MultiCare Health System
820 A Street, Tacoma, WA 98402
PO Box 5299, Tacoma, WA 98415-0299 ~ multicare.org

August 12, 2022

8/12/2022 Received

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

Re: MultiCare Health System Certificate of Need Application to Develop and Operate a New Certificate of Need Approved Ambulatory Surgery Facility (ASF) with Two (2) Operating Rooms in Thurston County.

Dear Mr. Hernandez:

I am pleased to submit this certificate of need application request on behalf of MultiCare Health System ("MultiCare"). MultiCare is requesting approval to develop and operate a new Certificate of Need approved ASF with 2 operating rooms in Thurston County.

MultiCare's vision is to be the highest *value* system of health in the Pacific Northwest. To create value, we aspire to deliver world-class health outcomes and exceptional experience at a competitive price. To do this, it is imperative we perform services outside of the hospital – in a lower cost setting – whenever possible.

The health care delivery model is migrating towards lower-cost, outpatient settings, like ASFs. Consumers deserve high-quality and accessible care, at a lower cost. Supporting this effort, payers and regulatory entities seek to steer surgeries to ASFs, when feasible. Further, the reality is that most surgeries done in a hospital can be performed in an ambulatory surgery center. The challenge is that there are not enough ambulatory surgery operating rooms in Thurston County today. MultiCare seeks to change that and respectfully requests Certificate of Need approval for an ASF with 2 operating rooms in the Thurston planning area.

Thank you for your assistance regarding this request. Please submit any notices, correspondence, communications and documents to:

Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
253-403-8771
ekobberstad@multicare.org

Frank Fox, PhD
HealthTrends
206-366-1550
frankfox@comcast.net

Sincerely,

K. Erin Kobberstad
Vice President, Strategic Planning
MultiCare Health System

Washington State Department of Health

Date Stamp Here

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: K. Erin Kobberstad Vice President, Strategic Planning **Signature:** K Erin Kobberstad **Dated:** 8/12/22	**Phone Number:** 253-403-8771 **Email Address:** ekobberstad@multicare.org
Legal Name of Applicant: MultiCare Health System **Address of Applicant:** MultiCare Health System 820 A Street Tacoma, WA 98402	**Number of Operating Rooms requested – include procedure rooms:** Two operating rooms **Estimated Capital Expenditure**: $5,403,772

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

Thurston County Planning Area

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Introduction and Rationale

MultiCare Health System ("MultiCare") respectfully submits this application, with the goal of receiving a Certificate of Need (CN) approval for a two (2) operating room, ambulatory surgical facility (ASF). MultiCare's vision is to be the Pacific Northwest's highest *value* system of health. To create value, we aspire to deliver world-class health outcomes and exceptional experience at a competitive price. To do this, it is imperative we perform services outside of the hospital – in a lower cost setting – whenever possible.

The health care system delivery model is migrating towards lower-cost, outpatient settings, like an ASF. Consumers deserve high-quality care at a lower cost (value). Supporting this effort, payers and regulatory entities seek to steer surgeries to ASFs, when feasible. Further, the reality is that most surgeries done in a hospital can be performed in an ambulatory surgical facility. The challenge is that there are not enough ambulatory surgery operating rooms in Thurston County to accommodate this shift today. MultiCare seeks to change that and respectfully requests CN approval for an ASF with 2 operating rooms in the Thurston planning area.

MultiCare acquired Capital Medical Center on April 1, 2021. MultiCare Capital Medical Center has 8 operating rooms for general use, and 2 operating rooms for c-sections. However, we do *not* have an ASF. We seek to open an ASF to meet the growing trend from inpatient to outpatient, to meet the consumer and payer demand, and expand access to care, with a special focus on women's services. We plan to locate the ASF at 601 McPhee Road Southwest. This center would open in July 2024. It will be freestanding, meaning that it will not be under the hospital license, thereby allowing us to match reduced payments from payers by performing surgeries in a lower cost setting.

The late Dr. Angela J. Bowen spearheaded a successful campaign during the late 1970's and early 1980's to bring a second hospital to Olympia. She was a fierce defender of women's reproductive rights and fought hard to protect access to care for women. Across from this proposed ASF, we are building a clinic for urology, and a first-of-its-kind women's clinic. This women's clinic will focus on breast health, pelvic floor, gynecology, reproductive health, and other services specific to women. This is important as other states implement laws instituting greater restrictions on reproductive care which are expected to lead to patients from those states deciding to seek care in Washington. As a community-based, secular, not-for-profit health system, MultiCare is committed to providing needed access to reproductive services. This women's clinic will allow us to expand upon Dr. Bowen's vision to enhance access to women's services and unrestricted reproductive services.

This ASF will be a place to perform a wide variety of surgeries. Our vision is to focus on urology and women's procedures – benefiting from being across the hall from the urology clinic and women's clinic. However, it will also allow us to address the reality that many other surgeries can safely be done in an ASF, including ear, nose, and throat (ENT), gastroenterology, general surgery, gynecology, neurology, podiatry, urology, and vascular surgery.

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)

   MultiCare Health System ("MultiCare")

   MultiCare Health System
   820 A Street
   Tacoma, WA 98402

   The ambulatory surgical facility(ASF) will be a DBA of MultiCare Health System. Following CN approval of the proposed request, a trade name for the facility will be selected. For the purposes of this application and subsequent screening responses, 'NEWDIV' is used for the proposed ASF.

   The address for the proposed NEWDIV facility is:

   601 McPhee Rd SW
   Olympia, WA 98502

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

   NEWDIV will be a DBA of MultiCare Health System.

   MultiCare Health System is a not-for-profit corporation. The UBI Number of MultiCare is 601-100-682.

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

   K. Erin Kobberstad
   Vice President, Strategic Planning
   253-403-8771
   MultiCare Health System
   820 A Street
   Tacoma, WA 98402
   ekobberstad@multicare.org

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.**

   Please see Exhibit 1 for an organization chart of MultiCare. NEWDIV will be a “Doing Business As” (dba) of MultiCare.

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.**

   NEWDIV is not an existing facility. Therefore, this question is not applicable.

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.**

   The address for the proposed NEWDIV is:

   601 McPhee Rd SW
   Olympia, WA 98502

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

   Please see the *Introduction and Rationale* section at the beginning of this application for a detailed description of the proposed project. MultiCare requests CN-approval to develop and operate a new certificate of need approved ASF with two (2) operating rooms in Thurston County.

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
Assumed CN Approval	March 2023
Design Complete	October 2023
Construction Commenced	December 2023
Construction Completed	June 2024
Facility Prepared for Survey	June 2024
Project Completion	July 2024

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: Neurology and Vascular

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: Colorectal Surgery

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

   NEWDIV is not an existing facility. Therefore, this question is not applicable.

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, NEWDIV would have a total of two (2) operating rooms.

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 operating rooms at NEWDIV would be exclusively dedicated to endoscopy, cystoscopy, or pain management services.

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

    The ASF will serve patients aged three years and older who require ENT, gastroenterology, general surgery, gynecology, neurology, podiatry, urology, and vascular 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.**

    Please see Exhibit 2 for the letter of intent.

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

    Please see Exhibit 3 for single-line drawings of the 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.**

Confirmed, NEWDIV week be licensed and certified by Medicare and Medicaid.

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

Yes, NEWDIV will seek accreditation from 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.

If your project includes construction, please indicate if you've consulted with CRS and provide your CRS project number.

We anticipate meeting with CRS in the fourth quarter of 2022. A CRS project number has not yet been assigned.

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 Exhibit 4 for a complete list of hospitals and ASFs in the Thurston Planning Area.

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

   ASFs which provide a service mix of ENT, gastroenterology, general surgery, gynecology, neurology, podiatry, urology, and vascular surgical procedures can be considered sufficiently similar to NEWDIV. Therefore, Olympia Surgery Center, Gastroenterology Associates (endoscopy), Olympia Multi-Specialty Clinic Ambulatory Procedure Center (endoscopy), and Ear Nose Throat Associates Southwest, Inc. P.S. (ENT) provide similar services as a subset of NEWDIV's proposed services.

   In the case of Olympia Surgery Center, although it was approved for multiple specialties in CN1520, its 2017 DOH Operating Room (OR) Response---the only one in recent history, it reported only providing orthopedic and pain management procedures. In summary, there is a very limited number of providers providing the range or mix of services NEWDIV proposes to provide.

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

   Based on need methodology from the Washington Department of Health, there is demonstrated quantitative need for 1.87 additional outpatient operating suites.[1] Therefore, there would not be an unnecessary duplication of services.

[1] The numeric need methodology does show a surplus of mixed-use rooms. But for the reasons described in this section, there is need for additional outpatient focused operating rooms in the planning area.

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).[2] Hospitals and ASFs voluntarily report OR utilization through an annual utilization survey distributed by the Washington Department of Health. As of July 1, 2022, OR utilization data for 2020 was available for six planning area hospitals and ASFs. For the remainder, we rely on earlier Department evaluations of projects in the Thurston Planning Area. In all cases, we prioritize the most recent data available. Table 1 lists the current supply of CN-approved operating rooms in the Thurston Planning Area not dedicated to endoscopy or pain management.

Table 1: Supply of CN-Approved Outpatient and Mixed Use ORs in the Thurston Planning Area

Hospitals, CN-Approved	Mixed Use Operating Rooms	Outpatient Operating Rooms
Providence St. Peter Hospital	11	5
Capital Medical Center	10	
ASFs, CN-Approved	**Mixed Use Operating Rooms**	**Outpatient Operating Rooms**
Laser and Surgery Center, LLC		3
Olympia Surgery Center		6
Total	**21**	**14**

Sources:
2021 Department of Health OR Survey, Eval of CN21-80

Notes:
Excludes Gastroenterology Associates which is endoscopy only and not counted in Department's numeric need methodology.

From Table 1, there are 35 CN-approved ORs in the Thurston Planning Area, including 21 inpatient/mixed use ORs and 14 CN-approved outpatient ORs. Additionally, licensed, CN-exempt outpatient ORs have been identified (listed in Table 2 below) and their outpatient surgery volumes included in the methodology to determine planning area surgery use rates, while their ORs have not been included in the count of ORs within the forecast need model. Operating rooms dedicated to

[2] 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 surgical facility in Bellevue within East King County". Department of Health, October 9, 2018, page 9.

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.[3]

Table 2: Supply of CN-Exempt Outpatient ORs in the Thurston Planning Area

ASFs, CN-Exempt	Mixed Use Operating Rooms	Outpatient Operating Rooms
Olympia Orthopedic Associates		6
Pacific Cataract and Laser Institute		2
Ear Nose Throat Associates Southwest, Inc. P.S.		1
Foley Plastic Surgery Center		1
Pearl Plastic Surgery		1
Pain Care Physicians PLLC		2
Total, CN Exempt ORs	**0**	**13**

Sources:
2021 Department of Health OR Survey, Eval of CN21-80, Eval of CN17-21

Notes:
Excludes Olympia Multi-Specialty Clinic Ambulatory Procedure Center (endoscopy Only) and Olympia Pain and Spine Surgery Center (Pain only).

Excludes Olympia Orthopedic Associates (The Spine Center). Determination of reviewability submitted for two CN-exempt outpatient ORs submitted on 06/30/22. As of July 21, 2022, a determination has not been posted to the Department's website.

The data and assumptions used in the numeric need calculations are presented in Table 3. These are generated from population forecasts by Washington State's Office of Financial Management (OFM) and planning area utilization data from the 2021 Department of Health OR Survey. We also rely on earlier Department evaluations[4] of projects in the Thurston Planning Area, where priority is given to the most recent data. For detail on the data sources by hospital, see Exhibit 4.

Table 3: Summary of Data and Assumptions Used in Numeric Need Methodology	
Planning area	Thurston County
Population estimates and forecasts, all ages	Year 2020: 294,332 Year 2027 (3rd Year of Operation)[5]: 324,109 Source: OFM GMA Projections (2017 Release, the most recent available)
Planning area surgeries	Inpatient or Mixed Use: 19,407 Outpatient: 17,138

[3] WAC 246-310-270(9)(iv)

[4] Evaluation of CN21-80 and CN17-21.

[5] NEWDIV is anticipated to begin operations in partial year 2024. Therefore, the third full year of operation will be 2027.

	Total: 36,545 Source: 2021 Department of Health OR Survey, Eval of CN21-80, Eval of CN17-21
Planning area use rate	Surgeries/2020 Population*1,000 = 102.51 per 1,000 persons
Surgery case mix	Outpatient: 58.48% Inpatient: 41.52%
Average minutes per case	Outpatient: 56.2 Inpatient: 102.0 Source: 2021 Department of Health OR Survey, Eval of CN21-80, Eval of CN17-21
OR annual capacity (in minutes)	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes
Existing OR capacity (in ORs)	14 dedicated outpatient ORs 21 mixed use ORs See Table 1
Summary of need calculations	Surplus of Mixed Use ORs Need of 1.87 Outpatient ORs

Exhibit 5 presents a step-by-step calculation of net need using the assumptions and data 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=14

Capacity = 68,850 minutes per year per OR

Total annual capacity in minutes: 14*68,850 = 963,900 minutes

Minutes per surgery = 56.24 minutes

Total annual capacity in outpatient surgeries:

963,900 / 56.24 = **17,138 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 = 21

Capacity = 94,250 minutes per year per OR

Total annual capacity in minutes: 21*94,250 = 1,979,250 minutes **(a)(iv)**

Minutes per surgery = 101.99 minutes

Total annual capacity in inpatient/mixed use surgeries:

1,979,250 / 101.99 = 19,407 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 2027 and the use rate of 102.51 per 1,000 residents, there is a projected total of 33,224 surgeries in the Thurston Planning area. [(b) (i)]

An estimated 41.52% of surgeries were performed as inpatient/mixed use and 58.48% as outpatient surgeries. Thus, of the 33,224 forecasted surgeries for 2027, 13,793 would be inpatient/mixed use surgeries and 19,431 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:

19,431 – 17,138 = 2,293 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 = 1,277,507

Inpatient/mixed use cases = 12,526

Average inpatient/mixed use minutes per case = 101.99

Outpatient surgery minutes = 992,455

Outpatient cases = 17,646

Average outpatient minutes per case = 56.24

(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: 14,464 surgeries * 101.99 minutes/surgery = 1,475,186 minutes, or [(b)(i) * (b)(iii)]

Remaining outpatient minutes: 2,293 surgeries (b)(i) * 56.24 minutes/surgery (b)(iii) = 128,960 minutes, or [(b)(ii) * (b)(iii)]

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

1,406,750 minutes + 128,960 minutes = 1,535,710 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.

1,535,710 minutes < 1,979,250 minutes

The model shows an overall surplus. However, this is due to a surplus of mixed-use rooms whereas there is need for 1.87 outpatient ORs in the Thurston Planning Area.

(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.

Not applicable.

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.

Although the model shows an overall surplus, this is due to a surplus of mixed-use rooms whereas there is need for additional outpatient operating rooms. There are also important qualitative arguments that support approval of the proposed project. These include an increasing use rate, a limited supply of planning area outpatient providers, and the efficiency and patient preference of outpatient ORs over inpatient ORs.

Increasing use rate and high population growth, particularly among older residents

The model as presented above and in Exhibit 5 assumes a constant use rate. However, it is likely this use rate will increase over the forecast period for the following reason:

(1) The planning area population is becoming older, with 2020-2025 population forecasts projecting average annual growth rates of about 3.64% for persons aged 65+ in the Thurston planning area (compared to growth rates of about 0.96% for persons under the age of 65). Since older persons have a higher surgery use rate than younger persons, as the population in the planning area ages, the surgery use rate will rise. As such, a 102.51 use rate per 1,000 residents for ambulatory surgeries, held constant, is a conservative approach and may underestimate future demand for outpatient surgeries.

Limited Supply of Outpatient Providers in the Thurston Planning Area

Currently, there are only two CN-approved outpatient facilities in the Thurston planning area, excluding Gastroenterology Associates. As of 2022, only eight facilities performed non-endoscopy outpatient procedures. A majority of these facilities performed only a limited range of services, with several facilities seemingly only performing a single specialty, including plastic surgery, ophthalmology, ENT, and orthopedics. Given the trend towards outpatient care, because the Department's numeric need methodology uses historical shares to predict future distributions of need for mixed use and outpatient ORs, the Department's numeric need methodology understates the demand for outpatient ORs in the Thurston Planning Area. Given the evolving landscape shifting more procedures to an outpatient setting, additional outpatient ORs are a critical need in the community.

Efficiency and Patient Preference for Outpatient ORs

If approved, NEWDIV can add two operating rooms, providing greater accessibility to planning area residents for outpatient surgical services. Given the existing planning area need, without this increase in outpatient surgery capacity, planning area residents in need of surgical services will need to either outmigrate to neighboring planning areas, or obtain services in a hospital-based setting.

Adding capacity with an additional ASF reduces travel time and costs, as well as patient inconvenience and anxiety when patients are able to obtain both office care and surgical care in the same location. Furthermore, outpatient facilities are generally more efficient and cost-effective in comparison to inpatient surgery departments, leading to lower contractual rates for purchasers and cost savings for patients. Constraints on the supply of outpatient surgical services will push patients into the higher cost inpatient operating rooms, and result in lower planning area efficiency.

Specific Focus on Outpatient Women's Care Delivery

As stated earlier, MultiCare's vision is to enhance and expand access to all outpatient surgeries, and additionally, to specifically focus on women's care. Our vision is to focus on urology and women's procedures at NEWDIV – benefiting from being located across the hall from the urology clinic and women's clinic.

The late Dr. Angela J. Bowen, who spearheaded a successful campaign during the late 1970's and early 1980's to bring a second hospital to Olympia, was a fierce defender of women's reproductive rights and fought hard to protect access to care for women. Across from this proposed ASF, we are building a clinic for urology, and a first-of-its-kind women's clinic. This women's clinic will focus on breast health, pelvic floor, gynecology, reproductive health, and other services specific to women. This is important as other states implement laws instituting greater restrictions on reproductive care which are expected to lead to patients from those states deciding to seek care in Washington. As a community-based, secular, not-for-profit health system, MultiCare is committed to providing needed access to reproductive services. This women's clinic will allow us to expand upon Dr. Bowen's vision to enhance access to women's services, in general, and specifically on unrestricted reproductive

services. The proposed ASF will have a focus on urology and women's procedures[6] – benefiting from being across the hall from the urology clinic and women's clinic.

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

   NEWDIV is not an existing facility. Therefore, this question is not applicable.

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 4 we present projected surgical volumes for the initial partial years of operation (2024) and the first three full years of operation given project approval (2025 through 2027). Upon project completion, NEWDIV anticipates providing the following surgical specialties: ENT, gastroenterology, general surgery, gynecology, neurology, podiatry, urology, and vascular surgery.

Table 4: NEWDIV Projected Case Count, 2024 to 2027

Cases	Jul to Dec 2024	2025	2026	2027
ENT	118	277	308	328
Gastroenterology	63	146	163	173
General Surgery	242	565	629	669
Gynecology	212	496	552	586
Podiatry	87	205	228	242
Urology	215	504	561	596
Neurology	55	128	142	151
Vascular	27	62	69	74
Total Cases	**1,019**	**2,383**	**2,653**	**2,819**

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").[7] This survey is included in our application as Exhibit 6. For utilization estimates by surgical specialty please see Table 5 below.

[6] In addition to gynecology, general surgery includes, but is not limited to, procedures related to breast health.
[7] The estimates are found in Table 3 of the report. This report was revised on February 28, 2017.

Table 5: 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

Source: "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.

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.[8] Estimates of population use rates were calculating by dividing the surgery 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.

2. The NCHS use rates were multiplied by 2020-2024 Thurston Planning Area population forecasts, and then divided by 10,000 in order to forecast Planning Area resident ambulatory surgeries by procedure type, by year. Table 8 includes these procedure estimates for the planning area.

[8] The NCHS survey covers procedures performed in ambulatory surgery facilities, both hospital-based and freestanding. Hospitals include non-institutional hospitals exclusive of federal, military, and Department of Veterans 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 for Medicare participation. The NSAS sample of facilities was selected using a multistage probability design with facilities having varying selection probabilities.

Table 6: NEWDIV Ambulatory Surgery Forecasts, 2024 to 2027

PROCEDURE (ICD-9-CM Code)	Utilization	Total Number of Procedures, Thurston County Planning Area			
	2010 Rate/10,000	Jul to Dec 2024	2025	2026	2027
Months		**6**	**12**	**12**	**12**
All Operations (01-86)	1560.3	24,279	49,383	49,972	50,570
Operations on the Nervous System (01-05)	136.6	2,126	4,324	4,376	4,428
Operations on the Endocrine System (06-07), operations on the hemic and lymphatic system (40-41), and obstetrical procedures (72-75)	11.3	175	356	360	365
Operations on the Eye (08-16)	254.7	3,964	8,063	8,159	8,257
Operations on the Ear (18-20)	34.1	530	1,078	1,091	1,104
Operations on the Nose, Mouth and Pharynx (21-29)	77.8	1,211	2,463	2,492	2,522
Operations on the Respiratory System (30-34)	9.1	142	289	292	295
Operations on the Cardiovascular System (35–39,00.50–00.51,00.53–00.55,00.61–00.66)	34.7	539	1,097	1,110	1,123
Operations on the Digestive System (42-54)	324.7	5,053	10,278	10,401	10,525
Operations on the Urinary System (55-59)	43.6	679	1,380	1,397	1,413
Operations on the Male Genital Organs (60-64)	17.0	264	537	544	550
Operations on the Female Genital Organs (65-71)	57.1	888	1,807	1,829	1,850
Operations on the Musculoskeletal System (76–84,00.70–00.73,00.80–00.84)	228.8	3,560	7,240	7,327	7,414
Operations on the Integumentary System (85-86)	140.3	2,183	4,441	4,494	4,547
Miscellaneous diagnostic and therapeutic procedures and new technologies (87-99, 00)	190.5	2,964	6,029	6,101	6,174
Total Planning Area Cases	**1560.3**	**24,278**	**49,382**	**49,971**	**50,568**
Service Area Population		**2024**	**2025**	**2026**	**2027**
Thurston Planning Area		311,215	316,507	320,279	324,109

Source: Applicant

3. A market share figure was applied to each procedure code group based on the experience of MultiCare's experience and expertise in the proposed specialties, as well as the expected shift from inpatient to outpatient. Table 7 presents our market share assumptions.

Table 7: NEWDIV Market Share Assumptions, 2024-2027

NEWDIV Market Share Assumptions	Jul to Dec 2024	2025	2026	2027
Market share annual change		**15%**	**10%**	**5%**
Operations on the Nervous System	1.5%	1.7%	1.9%	2.0%
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	10.0%	11.5%	12.7%	13.3%
Operations on the Eye	0.0%	0.0%	0.0%	0.0%
Operations on the Ear	4.0%	4.6%	5.1%	5.3%
Operations on the Nose, Mouth and Pharynx	4.0%	4.6%	5.1%	5.3%
Operations on the Respiratory System	0.0%	0.0%	0.0%	0.0%
Operations on the Cardiovascular System	3.0%	3.5%	3.8%	4.0%
Operations on the Digestive System	1.0%	1.2%	1.3%	1.3%
Operations on the Urinary System	20.0%	23.0%	25.3%	26.6%
Operations on the Male Genital Organs	20.0%	23.0%	25.3%	26.6%
Operations on the Female Genital Organs	10.0%	11.5%	12.7%	13.3%
Operations on the Musculoskeletal System	1.5%	1.7%	1.9%	2.0%
Operations of the Integumentary System	3.0%	3.5%	3.8%	4.0%
Miscellaneous diagnostic and therapeutic procedures and new technologies	1.0%	1.2%	1.3%	1.3%

Source: Applicant

4. Estimated planning area surgeries were then multiplied by the presumed market share figures for the ASF, yielding forecasted number of procedures, by year. These projections are included below in Table 8. Assuming project completion to occur by partial year 2024, Year One is then 2025, since that is the first full year of operations after project completion.

Table 8: NEWDIV Projected Number of Ambulatory Surgeries, by Type, 2024-2027 (Thurston Residents Only)

NEWDIV Cases, Based on Market Share	Jul to Dec 2024	2025	2026	2027
Operations on the Nervous System	32	75	83	88
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	18	41	46	48
Operations on the Eye	-	-	-	-
Operations on the Ear	21	50	55	59
Operations on the Nose, Mouth and Pharynx	48	113	126	134
Operations on the Respiratory System	-	-	-	-
Operations on the Cardiovascular System	16	38	42	45
Operations on the Digestive System	51	118	132	140
Operations on the Urinary System	136	317	353	375
Operations on the Male Genital Organs	53	124	138	146
Operations on the Female Genital Organs	89	208	231	246
Operations on the Musculoskeletal System	53	125	139	148
Operations of the Integumentary System	65	153	171	181
Miscellaneous diagnostic and therapeutic procedures and new technologies	30	69	77	82
Total Cases	612	1,431	1,593	1,692
Thurston Planning Area Cases	24,278	49,382	49,971	50,568
MultiCare Thurston ASF Market Share, Thurston Planning Area	2.5%	2.9%	3.2%	3.3%

Source: Applicant

5. NEWDIV is expected to have in-migration from patients residing outside of Thurston County. In-migration statistics were calculated based on utilization reported in CHARS for Capital Medical Center's 2021 inpatient cases by major diagnostic category (MDC). Each of the procedure groups from the NCHS survey is mapped to a MDC category, as presented in Table 9. The case counts included in Table 9 represent all patients by procedure category (i.e. Thurston Planning Area residents and out-of-area residents in-migrating).

Table 9: NEWDIV Projected Number of Ambulatory Surgeries, by Type, 2024-2027 (All Residents)

NEWDIV Cases	Jul to Dec 2024	2025	2026	2027	In-migration %	MDC for In-migration
Operations on the Nervous System	55	128	142	151	71%	1
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	25	58	65	69	42%	10
Operations on the Eye	-	-	-	-	0%	2
Operations on the Ear	36	84	94	100	70%	3
Operations on the Nose, Mouth and Pharynx	82	193	214	228	70%	3
Operations on the Respiratory System	-	-	-	-	88%	4
Operations on the Cardiovascular System	31	73	82	87	94%	5
Operations on the Digestive System	83	195	217	231	65%	6
Operations on the Urinary System	198	464	516	548	46%	11
Operations on the Male Genital Organs	116	272	303	321	120%	12
Operations on the Female Genital Organs	140	328	365	388	58%	13
Operations on the Musculoskeletal System	109	256	285	303	105%	8
Operations of the Integumentary System	93	218	243	258	42%	9
Miscellaneous diagnostic and therapeutic procedures and new technologies	49	114	127	135	65%	Hospital-wide
Total Cases	1,019	2,383	2,653	2,819		

Forecast Source: Applicant
In-migration Source: CHARS 2021. Capital Medical Center inpatient cases. In-migration % is calculated as out-of-Thurston cases divided by Thurston cases.

6. The specialty-specific case counts presented in Table 4 reflect an aggregation of procedures by ICD-9 grouping. Procedures within a certain specialty may bridge multiple ICD-9 groups, and we apply assumptions regarding the expected proportion of procedures within a given ICD-9 group to fall within each of the different specialties for NEWDIV. These market share and utilization figures are based on MultiCare's, and its consultants, experience providing and analyzing health services in the region and Washington State. These assumptions are:

    - Operations on the Nervous System: 100% to neurology.

- Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures: 50% to general surgery and 50% to gynecology.
- Operations on the Eye: not applicable.
- Operations on the Ear: 100% to ENT.
- Operations on the Nose, Mouth and Pharynx: 100% to ENT.
- Operations on the Respiratory System : not applicable.
- Operations on the Cardiovascular System: 85% to vascular and 15% to general surgery.
- Operations on the Digestive System: 75% to gastroenterology and 25% to general surgery.
- Operations on the Urinary System: 50% urology, 30% gyn, and 20% general surgery.
- Operations on the Male Genital Organs: 100% to urology.
- Operations on the Female Genital Organs: 100% to gynecology.
- Operations on the Musculoskeletal System: 80% to podiatry and 20% to general surgery.
- Operations of the Integumentary System: 100% to general surgery.
- Miscellaneous diagnostic and therapeutic procedures and new technologies: 100% to general surgery.

7. Based on the forecasted number of ambulatory surgeries at the ASF, estimated utilization is provided in Table 10, where cases are translated into surgery minutes using the default outpatient surgery case per minute figure of 50 minutes for surgical cases. Based on WAC 246-310-270(9)(iii), the two ORs at NEWDIV would be efficiently utilized. Please refer to Table 10 below.

Table 10: NEWDIV, Projected Number of Ambulatory Surgeries and Operating Room Utilization, 2024-2027

Cases	Jul to Dec 2024	2025	2026	2027
ENT	118	277	308	328
Gastroenterology	63	146	163	173
General Surgery	242	565	629	669
Gynecology	212	496	552	586
Podiatry	87	205	228	242
Urology	215	504	561	596
Neurology	55	128	142	151
Vascular	27	62	69	74
Total Cases	**1,019**	**2,383**	**2,653**	**2,819**
# of Months	6	12	12	12
Cases per Day (assumes 240 days of operation)	8.49	9.93	11.05	11.74
Minutes per case	50.00	50.00	50.00	50.00
Surgery minutes per year (assumes Planning Area outpatient minutes per case)	50,939	119,153	132,630	140,927
Estimated Number of Operating Rooms Needed (WAC 246-310-270 (9) (ii) (Divided minutes by 68,850).	1.48	1.73	1.93	2.05

Source: Applicant

Capacity Standard of 68,850 Minutes Per OR based on WAC 246-310-270 (9)

The NCHS use rates in the utilization forecast are based on national data sets and are national estimates. It is possible that local patterns could vary from the survey figures. However, there is no better 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. However, we assume a constant use rate over our forecast period.

Table 8 above also provides estimates of NEWDIV's Thurston Planning Area market share. It is projected to equal 2.5% of all Thurston County planning area ambulatory surgeries in 2024, increasing to 3.3% by 2027.

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

A relative paucity of outpatient ORs in the Thurston planning area limits the ability for further increases in utilization by the planning area population. This limited outpatient OR supply results in excess demand for outpatient services, thereby restricting access for patients. Patients in need of surgical services must then either utilize inpatient services or outmigrate to neighboring planning areas. For those patients

who outmigrate, geography and regional traffic patterns may also restrict access, limiting patient ability to access care in neighboring areas such as Tacoma or Seattle.

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.**

NEWDIV is committed to meeting community and regional health needs and provide charity care consistent with the MultiCare Charity Care Policy, included as Exhibit 7.

Our financial pro forma forecast provided in Exhibit 11 explicitly allocates 1.65% of total revenues to be provided for charity care, a figure above the Planning Area Hospital and equal to the Southwest Washington Regional charity care average for the most recent three years available (2018-2020). Please see Table 11 below which demonstrates that MultiCare's average charity care across its hospitals in the state is significantly above the planning area hospital and regional average.

Table 11: Southwest WA Regional and MultiCare Charity Care Statistics

		% of Total Revenues			
Lic. No	**Region/Hospital**	**2018**	**2019**	**2020**	**3 Year Average, 2018-2020**
197	MultiCare/Capital Medical Center	0.97%	1.12%	0.76%	0.95%
159	Providence/Saint Peter Hospital	1.51%	1.43%	1.08%	1.34%
	Thurston Planning Area Hospital Average	1.24%	1.27%	0.92%	1.14%
	SOUTHWEST WASH REGION TOTALS	1.50%	1.80%	1.64%	1.65%
	MultiCare Health System Average*	1.94%	1.87%	2.22%	2.01%

		% of Adjusted Revenues			
Lic. No	**Region/Hospital**	**2018**	**2019**	**2020**	**3 Year Average, 2018-2020**
197	MultiCare/Capital Medical Center	1.61%	1.85%	1.19%	1.55%
159	Providence/Saint Peter Hospital	5.43%	5.04%	3.64%	4.70%
	Thurston Planning Area Hospital Average	3.52%	3.44%	2.42%	3.13%
	SOUTHWEST WASH REGION TOTALS	4.81%	5.59%	4.27%	4.89%
	MultiCare Health System Average*	6.72%	5.59%	6.07%	6.13%

*MultiCare Health System average excludes Capital Medical Center which did not join MultiCare until CY2021.
Note: Thurston Planning Area Hospital and 3-Year averages are calculated based on unweighted average.
Source: DOH Charity Care Reports, 2018-2020

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 a copy of the MultiCare Capital Medical Center's Charity Care Policy. MultiCare is willing to accept a condition with its CN approval to provide a final executed charity care policy for NEWDIV prior to offering services that is consistent with Exhibit 7.

Please see Exhibits 8 for a copy of the MultiCare Capital Medical Center's Admissions Policy. MultiCare is willing to accept a condition with its CN approval to provide a final executed admission policy for NEWDIV prior to offering services with the addition of language that describes the types of patients that would be treated as the surgery center. The types of patients shall be consistent with those described in the application.

Exhibit 9 includes the Patient Rights and Responsibilities policy that will be applicable to NEWDIV.

Exhibit 10 includes the Non-discrimination policy that will be applicable to NEWDIV.

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.**

   The proposed project is for a new facility. Therefore, historical financial statements are not applicable.

   Exhibit 11 includes the required pro forma projections for the first three full years of operation. Exhibit 11 also provides key financial pro forma assumptions and sources of information used to prepare the projections.

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. Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

   None of the agreements listed above will be applicable to the proposed project. The medical director will be employed. Therefore, a medical director agreement is not applicable.

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)

Please see Table 11 presented above in the *Need* section.

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.**

   Included in Exhibit 12A is a copy of the lease agreement between MultiCare Health System (Lessee) and McPhee Road LLC (Lessor), dated March 30, 2022. Exhibit 12B contains property information from the Thurston County Assessor's Office indicating McPhee Road LLC (Lessor) is the owner of the parcel where the proposed site is located.

   The Lease Expiration Date of the lease is estimated to be September 30, 2037 (i.e. 180 calendar months from the rent commencement date which is estimated to be October 1, 2022).

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

   See Exhibit 12C for zoning documentation. The parcel that the proposed project is in is zoned High Density Corridor 4 (HDC-4). 'Offices, Medical' is a permitted use under HDC-4.

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.**

Item	Cost
a. Land Purchase	
b. Utilities to Lot Line	
c. Land Improvements	
d. Building Purchase	
e. Residual Value of Replaced Facility	
f. Building Construction	$2,825,723
g. Fixed Equipment (not already included in the construction contract)	$477,378
h. Movable Equipment	$1,407,412
i. Architect and Engineering Fees	$190,471
j. Consulting Fees	$60,000
k. Site Preparation	
l. Supervision and Inspection of Site	

m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	
n. Washington Sales Tax	$442,788
Total Estimated Capital Expenditure	$5,403,772

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.

The project will be financed with MultiCare Health System cash reserves. Please see Exhibit 15 for a letter of financial commitment.

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.

Table 12 below for startup costs, including notes detailing how they were calculated.

Table 12: Startup Costs

Description	Estimate	Notes
Staffing salaries & benefits	$347,554	3-month equivalent of Year 0 staffing and benefits
Medical Director	$27,000	6-month equivalent of Year 0 medical director expenses
Supplies	$127,991	1-month equivalent of Year 0 supplies
Total	$502,546	**Sum of above**

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

Please see Exhibit 13 for a non-binding contractor's estimate for the project construction costs.

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

In general, the cost of the project would not be expected to affect costs and charges, as rates are based on fee schedules with CMS and negotiated rates with other payers not directly impacted by project-related costs.

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 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."

Projected payer mix is anticipated to be generally consistent with the MultiCare Capital Medical Center's 2021 historical payer mix, presented in Table 13 below.

Table 13: Projected Payer Mix by Gross Revenue and by Cases

Payer	% of Cases	% of Gross Revenues
Medicare	25.5%	34.6%
Medicaid	3.9%	2.6%
Other Gov	6.8%	6.2%
Commercial	28.2%	23.6%
HMO	34.8%	32.3%
Other	0.8%	0.7%
Total	100%	100%

Source: CHARS 2021

Notes
"Other" includes all other payer sources but is principally self-pay (i.e. patient or family balance not covered under other categories).

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.

The project proposes CN approval for a new facility. Therefore, this question is not applicable.

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.

Please see Exhibit 14 for a listing of new equipment for this project with an estimated cost totaling $1,884,790, excluding sales tax. Sales tax is assumed at 9.4% of equipment costs which results in a total of $2,061,960.

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.

See Exhibit 15 for a letter from MultiCare's Executive Vice President of Population Based Care & Chief Financial Officer, James Lee, committing corporate reserves to

fully fund the estimated capital expenditures and any working capital requirements associated with the project.

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. MultiCare will finance the project with cash reserves.

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

Audited financial statements for MultiCare for the most recent three-year period available (CY2019-2021) are provided in Exhibit 16.

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.

Table 14: MultiCare Facility List

Name	Address	Medicare Provider Number	Medicaid Provider Number	Owned or Managed
MultiCare Mary Bridge Children's Hospital	317 Martin Luther King Jr. Way, Tacoma WA 98403	503301	3300340	Owned
MultiCare Auburn Medical Center	202 North Division St., Auburn WA 98001	500015	2022467	Owned
MultiCare Behavioral Health Inpatient Services- Auburn	202 North Division St., Auburn WA 98001	50-S015	3149101	Owned
MultiCare Deaconess	800 W 5th Ave Spokane, WA 99204-2803	500044	2083493	Owned
MultiCare Valley	12606 East Mission Ave. Spokane Valley 99216-3421	500119	2083493	Owned
MultiCare Tacoma General Hospital	315 Martin Luther King Jr. Way, Tacoma WA 98405	500129	3300332	Owned
MultiCare Tacoma General Behavioral Health Adolescent Inpatient Services	315 Martin Luther King Jr. Way, Tacoma, WA 98405	50-0129	2071315	Owned
MultiCare Allenmore Hospital	1901 South Union Avenue, Tacoma WA 98405	500129	3300332	Owned

MultiCare Good Samaritan Hospital	407 14th Ave. SE Puyallup, WA 98372	500079	3308707	Owned
MultiCare Good Samaritan Hospital, Inpatient Rehabilitation	401 15th Ave. SE, Puyallup, WA 98372	50T079	3200094	Owned
Navos	2600 Southwest Holden, Seattle, WA 98126	504009	3500311	Owned
MultiCare Covington Hospital	17700 SE 272nd Street Covington, WA 98042	500154	2102039	Owned
Wellfound Behavioral Health Hospital[9]	3402 S. 19th Street, Tacoma, WA 98405	504016	150453	Owned
MultiCare Capital Medical Center	3900 Capital Mall Dr SW, Olympia, WA 98502	500139	330365	Owned

Source: Applicant

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 15 below for the forecasted number of FTEs and salaries and benefits per FTE, by classification for both productive and non-productive FTEs for NEWDIV.

[9] A joint venture between MultiCare Health System and CHI Franciscan, now Virginia Mason Franciscan Health System.

Table 15: NEWDIV Ambulatory Surgical Facility FTEs by Type by Year

	Jul to Dec 2024	2025	2026	2027
Surgical Techs	4.00	4.00	4.00	4.00
RN	3.00	3.00	3.00	3.00
Peri-op	3.00	3.00	4.00	4.00
Scheduler	1.00	1.00	1.00	1.00
Reception	1.00	1.50	2.00	2.00
Manager	0.50	0.50	0.50	0.50
TOTAL	**12.50**	**13.00**	**14.50**	**14.50**

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.**

   FTE[10] projections assume two technicians per operating room and 1.5 RNs per room (i.e. 1 RN dedicated to each room plus one that circulates between the two rooms). Perioperative staffing is 1:1 care; consequently, it is assumed there will be two RNs for recovery and two anesthesia RNs. NEWDIV will incrementally require one scheduler and two receptionist FTEs. When fully ramped, it is assumed to require 14.5 FTEs.

   Hourly wages are based on MultiCare's operational experience. Benefits are 21% of salaries and wages based on current salary and benefits figures in the planning area.

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.**

   The proposed medical director is Richard Greene JR MD, MD60908938.

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

   The medical director will be employed. See Exhibit 17 for a copy of the proposed medical director's job description.

[10] One FTE is assumed to work 2,080 hours per annum.

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

   Weslee Wells-Stone is the anticipated operating room manager. Because NEWDIV is not an existing facility, other key staff are not known at this time.

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).**

   Please see Exhibit 18 for a list of physician names, license numbers, and specialties that are anticipated to use the proposed surgery center.

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

   NEWDIV is not an existing facility. Therefore, this question is not applicable.

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)**

   Overview. MultiCare has an excellent track record in Washington State for recruiting and retaining qualified staff to meet the needs of their multiple hospitals and well over 100 outpatient medical parks, clinics, surgery centers, and other sites. It has done this by partnering with local universities and colleges, supporting employee career development, and utilizing a broad range of local, regional and national recruiting strategies.

   Extensive recruitment resources. MultiCare's recruiting resources include a Talent Acquisition team and a Provider Services team, both led by recruitment professionals, each with more than twenty years of experience. The Talent Acquisition team includes full-time recruiters (including RNs), an Agency Staffing Specialist and Employment Coordinators. The Provider Services team includes full-time recruiters and support team members. Because MultiCare's recruiters are trained in state-of-the-art recruitment techniques, the need for outside search firms has been greatly reduced. Referrals from these firms account for less than one percent of total new hires. Other recruitment resources include contingent staffing agencies and employment branding consultants.

   Managing turnover and vacancy rates. MultiCare has consistently demonstrated how it values its employees and continually seeks ways to be a great place to work. Resources devoted to monitoring and controlling turnover include frequent employee surveys that identify employee concerns, coaching and training to help front-line managers become more effective leaders, and a total rewards strategy to continually offer highly competitive and relevant wages and benefits.

   Expanding and developing the healthcare workforce. MultiCare has devoted extensive resources to ensuring a robust pipeline of new healthcare workers. Examples include partnering with local universities, community colleges, and trade schools to provide clinical experiences each year; high school outreach programs including job shadows, Medical Explorers programs at two locations, and health careers camps; a Nurse Technician employment program; and strong residency and

apprenticeship programs. MultiCare's workforce development efforts extend to current employees who benefit from residency programs, fellowships, apprenticeships, tuition assistance, and targeted scholarship and training programs. MultiCare also boasts award-winning educational resources including state-of-the-art simulation labs, computer-based learning modules, classroom training and other educational opportunities.

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

NEWDIV is not an existing facility. Therefore, this question is not applicable.

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

MultiCare will use its experience operating across Washington State and Thurston County to ensure the appropriate ancillary and support services are established for NEWDIV. The following are examples of the ancillary and support services expected to be established for NEWDIV: diagnostic imaging (outpatient), laboratory services, wound care, and physical therapy (post-operative, outpatient).

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)

NEWDIV is not an existing facility. Therefore, this question is not applicable.

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)

NEWDIV is not an existing facility. Therefore, this question is not applicable.

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)

MultiCare's existing working relationships with healthcare facilities in the planning area are not expected to change as a result of the proposed 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)

NEWDIV will work with local inpatient health providers, as required. NEWDIV will be part of the MultiCare Health System. It will establish a patient transfer agreement with MultiCare-affiliated hospitals, including the planning area hospital MultiCare Capital Medical Center. Please see Exhibit 19 for a copy of the patient transfer agreement between Capital Medical Center and MultiCare Health System. MultiCare is willing to accept a condition with its CN approval to provide transfer agreement

between NEWDIV and MultiCare Health System, including MultiCare Capital Medical Center, consistent with the agreement provided in Exhibit 19.

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

    Please see Exhibit 19, which includes a copy of a patient transfer agreementwith MultiCare-affiliated hospitals. MultiCare is willing to accept a condition with its CN approval to provide transfer agreement between NEWDIV and MultiCare Health System, including MultiCare Capital Medical Center, consistent with the agreement provided in Exhibit 19.

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)**

    NEWDIV will promote continuity of care and offer outpatient care across a wide range of specialties, including diagnoses, treatment and outpatient surgery, if needed. CN approval will allow NEWDIV to meet the increased Planning Area demand for outpatient surgical procedures and continue to support continuity of care in its local market. Without further increases in supply, patients in search of outpatient surgical procedures will need to commute outside the Thurston planning area, thereby creating 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).**

    NEWDIV will be part of the MultiCare Health System. It will establish a patient transfer agreement with MultiCare-affiliated hospitals, including the planning area hospital MultiCare Capital Medical Center.

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.**

    MultiCare has no history with the actions described above. Therefore, 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.

NEWDIV is requesting certificate of need approval to operate two (2) operating rooms in Thurston County. In deciding to submit this application, NEWDIV explored the following options:

- Option One: develop a new freestanding ASF (The Project).
- Option Two: no project---do nothing.

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 16: Alternatives Analysis: Promoting Access to Healthcare Services

Option:	**Advantages/Disadvantages:**
Option One: develop a new freestanding ASF (The Project).	• Addresses need for additional dedicated outpatient operating rooms in the planning area. (Advantage, "A) • Provides additional capacity in the planning area for a wide variety of service specialties either not currently available or with limited availability in the community in a non-hospital-based setting. (A) • Enhances access to women's services and unrestricted reproductive services. (A)
Option Two: no project---do nothing.	• Without the project, the planning area will continue to have limited outpatient services available outside of a hospital-based setting. (Disadvantage, "D").

Table 17: Alternatives Analysis: Promoting Quality of Care and Staffing Impacts	
Option:	**Advantages/Disadvantages:**
Option One: develop a new freestanding ASF (The Project).	• The requested project meets and promotes quality and continuity of care in the planning area, given it improves access identified above. (A) • Limited staffing impact, as MultiCare would need comparable staffing under either option (Neutral, "N").
Option Two: no project---do nothing.	• This option would have relatively lower access which would reduce overall quality of care provided to community. (D) • Limited staffing impact, as MultiCare would need comparable staffing under either option (Neutral, "N").

Table 18: Alternatives Analysis: Capital Costs and Promoting Cost and Operating Efficiency	
Option:	**Advantages/Disadvantages:**
Option One: develop a new freestanding ASF (The Project).	• Although this option requires capital expenditures, it also promotes long-range cost and operating efficiency, as there are services that are feasible to provide outside of the hospital-setting at a lower cost which would result in greater efficiency of care delivery. (A)
Option Two: no project---do nothing.	• No capital costs. (A) • Lower efficiency of care delivery, as there are services that are feasible to provide outside of the hospital-setting which would result in lower cost for patients and payers. (D)

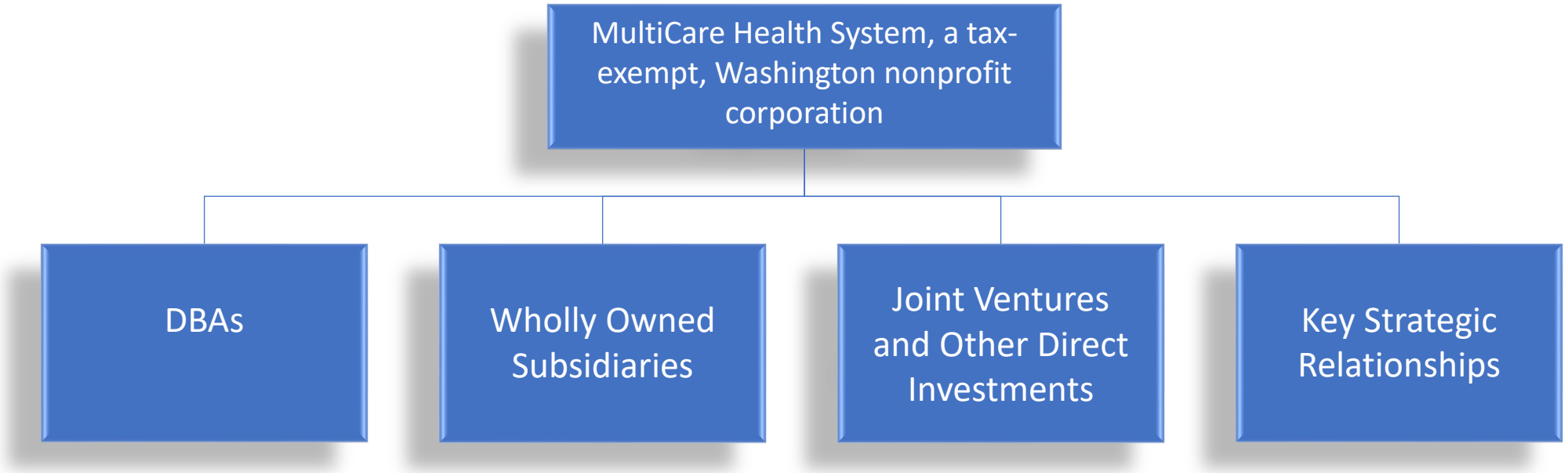
Table 19: Alternatives Analysis: Legal Restrictions.	
Option:	**Advantages/Disadvantages:**
Option One: develop a new freestanding ASF (The Project).	• Requires certificate of need approval. This requires time and expense. (D)
Option Two: no project---do nothing.	• No legal restriction. (A)

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 proposed project will meet MultiCare Health System's internal standards which have been engineered and tested to ensure that they support our high quality, efficient and patient-focused standards. Our standards also meet and or exceed all applicable state and local codes.

Exhibit 1. MultiCare Organizational Chart

MultiCare – How We Are Organized and Conduct Business



MultiCare Health System "Doing Business As"

Unless specifically noted, these DBAs operate within the MHS corporate entity as either divisions, programs or services of MultiCare.

