially all of its assets, files a petition in voluntary bankruptcy or makes an assignment for the benefit of creditors, or otherwise, voluntarily or involuntarily, takes or suffers action taken under any applicable Law for the benefit of debtors, except for the filing of a petition in involuntary bankruptcy against the Management Company which is dismissed within sixty (60) days thereafter;

(c) by the Management Company immediately and without notice if (i) the Company breaches this Agreement and fails to cure such breach within forty-five (45) days after receiving written notice from the Management Company describing in reasonable detail the nature of the breach, (ii) the Company admits in writing its inability to pay its debts generally when due, applies for or consents to the appointment of a trustee, receiver or liquidator of all or substantially all of its assets, files a petition in voluntary bankruptcy or makes an assignment for the benefit of creditors, or otherwise, voluntarily or involuntarily, takes or suffers action taken under any applicable Law for the benefit of debtors, except for the filing of a petition in involuntary bankruptcy against the Company which is dismissed within sixty (60) days thereafter, or (iii) the Company fails to provide notice to the Management Company of a meeting pursuant to Section 3.1; or

(d) by the Management Company immediately and without notice upon termination of the Deficit Funding Loan Agreement.

5.3 Effect of Expiration or Termination.

(a) The expiration or termination of this Agreement in accordance with Section 5.2 will automatically relieve and release each Party from the executory portion of such Party's obligations under this Agreement; *provided, however, that* all obligations expressly extended beyond the Term by the terms of this Agreement (including this Article V, Article VI, Article VII and Article IX) will survive the expiration or termination of this Agreement.

(b) Promptly (but in any event within ten (10) days) after the expiration or termination of this Agreement, the Company will, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns to, either return to the Company or destroy, delete or erase all written, electronic or other tangible forms of Confidential Information as required under Section 6.2.

(c) Promptly (but in any event within ten (10) days) after the termination or expiration of this Agreement, the Company will pay to the Management Company all Management Fees earned or accrued under this Agreement through the termination date, reimburse all reimbursable expenses incurred before the termination date and repay all Advances funded pursuant to the Deficit Funding Loan Agreement before the termination date thereunder; *provided, however, that* if the Management Company terminates this Agreement pursuant to Section 5.2(c) or the Company terminates this Agreement in breach of this Agreement, then such payment will include the immediate payment of all Management Fees owed to the Management Company for the remainder of the Term.

(d) After the expiration or termination of this Agreement, the Company will retain and provide the Management Company with full and unrestricted access to its books and records (including work papers in the possession of its accountants) with respect to all transactions and the Company's financial condition, assets, liabilities, operations and cash flows during the Term, in compliance with all applicable Laws.

ARTICLE VI
RESTRICTIVE COVENANTS

6.1 Restrictive Covenants. In the course of receiving the Management Services, the Company will have access to the most sensitive and most valuable trade secrets, proprietary information and other confidential information, including management reports, marketing studies, marketing plans, business plans, financial statements, feasibility studies, financial, accounting and statistical data, price and cost information, customer lists, contracts, policies and procedures, internal memoranda, reports and other materials or records of a proprietary or confidential nature (collectively, "Confidential Information") of the Management Company, which constitute valuable business assets of the Management Company and its Affiliates, and the use, application or disclosure of such Confidential Information will cause substantial and possibly irreparable damage to the business and asset value of the Management Company. Therefore, as an inducement for the Management Company to enter into this Agreement and to protect the Confidential Information and other business interests of the Management Company, the Company agrees to be bound by the restrictive covenants contained in this Article VI.

6.2 Disclosure of Confidential Information. After the date of this Agreement, the Company will, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns to, keep confidential and not disclose to any other Person or use for their own benefit or the benefit of any other Person any Confidential Information; *provided, however, that* the obligations under this Section 6.2 will not apply to Confidential Information that (i) is or becomes generally available to the public without breach of the commitments contemplated by this Section 6.2, (ii) was available to the Company or its Affiliates, directors, managers, officers, equityholders, employees or agents on a non-confidential basis before the date of this Agreement or (iii) is required to be disclosed by any Law or Order; *provided that* as soon as practicable before such disclosure, the Company gives the Management Company prompt written notice of such disclosure to enable the Management Company to seek a protective order or otherwise preserve the confidentiality of such information. Promptly after the expiration or termination of this Agreement, the Company will, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns to, (i) either return to the Company or destroy, delete or erase (with written certification of such destruction, deletion or erasure provided to the Management Company by the Company) all written, electronic or other tangible forms of Confidential Information. After the expiration or termination of this Agreement, the Company will not, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns not to, retain any copies, summaries, analyses, compilations, reports, extracts or other materials containing or derived from any Confidential Information. Notwithstanding such return, destruction, deletion or erasure, all oral Confidential Information and the information embodied in all written Confidential Information will continue to be held confidential pursuant to the terms of this Section 6.2.

6.3 Covenant Not to Solicit. Until the fifth (5th) anniversary of the expiration or termination of this Agreement, the Company will not, directly or indirectly:

(a) solicit or induce or attempt to solicit or induce (including by recruiting, interviewing or identifying or targeting as a candidate for recruitment) any director, limited liability company manager, partner, officer, employee, independent contractor or other agent of the Management Company Group (but excluding any employees or equityholders of the Company), who is acting in such capacity or acted in such capacity at any time within the twelve (12)-month period immediately preceding the date of such solicitation, inducement or attempt, (a "Business Associate") to terminate, restrict or hinder such Business Associate's association with any Management Company Group entity or interfere in any way with the relationship between such Business Associate and any Management Company Group; *provided, however, that* after the termination or expiration of this Agreement, general solicitations

published in a journal, newspaper or other publication or posted on an internet job site and not specifically directed toward Business Associates will not constitute a breach of the covenants in this Section 6.3(a);

(b) hire or otherwise retain the services of any Business Associate as equityholder, director, limited liability company manager, partner, officer, employee, independent contractor, licensee, consultant, advisor, agent or in any other capacity, or attempt or assist anyone else to do so; or

(c) interfere with the relationship between any Management Company Group entity and any Person who is a supplier, lessor, lessee, dealer, distributor, licensor, licensee, proprietor, partner, joint venturer, investor, lender, consultant, agent, customer, patient, physician referral source or any other Person having a business relationship with the Management Company Group, or attempt or assist anyone else to do so.

6.4 Non-Disparagement. After the date of this Agreement, the Company will not, directly or indirectly, make any disparaging, derogatory, negative or knowingly false statement about any Company Group entity or any of their respective directors, managers, officers, equityholders, employees, agents (including the Management Company Representative), successors and permitted assigns, or any of their respective businesses, operations, financial condition or prospects.

6.5 Scope of Covenants; Equitable Relief. The Company acknowledges and agrees that (i) the restrictive covenants contained in this Article VI and the territorial, time, activity and other limitations set forth herein are commercially reasonable and do not impose a greater restraint than is necessary to protect the goodwill and legitimate business interests of the Company Group and its businesses, (ii) any breach of the restrictive covenants in this Article VI will cause irreparable injury to the Company Group and that actual damages may be difficult to ascertain and would be inadequate, and (iii) if any breach of any such covenant occurs, then the Management Company will be entitled to injunctive relief in addition to such other legal and equitable remedies that may be available (without limiting the availability of legal or equitable remedies, including injunctive relief, under any other provisions of this Agreement), and (iv) the Company hereby waives the claim or defense that an adequate remedy at law exists for such a breach.

6.6 Equitable Tolling. If the Company breaches any covenant in this Article VI, then the duration of such covenant will be tolled for a period of time equal to the time of such breach and, if the Management Company seeks injunctive relief or other remedies for any such breach, then the duration of such covenant will be tolled for a period of time equal to the pendency of such proceedings (including all appeals).

ARTICLE VII
INDEMNIFICATION

7.1 Indemnification. The Company will indemnify, defend and hold harmless the Management Company, its Affiliates and their respective directors, managers, officers, equityholders, employees, agents (including the Management Company Representative), successors and permitted assigns (collectively, the "Management Company Indemnified Parties") from and against all losses, liabilities, demands, claims, actions or causes of action, regulatory, legislative or judicial proceedings or investigations, assessments, levies, fines, penalties, damages, costs and expenses (including reasonable attorneys', accountants', investigators' and experts' fees and expenses) incurred in connection with the defense or investigation of any claim ("Damages") sustained or incurred by any Management Company Indemnified Party arising from or related to illegal activity, intentional misconduct, negligence or breach of this Agreement by the Company and its directors, managers, officers, equityholders, employees, agents, successors and permitted assigns (collectively, the "Company Indemnified Parties"). Provided further, that the Management Company will indemnify, defend and hold harmless the Company Indemnified Parties from and against all Damages sustained or incurred by the Company Indemnified

Parties arising from or related to illegal activity, intentional misconduct, negligence or breach of this Agreement by the Management Company Indemnified Parties.

7.2 Cooperation and Settlement. The Company and the Management Company will coordinate the defense and settlement of actions in which they are named. To the extent consistent with insurance policies, the Company will not settle an action in which both Parties are named, unless the Management Company agrees to the terms and conditions of the settlement.

7.3 Advancement of Expenses. During the pendency of any suit, action or proceeding with respect to which the Management Company is entitled to indemnification under this Article VII, the Company will pay or reimburse the Management Company for reasonable defense expenses incurred in advance of final disposition of such suit, action or proceeding. If the Management Company ultimately is not entitled to indemnification under this Article VII, then the Management Company will promptly repay to the Company the full amount of all such expenses paid or reimbursed by the Company.

7.4 Other Remedies. The provisions of this Article VII are in addition to, and not in derogation of, any statutory, equitable or common law remedies that the Management Company may have with respect to this Agreement or the subject matter of this Agreement.

7.5 Survival. The Company's indemnification obligations under this Article VII will survive the termination or expiration of this Agreement.

ARTICLE VIII
DEFINITIONS

For purposes of this Agreement, the following terms have the following meanings:

"Advances" is defined in Section 4.4.

"Affiliate" means, with respect to a particular Person, (i) any other Person that, directly or indirectly, controls, is controlled by or is under common control with such Person, and (ii) any of such Person's spouse, siblings (by law or marriage), ancestors and decedents and (iii) any trust for the primary benefit of such Person or any of the foregoing. The term "control" means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of another Person, whether through the ownership of voting securities or equity interests, by contract or otherwise.

"AHP" means an allied health professional, who is a physician assistant, CRNA, nurse practitioner, RN, medical technician, medical assistant or any other clinical personnel who are not Physicians.

"Agreement" is defined in the preamble to this Agreement.

"Budget" is defined in Section 4.2.

"Business Associate" is defined in Section 6.3(a).

"Business Day" means a day that is not a Saturday, Sunday or legal holiday on which banks are authorized or required to be closed in New York, New York.

"Company" is defined in the preamble to this Agreement.

"Company Designee" is defined in Section 1.3.

"Management Company Group" means the Management Company or any of its Affiliates (including the other professional practice groups to which the Management Company provides business, administrative and back office services) other than the Company.

"Company Governing Documents" is defined in Section 1.3.

"Confidential Information" is defined in Section 6.1.

"Damages" is defined in Section 7.1.

"Deficit Funding Loan Agreement" is defined in Section 4.4.

"Employment Agreement" is defined in Section 3.5(a).

"HIPAA" is defined in Section 3.3.

"Independent Contractor Agreement" is defined in Section 3.5(b).

"Initial Term" is defined in Section 5.1.

"Law" means any federal, state, local, municipal, foreign, international, multinational or other constitution, statute, law, rule, regulation, ordinance, code, principle of common law or treaty.

"Lockbox Account(s)" is defined in Section 2.2(a)(ii).

"Management Company" is defined in the preamble to this Agreement.

"Management Company Indemnified Parties" is defined in Section 7.1.

"Management Company Representative" is defined in Section 3.1.

"Management Fee" is defined in Section 4.1.

"Management Services" is defined in Section 2.1(a).

"Operating Account(s)" is defined in Section 2.2(a)(ii).

"Order" means any order, injunction, judgment, decree, ruling, assessment or arbitration award of any governmental authority or arbitrator.

"Parties" is defined in the preamble to this Agreement.

"Person" means any natural individual, corporation, partnership, limited liability company, joint venture, association, bank, trust company, trust or other entity, whether or not legal entities, or any governmental entity, agency or political subdivision.

"Physician" means any natural person who is (i) licensed to practice medicine by the State and any other jurisdiction in which such natural person is deemed to be practicing medicine and (ii) employed or contracted by the Company.

"Practice" is defined in Recital A.

"Practice Sites" is defined in Recital A.

"Providers" is defined in Recital B.

"Provider Staffing Levels" is defined in Section 3.4(a).

"Renewal Term" is defined in Section 5.1.

"State" is defined in Recital A.

"Term" is defined in Section 5.1.

"Third-Party Payors" means all federal health care programs and all other state or local governmental insurance programs and private, non-governmental insurance and managed care programs with which the Company contracts to provide services and products or through which the Company receives reimbursements for services rendered and products provided.

ARTICLE IX
GENERAL PROVISIONS

9.1 Practice of Medicine. Nothing in this Agreement will be interpreted as prohibiting the Company or any Provider from (a) obtaining or maintaining membership on the medical staff of any hospital or health care provider, (b) obtaining or maintaining clinical privileges at any hospital or health care provider, or (c) referring patients to any hospital or health care provider.

9.2 Force Majeure. Neither Party will be liable for any failure or inability to perform, or delay in performing, such Party's obligations under this Agreement if such failure, inability or delay arises from an extraordinary cause beyond the reasonable control of the non-performing Party; *provided that* such Party diligently and in good faith attempts to cure such non-performance as promptly as practicable.

9.3 Notices. All notices and other communications required or permitted under this Agreement (a) must be in writing, (b) will be duly given (i) when delivered personally to the recipient, (ii) one (1) Business Day after being sent to the recipient by nationally recognized overnight private carrier (charges prepaid), or (iii) four (4) Business Days after being mailed to the recipient by certified or registered mail (postage prepaid and return receipt requested), and (c) addressed as follows (as applicable):

If to the Company:
South Sound Neurosurgery, PLLC
1519 Third Street SE, Suite 101
Puyallup, Washington 98372
Attn: President

with a copy (not constituting notice) to:
McDermott Will & Emery LLP
333 Avenue of the Americas, Suite 4500
Miami, Florida 33131
Attn: Danielle Golino, Esq.

If to the Management Company:
SP Practice Management, LLC
310 Seven Springs Way, Suite 500
Brentwood, Tennessee 37027
Attn: General Counsel

with a copy (not constituting notice) to:
McDermott Will & Emery LLP
333 Avenue of the Americas, Suite 4500
Miami, Florida 33131
Attn: Danielle Golino, Esq.

or to such other respective address as each Party may designate by notice given in accordance with this Section 9.3.

9.4 Entire Agreement. This Agreement constitutes the complete agreement and understanding among the Parties regarding the subject matter of this Agreement and supersedes any prior understandings, agreements or representations regarding the subject matter of this Agreement.

9.5 Amendments. The Parties may amend this Agreement only pursuant to a written agreement executed by the Parties.

9.6 Non-Waiver. The Parties' respective rights and remedies under this Agreement are cumulative and not alternative. Neither the failure nor any delay by any Party in exercising any right, power or privilege under this Agreement will operate as a waiver of such right, power or privilege, and no single or partial exercise of any such right, power or privilege will preclude any other or further exercise of such right, power or privilege or the exercise of any other right, power or privilege. No waiver will be effective unless it is in writing and signed by an authorized representative of the waiving Party. No waiver given will be applicable except in the specific instance for which it was given. No notice to or demand on a Party will constitute a waiver of any obligation of such Party or the right of the Party giving such notice or demand to take further action without notice or demand as provided in this Agreement.

9.7 Assignment. The Company may not assign this Agreement or any rights under this Agreement, or delegate any duties under this Agreement, without the Management Company's prior written consent. The Management Company may freely assign this Agreement or any rights under this Agreement, or delegate any duties under this Agreement without the Company's consent.

9.8 Binding Effect; Benefit. This Agreement will inure to the benefit of and bind the Parties and their respective successors and permitted assigns. Nothing in this Agreement, express or implied, may be construed to give any Person other than the Parties and their respective successors and permitted assigns any right, remedy, claim, obligation or liability arising from or related to this Agreement. This Agreement and all of its provisions and conditions are for the sole and exclusive benefit of the Parties and their respective successors and permitted assigns.

9.9 Severability. If any court of competent jurisdiction holds any provision of this Agreement invalid or unenforceable, then the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable.

9.10 References. The headings of Sections are provided for convenience only and will not affect the construction or interpretation of this Agreement. Unless otherwise provided, references to "Section(s)" and "Exhibit(s)" refer to the corresponding section(s) and exhibit(s) of this Agreement. Reference to a statute refers to the statute, any amendments or successor legislation and all rules and regulations promulgated under or implementing the statute, as in effect at the relevant time. Reference to a contract, instrument or other document as of a given date means the contract, instrument or other document as amended, supplemented and modified from time to time through such date.

9.11 Construction. Each Party participated in the negotiation and drafting of this Agreement, assisted by such legal and tax counsel as it desired, and contributed to its revisions. Any ambiguities with respect to any provision of this Agreement will be construed fairly as to all Parties and not in favor of or against any Party. All pronouns and any variation thereof will be construed to refer to such gender and number as the identity of the subject may require. The terms "include" and "including" indicate examples of a predicate word or clause and not a limitation on that word or clause.

9.12 Governing Law. THIS AGREEMENT IS GOVERNED BY THE LAWS OF THE STATE OF WASHINGTON, WITHOUT REGARD TO CONFLICT OF LAWS PRINCIPLES.

9.13 Waiver of Trial by Jury. EACH PARTY HEREBY WAIVES ITS RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY SUIT, ACTION OR PROCEEDING IN CONNECTION WITH ANY MATTER RELATING TO THIS AGREEMENT.

9.14 Counterparts. This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement. Electronic, PDF or facsimile signatures shall constitute fully-enforceable original signatures.

[SIGNATURE PAGE IMMEDIATELY FOLLOWS]

The Parties execute this Agreement as of the date first written above.

THE COMPANY:

South Sound Neurosurgery, PLLC, *a Washington professional limited liability company*

DocuSigned by:
Richard Wohns
4941B3BEC474410...

By: _____
Name: Richard Wohns, M.D., J.D., MBA
Title: Manager

THE MANAGEMENT COMPANY:

SP Practice Management, LLC, *a Delaware limited liability company*

DocuSigned by:
Jennifer Baldock
F6B9778D87B44DB...

By: _____
Name: Jennifer Baldock
Title: Senior VP & General Counsel

EXHIBIT A

MANAGEMENT SERVICES

The Management Company will provide the Management Services in consultation with the Company and at the Company's ultimate direction and discretion. The Management Services include, the following:

1. The Management Company will provide or obtain for the Company the following legal services:

(a) maintenance of a contract database (including for each contract, the name of the contract, the names of the contracting parties, the date of the contract, the date on which the contract expires and the date by which notice of non-renewal must be given);

(b) maintenance of all filings, licenses, permits, notices and other approvals required of the Company under applicable Laws and Orders for the operation of the Practice;

(c) regulatory compliance counseling and oversight of audits, investigations and accreditation processes;

(d) regulatory compliance counseling;

(e) risk management and education;

(f) professional liability and other insurance consulting; and

(g) assistance in responding to demands for payment, allegations of liability and lawsuits.

2. The Management Company will provide or obtain for the Company the following financial services:

(a) general accounting services and maintenance of accounting books;

(b) preparation of monthly, quarterly and annual profit and loss statements, income statements, balance sheets, cash flow statements and other financial statements and analyses;

(c) preparation and processing of client invoices, receivables and payables and the management of receipts;

(d) assistance in the handling and preparation of payroll and payroll tax-related statements and documents (including completion of K-1, W-2, and 1099 forms);

(e) preparation of tax returns and other tax forms for the Company and its medical director(s), as necessary;

(f) processing of expense accounts for the Company's employees (including IRS compliance and related services);

(g) assistance with cash management, bank reconciliation and banking relations (including establishing bank accounts for the sole use and benefit of the Company);

(h) management of the lockbox and deposit functions;

(i) assistance with Budget preparation and services; and

(j) assistance with the administration of Physician and employee benefit and bonus plans, including, without limitation, any profit sharing, pension or 401K plan.

3. The Management Company will provide all administrative personnel reasonably necessary to manage the business and administrative aspects of the Practice and manage all decisions regarding work assignments, scheduling, hiring, firing and disciplining of administrative personnel and determinations of compensation levels and other terms of employment or engagement for all administrative personnel (including determinations of salaries, wages, bonuses, fringe benefits, retirement benefits and health, disability and workers' compensation insurance).

4. The Management Company will provide or obtain for the Company the following human resources services for all personnel:

(a) development, administration and provision of guidance regarding employment policies and procedures;

(b) preparation of employment agreements for non-Provider employees;

(c) background checks and verification;

(d) orientation, fob, database entry and computer access to new employees;

(e) benefit enrollment, administration and process management services;

(f) implementation of workers compensation, equal employment opportunity and other employment-related regulatory requirements; and

(g) coordination of the Company non-Provider personnel.

5. The Management Company will provide or obtain for the Company the following human resources and other services for Providers:

(a) preparation of employment agreements and professional services agreements for Provider employees and independent contractors;

(b) non-clinical coordination of Company Physicians;

(c) assistance with the preparation of new Physician welcome packets;

(d) provision of software education services for Physicians;

(e) maintenance of a Physician database; and

(f) assistance with the development and production of printed communications intended for physicians and patients.

6. The Management Company will provide or obtain for the Company the following information management services, which shall comply with HIPAA privacy and security requirements and Company's HIPAA compliance program, to the extent applicable:

(a) management, maintenance and administration of hardware/software programs, databases and interfaces;

(b) communications resources and internet client connections;

(c) management of information technology service connections, security and connectivity maintenance;

(d) management of outside hardware and software vendor maintenance;

(e) planning and evaluation of new technology;

(f) design, management and integration of web sites;

(g) access to document copying and scanning interfaces;

(h) emergency power and database back-up;

(i) electronic medical records implementation and systems maintenance; and

(j) development and production of printed materials for external marketing purposes.

7. The Management Company will provide or obtain for the Company the following collection services for the Company's accounts ("Client Accounts"), as requested by the Company:

(a) receipt, crediting, depositing and recording payment of invoices for professional services (in cash, check, money order or wire transfer) into the Company's bank account ("Company Account") in accordance with the Management Company's procedures; and

(b) negotiate compromises and settlements of Client Accounts with responsible parties.

8. The Management Company will provide or obtain for the Company the following billing services for the professional services rendered by Providers as requested by the Company:

(a) review of incoming patient care forms to verify the accuracy and completeness of information required for billing purposes;

(b) editing the Company's patient care and charge collection forms as necessary to ensure that the Company collects information necessary to submit claims for professional services;

(c) review, as appropriate, of the coding submitted by Providers for purposes of billing, consistent with applicable Laws, the billing and coding requirements under any contracts between the Company and Third-Party Payors, and/or as required by applicable Third-Party Payor rules and procedures;

(d) preparation and submission to primary and secondary Third-Party Payors and other persons responsible for payment for professional services of the Providers, all claims and invoices for payment for the professional services in the name and under the provider number of the Company engaging the Providers or, if required by the Third-Party Payor, the provider number of the Providers rendering or supervising the professional service;

(e) issuing, with respect to client invoices, monthly invoices before instituting collection procedures, the last of which will incorporate an overdue, pre-collection notice (unless other procedures are required to comply with applicable Law or Third-Party Payor requirements);

(f) reference of any unpaid Client Account to debt collection agencies (which may, but need not be, affiliates of the Management Company), with all necessary supporting documentation, or to a collection attorney (whose services would be provided at an additional cost not included in the Management Fees);

(g) receipt and response to telephone communications and written or electronic correspondence received from clients with reference to invoices;

(h) appeals, corrections and rebilling, in the Management Company's commercially reasonable discretion, of claims for reimbursement filed by the Management Company with any Third-Party Payor that are denied or disputed by such Third-Party Payor;

(i) claim adjudication of disputed claims and resolution of outstanding billing events with Third-Party Payors;

(j) receipt, crediting, depositing and recording payment of invoices and claims for professional services (in cash, check, money order or wire transfer) into the Company Account in accordance with the Management Company's procedures;

(k) reconciliation of all bank deposits and deposit records;

(l) review of accounts receivable of the Company to determine the status of Client Accounts (i.e., current or delinquent), adjustment of account balances for partial payments received during the preceding month and correction of entries when required;

(m) process, issuance, mailing and recording of checks or electronic funds transfers for refunds due on Client Accounts;

(n) maintenance of professional fee schedule entries and creation and maintenance of physician fee schedules in the Management Company's practice management system;

(o) administration of database/payor interfaces, maintenance of Client Account history, interaction with Third-Party Payors for resolution of accounts (including eligibility inquiry, claim submission, status inquiry and appeals);

(p) accounts receivable write off processing; administration of public relations and complaint processes (including account review, appeal and adjustment of Client Account balances);

(q) assistance in the negotiation, on behalf of the Company, of provider agreements with Third-Party Payors and management, on behalf of the Company, of such contracts and relationships;

(r) Provider documentation and coding guidance upon the reasonable request of the Company or in response to changes to applicable Laws, CPT codes or Third-Party Payor rules;

(s) billing, coding and compliance education to newly-hired Providers and conduct of follow-up chart audits and reviews of patient documentation for such Providers consistent with past practice;

(t) conduct Provider chart audits when the Management Company has evidence of recurring non-compliance with applicable coding, documentation or billing Laws or Third-Party Payor rules or when reasonably requested by the Company; and

(u) preparation of provider enrollment, reassignment of benefits and credentialing applications and forms required by governmental and nongovernmental Third-Party Payors.

