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

September 3, 2024

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

RE: MultiCare Health System Skilled Nursing Facility Certificate of Need Application, Yakima County Washington, Submitted Electronically September 3, 2024

Dear Mr. Hernandez:

I am pleased to submit this certificate of need application request on behalf of MultiCare Health System for a 32-bed skilled nursing facility in Yakima County.

MultiCare acquired Yakima Memorial Hospital, which included the 20-bed hospice house Cottage in the Meadow. While this hospice house was needed in earlier years, changes in hospice care delivery and patient preferences have resulted in the majority of the facility sitting empty. This idle capacity made the operation of Cottage in the Meadow unsustainable, and in August 2024, the facility was closed.

The motivation for this application is to repurpose what was previously a hospice house with a 32-bed Skilled Nursing Facility ("SNF"). Based on MultiCare's experience, and the Department of Health's Skilled Nursing Facility Need Methodology, there is a current need for additional skilled nursing services in Yakima County. The existing structure, well-suited for a repurpose from a hospice house to a SNF, is an opportunity to help meet that need without incurring construction costs for a new building.

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

K. Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
253.403.8771
ekobberstad@multicare.org

Frank Fox, PhD
HealthTrends
206.914.8866
frankfox@comcast.net

Thank you for your assistance regarding this request.

Sincerely,

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

Washington State Department of Health

Certificate of Need Program
P.O. Box 47852
Olympia, Washington 98502-7852

Official Use Only-Date Received:

APPLICATION FOR CERTIFICATE OF NEED
Nursing Home Projects
(Excluding CCRC)

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990 and the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions of Chapter 70.38 Revised Code of Washington (RCW) and Rules and Regulations adopted by the Department (WAC 246-310). I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

APPLICANT(S)

OWNER:
K. Erin Kobberstad, Vice President, Strategic Planning
Name and Title of Responsible Officer
(PLEASE PRINT OR TYPE)
Legal Name of Owner:
MultiCare Health System
Address of Owner:
PO Box 5299, MS: 820-4-SBD
Tacoma WA 98415

K Erin Kobberstad
Signature of Responsible Officer
Date: 8/30/24 Telephone: (253) 403 – 8771

OPERATOR:
K. Erin Kobberstad, Vice President, Strategic Planning
Name and Title of Responsible Officer
(PLEASE PRINT OR TYPE)
Legal Name of Operator:
MultiCare Health System
Address of Operator:
PO Box 5299, MS: 820-4-SBD
Tacoma WA 98415

K Erin Kobberstad
Signature of Responsible Officer
Date: 8/30/24 Telephone: (253) 403 – 8771

TYPE OF OWNERSHIP:
[ ] District
[X] Private Non-Profit
[ ] Proprietary - Corporation
[ ] Proprietary - Individual
[ ] Proprietary - Partnership
[ ] State or County

Proprietor(s) or Stockholder(s) information:
Provide the name and address of each owner and indicate percentage of ownership:
PO Box 5299, MS: 820-4-SBD
Tacoma WA 98415

OPERATION OF FACILITY:
[X] Owner Operated
[X] Management Contract
[ ] Lease

TYPE OF PROJECT *(check all that apply):*
[ ] Total Replacement of Existing Facility
[X] New Facility
[ ] Renovation/Modernization
[ ] Bed Addition
[ ] Capital Expenditure Over the Minimum
[ ] Bed Capacity Change/Redistribution
[ ] New Institutional Health Service
[ ] Mandatory Correction of Fine/Deficiencies
[ ] Amend Current Certificate of Need
[ ] Expansion/Reduction of Physical Plant
[ ] Other _____

Intended Project Start Date: April 2025
ESTIMATED CAPITAL EXPENDITURE: $ 468,892
Intended Project Completion Date: October 2025

Project Description: Establishment of a new 32-bed Skilled Nursing Facility in Yakima County, WA.

INSTRUCTIONS FOR COMPLETION OF RATIO INFORMATION FOR ALL NURSING HOME PROJECTS

Utilizing the data from the financial statement submitted in the application, calculate the debt services coverage, current ratio, assets financed by liabilities ratio, and the total operating expenses to total operating revenue ratio. The method of calculating these ratios is listed below. Enter the ratio figures in the table on the next page. The normal or expected value for each of these ratios is: Debt Service Ratio 1.5 - 2.0; Current ratio 1.8 - 2.5; Assets Financed by Liabilities Ratio 0.6 - 08; and Total Operating Expense to Total Operating Revenue ratio 1.0. If the project's calculated ratios are outside the normal or expected range, please explain.

METHOD FOR CALCULATING FINANCIAL RATIOS

For each financial or calendar year, as appropriate, calculate the current ratio, the assets financed by liabilities ratio, the total operating expense to total operating revenue ratio, and the debt service coverage ratio:

RATIO	CALCULATION	LINE ITEMS
Current Ratio	Current Assets --- Current Liabilities	Schedule B, Line 14 --- Schedule B, Line 50
Assets Financed by Liabilities	Current Liabilities + Long Term Liabilities --- Total Assets	Schedule B, Line 50 + 60 --- Schedule B, Line 39
Total Operating Expense to Total Operating Revenue	Total Operating Expense --- Net Operating Revenue	Schedule C, Line 22 --- Schedule C, Line 9
Debt Service Coverage	Net Income + Interest Expense + Depreciation --- Current Portion of Long-Term Debt + Interest Expense	Schedule C, Line 28 + Schedule G, Line 160 + 158 --- Schedule B, Line 44 + Schedule G, Line 160

The financial ratios should be entered on the financial ratio table shown on page 5.

APPLICATION INFORMATION INSTRUCTIONS

These application information requirements are to be used in preparing a Certificate of Need application.

The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 78.38.115 and WAC 246-310-210, 220, 230, 240, 370, and 380.

- **The application must be submitted with a completed and signed Certificate of Need application face sheet and the appropriate review and processing fee. Send the original and a CD of the application to:**

  Department of Health
  Certificate of Need Program
  P O Box 47852
  Olympia, Washington 98504-7852

- **Submit a copy of the Letter of Intent for this project in the application.**

- **Please make the narrative information complete and concise. Data sources are to be cited. Extensive supporting data, that would tend to interrupt the narrative, should be placed in the appendix.**

- **All cost projections are to be in non-inflated dollars. Use the current year dollar value for all proforma data and projections. DO NOT inflate these dollar amounts.**

- **Capital expenditures should not include contingencies. Certificate of Need statute and regulation allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate of Need is required.**

MultiCare Health System

Certificate of Need Application
To Establish and Operate a Skilled Nursing Facility in Yakima County, Washington

September 3, 2024

Table of Contents

Table of Tables

Exhibit List

Exhibit No.	Exhibit Title
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2	Management Services Agreement
3	Single Line Drawings
4	Site Control Documents
5	Financial Assistance Policy
6	Admission Policies
7	Letter of Financial Commitment
8	MultiCare Health System Audited Financial Statements
9	Pro Forma Financial Statements
10	Letter from Avalon Compliance Officer
11	Example Hospital Transfer Agreement
12	Facility Discharge and Continuity of Care Policies

I. Introduction and Rationale

MultiCare Health System ("MultiCare"), a locally-governed, not-for-profit, integrated health system that owns and operates twelve hospitals and over 240 primary, specialty, and urgent care clinics throughout the Puget Sound, Yakima Valley, and Inland Northwest Regions, seeks Certificate of Need approval to operate a Medicare certified and Medicaid eligible Skilled Nursing Facility to serve residents of Yakima County in Washington State. MultiCare provides care across the continuum to Yakima residents through Yakima Valley Memorial Hospital, and the proposed project would represent an expansion of these services to include skilled nursing. The proposed Skilled Nursing Facility will complement MultiCare's provision of services across the care continuum, including home health and hospice services in King, Pierce, and Kitsap counties, and inpatient hospital services at its facilities in Spokane, Yakima, Thurston, Pierce, and King counties. It was also recently approved for hospice services in Thurston County (through PNW Hospice, LLC) and home health care in Kitsap and Thurston counties, and provides hospice care through MultiCare Yakima Memorial Hospital in Yakima County.

With its acquisition of Yakima Memorial Hospital, MultiCare obtained the 20-bed hospice house (Cottage in the Meadow). While this hospice house was needed in earlier years, changes in hospice care delivery and patient preferences have resulted in the majority of the facility sitting empty – at most, four of the twenty beds were in use for hospice house patients at a given time. This idle capacity made the operation of Cottage in the Meadow unsustainable, and in August 2024 the facility ceased hospice operations.

The motivation for this application is to repurpose what was previously a hospice house with a 32-bed Skilled Nursing Facility. Based on MultiCare's experience, and the Department of Health's Skilled Nursing Facility Need Methodology, there exists need for additional skilled nursing services in Yakima County. The existing structure, well-suited for a repurpose from a hospice house to a Skilled Nursing Facility, is an opportunity to help meet that need without incurring construction costs for a new building.

The proposed facility will be managed by Avalon, a leader in the skilled nursing industry for over 40 years. Avalon currently owns or manages 16 skilled nursing facilities across five states, including seven within Washington State, where Avalon has operated for more than 20 years. Another two facilities that will be owned or managed by Avalon in Washington are currently in development.

Over the past decade, Avalon has successfully planned, developed, financed, constructed, and operated five new skilled nursing facilities, showcasing its expertise in building facilities from the ground up. Avalon's CEO, Alan Hash, has personally overseen the development and opening of two skilled nursing facilities in Washington State: ManorCare of Lacey and ManorCare Salmon Creek.

MultiCare will provide skilled nursing services to all qualifying patients regardless of the patient's ability to pay for medically necessary health care services. Financial assistance for patients and their families will be based on MultiCare's Financial Assistance Policy. MultiCare has a documented history of providing financial assistance to its patients that exceeds the respective regional averages of other hospitals in the service areas it serves. This demonstrates MultiCare's commitment to provide quality health services to patients regardless of payer coverage or ability to pay, and who are unable to pay for medically necessary health care services. This commitment extends beyond just hospital care, as MultiCare provides financial assistance and support to its patients across the care continuum, and it will include those patients requiring skilled nursing services in Yakima County.

II. Applicant Description

Note: The term "applicant" for this purpose is defined as any person or individual with a ten percent or greater financial interest in a partnership, corporation, or other comparable legal entity or lessee that engages in any undertaking subject to review under provisions of RCW 70.38.

A. OWNER DESCRIPTION

1. Legal name(s) of owner(s)

MultiCare Health System.

2. Address of each owner

PO Box 5299, MS: 820-4-SBD
Tacoma, WA, 98415

Please see Exhibit 1 for our Letter of Internt.

3. Provide the following information about each owner:

a. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division. Show relationship to any organization as defined in Section 405.427 of the Medicare Regulations.

b. If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

MultiCare is not an out-of-state corporation, thus this question is not applicable

B. OPERATOR DESCRIPTION

1. Legal name and address of operating entity (unless same as owner).

While not the owner or operator, MultiCare intends to engage Avalon Care Center – Cottage in the Meadow, L.L.C. (“Avalon”) to manage the proposed Skilled Nursing Facility through a management services agreement. We include a draft of this agreement and intent to sign in Exhibit 2.

Consistent with guidance from the Department of Health during a Technical Assistance call,[1] we include information for both MultiCare and Avalon for his Section — “Operator Description.”

Avalon Care Center – Cottage in the Meadow, L.L.C.
206 N 2100 W
Salt Lake City, Utah 84116

[1] Technical Assistance (“TA”) Call, August 12, 2024. Based on the TA call discussion, the Department requested that information be included for Avalon for the “Operator Description” section of this form of application.

a. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

The owning entity, and holder of the facility license is MultiCare. It is not an out-of-state corporation.

The entity that MultiCare intends to engage pursuant to a management services agreement, Avalon, is registered within Washington State. Its UBI number is 605 607 027.

b. If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

This question is not applicable.

c. Is the applicant currently, or does the applicant propose to be reimbursed for services provided under Title V, Title XVIII, and/or Title XIX of the Social Security Act?

Given approval of the proposed project, MultiCare intends to be reimbursed for services provided under Title XVIII and Title XIX of the Social Security Act, but not Title V of the Social Security Act.

d. Name, title, address, and telephone number of the person to whom questions regarding this application should be directed.

Please direct questions regarding this application to:

K. Erin Kobberstad
Vice President, Strategic Planning
MultiCare Health System
Office phone: (253) 403 – 8771
Email: ekobberstad@multicare.org

And:

Frank Fox, PhD
HealthTrends
Office phone: 206-914-8866
Email: frankgfox@comcast.net

e. Provide separate listings of each Washington and out-of-state health care facility, including name, address, Medicare provider number, Medicaid provider number, owned and/or managed by each applicant or by a related party, and indicate whether owned or managed. For each

out-of-state facility, provide the name, address, telephone number, and contact person for the entity responsible for the licensing/survey of each facility.

Please see Table 1 for a list of facilities owned and/or managed by MultiCare Health System.

Table 1: MultiCare Health System Facility List

Facility/Agency Name	Address	License Number	Medicare Provider Number	Medicaid Provider Number
MultiCare Mary Bridge Children's Hospital	311 Martin Luther King Jr. Way, Tacoma WA 98403	HAC.FS.00000175	503301	3300340
MultiCare Auburn Medical Center	202 North Division St., Auburn WA 98001	HAC.FS.60311052	500015	2022467
MultiCare Behavioral Health - Auburn Medical Center	202 North Division St., Auburn WA 98001	BHA.FS.60872672	50-S015	3149101
MultiCare Deaconess Hospital	800 West 5th Ave Spokane, WA 99204	HAC.FS.60769397	500044	2083493
MultiCare Valley Hospital	12606 East Mission Ave. Spokane Valley 99216	HAC.FS.60769398	500119	2083494
MultiCare Covington Medical Center	17700 SE 272nd St, Covington, WA, 98042	HAC.FS.60803817	500154	2102039
MultiCare Tacoma General Hospital	315 Martin Luther King Jr. Way, Tacoma WA 98405	HAC.FS.00000176	500129	3300332
MultiCare Tacoma General Behavioral Health Adolescent Inpatient Services	315 Martin Luther King Jr Way, Tacoma, WA, 98405	BHA.FS.60873367	50-0129	2071315
MultiCare Allenmore Hospital (joint license with Tacoma General Hospital)	1901 S. Union Avenue, Tacoma WA 98405	HAC.FS.00000176	500129	3300332
MultiCare Good Samaritan Hospital	407 14th Ave. SE Puyallup, WA 98372	HAC.FS.60221541	500079	3308707
MultiCare Good Samaritan Hospital, Inpatient Rehabilitation	401 15th Ave. SE, Puyallup, WA 98372	BHA.FS.61030776	50T079	3200094
NAVOS	2600 Southwest Holden, Seattle, WA 98126	HPSY.FS.00000019	504009	3500311
Wellfound Behavioral Health Hospital*	3402 S. 19th Street, Tacoma, WA 98405	HPSY.FS.60919628	504016	150453
MultiCare Home Health, Hospice and Palliative Care	1313 Broadway Ste 200, Tacoma, WA, 98402	IHS.FS.60081744	HH - 507046; Hospice-501508	HH-1043537; Hospice-2012298
MultiCare Surgery Center	1519 3rd Street, Ste 240, Puyallup, WA 98372	ASF.FS.60534460	Pending	Pending

MultiCare Yakima Memorial Hospital	2811 Tieton Dr, Yakima, WA, 98902-3761	HAC.FS.00000058	500036	3307501
PNW Hospice	1313 Broadway Ste 500, Tacoma, WA 98402	IHS.FS.61337353	Pending	Pending
MultiCare Capital Medical Center	3900 Capital Mall Drive SW, Olympia, WA 98502	HAC.FS.60986502	500139	33065
MultiCare Surgery Center - Yakima	1111 South 11th Avenue, Suite 220 Yakima WA 98902	Pending	Pending	Pending

Notes:
*Wellfound Behavioral Health Hospital is a JV facility.
Recent acquisitions include MultiCare Capital Medical Center (April 2021), MultiCare Yakima Memorial Hospital (January 2023), MultiCare Surgery Center (September 2023), and MultiCare Surgery Center – Yakima (September 2024).

As the managing entity, we also include a facility list for Avalon Healthcare in Table 2.

Table 2: Avalon Healthcare Facility List

Facility	Address	Medicare #	Medicaid #	Control
California Facilities				
Avalon Care Center-Merced Franciscan, L.L.C. d/b/a Franciscan Post-Acute Care Center	3169 M Street, Merced, 95348	05-5979	ZZR05979H	Managed
Avalon Care Center-Newman, L.L.C. d/b/a San Luis Care Center	709 N Street, Newman, 95360	05-5839	ZZR05839H	Managed
Hawaii Facilities				
Avalon Care Center-Honolulu, L.L.C.	1930 Kamehameha IV Rd., Honolulu, 96819	12-5020	54946201	Managed
Oregon Facilities				
Avalon Care Center-Portland, L.L.C. d/b/a Avalon Care Center-Portland	12640 SE Bush St. Portland, 97236	NA	ICF: 500807400	Owned
Avalon Care Center - Scappoose, LLC	33910 E Columbia Ave, Scappoose, 97056	Pending	500837698	Owned
Utah Facilities				
Avalon Care Center-VA Salt Lake II, L.L.C. d/b/a William E. Christoffersen Salt Lake Veterans Home	700 S. Foothill Drive, Salt Lake City 84113	46-5150	1972754133	Managed
Avalon Care Center-VA Ogden, L.L.C. d/b/a George E. Wahlen Ogden Veterans Home	1102 N. 1200 W., Ogden 84404	46-5172	1114253275	Managed

Avalon Care Center-VA Payson, L.L.C. d/b/a Mervyn Sharp Bennion Central Utah Veterans Home	1551 N. Main St., Payson 84651	46-5181	1205177722	Managed
Avalon Care Center-VA Ivins, L.L.C. d/b/a Southern Utah Veterans Home-Ivins	160 N. 200 E., Ivins 84738	46-5180	1366783466	Managed
Washington Facilities				
Avalon Care Center – Federal Way, L.L.C.	135 S 336th St., Federal Way 98003	50-5510	4113551	Managed
Avalon Care Center-Aberdeen, L.L.C. d/b/a Grays Harbor Health & Rehabilitation Center	920 Anderson Dr., Aberdeen 98520	50-5016	4113569	Managed
Avalon Care Center-Kent, L.L.C. d/b/a Benson Heights Rehabilitation Center	22410 Benson Rd SE, Kent 98031	50-5519	4113635	Managed
Avalon Care Center-Pasco, L.L.C. d/b/a Avalon Health and Rehabilitation Center-Pasco	2004 N 22nd Ave., Pasco 99301	50-5126	4113627	Managed
Avalon Care Center-Spokane, L.L.C. d/b/a Avalon Care Center at Northpointe	9827 N. Nevada St., Spokane 99218	50-5496	4113585	Managed
Avalon Care Center - Bellingham, LLC d/b/a Avalon Healthcare - Bellingham	3121 Squalicum Pkwy, Bellingham, 98225	Pending	Pending	Owned
Avalon Care Center - Tacoma, LLC d/b/a Avalon Healthcare - Tacoma	7411 Pacific Ave, Tacoma, 98408	Pending	Pending	Owned
Notes: Agency name for California facilities:				

Regulatory agencies for out of state facilities:

California
CDPH - Fresno District Office
Address: 285 W Bullard Ave. Suite 101 Fresno, CA 93704
Phone: (559) 437-1500
Contact Name: Iris DelRosario

Hawaii
Office of Health Care Assurance, Medicare Section
Hawaii State Department of Health Ka 'Oihana Olakino
Address: 601 Kamokila Boulevard, Suite 395, Kapolei, Hawaii 96707
Phone: (808) 692-7420

Contact Name: Gina AK LeTourneur

Oregon
OHA- Health Facility Licensing and Certification Program
Address: 800 NE Oregon Street, Suite 465
Portland, OR 97232
Phone: 971-673-0540

Utah
State of Utah Department of Health & Human Services: Division of Licensing
Address: 195 North 1950 West, SLC, UT 84116
Phone: (801) 538-4242
Contact Name: Kelly Criddle

III. Facility Description

A. Name and address of the proposed/existing facility.

The proposed facility will be located at 1208 S 48th Ave, Yakima, WA 98908.

B. Provide the following information:

		Nursing Home		Boarding Home
		(SNF/ICF)		(Cong.)
Total number of beds currently licensed		0		N/A
Total number of beds currently set-up		0		N/A

IV. Project Description

Note: An amended Certificate of Need shall be required if certain modifications are made to a project for which a Certificate of Need was issued in accordance with WAC 246-310-570.

A. Describe the proposed project. This description should include discussion of any proposed conversion or renovation of existing space, as well as the construction of new facility space. Also, specify any unique services being proposed.

With its acquisition of Yakima Memorial Hospital, MultiCare obtained the 20-bed hospice house (Cottage in the Meadow). While this hospice house was needed in earlier years, changes in hospice care delivery and patient preferences have resulted in the majority of the facility sitting empty. While operational, at most four of the twenty beds were in use for hospice house patients at a given time. This idle capacity made the operation of the 20-bed hospice house unsustainable, and in August 2024 the facility ceased hospice operations.

The proposed project represents a repurpose of what was previously the 20-bed hospice house with a 32-bed Skilled Nursing Facility in which hospice services would be available. Based on MultiCare's experience, and the Department of Health's Skilled Nursing Facility Need Methodology, there exists need for additional skilled nursing services in Yakima County. The existing structure, well-suited for a repurpose from a hospice house to a SNF, is an opportunity to help meet that need without incurring construction costs for a new building.

The proposed facility will be managed by Avalon, a leader in the skilled nursing industry for over 40 years.

B. Health Services (check all in each column that apply):

Table 3: Health Support Services

TYPES OF THERAPY	*SUPPORT SERVICES*	*CURRENT SERVICES*	*PROPOSED SERVICES*
Physical Therapy	Inpatient		X
Physical Therapy	Outpatient		
Speech Therapy	Inpatient		X
Speech Therapy	Outpatient		
Occupational Therapy	Inpatient		X
Occupational Therapy	Outpatient		
Nursing Services	Outpatient		
Meals on Wheels	Outpatient		
Adult Day Care	Outpatient		
Other (specify)	Outpatient		
Clinical Nursing Services	Inpatient		X

C. Increase in total licensed beds or redistribution of beds among facility and service categories of skilled nursing and boarding home care:

The proposed facility will have a total of 32 beds.

D. Indicate if the nursing home would be Medicaid certified. Yes __X__ No ____

E. Indicate if the nursing home would be Medicare eligible. Yes __X___ No____
Indicate the number of Medicare certified beds. Current ___0___ Proposed __32__

F. Description of new equipment proposed, including cost of the equipment.

Table 4: Equipment List

Furniture	Unit Cost	Units	Total Cost
Beds with mattress	$3,000	12	$36,000
Armoires	$1,440	12	$17,280
TVs	$540	12	$6,480
Night Stands	$540	12	$6,480
Overbed Tables	$156	12	$1,872
Other furniture décor	$600	12	$7,200
Chairs	$540	12	$6,480
Modifications			
Electric/TV/Add'l outlets by bed	$6,000	12	$72,000
Cubical curtain tracking & curtains	$900	12	$10,800
Call light splitter	$300	12	$3,600
Food carts, dine EX system, etc.	$24,000	1	$24,000
Signage	$24,000	1	$24,000
Computers - IT	$36,000	1	$36,000
Office furniture	$4,800	5	$24,000
Rehab equipment	$42,000	3	$126,000
O2 Concentrators	$540	5	$2,700
Space Preparation & Finishing	$2,500	20	$50,000
Equipment Total			**$454,892**
Architect Fees			$14,000
Total			**$468,892**

Source: Applicant

G. Description of equipment to be replaced, including cost of equipment and salvage value (if any) or disposal or use of the equipment to be replaced.

The proposed project is not associated with an existing skilled nursing facility. Thus, this question is not applicable.

H. Blueprint size schematic drawings to scale of current locations of patient rooms, ancillary departments, and support services.

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

I. Blueprint size schematic drawings to scale of <u>proposed</u> locations of patient rooms, ancillary department, and support services, <u>clearly differentiating between remodeled areas and new construction</u>.

Please see Exhibit 3 for single-line drawings of the location, updated to include an additional 12 beds.

J. Geographic location of site of proposed project.

1. Indicate the number of acres in nursing home site: Acres ____5.01____

2. Indicate the number of acres in any alternate site for the nursing home (if applicable) Acres ___N/A_____

3. Indicate if the primary site or alternate site has been acquired (if applicable) Yes __X__ No ____

Address of site: __1208 S 48th Ave, Yakima, WA 98908_____

Address of alternate site: _____N/A_____

4. If the primary site or alternate site has not been acquired, explain the current status of the site acquisition plans, including proposed time frames.
Note: If approved, the Certificate of Need will specify the site and/or alternate site of the project. A change of location of the site authorized by the Certificate of Need may require an amendment to the Certificate of Need.

The primary site is owned by MultiCare Health System. Thus, this question is not applicable.

5. Demonstration of sufficient interest in project site. Provide a copy of a clear legal title to the proposed site and one of the following:

a. Lease for at least five years, with options to renew for not less than a total of twenty years; or

b. Legal, enforceable agreement to give such title or such lease in the event a Certificate of Need is issued.

Please see Exhibit 4 for a Warranty Deed for the project site.

6. Demonstration that the proposed site may be used for the proposed project. Please include a letter from the appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project, or a written explanation of why the proposed purpose is exempt.

The site for the proposed project was previously a hospice care home and is zoned Commercial B-1. Please see Exhibit 4 for a parcel summary indicating this site is appropriately zoned for the proposed project.

K. Space Requirements

1. **Existing gross square footage. 21,814**

2. **Total gross square footage for the proposed addition and the existing facility. N/A**

3. **Proposed new facility gross square footage. 21,814**

4. **Do the above responses include any shelled-in areas? Yes _____ No X**
   If yes, please explain the type of shelled-in space proposed (administration, patient beds, therapy space, etc.)

L. Proposed Timetables for Project Implementation:

Note: The Certificate of Need Program will use the following time tables in monitoring the applicant's conformance with the issued Certificate of Need. Failure to meet the timetable specified below may be grounds for withdrawal of a Certificate of Need. (WAC 246-310-600 (1)).

1. **Financing:**
   a. **Date for obtaining construction financing. Month N/A Year N/A**
   b. **Date for obtaining permanent financing. Month N/A Year N/A**

   c. **Date for obtaining funds necessary to undertake the project:**
   Month N/A Year N/A

2. **Design**
   a. **Date for completion and submittal of preliminary drawings to Consultation and Construction Review Section. Month Sep Year 2024**
   b. **Date for completion and submittal of final drawings and specifications to Consultation and Construction Review Section.**
   Month Oct Year 2024

3. **Construction**
   i. **Date for construction contract award. Month N/A Year N/A**
   ii. **Date for 25 percent completion of construction (25 percent of the dollar value of the contract in place). Month N/A Year N/A**

   iii. **Date for 50 percent completion of construction.**
   Month N/A Year N/A
   iv. **Date for 75 percent completion of construction.**
   Month N/A Year N/A
   v. **Date for completion of construction. Month N/A Year N/A**
   vi. **Date for obtaining licensure approval. Month N/A Year N/A**
   vii. **Date for occupancy/offering of service(s). Month N/A Year N/A**

There is no construction associated with the proposed project, thus this question is not applicable.