Region

Puget Sound Region

HOSPITALS

Auburn Medical Center

Covington Medical Center

Good Samaritan Hospital/Off Campus Emergency Departments (OCEDs)

Tacoma General/ Allenmore Hospitals/OCED

Capital Medical Center

CLINICS

Gig Harbor Multi-specialty Medical Center

Primary Care & Specialty Care Clinics

MultiCare Medical Associates

OTHER

New Adventures Daycare

Inland Northwest Region

Deaconess Hospital/North Deaconess OCED

Valley Hospital

Rockwood Clinic

Systemwide

Institute for Research & Innovation
MultiCare Capital Partners

Networks

Retail/Community

Indigo Urgent Care
Dispatch Health
Labs Northwest
Virtual Health
Occupational Health
Home Health & Hospice
Adult Day Health
System Pharmacy

Pulse Heart Institute*

Mary Bridge

Mary Bridge Children's Hospital Health Network

ABC Pediatrics by Mary Bridge

Woodcreek Pediatrics by Mary Bridge

Treehouse

Behavioral Health

Good Samaritan Behavioral Health
Navos*
Greater Lakes Mental Healthcare*

Population Health

MultiCare Connected Care, LLC*
Physicians of Southwest Washington, LLC*
PNW CIN, LLC* d/b/a Embright

* Operates through separate legal entity

MultiCare Health System wholly owned subsidiaries

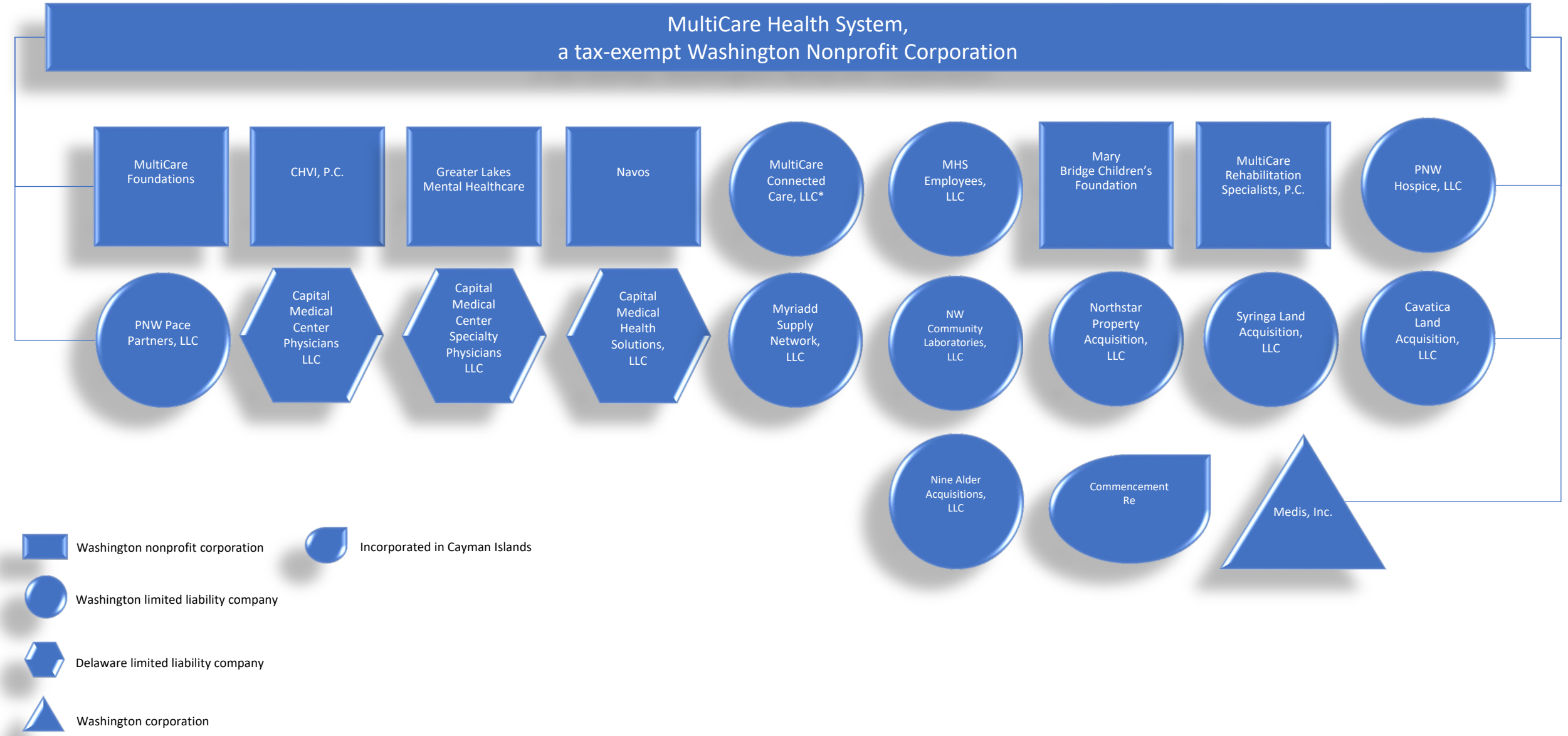


Exhibit 2. Letter of Intent

MultiCare Health System
820 A Street, Tacoma, WA 98402
PO Box 5299, Tacoma, WA 98415-0299 ~ multicare.org

July 1, 2022

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

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, MultiCare Health System hereby submits this letter of intent to apply for a certificate of need to develop and operate a new certificate of need approved Ambulatory Surgery Facility (ASF) with two (2) operating rooms in Thurston County. In conformance with WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:
   MultiCare Health System proposes to develop and operate a new certificate of need approved ASF. Upon project completion, the ASF will have two operating rooms.

2. Estimated Cost of the Proposed Project:
   The estimated capital cost of the project is $5,100,000.

3. Description of the Service Area:
   Per WAC 246-310-270, the primary service area is the Thurston Secondary Health Services Planning Area.

Please submit any notices, correspondence, communications and documents to:

Erin Kobberstad, Vice President, Strategic Planning
MultiCare Health System
PO Box 5299, Mailstop: 820-4-SBD
Tacoma, WA 98415
ekobberstad@multicare.org

Thank you,

K. Erin Kobberstad

Erin Kobberstad, Vice President, Strategic Planning
MultiCare Health Center

Exhibit 3. Single Line Drawings


EXAM
EXAM
NURSE STATION
PATIENT LOCKER
LOCKERS
MED DIST
NOURISH.
PRE-OP & POST-OP
EXISTING IS&T
SOILED
CLEAN
MED GAS
EVS
STAFF LOCKERS
STAFF LOCKERS
ELEC
EQUIP.
PATIENT TOILET
MANAGER'S OFFICE
CART RECEIVING/ SOILED STORAGE
SEMI-RESTRICTED CORRIDOR
ANESTH. OFFICE
CONSULT
ASC
5,164 SF
OR #1
386 SF
RESTRICTED CORRIDOR
SHELL (FUTURE OR #3)
345 SF
REGISTRATION
EMERGENCY EXIT ONLY
OR #2
400 SF
EQUIPMENT STORAGE
CLEAN STORAGE
STERILE STORAGE
WAITING

Exhibit 4. Planning Area Supply with Sources

Planning Area Supply
Thurston Planning Area

Facility Name	Exempt/ Approved	Nbr of ORs		Number of surgeries		Number of Minutes		Minutes/Case		Source
		OP	Mixed	OP	Mixed	OP	Mixed	OP	Mixed	
Hospital(s)										
Providence St. Peter Hospital	Approved	5	11	2,773	8,870	160,625	976,740	57.9	110.1	DOH 2021 Survey (CY2020)
Capital Medical Center	Approved		10		3,656		300,767		82.3	DOH 2021 Survey (CY2020)
ASF CN-Approved										
Laser and Surgery Center, LLC	Approved	3		2,284		114,200		50.0		DOH 2021 Survey (CY2020) - CORRECTED March 10, 2022; Default minutes
Olympia Surgery Center	Approved	6		6,730		424,680		63.1		Eval of CN21-80
Gastroenterology Associates	Approved	ENDOSCOPY ONLY. NOT COUNTED								Eval of CN21-80
ASF CN-Exempt										
Olympia Multi Specialty Clinic Ambulatory Procedure Center	Exempt	ENDOSCOPY ONLY. NOT COUNTED								DOH 2021 Survey (CY2020)
Olympia Orthopedic Associates	Exempt	6								New facility; no utilization data to date
Olympia Orthopedic Associates (The Spine Center)	Exemption Requested	2								New facility; no utilization data to date. Exemption requested 06/30/22.
Pacific Cataract and Laser Institute	Exempt	2		2,414		120,700		50.0		DOH 2021 Survey (CY2020); Default minutes
Ear Nose Throat Associates Southwest, Inc. P.S.	Exempt	1								New facility; no utilization data to date
Foley Plastic Surgery Center	Exempt	1		245		12,250		50.0		DOH 2021 Survey (CY2020); Default minutes
Pearl Plastic Surgery	Exempt	1		400		20,000		50.0		Eval of CN21-80
Pain Care Physicians PLLC	Exempt	2		2,800		140,000		50.0		Eval of CN21-80; DOR 19-22
Olympia Pain and Spine Surgery Center	Exempt	PAIN ONLY. NOT COUNTED								DOH September 2017 Evaluation of CN App #17-21

Exhibit 5. Numeric Need Methodology

Ambulatory Surgery Operating Suite Need Methodology, All Ages
Thurston Planning Area

Service Area Population, 2027		324,109		OFM 2017 GMA Projections - Medium Series			
Surgeries per, 1,000 residents, 2027 @	102.51	33,224					
a.i.	94,250	minutes per year, mixed use OR					
a.ii.	68,850	minutes per year, outpatient OR					
a.iii.	14	dedicated OP ORs x 68,850 minutes =		963,900	minutes, dedicated OR capacity.	17,138	Outpatient surgeries
a.iv.	21	dedicated mixed use ORs x 94,250 minutes =		1,979,250	minutes, mixed use OR capacity.	19,407	Mixed use surgeries
b.i.	Projected inpatient surgeries =		13,793 =		1,406,750 minutes, mixed use surgeries		
	Projectedoutpatient surgeries =		19,431 =		128,960 minutes, outpatient surgeries		
b. ii.	Forecast # of OP surgeries - capacity,of dedicated OP ORs						
			19,431 minus		17,138 =	2,293	
b.iii.	Average time of mixed use surgeries		=		101.99 minutes		
	Average time of outpatient surgeries		=		56.24 minutes		
b.iv.	mixed use surgeries, 2027 * average minutes/case		=		1,406,750 minutes		
	remianing OP surgeries (b.ii.) * average minutes/case		=		128,960 minutes		
					1,535,710 minutes		
c.i.	if b.iv. < a.iv., divide by (a.iv. - b.iv.) 94,250 to determine surplus of mixed use ORs						
	1,979,250						
	(1,535,710)						
	443,540 divided by		94,250 =		4.71 **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						
	1,406,750						
	(1,979,250)						
	(572,500) divided by		94,250 =		(6.07) **Surplus**		
	Divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated OP ORs						
	128,960 divided by		68,850 =		1.87 **Need**		

Exhibit 6. NCHS Survey

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.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
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.

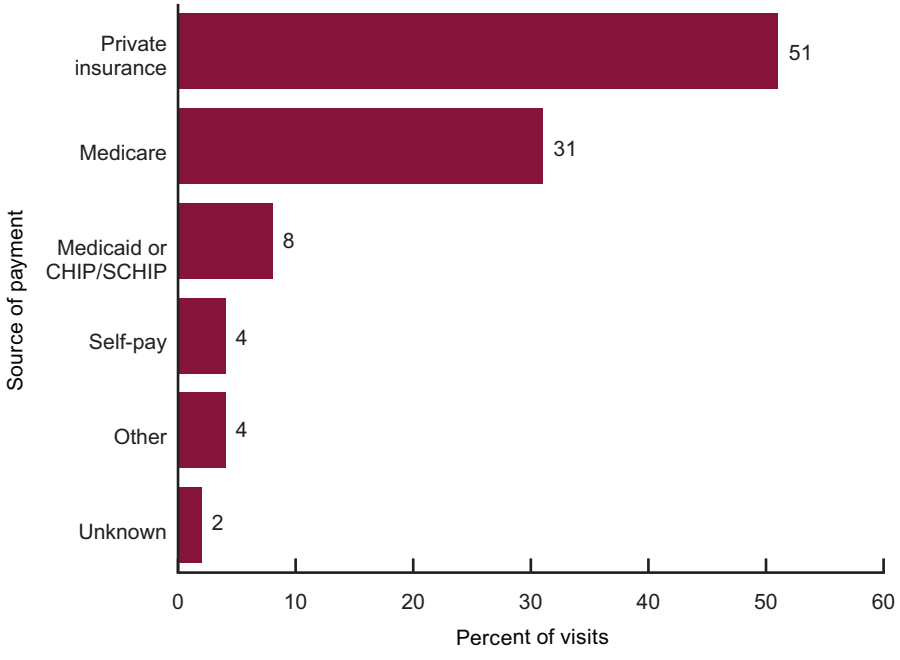
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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

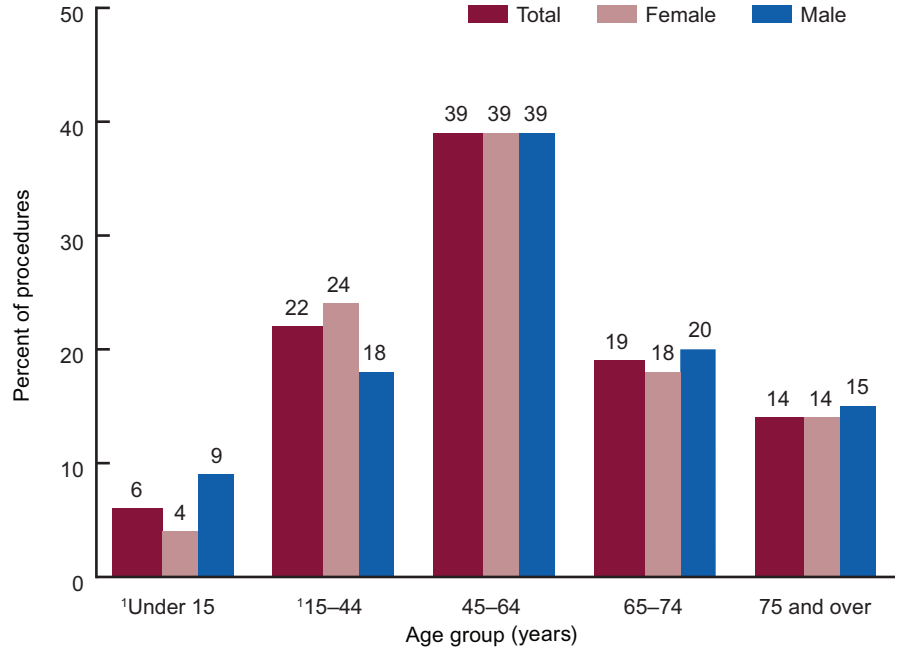
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6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

Centers for Disease Control and Prevention
National Center for Health Statistics
3311 Toledo Road, Room 4551, MS P08
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For more NCHS NHSRs, visit:
https://www.cdc.gov/nchs/products/nhsr.htm.

National Health Statistics Reports ■ Number 102 ■ February 28, 2017

Suggested citation

Hall MJ, Schwartzman A, Zhang J, Liu X. Ambulatory surgery data from hospitals and ambulatory surgery centers: United States, 2010. National health statistics reports; no 102. Hyattsville, MD: National Center for Health Statistics. 2017.

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DHHS Publication No. 2017–1250 • CS273765

Exhibit 7. Charity Care Policy

MultiCare	*Administrative*

Document Title: Financial Assistance – Hospital Based Services

Scope:

This policy applies to patients who qualify for Charity Care or Financial Assistance for the services received within the Hospital facilities of MultiCare Health System ("MHS") as provided by MHS.

Locations include Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, Home Health and Hospice, Navos Behavioral Health Center and Capital Medical Center.

Policy Statement:

MHS is guided by a mission to provide high quality, patient-centered care. We are committed to serving all patients, including those who lack health insurance coverage or who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that take into account an individual's ability to pay for medically necessary health care services.

Definitions:

1. **Collection Efforts** and **Extraordinary Collections Actions** (ECA) are defined by the MHS Collection Guidelines policy.
2. **Charity Care** and/or **Financial Assistance** means medically necessary hospital health care rendered to Eligible Persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. When communicating with patients, the phrase "Financial Assistance" will be used in lieu of "Charity Care." Both terms are synonymous with one another for the purposes of this policy and MHS billing statements.
3. **Eligible Person(s)** is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 500% the federal poverty standards adjusted for family size.
4. **Emergency Medical Conditions** (EMC) are defined by the MHS Emergency Medical Treatment and Active Labor Act (EMTALA), Compliance With policy, which is consistent with WAC 246-453-010.
5. **Family** is defined per WAC 246-453-010 (18) as a group of two or more persons related by birth, marriage or adoption that live together; all such related persons are considered as members of one family.
6. **Income** is defined per WAC 246-453-010(17) as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities.

7. **Medically Necessary** is defined per WAC 246-453-010 (7) as appropriate hospital-based medical services.
8. **Responsible Party** means that individual who is responsible for the payment of any hospital charges not otherwise covered by a funding source as described below.

Policy Guidelines:

This policy provides a guideline for making consistent and objective decisions regarding eligibility for Financial Assistance. Financial Assistance is available for medically necessary hospital-based health care services (to include emergency care) provided by MultiCare Health System.

Emergency care will be provided to patients with Emergent Medical Conditions regardless of their ability to pay. MHS shall allocate resources to identify charity cases and provide uncompensated care per RCW 70.170 and WAC 246- 453. *See* MHS Policy: Emergency Medical Treatment and Active Labor (EMTALA), Compliance With.

MHS supports the state-wide voluntary pledge of hospitals to provide Financial Assistance to Eligible Persons in accordance with the methodology provided and updated annually by the Washington State Hospital Association.

Consideration for Financial Assistance will be given equally to all Eligible Persons, regardless of race, color, sex, religion, age, national origin, veteran's status, marital status, sexual orientation, immigration status or other legally protected status. *See* MHS Policy: Patient Nondiscrimination

All information relating to the Financial Assistance application is confidential and protected by HIPAA guidelines. *See* HIPAA Privacy Compliance – Administrative policy.

Lists of providers accepting and not accepting Financial Assistance are available at https://www.multicare.org/financial-assistance/ .

This policy describes the processes for evaluating applications and awarding Financial Assistance for free and discounted care at the following levels based on the Federal Poverty Limit (FPL) adjusted for family size:

1. 100% Financial Assistance - Income levels at or below 300% of the (FPL); or
2. Sliding Scale Financial Assistance - Income levels between 300.5% and 500% of the FPL.

Procedure:

I. Eligibility Criteria

In order for a Responsible Party to be considered eligible for Financial Assistance, the following criteria must be met:

A. *Exhaustion of All Funding Sources*

1. Any of the following sources must first be exhausted before a Responsible Party will be considered for Financial Assistance:
   a. Group or individual medical plans
   b. Workers' compensation programs

c. Medicaid programs
d. Other state, federal or military programs
e. Third party liability situations (e.g., auto accidents or personal injuries)
f. Tribal health benefit programs
g. Health care sharing ministry programs
h. Any other persons or entities having a legal responsibility to pay
i. Health saving account (HSA) funds. MHS may require a Responsible Party to fully utilize any available funds from HSA to satisfy outstanding balances.
j. MHS will pursue payment from any available Funding Source. The remaining patient liability will be eligible for Financial Assistance based on the criteria in this policy.

B. *Accurate Completion of Financial Assistance application*.

1. Incomplete applications will be denied. Patients may appeal the denial and provide the missing information per the guidelines set forth below.
2. If the application places an unreasonable burden, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the Responsible Party's capability of complying with the application procedures on the Responsible Party, then the application process will not be imposed.

C. *Medicaid Eligibility Within 90 Days of Services in Lieu of Application*

1. A determination of Medicaid eligibility within (90) days of date of services may replace the Financial Assistance application and may be used to qualify the Responsible Party for 100% Financial Assistance except for spend down amounts. Proof of eligibility will be the presence of Medicaid coverage during the applicable timeframe in the patient’s coverage record in Epic.

D. *Presumptive determination or Extraordinary Circumstances*

1. The Responsible Party may qualify for Financial Assistance based on a presumptive determination or extraordinary life circumstances, as outlined below.

E. *Medically Necessary Health Care Services Rendered*

1. The services provided to the patient must be medically necessary and not elective.
2. Scheduled services that appear to not be medically necessary will be reviewed by Utilization Management prior to the date of service to determine medical necessity.

F. *International Patients*

1. Eligibility determinations for International Patients for non-emergent services will be considered on a case-by-case basis by a committee representing Physician Leadership, Revenue Cycle and Finance.

II. Proof of Income: Income will be evaluated based on the following criteria:

A. *Income Verification*

1. Any of the following types of documentation will be acceptable for purposes of verifying income:
    a. W2 withholding statements
    b. Payroll check stubs
    c. Most recent filed IRS tax returns
    d. Determination of Medicaid and/or state-funded medical assistance
    e. Determination of eligibility for unemployment compensation
    f. Written statements from employers or welfare agencies
2. For Social Security and Pension benefits, bank statements may be used to demonstrate the consistent monthly deposit.
3. In the event the Responsible Party is unable to provide the documentation described above, MHS must rely upon the written and signed statements from the Responsible Party for making a final determination of eligibility.
4. MHS may also use third party verification of ability to make a presumptive determination and apply a charity discount without receiving a financial assistance application.

B. *Calculation of Income*

1. MHS will use the following guidelines to calculate income:
    a. All Family income will be included in the calculation.
    b. Based on the type of documentation provided, the income will be calculated to represent a twelve (12) month period.

C. *Timing of Determination*

1. Income will be determined as of the time the services were provided.
2. Income at the time of application for Financial Assistance will be considered if the application is made within two years of the time the services were provided and the Responsible Party has been making good faith efforts towards payment for the services.

III. Process for Determination of Eligibility

A. At the time of registration or as soon as possible following the initiation of services, MultiCare will make an initial determination of eligibility following the patient's review of the FPL grid. If a patient is determined to likely fall below 300% of the FPL, they will not be asked for payment and will be referred to a Patient Financial Navigator (PFN), who will provide additional information about Financial Assistance and other programs that may be available to the patient.

B. Collection activity will cease for 30 calendar days for patients believed to be under 300% of the FPL and the Responsible Party will be asked to complete a Financial Assistance application. If no application is received within 30 days, collection activity will resume.

C. When an application is received, a PFN will review the application to determine eligibility.

D. Incomplete applications will be denied. The Responsible Party will be provided a letter specifying missing information and may Appeal the decision per the requirements below.

E. A written notice of determination will be sent to the applicant within fourteen (14) calendar days from receipt of the complete application.

F. If approved, this notice will include the amount for which the Responsible Party is financially responsible, if any.

G. Approvals will be valid for 180 days and a new application will be required after such time. Awards to Eligible Persons on fixed incomes like Social Security shall be approved for one (1) year, at the discretion of the PFN reviewing the application.

IV. Appeals

A. The Responsible Party may appeal the determination by providing additional verification of income or family size within thirty (30) calendar days of receipt of the determination.

B. MultiCare will respond to the appeal within fourteen (14) calendar days from receipt of the appeal.

C. All appeals will be reviewed and approved or denied by the Manager or Director, Patient Financial Navigation.

D. If an appeal is denied, it will be presented to the AVP, Financial Clearance, Vice President of Revenue Cycle or Chief Financial Officer (CFO) for final determination. If this determination affirms the previous denial of Financial Assistance, written notification will be sent to the Responsible Party and the Department of Health in accordance with state law.

E. Collection efforts will be suspended during the thirty (30) calendar day appeal period and the fourteen (14) calendar day appeal review period.

V. Application of Financial Assistance Discount Levels

A. Financial Assistance applies to combined balances for all open accounts for the Responsible Party at time of application submission. The amount owed by an Eligible Person qualifying under this Financial Assistance policy will not exceed amounts generally billed to a Responsible Party not receiving assistance. The method used to calculate the discount to an Eligible Person's balance will be based on an annual retrospective analysis. A rate will be determined for each hospital. This will be calculated using a Look-Back Method pulling a year of claims that have paid in full for Medicare and private/commercial health insurance Responsible Party to determine the "Amount Generally Billed". Patients may obtain information about the Amounts Generally Billed calculations free of charge by calling 800-919-1936.

1. Balances will be considered for Financial Assistance based on the FPL guidelines in Appendix A.
2. If an Eligible Person's residence is in Hawaii or Alaska, the associated FPL guidelines for those states will be utilized to make the determination of assistance.

B. Financial Assistance adjustments will be considered on an individual account balance basis. Approvals on adjustments will be authorized as follows:

1. Patient Financial Navigators: $0.01 - $4,999
2. Supervisor: $5,000 - $49,999
3. Manager/Director: $50,000 - $99,999
4. AVP: $100,000 - $499,999
5. Vice President: $500,000 - $999,999
6. SVP, CFO: $1,000,000 - $2,999,999

C. The volume of applications and adherence to this policy will be tracked and audited on a monthly basis. This report will be reviewed and signed by the Vice President of Revenue Cycle or AVP, Financial Clearance.

VI. Presumptive Eligibility

A. Eligibility may be determined presumptively.

1. MHS may utilize third party vendor software or software applications to determine an account's collectability. This is a "soft" credit check and will not impact the Responsible Party's credit standing.
2. If these reviews determine the patient may be at 300% or below of the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance.

VII. Extraordinary Life Circumstances

A. Extraordinary Life Circumstances may also warrant Financial Assistance. Examples of such circumstances may include:

1. **Homeless Persons:** A Homeless person is an individual who has no home or place of residence and depends on charity or public assistance. Such individuals will be eligible for Financial Assistance, even if they are unable to provide the documentation required for the Financial Assistance application.
2. **Deceased Patients:** The charges incurred by a patient who expires may still be considered eligible for Financial Assistance. For the Financial Assistance application, the deceased patient will count as a family member. Accounts in an "Estate" status or situations where the estate has not been opened are not eligible for Financial Assistance until the Estate is settled.
3. **Inmates:** Responsible Party who is incarcerated may be considered eligible in the event the State or County has made a determination that the State or County is not responsible for charges and the inmate/patient is responsible for the bill. Charges incurred while in custody are usually paid through the Law Enforcement Agency and would not qualify for Financial Assistance.
4. **Catastrophic Determinations:** Responsible Party may qualify for a Catastrophic Discount. Only medically necessary services are eligible for a Catastrophic Discount. A Catastrophic event will be determined on a case-by-case basis. Catastrophic cases may include extraordinary medical expenses or hardship situations. All income and non-income resources are considered in the determination, to include the Responsible Party's future income earning

potential, especially where his or her ability to work may be limited as a result of illness and/or their ability to make payments over an extended period of time. All of the debt or a portion of the debt may qualify for Financial Assistance. The Director or Manager of Patient Financial Navigation will assist in making a catastrophic event application determination.

B. Requests for Financial Assistance may originate from other sources including a physician, community or religious groups, social services, financial services personnel, and/or the Responsible Party.

VIII. Individuals that Qualify for Medical Assistance Programs

A. MHS takes the following steps to identify patients or guarantors that may qualify for medical assistance programs under RCW 74.09:

1. Patient Financial Navigators review completed financial assistance applications and will follow up with patients or guarantors that appear to qualify for medical assistance programs.
2. Navigators are available on site at MHS hospital facilities, including our off-campus emergency departments, to identify and screen patients and their guarantors.
3. All self-pay patients admitted to an MHS hospital facility are screened to determine if they qualify for any medical assistance programs.
4. Patients may be referred for screening for coverage or medical assistance programs by Care Managers, Registration staff, and providers.
5. Certified Navigators are located throughout MHS and are available at no cost to help customers sign up for coverage through Washington Healthplanfinder. This service is available to anyone searching for a health plan—not only MHS patients.

B. Once a patient or guarantor is identified as potentially being eligible for a medical assistance program:

1. The patient is screened by a Navigator, who helps determine eligibility for public health care coverage based on household size and income.
2. If the patient's eligibility is confirmed, then a Navigator will partner with the patient and assist the patient in applying for the appropriate health plan.
3. The patient account is flagged to ensure no billing occurs while the application is pending.

C. MHS is not obligated to provide financial assistance if a patient or their guarantor qualifies for retroactive health care coverage under RCW 74.09 and the patient or their guarantor fails to make reasonable efforts to cooperate with a Navigator's attempts to assist them in applying for such coverage. (RCW 70.170.060(5)).

IX. Collection Efforts for Outstanding Patient Accounts

A. MHS will not initiate collection efforts or requests for deposits, provided that the Responsible Party within a reasonable time is cooperative with the system's efforts to reach a determination of Financial Assistance eligibility status. ECA may only be initiated after the Notification Period, in accordance with the MHS Policy: Collection

Guidelines, Patient Accounts.

B. The Responsible Party's financial obligation remaining after application of the sliding fee schedule will follow regular collection procedures to obtain payment, pursuant to Policy.

C. In the event that a Responsible Party pays a portion or all of the charges related to medically necessary health care services, and is subsequently found to have met the Financial Assistance criteria, any payments for services above the qualified amount will be refunded to the Responsible Party within 30 days of the eligibility determination.

X. Staff Training

A. All relevant and appropriate staff supporting Hospital based locations who perform registration, admission, billing, or other related functions shall participate in standardized training based on this Financial Assistance Policy and the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about the availability of Financial Assistance.

B. The training shall help ensure staff can answer Financial Assistance questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.

XI. Dissemination of MHS Financial Assistance Policy

A. All patients are provided with information about the availability of Financial Assistance upon registration. Additional copies can be requested from the Hospital Financial Navigators or Patient Access Techs within the hospital facilities.

B. Notices in all languages spoken by more than 10 percent of the population advising patients of the availability of Financial Assistance will be posted in key public areas of the hospital, including Admissions and/or Registration, the Emergency Department, Billing and Financial Services.

C. This policy, the application, and a plain language summary are available to patients free of charge by contacting 800-919-1936.

D. Financial counselors are available to discuss Financial Assistance options in person at all hospital locations or over the phone for other areas of the health system.

E. Billing Statements sent to Responsible Parties will contain information regarding the availability of Financial Assistance in both English and Spanish.

F. Written materials are available in English, Spanish, Russian and Vietnamese. .

G. Wide-reaching community notifications will occur in the following ways:

1. Available at registration areas of all hospital facilities,
2. On MHS website www.multicare.org
3. Communications provided to our community partners for distribution, and
4. Upon request, by calling 800-919-1936

Related Forms:

	Proof of Income for Financial Assistance Instruction Sheet Financial Assistance Application Financial Assistance Letter to Patients Patient Brochure Containing Plain Language Summary
	Appendix A: Financial Assistance
	References: RCW 70.170 WAC 246-453 Federal Register Vol 79, December 31, 2014 Final Rule
	Point of Contact: AVP, Financial Clearance, rcardenas@multicare.org

Approval By:	***Date of Approval:***
Finance Leadership	***12/18, 4/21, 10/21, 4/22***
Corporate Compliance Leadership	***12/18, 4/21, 10/21, 4/22***
System Policy Council	***4/22***
MHS Quality Safety Steering Council	***7/12, 8/13, 7/14, 4/15, 9/19, 5/21, 12/21, 5/22***
Original Date:	*5/97*
Revision Dates:	*11/00, 8/03, 2/05, 2/06, 9/08, 11/09, 4/11, 6/12, 8/13, 7/14, 3/15, 2/17, 2/18, 8/18, 9/18, 4/21, 9/21, 4/22*
Reviewed with no Changes Dates:	*X/XX; X/XX*

Previously Titled: Charity Care and Financial Assistance (prior to 9/14)

Financial Assistance
Appendix A
2022

FAMILY SIZE	Gross Annual Income	300%	350%	400%	450%	500%
1	$13,590	$40,770	$47,565	$54,360	$61,155	$67,950
2	$18,310	$54,930	$64,085	$73,240	$82,395	$91,550
3	$23,030	$69,090	$80,605	$92,120	$103,635	$115,150
4	$27,750	$83,250	$97,125	$111,000	$124,875	$138,750
5	$32,470	$97,410	$113,645	$129,880	$146,115	$162,350
6	$37,190	$111,570	$130,165	$148,760	$167,355	$185,950
7	$41,910	$125,730	$146,685	$167,640	$188,595	$209,550
8	$46,630	$139,890	$163,205	$186,520	$209,835	$233,150
9	$51,350	$154,050	$179,725	$205,400	$231,075	$256,750
10	$56,070	$168,210	$196,245	$224,280	$252,315	$280,350
EACH ADD'L	$4,720					

Poverty Level, Up To					
300%	350%	400%	450%	500%
Charity Discount, %					
100%	95%	90%	80%	70%
Patient Responsibility, %					
0%	5%	10%	20%	30%

Exhibit 8. Admission Policy

Title: ADMISSION OF A PATIENT

Scope:

This scope applies to all inpatient areas at MultiCare Health System. It includes Tacoma General Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Rockwood Clinic and Capital Medical Center.

Policy Statement:

This policy applies to the admission of a patient. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient with a provider admission order, medical necessity and the expectation that patient will remain at least overnight and occupy a bed. Patients who are being admitted for elective inpatient surgery are considered formally admitted once anaesthesia induction has begun.

The medical record contains information to justify the admission of the patient.

Plans of care and discharge plans are initiated for each admission.

MHS does not exclude or deny admission to any person on the basis of race, color, creed, religion, gender, age, ethnicity, disability status, national origin, sexual orientation, marital status, pre-existing condition or any other illegal basis.

Procedure:

I. **All Members of the Medical Staff with Active Admitting Privileges May Admit Patients**

A. The Provider will:

1. Determine patient admission needs
2. Coordinate care between the patient's primary care provider and Specialists providing care to the patient
3. Identify necessary level of care and monitoring
4. Provide appropriate orders (preferably entered into the EMR, however may be called, faxed or sent to the appropriate unit). These orders should include but are not limited to:

a. Admission Status (inpatient, ambulatory, observation for)

b. Admitting Diagnosis,

c. Attending Physician and

d. Admitting unit

e. Vital sign parameters

f. Allergies/Reactions

g. Diet orders

h. Activity orders

i. Diagnostic, Lab and Imaging orders

j. Medications and IVs to be administered during hospital stay, including Medication Reconciliation of home medications.

k. Procedure/Treatments

l. Resuscitation status as appropriate

5. Assess patient at the bedside within timeframe outlined by Medical Staff Bylaws
6. Identify goals of treatment and treatment plan
7. Inform patient about risks, benefits and alternatives of surgery and/or procedures and obtain informed consent as indicated
8. Complete the patient's History and Physical (H&P) as outlined by Medical Staff Bylaws.
9. Initiate appropriate discharge plan as indicated

II. The Unit Secretary/Health Unit Coordinator is Responsible for Notifying Patient Access Services When Patient Has Arrived.

III. Patient Access Services will:

A. Upon notification, register the patient, generate the Face Sheet, Identification Band, Document Labels, and ensure delivery to the patient location.

B. Obtain demographic and insurance information and signatures on applicable forms at the time of registration.

C. Provide and review with the patient the MultiCare Handout entitled "Notice of Privacy Practices, Conditions for Treatment, Financial Disclosures, Patient Rights Materials, Financial Assistance" Form (87-9158-0A)

D. If the patient cannot read English, interpreter services should be sought and translated forms will be provided.

E. For every patient who has Medicare or a Managed Medicare as any insurance, primary, secondary, or tertiary, regardless of age the "An Important Message from Medicare" Form (87-0568-3e) must be reviewed with the patient and a signed copy of the document provided to the patient.

F. If the patient is eligible for TriCare the form "An Important Message from TriCare" (88-0061-0) must be reviewed with the patient and a signed copy of the document provided to the patient.

IV. Procedure for Admission to Clinical Care Area:

A. Obtain a Bed Assignment:

1. A Provider will contact the appropriate department for bed availability and assignment. This may be the MultiCare Transfer Center (MTC), or the House Supervisor.

2. The admitting patient care staff will be notified of pending admission and bed assignment.

B. Responsibilities

1. Clerical support responsibilities:

a. Retrieve past medical records, including recent ED or urgent care services, as needed

2. RN:

a. Obtain handoff/report of patient condition and receive patient into appropriate care area.

b. Place identification bands with appropriate information

c. Identify and prioritize appropriate patient care needs.

d. Obtain/acknowledge necessary physician orders

i. Medication orders must meet MHS standards prior to medication administration

ii. The RN ensures that orders are accurately implemented.

e. Complete the nursing admission documentation and verify that appropriate admission data is collected and documented

f. Ensure that the Advance Directive information has been obtained and document the content of the advanced directive in the patient's record if known.

g. If the patient is an adult and does not have a Health Care Directive or wishes additional information:

i. A referral may be made to Care Management/ Social Workers who can provide resources to the patient

ii. The Health Care Directive form (87-6030-2e) may be offered to the patient

iii. The care team initiates a patient plan of care

V. Patients will have a Standardized Patient Medical Record (Chart):

A. The type of chart created will be driven by patient location and availability of the EMR

Related Forms:
Notice of Privacy Practices, Conditions for Treatment, Financial Disclosures, Patient's Rights Materials, Financial Assistance Form #87-9158-0A
Important Message from Medicare Form # 87-0568-3e
Important Message from TriCare Form # 88-0061-0
Health Care Directive Form #87-6030-2e

References:

CMS Standards:

45 C.F.R. § 80

45 C.F.R. § 84

45 C.F.R. § 91

	29 U.S.C. § 794 Centers for Medicare and Medicaid. (2020). *State Operations Manual- Regulations and Interpretive Guidelines for Hospitals.* The Joint Commission. (2020). *Comprehensive Accreditation Manual for Hospitals.* PC 01.02.03, RC 02.01.01, RI 01.01.01 EP2, 5, RI 01.02.01, EP 1,2,22, RI 01.05.01 Washington State Department of Health. (2010). *Chapter 246-320 WAC Hospital Licensing Regulations.*
	Point of Contact: Executive Director, Patient Access 253-697-1865

Approval By:	***Date of Approval:***
Patient Access Leadership	8/12; 7/14; 4/17; 8/20
NOC	11/20
CapMC QSSC	7/21
MHS Quality Safety Steering Council	9/14; 5/17; 8/17; 4/18; 12/20
Original Date:	*12/00*
Revision Dates:	*8/04; 7/07; 9/09; 06/12; 8/14; 4/17; 10/20*
Reviewed with no Changes Dates:	XX

Distribution: MHS Intranet
Scope/locations of services updated March, 2017.
Ethnicity and Pre-existing condition added per non exclusion law 7/17
MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Rockwood Clinic
Added to scope 7/21/17
4/11/18 - Approved at SKRB 3/26/18 and QSSC 4/10/18 to apply to Covington Medical Center
Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 9. Patient Rights and Responsibilities

MultiCare	*Administrative*

Title: PATIENT RIGHTS AND RESPONSIBILITIES: ADULTS AND SPECIAL RIGHTS OF ADOLESCENTS

Scope:

This policy applies to all patients and their families within the MultiCare Health System (MHS).

This scope applies to all ambulatory and inpatient areas at MultiCare Health System. It includes Tacoma General Hospital/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital and Capital Medical Center.

Policy Statement:

This policy establishes the MHS procedure to define patient rights by law and policy and define the procedure for providing this information to patients and families with MultiCare.

A. Patients will be provided a copy of the Patient Rights and Responsibilities brochure. This occurs on an annual basis, usually at the time of registration (or as soon as feasible), or more frequently as desired by patient and family. Brochures will be available to patients and families in registration areas.

Procedure:

The following steps are to be followed to assure that the patients and families at MHS are aware of their rights and responsibilities:

A. MultiCare staff (employed, volunteer and contracted) will support and abide by the rights of patients who seek services within MultiCare Health System.

B. Personnel responsible for admitting patients to the "inpatient" status will provide a copy of the Patient Rights and Responsibilities brochure at the time of admission (or as soon as feasible) and validate that the patient has received a copy at least yearly.

C. Directors/Managers in patient registration areas will ensure the brochure is available for patients and families.

Related Policies: "Advanced Directives: Living Will and Mental Health", "Patient Grievances"

Related Forms: *Patient Rights and Responsibilities Booklet # 87-9158-0c*

References:
Joint Commission Standards on Patient Rights
CMS Conditions of Participation

Point of Contact: AVP, Registration 253-403-1326, kwilcox@multicare.org

Approval By:	Approval Date:
Patient Registration Leadership	4/19, 3/22
MHS Quality Safety Steering Council	4/14, 1/17, 6/19, 4/22
Original Date:	*9/90*

Revision Dates: Reviewed with no Changes Dates:	*3/93, 2/95, 5/96, 11/97, 3/99, 2/01, 2/03, 11/05, 3/09, 4/14, 1/17, 4/19 5/12*

Scope/locations of services updated March, 2017.
4/11/18 - Approved at SKRB 3/26/18 and QSSC 4/10/18 to apply to Covington Medical Center
Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 10. Non-Discrimination Policy

Document Title: Patient Nondiscrimination

Scope:

This applies to all MultiCare Health System (MHS) workforce members, which includes but not limited to, MHS affiliated covered entities (ACE), employees, residents, students, volunteers, and other persons who are under direct control of MHS, who access, use, disclose or come in contact with patient information, including Protected Health Information (PHI) and patient Personally Identifiable Information (PII) in any form (paper, electronic or verbal).

Location Scope:

This policy applies to all of MultiCare Health System, to include but not be limited to the following locations: MultiCare Tacoma General Hospital/Allenmore Hospital, MultiCare Mary Bridge Children's Hospital, MultiCare Good Samaritan Hospital, MultiCare Auburn Medical Center, MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Covington Medical Center, Capital Medical Center, Home Health and Hospice Services, and all administrative or associated ambulatory and retail sites of care to include primary care and specialty clinics,ancillary services, surgery centers, and urgent care centers.

As affiliated covered entities (ACEs), this policy also applies to the administrative and clinical areas and workforces of MultiCare Connected Care, MHS Employees, Greater Lakes BehavioralHealth, Navos, PNW PACE Partners, PNW Hospice, Capital Medical Center Physicians, Capital Medical Center Specialty Physicians, and CHVI.

Policy Statement:

MHS does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, creed, religion, age, disability, national origin, language, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, citizenship or immigration status, or any other basis prohibited by federal or state law in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by MHS directly or through a contractor of any other entity with which MHS arranges to carry out its programs and activities.

This policy applies to MHS and ACE personnel's interactions with patients, vendors, guests, and visitors of MHS and all ACE's. For questions regarding employment discrimination involving MHS, please see the MHS Policy and Procedure "*Equal Employment Opportunity and Employment Law*."

For questions call the Privacy & Civil Rights Office at (253) 459-8300, the Integrity Line at (866) 264-6121 or email compliance@multicare.org.

Special Instructions:

Any person who believes they or any specific class of individuals have been subjected to prohibited discrimination, such person may file a complaint with the MHS Privacy & Civil Rights Office,

	All reports will be responded to and investigated by the Privacy & Civil Rights Office. The availability and use submitting a complaint to MHS Privacy & Civil Rights Office does not prevent a person from filing a complaint of discrimination with the U.S. Department of Health and Human Services, Office for Civil Rights. No person will suffer retaliation for reporting discrimination, filing a complaint, or cooperating in an investigation of a discrimination complaint.
	Procedure: **Personnel will:** 1. Treat all patients and visitors receiving services from or participating in other programs of MHS and it's affiliates, with equality in a welcoming manner that is free from discrimination based on race, color, creed, religion, age, disability, national origin, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, or any other basis prohibited by federal or state law. 2. Provide notices to patients regarding this Nondiscrimination Policy and MultiCare Health System's commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner. 3. Inform patients of the availability of and make reasonable accommodations for patients consistent with federal and state requirements. For example, language interpretation services will be made available for non-English speaking patients and sign language interpretation will be made available for hearing impaired patients. 4. Afford appropriate visitation rights to patients free from discrimination and will ensure that visitors receive equal visitation privileges consistent with patient preferences, safety, and other applicable policies. At the time patients are notified of their patient rights, Hospital Personnel will also inform patient, or patient's support person, including the patient's attorney in fact, when appropriate, of the patient's visitation rights, including any clinical or safety restriction on those rights, and the patient's right, subject to the patients consent, to receive visitors whom the patient designates. 5. Determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment of the basis of race, color, creed, religion, age, disability, national origin, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, citizenship or immigration status, or any other basis prohibited by federal or state law.
	Related Policies: Compliance and Ethics Program, Reporting and Investigating Concerns of Violations Patient Grievances Equal Employment Opportunity and Employment Law Emergency Medical Treatment and Active Labor (EMTALA), Compliance with Employee Complaint Grievance Procedure
	References: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 if the Patient Protection and Affordable Care

	Act and Regulations of the U.S. Department of Health and Human Services issued pursuant to: 45 C.F.R. § 80 (2012) – Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964. 45 C.F.R. § 84 (2012) – Enforcement of nondiscrimination on the basis of handicap in programs or activities conducted by the Department of Health and Human Services. 45 C.F.R. § 91 (2012) – Nondiscrimination on the basis of age in programs or activities receiving Federal financial assistance from HHS. RCW 49.60 – Discrimination – Human Rights Commission Idaho Title 67, Chapter 59 – Idaho Human Rights Act 29 U.S.C. § 794 – Nondiscrimination under Federal grants and programs. RCW 49.60 I.C. § 67-5909
	Point of Contact: compliance@multicare.org

Approval By:	***Date of Approval:***
Privacy & Civil Rights Leadership	***8/19, 8/20, 3/22***
System Policy Council	***4/22***
MHS Quality Safety Steering Council	***8/12, 9/17, 9/19, 9/20, 6/22***
Original Date:	*6/12*
Revision Dates:	*8/17, 8/19, 8/20; 3/22*
Reviewed with no Changes Dates:	*X/XX; X/XX*

Approved at SKRB 4/12/18 and QSSC e-vote 4/18/18 to apply to Covington Medical Center
Approved at QSSC September 2019 to apply to Home Health and Hospice
Update scope to include Protected Health Information (PHI) and Personally Identifiable Information (PII) as well as Community-based locations – November, 2020
Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 11. Pro Forma Forecast

MultiCare Thurston ASC: NEWDIV
Revenue and Expense Statement Summary

	-----FORECAST-----			
	Year 0 Jul to Dec 2024	Year 1 2025	Year 2 2026	Year 3 2027
ASC Volumes				
# of Months	6	12	12	12
OR Cases ("Procedures")	1,019	2,383	2,653	2,819
OR Minutes	50,939	119,153	132,630	140,927
Number of Operating Rooms Utilized	1.48	1.73	1.93	2.05
Gross Revenues	$14,638,844	$34,241,853	$38,114,887	$40,499,256
Deductions From Revenue				
Medicare	$4,457,469	$10,426,506	$11,605,829	$12,331,860
Medicaid	$359,764	$841,528	$936,711	$995,310
Other Gov	$781,434	$1,827,859	$2,034,605	$2,161,884
Commercial	$2,484,828	$5,812,285	$6,469,702	$6,874,429
HMO	$3,406,160	$7,967,379	$8,868,555	$9,423,349
Other	$73,054	$170,880	$190,208	$202,107
Bad Debt	$219,583	$513,628	$571,723	$607,489
Charity care	$241,541	$564,991	$628,896	$668,238
Total Deductions From Revenue	$12,023,833	$28,125,056	$31,306,229	$33,264,666
Net Revenue	$2,615,012	$6,116,798	$6,808,657	$7,234,589
Total Expenses	$2,404,066	$5,204,290	$5,848,238	$5,848,238
Net Income	**$210,946**	**$912,507**	**$960,419**	**$1,386,351**

Revenues and Expenses per Case Forecasts				
Billed Revenues	$ 14,368.87	$ 14,368.87	$ 14,368.87	$ 14,368.87
Deductions From Revenue	$ 11,802.08	$ 11,802.08	$ 11,802.08	$ 11,802.08
Net Revenue	$ 2,566.78	$ 2,566.78	$ 2,566.78	$ 2,566.78
Total Expenses	$ 2,359.73	$ 2,183.87	$ 2,204.72	$ 2,074.92
Net Income (Loss)	$ 207.06	$ 382.91	$ 362.07	$ 491.87
Revenues and Expenses per OR Minute Forecasts				
Billed Revenues	$ 287.38	$ 287.38	$ 287.38	$ 287.38
Deductions From Revenue	$ 236.04	$ 236.04	$ 236.04	$ 236.04
Net Revenue	$ 51.34	$ 51.34	$ 51.34	$ 51.34
Total Expenses	$ 47.19	$ 43.68	$ 44.09	$ 41.50
Net Income (Loss)	$ 4.14	$ 7.66	$ 7.24	$ 9.84

Footnotes:

1. Assumes average 50 minutes per case.
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.

MultiCare Thurston ASC: NEWDIV
Volume and Revenue Statement

	---------FORECAST--------			
	Year 0	Year 1	Year 3	Year 3
	Jul to Dec 2024	2025	2026	2027
# of Months	6	12	12	12
ASC Volumes				
ENT	118	277	308	328
Gastroenterology	63	146	163	173
General Surgery	242	565	629	669
Gynecology	212	496	552	586
Podiatry	87	205	228	242
Urology	215	504	561	596
Neurology	55	128	142	151
Vascular	27	62	69	74
Total Cases	***1,019***	***2,383***	***2,653***	***2,819***
Gross Revenue				
Gross Revenue Per Case	$14,369	$14,369	$14,369	$14,369
Total Gross Revenue	**$14,638,844**	**$34,241,853**	**$38,114,887**	**$40,499,256**
Payer Mix (% of Gross Revenue)				
Medicare	34.6%	34.6%	34.6%	34.6%
Medicaid	2.6%	2.6%	2.6%	2.6%
Other Gov	6.2%	6.2%	6.2%	6.2%
Commercial	23.6%	23.6%	23.6%	23.6%
HMO	32.3%	32.3%	32.3%	32.3%
Other	0.7%	0.7%	0.7%	0.7%
Gross Revenue By Payer				
Medicare	$5,065,306	$11,848,302	$13,188,442	$14,013,477
Medicaid	$386,843	$904,868	$1,007,217	$1,070,225
Other Gov	$908,644	$2,125,417	$2,365,819	$2,513,819
Commercial	$3,451,151	$8,072,618	$8,985,697	$9,547,819
HMO	$4,730,778	$11,065,805	$12,317,438	$13,087,985
Other	$96,123	$224,843	$250,274	$265,931
Total Gross Revenue	***$ 14,638,844***	***$ 34,241,853***	***$ 38,114,887***	***$ 40,499,256***
% Contractual Allowance				
Medicare	88.0%	88.0%	88.0%	88.0%
Medicaid	93.0%	93.0%	93.0%	93.0%
Other Gov	86.0%	86.0%	86.0%	86.0%
Commercial	72.0%	72.0%	72.0%	72.0%
HMO	72.0%	72.0%	72.0%	72.0%
Other	76.0%	76.0%	76.0%	76.0%
Deductions From Revenue				
Medicare	$4,457,469	$10,426,506	$11,605,829	$12,331,860
Medicaid	$359,764	$841,528	$936,711	$995,310
Other Gov	$781,434	$1,827,859	$2,034,605	$2,161,884
Commercial	$2,484,828	$5,812,285	$6,469,702	$6,874,429
HMO	$3,406,160	$7,967,379	$8,868,555	$9,423,349
Other	$73,054	$170,880	$190,208	$202,107
Subtotal --- Contractual Allowances	$11,562,709	$27,046,437	$30,105,610	$31,988,940
Bad Debt	$219,583	$513,628	$571,723	$607,489
Charity Care	$241,541	$564,991	$628,896	$668,238
Total Deductions	***$12,023,833***	***$28,125,056***	***$31,306,229***	***$33,264,666***
Total Net Revenues	***$2,615,012***	***$6,116,798***	***$6,808,657***	***$7,234,589***