9. The Management Company will assist the Company in administering its relationships with Providers, including consulting with the Company as to performance standards, reviewing and proposing changes to the Company's standard employment and independent contractor agreements, participating in deliberations as to appropriate Provider Staffing Levels, reviewing staffing and coverage schedules, and, in consultation with the Company, recruiting additional Providers. The Management Company will recommend Provider compensation models and consult with the Company in determining Provider base and incentive compensation.

10. The Management Company, on behalf of the Company, as appropriate, will negotiate all agreements between the Company and third-parties for the provision of professional services that may be necessary or appropriate for the proper and efficient operation of the Practice.

11. The Management Company, on behalf of the Company, will negotiate all agreements between the Company and its clients, to the extent permitted by applicable Law.

12. The Management Company, on behalf of the Company, will negotiate and arrange for all medical and administrative office space in accordance with the terms of the Sublease Agreements and any other office arrangements executed and delivered by the Management Company in its name.

13. The Management Company, on behalf of the Company, will acquire for the benefit of the Company all leasehold improvements and furniture, fixtures and equipment reasonably necessary for the operation of the Practice and repair, maintain and replace such furniture, fixtures and equipment necessitated by the negligence of the Company or any Provider. Title to the equipment and other capital assets acquired by the Management Company for the benefit of the Practice will be in the name of the Management Company.

14. The Management Company will purchase and maintain, on behalf of the Company, all insurance policies reasonable and customary for enterprises engaged in the Practice (including, without limitation, professional liability insurance for the Company and the Physicians, comprehensive general liability insurance, extended coverage insurance and workers' compensation insurance), naming the Company as named insureds and the Management Company as an additional insured under all such policies.

15. The Management Company will supervise the Company's continuous efforts to create, update, maintain and store all files and records relating to the operation of the Practice, including accounting, billing, patient medical records and collection records**.**

16. The Management Company will purchase, for the account of the Company, all support services reasonably required for the day-to-day operation of the Practice (including all utilities, laundry, janitorial and cleaning, security, printing, postage, coping, telephone and internet services) and all supplies that are reasonably necessary for the day-to-day operation of the Practice.

17. The Management Company will make recommendations to the Company regarding the acquisition of medical equipment, instruments, medical fixtures, office equipment, telephones, computers, office furniture and supplies that the Management Company determines to be necessary or appropriate for the proper and efficient operation of the Practice.

18. The Management Company will manage equipment installation, testing and maintenance for the Company.

19. The Management Company will assist the Company in obtaining insurance policies required or appropriate to protect the financial interest of the Company and the Providers, and assist the Company will establishing risk compliance, loss prevention and risk management functions.

20. The Management Company will provide additional legal management, financial management, human resource-related, billing and collection-related and information technology-related services at Company's reasonable request and if necessary or appropriate for the proper management and administration of the Company; *provided, however, that* the Company will compensate the Management Company for the performance of such additional services at pre-determined, mutually-agreed-upon rate reflecting the fair market value of such additional services, all of which the Parties will set forth in a written amendment of this Agreement.

21. The Management Company will assist the Company with purchasing, advertising, sales, bidding, and marketing services for programs established by the Company.

EXHIBIT B

BUSINESS ASSOCIATE PROVISIONS

The Management Company will perform any Management Services involving Protected Health Information received from, or created or received by the Management Company on behalf of the Company ("PHI"), in accordance with the following Business Associate Provisions.

1. General Provisions.

(a) **Effect.** To the extent that the Management Company receives PHI to perform Business Associate activities, the terms and provisions of this Exhibit B supersede all conflicting or inconsistent terms and provisions of this Agreement to the extent of such conflict or inconsistency.

(b) **Capitalized Terms.** Capitalized terms used in this Exhibit B without definition in this Agreement (including this Exhibit B) are defined in the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended by HITECH (defined below) (collectively, "HIPAA").

(c) **No Third Party Beneficiaries.** The Parties have not created and do not intend to create by this Agreement any third party rights (including third party rights for Patients), except with respect to the Collateral Agent under the Credit Agreement (as such terms are defined in the Agreement).

(d) **Amendments.** The Parties acknowledge that the Health Information Technology for Economic and Clinical Health Act and its implementing regulations (collectively, "HITECH") impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements will be implemented by regulations to be adopted by HHS. The HITECH provisions applicable to business associates (as defined under HIPAA) will be collectively referred to as the "HITECH BA Provisions". A HITECH BA Provision is effective on the later of (i) the date of this Agreement and (ii) the date specified in HITECH.

2. Obligations of the Management Company.

(a) **Use and Disclosure of Protected Health Information.** The Management Company may use and disclose PHI as permitted or required under this Agreement (including this Exhibit B) or as Required by Law, but may not otherwise use or disclose any PHI. The Management Company will not, and will assure that its employees, other agents and contractors do not use or disclose PHI in any manner that would constitute a violation of HIPAA if so used or disclosed by the Company. Without limiting the generality of the foregoing, the Management Company is permitted to use or disclose PHI as set forth below:

(i) The Management Company may use PHI internally for the Management Company's proper management and administration or to carry out its legal responsibilities.

(ii) The Management Company may disclose PHI to a third party for the Management Company's proper management and administration, *provided that* the disclosure is Required by Law or the Management Company obtains reasonable assurances from the third party to whom such PHI is to be disclosed that the third party will (A) protect the confidentially of the PHI, (B) only use or further disclose the PHI as Required by Law or for the purpose for which the PHI was disclosed to the third party, and (C) notify the Management Company of any instances of which such third party is aware in which the confidentiality of the PHI has been breached.

(iii) The Management Company may use PHI to provide Data Aggregation services relating to the Health Care Operations of the Company if required or permitted under this Agreement.

(iv) The Management Company may de-identify PHI consistent with applicable HIPAA requirements.

(b) **Safeguards.** The Management Company will use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted or required by this Exhibit B. The Management Company will implement Administrative Safeguards, Physical Safeguards and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Company.

(c) **Minimum Necessary Standard.** To the extent required by the "minimum necessary" requirements of HIPAA, the Management Company will only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure.

(d) **Mitigation.** The Management Company will take reasonable steps to mitigate, to the extent practicable, any harmful effect (that is known to the Management Company) of a use or disclosure of PHI by the Management Company in violation of this Exhibit B.

(e) **Trading Partner Agreement.** The Management Company will not change the definition, Data Condition, or use of a Data Element or Segment in a Standard; add any Data Elements or Segments to the maximum defined Data Set; use any code or Data Elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standard's Implementation Specification(s); or change the meaning or intent of the Standard's Implementation Specification(s).

(f) **Agreements by Third Parties.** The Management Company will obtain and maintain an agreement with each agent or subcontractor that has or will have access to PHI, pursuant to which such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Management Company pursuant to this Agreement with respect to such PHI.

(g) **Reporting of Improper Disclosures of PHI.**

(i) If the Management Company becomes aware of a use or disclosure of PHI in violation of this Agreement by the Management Company or a third party to which the Management Company disclosed PHI, then the Management Company will report the use or disclosure to the Company without unreasonable delay.

(ii) Any actual, successful Security Incident involving PHI of which the Management Company becomes aware must be reported to the Company in writing without unreasonable delay, and

(iii) any attempted, unsuccessful Security Incident involving PHI of which the Management Company becomes aware must be reported to the Company within a reasonable time. If the HIPAA security regulations are amended to remove the requirement to report unsuccessful attempts at unauthorized access, the preceding requirement to report such unsuccessful attempts will no longer apply as of the effective date of the amendment.

(h) The Management Company will, following the discovery of a Breach of Unsecured PHI, notify the Company of the Breach in accordance with 45 C.F.R. § 164.410 without unreasonable delay (and in any event within sixty (60) days after discovery of the Breach).

(i) **Access to Information.** Within fifteen (15) Business Days after receipt of a request from the Company for access to PHI about an Individual contained in any Designated Record Set of the Company maintained by the Management Company, the Management Company will make available to the Company such PHI for so long as the Management Company maintains such information in the Designated Record Set. If the Management Company receives a request for access to PHI directly from an Individual, then the Management Company will forward such request to the Company within 10 Business Days.

(j) **Availability of PHI for Amendment.** Within fifteen (15) Business Days after receipt of a request from the Company for the amendment of an Individual's PHI contained in any Designated Record Set of the Company maintained by the Management Company, the Management Company will provide such information to the Company for amendment and incorporate any such amendments in the PHI (for so long as the Management Company maintain such information in the Designated Record Set) as required by 45 C.F.R. §164.526. If the Management Company receives a request for amendment to PHI directly from an Individual, then the Management Company will forward such request to the Company within 10 Business Days.

(k) **Accounting of Disclosures.** Within fifteen (15) Business Days after receipt of notice from the Company stating the Company has received a request for an accounting of disclosures of PHI (other than disclosures to which an exception to the accounting requirement applies), the Management Company will make available to the Company such information as is in the Management Company's possession and required for the Company to make the accounting required by 45 C.F.R. §164.528.

(l) **Availability of Books and Records.** The Management Company will make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services, Office of Civil Rights (the "Secretary") for purposes of determining the Company's and the Management Company's compliance with HIPAA.

3. Obligations of Company.

(a) **Permissible Requests.** The Company will not request that the Management Company use or disclose PHI in any manner that would not be permissible under HIPAA if done directly by the Company.

(b) **Minimum Necessary Information.** The Company represents that, to the extent the Company provides PHI to the Management Company, such information is the minimum necessary PHI for the accomplishment of the Management Company's purpose.

(c) **Consents/Authorizations.** The Company represents that, to the extent the Company provides PHI to the Management Company, the Company has obtained the consents, authorizations and other forms of legal permission required under HIPAA and other applicable Law, including any necessary authorizations for the use of PHI for Marketing purposes, if applicable.

4. Termination of this Agreement.

(a) **Right to Report.** If termination of this Agreement is not feasible following the Management Company's failure to cure a material breach of this Exhibit B, then the Company may report such breach to the Secretary.

(b) **Return or Destruction of PHI.** Promptly after the expiration or termination of this Agreement, the Management Company will either return to the Company or destroy, delete or erase all PHI then in the Management Company's possession; *provided, however, that* to the extent that the Management Company reasonably determines that the return or destruction of such PHI is not feasible, then the terms and provisions of this Exhibit B will survive the expiration or termination of this Agreement and such PHI may be used or disclosed only for the purposes that prevented the Management Company's return or destruction of such PHI.

EXHIBIT C

MANAGEMENT FEE

1. **Management Fee.** In consideration of the Management Services to be furnished by the Management Company under this Agreement, the Company shall pay the Management Company a monthly fee equal to one percent (1%) of the Company's net revenue for the applicable month (the "Management Fee").

   The Management Fee shall be payable monthly no later than the fifteenth (15th) day of the month following the month for which it is due. The Management Company is expressly authorized to, and shall, disburse from the Company's bank accounts all amounts owed by the Company to the Management Company pursuant to this Agreement.

   The Parties recognize that the Practice may change in size and scope over the term of this Agreement, which may cause the Management Fee, as adjusted, to no longer reflect the fair market value of the Management Services provided pursuant to this Agreement; accordingly, the Parties will review the Management Fee at least annually and make appropriate adjustments as the Parties may mutually agree to ensure that the Management Fee on a go-forward basis comports with the fair market value of the increased or decreased demand for Management Services based on material changes to the size and scope of the Practice.

2. **Monthly Bonus.** On a monthly basis, the Board of Directors or other governing body of the Company shall meet to determine an appropriate bonus to be paid to the Management Company, if any, based upon the quality, efficiency and satisfaction of the Management Services rendered by the Management Company for and on behalf of the Company during prior periods.

Exhibit 14

Medical Director Agreement

MEDICAL DIRECTOR AGREEMENT

THIS MEDICAL DIRECTOR AGREEMENT (the "Agreement") is entered into as of this 1ST day of July, 2013 (the "Effective Date"), by and between **NEOSPINE PUYALLUP SPINE CENTER, LLC, D/B/A MICROSURGICAL SPINE CENTER** (the "Center"), **AND RICHARD WOHNS, M.D.** (the "Physician").

RECITALS:

WHEREAS, Center operates an ambulatory surgery center located at 1519 3rd Street SE, Suite 102, Puyallup, Washington 98372 (the "Facility");

WHEREAS, Physician is licensed to practice medicine in the state of Washington (the "State") and is qualified by virtue of training and experience to provide medical direction and other related administrative services to the Facility; and

WHEREAS, Center desires to engage Physician to provide medical direction and certain other administrative services to the Facility, and Physician desires to provide the same, all on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, for and in consideration of the foregoing and of the mutual covenants and promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto do agree as follows:

1. **Physician's Obligations.**

(a) Generally. Physician hereby agrees to act as the medical director of the Facility and to perform the administrative services set forth in this Agreement and on Exhibit A, attached hereto and incorporated herein by reference. The Physician shall be accountable to the administrator of the Facility (the "Administrator") for the performance of the Physician's duties and for the performance by Physician of his or her obligations under this Agreement.

(b) Utilization of Other Physicians. In order to provide the Facility with the services set forth in this Agreement, Physician shall provide services by other physicians during vacations or illnesses of Physician, when Physician attends seminars and meetings, and as may otherwise be necessary to perform Physician's obligations under this Agreement. All physicians who temporarily provide medical director services to the Facility on behalf of Physician shall be employees or independent contractors of Physician. Physician shall be responsible for recruiting, contracting, scheduling, compensating and supervising all such other physicians; provided, however, prior approval of any physician providing coverage for Physician must be obtained from the Center. All physicians engaged by Physician to provide medical director services to the Facility shall meet the same license, certification and membership requirements required of Physician under this Agreement and shall have and maintain professional insurance in a type and amount equivalent to that which Physician is required to have and maintain under Section 1(d), below.

(c) Applicable Standards. Physician shall provide all services required to be provided by Physician hereunder in compliance with all applicable federal, state, and local laws, rules, regulations, and interpretations thereof, the applicable standards of any accrediting bodies specified by the Center, the rules, regulations, conditions of participation and requirements of all

applicable reimbursement bodies and third party payors, all Facility rules, regulations, procedures, policies and bylaws, all Facility medical staff rules, regulations, procedures, policies and bylaws, and the applicable standard of care in the community served by the Center.

(d) INTENTIONALLY OMITTED.

(e) Qualifications. Physician shall remain in full compliance with all of the following conditions continuously during the entire term of this Agreement. Failure of Physician to satisfy any or all of the following conditions shall constitute grounds for automatic termination of this Agreement as set forth in Section 4(d), below.

(i) is fully licensed to practice medicine in the State without restriction or subject to any disciplinary or corrective action;

(ii) has all customary, unrestricted narcotics and controlled substances numbers and licenses;

(iii) is an active member of the Facility's medical staff without restriction or subject to any disciplinary or corrective action, with privileges sufficient to perform all of the services required to be provided by Physician under this Agreement; and

(iv) is board certified in the specialty of neurosurgery.

(f) Time Required. Physician shall devote such amount of time as is necessary to carry out the duties and responsibilities of Physician as the medical director of the Facility and to provide the administrative services to the Facility as set forth in this Agreement. It is anticipated that generally the amount of time required for Physician to adequately provide the required services and act as the medical director of the Facility will be approximately twenty-one (21) hours per month. Said services shall be provided according to the schedule worked out by the parties. Physician and Center agree that one hundred percent (100%) of Physician's working hours covered by this Section 1(f) will be spent providing medical director and administrative services to the Facility.

(g) Records. Physician shall keep, maintain, and submit on a timely basis and shall ensure that the Physician keeps, maintains, and submits on a timely basis time allocation records as required by all applicable laws, rules, and regulations in connection with Medicare or other reimbursement programs and all such other paperwork, forms, reports and records that may be required under any applicable law, rule, or regulation or by the Center, the Administrator, any third-party payor, or any accrediting body. The parties acknowledge and agree that the ownership of all such paperwork, forms, reports, records, and supporting documents shall be vested in the Center; provided, however, that Physician shall have access to such records or documents as may be reasonably necessary for the rendering of current patient care or reviewing past patient care provided by Physician.

(h) Location of Service. Physician shall perform the obligations of Physician under this Agreement at the Facility.

(i) Financial Obligation. Physician shall not incur any financial obligation on behalf of the Center or for which the Center shall be responsible without the prior approval of the Administrator.

(j) Representations and Warranties. Physician represents and warrants to Center that upon the execution and through the term of this Agreement, Physician has not been suspended, excluded, barred or sanctioned under the Medicare or Medicaid Programs, or any government licensing agency, nor has Physician ever been convicted of a criminal offense related to healthcare or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation. Physician will notify the Center immediately in writing if the representations and warranties made by Physician in this Section 1(j) are no longer true and correct.

(k) Disclosure of Information. Physician recognizes and acknowledges that, by virtue of entering into this Agreement and providing medical director and administrative services to the Facility hereunder, Physician may have access to certain information of the Center and/or its designees that is confidential and constitutes valuable, special and unique property of the Center and/or its designees. Physician agrees that Physician will not at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the Center's or its designees' express prior written consent, except pursuant to Physician's duties hereunder, any confidential or proprietary information of the Center or its designees, including, but not limited to, information which concerns the Center's patients, costs, or treatment methods developed by the Center of its designees for the Facility, and which is not otherwise available to the public. The parties acknowledge and agree that the requirements of this Section 1(l) shall survive the expiration or earlier termination of this Agreement.

2. Center's Obligations.

(a) Space, Equipment, and Supplies. The Center shall make available such medical and other equipment, supplies, space and personnel, as the Center reasonably deems necessary and appropriate for the operation of the Facility.

3. Compensation.

(a) Medical Director and Administrative Services. In consideration of the medical director and administrative services provided by Physician to the Center under the terms of this Agreement, the Center agrees to pay Physician three hundred dollars ($300) per hour not to exceed a monthly maximum of six thousand two hundred fifty dollars ($6,250) per month. Such compensation shall be payable by the Center within ten (10) business days following the Center's receipt of the documentation described in Section 3(b), below.

(b) Documentation. Physician shall follow the Facility's policies and procedures for the maintenance of complete and accurate records of time spent providing the medical director and administrative services to the Facility under this Agreement. Within ten (10) days following the end of each month, Physician shall deliver to the Center a written detailed time report, in the form and format set forth in Exhibit B, which shall comply with all applicable regulations and instructions issued under the Medicare, Medicaid, CHAMPUS/TRICARE and other federal healthcare programs and shall specifically identify the time spent by Physician providing the medical direction and administrative services to the Facility during the month just ended.

(c) Billing. Physician shall not charge patients or any third party payor for the medical director and administrative services rendered by Physician as the medical director of the Facility.

(d) Taxes. To the extent required by law, Center shall provide Physician with an IRS Form 1099 or other reasonably necessary forms to enable Physician to identify income from the Center and pay any taxes owed on such amounts. The Center has no responsibility for calculating, paying, or withholding any taxes or benefits on behalf of Physician.

(e) Compensation Intended to Be Fair Market Value. The parties hereto acknowledge and agree that neither this Agreement nor the compensation paid hereunder is based on, takes into account, or is contingent upon the admission or referral of Physician's patients to the Facility, any entity affiliated with the Facility, or the generation of any business between the parties for which payment may be made or sought in whole or in part under Medicare or any state healthcare program. The parties further agree that the compensation payable hereunder has been negotiated at arm's length and represents fair market value compensation for the services provided by Physician.

4. **Term and Termination.**

(a) Term. The initial term of this Agreement (the "Initial Term") shall be three (3) calendar year(s), commencing on the Effective Date and ending on the third (3rd) anniversary thereof, unless sooner terminated in accordance with the provisions set forth herein. At the end of the Initial Term, this Agreement will automatically renew for additional terms of one (1) year each (each a "Renewal Term"), unless either party gives written notice of its intent not to renew this Agreement to the other party no less than thirty (30) days prior to the expiration of the Initial Term.

(b) Termination With or Without Cause. Either party may, in its sole discretion, terminate this Agreement with or without cause by giving the other party at least ninety (90) days prior written notice. The parties hereto agree that this termination provision shall be utilized in good faith and shall not be utilized by the parties to make an improper or illegal adjustment in compensation or other terms of the Agreement and, therefore, agree that in the event that this Agreement is terminated by either party pursuant to this Section 4(b), the parties will not enter into another agreement with each other for the same or similar services for the remainder of the then-current term.

(c) Termination for Breach. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for fifteen (15) days after receipt by the breaching party of written notice of such breach from the non-breaching party.

(d) Immediate Termination by Center. The Center may terminate this Agreement immediately by written notice to Physician upon the occurrence of any of the following:

(i) closure of the Facility, cessation of the Facility's patient care operations, or a sale of the Facility, or of all, or substantially all, of the Facility's assets;

(ii) failure of Physician to maintain the insurance required to be provided under the terms of Section 1(d) of this Agreement;

(iii) failure of Physician to satisfy the requirements set forth in Section 1(e) of this Agreement;

(iv) if any of the representations and warranties made by Physician in Section 1(j), above, are no longer true and correct

(v) conduct by Physician which, in the determination of the Center could affect the quality of professional care provided to the Facility's patients or the performance of duties required hereunder, or be prejudicial or adverse to the best interest and welfare of the Center or its patients;

(vi) breach by Physician of any of the confidentiality provisions hereof; or

(vii) a change in law or regulation or new legislation or regulations which have a material adverse effect on this Agreement, or which materially and adversely affects reimbursement under any third party payor reimbursement system.

(e) Effect of Termination; Survival. Physician acknowledges and agrees that neither the termination of this Agreement nor the failure by the Center to renew or extend this Agreement shall give rise to any appeal, review or hearing rights or procedures under or as provided in the Facility's medical staff by-laws, including, but not limited to, any Fair Hearing Plan or related manuals for Physician. Physician acknowledges and agrees that the Center has the right, upon termination of this Agreement, to enter into exclusive or non-exclusive arrangements with other healthcare providers for the services contemplated hereunder. As of the effective date of termination of this Agreement, neither party shall have any further rights or obligations hereunder except for rights and obligations accruing prior to such effective date of termination, or arising as a result of any breach of this Agreement. Notwithstanding the foregoing, any provisions of this Agreement creating obligations extending beyond the term of this Agreement or which by its explicit terms survives, shall survive the expiration or termination of this Agreement, regardless of the reason for such termination.

5. Patient Information. Physician shall comply with all applicable requirements of the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA"). The parties acknowledge and agree that by virtue of providing the services required to be provided under the terms of this Agreement, Physician will be a business associate of Center. Therefore, the parties agree to execute a business associate agreement set forth in Exhibit C of this Agreement. In addition, Physician shall not disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by Center and/or its designees in writing, which includes for the purposes of defense of a patient lawsuit against Physician, any patient or medical record information regarding Facility patients, and Physician shall comply with all applicable federal and state laws, rules and regulations, and all bylaws, rules, regulations, and policies of the Center, the Facility and the Facility's medical staff, regarding the confidentiality of such information. This Section shall survive the termination or expiration of this Agreement.

6. Indemnification.

(a) Physician. Physician shall indemnify, defend, and hold harmless the Center, all of its officers, directors, employees, agents and representatives from and against any and all claims, losses, damages, causes of action, lawsuits, liabilities, and expenses, including, without limitation reasonable attorneys fees, arising from or related to any service performed or required of Physician or Physician's agents, employees, or representatives in the performance of

any service hereunder. This Section 6(a) shall survive the termination or expiration of this Agreement.