M. As the applicant(s) for this project, please describe your experience and expertise in the planning, developing, financing, and construction of skilled nursing and intermediate care facilities.

The skilled nursing facility will be managed by Avalon, a leader in the skilled nursing industry for over 40 years. Avalon currently owns or manages 16 skilled nursing facilities across five states, including five within Washington State where Avalon has operated for more than 20 years. Another two facilities that Avalon will own or manage in Washington are currently in development.

Over the past decade, Avalon has successfully planned, developed, financed, constructed, and operated five new skilled nursing facilities, showcasing its expertise in building facilities from the ground up. Avalon's CEO, Alan Hash, has personally overseen the development and opening of two skilled nursing facilities in Washington State: ManorCare of Lacey and ManorCare Salmon Creek.

The Yakima project involves converting an existing healthcare facility into a skilled nursing facility, which is significantly easier than starting a new build. This positions Avalon well to manage a successful and well-executed conversion.

V. Project Rationale

Provide documentation to establish conformance of the project with applicable review criteria.

A. Need: (WAC 246-310-210 and WAC 246-310-380 (6))

1. **Identify and analyze the unmet health service need and/or other problems to which this project is directed.**
   a. **Describe the need of the people you plan to serve for the service you propose.**
   b. **Address the need for nursing home beds based on the 45 beds per 1,000 population and Substitute House Bill 2098, which encourages the development of a broad array of home and community-based long-term care services as an alternative to nursing home care.**

   In Yakima County, the Department's defined planning area for skilled nursing facilities, there currently exist eleven operational Skilled Nursing Facilities identified by the Department of Health in its February 2024 Nursing Home Bed Supply Log, as well as one facility which banked 39 beds in 2019.[2] Including the beds from this closed facility, there are 901 "available" SNF beds for Yakima County residents. Given a population for Yakima County residents aged 70 and over of 33,689, based on Washington Office of Financial Management 2022 statistics, this reflects a bed ratio of about 26.7 beds per 1,000 residents aged 70 and over.[3] This number is below the current target bed ratio of 40 beds per 1,000 persons aged 70 and over. Thus, there exists numeric need for the proposed project. The most recent Department Forecast, the 2024-2026 Washington State Nursing Home Bed Forecast, shows net need of 320 additional Skilled Nursing Home beds in Yakima County in 2026.[4]

2. **If your proposal exceeds the number of beds identified as needed in your county nursing home planning area as shown in WAC 246-310-380 (6), please discuss how the approval of beds beyond the projected need would further the policy that beds should be located reasonably close to the people they serve.**

   The proposed project does not exceed the number of beds identified as needed in Yakima County. Thus, this question is not applicable.

3. **Provide utilization data for each of the last three full fiscal years, the current annualized full fiscal year, and the next three full fiscal years: (USE SCHEDULE A which is attached to these guidelines.)**

   The proposed project is not associated with an existing skilled nursing facility. Thus, this question is not applicable.

4. **In the case of any proposed conversion of beds from other service categories to nursing care beds, provide evidence that the conversion will not jeopardize the**

[2] https://doh.wa.gov/sites/default/files/2024-02/NHBedSupplyLog.pdf, Last Accessed August 20, 2024.
[3] The population of Yakima County residents aged 70 and over of 33,689 differs from that applied by the Department of Health in its February 2024 Nursing Home Bed Projections due to the difference in population sources. Whereas the Nursing Home Bed Projections used the OFM 2017 Projections, we have used the more recent calculations published in 2022.
[4] https://doh.wa.gov/sites/default/files/2024-02/2024-2026NHBedForecast.pdf, Last accessed August 22, 22024.

availability of service. Document the availability and accessibility of the services that are to be converted.

Although the site was previously a hospice care home, operations at the project site ceased in August of 2024. Thus, this question is not applicable.

5. **In the context of the criteria contained in WAC 246-310-210 (2) (a) and (b), please describe how the service will be available to the following: low-income individuals, racial and ethnic minorities, women, handicapped individuals, elderly, and other under-served individuals.**

MultiCare provides care in an environment free from discrimination and bias, and strives to ensure all people receive high-quality, compassionate care based on their needs regardless of race, ethnicity, disability status, gender identity and expression, sexual orientation, socio-economic status, and other factors.

This work starts within our walls by embedding diversity and inclusion principles into our policies and practices systemwide. This includes providing our staff with culturally informed education and resources, focused on self-awareness, preventing implicit bias, and steps to build an anti-racist culture. It also includes ensuring patient access to interpreter services 24/7, conducting community health needs assessments to better identify and address our patients' and communities' health and health-related social needs, and exploring strategies to increase employee diversity. With regards to language access services, interpreters at MultiCare help patients and families communicate with doctors, nurses, schedulers, and other staff. Interpreters are available in person, over the phone and by video. Services are free and available 24 hours a day, seven days a week.

Furthermore, MultiCare has a number of policies in place designed to ensure safe, accessible, culturally competent care for our patients and to protect our employees from retaliation. This includes its policies for Patient Nondiscrimination, Non-Retaliation, Interpreter Services, and Service Animals.[5] These policies are available on MultiCare's website and in other formats to ensure public and patient access and awareness.

MultiCare has also recently embraced the "Raising the Bar" framework to advance our work in health equity and quality care delivery. The Raising the Bar framework, developed by the Robert Wood Johnson Foundation, presents actionable items that health systems can apply to equity efforts.[6] MultiCare is currently developing action plans in alignment with the five core principles:

- Mission – Commit to a mission of improving health and well-being.
- Equity – Systemically pursue health equity and racial justice.
- Community – Authentically partner with community.
- Power – Share resources, voice, and power.
- Trust – Earn and sustain trusting relationships.

MultiCare is committed to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to maintaining Financial Assistance policies that are consistent with our mission and

[5] https://www.multicare.org/about/policies-notices/#deib-policies
[6] https://rtbhealthcare.org/wp-content/uploads/2022/07/RWJF-RTB-FULL-REPORT-060622.pdf.

values regardless of an individual's ability to pay for medically necessary health care services. We include a draft Financial Assistance policy in Exhibit 5.

MultiCare has a documented history of providing financial assistance to its patients that exceeds the respective regional averages of hospitals in the service areas they serve. Table 5 presents MultiCare hospitals' charity care, as a percent of total revenues, compared to regional averages for the most recent three years available (2020-2022) from the Washington State Department of Health's website.[7] MultiCare's Puget Sound, King County, and Eastern Washington hospitals consistently are significantly above their respective regional averages. Furthermore, in Eastern Washington, MultiCare has significantly expanded access to financial assistance for patients receiving care at Deaconess and Valley hospitals. Before their acquisition in 2017, Deaconess and Valley's charity care figures were chronically under the regional average. In 2020 and 2021, these two hospitals exceeded the Eastern Washington regional average. This demonstrates MultiCare's commitment to provide quality health services to patients regardless of payer coverage or ability to pay, and who are unable to pay for medically necessary health care services. This commitment extends beyond just hospital care, as MultiCare provides financial assistance and support to its patients across the care continuum, and it will include those patients requiring skilled nursing services in Yakima County that MultiCare proposes to serve.

Table 5: MultiCare Health System Hospitals' Charity Care Compared to Regional Average, 2020-2022

Region/Hospital	2020	2021	2022	3 Year Average, 2020-2022
MultiCare Puget Sound Hospitals	1.63%	1.34%	1.25%	1.41%
PUGET SOUND REGION TOTALS	**1.69%**	**1.16%**	**1.18%**	**1.34%**
MultiCare King County	3.29%	1.75%	1.77%	2.27%
KING COUNTY LESS HARBORVIEW	**1.20%**	**0.88%**	**0.99%**	**1.02%**
MultiCare Eastern WA	1.49%	1.39%	1.30%	1.39%
EASTERN WASH REGION TOTALS	**1.12%**	**1.10%**	**1.24%**	**1.15%**

Source: DOH Charity Care Reports, 2020-2022

Notes: MultiCare Puget Sound Hospitals include Tacoma General Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, and Good Samaritan Hospital. MultiCare King County Hospitals include: Auburn Medical Center, Covington Medical Center, Navos Behavioral Health Hospital. MultiCare Eastern Washington Hospitals include Deaconess Hospital and Valley Hospital. Table excludes MultiCare Capital Medical Center and MultiCare Yakima Memorial, as they did not join MultiCare until CY2021.

6. Does/will the facility require a pre-admission deposit? Please explain the intent and use of the deposit.

The facility will not require a pre-admission deposit.

7. Please submit copies of the facility's admission agreement, policies, and procedures.

Please see Exhibit 6 for copies of the facility's admission policies and procedures.

[7] Available at https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-patient-information-and-charity-care/charity-care-washington-hospitals. Last accessed January 12, 2024.

8. **If you propose any special services including, but not limited to, heavy care, Alzheimer's care, respite care, and adult day care, please provide the following:**
   a. **Describe the service in full detail.**
   b. **Include program content, staffing by classification and FTE commitment, budget, and the amount of space dedicated to each service.**
   c. **Document the need for any special services.**

   The proposed facility will provide round-the-clock care for individuals who require medical treatment, rehabilitation, or assistance with daily living due to illness, injury, or surgery. The facility will offer services such as physical therapy, occupational therapy, wound care, medication management, respiratory, and specialized nursing care under the supervision of licensed healthcare professionals. The SNF will provide care to patients who need a higher level of care than what is typically provided in assisted living or home care but do not require the intensive services of a hospital. The goal is for patients to recover enough to return home or transition to a lower level of care.

   In addition, the facility will provide special services related to long term care, hospice care, Alzheimer's care, and respite care. Details regarding program content, staffing, space, and budget will be provided in screening.

9. **If the purpose of the project is to correct existing structure, fire, and/or life-safety code deficiencies, or licensing, accreditation, or certification standards as provided for under provisions of WAC 246-310-480, provide a detailed description of the cited deficiencies and attach copies of the two most recent Fire Marshal's surveys and/or surveys conducted by the Survey Program, Aging and Adult Services Administration, Department of Social and Health Services, or other surveying agency.**

   The purpose of the proposed project is not to correct structural deficiencies to an existing skilled nursing facility. Thus, this question is not applicable.

B. Financial Feasibility (WAC 246-310-220)
APPLICANTS MUST COMPLETE ONE OF THE FOLLOWING SECTIONS AS APPROPRIATE: SECTION I, SECTION II, SECTION III, OR SECTION IV. ALL APPLICANTS MUST COMPLETE SECTION V.

SECTION I:
Applicants proposing to construct a new nursing home or replace an existing nursing home on the same or a new site, should complete this section for the development of the building cost per bed and reasonable land cost.

The information requested in Section I must be provided by a licensed architect or engineer.

Indicate the name, address, and telephone number of the licensed architect or engineer that completed this section:

Section I is not applicable, based on TA call discussion with CN program staff, where this issue was specifically called out, given it does not include construction. The proposed location is a fully built-out facility.[8]

NAME: _____

ADDRESS: _____

_____

PHONE: _____

Proposed Site Address: _____ **Zip Code:** _____

The following Part I, Reasonable Building Cost Guidelines, and Part II, Reasonable Land Cost Guidelines, will be utilized to determine whether or not the building cost per bed and land cost are reasonable. These guidelines are based on WAC 388-96-745.

PART I -- REASONABLE BUILDING COST GUIDELINES

1. **The Marshall Valuation Services (updated August 1993) Section I, pages 3-12, describes the building class (A, B, C, and D) and the building quality (excellent, good, average, and low cost) of the building. Based on this description, state the building class and building quality that is proposed for construction by this project. Applicants proposing to add beds at an existing nursing home should also state the building class and building quality of the existing nursing home.**

   For New Construction: Class_N/A_ Quality_N/A_ Number of Beds_N/A_

   For Existing Construction: Class_N/A_ Quality_N/A_ Number of Beds_N/A_

[8] Technical Assistance ("TA") Call, August 12, 2024.

2. **Indicate the total number of square feet of construction that is proposed including walls, partitions, stairwells, etc. Total Square Feet _____**

   There is no construction associated with the proposed project, thus this question is not applicable. The total square footage of the proposed site is 21,814.

3. **The Marshall Valuation Services (updated August 1993) Section I, pages 3-12, describes the type of materials that can be utilized to construct the frame, floor, roof, and walls of a building. Based on this description, indicate the type of materials that would be utilized in the following major components of the proposed building.**

   There is no construction associated with the proposed project, thus this question is not applicable.

4. **Indicate the total cost of constructing the new nursing home, replacing the existing nursing home, or constructing a bed addition at the nursing home. In cases where a nursing home/boarding home facility shares a common foundation and roof, the cost of the shared items shall be apportioned to the nursing home based on the Medicare program methodology for apportioned costs to the nursing home service. Construction costs shall include the following:**

   There is no construction associated with the proposed project. Equipment expenditures are listed in Table 4 above.

5. **Provide a copy of a signed non-binding cost estimate or contractor's estimate of the project's land improvements, building construction cost, architect, and engineering fees, site preparation, supervision, and inspection of site, Washington Sate sales tax, and other projects costs (items c, f, i, k, m, n, and o above).**

   There is no construction associated with the proposed project, thus this question is not applicable.

6. **The reasonableness of building construction cost is based on the data shown in the table shown on the next page entitled, "Cost Guidelines for New Building and Improvements Plus Increments for Additional Beds." Reasonable building costs will be determined by:**
   a. **Locating the class of construction (A, B, C, or D) and quality of construction (good, average, low) in the table, multiply the number of beds proposed by the appropriate per bed base cost;**

      There is no construction associated with the proposed project, thus this question is not applicable.

   b. **Identify the appropriate base cost for the facility (using the same class and quality of construction);**

      The proposed project is for a 32-bed facility for which no construction is necessary, thus this question is not applicable.

   c. **Additional incremental allowances are allowed for projects requesting beds between 75-120 and projects of over 120 beds.**

i. **For projects greater than 74 beds, but less than 121 beds, multiply the appropriate per bed incremental allowance (using the same class and quality of construction) by the number of additional beds between 75 to 120: *or***

The proposed project is for a 32-bed facility for which no construction is necessary, thus this question is not applicable.

ii. **For projects greater than 120 beds, multiply the appropriate per bed incremental allowance (using the same class and quality of construction) by the number of additional beds over 75, but less than 120, then multiply the appropriate incremental allowance by the number of beds over 120 and add these two figures together.**

The proposed project is for a 32-bed facility for which no construction is necessary, thus this question is not applicable.

7. **The figures from 6a, 6b, and 6c, when applicable, are added to determine the construction cost lids. Final lid values will be adjusted for inflation using the actual change in the appropriate cost indexes.**

There is no construction associated with the proposed project, thus this question is not applicable.

8. **The above estimated building costs per bed may be adjusted when the following circumstances apply to the project.**
   a. **Construction changes required by Facilities and Services Licensing Section, Office of Resource Development, and/or Department of Health in the course of approving the building plans for the project.**
   b. **Four story or higher construction.**
   c. **Unusual labor or climatic conditions at time of construction that were not foreseeable by management.**
   d. **Cost savings realized in other components of the project such as equipment or operating costs.**
   e. **Where more than one major construction type is present, an average facility type shall be computed by weighing relative costs of the framing, floor, roof, and walls.**

Applicants requesting adjustments to the guidelines for responsible building cost per bed shall provide written justification and a financial analysis showing the rationale for the adjustments.

There is no construction associated with the proposed project, thus this question is not applicable.

PART II -- REASONABLE LAND COST GUIDELINES

1. **The land cost guidelines are for land that is utilized by the nursing home service. When an applicant proposes to construct a new nursing home/boarding home facility, the amount of land utilized by the nursing home services should be calculated based on Medicaid program methodology for apportioning costs to the nursing home for reimbursement purposes. Based on the above factors, the cost of land, plus cost of utilities to lot line for the proposed nursing home would be: $ N/A**

2. **Indicate the number of square feet of land that would be utilized for the nursing home service: N/A square feet**

3. **Indicate the cost per square foot for the utilized by the nursing home service: $ N/A**

4. **Exceptions to square foot cost lids (WAC 388-96-745 (7)) may be allowed to a maximum of ten percent (WAC 388-96-754(8)). An adjustment shall be granted only if requested by the applicant. Applicants requesting adjustments to the guidelines for reasonable land costs shall provide written justification and an analysis showing the rationale for the adjustments.**

   There is no construction associated with the proposed project, thus this question is not applicable.

5. **Exceptions to land area lids (WAC 388-96-762) may be allowed. An adjustment shall be granted only if requested by the applicant and meet the criteria defined in WAC 388-96-762(3). Applicants requesting adjustments to the guidelines for area land lids shall provide written justification and an analysis showing the rationale for the adjustments.**

   Questions regarding the construction cost lid exception process should be directed to the Residential Rates Program of Aging and Adult Services.

   There is no construction associated with the proposed project, thus this question is not applicable.

SECTION II

Applicants proposing to add beds at an existing nursing home or remodel a nursing home at a cost in excess of the Capital Expenditure Threshold should complete this section for the calculation of property and return on investment rate.

The information requested in this section must be provided by a licensed architect or engineer.

Indicate the name, address and phone number of the licensed architect or engineer that completed section.

Section II is not applicable, based on TA call discussion with CN program staff, where this issue was specifically called out, given it does not include construction, and it is not currently a skilled nursing facility.[9]

Name:.....
Address.....
Phone Number:.....

Proposed Site Address.....
Zip Code.....

1. **Indicate the total cost of constructing the bed addition or the cost of remodeling an existing nursing home. In cases where a nursing home/boarding home facility shares a common foundation and roof, etc., the cost of the shared items shall be apportioned to the nursing home based on the Medicaid program methodology for apportioning costs to the nursing home service. Construction costs shall include the following:**

   The proposed project does not entail a bed addition at an existing nursing home, thus this question is not applicable.

2. **Provide a copy of a signed, non-binding cost estimate or contractor's estimate of the project's land improvements, building construction cost, architect and engineering fees, site preparation, supervision and inspection of site, Washington State sales tax, and other project costs (Items c, f, i, k, m, n, and o above).**

   The proposed project does not entail a bed addition at an existing nursing home, thus this question is not applicable.

3. **Estimated Nursing Home Construction Costs**

   The proposed project does not entail a bed addition at an existing nursing home, thus this question is not applicable.

4. **For an existing facility, indicate the incremental increase in capital costs per patient day that would result from this project using the chart below.**

   The proposed project does not entail a bed addition at an existing nursing home, thus this question is not applicable.

SECTION III:
Applicants proposing to amend a Certificate of Need should complete this section for the calculation of property and return on investment rate.

Section III is not applicable, based on TA call discussion with CN program staff, where this issue was specifically called out, given it is not an amendment.[10]

[9] Ibid.
[10] Ibid.

The information requested in this section must be provided by a licensed architect or engineer.

Indicate the name, address, and phone number of the licensed architect or engineer that completed this section.

Name:.....
Address.....
Phone Number:.....

Proposed Site Address.....
Zip Code.....

1. **Indicate the total cost of constructing the new nursing home. In cases where a nursing home/boarding home facility share a common foundation and roof, the cost of the shared items shall be apportioned to the nursing home based on the Medicaid program methodology for apportioning costs to the nursing home service. Construction costs shall including the following:**

   The proposed project does not require amendment to an existing Certificate of Need. Thus this question is not applicable.

2. **Provide a copy of a signed, non-binding cost estimate or contractor's estimate of the project's land improvements, building construction cost, architect and engineering fees, site preparation, supervision and inspection of site, Washington State sales tax, and other project costs (Items c, f, i, k, m, n, and o above).**

   The proposed project does not require amendment to an existing Certificate of Need. Thus this question is not applicable.

3. **Provide a brief description of the contractor's or cost estimator's experience with nursing home projects.**

   The proposed project does not require amendment to an existing Certificate of Need. Thus this question is not applicable.

4. **Estimated Nursing Home Construction Costs.**

   The proposed project does not require amendment to an existing Certificate of Need. Thus this question is not applicable.

5. **For an existing facility, indicate the incremental increase in capital cost per patient day that would result from this project using the chart below:**

   The proposed project does not require amendment to an existing Certificate of Need. Thus this question is not applicable.

SECTION IV:
All applicants must provide interest rate, source of financing project costs, estimated start-up-initial operating deficits, financial statements, and projected patient charges.

1. **Identify the owner or operator who will incur the debt for the proposed project.**

   MultiCare Health System will fund all capital expenditure and startup costs. These costs will be funded through owner equity.

2. **Anticipated sources and amounts of financing for the project (actual sources for conversions)**

	Specify Type	Dollar Amount
Public Campaign		$
Bond Issue		$
Commercial Loans		$
Government Loans		$
Grants		$
Bequests & Endorsements		$
Private Foundations		$
Accumulated Reserves		$
Owner's Equity	Equity from MultiCare Health System	$468,892
Other - (specify)		$
Other - (specify)		$
TOTAL (must equal total Project Cost		**$468,892**

3. **Provide a complete description of the methods of financing which were considered for the proposed project. Discuss the advantages of each method in terms of costs and explain why the specific method(s) to be utilized was (were) selected.**

   MultiCare determined Owner's Equity was the best method of financing since it was both available and did not require payment of market interest.

4. **Indicate the anticipated interest rate on the loan for constructing the nursing home.**

   This project will be funded through owner equity. Thus, this question is not applicable.

5. **Indicate if the interest rate will be fixed or variable on the long-term loan and indicate the rate of interest.**

   This project will be funded through owner equity. Thus, this question is not applicable.

6. **Estimated start-up and initial operating expenses.**
   a. **Total estimated start-up costs $861,747** ***(expenses incurred prior to opening such as staff training, inventory, etc., reimbursed in accordance with Medicaid guidelines for start-up costs)***

b. Estimated period of time necessary for initial start-up: about 5 months *(period of time after construction completed, but prior to receipt of patients)*

c. Total estimated initial operating deficits $0 *(operating deficits occurring during initial operating period)*

d. Estimated initial operating period 0 months *(period of time from receipt of first patient until total revenues equal total expenses)*

7. Anticipated Sources of Financing Start-up and Initial Operating Deficits.

Unrestricted Cash of Proponent	$
Unrestricted Marketable Securities of Proponent	$
Accounts Receivable	$
Commercial Loan	$
Line of Credit (*specify source*)	$
Other (*Owner Equity*)	$861,747
TOTAL	**$861,747**

8. Evidence of Availability of Financing for the Project. Please submit the following:

a. Copies of letter(s) from the lending institution indicating a willingness to finance the proposed project (both construction and permanent financing). The letter(s) should include:

i. Name of person/entity applying
ii. Purpose of the loan(s)
iii. Proposed interest rate(s) (fixed or variable)
iv. Proposed term (*period)* of the loan(s)
v. Proposed amount of loan(s)

The proposed project will be funded through owner equity. Thus, this question is not applicable.

b. Copies of letter(s) from the appropriate source(s) indicating the availability of financing for the initial start-up costs. The letter(s) should include the same items requested in 8(a) above, as applicable.

Please see Exhibit 7 for a letter of financial commitment.

c. Copies of each <u>lease</u> or <u>rental</u> agreement related to the proposed project.

The site is owned by Yakima Valley Memorial Hospital Association, which, in turn, is 100% owned by MultiCare Health System. Please see Exhibit 4 for a copy of the Warranty Deed.

d. Separate amortization schedule(s) for each financing arrangement including long-term and any short-term start-up, initial operating deficit loans, and refinancing of the facility's current debt setting forth the following:

i. **Principal**
ii. **Term (*number of payment period, long-term loans may be annualize*)**
iii. **Interest**
iv. **Outstanding balance of each payment period**

The project will be funded through owner equity. Thus, this question is not applicable.

9. **Provide the following:**
   a. **Please supply copies of the following pages and accompanying footnotes of each applicant's three most recent financial statements: Balance Sheet, Revenue and Expense, and Changes in Financial Position. (If not available as a subsidiary corporation, please provide parent company's statements, as appropriate).**

      Please see Exhibit 8 for the audited financial statements for MultiCare Health System over the 2022 to 2023 period.

   b. **Please provide the following facility-specific financial statements through the third complete fiscal year following project completion. Identify all assumptions utilized in preparing the financial statements.**

      i. **Schedule B Balance Sheet**
      ii. **Schedule C Statement of Operations**
      iii. **Schedule D This Statement Has Been Eliminated**
      iv. **Schedule E Statement of Changes in Equity/Fund Balance**
      v. **Schedule F Notes to Financial Statements**
      vi. **Schedule G Itemized Lists of Revenue and Expenses**
      vii. **Schedule H Debt Information**
      viii. **Schedule I Book Value of Allowable Assets**

      NOTE: USE SCHEDULES ATTACHED TO THESE GUIDELINES.

      Please see Exhibit 9 for the financial schedules. The model for revenue, staffing, and cost are based on Avalon's extensive experience operating facilities for over 40 years. Additional assumptions include:

      - Charity care is forecast at 1.2% of Net Revenue based on hospitals in the Central Washington Planning Area. These include Astria Sunnyside, Astria Toppenish, and MultiCare Yakima Memorial.
      - No inflation is included in the model, consistent with Department of Health requirements and practice.
      - Startup expenses reflect two months of operating expenses for the categories presented in Exhibit 9 under the Startup table.
      - Depreciation reflects the new equipment and architect fees, amortized over 10 years.
      - The Balance Sheet reflects statistics from the Income Statement and necessary capital requirements for operational startup.

10. **Utilizing the data from the financial statements, please calculate the following:**
    a. **Debt Service Coverage**
    b. **Current Ratio**
    c. **Assets Financed by Liabilities Radio**
    d. **Total Operating Expense to Total Operating Revenue**

NOTE: USE FORMS ATTACHED TO THESE GUIDELINES.

As the source of funding for the proposed project, the following ratios are based on the 2023 financial statements for MultiCare Health System, included as Exhibit 8.

Ratio	MultiCare 2023 Value	"Normal Range"
Current Ratio	1.51	1.8 to 2.5
Assets financed by liabilities	0.49	0.6 to 0.8
Total Operating Expense to Total Operating Revenue	1.04	1.00
Debt Service Coverage	6.29	1.5 to 2.0

11. If the project's calculated ratios are outside the normal or expected range, please explain.

While these “normal” ranges date from over 25 years ago, the calculated ratios are close to the “normal range” specified within the form of application but differ slightly. The Current Ratio reflects the ability of MultiCare to cover its immediate liabilities, and a ratio of 1.5 indicates it is more than able to cover all current liabilities, with over $500M remaining. The Ratio of Assets to Liabilities reflects the proportion of Assets which have been financed. With a ratio of about 0.5, this indicates that about 50% of MultiCare’s assets have been financed by liabilities, while the other half can be viewed as owned absent loan or lien. The ratio of Operating Expense to Operating Revenue reflects whether operations are break even. For 2023, net income from operations reflected a loss of about $188M. However, including investment income, gains on interest rate swaps, inherent contributions, and other income, net income was a positive $411M. The Debt Service Coverage Ratio is much higher than the “Normal Range,” as it reflects the ability of MultiCare to cover its current portion of debt and interest more than 6 times over.