MultiCare Thurston ASC: NEWDIV
Operating and Non-Operating Expenses

	-------FORECAST-------			
	Year 0	Year 1	Year 2	Year 3
	Jul to Dec 2024	2025	2026	2027
Salaries/Wages	$ 574,470	$ 1,169,251	$ 1,303,962	$ 1,303,962
Benefits	$ 120,639	$ 245,543	$ 273,832	$ 273,832
Pro Fees	$ 210,000	$ 420,000	$ 420,000	$ 420,000
Supplies	$ 767,949	$ 1,796,316	$ 1,999,494	$ 2,124,577
Utilities	$ 30,984	$ 61,968	$ 61,968	$ 61,968
Purchased Services	$ 17,500	$ 35,000	$ 35,000	$ 35,000
Depreciation	$ 230,828	$ 461,656	$ 461,656	$ 461,656
Rents/Leases	$ 98,845	$ 204,865	$ 213,726	$ 222,975
Taxes	$ 39,225	$ 91,752	$ 102,130	$ 108,519
Other Direct Expenses	$ 25,125	$ 52,260	$ 58,290	$ 58,290
Allocated Expenses	$ 261,501	$ 611,680	$ 680,866	$ 723,459
Medical Director Expense	$ 27,000	$ 54,000	$ 54,000	$ 54,000
Total Expenses	**$ 2,404,066**	**$ 5,204,290**	**$ 5,664,924**	**$ 5,848,238**

MultiCare Thurston ASC: NEWDIV
FTE Schedule, Salaries, and Benefits

FTEs (Productive & Non-Productive)

	Jul to Dec 2024	2025	2026	2027
Surgical Techs	4.00	4.00	4.00	4.00
RN	3.00	3.00	3.00	3.00
Peri-op	3.00	3.00	4.00	4.00
Scheduler	1.00	1.00	1.00	1.00
Reception	1.00	1.50	2.00	2.00
Management	0.50	0.50	0.50	0.50
TOTAL	**12.50**	**13.00**	**14.50**	**14.50**

	Jul to Dec 2024	2025	2026	2027
Number of Months	6	12	12	12

Salaries

	Jul to Dec 2024	2025	2026	2027
Surgical Techs	$ 148,429	$ 296,858	$ 296,858	$ 296,858
RN	$ 171,600	$ 343,200	$ 343,200	$ 343,200
Peri-op	$ 171,600	$ 343,200	$ 457,600	$ 457,600
Scheduler	$ 27,529	$ 55,058	$ 55,058	$ 55,058
Reception	$ 20,311	$ 60,934	$ 81,245	$ 81,245
Management	$ 35,001	$ 70,002	$ 70,002	$ 70,002
TOTAL	**$ 574,470**	**$ 1,169,251**	**$ 1,303,962**	**$ 1,303,962**

MultiCare Thurston ASC: NEWDIV
FTE Schedule, Salaries, and Benefits

Benefits

	Jul to Dec 2024	$ 2,025	$ 2,026	$ 2,027
Surgical Techs	$ 31,170	$ 62,340	$ 62,340	$ 62,340
RN	$ 36,036	$ 72,072	$ 72,072	$ 72,072
Peri-op	$ 36,036	$ 72,072	$ 96,096	$ 96,096
Scheduler	$ 5,781	$ 11,562	$ 11,562	$ 11,562
Reception	$ 4,265	$ 12,796	$ 17,061	$ 17,061
Management	$ 7,350	$ 14,701	$ 14,701	$ 14,701
TOTAL	**$ 120,639**	**$ 245,543**	**$ 273,832**	**$ 273,832**

Salaries and Benefits

	Jul to Dec 2024	$ 2,025	$ 2,026	$ 2,027
Surgical Techs	$ 179,599	$ 359,198	$ 359,198	$ 359,198
RN	$ 207,636	$ 415,272	$ 415,272	$ 415,272
Peri-op	$ 207,636	$ 415,272	$ 553,696	$ 553,696
Scheduler	$ 33,310	$ 66,620	$ 66,620	$ 66,620
Reception	$ 24,577	$ 73,730	$ 98,306	$ 98,306
Management	$ 42,351	$ 84,703	$ 84,703	$ 84,703
TOTAL	**$ 695,109**	**$ 1,414,794**	**$ 1,577,795**	**$ 1,577,795**

MultiCare Thurston ASC: NEWDIV
Depreciation and Interest Schedule

	Initial Investment	Useful Life Assumption	Forecast			
			Year 0 Jul to Dec 2024	Year 1 2025	Year 2 2026	Year 3 2027
# of Months			6	12	12	12
ASC OR Buildout (Including A&E Fees)	$ 3,341,812	20	$ 83,545	$ 167,091	$ 167,091	$ 167,091
OR Equipment and Instruments	$ 2,061,960	7	$ 147,283	$ 294,566	$ 294,566	$ 294,566
Total Depreciation	**$ 5,403,772**		**$ 230,828**	**$ 461,656**	**$ 461,656**	**$ 461,656**

	Forecast			
	Year 0 Jul to Dec 2024	Year 1 2025	Year 2 2026	Year 3 2027
Project-related interest expense (Construction Loan)	$ -	$ -	$ -	$ -
Project-related interest expense (Equipment Loan)	$ -	$ -	$ -	$ -
Total Project-related Interest Expense	**$ -**	**$ -**	**$ -**	**$ -**

MultiCare Thurston ASC: NEWDIV
Cash Flow Statement

	Forecast				
		Year 0	Year 1	Year 2	Year 3
	Pre-Operational	Jul to Dec 2024	2025	2026	2027
OPERATING ACTIVITIES					
Startup Costs	$ (502,546)				
Net income		$ 210,946	$ 912,507	$ 960,419	$ 1,386,351
Depreciation		$ 230,828	$ 461,656	$ 461,656	$ 461,656
Days in A/R (50 days)		$ (358,221)	$ (837,917)	$ (932,693)	$ (991,040)
A/R From Prior Year		$ -	$ 358,221	$ 837,917	$ 932,693
Days in A/P (30 Days)		$ 181,103	$ 395,219	$ 433,606	$ 448,882
A/P From Prior Year		$ -	$ (181,103)	$ (395,219)	$ (433,606)
Cash Flow from Operating Activities	**$ (502,546)**	**$ 264,656**	**$ 1,108,584**	**$ 1,365,686**	**$ 1,804,937**
INVESTING ACTIVITIES					
Purchase of PP&E	$ (5,403,772)				
Cash Flow from Investing Activities	**$ (5,403,772)**	**$ -**	**$ -**	**$ -**	**$ -**
FINANCING ACTIVITIES					
Equity (Project Capital)	$ 5,403,772				
Equity (Startup Funding)	$ 502,546				
Cash Flow from Financing Activities	**$ 5,906,318**	**$ -**	**$ -**	**$ -**	**$ -**
Annual Increase (Decrease)	$ -	$ 264,656	$ 1,108,584	$ 1,365,686	$ 1,804,937
Ending Balance	$ -	$ 264,656	$ 1,373,240	$ 2,738,926	$ 4,543,863

MultiCare Thurston ASC: NEWDIV
Balance Sheet

	Pre-Operational	Jul to Dec 2024	Year 1 2025	Year 2 2026	Year 3 2027
			----------Forecast----------		
ASSETS					
Current Assets					
Cash and Equivalents	$ -	$ 264,656	$ 1,373,240	$ 2,738,926	$ 4,543,863
Accounts Receivable	$ -	$ 358,221	$ 837,917	$ 932,693	$ 991,040
Total Current Assets	**$ -**	**$ 622,877**	**$ 2,211,157**	**$ 3,671,619**	**$ 5,534,903**
Fixed Assets					
Property, Plant, & Equipment	$ 5,403,772	$ 5,403,772	$ 5,403,772	$ 5,403,772	$ 5,403,772
Accumulated Depreciation & Amortization		$ (230,828)	$ (692,485)	$ (1,154,141)	$ (1,615,797)
Total Fixed Assets	**$ 5,403,772**	**$ 5,172,944**	**$ 4,711,288**	**$ 4,249,631**	**$ 3,787,975**
Total Assets	**$ 5,403,772**	**$ 5,795,821**	**$ 6,922,445**	**$ 7,921,250**	**$ 9,322,878**
LIABILITIES AND OWNER EQUITY					
Current Liabilities					
Accounts Payable	$ -	$ 181,103	$ 395,219	$ 433,606	$ 448,882
Total Current Liabilities	**$ -**	**$ 181,103**	**$ 395,219**	**$ 433,606**	**$ 448,882**
Long Term Liabilities					
Long Term Debt	$ -	$ -	$ -	$ -	$ -
Working Capital Loan	$ -	$ -	$ -	$ -	$ -
Total Long Term Liabilities	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Liabilities	**$ -**	**$ 181,103**	**$ 395,219**	**$ 433,606**	**$ 448,882**
System Contributed Capital	$ 5,403,772	$ 5,403,772	$ 5,403,772	$ 5,403,772	$ 5,403,772
System Startup Funding	$ 502,546	$ 502,546	$ 502,546	$ 502,546	$ 502,546
Retained Earnings	$ (502,546)	$ (291,600)	$ 620,907	$ 1,581,326	$ 2,967,678
Net Assets (Equity)	**$ 5,403,772**	**$ 5,614,718**	**$ 6,527,225**	**$ 7,487,644**	**$ 8,873,996**
Total Liabilities and Equity	**$ 5,403,772**	**$ 5,795,821**	**$ 6,922,445**	**$ 7,921,250**	**$ 9,322,878**

MultiCare Health System - Thurston ASC: NEWDIV

Financial Model Key Assumptions

Certificate of Need Application

Volume Assumptions

1. See discussion presented in the *Need* section of the application describing the methodology, assumptions, and rationale underlying the utilization forecast for the proposed project.

Revenues

2. Models do not include any charge inflation.
3. Revenues are based on MultiCare contracted payor rates for ASC setting. Payor mix assumed based on current mix.
4. Contractual allowances are based on MultiCare contracted payor rates for ASC setting. Payor mix assume based on current mix.
5. Bad debt is forecasted to be 1.5% of gross revenues.
6. Projected charity care is based on the three-year (2018-2020) Southwest Washington regional average charity as a percent of total revenues (1.65%) to projected total patient revenues. Please note that this is higher than the planning area hospital average charity care percentage (1.14%).

Expenses

The expense assumptions are based on MultiCare's experience providing outpatient surgeries in the region and throughout Washington State but adjusted for a new freestanding ambulatory surgery center. Expenses have been calculated on a per statistic basis, unless otherwise indicated (e.g. specific agreement term, fixed expenses expected to be held constant).

7. Models do not include any expense inflation.
8. Salaries and wages are based on forecasted FTEs and assumed hourly wages. See discussion in the *Structure and Process of Care* section of the application describing the basis for the staffing assumptions.
9. Benefits are held at 21% of salaries and wages.
10. Professional fees are forecasted to be $420,000 and held constant through forecast period.
11. Supplies are forecasted to be $754 per case.
12. Utilities are forecasted to be $12 per square foot assuming 5,164 square feet.
13. Purchased services are forecasted to be $35,000 and held constant through forecast period.
14. Depreciation projections based on straight-line depreciation of $3,341,812 in buildout costs with a 20-year useful life and $2,061,960 in equipment costs with a 7-year useful life.
15. Rents/leases include base rent and NNN expenses. Base rent is forecasted to be $24.50 per square foot, assuming 5,164 square feet, for the initial twelve months upon rent commencement in October 2022 (i.e. October 2022 – September 2023). Base rent escalation will be a minimum of 2% or a maximum of 4%. For the purposes of this forecast, base rent is escalated at 4% per year at the anniversary of the rent commencement (October 1st). NNN expenses are forecasted to be $11.15 per square foot in 2022. Future NNN expenses are

increased at the maximum of 5% per year at the beginning of each calendar year (i.e. 01/01/23, 01/01/24, etc.).

16. Taxes are forecasted at 1.5% of net patient services revenue.
17. Other Direct Expenses are forecasted at $335 per month per FTE.
18. Allocated expenses are forecasted at 10% of net patient services revenue.
19. Medical Director expenses are estimated at $150 per hour for 30 hours per month.

Cash Flow Statement

20. Startup costs are based on estimates described in application.
21. Net income based on estimates from Revenue and Expense Statement Summary.
22. Depreciation based on estimates from Depreciation and Interest Schedule.
23. Days in accounts receivable assumed to be 50 days.
24. Days in accounts payable assumed to be 30 days.
25. Purchase of PP&E and equity contributions are based on capital expenditures for proposed project.

Balance Sheet

26. Cash and cash equivalents are based on estimates of cumulative net cash flow (i.e. ending balance) from cash flow statement.
27. Accounts receivable based on estimates from cash flow statement.
28. PP&E based on capital expenditures for proposed project.
29. Accumulated depreciation calculated as depreciation for current forecast period plus cumulative depreciation from prior periods.
30. Accounts payable based on estimates from cash flow statement.
31. System contributed capital is equity contributions from MultiCare Health System for capital expenditures of proposed project.
32. System contributed startup funding is equity contributions from MultiCare Health System for startup costs of proposed project.
33. Retained earnings for Year 0 to Year 3 is calculated as retained earnings from prior period plus net income of current period. Retained earnings for pre-operational period is consistent with startup costs estimates identified in cash flow statement.

Exhibit 12A. Lease Agreement

OFFICE BUILDING LEASE
Rear Building (Building 2)

Between

McPhee Road LLC, a Washington limited liability company
As Lessor

And

MultiCare Health System, a Washington nonprofit corporation
As Lessee

OFFICE BUILDING LEASE

THIS **OFFICE BUILDING LEASE ("Lease")** dated (for reference purposes only) March 30, 2022 is made by and between McPhee Road LLC, a Washington limited liability company (herein called "Lessor") and MultiCare Health System, a Washington nonprofit corporation (herein called "Lessee")

RECITALS

A. Lessor and Lessee are parties, as such, to that certain Office Building Lease dated (for reference purposes only) as of August 23, 2010 (the "Old Lease"), as subsequently amended, concerning the Premises (more particularly described in this Lease). The Old Lease was originally entered into between Lessor and Lessee's predecessor in interest thereunder, Columbia Capital Medical Center, Limited Partnership, a Washington limited partnership.

B. Lessor and Lessee entered into two amendments to the Old Lease concerning the Premises, which are the First Amendment to Lease dated May 21, 2016 (the "1st Amendment"), and the Second Amendment to Lease dated August 27, 2021 (the "2nd Amendment"). Under the 2nd Amendment, Lessor and Lessee agreed that the term of the Old Lease was extended for an additional ten (10) years, to expire on September 30, 2031.

C. Concurrently with the execution of this Lease, Lessor and Lessee, as such, are entering into a certain Office Building Lease dated (for reference purposes only) as of March 30, 2022 (the "Building 1 Lease") concerning a certain building and premises more particularly described therein, and located adjacent to the Premises under this Lease.

D. Lessor and Lessee intend that this Lease shall restate, amend, supersede, and replace the Old Lease in its entirety effective upon the Rent Commencement Date (as more particularly described in this Lease), which is intended to coincide with, and correspond to the Rent Commencement Date as set forth in the Building 1 Lease. In addition, it is intended that the Lease Term of this Lease (as further described below) shall run concurrently with the Lease Term of the Building 1 Lease (as described therein).

AGREEMENTS

In consideration of the foregoing recitals, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as of the Effective Date as follows:

1. BASIC LEASE PROVISIONS:

(a) PARTIES:
Lessor: McPhee Road LLC, a Washington limited liability company
Lessee: MultiCare Health System, a Washington nonprofit corporation

(b) PREMISES:
Premises Address: 601 McPhee Road SW (Rear Building or Building 2), Olympia, WA 98502
Space: Rear Building or Building 2 as outlined or crosshatched on **Exhibit "A"** situated on the real property described in **Exhibit "B".**
Total Rentable Square Feet of the Building: 15,552
Lessee's Percent of Space: 100%
Rentable Square Feet: 15,552+/-

(c) TERM:
Lease Term: Fifteen (15) years, beginning on the Rent Commencement Date and ending on Lease Expiration Date below.

Lease Expiration Date: One hundred and eighty (180) complete calendar months following the Rent Commencement date estimated to be September 30, 2037.

Options: Two (2) Five (5) year option(s) to extend at then fair market rates, but shall not be less than the previous year.

Option to Extend Notification Period: Lessee shall give written notice at least twelve (12) months prior to Lease Expiration Date (See Section 3.b.)

Occupancy Date: Currently occupied.

Effective Date: Upon mutual execution of the Lease Agreement.

Rent Commencement Date: The first day of the calendar month following completion of the Lessor Improvements for the Front Building (Building 1) estimated to be October 1, 2022, in accordance with the terms set forth in the Building 1 Lease. Rent Commencement Date will only be delayed by Lessor's failure to complete its Delivery Obligations (if any) for the Front Building (Building 1) by the Occupancy Date, subject to force majeure. As set forth more fully in Section 3(c)(i) below, after the Rent Commencement Date, this Lease will restate, amend, supersede, and replace the Old Lease (except for those terms in the Old Lease that expressly survive termination or expiration of the Old Lease).

(d) BASE RENT: The annual base rent shall be $24.50 per rentable square foot; such amount does not include NNN Charges, which shall be in addition. Monthly Base Rent at Rent Commencement shall be $31,752.00.

(e) TRIPLE NET EXPENSES (NNN CHARGES): Initially estimated at $11.15 Per Rentable Square Foot per year for 2022, subject to adjustment and reconciliation as provided herein.

(f) SECURITY DEPOSIT: None required.

(g) COST OF LIVING ADJUSTMENT (BASE RENT ESCALATION): Each year upon the anniversary of the Rent Commencement Date, the Base Rent of the Lease shall be increased by the percentage increase in the 12 month CPI-U index for Seattle-Tacoma-Bellevue, WA area, as published by the U.S. Bureau of Labor Statistics for the 12 month period ending in the closet preceding publication date to the Rent Commencement Date compared to the year prior. If publication of the CPI-U index is discontinued, a reliable governmental or other nonpartisan publication evaluating the information used in determining the Consumer Price Index shall be used in its place, which shall be mutually agreed to by both Lessor and Lessee. The annual Base Rent increases will be a minimum of two percent (2.0%) and a maximum of four percent (4.0%) of the prior year's Base Rent. The adjusted Base Rent shall be paid on or before the first (1st) day of each calendar month. (See Section 7.)

(h) USE: The conduct of medical or related health care practices and the provision of services that are generally ancillary, related to, or associated with Lessee's medical or related health care practices, including but not limited to, the use of any imaging modalities, the provision of laboratory services or pharmacy services and the operation of an urgent care clinic; (ii) the conduct of administrative office activities in support of Lessee's medical or related health care practices; and (iii) ingress, egress, and the parking of motor vehicles in the parking area by Lessee's health care providers, employees, patients, visitors and invitees. (See Section 8.)

(i) EXCLUSIVE USE RIGHTS: See Section 9.

(j) LESSEE IMPROVEMENTS: Lessor shall pay to Lessee the same "Tenant Improvement Allowance" as provided in Section 5 of the 2nd Amendment to the Old Lease, in the amount of $15.00 per rentable square foot for a total amount of $233,280.00. If Lessee has received any portion of the Tenant Improvement Allowance under the Old Lease prior to the Rent Commencement Date, such portion already received shall be deducted from the Tenant Improvement Allowance available under this Lease, and only such remaining balance of the

Tenant Improvement Allowance not already paid by Lessor to Lessee shall carry over to this Lease and be payable by Lessor to Lessee hereunder. The Tenant Improvement Allowance shall be paid by the Lessor as a cash reimbursement to Lessee; 1) within ninety (90) days of written notice of substantial completion of Lessee's improvements on the Premises, as reasonably determined by Lessee and Lessor, and 2) Lessor's receipt of Lessee's general contractor's lien waivers, as-built drawings or plans, and evidence of completed work. Lessee must complete all improvements under this Section no later than September 30, 2024. If Lessee fails to comply with the preceding sentence, then Lessee forfeits it right to receive the Tenant Improvement Allowance, as described in this Section.

(k) SIGNAGE: Lessor will add Lessee's name to all appropriate interior signage; directories, suite signs etc. at Lessor's cost. Monument signage will be provided at Lessee cost as applicable to the specific building. Lessor will allow Lessee to install exterior building signage, at Lessee's expense, in a specified location as reasonably approved by Lessor, which such approval shall not be unreasonably withheld, delayed, or conditioned. All exterior building signage must be reasonably approved by Lessor, which such approval shall not be unreasonably withheld, delayed, or conditioned, and permitted by the appropriate municipality prior to production and installation. Costs of any and all repairs required to the building due to signage installation, removal or change will be the responsibility of the Lessee, except for any costs or repairs resulting from the gross negligence or willful misconduct of Lessor.

(l) PARKING: Lessee will have the proportional use of all parking opportunities at the Building and no right to reserve or mark stalls for exclusive use.

(m) RIGHT OF FIRST OFFER TO PURCHASE: Lessee shall have a Right of First Offer to purchase both the Front Building (Building 1) and Rear Building (Building 2) collectively in the event that Lessor intends to sell the buildings. The Right of First Offer shall be a one-time right and include a 20-day exclusive period, which commences upon Lessor providing notice to Lessee in writing of Lessor's intent to sell the buildings, for Lessor and Lessee to negotiate a mutually agreeable letter of intent for Lessee to purchase the buildings. If Lessor and Lessee are not able to mutually agree on terms within the 20-day exclusive period then the Right of First Offer expires unless Lessor and Lessee mutually agree to extend the exclusive period.

2. PREMISES: Lessor does hereby lease to Lessee and Lessee hereby leases from Lessor that certain office space, named in Section 1(b), (herein called "Premises"). Said Premises being agreed to be the approximate rentable square feet specified in Section 1(b) and situated on the floor (specified in Section 1(b)) of the building located at the Premises Address specified in Section 1(b) (hereinafter referred to as the "Building"). Lessee's proportionate share of the common areas in the Building is specified in Section 1(b), applicable per Section 5 of this Lease. Rentable and Usable Square Footage figures, and resulting Percentage Share, Load Factor, Base Rent and NNN Charges are subject to change as a result of area re-measurement by Lessor or Lessee, provided BOMA standards are used and the resulting impact on Lessee rent is no more than 5%. The non-measuring party may hire an architect to review these changes, in its discretion. The legal description of the Building, land, or property of which the Premises are a part is set forth on **Exhibit "B".** Lessor warrants to Lessee that, to Lessor's knowledge, Lessee's permitted use and exclusive use do not violate any other exclusivity agreement or covenant with any third party, including any other lessee, nor do they violate any instrument recorded against the property. In the event any asbestos is found within the Premises or Building, to the extent such asbestos relates to any of the Lessee Improvements completed by Lessor pursuant to the Old Lease, Lessor will be responsible for all abatement and certification costs. Additionally, Lessor shall provide evidence of final inspection by any applicable governing authority. Lessee will be responsible for all costs in connection with asbestos related to repairs, improvements, or any other work performed by or under the direction and control of Lessee during the term of the Old Lease (including any extended terms), and during the term of this Lease.

Said Lease is subject to the terms, covenants and conditions herein set forth and the Lessee covenants as a material part of the consideration for this Lease to keep and perform each and all of said terms, covenants and conditions by it to be kept and performed and that this Lease is made upon the condition of said performance.

3. TERM:

3.a. Original Term. The term of this Lease shall be for the term specified in Section 1(c).

3.b. Extension Option. If Lessee has one or more options to extend the term of this Lease as specified in Section 1(c), such option may be exercised serially (i.e., one at a time) by delivering written notice of Lessee's intention to extend the Lease at least twelve (12) months prior to the then-pending Lease expiration date, provided that Lessee is not in default beyond all applicable cure periods at the time of giving such notice or on the Lease expiration date. Such extended term shall be upon all of the provisions applicable to then expiring term of the Lease, except that the Base Rent in Section 4 as herein shall be renegotiated and established at an amount commensurate with the then prevailing market rate for Class A Commercial Space, but no less than the rent for the then-expiring term. In the event that the parties fail to negotiate a new Base Rent amount, each party shall select a qualified commercial leasing agent/broker to establish the rent, and if they cannot agree, then they shall select a similarly qualified agent/broker to determine the rent. If the two cannot agree on the rent or on a third qualified agent/broker, then the Lessor shall select the third qualified commercial leasing agent/broker to determine the rent. Notwithstanding the foregoing, Base Rent for the renewal term shall not be less than the Base Rent for the last period of the then-expiring term.

3.c. Commencement Dates. The Occupancy Date shall be as specified in Section 1(c). The Effective Date shall be as specified in Section 1(c). Abated rent period shall be as specified in Section 1(c). The Rent Commencement Date will be the date as of which Lessee shall begin paying monthly Base Rent hereunder, as specified in Section 1(c), which will only be extended for delays on the part of Lessor in delivering the Premises. Lessee will be obligated for triple net (NNN) charges starting on the Occupancy Date, notwithstanding any abated rent period.

(i) Supersession of the Old Lease. Effective as of the Rent Commencement Date, the Old Lease shall be amended, restated, superseded, and replaced in its entirety by this Lease, and the Old Lease shall be of no further force or effect with respect to any rights, covenants, and responsibilities of Lessor and Lessee concerning the Premises arising after the Rent Commencement Date (except for those terms in the Old Lease that expressly survive termination or expiration of the Old Lease).

3.d. Substituted Premises. Intentionally Deleted.

4. RENT: Lessee agrees to pay to Lessor as rental, without prior notice or demand, for the Premises the sum of Base Rent specified in Section 1(d), said Base Rent shall be paid in equal monthly installments on or before the first day of the first full calendar month of the term hereof and a like sum, as thereafter adjusted as herein provided, on or before the first day of each and every successive calendar month thereafter during the term hereof.

Base Rent shall be calculated on Lessee's actual rentable square footage, as determined at completion of Lessee's architectural plans, using the then current BOMA Standard. In addition to paying Base Rent on Lessee's office space, Lessee shall pay rent on its proportionate share of common areas, as determined in Section 2. Triple net expenses are in the amount specified in Section 1(e) annually for year one or as adjusted per 5(f) below, if reconciliation has occurred between Effective Date and Rent Commencement.

Base Rent and additional amounts due for any period during the term hereof which are for less than one (1) month shall be a prorated portion of the monthly installments due based upon a thirty (30) day month. Said Base Rent and additional amounts shall be paid to Lessor, without deduction or offset, in lawful money of the United States of America, at Rush Properties, Inc., 6622 Wollochet Dr., Gig Harbor, WA 98335, or to such other person or at such other place as Lessor may from time to time designate in writing. The annual Base Rent and annual triple net expenses for the first month are currently estimated to be in the amount of the Base Rent per rentable square foot specified in Section 1(d) plus the triple net expenses per rentable square foot specified in Section 1(e) less any proration for a partial month, and shall be due and payable prior to Lessee occupying the Premises.

5. TRIPLE NET EXPENSES (NNN CHARGES). For the purpose of this Section, the following terms are defined as follows:

5.a. Total Rentable Square Feet of the Building. The Building's rentable square footage is agreed to be the total square footage specified in Section 1(b).

5.b. Lessee's Percent of Space. The Lessee's percent of Building square footage is agreed to be the percentage stated in Section 1(b). This percentage being the ratio that the rentable square footage of the Premises, bears to the total rentable square footage of the Building.

5.c. Direct Expenses. All fixed and variable direct expenses of property operation and maintenance, as reasonably determined by generally accepted accounting practices (sometimes referred to herein collectively as "Operating Costs"), shall include the following costs, but not limited to: real property taxes and assessments (excluding any real estate excise tax) , rent taxes (excluding income taxes of which rental income may be part), gross receipt taxes (whether assessed against the Lessor or assessed against the Lessee and collected by the Lessor, or both); water and sewer charges, insurance premiums paid by Lessor that are consistent with other insurance policies commonly maintained by landlords of similar buildings in the region, utilities, common area janitorial services, property management fees not to exceed 4% of gross receipts, reasonable cost of labor for direct expenses air conditioning, ventilation and heating; supplies, materials, equipment and tools, including maintenance and repair costs deemed reasonably necessary by Lessor, replacement and repairs of the HVAC system serving the Premises (provided that such cost is amortized over the useful life of the HVAC system in accordance with generally accepted accounting principles) and upkeep of all common areas. Operating Costs shall not include repairs to the structural components of the Building and property including the roof and roof membrane, floors, load bearing walls and foundations; capital improvements, expenses that according to generally accepted accounting principles would be considered capital expenses; expenses paid directly by Lessor or otherwise reimbursed to Lessor; legal fees, financing costs, depreciation on the Building, property and equipment; compensation for any of Lessor's employees above the grade of building or property manager; overhead, taxes on Lessor's business, and other expenses not attributable to operating and management of the Building; income taxes; excise and transfer taxes; marketing costs (including advertising and promotional expenses) and leasing/broker commissions; cost incurred by Lessor for the repair or damage to the Building, property, and/or underlying land to the extent that Lessor is reimbursed by insurance or condemnation proceeds or by tenants, warrantors, or other third parties; costs associated with removal or remediation of asbestos or other hazardous or toxic materials and associated claims to the extent such costs are not allocated to Lessee under Section 34 of this Lease; capital reserves (including any portion of any condominium or other community association assessment for capital reserves); and all costs for which Lessee is not responsible in accordance with Section 15.

Notwithstanding any of the foregoing to the contrary, when computing Lessee's proportionate share of Operating Costs after December 31, 2022, the Controllable Costs (as defined herein) shall not increase by more than five percent (5%) of the total Maximum Controllable Costs (as defined herein) for the Calendar Year immediately preceding the Calendar Year for which Operating Costs are being computed, and Lessee shall not be liable to Lessor for any portion in excess of such amount. For the purposes of this Lease, the following definitions shall apply:

(i) "Base Year" shall mean the 2023 Calendar Year (January 1, 2023 through December 31 2023).

(ii) "Controllable Costs" shall be defined as all Operating Costs other than taxes, insurance expenses, utilities expenses, snow removal and ice maintenance, or any costs caused or sustained by excessive wear and tear on the Building by Lessee (or Lessee's subtenants or assigns), acts of God, or items outside of Lessor's reasonable control.

(iii) "Maximum Controllable Costs" shall mean, on January 1, 2024, one hundred five percent (105%) of the total Controllable Costs for the Building in the Base Year. For the remainder of the Lease term, on each subsequent January 1 to occur, the term "Maximum Controllable Costs" shall mean one hundred five percent (105%) of the Maximum Controllable Costs for the Calendar Year immediately preceding the Calendar Year for which Operating Costs are being computed. By wav of illustration only.

assuming the total Controllable Costs for the Base Year are $100.00, then during the Calendar Year 2024, the Maximum Controllable Costs would be $105.00 ($100.00 plus five percent (5%)). During the Calendar Year 2025, the Maximum Controllable Costs would be $110.25 ($105.00 plus five percent (5%)). During the Calendar Year 2026, the Maximum Controllable Costs would be $115.76 ($110.25 plus five percent (5%)), and the same process shall continue throughout the remainder of the Lease term.

5.d. Prorate of Rent. Rent for any period during the term of this Lease which is for less than one (1) month shall be a prorated portion of the monthly installment, based upon a thirty (30) day month.

5.e. Lessee Share in Certain Circumstances. Lessee acknowledges that certain expenses may, by their very nature or other circumstance, not be identical for each square foot of space in the Building of which the Premises are a part, and that Lessor shall have the right to make an equitable allocation given the facts and circumstances, provided that Lessor delivers sufficient proof to Lessee that such equitable allocation is reasonable under the circumstances. Lessee further acknowledges that certain Operating Costs are variable based on occupancy of the Building, such as electricity, gas, water, and garbage, and that such Operating Costs will be grossed up to reflect the amount that Lessor determines would be incurred if the Building were not less than 95% occupied, and/or prorated and allocated by Lessor based on occupancy of the building and given facts and circumstances from time to time. For example and not limitation,

(I) if real property taxes are assessed against different portions of the Building of which the Premises are a part at different rates, then the Lessor shall allocate the real property taxes among the Premises and other portions of the Building on such basis.

(II) if one commercial Lessee requires a different power source that is separately metered and charged to that Lessee directly, then that Lessee's square footage would be excluded from the total square footage of the Building to determine Lessee's pro rata share of that utility expense.

(iii) if a portion of the Building is vacant, and therefore not using certain utilities, Lessor shall have the right to either gross up the expense based on the vacancy (and allocate based on the grossed-up amount), or to exclude the vacant space from the total square footage of the Building to determine Lessee's pro rata share of that utility expense.

5.f. Reconciliation; Audit; Costs. The parties acknowledge the intent that NNN Charges are estimated in advance and paid prospectively in installments throughout the year, and that Lessee shall, in any event, be responsible for its share of the actual expenses incurred or accrued during its period of occupancy. Lessor shall give Lessee, on or before the first day of April of each year, a reconciliation and comparison of actual NNN expenses for the previous calendar year, together with the calculation of Lessee's share thereof, and the amount by which Lessee's estimated payments is either greater or less than Lessee's actual share (the "Reconciliation"), provided that Lessor's failure to deliver the Reconciliation to Lessee on or before April 1 of each year shall not be considered a default or breach of this Lease, unless Lessor fails to deliver the Reconciliation to Lessee on or before May 1 of each year. Any amount by which Lessee's actual share exceeds its payments for the preceding period shall be due within thirty (30) days of Lessor's delivery of the invoice therefor. Any amount by which Lessee's estimated payments exceeds Lessee's actual share shall be credited toward Lessee's future monetary obligations or, if none, refunded to Lessee. Notwithstanding the foregoing, final payment of amounts due from Lessee may be deferred if, during the thirty (30) days following delivery of the reconciliation any Lessee delivers a notice of objection to the Reconciliation. Lessee shall have one hundred twenty days (120) days from receipt of the Reconciliation to challenge or object to Lessor's determination of Lessee's share, and failure to deliver written notice during such period shall be conclusive acceptance of such calculation. Concurrent with Lessor's delivery of the Reconciliation, Lessor shall provide Lessee with a general ledger of all NNN Charges, copies of all tax and insurance statements billed through as NNN Charges, and any other information or documentation reasonably requested by Lessee. Lessee shall also have the right to audit, inspect, and copy the books and records of the Lessee at its local office with respect to any NNN Charges. If the audit shows an overage to Lessee of more than 5% of the actual amount owed by Lessee for its NNN Charges, Lessor shall pay the reasonable cost of such audit. Any material dispute of the NNN Charges shall be referred to the CPA that prepares the Lessor's tax return for resolution.

6. SECURITY DEPOSIT: Intentionally Deleted.

7. COST OF LIVING ADJUSTMENT: On each one-year anniversary of the **Rent Commencement** Date the Base Rent for the most recent period shall be prospectively increased by the amount or process stated in Section 1(g). Failure of Lessor to timely notify Lessee of the increased Base Rent amount, or any delay in the determination thereof, shall not be construed as a waiver of Lessor's entitlement to such increase or increased amount.

8. USE: Lessee shall use the Premises only for the purposes stated in Section 1(h) and shall not use or permit the Premises to be used for any other purpose without the prior written consent of Lessor. Lessee shall not do or permit anything to be done in or about the Premises, nor bring or keep anything therein which will in any way increase the existing rate of or affect any fire or other insurance upon the Building or any of its contents, or cause cancellation of any insurance policy covering said building or any part thereof or any of its contents. Lessee shall not do or permit anything to be done in or about the Premises which will in any way unreasonably obstruct or materially interfere with the rights of other lessees or occupants of the Building or injure or annoy them or use or allow the Premises to be used for any unlawful (of any federal, state or local law, regardless of whether permitted under any or more of the foregoing, e.g., marijuana dispensary) purpose, or purposes not allowed by Lessor's mortgagee (provided that Lessor warrants that Lessee's intended use is allowed by Lessor's mortgagee), nor shall Lessee cause, maintain or permit any nuisance in, on or about the Premises. Lessee shall not commit or suffer to be committed any waste in or upon the Premises. Lessee shall not install any antennae, satellite dishes, or other apparatus visual from outside of the Premises, or use the Premises for any purpose that could reasonably be expected to create or generate radio frequency or other similar interference that affects any Lessee in the Building or its systems. Lessee shall not, and shall not allow or permit Lessee's employees or customers, to smoke or use tobacco products within the minimum required distances from Building entrances as established by law, or near any ventilation or other access to Building that could reasonably be expected to result in the infiltration of smoke or other odors into the Building, the Premises, any common areas, or access-ways used by other Lessees or their customers or invitees. Without limiting the generality of the foregoing, no portion of the Premises shall in any event be used for: (i) the display, distribution or sale of any "adult" books, "adult" films, "adult" periodicals or "adult" entertainment; (ii) the establishment or maintenance of a massage parlor (except that this provision shall not prohibit day spas and medical offices and massages in connection with such day spas, or medical offices), gambling operation, "adult" theater, "adult" bookstore, "sex" shop, "peep show" or bawdy house or brothel, or any use in violation of applicable zoning and other governmental laws and regulations; (iii) any use which emits an obnoxious odor, noise or sound which can be heard or smelled outside of the Premises (it being expressly understood that the entire Building may have a common air recirculation pattern or system), or which is a public or private nuisance, or which is likely to generate public protests or controversy interfering with the operation of the Building; (iv) any distilling or brewing (other than as part of a restaurant operation), refining, smelting, agricultural, animal raising or boarding (other than consumer pet shops), or mining operation; (v) any short or long term residential use; (vi) any primary use as a warehousing, assembling, manufacturing, waste processing or other industrial operation; or (vii) any place for public assembly (such as a church, mortuary or meeting hall), in each case, each of which shall be deemed objectionable and prohibited within the Premises and the Building. Lessor shall have the absolute right, in its sole and absolute discretion, to refuse consent to any use or sublease or assignment to any person for any such foregoing actual or proposed use. Notwithstanding the foregoing, nothing in this Section 8 shall prohibit Lessee from using the Premises for the permitted use stated in Section 1(h).

9. EXCLUSIVITY: Contingent on Lessee being open for business in the Premises and not in default past any applicable cure period as set forth in the Lease, Lessor will not lease space within the property to Providence St. Joseph Health System without Lessee's express written permission.

10. GENERAL CONTRACTOR: Intentionally deleted.

11. LEGAL DESCRIPTION: In the event any legal description of the Premises or Building as set forth herein shall be deemed lacking, or otherwise insufficient or erroneous, Lessor and Lessee agree that either party hereto has the power to place the Lease in the hands of an attorney licensed to practice in the State of Washington to fill in, attach, or otherwise supplement this Lease with a sufficient legal description, with the same force and effect as if it had been included when this Lease was first executed.

The parties acknowledge and agree that part performance by Lessee's taking possession of the Premises shall be sufficient to resolve any ambiguity or question regarding the parties' intent with respect to the identification of the Premises, and agree to waive any claim or defense with respect to the sufficiency of the legal description or failure to attach an accurate legal description.

12. POSSESSION; OPERATION:

12.a. If the Lessor, for any reason whatsoever, cannot deliver possession of the Premises to the Lessee at the commencement of the term hereof, this Lease shall not be void or voidable, nor shall Lessor be liable to Lessee for any loss or damage resulting therefrom but, in that event, all rent shall be abated during the period between the commencement of said term and the time when Lessor delivers possession.

12.b. Lessee agrees to take possession of the Premises promptly after the Occupancy Date. Lessee may set its own hours of operations including weekends. If Lessee vacates the Premises (defined as an absence for at least 10 consecutive days without prior notice to Lessor), or Lessee abandons the Premises (defined as an absence of 365 days or more), as long as Lessee is paying rent and keeping up the Premises, such vacation or abandonment shall not be considered Lessee's default or breach of this Lease, subject to Lessor's option to declare a default as a result of Lessee's abandonment of the Premises, as provided in Section 28.d, and to exercise its remedies set forth in Section 29.

13. COMPLIANCE WITH LAW: Lessee shall not use the Premises or permit anything to be done in or about the Premises which will in any way conflict with any law, statute, ordinance or governmental rule or regulation now in force or which may hereafter be enacted or promulgated. Each party agrees that no party to this Lease has a duty or obligation to refer patients to one another and patient referral is not an obligation of this Lease. Nothing contained herein or in the relationship of Lessor and Lessee is intended to interfere with the exercise of independent medical judgment of either party. The parties further agree: (i) the Lease payments represent fair market value; (i) the Lease terms are commercially reasonable and not determined in an manner that takes into account the volume or value of referrals or other business generated between the parties; (iii) the aggregate space and/or equipment rented does not exceed that which is necessary to accomplish the commercially reasonable business purpose of the rental; and (iv) at Lessee's election, Lessor and Lessee shall document this Lease and all other arrangements between them (or between Lessee and a physician member of the other party or his or her family member) in a master contract list and/or repository that is maintained and updated centrally and available for review upon request by such party or any governmental agency with authority to request the information. Lessee shall maintain the master policy/repository in a manner that preserves the historical record of the past arrangements between Lessor and Lessee. In addition, Lessor and its employees, agents, and contractors shall comply with Lessee's reasonable access rules and regulations related to Lessee's sensitive healthcare use, including, without limitation, any rules and regulations Lessee implements to comply with executive orders or other regulations promulgated by any government authority.

14. ALTERATIONS AND ADDITIONS: Lessee shall not make or suffer to be made any alterations, additions, or improvements over the amount of $50,000 to or of the Premises or any building systems or any part thereof without the written consent of Lessor first had and obtained. Lessor's consent or approval will not be unreasonably withheld, conditioned or delayed. Any alterations, additions or improvements to or of said Premises including, but not limited to, wall coverings, paneling and built in cabinet work, but excepting movable furniture and Lessee's trade fixtures, shall on the expiration of the Term, at Lessee's election, become a part of the realty and belong to the Lessor and shall be surrendered with the Premises. In the event Lessor consents to the making of any alterations, additions or improvements to the Premises by Lessee, the same shall be made by Lessee at Lessee's sole cost and expense, and any contractor or person selected by Lessee to make the same must first be approved of in writing by the Lessor, which such approval shall not be unreasonably withheld, delayed, or conditioned. Any and all work performed in the Premises must be performed by a licensed and bonded contractor in the State of Washington and performed at such times and upon such reasonable conditions as may be imposed by Lessor to minimize and/or avoid disruption of other Lessees of the Building. Upon the expiration or sooner termination of this Lease or Lessee's right of possession, Lessee shall repair any damage to the Premises caused by any removal of Lessee's furniture and trade fixtures and shall vacate and surrender possession of the entire Premises in the condition it was delivered to Lessee, and with

ordinary wear and tear excepted, shall surrender all keys (and key cards) and shall remove all personal property and trade fixtures that may be readily removed without damage to the Premises or Building. All improvements, fixtures and other items, including ceiling light fixtures, HVAC equipment, plumbing fixtures, hot water heaters, fire suppression and sprinkler systems, interior stairs, wall coverings, carpeting and other flooring, blinds, drapes and window treatments, in or serving the Premises, whether installed by Lessee or Lessor, shall be Lessor's property and shall remain upon the Premises, all without compensation, allowance or credit to Lessee, unless Lessor elects otherwise as provided herein. If Lessee shall fail to perform any repairs, or fail to remove any items from the Premises required hereunder, Lessor may do so and Lessee shall pay Lessor's charges therefore upon demand All property removed from the Premises by Lessor pursuant to any provisions of this Lease or any Law may be handled or stored by Lessor at Lessee's expense, and Lessor shall in no event be responsible for the value, preservation or safekeeping thereof. All property not removed from the Premises upon termination, or retaken from storage by Lessee within thirty (30) days after expiration or earlier termination of this Lease or Lessee's right to possession if stored at Lessor's discretion, shall at Lessor's option be conclusively deemed to have been conveyed by Lessee to Lessor as if by bill of sale without payment by Lessor. Lessee hereby waives any statutory notices to vacate or quit the Premises upon expiration of this Lease.

15. REPAIRS:

15.a. By taking possession of the Premises, Lessee shall be deemed to have accepted the Premises as being in good, sanitary order, condition and repair. Lessee shall, at Lessee's sole cost and expense, keep the Premises and every part thereof in good condition and repair. Lessee shall upon the expiration or sooner termination of this Lease hereof surrender the Premises to the Lessor in good condition, ordinary wear and tear excepted. Except as specifically provided in herein as items for which Lessor is responsible upon delivery of the Premises, Lessor shall have no obligation whatsoever to alter, remodel, improve, repair, decorate or paint the Premises or any part thereof. The parties hereto affirm that Lessor has made no representation to Lessee respecting the condition of the Premises or the Building except as specifically herein set forth.

15.b. Notwithstanding the provisions of Section 15.a. above, Lessor shall repair and maintain at its expense the Building, common areas, and property in safe and good order, condition, and repair; provided, however, that such maintenance work shall not materially limit Lessee's access to the Premise nor deny Lessee the beneficial use of the Premises, Building, common areas, and property; and further provided that such work will be performed on a mutually agreed schedule between Lessor and Lessee. In addition to the foregoing, Lessor will be responsible for the costs to repair or replace the Building structure, foundation, load bearing walls, roof system including roof membrane, and exterior utility lines serving the Building and Premises at its sole cost and expense, and not as an NNN Charge. If any damage to Premises occurs as a result of the Lessor's failure to promptly address a repair to any of the foregoing items, including Lessor's failure to maintain the roof, HVAC system, or any other portion of the Building, Premises, property, or common areas as required under this Lease, then Lessor will be liable for any of Lessee's claims, damages, or liabilities arising therefrom. In performing such repairs and maintenance, Lessor shall use reasonable efforts to minimize interference with Lessee's use and enjoyment of the Premises. Lessor shall make repairs or ensure that repairs are made in a safe and workmanlike manner, keeping in mind Lessee's employees and invitees and their health and safety. Lessor will be solely responsible for providing snow and ice removal services subject to reimbursement as a NNN Charge. Lessee and Lessor agree on their division of responsibility regarding repair and maintenance of the Building, common areas, property, and Premises pursuant to the attached Exhibit D. If there is any discrepancy between this Section 15(b) and Exhibit D, the provisions of this Section 15(b) shall prevail. Lessee shall not be responsible for defects or deferred maintenance incurred in or on the Building or property prior to the Rent Commencement Date. Lessor shall maintain and test all sprinkler systems and fire alarms, (the "Safety Systems") in accordance with all applicable laws and regulations and Lessor shall make regular inspection and testing reports on all Safety Systems serving the Building and Premises available to Lessee upon Lessee's request or as required by the Washington State Department of Health ("DOH") or the Joint Commission on Accreditation of Healthcare Organizations ("JC"). If Lessee's current or future permitted use is subject to compliance with JC regulations, Lessor shall perform the testing of Safety Systems as outlined in Exhibit E and Lessor shall provide such test results to Lessee as outlined in Exhibit F, subject to Lessee's reimbursement of costs as a NNN Charge.

Lessor shall not be liable for any injury to or interference with Lessee's business arising from the making of any repairs, alterations or improvements in or to any portion of the Building or the Premises or in or to fixtures, appurtenances and equipment therein, unless such injury to or interference with Lessee's business arises from Lessor's gross negligence willful misconduct, or breach of the Lease.

15.c. Lessee acknowledges that Lessor does not warrant any repairs, improvements, or alterations to the Premises or the Building, except as otherwise provided herein. Repairs, improvements, and alterations performed by third parties, even if such parties may be affiliated with Rush Commercial or one or more persons with an ownership interest in Lessor, are warranted only by such third party and not by Lessor, except as otherwise provided herein.

16. LIENS: Lessee shall keep the Premises and the property in which the Premises are situated free from any liens arising out of any work performed, materials furnished or obligations incurred by Lessee. Lessor may require, at Lessor's sole option, that Lessee provide to Lessor, at Lessee's sole cost and expense, a lien and completion bond in an amount equal to one and one-half (1-1/2) times all estimated costs of any improvements, additions, or alterations in the Premises, to insure Lessor against any liability for mechanics' and materialmen's liens and to insure completion of the work.