(b) Center. Center shall indemnify, defend, and hold harmless Physician and his or her agents, employees, and representatives from and against any and all claims, losses, damages, causes of action, lawsuits, liabilities, and expenses, including, without limitation reasonable attorneys fees, arising from or related to any service performed or required of the Center or the Center's officers, directors, employees, agents, or representatives in the performance of any service hereunder.

7. **Independent Contractor.** Physician is retained by the Center only for the purposes and to the extent set forth in this Agreement. The relationship of Physician (and any of his or her associates, employees, etc.) to the Center shall be that of independent contractors, and it is specifically understood that no relationship of employer-employee (or master/servant or other relationship to which the doctrine of respondeat superior applies), joint venture, or landlord-tenant is created or shall exist. Except as expressly provided herein, the Center is not obligated to and will not provide vacation pay, sick leave, retirement benefits, social security or income tax or worker's compensation, disability, unemployment or any other type benefits of any kind. The Center shall have the right to exercise control and direction as to the results only and not as to the methods by which Physician practices medicine or performs professional services hereunder, it being recognized that Physician will be exercising his or her independent medical judgment.

8. **Non-Discrimination.** All services provided hereunder shall be provided in a nondiscriminatory manner, without regard to race, color, national origin or handicapping condition.

9. **Access to Books and Records.** Physician shall allow the Secretary of the Department of Health and Human Services and the Comptroller General and their authorized representatives to have access, upon request, to this Agreement and to any of Physician's books, documents, and records that are necessary to verify the nature and extent of costs and services furnished under the Agreement, for a period of four (4) years after the services are furnished. In addition, Physician shall allow similar access for such period to any subcontracts of a similar nature, costs, or value, between it (or him) and any related organizations and to their books, documents and records. Physician shall promptly notify the Center of any such request and consult and cooperate with the Center in regard to compliance with requirements of the Medicare or Medicaid programs or other third party reimbursement programs. If such access and cooperation is not provided, and the Center's reimbursement is diminished because of an action or inaction by Physician, Physician will indemnify the Center against such loss.

10. **Fraud and Abuse.** The parties expressly acknowledge that it has been and continues to be their intent to comply fully with all applicable federal, state, and local laws, rules, and regulations. It is neither a purpose nor a requirement of this Agreement or any other agreement between the parties to offer or receive any remuneration or benefit of any nature for the referral of, or to solicit, require, induce, or encourage the referral of any patient, item, or business for which payment may be made or sought in whole or in part by Medicare, Medicaid, or any other state reimbursement program. This Agreement has been prepared to comply, to the extent possible, with all applicable federal Anti-Kickback Statute Safe Harbor regulations and to comply with the Stark Law and all rules and regulations promulgated thereunder. All compensation and payments provided hereunder are intended to represent fair market value for the services provided, and it is expressly acknowledged that no payment made or received under this Agreement is in return for the referral of patients or in return for the purchasing, leasing, ordering, arranging for, or recommending the

purchasing, leasing, or ordering of any good, service, item, or product for which payment may be made or sought in whole or in part under Medicare, Medicaid, or any other state reimbursement program. In the event of any applicable legislative or regulatory change or action, whether federal or state, that has or would have a significant adverse impact on either party hereto in connection with the performance of services hereunder, or should either party be deemed for any reason in violation of any statute or regulation arising from this Agreement, or should it be determined that this Agreement gives rise to a financial relationship with a provider of designated health services under the Stark Law which is not subject to an applicable exception so that referrals between the parties, or billing for such referrals, would be prohibited or restricted by the Stark Law or other state or federal "anti-referral" law, then this Agreement shall be renegotiated to comply with the then current law and, if the parties hereto are unable to reach a mutually agreeable and appropriate modification, either party may terminate this Agreement upon sixty (60) days written notice to the other party.

11. **Notices**. All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or one (1) day after being deposited in the United States mail, postage prepaid, or one (1) day after being deposited with the overnight courier, addressed as follows:

If to Center:	Neospine Puyallup Spine Center, LLC 1519 3rd Street, SE, Suite 102 Puyallup, Washington 98372 Attention: Administrator
With a copy to:	Symbion, Inc. 40 Burton Hills Blvd., Suite 500 Nashville, Tennessee 37215 Attention: General Counsel
If to Physician:	Richard Wohns, M.D. 1519 3rd Street, SE, Suite 101 Puyallup, Washington 98372

or to such other persons or places as either party may from time to time designate by notice pursuant to this Section 11.

12. **Duty to Cooperate.** Each party agrees to cooperate with the other in fully formulating and implementing the goals and objectives which are in the best interests of the Facility and its patients.

13. **Severability.** In the event that any provision of this Agreement is held to be unenforceable for any reason, the unenforceability of that provision shall not affect the remainder of this Agreement, which shall remain in full force and effect in accordance with its terms.

14. **Captions.** The captions for each Section of this Agreement are included for reference only and are not to be considered a part hereof, and shall not be deemed to modify, restrict, or enlarge any of the terms or provisions of this Agreement.

15. **Governing Law.** This Agreement shall be construed in accordance with the laws of the State, without regard to any conflicts of laws provisions contained therein.

16. **Assignment; Binding Effect.** Physician may not assign his rights or obligations under this Agreement other than to a professional corporation owned entirely by Physician. Further, Physician may not subcontract or otherwise arrange for another individual or entity to perform his duties under this Agreement, with the exception of the limited coverage provisions set out in Section 1(b) of this Agreement. This Agreement is assignable by Center without consent, provided that Center provides prompt written notice of the assignment. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

17. **Entire Agreement; Amendment; Waiver.** This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter, including, without limitation that certain Medical Director Agreement between Center and South Sound Neurosurgery, PLLC. This Agreement may not be amended or modified except by mutual written agreement signed by the parties. Failure of any party at any time to require performance of any provision of this Agreement shall not limit such party's right to enforce such provision, nor shall any waiver of any breach of any provision of this Agreement constitute a waiver of any succeeding breach of such provision or a waiver of such provision itself.

18. **Other Agreements.** All other agreements existing as of the date of this Agreement between Center and Physician or the Physician's immediate family members are set forth in a centralized list maintained by the Center.

[signatures appear on following page]

IN WITNESS WHEREOF, the parties hereto or their duly authorized representatives have executed this Agreement as of the day and year first written above.

Center:

NEOSPINE PUYALLUP SPINE CENTER, LLC
D/B/A MICROSURGICAL SPINE CENTER

By: _____

Its: Governing Board Member

Physician:

_____
RICHARD WOHNS, M.D.

EXHIBIT A

Position Description and Responsibilities of Physician

Physician hereby agrees to act as the Medical Director of the Facility and shall perform such consultations as shall be reasonably necessary to carry out general medical direction of the Facility. Functions of the Medical Director shall include, but shall not be limited to:

1. Physician shall act as Chief Medical Officer for the Facility, act as a liaison between members of the Facility's medical staff and the Facility, and work in concert with Facility to carry out the policies of the Governing Body of the Facility.

2. Physician shall be available and shall work with other physicians to ensure that Facility has physician accessibility at all times.

3. Physician shall consult with the Administrator and the Governing Body of the Center with respect to the general operation of the Facility.

4. Physician shall assist the Facility, as reasonably requested, in activities designed to increase public awareness of the Facility.

5. Physician shall assist in establishing and implementing procedures to provide consistency and quality of the Facility's services; participate, as requested, in the overall quality assessment program and assist, as requested, in overseeing and implementing quality control and assessment and safety measures in line with applicable accrediting and licensing agency requirements; and serve as liaison to the local medical community.

6. Physician shall assist the Facility in complying with, all applicable standards and requirements of the Centers for Medicare and Medicaid Services, State licensing agencies, and any other accrediting agencies designated by the Facility.

7. Physician shall provide medical leadership for the Facility's patient programs and/or services through regularly scheduled meetings and reviewing, recommending, and approving admission criteria, discharge criteria, and procedures of a medical nature on a regular basis and as requested by Facility.

8. Physician shall review all professional practices within the Facility, including reviewing incident reports, accident reports, and identifying health and safety hazards, and take appropriate action where indicated and recommend changes as appropriate to maintain efficient and effective patient care. Physician shall, at the request of the Facility, assess individual and team performance and recommend corrective plans of action as necessary.

9. Physician shall participate in the development of medical/technical standards of care and evaluate existing procedural techniques and capabilities relative to established standards and/or opportunities for improvement, including, but not limited to, identifying, evaluating, and implementing new/developing invasive diagnostic or interventional techniques. Physician shall also direct performance improvement for

the Facility and submit plans for improvement to the Facility's administration and to other review committees as necessary.

10. By no later than January 31st of the then current calendar year, Physician shall present a planning document to the Facility's administration detailing the previous year's performance with respect to care indicators, standardization of practices and procedures, training programs, evaluation of equipment and physical resources, and the like. Said planning document shall also include Physician's improvement goals and plans of action for each of these categories in the upcoming year.

11. Upon request by the Facility, Physician shall conduct training of staff and/or attend staff meetings.

12. Physician shall assist in providing direction for new programs.

13. Physician shall consult with other physicians regarding appropriate utilization of care.

14. Physician shall perform such other duties as may reasonably be requested by Center.

The parties acknowledge and agree that the range or variety of services may change because of advancements in medicine, equipment, or techniques and that certain procedures or services now performed at the Facility may become outdated and obsolete. Therefore, the parties pledge to cooperate with each other to ensure that the Physician provides such other or additional medical director or related administrative services as may be necessary to ensure that quality specialty medical care services continue to be provided at the Facility to patients and their attending physicians on a cost-effective basis.

EXHIBIT B

MEDICAL DIRECTOR ACTIVITY REPORT

Instructions for Completion

All medical directors must use the attached Medical Director Activity Report to account for and document the time spent providing medical director services to the Facility. In the boxes of the Report, the medical director should, for each instance of service provided, record the date, the medical director activities performed, and the time spent by the medical director performing such activities. The detailed instructions for completing the Medical Director Activity Report are as follows:

Column 1: Column 1 lists the various activities that are required to be provided by the Facility's medical director. The medical director's time should generally be recorded and categorized by activity type and reported as set forth below.

Column 2: Specify the month and day (mm/dd) the services were provided.

Column 3: Provide a detailed description of the actual medical director activity that was performed for the Facility. All services listed must be required by and consistent with the duties set forth in the applicable medical director agreement. The Facility may, in its sole discretion, request a more detailed description of or additional information or documentation regarding the activities and services that have been listed.

Columns 4-8 : Specify the total time spent on the particular activity for the applicable week. Time should generally be recorded in 15-minute (.25 hour) increments. For example, if a medical director attended a Medical Advisory Board Meeting that lasted 1 hour and 15 minutes, the medical director would list the time spent for the meeting as 1.25 hours.

Column 9: Specify the time spent on the particular activity for the month.

Total Hours: Specify the total number of hours of medical director services for all activities that were provided to the Facility during the applicable monthly period.

The original copy of the Medical Director Activity Report should be submitted to the Facility's administrator at the end of the applicable month. The medical director should keep a copy of each Medical Director Activity Report that he or she submits for his or her records.

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MEDICAL DIRECTOR ACTIVITY REPORT

Name:_____ Month/Year:_____ Facility:_____

Time Record

Activity	Date(s)	Detailed Description of Activity	Time for Week 1	Time for Week 2	Time for Week 3	Time for Week 4	Time for Week 5	Time for Month
Attend Center Staff Meeting								
Review Professional Practices[1]								
Center Staff Training								
General Center Consultation								
Center Marketing								
Quality Matters								
Governmental & Accreditation Requirements								
Attend Medical Advisory Board Meeting								
Attend Advisory Board Meeting								
Review Policies and Procedures								

[1] Review incident reports, accident reports, identify health and safety hazards and taking appropriate action; recommend changes to maintain efficient and effective patient care; assess individual and team performance and recommend corrective plans of action.

MEDICAL DIRECTOR ACTIVITY REPORT - Continued

Activity	Date(s)	Detailed Description of Activity	Time for Week 1	Time for Week 2	Time for Week 3	Time for Week 4	Time for Week 5	Time for Month
Development of Standards[2]								
							Total Number of Hours for Month:	

By signing below, I, the undersigned, do hereby certify that I actually worked the hours set forth above and that the services I provided during such hours are required by and consistent with the duties set forth in my medical director agreement.

_____ _____

Medical Director's Signature Date

Reviewed and Approved By:

_____ _____

Administrator's Signature Date

[2] Development of medical/technical standards of care and evaluate existing procedural techniques and capabilities relative to established standards and/or opportunities for improvement; direct performance improvement for the facility and submit plans for improvement to the administrator and other applicable committees.

EXHIBIT C

HIPAA Business Associate Agreement

THIS AGREEMENT is made and entered into this 12 day of July, 2013 by and between **NEOSPINE PUYALLUP SPINE CENTER, D/B/A MICROSURGICAL SPINE CENTER** (the "Facility"), and **RICHARD WOHNS, M.D.** (the "Business Associate").

WHEREAS, Business Associate has agreed to provide certain services for the Facility involving the use and/or disclosure of individually identifiable health information relating to the Facility's patients ("Protected Health Information" or "PHI"); and

WHEREAS, in accordance with the federal privacy regulations set forth at 45 CFR Part 160 and Part 164 (the "HIPAA Privacy Regulations") and federal security regulations set forth at 45 CFR Parts 160, 162 and 164 (the "HIPAA Security Regulations"), as amended from time to time, including, without limitation, the changes made to the HIPAA Privacy Regulations and the HIPAA Security Regulations by the American Recovery and Reinvestment Act of 2009 and any applicable regulations promulgated thereunder as they become effective ("ARRA") which require the Facility to have a written contract with each of its business associates, the parties wish to incorporate satisfactory assurances that the Business Associate will appropriately safeguard Protected Health Information.

NOW, THEREFORE, in consideration of the mutual promises and other consideration contained herein, the sufficiency of which is hereby acknowledged, the parties agree as follows:

1. Services. The services to be provided by Business Associate are identified in the Medical Director Agreement between the parties dated as of even date herewith, to which this agreement serves as an addendum.

2. Permitted Uses and Disclosures. Business Associate shall not use or disclose any Protected Health Information other than as permitted by this Agreement in order to perform Business Associate's obligations hereunder or as required by law. Business Associate shall not use or disclose the PHI in any way that would be prohibited if used or disclosed in such a way by the Facility. Business Associate may also use or disclose PHI as required for Business Associate's proper management and administration, provided that if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring that party (i) to hold the PHI confidentially and not to use or further disclose the PHI except as required by law, and (ii) to notify Business Associate immediately of any instances of which it becomes aware in which the confidentiality of the PHI is breached.

3. Minimum Necessary Information. Business Associate shall only request from the Facility, and shall only use and disclose, the minimum amount of PHI necessary to carry out the Business Associate's responsibilities under this Agreement in accordance with any regulations promulgated under the ARRA or any guidance provided by the Secretary of Health and Human Services (the "Secretary").

4. Reporting; ARRA Data Breach Notice and ARRA safeguards. If Business Associate becomes aware of any use or disclosure of PHI in violation of this Agreement, Business Associate shall immediately report such information to the Facility. Business Associate shall also require its employees, agents, and subcontractors to immediately report any use or disclosure of PHI in violation of this Agreement. Business Associate shall cooperate with, and take any action required by, the Facility to mitigate any harm caused by such improper disclosure. At such time as required by the ARRA, in the event that Business Associate has Knowledge or a Reasonable Belief that a Breach of Unsecured PHI of the Facility has occurred or may have occurred, Business Associate shall promptly (but in no event more than thirty (30) days of Knowledge of the Breach or Reasonable Belief that a Breach has occurred) notify the Facility of the identification of each individual who has been or is reasonably believed to have been affected by the Breach, along with any other information that the Facility as a Covered Entity will be required to include in its notification of the individual under the ARRA, including, without limitation, a description of the breach, the date of the breach and its discovery, types of Unsecured PHI involved and description of the Business Associate's investigation, mitigation and prevention efforts. At such time required by the ARRA and in the manner required by the ARRA, Business Associate shall implement safeguards and policy, procedure, and documentation requirements consistent with the requirements of 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.

5. Agents and Subcontractors. Business Associate shall require its employees, agents, and subcontractors to agree not to use or disclose PHI in any manner except as specifically allowed herein, and shall take appropriate disciplinary action against any employee or other agent who uses or discloses PHI in violation of this Agreement. Business Associate shall require any agent or subcontractor that carries out any duties for Business Associate involving the use, custody, disclosure, creation of, or access to PHI to enter into a written contract with Business Associate containing provisions substantially identical to the restrictions and conditions set forth in this Agreement.

6. Policies and Restrictions. The Facility shall provide Business Associate with access to the Facility's notices, policies, and procedures, including updates thereto provided from time to time by the Facility, and Business Associate shall comply with all such notices, policies, and procedures. Business Associate shall assure that each of its agents and employees has received appropriate training regarding HIPAA confidentiality, patient privacy and security compliance issues. In the event Facility agrees to a restriction requested by a patient required under the ARRA, Facility shall notify Business Associate and Business Associate agrees to abide by the patient's restriction with respect to the patient's PHI. Business Associate shall ensure any agent or subcontractor receiving such patient's PHI also abide by the patient's restriction.

7. Patient Rights. Business Associate acknowledges that the HIPAA Privacy Regulations require the Facility to provide patients with a number of privacy rights, including (a) the right to inspect PHI within the possession or control of the Facility, its business associates, and their subcontractors, (b) the right to amend such PHI, and (c) the right to obtain an accounting of certain disclosures of their PHI to third parties. Business Associate shall establish and maintain adequate internal controls and procedures allowing it to readily assist the Facility in complying with patient requests to exercise any patient rights granted by the Privacy Regulations, and shall, at no additional cost to the Facility, immediately comply with all Facility requests to amend, provide access to, or create an accounting of disclosures

of the PHI in the possession of Business Associate or its agents and subcontractors. If Business Associate receives a request directly from a patient to exercise any patient rights granted by the Privacy Regulations, Business Associate shall immediately forward the request to the Facility.

8. Security Requirements. By the compliance date for the HIPAA Security Regulations, Business Associate agrees to (a) implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Facility; (b) ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; (c) make Business Associate's policies and procedures, and documentation required by the HIPAA Security Rules relating to such safeguards, available to the Secretary of Health and Human Services for purposes of determining Facility's compliance with the Security Rules; (d) report to the Facility any Security Incident, as such term is defined in the HIPAA Security Regulations, of which it becomes aware, in the following time and manner: (i) any actual, successful Security Incident will be reported to the Facility in writing, within two (2) business days of the date on which Business Associate becomes aware of such Security Incident. At the request of the Facility, Business Associate shall identify: the date of the Security Incident, the Business Associate's response to the Security Incident, and the identification of the party responsible for causing the Security Incident, if known; and (ii) any attempted, unsuccessful Security Incident, of which Business Associate becomes aware, will be reported to the Facility in writing, on a reasonable basis, at the written request of Facility. If the HIPAA Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection (ii) shall no longer apply as of the effective date of the amendment of the HIPAA Security Rule. Business Associate shall use appropriate physical, technical, and administrative safeguards to prevent the use or disclosure of PHI in any manner other than as provided for by this Agreement and as required by the Facility's privacy and security policies. Upon request, Business Associate shall allow the Facility to review such safeguards. If Business Associate uses electronic media to obtain, transmit, or store PHI, Business Associate shall comply with all "chain of trust" requirements established by applicable HIPAA security and transaction regulations, including the implementation of appropriate security measures and procedures for its data systems which shall maintain the integrity and confidentiality of the transmitted information and otherwise prevent unauthorized access to the PHI as required by this Agreement.

9. Audits and Inspections. Business Associate shall make its internal facilities, books, and records relating to the use and disclosure of PHI available to the Facility for inspection upon request, and to the Secretary of Health and Human Services to the extent required for determining the Facility's compliance with the Privacy Regulations. Notwithstanding the above, no attorney-client, accountant-client, or other legal privilege shall be deemed waived by the Facility or Business Associate by virtue of this provision.

10. Termination and Return of PHI. Notwithstanding anything to the contrary in the Agreement, Facility may terminate this Agreement immediately if, in the Facility's reasonable opinion, Business Associate breaches any provision of this Agreement. The Facility may, in its sole discretion, give Business Associate 30 days in which to cure the breach and mitigate any damages. Upon termination of this Agreement for any reason,

Business Associate shall, if feasible, return or destroy all PHI received from the Facility or created by Business Associate on behalf of the Facility. If such return or destruction is not feasible, the parties agree that the requirements of this Agreement shall survive termination and that Business Associate shall limit all further uses and disclosures of PHI to those purposes that make the return or destruction of such information infeasible.

11. Indemnification. Business Associate agrees to indemnify, defend, and hold the Facility, its officers, directors, employees, agents, and assigns, harmless from and against any and all losses, liabilities, damages, costs, and expenses (including reasonable attorneys' fees) arising out of or related to the Business Associate's breach of its obligations under this Agreement. This Section shall survive the termination or expiration of this Agreement.

12. FTC Red Flag Rules-Service Provider. If Business Associate performs services for Facility with respect to Covered Accounts as such term is defined in the Identity Theft Red Flags rules published by the Federal Trade Commission (the "Rules"), Business Associate shall also be deemed a "Service Provider" of Facility and as to such Covered Accounts, Business Associate shall: (a) perform its activities under the Agreement in accordance with reasonable policies and procedures of Business Associate designed to detect, prevent, and mitigate the risk of identity theft, as required of a Service Provider under the Rules (the "Program"); and (b) promptly report to Facility but in no event more than five (5) days of learning of any specific Red Flag Incidents (as such term is defined in the Rules) which Business Associate detects as to Covered Accounts of Facility pursuant to the Program and respond to, or reasonably assist Facility in responding to, such reported Red Flag Incidents as directed by Facility.

13. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Facility to comply with the HIPAA Privacy Regulations and HIPAA Security Regulations. In the event of any inconsistencies between the terms of this Agreement and any other agreement between the parties, the terms of this Agreement shall prevail. Capitalized terms used herein without definition shall have the meanings ascribed thereto in the HIPAA Privacy Regulations and HIPAA Security Regulations as amended by the ARRA.

14. Changes in Law. The parties acknowledge that the ARRA requires the Secretary to promulgate regulations and interpretative guidance that is not available at the time of executing this Agreement. In the event Facility determines in good faith that any such regulation or guidance adopted or amended after the execution of this Agreement shall cause any paragraph or provision of this Agreement to be invalid, void or in any manner unlawful or subject either party to penalty, then the parties agree that if the risk can be eliminated by restructuring the Agreement, this Agreement shall be renegotiated in good faith so as to amend this Agreement in a manner that would eliminate any such substantial risk.

15. State Law. Business Associate shall comply with applicable state privacy and security laws to the extent that such state laws are not preempted by the HIPAA Privacy Regulations and HIPAA Security Regulations.

IN WITNESS WHEREOF, the parties enter into this Agreement, to become effective as of the later of the date set forth above.

ACCEPTED BY THE FACILITY:

Signed: W. Trent Webb
Name: W. Trenton Webb
Title: Governing Board Member
Date: 9/26/13

ACCEPTED BY BUSINESS ASSOCIATE:

Signed: Richard Wohns MD
Name: Richard Wohns MD
Title: Medical Director
Date: 9/25/13

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Exhibit 15

Site Control Documents

Exhibit 15a

Building Lease

CONSENT TO ASSIGNMENT

The undersigned, Tres Amigos I, LLC, a Washington limited liability company ("Landlord"), the landlord under the Medical Office Lease Agreement (ASC) dated January 23, 2002 (the "Lease") between Landlord and South Sound Neurosurgery P.L.L.C. ("Assignor"), hereby consents to the forgoing assignment of the Lease to South Sound Spine Center, LLC ("Assignee"), provided that (i) neither such assignment nor Landlord's consent thereto shall release Assignor from its liability under the Lease, and (ii) the consent of Landlord is conditioned upon the execution by Richard N.W. Wohns, M.D. ("Guarantor") of the Reaffirmation of Guaranty set forth below.

Tres Amigos I, LLC,
a Washington limited liability
company

By _____
Timothy A. Rector, Managing Partner

REAFFIRMATION OF GUARANTY

The undersigned, Richard N.W. Wohns, M.D., the Guarantor under that certain Amended and Restated Guaranty dated December 31, 2001 (the "Guaranty") hereby reaffirms his obligations under the Guaranty and confirms that the Guaranty remains in full force and effect, notwithstanding the assignment of the Lease to Assignee as set forth above.

_____
Richard N.W. Wohns, M. D.

MEDICAL OFFICE LEASE AGREEMENT (ASC)

THIS MEDICAL OFFICE LEASE AGREEMENT (ASC) (this "Lease"), dated the 23rd day of ~~August~~ January, 2002, is by and between **Tres Amigos I, LLC**, a Washington limited liability company, hereinafter called "Landlord," and **South Sound Neurosurgery, P.L.L.C.**, doing business as South Sound Neurosurgery Center, hereinafter called "Tenant."