12. If a financial feasibility study has been prepared, either by or on behalf of the proponent in relation to this project, please provide a copy of that study.

A financial feasibility study has not been prepared in relation to the proposed project.

13. Current and Projected Charges and Percentage of Patient Revenue

a. Per Diem Charges for Nursing Home Patients for Each of the Last Three Fiscal Years:

The proposed project is not related to an existing facility, thus this question is not applicable.

b. Current Average Per Diem Charges for Nursing Home Patients:

The proposed project is not related to an existing facility, thus this question is not applicable.

c. Projected Average Per Diem Charges for Nursing Home Patients for Each of the First Three Years of Operation:

Table 6: Projected Per Diem Net Revenue by Payer			
	Year 1	Year 2	Year 3
Private Pay			
Medicaid	$363.99	$363.99	$363.99
Medicare	$633.20	$633.20	$633.20
VA			
Other-Specify			

d. Please indicate the percentage of patient revenue that will be received for the:

Existing Facility	
Private Pay	%
Medicaid	%
Medicare	%
VA	%
Other-Specify	%

Proposed Facility Percent of Net Revenue (expansion)	
Private Pay	%
Medicaid	17.3%
Medicare	82.7%
VA	%
Other-Specify	%

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

1. Staffing Schedule:

Staffing	Projected Number of Employees	
	Full-Time Equivalent	*Consultant hr/week*
Registered Nurse	4.20	
LPN	4.20	
Nurses Aides & Assistants	13.13	
Unit Manager RN	1.4	
Infection Prevention LPN/LVN	1.00	
NURSING TOTAL	**23.93**	
Dietitians		12
Dining Services Director	1.00	
Cook	1.50	
Aides	2.10	
DIETARY TOTAL	**4.60**	
Administrator	1.00	
Admissions	1.00	
Business Office Manager	1.00	
Recreation Coordinator	1.00	
Recreation Assistant	0.40	
Medical Director		5
MDS Coordinator	1.00	
In-service Director		
Receptionist	0.90	
Director of Nursing	1.00	
Clerical		
Housekeeping/ Maintenance	1.31	
Laundry	1.31	
ADMINISTRATION TOTAL	**9.93**	
Physical Therapist		60
Occupational Therapist		60
Speech Therapy		40
Pharmacist		2
Medical Records	0.50	
Social Worker	1.00	
Central Supply	0.50	
Plant Operations	1.00	

ALL OTHERS TOTAL	**3.00**	
TOTAL STAFFING	**41.46**	

2. Nursing hours per patient day

Registered Nurse	0.8
LPNs	0.8
Nurse's Aides & Assistants	2.5
TOTAL	**4.1**

3. Provide evidence that the personnel needed to staff the nursing home will be available.

The ability of a skilled nursing facility to recruit and retain sufficient staff is essential, particularly given there exist staffing shortages across Washington, as well as in Yakima County.

Staff recruitment will be handled through MultiCare's recruitment department. Recruiters and agency leadership review open positions and discuss the various recruitment strategies being used. Virtual hiring events are held every 4-6 weeks. For retention, an employee satisfaction survey is completed annually to help leadership identify opportunities for improvement in the work environment. The employee-run Practice Council operates to discuss any concerns with leadership, develop quality initiatives for increased quality of care, and problem solve any identified issues.

While staffing shortages exist, MultiCare can respond proactively to these shortages and is able to recruit and retain sufficient qualified caregivers. Furthermore, due to its established presence and respected reputation in the area, together with its strong local recruitment program and existing network of local and national recruiting resources, MultiCare can leverage its market competitive compensation package to quickly and successfully recruit the new staff who will be required. With these practices, MultiCare surpasses national benchmarks with staff turnover, and we expect this to also be the case for the proposed skilled nursing facility.

4. Provide evidence that there will be adequate ancillary and support services to provide the necessary patient services.

MultiCare is an existing provider of inpatient, hospice, and other healthcare services in Yakima County, and has established relationships with ancillary and support vendors which it will utilize with the proposed facility.

5. Provide evidence that indicates the services provided at your facility will be in compliance with applicable federal and state laws, rules, and regulations for health care facilities.

The proposed facility will be managed by Avalon, whose corporate support team provides award-winning support services to its managed facilities to will ensure the care center can provide high-quality care for its patients from the start. Person-centered care will be provided in in all areas of service and in compliance with Medicare and Medicaid Certification and

Licensing Standards and Avalon's policies, procedures, and compliance standards, including rules and/or standards issued by the Centers for Medicare and Medicaid Services (CMS).

Avalon's corporate consultant staff have developed standard clinical protocols in all areas of long-term care and for federal and state certification. This will directly benefit the proposed facility as part of its management services. Policies and procedures meet State and Federal Medicaid/Medicare certification and VA standards. In addition, the proposed facility will benefit from Avalon's established Corporate Compliance Plan, overseen by the Corporate Legal Officer and approved by its Board of Directors. We include a letter from the Avalon's Compliance Officer explaining the proposed facility will operate in compliance with applicable State and Federal rules and regulations in Exhibit 10.

Each facility also holds a "Triple Check" meeting prior to Medicare billing each month to ensure billing accuracy. Avalon contracts with a third-party company to host an anonymous compliance hotline. The phone number for this hotline will be posted throughout the facility and on pocket cards. The Administrator provides training during employee orientation, in daily meetings, and in regularly scheduled staff meetings. Employees also read and sign a Code of Conduct and an employee handbook annually. Employee files are audited upon completion of orientation and routinely thereafter.

Avalon and the proposed facility will utilize key compliance processes such as internal audits, corporate audits, and the QAPI process to manage risk and achieve and surpass regulatory compliance, legal, and accreditation goals. These are supported by Avalon's core competency of managing and using systems and processes. Each of the measures in these individual processes have thresholds. Any measure outside of its threshold is assessed for a potential action plan. Avalon's goal each year is to have zero regulatory deficiencies, no adverse legal action, and no concerns that could create a barrier for accreditation.

6. **Provide evidence that the project will be in compliance with applicable conditions of participation related to the Medicare and Medicaid programs.**

   Please see the response to Question 5 above.

7. **Fully describe any history of each applicant with respect to the actions noted in the Certificate of Need criterion. (WAC 246-310-230 (5) (a). If there is such a history, provide evidence that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.**

   MultiCare does not have a history with respect to the actions noted in WAC 246 310-230(5).

   The managing company, Avalon, also does not have a history with respect to the actions noted in WAC 246 310-230(5).

8. **Provide evidence that the project will adequately address continuity of care. Describe the arrangements that will be made with other providers for patient care consultation services. Provide assurance that patients will be referred to a hospital for acute care needed. Also, provide assurance that patients discharged from the nursing home will be referred to home health, hospice, or assisted living agencies when such care is needed.**

As an existing provider of inpatient, hospice, and other healthcare services along the health care continuum in Yakima County, MultiCare will ensure continuity of care for skilled nursing patients at the proposed facility. We include an example hospital transfer agreement in Exhibit 11 and discharge/continuity of care policies in Exhibit 12.

9. **Existing nursing homes will document the number of patients discharged from the nursing home to the patients home, referred to home health, hospice agency, or assisted living services during the last three years.**

   The proposed facility is not an existing nursing home, thus this question is not applicable.

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

1. Describe distinct alternative means for meeting the need described previously. Identify alternative advantages and disadvantages, including cost, efficiency, or effectiveness.

The following two options were evaluated in the alternatives analysis:

- Option One: Repurpose the 20-bed hospice house facility into a 32-Bed Skilled Nursing Facility—The Project
- Option Two: Do Nothing, leaving the hospice house facility idle

Please see Table 7 through Table 11. These tables provide a summary of advantages and disadvantages of each of the options based on the following evaluative criteria: Promoting availability, or access to healthcare services; Promoting Quality of Care; Promoting Cost and Operating Efficiency; and Legal Restrictions.

Table 7. Alternatives Analysis: Promoting Access to Healthcare Services.

Option:	Advantages/Disadvantages:
Option One Establish a 32-Bed SNF in Yakima County—The Project	• Preserves access to facility-based hospice services and helps meet need for additional skilled nursing beds based on the Department's numeric need methodology (Advantage, "A")
Option Two Do nothing	• Would do nothing to improve access for Skilled Nursing beds (Disadvantage ("D")). • Would reduce access for facility-based hospice care. (D) • Without additional capacity, some patients may have to delay or not receive care altogether. (D)

Table 8. Alternatives Analysis: Promoting Quality of Care.

Option:	Advantages/Disadvantages:
Option One Establish a 32-Bed SNF in Yakima County—The Project	• Residents of the Planning Area would have increased access to skilled nursing services--this improves quality and continuity of care. (A)
Option Two Do nothing	• Without sufficient access to skilled nursing services, this will harm quality of care, and it can also lead to preventable emergency room visits or hospitalizations. (D)

Table 9. Alternatives Analysis: Cost Efficiency and Capital Impacts.

Option:	Advantages/Disadvantages:
Option One Establish a 32-Bed SNF in Yakima County—The Project	• Limited capital expenditures are necessary. (A) • Repurposes a facility which would otherwise sit empty; a more efficient use of scarce capital (A) • Improved access prevents unnecessary emergency room and hospitalization visits. (A)
Option Two Do nothing	• Least costly with respect to capital expenditures. (A) • However, results in idle facility which does nothing to improve access to skilled nursing and facility-based hospice services. A lack of sufficient access to these services leads to increased use of more expensive alternatives (emergency room utilization, hospitalization, etc.). (D)

Table 10. Alternatives Analysis: Staffing Impacts.

Option:	Advantages/Disadvantages:
Option One Establish a 32-Bed SNF in Yakima County—The Project	• As an urban area with proximate colleges such as WSU College of Nursing in Yakima and Central Washington University in Ellensburg, there is a concentration of skilled healthcare professionals in Yakima. (A). • Competitive market in demand for healthcare professionals. (D) • Admissions would be balanced with available staff (Neutral, "N")
Option Two Do nothing	• No impact. (N)

Table 11. Alternatives Analysis: Legal Restrictions.

Option:	Advantages/Disadvantages:
Option One Establish a 32-Bed SNF in Yakima County—The Project	• This option requires certificate-of-need approval. (N)
Option Two Do nothing	• There are no legal implications with this option. (A)

2. Describe, in as much detail as possible, specific efforts that were undertaken to contain the costs of offering the proposed service.

Through the repurpose of what was previously a hospice house, MultiCare is able to establish a new 32-bed Skilled Nursing Facility in Yakima County and help meet the need for additional SNF beds in Yakima. We expect the capital costs for the proposed project to include $468,892

in equipment and architect fees, which is **orders of magnitude** below the cost of a typical new facility construction. A comparable example to the proposed project is the 36-bed facility proposed by Soundcare, Inc in Pierce County in 2022. This 36-bed facility was estimated to cost over $18 million.[11] There is, quite simply, no more cost-effective way to increase access to SNF services in Yakima County.

3. **In the case of construction, renovation, or expansion, describe any operating or capital cost reductions achieved by architectural planning, engineering methods, methods of building design and construction, or energy conservation methods used.**

   The proposed project does not entail any construction. Thus, this question is not applicable.

4. **Under a concurrent or comparative review, preference will be given to the project which meets the greatest number of criteria listed below. Provide documentation describing how the proposed project meets the following criteria.**
   a. **Projects that include other institutional long-term care services or evidence of relatively greater linkages to community-based, long-term care services.**
   b. **Projects which improve the geographic distribution and/or provide access to nursing home beds in a currently under-served area.**
   c. **Nursing home operators having (or proposing to have) a Medicare contract in areas with less than the statewide proportion of Medicare nursing home beds to total nursing home beds.**
   d. **Nursing home operators serving (or proposing to serve) Medicaid clients.**
   e. **Nursing home operators proposing to serve additional heavy care patients in areas where CSO placement staff or hospital discharge planners document significant and continuing difficulties in placing such patients in nursing homes.**
   f. **Existing nursing home operators in the state who are seeking to achieve a 100-bed minimum efficient operating size for nursing homes or to otherwise upgrade a facility with substantial physical plant waivers or exemptions, as determined by Washington State Aging and Adult Services Administration.**
   g. **Projects that propose to serve individuals requiring mental health services and care for Alzheimer's or dementia conditions.**

      No other organization submitted a letter of intent under the concurrent review cycle. Thus, there are no other applicants and this question is not applicable.

[11] CN23-11, p. 2.

INSTRUCTIONS FOR COMPLETION OF COST REPORTING FORMS REQUIRED FOR SUBMISSION OF CERTIFICATE OF NEED APPLICATIONS FOR NURSING HOME PROJECTS

A complete application for a Certificate of Need will include the information requested in the "Application Information Requirements for Health Care Facility Certificate of Need Applications Nursing Home Related Projects." When completed, the enclosed forms will satisfy the information requirements in the Application Information Requirements under B, Financial Feasibility Section III 9(b) i, ii, iii, iv, v, vi, except that an application should list start-up costs separately, and should also identify the anticipated period of deficit operations before the project is utilized at a break-even point.

NOTE: ALL FINANCIAL STATEMENTS MUST BE FOR NURSING HOME OPERATIONS ONLY

"NON-INFLATED" PROJECTIONS

All projections for the first through third years of operation shall be shown in *"non-inflated"* collars based on the last complete fiscal year. Do not show increased costs due to anticipated inflationary trends. These *"non-inflated"* costs should show all anticipated costs resulting from increased staffing, supplies, utilities, etc., and should also show anticipated interest expense and depreciation expense.

EXPLANATION OF COLUMN HEADINGS

"Actual" - These columns apply to existing nursing homes proposing the addition of beds or total replacement of an existing facility. "Actual" must be by fiscal year, in accordance with the way books are kept.

"Estimate" - This column applies to existing nursing homes and shall show estimated operational figures for the current twelve months of operation of the facility.

"Projected" - means each twelve months of operation through at least three full fiscal years following completion of the project.

The dates requested *(directly beneath column headings discussed above)* refer to the actual dates of the fiscal year for historical data, and the anticipated dates for each fiscal year of operation.

RECEIVED
By Andrew Struska at 3:52 pm, Sep 03, 2024

Exhibit 1

Letter of Intent

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

July 31, 2024

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

RE: Letter of Intent to operate a certificate of need approved Skilled Nursing Facility in Yakima County, Washington

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, MultiCare Health System ("MultiCare") submits this Letter of Intent ("LOI") to establish and operate a certificate of need approved Skilled Nursing Facility in Yakima County, Washington.

1. Description of Proposed Service:
   The establishment and operation of a certificate of need approved Skilled Nursing Facility with 32 beds in Yakima County, Washington.

2. Estimated Cost of the Project
   The estimated capital cost of the project is $440,100.

3. Identification of the Service Area
   The service area is Yakima County, Washington.

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

K. Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
P.O. Box 5299, Mail Stop: 820-4-SBD
Tacoma, WA 98415
ekobberstad@multicare.org

Frank Fox, PhD
HealthTrends
frankfox@comcast.net

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

Sincerely,

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

Exhibit 2

Management Services Agreement

Via Electronic Mail

Avalon Care Center – Cottage in the Meadow, L.L.C.
c/o Avalon Health Care Management, Inc.
206 North 2100 West, Suite 300
Salt Lake City, Utah 84116
Attn: Hyrum Kirton

Re: Non-Binding Letter of Intent – SNF Management Services

Greetings Hyrum:

The purpose of this confidential non-binding letter of intent ("**LOI**") is to set forth the general basis upon which Avalon Care Center – Cottage in the Meadow, L.L.C. ("**Avalon**"), and MultiCare Health System ("**MHS**" or "**MultiCare**") (each, a "**Party**" and collectively, the "**Parties**") propose to enter into a skilled nursing facility management agreement related to that certain facility located at 1208 S. 48th Avenue, Yakima, Washington.. This LOI shall function as the framework from which the Parties shall jointly develop, negotiate, and eventually draft definitive agreements that are necessary to consummate any or all portions of the proposed arrangement. Each Party's respective legal counsel shall work with each other to finalize the definitive agreements.

1. Structure of the Arrangement. The contemplated management services arrangement shall be substantially in the form of the attached Skilled Nursing Facility Management Agreement (the "**Management Services Arrangement**").

2. Expenses. MultiCare, on one hand, and Avalon, on the other, will each pay its own fees and expenses and those of their agents, advisers, attorneys, and accountants with respect to the negotiation of this LOI, the conduct of due diligence, the negotiation and execution of the **Management Services Arrangement**.

3. Confidentiality. Except as required disclosures to regulatory and licensing authorities, each Party acknowledges it shall maintain confidentiality regarding this LOI and the **Management Services Arrangement** until mutual execution of that agreement.

4. Public Announcement. The Parties mutually agree that neither Party will issue any press release or make any public announcement of the **Management Services Arrangement** or this LOI without the prior consent of the other Party, except where a public announcement is required by law as reasonably determined by such Party. The form, content, timing, and means of publication of any such press release or public announcement will be mutually agreed upon in advance by the Parties. Notwithstanding the foregoing, in the event a Party hereto determines that this LOI or the terms hereof will be the subject of discovery in any litigation involving such Party, such Party will promptly notify the other Party hereto of such determination and if the other Party concludes that such disclosure through discovery is inevitable, then: (i) the Parties will make a public announcement of the terms hereof prior to such discovery taking place; (ii) such public announcement will be made in a manner and at a time mutually agreed by the Parties; and (iii) both Parties will be represented at and permitted to participate in such announcement.

5. Non-Binding Nature of LOI and Draft MSA. The provisions set forth in the attached draft **Management Services Agreement** reflect the Parties' mutual understandings and current expectations, but each Party acknowledges that the attachment is not intended to create or constitute any legally binding obligation between Avalon and MultiCare, and neither Avalon nor MultiCare will have any liability to the other Party with respect to the provisions set forth in the attachment, except to the extent that such provisions are reflected in the final **Management Services Agreement** entered into by the Parties. If the Parties do not enter into a **Management Services Agreement** for any reason, neither Party to this LOI will have any liability to the other Party based upon or relating to the attachment.

6. Termination. This LOI may be terminated: (i) at any time, upon the agreement of the Parties; (ii) at any time, by either Party upon written notice to the other Party; (iii) upon execution of one or more Definitive Agreements; or (iv) if not earlier terminated pursuant to (i) through (iii) above, automatically, unless the Parties mutually agree to extend the LOI. Upon any such termination, neither Party will have any obligation or liability, except for those that arose prior to the effective date of termination.

If you are in agreement with the provisions of this LOI, please sign below and deliver a copy to the undersigned.

Sincerely,

MULTICARE HEALTH SYSTEM

Lynn Siedenstrang

By: Lynn Siedenstrang
Title: VP Care Continuum

ACCEPTED AND AGREED to this 29 day of August, 2024:

AVALON CARE CENTER – COTTAGE IN THE MEADOW, L.L.C.

By: Avalon Holding, Inc.
Its: Manager

By: Alan Hash
Title: Chief Executive Officer

SKILLED NURSING FACILITY

MANAGEMENT AGREEMENT

by and between

MultiCare Yakima Memorial Hospital
a Washington limited liability company,

and

AVALON CARE CENTER – Cottage in the Meadow, L.L.C.,
a Utah limited liability company,

Dated as of September 1, 2024

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SKILLED NURSING FACILITY
MANAGEMENT AGREEMENT

This Management Agreement is made as of the 1st day of September, 2024 (the "**Effective Date**"), by and between (MULTICARE ENTITY), a Washington limited liability company ("**Operator**"), and AVALON CARE CENTER – Cottage in the Meadow, L.L.C., a Utah limited liability company ("**Manager**").

RECITALS

A. As of the Commencement Date (as defined below), Operator intends to operate a skilled nursing facility known as Cottage in the Meadow located at 1208 S. 48th Avenue, Yakima, Washington (the skilled nursing facility, together with the land upon which such facility and the improvements thereon are located, the "**Facility**") under a license granted to Operator and approved by the Social and Health Services for the State of Washington.

B. Operator desires that Manager provide management services for the Facility on behalf of Operator in accordance with the terms and conditions described in this Agreement.

C. Manager has expertise in providing management services and is willing to perform management services for the benefit of the Facility in accordance with, and subject to, the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth herein, the receipt and legal sufficiency of which are acknowledged, the parties hereto agree as follows:

1. DEFINITIONS. Initially capitalized terms used in this Agreement, unless the context otherwise requires or they are otherwise defined herein, shall have the following meanings:

"**AAA**" has the meaning set forth in Section 14.1.

"**Administrator**" means the person charged with performing, and who holds all required licenses, and possesses the requisite skills, abilities and experience, to perform, the senior executive functions for the Facility. The Administrator shall be an employee of Manager. The Administrator is also commonly known as the administrator or the general manager.

"**Affiliate**" means, when used with reference to a specified Person, any Person that directly or indirectly, including through one or more intermediaries, controls or is controlled by or is under common control with such Person. For purposes of this Agreement, "control" (and, with correlative meaning, "controlled by" and "under common control with") will be deemed to exist if the Person or party in question is, directly or indirectly, the owner of more than fifty percent (50%) of the voting equities of the Person or party in question or such Person or party has the ability, through contract or otherwise, to direct the management or operations of the party in question.

"**Agreement**" means this Agreement, as amended, modified, supplemented, restated or otherwise changed from time to time as provided herein.

"**Authorized Discloses**" has the meaning set forth in Section 17.2.

"**Base Management Fee**" has the meaning set forth in Section 7.1(a).

"**Budget**" has the meaning set forth in Section 5.1 and, with respect to the Capital Plan portion thereof, Section 5.2.

"**Business Day**" means any day other than Saturday, Sunday or a legal holiday in the State

"**Calendar Year**" means a 12-month period commencing on the first day of January and ending on the last day of December, except that the first "Calendar Year" shall be the period commencing on the Commencement Date and ending on the next succeeding December 31st.

"**Capital Plan**" has the meaning set forth in Section 5.2.

"**City**" means Yakima, Washington, and all departments, agencies, political subdivisions and instrumentalities thereof.

"**Commencement Date**" means the date of the closing of the acquisition of the Facility by Operator. Upon request by either party after the Commencement Date, the parties hereto shall execute a certificate memorializing the Commencement Date.

"**Confidential Information**" means all financial, operating, patient, vendor, marketing, regulatory, training, recruiting, customer, and personnel materials and information, including, but not limited to, procedure manuals, patient care procedures and policies, pro formas, projections, and computer programs and data, relating to, or utilized in (as applicable), the Facility and which is not (i) information that was already lawfully known to the receiving party hereunder or lawfully in the possession of the receiving party prior to its disclosure hereunder; (ii) information that the receiving party obtained from a third party who, to the receiving party's knowledge, is not prohibited from disclosing the information to the receiving party by a contractual, legal or fiduciary obligation to the disclosing party; (iii) information that is or becomes publicly available (other than as a result of the receiving party's disclosure in violation of this Agreement); or (iv) information that the receiving party independently develops.

"**Default**" has the meaning set forth in Section 11.2.

"**Defaulting Party**" has the meaning set forth in Section 11.2.

"**Dispute**" has the meaning set forth in Section 14.

"**Distributable Cash**" means, as of a given date, all cash in the Operating Account as of such date in excess of the greater of (i) the sum of all outstanding Operating Expenses and all Operating Expenses to be incurred, or reasonably expected to be incurred, in the reasonable judgment of Manager and Operator, and (ii) the Minimum Operating Account Balance.

"**Emergency**" means an event occurring at the Facility which poses actual or imminent risk of serious personal injury, physical damage, environmental contamination or monetary loss.

"**Expense Category**" means each category of costs set out in the Budget or other chart of accounts established and amended from time to time by Manager.

"**Facility**" has the meaning set forth in the Recitals.

"**Facility Lender**" means the holder of any mortgage lien against the Facility.

"**Facility Standards**" means the management, upkeep and improvement standards typically associated with a well maintained, quality skilled nursing facility similar to the Facility in an area in which the Facility is located.

"**Federal Privacy and Security Regulations**" has the meaning set forth in Section 17.4.

"**FF&E**" means the furniture, furnishings, fixtures, soft goods, case goods, vehicles and equipment (including but not limited to telephone systems, facsimile machines, communications and computer systems hardware) but shall not include Household Replacements or any software. Manager shall have no interest in the FF&E.

"**FF&E Reserves**" has the meaning set forth in Section 5.2.

"**Force Majeure**" has the meaning set forth in Section 15.1.

"**GAAP**" means generally accepted accounting principles, as consistently applied.

"**Governmental Entities**" means Secretary of the United States Department of Health and Human Services, Comptroller General of the United States, Veterans Administration, Medicare, Internal Revenue Service, Social and Health Services for the State of Washington, and all other City, State and federal agencies, having jurisdiction over the Facility and the ownership, use and operation thereof.

"**Gross Revenues**" means for each applicable accounting period, all revenues and receipts of every kind derived from operating the Facility.

"**Household Replacements**" means supply items, except for FF&E, used or held in storage for future use, as are customarily used on a daily basis and are necessary in connection with the operation of the Facility in accordance with the terms of this Agreement, including linen, china, glassware, silver, uniforms, and similar items, including food, beverages, medical supplies, soaps, shampoos or any other similar consumable product.

"**Incentive Fee**" has the meaning set forth in Section 7.1(b).

"**Indemnitees**" with respect to a party means each of its Affiliates and permitted assignees and each of the officers, directors, partners, members, managers, employees and agents of the party, its Affiliates, or any permitted assignee thereof.

"**Initial Term**" has the meaning set forth in Section 11.1.

"**Legal Requirements**" means the requirements and conditions imposed by applicable law, all Governmental Entities, and all governmental permits, licenses and approvals with respect to the Facility and the ownership, use, management and operation thereof, as the same may be amended, supplemented and/or substituted from time to time

"**Management Fees**" means the Base Management Fees and Incentive Fees.

"**Manager**" has the meaning set forth in the preamble to this Agreement.

"**Minimum Operating Account Balance**" means the average amount needed to fund Operating Expenses and Management Fees for forty-five (45) days.

"**Non-Defaulting Party**" has the meaning set forth in Section 11.2.

"**Operating Account**" is the checking account in the name, or held for the benefit and use, of Operator established by or for the benefit of Operator, into which Manager shall deposit or cause to deposit Gross Revenues and shall make payments on behalf of Operator of Operating Expenses and, subject to Section 9.1, the Management Fees.

"**Operating Expenses**" means those costs and expenses that are related to the operating costs and staffing of the Facility, including, without limitation:

1. the reasonable cost and expenses of technical consultants and operational experts, approved by Operator, who may be employees of Manager or one of its Affiliates and who perform specialized services (that is, services not otherwise required to be provided by staff of Operator or Manager to provide the Services for and in consideration of the Management Fees payable hereunder) in connection with the Facility (including, but not limited to, regional office employees and employees of Manager's Affiliates who assist with the Facility operations, such as an information technology help desk and a regional business, clinical or other manager operations); provided, however, that the costs and expenses so incurred shall only be Operating Expenses to the extent they are reasonable and competitively priced as compared to similar work done by outside consultants or experts;

2. fully-burdened costs of the Facility employees, such costs to include, without limitation: (i) salary and wages (including costs of processing, printing, and mailing of payroll checks and W-2 forms), training programs, hiring expenses, premium costs for employee-related professional or other liability policies (including employment practices liability insurance) and any self-insurance or deductible layer copay, channel or corridor payment, claims, administration costs, payroll taxes and processing fees, workers' compensation, bonus compensation, incentive compensation, retirement plan payments, travel expenses and other benefits payable (including, for example, self-funded health insurance, dental insurance, life insurance and disability insurance) to or for the benefit of such personnel; and (ii) punitive damages, collateral fees, bonds, settlement costs, fines, penalties, interest, attorney's fee or other amounts for matters relating to employment practices liability or employment practices in general (collectively, "**Employee Extraordinary Costs**"), so long as the Employee Extraordinary Costs in question did not arise from the gross negligence or willful misconduct of Manager;

3. the Management Fees; and

4. Shared Expenses.

"**Operating Plan**" has the meaning set forth in Section 2.4.