17. ASSIGNMENT AND SUBLETTING: Lessee shall have the right to sublet all or any portion of the Premises without the prior written consent of Lessor; provided that each such sublease shall be subject and subordinate to this Lease and Lessee shall remain liable for the performance of all of its covenants and agreements under this Lease with respect to such subleased space. Lessee shall provide notice and a copy of any sublease agreement entered into in accordance herewith. Except as expressly provided herein, Lessee shall not either voluntarily or by operation of law, assign, transfer, mortgage, pledge, hypothecate or encumber this Lease or any interest therein, and shall not sublet the said Premises or any part thereof, or any right or privilege appurtenant thereto, or suffer any other person (the employees, agents, servants and invitees of Lessee excepted) to occupy or use the Premises, or any portion thereof, without the written consent of Lessor first had and obtained, which consent shall not be unreasonably withheld, conditioned or delayed. If such consent is granted, Lessee will be responsible to prepare the legal documents and agreements to effectuate such assignment or transfer, and Lessee shall pay Lessor for any other costs incurred by the process in an amount not to exceed $1,500.00. Consent to one assignment, subletting, occupation or use by any other person shall not be deemed to be consent to any subsequent assignment, subletting, occupation or use by another person. Any such assignment or subletting without such consent shall be void; provided that, without the consent of Lessor, Lessee may assign this Lease to (i) to any person, firm or corporation who is the purchaser of all or substantially all of the assets of Lessee or is the successor to substantially all the assets and business of Lessee by virtue of a corporate merger or consolidation of, with or into Lessee, or (ii) to any person, firm or corporation who is the purchaser or shall otherwise become the owner of all or substantially all of the assets of Lessee. No such assignment without the consent of Lessor, shall be effective unless each such assignee by written instrument or operation of law, shall assume and become bound to perform and observe all of the covenants and agreements of Lessee under this Lease. A change in control (as defined below) of Lessee shall be deemed and constitute an assignment of Lessee's interest in this Lease and the Premises that is subject to and requires the consent of Lessor as provided herein. Upon the effective date of any assignment, Lessor shall look solely to Lessee's assignee for performance of duties and obligations accruing after the effective date of the assignment. Any prospective assignee or sublessee otherwise shall assume in writing all obligations of Lessee under this Lease accruing after the effective date of the assignment. Lessor may assign its interests, rights, duties, and obligations under this Lease to any person who owns the property without the consent of Lessee, provided that such assignment does not materially interfere with Lessee's beneficial use of the Premises. Lessor shall provide 30 days' written notice to Lessee in advance of such assignment. Thereafter, Lessor's assignee shall be solely responsible for the performance of all terms, conditions, covenants, and agreements contained in this Lease in accordance with Section 35(xiv). With respect to any sublease or assignment requiring Lessor's consent hereunder, Lessee shall notify Lessor of its intention to so assign the Lease and shall provide such documents or information reasonably requested by Lessor to determine the nature of the proposed assignment and the financial strength and creditworthiness of such assignee. If Lessor reasonably determines that the financial strength and creditworthiness of the assignee, together with the financial strength and creditworthiness of any proposed guarantors of the Lease, is not reasonably capable of

satisfying the financial obligations of Lessee under this Lease, it shall be reasonable for Lessor to withhold or condition consent to such proposed assignment to Lessee's assignee. In the event of any transfer or transfers of Lessor's interest in the Premises, upon the assumption of this Lease by the transferee, Lessor shall be relieved of obligations and liabilities accruing from and after the date of such transfer in accordance with Section 35(xiv).

18. INDEMNITY:

18.a. Lessee Indemnity. Subject to Section 20, Lessee shall defend, protect, indemnify, and hold Lessor and Lessor's agents, officers, directors, employees, and contractors harmless from and against any and all injuries, costs, expenses, liabilities, losses, damages, injunctions, suits, actions, fines, penalties, and demands of any kind or nature (including reasonable attorneys' fees) by or on behalf of any person, entity, or governmental authority occasioned by or arising out of: (a) injuries occurring on the Premises; (b) any intentional misconduct or negligence of Lessee or Lessee's agents, employees, or contractors; (c) any breach or default in the performance of any obligation on Lessee's part to be performed under this Lease; and/or (d) the failure of any representation or warranty made by Lessee herein to be true when made. This indemnity does not include indemnification for claims to the extent they are based on the intentional misconduct or negligent acts or omissions of Lessor or its agents, officers, contractors or employees. This indemnity shall survive termination of this Lease only as to claims arising out of events that occur during the Term. Lessee's obligation to indemnify Lessor under this Section includes an obligation to indemnify for losses resulting from death or injury to Lessee's employees, and Lessee, solely as between the parties hereto and to give effect to the provisions of this Section, accordingly hereby waives any and all immunities it now has or hereafter may have under any Industrial Insurance Act, or other worker's compensation, disability benefit or other similar act which would otherwise be applicable in the case of such a claim.

18.b. Lessor's Indemnity. Subject to Section 20, Lessor shall defend, protect, indemnify, and hold Lessee and Lessee's agents, officers, directors, employees, and contractors harmless from and against any and all injuries, costs, expenses, liabilities, losses, damages, injunctions, suits, actions, fines, penalties, and demands of any kind or nature (including reasonable attorneys' fees) by or on behalf of any person, entity, or governmental authority occasioned by or arising out of: (a) injuries occurring in the common areas or any portion of the Building outside of the Premises; (b) any intentional misconduct or gross negligence of Lessor or Lessor's agents, employees, or contractors; (c) any breach or default in the performance of any obligation on Lessor's part to be performed under this Lease; and/or (d) the failure of any representation or warranty made by Lessor herein to be true when made. This indemnity does not include indemnification for claims to the extent they are based on the intentional misconduct or negligent acts or omissions of Lessee or its agents, officers, contractors or employees. This indemnity shall survive termination of this Lease only as to claims arising out of events that occur prior to or during the Term. Lessor's obligation to indemnify Lessee under this Section includes an obligation to indemnify for losses resulting from death or injury to Lessor's employees, and Lessor, solely as between the parties hereto and to give effect to the provisions of this Section, accordingly hereby waives any and all immunities it now has or hereafter may have under any Industrial Insurance Act, or other worker's compensation, disability benefit or other similar act which would otherwise be applicable in the case of such a claim.

19. MOLD DISCLAIMER: As of the Occupancy Date, Lessee has inspected the Premises and found no evidence of mold or other toxic materials, or materials that may be considered toxic (or if found, will deliver written notice to Lessor). Lessee acknowledges that (a) spores that cause mold occur and are naturally present in the environment; (b) that mold growth inside the Premises requires a source of moisture; (c) Lessor does not and will not routinely inspect the Premises for signs of moisture or mold; and (d) that conditions within the Premises are within the control of and are the responsibility of Lessee. EXCEPT AS OTHERWISE STATED IN THIS LEASE, LESSOR DISCLAIMS ANY AND ALL LIABILITY, AND LESSEE AGREES TO DEFEND, INDEMNIFY, AND HOLD HARMLESS LESSOR FROM AND AGAINST, ANY AND ALL CLAIMS (INCLUDING BUT NOT LIMITED TO ANY CLAIMS FOR PERSONAL OR BODILY INJURY, ADVERSE HEALTH EFFECTS OR OTHERWISE) AGAINST LESSEE OR LESSOR ARISING FROM LESSEE'S NEGLIGENCE RELATED TO THE PRESENCE OF MOLD OR ANY DERIVATIVE THEREOF WITHIN THE PREMISES.

20. SUBROGATION: As long as their respective insurers so permit, Lessor and Lessee hereby

mutually waive their respective right of recovery against each other for any loss to the extent insured by fire, extended coverage and other property insurance policies, existing for the benefit of the respective parties. Each party shall obtain any special endorsements, if required by their insurer to evidence compliance with the aforementioned waiver.

21. LIABILITY INSURANCE: Lessee shall, at Lessee's expense, obtain and keep in force during the term of this Lease a policy of comprehensive public liability insurance, naming Lessor as an additional insured, insuring Lessor and Lessee against any liability arising out of the ownership, use, occupancy or maintenance of the Premises and all areas appurtenant thereto. The limit for such insurance shall be a minimum of One Million Dollars ($1,000,000). The limitations of said insurance shall not, however, limit the liability of the Lessee hereunder. Lessee may carry said insurance under a blanket policy, providing, however, said insurance by Lessee shall have a Lessor's protective liability endorsement attached hereto. If Lessee shall fail to procure and maintain such insurance, Lessor may, but shall not be required to, procure and maintain same, but at the expense of Lessee. Lessee shall deliver to Lessor prior to occupancy of the Premises copies of policies of liability insurance required herein or certificates evidencing the existence and amount of such insurance with loss payable clauses satisfactory to Lessor. No policy shall be cancelable or subject to reduction of coverage except after ten (10) days' prior written notice to Lessor. Lessor reserves the right to increase the minimum coverage amount over time. In the event of such an increase, the minimum coverage shall not exceed the minimum coverage for comparably sized Lessees in comparable buildings in the area.

Notwithstanding the above, Lessee shall have the right to satisfy its insurance obligations under this Lease by means of self-insurance to the extent of all or part of the insurance required hereunder but only so long as such self-insurance is permitted under all laws applicable to Lessee at the time in question. If Lessee elects to self-insure, Lessor shall have the same benefits and protections as if Lessee carried insurance with a third-party insurance company satisfying the requirements of this Lease. Further, Lessee may only elect to self-insure under this Lease so long as (and only so long as): (i) Lessee has not assigned this Lease; (ii) Lessee maintains a tangible net worth of at least $25,000,000.00 according to its most recent audited financial statement; and (iii) Lessee governs and manages its self-insurance program in a manner consistent with programs managed by prudent businesses whose stock is publicly traded on recognized national exchanges. Upon request, Lessee shall supply Lessor from time to time with evidence reasonably satisfactory to Lessor of Lessee's tangible net worth and the satisfaction of the conditions set forth above. If Lessee elects to self-insure against the risks which would be covered by the insurance policies Lessee is required to carry under this Lease, Lessee shall be responsible for any losses or liabilities which would have been assumed by the insurance company or companies which would have issued such policies. Prior to implementing any self-insurance program as contemplated in this Section, Lessee shall give Lessor thirty (30) days prior written notice in advance of any period for which it intends to self-insure for such risks and shall provide Lessor with satisfactory evidence that it is in compliance with the requirements of this Section and such other reasonable documentation as Lessor shall request regarding the proposed self-insurance program.

22. SERVICES AND UTILITIES: Lessor agrees to furnish to the Premises during Lessee's operating hours and subject to the reasonable rules and regulations of the Building of which the Premises are a part, electricity for normal lighting, and heat and air conditioning required for the comfortable use and occupation of the Premises. Lessor shall also maintain and keep lighted the common stairs, common entries and toilet rooms in the Building of which the Premises are a part. Lessor shall not be liable for, and Lessee shall not be entitled to, any reduction of rental by reason of Lessor's failure to furnish any of the foregoing when such failure is caused by accident, breakage, repairs, strikes, lockouts or other labor disturbances or labor disputes of any character, or by any other cause, similar or dissimilar, beyond the reasonable control of Lessor. Lessor shall not be liable for a loss of or injury to property, however occurring, through or in connection with or incidental to failure to furnish any of the foregoing, unless such loss of or injury to property is caused by the grossly negligent acts or omissions of Lessor. If Lessee shall require water or electric current in excess of that usually furnished or supplied for the use of the Premises as a medical space, Lessee shall first procure the written consent of Lessor, to the use thereof and Lessor may cause a water meter or electrical current meter to be installed in the Premises so as to measure the amount of water and electric current consumed for any such use. The cost of any such

meters and of installation, maintenance and repair thereof shall be paid for by the Lessee and Lessee agrees to pay to Lessor promptly upon demand therefore by Lessor for all such water and electric current consumed as shown by said meters, at the rates charged for such services by the local public utility furnishing the same. If a separate meter is not installed, such excess cost for such water and electric current will be established by an estimate made by a utility company or electrical engineer at Lessee's cost and expense; pending any such determination, Lessor shall have the right to reasonably estimate and allocate the increased costs based on changes in or from historical usage patterns.

23. PROPERTY TAXES: Lessee shall pay, or cause to be paid, before delinquency, any and all taxes levied or assessed and which become payable during the term hereof upon all of Lessee's leasehold improvements, equipment, furniture, fixtures and personal property located in the Premises; except that which has been paid for by Lessor, and is the standard of the Building. In the event any or all of the Lessee's leasehold improvements, equipment, furniture, fixtures and personal property shall be assessed and taxed with the Building, Lessee shall pay to Lessor its share of such taxes within thirty (30) days after delivery to Lessee by Lessor of a statement in writing setting forth the amount of such taxes applicable to Lessee's property.

24. RULES AND REGULATIONS: Lessee shall faithfully observe and comply with the rules and regulations that Lessor shall from time to time promulgate, provided that such rules and regulations are reasonable and do not materially interfere with Lessee's beneficial use of the Premises. The initial rules and regulations are attached hereto as **Exhibit "C".** Lessor reserves the right from time to time to make all reasonable modifications to said rules. The reasonable additions and modifications to those rules shall be binding upon Lessee upon delivery of a copy of them to Lessee's premises during regular hours of business day. Lessor shall not be responsible to Lessee for the nonperformance of any said rules by any other Lessee or occupants.

25. HOLDING OVER: If Lessee remains in possession of the Premises or any part thereof after the expiration of the term hereof, without the written consent of Lessor, such occupancy shall be a tenancy from month to month at a rental in the amount of 125% of the last monthly rental, or any increased rent for which proper notice has been given Lessee, plus all other charges payable hereunder, and upon all the terms hereof applicable to a month to month tenancy.

26. ENTRY BY LESSOR: Lessor reserves and shall at any and all times have the right to enter the Premises on forty-eight (48) hour prior notice (except in the case of an emergency when no advance notice is required), for the purposes of inspecting the physical condition of the Premises, and supply any service to be provided by Lessor to Lessee hereunder, to show said Premises to prospective purchasers of the Building or future lessees, to post notices of non-responsibility, and to alter, improve or repair the Premises and any portion of the Building of which the Premises are a part that Lessor may deem necessary or desirable, without abatement of rent. Lessee hereby waives any claim for damages or for any injury or inconvenience to or interference with Lessee's business, any loss of occupancy or quiet enjoyment of the Premises, and any other loss occasioned thereby. For each of the aforesaid purposes, Lessor shall at all times have and retain a key with which to unlock all of the doors in, upon and about the Premises, excluding Lessee's vaults, safes and files. Lessor shall have the right to use any and all means which Lessor may deem proper to open said doors in an emergency, in order to obtain entry to the Premises without liability to Lessee except for failure to exercise reasonable care for Lessee's property. Any entry to the Premises obtained by Lessor by any of said means, or otherwise shall not under any circumstances be construed or deemed to be a forcible or unlawful entry into, or a detainer of, the Premises, or an eviction of Lessee from the Premises or any portion thereof. Lessor acknowledges that, in connection with any entry into the Premises, Lessor and its trustees, members, principals, beneficiaries, partners, officers, directors, employees, mortgagees and agents (collectively, "Lessor Related Parties") may come into contact with protected health information ("PHI") within the meaning of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, and regulations promulgated thereunder ("HIPAA"). Lessor (i) shall not disclose, and shall cause Lessor Related Parties not to disclose, any such PHI, (ii) shall implement such appropriate safeguards as may be necessary to protect the confidentiality of any such PHI against unauthorized access and use in connection with such entries into the Premises, and (iii) shall report to Lessee in writing any unauthorized use or disclosure of

any such PHI by Lessor or Lessor Related Parties in connection with any such entry into the Premises within five (5) business days of becoming aware of such unauthorized use or disclosure. In the event HIPAA or any similar or related law or regulation requires a written contract with respect to the obligations of Lessee, Lessor, or Lessor Related Parties in connection with the privacy and security of PHI, then Lessee and Lessor shall execute, and Lessor shall cause Lessor Parties to execute, such written contract on such terms as are required by law. Lessor further acknowledges that, for Lessee to comply with HIPAA, Lessee may need to restrict access to the portions of the Premises where PHI is kept or stored. Except in cases of emergency, Lessor agrees that, notwithstanding the rights granted to Lessor under this Lease, except when accompanied by an authorized representative of Lessee, neither Lessor nor any agent of Lessor shall be permitted to enter those areas of the Premises, if any, designated by Lessee as locations where patients are treated (when a patient is present) and where PHI and medical records are kept or stored.

27. RECONSTRUCTION: In the event the Premises or the Building of which the Premises are a part are damaged by fire or other perils covered by extended coverage insurance and the proceeds of such insurance are actually received by Lessor and available to Lessor and sufficient to pay for reconstruction, Lessor agrees to forthwith repair the same within 180 days of the date of such damage, unless such repairs cannot, in the reasonable determination of Lessor, be completed within such 180-day period, in which event Lessor shall commence such repairs as soon as reasonably practicable and continuously work diligently toward completion. During such period of repairs, this Lease shall remain in full force and effect, except that Lessee shall be entitled to a proportionate reduction of the rent while such repairs are being made. Such proportionate reduction shall be based on the extent to which the making of such repairs shall materially interfere with the business carried on by the Lessee in the Premises. If the damage is due to the fault or neglect of Lessee or its employees, there shall be no abatement of rent.

In the event the Premises or the Building of which the Premises are a part are damaged as a result of any cause other than the perils covered by fire and extended coverage insurance and other than intentional misconduct, recklessness, negligence, or breach of this Lease by Lessee, then Lessor shall forthwith repair the same, provided the extent of the destruction be less than ten percent (10%) of the then full replacement cost of the Premises or the Building of which the Premises are a part. In the event the destruction of the Premises or the Building is to an extent greater than ten percent (10%) of the full replacement cost, or are caused by the fault or neglect of Lessee or its employees, or breach of this Lease by Lessee, then Lessor shall have the option; (1) to repair or restore such damage, this Lease continuing in full force and effect, but the rent to be proportionately reduced as hereinabove in this Section provided; except if such uninsured damage is caused by the fault or neglect of Lessee or its employees, or breach of this Lease by Lessee, rent shall not be abated or adjusted and Lessor may charge the cost of such repairs to Lessee; or (2) give no less than thirty (30) days and no more than sixty (60) days' notice after such damage terminating this Lease as of the date specified in such notice, which date shall be no less than thirty (30) days and no more than sixty (60) days after the giving of such notice. In the event of giving such notice, this Lease shall expire and all interest of the Lessee in the Premises shall terminate on the date so specified in such notice and the rent, reduced by a proportionate amount, based upon the extent, if any, to which such damage materially interfered with the business carried on by the Lessee in the Premises, shall be paid up to date of said such termination.

Notwithstanding anything to the contrary contained in this Section, Lessor shall not have any obligation whatsoever to repair, reconstruct or restore the Premises when the damage resulting from any casualty covered under this Section occurs during the last twelve (12) months of the term of this Lease or any extension thereof or if such damage is caused by the fault or neglect of Lessee or its employees, or breach of this Lease by Lessee.

Lessor shall not be required to repair any injury of damage of fire or other cause, or to make any repairs or replacements of any panels, decoration, office fixtures, railings, floor covering, partitions, or any other property installed in the Premises by Lessee, unless such damage is caused by the gross negligence or willful misconduct of Lessor.

Lessee shall not be entitled to any other compensation or damages from Lessor for loss of the use of the whole or any part of the Premises, Lessee's personal property or any inconvenience or annoyance occasioned by such damage, repair, reconstruction or restoration, unless such lose is caused by the gross negligence or willful misconduct of Lessor.

If any damages or casualty to the Premises or the Building, (i) occurs in the last year of the Lease term and the destruction of the Premises or the Building is to an extent greater than ten percent (10%) of the full replacement cost, or (ii) repairs of any such casualty or damage cannot, in the reasonable determination of Lessor, be completed within 270 days of the date of such damage and the destruction of the Premises or the Building is to an extent greater than twenty percent (20%) of the full replacement cost, then Lessee may terminate this Lease upon thirty (30) days' written notice to Lessor thereof; provided, Lessee shall have no right to terminate this Lease as provided herein if the damages or casualty to the Premises or the Building do not, or with reasonable accommodations or repairs completed by Lessor, would not prevent Lessee's use of substantially all of the useable square footage of the Premises or would not materially limit Lessee's use of the Premises.

It shall be reasonable in determining the number of days required to complete repairs of damages or casualty as provided in this Section 27, that Lessor consider only the actions within Lessor's reasonable control, and not possible delays by third parties over which Lessor has no reasonable control (e.g., delays in obtaining permit approval).

28. DEFAULT: The occurrence of any one or more of the following events shall constitute a default and breach of this Lease by Lessee.

28.a. The failure by Lessee to make any payment of rent or any other payment required to be made by Lessee hereunder, as and when due, where such failure shall continue for a period of ten (10) days after written notice thereof by Lessor to Lessee;

28.b. The failure by Lessee to observe or perform any of the covenants, conditions or provisions of this Lease or the written Rules or Regulations referred to in Section 24 above, to be observed or performed by the Lessee, where such failure shall continue for a period of thirty (30) days after written notice thereof by Lessor to Lessee; provided, however, that if the nature of Lessee's default is such that more than thirty (30) days are reasonably required for its cure, then Lessee shall not be deemed to be in default if Lessee commences such cure within said thirty (30) day period and thereafter diligently prosecutes such cure to completion; or

28.c. The making by Lessee of any general assignment or general arrangement for the benefit of creditors; or the filing by or against Lessee of a petition to have Lessee adjudged a bankrupt, or a petition or reorganization, or arrangement under any law relating to bankruptcy unless, in the case of a petition filed against Lessee, the same is dismissed within sixty (60) days; or, the appointment of a trustee or a receiver to take possession of substantially all of Lessee's assets located at the Premises or of Lessee's interest in this Lease, where possession is not restored to Lessee within thirty (30) days; or the attachment, execution or other judicial seizure of substantially all of Lessee's assets located at the Premises or of Lessee's interest in this Lease, where such seizure is not discharged in thirty (30) days.

28.d. At Lessor's option, upon Lessee's abandonment of the Premises as provided in Section 12.b, exercised by Lessor's delivery of thirty (30) days' written notice to Lessee that Lessor has exercised such option to declare a default and breach of this Lease by Lessee.

The occurrence of the following shall constitute a default and breach of this Lease by Lessor: Lessor defaults in the performance of any covenant required to be performed by Lessor and Lessee has given Lessor a 30-day written notice of such default, specifying the nature of such default. If Lessor does not remedy the default within 30 days following receipt of Lessee's notice, or in the case of default which reasonably requires more than 30 days to cure, if Lessor has not commenced to remedy the same within 30 days following receipt of Lessee's notice or Lessor is not diligently prosecuting such cure to completion, then Lessee may notwithstanding anything to the contrary contained in this Lease, (i) pay any sums necessary to perform any obligation of Lessor in default hereunder and deduct the cost thereof from rent then and thereafter becoming due to Lessor hereunder, or require Lessor to reimburse such sum to Lessee immediately upon Lessor's receipt of Lessee's written demand therefor; or (ii) pursue any other available legal or equitable remedy. If Lessee incurs any expenses because of Lessor's failure to fulfill its obligations set forth in this Lease, Lessor agrees to reimburse Lessee for such expense no later than thirty (30) days following demand by Lessee. If Lessor fails to so reimburse Lessee, Lessee, in addition to any other remedies it may have, may deduct such expense from any rent then or thereafter becoming due to Lessor hereunder. If Lessor fails to cure any such default within the allotted cure period, Lessee shall have the right to seek monetary damages for loss arising from Lessor's failure to discharge its

obligations under this Lease. Nothing herein contained shall relieve Lessor from its duty to perform any of its obligations to the standard prescribed in this Lease.

29. REMEDIES IN DEFAULT: In the event of any such material default or breach by Lessee, Lessor may at any time thereafter, with or without notice or demand and without limiting Lessor in the exercise of a right or remedy which Lessor may have by reason of such default or breach (provided that Lessor uses commercially reasonable efforts to mitigate its damages):

29.a. Terminate Lessee's right to possession of the Premises by any lawful means, in which case this Lease shall terminate and Lessee shall immediately surrender possession of the Premises to Lessor. In such event Lessor shall be entitled to recover from Lessee all damages incurred by Lessor by reason of Lessee's default including, but not limited to, the cost of recovering possession of the Premises; expenses of reletting, reasonable attorneys' fees and costs, real estate commission actually paid; the worth at the time of award by the court having jurisdiction thereof of the amount by which the unpaid rent for the balance of the term after the time of such award exceeds the amount of such rental loss for the same period that Lessee proves could be reasonably avoided; that unamortized portion of the leasing commission; and all other amounts payable by Lessee hereunder for the balance of the term, subject, however, to the obligation of Lessor to exercise reasonable effort to relet the Premises and otherwise mitigate its damages. Unpaid installments of rent or other sums shall bear interest from the date due at the rate of twelve percent (12%) per annum. In the event Lessee shall have abandoned the Premises under Section 12.b, and following Lessor exercising its election to declare the Lease to be in default under Section 28.d, Lessor shall have the option of (a) taking possession of the Premises and recovering from the Lessee the amount specified in this paragraph, or (b) proceeding under the provision of Sections 29.b or 29.c;

29.b. Maintain Lessee's right to possession, in which case this Lease shall continue in effect whether or not Lessee shall have abandoned the Premises. In such event Lessor shall be entitled to enforce all of Lessor's rights and remedies under this Lease, including the right to recover the rent as it becomes due hereunder.

29.c. Terminate Lessee's right to possession and re-enter and re-possess the Premises without terminating this Lease and Lessee shall immediately surrender the Premises to Lessor. If Lessee fails to do so, Lessor may, without prejudice to any other remedy which it may have for possession or arrearage in rental, enter upon and take possession of the Premises and expel or remove Lessee and any other person who may be occupying the Premises or any part thereof, with or without legal proceedings. Unless Lessor elects to terminate the Lease by written notice as provided in Section 29.a, this Lease shall continue and Lessor may re-enter and may collect, by suit or otherwise, each installment of Base Rent, NNN Charges, the unamortized portion of the leasing commission, costs of Lessee improvements paid by Lessor and applicable to the unexpired term of this Lease, and all other amounts payable by Lessee as they become due and may enforce any other term or provision of this Lease on the part of Lessee required to be kept or performed. Lessee shall be liable for and shall pay to Lessor all rental and other required payments accrued to the date of termination of possession, plus all rental and other required payments for and during the remainder of the term, as such rental and other payments become due. Actions to collect amounts due by Lessee to Lessor may be brought from time to time, on one or more occasions, without the necessity of Lessor's waiting until expiration of the term. Lessee shall remain and continue to be liable to Lessor for all Base Rent, NNN Charges, the unamortized portion of the leasing commission, costs of Lessee improvements paid by Lessor and applicable to the unexpired term of this Lease, and other amounts due hereunder for the balance of the term, subject, however, to the obligation of Lessor to exercise reasonable effort to relet the Premises and otherwise mitigate its damages. If the rentals received from such reletting during any month are less than that to be paid during such month by Lessee hereunder, Lessee shall pay such deficiency to Lessor monthly upon demand. In no event shall Lessee be entitled to any excess of any rental obtained by reletting over and above the rental herein reserved. Notwithstanding any such reletting without termination, Lessor may at any time thereafter elect to terminate this Lease by written notice for Lessee's previous (and then-continuing uncured) breach.

29.d. Pursue any other remedy now or hereafter available to Lessor under the laws and/or judicial decisions of the State of Washington.

30. EMINENT DOMAIN: If more than twenty-five percent (25%) of the Premises shall be taken or

appropriated by any public or quasi-public authority under the power of eminent domain, either party hereto shall have the right, at its option, to terminate this Lease, and Lessor shall be entitled to any and all income, rent, award, or any interest therein whatsoever which may be paid or made in connection with such public or quasi-public use or purpose, and Lessee shall have no claim against Lessor for the value of any unexpired term of this Lease. If any portion of the Premises is taken, and neither party elects to terminate as herein provided, the rental thereafter to be paid shall be equitably reduced. If any part of the Building other than the Premises may be so taken or appropriated, Lessor shall have the right at its option to terminate this Lease and shall be entitled to the entire award as above provided.

31. OFFSET (ESTOPPEL) STATEMENT: Lessee shall at any time and from time to time upon not less than fifteen business (15) days' prior written notice from Lessor execute, acknowledge and deliver to Lessor a statement in writing, (a) certifying that this Lease is unmodified and in full force and effect (or, if modified, stating the nature of such modification and certifying that this Lease as so modified, is in full force and effect), and the date to which the rental and other charges are paid in advance, if any, (b) acknowledging that there are not, to Lessee's knowledge, any uncured defaults on the part of the Lessor hereunder, or specifying such defaults if any are claimed; (c) such other matters as Lessor, or the party requesting such certificate, may reasonably request. Any such statement may be reasonably relied upon by any prospective purchaser or encumbrance of all or any portion of the real property of which the Premises are a part.

32. AUTHORITY OF PARTIES: Lessee represents and warrants that those individuals executing this Lease on behalf of Lessee are duly authorized to execute and deliver this Lease on behalf of said entity and that this Lease is binding upon said entity in accordance with its terms.

33. CLAIMS AGAINST LESSOR: Any claims by Lessee on Lessor shall be limited to the assets of Lessor (including the Premises, Building, property, and all revenue derived therefrom), and Lessee expressly waives any and all rights to proceed against the individual partners, members, officers, directors or shareholders of Lessor, or any person holding an interest therein, and against any director, officer, agent, manager, or employee of Lessor or any person holding an interest in Lessor or any of them.

34. HAZARDOUS MATERIAL: Lessor represents and warrants to Lessee that, to the best of Lessor's knowledge, there is no "Hazardous Material" (later defined) on, in, or under the Premises, Building or property as of the Effective Date. If there is any Hazardous Material on, in, or under the Premises, Building or property as of the Effective Date which has been or thereafter becomes unlawfully released through no fault of Lessee or its agents, employees, contractors invitees, or affiliates , then Lessor shall indemnify, defend, and hold Lessee harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including without limitation sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees, incurred or suffered by Lessee either during or after the Lease term as the result of such contamination. Lessee shall not cause or permit any Hazardous Material to be brought upon, kept, or used or disposed of in or about the Premises by Lessee, its agents, employees, contractors or invitees, except in strict compliance with all applicable federal, state and local laws, regulation, codes and ordinances. If Lessee breaches the obligations stated in the preceding sentence, then Lessee shall indemnify, defend and hold Lessor harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including without limitation, diminution in the value of the Premises, damages for the loss or restriction on use or rentable or usable space or on any amenity of the Premises, or elsewhere, , and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees incurred or suffered by Lessor either during or after the Lease term. These indemnifications by Lessor and Lessee include, without limitation, costs incurred in connection with any investigation of site conditions or clean-up, remedial, removal or restoration work, whether or not required by any federal, state or local governmental agency or political subdivision, because of hazardous Material present in the Premises, or in soil or ground water on or under the Premises. Lessee shall immediately notify Lessor of any inquiry, investigation or notice that Lessee may receive from any third party regarding the actual or suspected presence of Hazardous Material on the Premises.

Without limiting the foregoing, if the presence of any Hazardous Material brought upon, kept or used in or about the Premises by Lessee, its agents, employees, contractors, or invitees, results in any

unlawful release of Hazardous Materials on the Premises or any other property, Lessee shall promptly take all actions, at its sole expense, as are necessary to return the Premises or any other property, to the condition existing prior to the release of any such Hazardous Material; provided that Lessor's approval of such actions shall first be obtained, which approval may be withheld at Lessor's sole discretion and without waiving any right or claim against Lessee hereunder.

As used herein, the term "Hazardous Material" means any hazardous, dangerous, toxic or harmful substance, material or waste including, but not limited to, biomedical waste, which is or becomes regulated by any local governmental authority, the State of Washington or the United States Government, due to its potential harm to the health, safety or welfare of humans or the environment.

35. GENERAL PROVISIONS:

(i) Plats and Riders. Clauses, plats and riders, if any, signed by the Lessor and the Lessee and endorsed on or affixed to this Lease are a part hereof.

(ii) Waiver. The waiver by Lessee or Lessor of any term, covenant or condition herein contained shall not be deemed to be a waiver of such term, covenant or condition on any subsequent breach of the same or any other term, covenant or condition of this Lease, other than the failure of the Lessee to pay the particular rental so accepted, regardless of Lessor's knowledge of such preceding breach at the time of the acceptance of such rent.

(iii) Notices. All notices and demands which may or are to be required or permitted to be given by either party to the other hereunder shall be in writing. All notices and demands by the Lessor to the Lessee shall be sent by United States mail, personal delivery or nationally recognized overnight private carrier, postage prepaid, addressed to the Lessee at the following addresses, or to such other person or place as the Lessee may from time to time designate in a notice to the Lessor.

Lessee:

MultiCare Health System
Attn: CBRE, Inc.-Real Estate Services
315 Martin Luther King Jr. Way
PO Box 5299
MS: 1313-5-CON
Tacoma, WA 98415-0299
E: MHSrealestateleaseadministration@multicare.org

With Mandatory Copies To:

MultiCare Health System
Attn: General Counsel
315 Martin Luther King Jr. Way
PO Box 5299
MS: 820-4-LEG
Tacoma, WA 98415-0299
Legal.Services@multicare.org
Contractsupport@multicare.org

Lessor:
Rush Properties Inc.
6622 Wollochet Dr.
Gig Harbor, WA 98335
Attn: Danny Kruse
E: dkruse@therushcompanies.com

(iv) Joint Obligation. Intentionally deleted.

(v) Marginal Headings. The marginal headings and titles to the Sections of this Lease are not a part of this Lease and shall have no effect upon the construction or interpretation of any part hereof.

(vi) Time. Time is of the essence of this Lease and each and all of its provisions in which performance is a factor.

(vii) Successors and Assigns. The covenants and conditions herein contained, subject to the provisions as to assignment, apply to and bind the heirs, successors, executors, administrators and assigns of the parties hereof.

(viii) Recordation. Neither Lessor nor Lessee shall record this Lease or a short form memorandum hereof without the prior written consent of the other party.

(ix) Quiet Possession. Upon Lessee paying the rent reserved hereunder and observing and performing all of the covenants, conditions and provisions on Lessee's part to be observed and performed hereunder, Lessee shall have quiet possession of the Premises for the entire term hereof, subject to all the provisions of this Lease.

(x) Late Charges. Lessee hereby acknowledges that late payment by Lessee to Lessor of rent or other sums due hereunder will cause Lessor to incur costs not contemplated by this Lease, the exact amount of which will be extremely difficult to ascertain. Such costs include, but are not limited to, processing and accounting charges, and late charges which may be imposed upon Lessor by terms of any mortgage or trust deed covering the Premises. Accordingly, if any installment of rent or a sum due from Lessee shall not have been received by Lessor or Lessor's designee within ten (10) days after said amount is due (without requirement of notice or demand therefor), then Lessee shall pay to Lessor a late charge equal to five percent (5%) of such overdue amount but such late charge shall not be less than $50.00. Lessee however will be granted one late payment per each calendar year at no penalty. The parties hereby agree that such late charges represent a fair and reasonable estimate of the cost that Lessor will incur by reason of the late payment by Lessee. Acceptance of such late charges by the Lessor shall in no event constitute a waiver of Lessee's default with respect to such overdue amount, nor prevent Lessor from exercising any of the other rights and remedies granted hereunder.

(xi) Prior Agreements. This Lease contains all of the agreements of the parties hereto with respect to any matter covered or mentioned in this Lease, and no prior agreements or understanding pertaining to any such matters shall be effective for any purpose. No provision of this Lease may be amended or added to except by an agreement in writing signed by the parties hereto or their respective successors in interest. This Lease shall not be effective or binding on any party until fully executed by both parties hereto.

(xii) Inability to Perform/Force Majeure. The obligations of either Lessor or Lessee hereunder, except for the obligations of Lessee to pay Base Rent, Minimum Rent, Additional Rent, NNN Charges, and other charges, shall be excused for a period equal to the time by which such performance is prevented or delayed due to strikes, labor disputes, natural disasters, riots, governmental laws, orders, or regulations prohibiting Lessee from opening for business in the Premises, war, acts of God, pandemics, or any other causes beyond the reasonable control of the party obligated to perform (each a "Force Majeure Event"). As a condition to Lessee's right to claim a Force Majeure Event, Lessee shall notify Lessor after the delay first occurs and thereafter, upon Lessor's request, describe in reasonable detail the nature and the status of Lessee's diligent efforts to end the delay. Notwithstanding the foregoing, Lessee shall not be required, as a condition to claiming a Force Majeure Event, to give Lessor notice of a publicly known event.

(xiii) Attorneys' Fees. In the event of any default hereunder, or the occurrence of any event that, with notice would constitute an event of default, or if Lessor or Lessee refers this Lease to, consults with, or engages legal counsel for advice or assistance with enforcing its terms, then all costs of such counsel shall be chargeable to and paid by the other party upon demand as a condition to curing any default. In the event of any arbitration, action or proceeding brought by either party against the other under this Lease, the prevailing party shall be entitled to recover all costs and expenses including the fees of its attorneys in such action or proceeding in such amount as the court/arbitration may adjudge reasonable as attorneys' fees.

(xiv) Sale of Premises by Lessor. In the event of any sale of the Building, Lessor shall be and is hereby entirely freed and relieved of all liability under any and all of its covenants and obligations contained in or derived from this Lease arising out of any act, occurrence or omission occurring after the consummation of such sale. The purchaser, at such sale or any subsequent sale of the Premises, shall be deemed, without any further agreement between the parties or their successors in interest or between the parties and any such purchaser, to have assumed and agreed to carry out any and all of the covenants and obligations of the Lessor under this Lease. Upon Lessee's request, the purchaser shall acknowledge in writing its assumption of this Lease as a result of its purchase of the Premises. Lessor shall transfer any deposits that it received from the Lessee to the purchaser of the Building.

(xv) Subordination, Attornment. Upon request of the Lessor and provided that such subordination does not materially increase Lessee's obligations in the Lease and further provided that such subordination does not materially decrease Lessee's rights in the Lease, Lessee will in writing subordinate its right hereunder to the lien of any first mortgage, or first deed of trust to any bank, insurance company or other lending institution, now or hereafter in force against the land and Building of which the Premises are a part, and upon any buildings hereafter placed upon the land of which the Premises is a part, and to all advances made or hereafter to be made upon the security thereof.

In the event any proceedings are brought for foreclosure, or in the event of the exercise of the power of sale under any mortgage or deed of trust made by the Lessor covering the Premises, the

Lessee shall attorn to the purchaser upon any such foreclosure or sale and recognize such purchaser as the Lessor under this Lease, provided that such attornment does not materially increase Lessee's obligations in the Lease and further provided that such attornment does not materially decrease Lessee's rights in the Lease.

The provisions of the Section to the contrary notwithstanding, and so long as Lessee and Lessor are not in default hereunder, this Lease shall remain in full force and effect for the full term hereof.

(xvi) **Name**. Lessee shall not use the name of the Building or of the development in which the Building is situated for any purpose other than as an address of the Business to be conducted by the Lessee in the Premises.

(xvii) **Severability**. Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision hereof and such other provision shall remain in full force and effect.

(xviii) **Cumulative Remedies**. No remedy or election hereunder shall be deemed exclusive but shall, wherever possible, be cumulative with all other remedies at law or in equity.

(xix) **Choice of Law**. This Lease shall be governed by the laws of the State of Washington. Venue of any action shall be in Pierce County, Washington.

(xx) **Arbitration**. Disputes under this Lease shall be submitted to binding arbitration under the Pierce County Superior Court Rules and the decision of a single arbitrator shall be final and binding on the parties hereto.

(xxi) **Common Areas.** Lessee shall have the nonexclusive use of all areas of the Building Lessor designates as common areas, subject to the Building's reasonable rules and regulations. Lessor shall maintain the common areas in good condition, and may modify such commons areas so long as Lessee has reasonable access to the Premises.

(xxii) **Light, Air and View.** Lessor does not guarantee the continued present status of light, air or view over any premises adjoining or in the vicinity of the Building.

(xxiii) **Due Date**. Any payments or other performance due hereunder, if due on a Saturday, Sunday or legal holiday, shall be due on the next regular business day.

36. LESSEE FINANCIAL STATEMENTS. If requested by Lessor's mortgagee or proposed mortgagee or other financier, or by Lessor to verify Lessee's compliance with the terms of this Lease, and provided that Lessor agrees to hold the same in confidence and not to use or disclose the contents thereof for any other purpose, and without requiring any additional confidentiality agreement other than the provisions of this Section, Lessee agrees to promptly upon Lessor's request therefor, deliver financial statements as requested by Lessor in connection with such financing or to verify Lessee's compliance with the terms of this Lease, provided, however, that this provision shall not apply so long as Lessee's financials are publicly available on websites like ProPublica or Guidestar or are otherwise available to the public on request.

37. PREPARATION NOT AN OFFER: Lessor's preparation and delivery of this Lease shall not be deemed and offer acceptable by Lessee. A valid and binding agreement shall only be reached by this Lease mutually executed by Lessor and Lessee.

38. EXHIBITS:

The following shall be attached to and made part hereof:

a. Exhibit "A" – Site/Building Plan Identifying Premises
b. Exhibit "B" – Legal Description
c. Exhibit "C" – Rules and Regulations
d. Exhibit "D" – Maintenance Matrix
e. Exhibit "E" – JC Testing Schedule
f. Exhibit "F" – JC Testing Format

The parties hereto have executed this Lease at the place and on the dates specified next to their respective signatures.

LESSOR:

McPhee Road LLC,
a Washington limited liability company

By: Danny Kruse
Its: Authorized Agent

Date: 3/30/2022

Address: c/o Rush Properties, Inc.
6622 Wollochet Dr.
Gig Harbor, Washington 98335

Please make checks payable to: McPhee Road LLC

Send EFT/ACH notifications to: RPI-AR@therushcompanies.com

LESSEE:

MultiCare Health System,
a Washington nonprofit corporation

By: Florence Chang
Its: President

Date: 3/28/2022

MultiCare Health System,
a Washington nonprofit corporation

By: Jason Mitchell
Its: Senior Vice President and Interim CFO

Date: 3/28/2022

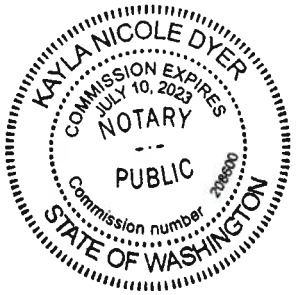
MultiCare Health System,
a Washington nonprofit corporation

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

On this 30 day of March, 2022 personally appeared before me **Danny Kruse** known to me as the **Authorized Agent** of **McPhee Road LLC** who executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the purposes therein mentioned, and that he or she was authorized to execute said instrument.

I certify that I know or have satisfactory evidence that the person appearing before me and making this acknowledgment is the person whose true signature appears on this document.

GIVEN under my hand and official seal hereto affixed the day and year in the certificate above written.



Signature _____

Print Name Kayla Nicole Dyer

NOTARY PUBLIC in and for the State of Washington residing in Kitsap.

My commission expires July 10, 2023

STATE OF WASHINGTON)
) ss.
COUNTY OF Pierce)

On this 28th day of March, 2022, personally appeared before me **Florence Chang** known to me to be the **President** of **MultiCare Health System** who executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the purposes therein mentioned, and that she was authorized to execute said instrument.

I certify that I know or have satisfactory evidence that the person appearing before me and making this acknowledgment is the person whose true signature appears on this document.

GIVEN under my hand and official seal hereto affixed the day and year in the certificate above written.

HC

HARRIET HEFTON CHILDS
NOTARY PUBLIC
STATE OF WASHINGTON
License Number 176756
My Commission Expires August 15, 2022

Signature Harriet Hefton Childs

Print Name Harriet Hefton Childs

NOTARY PUBLIC in and for the State of Washington, residing at Tacoma, WA

My commission expires 8/15/2022

STATE OF WASHINGTON)

COUNTY OF Pierce) ss.

On this 28th day of March, 2022, personally appeared before me **Jason Mitchell** known to me to be the **Senior Vice President and Interim CFO of MultiCare Health System** who executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the purposes therein mentioned, and that he was authorized to execute said instrument.

I certify that I know or have satisfactory evidence that the person appearing before me and making this acknowledgment is the person whose true signature appears on this document.

GIVEN under my hand and official seal hereto affixed the day and year in the certificate above written.

HARRIET HEFTON CHILDS
NOTARY PUBLIC
STATE OF WASHINGTON
License Number 176756
My Commission Expires August 15, 2022

Signature Harriet Hefton Childs

Print Name Harriet Hefton Childs

NOTARY PUBLIC in and for the State of Washington, residing at Tacoma, WA

My commission expires 8/15/2022

Exhibit "A" – Site/Building Plan Identifying Premises

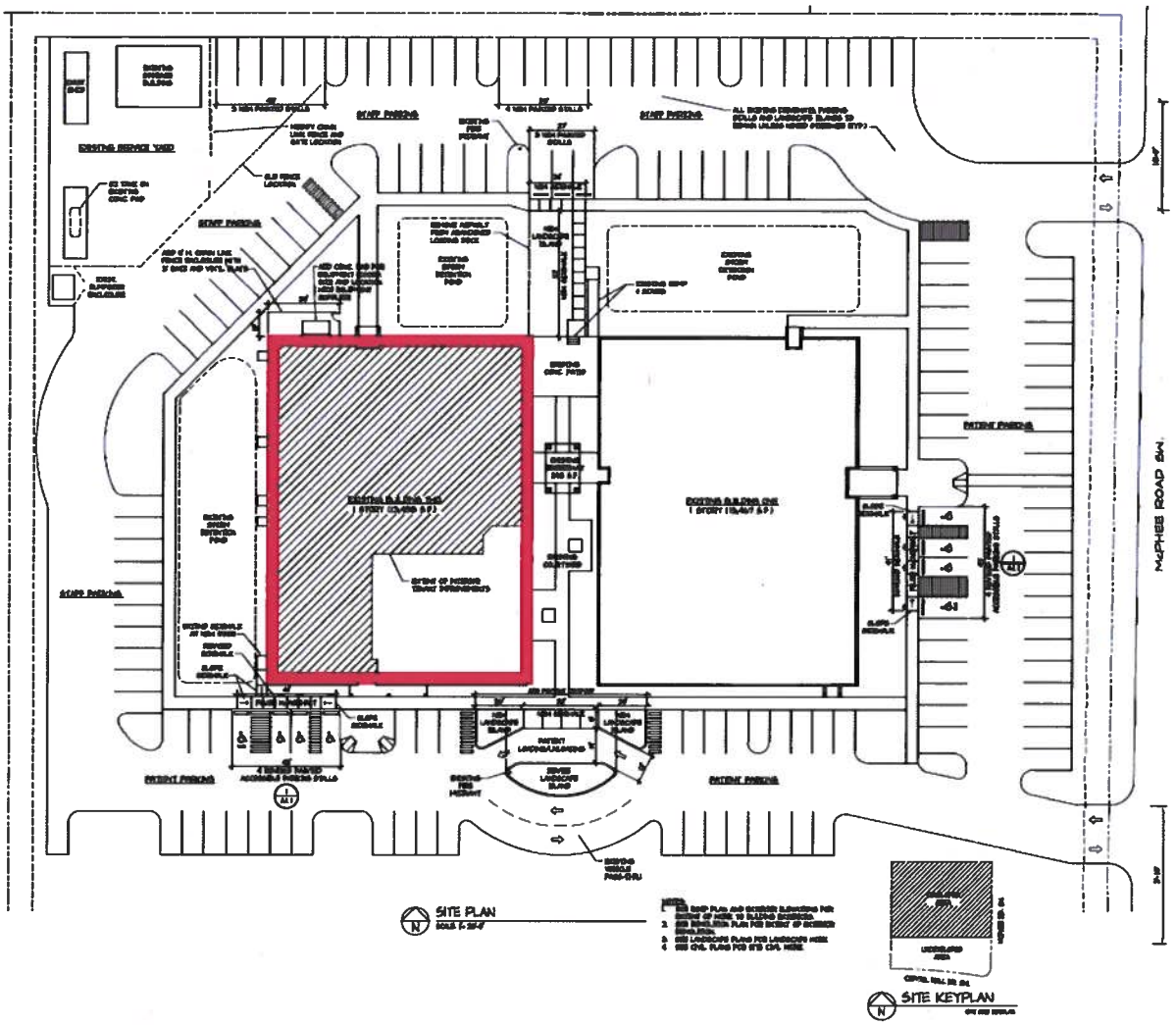


Exhibit "B" – Legal Description

Unit 1 of 601 McPhee Road, a Master Condominium, according to the Declaration and Covenants, Restrictions and Reservations recorded May 17, 2011 under Recording No. 4211105, as set forth on the Survey Map and Plans recorded May 17, 2011 under Recording No. 4211106;

In Thurston County, Washington.

Exhibit "C" – Rules and Regulations

Subject to the provisions as set forth in the attached Lease, Lessee agrees to abide by the following:

1. No sign, placard, picture, advertisement, name or notice shall be inscribed, displayed or printed or affixed on or to any part of the outside or inside of the Building without the written consent of Lessor first had and obtained and Lessor shall have the right to remove any such sign, placard, picture, advertisement, name or notice without notice to and at the expense of Lessee.

   All approved signs or lettering on doors shall be printed, painted, affixed or inscribed at the expense of Lessee by a person approved of by Lessor.

   Lessee shall not place anything or allow anything to be placed near the glass of any window, door, partition or wall which may appear unsightly from outside the Premises; provided, however, that Lessee may furnish and install a building standard window covering on all exterior windows. Lessee shall not without prior written consent of Lessor cause or otherwise sunscreen any window.

2. The sidewalks, halls, passages, exits, entrances, elevator and stairways shall not be obstructed by any of the Lessees or used by them for any purpose other than for ingress and egress from their respective Premises.

3. Lessee shall not alter any lock or install any new or additional locks or any bolts on any doors or windows of the Premises.

4. The toilet rooms, urinals, wash bowls and other apparatus shall not be used for any purpose other than that for which they were constructed and no foreign substance of any kind whatsoever shall be deposited or disposed of therein and the expense of any breakage, stoppage or damage resulting from the violation of this rule shall be borne by the Lessee who, or whose employees or invitees shall have caused it.