1. LEASE SUMMARY

The following is a Summary of some of the details of the Lease. To the extent any of this summary is not consistent with the body of the Lease, the provisions of the body of the Lease shall prevail:

1.1 Building: The building located on the real property more particularly described in Exhibit A, with a tentative address of 304 15th Avenue S.E., Puyallup, Pierce County, Washington.

1.2 Premises: The area on the 1st floor of the Building outlined in red on the floor plan of the Building attached hereto as Exhibit B.

1.3 Rentable Square Footage Data: The rentable Square Footage of the Premises is approximately 4,962.1351 sq. ft.

1.4 Initial Term:

1.4.1 Commencement Date: Upon the earlier of (i) May 1, 2002 or (ii) the Delivery Date as defined in Section 8.5.

1.4.2 Expiration Date: Ten years from Commencement Date, subject to extensions as provided in Section 1.8.

1.5 Use: The Premises are to be used and occupied by Tenant solely for a medical outpatient surgical center and clinic, including but not limited to the following specific uses: medical examinations, treatments, procedures, operations, counseling, education, including community education sessions, retail sales of drugs and literature, referral services and related medical and office uses.

1.6 Rent: Tenant shall pay Landlord "Base Rent" according to the following schedule:

Lease Year	Monthly Base Rent
One and Two	$ 9,428.06
Three and Four	$ 10,916.70
Five	$ 11,412.91
Six and each Lease Year thereafter	The sum of (x) prior Lease Year's Base Rent plus (y) four percent (4%) of Prior Lease Year's Base Rent

In addition to the Base Rent, Tenant shall pay to Landlord any amounts of Additional Rent determined to be due pursuant to Article 7, below.

1.7 Tenant's Pro Rata Share: 19.21%

1.8. Extension Options. Tenant shall have the right to extend this Lease for two (2) additional periods of five (5) years (each an "Option"), upon the same terms and conditions of this Lease. To exercise an Option, Tenant must not be in Default at the time it exercises the Option, and must give notice to Landlord that Tenant is exercising the Option at least one hundred twenty (120) days before the Term expires. Any remaining Option will

expire if Tenant does not timely exercise the preceding Option. The rights of Tenant under this Section 1.8 are for the sole benefit of Tenant and its permitted assignees and shall automatically terminate upon any assignment (other than a Permitted Assignment) of this Lease, sublease of the Premises (other than a Permitted Sublet), or other transfer of this Lease and/or the rights of Tenant.

2. LEASE OF PREMISES

In consideration of the covenants and agreements set forth herein, Landlord leases to Tenant the Premises together with appurtenances and the benefits of any appurtenant easements and rights of way. Tenant, its agents, employees and invitees shall have the non-exclusive privilege and easement to use in common with other tenants of the Building, the Common Areas described below for the purposes for which they were intended, including adequate pedestrian and vehicular traffic, access, ingress and egress to, from and between the streets and highways adjoining the Building. "Common Areas" means the Building common entrances, lobbies, public restrooms, stairways and accessways, ramps, drives and platforms and any passageways and serviceways thereto, and the common pipes, conduits, wires and appurtenant equipment serving the Premises, trash areas, parking areas, roadways, sidewalks, walkways, parkways, driveways and landscaped areas and similar areas and facilities.

3. DEFINITIONS

For the purpose of this Lease:

"Actual Operating Cost Allocable to the Premises" for any Lease Year shall mean the Tenant's Pro Rata Share of Actual Operating Cost for such Lease Year.

"Building" means the structure to be constructed in accordance with the Construction Documents (defined in Section 8.1 hereof) and located at and situated on the real property legally described on Exhibit A, including any area servicing the same such as adjoining access areas, or other public or common areas, as now or hereafter constructed.

"Cost of Services and Utilities" shall mean all expenses paid or incurred by Landlord for:

(i) wages, salaries and related expenses (including employment taxes and fringe benefits) of all employees engaged in the operation and maintenance and security of the Building, incurred by Landlord;

(ii) all supplies and materials used in the operation and maintenance of the Building;

(iii) all utilities, including, without limitation, water, sewer and garbage;

(iv) all costs of heating, lighting, air conditioning and ventilating the Building, which are not included in "Costs of Energy" as defined herein;

(v) management costs (such management costs not to exceed $1500 per month for the Building) and the cost of maintenance and service agreements for the Building and the equipment therein, including, without limitation, alarm service, window cleaning;

(vi) accounting costs, including the costs of audits by certified public accountants;

(vii) the cost of all insurance, including but not limited to, fire, casualty, liability and rental abatement insurance applicable to the Building, the Tenant Improvements and Landlord's personal property used in connection therewith;

(viii) the cost of all repairs, replacements and general maintenance (excluding repairs and general maintenance paid by proceeds of insurance or by Tenant or other third parties), including permit and inspection fees;

(ix) all common area maintenance costs related to public areas of the Building, including sidewalks, landscaping and service areas; and,

(x) the cost of any equipment leased or rented in connection with operation of the Building;

"Cost of Improvements" shall mean all the cost, including reasonable interest charges thereon, of capital expenditures made for repairs, replacements or improvements to the Building or purchase of equipment which will be amortized over the expected life thereof, and that are required by any governmental authority or insurance carrier or that will improve the operating efficiency of the Building or reduce the cost of operating or maintaining the Building.

"Cost of Energy" shall mean all expenses incurred by Landlord in operation and maintenance of the Building for electricity, subject to the provisions of Article 7 including any surcharges imposed, and all expenses for gas or other energy fuels and heat sources;

"Cost of Taxes" shall mean the following taxes, charges and assessments payable during or with respect to the lease term, subject to the provisions of Article 7: All taxes on real property and personal property, including all improvements, which have not been paid by tenants directly to the taxing authority; all charges and special or general assessments levied with respect to the Land, the Building, any improvements, fixtures and equipment, and all other property of Landlord, real or personal, used directly in the operation of the Building and located in or on the Building; and all taxes levied or assessed in addition to or in lieu of, in whole or in part, such real property or personal property taxes, or any other tax upon leasing of the Building or rents collected, but not including any federal or state income tax or franchise tax.

"Estimated Operating Cost" means, for any particular Lease Year, the Landlord's estimate of the Actual Operating Cost for the Building for such Lease Year, computed prior to the start of such Lease Year.

"Estimated Operating Cost Allocable to the Premises" shall mean Tenant's pro rata share of Estimated Operating Cost.

"Force Majeure" is described in Section 36.10 hereof.

"Independent Arbiter" means practicing architect with at least ten (10) years experience and membership in the American Institute of Architects ("AIA") who has not been employed by either party or any affiliate of either party. The Independent Arbiter shall be appointed by the president of the AIA chapter in the locality where the Premises are located. Either Landlord or Tenant may apply for appointment of the Independent Arbiter. Except as otherwise provided in this Lease, each party shall pay one half (1/2) of the expenses of the Independent Arbiter.

"Lease Term" means the period from and including the Commencement Date to and including the Expiration Date, as the same may be extended pursuant to Section 1.8 hereof.

"Lease Year" means each twelve-month period beginning on the Commencement Date and ending the preceding day in the following year.

"Operating Cost" (sometimes herein referred to as "Actual Operating Cost") shall mean and include all expenses and costs (excluding, however, depreciation and payments of principal or interest on any mortgage or other encumbrance related to any financing by Landlord of the Premises or the Building) which Landlord or Landlord's manager shall pay or become obligated to pay or incur because of, or in connection with the ownership, maintenance, management and operation of the Building, including but not limited to the "Cost of Energy", "Cost of Services and Utilities", "Cost of Improvements" and "Cost of Taxes" (each of which is defined below), and subject to the provisions of Article 7. Operating Costs shall be adjusted, if necessary, as determined by Landlord in its discretion, to reflect Operating Costs that would have been incurred had the Building been 95% occupied and fully assessed.

"Permitted Assignment" means an assignment of all the rights and obligations under this Lease in connection a sale, merger or corporate restructuring of the Tenant's practice or medically related businesses which conforms with the following conditions:

(a) such assignment is in writing in form and substance satisfactory to Landlord;

(b) the assignee of this Lease agrees to comply with the terms and conditions of this Lease, including but not limited to the use limitations set forth in Section 1.5 hereof; and

(c) the assigning Tenant agrees to remain primarily liable under this Lease and indemnify Landlord from any cost, loss or expense of Landlord arising out of or relating to such assignment.

"Permitted Sublet" means a sublease of the Premises which conforms with the following conditions:

(a) such sublease is in writing in form and substance satisfactory to Landlord;

(b) the subtenant under such sublease agrees to comply with the terms and conditions of this Lease, including but not limited to the use limitations set forth in Section 1.5 hereof;

(c) the Tenant agrees to remain primarily liable under this Lease and indemnify Landlord from any cost, loss or expense of Landlord arising out of or relating to such sublease; and

(d) such subtenant is not in negotiations to lease space in the Building.

"Premises" shall mean the premises leased by Tenant pursuant to this Lease, referred to in Article 1.2, above.

"Tenant's Pro Rata Share" shall mean 19.21%.

"Tenant Improvements" shall mean all alterations, improvements and additions to the Premises whether performed by or paid for by Landlord or Tenant but excluding Tenant's personal property and removable trade fixtures.

4. GUARANTY

The obligations, liabilities and indebtedness owing by Tenant to Landlord under this Lease shall at all times be guaranteed by Richard N.W. Wohns, M.D. (the "Guarantor") pursuant to an Amended and Restated Guaranty dated even date herewith.

5. RENT PAYMENT

Tenant shall pay Landlord without notice the Rent stated in Article 1.6 hereof and Additional Rent as provided in Article 7, and any other additional payments due under this Lease without deduction, abatement or offset in lawful money of the United States, at Landlord's Notice Address set forth herein, or to such other party or at such other place as Landlord may hereafter from time to time designate in writing. Rent shall be paid as follows:

The Base Rent specified in Article 1.6, above, as such may be increased pursuant to the terms of this Lease, shall be paid in advance on or before the first day of each month.

The Estimated Operating Cost allocable to the Premises shall be paid in twelve (12) monthly installments, each of which shall be paid in advance on or before the first date of each month.

Tenant shall pay Landlord a $20.00 fee for any payment of Rent or Additional Rent which is returned due to insufficient funds. If, twice during the term of this Lease, any payments of Rent or Additional Rent are returned due

to insufficient funds, at the option of Landlord all subsequent payments of Rent and Additional Rent by Tenant shall be by a cashier's check drawn on a bank in the greater Seattle area.

6. SERVICE CHARGE

If any rent and other sums payable hereunder by Tenant are not paid within ten (10) days after any such rent or other sum becomes due, a late charge of five percent (5%) of the amount due and not paid or Fifty Dollars ($50.00), whichever is greater, shall be payable by the Tenant as a special handling charge. If any rent or other sums payable hereunder by Tenant is not paid within thirty (30) days of its due date, then in addition to the above stated late charge, Tenant shall pay Landlord interest on all sums due and not paid at an annual rate of interest equal to the lesser of (a) eighteen percent (18%), or (b) the highest rate permitted by law. Unless otherwise stated in this Lease, all payments are due in advance, on the first day of each month during the term of this Lease.

7. ADDITIONAL RENT

7.1 Tenant's Obligation to Pay Additional Rent. In addition to the Base Rent provided in Article 1.6 of this Lease, Tenant shall pay to Landlord as "Additional Rent" the Actual Operating Cost Allocable to the Premises.

7.2 Estimated Operating Cost Allocable to the Premises. Before the start of each Lease Year, Landlord shall furnish Tenant a written statement of the Estimated Operating Cost Allocable to the Premises for such Lease Year. Said amount shall be Additional Rent payable by Tenant as provided in Article 5 for each month during such Lease Year.

7.3 Adjustment to Estimated Operating Cost During Lease Year. If at any time or times during a Lease Year, it appears to Landlord that the Actual Operating Cost Allocable to the Premises will vary from Landlord's estimate by more than five percent (5%) on an annual basis, Landlord may, by written notice to Tenant, revise its estimate for such Lease Year and subject to Article 5 the Additional Rent payment by Tenant for the remainder of such Lease Year (starting with the Additional Rent due for the month following the month in which Landlord notifies Tenant of such revised estimate) shall be based on such revised estimate.

7.4 Actual Operating Cost. After the close of each Lease Year, Landlord shall deliver to Tenant a written statement setting forth the Actual Operating Cost Allocable to the Premises during the such Lease Year. If such costs for any Lease Year exceed the Estimated Operating Cost Allocable to the Premises paid by Tenant to Landlord pursuant to Article 7.2, Tenant shall pay the amount of such excess to Landlord as added Additional Rent within thirty (30) days after receipt of such statement by Tenant. If such statement shows such costs to be less than the amount paid by Tenant to Landlord pursuant to Article 7.2, then the amount of such overpayment by Tenant shall be credited by Landlord to the next Base Rent payable by Tenant. Any discrepancies in amounts paid occurring at the end of the Lease Term shall be paid by Tenant or Landlord, as the case may be, within thirty (30) days following expiration or termination of the Lease. The failure of Landlord to make written demand for payment of any such costs within any particular period of time shall not be deemed a waiver by Landlord of its right of payment of such and shall not relieve Tenant of its duty to pay the same. Tenant shall, upon request, have full access to the books and records of Landlord relating to Operating Cost at reasonable times and during regular business hours

7.5 Nonpayment of Additional Rent. In the event of nonpayment of Additional Rent hereunder, Landlord shall have the same rights with respect to such nonpayment as it has with respect to any other nonpayment of Rent hereunder.

7.6 Personal Property Taxes. In addition to any Additional Rent payable by Tenant, Tenant shall pay, prior to delinquency, all Personal Property Taxes payable with respect to all property of Tenant located on the Premises or the Building and promptly upon request of Landlord shall provide written proof of such payment. "Personal Property Taxes" shall include all property taxes assessed against personal property and trade fixtures placed by Tenant in the Premises, whether assessed as real or personal property. If any such taxes are levied against Landlord or Landlord's property and if Landlord elects to pay the same or if the assessed value of Landlord's

property is increased by inclusion of personal property and trade fixtures placed by Tenant in the Premises and Landlord elects to pay the taxes based on such increase, Tenant shall pay to Landlord upon demand that part of such taxes for which Tenant is primarily liable hereunder.

8. CONSTRUCTION AND COMMENCEMENT DATE.

8.1 Building Plans. Landlord has provided and Tenant has approved working drawings and specifications for the shell of the Building attached hereto as Exhibit C (the "Working Plans"). To the extent Landlord makes material changes to the Working Plans, Landlord shall submit such changes to Tenant for approval, which approval shall not be unreasonably withheld. If Tenant does not object to Landlord in writing within five (5) days of receiving such changes, such changes shall be deemed approved. Should Tenant desire any change in the Working Plans, Tenant shall submit any desired changes to Landlord for Landlord's approval, which not be unreasonably withheld. Tenant shall be provided an opportunity to suggest design aesthetics for the Building exterior which Landlord shall make reasonable efforts to include in the Working Plans, provided that Tenant's suggestions will not, in Landlord's opinion, increase the cost of the Shell Work or delay construction. Upon agreement to the Working Plans by Landlord and Tenant, the Working Plans (as they may be amended pursuant to Sections 8.1 or 8.3 hereof) shall become the "Construction Documents." The construction of the Building's shell according to the Construction Documents is referred to herein as the "Shell Work", and the types of Shell Work to be completed are described on Exhibit D hereto. Landlord and Tenant hereby agree that the most recent set of Working Plans have been approved.

8.2 Construction of Shell Work. Upon establishment of the Construction Documents, Landlord shall promptly commence construction of Shell Work and diligently proceed to complete same. The construction shall be performed by or on behalf of Landlord in a good and workmanlike manner and in compliance with all applicable laws.

8.3 Changes in Construction Documents. If Tenant requests a change to the Construction Documents or the Working Plans, Landlord shall notify Tenant in writing, before executing the change, of the cost thereof, if any, and the delay in substantial completion, if any, in the Shell Work caused by the change. Tenant shall, within three (3) days thereafter, either tell Landlord to proceed with the change order or withdraw it. If Tenant fails to respond in that time, the change order is deemed withdrawn hereby. The cost of a change order shall be determined by Landlord in good faith. Payments by Tenant to Landlord for changes that increase the cost of the Shell Work shall be made pro rata as such work progresses so long as Landlord has submitted an itemized bill. Such payment shall be made within ten (10) days of receipt of all of the foregoing by Tenant. The Shell Target Date shall be postponed by the length of such delay.

8.4 Tenant's Access During Construction. During construction of the Shell Work, Tenant or its representative(s) may enter upon the Premises for purposes of inspecting the Shell Work, taking measurements, making plans, installing trade fixtures and doing such other work as may be appropriate or desirable without being deemed thereby to have taken possession. Tenant's use of the Premises for the purposes herein stated shall be on all of the terms, covenants, and conditions of this Lease, except as to commencement of the Term and payment of Rent. In exercising its rights under this paragraph, Tenant shall not interfere with Landlord's construction of the Shell Work of the Building.

8.5 Substantial Completion/Delivery Date Notice. The phrases "substantial completion" or "substantially complete(d)" as used in this Lease shall be deemed to mean the availability of the Premises for uninterrupted use and occupancy by Tenant with a minimum of interference by Landlord which will be indicated by the fact that all Shell Work shall have been completed, except for minor or insubstantial details of construction, mechanical adjustments or finishing touch-up ("punchlist items"). The term "Delivery Date" means the date on which the Premises are substantially completed. Landlord shall give Tenant at least thirty (30) days advance notice of the estimated substantial completion date if later than March 15, 2002 (as the same may be postponed in accordance with Section 8.3 hereof or due to Force Majeure, the "Shell Target Date"). If the estimated substantial completion date changes at any time after Landlord gives notice, then Landlord shall give thirty (30) days advance notice of the new estimated substantial completion date.

8.6 Punchlist/As-Built Plans. Landlord shall complete all punchlist items as expeditiously as possible but in any event within sixty (60) days after substantial completion of Tenant's Work. The punchlist shall be developed by Landlord and Tenant.

8.7 Dispute About Substantial Completion. If Landlord alleges that the date of substantial completion of Tenant's Work would have occurred earlier than the actual date thereof but for the fault of Tenant or Force Majeure and the parties cannot agree on the date, the matter shall be submitted to the Independent Arbiter for determination of the date of substantial completion of the Shell Work or Tenant's Work, as applicable.

8.8 Tenant Plans. Landlord has approved the leasehold improvements schematic designs and other data relating thereto (collectively called the "Tenant Plans") which Tenant has provided to Landlord prior to the date hereof. These leasehold improvements are referred to as "Tenant's Work." Tenant will select the architect(s) to prepare construction drawings.

8.9 Contractor. Tenant's Work shall be performed in accordance with Tenant's Plans as approved by Landlord by reputable contractors reasonably satisfactory to Landlord. Landlord shall be deemed to have approved a Tenant contractor if Landlord does not respond to Tenant's request for approval within ten (10) days after the request is made.

8.10 Construction of Tenant's Work. Upon obtaining all necessary permits for construction of Tenant's Work, Tenant may commence construction of Tenant's Work. The construction shall be performed by or on behalf of Tenant in a good and workmanlike manner and in compliance with all laws.

8.11 Construction Insurance. During construction, each of the parties who is performing work under this Lease or its general contractor shall procure and maintain in effect the following insurance coverages with an insurance company or companies authorized to do business Washington:

(a) Workmen's Compensation - Statutory Limits for the State in which the work is to be performed, together with "ALL STATES," "VOLUNTARY COMPENSATION" and "FOREIGN COMPENSATION" coverage endorsements;

(b) Employer's Liability Insurance with a limit of not less than One Million and 00/100 Dollars ($1,000,000.00);

(c) Commercial General Liability - at least Two Million and 00/100 Dollars ($2,000,000.00) Combined Single Limit, including Personal Injury, Contractual and Products/Completed Operations Liability naming Landlord and Tenant as additional insured.

(d) Automobile Liability - Including Owned, Hired and Non-owned licensed vehicles used in connection with performance of the construction work of at least: One Million and 00/100 Dollars ($1,000,000.00) each person Bodily Injury Three Million and 00/100 Dollars ($3,000,000.00) each occurrence Bodily Injury Five Hundred Thousand and 00/100 Dollars ($500,000.00) each occurrence Property Damage.

(e) Procure or cause contractor to procure and maintain installation floater insurance to protect against the risk of physical damage until acceptance of the construction work;

(f) Furnish Tenant or Landlord, as the case may be, with certificates of insurance evidencing such coverage prior to the commencement of the construction work. All insurance shall be carried in companies reasonably acceptable to the other party;

(g) The following statement shall appear in each certificate of insurance provided Tenant by Landlord hereunder:

"It is agreed that in the event of any material change in, cancellation or non-renewal of this policy, the Company shall endeavor to give ten (10) days prior notice to;"

(h) During construction of Tenant's Work, Landlord shall give prompt notice to Tenant of all losses, damages, or injuries to any person or to property of Tenant, Landlord or third parties. Landlord shall promptly report to Tenant all such claims of which Landlord has notice, whether related to matters insured or uninsured. No settlement or payment for any claim for loss, injury or damage or other matter as to which Tenant may have an obligation for any payment or reimbursement, shall be made by Landlord without the written approval of Tenant;

(i) The carrying of any of the insurance required hereunder shall not be interpreted as relieving the insuring party of any responsibility to the other party, and the other party does not waive any rights that it may have against the insuring party and/or its representatives for any expense and damage to persons and property (tangible and intangible) from any cause whatsoever with respect to the insuring party's work;

(j) Landlord and Tenant shall assist and cooperate with any insurance company in the adjustment or litigation of all claims arising under the terms of this Section 8.11; and

(k) The contract for construction shall include an indemnification substantially similar to the text of Article 17 by the contractor for the benefit of Landlord and Tenant.

8.12 Signage. Tenant is authorized to install at its expense a sign identifying Tenant by its business name on the Building exterior. Such sign shall be approved by Landlord as part of Tenant's Plans and installed in compliance with the requirements of applicable laws.

9. ACCEPTANCE OF PREMISES

9.1 Representations and Warranties. Tenant, by execution of this Lease, shall be deemed to have accepted the Premises on the Commencement Date (provided the Delivery Date shall have occurred and subject to punchlist items) in the condition existing as of such date and in any event this Lease shall be subject to all applicable zoning ordinances and to any municipal, county and state laws and regulations governing and regulating the use of the Premises and any covenants or restrictions of record. Tenant acknowledges that neither Landlord nor Landlord's agent has made any representation or warranty about the suitability of the premises for the conduct of Tenant's business.

9.2 Zoning Compliance. It shall be the sole responsibility of the Tenant to obtain appropriate zoning for its operation. Tenant shall do nothing which will affect the zoning classification applicable to the Premises permitting the use described in Article 1.6 hereof.

10. ALTERATIONS, ADDITIONS, IMPROVEMENTS BY TENANT

Subject to the provisions of Articles 8 and 21 hereof, Tenant agrees not to permit the Premises to be used for any purpose other than stated in Article 1.6, or to make or allow to be made any alterations, additions or improvements in or about the Premises without first obtaining the written consent of Landlord and, where appropriate, in accordance with plans and specifications approved by Landlord. Tenant shall reimburse Landlord for any reasonable sums expended for examination and approval of such plans and specifications and direct costs reasonably incurred during any inspection or supervision of any alterations, additions or improvements.

11. CARE OF PREMISES

Subject to the provisions of Article 21.1, Tenant shall at Tenant's own expense and pursuant to the terms of this Lease, keep the Premises in good order, repair and condition at all times during the Lease Term, including all improvements, fixtures and furnishings, plumbing, mechanical and electrical systems, heating, ventilating and air conditioning system servicing the Premises, and all windows, doors, toilets and sinks in the Premises. Tenant shall also perform all necessary cleaning of the Premises, including walls, windows, doors and floors, and shall replace all

inoperative light bulbs and ballasts and broken glass; provided, however, that as to all plumbing, mechanical, electrical, heating, ventilating and air conditioning repairs and maintenance, Tenant shall use the services of Landlord or its designated agent and shall pay the cost thereof to Landlord promptly on demand. Tenant hereby waives all rights to make repairs at the expense of Landlord as provided by any law, statute or ordinance now or hereinafter in effect. Tenant will reimburse Landlord for the annual cost of maintenance for the Building standard heating or air-conditioning equipment servicing the Premises. In addition, Tenant shall, at Tenant's own expense but under the supervision and subject to the prior approval of Landlord, and within any reasonable period of time specified by Landlord, pursuant to the terms of this Lease, promptly and adequately repair all damage to the Premises and replace or repair all damaged or broken fixtures and appurtenances; provided however, that, at Landlord's option, or if Tenant fails to make such repairs, Landlord may, but need not, make such repairs and replacements, and Tenant shall pay Landlord the cost thereof, including a percentage of the cost thereof (to be uniformly established for the Building) sufficient to reimburse Landlord for all overhead, general conditions, fees and other costs or expenses arising from Landlord's involvement with such repairs and replacements forthwith upon being billed for same. Landlord may, but shall not be required to, enter the Premises at all reasonable times to make such repairs, alterations, improvements and additions to the Premises or to the Building or to any equipment located in the Building as Landlord shall desire or deem necessary or as Landlord may be required to do by the terms of this Lease or by governmental or quasi-governmental authority or court order or decree, and any such entry shall not be deemed to be or shall be construed as an eviction of Tenant.