"**Operating Services**" has the meaning set forth in Section 2.2.

"**Operator**" has the meaning set forth in the preamble to this Agreement.

"**Person**" means any individual, partnership, corporation, limited liability company, association, business, trust, government or political subdivision thereof, governmental agency or other entity.

"**Proprietary Materials**" means all computer systems, data (including all patient and employee records and information) and software programs (including all billing and accounting software programs and information), trade names, trademarks, logos, service marks, signage, marketing and promotional literature and materials, patient and other information and data, manuals, plans, systems, charts and other materials and information developed by or for a party or at the party's expense.

"**Routine Capital Expenditures**" has the meaning set forth in Section 5.3(a).

"**Rules**" has the meaning set forth in Section 14.1.

"**Services**" has the meaning set forth in Section 2.2.

"**Shared Expenses**" means costs incurred by Manager and its Affiliates in connection with providing services to, and allocated equitably among, senior living communities and skilled nursing facilities managed or operated by Manager or its Affiliates Shared Expenses reasonably allocated to the Facility shall be an Operating Expense. Initial categories of Shared Expenses are set forth in **Schedule 1** attached hereto.

"**State**" means the State of Washington and all departments, agencies, political subdivisions and instrumentalities thereof.

"**Subcontractor**" means either an entity contracting directly with Manager or Operator to furnish services or materials as a part of or related to the Services, or an entity contracting with a Subcontractor of any tier to furnish services and/or materials as a part of or related to the Services.

"**Term**" means the Initial Term, as such period may be extended or sooner terminated in accordance with this Agreement.

2. SERVICES; DUTIES AND RESPONSIBILITIES OF MANAGER.

2.1 Appointment and Acceptance. Operator hereby appoints and retains Manager, and Manager hereby accepts Operator's appointment, as of the Commencement Date, as the sole and exclusive manager of the Facility to carry out and perform the Services. Notwithstanding the generality of the foregoing, Operator shall have ultimate responsibility for the operation of the Facility, its compliance with the Legal Requirements and the satisfaction of the Facility's obligations. For the avoidance of doubt, Operator hereby retains all control and authority (a) required by law for the Facility to maintain the license from the State that is required for the operation of the Facility as a skilled nursing facility, and (b) not otherwise specifically delegated to Manager under this Agreement. Operator acknowledges that Manager's Affiliates may provide management or other services similar to the Services to or for the Facility, so long as those services are charged at market rates, not more than arm's length prices.

2.2 Operating Services. Commencing as of 12:01 a.m. on the Commencement Date and at all times thereafter during the Term, Manager shall directly or through the Facility employees and Subcontractors, perform or provide operational functions over the following matters, all of which, except as specifically provided in this Agreement, will be an Operating Expense to be paid by, or on behalf of Operator (collectively, the "**Operating Services**" or the "**Services**"):

(a) Operate and manage all aspects of the Facility in accordance with this Agreement, the Operating Plan, the Budget, and in compliance with all Legal Requirements.

(b) Hire, train, and supervise qualified employees and Subcontractors to operate the Facility, which employees shall be employed by Manager. Manager's obligations under this Section 2.2(b) shall be contingent on Operator's satisfaction of its obligations under Section 4.

(c) Market the occupancy and use of the Facility, consistent with a reasonable marketing plan.

(d) Prepare, negotiate and finalize for approval and execution by Operator, patient agreements and/or leases and other required agreements with patients and other users of the Facility, consistent with the Legal Requirements and standards established by Manager from time to time for the Facility and approved by Operator, which approval shall not be unreasonably withheld, conditioned or delayed.

(e) Assist Operator in negotiating contracts, to be executed by Operator, for the procurement of materials, supplies, parts, equipment, vehicles, services and other items necessary for the operation and maintenance of the Facility.

(f) Take such actions and implement such procedures as Manager deems necessary or prudent to provide safety and security for the Facility and its employees, occupants and guests.

(g) Perform, or cause to be performed by employees of Operator or Subcontractors, all maintenance, repair and capital improvements for the Facility in accordance with the Operating Plan.

(h) Collect data for reporting to permitting and licensing Governmental Entities.

(i) Collect Gross Revenues and deposit them, as agent for Operator, into the Operating Account.

2.3 Emergency. Notwithstanding the provisions of Section 2.1 or any limitation in the description of Services in Section 2.2, if Manager believes in good faith that an Emergency exists and that changes or modifications in the Services or employees of the Facility are required to avoid or mitigate losses from such Emergency, Manager shall have the right to temporarily make such changes or modifications, and effect such personnel changes, to the extent required by such Emergency. Manager shall promptly notify Operator of the Emergency.

2.4 Operating Plan. In furtherance of its general responsibilities described elsewhere in this Agreement, Manager shall have the following planning and budgeting responsibilities:

Manager shall prepare and submit for Operator's approval, which approval shall not be unreasonably withheld, conditioned or delayed, a detailed plan for the marketing, operation, repair, maintenance and improvement of the Facility ("**Operating Plan**"), which Operating Plan shall be revised from time to time.

(a) Manager shall consult with Operator as it may reasonably request regarding the assumptions and projections underlying Manager's proposed Operating Plan. Operator shall, as set forth in Section 5, either accept the proposed Operating Plan, or require Manager to modify the proposed Operating Plan and re-submit the modified Operating Plan to Operator for approval in accordance herewith.

2.5 Manager Reports. Manager shall prepare and provide to Operator (or provide Operator access to) its automated reports for the Facility, including, without limitation, reports related to the financial performance, census, and clinical reports.

2.6 Contracts.

(a) As part of its Services, Manager shall, and is authorized to, initiate, negotiate, advise and provide recommendations to the Administrator for all agreements, contracts or purchase orders necessary and prudent for the proper operation of the Facility, all of which Operator agrees may be executed by the Administrator (or other Manager-authorized signatory) on behalf of Operator.

(b) Manager, the Administrator or other appropriate Facility employee shall act on behalf of Operator in executing patient agreements and amendments and renewals thereof. The form of the patient agreements shall be reasonably acceptable to Operator; provided, that Manager may make such changes to the approved forms as Manager may determine in its discretion to be necessary or desirable for the operation of the Facility, provided that such changes meet Legal Requirements and reflect the Facility Standards.

3. STANDARD OF SERVICES.

3.1 General Standards. Subject to the availability of sufficient funds, Manager shall perform the Services in a manner consistent with maintaining the Facility Standards; and in all material respects in accordance with all Legal Requirements.

4. PERSONNEL.

4.1 Personnel Standards and Training of Employees. All regular employees of the Facility (including the Administrator) shall be employees of Manager. All employees of Manager providing Services hereunder at the Facility shall receive commercially reasonable training in connection therewith.

4.2 Performance Standards. The working hours, rates of compensation, benefits and all other labor matters relating to the performance by all employees at the Facility shall be established (and modified as necessary and prudent to reflect local standards) by Manager. The working hours, rates of compensation, benefits and all other labor matters relating to the performance of the Services by the Administrator and Manager's employees working at the Facility, shall be determined solely by Manager.

4.3 Equal Opportunity and Affirmative Action. Neither Operator nor Manager shall discriminate because of race, color, religion, gender, age, national origin, sexual orientation, disability or status as a military veteran, as defined and prohibited by applicable law, in the recruitment, selection, training, utilization, promotion, termination or other employment related activities of any employee of Manager with respect to the Facility, applicant for employment with the Facility or Subcontractor. Manager affirms that it is an equal opportunity and affirmative action employer, and shall comply with all applicable federal, state and local laws and regulations relating to non-discrimination and affirmative action.

4.4 Restrictions on Soliciting Employees. The parties acknowledge that each of Manager and Operator will invest considerable amounts of time and money in training its employees and consultants in the systems, procedures, methods, and techniques of its operation. Accordingly, during the period beginning as of the day following the Commencement Date and continuing (except as provided below) through the first (1st) anniversary of the termination or expiration of this Agreement, no party hereunder shall, directly or indirectly: (i) solicit or induce any employees or independent contractors of the other party or parties or their Affiliates to terminate, diminish or otherwise alter their relationship with such other party or its Affiliates; or (ii) contact or assist others in contacting any such employees or independent contractors for such purpose. Notwithstanding the generality of the foregoing, a party will not be deemed to have violated this Section 4.4 with respect to an employee or independent contractor as a result of interviewing or hiring any person (A) with whom such party has been in communication regarding employment or consulting prior to the date of this Agreement, (B) who responds to a general advertisement for open positions (including through job fairs, internet job sites, or advertisements in newspapers or other periodicals), (C) who responds to contacts made by independent agents (such as recruiting firms) without the party or such agent knowing that such contacts might potentially violate this section, or (D) is hired in connection with the initial transition of employees as contemplated by Section 4.2 above.

5. BUDGETS.

5.1 Budget and Operating Plan Preparation. At least thirty (30) days before the start of each Calendar Year following the first Calendar Year of the Term, Manager shall prepare and submit to Operator proposed annual budgets for the following Calendar Year (prepared in monthly detail), which shall be Manager's good faith estimate of the costs of implementing the Operating Plan proposed by Manager pursuant to Section 2.4 for the same period. The proposed annual budget shall provide an itemized estimate of the costs to be incurred in connection with the proposed marketing, operations, maintenance and capital improvement plan and programs, allocated among Expense Categories, and reserves for civil monetary penalties and other items. Operator shall, within thirty (30) days following its receipt of Manager's proposed annual budget and after consultation with Manager, provide to Manager in writing changes, additions, deletions and modifications. Manager will then prepare and provide to Operator a revised budget incorporating all changes, additions, deletions and modifications (if any) provided by Operator to the extent approved by Manager. Operator shall within five (5) Business Days after receipt then either provide comments to such revised budget or approve such budget. The process described above shall be repeated, if necessary, until the budget finally has been approved by Operator (the "**Budget**"). Such final Budget shall remain in effect throughout the applicable Calendar Year. If there is a delay in the finalization of a new Budget, or if the changes proposed by Operator to a proposed Budget are not agreed upon by Manager, Manager shall operate the Facility pursuant to the prior Calendar Year's Budget increased by the three percent (3%) until the proposed Budget is agreed upon by Operator and Manager. Manager shall use commercially reasonable efforts according to the Facility Standards to adhere to the Budget as approved, it being understood, however, that an approved Budget is only a projection by Manager of estimated results and that various circumstances such as, but not limited to, the cost of labor, material, services and supplies, casualty, operation of law, or economic and market conditions may make achievement of the approved Budget impracticable or not obtainable.

5.2 Capital Plan and FF&E Issues. Manager shall prepare, as part of any proposed Budget, an annual estimate of capital expenditures for both routine and non-routine matters (the "**Capital Plan**"). Manager shall submit such Capital Plan to Operator for Operator's approval at the same time the proposed Budget is submitted to Operator, which Capital Plan and/or Budget shall, unless otherwise agreed by the parties include reserves ("**FF&E Reserves**") to be maintain and used by Manager for such capital expenditures. Operator shall not unreasonably withhold (or delay) its consent with respect to such Capital Plan expenditures which are (1) required, in Manager's reasonable professional judgment, to keep the Facility in a competitive, efficient and economical operating condition to meet the Facility Standards, (2) reasonably required to achieve material compliance with any applicable Legal Requirements, or (3) repairs or replacements of portions of the Facility with respect to which it is no longer reasonably prudent to perform only routine maintenance in order to keep the Facility in good condition and repair, consistent with the Facility Standards.

5.3 FF&E Reserve.

(a) To facilitate compliance in material part with the obligations set forth in Section 5.2, Operator will establish and maintain the FF&E Reserves in an account designated by Operator to cover the cost of the following (collectively "**Routine Capital Expenditures**"):

(i) Replacements, renewals and additions to the Facility's FF&E as required to meet the Facility Standards and Legal Requirements; and

(ii) Certain routine repairs and maintenance to the Facility as required to meet the Facility Standards and Legal Requirements and which are included in the Budget and which are normally capitalized under GAAP (such as exterior and interior repainting, resurfacing building walls, floors, roofs and parking areas), but which are not major repairs, alterations, improvements, renewals or replacements to the Facility's structure or exterior facade or to the Facility's mechanical, electrical, heating,

ventilating, air conditioning, plumbing or vertical transportation systems, the cost of which shall be Operator's sole responsibility.

(b) For the avoidance of doubt, in the event a Facility Lender requires an FF&E reserve account, Manager shall be permitted to satisfy any such requirement simultaneously using the FF&E Reserve.

(c) All amounts transferred into the FF&E Reserve shall be paid from Gross Revenues. With respect to any capital expenditure items not included in the Budget and/or Capital Plan, Manager may submit a written request for approval to Operator, detailing Manager's Routine Capital Expenditures for the year to date, together with reasonable information outlining the need to expend funds for additional Routine Capital Expenditures not included in the Budget. Manager shall not in any case be required to advance its own funds for such capital expenditures. Such requests for approval of Routine Capital Expenditures outside the Budget shall be made on a quarterly or such other basis as shall be agreed to by Manager and Operator. Operator will respond with its approval or disapproval (and to the extent approved, with Operator's authorization to withdraw funds from the FF&E Reserve) within thirty (30) days after such submission by Manager. If Operator does not respond within such thirty (30) day period, Operator will be deemed to have consented to Manager's request for additional Routine Capital Expenditures outside the Budget and/or Capital Plan. With respect to those Routine Capital Expenditures included in the Budget, Capital Plan or otherwise approved by Operator in writing, Operator shall be required to fund payments for those expenditures into the FF&E Reserve within ten (10) days of written request from Manager for such funds.

6. RECORDS AND INSPECTION.

6.1 Accuracy of and Access to Records. Manager shall maintain accurate books and records in connection with the Services, and shall, subject to the application of Section 9.3, retain such records for a minimum period of three (3) years. Operator may, at its expense, audit such records at any time during regular business hours, upon reasonable advance notice. During the Term and for a period of three (3) years thereafter, Manager shall make available, upon written request, to all Governmental Entities, or any of their duly authorized representatives, this Agreement (including all amendments) and Manager's supporting books, documents and records to the extent necessary to verify Operator's payments hereunder.

6.2 Access and Inspection. Subject to the Legal Requirements, Operator and the Facility Lender and their respective employees, agents, contractors and representatives shall, upon prior written notice, have access at all reasonable times to the Facility, Facility operations, and, upon reasonable notice, documents, materials, records and accounts relating to the Facility operations, all for purposes of inspection and review. Manager agrees to reasonably cooperate with the Facility Lender and/or any authorized representative(s) designated from time to time by the Facility Lender at the expense of Operator or the Facility Lender to visit and inspect the Facility, review the Facility's financial and accounting records, and to make copies and take extracts therefrom, and to discuss the affairs, finances and accounts of the Facility with Manager and its representatives, all upon reasonable notice and at such reasonable times during normal business hours, as often as may be reasonably requested by the Facility Lender.

7. COMPENSATION; EXPENSES.

7.1 Compensation.

(a) Base Management Fee. Beginning as of the Commencement Date and through the termination or expiration of this Agreement, Operator shall pay to Manager, base management fees (the

"**Base Management Fee**") in an amount equal to six percent (6%) of net revenues from operating the Facility for the preceding month.

(b) Incentive Fees. Manager shall also be entitled to receive an amount equal to fifteen percent (15%) of quarterly net income in excess of the net income identified in the board approved annual budget, calculated on a cumulative year-to-date basis. Incentive Fees shall be paid quarterly to Manager within forty-five (45) days after the expiration of the quarter. An example is provided to illustrate how the Incentive Fees will be calculated.. Incentive Fees shall be paid quarterly to Manager.

i. If the Facility had a net income of $100,000 in the first quarter of the calendar year, the Incentive Fees paid to Manager would be $15,000 ($100,000 * 15%).

ii. If the Facility sustained a loss of $30,000 to net income during the second quarter of the calendar year, Manager would not receive an Incentive Fees payment.

iii. If the Facility had a net income of $60,000 in the third quarter of the calendar year, calculating the Incentive Fees paid to Manager would first account for the loss to net income occurring during the second quarter (i.e. $60,000 minus $30,000 = $30,000 cumulative net income). Manager's third quarter Incentive Fees would be $4,500 (i.e. $30,000 * 15%).

(c) Manager Payment Right. Manager shall pay itself the Management Fees for each month during the Term from the Operating Account, commencing on the month following the Commencement Date. To the extent that any Management Fees are payable and funds in the Operating Account are not available to make such payment, Operator shall make such payment directly to Manager within ten (10) Business Days after Manager's invoice therefor. If any period for calculation with respect to the Management Fees is less than a full month, the amount shall be prorated, based on an assumed 30-day month.

7.2 Operating Expenses. Operating Expenses are not included in the Management Fees and shall be paid directly by or on behalf of Operator, reimbursed by Operator or on behalf of Operator or paid by Manager from the Operating Account on behalf of Operator pursuant to Section 9. In no event shall the Management Fees be calculated based on Operating Expenses. Additionally, for uninsured patients referred by MultiCare Health System or an affiliate thereof, Operator shall pay Manager an amount equal to Four Hundred and Fifty dollars ($450.00) per day.

8. PAYMENT.

8.1 Operating Expenses. From and after the Commencement Date, Operator shall make payments from the Operating Account, or Manager shall pay from the Operating Account on behalf of Operator, the Operating Expenses before the same become delinquent and reimburse Manager for Operating Expenses (including Shared Expenses) paid by Manager from other than the Operating Account, together with a reimbursement of impositions under applicable law (if any) to the extent required under applicable State law, actually paid by Manager for the Facility within thirty (30) days of the invoice date, subject to the limitations contained herein. Manager shall be authorized to withdraw amounts from the Operating Account from time to time as needed to make any such payments pursuant to the terms of this Agreement, including payments to itself.

9. RESPONSIBILITIES AND DUTIES OF OPERATOR.

Operator shall furnish to Manager, at Operator's expense, the funds, information, materials and other items described below in this Section 9. All such items shall be made available at such times and in such manner as may be required for the expeditious and orderly performance of the Services by Manager.

9.1 Funding of Operating Account, Working Capital Reserve. Operator shall ensure that adequate funds are on deposit at all times in the Operating Account to allow for the timely payment of Operating Expenses and Management Fees. In connection therewith, Operator shall maintain in the Operating Account from and after the Effective Date sufficient funds, with a minimum balance of at least the Minimum Operating Account Balance to provide for the timely payment of the Operating Expenses and Management Fees, all as set forth in the current Budget. Manager shall have no obligation to advance funds to or for the benefit of the Facility, its operation or to or for the benefit of Operator. Operator agrees to deposit an amount of money into the Operating Account (a) that is sufficient to restore the Minimum Operating Account Balance within five (5) Business Days of receiving written notice from Manager of the shortfall that includes a reasonable explanation accounting for the shortfall, and (b) that is sufficient to satisfy all payroll obligations (including, employee-related taxes and F.I.C.A. and other employee benefits or compensation) within three (3) Business Days of receiving written notice from Manager of the shortfall that includes a reasonable explanation accounting for the shortfall. For clarity, the foregoing requirement for Operator to fund and maintain the Minimum Operating Account Balance shall be a condition precedent to Manager's obligation to employ the Facility employees.

9.2 Easements, Etc. Operator shall, upon notice from Manager and with its assistance, obtain and maintain, to the extent reasonably possible at a reasonable cost, all easements, rights-of-way, permits and licenses necessary to allow the Facility to be operated as contemplated under this Agreement.

9.3 Review Plans. Operator shall bear responsibility for reviewing and approving all required plans, budgets, and schedules in a timely fashion as set forth herein, and for complying with all approval, consent and authorization requirements of Operator hereunder.

9.4 Insurance. Operator shall provide the insurance coverages described in Section 13.1.

9.5 Acknowledgement of Manager Commitments. Operator shall honor, as its own, all contracts, agreements, and commitments entered into by Manager with respect to the management and operation of the Facility so long as they are required or permitted pursuant to the Operating Plan, the Budget and/or this Agreement.

9.6 Applications. Operator shall execute all applications or other relevant documentation for licenses, permits or other instruments necessary for operation of the Facility and provide such information and perform such acts relative to the operation of the Facility as are required by law, regulation or governmental agency in order to obtain and/or maintain any license, permit, instrument, certificate, certification or approval with respect to the proper operation of the Facility.

9.7 Licenses; Permits. Operator shall reasonably cooperate with Manager in its responsibility to obtain and keep in full force and effect in the name of Operator any and all licenses and permits necessary for the operation of the Facility.

9.8 Inspections. Operator shall reasonably cooperate, participate in and be responsible for any survey, inspection or site investigation conducted by a governmental, regulatory, certifying or accrediting entity with authority or jurisdiction over the Facility.

9.9 Distributable Cash. Notwithstanding anything to the contrary in this Agreement, at no time may Operator withdraw funds from the Operating Account or otherwise distribute funds received by the Facility unless such funds are Distributable Cash.

10. INDEPENDENT CONTRACTOR. Manager shall be an independent contractor, for tax and all other purposes, with respect to the performance of the Services hereunder. Neither Manager nor its employees, Subcontractors, vendors or suppliers, nor the employees of any such parties employed in the Facility operations, shall be deemed to be agents, representatives, employees, or servants of Operator, except to the extent of any express employment or agency is approved by Operator. Except as otherwise expressly provided herein, this Agreement shall not constitute Manager as the legal representative or agent of Operator, nor shall Manager have the right or authority to assume, create or incur any liability or obligation, express or implied, against, in the name of, or on behalf of Operator or its owners. This Agreement is not intended to create, and shall not be construed to create, a relationship of partnership or an association for profit between Operator and Manager.

11. TERM AND TERMINATION.

11.1 Term of the Agreement. The initial term of this Agreement (the "**Initial Term**") shall commence on the Effective Date and continue through the fifth (5^{th}) anniversary of the Commencement Date and shall thereafter continue for successive one (1) year renewal terms. Notwithstanding the foregoing, in the event the Facility is sold by Operator to an unrelated third party, either party may terminate this Agreement by written notice to the other party upon the date of the sale.

11.2 Termination for Convenience. After the third anniversary of the Commencement Date, either Party may terminate this Agreement for any or no reason upon one hundred and eighty (180) days written notice to the other Party.

11.3 Termination for Breach. If Manager or Operator (hereinafter the "**Defaulting Party**") has committed a material breach of its obligations or representations and warranties under this Agreement (a "**Default**"), the other party (the "**Non-Defaulting Party**") may elect to terminate this Agreement as follows:

(a) The Non-Defaulting Party shall give the Defaulting Party a written notice describing such default in reasonable detail and demanding that the Defaulting Party cure the default.

(b) If within thirty (30) days after receiving such notice, the Defaulting Party has not either (i) negotiated a termination of such notice, or (ii) cured the default, then the Non-Defaulting Party may terminate this Agreement by written notice to the Defaulting Party; provided, however, that if the default is such that it cannot be cured within the 30-day time period, but is reasonably curable within a longer period without material additional adverse effect on the Non-Defaulting Party and if the Defaulting Party promptly commences action reasonably calculated to cure such default within a reasonable period of time and thereafter diligently pursues such action to completion, the 30-day period provided in this clause shall be deemed extended for such reasonable period of time not to exceed an additional forty-five (45) days. Notwithstanding any provision herein to the contrary, no failure of Manager to do any act or perform any Services which arises or results from a lack of Budget authority, insufficient funds, or other required approval by Operator shall be deemed a breach of this Agreement.

(c) If the parties disagree as to the materiality of any claimed default, or as to the applicability of any cure period, or as to the adequacy of any cure, that disagreement shall be resolved in arbitration pursuant to Section 16 of this Agreement.

11.4 Employees. Upon the termination or expiration of this Agreement, Manager shall have the right to terminate all the Facility employees, including the Administrator. Operator agrees to comply with the Worker Adjustment and Retraining Notification Act and all Department of Labor regulations related thereto and all state counterpart laws in connection with the termination by Manager of all employees. Operator shall be solely liable and responsible for all severance payments, accrued wages, salary, overtime, paid vacation and sick leave and their equivalents, pension and other employee benefits or compensation, of any nature, relating to employees of the Facility (collectively, the "**Severance Payments**"), which amounts Manager shall have the right to pay from the Operating Account unless (a) Operator or it's designee assumes such Severance Payments pursuant to an assumption agreement reasonably acceptable to Operator and Manager, and (b) such assumption is permitted by applicable laws. To the extent Manager pays any Severance Payments from its own funds, Operator shall reimburse and pay to Manager such amount within five (5) Business Days after receipt therefor. The terms of this Section will survive the termination of the Agreement.

11.5 Effect of Termination. No termination of this Agreement shall deprive a party of amounts or other performance due to such party for any period prior to the date of such termination, or relieve any party of the consequences of its breach of this Agreement. Election to terminate this Agreement pursuant to this Section 12 shall not constitute an election of remedies and, subject to Section 18, shall be without prejudice to any other remedies at law or in equity available to the Non-Defaulting Party by reason of any default of the other party.

11.6 Survival. Sections 4.5 (concerning restrictions on hiring employees); 11 (concerning indemnification), 13 (concerning insurance); 14 (concerning dispute resolution); 16 (concerning limitations of liability); 17 (concerning publicity, confidentiality and proprietary materials); 18 (concerning general provisions); and all other provisions that must survive to be enforceable or effective, shall survive the Term and termination of this Agreement.

12. INDEMNIFICATION.

12.1 By Manager. Manager shall defend, indemnify and hold Operator and its Indemnitees harmless from and against any and all claims, actions, damages, expenses (including reasonable attorneys' fees), losses or liabilities incurred by or asserted against Operator or its Indemnitees for injury (including death) to Persons or damage or destruction to property and any and all fees or penalties incurred by Operator to the extent that such claims, actions, damages, expenses, losses or liabilities are caused by (a) any uncured breach or default of the Agreement by Manager or its employees (other than the Facility employees), and/or (b) the grossly negligent acts or omissions or willful misconduct of Manager or its employees (other than the Facility employees), partners, agents, officers or directors in connection with this Agreement, provided that the foregoing indemnification shall not apply if it is determined by a court of competent jurisdiction that the indemnified loss was caused by the gross negligence or willful misconduct of Operator.