5. Lessee shall not overload the floor of the Premises or in any way deface the Premises or any part thereof.

6. No furniture, freight or equipment of any kind shall be brought into the Building without the prior notice to Lessor and all moving of the same into the Building shall be done at such time and in such manner as Lessor shall designate. Lessor shall have the right to prescribe the weight, size and position of all safes and other heavy equipment brought into the Building and also the times and manner of moving the same in and out of the Building. Safes or other heavy objects shall, if considered necessary by Lessor, stand on supports of such thickness as is necessary to properly distribute the weight. Lessor will not be responsible for loss of or damage to any such safe or property from any cause and all damage done to the Building by moving or maintaining any such safe or other property shall be repaired at the expense of Lessee.

7. Lessee shall not use, keep or permit to be used or kept any foul or noxious gas or substance in the Premises, or permit or suffer the Premises to be occupied or used in a manner offensive or objectionable to the Lessor or other occupants of the Building by reason of noise (including, but not limited to singing, playing musical instruments, loud operation of a radio or television, shouting, and boisterous conduct), odors (including, but not limited to cigarette, pipe or cigar smoking) and/or vibrations, or interfere in any way with other Lessees or those having business therein, nor shall any animals or birds be brought in or kept in or about the Premises or the Building.

8. Any cooking or food preparation that is done in the Premises shall be done with the use of proper ventilation, in such a way as not to produce any odors throughout the Building. The Premises will not be used for the storage of merchandise, for washing clothes or for lodging or for any improper, objectionable or immoral purposes.

9. Lessee shall not use or keep in the Premises or the Building any kerosene, gasoline or flammable or combustible fluid or material with the exception of medical gases used by the Lessee in its course of business, or use any method of heating or air conditioning other than that supplied by Lessor.

10. Lessor will direct electricians as to where and how telephone and telegraph and computer networking wires are to be introduced. No boring or cutting for wires will be allowed without the consent of Lessor. The location of telephones, call boxes and other office equipment affixed to the Premises shall be subject to the approval of Lessor.

11. On Saturdays, Sundays and legal holidays, and on other days between the hours of 6:00 PM to 8:00 AM the following day, access to the Building, or to the halls, corridors, elevator or stairways in the Building, or to the Premises may be refused unless the person seeking access is known to the person or employee of the Building in charge, or is known by the person or employee of the Premises and has a pass or is properly identified. The Lessor shall in no case be liable for damages for any error with regard to the admission to or exclusion from the Building of any person. In case of invasion, mob, riot, public excitement, or other such commotion, the Lessor reserves the right to prevent access to the Building during the continuous of the same by closing of the doors or otherwise, for the safety of the Lessees and protection of property in the Building.

12. Lessor reserves the right to exclude or expel from the Building any person who, in the judgment of Lessor, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the rules and regulations of the Building.

13. No vending machine(s) or non-office machine(s) of any description shall be installed, maintained or operated upon the Premises without the written consent of the Lessor.

14. Lessor shall have the right, exercisable with reasonable notice and without liability to Lessee, to change the name and street address of the Building of which the Premises are a part. However, Lessor agrees to make any such change in a manner least disruptive to local telephone advertisement.

15. Lessee shall not disturb, solicit or canvass any occupant of the Building and shall cooperate to prevent same.

16. Lessee shall have the right to use the name of the Building in connection with and in promoting or advertising of the business.

17. Lessor shall have the right to control and operate the public portions of the Building, and the public facilities, and heating and air conditioning, as well as facilities furnished for the common use of the Lessees in such manner as it deems best for the benefit of the Lessees generally.

18. All entrance doors in the Premises shall be left locked when the Premises are not in use, and all doors opening to public corridors shall be kept closed except for normal ingress and egress from the Premises.

19. Any regulations or restrictions, either temporary or permanent, which shall be imposed by public agencies and which Lessor has no control, shall automatically supersede any provisions of this lease or its rules and regulations and be followed by Lessee.

20. Lessor shall not be responsible for the loss or theft of Lessee's or Lessee's invitees property in the premises.

21. The work of the custodian, janitor or gardener shall not be interfered with by Lessee.

22. Lessee must contact Lessor or Lessor's designated agent immediately upon the occurrence or noting any occurrence of damage to the premises or its fixtures, furnishings and common equipment.

23. Smoking is strictly prohibited within the Premises.

24. Lessee shall ensure its children or the children of its employees and invitees are supervised at all times and are in compliance with the general nuisance provisions stated in Paragraph 7 herein.

25. Lessee shall be expected to cooperate in parking its privately owned vehicle(s) in an on-site location that facilitates convenient and accessible parking for all patrons using the Building.

26. Each Lessee, upon the termination of the lease, shall deliver to Lessor the keys of offices, rooms, and toilet rooms that shall have been furnished the Lessee or which the Lessee shall have had made. In the event of loss of any keys so furnished, the Lessee shall pay Lessor for them.

EXHIBIT "D"
Maintenance Matrix

Item / Description	Lessee or Lessor Responsibility	Reimbursable (Yes [Y] / No [N])	Frequency	Documentation Required	Comment
Building Exterior					
Awnings	Lessor	Y			
Building Backflow Testing	Lessor	Y			
Building Exterior Lights	Lessor	Y			
Exterior Utility Lines	Lessor				
Gutters/Downspout	Lessor	Y			
Internet Cabling Into Building	Lessee				
Loading Dock / Loading Dock Equipment	Not Applicable				
Painting	Lessor				
Railings/Fences/Gates	Lessor	Y			
Roof Membrane	Lessor				
Roof Structure	Lessor				
Storefront (Doors & Windows)	Lessor				
Structural/Foundation/	Lessor				
Tenant Building Signage	Lessee				
Trash, Recycle Area / Bins	Lessor	Y			
Walls/Windows	Lessor				
Window Washing	Lessor	Y			
Building Systems - Interior					

Electrical Systems (Common Area)	Lessor	Y			
Elevators Repair/Maintenance/ Testing	Not Applicable				If subject to Joint Commission requirements see Exhibit H and Exhibit I
Fire/Life Safety/Electrical Systems	Lessor	Y			If subject to Joint Commission requirements see Exhibit H and Exhibit I
Grounds					
Landscaping	Lessor	Y			
Monument Signage (Installed by Tenant)	Lessee				
Parking Lot/ Hardscape/Sweeping	Lessor	Y			
Parking Lot Lights	Lessor	Y			
Parking Lot Striping	Lessor	Y			
Sidewalks	Lessor	Y			
Snow Removal/Deicing	Lessor	Y			
Premises					
Backflow Testing	Lessor	Y			
Ceiling Tiles	Lessee				
Doors/Windows	Lessee				
Electrical Systems	Lessor	Y			
Fire Extinguisher Testing	Lessor	Y			
Flooring	Lessee				
HVAC Repairs	Lessor	Y			
HVAC Replacement	Lessor	Y (amortized)			
HVAC Quarterly Maintenance	Lessor	Y			
Janitorial	Lessee				
Keys/Locks	Lessor	Y			

Lighting Fixtures/Lamps	Lessee				
Plumbing	Lessee				
Miscellaneous					
1st Floor Lobby Bathroom	Not applicable				

EXHIBIT "E"
JC Testing Schedule

Joint Commission Maintenance Periodicities

System	Weekly	Monthly	Quarterly	Semi-Annual	Annual	Other (Specifics)
ATS Transfer						
Backflows						
Battery Powered Lights						
Electrical Outlets						
Elevator Recall						Elevator Recall (usually done with Fire Alarm)
HVAC Shutdown						HVAC shutdown (usually done with Fire Alarm)
Emergency Power Supply System						
Fire Alarm						
Fire Dampers						Fire Dampers (1 year after construction, then every 4 years)
Fire Doors						
Fire Extinguisher						
Fire Pump						
Fire Sprinkler						Sprinkler Standpipe (every 5 years)
Generator						Generator
IR Inspections of Electrical Equipment Distribution						
Kitchen Hood						
Smoke Detector						Every Other Year

EXHIBIT "F"
JC Testing Format

Joint Commission Report Requirements:

- The Code Reference of the test must be on the page (i.e. The paragraph number)
- The Code Reference Paragraph must be on the page (i.e. The paragraph text)
- The date of test must be listed on the test
- A summary of testing showing total devices in the building (separated by type), number of devices tested, and number of devices failed must be included
- Each device must have a unique identifier
- Each device must be separately listed (table format is fine, if it makes sense)
- Each device must be marked Pass or Fail
- Specific data as required by the Code Reference Paragraph must be listed
- Each test must include the testing technician's name (printed), signature, company, and license number (if required for that test)
- A deficiency page with all deficiencies found during testing must be included
- For multiple page reports, the page number and the total number of pages is required on all pages
- For maintenance actions with more than one Code Reference, each unique test must have its own page meeting the above requirement, but it may all be collated into a single report with only one summary and one deficiency page

Exhibit 12B. Parcel Property Information

Thurston County Assessor

Parcel Number: 86030000100

Date: 6/27/2022

Situs Address:	601 MCPHEE RD SW	**Sect/Town/Range:**	17 18 2W
Owner:	MCPHEE ROAD LLC	**Size:**	.00 Acres
Address:	6622 WOLLOCHET DR NW GIG HARBOR, WA 98335	**UseCode:**	63 Service - Business
		TCA Number:	110
		Neighborhood:	3MEA
Taxpayer:	MCPHEE ROAD LLC	**Property Type:**	MED
Address:	6622 WOLLOCHET DR NW GIG HARBOR, WA 98335	**Taxable:**	YES
		Active Exemptions:	None
		School District:	OLYMPIA S.D. #111
Abbreviated Legal:	Section 17 Township 18 Range 2W Quarter SE Condominium 601 MCPHEE ROAD, A MASTER CONDOMINIUM UNIT 1 Document 4211106	**Water Source:**	PUBLIC
		Sewer Type:	SEWER
Associations:	99002126309 ACCELECARE WOUND CENTERS		

Market Values

Tax Year	**2022**	**2021**	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**	**2014**	**2013**
Assessment Year	**2021**	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**	**2014**	**2013**	**2012**
Market Value Land	$216,900	$452,500	$403,500	$219,800	$287,400	$141,450	$209,750	$196,400	$181,150	$179,250
Market Value Buildings	$3,890,100	$3,740,900	$3,029,900	$2,828,900	$2,789,000	$3,312,900	$3,644,200	$3,754,700	$2,705,900	$2,391,400
Market Value Total	**$4,107,000**	**$4,193,400**	**$3,433,400**	**$3,048,700**	**$3,076,400**	**$3,454,350**	**$3,853,950**	**$3,951,100**	**$2,887,050**	**$2,570,650**

Commercial Structures

Building	Year Built	Floor	Square Feet	No. Floors	Total Sq. Ft.	Quality	Condition
MEDICAL-OFC	1980	1	15680	1	15680	AVERAGE	AVERAGE
MEDICAL-OFC	1990	1	15776	1	15776	AVERAGE	GOOD

					31456		

Detached Structures

Structure	Year Built	Square Feet	Quality	Condition
FRAME-GARAGE	1980	648	FAIR	AVERAGE
PVNG-CONCRTE	1990	5880	FAIR	AVERAGE

Land Characteristics

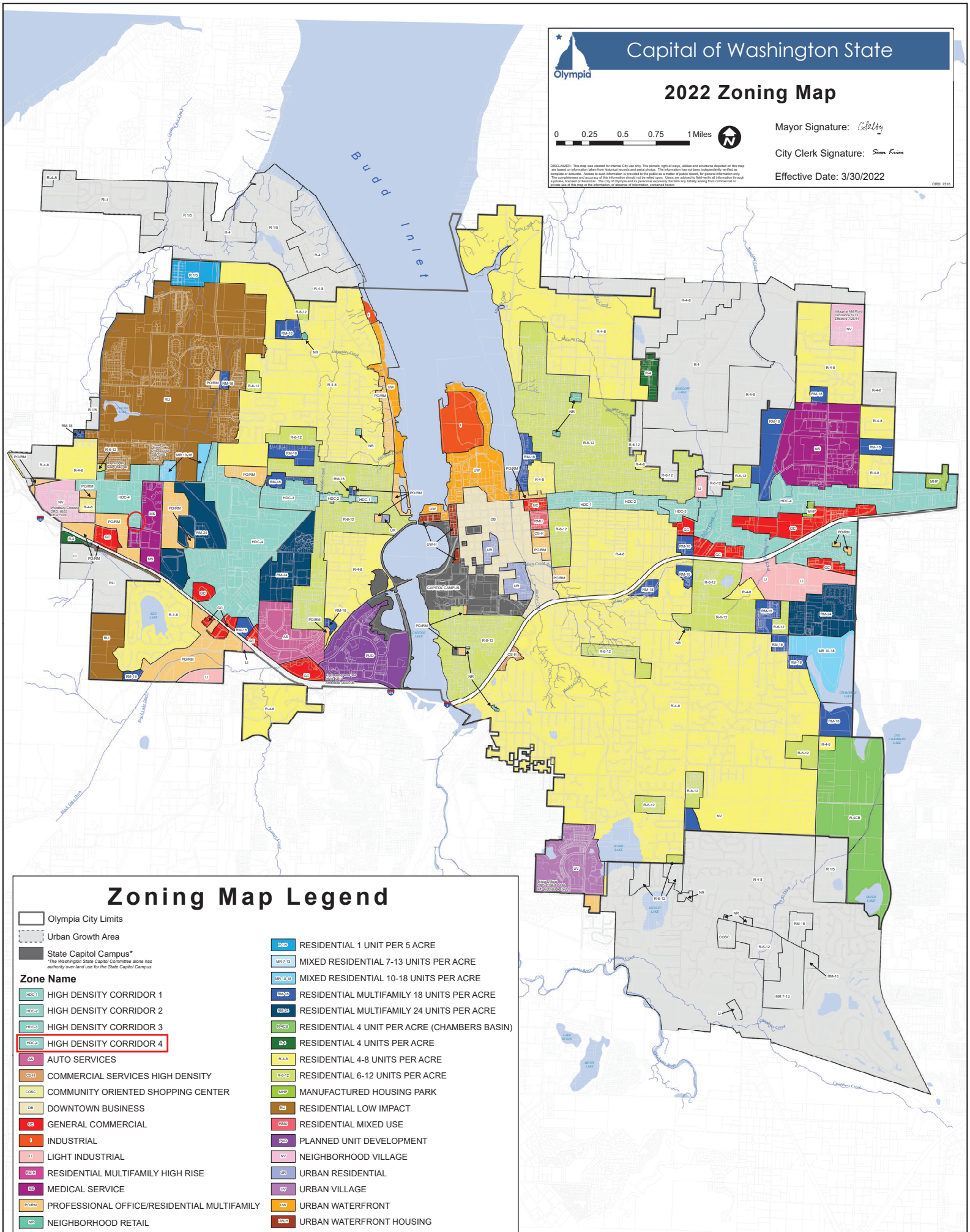
Land Flag	5860	**Land Influence(s)**	PO-PCT OWNERSHIP CO-CONDO MT-MOD-TRAFFIC
Lot Square Footage	405627		
Lot Acreage	9.31		
Effective Frontage	Not Listed		
Effective Depth	Not Listed		
Water Source	Public		
Sewer Source	Public		

Sales

Sale Date:	05/26/2011
Price:	$3,560,000
Excise:	369411S
Sale Type:	STATUTRY WARNTY DEED
Recording Number:	4214121
Seller:	ESD #113
Buyer:	MCPHEE ROAD LLC
Multiple Parcel Sale:	N

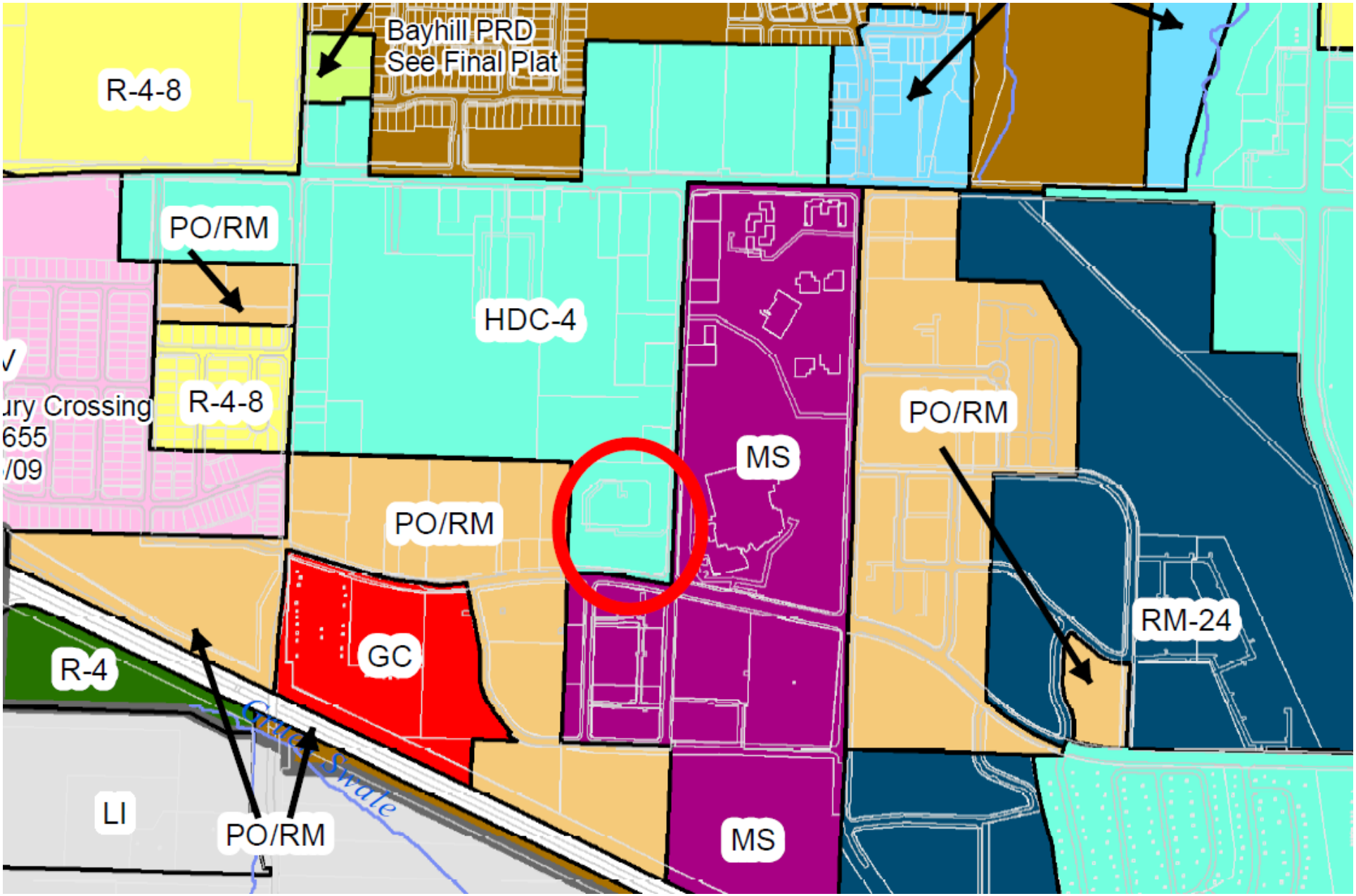
Office of the Assessor
Steven J. Drew, Assessor
2000 Lakeridge Drive SW - Olympia, WA 98502
Customer Service (360)867-2200 -- Fax (360)867-2201 -- TDD (360)754-2933

Exhibit 12C. Zoning Documentation



Map Prepared by: Casey Schaufler
phone: 360.753.8254
email:cpdinfo@ci.olympia.wa.us

Last Updated: 4/12/2022


Bayhill PRD
See Final Plat
R-4-8
PO/RM
HDC-4
R-4-8
MS
PO/RM
PO/RM
RM-24
GC
R-4
LI
PO/RM
MS

OMC 18.06.040 - Table 6.01
Permitted and Conditional Uses

OMC 18.06.080 - Table 6.02
Development Standards

Updated April 2022

18.06.040 TABLES: Permitted and Conditional Uses

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
District-Wide Regulations	18.06.060(R)				18.06.060 (F)(2)	18.06.060 (HH)	18.06.060 (F)(2)						18.130.020	
1. EATING & DRINKING ESTABLISHMENTS														
Drinking Establishments			P		P	P	P		C 18.06.060(P)		P	P	P	
Drinking Establishments - Existing		P 18.06.060 (GG)				P								
Restaurants, with drive-in or drive-through			P 18.06.060 (F)(3)								C 18.06.060 (F)(1)	C 18.06.060 (F)(1)	P 18.06.060 (F)(3)	
Restaurants, with drive-in or drive-through, existing			P				P 18.06.060 (U)					C	P	
Restaurants, without drive-in or drive-through	P 18.06.060 (U)(3)	C	P	P 18.06.060 (U)(2)	P	P	P 18.06.060 (U)(1)	P	P	P	P	P	P	
District-Wide Regulations	18.06.060(R)				18.06.060 (F)(2)	18.06.060 (HH)	18.06.060 (F)(2)							
2. INDUSTRIAL USES														
Industry, Heavy														

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Industry, Light			C		P/C 18.06. 060(N)									
On-Site Treatment & Storage Facilities for Hazardous Waste					P 18.06. 060(Q)									
Piers, Wharves, Landings					P									
Printing, Industrial			C		P/C 18.06. 060(N)									
Publishing		C	C		P		P		C	C				
Warehousing			P		P/C 18.06. 060(AA)		P							
Welding & Fabrication			C		P/C 18.06. 060(N)		P							
Wholesale Sales		C	P		P/C	P		P		P	18.06. 060 (BB)(2)			
Wholesale Products Incidental to Retail Business			P		P	P						P	P	
District-Wide Regulations	18.06. 060(R)				18.06. 060 (F)(2)	18.06. 060 (HH)	18.06. 060 (F)(2)							

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
3. OFFICE USES (See also SERVICES, HEALTH)														
Banks		P	P		P/C 18.06.060 (D)(2)	P 18.06.060 (D)(2)	P/C 18.06.060 (D)(2)	P	P	P	P	P 18.06.060 (D)(1)	P 18.06.060 (F)(3)	
Business Offices		P	P		P	P	P	P	P	P	P	P	P	
Government Offices		P	P		P	P	P	P	P	P	P	P	P	
District-Wide Regulations	18.06.060(R)				18.06.060 (F)(2)	18.06.060 (HH)	18.06.060 (F)(2)							
4. RECREATION AND CULTURE														
Art Galleries	P	P	P		P	P	P		P	P	P	P	P	
Auditoriums and Places of Assembly			P		P	P	P					P	P	
Boat Clubs					P	P								
Boating Storage Facilities					P			P						
Commercial Recreation		C	P		P	P	P	P		C	C	P	P	
Health Fitness Centers and Dance Studios	P	P 18.06.060(L)	P	P	P	P	P	P	P	P 18.06.060(L)	P 18.06.060(L)	P	P	
Libraries	C	C	C	C	P	P	P		P	C	P	P	P	18.04.060(V)
Marinas/Boat Launching Facilities					P 18.06.060(CC)	P								

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Museums		C	P		P	P	P		P	C	C	P	P	18.04.060(V)
Parks, Neighborhood	P	P	P	P	P	P	P		P	P	P	P	P	18.04.060(T)
Parks & Playgrounds, Other	P	P	P	P	P	P	P		P	P	P	P	P	18.04.060(T)
Theaters (Drive-in)			C											
Theaters (No drive-ins)			P		P	P	P				C	P	P	
District-Wide Regulations	18.06. 060(R)				18.06. 060 (F)(2)	18.06. 060 (HH)	18.06. 060 (F)(2)							
5. RESIDENTIAL														
Apartments		P	P	P	P	P	P		P	P	P	P	P	
Apartments above ground floor in mixed use development	P	P	P	P	P	P	P		P	P	P	P	P	
Boarding Houses		P	P	P	P	P	P		P	P	P	P	P	
Co-Housing		P	P			P	P			P	P		P	
Collegiate Greek system residence, dormitories		C	P	P	P	P	P		P	C	P	P	P	
Duplexes	P	P	P	P			P		P	P	P		P	
Duplexes on Corner Lots	P	P	P	P			P		P	P	P	P	P	18.04.060(HH)

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Group Homes (6 or less or up to 8 with DSHS approval)	P	P	P 18.06. 060(K)	P	P	P	P 18.06. 060(K)		P	P	P	P 18.06. 060(K)	P 18.06. 060(K)	18.04.060(K)
Group Homes (7 or more)	C	C	C 18.06. 060(K)	C	C	C	C 18.06. 060(K)		C	C	C	C 18.06. 060(K)	P 18.06. 060(K)	18.04.060(K)
Mobile or Manufactured Homes Park - Existing		C	C	C						C			C	18.04.060(P)
Quarters for Night Watch person/Caretaker					P	P								
Retirement Homes		P	P	P	P	P	P		P	P	P	P	P	
Single-Family Residences	P	P	P	P			P		P	P	P	P	P	
Single Room Occupancy Units		P	P	P	P	P	P		P	P	P	P	P	
Townhouses	P	P	P	P		P	P		P	P	P	P	P	
Triplexes, Four-plexes, and Cottage Housing		P											P	
Transitional Housing, Permanent Supportive Housing	P	P	P	P	P	P	P		P	P	P	P	P	

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
District-Wide Regulations	18.06.060(R)				18.06.060 (F)(2)	18.06.060 (HH)	18.06.060 (F)(2)							
6. RETAIL SALES														
Apparel and Accessory Stores			P		P	P	P					P	P	
Boat Sales and Rentals			P		P	P	P	P					P	
Building Materials, Garden and Farm Supplies	P		P		P	P	P					P	P	
Commercial Greenhouses, Nurseries, Bulb Farms	C	C 18.04.060(G)	C	C					C		P	P		18.04.060(G)
Electric Vehicle Infrastructure	P	P	P	P	P 18.06.060(W)	P 18.06.060(W)	P 18.06.060(W)	P	P	P	P	P	P	
Food Stores	P	P 18.06.060(H)	P		P	P	P		P	P 18.06.060(H)	P	P	P	
Furniture, Home Furnishings, and Appliances			P		P	P	P				P	P	P	
Gasoline Dispensing Facilities accessory to a permitted use	P 18.06.060 (W)(4)		P		P 18.06.060(W)		P 18.06.060 (W)(2)	P				P 18.06.060(W)	P 18.06.060(W)	

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Gasoline Dispensing Facility accessory to a permitted use - Existing	P 18.06. 060(W)		P		P 18.06. 060(W)		P 18.06. 060(W)				P	P 18.06. 060(W)	P	
General Merchandise Stores	P	P 18.06. 060(J)	P		P	P	P			P 18.06. 060(J)	P	P	P	
Mobile, Manufactured, and Modular Housing Sales			P											
Motor Vehicle Sales			P				P	P					P	
Motor Vehicle Supply Stores			P		P	P	P	P			P	P	P	
Office Supplies and Equipment		P 18.06. 060(DD)	P		P	P	P		P	P 18.06. 060(DD)	P	P	P	18.06.060(CC)
Pharmacies and Medical Supply Stores	P	P 18.06. 060(EE)	P	P	P	P	P		P	P 18.06. 060(EE)	P	P	P	18.06.060(DD)
Specialty Stores	P 18.06. 060 (Y)(3)	P 18.06. 060 (Y)(4)	P	C 18.06. 060 (Y)(2)	P	P	P			P 18.06. 060 (Y)(4)	P	P 18.06. 060 (Y)(1)	P	
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
7. SERVICES, HEALTH														
Hospitals				P			P		P					
Nursing, Congregate Care, and Convalescence Homes	C	P	C	P			C		C	C	C	P	P	18.04.060(S)
Offices, Medical		P	P	P	P	P	P	P	P	P	P	P	P	
Veterinary Offices/Clinics		P	P	P			P			P	P	P	P	
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							
8. SERVICES, LODGING														
Bed & Breakfast Houses (1 guest room)	P	P 18.06. 060(E)	P 18.06. 060(E)	P 18.06. 060(E)	P	P	P			P	P	P	P	18.04.060(L)(3)(c)
Bed & Breakfast Houses (2 to 5 guest rooms)	C	P 18.06. 060(E)	P 18.06. 060(E)	P 18.06. 060(E)	P	P	P		C	P	P	P	P	18.04.060(L)(3)(c)
Short-Term Rentals – Vacation Rentals	P	P	P	P	P	P	P		P	P	P	P	P	
Hotels/Motels			P	C	P		P		P				P	
Indoor Emergency Shelters, Indoor Emergency Housing			P	C	P		P		P				P	
Lodging Houses		P	P	P	P		P		P	P	P	P	P	

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Recreational Vehicle Parks			P										P	
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							
9. SERVICES, PERSONAL														
Adult Day Care Home	P	P	P	P	P	P	P		P	P	P	P	P	18.04.060(L)(3)(b)
Child Day Care Centers	C	P	P	P	P	P	P		P	P	C	P	P	18.04.060(D)
Crisis Intervention	C	P	C	P			P		C	P	C	C	C	18.04.060(I)
Family Child Care Homes	P	P	P	P	P	P	P		P	P	P	P	P	18.04.060(L)
Funeral Parlors and Mortuaries		C	P				P			C		P	P	
Laundries and Laundry Pick-up Agencies	P	P	P	P	P	P	P			P 18.06. 060(O)	P 18.06. 060(O)	P 18.06. 060(O)	P	
Personal Services	P	P	P	P	P	P	P	P	P	P	P	P	P	
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							
10. SERVICES, MISCELLANEOUS														
Auto Rental Agencies			P		P	P	P	P			C	P	P	
Equipment Rental Services, Commercial			P		P		P				P	P	P	

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Equipment Rental Services, Commercial - Existing		P 18.06. 060(FF)												
Ministorage			P				P							
Printing, Commercial	P	P	P		P	P	P		P	P	P	P	P	
Public Facilities (see also Public Facilities, Essential on next page)	C	C	C	C	P	C	P	P	P	C	C	C	C	18.04.060(V)
Radio/T.V. Studios		P	P		P	P	P		P	P	P	P	P	
Recycling Facilities	P	P	P	P	P		P		P	P	P	P	P	18.06.060(V)
School - Colleges and Business, Vocational or Trade Schools		C	P		P	P	P		P	C	C	C	P	18.06.060(X)
Service and Repair Shops			P				P	P				P	P	
Service Stations/Car Washes			P				P 18.06. 060(W)	P				P 18.06. 060(W)	P 18.06. 060 (W)	
Service Stations/Car Washes - Existing			P		P 18.06. 060(W)		P 18.06. 060(W)				P	P 18.06. 060(W)	P 18.06. 060(W)	

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Servicing of Personal Apparel and Equipment	P	P	P		P	P	P			P	P	P	P	
Truck, Trailer, and Recreational Vehicle Rentals			P					P						
Workshops for Disabled People	C	C	C	C	P	C	P		C	C	C	C	C	18.04.060(R)
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							
11. PUBLIC FACILITIES, ESSENTIAL														
Airports			C										C	18.06.060(G)
Inpatient Facilities		C	C	C 18.06. 060(G)	C		C		C	C	C	P	P	18.06.060(G) 18.04.060(K)
Jails			C		C		C		C				C	18.06.060(G)
Mental Health Facilities			C	C 18.06. 060(G)	C		C						C	18.06.060(G) 18.04.060(K)
Other Correctional Facilities		C	C	C 18.06. 060(G)	C	C	C		C	C	C	C	C	18.06.060(G)
Other facilities as designated by the Washington State Office of Financial Management, except prisons and		C	C		C		C			C	C	C	C	18.06.060(G)

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
solid waste handling facilities														
Radio/TV and Other Communication Towers and Antennas	C	C	C	C	C	C	C	C	C	C	C	C	C	18.06.060(G) 18.44.100
Sewage Treatment Facilities	C	C	C	C	P		P		C	C	C	C	C	18.06.060(G) 18.04.060(X)
State Education Facilities		C	C		C		C		C	C	C	C	C	18.06.060(G) 18.06.060(X)
State or Regional Transportation Facilities	C	C	C	C	C	C	C		C	C	C	C	C	18.06.060(G)
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							
12. TEMPORARY USES														
Entertainment Events			P		P	P	P						P	
Off Site Contractor Offices	P	P	P	P	P	P	P	P	P	P	P	P	P	18.04.060(DD)
Emergency Housing	P	P	P	P	P			P	P	P	P	P	P	18.04.060(DD)
Emergency Housing Facilities	P	P	P	P	P	P	P	P	P	P	P	P	P	18.50
Fireworks, as determined by Fire Dept.			P		P	P	P				P	P	P	9.48.160

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Mobile Sidewalk Vendors		P	P	P	P	P	P			P	P	P	P	
Parking Lot Sales			P		P	P	P	P			P	P	P	
Residences Rented for Social Event (6 or less in 1 year)	P	P	P	P	P	P	P		P	P	P	P	P	18.04.060(DD)
Residences Rented for Social Event (7 or more in 1 year)	C	C	C	C	C	C	C		C	C	C	C	C	
Temporary Surface Parking Lot		P	P		P	P	P		P					
District-Wide Regulations	18.06. 060(R)				18.06. 060(F)(2)	18.06. 060(HH)	18.06. 060(F)(2)							
13. OTHER USES														
Accessory Structures/Uses	P	P	P	P	P	P	P	P	P	P	P	P	P	
Adult Oriented Businesses			P										P	18.06.060(B)
Agriculture	P	P	P	P					P	P	P	P	P	
Animals	P	P	P	P	P	P	P		P	P	P	P	P	18.06.060(C)
Cemeteries	C	C	C	C					C	C	C		C	
Conference Center			P		P	P	P						P	
Gambling Establishments			C											

TABLE 6.01
PERMITTED AND CONDITIONAL USES

COMMERCIAL DISTRICT	NR	PO/RM	GC	MS	UW	UW-H	DB	AS	CSH	HDC-1	HDC-2	HDC-3	HDC-4	APPLICABLE REGULATIONS
Garage/Yard/Rummage and Other Outdoor Sales	P	P	P	P	P	P	P		P	P	P	P	P	5.24
Home Occupations	P	P	P	P	P	P	P		P	P	P	P	P	18.04.060(L)
Parking Facility, Commercial		P	P		P	P	P 18.06. 060(S)			P	P	P 18.06. 060(S)	P	18.04.060(V)
Places of Worship	C	C	P	C	P	P	P		C	C	C	P	P	18.04.060(U)
Racing Pigeons	C	C	C	C					C	C	C	C	C	18.04.060(Y)
Satellite Earth Stations	P	P	P	P	P	P	P	P	P	P	P	P	P	18.44.100
Schools	C	C	P	C	C	C	C		C	C	C	P	P	18.04.060(CC)
Social Organizations		P	P		P	P	P		P/C 18.06. 060(I)	P	P	P	P	
Utility Facility	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	18.04.060(X)
Wireless Communications Facilities	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	18.44

LEGEND			
P = Permitted Use	PO/RM = Professional Office/Residential Multifamily	GC = General Commercial	HDC-1=High Density Corridor-1
MS = Medical Services		UW = Urban Waterfront	HDC-2=High Density Corridor-2
DB = Downtown Business	AS=Auto Services	UW-H = Urban Waterfront-Housing	HDC-3=High Density Corridor-3
C = Conditional Use	NR = Neighborhood Retail	CSH = Commercial Services-High Density	HDC-4=High Density Corridor-4

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
MINIMUM LOT SIZE	7,200 Sq. Ft.	No minimum, except: 1,600 = cottage; 3,000 = zero lot; 1,600 sq. ft. minimum, 2,400 sq. ft. average = townhouse; 6,000 sq. ft. = duplex; 7,200 sq. ft. = multifamily; 4,000 = other	No minimum, except: 1,600 sq. ft. minimum, 2,400 sq. ft. average = townhouse	No minimum, except: 1,600 = cottage; 3,000 = zero lot; 1,600 sq. ft. minimum, 2,400 sq. ft. average = townhouse; 6,000 sq. ft. = duplex; 7,200 sq. ft. = multifamily; 4,000 = other	No minimum, except: 1,600 = cottage; 3,000 = zero lot; 1,600 sq. ft. minimum, 2,400 sq. ft average = townhouse; 6,000 sq. ft. = duplex; 7,200 sq. ft. = multifamily; 4,000 = other	No minimum, except: 1,600 sq. ft. minimum, 2,400 sq. ft. average = townhouse	No minimum, except: 1,600 sq. ft minimum, 2,400 sq. ft. average = townhouse	See also 18.06.100(D) for regulations on existing undersized lots of record.
FRONT YARD SETBACK	See Chapter 18.110, Basic Commercial Design Criteria	10' maximum, if located in a High Density Corridor; 10' minimum otherwise.	5' minimum for residential, otherwise none.	0-10' See 18.130	0-10' See 18.130	0-10' See 18.130	0-10' See 18.130	1. 50' minimum from property line for agriculture buildings (or structures) which house animals other than pets. 2. Must comply with clear sight triangle requirements, Section 18.40.060(C). 3. Must comply with site design standards, Chapter 18.100.

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
REAR YARD SETBACK	15' minimum.	10' minimum; Except: 1. Next to an R 4, R 4-8, or R 6-12 district = 15' minimum + 5' for each bldg. floor above 2 stories. 2. Next to MR 7-13, MR 10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories.	10' minimum; Except: 1. Next to single-family use or an R 4, R 4-8, or R 6-12 district = 15' minimum + 5' for each bldg. floor above 2 stories. 2. Next to MR 7-13, MR 10-18, RM-18, RM-24 or RMH district (refer to 1 above if adjacent use is single-family) = 10' minimum + 5' for each bldg. floor above 2 stories.	10' minimum; Except: 1. Next to an R4, R4-8, or R6-12 district = 15' minimum + 5' for each bldg. floor above 2 stories; 10 ft. where an alley separates HDC-1 from the above residential district. 2. Next to MR7-13, MR 10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories.	10' minimum; Except: 1. Next to an R4, R4-8, or R6-12 district = 15' minimum + 5' for each bldg. floor above 2 stories; 10 ft. where an alley separates HDC-2 from the above residential district. 2. Next to MR7-13, MR 10-18, RM-18, RM-24, or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories.	10' minimum; Except: 1. Next to single-family use or an R4, R4-8, or R6-12 district = 15' minimum + 5' for each bldg. floor above 2 stories. 2. Next to MR7-13, MR10-18, RM-18, RM-24 or RMH district (refer to 1 above if adjacent use is single-family) = 10' minimum + 5' for each bldg. floor above 2 stories.	10' minimum; Except: 1. Next to single-family use or an RLI, R4, R4-8, or R6-12 district - 15' minimum + 5' for each bldg. floor above 2 stories. 2. Next to MR7-13, MR10-18, RM-18, RM-24 or RMH district (refer to 1 above if adjacent use is single-family) = 10' minimum + 5' for each bldg. floor above 2 stories.	1. 50' minimum from property line for agriculture buildings (or structures) which house animals other than pets. 2. Must comply with site design standards, Chapter 18.100.
SIDE YARD SETBACK	15' minimum.	No minimum on interior, 10' minimum on flanking street; Except:	No Minimum; Except: 1. Next to R 4, R 4-8, or R 6-12 district = 15'	No minimum on interior, 10' minimum on flanking street; Except:	No minimum on interior, 10' minimum on flanking street; Except:	No Minimum; Except: 1. Next to R4, R4-8, or R6-12 district = 15'	No Minimum; Except: 1. Next to RLI, R4, R4-8, or R6-12 district =	1. 50' minimum from property line for agriculture buildings (or structures) which

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
		1. Next to R 4, R 4-8, or R 6-12 district = 15' minimum + 5' for each building floor above 2 stories. 2. Next to MR 7-13, MR 10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories. 3. Residential excluding mixed use structures: 5' except 6' on one side of zero lot.	minimum + 5' for each building floor above 2 stories. 2. Next to MR 7-13, MR 10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories. 3. Residential excluding mixed use structures: 5' except 6' on one side of zero lot.	1. Next to R4, R4-8, or R6-12 district = 15' minimum + 5' for each building floor above 2 stories. 2. Next to MR7-13, MR10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories. 3. Residential excluding mixed use structures: 5' except 6' on one side of zero lot.	1. Next to R4, R4-8, or R6-12 district = 15' minimum + 5' for each building floor above 2 stories. 2. Next to MR7-13, MR10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each building floor above 2 stories. 3. Residential excluding mixed use structures: 5' except 6' on one side of zero lot.	minimum + 5' for each building floor above 2 stories. 2. Next to MR7-13, MR10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories. 3. Residential excluding mixed use structures; 5' except 6' on one side of zero lot.	15' minimum + 5' for each building floor above 2 stories. 2. Next to MR7-13, MR10-18, RM-18, RM-24 or RMH district = 10' minimum + 5' for each bldg. floor above 2 stories. 3. Residential excluding mixed use structures; 5' except 6' on one size of zero lot.	house animals other than pets. 2. Must comply with clear sight triangle requirements, Section 18.40.060(C). 3. Residential sideyards can be reduced consistent with 18.04.080(H)(5). 4. Must comply with site design standards, Chapter 18.100.
MAXIMUM BUILDING HEIGHT	35'	Up to 35', if any portion of the building is within 100' of R 4, R 4-8, or R 6-12 district;	Up to 35', if any portion of the building is within 100' of R 4, R 4-8, or R 6-12 district;	The portion of a building within 100' of land zoned for maximum	The portion of a building within 100' of land zoned for maximum	The portion of a building within 100' of land zoned for maximum	The portion of a building within 100' of land zoned for maximum	1. Not to exceed height limit set by State Capitol Group Height District, 18.10.060, for

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
		Up to 60' otherwise.	Up to 60' otherwise; or up to 70', if at least 50% of the required parking is under the building; or up to 75', if at least one story is residential.	density of less than 14 units per acre is limited to 35'. The portion of a building within 50' of land zoned for a maximum density of 14 units per acre or more is limited to the lesser of 60' or the height allowed in the abutting district. Up to 60' otherwise. Provided that one additional story may be built for residential development only.	density of less than 14 units per acre is limited to 35'. The portion of a building within 50' of land zoned for a maximum density of 14 units per acre or more is limited to the lesser of 60' or the height allowed in the abutting district. Up to 60' otherwise. Provided that one additional story may be built for residential development only.	density of less than 14 units per acre is limited to 35'. The portion of a building within 50' of land zoned for a maximum density of 14 units per acre or more is limited to the lesser of 60' or the height allowed in the abutting district. Up to 60' otherwise; or up to 70', if at least 50% of the required parking is under the building; or up to 75', if at least one story is residential.	density of less than 14 units per acre is limited to 35'. The portion of a building within 50' of land zoned for a maximum density of 14 units per acre or more is limited to the lesser of 60' or the height allowed in the abutting district. Up to 60' otherwise; or up to 70', if at least 50% of the required parking is under the building; or up to 75', if at least one story is residential. See 18.130.060 Significant	properties near the State Capitol Campus. 2. Must comply with site design standards, Chapter 18.100. 3. HDC-1 and HDC-2 additional story must comply with OMC 18.06.100.A.6. 4. In a Downtown Design Sub-District, see 18.120.220 and 18.120.440 for upper story step back requirements.

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
							Building Entry tower exemption (allows an additional 30' for a tower element at Capital Mall). Up to 75' for HDC-4 zoned properties where the proposed project provides for the development of replacement dwelling units in a development agreement and the project site is all or part of an area of 40 acres or more that was in contiguous common ownership in 2009.	

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
MAXIMUM BUILDING COVERAGE	45%	70%, except 55% for residential only structures	70%; or 85% if at least 50% of the required parking is under the building.	70% for all structures	70% for all structures	70% for all structures, 85% if at least 50% of the required parking is under the building.	70% for all structures. 85% of the site if at least 50% of the required parking is under the building. On redeveloped sites, 85% if at least 50% of new required parking is under the building or in a structured parking form. 85% for HDC-4 zoned properties where the proposed project provides for the development of replacement dwelling units in a development agreement and	For projects in the GC and HDC-4 zones west of Yauger Way, limitations of building size per 18.06.100(C) and 18.130.020 apply.

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
							the project site is all or part of an area of 40 acres or more that was in contiguous common ownership in 2009.	
MAXIMUM IMPERVIOUS SURFACE COVERAGE	50%	70%	85%	85% for all structures	85% for all structures	85% for all structures	85% for all structures	See OMC 18.06.100(D).
MAXIMUM HARD SURFACE	70%	85%	100%	100%	100%	100%	100%	Hard Surfaces are treated as impervious, unless shown workable through an approved design (complies with DDECM), which requires adequate underlying soils.
ADDITIONAL DISTRICT-WIDE DEVELOPMENT STANDARDS	Maximum building size (gross sq. ft.): 3,000 for single use; 6,000 for mixed use.	Building floors above 3 stories which abut a street or residential district must be stepped back a minimum of 8 feet	Building floors above 3 stories which abut a street or residential district must be stepped back a minimum of 8 feet	Building floors above 3 stories which abut a street or residential district must be stepped back a minimum of 8	Building floors above 3 stories which abut a street or residential district must be stepped back a minimum of 8	Building Floors above 3 stories which abut a street or residential district must be stepped back a minimum of 8	Building floors above 3 stories which abut a street or residential district must be stepped back a minimum of 8	For properties in the vicinity of Kaiser Road and Harrison Ave NE, also see Pedestrian Streets Overlay District, Chapter 18.16.

TABLE 6.02
COMMERCIAL DISTRICTS' DEVELOPMENT STANDARDS

STANDARD	NR	PO/RM	GC	HDC-1	HDC-2	HDC-3	HDC-4 and HDC-4 Capital Mall	ADDITIONAL REGULATIONS
		(see 18.06.100(B) and Figure 6-3). In a Downtown Design Sub-District, see Chapter 18.120 for upper story stepbacks.	(see 18.06.100(B)). In a Downtown Design Sub-District, see Chapter 18.120 for upper story stepbacks.	feet (see 18.06.100(B)).	feet (see 18.06.100(B)).	feet (see 18.06.100(B)).	feet (see 18.06.100(B)).	For retail uses over 25,000 square feet in gross floor area, see Section 18.06.100(G) Large Scale Retail Uses. EXCEPTION: Section 18.06.100(G) shall not apply to motor vehicle sales. In a Downtown Design Sub-District, see Chapter 18.120.

LEGEND		
NR = Neighborhood Retail GC = General Commercial	PO/RM = Professional Office/Residential Multifamily	HDC-1=High Density Corridor-1 HDC-2=High Density Corridor-2 HDC-3=High Density Corridor-3 HDC-4=High Density Corridor-4

TABLE 6.02
COMMERCIAL DEVELOPMENT STANDARDS

STANDARD	MS	UW	UW-H	DB	CS-H	AS	ADDITIONAL REGULATIONS
MINIMUM LOT AREA	7,200 Sq. Ft.	No minimum.	No minimum.	No minimum.	7,200 Sq. Ft. if bldg. height is 35' or less. 12,500 Sq. Ft. if bldg. height is over 35'.	No minimum.	
FRONT YARD SETBACK	10' maximum.	No minimum; however, see Chapter 18.100 for design guidelines for pedestrian access and view corridors. In a Downtown Design Sub-District: 12' from the curb on Type A and B Streets, 10' from curb for Type C Streets.	No minimum. In a Downtown Design Sub-District: 12' from the curb on Type A and B Streets, 10' from curb for Type C Streets.	No minimum. In a Downtown Design Sub-District: 12' from the curb on Type A and B Streets, 10' from curb for Type C Streets.	No minimum.	30' minimum for buildings; 15' for other structures except signs	1. 50' minimum from property line for agriculture buildings (or structures) which house animals other than pets. 2. Must comply with clear sight triangle requirements, Section 18.40.060(C). 3. See Design Guidelines, Chapter 18.100.
REAR YARD SETBACK	15' minimum; If next to a residential zone, 15' minimum plus 5' for every story over 3 stories.	No minimum; however, see Chapter 18.100 for design guidelines for pedestrian access and view corridors.	No minimum.	No minimum.	5' minimum if building has 1 or 2 stories. 10' minimum if building has 3 or more stories.	15' minimum.	50' minimum from property line for agriculture buildings (or structures) which house animals other than pets.

TABLE 6.02
COMMERCIAL DEVELOPMENT STANDARDS

STANDARD	MS	UW	UW-H	DB	CS-H	AS	ADDITIONAL REGULATIONS
SIDE YARD SETBACK	10' minimum; 15' minimum plus 5' for every story over 3 stories if next to a residential zone.	No minimum; however, see Chapter 18.100 for design guidelines for pedestrian access and view corridors.	No minimum.	No minimum.	5' minimum if building has 1 or 2 stories. 10' minimum if building has 3 or more stories; AND the sum of the 2 side yards shall be no less than 1/2 the building height.	5' minimum 30' minimum for buildings and 15' minimum for other structures from flanking streets.	1. 50' minimum from property line for agriculture buildings (or structures) which house animals other than pets. 2. Must comply with clear sight triangle requirements, Section 18.40.060(C). 3. See Design Guidelines, Chapter 18.100.
MAXIMUM BUILDING HEIGHT	75'; except hospitals, which may exceed that height.	See 18.06.100(A)(2) and Figure 6-2, Urban Waterfront District Height Limits Exceptions: 1) In the portion of the area Downtown with a height limit of 65', two additional residential stories may be built. See 18.06.100. 2) In the portion of the area on West Bay Drive with a height limit of 42' to 65', the taller height limit is conditioned upon the provision of certain	Refer to Figure 6-2 and 6-2B for specific height and building configurations required on specific blocks. In a Downtown Design Sub-District, see view protection measures in 18.06.100 and Chapter 18.120.	75'; PROVIDED, however, that two additional stories may be built, if they are residential. For details, see 18.06.100(A)(4), Downtown Business District. There are restrictions around Sylvester Park (see 18.100.080.)	75' Exception: Up to 100' may be allowed with conditional approval by the City Council, upon recommendation of the Hearing Examiner. For details, see 18.06.100(C)(5), Height, Commercial Services-High Density. In a Downtown Design Sub-District, see view protection	40' accessory building limited to 20'.	Not to exceed height limit set by State Capitol Group Height District, 18.10.060, for properties near the State Capitol Campus.