12. MECHANICS' LIENS

Tenant will not permit any mechanics', laborers' or materialmen's liens to stand against the Premises or the Building for any labor or material furnished to or on account of Tenant or claimed to have been furnished in connection with any work performed or claimed to have been performed in, on or about the Premises, and Tenant shall indemnify and hold Landlord harmless from any such lien.

13. SURRENDER OF PREMISES

Upon the expiration or termination of this Lease, Tenant shall, at its expense: (i) unless Landlord otherwise elects pursuant to Article 30.6, remove Tenant's goods and effects and those of all persons claiming under Tenant, including but not limited to all trade fixtures, appliances and equipment which do not become a part of the Premises and alterations made by Tenant without the approval of Landlord which Landlord designates to be removed, (provided that this provision shall not be deemed a waiver of Tenant's obligation to obtain Landlord's approval before beginning any alteration of the Premises), and shall restore the Premises to the condition they were in before the installation of said items; (ii) quit and deliver up the Premises to Landlord peaceably and quietly in as good order and condition as the same were in on the Lease Commencement date, ordinary wear and tear excepted. Any property left in the Premises after expiration or termination of this Lease may be disposed of by Landlord as Landlord deems expedient. Tenant's obligation to perform this covenant shall survive the expiration or termination of this Lease.

14. USES

14.1 Use. The Premises are to be used only for the uses described in Section 1.5 hereof ("Permitted Uses"), and for no other business or purpose without the prior written consent of Landlord, which consent may be withheld for reasons within Landlord's sole discretion including, without limitation, a determination by Landlord that any proposed use is inconsistent with or detrimental to the maintenance and operation of the Building or is inconsistent with any restriction on use of the Premises. Tenant agrees not to occupy or use, or permit any portion of the Premises to be used, for any purpose which is unlawful, disreputable, or deemed to be hazardous on account of fire, or permit anything to be done in or about the Premises which would, directly or indirectly, in any way cause the cancellation of insurance coverage on the Building, the Premises or their contents or Landlord or Tenant's liability insurance. If Tenant's activities or the activities of third parties related to Tenant's activities on the Premises (irrespective of Tenant's conduct or compliance with the terms of this Lease) result in an increase in the rate of such insurance, Landlord may charge Tenant the cost of any such additional insurance. Tenant's activities, or the activities of third parties as described in the foregoing sentence which cause the cancellation of such insurance, or

Tenant's failure to pay the cost of such additional insurance as provided in the foregoing sentence, will be deemed a default by Tenant and Landlord shall be entitled to exercise its remedies pursuant to Article 30.

14.2 Compliance. Tenant agrees to comply with all laws, ordinances, orders, rules and regulations (state, federal, municipal, or promulgated by other agencies or bodies having any jurisdiction thereof) relating to the use, condition or occupancy of the Premises.

14.3 Disruption. Tenant shall not, without the written consent of Landlord, use any apparatus, machinery or device in or about the Premises or engage in any activity which will cause any substantial noise, nuisance, fumes or vibration or any increase in the normal use of electric power. Tenant shall not permit its employees, agents or clients to engage in disruptive behavior or act with disregard for the law.

14.4 Prohibited Acts. Tenant shall not do or permit anything to be done in or about the Premises which will in any way obstruct or interfere with the rights of other tenants or occupants of any portion of the Building, or injure or annoy them; nor shall Tenant cause, maintain or permit any nuisance in, on or about the Building. Tenant shall not commit or suffer to be committed any waste in or upon the Premises or the Building.

14.5 Rules and Regulations. Tenant shall comply with and observe such reasonable rules and regulations as may be adopted and published by Landlord from time to time for the safety, care and cleanliness of the Premises or the Building, or the surrounding property, and for the preservation of good order therein and thereon all of which will be sent by Landlord to Tenant in writing and shall be thereafter carried out and observed by Tenant.

14.6 Hazardous Substances. Without Landlord's prior written consent, Tenant shall not receive, store or otherwise handle any product, material or merchandise on the Premises which is a Hazardous Substance. With respect to the release of any Hazardous Substances on or about the Premises occurring on or after the Commencement Date of this Lease which violates the provisions of, or necessitates any removal, treatment or other remedial action under, any past, present, or future federal, state or local statute or ordinance or any regulation, directive, or requirement of any governmental authority with jurisdiction relating to protection of the environment, Tenant agrees to defend, indemnify, and hold harmless Landlord, its employees, agents, and contractors, from and against any and all losses, claims, liabilities, damages, demands, fines, costs, and expenses (including reasonable attorneys' fees) arising out of or resulting therefrom. The provisions of this Article shall survive the termination or expiration of this Lease and the surrender of the Premises by Tenant. As used herein, the term "Hazardous Substance" means any hazardous, toxic, or dangerous substance, waste or material which is or becomes regulated under any federal, state or local statute, ordinance, rule, regulation or other law, now or hereafter in effect, pertaining to environmental protection, contamination or cleanup, including without limitation, any substance, waste or material which now or hereafter is designated as a "Hazardous Substance" under the Comprehensive Environmental Response Compensation and Liability Act ("CERCLA", 42 U.S.C. §§9601 et. seq.) or under the Washington Model Toxics Control Act.

15. LANDLORD'S RIGHT OF ENTRY

Tenant agrees to permit Landlord, or its agents or representatives, to enter into and upon any part of the Premises at all reasonable hours to inspect the same, clean, make repairs, alterations or additions thereto, or exhibit the Premises to prospective tenants, purchasers or others, or for such other reasonable purposes as Landlord may deem necessary or desirable; and Tenant shall not be entitled to any abatement or reduction of Rent, Additional Rent or any other sums due under this Lease by reason thereof. Landlord has the right to enter upon the Premises at any time in case of emergency.

16. ASSIGNMENT AND SUBLETTING

16.1 Landlord's Consent. Tenant shall not, except for Permitted Sublets and Permitted Assignments, assign or in any manner transfer this Lease or any interest therein nor sublet the Premises or any part or parts thereof, nor permit occupancy by anyone without the prior written consent of Landlord, which consent shall not be unreasonably withheld.

16.2 Landlord's Termination Right. In lieu of granting consent to any proposed assignment, sublease or transfer (other than a Permitted Sublet or a Permitted Assignment), Landlord reserves the right to terminate this Lease or, in the case of subletting of less than all the Premises, to terminate this Lease with respect to such portion of the Premises, as of the proposed effective date of such subletting, assignment or transfer, in which event Landlord may enter into the relationship of landlord and tenant with such proposed assignee, sublessee or transferee, based upon the Rent and other compensation and terms agreed to by such assignee, sublessee or transferee and otherwise on the terms and conditions of this Lease.

16.3 Intentionally Omitted.

16.4 Fees. In connection with each request for an assignment, subletting or transfer, Tenant shall pay Landlord, at the time the request is initially made and as a prerequisite for Landlord's consideration of any such request, Five Hundred Dollars ($500.00) for the cost of processing such request. If Landlord's actual costs reasonably exceed $500.00, Tenant shall, within five (5) days after written demand from Landlord, pay Landlord as Additional Rent the additional amount of such actual costs.

16.5 Obligations. As a condition to Landlord's approval, any potential assignee, sublessee or transferee shall assume in writing all obligations, or in case of a sublease of less than the entire Premises all obligations with respect to the portion of the Premises subleased to such sublessee, and shall be jointly and severally liable with Tenant for rental and other payments and performance of all terms, covenants, and conditions of this Lease with respect to the Premises or the portion subleased to a sublessee of less than the entire Premises.

16.6 Prohibited Transfers. To the fullest extent permitted by law, neither this Lease nor any interest herein shall pass to any trustee in bankruptcy, receiver appointed for Tenant or its property, or any assignee for the benefit of creditors of tenant, or by operation of the law. This lease shall terminate automatically upon the happening of any of said events, unless Landlord, in writing, specifically elects to continue this Lease.

17. SUBORDINATION TO MORTGAGE

Tenant covenants and agrees that this Lease is subject and subordinate to any mortgage or deed of trust which may now or hereafter encumber the Building or the Premises, created by or at the instance of Landlord, and to all renewals, modifications, consolidations, replacements and extensions thereof. This clause shall be self-operative and no further instrument of subordination need be requested by any mortgagee. In confirmation of such subordination, however, Tenant shall at Landlord's request execute promptly any appropriate certificate, instrument or document confirming such subordination. In the event any trustee, mortgagee or the beneficiary under any such mortgage or deed of trust shall succeed to the interest of Landlord hereunder, by foreclosure, by deed in lieu thereof, or otherwise, Tenant will, upon request of any such person or parties so succeeding to the interest of Landlord, automatically attorn to and become the Tenant of such successor interest without change in the terms of other provisions of this Lease. Tenant shall execute and deliver any instrument or instruments confirming the attornment herein provided for.

18. ESTOPPEL CERTIFICATE

At Landlord's request, Tenant will execute and deliver an estoppel certificate addressed to any mortgagee, assignee, or transferee of Landlord containing such information concerning this Lease and Tenant's agreement to such notice provisions and other matters as any mortgagee, assignee or transferee may reasonably require in connection with Landlord's financing, or the mortgage transaction, assignment or transfer. If Tenant shall fail to

respond within ten (10) days of receipt by Tenant of a written request by Landlord as herein provided, Tenant shall be deemed to have given such estoppel certificate as above provided without modification, and shall be deemed to have admitted the accuracy of any information supplied by Landlord to any such mortgagee, assignee or transferee and; that this Lease is in full force and effect; that there are no uncured defaults in Landlord's performance under this Lease; and that no more than one month's rental has been paid in advance. In addition, if Tenant shall refuse to execute and deliver any such certificate or agreement, Tenant hereby irrevocably constitutes and appoints Landlord the Tenant's attorney-in-fact to execute and deliver any such certificate or agreement for and on behalf of Tenant and any such mortgagee, assignee or transferee of Landlord shall be entitled to rely upon any such certificate or agreement.

19. SIGNS AND GRAPHICS

Except for the exterior sign permitted by Section 8.13 hereof or with the prior written consent of Landlord, Tenant shall not display, or permit the display of, any lettering, sign, advertisement, notice or object and permit no such display on the windows or doors, or on the outside of the perimeter walls of the Premises, or so as to be visible through the windows, glass walls or exterior doors of the Premises. Any such consent by Landlord shall be upon the understanding and condition that Tenant shall remove the same at the expiration or sooner termination of this Lease and Tenant shall repair any damage to the Premises or Building caused thereby. Any sign or object not approved by the Landlord may be removed by it and the cost of such removal, and the restoration of the Premises resulting therefrom, shall be paid forthwith by Tenant.

20. TENANT INSURANCE

Tenant agrees throughout the term of this Lease and any renewal thereof, to procure and maintain, at its own expense, a policy or policies of comprehensive liability insurance, insuring Landlord and Tenant from all claims, demands or actions for injury or death or property damage in or about the Premises in amounts which are from time to time reasonably required by Landlord, but not less than One Million and No/100 Dollars ($1,000,000.00) for all claims arising as a result of any one occurrence and a Three Million and No/100 Dollars ($3,000,000) annual aggregate limit. The policy shall insure the hazards and operations of independent contractors, contractual liability and shall (a) name Landlord and any affiliates, as additional insureds, and (b) contain a provision that the insurance provided the Landlord hereunder shall be primary and non-contributing with any other insurance available to Landlord. Said insurance shall be in a form and with an insurer acceptable to Landlord, shall not be subject to cancellation except after at least thirty (30) days prior written notice to Landlord, and the policy or policies, or duly executed certificate or certificates for the same evidencing Landlord as an additional insured, together with satisfactory evidence of the payment of premium thereon, shall be deposited with Landlord at the commencement of the term, and upon any renewal of said insurance not less that 30 days prior to the expiration of the term of such coverage. Tenant shall also provide its own fire and extended coverage insurance covering the full replacement value of all Tenant's personal property and removable trade fixtures, without depreciation and co-insurance, and, where applicable, with an agreed amount endorsement.

21. SERVICES AND UTILITIES PROVIDED BY LANDLORD

21.1 Maintenance. Landlord shall provide janitorial and refuse service, lights and ballast, plumbing and fixtures, and replacement of exterior glass (windows and doors). Landlord shall maintain or caused to maintained in reasonably good order the Premises and the public and common areas of the Building, parking facilities, elevator, fire protection and equipment serving the Building and the structural portions of the Building. If any such maintenance or repair is required because of the act or omission of Tenant or any person claiming through Tenant, or any of their respective agents, employees, contractors, or invitees, all costs and expenses incurred by Landlord shall be paid by Tenant on demand by Landlord. Any injury to or interference with Tenant's business arising from any repairs, maintenance, alteration or improvement in or to any portion of the Building, including the Premises, or in or to the fixtures, appurtenances and equipment therein shall not be deemed to be an eviction of Tenant or relieve Tenant of any of its obligations hereunder.

21.2 Services. Landlord shall not be liable for any loss, injury or damage to person or property directly or indirectly caused by or resulting from any variation, interruption, failure of (or failure to provide) such services or utilities, whether or not such interruption or failure results from matters within Landlord's control. No interruption or failure of such services or utilities incident to the making of repairs, alterations, or improvements, or due to accident, strike or conditions or events beyond Landlord's reasonable control shall be deemed an eviction of Tenant or relieve Tenant from any of Tenant's obligations hereunder or give Tenant the right to terminate this Lease.

21.3 Obligation. Landlord's obligations as set forth in this Article shall continue so long as Tenant is not in default of any of its obligations under this Lease.

22. QUIET ENJOYMENT

Landlord covenants that Tenant shall, and may peacefully have, hold and enjoy the Premises, subject to the provisions of this Lease, if Tenant pays the rental herein recited and performs all of Tenant's covenants and agreements herein contained. It is understood and agreed that this covenant and any and all other covenants of Landlord contained in this Lease shall be binding upon Landlord and its successors or assigns only with respect to breaches occurring during it's and their respective ownerships of the Landlord's interest hereunder.

23. ASSIGNMENT BY LANDLORD

Landlord shall have the right to sell, convey, transfer and assign, in whole or in part, all its rights and obligations hereunder and in the Building and the property referred to herein, and in such event, no further liability or obligations shall thereafter accrue against Landlord hereunder. Tenant agrees to attorn to such transferee.

24. CONDEMNATION

24.1 Entire Taking. If all of the Premises or such portions of the Building as may be required for the reasonable use of the Premises, are taken by eminent domain, this Lease shall automatically terminate as of the date title vests in the condemning authority. In the event of a taking of a material part of but less than all of the Building, where Landlord shall determine that the remaining portions of the building cannot be economically and effectively used by it (whether on account of physical, economic, aesthetic or other reasons) or where Landlord determines the Building should be restored in such a way as to materially alter the Premises, Landlord shall forward a written notice to Tenant of such determination not more than sixty (60) days after the date of taking. The term of this Lease shall expire upon such date as Landlord shall specify in such notice but not earlier than sixty (60) days after the date of such notice.

24.2 Partial Taking. Subject to the provisions of the preceding Section 24.1, in case of taking of a part of the Premises, or a portion of the Building not required for the reasonable use of the Premises, then this Lease shall continue in full force and effect and the Rent shall be equitably reduced based on the proportion by which the floor area of the Premises is reduced, such Rent reduction to be effective as of the date title to such portion vests in the condemning authority. However, if a portion of the Premises shall be so taken which renders the remainder of the Premises unsuitable for continued occupancy by Tenant under this Lease, Landlord may terminate this Lease by written notice to Tenant no later than sixty (60) days after the date of such taking and the term of this Lease shall expire upon such date as Landlord shall specify in such notice not later than sixty (60) days after the date of such notice.

24.3 Awards and Damages. Landlord reserves all rights to damages to the Premises for any partial, constructive, or entire taking by eminent domain, and Tenant hereby assigns to Landlord any right Tenant may have to such damages or award. Tenant shall make no claim against Landlord or the condemning authority for damages for termination of the leasehold interest. Tenant shall have the right, however, to claim and recover from the condemning authority compensation for any loss to which Tenant may be put for Tenant's moving expenses, business interruption or taking of Tenant's personal property and leasehold improvements paid for by Tenant (not including Tenant's leasehold interest) provided that such damages may be claimed only if they are awarded separately in the eminent domain proceedings and not out of or as part of the damages recoverable by Landlord.

25. DAMAGE TO BUILDING

If the Building or Premises are damaged to such an extent as to make the same untenantable in whole or in a substantial part thereof, or are destroyed, or if insurance proceeds sufficient to pay the costs of repair are for any reason unavailable, it shall be optional with the Landlord to repair or rebuild the same. Promptly after the happening of any such contingency, the Tenant shall give Landlord written notice thereof. Landlord shall within ninety (90) days after date of such damage notify the Tenant in writing of Landlord's intention to repair or rebuild the Building or Premises. If Landlord chooses to do so, Landlord shall prosecute the work of such repairing or rebuilding without unnecessary delay, subject to delay beyond Landlord's reasonable control and during such period the rent for the Premises shall be abated in the same ratio that portion of the Premises rendered for the time being unfit for occupancy (if any) bears to the whole of the leased Premises; provided, however, in the event such damage resulted from, or was contributed to, directly or indirectly, by the act, fault or neglect of Tenant, Tenant's officers, contractors, agents, employees, clients, customers, licensees, rent shall abate only to the extent Landlord receives proceeds from any rental income insurance policy to compensate Landlord for loss of rent hereunder. In the alternative, Landlord may give notice of its election to terminate this Lease. If, after the expiration of said ninety (90) day period, Landlord shall fail to give either of said notices within ten (10) days after written request by Tenant for an election by Landlord, Tenant shall have the right to declare this Lease terminated by written notice upon the Landlord.

If Premises are damaged or destroyed, and Landlord chooses to repair and reconstruct the Premises as provided above, then the term of this Lease shall, at Landlord's election, be extended for the time required to complete such repair and reconstruction.

Landlord shall not be responsible to the Tenant for damage to, or destruction of, Tenant's personal property and removable trade fixtures including, without limitation, Tenant's furniture, furnishings and equipment, in, on or about the Premises regardless of the cause of damage or destruction, except that, if Landlord chooses to repair and reconstruct the Premises as provided above, Landlord on behalf of Tenant, and at Landlord's expense, shall repair or restore Tenant Improvements which were originally made by Landlord pursuant to this Lease to as near the condition which existed on the Commencement of the Term of this Lease as reasonably possible. Landlord shall have the exclusive right to all insurance proceeds relating to Tenant Improvements.

26. HOLDING OVER

If Tenant holds over after expiration or termination of this Lease without written consent of Landlord, Tenant shall pay twice the Base Rent (prorated on a monthly basis) which Tenant was obligated to pay for the month immediately preceding the end of the term of this Lease plus Additional Rent for each month or any part thereof of any such holdover period. No holding over by Tenant after the term of this Lease shall operate to extend the Lease term. In the event of any unauthorized holding over, Tenant shall indemnify Landlord against all claims for damages by any other tenant to whom Landlord may have leased all or any part of the Premises covered hereby effective upon the termination of this Lease. Any holding over, with the consent of Landlord in writing, shall be deemed a month-to-month tenancy which may be terminated as provided by applicable law and during such tenancy Tenant shall be bound by all of the terms, covenants and conditions herein so far as applicable, except rental which shall be the greater of (a) the then quoted rates for similar space in the Building or (b) the Base Rent and Additional Rent stated herein.

27. COSTS AND ATTORNEYS' FEES

If by reason of any default on the part of the Tenant it becomes necessary for Landlord to employ an attorney or in case Landlord shall bring suit to recover any rent due hereunder, or for breach of any provision of this Lease or to recover possession of the Premises, or if Tenant shall bring any action for any relief against Landlord, declaratory or otherwise, arising out of the Lease then the non-prevailing party in such action shall pay the other's reasonable attorneys' fee and all reasonable costs incurred by it in connection with such default or action. To the extent permitted by law, each party shall and hereby does waive trial by jury in any such action.

28. DEFAULT BY TENANT

28.1 Defaults. If default be made in the payment of any sum to be paid by Tenant under this Lease, and such default shall continue for five (5) days; or if default shall be made in the performance of any of the other covenants or conditions which Tenant is required to observe and to perform, and such default shall continue for twenty (20) days; or if the interest of Tenant under this Lease shall be levied on under execution or other legal process; or if any petition shall be filed by or against Tenant to declare Tenant a bankrupt or to delay, reduce or modify Tenant's debts or obligations; or if any petition shall be filed or other action taken to reorganize or modify Tenant's capital structure, if Tenant be a corporation or other entity; or if Tenant be declared insolvent according to law; or if assignment of Tenant's property shall be made for the benefit of creditors; or if a receiver or trustee is appointed for Tenant or any of its property; or if Tenant shall vacate or abandon the Premises during the term of this Lease or any renewals or extensions thereof; then Landlord may treat the occurrence of any one or more of the foregoing events as a breach of this Lease (provided that no such levy, execution, legal process or petition filed against Tenant shall constitute a breach of this Lease if Tenant shall vigorously contest the same by appropriate proceedings and shall remove or vacate the same within sixty (60) days from the date of its creation, service or filing). Notwithstanding anything herein to the contrary, if Landlord serves Tenant with three (3) default notices in any twelve (12) month period, Landlord shall have the right to terminate this Lease without providing Tenant with any cure period. Upon any such occurrence of default, at Landlord's option, Landlord may have any one or more of the remedies described below in addition to all other rights and remedies provided at law or in equity:

28.2 Termination. Landlord may terminate this Lease and forthwith repossess the Premises and remove all persons or property therefrom, and be entitled to recover forthwith as damages a sum of money equal to the total of (i) the cost of recovering the Premises, (ii) the unpaid rent owed at the time of termination, plus interest on all sums due and not paid at an annual rate of interest equal to the lesser of (a) eighteen percent (18%), or (b) the highest rate permitted by laws; (iii) the amounts of Rent reserved in this Lease for the remainder of the Term of the Lease (which shall be accelerated and become due at the time of such default) in excess of the fair market rental value of the Premises for the same period; and (iv) any other sum of money, late charges and damages owed by Tenant to Landlord, including without limitation, amounts owed pursuant to Article 30.3 herein.

28.3 Right to Reenter and Relet. With or without terminating this Lease, Landlord may reenter the Premises or any part thereof and remove all persons and property therefrom, without such reentry diminishing Tenant's obligation to pay rent for the full term hereof, and relet the Premises or any part thereof for such term or terms (which may extend beyond the term of this Lease), for such rent and upon such other conditions as Landlord in its sole discretion deems advisable, with Landlord having the right to repair, remodel and change the Premises and Tenant remaining liable for any deficiency computed as provided herein. At the option of Landlord, rents received by Landlord from such reletting shall be applied first to the payment of any indebtedness from Tenant to Landlord, other than rent due hereunder, plus interest thereon at an annual rate of interest equal to the lesser of (i) eighteen percent (18%), or (ii) the maximum rate permitted by applicable law; and second, to the payment of rent due (earned but unpaid at the time of reletting) and to become due hereunder. If the rents received from such subletting are not sufficient to pay the amounts due as provided in the foregoing sentence, Tenant shall pay the deficiency upon demand. Landlord may recover sums due from Tenant under this section from time to time, and Tenant agrees that Landlord may file suit to recover any sums falling due under the terms of this Article from time to time on one or more occasions without Landlord being obligated to wait until the expiration of the term of this Lease. Any payment made or suits brought to collect the amount of the deficiency for any month shall not prejudice in any way the right of Landlord to collect the deficiency for any subsequent month. Subject to any applicable duty to mitigate damages, the failure of Landlord to relet the Premises or any part or parts thereof shall not release or affect Tenant's liability hereunder, nor shall Landlord be liable for failure to relet, or in the event of reletting, for failure to collect the rent thereof, and in no event shall Tenant be entitled to receive any excess of net rents collected over sums payable by Tenant to Landlord hereunder. No such re-entry or taking possession of the Premises shall be construed as an election on Landlord's part to terminate this Lease unless a written notice of such intention be given to Tenant. Notwithstanding any such reletting without termination, Landlord may at any time thereafter elect to terminate this Lease for such previous breach.