12.2 By Operator. Operator shall defend and indemnify Manager and its Indemnitees from and against any and all claims, actions, damages, expenses (including reasonable attorneys' fees), losses or liabilities incurred by or asserted against Manager or its Indemnitees, partners, officers, directors, employees, representatives, or agents, to the extent that such claims, actions, damages, expenses, losses or liabilities arising out of or relating in any way to (a) the ownership, operation and maintenance of the Facility, including all employee-related claims and medical malpractice claims; (b) any uncured breach or default of the Agreement by Operator; and/or (c) the grossly negligent acts or omissions, or willful misconduct, of Operator or its employees, partners, agents, officer or directors in connection with this Agreement, provided that the foregoing indemnification shall not apply if it is determined by a court of competent jurisdiction that the indemnified loss was caused by the gross negligence or willful misconduct of Manager (other than Facility employes)..

12.3 Indemnification Process. If an Indemnitee receives actual knowledge of any claim subject to this Section 12, it will give prompt notice of that claim to the indemnifying party and, at the Indemnitee's election at any time while that claim is not resolved, in addition to the indemnifying party's other obligations under this Section 12 as to indemnity, the indemnifying party (i) will assume, and promptly pay and discharge as incurred, the costs of defending such claim, and (ii) may elect to undertake the defense of such claim with counsel reasonably acceptable to the Indemnitee. No Indemnitee in the defense of any such claim shall, except with the indemnifying party's consent, consent to entry of any judgment or enter into any settlement that does not include the full release from all liability in respect to such claim or litigation from the plaintiff or claimant in question.

12.4 No Specific Outcome. Manager is not making any representations or guaranties as to any specific outcome or achievement of goals or results (including financial or operating results) in performing its Services under this Agreement.

12.5 Survival. The provisions of this Section 12 shall survive termination, cancellation or expiration of this Agreement.

13. INSURANCE.

13.1 Operator's Insurance. Beginning at the Commencement Date and continuing until the termination of this Agreement, Operator shall procure and maintain in full force and effect the following insurance policies, as an Operating Expense.

(a) Property insurance in an amount equal to the full replacement cost of the Facility and business personal property, loss of income and such other insurance required by the Facility Lender. Operator shall be first named insured and Manager shall be named as a loss payee with respect to the property insurance and any earlier insurance obtained by or for the benefit of Operator with respect to the Facility.

(b) Commercial general liability insurance, including public liability insurance, bodily injury, property damage, professional liability, contractual, and personal injury liability, with a combined single limit of at least One Million Dollars ($1,000,000) each occurrence, Three Million Dollars ($3,000,000) aggregate. Manager shall be named as an additional insured.

(c) Umbrella liability with a limit of Five Million Dollars ($5,000,000), which shall name Manager as an additional insured.

(d) Worker's compensation insurance with statutory limits, and employer liability insurance for all of Operator's employees at the Facility providing Services.

13.2 Manager's Insurance. From and after the Commencement Date, Manager shall procure and maintain in full force and effect, as an Operating Expense, the following insurance coverage:

(a) Employment Practice Liability Insurance to cover the Administrator and all of Operator's employees at the Facility during their course of work.

(b) Automobile Insurance to cover the Administrator and all of Operator's employees at the Facility while driving for Facility purposes. If there is no automobile exposure, then Manager shall carry Non-Owned and Hired Automobile Liability Insurance unless otherwise Operator and Manager agree otherwise.

(c) Worker's compensation insurance with statutory limits, and employer liability insurance for the Administrator.

(d) Fidelity coverage in the amount of at least the value of two (2) months of Gross Revenues (capped at Five Million Dollars ($5,000,000)) set forth in the Budget maintained on behalf of Manager for employee dishonesty coverage for the Facility employees who handle or are responsible for safekeeping of any monies of Operator or who participate directly or indirectly in the management and maintenance of the Facility and its assets, accounts and records. Such coverage shall name Operator, the Facility Lender and any other Person to the extent required by the Legal Requirements, as additional loss payees.

13.3 Insurance Requirements. The insurance policy required under this Agreement shall be with companies authorized to do business in the State and having a rating of not less than A:XII in the most recent issue of Best's Key Rating Guide, Property-Casualty. All such policies shall be written as primary policies, not contributing with and not in excess of the coverage that the other party may carry, and shall only be subject to reasonable deductibles. Manager may maintain all or any part of the insurance required pursuant to this Agreement in the form of a blanket policy covering other locations in addition to the Facility. Manager and Operator release each other from all rights of recovery under or through subrogation or otherwise for any loss or damage insured under the policies required under this Agreement and agree that no insurer shall have a right to recover any amounts paid in respect of a claim from the other party. Operator and Manager shall deliver to one another, at the request of the other party from time to time, a certificate from the insurance broker for the coverages set forth in this Section 13 showing the amount of coverage as of the requested date, and that such policies will include effective waivers (whether under the terms of any such policy or otherwise) by the insurer of all claims for insurance premiums against all loss payees and additional insureds and all rights of subrogation against all loss payees and additional insureds, and that if all or any part of such policy is canceled, terminated or expires, the insurer will forthwith give notice thereof to each additional insured, assignee and loss payee and that no cancellation, reduction in amount or material change in coverage thereof shall be effective until at least thirty (30) days after receipt by each additional insured, assignee and loss payee of written notice thereof. Each of Operator and Manager shall, within five (5) Business Days of receipt of notice from any insurer, provide the other party with a copy of any notice of cancellation, nonrenewal or material change in coverage from that existing on the date of this Agreement, forthwith, notice of any cancellation or nonrenewal of coverage.

14. DISPUTE RESOLUTION.

14.1 Arbitration. Any dispute, controversy, or claim arising out of or relating to this Agreement, or breach thereof (each a "**Dispute**" and collectively the "**Disputes**"), shall be fully and finally determined by binding arbitration conducted in Salt Lake City, Utah in accordance with the then-current Commercial Arbitration Rules and Mediation Procedures ("**Rules**") of the American Arbitration Association ("**AAA**"), and any judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. (Capitalized terms in this Section 14, unless otherwise defined, shall be given the meaning set forth in the Rules.) In the circumstances set forth in the Rules, Expedited Procedures and Procedures for Large, Complex Commercial Disputes shall be followed, unless otherwise agreed to in writing by the parties.

14.2 Arbitrator. If any claim or counterclaim exceeds $1 million, exclusive of interest, attorneys' fees, and arbitration fees and costs, either party to the proceedings may demand a panel of three arbitrators. Such demand must be in that party's initial filing in the arbitration, whether a demand for arbitration, answering statement, or counterclaim. In such a case, each party shall appoint one arbitrator from the AAA National Roster, and those two shall appoint a third from the National Roster. In all other cases, the number and appointment of arbitrators shall be as set forth in the Rules.

14.3 Discovery. The exchange of documents and information and other discovery procedures shall be as set forth in the Rules; however, discovery beyond that contemplated in the Rules, including depositions, may be agreed to by the parties, or a party may request from the arbitrator(s) leave to conduct discovery, which request shall be granted upon good cause shown and that the requested discovery, in time and expense, is proportionate to the Dispute.

14.4 Timing. The arbitrator(s) shall take such steps as may be necessary to hold the hearing within ninety (90) days of the initial demand for arbitration. The arbitrator(s) may for good cause shown permit reasonable extensions or delays. Absent fraud, collusion or willful misconduct by the arbitrator(s), the award shall be final and judgment may be entered in any court having jurisdiction thereof.

14.5 Fees and Expenses. If the arbitrator(s) determines that the claim or defense of either Operator or Manager in the arbitration was frivolous (that is, without justifiable merit), the arbitrator(s) may require that the party at fault pay or reimburse the other party for any or all of the following: (i) all fees and expenses of the arbitrator(s), (ii) the reasonable attorneys' fees of such other party, and (iii) any other reasonable out-of-pocket expenses incurred by such other party in connection with the arbitration proceeding. In all other instances not otherwise provided therein, each party shall pay for its own costs and expenses, including attorneys' fees, arising out of any arbitration, with the cost of the arbitrator(s) being shared equally by the parties. The arbitrator(s) shall not have the power to award punitive damages.

15. FORCE MAJEURE.

15.1 Definition. The term "**Force Majeure**" as used herein means acts, events, occurrences and conditions beyond the reasonable control of the party claiming Force Majeure including, but not limited to, acts of God, labor disputes, sudden actions of the elements, the effect of changes in applicable laws or regulations, actions by federal, state, or municipal agencies, actions of legislative, judicial, or regulatory agencies or denial, lapse or revocation of any permit, license or regulatory approval necessary in connection with the operation or maintenance of the Facility.

15.2 Excused. If either party because of Force Majeure is rendered wholly or partly unable to perform its obligations under this Agreement (except any obligation to pay money), that party shall be excused from whatever performance is affected by the Force Majeure (except any obligation to pay money) to the extent so affected provided that:

(a) the non-performing party, within five (5) days after obtaining actual knowledge of the occurrence of the Force Majeure, gives the other party written notice describing the particulars of the occurrence;

(b) the suspension of performance is of no greater scope and of no longer duration than is required by the Force Majeure;

(c) the non-performing party uses its reasonable efforts to remedy its inability to perform (this subsection shall not require the settlement of any strike, walkout, lockout or other labor dispute on terms which, in the sole judgment of the party involved in the dispute, are contrary to its interest, it being understood that the settlement of strikes, walkouts, lockouts or other labor disputes shall be at the sole discretion of the party having the difficulty); and

(d) when the non-performing party is able to resume performance of its obligations under this Agreement, such party shall give the other party written notice to that effect.

15.3 Regulatory Change. If a party is unable to perform due to legislative, judicial, or regulatory agency action, the parties shall meet in good faith to amend this Agreement as appropriate to comply with the legal change which caused the non-performance.

15.4 Payment. Notwithstanding any provision herein to the contrary, during the occurrence and continuation of any event of Force Majeure, Operator shall remain obligated to pay to Manager the compensation set forth in Section 7, subject to an amendment of the Budget pursuant to Section 5, if appropriate, to provide for any increase or decrease in Operating Expenses or other costs incurred by Manager as a result of such Force Majeure.

16. LIMITATIONS OF LIABILITY.

16.1 Consequential Damages. Notwithstanding any provision in this Agreement to the contrary, except with respect to damages subject to indemnification pursuant to Section 12.2(a) neither party nor its Affiliates, partners, shareholders, officers, directors, agents, or Subcontractors shall be liable hereunder for consequential or indirect loss or damage, including loss of Gross Revenues, cost of capital, loss of goodwill, increased operating costs, or any other special or incidental damages. The parties further agree that the waivers and disclaimers of liability, indemnification provisions, releases from liability, and limitations on liability expressed in this Agreement shall survive termination or expiration of this Agreement, and shall apply (unless otherwise expressly indicated), whether in contract, equity, tort or otherwise, and shall extend to the partners or shareholders, directors, officers and employees, agents and related or affiliated entities of such party, and their partners, principals, directors, officers and employees.

16.2 Warranties and Guarantees. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, NEITHER PARTY MAKES ANY WARRANTIES OR GUARANTEES TO THE OTHER, EITHER EXPRESS OR IMPLIED, WITH RESPECT TO THE SUBJECT MATTER OF THIS AGREEMENT, AND EACH PARTY DISCLAIMS AND WAIVES ANY IMPLIED WARRANTIES OR WARRANTIES IMPLIED BY LAW.

17. PUBLICITY, CONFIDENTIALITY AND PROPRIETARY MATERIALS.

17.1 Publicity. Neither party shall issue any press release or make any public statement regarding the transactions contemplated hereby, without the prior written approval of the other party, except, if after discussion between the parties or their counsel, in the opinion of any party's counsel such party is required under any applicable law or regulation to make a public statement or announcement, such party shall be permitted to issue the legally required statement or announcement.

17.2 Confidential Information. Each party acknowledges that it may disclose its Confidential Information to the other party in connection with this Agreement. If a party receives Confidential Information from or relating to the other party, the receiving party shall: (i) maintain the Confidential Information in strict confidence; (ii) use at least the same degree of care in maintaining the secrecy of the Confidential Information as it uses in maintaining the secrecy of its own proprietary, secret, or Confidential Information, but in no event less than a reasonable degree of care; (iii) use such Confidential Information only to fulfill its obligations under this Agreement; (iv) not photocopy or otherwise duplicate any such Confidential Information without the prior written consent of the disclosing party; and (v) return or destroy all documents, copies, notes, or other materials containing any portion of the Confidential Information upon request of the other party and upon termination or expiration of this Agreement. The receiving party shall not disclose any portion of the Confidential Information to any Person except those of its agents, employees, attorneys, accountants and Affiliates (and the officers, employees and agents of its Affiliates) (collectively, "**Authorized Disclosees**") having a need to know such Confidential Information to accomplish the purposes contemplated by this Agreement; and in the event of such disclosure, the party making such disclosure shall

inform the recipient of the foregoing limitations. Any breach by an Authorized Disclosee of the provisions of this Section 17.2 shall be deemed a breach of this Section 17.2 by the receiving party that made the disclosure to the Authorized Disclosee.

17.3 Proprietary Materials. Operator agrees that all Proprietary Materials of Manager shall be and remain the property of Manager and Operator hereby assigns, conveys and transfers any claim of right with respect to Manager's Proprietary Materials. Manager agrees that all Proprietary Materials of Operator shall be and remain the property of Operator and Manager hereby assigns, conveys and transfers any claim of right with respect to Operator's Proprietary Materials. Upon termination of this Agreement, all use of Operator's Proprietary Materials shall be discontinued by Manager, and Manager shall immediately return to Operator all such Proprietary Materials and all copies thereof. Upon termination of this Agreement, all use of Manager's Proprietary Materials shall be discontinued by Operator, and Operator shall immediately return to Manager all such Proprietary Materials and all copies thereof. Operator and Manager will make all such information available for use or inspection by any regulatory or compliance agency to the extent required by such agency.

17.4 HIPAA Compliance. To the extent required, the Facility will be in material compliance with Subpart F (Administrative Simplification) of HIPAA, as defined herein, the Health Information Technology for Economic and Clinical Health Act, and the regulations contained in 45 C.F.R. Parts 160 and 164, as amended (collectively, the "**Federal Privacy and Security Regulations**"), the regulations contained in 45 C.F.R. Parts 160 and 162, as amended and all other Laws relating to the privacy, security and transmission of health information. Manager's policies relating to the privacy and security of "Protected Health Information" (as defined in the Federal Privacy and Security Regulations) with respect to the Facility will comply with the Federal Privacy and Security Regulations and applicable state Legal Requirements in all material respects. Manager will conduct Security Risk Assessments required to ensure the Facility's compliance with security obligations under the HIPAA Security Rule. On the Execution Date, the parties shall execute and deliver a business associate agreement in the form attached to this Agreement.

18. GENERAL PROVISIONS.

18.1 Essence of Time. Time is of the essence of this Agreement and each of its provisions. If any date herein set forth for the performance of any obligations by Operator or Manager or for the delivery of any instrument, consent, approval or notice as herein provided should be on a Saturday, Sunday or legal holiday, the compliance with such obligations or delivery shall be deemed acceptable on the next Business Day following such Saturday, Sunday or legal holiday. As used herein, the term "legal holiday" means any holiday (but not any furlough days) for which the departments and agencies of the State are generally closed for observance thereof.

18.2 No Waiver. No waiver will be effective against either party unless it is in writing, specifies the breach waived, and is signed by the waiving party. A waiver of any particular breach of any term contained in this Agreement will not operate as a waiver of that term itself, or as a waiver of any subsequent breach thereof. The failure of either party to exercise any right or remedy available under this Agreement upon the other party's breach of the terms, representations, covenants or conditions of this Agreement or the failure to demand the prompt performance of any obligation under this Agreement shall not be deemed a waiver of (i) such right or remedy; (ii) the requirement of punctual performance; or (iii) any right or remedy in connection with any subsequent breach or default on the part of the other party.

18.3 Invalidity. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects to carry out its purposes to the maximum extent legally possible, including, if necessary, as if such invalid or unenforceable provision were omitted.

18.4 Authority. Each party represents and warrants that it has the requisite authority, licenses and permits to enter into this Agreement and to perform its duties hereunder (including the Services by Manager), that the individual signing below on that party's behalf has all requisite authority and approvals to do so and to bind that party, and that it has done and will do all things necessary so that this Agreement will be valid, binding and legally enforceable upon that respective party.

18.5 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State and all obligations of the parties created hereunder are performable in the State.

18.6 Entire Agreement; Amendments. This Agreement, including the Exhibits and Schedules hereto, which are incorporated herein by this reference, constitutes the entire agreement of the parties with respect to its subject matter and shall supersede any and all prior agreements or understandings related to the same subject matter. This Agreement may be amended only by a writing signed by a duly authorized representative of each party.

18.7 Notices. All notices, requests, offers, reports and other communications required or permitted to be made under this Agreement shall be in writing, and shall be given by first class, registered or certified mail, postage prepaid, or by hand-delivery, facsimile or electronic mail. All notices shall be addressed as follows:

If to Operator:

(MultiCare Yakima Memorial)
820-4-LEG, 820 A Street, Fourth Floor
Tacoma, WA 98402
Attn: Lynn Siedenstrang
Email: Lynn.Siedenstrang@multicare.org

If to Manager:

Avalon Care Center – Yakima Meadow, L.L.C.
c/o Avalon Health Care Management, Inc.
206 North 2100 West, Suite 300
Salt Lake City, Utah, 84116
Attn: Hyrum Kirton

or at such other addresses as either party may designate from time to time in writing by like notice to the other party. Notices shall be deemed duly given at the time delivery is received at the address provided for above.

18.8 Counterparts. This Agreement may be executed in counterparts, and any number of counterparts signed in the aggregate by the parties hereto shall constitute a single original document.

18.9 Headings. All section and paragraph headings contained in this Agreement are for convenience of reference only, do not form a part of this Agreement, and shall not affect in any way the meaning or interpretation of this Agreement.

18.10 No Third-Party Beneficiaries. This Agreement does not and is not intended to confer any rights or remedies upon any Person other than the parties.

18.11 Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns where permitted by this Agreement.

18.12 Gender. Words of any gender used in this Agreement shall be held and construed to include any other gender, and words in the singular number shall be held to include the plural, and vice versa, unless the context requires otherwise.

18.13 Attorneys' Fees. Except as otherwise provided herein, any legal action or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any provisions of this Agreement, the party prevailing to the greater extent shall be entitled to recover reasonable attorneys' fees, court costs and all expenses even if not taxable as court costs, incurred in that action or proceeding, in addition to any other relief to which such party or parties may be entitled.

18.14 Governing Document. This Agreement shall govern in the event of any inconsistency between this Agreement and any of the Exhibits or Schedules attached hereto or any other document or instrument executed or delivered pursuant hereto or in connection herewith.

18.15 Signage. Manager shall have the right to identify itself as manager of the Facility through advertising media (other than Facility signage) in a time, place and manner subject to Operator's prior consent (which shall not be unreasonably withheld, delayed or conditioned) and in compliance with all applicable laws to be displayed at such location (and in such size and configuration) as shall be mutually agreed upon by the parties. Manager may, in connection with its identification and marketing efforts as part of the Services, market itself and the Services under an affiliated Manager brand. Each party shall, in connection with the marketing and operation of the Facility permit the reasonable use of its name and affiliation with the Facility in a manner that does not misstate the relationship of the parties or misrepresent the operations of the Facility. No such use or permission will be deemed a general license to use the trademarks, logos or other intellectual property of a party, and all such rights shall be limited by the scope and terms of this Section. Upon any termination or expiration of this Agreement, the parties shall cease any use of such signage, trademarks, logos and other intellectual property.

18.16 Rule of Construction. Each party (and its counsel) has reviewed and revised this Agreement and the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement or any amendments or Exhibits or Schedules hereto.

18.17 No Partnership or Joint Venture. Nothing contained in this Agreement shall be deemed or construed by the parties hereto or by any third party as creating the relationship of a partnership or a joint venture between the parties hereto; it being understood and agreed that neither any provisions contained herein nor any acts of the parties hereto shall be deemed to create any relationship between the parties hereto other than the relationship of operator/tenant and manager.

18.18 Further Assurances. Operator and Manager shall execute and deliver all other appropriate supplemental agreements and other instruments and take any other action necessary to make this Agreement fully and legally effective, binding and enforceable as between them and as against third parties.

18.19 Remedies Cumulative. No remedy herein conferred upon any party is intended to be exclusive of any other remedy, and each and every such remedy shall be cumulative and shall be in addition to every other remedy given hereunder or now or hereafter existing at law or in equity or by statute or otherwise. No single or partial exercise by any party of any right, power or remedy hereunder shall preclude any other or further exercise thereof.

[*The remainder of this page is intentionally left blank; signature pages follow.*]

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties have executed this Agreement as of the date shown first above.

OPERATOR:
MultiCare Yakima Memorial Hospital

By: _____
Name:
Title:

MANAGER

AVALON CARE CENTER – YAKIMA MEADOW, L.L.C.

By: Avalon Holding, Inc.
Its: Manager

By _____
Hyrum Kirton, Senior Vice President

SCHEDULE 1

Categories of Shared Expenses

Payroll processing fees
Tax preparation and consulting fees (if needed)
General IT services and support
Electronic health record applications (e.g. clinical module, AR sub-ledger module, billing module, reimbursement module)
Insurance cost to the extent the Facility participates in Manager's group policies
Cost reporting and regulatory compliance fees
Time and attendance program fees
Scheduling application and service fees
Email and other software application user fees
Recruiting platforms and applications
Clinical, quality and operational oversight program fees (examples: Simple LTC, Abaqis, Building Engines, etc.)

SCHEDULE 2

Conditions for Incentive Fees

The 30-day re-hospitalization rate of residents/patients in the Facility is eighteen percent (18%) or less during the last 12-month period.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is made by and between _____ ("BA"), a _____ formed under the laws of the State of _____ and Yakima Valley Memorial Hospital Association d/b/a MultiCare Yakima Memorial ("MYM"), a nonprofit corporation formed under the laws of the State of Washington. MYM and BA are sometimes referred to in this BAA individually as "Party" or, collectively, as the "Parties."

BA provides MYM with services rendered in conjunction with one or more separate engagements or agreements related to BA's principal business activities, referred to jointly and severally as the "Services Agreement."

In the performance of the underlying Services Agreement between BA and MYM, BA may use, disclose, receive, create, transmit, or maintain Protected Health Information or Electronic Protected Health Information, as those terms are defined in 45 CFR § 160.103 ("PHI"), from MYM and, therefore, might constitute a "business associate" of MYM within the meaning of 45 CFR § 160.103. The purpose of this BAA is to permit MYM to comply with requirements concerning "business associates" imposed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") the Privacy Rule and Security Rule, 45 CFR Parts 160 and 164 (the "Privacy Rule" and the "Security Rule" respectively) and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), which is Title XIII of the American Reinvestment and Recovery Act, and any amendments, regulations, rules, and guidance issued thereto and the relevant dates for compliance. This BAA is intended to document the assurances required by the HIPAA Privacy regulations (at 45 CFR § 164.504(e)) and the HIPAA Security Regulations (at 45 CFR § 164. 314(a)).

In situations where BA needs to access MYM Data, Network, or Systems (as defined below), MYM has an obligation to ensure the integrity of its computing environment and the confidentiality of Data in its care. Further, MYM has an obligation to ensure that any BA is enacting appropriate Information and Cyber Security Controls to reduce the risk to the Data in its care.

BA and MYM agree as follows:

1. Definitions.

   MYM: MultiCare Yakima Memorial ("MYM") is a not-for-profit healthcare organization which provides acute hospital, emergency and general medical services in and around Yakima County, Washington.

   Covered Entity: "Covered Entity" shall have the same meaning as the term "covered entity" in 45 CFR § 160.103.

   Data: "Data" refers to Personally Identifiable Information (PII), Personal Health Information (PHI), and physician information that has been identified as appropriate for sharing between MYM and BA in any medium including but not limited to paper, electronic, or oral. Each individual who is the subject of Data is the owner of data rights and information (to the extent provided for in law). MYM is the owner of all data rights and information outside of the individual's ownership.

Data Aggregation: "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR § 164.501.

Individual: "Individual" shall mean the person who is the subject of PHI as provided in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

Minimum Necessary: "Minimum Necessary" shall have the same meaning as the term "minimum necessary" in 45 CFR § 164.502.

Notice of Privacy Practices: "Notice of Privacy Practices" shall have the same meaning as the term "notice of privacy practices" in 45 CFR § 164.520.

Part 2 Program: A "part 2 program" is as defined in 42 CFR § 2.11.

Personally Identifiable Information (PII): "Personally Identifiable Information" means an individual's first name or first initial and last name in combination with social security number, driver's license number, state or federal identification card number, account number or credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account, full date of birth, student, military or passport ID numbers, any personally identifiable health information (PHI), biometric data, usernames or email addresses combined with password(s) or security questions and answers. This does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

Protected Health Information or PHI: "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present, or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including but not limited to, 45 CFR § 160.103.

Offshoring: "Offshoring" refers to any situation where BA allows any individual or entity to access, view, copy, hold, receive, possess, process, or download Data during any period of time such individual or entity is located outside of the United States.

Qualified Service Organization: A "Qualified Services Organization" is an individual or entity that provides services to a Part 2 program, as defined in 42 CFR § 2.11.

Remote IT Service(s): "Remote IT Services" means all information and technology (IT) related products and services supplied by a subcontractor or third party that are remotely delivered that involve access, receipt, storage, transmission, and/or destruction of PHI or PII, or systems that store, process, or transmit this data. Remote IT Services are not intended to include Professional Services, unless the Professional Services include the third party receiving, storing, transmitting, and/or remotely destroying PHI or PII of MYM.

Professional Services: "Professional Services" means services provided by an individual, often as a representative of a subcontractor or third party, that involve expertise that an organization either does not possess or does not have sufficient capacity to perform itself.

Unsecured Protected Health Information: "Unsecured Protected Health Information" shall have the same meaning as "unsecured protected health information" in 45 CFR § 165.402, limited to the information created and/or received by BA from or on behalf of MYM.

2. Compliance with Applicable Law. The Parties acknowledge and agree that beginning with the applicable effective dates, BA shall comply with its obligations under this BAA and with all obligations of a business associate under HIPAA, HITECH, Washington State Law 70.02, Idaho State Laws and other related laws and any implementing regulations, as they exist at the time this BAA is executed and as they are amended, for so long as this BAA is in place. To the extent that the BA is to carry out one or more of the covered entity's obligations under Subpart E of 45 CFR Part 164, BA shall comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligations.

3. Use of Protected Health Information. BA shall not use or disclose PHI for any purpose other than:

   a. to fulfill the BA's obligations under the Services Agreement(s);

   b. for the proper management and administration of BA;

   c. as required or allowed under HIPAA;

   d. to a subcontractor or agent meaning the requirements of Section 7; and/or

   e. as otherwise required by law according to 45 CFR § 164.103.

   BA may not use or disclose PHI it receives from MYM in a manner that would violate HIPAA if done by MYM.

   All uses and disclosures of and requests by BA for PHI are subject to the Minimum Necessary requirements of the Privacy Rule and shall be limited to the information contained in a limited data set, to the extent practical, unless additional information is needed to accomplish the intended purpose, or as otherwise permitted under HIPAA, HITECH, and any implementing regulations.

4. Off-Shore. MYM defines "offshoring" PHI as BA allowing any individual or entity to access, view, copy, hold, receive, possess, process, or download Data during any period of time such individual or entity is located outside of the United States.