TABLE 6.02
COMMERCIAL DEVELOPMENT STANDARDS

STANDARD	MS	UW	UW-H	DB	CS-H	AS	ADDITIONAL REGULATIONS
		waterfront amenities. See 18.06.100(A)(2)(c).			measures in 18.06.100 and Chapter 18.120.		
MAXIMUM BUILDING COVERAGE	50%	60% for properties between the shoreline and the nearest upland street. 100% for properties not between the shoreline and the nearest upland street. See also Chapter 18.100 for design guidelines for pedestrian access and view corridors.	100%	No requirement.	No requirement.	85%	
MAXIMUM IMPERVIOUS SURFACE COVERAGE	60%	100%	100%	100%	100%	85%	See OMC 18.06.100(D).
MAXIMUM HARD SURFACE	80%	100%	100%	100%	100%	100%	Hard Surfaces are treated as impervious, unless shown workable through an approved design (complies with DDECM), which requires adequate underlying soils.
ADDITIONAL DISTRICT-WIDE DEVELOPMENT STANDARDS	Building floors above 3 stories which abut a street or residential district must be	Street ends abutting the water shall be preserved to provide views of and public access to the water, pursuant to Section 12.16.050(D) OMC.	Street ends abutting the water shall be preserved to provide views of and public access to the water,		Residential uses must comply with High Rise Multi-family (RM-H) development standards.	6' of sight-screening buffer shall be provided along north, east, and	For properties in the vicinity of the Downtown, also see the Downtown Design Guidelines in 18.120.

TABLE 6.02
COMMERCIAL DEVELOPMENT STANDARDS

STANDARD	MS	UW	UW-H	DB	CS-H	AS	ADDITIONAL REGULATIONS
	stepped back a minimum of 8 feet (see 18.06.100(F)). Residential uses (Section 5 of Table 6.01) may not be constructed within 600 feet of Lilly Road except in upper stories of mixed use building; all other development standards are the same as for commercial uses.	Section 18.06.100(A)(2)(c) for West Bay Drive building height and view blockage limits; and Chapter 18.100 for West Bay Drive view corridors. See also Chapter 18.100 for Downtown design guidelines for Pedestrian Access and View Corridors and Waterfront Public Access; Chapter 18.100 for Port Peninsula design guidelines for Pedestrian Connections and View Corridors; Section 18.06.100(A)(2)(c) for West Bay Drive building height and view blockage limits; and Chapter 18.100 for West Bay Drive view corridors.	pursuant to OMC Section 12.16.050(D).			west district boundaries. See Olympia Park Replat covenants for access, and other standards applicable to replat lots.	For retail uses over 25,000 square feet in gross floor area, see Section 18.06.100 (C) Large Scale Retail Uses. EXCEPTION: Section 18.06.100 (C) shall not apply to motor vehicle sales.

LEGEND		
MS = Medical Services DB = Downtown Business	CS-H = Commercial Services - High Density	UW = Urban Waterfront UW-H = Urban Waterfront-Housing AS=Auto Services

Exhibit 13. Contractor’s Estimate Letter

Brett Griffin
Bgriffin@therushcompanies.com
(253) 549-5163

Proposal and Clarifications

Multicare Olympia ASC
601 McPhee Rd SW
Olympia, WA 98502
July 28, 2022

Rush Commercial Construction is pleased to present the below **Prelimiary Budget** for the subject project:

Base Bid

BASE BID (excludes WSST)	**$2,825,723**

Recommended Contingencies

Estimating Contingecy @ 5%	**$131,543**
Inflation @ 7%	**$184,160**
Construction Contingency @ 3%	**$94,243**

GENERAL INCLUSIONS

1.0 This proposal assumes the contract type will be an AIA A104 GMP or similar.

2.0 Work is scheduled for standard day shift, except the following activities:
- Demolition to be complete at night
- Concrete sawcutting to be complete prior to 7am

3.0 We have included Edge-Guard barriers, negative air machines and tacky mats for infection control along the existing hallway where work is to occur.

4.0 We have assumed parking stalls will be available for the construction dumpster, toilet and laydown.

5.0 An allowance of $10,000 is included for structural upgrades to shear walls or roof to support HVAC.

6.0 All backing is included as fire treated wood or metal strap at all new casework.

7.0 Standard doors are included as PLAM doors in hollow metal frames with standard Schlage hardware. Specialty doors are included as a $2,500/ea allowance.

8.0 Window film is included on all exterior windows.

9.0 Walls are included as light guage metal stud with 5/8" gwb and level 4 finish throughout. Drywall ceilings are included where shown on takeoffs.

10.0 Acoustical ceiling is included as shown based on Certainteed Dune tile throughout, except at areas requiring clean room tile.

11.0 Paint of all GWB and hollow metal door frames.

12.0 Standard Bobrick (or similar) toilet accessories in restrooms and an allowance of $5,400 is included for OFCI support.

13.0 Acrovyn wall protection is included up to 4' AFF on 50% of walls

14.0 Standard PLAM casework and Corian solid surface countertops included at locations shown. Additional casework included on new furred walls in OR #1 and OR #2 where shown.

15.0 Fire sprinkler modifications are included to meet the new layout assuming walls will not be built full height. If walls are extended to structure, additional modifications to the upright heads may be required.

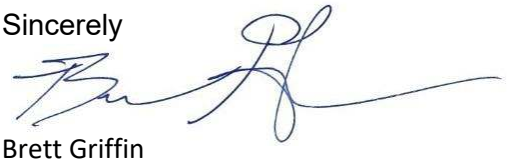
16.0 Design-build plumbing system included based on MacDonald Miller assessment.
17.0 Design-build HVAC system included based on MacDonald Miller assessment.
18.0 Design-build Electrical system included based on EBD assessment.
19.0 An allowance of $10,000 is included for trenching, backfill, and lanscape repairs to support the generator install.

PROJECT EXCLUSIONS

The following is a listing of items which have been excluded from our proposal for this project.

1. Building permit or permit fees.
2. Prevailing wages.
3. Special Testing and Inspection services (e.g. concrete, steel, etc.).
4. Building utility consumption charges (e.g. water, natural gas, electricity, sewer, etc.).
5. Low voltage cabling.
6. Overtime / Shift Premiums.
7. Unforeseen conditions or relocation of existing services not identified in the project documents.
8. Washington State Sales Tax (WSST)
9. Any work not specifically listed above.

Sincerely



Brett Griffin
Director of Special Projects
Rush Commercial Construction

END OF PROPOSAL

Exhibit 14. Equipment List

MultiCare Health System - NEWDIV Thurston ASC

Equipment List

Category	Item Description	Item Qty	Price	Grand Total
Total				**$1,884,790**
Fixed				$477,378
Boom	Boom: Equipment, Dual Arm	2	$32,562	$65,124
Cabinet, Warming	Cabinet, Warming: Dual, Mobile	2	$13,129	$26,258
Light, Surgical	Light, Surgical: Dual, Ceiling, w/Monitor Arm	2	$35,028	$70,056
Monitor, Video	Monitor, Video: 26 - 32 inch, Medical Grade	12	$12,995	$155,940
Table OR	OR Table	2	$80,000	$160,000
Moveable				$1,407,412
Allowance	Allowance: Accessories	4	$500	$2,000
Analyzer, Lab	Analyzer, Lab: Coagulation, Portable	2	$8,295	$16,590
Anesthesia Machine	Anesthesia Machine: General	2	$60,037	$120,074
Board	Board: Patient Transfer Device	2	$195	$390
Board	Board: White, Dry Erase	2	$438	$876
Bracket	Bracket: Patient Transfer Device, Wall Mount	2	$75	$150
Bucket	Bucket: Kick	6	$250	$1,500
Cabinet, Storage, Clinical	Cabinet, Storage, Clinical: Supply/Accessory	14	$2,857	$39,998
Cart, Computer	Cart, Computer: Workstation	4	$3,199	$12,796
Cart, Procedure	Cart, Procedure: General	2	$3,671	$7,342
Cart, Procedure	Cart, Procedure: Isolation	2	$1,195	$2,390
Cart, Procedure	Cart, Procedure: Resuscitation, Pediatric	2	$1,810	$3,620
Cart, Supply	Cart, Supply: Chrome, 60 inch	8	$855	$6,840
Cart, Utility	Cart, Utility: Stainless	2	$232	$464
Dispenser, Glove	Dispenser, Glove: Quadruple Box	4	$80	$320
Dispenser, Medication	Dispenser, Medication: Host (Main)	2	$20,115	$40,230
Disposal, Sharps	Disposal, Sharps: Floor Bin	2	$46	$92
Disposal, Sharps	Disposal, Sharps: Floor Bin, Pharmacy	4	$33	$132
Disposal, Sharps	Disposal, Sharps: Floor Bin, Pharmacy	2	$77	$154
Doppler	Doppler: Vascular	2	$1,155	$2,310
Flowmeter	Flowmeter: Oxygen	4	$62	$248
Hamper	Hamper: Linen	8	$125	$1,000
Injector, Contrast Media	Injector, Contrast Media: Mobile	2	$24,500	$49,000
IS&T	IT Allocation	2	$300,000	$600,000
Laryngoscope Set	Laryngoscope Set: Video	2	$19,000	$38,000
Mattress	Mattress: Air Transfer, Patient	2	$2,943	$5,886
Monitor	Monitor: Temperature & Humidity	2	$492	$984
PACS	PACS: Allowance	2	$0	$0
Pump, Infusion	Pump, Infusion: Controller, Modular	4	$2,900	$11,600
Pump, Infusion	Pump, Infusion: Single	4	$2,300	$9,200
Pump, Suction/Aspirator	Pump, Suction/Aspirator: General, Portable	2	$995	$1,990
Rack	Rack: Apron, Wall Mount	4	$330	$1,320
Regulator	Regulator: Suction, Continuous	6	$485	$2,910
Router	Router: Surgical Suite Integration	2	$69,078	$138,156
Shield	Shield: Lead, Mobile	2	$6,236	$12,472
Stand, Basin	Stand, Basin: Single	4	$430	$1,720
Stand, IV	Stand, IV: w/Support	6	$550	$3,300
Stand, Mayo	Stand, Mayo: Foot-Operated	4	$1,020	$4,080
Stool	Stool: Step, Stackable	10	$274	$2,740
Stool	Stool: Step, w/Handrail	2	$217	$434
Table, Instrument	Table, Instrument: 30-36 inch	4	$567	$2,268
Table, Instrument	Table, Instrument: 45-48 inch	6	$897	$5,382
Ultrasound, Imaging	Ultrasound, Imaging: Multipurpose, Portable	2	$75,000	$150,000
Warmer	Warmer: Patient, Hypothermia	2	$2,750	$5,500
Waste Disposal	Waste Disposal: Surgical Fluid Collection	2	$29,425	$58,850
Waste Disposal	Waste Disposal: Surgical Fluid Disposal	2	$21,052	$42,104

Exhibit 15. Letter of Financial Commitment

MultiCare Health System
820 A Street, Tacoma, WA 98402
PO Box 5299, Tacoma, WA 98415-0299 ~ multicare.org

July 12, 2022

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

RE: MultiCare Health System Certificate of Need Request to Develop and Operate an Ambulatory Surgical Facility in Thurston County

Dear Mr. Hernandez:

Please accept this letter as evidence of financial support for MultiCare Health System'scertificate of need application request to develop and operate a new certificate of need approved ambulatory surgery facility with two (2) operating rooms in Thurston County.

MultiCare is pleased to commit from its corporate reserves, full funding for the estimatedcapital expenditures and any working capital requirements associated with the project.
MultiCare has sufficient cash reserves to fully fund the project.

Please contact me if there are any questions regarding this letter of financial commitment. I can be reached at James.g.lee@multicare.org or at 253-459-8081. Thank you for your time and assistance in this important matter.

Sincerely,

James Lee, Executive Vice President
Population Based Care & CFO
MultiCare Health System

Exhibit 16A. MultiCare Health System Audited Financial Statements – 2019-2020

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2020 and 2019

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

We have audited the accompanying consolidated financial statements of MultiCare Health System (a Washington nonprofit corporation), which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of MultiCare Health System as of December 31, 2020 and 2019, and the results of its operations and changes in net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
March 24, 2021

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2020 and 2019

(In thousands)

Assets		2020	2019
Current assets:			
Cash and cash equivalents	$	946,223	434,854
Accounts receivable		374,372	376,500
Supplies inventory		49,167	41,738
Other current assets, net		85,144	71,397
Total current assets		1,454,906	924,489
Donor restricted assets held for long-term purposes		88,900	70,783
Investments		1,970,458	1,797,483
Property, plant, and equipment, net		1,763,666	1,763,345
Right-of-use operating lease asset, net		137,763	144,140
Right-of-use financing lease asset, net		15,694	—
Other assets, net		502,459	384,004
Total assets	$	5,933,846	5,084,244
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	208,422	195,356
Accrued compensation and related liabilities		299,523	247,971
Accrued interest payable		18,649	15,168
Current portion of right-of-use operating lease liability		28,574	28,322
Current portion of right-of-use financing lease liability		2,836	—
Current portion of long-term debt		7,950	13,668
Total current liabilities		565,954	500,485
Interest rate swap liabilities		154,347	88,311
Right-of-use operating lease liability, net of current portion		114,288	120,345
Right-of-use financing lease liability, net of current portion		13,200	—
Long-term debt, net of current portion		1,618,849	1,276,973
Other liabilities, net		213,046	155,320
Total liabilities		2,679,684	2,141,434
Commitments and contingencies (note 15)			
Net assets:			
Without donor restrictions		3,111,401	2,819,420
With donor restrictions		142,761	123,390
Total net assets		3,254,162	2,942,810
Total liabilities and net assets	$	5,933,846	5,084,244

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2020 and 2019

(In thousands)

	2020	2019
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 3,105,968	3,107,525
Other operating revenue	256,819	120,355
Net assets released from restrictions for operations	4,655	6,225
Total revenues, gains, and other support without donor restrictions	3,367,442	3,234,105
Expenses:		
Salaries and wages	1,616,021	1,548,101
Employee benefits	248,132	241,346
Supplies	520,378	501,688
Purchased services	298,256	271,114
Depreciation and amortization	168,188	165,670
Interest	45,970	46,585
Other	369,741	357,486
Total expenses	3,266,686	3,131,990
Excess of revenues over expenses from operations	100,756	102,115
Other income (loss):		
Investment income	272,266	255,460
Loss on interest rate swaps, net	(75,033)	(45,436)
Other (loss) income, net	(13,068)	869
Total other income, net	184,165	210,893
Excess of revenues over expenses	284,921	313,008
Other changes in net assets without donor restrictions:		
Changes in pension asset	2,513	13,276
Net assets released from restriction – capital acquisitions	4,327	9,689
Other	220	(7,550)
Increase in net assets without donor restrictions	291,981	328,423
Changes in net assets with donor restrictions:		
Contributions and other	21,425	20,032
Income on investments	2,482	1,116
Net assets released from restriction – capital acquisitions	(4,327)	(9,689)
Net assets released from restrictions for operations and other	(4,655)	(6,225)
Increase in assets held in trust by others	4,446	2,620
Increase in net assets with donor restrictions	19,371	7,854
Increase in net assets	311,352	336,277
Net assets, beginning of year	2,942,810	2,606,533
Net assets, end of year	$ 3,254,162	2,942,810

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2020 and 2019

(In thousands)

	2020	2019
Cash flows from operating activities:		
Increase in net assets	$ 311,352	336,277
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	168,188	165,670
Amortization of bond premiums, discounts, and issuance costs	(2,494)	(2,728)
Net realized and unrealized gains on investments	(251,078)	(216,859)
Change in fair value of interest rate swap	67,298	42,620
(Gain) loss on disposal of assets, net	(90)	824
Gain on bond refinancing	—	(869)
Losses on joint ventures, net	4,709	8,002
Restricted contributions for long-term purposes	(12,188)	(2,795)
Changes in operating assets and liabilities:		
Accounts receivable	2,128	(659)
Supplies inventory and other current assets	(21,176)	(12,298)
Right-of-use lease asset	35,391	29,282
Other assets, net	(104,363)	(16,374)
Accounts payable and accrued expenses and accrued interest payable	16,547	(7,144)
Accrued compensation and related liabilities	51,552	26,117
Right-of-use lease liability	(33,111)	(24,756)
Other liabilities, net	57,479	27,675
Net cash provided by operating activities	290,144	351,985
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(169,168)	(195,206)
Proceeds from disposal of property, plant, and equipment	997	1,157
Investments in joint ventures, net	(26,199)	(15,084)
Purchases of investments	(4,397,377)	(2,342,719)
Sales of investments	4,472,955	2,263,097
Change in donor trusts	(9,457)	(5,571)
Net cash used in investing activities	(128,249)	(294,326)
Cash flows from financing activities:		
Repayment of long-term debt	(20,796)	(12,009)
Proceeds from bond issuance	300,000	—
Proceeds from debt issuance	61,794	—
Payment of debt issue expenses	(2,346)	—
Principal payments on finance lease obligations	(1,366)	—
Restricted contributions for long-term purposes	12,188	2,795
Net cash provided by (used in) financing activities	349,474	(9,214)
Net change in cash and cash equivalents	511,369	48,445
Cash and cash equivalents, beginning of year	434,854	386,409
Cash and cash equivalents, end of year	$ 946,223	434,854
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 42,967	47,781
Noncash activities:		
Increase in deferred compensation plans	13,726	16,198
Increase (decrease) in accounts payable for purchases of property, plant, and equipment	349	(3,716)

See accompanying notes to consolidated financial statements.

(1) Nature of Organization and Summary of Significant Accounting Policies

(a) Organization Description

MultiCare Health System (MHS), a Washington nonprofit corporation, is an integrated healthcare delivery system providing inpatient, outpatient, and other healthcare services primarily to the residents of Pierce, South King and Spokane Counties and, with respect to pediatric care, much of the southwest Washington area. As of December 31, 2020, MHS is licensed to operate 1,992 inpatient hospital beds, including 120 beds associated with Wellfound Behavioral Health Hospital (Wellfound), a 50% owned joint venture located in Tacoma, Washington, which opened in May 2019. MHS currently operates eight acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital and Valley Hospital) and one behavioral health hospital (Navos).

As of December 31, 2020, MHS also operates eight outpatient surgical sites, five free-standing emergency departments, home health, hospice, and a network of urgent care, primary care and multispecialty clinics located throughout the MHS service areas.

The consolidated financial statements include the operations of these facilities and services as well as those of three wholly owned subsidiaries (Greater Lakes Mental Healthcare, Medis, Inc. and MultiCare Rehabilitation Specialists, P.C.), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned accountable care organization (MultiCare Connected Care), and two fundraising foundations (Mary Bridge Children's Foundation and MultiCare Foundations, which is doing business as MultiCare Health Foundation, Good Samaritan Foundation, MultiCare South King Health Foundation, MultiCare Behavioral Health Foundation and MultiCare Inland Northwest Foundation).

In December 2020, MHS announced that it reached an agreement with an affiliate of LifePoint Health to acquire a majority ownership interest in Capital Medical Center in Olympia. The acquisition is subject to regulatory approval but is anticipated to close on or about March 31, 2021.

(b) Principles of Consolidation

The accompanying consolidated financial statements include the accounts of MHS after elimination of all significant intercompany accounts and transactions.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and assumptions.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid instruments with maturities of three months or less at the date of purchase. Cash equivalents and investments that are held by

outside investment managers or restricted per contractual or regulatory requirements are classified as investments on the consolidated balance sheets.

(e) Accounts Receivable

Accounts receivable are primarily comprised of amounts due for healthcare services from patients and third-party payors and are recorded net of amounts for contractual adjustments and implicit price concessions.

(f) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is stated at lower of cost or net realizable value using the average cost method, except for pharmacy, which uses the first-in, first-out (FIFO) method. Obsolete and unusable items are expensed at the time such determination is made.

(g) Donor Restricted Assets

The majority of the donor restricted assets are invested in MHS' investments and are stated at fair value or estimated fair value. Donor restricted assets that are held separately from MHS' investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in mutual funds, fixed income securities, and equity securities. Those with readily determinable fair values are stated at fair value. Those investments for which quoted market prices are not readily determinable are carried at values provided by the respective investment managers or trustees, which management believes approximates fair value.

Charitable gift annuities, which are included in donor restricted assets, totaled $2,471 and $2,410 at December 31, 2020 and 2019, respectively. MHS has recorded a corresponding payable of $1,119 and $1,222 at December 31, 2020 and 2019, respectively, to pay for estimated future obligations to beneficiaries. The current portion of these obligations is included in accounts payable and accrued expenses and the long-term portions are included in other liabilities, net in the accompanying consolidated balance sheets. According to Washington State law, MHS, as a distinct legal entity holding charitable gift annuities, is required to maintain unrestricted net assets of at least $500, which MHS has done for each of the periods presented.

(h) Investments

MHS accounts for its investment portfolio as a trading portfolio, therefore, investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are recorded at fair value, which are determined based on quoted market prices or prices with observable inputs obtained from national securities exchanges or similar sources. Other investments, including limited partnerships, commingled real estate trust funds, limited liability partnerships, and hedge funds are carried at net asset value (NAV) provided by the respective investment managers, which management believes approximates fair value. Valuations provided by investment managers consider variables such as valuation and financial performance of underlying investments, quoted market prices for similar securities, recent sale prices of underlying investments, and other pertinent information. Management reviews the valuations provided by investment managers and believes that the carrying values of these financial instruments are reasonable estimates of fair value.

Realized gains and losses are recorded using the average cost method. Investment income or loss (including realized gains and losses on investments, change in unrealized gains or losses, interest, and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law.

(i) Property, Plant, and Equipment

Property, plant, and equipment are recorded at cost. Depreciation expense is computed using the straight-line method over the following estimated useful lives of the assets:

Buildings	25–50 years
Land improvements	8–20 years
Equipment	3–25 years

Maintenance and repairs are charged to operations as they occur. Expenditures that materially increase values, change capacities, or extend useful lives are capitalized. Gains upon sale or retirement of property, plant, and equipment are included in other operating revenue whereas losses are included in other expenses. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of constructing those assets.

MHS assesses potential impairments to its long-lived assets as well as its intangible assets, as described below, when there is evidence that events or changes in circumstances indicate that an impairment has been incurred. These changes can include a deterioration in operating performance, a reduction in reimbursement rates from government or third-party payors or a change in business strategy. An impairment charge is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2020 and 2019, there were no impairment charges.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(j) Leases

Management reviews contracts in order to identify leases and properly classify leases as either operating or financing. MHS is a lessee of various equipment and facilities under noncancelable operating and financing leases. Operating and financing right-of-use (ROU) liabilities are recognized based on the net present value of lease payments over the lease term at the commencement date of the lease, and are reduced by payments made on each lease on the straight-line basis. Since most of the leases do not provide an implicit rate of return, MHS uses its incremental borrowing rate based on information available at the commencement date of the lease in determining the present value of lease

payments. Generally, MHS cannot determine the interest rate implicit in the lease because it does not have access to the lessor's estimated residual value or the amount of the lessor's deferred initial direct costs. Therefore, MHS generally uses its incremental borrowing rate as the discount rate for the lease. MHS' incremental borrowing rate for a lease is the rate of interest it would have to pay on a collateralized basis to borrow an amount equal to the lease payments using similar terms. Leases with an initial term of 12 months or less are not recorded on the balance sheet; rather, rent expense for these leases is recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

If a lease contains a renewal option at the commencement date and it is considered reasonably certain that the renewal option will be exercised by management to renew the lease, the renewal option payments are included in MHS' net minimum lease payments used to determine the right-of-use lease liabilities and related lease assets. All other renewal options are included in right-of-use lease liabilities and related lease assets when they are reasonably certain to be exercised.

All lease agreements generally require MHS to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU lease liability or ROU lease asset. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation.

Variable lease payments associated with MHS' leases are recognized when the event, activity, or circumstance in the lease agreement on which those payments are assessed occurs. Variable lease payments are presented in other expenses in the consolidated statement of operations and changes in net assets.

MHS has elected the practical expedient to not separate lease components from nonlease components related to its real estate leases.

(k) Goodwill and Intangible Assets

Goodwill is an asset representing the future economic benefits arising from the difference in the fair value of the business acquired and the fair value of the identifiable and intangible net assets acquired in a business combination. Indefinite-lived intangible assets are assets that are not amortized because there is no foreseeable limit to cash flows generated from them. Goodwill and intangible assets is included in other assets, net in the accompanying consolidated balance sheets.

If it is more likely than not that goodwill is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment charge. Goodwill is not amortized and along with indefinite-lived intangible assets is evaluated at least annually for impairment. There were no impairment charges recognized during the years ended December 31, 2020 or 2019.

Amortizing intangible assets are comprised of certificates of need, license agreements, trade names and lease arrangements, which all have finite useful lives. Amortization expense is recorded on a

straight-line basis over the estimated useful life of the assets, which ranges from three to thirty years, associated with the nature of the intangible asset.

(l) Investment in Joint Ventures

MHS maintains ownership in certain joint ventures related to imaging, office buildings, behavioral health and other healthcare focused activities and accounts for these joint ventures under the equity method of accounting. As of December 31, 2020 and 2019, MHS held ownership interests in 21 and 15 joint ventures, respectively. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheets. Losses on joint ventures for the years ended December 31, 2020 and 2019 were $4,709 and $8,002, respectively, primarily associated with the startup costs at Wellfound and are included in other operating revenue on the consolidated statements of operations and changes in net assets.

(m) Estimated Third-Party Payor Settlements

Medicare cost reports are filed annually by MHS with the Medicare intermediary and are subject to audit and adjustment prior to settlement. Estimates of net settlements due to Medicare were $3,456 and $3,562 as of December 31, 2020 and 2019, respectively, and have been recorded within accounts payable and accrued expenses in the accompanying consolidated balance sheets. Third-party settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, based upon the amount of the final settlements. Patient service revenue increased by $106 and $2,746 for 2020 and 2019, respectively, to reflect changes in the estimated Medicare settlements for prior years.

(n) Interest Rate Swaps

MHS maintains several interest rate swap agreements as a means of hedging its exposure to variable-based interest rates and fluctuations in cash flows as part of its overall interest rate risk management strategy. All MHS interest rate swaps are recorded at fair value. The accounting for changes in the fair value of these swaps depends on whether those had been designated as cash flow hedges. As of December 31, 2020 and 2019, none of MHS' interest rate swaps were designated as cash flow hedges and therefore, the changes in fair value are recognized and included in other income (loss) on the consolidated statements of operations and changes in net assets. These swaps have notional amounts totaling approximately $709,000 and expire starting in August 2027 through August 2049. The majority of the swaps have the economic effect of fixing the LIBOR-based variable interest rate on an equivalent amount of MHS' outstanding floating rate principal debt.

Under master netting provisions of the International Swap Dealers Association (ISDA) agreement with each of the counterparties, MHS is permitted to settle with the counterparties on a net basis. Due to the right of offset under these master netting provisions, MHS offsets the fair value of certain interest rate swap assets with swap liabilities on the consolidated balance sheets.

(o) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by MHS in perpetuity. When restricted funds to be used for operations are

expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains, and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restriction – capital acquisitions.

MHS applies the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, related to using the present value technique to measure fair value of pledges receivable. In accordance with ASC Topic 820, MHS has applied the expected present value technique to pledges received after January 1, 2009 that adjusts for a risk premium to take into account the risks inherent in those expected cash flows. Pledges of financial support are recorded as pledges receivable when unconditional pledges are made and are stated at net realizable value. Pledges are reported net of an allowance for uncollectible pledges and pledges to be collected in future years are reflected at a discounted value using a weighted average discount rate. As of December 31, 2020, and 2019, MHS has recorded $14,160 and $8,024, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2020, $5,436 of pledges are due in one year or less and $8,724 in two to seven years.

(p) Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which MHS expects to receive in exchange for providing patient services. These amounts are due from patients, third-party payors, and others and include the variable consideration for retroactive adjustments to revenue due to final settlement of audits, reviews, and investigations. MHS bills the patient and third-party payors several days after the services are performed or when the patient is discharged from the facility, whichever is later.

(q) Hospital Safety Net Assessment

The State of Washington (the State) has a safety net assessment program involving Washington State hospitals to increase funding from other sources and obtain additional federal funds to support increased payments to providers for Medicaid services. In connection with this program, MHS recorded increases in patient service revenue of $83,884 and $84,831 for 2020 and 2019, respectively, and incurred assessments of $61,112 and $59,460 for 2020 and 2019, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations and changes in net assets. MHS has outstanding receivables of $14,649 and $4,679 associated with this program as of December 31, 2020 and 2019, respectively, which are included with accounts receivable on the consolidated balance sheets.

(r) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated and undercompensated healthcare services to the communities it serves within the purview of its mission. Because MHS does not pursue collection of amounts determined to qualify as uncompensated care, MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between

amounts billed to patients and the amount MHS expects to receive based on its historical collections from these patients. Patients who meet the criteria of MHS' uncompensated care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Such amounts determined to qualify as charity care are not reported as revenue. The State provides guidelines for charity care provided by hospitals in the state. Hospitals are recommended to provide full charity care to patients who meet 100% of the federal poverty guidelines and a lesser amount to patients who meet up to 200% of the federal poverty guidelines. MHS provides full charity care to patients who meet 300% of the federal poverty guidelines and also provides uncompensated care on a sliding scale for patients whose income is between 301% and 500% of the federal poverty guidelines for true self-pay patients and patients with deductibles and coinsurance amounts. The estimated cost of charity care provided was approximately $51,000 and $58,000 in 2020 and 2019, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $218,443 and $203,000 in 2020 and 2019, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(s) Other Operating Revenue

Other operating revenue includes revenue from cafeteria sales, retail pharmacy, laboratory revenue from community providers, medical office rental income, contributions without donor restrictions, grant revenue, contracted behavioral healthcare revenue and other miscellaneous revenue.

(t) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in net assets without donor restrictions, which are excluded from the excess of revenues over expenses, primarily include changes in accrued pension asset, net assets released from restrictions for capital expenditures, and capital assets received.

(u) Federal Income Taxes

ASC Subtopic 740-10, *Income Taxes*, clarifies the accounting for uncertainty in income taxes recognized in MHS' consolidated financial statements. This topic also prescribes a recognition threshold and measurement standard for the financial statement recognition and measurement of an income tax position taken or expected to be taken in a tax return. Only tax positions that meet the "more-likely-than-not" recognition threshold at the effective date may be recognized or continue to be recognized upon adoption. In addition, this topic provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition. Other than Medis, Inc., which is a taxable corporation, all of the other entities have obtained determination letters from the Internal Revenue Service that they are exempt from federal income taxes under Section 501(a) of the Internal Revenue Code as an organization described in 501(c)(3) of the Internal Revenue Code, except for tax on unrelated business income.

(v) Self-Insurance Reserves

MHS is self-insured with respect to professional and general liability, workers compensation and medical and other health benefits with excess insurance coverage over self-insured retention limits. MHS records insurance liabilities for these specific items by using third party actuarial calculations and certain assumptions and inputs such as MHS historical claims experience and the estimated amount of future claims that will be incurred.

(w) New and Pending Accounting Standards

In June 2016, FASB issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments,* The amendments in this update require that financial assets are measured at amortized cost basis and presented at the net amount expected to be collected. This eliminates the probable initial recognition threshold in current GAAP and, instead, reflects an entity's current estimate of all expected credit losses and broadens the information that an entity must consider in developing its expected credit loss estimate for assets measured either collectively or individually. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2021. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In August 2018, FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement.* The amendments in this update modify the disclosure requirements on fair value measurements in Topic 820, *Fair Value Measurement*, based on the concepts in the Concepts Statement, including the consideration of costs and benefits. The changes in this ASU remove certain disclosure requirements, modify certain disclosure requirements, and add two new disclosure requirements, as applicable. Most of these changes relate to Level 3 fair value measurements. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2020. MHS has adopted this ASU, and it did not have a material effect on its consolidated financial statements.

In August 2018, FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract.* The amendments in this update align the requirements for

capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal-use software license). The guidance in Subtopic 350-40 is used to determine which implementation costs to capitalize as an asset related to the service contract and which costs to expense and is also used to determine the amortization period of the capitalized costs. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2021. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In April 2019, FASB issued ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments – Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments.* The amendments in this update are divided into four separate topics that discuss the details of the improvement areas and the amendments made to the Codification for these improvement areas. Topics 1, 2 and 5 in this ASU relate specifically to ASU 2016-13, which is effective for MHS for the year beginning January 1, 2023. Topics 3 and 4 in this ASU have been evaluated and are not applicable to MHS. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In March 2020, FASB issued ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the effects of Reference Rate Reform on Financial Reporting.* The amendments in this update provide practical expedients to contract modifications when it is being modified due to the replacement of a reference rate within the contract. The provisions of this ASU are effective immediately and will be available through December 31, 2022. Modifications completed after December 31, 2022 must use current guidance instead of the provisions in this ASU. MHS anticipates making contract modifications in 2021 and 2022 but does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

(2) Coronavirus (COVID-19) Impact

MHS, along with most other healthcare providers across the United States, has experienced operational challenges related to the outbreak of the COVID-19 pandemic. On February 29, 2020, the Governor of the State of Washington (the Governor) declared a state of emergency after the State of Washington reported its first known death from COVID-19. COVID-19 was declared a pandemic by the World Health Organization on March 11, 2020, and on March 13, 2020, the President of the United States declared a national emergency as a result of the pandemic. On March 23, 2020, the Governor implemented a stay at home order called "Stay Home, Stay Healthy." On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law, which was aimed to direct economic assistance for American workers, families, and small businesses, and preserve jobs for American industries. The COVID-19 pandemic impacted all hospitals and physician offices throughout the health system.

On March 16, 2020, MHS canceled or postponed all nonemergent procedures as a precautionary measure to allow for the preservation of Personal Protective Equipment (PPE). Further, MHS set up temporary facilities and secured additional patient beds to accommodate the surge impacts that were projected in the early stages of the pandemic. On May 18, 2020, the Governor modified the restrictions on elective procedures for all medical and dental facilities. Based on this modification, MHS resumed all procedures within its facilities, while taking all appropriate social distancing precautions and usage of PPE for staff,

patients and visitors in accordance with national, state and local guidance. MHS ensured that sufficient PPE was maintained for surge capacity of at least 20% within the hospital facilities.

The CARES Act requires the amount of funding received to be validated, which requires management to quantify lost revenues and increased expenses associated with the pandemic for Provider Relief Funds (PRF). MHS has recognized revenue associated with the PRF funding according to the terms and conditions of the CARES Act, and as contribution revenue under FASB ASC 958-605. Contribution revenue attributable to PRF funding totaled $118,965 and is included within other operating revenue on the consolidated statements of operations and changes in net assets. Refunding of amounts received may be required by the CARES Act if a receiving entity is unable to quantify the financial losses intended to be covered by funding. MHS has determined that it is able to justify retaining all funding received in 2020 by the PRF and has not recorded any liabilities as of December 31, 2020 for potential repayment of PRF payments received.

In March 2020, MHS chose to support employees by protecting pay and benefits for those that were unable to work due to the cancellations/postponements of procedures. MHS protected the pay and benefits for those individuals through April 25, 2020. Approximately 50% of this cost has been recovered through the employee retention credits offered to employers as part of the CARES Act, which totaled $2,409. The CARES Act also allowed MHS to defer payment of the employer portion of the FICA taxes due to the federal government through December 31, 2020. Payment of these deferred taxes will occur with 50% paid by the end of 2021 and the other 50% by the end of 2022. The total amount of FICA taxes deferred in 2020 was $71,866, with the current portion of $35,933 recorded within accrued compensation and related liabilities, and the long-term portion of $35,933 recorded within other liabilities, net on the consolidated balance sheets. MHS considered whether to utilize the Medicare Advanced Payment Program (MAPP) when it was available to obtain additional cash flow but chose not to engage in this program.

MHS has filed applications and obtained reimbursement of additional expenses from the Federal Emergency Management Agency (FEMA) based on criteria due to the national emergency declaration made due to COVID-19. MHS submitted an expedited funding application with FEMA that covers the period from the start of the national disaster declaration to June 30, 2020. The expedited application allowed MHS to recover up to 50% of the total funding applied for on the application. However, based on FEMA guidelines for this expedited application, FEMA only reimbursed 75% of the recoverable amount. MHS continues to complete the final reconciliation of the expedited funding application to receive the remainder of the funding and will apply for additional funding pertaining to later periods until the national disaster declaration is no longer in effect.

The following table shows the funding that has been received to prepare and respond to COVID-19 and recognized as other operating revenue through December 31, 2020:

(Dollars in thousands)

Sources of external relief funding		Amount
CARES Act PRF funding	$	118,965
FEMA		4,214
Insurance Funds for Business Interruption		1,004
State of Washington Coronavirus Relief Fund		2,922
Total proceeds received and recognized in 2020	$	127,105

In January 2021, MHS received an additional $160,032 in CARES Act PRF funding. MHS continues to reconcile and analyze its lost revenue and increased expenses based on known reporting guidance.

The impact of COVID-19 has increased the uncertainty associated with management's assumptions and estimates made on these financial statements. The actual impact of COVID-19 on MHS's consolidated financial statements may differ significantly from the assumptions and estimates made for the year ended December 31, 2020.

(3) Revenue from Contracts with Customers

Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by MHS and are recognized either over time or at a point in time. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred through a point in time in relation to total actual charges incurred. MHS believes that this method provides a useful depiction of the provision of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospitals or clinics receiving inpatient or outpatient services. MHS measures an inpatient performance obligation from time of admission to time of discharge and an outpatient performance obligation from the start of the outpatient service to the completion of the outpatient service. Revenue for performance obligations satisfied at a point in time are recognized when goods or services are provided to patients and customers.

MHS has elected to apply the optional exemption in ASC 606-10-50-14a as all of MHS' performance obligations related to contracts with a duration of less than one year. Under this exemption, MHS was not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Any unsatisfied or partially unsatisfied performance obligations are completed within days or weeks of the end of the year.

MHS determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with MHS policy, and implicit price concessions provided to uninsured patients. MHS determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies and historical experience. MHS determines its estimate of implicit price concessions based on its historical collection experience with each class of patients.

(Continued)

Contractual agreements with third-party payors provide for payments at amounts less than MHS' established charges. A summary of the payment arrangements with major third-party payors is as follows:

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, which provides for reimbursement based on Medicare Severity Diagnosis-Related Groups (MS-DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis, acuity, and expected use of hospital resources. The majority of Medicare outpatient services is reimbursed under a prospective payment methodology, the Ambulatory Payment Classification System (APCs), or fee schedules.
- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare; however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services is reimbursed under a prospective payment methodology, the Enhanced Ambulatory Patient Groups (EAPG), or fee schedules.
- Other – MHS has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to MHS under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates and fee schedules.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from the related programs. There can be no assurance that regulatory or governmental authorities will not challenge MHS' compliance with these laws and regulations, and it is not possible to determine the impact, if any, that such claims or penalties would have upon MHS. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims that can reduce the amount of revenue ultimately received.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled and no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2020 or 2019.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. MHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. MHS estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on

(Dollars in thousands)

historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for prior years were not significant for 2020 or 2019. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

Consistent with MHS' mission, care is provided to patients regardless of their ability to pay. MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its collection experience with those patients. Patients who meet the criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as uncompensated care are not reported as revenue.

MHS has determined that the best depiction of its revenue is by its mix of payors as this shows the amount of revenue recognized from each portfolio. Patient service revenue disaggregated by payor for the years ended December 31, 2020 and 2019 are as follows:

		2020	2019
Payors:			
Medicare	$	847,084	833,070
Medicaid		497,785	479,340
Premera		445,238	458,091
Regence		306,588	326,247
Aetna		190,029	195,283
Kaiser Permanente		142,854	128,354
First Choice		112,142	116,867
Self-pay		16,246	15,963
Other		548,002	554,310
	$	3,105,968	3,107,525

MHS has elected to apply the practical expedient under ASC 340-40-25-4 and therefore, all incremental customer contract acquisition costs are expensed as incurred, as the amortization period of the asset that MHS would have otherwise recognized is one year or less in duration.

(Continued)

(Dollars in thousands)

(4) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are residents of the communities it serves and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2020 and 2019 was as follows:

	2020	2019
Medicare	32 %	30 %
Medicaid	24	23
Premera	10	9
Self-pay	9	8
Regence	5	6
First Choice	1	2
Health Care Exchange	1	1
Other commercial insurance	18	21
	100 %	100 %

(5) Fair Value Measurements

(a) Fair Value Hierarchy

In accordance with ASC Topic 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for similar assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical or similar assets or liabilities that MHS could access at the measurement date. Level 1 securities generally include investments in equity securities, mutual funds and certain fixed income securities.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are based upon observable market inputs for the asset or liability, either directly or indirectly. Level 2 securities generally include investments in fixed income securities (composed primarily of government, agency and corporate bonds), and interest rate swaps.
- Level 3 inputs are unobservable market inputs for the asset or liability. Level 3 securities include donor trusts where MHS is not the trustee.

The level in the fair value hierarchy within which a fair value measurement, in its entirety, falls is based on the lowest level input that is significant to the fair value measurement.

(Continued)

(Dollars in thousands)

ASC Subtopic 820-10 allows for the use of a practical expedient for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value. The practical expedient used by MHS is the Net Asset Value (NAV) per share, or its equivalent. In some instances, the NAV may not equal the fair value that would be calculated under fair value accounting standards. Valuations provided by investment managers consider variables such as the financial performance of underlying investments, recent sales prices of underlying investments and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the redemption price. MHS reviews valuations and assumptions provided by investment managers for reasonableness and believes that the carrying amounts of these financial instruments approximate the estimated of fair value of the instrument. Where investments are not presented at fair value, NAV is used as a practical expedient to approximate fair value.

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2020 and 2019:

		Fair value measurements at reporting date using		
	December 31, 2020	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 592,499	592,499	—	—
Equity securities	243,866	243,866	—	—
Fixed income bond funds	364,126	364,126	—	—
Fixed income governmental obligations	67,186	21,137	46,049	—
Fixed income other	95,268	—	95,268	—
Commingled trust fund – international equity	169,362	—	169,362	—
Donor trusts	30,807	—	—	30,807
Total assets at fair value	1,563,114	$ 1,221,628	310,679	30,807
Investment assets valued at NAV	456,274			
Total assets at fair value or NAV	$ 2,019,388			
Liabilities:				
Interest rate swaps	$ 154,347	—	154,347	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2019	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 649,528	649,528	—	—
Equity securities	122,103	122,103	—	—
Fixed income bond funds	343,709	343,709	—	—
Fixed income governmental obligations	65,137	26,912	38,225	—
Fixed income other	84,106	—	84,106	—
Commingled trust fund – international equity	144,659	—	144,659	—
Interest rate swaps	1,263	—	1,263	—
Donor trusts	25,904	—	—	25,904
Total assets at fair value	1,436,409	1,142,252	268,253	25,904
Investment assets valued at NAV	403,840			
Total assets at fair value or NAV	$ 1,840,249			
Liabilities:				
Interest rate swaps	$ 88,311	—	88,311	—

(Continued)

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2020 and 2019:

	NAV December 31, 2020	NAV December 31, 2019	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 239,797	213,291	60	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	205,844	175,882	N/A	Daily	1 business day prior to valuation date
Limited partnerships	10,633	14,667	1,800	N/A	N/A
Total investments valued at NAV	$ 456,274	403,840	1,860		

Hedge funds include investments in hedge fund-of-funds products with certain investment managers. The fair values of the investments in this category have been estimated using the NAV per share of the investment.

Common trust funds include investments in a collective or common trust account that invests funds in an underlying fund or set of funds. The trust account seeks an investment return that approximates the performance of an index as defined by each common trust fund. The fair value of the investments in this category are estimated using the NAV per share of the fund that is derived from the underlying investments in the trust fund.

Limited partnerships include investments in private equity and venture capital funds in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(b) Interest Rate Swaps

The interest rate swaps are recorded at estimated fair value by using certain observable market inputs that participants would use from closing prices for similar assets. In addition, other valuation techniques and market inputs are used that help determine the fair values of these swaps, which include certain valuation models, current interest rates, forward yield curves, implied volatility and credit default swap pricing.

At December 31, 2020 and 2019, these interest rate swaps did not qualify as cash flow hedges and therefore, any changes in the fair value of these swaps are recorded as a gain or loss in the consolidated statements of operations and changes in net assets.

(Dollars in thousands)

The fair value of the interest rate swaps liability is included in interest rate swap liabilities on the consolidated balance sheets, and the fair value of the interest rate swap asset is included in other assets, net on the consolidated balance sheets. The fair value losses of these interest rate swaps for the years ended December 31, 2020 and 2019 were $67,298 and $42,620, respectively, and are included in loss on interest rate swaps in other (loss) income, net in the consolidated statements of operations and changes in net assets. Also included in the loss on interest rate swaps is the loss on net cash settlement amounts associated with the swaps of $7,735 and $2,816, respectively, for the years ended December 31, 2020 and 2019, respectively.

The following table represents both the fair value and settlement value for the interest rate swap assets and liabilities as of December 31, 2020 and 2019 as follows:

	Asset derivatives					
	2020			2019		
	Balance Sheet Location	Fair value	Settlement value	Balance Sheet Location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Other assets	—	—	Other assets	1,263	1,438

	Liability derivatives					
	2020			2019		
	Balance Sheet Location	Fair value	Settlement value	Balance Sheet Location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	154,347	159,666	Interest rates swap liabilities	88,311	94,899

(Continued)

(Dollars in thousands)

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2020 and 2019 is as follows:

	December 31, 2020		
	Donor restricted assets	Investments	Total
Mutual funds	$ 5,400	587,099	592,499
Equity securities	2,222	241,644	243,866
Fixed income securities	4,799	521,781	526,580
Commingled trust fund – international equity	1,543	167,819	169,362
Hedge funds	2,185	237,612	239,797
Common trust funds	1,876	203,968	205,844
Limited partnerships	98	10,535	10,633
Donor trusts	30,807	—	30,807
Pledge receivables, net and other	39,970	—	39,970
Total	$ 88,900	1,970,458	2,059,358

	December 31, 2019		
	Donor restricted assets	Investments	Total
Mutual funds	$ 5,588	643,940	649,528
Equity securities	1,050	121,053	122,103
Fixed income securities	4,241	488,711	492,952
Commingled trust fund – international equity	1,245	143,414	144,659
Hedge funds	1,836	211,455	213,291
Common trust funds	1,513	174,369	175,882
Limited partnerships	126	14,541	14,667
Donor trusts	25,904	—	25,904
Pledge receivables, net and other	29,280	—	29,280
Total	$ 70,783	1,797,483	1,868,266

Fixed income securities include mutual funds, corporate bonds, mortgage-backed securities, asset-backed securities, U.S. government obligations, and state government obligations.

(Dollars in thousands)

(7) Liquidity and Availability of Financial Assets

MHS actively monitors the availability of resources required to meet its operating obligations and other contractual commitments, while also striving to maximize investment returns of its available funds. To help meet its general obligations, MHS can also access the credit markets as a means of producing liquidity, if needed. MHS draws income, appreciation and distributions from its endowment fund up to 5% of the endowment average account value annually, as applicable donor restrictions are met, as another way of providing liquidity. For purposes of analyzing resources available to meet general expenditures over a twelve-month period, MHS considers all expenditures related to its ongoing activities to provide integrated healthcare delivery as well as the conduct of services undertaken to support these activities to be general expenditures.

At December 31, 2020 and 2019, MHS' financial resources are as follows:

		2020	2019
Cash and cash equivalents	$	946,223	434,854
Accounts receivable		374,372	376,500
Other current assets, net		85,144	71,397
Donor restricted assets		88,900	70,783
Investments		1,970,458	1,797,483
		3,465,097	2,751,017
Less prepaid assets included in other current assets, net		(37,612)	(35,222)
Less donor restricted assets		(88,900)	(70,783)
Less investments with redemption limitations of greater than one year		(10,633)	(14,667)
Total financial assets available for general expenditures	$	3,327,952	2,630,345

In addition to financial assets available to meet general expenditures over the next twelve months, MHS operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures.

(Dollars in thousands)

(8) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2020 and 2019 is as follows:

		2020	2019
Land and land improvements	$	131,993	131,635
Buildings		2,202,449	2,094,270
Equipment		1,115,316	1,020,402
		3,449,758	3,246,307
Less accumulated depreciation		(1,751,452)	(1,585,761)
		1,698,306	1,660,546
Construction in progress		65,360	102,799
Property, plant, and equipment, net	$	1,763,666	1,763,345

Depreciation expense charged to operations for the years ended December 31, 2020 and 2019 amounted to $166,517 and $163,826, respectively. Depreciation and amortization expense for the years ended December 31, 2020 and 2019 was $168,188 and $165,670, respectively.

(9) Other Assets, Net

Other assets are as follows at December 31, 2020 and 2019:

		2020	2019
Investment in joint ventures	$	64,534	45,575
Deferred compensation plan assets held in trust (note 11)		85,320	71,594
Accrued pension asset (note 11)		45,590	45,420
Self-insured retention receivables, net of current portion (notes 12 and 13)		23,435	22,383
Interest rate swaps (note 5(b))		—	1,263
Goodwill and other intangibles		167,083	168,284
Net investment in lease (note 16(b))		23,200	25,798
Loans receivable		75,606	1,160
Other		17,691	2,527
Other assets, net	$	502,459	384,004

Deferred compensation plan assets held in trust are participant-managed investments consisting of equity and fixed income mutual funds with prices quoted in active markets.

(Dollars in thousands)

In December 2020, MHS funded $75,000 into an escrow account as part of a loan based on a credit agreement executed with Astria Health. The loan bears a fixed interest rate of 9.5% with payments due at June 30 and December 31 of each year. In January 2021, the final promissory note documents were executed and funds were disbursed at that time. The loan matures in January 2024.