28.4 No Waiver. Failure of Landlord to declare any default immediately upon occurrence thereof, or delaying taking any action in connection therewith, shall not waive such default, but Landlord shall have the right to declare any such default at any time thereafter.

28.5 Landlord's Cure. If Tenant defaults in the observance or performance of any of Tenant's covenants, agreements or obligations hereunder, Landlord may, but without obligation and without limiting any other remedies which it may have by reason of such default, cure the default, charge the costs thereof to Tenant, and Tenant shall pay the same as Additional Rent promptly upon demand, together with interest thereon at the default rate specified herein.

28.6 Tenant's Property. In the event of default at Landlord's option any one or any combination of the following shall occur: (1) all or any part of Tenant's trade fixtures, furniture, appliances, equipment, and other personal property, which in no event shall include Tenant Improvements ("Tenant's Property"), as designated by Landlord shall remain on the Premises and in that event, and continuing during the length of said default, Landlord shall have the right to take the exclusive possession of same and to use same rent or charge free, until all defaults are cured; (ii) Tenant shall forthwith remove Tenant's Property; or (iii) Landlord shall have the right, but not the obligation, to remove therefrom all or any part of Tenant's Property located on the Premises and to dispose of the same in accordance with the provisions of law.

28.7 Remedies Cumulative. Landlord's remedies hereunder are cumulative, and Landlord's exercise of any right or remedy due to a default or breach by Tenant shall not be deemed a waiver of, or alter, affect or prejudice any other right or remedy which Landlord may have under this Lease or by law or in equity.

29. INDEMNIFICATION

To the fullest extent permitted by law, Landlord shall not be liable to Tenant or Tenant's employees, agents, servants, guests, invitees or visitors, or to any other person whomsoever, for any injury to person or damage to property on or about the Premises, Building or the building on the adjacent property owned by Landlord as described on Exhibit B, attached hereto, resulting from and/or caused in part or whole by the negligence or misconduct of Tenant, its employees, agents, servants, guests, invitees or visitors, or of any other person entering upon the Premises, or caused by the Building and improvements located on the Premises becoming out of repair, or caused by leakage of gas, oil, water or steam or by electricity emanating from the Premises, or caused by theft, or due to any cause whatsoever related to or arising out of Tenant's use and occupancy of the Premises or the conduct of Tenant's business or from any activity, work or thing done, permitted or suffered by Tenant in or about the Premises, and Tenant hereby covenants and agrees that it will at all times indemnify and hold safe and harmless Landlord (including without limitation the trustee and beneficiaries if Landlord is a trust), Landlord's employees, agents, servants, guests, invitees, and visitors from any loss, liability, claims, suits, costs, expenses, including without limitation attorney's fees and damages, both real and alleged, arising out of any such damage or injury, except injury to persons or damage to property the sole cause of which is the negligence of Landlord or the failure of Landlord to repair any part of the Premises which Landlord is obligated to repair and maintain hereunder within a reasonable time after the receipt of written notice from Tenant of needed repairs; provided that with respect to matters Tenant establishes in any action are within the scope of RCW 4.24.115, Landlord shall be entitled to indemnification by Tenant for damages arising out of bodily injury to persons or damage to property caused by or resulting from the concurrent negligence of Landlord, its agents or employees and Tenant, its agents or employees, but only to the extent of the concurrent negligence of Tenant, its agents or employees. In case of any action or proceeding brought against Landlord by reason of any claim for which Tenant is obligated to indemnify Landlord, Tenant upon notice from Landlord shall defend the same at Tenant's expense.

WAIVER: In consideration of Landlord's execution of this Lease, Tenant hereby waives any immunity Tenant may have under industrial insurance, Title 51 RCW, in connection with the foregoing indemnity.

30. WAIVER OF SUBROGATION

Anything in this Lease to the contrary notwithstanding, Landlord and Tenant each hereby waives any and all rights of recovery, claim, action or cause of action, against the other, its agents (including partners, both general and limited), officers, directors, shareholders or employees, for any loss or damage that may occur to the Building, the Premises, or any improvements thereto, or any personal or real property of such party therein, by reason of fire, the elements, or any other cause which could be insured against under the terms of standard fire and extended coverage insurance policies, regardless of cause or origin, including negligence of the other party hereto, its agents, officers or employees, and covenants that no insurer shall hold any right of subrogation against such other party. Each party shall cause each insurance policy obtained by it to provide that the insurance waives all right of recovery by way of a subrogation against either party in connection with any damage covered by any policy, provided that this Article shall be inapplicable if it would have the effect, but only to the extent it would have the effect, of invalidating insurance coverages of the parties. Tenant shall, upon obtaining the policy of fire and extended coverage required by this Lease, give notice to the insurance carrier that the foregoing waiver of subrogation is contained in this Lease.

31. LIMIT ON LANDLORD'S LIABILITY

31.1 Landlord's Interest. Anything in this Lease to the contrary notwithstanding and to the fullest extent permitted by law, covenants, undertakings and agreements herein made on the part of Landlord are made and intended not as personal covenants, undertaking and agreements for the purpose of binding Landlord personally or the assets of Landlord except Landlord's interest in the Premises and Building, but are made and intended for the purpose of binding only the Landlord's interest in the Premises and Building, as the same may from time to time be encumbered. No personal liability or personal responsibility is assumed by, nor shall at any time be asserted or enforceable against Landlord, its respective heirs, legal representatives, successors or assigns on account of this Lease or on account of any covenant, undertaking or agreement of Landlord in this Lease contained. In the event of any default or breach by Landlord with respect to any of the terms, covenants and conditions of this Lease to be observed, honored or performed by Landlord, Tenant shall look solely to the estate and property of Landlord in the Premises and the Building for the collection of any judgment (or any other judicial procedures requiring the payment of money by Landlord) and no other property or assets of Landlord shall be subject to levy, execution or other procedures for satisfaction of Tenant's remedies.

31.2 Tenant's Business Interruption. Notwithstanding any other provision of this Lease, and to the fullest extent permitted by law, Tenant hereby agrees that Landlord shall not be liable for injury to Tenant's business or any loss of income therefrom, whether such injury or loss results from conditions arising upon the Premises or the Building, or from other sources or places, including without limitation any interruption of services and utilities, or any casualty, or from any cause whatsoever, including, Landlord's negligence, and regardless of whether the cause of such injury or loss or the means of repairing the same is inaccessible to Landlord or Tenant. Tenant may elect, at its sole cost and expense to obtain business interruption insurance with respect to such potential injury or loss.

32. SEVERABILITY

If any term or provision of this Lease, or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable, the remainder of this Lease, or the application of such provision to persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each provision of this Lease shall be valid and enforceable to the extent permitted by law.

33. WAIVER OF COVENANTS

Failure of Landlord to insist in any one or more instances upon strict performance of any term, covenant or condition of this Lease or to exercise any option herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, covenant, condition or option, but the same shall continue and remain in full force and effect. The receipt by Landlord of rents with knowledge of a breach in any of the terms, covenants or conditions of this Lease to be kept and performed by Tenant shall not be deemed a waiver of such breach, and

Landlord shall not be deemed to have waived any provisions of this Lease until expressed in writing and signed by Landlord.

34. NOTICES

All notices, demands, consents and approvals which may or are required to be given by either party to the other hereunder shall be in writing and shall be deemed to have been fully given when deposited in the United States mail, certified or registered, return receipt requested, postage prepaid, and addressed to the party to be notified at the address for such party specified in this Lease, or to such other place as the party to be notified may from time to time designate by at least 15 days written notice to the notifying party.

To Landlord: **Tres Amigos I, LLC**
P.O. Box 890
Black Diamond, WA 98010

To Tenant: **South Sound Neurosurgery, P.L.L.C.**
7410 Eastside Dr. N.E.
Tacoma, Washington 98422

Tenant hereby appoints as its agent to receive the service of all dispossessory or distraint proceedings and notices thereunder the person in charge of or occupying the Premises at the time, and, if no person shall be in charge of occupying the same, then such service may be made by attaching the same on the main entrance of the Premises.

35. LIGHT AND AIR

Tenant agrees and covenants that no diminution of light, air or view by any structure which may hereafter be erected shall entitle Tenant to any reduction in Rent or Additional Rent under this Lease, result in any liability or obligation of Landlord to Tenant, or in any way affect this Lease or Tenant's obligations hereunder.

36. MISCELLANEOUS

36.1 Binding Effect. This Lease shall be binding upon and inure to the benefit of Landlord, its successors and assigns, and shall be binding upon and inure to the benefit of Tenant, its successors, and, to the extent assignment may be approved by Landlord hereunder, Tenant's assigns.

36.2 Remedies, Law and Venue. All rights and remedies of Landlord under this Lease shall be cumulative and none shall exclude any other rights or remedies allowed by law, and this Lease is declared to be a Washington contract, and all the terms hereof shall be construed according to the laws of the State of Washington and venue for any action brought hereunder shall lie in King County, Washington.

36.3 Captions. The captions in the Lease are for convenience only and are not part of this Lease.

36.4 Counterparts. This Lease may be simultaneously executed in several counterparts, each of which shall be an original and all of which shall constitute one and the same instrument.

36.5 Examination Of Lease. Submission of this instrument for examination or execution by Tenant does not constitute a reservation or option for lease, and this instrument shall not become effective as a lease or otherwise until execution and delivery by both Landlord and Tenant.

36.6 Entire Agreement. All negotiations, considerations, representations and understandings between Landlord and Tenant are incorporated herein and may be modified or altered only by agreement in writing between Landlord and Tenant, and no act omission of any employee or agent of Landlord or of Landlord's broker shall alter, change or modify any of the provisions hereof.

36.7 Authority. If Tenant is a corporation, each individual executing this Lease on behalf of said corporation represents and warrants that he is duly authorized to execute and deliver this Lease on behalf of said corporation in accordance with a duly adopted resolution of the Board of Directors of said corporation or in accordance with the Bylaws of said corporation, and that this Lease is binding upon said corporation in accordance with its terms. Concurrently with the execution of this Lease, Tenant shall deliver to Landlord a certified copy of a resolution of the Board of Directors of said corporation authorizing the execution of this Lease. If Tenant is a partnership, each individual executing this Lease on behalf of said partnership represents and warrants that he is duly authorized to execute and deliver this Lease on behalf of said partnership and that this Lease is binding upon said partnership in accordance with its terms, and concurrently with execution of this Lease, Tenant shall deliver to Landlord such evidence of authorization as Landlord may require. If Tenant is a marital community, or a member of a marital community, both members of the marital community shall execute this Lease or, concurrently with execution of this Lease, Tenant shall deliver to Landlord such evidence as Landlord may require that the member signing this Lease has the authority to sign on behalf of the marital community or that Tenant's interest in this Lease is to be the separate estate of the signing member.

36.8 Time. Time is of the essence of this Lease and each and every provision hereof, except as to the conditions relating to the delivery of possession of the Premises to Tenant.

36.9 No Brokers. Tenant represents and warrants to Landlord that it has not engaged any broker, finder or other person who would be entitled to any commission or fees in respect of the negotiation, execution or delivery of this Lease.

36.10 Force Majeure. Except for the payment of Rent, Additional Rent or other sums payable by Tenant, any prevention, delay or stoppage due to strikes, lockouts, labor disputes, acts of God, inability to obtain services, labor, or materials or reasonable substitutes therefor, governmental actions (including but not limited to failure to issue permits), civil commotions, fire or other casualty, and other causes beyond the reasonable control of Landlord (collectively, "Force Majeure"), shall excuse the performance of Landlord or Tenant for a period equal to any such prevention, delay or stoppage and, therefore, if this Lease specifies a time period for performance of an obligation by Landlord or Tenant, that time period shall be extended by the period of any delay in Landlord's or Tenant's performance caused by a Force Majeure.

36.11 Building Name. Tenant and Landlord shall cooperate with each other and the other tenants of the Building to appropriately name the Building.

36.12 Recordation. This Lease shall not be recorded, except that, at the request of either party, the parties shall execute a mutually acceptable memorandum of this Lease in recordable form, and shall record the same.

36.13 Joint Obligation. Where Tenant is comprised of more than one (1) person or entity, all covenants, agreements and obligations of Tenant hereunder shall be the joint and several covenants, agreements and obligations of each person or entity comprising Tenant.

IN WITNESS WHEREOF, Landlord and Tenant have executed this lease as of the day and year first above written.

LANDLORD	TENANT
Tres Amigos ~~1~~ I, LLC, a Washington limited liability company	~~Neurosurgical Consultants of Washington Inc.~~ ~~P.S.~~ South Sound Neurosurgery, P.L.L.C.
By: _____	By: _____
Name: Timothy A. Rector	Name: Richard Johns MD
Its: MANAGING MEMBER	Its: President

STATE OF WASHINGTON)
) ss.
COUNTY OF King)

On this 23rd day of January, 2002, before me, the undersigned, a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared TIMOTHY A. RECTOR, to me known to be Manag. Partner of Tres Amigos –I, LLC, a Washington limited liability company and who executed the within and foregoing instrument, and acknowledged to me that he signed and sealed the said instrument as his free and voluntary act and deed for the uses and purposes therein mentioned.

WITNESS my hand and official seal hereto affixed the day and year in this certificate above written.

JEANINE KIRPES NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXP. JULY 7, 2005

Jeanine Kirpes
NOTARY PUBLIC in and for the State of Washington, residing at Enumclaw
Print Name Jeanine Kirpes
My commission expires July 7, 2005

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

On this 20th day of February, 2002, before me, the undersigned, a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared Richard N.W. Wohms, to me known to be Manager Member of South Sound Neurosurgery, P.L.L.C., a Prof. Limited Liab. Co. and who executed the within and foregoing instrument, and acknowledged to me that he signed and sealed the said instrument as his free and voluntary act and deed for the uses and purposes therein mentioned.

WITNESS my hand and official seal hereto affixed the day and year in this certificate above written.

PAUL J. DAUENHAUER NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 7-10-03

Paul J. Dauenhauer
NOTARY PUBLIC in and for the State of Washington, residing at Seattle
Print Name P. Dauenhauer
My commission expires 7-10-03

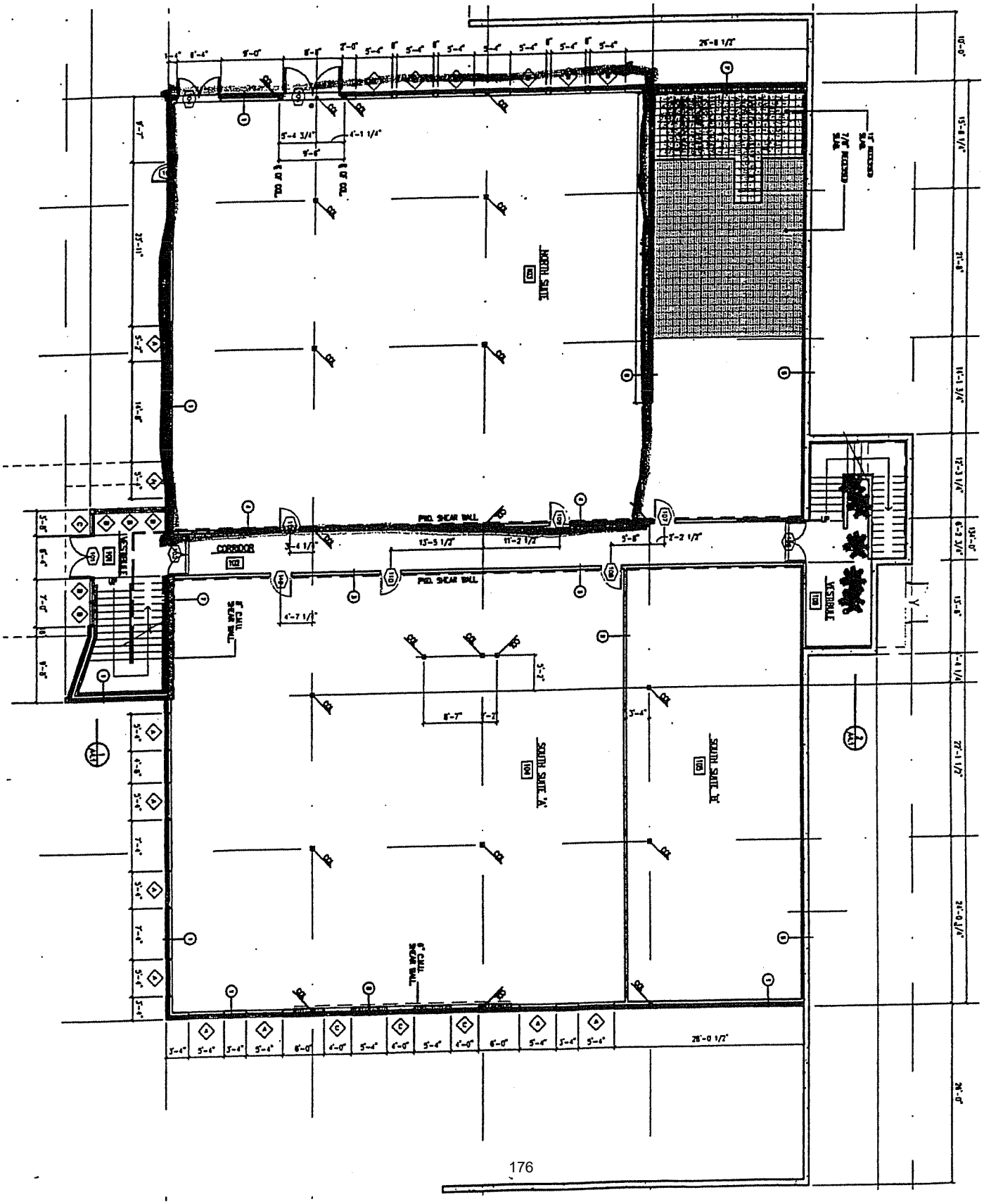
EXHIBIT A

LEGAL DESCRIPTION

The legal description is a 2.12 acre Northwest portion of lots 1 and 2, block 4, Southside addition to Puyallup, according to Plat recorded in volume 6 of Plats at page 90, in Pierce County, Washington. Except 15th Avenue SE, as delineated on said Plat and conveyed to the City of Puyallup by warranty deed recorded January 2, 1906 and recorded under recording number 203392.

EXHIBIT B

PREMISES



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Rev. 8/02/01

EXHIBIT C

DESCRIPTION OF SHELL WORK AT GROUND FLOOR (FIRST LEVEL OF MEDICAL OFFICE, 3RD STREET SIDE)

1. Complete floor structure with smooth concrete slab, no sealer and no finish.

2. Ceiling to be a sheetrock ceiling which is part of the floor structure for the 2nd floor. No suspended ceiling or finished sheetrock.

3. Exterior walls complete with framing, exterior finish, insulation and windows. No sheetrock on exterior walls except at common areas such as stairs. The cost of the excluded sheetrock (to 8'-6" above finish floor, screwed to framing, taped, one coat of mud, no sanding) will be credited to the tenant. Sheetrock at common areas will be screwed to framing, taped, one coat of mud, no sanding.

4. Interior walls only at common areas such as stairs and corridor, including framing and sheetrock one side (screwed to framing, taped, two coats of mud, sanding and finished). Interior wall in corridors on Tenant T/I side to be screwed to framing, taped, one coat of mud, no sanding. (The cost of such to be credited to Tenant). Sheetrock on the inside of the mechanical shaft is excluded; the cost of such (screwed to framing, taped, on coat of mud, no sanding) will be credited to the tenant. All floors finished in common areas, stairs and corridors are also part of shell work.

5. HVAC – The cost of a standard HVAC system for ~~10,725~~ 4575 square feet of office (including roof-top mounted HVAC units, ducts to the end of the mechanical shaft at 11'-0" above finish floor, power and gas lines from panel/meter to units, controls/thermostat) will be credited to the tenant. The mechanical shaft should allow for HVAC supply and return ducts for this floor as well as two 6-inch and two 4-inch conduits for power/telephone lines, two 6-inch fire sprinkler lines, and two 1-inch gas lines for service to the two medical office floors.

6. Electrical – Main electrical service with a buss gutter will be provided in the electrical room (located in southwest corner) for tenant distribution. Duplex outlets will be provided in the main corridor, one per tenant space wired to tenants space.

7. Fire Sprinkler system will be provided just below the ceiling level, which is the floor structure above including tees and plugs for drops for tenant.

8. Gas Service will be provided. The meters will be on the southside of the building for tenant distribution, and other than for the HVAC units.

9. Phone service – A 4-inch duct will be provided from the exterior building to the mechanical room (located in the southwest corner) to the tenant space for tenant installation and distribution.

10. Plumbing – A water service main will be located near the southeast corner of the building with a tee and valve for tenant distribution. A waste line main will be located under the floor structure of this level running east-to-west at the center of the tenant space. Tenant will supply taps for fixtures and vents as well as coring of concrete floor. Tenant to coordinate vent locations with tenants on 2nd floor. Location of line and the ability to run pipes before pouring of concrete will be coordinated with tenant's contractor.

TRIPLE NET EXPENSES (NNN)
OR
COMMON AREA MAINTENANCE (CAM)

THESE ARE ESTIMATES ONLY!

EXPENSE CATAGORIES – PER MONTH

taxes: real estate taxes	$2,295.
triple net expenses: maintenance	$ 400.
triple net expenses: general	$1,500.
triple net expenses: insurance	$ 785.
triple net expenses: fire alarm	$ 205.
triple net expenses: power	$ 290.
triple net expenses: cleaning	$ 200.
triple net expenses: garbage	$ 290.
triple net expenses: water	$ 215.
triple net expenses: landscape	$ 160.
triple net expenses: sewer	$ 85.
triple net expenses: parking lot	$ 85.
triple net expenses: cleaning supplies	$ 25.
triple net expenses: postage	$ 3.
Total Expense Categories:	$6,538.

Based on a 25,004 square foot building – the triple net or common area maintenance charge would be $.26 per square foot per month

(i.e.: 1500 square feet x $.26 = $390.00 per month or 25004 square feet x $.261 = $6,538.00 per month)

FIRST AMENDMENT TO MEDICAL OFFICE LEASE AGREEMENT (ASC)

FIRST AMENDMENT TO MEDICAL OFFICE LEASE AGREEMENT (ASC), made and entered into this __ day of October, 2003, by and between Tres Amigos I, LLC, a Washington limited liability company ("Landlord") and South Sound Neurosurgery, P.L.L.C., doing business as South Sound Neurosurgery Center ("Tenant").

Recitals

A. Landlord and Tenant are parties to that certain Medical Office Lease Agreement (ASC) dated January 23, 2002 (the "Lease").

B. Landlord has agreed to advance Tenant the sum of $30,186.89 to allow Tenant to pay and settle a claim asserted against Tenant and Tenant's contractor by McMullen Electric, Inc. (the "McMullen Claim").

C. The parties have agreed that Tenant will reimburse Landlord for such advance by increasing the Base Rent payable under the Lease.

Agreements

1. Advance. Upon the execution hereof, Landlord will advance to Tenant the sum of $30,186.89. Tenant agrees it will use such advance solely to pay the McMullen Claim, that it will cause the release of all liens related to the McMullen Claim, and that it will indemnify and hold Landlord harmless against and from the McMullen Claim and/or any lien or claim of lien arising out of the McMullen Claim.

2. Rent Adjustment. Commencing December 1, 2003, the Base rent payable each month under the Lease shall be increased by $298.88 ($30,186.89/101 remaining months). Accordingly, the table in Section 1.6 of the Lease is amended, effective December 1, 2003, to read as follows:

Lease Year	Monthly Base Rent
One and Two	$9726.94
Three and Four	$11,215.58
Five	$11,711.79
Six and each Lease Year thereafter	The sum of (x) the prior Lease Year's Base rent plus (y) four percent (4%) of prior Lease Year's Base Rent

3. No Other Amendments. Except as expressly modified herein, the Lease remains unmodified and in full force and effect.

Tres Amigos I, LLC, a Washington limited liability company

By _____
Timothy A. Rector, Manager

South Sound Neurosurgery, P.L.L.C.

By _____
Richard Wohns, M.D., President.