   ☐ The Parties agree that BA shall not at any time "offshore" MYM's Data.

   ☐ The Parties agree that BA may access MYM's Data from an offshore or foreign location as detailed in the Agreement, but data will not be stored in an off-shore location.

   ☐ The Parties agree that BA may "offshore" MYM's Data as detailed in the Agreement.

BA agrees that under no circumstances will it offshore MYM Data to individuals or entities located in China, Russia, North Korea, Malaysia, Syria, Nigeria, Iran, Iraq, Belarus, Kazakhstan, Azerbaijan, Georgia, Libya, Lebanon, Cuba, Burundi, Crimea "Region", Venezuela, Romania, or Afghanistan.

5. De-Identified PHI. BA may only de-identify PHI it receives from MYM pursuant to 45 CFR § 164.514. BA may not sell or disclose de-identified information to any third-party unless MYM has first approved such use or disclosure in writing.

6. Safeguards. BA shall use appropriate safeguards and provide training to its employees, contractors, and agents to prevent the use or disclosure of MYM's PHI not permitted by this BAA, and shall follow MYM policies, rules, and guidelines with respect to privacy and security when on MYM premises, including but not limited to MYM' Vendors Representatives policy and Non-Employee On and Off-Boarding policy (copies of which are available upon request). BA shall comply with Subpart C of 45 CFR part 164 to prevent use and disclosure of PHI other than as provided for by the BAA.

   BA agrees to maintain an overall information security program aligned with an industry standard framework such as HITRUST, ISO, NIST, CIS, etc. BA will provide evidence of assessment of program design and effectiveness upon request. As part of the evidence of assessment, BA will disclose the security measures it uses to protect Data, which must meet applicable professional standards, and which may require compliance with some parts of HIPAA (any such disclosure shall be deemed confidential information of BA) or allow MYM, or its third-party agent (after executing a confidentiality agreement satisfactory to BA), to audit the BA's privacy and security practices at the expense of the BA, upon reasonable advance written notice.

7. Sub-Contractors and Agents. BA shall enter into a written agreement with any agent or sub-contractor of BA that will have access to PHI that is received from, created or received by, transmitted or stored by BA on behalf of MYM. Pursuant to such written agreement, the agent or sub-contractor shall agree to be bound by the same or greater restrictions that apply to BA under this BAA with respect to such PHI including but not limited to all of the requirements in Section 3 above and in accordance with 45 CFR § 164.502(e)(1)(ii) and 164.308(b)(2). The Parties agree that MYM is a third-party beneficiary in BA's relationships with its subcontractor's and agents that have access to/receive MYM PHI and related Data and BA shall take all reasonable action to enable MYM to protect its rights and PHI and related Data against such subcontractors and/or agents as MYM deems necessary. BA and its subcontractor(s)/agent(s) shall maintain records as required in order to provide an accounting of disclosures in accordance with 45 CFR § 164.528 within fifteen business (15) days of receiving a written request from MYM.

8. Access for Audit. BA shall make its internal practices, policies, and records relating to the use and disclosure of Data from or on behalf of MYM available to MYM for purposes of determining BA and MYM's compliance with applicable laws. BA agrees that MYM has the right to audit MYM's Data, upon request from Covered Entity.

9. Accounting to HHS. BA shall make its internal practices, books, and records relating to the use and disclosure of Data received from or on behalf of MYM available to the Secretary of the United States Department of Health and Human Services ("Secretary") for purposes of determining MYM's compliance with the Privacy or Security Rules.

10. Mitigation and Reporting. If BA becomes aware of an access, use, or disclosure of MYM's PHI and related Data not permitted by this BAA ("Prohibited Disclosure"), then BA shall:

a. Promptly, and no later than five (5) business days after discovery or upon BA's reasonable suspicion of a Prohibited Disclosure, use commercially reasonable efforts to mitigate any potential adverse effect of the Prohibited Disclosure, including, but not limited to, compliance with any state law or contractual data breach requirements; and

b. no later than five (5) business days after discovery or upon BA's reasonable suspicion of a Prohibited Disclosure report the use or disclosure to MYM, as required by 45 CFR § 164.410.

A report to MYM required under this Section shall include: (i) to the extent possible, the names of the individual(s) whose Data has been, or is reasonably believed by BA to have been accessed, acquired, used or disclosed during the Prohibited Disclosure; (ii) a brief description of what happened including the date of Prohibited Disclosure and the date of the discovery, if known; (iii) a description of the types of Data that were involved in the Prohibited Disclosure; (iv) a brief description of what BA is doing or will be doing to investigate the Prohibited Disclosure, to mitigate harm to the individual(s), and to protect against further prohibited use or disclosures; and (v) any other information that MYM determines is needed for notifications to the individual(s) under 45 CFR § 164.404(c). In the event of a Prohibited Disclosure, BA shall provide reasonable cooperation with MYM in any investigation MYM undertakes related to the Prohibited Disclosure.

This Section constitutes notice to MYM of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to MYM is required. For purposes of this BAA, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on BA's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of data.

MYM and BA may agree that BA shall provide notice to any or all individuals affected by a Prohibited Disclosure. In such cases, BA will inform MYM of its proposed notification process and timeline and provide MYM the opportunity to review and approve the proposed notice and timeline prior to any notification to any individual, media outlet, or to the Secretary regarding Prohibited Disclosure involving MYM Data.

11. Obligations of MYM.

a. Limited Disclosure Obligations: To the extent possible, MYM will limit the PHI provided to BA to only that necessary for BA to perform its obligations under the Services Agreement. Prior to transmission of PHI to BA, MYM will notify BA of the need to transmit PHI and will arrange with BA for the proper and secure transmission of such PHI.

b. Requested Restrictions. MYM shall notify BA, in writing, of any restriction on the use or disclosure of PHI that MYM has agreed to in accordance with 45 CFR § 164.522, which permits an Individual to request certain restrictions of uses and disclosures, to the extent that such restriction may affect BA's use or disclosure of PHI.

c. Changes in or Revocation of Permission. MYM will notify BA in writing of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes or revocation may affect BA's use or disclosure of PHI.

d. Permissible Requests by MYM. MYM shall not request BA to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy or Security Rules if done by MYM, except to the extent that BA will use or disclose PHI for Data Aggregation or management and administrative activities and legal responsibilities of BA.

e. Privacy Practices. MYM shall notify BA of any limitation(s) in the Notice of Privacy Practices of MYM under 45 CFR § 164.520, to the extent that such limitation may affect BA's use or disclosure of protected health information.

f. MYM agrees to treat security, personnel, and policy information disclosed to it by BA under this BAA as confidential.

MYM may provide BA with Data in the form of both paper and digital output from MYM's systems, and by electronic transmission. MYM may also elect at its option to afford BA access to certain primary source patient encounter data, through MYM's Information Services department, including but not limited to potential on-line access through internet / intranet channels approved in advance by MYM and consistent with MYM's licenses associated with such systems.

12. Right to Terminate for Material Breach. In addition to any other rights the Parties may have in the Service Agreement, this BAA or by operation of law or in equity, either Party may terminate this BAA and the Services Agreement(s) if such Party makes the determination that the other Party has breached a material term of this BAA, provided that the non-breaching Party has (i) provided the breaching Party with written notice of the existence of an alleged material breach and thirty (30) days to cure the breach and (ii) the breaching Party has failed to cure said alleged material breach within such thirty (30) day period. If termination is not feasible, the terminating Party may report the breach to the Secretary.

13. Indemnification & Exclusion from Limitations of Liability. BA shall indemnify and hold MYM harmless from and shall defend MYM against any claims by a third-party against MYM for losses, injuries, damages, penalties, expenses, including reasonable attorney fees ("Damages") caused by conduct of BA, or its employees, officers, agents, or subcontractors, in violation of this BAA, except to the extent that MYM participated in, caused, or otherwise contributed to any such claim or damages through its own errors or omissions. BA shall make itself, and any subcontractors, employees, or agents assisting BA in the performance of its obligations under this BAA, available to MYM, at no cost to MYM, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against MYM, its directors, officers, or employees based upon claimed violations of the Privacy or Security Rules or other applicable laws, except where BA or its subcontractor, employee, or agent is named as an adverse party.

MYM shall indemnify and hold BA harmless from and shall defend BA against any claims by a third-party against BA for Damages caused by conduct of MYM, or its employees, officers, agents, or subcontractors, in violation of this BAA, except to the extent that BA participated in, caused, or otherwise contributed to any such claim or damages through its own errors or omissions. MYM shall make itself, and any subcontractors, employees, or agents assisting MYM in the performance of its obligations under this BAA, available to BA, at no cost to BA, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against BA, its directors,

officers, and/or employees based upon claimed violations of the Privacy Rule or Security Rule or other applicable laws, except where MYM or its subcontractor, employee, and/ or agent is named as an adverse party.

To the extent that either Party has limited its liability under the terms of the Service Agreement or under another written agreement, whether with a maximum recovery for direct damages or a disclaimer against any direct, consequential, indirect or punitive damages, or other such limitations, all limitations shall exclude any third-party damages or claims (including penalties) arising from a breach of a Party's obligations relating to the use and disclosure of PHI and related Data.

14. Injunctive Relief. Each Party acknowledges and stipulates that its unauthorized use or disclosure of PHI and related Data while performing pursuant to the Services Agreement or this BAA would cause irreparable harm to the non-disclosing Party, and in such event, the non-disclosing Party shall be entitled, if it so elects, to institute and prosecute proceedings in any court of competent jurisdiction, either in law or in equity, to obtain damages and injunctive relief, together with the right to recover from the disclosing Party costs, including reasonable attorneys' fees, for any such breach of the terms and conditions of this BAA.

15. Return or Destruction of Information. At the termination or expiration of this BAA, BA, if feasible, shall return or destroy and maintain no copies of Data received from or created on behalf of MYM, other than as may be required by BA for BA's own document retention requirements. If destroying the Data, BA will provide MYM with a Certificate of Destruction that commercially reasonable standards were followed in the destruction, compliant with laws and agreements. If it is infeasible to return or destroy the PHI and related Data, then BA will notify MYM of the conditions that make return or destruction infeasible upon receipt of written request from MYM and BA will extend the protections of this BAA and limit further uses and disclosures of the Data to the purposes that make the return or destruction infeasible. All the provisions in this Section 16 shall also apply to Data that is in the possession of a subcontractor and/or agent of BA. Destruction is applicable to all formats or mediums, physical or digital and means that Data cannot be read, accessed or otherwise used.

16. Ownership. MYM is the guardian of all rights and information contained within the Data shared with BA. Each individual about whom Data is shared with BA is the owner of all data rights and information that is being shared.

17. Qualified Service Organizations:

☐ This agreement does not include Part 2 Program (substance use disorder program) information and this agreement does not require a Qualified Service Organizations Agreement.

☐ This agreement does include Part 2 Program (substance use disorder program) information and Exhibit B applies.

18. Conformance with Modification of HIPAA and applicable laws. The Parties hereto shall comply with the applicable laws and regulations governing their relationship, including, without limitation, the Privacy and Security Rules and any other federal or state laws or regulations governing the privacy, confidentiality, or security of patient health information, including without limitation, the Washington State Uniform Healthcare Information Act, RCW 70.02. If an amendment to or modification of HIPAA, HITECH, the implementing regulations, including the Privacy Rule or the

Security Rule, or any other federal or state laws or regulations applies to the information exchanged between the Parties to this BAA, both Parties agree to fully observe and comply with any additional requirements contained in such amendment or modification as if such requirements were fully set forth and incorporated in this BAA.

Any reference herein to a federal regulatory section within the Code of Federal Regulations in this BAA or its exhibits shall be a reference to such section as it may be subsequently updated, amended, or modified.

19. Other Agreements. In the event that the Parties execute any other agreements by which BA may receive, access or otherwise become privy to any PHI or related Data, the terms and conditions of this BAA shall apply equally to any PHI or related Data received by BA under such other agreements, absent written agreement to the contrary.

20. Term. This BAA shall be deemed effective on the date of commencement of the Services Agreement(s) or engagement, and shall remain in effect until the later of (i) expiration or termination of the underlying Services Agreement(s) or engagement, or (ii) completion of the return or destruction of all PHI and related Data in accordance with Section 16 above. (If MYM PHI is retained by BA for BA's own business purposes under Section 16, this BAA shall continue to apply to all such PHI until returned or destroyed as provided herein.) This BAA shall be deemed to be supplemental to any previously executed BAA between the Parties, in which event this BAA shall be deemed to commence upon execution by BA and shall apply to all MYM PHI and related Data held by BA at the time of execution.

21. Notices. All notices under this BAA shall be addressed to the person listed under the signature line below for each Party. Notices under this BAA shall be delivered in the most expedient manner possible and followed-up by a copy personally delivered, or mailed by certified mail, return receipt requested. The designated representative and addresses may be changed as necessary by giving notice in the same manner as required for a notice.

22. Survival. The respective rights and obligations of the Parties set forth in Sections 13, 14, 15 and 16 shall survive termination of this BAA.

23. Interpretation. Any ambiguity in this BAA shall be resolved to permit the Parties to comply with HIPAA.

24. Application. In circumstances where BA's relationship with MYM may involve BA working in both a (i) business associate capacity and (ii) another capacity (such as a covered entity under HIPAA), the terms of this BAA shall only apply to those activities of BA which are performed by BA in its business associate capacity.

25. Data Protection and Chain of Trust Provisions. This Section 25 applies when MYM's PHI and related Data leave the security of MYM's servers and is stored or resides on the BA's server. The Parties shall check the box below for the applicable provision. If neither box is checked and BA is creating, receiving, maintain and/or transmitting electronic PHI, the second option will apply.

    ☐ The Parties agree that BA shall not at any time create, receive, maintain, and/or transmit electronic PHI or related Data from MYM's premises during the term of the Services

Agreement. If at any time during this BAA those circumstances change, the provisions of this Section 25 shall immediately apply without necessity of modification of this BAA.

☐ The Parties agree that BA shall create, receive, maintain and/or transmit electronic PHI or related Data from MYM's premises during the term of the Services Agreement and the following provisions apply:

BA shall:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the data from tampering and unauthorized access and disclosures, in accordance with Sections 164.308, 164.310, 164.312, and 164.316 of Title 45 of the CFR and Section 13401(a) of HITECH. Accordingly, BA shall:

i. ensure that all storage and/or transmissions of PHI and related Data are authorized and protect MYM PHI and related Data from improper access.

ii. When information must travel across lines of communication where both ends are not under the control of MYM, BA agrees to use, at a minimum, strong authentication and encryption to protect the PHI and related Data.

iii. When information is stored by BA on non-MYM and non-BA controlled storage devices, computers or other portable devices or systems of any kind or nature, such information shall at all times be encrypted unless MYM has authorized, in writing, the use of non-encrypted techniques by BA.

iv. Maintain the confidentiality of passwords, encryption keys, and other codes or credentials required for accessing Data.

v. Provide and maintain the equipment, software services and testing services necessary for BA to effectively convert, process, interchange, and electronically transmit Data and ensure the integrity of all Data converted, processed, or interchanged, or transmitted.

26. Remote IT Services.

☐ The Parties agree Remote IT Services, as defined in this agreement, are not applicable to this agreement.

☐ The Parties agree that BA participates in Remote IT Services and the following provisions apply:

BA shall:

i. Require any subcontractor and/or service provider(s) it uses to deliver Remote IT Services which require the use, access, disclosure, transmission, or storage of Data to comply with these terms.

ii. Ensure that Remote IT Services delivered by BA and its suppliers to MYM are performed using information systems and workers physically located in the United States of America (USA). Processing includes the transmission, storage and destruction of MYM Data.

iii. Where relevant to the Remote IT Services provided, BA's handling of specific forms of regulated Data may be required to adhere to additional specific standards (such as Payment Card Industry (PCI) Security Standards).

iv. Not sell or otherwise receive benefit from a third party by sharing information received from MYM or derived from Data without the written approval of MYM.

v. Ensure that its staff is properly trained in the handling of Data under State and Federal law.

vi. Notify MYM before outsourcing any work identified in this BAA to a subcontractor and completing the requirements in Section 7. (including but not limited to the execution of a written agreement prohibiting the accessing, viewing, copying, holding, receiving, possessing, processing or downloading MYM Data outside of the United States). This Section shall extend to any third party that will view or extract data in any form from the Data placed in BA's care. BA will enter into a Data Security Agreement with their Third Party that meets or exceeds the requirements of the BAA and this Agreement.

vii. Not copy the Data in any media, except that which is necessary to complete the processes required of or by BA in order for BA to perform its obligations in the underlying Services Agreement. Any instances of copy Data will adhere to all requirements outlined in this agreement.

27. Designated Record Set. Exhibit A applies when the BA has access to MYM's designated record set and modifies it and MYM has no access to the modified version. The Parties shall check the box below for the applicable provision. If neither box is checked and BA maintains a Designated Record Set, the second option will apply.

☐ The Parties agree that BA shall not, by virtue of BA's performance of services under the Services Agreement, maintain a "Designated Record Set," as that term is defined by 45 CFR § 164.501, for MYM regarding any individual, unless otherwise agreed in writing.

☐ The Parties agree that, by virtue of BA's performance of services under the Services Agreement, BA maintains PHI in a Designated Record Set, or causes one or more of its subcontractors to maintain PHI in a Designated Record Set. The attached Exhibit A is incorporated into this BAA as if fully set forth herein.

IN WITNESS THEREOF, the Parties hereto have executed this BAA or caused it to be extended in their names and on their behalf by their respected representatives thereunto duly authorized.

MultiCare Yakima Memorial:		**Business Associate:**	
By:		By:	
Print Name:		Print Name:	
Title:		Title:	
Date:		Date:	
	MYM's Contact Information:		BA's Contact Information:
Designated Representative:		Designated Representative:	
Title:		Title:	
Address:		Address:	
Telephone:		Telephone:	
E-mail address:		E-mail address:	
Security Contact:			
Title:		Security Contact:	
E-mail address:		E-mail address:	
Copy to Email:			

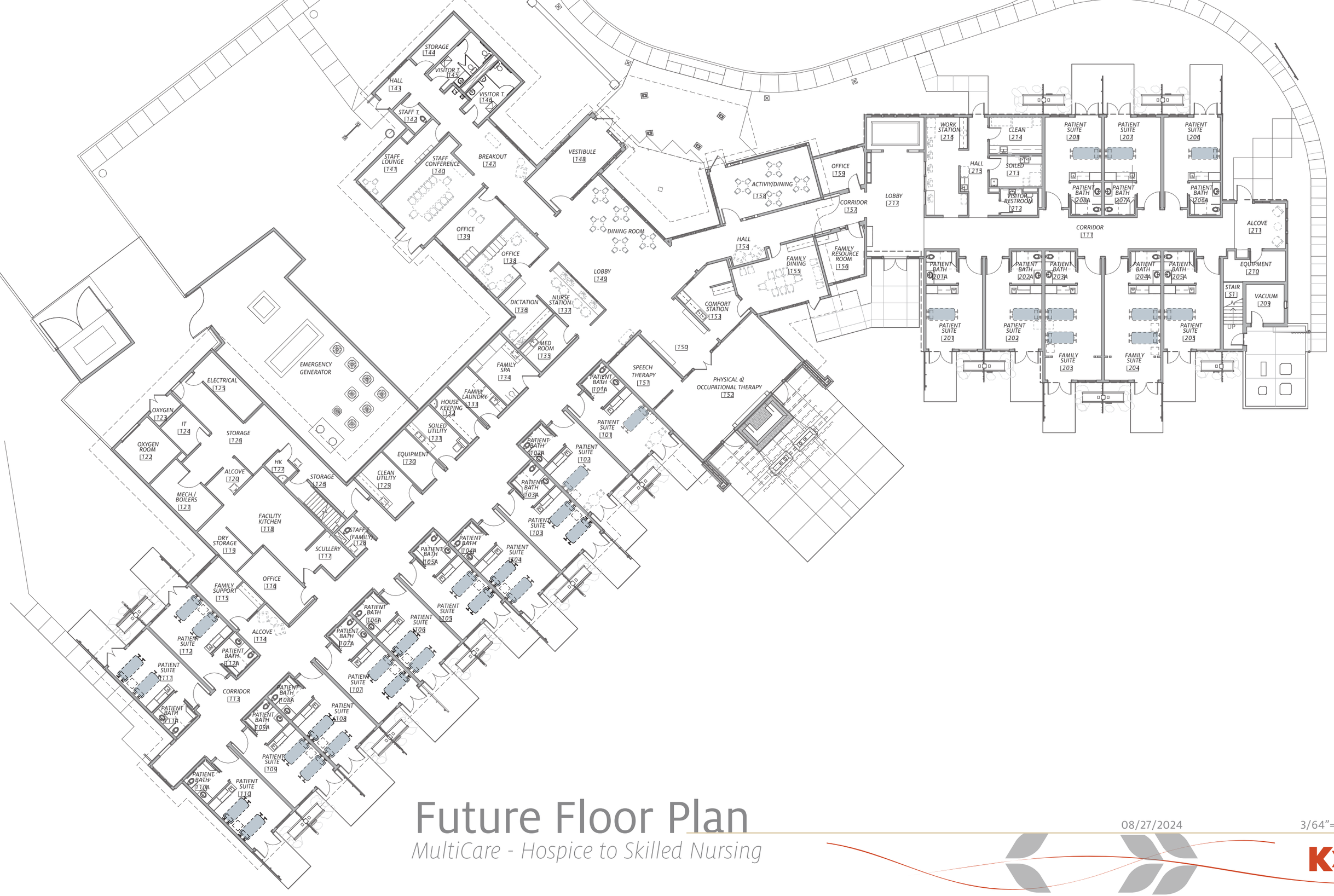
Exhibit 3
Single Line Drawings

Existing Floor Plan

MultiCare - Hospice to Skilled Nursing

08/27/2024

3/64”=1’-0”



Future Floor Plan

MultiCare - Hospice to Skilled Nursing

08/27/2024

3/64”=1’-0”

Exhibit 4
Site Control Documents

7656820 2

FILE# 7656820
YAKIMA COUNTY, WA
06/16/2009 10:58:46AM
DEED
PAGES: 2
FIDELITY TITLE COMPANY

Recording Fee: 43.00

When recorded return to:

Yakima Valley Memorial Hospital Association
Attn: John Vornbrock
2811 Tieton Drive
Yakima WA 98902

YAKIMA COUNTY WASHINGTON
REAL ESTATE EXCISE TAX
PAID
AMT 33,892.64
DATE JUN 16 2009
AFF 409062
BY
ILENE THOMSON, TREASURER

STATUTORY WARRANTY DEED

72411

THE GRANTOR, ALMON FAMILY INVESTMENTS, L.L.C., a Washington limited liability company, for and in consideration of TEN DOLLARS and other good and valuable consideration, in hand paid, conveys, and warrants to YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION, a Washington non-profit corporation, the following described real estate, situated in the County of Yakima, State of Washington:

Lot 1 of Short Plat recorded under Auditor's File Number 7655477, records of Yakima County, Washington

TOGETHER WITH all appurtenances belonging thereto.

TOGETHER WITH non-exclusive 50' access easement described in said Short Plat.

SUBJECT TO rights reserved in federal patents, state or railroad deeds; building or use restrictions general to the area; zoning regulations; utility and access easements of record.

SUBJECT TO all rights, liabilities, obligations, litigation and all other matters with regard to water and water rights.

SUBJECT TO easements, rights of way, covenants, rights of ingress and egress as disclosed on the face of said Short Plat, and in instruments recorded under Auditor's File Nos. 61833, 23635, 27852, 1999175, 36138, 2729842, and 7045455.

SUBJECT TO rights of way for necessary conduits and facilities for the distribution of water, and right of entry for repair and maintenance.

SUBJECT TO future assessment by way of inclusion of said property within Weed District #1 and Horticulture Pest & Disease Control District.

Tax Parcel Number: 181328-~~41408~~ (Parent Parcel)
41421

ALMON FAMILY INVESTMENTS, L.L.C., a Washington limited liability company

By: _____
William F. Almon, Member/Manager

By: _____
Joanne D. Almon, Member

Dated: June 9th, 2009

STATE OF WASHINGTON)
ss.
COUNTY OF YAKIMA)

On this day personally appeared before me, WILLIAM F. ALMON and JOANNE D. ALMON, to me known to be the authorized representatives of **ALMON FAMILY INVESTMENTS, L.L.C.**, to me known to be the individuals authorized to execute the within and foregoing instrument, and acknowledged the instrument to be their free and voluntary act and deed for the uses and purposes therein mentioned.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 9th day of June, 2009.

CHRISTINA K. MOREHEAD NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES AUGUST 28, 2010

_____
NOTARY PUBLIC in and for the State of Washington, residing at Selah
My Commission expires: 8/28/10

FILED
Secretary of State
State of Washington
Date Filed: 01/18/2023
Effective Date: 01/18/2023

RESTATED ARTICLES OF INCORPORATION OF YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION

UBI No: 397 011 023

The undersigned, a duly appointed officer of Yakima Valley Memorial Hospital Association, hereby signs and verifies the following Restated Articles of Incorporation, to consolidate all amendments into a single document without substantive change.

ARTICLE 1

The sole member of this corporation shall be MultiCare Health System, a Washington nonprofit corporation described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The qualifications, powers, rights and duties of membership shall be such as are prescribed by the Bylaws of the corporation.

ARTICLE 2

The name of the corporation is Yakima Valley Memorial Hospital Association.

ARTICLE 3

The duration of the corporation shall be perpetual.

ARTICLE 4

The address of the registered office of the corporation is 711 Capital Way South, Suite 204, Olympia, Washington 98501, and the registered agent at such address is CT Corporation.

ARTICLE 5

Section 5.1 Purposes. To operate exclusively for charitable, scientific or educational purposes, within the meaning of Section 501(c)(3) of the Code, or any successor provision, including, without limitation, to engage in activities related to the provision of health care services; to acquire, establish, maintain, conduct, manage and operate hospitals, clinics, nursing homes and other health care delivery institutions for the diagnosis, treatment and care of the sick, afflicted and aged; and to furnish and supply, with or without compensation therefor, related care, treatment, hospitalization, education, training, medical research, laboratory services and other services including, but not limited to, extended care, outpatient and home care for the mutual benefit of all the citizens of Yakima County, Washington, and surrounding areas, regardless of race, creed, color, national origin or sex.

Section 5.2 Limitations.

5.2.1 The corporation shall have no capital stock, and no part of its net earnings shall inure to the benefit of any director or officer of the corporation, or any private individual.

5.2.2 No director or officer of the corporation, nor any private individual shall be entitled to share in the distribution of any of the corporate assets upon dissolution of the corporation, or the winding up of its affairs. Upon such dissolution or winding up, the assets of the corporation shall be distributed to one or more recipients selected by the Board of Directors of the corporation; provided that each recipient (1) then qualifies for exemption from federal income taxes under the provisions of Section 501(c)(3) of the Code, or any successor provision, and (2) which will as closely as possible further the mission, purposes and objectives as set forth in these Articles and the Bylaws.

5.2.3 No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting, to influence legislation except as may be permitted to Section 501(c)(3) organizations by the Code, and the corporation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

5.2.4 Notwithstanding any other provisions of these Articles, the corporation shall not conduct or carry on activities not permitted to be conducted or carried on by an organization described in Section 501(c)(3) of the Code, or any successor provision, or by an organization contributions to which are deductible under Section 170(c)(2) of the Code, or any successor provision.