(10) Other Liabilities, Net

Other liabilities are as follows at December 31, 2020 and 2019:

		2020	2019
Professional liability, net of current portion (note 12)	$	73,822	67,204
Deferred compensation liability (note 11)		85,320	71,594
Workers' compensation liability, net of current portion (note 13)		14,166	12,943
Deferred FICA liability (note 2)		35,933	—
Other		3,805	3,579
Other liabilities, net	$	213,046	155,320

(11) Retirement Plans

(a) Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the Plan) covering eligible employees. The Plan was closed to new employees effective after July 31, 2002. The benefits are based on years of service and the employee's highest five consecutive years of compensation. MHS contributions to the Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2016, participants no longer accrue pension benefits under the Plan.

(Dollars in thousands)

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the Plan, which has measurement dates of December 31, 2020 and 2019:

		2020	2019
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	639,993	576,605
Service cost		670	1,230
Interest cost		22,963	25,779
Actuarial loss		85,184	71,704
Expected administrative expenses		(670)	—
Benefits paid		(32,854)	(35,325)
Projected benefit obligations at end of year	$	715,286	639,993
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	685,413	604,690
Actual gain on plan assets		108,966	116,048
Actual administrative expenses		(649)	—
Benefits paid		(32,854)	(35,325)
Fair value of plan assets at end of year	$	760,876	685,413
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	45,590	45,420
Amount recognized in net assets without donor restrictions:			
Net loss		115,669	118,182

	2020	2019
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	2.70 %	3.70 %
Expected return on plan assets	4.50	5.00

The expected return on plan assets assumption is based upon an analysis of historical long-term returns for various investment categories as measured by appropriate indices. These indices are weighted based upon the extent to which plan assets are invested in the particular categories in arriving at MHS' determination of a composite expected return. An actuary reviews the assumptions annually for reasonableness.

(Continued)

(Dollars in thousands)

The components of net periodic benefit cost are as follows during the years ended December 31, 2020 and 2019:

	2020	2019
Components of net periodic benefit cost:		
Service cost	$ 670	1,230
Interest cost	22,963	25,779
Expected return on plan assets	(31,730)	(36,593)
Amortization of net actuarial loss	10,441	5,524
	$ 2,344	(4,060)

The accumulated benefit obligation for the Plan was $715,286 and $639,993 at December 31, 2020 and 2019, respectively.

(i) Cash Flows – Contributions

MHS expects to make contributions to the Plan totaling approximately $650 in 2021.

(ii) Estimated Future Benefit Payments

The following benefits payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

	Pension benefits
2021	$ 38,071
2022	40,010
2023	40,044
2024	39,850
2025	40,770
2026–2030	195,246

(Continued)

(Dollars in thousands)

(iii) Plan Assets

The following tables set forth by level, within the fair value hierarchy, the Plans' investments at fair value:

		Fair value measurements at reporting date using		
	December 31, 2020	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 12,053	12,053	—	—
Trading securities:				
Mutual funds	106,439	106,439	—	—
Fixed income bond funds	105,998	105,998	—	—
Fixed income governmental obligations	312,189	270,336	41,853	—
Fixed income other	211,950	—	211,950	—
Commingled trust fund – international equity	22,485	—	22,485	—
	771,114	$ 494,826	276,288	—
Broker receivables	40,662			
Broker payables	(164,621)			
Total assets at fair value	647,155			
Investments valued at NAV	113,721			
Total assets at fair value or NAV	$ 760,876			

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2019	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 15,320	15,320	—	—
Trading securities:				
Mutual funds	89,996	89,996	—	—
Equity securities	267	267	—	—
Fixed income bond funds	115,559	115,559	—	—
Fixed income governmental obligations	267,627	211,270	56,357	—
Fixed income other	184,525	—	184,525	—
Commingled trust fund – international equity	22,286	—	22,286	—
	695,580	$ 432,412	263,168	—
Broker receivables	56,641			
Broker payables	(171,268)			
Total assets at fair value	580,953			
Investments valued at NAV	104,460			
Total assets at fair value or NAV	$ 685,413			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2020 and 2019.

(Continued)

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2020 and 2019:

	Fair value at December 31, 2020	Fair value at December 31, 2019	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 22,426	22,333	N/A	Quarterly	45 days
Absolute return funds	85,603	74,741	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	5,692	7,386	850	N/A	N/A
Total investments valued at NAV	$ 113,721	104,460	850		

Real estate is a real estate commingled trust that invests in U.S. commercial real estate. The fund owns real estate assets in the U.S. office, industrial, residential, and retail sectors.

Absolute return fund investments consist primarily of listed equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles. These investments use derivatives or other instruments for both investment and hedging purposes and may take long and/or short positions, and the derivative investments may include but are not restricted to futures, options, swaps, and forward currency contracts.

Limited partnerships include investments in private equity and venture capital in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(Continued)

(Dollars in thousands)

The defined benefit plan weighted average asset allocations at December 31, 2020 and 2019 by asset category are as follows:

	2020	2019
Asset category:		
Domestic equities	10 %	7 %
International equities	7	7
Emerging markets	1	1
Fixed income securities	78	79
Alternative investments	1	1
Real estate	3	3
Global asset allocation	—	2
	100 %	100 %

(iv) Investment Objectives

The target asset allocations for each asset class are set based on the achieved funding levels for the Plan and are summarized below:

	2020	2019
Asset category:		
Domestic equities	9 %	8 %
International equities	8	6
Emerging markets	—	1
Fixed income securities	80	80
Real estate	3	3
Global asset allocation	—	2
	100 %	100 %

(v) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected market returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. stock market using multimanager portfolio strategies; and achieve returns in excess of passive indices using active investment managers and strategies.

The strategic role of international equities is to provide higher expected market return premiums (along with domestic equities) of the major asset classes and diversify the Plans' overall equity exposure by investing in non-U.S. stocks that are less than fully correlated to domestic equities with similar return expectations; to maintain a diversified exposure within the international stock

market through the use of multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies.

The strategic role of emerging markets is to diversify the portfolio relative to domestic equities and fixed income investments and to specifically include equity investment in selected global markets and may also include currency hedging for defensive purposes.

Fixed Income

The strategic role of fixed income securities is to diversify the Plan's equity exposure by investing in fixed income securities that exhibit a low correlation to equities and lower volatility; maintain a diversified exposure within the U.S. fixed income market using multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies. It also provides effective diversification against equities and a stable level of cash flow.

Alternative Investments

The strategic role of alternative investments is for diversification relative to equities and fixed income investments, to add absolute return using hedging strategies, and to achieve significant expected return premiums over longer holding periods. Alternative investments include investments in hedge funds and private equities and are under the supervision and control of investment managers. Hedge funds include investments in a variety of instruments including stocks, bonds, commodities, and a variety of derivative instruments. Private equities consist primarily of equity investments made in companies that are not quoted on a public stock market, which can include U.S. and non-U.S. venture capital, leveraged buyouts, and mezzanine financing.

Real Estate

The strategic role of real estate is to diversify the Plan's portfolio relative to equities and fixed income investments to include a component of real property investment through a commingled fund structure and providing higher returns than benchmark investments of a similar class. Real estate investments may also include publicly and privately traded real estate investment trusts as well as direct investment through properties and mortgages.

Global Asset Allocation

The strategic role of global asset allocation is to add value through broad diversification among traditional asset classes and tactical allocation shifts. Global asset allocation includes investments in diversified multi-asset funds to achieve returns above other broad diversified benchmarks.

(b) Defined Contribution Plans

MHS currently maintains three defined contribution plans including the MHS 401(a) Retirement Account Plan (RAP), the MHS 403(b) Employee Savings Plan, and the MHS 401(k) Plan. Most employees assigned to work at Deaconess Hospital, Valley Hospital and Rockwood Clinic are eligible for participation in the MHS 401(k) Plan, which is funded by both MHS and employee contributions. The MHS 403(b) Employee Savings Plan is 100% funded by employee contributions and the RAP is 100% funded by MHS contributions.

MHS' funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2020 and 2019 were approximately $49,550 and $47,200, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to the defined benefit and defined contribution plans as described above, MHS also maintains several deferred compensation arrangements for the benefit of eligible employees. Substantially all amounts that are deferred under these arrangements are held in trust until such time as these funds become payable to the participating employees.

(12) Professional Liability

MHS maintains a self-insurance program for professional liability with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability as of December 31, 2020 and 2019, which comprises estimated deductibles and retentions for known claims at year-end and a liability for incurred but not reported claims based on an actuarially determined estimate.

At December 31, 2020 and 2019, the estimated gross professional liability (including current and long-term portions) was $97,997 and $85,634, respectively. The current portion is included in accounts payable and accrued expenses and the remainder is included in other liabilities, net. MHS has recorded a receivable for amounts to be received from the excess insurance carriers for their portion of the claims (including current and long-term portions) of $32,450 and $30,026 as of December 31, 2020 and 2019, respectively. The current amount is included in other current assets, net and the remainder is included in other assets, net in the accompanying consolidated balance sheets.

(13) Workers' Compensation and Employee Health Benefit Programs

MHS maintains a self-insurance program for workers' compensation with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability based on an actuarial estimate of future claims payments. At December 31, 2020 and 2019, the estimated net liability based on future claims cost totaled $17,726 and $16,127, respectively. The gross liabilities (including both current and long-term portions) total $21,083 and $19,135 as of December 31, 2020 and 2019, respectively. The long-term amounts are included in other liabilities, net and the current portions are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets. These liabilities are secured by a letter of credit with the State of Washington. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,357 and $3,008 as of

(Dollars in thousands)

December 31, 2020 and 2019, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

MHS maintains a self-insurance program for employee medical and dental insurance. Employees can elect to be included in the self-insurance plan as a part of their fringe benefit package. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2020 and 2019 was $10,129 and $12,083, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(14) Long-Term Debt

Long-term debt consists of the following at December 31, 2020 and 2019:

	2020	2019
2020 Taxable bonds	$ 300,000	—
2020 OCED financing	60,889	—
2019 Term loan	35,255	35,255
WHCFA Revenue bonds, 2017 Series A and B	321,705	325,020
WHCFA Revenue bonds, 2017 Series C, D, and E	191,010	191,010
2017 Term loans	130,170	130,170
WHCFA Revenue bonds, 2015 Series A and B	352,315	356,365
WHCFA Revenue bonds, 2012 Series A	60,000	60,000
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
Other	22,313	34,839
	1,571,787	1,230,789
Adjusted for:		
Current portion	(7,950)	(13,668)
Bond premiums, discounts, and debt issuance costs	55,012	59,852
Long-term debt, net of current portion	$ 1,618,849	1,276,973

(a) 2020 Taxable Bonds

In July 2020, MHS issued $300,000 of taxable 2020 series bonds. These bonds were issued as fixed rate bonds that bear interest of 2.803%. The principal of $300,000 is due in 2051, with interest only payments made semiannually in February and August of each year.

(b) 2020 OCED Financing

In June 2020, MHS finalized a sale-leaseback transaction for three completed off-campus emergency departments (OCED) and one OCED still in progress of being constructed with total cash proceeds received of $61,794. Due to the specific terms of the agreement, the lease qualified as a financing type lease. The agreement did not meet the criteria for sale-leaseback accounting treatment and instead, is considered a financing liability. The agreement bears an implicit interest rate of 4.64%. Annual principal payments range from $1,803 in 2021 to $4,461 in 2039 with a final principal payment of $96 in 2041.

(c) 2019 Term Loan

In August 2019, MHS entered into a fixed rate term loan agreement with JPMorgan Chase Bank, N.A., with an interest rate of 1.89%. The principal balance of $35,255 is due in 2022.

(d) Washington Health Care Facility Authority (WHCFA) Revenue Bonds 2017 Series A and B

In November 2017, MHS issued $333,970 of 2017 Series A and B bonds. These bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.0%. Annual principal payments range from $3,315 in 2020 to $62,410 in 2047.

(e) WHCFA Revenue Bonds 2017 Series C, D, and E

In November 2017, MHS entered into a $111,010 variable rate private placement agreement (Series C and D) with JPMorgan Chase Bank, National Association and an $80,000 variable rate private placement agreement (Series E) with Wells Fargo Municipal Capital Strategies, LLC. Annual principal payments range from $390 in 2043 to $55,505 in 2049. The interest rates, which were between 0.56% and 1.98% at December 31, 2020, reset monthly and are based on 70% of the one-month U.S. LIBOR plus a spread.

(f) 2017 Term Loans

In November 2017, MHS entered into two $65,085 variable rate term loan agreements with Wells Fargo Bank, N.A. The principal balance of $130,170 is due in 2047. The interest rates, which were between 0.84% and 2.55% at December 31, 2020, reset monthly and are based on the one-month U.S. LIBOR plus a spread.

(g) WHCFA Revenue Bonds 2015 Series A and B

In April 2015, MHS issued $373,390 of 2015 Series A and B bonds. Series A and B bonds were issued as fixed rate bonds that bear interest ranging from 2.0% to 5.0%. Annual principal payments range from $4,050 in 2020 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(h) WHCFA Revenue Bonds 2012 Series A

In November 2012, MHS issued $60,000 of 2012 Series A bonds. 2012 Series A bonds were issued as fixed rate bonds that bear interest ranging from 3.8% to 4.1%. Annual principal payments range from $5,190 in 2040 to $22,085 in 2045 with a final payment of $19,715 due in 2046.

(i) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. In August 2019, the 2010 bonds were refinanced with the proceeds from the 2019 Term Loan as described below. This refinancing resulted in a gain of $869 that is recognized in other (loss) income, net in the consolidated statements of operations and changes in net assets.

(j) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued the 2009 Series A and B bonds as variable rate demand bonds for $50,000 each. The bonds were backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds that bear interest ranging from 4.4% to 5.0%. Annual principal payments range from $3,690 in 2040 to $38,890 in 2044.

(k) Other

The other debt listed is primarily made up of debt held by Navos. In April 2020, MHS paid $11,488 of Navos' debt outstanding to third-party creditors. Of the outstanding debt at December 31, 2020, $16,092 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. These provisions state that Navos maintains the assets that were built or purchased with these notes and maintains their usage when the promissory note was signed for the length specified. If these provisions are not met, the note must be repaid based on the terms of the agreement. The forgivable debt is subject to a forgiveness provision in years 2028 through 2068.

(l) 2020 Line of Credit

In April 2020, MHS secured a $200,000 line of credit through JPMorgan Chase Bank, N.A. The term of the line of credit is for 12 months and bears interest at a variable rate based upon the Central Bank Floating Rate. No draws have occurred as of December 31, 2020.

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2020 and 2019.

Each fixed-rate revenue bond requires semiannual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

(Dollars in thousands)

Principal maturities on long-term debt are as follows:

Year ending December 31:		
2021	$	7,950
2022		45,390
2023		20,616
2024		21,641
2025		22,716
Thereafter		1,453,474
	$	1,571,787

A summary of interest costs is as follows during the years ended December 31, 2020 and 2019:

		2020	2019
Interest cost:			
Charged to operations	$	48,464	49,313
Amortization of bond premiums, discounts, and issuance costs		(2,494)	(2,728)
Capitalized		478	1,231
	$	46,448	47,816

(15) Commitments and Contingencies

Approximately 48% of MHS employees were covered under collective bargaining agreements as of December 31, 2020. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through March 2023.

(16) Leases

(a) Lessee

MHS leases various equipment and facilities under noncancelable operating and finance leases. Lease terms for noncancelable operating leases range from 1 to 18 years, and existing leases have expiration dates through 2036. Lease terms for finance leases range from 3 to 21 years, and existing leases have expiration dates through 2040.

(Continued)

(Dollars in thousands)

The components of lease cost for the years ended December 31, 2020 and 2019 were as follows:

		2020	2019
Operating lease cost	$	37,232	36,532
Finance lease cost:			
Amortization of right-of-use assets		1,550	—
Interest on lease liabilities		388	—
Total finance lease cost		1,938	—
Short term lease cost		1,644	344
Variable lease cost		7,242	7,141
Sublease income		(1,049)	(4,518)
Total lease cost	$	47,007	39,499

Other information related to leases as of December 31, 2020 and 2019 was as follows:

	2020	2019
Weighted average remaining lease term (years)		
Operating leases	6.7	6.8
Finance leases	7.7	N/A
Weighted average discount rate		
Operating leases	4.0 %	4.0 %
Finance leases	4.4	N/A
Operating cash flows from operating leases	(36,707)	(35,619)
Operating cash flows from finance leases	(388)	—
Financing cash flows from finance leases	(1,366)	—
Right-of-use assets obtained in exchange for new operating lease liabilities	19,850	40,717
Right-of-use assets obtained in exchange for new finance lease liabilities	16,739	—

(Continued)

(Dollars in thousands)

Maturities of lease liabilities under noncancelable leases as of December 31, 2020 are as follows:

		Operating Leases	Finance Leases	Total
For year ended December 31:				
2021	$	33,673	3,482	37,155
2022		26,333	3,482	29,815
2023		22,904	3,321	26,225
2024		18,102	3,096	21,198
2025		16,258	1,719	17,977
Thereafter		45,847	3,840	49,687
Total undiscounted lease payments		163,117	18,940	182,057
Less present value discount		(20,255)	(2,904)	(23,159)
Total lease liabilities	$	142,862	16,036	158,898

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS, and is the only asset that MHS leases out as a lessor. The lease has a 20 year initial lease term, with four 5 year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40 year lease. There is no purchase option stated in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. At December 31, 2020, MHS' other assets, net include a net investment in lease of $23,200.

Revenue from leases for the years ended December 31, 2020 and 2019 is as follows:

		2020	2019
Interest income on net investment in finance leases	$	1,136	812
Variable lease income		28	25
Total lease income	$	1,164	837

(Dollars in thousands)

Future lease payments receivable as of December 31, 2020 are as follows:

Year ended December 31:		
2021	$	1,246
2022		1,246
2023		1,246
2024		1,246
2025		1,246
Thereafter		43,495
Total lease payments to be received		49,725
Less: unearned interest income		(26,525)
Net investment in lease	$	23,200

(17) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2020 and 2019:

		2020	2019
Healthcare services	$	52,151	49,866
Endowment funds, perpetual trusts and related receivables		71,651	64,273
Purchase of property, plant and equipment		16,234	6,377
Indigent care		1,533	1,634
Health education		1,192	1,240
Total net assets with donor restrictions	$	142,761	123,390

(18) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

(Dollars in thousands)

The following tables present MHS' endowment net asset composition as well as associated changes therein:

		Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2019	$	2,673	39,700	42,373
Investment return:				
Investment income		39	493	532
Net appreciation – realized and unrealized		153	1,989	2,142
Total investment return		192	2,482	2,674
Contributions		—	443	443
Appropriation of endowment assets for expenditure		(40)	(201)	(241)
Endowment net assets, December 31, 2020	$	2,825	42,424	45,249

		Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2018	$	2,923	38,140	41,063
Investment return:				
Investment income		62	782	844
Net appreciation – realized and unrealized		27	334	361
Total investment return		89	1,116	1,205
Contributions		—	1,990	1,990
Appropriation of endowment assets for expenditure		(339)	(1,546)	(1,885)
Endowment net assets, December 31, 2019	$	2,673	39,700	42,373

(Continued)

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $28,290 and $23,445, respectively, as of December 31, 2020 and 2019. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $937 and $1,128, respectively, as of December 31, 2020 and 2019.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2020 or 2019.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that an annual spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(Dollars in thousands)

(19) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2020 and 2019:

	2020				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 969,456	392,470	51,225	202,870	1,616,021
Employee benefits	119,926	66,759	11,931	49,516	248,132
Supplies	416,964	34,712	54,952	13,750	520,378
Purchased services	98,027	25,874	18,409	155,946	298,256
Depreciation and amortization	110,868	17,914	1,921	37,485	168,188
Interest	41,004	3,936	—	1,030	45,970
Other	226,092	49,321	25,724	68,604	369,741
	$ 1,982,337	590,986	164,162	529,201	3,266,686

	2019				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 918,459	407,097	47,490	175,055	1,548,101
Employee benefits	120,308	69,120	11,259	40,659	241,346
Supplies	424,852	35,609	36,278	4,949	501,688
Purchased services	109,060	34,682	12,763	114,609	271,114
Depreciation and amortization	106,384	20,090	1,425	37,771	165,670
Interest	46,226	2,859	—	(2,500)	46,585
Other	217,900	44,851	16,565	78,170	357,486
	$ 1,943,189	614,308	125,780	448,713	3,131,990

(20) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(21) Subsequent Events

MHS has evaluated the subsequent events through March 24, 2021, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 16B. MultiCare Health System Audited Financial Statements – 2020-2021

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2021 and 2020

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

Opinion

We have audited the consolidated financial statements of MultiCare Health System (the Company)(a Washington nonprofit corporation), which comprise the consolidated balance sheets as of December 31, 2021 and 2020, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with U.S. generally accepted accounting principles, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the consolidated financial statements are issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

KPMG LLP

Seattle, Washington
March 23, 2022

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2021 and 2020

(In thousands)

Assets		2021	2020
Current assets:			
Cash and cash equivalents	$	308,732	946,223
Accounts receivable		460,569	374,372
Supplies inventory		60,056	49,167
Other current assets, net		96,361	85,144
Total current assets		925,718	1,454,906
Donor restricted assets held for long-term purposes		96,775	88,900
Investments		2,610,531	1,970,458
Property, plant, and equipment, net		2,010,134	1,763,666
Right-of-use operating lease asset, net		140,718	137,763
Right-of-use financing lease asset, net		20,458	15,694
Other assets, net		554,625	502,459
Total assets	$	6,358,959	5,933,846
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	283,004	208,422
Accrued compensation and related liabilities		340,029	299,523
Accrued interest payable		18,059	18,649
Current portion of right-of-use operating lease liability		26,376	28,574
Current portion of right-of-use financing lease liability		4,283	2,836
Current portion of long-term debt		43,609	7,950
Total current liabilities		715,360	565,954
Interest rate swap liabilities		119,100	154,347
Right-of-use operating lease liability, net of current portion		120,273	114,288
Right-of-use financing lease liability, net of current portion		16,933	13,200
Long-term debt, net of current portion		1,572,235	1,618,849
Other liabilities, net		208,307	213,046
Total liabilities		2,752,208	2,679,684
Commitments and contingencies (note 15)			
Net assets:			
Without donor restrictions		3,430,009	3,111,401
With donor restrictions		176,742	142,761
Total net assets		3,606,751	3,254,162
Total liabilities and net assets	$	6,358,959	5,933,846

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2021 and 2020

(In thousands)

	2021	2020
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 3,504,691	3,105,968
Other operating revenue	314,323	256,819
Net assets released from restrictions for operations	5,170	4,655
Total revenues, gains, and other support without donor restrictions	3,824,184	3,367,442
Expenses:		
Salaries and wages	1,870,645	1,616,021
Employee benefits	278,185	248,132
Supplies	600,757	520,378
Purchased services	349,159	298,256
Depreciation and amortization	126,307	168,188
Interest	47,670	45,970
Other	486,005	369,741
Total expenses	3,758,728	3,266,686
Excess of revenues over expenses from operations	65,456	100,756
Other income (loss):		
Investment income	213,993	272,266
Gain (loss) on interest rate swaps, net	25,873	(75,033)
Other loss, net	(13,729)	(13,068)
Total other income, net	226,137	184,165
Excess of revenues over expenses	291,593	284,921
Other changes in net assets without donor restrictions:		
Changes in pension asset	24,810	2,513
Net assets released from restriction – capital acquisitions	1,715	4,327
Other	490	220
Increase in net assets without donor restrictions	318,608	291,981
Changes in net assets with donor restrictions:		
Contributions and other	35,697	21,425
Income on investments	1,816	2,482
Net assets released from restriction – capital acquisitions	(1,715)	(4,327)
Net assets released from restrictions for operations and other	(5,170)	(4,655)
Increase in assets held in trust by others	3,353	4,446
Increase in net assets with donor restrictions	33,981	19,371
Increase in net assets	352,589	311,352
Net assets, beginning of year	3,254,162	2,942,810
Net assets, end of year	$ 3,606,751	3,254,162

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2021 and 2020

(In thousands)

	2021	2020
Cash flows from operating activities:		
Increase in net assets	$ 352,589	311,352
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	126,307	168,188
Amortization of bond premiums, discounts, and issuance costs	(2,433)	(2,494)
Net realized and unrealized gains on investments	(188,615)	(251,078)
Change in fair value of interest rate swap	(35,247)	67,298
Loss (gain) on disposal of assets, net	2,373	(90)
(Gain) loss on joint ventures, net	(513)	4,709
Restricted contributions for long-term purposes	(16,952)	(12,188)
Changes in operating assets and liabilities:		
Accounts receivable	(73,590)	2,128
Supplies inventory and other current assets	(17,586)	(21,176)
Right-of-use lease asset	40,614	35,391
Other assets, net	(38,219)	(104,363)
Accounts payable and accrued expenses and accrued interest payable	67,751	16,547
Accrued compensation and related liabilities	38,053	51,552
Right-of-use lease liability	(30,721)	(33,111)
Other liabilities, net	(8,287)	57,479
Net cash provided by operating activities	215,524	290,144
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(216,973)	(169,168)
Proceeds from disposal of property, plant, and equipment	7,629	997
Purchase of Capital Medical Center and related real estate	(179,662)	—
Investments in joint ventures, net	(10,373)	(26,199)
Purchases of investments	(5,634,748)	(4,397,377)
Sales of investments	5,175,627	4,472,955
Change in donor trusts	5,700	(9,457)
Net cash used in investing activities	(852,800)	(128,249)
Cash flows from financing activities:		
Repayment of long-term debt	(8,522)	(20,796)
Proceeds from bond issuance	—	300,000
Proceeds from debt issuance	—	61,794
Payment of debt issue expenses	—	(2,346)
Principal payments on finance lease obligations	(8,645)	(1,366)
Restricted contributions for long-term purposes	16,952	12,188
Net cash (used in) provided by financing activities	(215)	349,474
Net change in cash and cash equivalents	(637,491)	511,369
Cash and cash equivalents, beginning of year	946,223	434,854
Cash and cash equivalents, end of year	$ 308,732	946,223
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 48,260	42,967
Noncash activities:		
Increase in deferred compensation plans	13,471	13,726
Increase in accounts payable for purchases of property, plant, and equipment	1,266	349

See accompanying notes to consolidated financial statements.

(1) Nature of Organization and Summary of Significant Accounting Policies

(a) Organization Description

MultiCare Health System (MHS), a Washington nonprofit corporation, is an integrated healthcare delivery system providing inpatient, outpatient, and other healthcare services primarily to the residents of Pierce, King, Spokane and Thurston Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2021, MHS was licensed to operate 2,099 inpatient hospital beds, including 120 beds associated with a joint venture psychiatric hospital in Tacoma, Washington. MHS operates nine acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Covington Hospital, Deaconess Hospital, Valley Hospital and Capital Medical Center) and one behavioral health hospital (Navos). MHS also operates eight outpatient surgical sites, five free-standing emergency departments, home health, hospice, and multiple urgent care, primary care and multispecialty clinics located throughout the MHS service areas.

The consolidated financial statements include the operations of these facilities and services as well as those of three wholly owned subsidiaries (Greater Lakes Mental Healthcare, Medis, Inc. and MultiCare Rehabilitation Specialists, P.C.), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned accountable care organization (MultiCare Connected Care), and two fundraising foundations (Mary Bridge Children's Foundation and MultiCare Foundations, which is doing business as MultiCare Health Foundation, Good Samaritan Foundation, MultiCare South King Health Foundation, MultiCare Behavioral Health Foundation and MultiCare Inland Northwest Foundation).

On April 1, 2021, MHS completed the purchase of Capital Medical Center in Olympia, Washington from an affiliate of LifePoint Health and physician owners to acquire a 100% ownership interest. Capital Medical Center is licensed to operate 107 inpatient hospital beds as well as operates multiple primary care and multispecialty clinics within Thurston County. The acquisition of Capital Medical Center was valued at $44,662. Assets and liabilities purchased included land, buildings, equipment, accounts receivable, intangibles and other assets offset by accounts payable, accrued compensation, other current liabilities and other liabilities and were recorded at their estimated fair values as determined based on standard asset appraisal techniques. MHS hired substantially all of the employees previously employed by Capital Medical Center. The following table summarizes the estimated fair values of

(Dollars in thousands)

assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Patient accounts receivable	$	13,500
Other current assets		3,628
Land, buildings and equipment		30,551
Intangibles and other assets		8,915
Accounts payable, accrued compensation and other current liabilities		(8,695)
Other liabilities		(3,295)
Total identifiable net assets assumed		44,604
Recognized amount of goodwill assumed:		
Goodwill		58
Total	$	44,662
Total cash consideration transferred	$	39,173

On December 20, 2021, MHS completed a separate purchase of land and buildings associated with the Capital Medical Center hospital campus and several surrounding clinic offices from an affiliate of Medical Properties Trust (MPT). The acquisition was valued at $135,000 of land, buildings and other related assets acquired.

Recognized amounts of identifiable assets acquired:		
Land	$	20,053
Buildings		114,069
Leasehold improvements		163
Intangible assets		715
Total		135,000
Transaction expenses		3,148
Total cash consideration transferred	$	138,148

(b) Principles of Consolidation

The accompanying consolidated financial statements include the accounts of MHS after elimination of all significant intercompany accounts and transactions.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the

reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and assumptions.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid instruments with maturities of three months or less at the date of purchase. Cash equivalents and investments that are held by outside investment managers or restricted per contractual or regulatory requirements are classified as investments on the consolidated balance sheets.

(e) Accounts Receivable

Accounts receivable are primarily comprised of amounts due for healthcare services from patients and third-party payors and are recorded net of amounts for contractual adjustments and implicit price concessions.

(f) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is stated at lower of cost or net realizable value using the average cost method, except for pharmacy, which uses the first-in, first-out (FIFO) method. Obsolete and unusable items are expensed at the time such determination is made.

(g) Donor Restricted Assets

The majority of the donor restricted assets are invested in MHS' investments and are stated at fair value or estimated fair value. Donor restricted assets that are held separately from MHS' investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in mutual funds, fixed income securities, and equity securities. Those with readily determinable fair values are stated at fair value. Those investments for which quoted market prices are not readily determinable are carried at values provided by the respective investment managers or trustees, which management believes approximates fair value.

Charitable gift annuities, which are included in donor restricted assets, totaled $2,308 and $2,471 at December 31, 2021 and 2020, respectively. MHS has recorded a corresponding payable of $775 and $1,119 at December 31, 2021 and 2020, respectively, to pay for estimated future obligations to beneficiaries. The current portion of these obligations is included in accounts payable and accrued expenses and the long-term portions are included in other liabilities, net in the accompanying consolidated balance sheets. According to Washington State law, MHS, as a distinct legal entity holding charitable gift annuities, is required to maintain unrestricted net assets of at least $500, which MHS has done for each of the periods presented.

(h) Investments

MHS accounts for its investment portfolio as a trading portfolio, therefore, investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are recorded at fair value, which are determined based on quoted market prices or prices with observable inputs

obtained from national securities exchanges or similar sources. Other investments, including limited partnerships, commingled real estate trust funds, limited liability partnerships, and hedge funds are carried at net asset value (NAV) provided by the respective investment managers, which management believes approximates fair value. Valuations provided by investment managers consider variables such as valuation and financial performance of underlying investments, quoted market prices for similar securities, recent sale prices of underlying investments, and other pertinent information. Management reviews the valuations provided by investment managers and believes that the carrying values of these financial instruments are reasonable estimates of fair value.

Realized gains and losses are recorded using the average cost method. Investment income or loss (including realized gains and losses on investments, change in unrealized gains or losses, interest, and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law.

(i) Property, Plant, and Equipment

Property, plant, and equipment are recorded at cost. Depreciation expense is computed using the straight-line method over the following estimated useful lives of the assets:

Buildings	5–80 years
Land improvements	8–20 years
Equipment	3–30 years

In 2021, MHS re-evaluated the useful lives of property, plant, and equipment used to compute depreciation expense, resulting in a prospective change in estimated useful lives of certain buildings and equipment. The method of determining the new estimated useful lives is based on historical data of similar assets at MHS and similarly sized entities. MHS believes this change aligns the useful life with the actual usage of the asset and is a better depiction of the net book value of the assets held and in-use. This change is recognized prospectively as a change in accounting estimate. MHS recorded reductions in depreciation expense of property, plant and equipment of $48,094 for the year ended December 31, 2021.

The Company capitalizes all software implementation costs that meet the criteria for capitalization, including those that relate to a service contract (e.g. hosting arrangement). The capitalized software implementation costs are reflected within property, plant and equipment in the consolidated balance sheets. These costs are amortized together with the costs of the related software license; however, the implementation costs related to a service arrangement are amortized over the term of the arrangement. The amortization period for all capitalized implementation costs is generally 10 years.

Maintenance and repairs are charged to operations as they occur. Expenditures that materially increase values, change capacities, or extend useful lives are capitalized. Gains upon sale or retirement of property, plant, and equipment are included in other operating revenue whereas losses are included in other expenses. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of constructing those assets.

MHS assesses potential impairments to its long-lived assets as well as its intangible assets, as described below, when there is evidence that events or changes in circumstances indicate that an impairment has been incurred. These changes can include a deterioration in operating performance, a reduction in reimbursement rates from government or third-party payors or a change in business strategy. An impairment charge is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2021 and 2020, there were no impairment charges.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(j) Leases

Management reviews contracts in order to identify leases and properly classify leases as either operating or financing. MHS is a lessee of various equipment and facilities under noncancelable operating and financing leases. Operating and financing right-of-use (ROU) liabilities are recognized based on the net present value of lease payments over the lease term at the commencement date of the lease and are reduced by payments made on each lease on the straight-line basis. Since most of the leases do not provide an implicit rate of return, MHS uses its incremental borrowing rate based on information available at the commencement date of the lease in determining the present value of lease payments. Generally, MHS cannot determine the interest rate implicit in the lease because it does not have access to the lessor's estimated residual value or the amount of the lessor's deferred initial direct costs. Therefore, MHS generally uses its incremental borrowing rate as the discount rate for the lease. MHS' incremental borrowing rate for a lease is the rate of interest it would have to pay on a collateralized basis to borrow an amount equal to the lease payments using similar terms. Leases with an initial term of 12 months or less are not recorded on the balance sheet; rather, rent expense for these leases is recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

If a lease contains a renewal option at the commencement date and it is considered reasonably certain that the renewal option will be exercised by management to renew the lease, the renewal option payments are included in MHS' net minimum lease payments used to determine the right-of-use lease liabilities and related lease assets. All other renewal options are included in right-of-use lease liabilities and related lease assets when they are reasonably certain to be exercised.

All lease agreements generally require MHS to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU lease liability or ROU lease asset. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation.

Variable lease payments associated with MHS' leases are recognized when the event, activity, or circumstance in the lease agreement on which those payments are assessed occurs. Variable lease payments are presented in other expenses in the consolidated statement of operations and changes in net assets.

MHS has elected the practical expedient to not separate lease components from nonlease components related to its real estate leases.

(k) Goodwill and Intangible Assets

Goodwill is an asset representing the future economic benefits arising from the difference in the fair value of the business acquired and the fair value of the identifiable and intangible net assets acquired in a business combination. Indefinite-lived intangible assets are assets that are not amortized because there is no foreseeable limit to cash flows generated from them. Goodwill and intangible assets is included in other assets, net in the accompanying consolidated balance sheets. At December 31, 2021 and 2020, MHS has goodwill of $152,927 and $152,869, respectively, which includes $58 of goodwill recognized as part of the acquisition of Capital Medical Center. At December 31, 2021 and 2020, MHS has intangible assets, net of accumulated amortization, of $19,136 and $14,214, respectively, which includes $8,466 of intangible assets recognized as part of the acquisition of Capital Medical Center. Goodwill and intangible assets are included in other assets, net in the accompanying consolidated balance sheets.

If it is more likely than not that goodwill is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment charge. Goodwill is not amortized and along with indefinite-lived intangible assets is evaluated at least annually for impairment. There were no impairment charges recognized during the years ended December 31, 2021 or 2020.

Amortizing intangible assets are comprised of certificates of need, license agreements, trade names and lease arrangements, which all have finite useful lives. Amortization expense is recorded on a straight-line basis over the estimated useful life of the assets, which ranges from three to thirty years, associated with the nature of the intangible asset. Amortization expense was $3,544 and $1,621 for the years ended December 31, 2021 and 2020, respectively.

(l) Investment in Joint Ventures

MHS maintains ownership in certain joint ventures related to imaging, office buildings, behavioral health and other healthcare focused activities and accounts for these joint ventures under the equity method of accounting. As of December 31, 2021 and 2020, MHS held ownership interests in 21 and 15 joint ventures, respectively. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheets. Gain on joint ventures for the year ended December 31, 2021 was $513 associated with several joint ventures performance. Loss on joint ventures for the year ended December 31, 2020 was $4,709. Gains and losses are included in other operating revenue on the consolidated statements of operations and changes in net assets.

(m) Estimated Third-Party Payor Settlements

Medicare cost reports are filed annually by MHS with the Medicare intermediary and are subject to audit and adjustment prior to settlement. Estimates of net settlements due to Medicare were $4,634 and $3,456 as of December 31, 2021 and 2020, respectively, and have been recorded within accounts payable and accrued expenses in the accompanying consolidated balance sheets. Third-party settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, based upon the amount of the final settlements. Patient service revenue decreased by $1,178 in 2021 and increased by $106 in 2020 to reflect changes in the estimated Medicare settlements for prior years.

(n) Interest Rate Swaps

MHS maintains several interest rate swap agreements as a means of hedging its exposure to variable-based interest rates and fluctuations in cash flows as part of its overall interest rate risk management strategy. All MHS interest rate swaps are recorded at fair value. The accounting for changes in the fair value of these swaps depends on whether those had been designated as cash flow hedges. As of December 31, 2021 and 2020, none of MHS' interest rate swaps were designated as cash flow hedges and therefore, the changes in fair value are recognized and included in other income (loss) on the consolidated statements of operations and changes in net assets. These swaps have notional amounts totaling approximately $709,000 and expire starting in August 2027 through August 2049. The majority of the swaps have the economic effect of fixing the LIBOR-based variable interest rate on an equivalent amount of MHS' outstanding floating rate principal debt.

Under master netting provisions of the International Swap Dealers Association (ISDA) agreement with each of the counterparties, MHS is permitted to settle with the counterparties on a net basis. Due to the right of offset under these master netting provisions, MHS offsets the fair value of certain interest rate swap assets with swap liabilities on the consolidated balance sheets.

(o) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by MHS in perpetuity. When restricted funds to be used for operations are expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains, and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restriction – capital acquisitions.

MHS applies the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, related to using the present value technique to measure fair value of pledges receivable. In accordance with ASC Topic 820, MHS has applied the expected present value technique to pledges received after January 1, 2009 that adjusts for a risk premium to take into account the risks inherent in those expected cash flows. Pledges of financial support are recorded as pledges receivable when unconditional pledges are made and are stated at net realizable value. Pledges are reported net of an allowance for uncollectible pledges and pledges to

be collected in future years are reflected at a discounted value using a weighted average discount rate. As of December 31, 2021 and 2020, MHS has recorded $20,305 and $14,160, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2021, $5,652 of pledges are due in one year or less and $14,653 in two to seven years.

(p) Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which MHS expects to receive in exchange for providing patient services. These amounts are due from patients, third-party payors, and others and include the variable consideration for retroactive adjustments to revenue due to final settlement of audits, reviews, and investigations. MHS bills the patient and third-party payors several days after the services are performed or when the patient is discharged from the facility, whichever is later.

(q) Hospital Safety Net Assessment

The State of Washington (the State) has a safety net assessment program involving Washington State hospitals to increase funding from other sources and obtain additional federal funds to support increased payments to providers for Medicaid services. In connection with this program, MHS recorded increases in patient service revenue of $89,738 and $83,884 for 2021 and 2020, respectively, and incurred assessments of $64,570 and $61,112 for 2021 and 2020, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations and changes in net assets. MHS has outstanding receivables of $16,737 and $14,649 associated with this program as of December 31, 2021 and 2020, respectively, which are included with accounts receivable on the consolidated balance sheets.

(r) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated and undercompensated healthcare services to the communities it serves within the purview of its mission. Because MHS does not pursue collection of amounts determined to qualify as uncompensated care, MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its historical collections from these patients. Patients who meet the criteria of MHS' uncompensated care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Such amounts determined to qualify as charity care are not reported as revenue. The State provides guidelines for charity care provided by hospitals in the state. Hospitals are recommended to provide full charity care to patients who meet 100% of the federal poverty guidelines and a lesser amount to patients who meet up to 200% of the federal poverty guidelines. MHS provides full charity care to patients who meet 300% of the federal poverty guidelines and also provides uncompensated care on a sliding scale for patients whose income is between 301% and 500% of the federal poverty guidelines for true self-pay patients and patients with deductibles and coinsurance amounts. The estimated cost of charity care provided was approximately $48,000 and $51,000 in 2021 and 2020, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $300,406 and $218,443 in 2021 and

2020, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(s) Other Operating Revenue

Other operating revenue includes revenue from cafeteria sales, retail pharmacy, laboratory revenue from community providers, medical office rental income, contributions without donor restrictions, grant revenue, contracted behavioral healthcare revenue and other miscellaneous revenue.

(t) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in net assets without donor restrictions, which are excluded from the excess of revenues over expenses, primarily include changes in accrued pension asset, net assets released from restrictions for capital expenditures, and capital assets received.

(u) Federal Income Taxes

ASC Subtopic 740-10, *Income Taxes*, clarifies the accounting for uncertainty in income taxes recognized in MHS' consolidated financial statements. This topic also prescribes a recognition threshold and measurement standard for the financial statement recognition and measurement of an income tax position taken or expected to be taken in a tax return. Only tax positions that meet the "more-likely than-not" recognition threshold at the effective date may be recognized or continue to be recognized upon adoption. In addition, this topic provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition. Other than Medis, Inc., which is a taxable corporation, and Columbia Capital Medical Center, LP (operating as Capital Medical Center), which is a taxable partnership, all of the other entities have obtained determination letters from the Internal Revenue Service that they are exempt from federal income taxes under Section 501(a) of the Internal Revenue Code as an organization described in 501(c)(3) of the Internal Revenue Code, except for tax on unrelated business income.

(v) Self-Insurance Reserves

MHS is self-insured with respect to professional and general liability, workers compensation and medical and other health benefits with excess insurance coverage over self-insured retention limits. MHS records insurance liabilities for these specific items by using third party actuarial calculations and certain assumptions and inputs such as MHS historical claims experience and the estimated amount of future claims that will be incurred.

(w) New and Pending Accounting Standards

In June 2016, FASB issued Accounting Standards Update (ASU) 2016-13 and in November 2019, issued ASU 2019-10, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* The amendments in this update require that financial assets are measured at amortized cost basis and presented at the net amount expected to be collected. This eliminates the probable initial recognition threshold in current GAAP and, instead, reflects an entity's current estimate of all expected credit losses and broadens the information that an entity must consider in developing its expected credit loss estimate for assets measured either collectively or individually.

The provisions of this ASU are effective for MHS for the year beginning on January 1, 2023. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In August 2018, FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*. The amendments in this update align the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal-use software license). The guidance in Subtopic 350-40 is used to determine which implementation costs to capitalize as an asset related to the service contract and which costs to expense and is also used to determine the amortization period of the capitalized costs. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2021. MHS has applied the provisions of this ASU prospectively as is allowed and this ASU does not have a material effect on its consolidated financial statements.

In April 2019, FASB issued ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments – Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments.* The amendments in this update are divided into four separate topics that discuss the details of the improvement areas and the amendments made to the Codification for these improvement areas. Topics 1, 2 and 5 in this ASU relate specifically to ASU 2016-13, which is effective for MHS for the year beginning January 1, 2023. Topics 3 and 4 in this ASU have been evaluated and are not applicable to MHS. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In March 2020, FASB issued ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the effects of Reference Rate Reform on Financial Reporting.* The amendments in this update provide practical expedients to contract modifications when it is being modified due to the replacement of a reference rate within the contract. The provisions of this ASU are effective immediately and will be available through December 31, 2022. Modifications completed after December 31, 2022 must use current guidance instead of the provisions in this ASU. MHS will make contract modifications in 2022 but does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

(2) Coronavirus (COVID-19) Impact

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law and on March 11, 2021, the American Rescue Plan Act (ARPA) was signed into law. Both the CARES Act and ARPA were aimed to direct economic assistance for American workers, families, and small businesses, and preserve jobs for American industries. The COVID-19 pandemic impacted all hospitals and physician offices throughout the health system.

The CARES Act and ARPA require the amount of funding received to be validated, which requires management to quantify lost revenues and increased expenses associated with the pandemic. The CARES Act authorized funding to be distributed under the Provider Relief Fund (PRF) and the Coronavirus Relief Fund (CRF). MHS has recognized revenue associated with the PRF, CRF and ARPA funding according to the terms and conditions of the CARES Act and ARPA, and as contribution revenue under

(Dollars in thousands)

FASB ASC 958-605. Refunding of amounts received may be required by the CARES Act if a receiving entity is unable to quantify the financial losses intended to be covered by funding. MHS has determined that it is able to justify retaining all funding received in 2021 and 2020 and has not recorded any liabilities as of December 31, 2021 and 2020 for potential repayment of funds received.

MHS has filed applications and obtained reimbursement of additional expenses from the Federal Emergency Management Agency (FEMA) based on criteria due to the national emergency declaration made due to COVID-19. MHS submitted an expedited funding application with FEMA that covers the period from the start of the national disaster declaration to June 30, 2020. The expedited application allowed MHS to recover up to 50% of the total funding applied for on the application. MHS continues to complete the final reconciliation of the expedited funding application to receive the remainder of the funding and will apply for additional funding pertaining to later periods until the national disaster declaration is no longer in effect.

In March 2020, MHS chose to support employees by protecting pay and benefits for those that were unable to work due to the cancellations/postponements of procedures. Approximately 50% of this cost has been recovered through the employee retention credits offered to employers as part of the CARES Act, which totaled $2,409. The CARES Act also allowed MHS to defer payment of the employer portion of the FICA taxes due to the federal government through December 31, 2020. Payment of these deferred taxes did occur with 50% paid by the end of 2021 and the other 50% by the end of 2022. The total amount of FICA taxes deferred in 2020 was $71,866 with $35,933 due in 2021 and $35,933 due in 2022. MHS paid the FICA taxes due in 2021 with the remaining amount due in 2022 recorded within accrued compensation and related liabilities on the consolidated balance sheets. MHS considered whether to utilize the Medicare Advanced Payment Program (MAPP) when it was available to obtain additional cash flow but chose not to engage in this program.

The following table shows the funding that has been received to prepare and respond to COVID-19 and recognized as other operating revenue for the years ended December 31, 2021 and 2020:

Sources of external relief funding		2021	2020	Total
CARES Act Provider Relief Fund	$	176,448	118,965	295,413
American Rescue Plan Rural Funds		5,284	—	5,284
FEMA		1,405	4,214	5,619
CARES Act Coronavirus Relief Fund		—	2,922	2,922
Insurance Funds for Business Interruption		—	1,003	1,003
Total	$	183,137	127,104	310,241

The impact of COVID-19 has increased the uncertainty associated with management's assumptions and estimates made on these financial statements. The actual impact of COVID-19 on MHS's consolidated financial statements may differ significantly from the assumptions and estimates made for the years ended December 31, 2021 and 2020.

(3) Revenue from Contracts with Customers

Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by MHS and are recognized either over time or at a point in time. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred through a point in time in relation to total actual charges incurred. MHS believes that this method provides a useful depiction of the provision of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospitals or clinics receiving inpatient or outpatient services. MHS measures an inpatient performance obligation from time of admission to time of discharge and an outpatient performance obligation from the start of the outpatient service to the completion of the outpatient service. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided to patients and customers.

MHS has elected to apply the optional exemption in ASC 606-10-50-14a as all of MHS' performance obligations related to contracts with a duration of less than one year. Under this exemption, MHS was not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Any unsatisfied or partially unsatisfied performance obligations are completed within days or weeks of the end of the year.

MHS determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with MHS policy, and implicit price concessions provided to uninsured patients. MHS determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies and historical experience. MHS determines its estimate of implicit price concessions based on its historical collection experience with each class of patients.

Contractual agreements with third-party payors provide for payments at amounts less than MHS' established charges. A summary of the payment arrangements with major third-party payors is as follows:

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, which provides for reimbursement based on Medicare Severity Diagnosis-Related Groups (MS-DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis, acuity, and expected use of hospital resources. The majority of Medicare outpatient services is reimbursed under a prospective payment methodology, the Ambulatory Payment Classification System (APCs), or fee schedules.
- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare; however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services is reimbursed under a prospective payment methodology, the Enhanced Ambulatory Patient Groups (EAPG), or fee schedules.
- Other – MHS has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to MHS under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates and fee schedules.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from the related programs. There can be no assurance that regulatory or governmental authorities will not challenge MHS' compliance with these laws and regulations, and it is not possible to determine the impact, if any, that such claims or penalties would have upon MHS. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims that can reduce the amount of revenue ultimately received.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled and no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2021 or 2020.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. MHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. MHS estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for prior years were not significant for 2021 or 2020. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

Consistent with MHS' mission, care is provided to patients regardless of their ability to pay. MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its collection experience with those patients. Patients who meet the criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as uncompensated care are not reported as revenue.

(Dollars in thousands)

MHS has determined that the best depiction of its revenue is by its mix of payors as this shows the amount of revenue recognized from each portfolio. Patient service revenue disaggregated by payor for the years ended December 31, 2021 and 2020 are as follows:

		2021	2020
Payors:			
Medicare	$	947,979	847,084
Medicaid		554,039	497,785
Premera		501,370	445,238
Regence		334,844	306,588
Aetna		202,379	190,029
Kaiser Permanente		128,538	142,854
First Choice		119,596	112,142
Self-pay		25,450	16,246
Other		690,496	548,002
	$	3,504,691	3,105,968

MHS has elected to apply the practical expedient under ASC 340-40-25-4 and therefore, all incremental customer contract acquisition costs are expensed as incurred, as the amortization period of the asset that MHS would have otherwise recognized is one year or less in duration.