ADDENDUM A

LANDLORD'S ACKNOWLEDEGEMENT AND CONSENT TO TENANT'S COLLATERAL ASSIGNMENT OF TENANT'S RIGHTS IN PREMISES LEASE

A. **Notices.** Landlord hereby acknowledges and consents to the foregoing Assignment in its entirety. The capitalized terms in this Addendum shall have the same meaning as the Assignment. Landlord agrees to promptly deliver to Assignee copies of all written notice(s) that Landlord, its agents or attorneys may hereinafter deliver to Assignor arising in connection with any action(s) to enforce Landlord's rights in connection with the Premises Lease or to recover possession of the Premises, including, but not limited to Landlord's notices of any demands for unpaid rent, any actions calculated to evict Assignor from the Premises, forcible entry and detainer proceedings and summonses to recover possession of the Premises. Such notices shall be delivered in the manner described in the Section 5 of the Assignment.

B. **The Equipment.** In the event Landlord retakes possession of the Premises, Landlord agrees to take reasonable steps necessary to secure the Premises and protect the Equipment. Landlord agrees to take no action that may reasonably be calculated to result in damage to the Equipment, including but not limited to operation, relocation, or disassembly of the Equipment. Landlord shall not terminate the utilities to the Premises and shall promptly forward to Assignee any notice of, or any threat to terminate such utilities it receives. Landlord shall allow Assignee a reasonable opportunity to take those efforts as may be reasonable necessary to protect, secure or restore such utilities, including but not limited to allowing utilities access to the Equipment, the Premises or such areas necessary to restore or maintain utilities. Landlord agrees to cooperate with Assignee's and/or Assignee's agent's reasonable efforts to protect, secure or restore the Equipment in the event Landlord takes possession of the Premises, which may include, but shall not limited to, servicing, maintaining, inspecting, marking, identifying and demonstrating the Equipment. Assignee agrees to reimburse Landlord for all reasonable out-of pocket expenses incurred in connection with the foregoing.

C. **Assignee's Options.** Upon Assignee's receipt of any notice of Landlord's intention to enforce its rights under the Premises Lease, Assignee shall have the option (whether or not Assignor is then in default under the Financing Agreements) to: (i) advise Landlord in writing that it intends to remove the Equipment from the Premises, free and clear of any liens or other claims by Landlord for unpaid rent or other indebtedness owed Landlord in connection with the Premises Lease; or (ii) "cure" the Lease by tendering to Landlord the pro-rata portion of any unpaid rent for the Premises that due for the month which Assignee elects to cure the Premises Lease, after which Assignee may immediately take possession of the Premises and have full access and enjoyment thereof provided Assignee continues to cure the Lease by paying any ensuing rental payments to Landlord in the manner provided in the Premise Lease until such time as Assignee notifies Landlord that it desires to exercise options (i) or (iii) hereof; or (iii) to notify Landlord that Assignee desires to assume and/or assign the Lease to a new tenant. In the event Assignee exercises options (ii) or (iii) hereof, Landlord shall promptly deliver to Assignee copies of any keys to the Premises that may be in Landlord's possession or control. If Assignee elects to remove the Equipment from the Premises as provided in subsection (i), hereof, Assignee agrees to repair all damage resulting from such removal, or to pay any reasonable, out-of-pocket costs incurred by Landlord to repair such damages.

D. **Assumption or Assignment.** Assignee and/or Assignee's designated new tenant shall not be obligated to pay any past-due amounts owed to Landlord by Assignor under the Premises Lease, but Assignee and/or its designated new tenant shall otherwise be bound by all of the terms and conditions of the Premises Lease after the date of the assumption. Landlord may withhold consent to the assignment and assumption of the Premises Lease by Assignee, or its nominee for assumption, however Landlord shall not unreasonably withhold such consent and shall apply reasonable, standard and customary procedures and requirements for accepting new tenants on a non-priority, non-discriminatory basis.

[the remainder of this page has been intentionally left blank – signature page follows]

IN WITNESS WHEREOF, this Landlord's Acknowledgment and Consent to Tenant's Collateral Assignment of Tenant's Rights In Premises Lease has been duly executed the day and year first above written.

Landlord: Tres Amigos I LLC

(please print full legal name)

By: _____

(signature of duly authorized representative)

Print Name: T. A. RECTOR

Title: Mang MEMBER

Address: Box 890

Black Diamond

Telephone: 253 804 6600

STATE OF Washington

COUNTY OF Pierce

Before me, the undersigned, a Notary Public in and for said County and State, on this day personally appeared Tim Rector known to me to be the person(s) whose name(s) are/is subscribed to the foregoing instrument and acknowledged that they-s/he executed said instrument as their– her/his free and voluntary act and, if subscribed as a partner of a partnership, member of a limited liability company or officer of a corporation, as the free and voluntary act of said partnership or corporation, in each case for the uses and purposes therein set forth.

Given under my hand and seal this 10 day of Oct, 2005

RHONDA R JOHNSON NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 06/01/2008

Rhonda R. Johnson

Expires 6-1-2008

Exhibit 15b

Suite 102 Extension

LEASE EXTENSION AND AMENDMENT AGREEMENT
(Suite 102)

WHEREAS, Tres Amigos I, LLC a Washington Limited Liability Company, hereinafter "Landlord" entered into a lease dated January 23, 2002 (the "Lease") with South Sound Neurosurgery, PLLC and later assigned to Neospine Puyallup Surgery Center, LLC, a Washington Limited Liability Company, hereinafter "Tenant," for the following described space:

4,962.14 rentable square feet commonly known as the 1st Floor or Suite 102, 1519 3rd Street S.E., Puyallup, Pierce County, Washington

The Lease was for an initial term of ten (10) years commencing on October 1, 2002 through September 30, 2012. Through a written lease extension agreement, Landlord and Tenant extended the Lease term through September 30, 2017.

Whereas, Tenant is current on its rental payments to Landlord, Tenant desires to extend the Lease for an additional seven (7) year term beyond the September 30, 2017 Lease termination date, Tenant desires to receive a reduction in the current Monthly Base Rent, and Tenant desires to receive $7.00 per rentable square foot for Tenant Improvements to the Premises, and Landlord desires to amend the Lease to account for additional management fees, and Landlord and Tenant are in agreement.

NOW THEREFORE, for and in consideration of the covenants and agreement herein contained and or other good and valuable consideration, receipt and sufficiency of which is hereby mutually acknowledged, Landlord and Tenant agree as follows:

The Lease extension shall commence on August 1, 2015 and shall terminate on September 30, 2024.

Monthly Base Rent for the term of the Lease and this extension shall be:

> Monthly Base Rent shall be Eleven Thousand Four Hundred Seventy Four and 95/100 dollars ($11,474.95) per month commencing on September 1, 2015 and shall not increase until October 1, 2016. Commencing October 1, 2016, the Base Rent shall increase annually at three percent (3%) per annum. The Monthly Base Rent for the annual increases shall be calculated on the first day of October each year by taking the sum of x + y where "x" equals the prior Lease Year's Base Rent and "y" equals three percent of the prior Lease Year's Base Rent.

Tenant Improvements.

> Landlord agrees to contribute the sum of $7.00 per rentable square foot of the Premises (the "Allowance") toward the cost of performing Tenant Improvements to the Premises. The Allowance may only be used for the costs relating to the design, permitting, and construction of Tenant Improvements. The Allowance shall be paid to Tenant or, at Landlord's option and only to the extent owed to such party, to the order of the general contractor that performed the Tenant Improvements, within thirty (30) days following receipt by Landlord of (a) receipted bills covering all labor and materials expended and used in the Tenant Improvements; (b) a request to disburse from Tenant; (c) full and final waivers of lien (conditioned only upon payment of amounts not to exceed the Allowance); and (d) as-built plans of the Tenant Improvements. The Allowance shall be disbursed in the amount reflected on the receipted

bills meeting the requirements above. Notwithstanding anything herein to the contrary, Landlord shall not be obligated to disburse any portion of the Allowance during the continuance of an uncured default under the Lease, and Landlord's obligation to disburse shall only resume when and if such default is cured.

In no event shall the Allowance be used for the purchase of equipment, furniture or other items of personal property of Tenant. If Tenant does not submit a request for payment of the entire Allowance to Landlord in accordance with the provisions contained in this Lease Extension and Amendment Agreement by June 30, 2016, any unused amount shall accrue to the sole benefit of Landlord, it being understood that Tenant shall not be entitled to any credit, abatement or other concession in connection therewith. Tenant shall be responsible for all applicable state sales or use taxes, if any, payable in connection with the Tenant Improvements and/or Allowance, provided that such amounts shall be deemed to relate to the design, permitting, and construction of Tenant Improvements for purposes of reimbursement requests.

Landlord shall not unreasonably withhold, condition, or delay consent of any item requiring Landlord's approval under the terms of the Lease and related to Tenant Improvements under this Lease Extension and Amendment Agreement, and in the event of disapproval, shall provide Tenant with the specific reasons for the disapproval. Tenant shall not be liable for any of Landlord's costs or expenses related to such requested consents or related to the approval, supervision, monitoring, examination, or inspection of Tenant Improvements constructed by Tenant under this Lease Extension and Amendment Agreement.

Management Costs. Section 3(v) of the Lease shall be amended to read as follows:

(v) management costs (such management costs not to exceed $2,400 per month for the Building) and the cost of maintenance and service agreements for the Building and the equipment therein, including, without limitation, alarm service, window cleaning;

All other terms and conditions of the aforementioned Lease shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on this 14th, day of August, 2015.

Tres Amigos I, LLC

By: Tim Rector
Its: Manager/Member

Neospine Puyallup Surgery Center, LLC

By: Trent Webb
Its: Manager

STATE OF WASHINGTON
County of Pierce

On this _____ day of August 2015, personally appeared before me Tim Rector, manager and member of Tres Amigos I, LLC, that executed the within and foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said ownership, for the uses and purposes therein mentioned, and on oath stated that he is authorized to execute the said instrument.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, the day and year first written above.

NOTARY PUBLIC in and for the State of Washington

Residing at: _____
My Commission Expires: _____

Tennessee
STATE OF ~~WASHINGTON~~
County of ~~Pierce~~ Davidson

On this 14th day of August 2015, personally appeared before me Trent Webb, Manager of Neospine Puyallup Surgery Center, LLC, that executed the within and foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said ownership, for the uses and purposes therein mentioned, and on oath stated that he is authorized to execute the said instrument.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, the day and year first written above.

Linda Lyons
NOTARY PUBLIC in and for the State of ~~Washington~~ Tennessee

LINDA LYONS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

Residing at: Davidson, TN
My Commission Expires: 8-23-16

Exhibit 15c

Letter of Intent for Extension

CUSHMAN & WAKEFIELD

1290 Avenue of the Americas
7th Floor
New York, NY 10104
Tel +917-656-2708
cushmanwakefield.com

July 27, 2022

Ivar Gunderson
Tres Amigos I LLC
P.O. Box 160
Puyallup, WA 98371

Re:
Proposal to Lease – 1519 3rd St. S.E. Puyallup, WA

Dear Mr. Gunderson:

Cushman & Wakefield has been authorized by **Neospine Puyallup Surgery Center, L.L.C** (hereinafter referred to as Tenant") to release the following Letter of Intent to extend the current leases at space **1519 3rd St. S.E. Puyallup, WA** (hereinafter referred to as the "Building"). Please respond to us with a written response that addresses and confirms the following:

1. **Building Ownership/Landlord:**	Tres Amigos I LLC
2. **Tenant:**	**Neospine Puyallup Surgery Center, L.L.C**
3. **Area & Premises:**	13,086 square feet consisting of 4 suites **(Premises)** Suite 101: 4,714.1575 RSF, Suite 102: 4,962.14 RSF, Suite 103: 1,575.69 RSF, Suite 104: 1,834 RSF
4. **Lease Commencement Date:**	Lease Commencement Date shall be October 1, 2024
5. **Lease Term:**	Ten (10) years from the Lease Commencement date.
6. **Base Rental Rate & Escalations:**	$28.75 per RSF per month NNN. Three percent (3%) annual increases.
7. **Real Estate Taxes & Operating Expenses:**	Tenant responsible for payment of Real Estate Taxes. Landlord will at Tenant's request and cost dispute the real estate taxes and pursue a tax certiorari. Tenant responsible for all operating expenses.
8. **Tenant Improvement Allowance:**	Landlord shall provide Tenant a Tenant Improvement Allowance equal to $30.00 per RSF for the entire Premises. Tenant shall reserve the right to self-perform construction. Tenant shall have the following rights with respect to the TI Allowance: (a) the right to use the allowance for hard and soft construction costs, including architect and engineering fees, as well as for the cost of tele/data cabling, FF&E, etc.; (b) the right to competitively bid all construction work (including general contracting work) and; (c) the right to allow access to the loading docks,

CUSHMAN & WAKEFIELD

elevators, construction hoists, electrical service, etc. During the construction process at no charge to Tenant or Tenant's vendors and contractors. No supervisory fee will be payable to the Landlord with respect to Tenant's improvements.

Please note, Tenant intends on making a significant investment to upgrade the facility.

Tenant will provide Landlord paid receipts for invoices every 30 days during the construction period. The Landlord will reimburse Tenant from the TI Allowance for paid receipts every 30 days until the either the construction is completed or the TI allowance has been exhausted.

9. Alterations: Lessee shall not require Lessor's consent for all non-structural alterations or modifications to the interior of their space that do not exceed fifteen thousand dollars ($15,000).

10. Repairs By Lessee: Lessee shall keep or cause to be kept the interior portions of their space in good order, repair and condition, and shall perform all other maintenance and repair of the interior of the Premises, of whatsoever kind and nature, and shall make all replacements to the Premises required.

11. Building Base Conditions, Floor Slab, Roof & Structural Responsibility: Landlord shall provide a Building free of structural defect including the floor structure, structural beams, and structural columns.

Landlord shall bear sole responsibility for all structural defects or repairs required whether by deterioration over time or through act of nature. This includes but is not limited to the walls, slab, columns, beams, and roof.

12. Space Plan: Landlord to provide space plans as PDF and AutoCAD files.

13. Use: Tenant's use of the Premises will be as outpatient ambulatory surgical center with 23hr and 59 minute stay capability.

14. Security Deposit: As per existing lease

15. Options to Renew: Tenant shall have two (2) consecutive rights to renew the term, each upon nine (9) months prior written notice, and each for a five (5) year period. The Base Rent Rate for the renewal period shall be the lesser of (i) the then escalated Base Rental Rate or (ii) 95% of fair market value for similar product taking into consideration typical market concessions including TI allowance, free rent, etc.

16. Assignment & Sublease: Provided Tenant is not in default, Tenant shall have the right to assign or sublet the premises during the Lease Term, subject to standard building restrictions with prior Landlord consent which shall not be unreasonably withheld. Landlord shall have ten (10) business days to either accept or reject Tenants' prospective Subtenant, provided Landlord is provided with the necessary background and financials. Failure to respond within ten (10) business days shall be deemed as landlord having approved Tenant's request to sublet the space to a prospective Subtenant. Tenant may, upon written notice to landlord, but without Landlord's consent, assign the lease to

	any company which owns or controls Tenant, which acquires tenant, or which merges or consolidates with Tenant, so long as Tenant continues to remain liable under the Lease. Consent shall not be required for assignment or sublease to a direct affiliate, parent, or subsidiary of Surgery Partners.
17. Holdover:	Tenant shall have the right to hold over up to two (2) months following the expiration of the Lease Term, or any extension thereof, at the same Base Rent and other terms that are in effect during the last month of the previous Lease. Thereafter, the holdover rent will be at 125% of the Base Rent in effect during the last month of the previous Lease.
18. HVAC:	Tenant at Tenant's sole cost and expense shall have the right to modify and or add units to meet healthcare guidelines. Landlord will have ten (10) business days to review and approve all engineering drawings and reports to ensure they comply with city code and building structural tolerances. **Landlord will provide Tenant with a $100,000 HVAC improvement allowance.**
19. Signage:	As per existing lease.
20. Access:	Tenant's employees shall have access to the Premises 24 hours per day, seven days per week, 365 days per year.
21. Parking:	As per existing lease.
22. Generator:	As per existing lease.
23. Roof Rights:	As per existing lease
24. Right to Go Dark:	Tenant's vacating of its Premises shall not be grounds for default under the proposed lease.
25. Default/Self Help:	Tenant requires a Landlord Default provision, which provision shall include a Tenant Self Help remedy. Tenant must have the right to cure the default and offset rent for the cost thereof.
26. Non-Disturbance Agreement:	Confirm that Tenant will receive a non-disturbance agreement from current and future mortgagees and ground lessors, if any, in a form acceptable to Tenant.
27. Commission:	Landlord will pay Cushman & Wakefield a single full market commission of $0.50 per square foot per year of additional term.
28. Confidentiality:	Landlord and tenant shall agree to maintain confidentiality with respect to all conversations and documents related to the proposed transaction.
29. Non-Binding:	This Letter of Intent has been submitted for the purpose of facilitating lease negotiations between Tenant and Landlord, but it does not contain all of the essential terms of a lease document that Tenant would be willing to sign.

Please direct your proposal response to Cushman & Wakefield in writing directly on this form and return via email

to yarden.drimmer@cushwake.com. It would be greatly appreciated your response to this proposal is submitted no later than 5:00 PM Pacific on Friday, July 29th. Thank you and please call should you have any questions or need further clarification. We look forward to your timely response.

Sincerely,
Tres Amigos I LLC

Ivar Gunderson
Managing Member
(253) 347-8824

Cushman & Wakefield

Yarden Drimmer
Executive Director
(212)-328-4220

Cc: Brian Blankenship, Surgery Partners

Exhibit 15d

Property Tax Statement

Pierce County Assessor-Treasurer
Property Summary

1519 3RD ST SE

TRES AMIGOS I LLC
7790000553

Tax Description

Section 34 Township 20 Range 04 Quarter 32 SOUTH SIDE ADD TO PUYALLUP: SOUTH SIDE ADD TO PUYALLUP NW OF SW 34-20-04E L 1 OF S P 2001-11-29-5005 TOG/W EASE & RESTRICTIONS OF REC APPROX 92,510 SQ FT OUT OF 055-1 SEG N-0440 JU 1/15/02JU

Property Details

Parcel Number	7790000553
Site Address	1519 3RD ST SE
Account Type	Real Property
Category	Land and Improvements
Use Code	6511-MEDICAL OFFICES SERVICES

Taxpayer Details

Taxpayer Name	TRES AMIGOS I LLC
Mailing Address	PO BOX 160 PUYALLUP, WA 98371

Appraisal Details

Neighborhood	503 / 830
Value Area	PI3
Appr Acct Type	Commercial
Business Name	TRES AMIGOS MEDICAL CENTER
Last Inspection	07/14/2016-New Construction
Appraisal Area	5

Related Parcels

Group Account Number	n/a
Located On	n/a
Associated Parcels	1200055538 2092002965 2620002095

Assessed Value

Value Year	2021	**Assessed Total**	6,837,700
Tax Year	2022	**Assessed Land**	1,201,600
Taxable Value	6,837,700	**Assessed Improvements**	5,636,100
Tax Code Area	096	**Current Use Land**	0
Tax Code Area Rate	10.356250150438	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$6,837,700
Assessed Value	$6,837,700

Tax Amounts Due

Tax Year	Minimum Due	Total Due
2022	36,974.29	73,948.58
TOTAL	**36,974.29**	**73,948.58**

Due Date 4/29/22

Property Tax Exemptions

No exemptions

Land Details

Land Economic Area	2053
RTSQQ	04-20-34-32
Value Area	PI3
Neighborhood	503 / 830
Square Footage	92,510
Acres	2.124
Front Foot	208
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Building 1 Details

General Characteristics

Property Type	Commercial
Condition	Average
Quality	Good
Neighborhood	503
Occupancy	Medical
Square Feet	25,426
Net Square Feet	25,426
Attached Garage Square Feet	0
Detached Garage Square Feet	0
Carport Square Feet	0
Finished Attic Square Feet	0
Total Basement Square Feet	0
Finished Basement Square Feet	0
Basement Garage Door	0
Fireplaces	0

Built-As

DESCRIPTION	Medical Offices
YEAR BUILT	2002
ADJUSTED YEAR BUILT	2002
SQUARE FEET	25,426
STORIES	2
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Masonry
ROOF	n/a
HVAC	Complete HVAC
UNITS	1
SPRINKLER SQUARE FEET	25,426

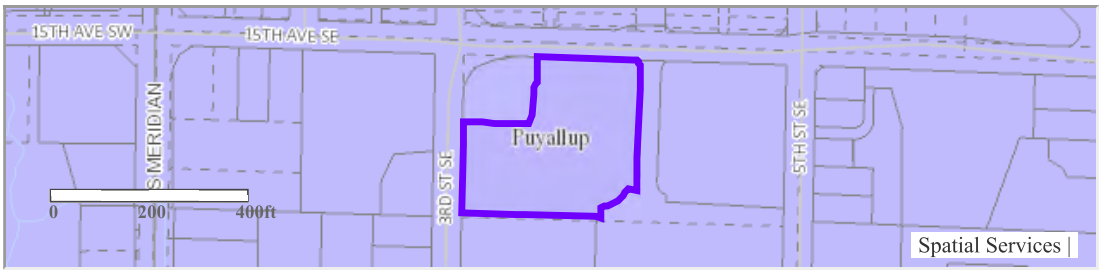
Improvement Details

Type	Description	Units
Add On	Asphalt (AV)	51,140

Sales History

SALE DATE	11/01/2001
ETN	1077969
PARCEL COUNT	1
GRANTOR	
GRANTEE	
SALE PRICE	970,900
DEED TYPE	Statutory Warranty Deed
SALES NOTES	Improved after sale

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Exhibit 16

Historical Financials

Microsurgical Spine Center
Historical Income Statement

	2018	2019	2020	2021
Revenue				
Patient Revenue	$ 15,565,306	$ 22,627,485	$ 20,547,522	$ 22,352,180
Contractual Adjustments	$ (11,550,804)	$ (15,960,241)	$ (14,414,973)	$ (15,902,059)
Other Revenue	$ -	$ -	$ 132,930	$ 5,886
Net Patient Revenue	$ 4,014,503	$ 6,667,245	$ 6,265,478	$ 6,456,006
Expenses				
Salaries & Wages	$ 707,162	$ 853,318	$ 873,954	$ 849,579
Contract Labor	$ 22,309	$ 21,535	$ 584	$ 822
Employee Benefits	$ 118,016	$ 153,600	$ 146,108	$ 190,362
Employee General & Admin	$ 2,774	$ 3,434	$ 944	$ 1,008
Seminars & Education	$ 4,734	$ 4,077	$ 1,377	$ 275
Dues, Fees, & Subscriptions	$ 7,387	$ 10,410	$ 9,832	$ 14,746
Travel & Entertainment	$ 19,219	$ 38,736	$ 7,330	$ 20,130
Office Supplies	$ 17,914	$ 21,724	$ 17,617	$ 22,749
Medical Supplies	$ 848,913	$ 1,632,983	$ 1,565,580	$ 1,647,546
Professional Fees	$ 139,748	$ 74,104	$ 63,010	$ 84,536
Medical Related Fees	$ 105,627	$ 110,364	$ 108,540	$ 116,227
Leases & Rentals	$ 136,297	$ 139,178	$ 154,326	$ 150,425
Repairs & Maintenance	$ 82,378	$ 101,373	$ 106,633	$ 106,006
Utilities	$ 26,555	$ 29,142	$ 27,344	$ 27,769
Internal Mgmt & Collection Fees	$ 241,817	$ 397,849	$ 376,045	$ 385,110
Insurance, Taxes, & Licenses	$ 110,728	$ 163,164	$ 219,521	$ 225,089
Other Expenses	$ 3,200	$ -	$ -	$ -
Bad Debts	$ (15,786)	$ 21,494	$ (1,944)	$ 37,512
Total Expenses	$ 2,578,993	$ 3,776,484	$ 3,676,800	$ 3,879,891
Net Income	**$ 1,435,509**	**$ 2,890,760**	**$ 2,588,678**	**$ 2,576,116**
Depreciation	$ 151,730	$ 157,618	$ 158,291	$ 178,655
Gain/(Loss) on Disposal	$ (747)	$ -	$ -	$ -
Interest & Other Income	$ 17,607	$ (3,855)	$ 5,807	$ 2,565
Interest & Other Expense	$ (6,946)	$ (4,882)	$ (3,144)	$ (16,033)
Net Income Less Interest & Depreciation	**$ 1,293,693**	**$ 2,724,406**	**$ 2,433,052**	**$ 2,383,993**