Section 5.3 Powers. In general, and subject to such limitations and conditions as are or may be prescribed by law, or in the corporation's Articles of Incorporation or Bylaws, the corporation shall have all powers which now or are hereafter conferred by law upon a corporation organized for the purposes hereinabove set forth, or necessary or incidental to the powers so conferred, or conducive to the attainment of the purposes of the corporation.

ARTICLE 6

The management of the corporation will be vested in a Board of Directors consisting of no fewer than nine (9) directors. The number, qualifications, terms of office, manner of election, time and place of meeting, and powers and duties of directors shall be such as are prescribed by the Bylaws of the corporation. The names and addresses of the persons currently serving as members of the Board of Directors of the corporation are as follows:

Name	Mailing Address
David Hargreaves, ***Chair***	Hub International Limited PO Box 2945 Yakima, WA 98907-2945
Kerry Harthcock, MD	348 N. 23rd Ave. Yakima, WA 98902
Maribel Jiménez, Ed.D	33221 47th Ave. SW Federal Way, WA 98023

Cynthia Juarez, ***Secretary***	c/o ESD 105 33 S. 2nd Ave. Yakima, WA 98902
Mirna Ramos-Diaz, MD	83 Valley View Road Zillah, WA 98953
Patrick Oshie	507 Ballard Rd. Zillah, WA 98953
Duane Rossman, ***Treasurer***	17432 Bothell Way NE Bothell, WA 98011
Steve Rupp, MD	3145 E. Laurelhurst Drive NE Seattle, WA 98105
Gail Weaver, ***Vice Chair***	4902 Webster Road Yakima, WA 98908
Rob Williams, MD	2005 S. 87th Ave. Yakima, WA 98903
Doug Ellison	1740 Leisure Lane Yakima, WA 98908

ARTICLE 7

These Restated Articles of Incorporation may only be amended, altered, repealed or replaced by the affirmative vote of the Board of Directors, subject to the approval of the sole member. The Bylaws may only be amended, altered, repealed or replaced by the sole member.

ARTICLE 8

A director shall have no liability to the corporation for monetary damages for conduct as a director, except for acts or omissions that involve intentional misconduct by the director, or a knowing violation of law by the director, or for any transaction from which the director will personally receive a benefit in money, property or services to which the director is not legally entitled. If the Washington Nonprofit Corporation Act is hereafter amended to authorize corporate action further eliminating or limiting the personal liability of directors, then the liability of a director shall be eliminated or limited to the full extent permitted by the Washington Nonprofit Corporation Act, as so amended. Any repeal or modification of this Article shall not adversely affect any right or protection of a director of the corporation existing at the time of such repeal or modification for or with respect to an act or omission of such director occurring prior to such repeal or modification.

ARTICLE 9

Section 9.1 Right to Indemnification. Each person who was, or is threatened to be made a party to or is otherwise involved (including, without limitation, as a witness) in any actual or threatened action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director or officer of the corporation or, while a director or officer, he or she is or was serving at the request of the corporation as a director, trustee, officer, employee or agent of another corporation or of a partnership, joint venture, trust or other enterprise, including service with respect to employee benefit plans, whether the basis of such proceeding is alleged action in an official capacity as a director, trustee, officer, employee or agent or in any other capacity while serving as a director, trustee, officer, employee or agent, shall be indemnified and held harmless by the corporation, to the full extent permitted by applicable law as then in effect, against all expense, liability and loss (including attorney's fees, judgments, fines, ERISA excise taxes or penalties and amounts to be paid in settlement) actually and reasonably incurred or suffered by such person in connection therewith, and such indemnification shall continue as to a person who has ceased to be a director, trustee, officer, employee or agent and shall inure to the benefit of his or her heirs, executors and administrators; provided, however, that except as provided in Section 9.2 of this Article with respect to proceedings seeking solely to enforce rights to indemnification, the corporation shall indemnify any such person seeking indemnification in connection with a proceeding (or part thereof) initiated by such person only if such proceeding (or part thereof) was authorized by the Board of Directors of the corporation. The right to indemnification conferred in this Section 9.1 shall be a contract right and shall include the right to be paid by the corporation the expenses incurred in defending any such proceeding in advance of its final disposition; provided, however, that the payment of such expenses in advance of the final disposition of a proceeding shall be made only upon delivery to the corporation of an undertaking, by or on behalf of such director or officer, to repay all amounts so advanced if it shall ultimately be determined that such director or officer is not entitled to be indemnified under this Section 9.1 or otherwise.

Section 9.2 Right of Claimant to Bring Suit. If a claim for which indemnification is required under Section 9.1 of this Article is not paid in full by the corporation within sixty (60) days after a written claim has been received by the corporation, except in the case of a claim for expenses incurred in defending a proceeding in advance of its final disposition, in which case the applicable period shall be twenty (20) days, the claimant may at any time thereafter bring suit against the corporation to recover the unpaid amount of the claim and, to the extent successful in whole or in part, the claimant shall be entitled to be paid also the expense of prosecuting such claim. The claimant shall be presumed to be entitled to indemnification under this Article upon submission of a written claim (and, in an action brought to enforce a claim for expenses incurred in defending any proceeding in advance of its final disposition, where the required undertaking has been tendered to the corporation), and thereafter the corporation shall have the burden of proof to overcome the presumption that the claimant is so entitled. Neither the failure of the corporation (including its Board of Directors or independent legal counsel) to have made a determination prior to the commencement of such action that indemnification of or reimbursement or advancement of expenses to the claimant is proper in the circumstances nor an actual determination by the corporation (including its Board of Directors or independent legal counsel) that the claimant is not entitled to indemnification or to the reimbursement or advancement of expenses shall be a defense to the action or create a presumption that the claimant is not so entitled.

Section 9.3 Nonexclusivity of Rights. The right to indemnification and the payment of expenses incurred in defending a proceeding in advance of its final disposition conferred in this Article shall not be exclusive of any other right which any person may have or hereafter acquire under any statute, provision of the Articles of Incorporation, Bylaws, agreement, reserved power of the sole member, vote of disinterested directors or otherwise.

Section 9.4 Insurance, Contracts and Funding. The corporation may maintain insurance at its expense, to protect itself and any director, trustee, officer, employee or agent of the corporation or another corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss, whether or not the corporation would have the power to indemnify such person against such expense, liability or loss under Chapter 24.03A of the Washington Nonprofit Corporation Act and Chapter 23B.08 of the Washington Business Corporation Act, as applied to nonprofit corporations, or any successor provisions. The corporation may enter into contracts with any director or officer of the corporation in furtherance of the provisions of this Article and may create a trust fund, grant a security interest or use other means (including, without limitation, a letter of credit) to ensure the payment of such amounts as may be necessary to effect indemnification as provided in this Article.

Section 9.5 Indemnification of Employees and Agents of the Corporation. The corporation may, by action of its Board of Directors from time to time, provide indemnification and pay expenses in advance of the final disposition of a proceeding to employees and agents of the corporation with the same scope and effect as the provisions of this Article with respect to the indemnification and advancement of expenses of directors and officers of the corporation or pursuant to rights granted pursuant to, or provided by, Chapter 24.03A of the Washington Nonprofit Corporation Act and Chapter 23B.08 of the Washington Business Corporation Act, as applied to nonprofit corporations, or otherwise.

The undersigned has executed these Restated Articles of Incorporation this 18th day of January, 2023.

YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION

By: DocuSigned by: David Hargreaves 5D361F0EC482496...

Name: David Hargreaves

Its: Chair

CERTIFICATION

These Restated Articles of Incorporation correctly set forth without change the provisions of the Articles of Incorporation as amended by the Articles of Amendment. These Restated Articles of Incorporation supersede the Restated Articles of Incorporation of Yakima Valley Memorial Hospital Association, effective January 1, 2021, and all amendments thereto. The undersigned, being the Secretary of the Board of Directors of Yakima Valley Memorial Hospital Association, hereby certifies that the foregoing Restated Articles of Incorporation were duly adopted by the Board of Directors at a special meeting held on January 10, 2023.

Executed under penalty of perjury under the laws of the State of Washington, this 18th day of January, 2023.

YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION

By: DocuSigned by: Cynthia Juarez 5C00026BEF3A4D0...

Name: Cynthia Juarez

Its: Secretary

CONSENT TO SERVE AS REGISTERED AGENT - REQUIRED FOR ALL TYPES I hereby consent to serve as Registered Agent in the State of Washington for the named business. I understand it will be my responsibility to accept service of process, notices, and demands on behalf of the business; to forward mail to the business; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.

CT CORPORATION

Sherry McGinnes	Sherry McGinnes, Asst Secretary
Signature of Registered Agent	Printed Name, Title
1/17/23	
Date	

WASHINGTON
Secretary of State
Corporations & Charities Division

Corporations and Charities Division
Physical/Overnight address:
801 Capitol Way S
Olympia, WA 98501-1226
Mailing address:
PO Box 40234
Olympia, WA 98504-0234
Tel: 360.725.0377
sos.wa.gov/corps

01/18/2023

YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION
C T CORPORATION SYSTEM
711 CAPITOL WAY S STE 204
OLYMPIA WA 98501-1267

UBI Number: 397 011 023
Business Name: YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION

Greetings C T CORPORATION SYSTEM,

Thank you for your recent submission. This letter is to confirm that the following documents have been received and successfully filed:

RESTATED ARTICLES OF INCORPORATION

You can view and download your filed document(s) for no charge at our website, www.sos.wa.gov/ccfs

To file online, request certified copies and certificates, conduct searches, subscribe to corporation and/or charities and receive filing status updates, please create a user account at www.sos.wa.gov/ccfs If you already have an account created, simply sign in to access these features.

If you have questions, need assistance, or would like to provide feedback, please visit the Corporations Division website at www.sos.wa.gov/corps email corps@sos.wa.gov or call 360-725-0377.

Sincerely,
Washington Secretary of State
Corporations and Charities Division
corps@sos.wa.gov

Exhibit 5
Financial Assistance Policy

PATIENT FINANCIAL ASSISTANCE POLICY

Policy Statement:
MultiCare is committed to serving all patients, including those who lack health insurance coverage and 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 consider 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** refers to balance adjustments taken for medically necessary health care services provided to Eligible Persons. 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.

3. **Eligible Person(s)** is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 400% the federal poverty standards adjusted for family size.

4. **Emergency Medical Conditions** (EMC) are defined by the Emergency Medical Treatment and Active Labor Act (EMTALA), 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 as health care services or supplies needed to diagnose or treat an injury, illness, condition or disease or its symptoms and that meet accepted standards of medicine.

8. **Responsible Party** means that individual who is responsible for the payment of any 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 skilling nursing services provided by MultiCare Health System.

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.

All information relating to the Financial Assistance application is confidential and protected by HIPAA guidelines.

Applications for Financial Assistance for free and discounted care are evaluated 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 400% of the FPL.

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. MultiCare may require a Responsible Party to fully utilize any available HSA funds to satisfy outstanding balances.

2. Payment will be pursued 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.

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.

F. International Patients.
   1. Eligibility determinations for International Patients for non-emergent services will be considered on a case-by-case basis.

Procedure:

1. 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, MultiCare must rely upon the written and signed statements from the Responsible Party for making a final determination of eligibility.

4. MultiCare 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. The following guidelines will be used 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.

2. 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 provided 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, the application will be reviewed 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 MultiCare.

3. 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. 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.

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

4. 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.

B. The method used to calculate the discount to an Eligible Person's balance will be based on an annual retrospective analysis. 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."

1. Balances will be considered for Financial Assistance based on the current FPL guidelines (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines).

5. Presumptive Eligibility

A. Eligibility may be determined presumptively.

1. MultiCare 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 the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance.

6. 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 due to illness and/or their ability to make payments

over an extended period. The debt or a portion of the debt may qualify for Financial Assistance. A representative for MultiCare 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.

7. Collection Efforts for Outstanding Patient Accounts

A. MultiCare will not initiate collection efforts or requests for deposits, provided that the Responsible Party within a reasonable time is cooperative with MultiCare's efforts to reach a determination of Financial Assistance eligibility status.

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

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.

Exhibit 6
Admission Policies

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **ADMISSION, TRANSFER AND DISCHARGES** **Admissions**	**NUMBER** **620**

PURPOSE: The facility has admissions policy which complies with the regulatory requirements.

POLICY: The facility has an established and implemented admissions policy.

GUIDELINES:

1. The facility will not require residents or potential residents to waive their rights as set forth in the federal regulation or in the applicable federal, state, or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid.

2. The facility does not request or require oral and written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

3. The facility does not request or require residents or potential residents to waive potential facility liability for losses of personal property.

4. The facility does not request or require a third-party guarantee of payment to the facility as a condition of admission or expedited admission or continued stay in the facility.

5. The facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from resident's income or resources.

6. In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the

State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.

7. The nursing facility can charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident’s admission or continued stay on the request for and receipt of such additional services.

8. The facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission or continued stay in the facility for a Medicaid eligible resident.

9. States or political subdivisions may not apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

10. The nursing facility will disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

11. The nursing facility that is a composite of distinct part, as defined in this regulation, must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under 483.15(c)(9).

References	
Regulation(s)	483.15(a)(1)-(7)
FTag(s)	F620
Other References	
Version	

	CLINICAL SERVICES **POLICY AND GUIDELINES FOR IMPLEMENTATION**
SUBJECT **ADMISSION, TRANSFER & DISCHARGE** **Equal Access to Quality Care**	**NUMBER** **621**

PURPOSE: Residents are treated equally regarding transfer, discharge and the provision of services, regardless of payment source.

POLICY: Facility will not distinguish between residents based on their source of payment when providing services that are required to be provided under law.

GUIDELINES:

1. Services mandated by law will be provided to residents according to their individual needs, as determined by assessments and care plans.

2. These services include, but are not limited to nursing services, specialized rehabilitation services, behavioral health services, social services, dietary services, and pharmacy services, or activities.

3. The facility will inform the resident in writing before or at admission, and periodically during the stay, such as when a change in coverage occurs, of the facility's available services and associated costs.

4. Room changes within either a composite distinct part SNF or a distinct part SNF are subject to F560 and F561, which address the resident's right to refuse such a transfer or room change.

References	
Regulation(s)	483.15(b))1)-(3), (c)(9)
FTag(s)	F621
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **RESIDENT ASSESSMENTS** **Admission Physician Order for Immediate Care**	**NUMBER** **635**

PURPOSE: To provide each resident with necessary care and services upon admission.

POLICY: The facility will have physician orders for the resident's immediate care, at the time of admission.

GUIDELINES:

1. Physician orders for immediate care may be written or verbal.

2. These orders will enable facility staff to provide essential care to the newly admitted resident.

3. These orders will be consistent with the resident's mental and physical status.

4. These orders will include, at a minimum:
    a. Dietary
    b. Medications (if necessary)
    c. Routine care to maintain or improve the resident's functional abilities.

5. These orders will be in place to facilitate care for the resident until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.

References	
Regulation(s)	483.20(a)
FTag(s)	F635
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **RESIDENT ASSESSMENT**	**NUMBER** **636**

PURPOSE: To utilize the Resident Assessment Instrument (RAI) to conduct comprehensive, significant change of condition and quarterly assessments, and others as required, to reflect the resident's status and identify the resident's preferences and goals of care.

POLICY: The facility will conduct an initial and periodic comprehensive, accurate assessment of a resident's functional capacity which will include needs, strengths, goals, life history and preferences utilizing the RAI. The assessments will be reproducible, transmitted to CMS and will be in accordance with the timeframes identified in the RAI regulations specified by CMS.

GUIDELINES:

1. The facility will address resident needs and strengths regardless of whether or not the issue is included in the Minimum Data Set (MDS) or Care Area Assessments (CAAs).

2. The facility will use resident observation and communication as the primary source when completing the RAI. Additionally, record review, communication with staff and other sources which may include the resident's physician, resident's representative, family members or others, as needed, will be used.

3. The facility will conduct a comprehensive assessment of resident within the timeframes specified in the RAI regulations.

4. When the resident experiences a significant change in condition that, based on CMS guidelines, would require a new, comprehensive assessment, one will be completed within the required timeframe.

5. A quarterly review assessment of the resident will be conducted utilizing the standardized Quarterly Review assessment tool based on the requirements in the RAI manual.

6. The facility will maintain resident assessments in the resident's active record for a minimum of 15 months from the final completion date of the assessment.

7. The results of the assessment will be used to develop, review and revise the resident's comprehensive care plan.

8. Upon completion of the assessments, the data will be submitted electronically to the CMS System in a format specified by CMS within the specified timeframes.

9. The assessments will be conducted by individuals with the knowledge to complete an accurate assessment of relevant care areas and are knowledgeable about the resident's status, physical, mental and psychosocial needs, strengths and areas of decline.

10. Assessments will be coordinated by a registered nurse.

11. Individuals who complete a portion of the assessment will sign and certify the accuracy of that portion of the assessment.

12. Individuals participating in the assessment will not willfully and knowingly certify a material and false statement, or cause another individual to do so, in a resident assessment.

References	
Regulation(s)	483.20(b)-(2)(i)-(iii),(c)-(d),(f)(1)-(4),(g)-(j)
FTag(s)	F636 - 642
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **RESIDENT ASSESSMENT** **Preadmission Screening and Resident Review (PASARR) for MD and ID**	**NUMBER** **645**

PURPOSE: To validate each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.

POLICY: A Preadmission Screening and Resident Review (PASARR) screening will be completed for each resident prior to admission.

GUIDELINES:

1. The nursing facility will not admit any new residents with:
    a. Mental Disorder as defined in the regulation unless the State mental health authority has determined, based upon an independent physical and mental evaluation performed by a person or entity other than the State mental health authority prior to admission,
        i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by the nursing facility; and
        ii. If the individual requires such level of services, whether the individual requires specialized services.
    b. Intellectual Disability, as defined by the regulation, unless the State Intellectual Disability or developmental disability authority has determined prior to admission
        i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by the nursing facility, and
        ii. If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

2. The Exceptions for this regulation include:

a. The preadmission screening program need not provide for determination in the case of readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital
b. The State may choose not to apply the preadmission screening to the admission to a nursing facility of an individual
    i. Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital;
    ii. Who requires nursing facility services for the condition for which the individual received care at the hospital and
    iii. Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

3. PASARR is completed for applicants for admission to a Medicaid certified nursing facility. The applicants are evaluated for a serious mental disorder (MD) or intellectual disability (ID).

4. Residents are offered the most appropriate setting for their needs and receive the services for their needs in those settings.

5. Specialized services will be offered to individuals with MD or ID in accordance with the determination of appropriate state designated authority.

6. Any resident with newly evident or possible serious MD, ID, or a related condition will be referred by the facility to the appropriate state-designated mental health or intellectual disability authority for review.

7. For residents with a Level II determination and recommendations, the facility incorporates the determination and recommendations into the resident's assessment and care plan.

References	
Regulation(s)	483.20(k)(1)-(3)
FTag(s)	F645
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **COMPREHENSIVE CARE PLAN** **Baseline Care Plan**	**NUMBER** **655**

PURPOSE: Facility will complete and implement a baseline care plan within 48 hours of a resident's admission. The care plan is intended to promote continuity of care and communication among staff, increase resident safety, minimize potential adverse events that may occur right after admission.

POLICY: Facilities are required to develop a baseline care plan within the first 48 hours of admission which provides for the provision of effective and person-centered care to each resident and their representative. The care plan is a balance between conditions and risks affecting resident's health and safety, and the resident's goals and choices.

GUIDELINES:

1. The baseline care plan is developed within 48 hours of admission and should include a minimum health information necessary to care for the resident, but not limited to-
    a. Initial goals based on admission orders
    b. Dietary Orders
    c. Therapy Services
    d. Social Services
    e. PASARR recommendation, if applicable

2. The facility may develop a comprehensive care planning place of the baseline care plan if the comprehensive care plan is developed with 48 hours of resident's admission and meets the above criteria.

3. The facility must provide the resident and/or their representative with a written summary of the baseline care plan that includes but is not limited to:
    a. The initial goals of the resident.
    b. A summary of the resident's medications and dietary instructions.
    c. Any services and treatments to be administered by the facility and personnel.
    d. Any updated information based on the comprehensive care plan, as necessary.
    e. The written summary of the baseline care plan will be in a language and conveyed in a manner the resident and/or representative can understand.

4. If the Care plan based on the initial comprehensive assessment, differs from the baseline care plan previously completed, the facility will again provide a written summary of the changes and/or additions.

References	
Regulation(s)	483.21(a)
FTag(s)	F655
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **COMPREHENSIVE CARE PLANS**	**NUMBER** **656**

PURPOSE: To provide each resident with a person-centered, comprehensive care plan to address the resident's medical, nursing, physical, mental and psychosocial needs.

POLICY: The facility Interdisciplinary Team (IDT) will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, physical, mental, and psychosocial needs that are identified in the comprehensive assessment.

GUIDELINES:

1. The care plan will be comprehensive and person-centered. It will drive the type of care and services that a resident receives and will describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences; as well as how the facility will assist in meeting these needs and preferences.

2. The comprehensive care plan will be developed within seven (7) days after completion of the comprehensive assessment, no more than 21 days following admission. It will be prepared by an IDT which may include, but not limited to:
    a. Attending physician or designee (e.g. NP, CNS or PA)
    b. Registered nurse
    c. Nurse aide with responsibility for the resident
    d. Food and nutrition services staff member
    e. Resident and/or resident representative
    f. Other staff or professionals as needed or requested by resident/representative

3. The comprehensive care plan will be reviewed and revised by the IDT following both comprehensive and quarterly review assessments.

4. Interventions identified by the comprehensive care plan will be provided by qualified, competent persons.

5. Services provided or arranged by the facility, as outlined by the comprehensive care plan will meet professional standards of quality.

6. Services will be culturally-competent and trauma-informed. *(to be implemented by November 28, 2019)*

7. The care plan will be person-specific with measurable objectives, interventions and timeframes. It will address goals, preferences, needs and strengths of the resident.

8. Care plan will include:
    a. The services the facility will provide to assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being.
    b. Services that would have been provided but the resident has refused
    c. Specialized services or rehab services based upon PASARR recommendations
        NOTE: if facility disagrees with PASARR findings, the rationale will be in the resident's medical record
    d. In consultation with the resident or resident representative:
        i. Resident's goals for admission and desired outcomes
        ii. The resident's preference and potential for discharge to the community
        NOTE: Facility will document assessments related to return to community and referrals to local agencies.

9. The MDS will be used to assess the resident's clinical condition, cognitive and functional status and use of services in developing the comprehensive care plan.

10. The facility will document in the medical record the rationale for deciding whether or not to proceed with care planning for each triggered CAA.

11. The care planning process will be an on-going process.

12. Resident care needs and care plan interventions will be communicated to direct care staff.

13. If a resident or resident representative refuses care or treatment deemed necessary by the facility, the facility will attempt to find an alternative to address the identified need. The medical record will reflect the facility's attempts and education provided to the resident and the representative.

14. To encourage participation in the care planning process, the resident and/or resident representative will be notified in advance of care planning meeting. If the resident and/or resident representative is unable to attend, alternate times or methods of participation will be offered.

15. If it is not feasible or practicable for the resident/resident representative to participate in the care planning process, the facility will document in the medical record the reasons and the steps taken by the facility to facilitate participation.

References	
Regulation(s)	483.21(b)(1)-(3)
FTag(s)	F656 - 659
Other References	
Version	

Exhibit 7

Letter of Financial Commitment

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

August 19, 2024

Eric Hernandez, Manager
Certificate of Need Program
Washington Department of Health
111 Israel Road SE
Tumwater WA 98501

Re: Certificate of Need Application for Skilled Nursing Facility in Yakima County, WA

Dear Mr. Hernandez:

Please accept this letter as evidence of financial support for MultiCare Health System's certificate of need application request to operate a certificate of need approved skilled nursing facility in Yakima County, WA.