(4) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are residents of the communities it serves and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2021 and 2020 was as follows:

	2021	2020
Medicare	33 %	32 %
Medicaid	21	24
Premera	10	10
Self-pay	7	9
Regence	7	5
First Choice	1	1
Health Care Exchange	1	1
Other commercial insurance	20	18
	100 %	100 %

(5) Fair Value Measurements

(a) Fair Value Hierarchy

In accordance with ASC Topic 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for similar assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical or similar assets or liabilities that MHS could access at the measurement date. Level 1 securities generally include investments in equity securities, mutual funds and certain fixed income securities.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are based upon observable market inputs for the asset or liability, either directly or indirectly. Level 2 securities generally include investments in fixed income securities (composed primarily of government, agency and corporate bonds), and interest rate swaps.
- Level 3 inputs are unobservable market inputs for the asset or liability. Level 3 securities include donor trusts where MHS is not the trustee.

The level in the fair value hierarchy within which a fair value measurement, in its entirety, falls is based on the lowest level input that is significant to the fair value measurement.

ASC Subtopic 820-10 allows for the use of a practical expedient for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value. The practical expedient used by MHS is the Net Asset Value (NAV) per share, or its equivalent. In some instances, the NAV may not equal the fair value that would be calculated under fair value accounting standards. Valuations provided by investment managers consider variables such as the financial performance of underlying investments, recent sales prices of underlying investments and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the redemption price. MHS reviews valuations and assumptions provided by investment managers for reasonableness and believes that the carrying amounts of these financial instruments approximate the estimated of fair value of the instrument. Where investments are not presented at fair value, NAV is used as a practical expedient to approximate fair value.

(Dollars in thousands)

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2021 and 2020:

		Fair value measurements at reporting date using		
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 825,254	825,254	—	—
Equity securities	304,915	304,915	—	—
Fixed income bond funds	403,280	403,280	—	—
Fixed income governmental obligations	210,812	141,941	68,871	—
Fixed income other	376,108	—	376,108	—
Commingled trust fund – international equity	172,069	—	172,069	—
Donor trusts	22,455	—	—	22,455
Total assets at fair value	2,314,893	$ 1,675,390	617,048	22,455
Investment assets valued at NAV	343,651			
Total assets at fair value or NAV	$ 2,658,544			
Liabilities:				
Interest rate swaps	$ 119,100	—	119,100	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using			
	December 31, 2020	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 592,499	592,499	—	—
Equity securities	243,866	243,866	—	—
Fixed income bond funds	364,126	364,126	—	—
Fixed income governmental obligations	67,186	21,137	46,049	—
Fixed income other	95,268	—	95,268	—
Commingled trust fund – international equity	169,362	—	169,362	—
Donor trusts	30,807	—	—	30,807
Total assets at fair value	1,563,114	$ 1,221,628	310,679	30,807
Investment assets valued at NAV	456,274			
Total assets at fair value or NAV	$ 2,019,388			
Liabilities:				
Interest rate swaps	$ 154,347	—	154,347	—

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2021 and 2020:

	NAV December 31, 2021	NAV December 31, 2020	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 132,637	239,797	N/A	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	199,212	205,844	N/A	Daily	1 or more business days prior to valuation date
Limited partnerships	11,802	10,633	1,800	N/A	N/A
Total investments valued at NAV	$ 343,651	456,274	1,800		

Hedge funds include investments in hedge fund-of-funds products with certain investment managers. The fair values of the investments in this category have been estimated using the NAV per share of the investment.

Common trust funds include investments in a collective or common trust account that invests funds in an underlying fund or set of funds. The trust account seeks an investment return that approximates the performance of an index as defined by each common trust fund. The fair value of the investments in this category are estimated using the NAV per share of the fund that is derived from the underlying investments in the trust fund.

Limited partnerships include investments in private equity and venture capital funds in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(b) Interest Rate Swaps

The interest rate swaps are recorded at estimated fair value by using certain observable market inputs that participants would use from closing prices for similar assets. In addition, other valuation techniques and market inputs are used that help determine the fair values of these swaps, which include certain valuation models, current interest rates, forward yield curves, implied volatility and credit default swap pricing.

The fair value of the interest rate swaps liability is included in interest rate swap liabilities on the consolidated balance sheets, and the fair value of the interest rate swap asset is included in other assets, net on the consolidated balance sheets. The fair value gains and losses of these interest rate swaps for the years ended December 31, 2021 and 2020 were $35,246 and ($67,298), respectively, and are included in gain (loss) on interest rate swaps in other (loss) income, net in the consolidated statements of operations and changes in net assets. Also included in the gain (loss) on interest rate swaps is the loss on net cash settlement amounts associated with the swaps of $9,373 and $7,735 for the years ended December 31, 2021 and 2020, respectively.

(Dollars in thousands)

The following table represents both the fair value and settlement value for the interest rate swap liabilities as of December 31, 2021 and 2020:

	Liability derivatives					
	2021			2020		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	$ 119,100	124,921	Interest rates swap liabilities	$ 154,347	159,666

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2021 and 2020 is as follows:

	December 31, 2021		
	Donor restricted assets	Investments	Total
Mutual funds	$ 8,002	817,252	825,254
Equity securities	2,956	301,959	304,915
Fixed income securities	9,600	980,600	990,200
Commingled trust fund – international equity	1,668	170,401	172,069
Hedge funds	1,286	131,351	132,637
Common trust funds	1,931	197,281	199,212
Limited partnerships	115	11,687	11,802
Donor trusts	22,455	—	22,455
Pledge receivables, net and other	48,762	—	48,762
Total	$ 96,775	2,610,531	2,707,306

(Dollars in thousands)

	December 31, 2020		
	Donor restricted assets	Investments	Total
Mutual funds	$ 5,400	587,099	592,499
Equity securities	2,222	241,644	243,866
Fixed income securities	4,799	521,781	526,580
Commingled trust fund – international equity	1,543	167,819	169,362
Hedge funds	2,185	237,612	239,797
Common trust funds	1,876	203,968	205,844
Limited partnerships	98	10,535	10,633
Donor trusts	30,807	—	30,807
Pledge receivables, net and other	39,970	—	39,970
Total	$ 88,900	1,970,458	2,059,358

Fixed income securities include mutual funds, corporate bonds, mortgage-backed securities, asset-backed securities, U.S. government obligations, and state government obligations.

(7) Liquidity and Availability of Financial Assets

MHS actively monitors the availability of resources required to meet its operating obligations and other contractual commitments, while also striving to maximize investment returns of its available funds. To help meet its general obligations, MHS can also access the credit markets as a means of producing liquidity, if needed. MHS draws income, appreciation and distributions from its endowment fund up to 5% of the endowment average account value annually, as applicable donor restrictions are met, as another way of providing liquidity. For purposes of analyzing resources available to meet general expenditures over a twelve-month period, MHS considers all expenditures related to its ongoing activities to provide integrated healthcare delivery as well as the conduct of services undertaken to support these activities to be general expenditures.

(Dollars in thousands)

At December 31, 2021 and 2020, MHS' financial resources are as follows:

	2021	2020
Cash and cash equivalents	$ 308,732	946,223
Accounts receivable	460,569	374,372
Other current assets, net	96,361	85,144
Donor restricted assets	96,775	88,900
Investments	2,610,531	1,970,458
	3,572,968	3,465,097
Less prepaid assets included in other current assets, net	(37,444)	(37,612)
Less donor restricted assets	(96,775)	(88,900)
Less investments with redemption limitations of greater than one year	(11,802)	(10,633)
Total financial assets available for general expenditures	$ 3,426,947	3,327,952

In addition to financial assets available to meet general expenditures over the next twelve months, MHS operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures.

(8) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2021 and 2020 is as follows:

	2021	2020
Land and land improvements	$ 138,910	131,993
Buildings	2,313,543	2,202,449
Equipment	940,116	1,115,316
	3,392,569	3,449,758
Less accumulated depreciation	(1,500,929)	(1,751,452)
	1,891,640	1,698,306
Construction in progress	118,494	65,360
Property, plant, and equipment, net	$ 2,010,134	1,763,666

Total depreciation and amortization expense for the years ended December 31, 2021 and 2020 was $126,307 and $168,188, respectively. Depreciation expense charged to operations for the years ended December 31, 2021 and 2020 amounted to $122,293 and $166,517, respectively. Depreciation expense

(Dollars in thousands)

charged to operations for the year ended December 31, 2021 is net of a $48,094 reduction in expense as part of the change in estimated useful lives.

(9) Other Assets, Net

Other assets are as follows at December 31, 2021 and 2020:

		2021	2020
Investment in joint ventures	$	77,951	64,534
Deferred compensation plan assets held in trust (note 12)		98,789	85,320
Accrued pension asset (note 12)		60,951	45,590
Self-insured retention receivables, net of current portion (notes 13 and 14)		22,558	23,435
Goodwill and other intangibles		172,063	167,083
Net investment in lease (note 17(b))		23,172	23,200
Notes receivable (note 10)		75,546	75,413
Other		23,595	17,884
Other assets, net	$	554,625	502,459

Deferred compensation plan assets held in trust are participant-managed investments consisting of equity and fixed income mutual funds with prices quoted in active markets.

(10) Notes receivable

In December 2020, MHS funded $75,000 into an escrow account as part of a loan based on a credit agreement executed with Astria Health. In January 2021, the final promissory note documents were executed and funds were disbursed at that time to Astria Health. The loan bears a fixed interest rate of 9.5% with payments due June 30 and December 31 of each year. The loan matures in January 2024.

(11) Other Liabilities, Net

Other liabilities are as follows at December 31, 2021 and 2020:

		2021	2020
Professional liability, net of current portion (note 13)	$	89,628	73,822
Deferred compensation liability (note 12)		98,789	85,320
Workers' compensation liability, net of current portion (note 14)		15,454	14,166
Deferred FICA liability (note 2)		—	35,933
Other		4,436	3,805
Other liabilities, net	$	208,307	213,046

(Continued)

(Dollars in thousands)

(12) Retirement Plans

(a) Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the Plan) covering eligible employees. The Plan was closed to new employees effective after July 31, 2002. The benefits are based on years of service and the employee's highest five consecutive years of compensation. MHS contributions to the Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2016, participants no longer accrue pension benefits under the Plan.

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the Plan, which has measurement dates of December 31, 2021 and 2020:

		2021	2020
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	715,286	639,993
Service cost		650	670
Interest cost		18,786	22,963
Actuarial (gain) loss		(23,106)	85,184
Expected administrative expenses		(650)	(670)
Benefits paid		(47,927)	(32,854)
Projected benefit obligations at end of year	$	663,039	715,286
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	760,876	685,413
Actual gain on plan assets		11,700	108,966
Actual administrative expenses		(659)	(649)
Benefits paid		(47,927)	(32,854)
Fair value of plan assets at end of year	$	723,990	760,876
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	60,951	45,590
Amount recognized in net assets without donor restrictions:			
Net loss		90,859	115,669

	2021	2020
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	3.00 %	2.70 %
Expected return on plan assets	4.50	4.50

(Continued)

(Dollars in thousands)

The expected return on plan assets assumption is based upon an analysis of historical long-term returns for various investment categories as measured by appropriate indices. These indices are weighted based upon the extent to which plan assets are invested in the particular categories in arriving at MHS' determination of a composite expected return. An actuary reviews the assumptions annually for reasonableness.

The components of net periodic benefit cost are as follows during the years ended December 31, 2021 and 2020:

	2021	2020
Components of net periodic benefit cost:		
Service cost	$ 650	670
Interest cost	18,786	22,963
Expected return on plan assets	(29,726)	(31,730)
Amortization of net actuarial loss	16,205	10,441
Settlement cost	3,534	—
	$ 9,449	2,344

The accumulated benefit obligation for the Plan was $663,039 and $715,286 at December 31, 2021 and 2020, respectively.

(i) Estimated Future Benefit Payments

The following benefits payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

	Pension benefits
2022	$ 40,146
2023	40,579
2024	40,010
2025	40,892
2026	39,854
2027–2031	193,155

(Dollars in thousands)

(ii) Plan Assets

The following tables set forth by level, within the fair value hierarchy, the Plans' investments at fair value:

	Fair value measurements at reporting date using			
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 11,324	11,324	—	—
Trading securities:				
Mutual funds	124,670	124,670	—	—
Fixed income bond funds	97,505	97,505	—	—
Fixed income governmental obligations	209,474	177,503	31,971	—
Fixed income other	202,017	—	202,017	—
Commingled trust fund – international equity	16,625	—	16,625	—
	661,615	$ 411,002	250,613	—
Broker receivables	5,983			
Broker payables	(34,584)			
Total assets at fair value	633,014			
Investments valued at NAV	90,976			
Total assets at fair value or NAV	$ 723,990			

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2020	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 12,053	12,053	—	—
Trading securities:				
Mutual funds	106,439	106,439	—	—
Fixed income bond funds	105,998	105,998	—	—
Fixed income governmental obligations	312,189	270,336	41,853	—
Fixed income other	211,950	—	211,950	—
Commingled trust fund – international equity	22,485	—	22,485	—
	771,114	$ 494,826	276,288	—
Broker receivables	40,662			
Broker payables	(164,621)			
Total assets at fair value	647,155			
Investments valued at NAV	113,721			
Total assets at fair value or NAV	$ 760,876			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2021 and 2020.

(Continued)

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2021 and 2020:

	NAV December 31, 2021	NAV December 31, 2020	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ —	22,426	N/A	Quarterly	45 days
Absolute return funds	84,911	85,603	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	6,065	5,692	850	N/A	N/A
Total investments valued at NAV	$ 90,976	113,721	850		

Real estate is a real estate commingled trust that invests in U.S. commercial real estate. The fund owns real estate assets in the U.S. office, industrial, residential, and retail sectors.

Absolute return fund investments consist primarily of listed equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles. These investments use derivatives or other instruments for both investment and hedging purposes and may take long and/or short positions, and the derivative investments may include but are not restricted to futures, options, swaps, and forward currency contracts.

Limited partnerships include investments in private equity and venture capital in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(Dollars in thousands)

The defined benefit plan weighted average asset allocations at December 31, 2021 and 2020 by asset category are as follows:

	2021	2020
Asset category:		
Domestic equities	12 %	10 %
International equities	7	7
Emerging markets	—	1
Fixed income securities	80	78
Alternative investments	1	1
Real estate	—	3
	100 %	100 %

(iii) Investment Objectives

The target asset allocations for each asset class are set based on the achieved funding levels for the Plan and are summarized below:

	2021	2020
Asset category:		
Domestic equities	12 %	9 %
International equities	8	8
Emerging markets	—	—
Fixed income securities	80	80
Real estate	—	3
	100 %	100 %

(iv) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected market returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. stock market using multimanager portfolio strategies; and achieve returns in excess of passive indices using active investment managers and strategies.

The strategic role of international equities is to provide higher expected market return premiums (along with domestic equities) of the major asset classes and diversify the Plans' overall equity exposure by investing in non-U.S. stocks that are less than fully correlated to domestic equities with similar return expectations; to maintain a diversified exposure within the international stock market through the use of multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies.

The strategic role of emerging markets is to diversify the portfolio relative to domestic equities and fixed income investments and to specifically include equity investment in selected global markets and may also include currency hedging for defensive purposes.

Fixed Income

The strategic role of fixed income securities is to diversify the Plan's equity exposure by investing in fixed income securities that exhibit a low correlation to equities and lower volatility; maintain a diversified exposure within the U.S. fixed income market using multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies. It also provides effective diversification against equities and a stable level of cash flow.

Alternative Investments

The strategic role of alternative investments is for diversification relative to equities and fixed income investments, to add absolute return using hedging strategies, and to achieve expected return premiums over longer holding periods. Alternative investments include investments in equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles, hedge funds and private equities and are under the supervision and control of investment managers. Hedge funds include investments in a variety of instruments including stocks, bonds, commodities, and a variety of derivative instruments. Private equities consist primarily of equity investments made in companies that are not quoted on a public stock market, which can include U.S. and non-U.S. venture capital, leveraged buyouts, and mezzanine financing.

Real Estate

The strategic role of real estate is to diversify the Plan's portfolio relative to equities and fixed income investments included a component of real property investment through a commingled fund structure and providing higher returns than benchmark investments of a similar class. Real estate investments may also include publicly and privately traded real estate investment trusts as well as direct investment through properties and mortgages.

(b) Defined Contribution Plans

MHS currently maintains three defined contribution plans including the MHS 401(a) Retirement Account Plan (RAP), the MHS 403(b) Employee Savings Plan, and the MHS 401(k) Plan. Most employees assigned to work at Deaconess Hospital, Valley Hospital, Rockwood Clinic and Capital Medical Center are eligible for participation in the MHS 401(k) Plan, which is funded by both MHS and employee contributions. The MHS 403(b) Employee Savings Plan is 100% funded by employee contributions, and the RAP is 100% funded by MHS contributions.

MHS' funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2021 and 2020 were approximately $54,545 and $49,550, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to the defined benefit and defined contribution plans as described above, MHS also maintains several deferred compensation arrangements for the benefit of eligible employees. Substantially all amounts that are deferred under these arrangements are held in trust until such time as these funds become payable to the participating employees.

(13) Professional Liability

MHS maintains a self-insurance program for professional liability with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability as of December 31, 2021 and 2020, which comprises estimated deductibles and retentions for known claims at year-end and a liability for incurred but not reported claims based on an actuarially determined estimate.

At December 31, 2021 and 2020, the estimated gross professional liability (including current and long-term portions) was $119,073 and $97,997, respectively. The current portion is included in accounts payable and accrued expenses, and the remainder is included in other liabilities, net in the accompanying consolidated balance sheets. MHS has recorded a receivable for amounts to be received from the excess insurance carriers for their portion of the claims (including current and long-term portions) of $33,191 and $32,450 as of December 31, 2021 and 2020, respectively. The current amount is included in other current assets, net, and the remainder is included in other assets, net in the accompanying consolidated balance sheets.

(14) Workers' Compensation and Employee Health Benefit Programs

MHS maintains a self-insurance program for workers' compensation with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability based on an actuarial estimate of future claims payments. At December 31, 2021 and 2020, the estimated net liability based on future claims cost totaled $21,133 and $17,726, respectively. The gross liabilities (including both current and long-term portions) total $24,341 and $21,083 as of December 31, 2021 and 2020, respectively. The long-term amounts are included in other liabilities, net, and the current portions are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets. These liabilities are secured by a letter of credit with the State of Washington. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,207 and $3,357 as of

(Dollars in thousands)

December 31, 2021 and 2020, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

MHS maintains a self-insurance program for employee medical and dental insurance. Employees can elect to be included in the self-insurance plan as a part of their fringe benefit package. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2021 and 2020 was $9,632 and $10,129, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(15) Long-Term Debt

Long-term debt consists of the following at December 31, 2021 and 2020:

	2021	2020
2020 Taxable bonds	$ 300,000	300,000
2020 OCED financing	59,289	60,889
2019 Term loan	35,255	35,255
WHCFA Revenue bonds, 2017 Series A and B	318,220	321,705
WHCFA Revenue bonds, 2017 Series C, D, and E	191,010	191,010
2017 Term loans	130,170	130,170
WHCFA Revenue bonds, 2015 Series A and B	348,085	352,315
WHCFA Revenue bonds, 2012 Series A	60,000	60,000
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
Other	23,106	22,313
	1,563,265	1,571,787
Adjusted for:		
Current portion	(43,609)	(7,950)
Bond premiums, discounts, and debt issuance costs	52,579	55,012
Long-term debt, net of current portion	$ 1,572,235	1,618,849

(a) 2020 Taxable Bonds

In July 2020, MHS issued $300,000 of taxable 2020 series bonds. These bonds were issued as fixed rate bonds that bear interest of 2.803%. The principal of $300,000 is due in 2051, with interest only payments made semiannually in February and August of each year.

(b) 2020 OCED Financing

In June 2020, MHS finalized a sale-leaseback transaction for four off-campus emergency departments (OCED) with total cash proceeds received of $61,794. Due to the specific terms of the agreement, the lease qualified as a financing type lease. The agreement did not meet the criteria for sale-leaseback accounting treatment and instead is considered a financing liability. The agreement bears an implicit interest rate of 4.64%. Annual principal payments range from $2,040 in 2022 to $4,482 in 2039 with a final principal payment of $390 in 2041.

(c) 2019 Term Loan

In August 2019, MHS entered into a fixed rate term loan agreement with JPMorgan Chase Bank, N.A., with an interest rate of 1.89%. The principal balance of $35,255 is due in 2022.

(d) Washington Health Care Facility Authority (WHCFA) Revenue Bonds 2017 Series A and B

In November 2017, MHS issued $333,970 of 2017 Series A and B bonds. These bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.0%. Annual principal payments range from $3,670 in 2022 to $62,410 in 2047.

(e) WHCFA Revenue Bonds 2017 Series C, D, and E

In November 2017, MHS entered into a $111,010 variable rate private placement agreement (Series C and D) with JPMorgan Chase Bank, National Association and an $80,000 variable rate private placement agreement (Series E) with Wells Fargo Municipal Capital Strategies, LLC. The first annual principal payment of $80,000 is due in 2043, with a final principal payment of $55,505 in 2049. The interest rates, which were between 0.5% and 0.6% at December 31, 2021, reset monthly and are based on 70% of the one-month U.S. LIBOR plus a spread.

(f) 2017 Term Loans

In November 2017, MHS entered into two $65,085 variable rate term loan agreements with Wells Fargo Bank, N.A. The principal balance of $130,170 is due in 2047. The interest rates, which were between 0.8% and 0.9% at December 31, 2021, reset monthly and are based on the one-month U.S. LIBOR plus a spread.

(g) WHCFA Revenue Bonds 2015 Series A and B

In April 2015, MHS issued $373,390 of 2015 Series A and B bonds. Series A and B bonds were issued as fixed rate bonds that bear interest ranging from 2.0% to 5.0%. Annual principal payments range from $4,410 in 2022 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(h) WHCFA Revenue Bonds 2012 Series A

In November 2012, MHS issued $60,000 of 2012 Series A bonds. 2012 Series A bonds were issued as fixed rate bonds that bear interest ranging from 3.8% to 4.1%. Annual principal payments range from $5,190 in 2040 to $22,085 in 2045 with a final payment of $19,715 due in 2046.

(Dollars in thousands)

(i) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued the 2009 Series A and B bonds as variable rate demand bonds for $50,000 each. The bonds were backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds that bear interest ranging from 4.4% to 5.0%. Annual principal payments range from $3,690 in 2040 to $38,890 in 2044.

(j) Other

The other debt listed is primarily made up of debt held by Navos. In April 2020, MHS paid $11,488 of Navos' debt outstanding to third-party creditors. Of the outstanding debt at December 31, 2021, $16,965 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. These provisions state that Navos maintains the assets that were built or purchased with these notes and maintains their usage when the promissory note was signed for the length specified. If these provisions are not met, the note must be repaid based on the terms of the agreement. The forgivable debt is subject to a forgiveness provision in years 2028 through 2068.

(k) 2020 Line of Credit

In April 2020, MHS secured a $200,000 line of credit through JPMorgan Chase Bank, N.A. The term of the line of credit is for 12 months and bears interest at a variable rate based upon the Central Bank Floating Rate. The line of credit had no draws and was not renewed.

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2021 and 2020.

Each fixed-rate revenue bond requires semiannual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

Principal maturities on long-term debt are as follows:

Year ending December 31:	
2022	$ 43,609
2023	20,601
2024	21,627
2025	22,704
2026	23,825
Thereafter	1,430,899
	$ 1,563,265

(Dollars in thousands)

A summary of interest costs is as follows during the years ended December 31, 2021 and 2020:

		2021	2020
Interest cost:			
Charged to operations	$	50,103	48,464
Amortization of bond premiums, discounts, and issuance costs		(2,433)	(2,494)
Capitalized		382	478
	$	48,052	46,448

(16) Commitments and Contingencies

Approximately 45% of MHS employees were covered under collective bargaining agreements as of December 31, 2021. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through March 2023.

(17) Leases

(a) Lessee

MHS leases various equipment and facilities under noncancelable operating and finance leases. Lease terms for noncancelable operating leases range from 1 to 18 years, and existing leases have expiration dates through 2036. Lease terms for finance leases range from 1 to 21 years, and existing leases have expiration dates through 2040.

The components of lease cost for the years ended December 31, 2021 and 2020 were as follows:

		2021	2020
Operating lease cost	$	37,283	37,232
Finance lease cost:			
Amortization of right-of-use assets		9,031	1,550
Interest on lease liabilities		3,402	388
Total finance lease cost		12,433	1,938
Short term lease cost		1,578	1,644
Variable lease cost		9,233	7,242
Sublease income		(1,662)	(1,049)
Total lease cost	$	58,865	47,007

(Dollars in thousands)

Other information related to leases as of December 31, 2021 and 2020 was as follows:

	2021	2020
Weighted average remaining lease term (years):		
Operating leases	6.5	6.7
Finance leases	6.6	7.7
Weighted average discount rate:		
Operating leases	4.0 %	4.0 %
Finance leases	4.4	4.4
Operating cash flows from operating leases	$ (36,688)	(36,707)
Operating cash flows from finance leases	(3,402)	(388)
Financing cash flows from finance leases	(8,645)	(1,366)
Right-of-use assets obtained in exchange for new operating lease liabilities	36,385	19,850
Right-of-use assets obtained in exchange for new finance lease liabilities	11,948	16,739

Maturities of lease liabilities under noncancelable leases as of December 31, 2021 are as follows:

	Operating leases	Finance leases	Total
For year ended December 31:			
2022	$ 32,130	5,041	37,171
2023	28,972	4,884	33,856
2024	24,000	4,664	28,664
2025	21,696	2,736	24,432
2026	19,343	503	19,846
Thereafter	41,124	6,351	47,475
Total undiscounted lease payments	167,265	24,179	191,444
Less present value discount	(20,616)	(2,963)	(23,579)
Total lease liabilities	$ 146,649	21,216	167,865

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS, and is the only asset that MHS leases out as a lessor. The lease has a 20 year initial lease term, with four 5 year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40 year lease. There is no purchase option stated

(Dollars in thousands)

in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. At December 31, 2021, MHS' other assets, net include a net investment in lease of $23,172.

Revenue from leases for the years ended December 31, 2021 and 2020 is as follows:

		2021	2020
Interest income on net investment in finance leases	$	1,048	1,136
Variable lease income		28	28
Total lease income	$	1,076	1,164

Future lease payments receivable as of December 31, 2021 are as follows:

Year ended December 31:		
2022	$	1,227
2023		1,227
2024		1,227
2025		1,227
2026		1,227
Thereafter		42,114
Total lease payments to be received		48,249
Less unearned interest income		(25,077)
Net investment in lease	$	23,172

(18) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2021 and 2020:

		2021	2020
Healthcare services	$	57,511	52,151
Endowment funds, perpetual trusts and related receivables		76,079	71,651
Purchase of property, plant and equipment		39,721	16,234
Indigent care		2,167	1,533
Health education		1,264	1,192
Total net assets with donor restrictions	$	176,742	142,761

(Dollars in thousands)

(19) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

The following tables present MHS' endowment net asset composition as well as associated changes therein:

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2020	$ 2,825	42,424	45,249
Investment return:			
Investment income	18	527	545
Net appreciation – realized and unrealized	65	1,289	1,354
Total investment return	83	1,816	1,899
Contributions	—	2,271	2,271
Appropriation of endowment assets for expenditure	(47)	(2,499)	(2,546)
Endowment net assets, December 31, 2021	$ 2,861	44,012	46,873

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2019	$ 2,673	39,700	42,373
Investment return:			
Investment income	39	493	532
Net appreciation – realized and unrealized	153	1,989	2,142
Total investment return	192	2,482	2,674
Contributions	—	443	443
Appropriation of endowment assets for expenditure	(40)	(201)	(241)
Endowment net assets, December 31, 2020	$ 2,825	42,424	45,249

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $31,008 and $28,290, respectively, as of December 31, 2021 and 2020. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $1,059 and $937, respectively, as of December 31, 2021 and 2020.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2021 or 2020.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that an annual spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(Dollars in thousands)

(20) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2021 and 2020:

	2021				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 1,130,560	432,037	65,231	242,817	1,870,645
Employee benefits	128,295	72,692	15,595	61,603	278,185
Supplies	482,058	43,267	66,679	8,753	600,757
Purchased services	132,808	44,695	25,750	145,906	349,159
Depreciation and amortization	70,583	18,057	3,626	34,041	126,307
Interest	40,788	3,936	—	2,946	47,670
Other	293,968	57,179	20,779	114,079	486,005
	$ 2,279,060	671,863	197,660	610,145	3,758,728

	2020				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 969,456	392,470	51,225	202,870	1,616,021
Employee benefits	119,926	66,759	11,931	49,516	248,132
Supplies	416,964	34,712	54,952	13,750	520,378
Purchased services	98,027	25,874	18,409	155,946	298,256
Depreciation and amortization	110,868	17,914	1,921	37,485	168,188
Interest	41,004	3,936	—	1,030	45,970
Other	226,092	49,321	25,724	68,604	369,741
	$ 1,982,337	590,986	164,162	529,201	3,266,686

(21) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(22) Subsequent Events

MHS has evaluated the subsequent events through March 23, 2022, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 17. Medical Director Job Description

MultiCare

MultiCare believes that each employee makes a significant contribution to our success. Contributions can be within and outside of assigned responsibilities. It is our expectation that each employee will offer services wherever and whenever necessary to ensure the success of our endeavors.

JOB TITLE: ASC Site Medical Director **POSITION CODE:** *For HR Use Only*

DEPARTMENT: *MultiCare Capital ASC* **FLSA STATUS:** Exempt

REPORTS TO: *Chief Medical Officer* **DATE:** *July, 5 2022*

GENERAL DESCRIPTION

ASC Site Medical Director(SMD) reports to and their work is overseen by the Chief Medical Officer and performs in collaboration as a dyad with the site ASC Manager. The SMD leads the clinical work of the ASC Site and is accountable for the management of ASC Site providers including engagement, provider performance reviews and adherence to Capital Medical Group (CMG)cultural and other standards, bi-directional communication, and ASC performance.
In this role, the SMD is employed by the Capital Medical Group (CMG)ASC and reports to the Chief Medical Officer (CMO) and functionally to the Assistant Vice President (AVP) and/or Ambulatory Director of CMG. The SMD facilitates communication concerning the ASC work, metrics and performance improvement activities of the ASC and drives collaboration with administrative leaders, ASC Managers, Clinic managers and Directors and Ambulatory AVP. This role is operatively constructed in a formal Dyad relationship with the ASC Manager, and ASC providers functionally report to the SMD for the ASC, operational, financial, and behavioral standards, and performance. This function is foundationally essential to the successful operations of MultiCare Health System (MHS) and CMG.

PRINCIPAL ACCOUNTABILITIES

1. ASC Department Meetings

a. **Participation:** The SMD is expected to attend monthly (or otherwise scheduled) Division and other periodic leadership meetings. The SMD shall sufficiently prepare, read pre-work, and participate in the work of the Department.

b. **Meeting Attendance:** The SMD shall attend at least 75% of Department meetings. This meeting is anticipated to be of at least one- and 1/2-hours duration monthly.

2. Clinic(s) and Providers

a. **Leadership:** The SMD, in close collaboration with CMG leadership and administrative leaders, shall be accountable for the clinical leadership and bi-directional communication necessary for the performance of the assigned clinic(s). This includes a formal role in assuring distributive accountability for clinical, behavioral, cultural, operational, and financial standards, metrics for

assigned clinic providers and team collaboration. The SMD supports their Dyad Practice Manager in the development of and adherence to annual budgets, call schedules, ASC coverage, coding and documentation processes, patient grievances, HeRO clinical review, staff interactions and other management duties. The SMD participates in the Department accountabilities, strategic planning, and interdependency functions necessary to produce the highest possible quality and value clinical product. The SMD role acts as the accountable leader, as needed and as applicable, for clinic drug procurement and appropriate utilization under Drug Enforcement Agency requirements, certain laboratory regulatory functions, vaccine programs and other similar clinical leader management requirements.

b. **Meetings:** The SMD shall be responsible for periodic Department meetings (at least one meeting monthly) as an ASC Operations meeting of such sufficiency to achieve the stated objectives, including the development of agendas, content, and meeting notes. Meetings should be facilitated in person with attendance of clinic personnel expected. As well, other, less formal meetings may from time to time be necessary to achieve the stated objectives.

c. **Communication and Engagement Objectives:** In close collaboration with CMG Ambulatory leaders and the Surgical Medical Director, the SMD is accountable, from a clinical leadership perspective, to explain various rationales and performance plans to achieve the outcomes necessary to achieve Capital Pacific Region (CPR) and MHS Strategies including:

i. Clinic performance to metrics that matter and support System Performance Objectives.

ii. Appropriate adherence to CMG, ASC and MHS cultural, behavioral, administrative, and clinical standards.

iii. Operational performance necessary to achieve the Quadruple Aim (*Better Experience of Care, Better Health for Populations, Lower per Capita Cost and Provider Professional Fulfillment*).

iv. Financial performance required for sustainability.

v. Opportunities for improvement of or introduction of new clinical quality initiatives through PDSA (*plan-do-study-act*) or other evidence-based methodologies.

vi. Opportunities to “bright spot” or employ other methodologies to communicate rapid cycle process improvement successes.

vii. Employee, provider, and patient engagement. As well, and of critical importance, the SMD acts as the champion, role models and excites and engages other clinic personnel in the MHS mission, vision, values, and culture of excellence.

d. **Performance Improvement:** Achieve familiarity and facilitate the information tools, systems, processes, methodologies, reporting functions necessary to guide clinic and department results and interact with system resources (*i.e., Organizational Effectiveness, IS&T, Human Potential, Organizational Development*) as appropriate and available.

- Adheres to MHS Attendance and Punctuality Policy and Procedure standards, and maintains reliable attendance
- Contributes to the success of the organization by meeting organizational competency expectations and core values (respect, integrity, stewardship, excellence, collaboration, and kindness), continuously learning, and by performing other duties as needed or assigned

VALUES BASED BEHAVIORS

– Respect: Seek first to understand
– Integrity: Do the right thing
– Stewardship: Live lean
– Excellence: Be your best/Act for safety's sake
– Collaboration: Team up
– Kindness: Create warmth and comfort

MHS Performance Standards

- Adheres to MHS Attendance and Punctuality Policy and Procedure standards. Maintains reliable attendance
- Contributes to the success of the organization by meeting organizational competency expectations and core values (Respect | Integrity | Stewardship | Excellence | Collaboration | Kindness), continuously learning, and by performing other duties as needed or assigned

LEADERSHIP COMPETENCIES

Personal Competencies
- Integrity
- Accountability
- Self-Development

Interpersonal Competencies
- Communication
- Collaboration
- Fostering Teamwork
- Developing Others

Organizational competencies
- Customer Focus
- Quality and Strategic Focus
- Financial and Operational Management

MINIMUM QUALIFICATIONS

KNOWLEDGE, SKILLS, & ABILITIES

The SMD must be a credible and practicing provider (physician or advanced practice provider) and shall be able to effectively manage meetings, bi-directionally communicate and engage, and hold providers and clinical personnel appropriately accountable. The SMD must collaborate with others to articulate and implement plans that lead to successful performance of the ASC, CMG and MHS.

– Clinical credibility as determined by CMG leadership
– Strong interpersonal and communication skills
– Commitment to leadership training and capabilities growth
– Ability to effectively prepare, present, champion and discuss reports, metrics and performance improvement/project management efforts with providers, clinical staff, and administrative personnel
– Ability to develop and implement mechanisms of accountability for operational, financial, clinical, and behavioral metrics and cultural standards
– Ability to maintain confidentiality as the nature of the information and data available to this position
– Ability to separate personal motivation from the needs of the team, department and MHS
– Ability to work independently and take initiative

– Ability to accept responsibility willingly
– Ability to set priorities and use good judgment
– Skill in time management, including in carving out dedicated administrative time, and ability to meet deadlines
– Knowledge of and skill in the use of personal computer and related software and system

- Oversees staff providing direction and guidance and administering management functions within the provisions of MultiCare policies and standards and federal, state, and local regulations.
- Knowledge of the principles of ASC operations to effectively analyze data and make decisions
- Skill in directing the work and activities of staff with the ability to delegate effectively
- Skill in providing leadership and in the mentoring of staff
- Skill in time management and ability to meet deadlines
- Skill in creating high-performing teams
- Ability to establish a climate that achieves optimal performance levels
- Ability to establish and maintain a cohesive work team
- Ability to work independently and take initiative
- Ability to accept responsibility willingly
- Ability to communicate effectively
- Ability to set priorities and use good judgment
- Ability to be caring, sympathetic, calm, and able to work as part of a team

EDUCATION & EXPERIENCE

- Active MD, DO, ARNP, or PA-C licensure and other associated credentials determined relevant by the CMG Chief Medical Officer and relevant facility privileges as applicable
- Previous leadership experience preferred
- Completion of formal leadership training preferred

PHYSICAL & ENVIRONMENTAL FACTORS

Job descriptions represent a general outline of job duties, functions, and qualifications. They are not intended to be comprehensive in nature. In addition, jobs evolve over time and therefore their description may not reflect the precise nature of the position at a given point in time.

It is MultiCare's policy to base hiring decisions solely on the individual's ability to perform essential job functions. Persons with disabilities are eligible for this position provided they can perform those functions with reasonable accommodation.

Original Approval: Will Callicoat, President
Reviewed/Revised: Bill Kriegsman, CMO
Reviewed/Revised: Robin Henrich, Ambulatory Director
Reviewed/Revised:

Exhibit 18. List of Physician Names, License Numbers, and Specialties

MultiCare Health System - NEWDIV Thurston ASC

List of Physician Names, License Numbers, and Specialties

Certificate of Need Application

NAME	License Number	Specialty
Dr. Jordan Mulder	OP60262509	ENT
Dr. Alan Cowan	MD60511902	ENT
Dr. Marshall McCabe III	MD00023393	GI
Dr. Marshall McCabe IV	OP60945227	GI
Dr. Keaton Jones	MD60838593	GI
Dr. John Kuczynski	MD60202111	GI
Dr. Darien Heap	MD00044714	GI
Dr. Michelle Thompson	OP60726268	GI
Dr. Nathaniel Paull	MD60583701	General Surgery
Dr. Monica Young	MD60639187	General Surgery
Dr. Timothy Feldmann	MD60654251	General Surgery
Dr. Salam Hallak	MD60232079	General Surgery
Dr. Laurel Dickason	MD00033356	OB/Gyn
Dr. Kym Walker	MD00048276	OB/Gyn
Dr. Rishi Patel	MD61288965	General Surgery
Dr. Casey Bowles	PO60653492	Podiatry
Dr. Michael Lundborg	PO60886423	Podiatry
Dr. Adam Saleh	PO60906672	Podiatry
Dr. Richard Greene	MD60908938	Urology
Dr. Patrick Murray	MD60835685	Urology
Dr. John Muenchrath	MD60675016	Urology
Dr. Rachel Carlin	MD61273843	Neurology

Exhibit 19. Transfer Agreement

MULTICARE HEALTH SYSTEM
PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is made by and between MultiCare Health System ("MHS"), a nonprofit corporation formed under the laws of the State of Washington and Columbia Capital Medical Center, DBA MultiCare Capital Medical Center ("Facility"), an Acute Care Hospital formed under the laws of the State of _Washington, 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. MHS and Facility are sometimes referred to in this Agreement individually as "Party" or, collectively, as the "Parties."

NOW, THEREFORE, MHS and Facility agree as follows:

1. Term of Agreement. This Agreement shall be effective April 1, 2021 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 Party. In the event of a transfer, the transferred patient will qualify for admission to the receiving Party on an emergency basis. If a transferred patient does not have an attending provider able to continue care at the receiving Party, the receiving Party may refer the patient to an appropriate attending provider.

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 A.
b. Patients transferred to neuro interventional radiology must meet the requirements set forth on Exhibit B.
c. Patients transferred for obstetrics must meet the requirements set forth on Exhibit C.
d. Neonate patient transfers must meet the requirements set forth on Exhibit D.
e. Pediatric patients transferred to Mary Bridge Children's Hospital and Medical Center 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 with emergency medical condition within the meaning of the Emergency Medical Treatment and Active Labor Act (codified at 42 USC § 1395dd) 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 will accept the patient. To the extent applicable, the Emergency Medical Treatment and Active Labor Act of 1985 (the "Act") and its implementing regulations shall supersede any contrary provision of this Agreement.

6. Patient Medical Records. The transferring Party shall send with each transferred patient copies of pertinent medical and other information necessary to continue the patient's treatment without interruption including, without limitation, a discharge summary and 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. Unless otherwise agreed, the transferring Party shall arrange 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. 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's facility.

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) for the transfer.

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 Party, further agrees to accept "block transfers" of as many patients sent from the sending Party as may be practicable, in order to free up beds in the facility of the Party 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 Party are better understood in the context of the event, the sending Party will advise the receiving Party 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 sending Party or remaining at the receiving Party.

12. Nondiscrimination. Neither Party may refuse to receive a patient by reason of such patient's race, religion, gender, age, national origin, sexual orientation, marital status, handicap, disability or medical diagnosis in providing services under this Agreement.

13. Patient Infectious Disease Status. Sending Facility will share all known infectious diseases occurring to include carrier of Multi Drug Resistant Organisms to accepting facility at time of transition discussion and within the patients' medical records.

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 patients transferred 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 thirty (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. 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.

21. Claims. The Parties shall promptly notify one another in writing of any claim or demand to indemnify arising out of performance of transfer pursuant to this Agreement and shall cooperate with one another in a reasonable manner to facilitate the defense of such claim.

22. 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.

23. Assignment. This Agreement may not be assigned by either Party without the prior written consent of the other Party.

24. Severability. If any part of this Agreement is held to be unenforceable, the remainder of this Agreement will remain in full force and effect.

25. Amendments. This Agreement may be supplemented, amended, or revised only in writing by agreement of both Parties.

26. 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.

27. 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.

28. 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.

Signature Page to Follow

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed to be effective the day and year set forth above.

	MultiCare Health System:	**Columbia Capital Medical Center (DBA as MultiCare Capital Medical Center)**
By:	Deena Hannen	William Callicoat
Print Name:	Deena Hannen	Will Callicoat
Title:	Vice President Case Management	President-CapMC & Mrkt Ldr Thurston Co
Date:	07/20/2021 02:49 PM EDT	07/20/2021 03:38 PM EDT
	MultiCare's Contact Information:	Columbia Capital Medical Center Contact Information:
Designated Representative:	Deena Hannen	Will Callicoat
Designated Representative Title:	Vice President Case Management	President-CapMC & Mrkt Ldr Thurston Co
Address:	PO Box 5299 Tacoma, Washington 98415	3900 Capital Mall Dr. SW Olympia, WA 98502
Telephone:	243-403-9375	253-403-1453
Email Address:	hannede@multicare.org	
E-mail address:		wcallicoat@multicare.org
Copy to Email:	ContractSupport@multicare.org	

Exhibit A

Requirements for Elective PCI Patients

Purpose: This Exhibit A to the Patient Transfer Agreement (the "Agreement") between MultiCare Health System ("MHS") and Columbia Capital Medical Center ("Facility"), applies to patients transferred to MHS' Tacoma General Hospital in order to obtain cardiac surgery back-up and support due to undergoing elective percutaneous coronary interventions without on-site cardiac surgery ("PCI Patients"). MHS and Facility are sometimes referred to in this Exhibit A individually as "Party" or, collectively, as the "Parties."

1. Consent. In addition to the requirements set forth in the Agreement, the Party performing the intervention or PCI shall obtain 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 which would require a transfer to MHS' Tacoma General Hospital for on-site surgery back-up, 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 and that the only MHS Hospital that has on-site surgery back-up is MHS' Tacoma General Hospital.

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.
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 the Party 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 6 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 Patient Transfer Agreement between MultiCare Health System ("MHS") and Columbia Capital Medical Center ("Facility"), applies to stroke patients transferred to a MHS neuro-interventional radiology program ("Stroke Program"). MHS and Facility are sometimes referred to in this Exhibit B individually as "Party" or, collectively, as the "Parties."

1. Coordination. The Parties shall coordinate, to the extent possible, transfer process and communication through the MultiCare Health System Transfer and Triage Center. There is a reasonable likelihood that MHS has the capacity to immediately accept a transfer.

2. 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.

3. Transportation of Stroke 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 stroke patient that requires transfer to MHS. A qualified vendor is one whose transport staff is ACLS certified; critical care transport is preferred.

b. The patient's medical condition and the ability of the transferring hospital to provide necessary stabilizing treatment and the clinical judgment of the transferring and receiving physicians is the determining factor as to when the patient should be transferred.

c. Provide the following patient care including:
-IV access (Preference is RAC and Left arm 18 gauge if possible)
-Use Normal saline for all fluids
-NPO unless patient passed a documented RN swallow screen (consider gastric tube for medications)

4. Stroke Patient Medical Records. In addition to the information required in Section 6 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.

5. **Physician Communication**. Facility will monitor all transfers to assure that the receiving physician immediately is available to address the clinical reasons for the urgent transfer and patient's clinical condition.

7. **Quality Assurance**. The receiving facility shall provide hospital summary after discharge. This is handled by the MHS Transfer and Triage Center. The receiving facility reviews 100% of transfers, coordinated by the Director of Stroke Quality Management. Summary reports are provided on a quarterly basis to the sending facilities.

Exhibit C

Requirements for Obstetric Patients

Purpose: This Exhibit C to the Patient Transfer Agreement between MultiCare Health System ("MHS") and Columbia Capital Medical Center ("Facility"), applies to obstetric patients transferred to a MHS location. MHS and Facility are sometimes referred to in this Exhibit E individually as "Party" or, collectively, as the "Parties."

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 Section 4 below, All MHS Obstetrics Transfers.

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 transferred 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 Section 4 below, All MHS Obstetrics Transfers.

4. **All MHS Obstetrics Transfers.** After consultation, if the patient is accepted for transfer, follow sending Party'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

(documentation of which shall be provided under Section 4(d) below), 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 Party, 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 Party through EPIC or other systems maintained by MHS at the receiving Party:
    i. Copy of the patient's hospital chart including:
        1. Prenatal record
        2. Allergies
        3. Past medical history, home medications
        4. Medications and treatment at the transferring Party
        5. Summary of current complaint to include onset, signs and symptoms
        6. Demographic face sheet
        7. Documentation of the (1) labor assessment, (2) last exam, (3) fetal heart rate and (4) vital signs.

Exhibit D

Requirements for Neonates

Purpose: This Exhibit D to the Patient Transfer Agreement between MultiCare Health System ("MHS") and Columbia Capital Medical Center ("Facility"), applies to neonate patients transferred to a MHS location. MHS and Facility are sometimes referred to in this Exhibit D individually as "Party" or, collectively, as the "Parties."

1. **Contact Numbers:**
    a. Transfers to TG: (253-403-1024)
    b. Transfers to GSH: (253-697-5900)
    c. Transfers to AMC: (253-545-2522 and request the NICU dept)

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 by the neonatologist, 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):
        i. Signed, dated, and timed "Neonatal Transport Consent"
        ii. Signed, dated, and timed "Notice of Privacy Practices Acknowledgement Form"
        iii. Signed, dated, and timed "Authorization for MultiCare to use or disclose My Health Care Information"
        iv. Provide copies of the patient/maternal chart:
            1. All maternal documentation (i.e. Maternal History/physical; lab values; delivery notes; nurses/physician notes; etc.)
            2. 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. Any patient less than 34 weeks or deemed high risk must be transferred 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 Party's policies for transferring a patient to another facility.
    e. Prior to the patient's departure from the transferring Party, a hand off report to the Special Care Nursery Nurse must occur.
    f. In addition to the requirements of this Agreement, provide the following, if such records are not directly available at the receiving Party through EPIC or other systems maintained by MHS at the receiving location:
        i. Copy of the patient's hospital chart including:
            1. Birth record

2. Medications and treatment at the transferring Party
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

Exhibit E

Requirements for Pediatric Patients

Purpose: This Exhibit E to the Patient Transfer Agreement between MultiCare Health System ("MHS") and Columbia Capital Medical Center ("Facility"), (collectively referred to as the "Party" or "Parties") applies to pediatric patients transferred to Mary Bridge Children's Hospital.

1. **Contact Numbers:**

Transfer to Mary Bridge Children's Hospital:

Contact the Transfer Center (855-647-1010)

2. **Transfers to Mary Bridge:** Facility shall adhere to the following when requesting a transfer to Mary Bridge Children's Hospital:
    a. Contact the transfer center to get in touch with any of the following Inpatient Physician Services (IPS), Emergency Department physician or Pediatric Intensivist. (855-647-1010)
    b. The transfer center will connect the referring physician to the correct MB physician to consult and accept transfer.
    c. If the patient is accepted for transfer by the MB designated physician, the MB physician will offer the pediatric transport team (TT) to come and retrieve the patient.
    d. In the event that the TT is not available, the referral physician and the MB physician will discuss the safest alternative mode of transportation for the patient.
    e. 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, dated, and timed "Transport Consent"
        2. Signed, dated, and timed "Notice of Privacy Practices Acknowledgement Form"
        3. Signed, dated, and timed "Authorization for MultiCare to use or disclose My Health Care Information"
        4. Provide copies of the patient's chart:
            1. All pediatric documentation: (i.e. Admission physical, lab values, radiology studies, nursing notes, physician notes, transfer summary, etc.)
        5. Signed, dated, and timed "Passenger Release of Liability"
            1. It will be at the TT discretion to allow 1 family member to accompany the patient in the ambulance. So long as the patient's status is stable, and the family member will not be a hindrance to the safe transport of the patient.