Microsurgical Spine Center
Balance Sheet

	Historical			
	2018	2019	2020	2021
Months	12	12	12	12
ASSETS				
Current Assets				
Cash and Equivalents	$ 552,294	$ 285,539	$ 3,281,399	$ 2,692,440
Accounts Receivable (Net)	$ 586,463	$ 874,168	$ 665,388	$ 1,088,265
Other Receivables	$ 9,544	$ -	$ -	$ -
Inventories	$ 37,301	$ 36,078	$ 48,191	$ 57,557
Prepaid Expenses	$ 22,614	$ 29,771	$ 7,207	$ 19,814
Due from Related Party	$ 561,248	$ 3,384,091	$ 3,157,781	$ 5,438,466
Total Current Assets	**$ 1,769,465**	**$ 4,609,648**	**$ 7,159,966**	**$ 9,296,543**
Property & Equipment				
Leasehold Improvements	$ 858,554	$ 858,554	$ 858,554	$ 858,554
Furniture, Fixtures, & Equipment	$ 27,253	$ 27,253	$ 27,253	$ 27,253
Computers & Software	$ 123,690	$ 123,690	$ 123,690	$ 124,802
Medical Equipment	$ 1,336,755	$ 1,430,711	$ 1,230,432	$ 1,552,976
Right of Use	$ -	$ -	$ 200,370	$ 436,731
Accumulated Depreciation	$ (1,807,244)	$ (1,934,862)	$ (2,086,535)	$ (2,265,190)
Total Property & Equipment	**$ 539,007**	**$ 505,346**	**$ 353,765**	**$ 735,126**
Other Assets				
Right of Use - Operating	$ -	$ -	$ 460,024	$ 348,557
Total Assets	**$ 2,308,472**	**$ 5,114,994**	**$ 7,973,754**	**$ 10,380,226**
LIABILITIES AND OWNER EQUITY				
Current Liabilities				
Accounts Payable	$ 104,012	$ 128,845	$ 132,947	$ 174,400
Accrued Payroll	$ 34,915	$ 80,729	$ 58,008	$ 32,962
Employer Liabilities	$ 47,582	$ 59,403	$ 57,948	$ 62,011
Capital Leases	$ 39,856	$ 41,595	$ 42,948	$ 59,739
Interest Payable	$ -	$ -	$ 619	$ 158
Taxes Payable	$ 7,464	$ 9,520	$ 10,696	$ 10,894
Other Current Liabilities	$ 40,553	$ 76,589	$ 207,359	$ 182,139
Total Current Liabilities	**$ 274,383**	**$ 396,681**	**$ 510,525**	**$ 522,303**
Long Term Liabilities				
Long Term Capital Leases	$ 92,421	$ 50,826	$ 18,444	$ 165,410
Other Long Term Liabilities	$ 55,865	$ 57,278	$ 414,488	$ 278,223
Total Long Term Liabilities	**$ 148,286**	**$ 108,104**	**$ 432,932**	**$ 443,633**
Shareholders' Equity				
Acquisition Equity	$ 1,344,208	$ 1,344,208	$ 1,344,208	$ 1,344,208
GP Distributions	$ (7,617,204)	$ (7,617,204)	$ (7,617,204)	$ (7,617,204)
Physicians Acquisition Equity	$ 12,709	$ 12,709	$ 12,709	$ 12,709
LP Distributions-Physicians	$ (6,350,937)	$ (6,350,937)	$ (6,350,937)	$ (6,350,937)
Total Additional Capital	$ -	$ -	$ (12,963)	$ (12,963)
Retained Earnings	$ 14,497,027	$ 17,221,433	$ 19,654,484	$ 22,038,477
Total Shareholders' Equity	**$ 1,885,804**	**$ 4,610,209**	**$ 7,030,297**	**$ 9,414,291**
Total Liabilities and Equity	**$ 2,308,472**	**$ 5,114,994**	**$ 7,973,754**	**$ 10,380,226**

Exhibit 17

Patient Transfer Agreement

MULTICARE HEALTH SYSTEM
PATIENT TRANSFER AGREEMENT
FOR MHS UNAFFILIATED HOSPITALS & FACILITIES

This Patient Transfer Agreement ("Agreement") is made by and between **MultiCare Health System ("MHS")** and **Microsurgical Spine Center ("Facility"), (collectively referred to as the "Party" or "Parties")** to establish a coordinated program for the use of the respective skills, resources and physical plant of each Party to provide improved and continuous patient care.

NOW, THEREFORE, MHS and Facility agree as follows:

1. Term of Agreement. This Agreement shall be effective June 1, 2014 and shall continue for a term of three (3) years unless terminated earlier as set forth below. Thereafter, unless terminated by written noticed delivered at least thirty (30) days prior to the effective date of termination, this Agreement shall automatically renew for an additional three (3) year terms.

2. Purpose of Agreement. In order to provide continuous patient care to meet the needs of patients, each Party agrees to accept appropriate transfers from one Party to the other Party of patients in need of the specialized services of the type provided by the receiving institution. In the event of a transfer, the transferred patient will qualify for admission to the receiving Facility on an emergency basis. If a transferred patient does not have a covering provider able to continue care at the transferee Facility, the transferee Facility may refer the patient to appropriate providers.

3. Independent Contractor Status. Each Party is an independent contractor with respect to the other Party. Neither Party is authorized or permitted to act or to claim to be acting as an agent or employee of the other Party. Nothing in this Agreement alters in any way control of the management, assets or affairs of either Party. Neither Party by virtue of this Agreement assumes any liability for any debts or obligations of any kind incurred by the other Party to this Agreement. Nothing in this Agreement shall be construed as limiting the rights of either Party to contract with any other Facility on a limited or general basis.

4. Patient Transfer & Transport Policy. Facility shall follow the guidelines and provisions of the MultiCare Health System Patient Care Policy, entitled: Patient Transfer & Transport to Another Facility, as amended, whenever transferring or transporting an MHS patient between Facilities. In addition:

a. Patients transferred for cardiac surgery back-up must meet the requirements on Exhibit B.

b. Patients transferred to neuro interventional radiology must meet the requirements set forth on Exhibit C.

c. Patients transferred for obstetrics must meet the requirements set forth on Exhibit D

d. Neonate patient transfers must meet the requirements set forth on Exhibit E

5. Coordination of Transfer of Patient. The need to transfer a patient from one Party to the other shall be determined by the patient's attending physician. When such a determination has been made, the transferring Party shall immediately notify the appropriate physician in the receiving Party's unit of the proposed transfer. The transferring physician and the receiving physician shall confer and jointly determine the patient's appropriateness for transfer. A patient in an emergency medical condition within the meaning of the Act (defined below) may be transferred only if the receiving Party has agreed to accept the transfer and to provide appropriate medical treatment and has available space and qualified personnel to treat the patient. Prior to moving the patient, the transferring Party must receive confirmation from the receiving Party that it can accept the patient. To the extent applicable, the Emergency Medical Treatment and Active Labor Act of 1985 (42 USC § 1395dd) (the "Act") shall apply its implementing regulations and supersede any contrary provision of this Agreement.

6. Patient Medical Records. The transferring Party shall send along with each transferred patient an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption including a discharge summary together with essential identifying and administrative information. The information shall include, when appropriate, the following:

a. Initial diagnostic impression.

b. Patient's name, address, hospital number and age, and name, address and phone number of next of kin.

c. History of injury or illness.

d. Condition at admission.

e. Vital signs (including Glasgow coma score).

f. Pre-hospital condition and treatment.

g. Condition and treatment during stay in emergency department and at time of transfer.

h. Treatment rendered to patient including medications given and route of administration.

i. Laboratory and x-ray findings, appropriate laboratory specimens (when appropriate or indicated) and all x-ray films.

j. Fluids given by type and volume.

k. Name, address and phone number of physician referring the patient.

l. Name of physician at receiving Party who has been contacted about the patient.

m. Name, address and phone number of patient's designee who is patient's attorney-in-fact under patient's healthcare power of attorney.

n. The original or a copy of patient's healthcare power of attorney, living will and/or healthcare directives.

Additional information may be required as set forth on the applicable Exhibit.

7. Transportation of Patient. The transferring Party shall arrange for transportation of the patient to the receiving Party including selection of the mode of transportation and providing qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transfer unless otherwise agreed between the parties. The receiving Party's responsibility for the patient's care shall begin when the patient is admitted either as an inpatient or an outpatient to the receiving Party.

8. Transfer of Patient's Personal Property. The transferring Party is responsible for the transfer or the appropriate disposition of the patient's personal effects including money and valuables and information related to these items. The receiving Party's responsibility for the Patient's personal effects and belongings shall begin at such time as the receiving Party has inventoried and documented receipt of such items.

9. Patient's Consent to Transfer. The transferring Party is responsible for obtaining the patient's consent (or proper substituted or implied consent) to the extent necessary under the Act.

10. Patient Transfer Coordinators. Each Party shall provide the other Party with the name and title of persons authorized to initiate, confirm and accept the transfer of a patient on behalf of such Party. Each receiving Party shall inform the transferring Party of the location to which to bring patients in the Facility. The parties agree to provide each other information about the patient care services offered by such Party. The parties agree to cooperate and jointly review cases in which either Party has questions about appropriateness of transfer.

11. Transfers Arising From Mass Casualties or Natural Disasters: Mutual Aid Pact. In the event of any cause or circumstance arising from a natural disaster or mass casualty, the Parties shall communicate with one another as soon thereafter as is practicable, in order to ascertain the relative impacts of such disaster or casualty upon one another and their respective capabilities for sending and/or receiving patients under the Agreement. In such situations:

a. Whenever circumstances allow, each Party, as the receiving Facility, further agrees to accept "block transfers" of as many patients sent from the sending Facility as may be practicable, in order to free up beds in the Facility most directly impacted by the event, including patients with lower acuity levels or non-emergent needs.

b. The Parties will, in addition to their obligations under the Agreement, establish communications protocols to be triggered in the event of a natural disaster or mass casualty, including the appointment of designated patient transfer coordinators at MHS and Facility who shall act as the primary point(s) of contact during any such event or circumstance.

c. At such time as the long-term needs of the sending Facility are better understood in the context of the event, the sending Facility will advise the receiving Facility of its capacity to retrieve patients sent in contemplation of the need for bed space, at which time the parties will evaluate the plan of care for each such patient and determine whether the patient's needs will best be met by returning to the original Facility or remaining at the receiving Facility.

12. Nondiscrimination. Neither Party may refuse to receive a patient by reason of such patient's race, religion, gender, age, national origin, sexual orientation, martial status, handicap, disability or medical diagnosis in providing services under this Agreement.

13. Patient HIV Status. Neither Party may refuse to receive a patient because the patient is HIV positive or has AIDS. The portion of the medical records reflecting the patient's HIV or AIDS status will be transmitted in a secure and sealed envelope with the patient's medical records. The patient's HIV status may be disseminated only to those healthcare providers who have a medical need to know or as provided by law.

14. Confidentiality. Both parties agree that the confidentiality of each patient's medical records must be maintained. To achieve that goal, the Parties agree to transport medical records in a manner designed to maintain the confidentiality of the medical record as required by applicable law, including applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The parties agree

to amend or modify this Agreement at such times as may be required by the terms of HIPAA with respect to the exchange of protected health information for purposes of each Party's treatment, payment or operations associated with any transfers conducted under this Agreement.

15. Financial Arrangement. Charges for services performed by either of the Parties for patient's transfer pursuant to this Agreement shall be collected by the Party rendering such services and shall be collected directly from patient, from third Party payors or other sources of payment. Neither Party shall have any liability to the other for the billing, collection or payment of charges for services performed by such other Party except as otherwise provided in this Agreement or to the extent that such liability would exist separate and apart from this Agreement.

16. Compliance with Laws and Regulations. Each Party is deemed an instrumentality of the Federal Government [Medicare/Medicaid Providers] and terms of this agreement will be construed in accordance with applicable Federal and State statutes.

17. Notice. Any notice given with respect to this Agreement must be in writing and shall be delivered either by hand to the Party or by certified mail, return receipt requested to the Party at the Party's address stated herein. Any Party may change its address herein by giving notice of the change in the manner described in this section.

18. Termination Without Cause. Either Party may terminate this Agreement without cause, upon 30 days advance written notice, in which event the terminating Party must complete its duties under the Agreement with respect to any patient who is being transferred at the time of termination.

19. Automatic Termination. This Agreement shall be terminated immediately upon the occurrence of any of the following:

a. Either Party fails to maintain its licensure, certification or accreditation under local, state or federal law or is otherwise legally prohibited from providing the services described herein.

b. Either Party is in material default under any of the terms of this Agreement.

20. Advertising and Publicity. Neither Party shall use the name of the other or the existence of this Agreement in any promotional or advertising material unless prior written approval of the material to be used and the intended use is first obtained from the other Party.

21. Liability. Each Party shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Party.

22. Claims. The parties shall promptly notify one another in writing of any claim arising out of performance of Transfers pursuant to this Agreement or demand to indemnify and shall cooperate with one another in a reasonable manner to facilitate the defense of such claim.

23. Non-waiver. The failure of either Party to exercise any of its rights under this Agreement is not a waiver of such rights or a waiver of any rights for subsequent breach.

24. Assignment. This Agreement may not be assigned by either Party without the prior written consent of the other Party.

25. Severability. If any part of this Agreement is held to be unenforceable, the remainder of this Agreement will remain in full force and effect.

26. Amendments. This Agreement may be supplemented, amended, or revised only in writing by agreement of both parties.

27. Headings. The heading to the various sections of this Agreement have been inserted for convenience only and shall not modify, define, limit or expand express provisions of this Agreement.

28. Authorization for Agreement. The execution and performance of this Agreement by each Party have been duly authorized by all necessary laws, resolutions or corporate actions and this Agreement constitutes the valid and enforceable obligation of each Party in accordance with its terms.

29. Entire Agreement. This Agreement sets forth the parties' final and entire agreement and supersedes all prior and contemporaneous oral or written communications between the parties, their agents and representatives related to this matter. There are no representations, promises, terms, conditions or obligations other than those contained herein.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed to be effective the day and year set forth above.

FACILITY

By: Cathie Rosa
Print: Cathie Rosa
Title: Business Office Manager
Date: 7-7-2014

MULTICARE HEALTH SYSTEM

By: Marcia Johnson
Print: Marcia Johnson
Title: COO
Date: June 25, 2014

Exhibit A

Requirements for Elective PCI Patients

Purpose: This Exhibit A to the Patient Transfer Agreement (the "Agreement") between **MultiCare Health System ("MHS") and Microsurgical Spine Center ("Facility"), (collectively referred to as the "Party" or "Parties")** applies to patients transferred to obtain cardiac surgery back-up and support due to undergoing elective percutaneous coronary interventions without on-site cardiac ("PCI Patients").

1. Consent. In addition to the requirements set forth in the Agreement, the Party performing surgery shall obtain a consent from PCI Patients which explicitly communicates to such patients that the percutaneous coronary intervention ("PCI") is being performed without on-site surgery back-up and addresses risks related to transfer, the risk of urgent surgery, and refer to this Agreement.

2. Coordination. The Parties shall coordinate, to the extent possible, the availability of surgical teams and operating rooms at MHS so that for all hours that elective PCIs are being performed at Facility, there is a reasonable likelihood that MHS has the capacity to immediately accept a referral. The parties acknowledge and agree that nothing in this Agreement imposes an obligation on MHS to maintain an available cardiac surgical suite twenty-four hours a day, seven days a week.

3. Periods of High Occupancy. During times of high census where MHS' ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), MHS will notify Facility and Facility's elective procedures will be rescheduled subject to the attending physician's assessment that such delay does not compromise the patient's care and condition.

4. Transportation of PCI Patients. In addition to the requirements set forth in Section 6 of the Agreement, Facility shall:

a. Maintain a signed transportation agreement with a qualified vendor that provides for expeditious transport for any patient experiencing complications during an elective PCI that requires transfer to MHS. A qualified vendor is one whose transport staff is ACLS certified. Facility will provide the experienced and skilled personnel and equipment to monitor and treat the patient en route, including management of an intra-aortic balloon pump (IABP);

b. Document and confirm that emergency transportation begins for each patient within twenty minutes of the initial identification of a complication by the attending physician;

c. Document transportation times from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of MHS and confirm transportation time is less than one hundred twenty minutes; and

d. Participate annually in two timed emergency transportation drills with outcomes communicated to both parties' quality assurance programs. The staff and cost of internal resources used for such drills will be the responsibility of Facility employing such staff or owning that resource. The cost of any external resources required for such drills will be the responsibility of Facility.

MHS shall not have any financial obligation or liability whatsoever under this Section 4.

5. PCI Patient Medical Records. In addition to the information required in Section 5 of the Agreement, Facility shall send to MHS all records (or copies thereof) related to the emergency condition which the patient has presented available at the time of the transfer, along with all diagnostic imaging and videos.

6. Physician Communication. Facility will monitor all transfers to assure that the physician performing the elective PCI communicates immediately and directly with MHS' cardiac surgeon(s) about the clinical reasons for the urgent transfer and the PCI Patient's clinical condition.

7. Quality Assurance. The parties shall schedule cardiac patient care quality assurance conferences at least twice per year that involve case reviews of a significant number of pre-operative and post-operative PCI cases at Facility including a one-hundred percent (100%) review of all transport cases.

Exhibit B

Requirements for Stroke Patients

Purpose: This Exhibit B to the MHS Inter-Facility Transfer Agreement applies to stroke patients transferred to any Facility hosting a neuro-interventional radiology program ("Stroke Program").

1. Checklist. Each Facility shall use the following checklist when transferring stroke patients to any Facility hosting an MHS Stroke Program:

a. Consult MHS' endovascular interventional neuroradiologist at 253-934-1020 who is typically either Brian Kott, MD or Alison Nohara, MD.

b. After consultation, if the patient is accepted for transfer, follow sending Facility's policies for transferring a patient to another Facility.

c. Typically whenever the patient is being directly transferred to interventional radiology located at Tacoma General Hospital; use the emergency department entrance for access to 2K.

d. Subject to EMTALA requirements, DO NOT delay the transfer if all test/procedures cannot be completed.

e. Discuss with receiving physician if unsure of which tests/procedures to complete.

f. In addition to the requirements of this Agreement, provide the following, if such records, images and studies are not directly available at the receiving Facility through EPIC or other systems maintained by MHS at the receiving Facility:

i. Copy of patient's hospital chart including:
-allergies
-past medical history, home medications
-medications and treatments at your hospital
-NIH Stroke Scale Assessments
-Time of symptom onset, last known well, situation, background
-Face Sheet – (Demographics, Family contact info, billing info)

ii. Imaging – CD copies of all imaging with results or PACS transfer

-head CT
-chest X ray
-Any other imaging

iii. Copy of Lab Studies:
-PT, PTT, INR
-Complete Blood Count
-Basic Metabolic panel, including BUN and Creatinine
-Any other lab results

g. Provide the following patient care including:
-IV access (Preference is RAC and Left arm 18 gauge if possible)
-Use Normal saline for all fluids
-Foley (retention) catheter
-NPO unless patient passed a documented RN swallow screen (consider gastric tube)

h. Key phone numbers:

253-403-1062 Interventional Radiology Department (fax 253-403-3909)
253-403-1050 Emergency Department
877-523-9835 Hospital Supervisor (pager)
253-934-1020 On call pager for Kott/Nohara

Exhibit C

Requirements for Obstetric Patients

1. **Contact Numbers:**
   a. Transfers to TG: (253-403-1034)
   b. Transfers to GSH: (253-697-5900)
   c. Transfers to AMC: (232-333-2522)

2. **Tacoma General Hospital**. Each Facility shall use the following checklist when transferring obstetric patients to Tacoma General Hospital.
   a. Contact the Birth Center Charge Nurse (253-403-1034) to coordinate transfer, to include confirmation of available obstetric bed space, confirmation of available NICU bed space (if applicable), and identification of an accepting provider.
   b. If transferring to Maternal Fetal Medicine service, the Birth Center Charge Nurse will contact the MFM Provider on call and arrange a return call to the transferring provider.
   c. If transferring a low risk patient due to unavailable obstetric services and the patient has no Obstetric provider at Tacoma General Hospital, the Birth Center Charge Nurse will facilitate contact with the MultiCare OB/GYN Associate on call to receive the patient as an obstetric "NO DOC" patient.
   d. If transferring a low risk patient requiring the level of services available at Tacoma General Hospital, but transferring provider is retaining status as attending provider, coordinate transfer with the Birth Center Charge Nurse.
   e. Proceed to **III. All MHS Obstetrics Transfers** checklist.

3. **Good Samaritan Hospital and Auburn Medical Center**. Each Facility shall use the following checklist when transferring obstetric patients to Good Samaritan Hospital or Auburn Medical Center.
   a. Patients must be 34 weeks or greater and deemed low risk prior to transfer. All pt less than 34 weeks or deemed high risk will be transfer to TG.
      b. Contact the Labor and Delivery Charge Nurse at Good Samaritan (253-697-4383) or Auburn Medical Center (232-333-2522) to coordinate transfer, to include confirmation of available obstetric bed space, confirmation of available SCN bed space (if applicable), and identification of an accepting provider.
   c. OBHG will be contacted to assess and accept appropriate transfers. This will be a provider to provider call.
   d. Proceed to **III. All MHS Obstetrics Transfers** checklist.

4. **All MHS Obstetrics Transfers.** After consultation, if the patient is accepted for transfer, follow sending Facility's policies for transferring a patient to another

Facility. For patients whose prenatal course is not documented in EPIC, include copy of the prenatal chart with transport documents.

a. For patients with diagnosis of preterm labor or active term labor, reassess cervical dilatation prior to transporting the patient, if last exam has been greater than 1 hour, to assure that advanced labor has not increased the risk of in transit delivery.

b. For patients with preterm labor or active labor with fetal concerns, where risk for delivery in transit is high, contact the NICU to coordinate attendance of the Neonatal Transport Team to stabilize and transport the neonate.

c. Prior to the patient's departure from the transferring Facility, a hand off report to the Birth Center Charge Nurse will occur.

d. In addition to the requirement s of this Agreement, provide the following, if such records are not directly available at the receiving Facility through EPIC or other systems maintained by MHS at the receiving Facility: Copy of the patient's hospital chart including:
    i. Prenatal record
    ii. Allergies
    iii. Past medical history, home medications
    iv. Medications and treatment at the transferring Facility
    v. Summary of current complaint to include onset, signs and symptoms
    vi. Demographic face sheet

Exhibit E

Requirements for Neonates

1. **Contact Numbers:**
   a. Transfers to TG: (253-403-1034)
   b. Transfers to GSH: (253-697-5900)
   c. Transfers to AMC: (232-333-2522)

2. **Tacoma General**. Facility shall adhere to the following when requesting a transfer to the Tacoma General NICU:
   a. Consult with the Neonatologist on call in the MHS NICU (253-403-1024).
   b. After consultation, if the patient is accepted for transfer, the TG NICU Transport Team will be dispatched to transport the infant.
   c. The Transport Team will provide the following documents and request they be completed (the transport team may assist in completing the forms or the physician at the referring hospital may do so):
      1) Signed "Neonatal Transport Consent"
      2) Signed, "Notice of Privacy Practices Acknowledgement Form"
      3) Signed, "Authorization for MultiCare to use or disclose My Health Care Information"
      4) Provide copies of the patient/maternal chart:
         a) All maternal documentation (i.e. Maternal History/physical; lab values; delivery notes; nurses/physician notes; etc.)
         b) All infant documentation: (i.e. Admission physical, lab values, radiology studies, nursing notes, physician notes, etc.)

3. **Good Samaritan Hospital and Auburn Medical Center.** Facility shall use the following checklist when transferring neonatal patients to Good Samaritan Hospital or Auburn Medical Center.
   a. Patients must be 34 weeks or greater and deemed low risk prior to transfer. All pt less than 34 weeks or deemed high risk will be transfer to the TG NICU.
   b. Contact the Labor and Delivery Charge Nurse at Good Samaritan (253-697-4383) or Auburn Medical Center (232-333-2522) to coordinate transfer, to include confirmation of available SCN bed space and identification of an accepting provider.
   c. IPS (253-597-4626) will be contacted to assess and accept appropriate transfers. This will be a provider to provider call.
   d. After consultation, if the patient is accepted for transfer, follow sending Facility's policies for transferring a patient to another Facility.
   e. Prior to the patient's departure from the transferring Facility, a hand off report to the Special Care Nursery Nurse will occur.
   f. In addition to the requirements of this Agreement, provide the following, if such records are not directly available at the receiving Facility through EPIC or other systems maintained by MHS at the receiving Facility:

Copy of the patient's hospital chart including:

1) Birth record
2) Medications and treatment at the transferring facility
3) Nursing notes
4) Summary of current complaint to include onset, signs and symptoms (H&P and progress notes)
5) Physician orders
6) Demographic face sheet