MultiCare is pleased to commit from its corporate reserves full funding for the estimated capital expenditures and any working capital requirements associated with this 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 8

MultiCare Health System Audited Financial Statements

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2023 and 2022

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2800
401 Union Street
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

Report on the Audit of the Consolidated Financial Statements

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, 2023 and 2022, and the related consolidated statements of operations, 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, 2023 and 2022, 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 20, 2024

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2023 and 2022

(In thousands)

Assets		2023	2022
Current assets:			
Cash and cash equivalents	$	512,076	542,067
Accounts receivable		659,925	511,727
Supplies inventory		70,636	60,070
Other current assets, net		244,617	165,586
Total current assets		1,487,254	1,279,450
Donor restricted assets held for long-term purposes		151,563	119,526
Investments		1,996,970	1,968,205
Property, plant, and equipment, net		2,469,467	2,109,253
Right-of-use operating lease asset, net		235,679	169,823
Right-of-use financing lease asset, net		18,003	16,798
Goodwill and intangible assets, net		259,830	253,274
Other assets, net		401,519	329,808
Total assets	$	7,020,285	6,246,137
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	409,309	326,664
Accrued compensation and related liabilities		420,730	329,672
Accrued interest payable		27,333	23,643
Line of credit		62,935	—
Current portion of right-of-use operating lease liability		37,412	29,908
Current portion of right-of-use financing lease liability		6,443	4,965
Current portion of long-term debt		22,411	18,496
Total current liabilities		986,573	733,348
Interest rate swap liabilities		6,425	9,470
Right-of-use operating lease liability, net of current portion		208,545	147,116
Right-of-use financing lease liability, net of current portion		12,504	12,491
Long-term debt, net of current portion		1,961,949	1,972,137
Other liabilities, net		247,573	231,045
Total liabilities		3,423,569	3,105,607
Commitments and contingencies (note 15)			
Net assets:			
Controlling interest		3,301,130	2,930,546
Noncontrolling interest		34,925	34,471
Without donor restrictions		3,336,055	2,965,017
With donor restrictions		260,661	175,513
Total net assets		3,596,716	3,140,530
Total liabilities and net assets	$	7,020,285	6,246,137

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations

Years ended December 31, 2023 and 2022

(In thousands)

	2023	2022
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 4,521,328	3,765,888
Other operating revenue	417,619	231,429
Net assets released from restrictions for operations	10,068	6,382
Total revenues, gains, and other support without donor restrictions	4,949,015	4,003,699
Expenses:		
Salaries and wages	2,518,778	2,199,265
Employee benefits	381,067	297,613
Supplies	807,705	658,470
Purchased services	486,031	396,747
Depreciation and amortization	163,267	140,892
Interest	81,941	56,842
Other	698,697	541,246
Total expenses	5,137,486	4,291,075
Deficit of revenues over expenses from operations	(188,471)	(287,376)
Other income (loss):		
Investment income (loss)	282,866	(344,301)
Gain on interest rate swaps, net	14,410	127,688
Inherent contribution	293,012	—
Other income (loss), net	9,382	(11,047)
Total other income (loss), net	599,670	(227,660)
Excess (deficit) of revenues over expenses	$ 411,199	(515,036)

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2023 and 2022

(In thousands)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2021	$ 3,430,009	—	176,742	3,606,751
Deficit of revenues over expenses	(515,036)	—	—	(515,036)
Changes in pension assets	(15,508)	—	—	(15,508)
Changes from noncontrolling interest	—	34,471	—	34,471
Contributions and other	26,539	—	14,875	41,414
Net assets released from restriction for capital acquisitions	4,542	—	(4,542)	—
Net assets released from restriction for operations	—	—	(6,382)	(6,382)
Loss on investments	—	—	(611)	(611)
Decrease in assets held in trust by others	—	—	(4,569)	(4,569)
Change in net assets	(499,463)	34,471	(1,229)	(466,221)
Balance, December 31, 2022	2,930,546	34,471	175,513	3,140,530
Excess of revenues over expenses	349,718	61,481	—	411,199
Changes in pension assets	(158)	—	—	(158)
Changes from noncontrolling interest	—	(61,027)	—	(61,027)
Contributions and other	20,582	—	65,863	86,445
Net assets assumed in affiliation	—	—	19,657	19,657
Net assets released from restriction for capital acquisitions	442	—	(442)	—
Net assets released from restriction for operations	—	—	(10,068)	(10,068)
Gain on investments	—	—	12,095	12,095
Decrease in assets held in trust by others	—	—	(1,957)	(1,957)
Change in net assets	370,584	454	85,148	456,186
Balance, December 31, 2023	$ 3,301,130	34,925	260,661	3,596,716

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2023 and 2022

(In thousands)

	2023	2022
Cash flows from operating activities:		
Increase (decrease) in net assets	$ 456,186	(466,221)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by (used in) operating activities:		
Depreciation and amortization	163,267	140,892
Amortization of bond premiums, discounts, and issuance costs	(4,120)	(2,163)
Net realized and unrealized gains on investments	(222,484)	378,740
Change in fair value of interest rate swap	(5,970)	(133,126)
Gain on disposal of assets, net	(34,027)	(3,009)
Loss on joint ventures, net	4,371	7,032
Net assets assumed from affiliation	(312,669)	—
Restricted contributions for long-term purposes	(24,336)	(4,968)
Changes in operating assets and liabilities:		
Accounts receivable	(78,278)	(51,158)
Supplies inventory and other current assets	(72,922)	(43,673)
Right-of-use lease asset	57,252	35,690
Other assets, net	40,427	80,665
Accounts payable and accrued expenses and accrued interest payable	41,947	27,421
Accrued compensation and related liabilities	60,582	(14,765)
Right-of-use lease liability	(34,518)	(30,021)
Other liabilities, net	14,918	21,842
Net cash provided by (used in) operating activities	49,626	(56,822)
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(294,860)	(237,295)
Proceeds from disposal of property, plant, and equipment	57,640	6,360
Cash obtained from affiliation	29,814	—
Purchase of additional ownership in PSW and OSS, net of cash received	—	(86,915)
Investments in joint ventures, net	(38,393)	(11,445)
Purchases of investments	(6,831,712)	(8,827,993)
Sales of investments	7,021,038	9,072,857
Change in donor trusts	(22,232)	(2,833)
Net cash used in investing activities	(78,705)	(87,264)
Cash flows from financing activities:		
Repayment of long-term debt	(82,401)	(415,646)
Proceeds from line of credit, net	62,935	—
Proceeds from bond issuance	—	798,300
Payment of debt issue expenses	—	(5,702)
Principal payments on finance lease obligations	(5,782)	(4,499)
Restricted contributions for long-term purposes	24,336	4,968
Net cash (used in) provided by financing activities	(912)	377,421
Net change in cash and cash equivalents	(29,991)	233,335
Cash and cash equivalents, beginning of year	542,067	308,732
Cash and cash equivalents, end of year	$ 512,076	542,067
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 77,251	52,258
Noncash activities:		
Increase (decrease) in deferred compensation plans	17,628	(11,750)
(Decrease) increase in accounts payable for purchases of property, plant, and equipment	(7,492)	9,301

See accompanying notes to consolidated financial statements.

(Dollars in thousands)

(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, Thurston and Yakima Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2023, MHS was licensed to operate 2,577 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, Capital Medical Center and Yakima Memorial Hospital) and one behavioral health hospital (Navos). MHS also operates eight outpatient surgical sites, six 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 four wholly owned subsidiaries (Greater Lakes Mental Healthcare, Medis, Inc., MultiCare Rehabilitation Specialists, P.C., and PNW PACE Partners, LLC), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned professional services organization that employes providers for Yakima Memorial Hospital (Memorial Physicians, LLC), a wholly owned accountable care organization (MultiCare Connected Care), a wholly owned clinically integrated healthcare network (Central Washington Healthcare Partners, LLC dba SignalHealth), a leading population health company (Physicians of Southwest Washington), a physical therapy provider (Olympic Sports & Spine) and three fundraising foundations (Yakima Valley Memorial Hospital Charitable Foundation, 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 January 17, 2023, MHS completed its affiliation with Yakima Valley Memorial Hospital (Yakima) and became the sole corporate member. No consideration was exchanged as part of this transaction. Yakima operates an acute care facility, clinics and other services to the greater Yakima Valley region. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. The net assets assumed resulted in an inherent contribution of $293,012 in the consolidated statements of operations. The remaining contribution of $19,657 was restricted and is included in net assets assumed in affiliation with donor restrictions in the consolidated statements of changes in net assets. The following table summarizes the estimated fair values of assets acquired and liabilities assumed as of the acquisition date.

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	29,814
Accounts receivable		69,920
Other current assets		16,675
Land, buildings and equipment		252,096

(Continued)

(Dollars in thousands)

Intangible asset and other assets	$	105,830
Accounts payable, accrued compensation and other current liabilities		(112,076)
Long-term debt and other non-current liabilities		(49,590)
Total identifiable net assets assumed	$	312,669

The following are the results of Yakima in 2023 that have been included in the consolidated statements of operations and consolidated statements of changes in net assets from the acquisition date for the year ended December 31, 2023:

Total operating revenues	$	544,287
Change in net assets without restrictions		151,121
Change in net assets with restrictions		4,693

The following unaudited information presents MultiCare's results for the years ended December 31, 2023 and 2022, had the acquisition date been January 1, 2022 for the Yakima affiliation:

		2023	2022
		(Unaudited)	
Total operating revenues	$	4,949,015	4,524,987
Changes in net assets without donor restrictions		463,044	(504,189)
Changes in net assets with donor restrictions		85,148	5,394

On May 1, 2022, MHS completed the purchase of additional units of Physicians of Southwest Washington, LLC (PSW). Total consideration of this transaction was $49,956 and increased MHS' ownership to 75%. As part of the consideration of this business combination, MHS equity interest was valued at its estimated fair value based on the cash consideration transferred using standard valuation techniques of the equity acquired. As a result of the remeasurement of MHS equity interest in PSW, a gain of $9,105 was recognized within other operating revenue on the consolidated statement of operations for the year ended December 31, 2022. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. PSW is a leading population health company that provides management of risk contracts and manages a leading national accountable care organization (ACO) among other population health service offerings. The following table summarizes the total consideration and the estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Consideration:		
Cash consideration transferred	$	17,358
Fair value of MHS's equity interest before business combination		32,598
Total	$	49,956

(Continued)

(Dollars in thousands)

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	24,649
Other current assets		21,640
Land, buildings and equipment		647
Intangibles and other assets		1,799
Accounts payable, accrued compensation and other current liabilities		(24,454)
Total identifiable net assets assumed		24,281
Noncontrolling interest recognized		(23,731)
Goodwill		49,406
Total	$	49,956

The following are the results of PSW in 2022 that have been included in the consolidated statement of operations and statement of changes in net assets from the acquisition date for the year ended December 31, 2022:

Total operating revenues	$	36,305
Excess of revenue over expenses		1,394

The following unaudited information presents MHS's results for the year ended December 31, 2022, had the acquisition date been January 1, 2022 for the PSW acquisition:

		2022 (Unaudited)
Total operating revenues	$	4,010,866
Deficit of revenues over expenses		(513,848)

On September 22, 2022, MultiCare Rehabilitation Specialists, P.C. completed the purchase of additional units of Olympic Sports & Spine, PLLC (OSS). Total consideration of this transaction was $36,959 and increased MHS's ownership to 80.16%. As part of the consideration of this business combination, MHS equity interest was valued at its estimated fair value based on the cash consideration transferred using standard valuation techniques of the equity acquired. As a result of the remeasurement of MHS equity interest in OSS, a loss of $8,191 was recognized within other operating revenue on the consolidated statement of operations for the year ended December 31, 2022. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. OSS provides physical, occupational, and massage therapy services in the south Puget Sound area. The following table summarizes the total consideration and the

(Dollars in thousands)

estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Consideration:		
Cash consideration transferred	$	7,377
Fair value of MHS's equity interest before business combination		29,582
Total	$	36,959
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	5,988
Other current assets		6,167
Land, buildings and equipment		5,156
Intangibles and other assets		1,453
Accounts payable, accrued compensation and other current liabilities		(2,409)
Total identifiable net assets assumed		16,355
Noncontrolling interest recognized		(9,148)
Goodwill		29,752
Total	$	36,959

The following are the results of OSS in 2022 that have been included in the consolidated statement of operations and statement of changes in net assets from the acquisition date for the year ended December 31, 2022:

Total operating revenues	$	15,176
Excess of revenue over expenses		1,146

The following unaudited information presents MHS's results for the year ended December 31, 2022, had the acquisition date been January 1, 2021 for the OSS acquisition:

		2022 (Unaudited)
Total operating revenues	$	3,994,219
Deficit of revenues over expenses		(512,468)

(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 $1,947 and $1,749 at December 31, 2023 and 2022, respectively. MHS has recorded a corresponding payable of $1,406 and $1,301 at December 31, 2023 and 2022, 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

MHS 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 2023 and 2022, 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.

(Dollars in thousands)

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 non-lease 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.

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, 2023 or 2022.

The following table summarizes the balances of goodwill and intangible assets at December 31, 2023 and 2022:

		2023	2022
Goodwill	$	232,085	232,085
Intangible assets, net of accumulated amortization of $7,712 and $7,035, respectively		27,745	21,189
Total	$	259,830	253,274

The balance sheet as of December 31, 2023 includes intangible assets recognized as part of the Yakima affiliation in the amount of $7,696. The balance sheet as of December 31, 2022 includes goodwill recognized as part of the PSW and OSS transactions in the amounts of $49,406 and $29,752, respectively, and intangible assets recognized of $1,719 and $1,421, respectively.

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 $677 and $1,474 for the years ended December 31, 2023 and 2022, 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, 2023 and 2022, MHS held ownership interests in 27 and 26 joint ventures, respectively. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheets. Loss on joint ventures for the years ended December 31, 2023 and 2022 were $4,371 and $7,032, respectively, associated with several joint ventures. Gains and losses are included in other operating revenue on the consolidated statements of operations.

(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 $7,646 and $4,781 as of December 31, 2023 and 2022, 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 $2,865 in 2023 and decreased by $148 in 2022 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, 2023 and 2022, 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. These swaps have notional amounts totaling approximately $559,000 and expire starting in August 2027 through August 2049. During 2023, the interest rate swap agreements were amended to change the variable rate basis from LIBOR to SOFR due to the discontinuation of LIBOR. The majority of the swaps have the economic effect of fixing the SOFR-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. However, due to the nature of the specific swap arrangements in MHS' interest rate swap portfolio, the fair value of interest rate swap assets and swap liabilities are presented on a gross basis 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, 2023 and 2022, MHS has recorded $26,678 and $21,265, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2023, $15,886 of pledges are due in one year or less and $10,792 in two to eight 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 $99,048 and $89,946 for 2023 and 2022, respectively, and incurred assessments of $68,134 and $63,961 for 2023 and 2022, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations. MHS has outstanding receivables of $13,666 and $17,287 associated with this program as of December 31, 2023 and 2022, 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 $67,000 and $52,000 in 2023 and 2022, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $496,000 and $424,000 in 2023 and 2022, 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, capitated revenue, and other miscellaneous revenue.

(t) Excess of Revenues over Expenses

The consolidated statements of operations 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 assumed in affiliation, 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., Physicians of Southwest Washington, LLC and Olympic Sports & Spine, PLLC, which are all taxable

entities, 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. The adoption of this ASU did not have a material impact on our 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. The adoption of this ASU did not have a material impact on our financial statements.

(2) Coronavirus (COVID-19) Impact

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 has submitted funding applications with FEMA that covers costs incurred in order to respond to the COVID-19 pandemic. MHS recognizes FEMA reimbursements as they are obligated by the agency. MHS recognized $111,226 and $14,578 of FEMA reimbursements for the years ended December 31, 2023 and 2022, respectively, within other operating revenue in the statements of operations.

(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 Classifications (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 2023 or 2022.

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 2023 or 2022. 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, 2023 and 2022 are as follows:

	2023	2022
Payors:		
Medicare	$ 1,392,360	1,068,131
Medicaid	697,273	623,026
Premera	568,520	521,521
Regence	408,562	392,750
Aetna	191,124	192,352
United Healthcare	150,687	133,716
First Choice	131,606	117,366
Kaiser Permanente	112,527	134,237
Self-pay	20,654	23,149
Other	848,015	559,640
	$ 4,521,328	3,765,888

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, 2023 and 2022 was as follows:

	2023	2022
Medicare	35 %	35 %
Medicaid	22	25
Premera	8	7
Regence	7	6
Self-pay	5	5
First Choice	2	1
Health Care Exchange	1	1
Other commercial insurance	20	20
	100 %	100 %

(Continued)

(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, 2023 and 2022:

		Fair value measurements at reporting date using		
	December 31, 2023	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	$ 1,069,171	1,069,171	—	—
Fixed income bond funds	363,707	363,707	—	—
Fixed income governmental obligations	160,305	124,321	35,984	—
Fixed income other	163,597	—	163,597	—
Donor trusts	36,427	—	—	36,427
Interest rate swaps	26,421	—	26,421	—
Total assets at fair value	1,819,628	$ 1,557,199	226,002	36,427
Investment assets valued at NAV	289,026			
Total assets at fair value or NAV	$ 2,108,654			
Liabilities:				
Interest rate swaps	$ 6,425	—	6,425	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2022	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	$ 927,945	927,945	—	—
Equity securities	8,204	8,204	—	—
Fixed income bond funds	327,965	327,965	—	—
Fixed income governmental obligations	152,312	114,851	37,461	—
Fixed income other	178,595	—	178,595	—
Commingled trust fund – international equity	14,376	—	14,376	—
Donor trusts	29,431	—	—	29,431
Interest rate swaps	23,496	—	23,496	—
Total assets at fair value	1,662,324	$ 1,378,965	253,928	29,431
Investment assets valued at NAV	403,251			
Total assets at fair value or NAV	$ 2,065,575			
Liabilities:				
Interest rate swaps	$ 9,470	—	9,470	—

(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, 2023 and 2022:

	NAV December 31, 2023	NAV December 31, 2022	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 1,472	125,067	60	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	280,800	269,628	N/A	Daily	1 or more business days prior to valuation date
Limited partnerships	6,754	8,556	1,800	N/A	N/A
Total investments valued at NAV	$ 289,026	403,251	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.

(Continued)

(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 gains of these interest rate swaps for the years ended December 31, 2023 and 2022 were $5,969 and $133,126, respectively, and are included in gain on interest rate swaps in other income (loss), net in the consolidated statements of operations. Also included in the gain on interest rate swaps is the gain (loss) on net cash settlement amounts associated with the swaps of $8,441 and ($5,439) for the years ended December 31, 2023 and 2022, respectively.

The following table represents both the fair value and settlement value for the interest rate swap assets and liabilities as of December 31, 2023 and 2022:

	Asset derivatives					
	2023			2022		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Other assets, net	$ 26,421	29,351	Other assets, net	$ 23,496	26,079

	Liability derivatives					
	2023			2022		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	$ 6,425	7,143	Interest rates swap liabilities	$ 9,470	11,317

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2023 and 2022 is as follows:

	December 31, 2023		
	Donor restricted assets	Investments	Total
Mutual funds	$ 25,522	1,043,649	1,069,171
Fixed income securities	16,414	671,195	687,609
Hedge funds	35	1,437	1,472

(Continued)

(Dollars in thousands)

	December 31, 2023		
	Donor restricted assets	Investments	Total
Common trust funds	$ 6,703	274,097	280,800
Limited partnerships	162	6,592	6,754
Donor trusts	36,427	—	36,427
Pledge receivables, net and other	66,300	—	66,300
Total	$ 151,563	1,996,970	2,148,533

	December 31, 2022		
	Donor restricted assets	Investments	Total
Mutual funds	$ 20,491	907,454	927,945
Equity securities	181	8,023	8,204
Fixed income securities	14,548	644,324	658,872
Commingled trust fund – international equity	317	14,059	14,376
Hedge funds	2,762	122,305	125,067
Common trust funds	5,954	263,674	269,628
Limited partnerships	190	8,366	8,556
Donor trusts	29,431	—	29,431
Pledge receivables, net and other	45,652	—	45,652
Total	$ 119,526	1,968,205	2,087,731

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 12-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, 2023 and 2022, MHS' financial resources are as follows:

		2023	2022
Cash and cash equivalents	$	512,076	542,067
Accounts receivable		659,925	511,727
Other current assets, net		244,617	165,586
Donor restricted assets		151,563	119,526
Investments		1,996,970	1,968,205
		3,565,151	3,307,111
Less prepaid assets included in other current assets, net		(68,927)	(58,353)
Less donor restricted assets		(151,563)	(119,526)
Less investments with redemption limitations of greater than one year		(6,754)	(8,556)
Total financial assets available for general expenditures	$	3,337,907	3,120,676

In addition to financial assets available to meet general expenditures over the next 12 months, MHS operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures. MHS also has a $200,000 line of credit available for general expenditures, if needed (note 15).

(8) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2023 and 2022 is as follows:

		2023	2022
Land and land improvements	$	218,551	164,041
Buildings		2,596,458	2,360,383
Equipment		1,236,255	1,051,005
		4,051,264	3,575,429
Less accumulated depreciation		(1,806,178)	(1,640,005)
		2,245,086	1,935,424
Construction in progress		224,381	173,829
Property, plant, and equipment, net	$	2,469,467	2,109,253

(Continued)

(Dollars in thousands)

Total depreciation and amortization expense for the years ended December 31, 2023 and 2022 was $163,267 and $140,892, respectively. Depreciation expense charged to operations for the years ended December 31, 2023 and 2022 amounted to $162,991 and $139,145, respectively.

(9) Other Assets, Net

Other assets are as follows at December 31, 2023 and 2022:

		2023	2022
Investment in joint ventures	$	92,953	58,977
Deferred compensation plan assets held in trust (note 12)		104,668	87,039
Accrued pension asset (note 12)		49,236	36,428
Self-insured retention receivables, net of current portion (notes 13 and 14)		18,128	17,462
Net investment in lease (note 17(b))		22,459	22,655
Notes receivable (note 10)		75,138	75,284
Interest rate swaps (note 5(b))		26,421	23,496
Other		12,516	8,467
Other assets, net	$	401,519	329,808

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 executed a promissory note with Astria Health for a $75,000 loan. The loan bears a fixed interest rate of 9.5% with payments due June 30 and December 31 of each year. In December 2022, the credit agreement was amended to extend the maturity date. The loan matures in December 2025.

(11) Other Liabilities, Net

Other liabilities are as follows at December 31, 2023 and 2022:

		2023	2022
Professional liability, net of current portion (note 13)	$	121,130	103,813
Deferred compensation liability (note 12)		104,668	87,039
Workers' compensation liability, net of current portion (note 14)		15,651	15,444
Other		6,124	24,749
Other liabilities, net	$	247,573	231,045

(Continued)

(Dollars in thousands)

(12) Retirement Plans

(a) MHS Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the MHS Plan) covering eligible employees. The MHS 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 MHS 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 MHS Plan, which has measurement dates of December 31, 2023 and 2022:

		2023	2022
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	454,337	663,039
Service cost		780	650
Interest cost		24,026	19,329
Actuarial loss (gain)		10,060	(142,861)
Expected administrative expenses		(780)	(650)
Benefits paid		(32,492)	(85,170)
Projected benefit obligations at end of year	$	455,931	454,337
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	490,765	723,990
Actual gain (loss) on plan assets		47,597	(147,327)
Actual administrative expenses		(703)	(728)
Benefits paid		(32,492)	(85,170)
Fair value of plan assets at end of year	$	505,167	490,765
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	49,236	36,428
Amount recognized in net assets without donor restrictions:			
Net loss		106,209	106,367

(Continued)

(Dollars in thousands)

	2023	2022
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	5.30 %	5.50 %

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, 2023 and 2022:

	2023	2022
Components of net periodic benefit cost:		
Service cost	$ 780	650
Interest cost	24,026	19,329
Expected return on plan assets	(37,568)	(30,858)
Amortization of net actuarial loss	112	5,335
Settlement cost	—	14,559
	$ (12,650)	9,015

	2023	2022
Weighted average assumptions used to determine benefit obligation as of December 31:		
Discount rate	5.50 %	3.00 %
Expected return on plan assets	6.30	4.50

During the year ended December 31, 2022, the MHS Plan made lump-sum cash payments (settlements) to plan participants and in exchange the MHS Plan was relieved of all remaining liabilities of future payments to those plan participants. These settlements are included in benefits paid within the change in projected benefit obligation. The total amount of these settlements exceeded the total service costs and interest costs for the year ended December 31, 2022 and the pro-rata portion of the remaining balance in net assets without donor restrictions was recognized as part of net periodic benefit costs.

(Continued)

(Dollars in thousands)

The accumulated benefit obligation for the MHS Plan was $455,931 and $454,337 at December 31, 2023 and 2022, 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
2024	$ 36,424
2025	35,716
2026	36,681
2027	36,443
2028	36,330
2029–33	170,058

(ii) Plan Assets

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

		Fair value measurements at reporting date using		
	December 31, 2023	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	$ 2,586	2,586	—	—
Trading securities:				
Mutual funds	47,061	47,061	—	—
Fixed income bond funds	38,421	38,227	194	—
Fixed income governmental obligations	199,689	159,733	39,956	—
Fixed income other	166,770	6,764	160,006	—
Commingled trust fund – international equity	10,724	—	10,724	—
	465,251	$ 254,371	210,880	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2023	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$ 20,343			
Broker payables	(54,381)			
Total assets at fair value	431,213			
Investments valued at NAV	73,954			
Total assets at fair value or NAV	$ 505,167			

		Fair value measurements at reporting date using		
	December 31, 2022	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	$ 8,926	8,926	—	—
Trading securities:				
Mutual funds	91,812	91,812	—	—
Fixed income bond funds	5,100	4,921	179	—
Fixed income governmental obligations	187,978	140,834	47,144	—
Fixed income other	162,979	13,368	149,611	—
Commingled trust fund – international equity	12,729	—	12,729	—
	469,524	$ 259,861	209,663	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using			
		December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$	38,910			
Broker payables		(85,854)			
Total assets at fair value		422,580			
Investments valued at NAV		68,185			
Total assets at fair value or NAV	$	490,765			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2023 and 2022.

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2023 and 2022:

		NAV December 31, 2023	NAV December 31, 2022	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Absolute return funds	$	70,377	63,783	N/A	Monthly	5 business days prior to valuation date
Limited partnerships		3,577	4,402	850	N/A	N/A
Total investments valued at NAV	$	73,954	68,185	850		

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.

(Continued)

(Dollars in thousands)

Limited partnerships include investments in private equity and venture capital in both developed and 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.

The defined benefit plan weighted average asset allocations at December 31, 2023 and 2022 by asset category are as follows:

	2023	2022
Asset category:		
Domestic equities	6 %	13 %
International equities	5	9
Fixed income securities	88	77
Alternative investments	1	1
	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:

	2023	2022
Asset category:		
Domestic equities	5 %	12 %
International equities	5	8
Fixed income securities	90	80
	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 Plan's 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 to 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.

(b) Yakima Defined Benefit Pension Plan

Yakima operates one qualified defined benefit pension plan (the Yakima Plan) covering eligible employees. The Yakima Plan was closed to new employees effective after May 31, 2008. The benefits are based on years of service and the employee’s highest five consecutive years of compensation. Contributions to the Yakima Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2010 for nonunion participants and December 31, 2011 for union participants, participants no longer accrue pension benefits under the Yakima 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 Yakima Plan, which has measurement dates of December 31, 2023:

Change in projected benefit obligation:		
Projected benefit obligations at beginning of year	$	111,906
Interest cost		5,899
Actuarial loss		2,107
Benefits paid		(8,168)
Projected benefit obligations at end of year	$	111,744
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	$	111,962
Actual gain on plan assets		9,534
Benefits paid		(8,168)
Fair value of plan assets at end of year	$	113,328
Funded status recognized in consolidated balance sheets consist of:		
Asset for pension benefits	$	1,584
Amount recognized in net assets without donor restrictions:		
Net loss		(5,190)
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate		5.25 %

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 Yakima's 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 year ended December 31, 2023:

Components of net periodic benefit cost:		
Interest cost	$	5,899
Expected return on plan assets		(6,191)
	$	(292)

(Continued)

(Dollars in thousands)

Weighted average assumptions used to determine benefit obligation as of December 31:	
Discount rate	5.25 %
Expected return on plan assets	5.75

The accumulated benefit obligation for the Yakima Plan was $111,744 at December 31, 2023.

(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
2024	$ 8,737
2025	8,842
2026	8,840
2027	8,831
2028	8,784
2029–2033	42,065

(ii) Plan Assets

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

		Fair value measurements at reporting date using			
	December 31, 2023	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	$ 16,006	16,006	—	—
Trading securities:				
Equity securities	97,322	97,322	—	—
Total assets at fair value	$ 113,328	113,328	—	—

(Continued)

(iii) Investment Categories

Equity securities

The strategic role of equity securities (domestic and international) is to provide higher expected market returns of the major asset classes within the applicable markets and maintain a diversified exposure within the portfolio.

(c) 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.

Yakima currently maintains two defined contribution plans including a 403(b) tax-deferred annuity plan and a 401(k) plan, which is a safe harbor plan. The 403(b) plan was frozen to contributions as of January 1, 2020. The 401(k) plan is funded by both Yakima and employee contributions.

MHS' and Yakima's 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 2023 and 2022 were approximately $65,000 and $58,000, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(d) Other

In addition to the defined benefit and defined contribution plans as described above, MHS and Yakima also maintain 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, 2023 and 2022, 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.

During 2022, MHS began operations of a wholly owned insurance captive, Commencement Re (the Captive). On September 15, 2022, the Captive took on the risk to self-insure and reinsure certain layers of professional and general liability risk from MHS.

(Dollars in thousands)

At December 31, 2023 and 2022, the estimated gross professional liability (including current and long-term portions) was $156,125 and $128,101, 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 $15,100 and $22,754 as of December 31, 2023 and 2022, 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, 2023 and 2022, the estimated net liability based on future claims cost totaled $21,711 and $21,470, respectively. The gross liabilities (including both current and long-term portions) total $24,738 and $24,836 as of December 31, 2023 and 2022, 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 $3,028 and $3,366 as of December 31, 2023 and 2022, 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. Yakima maintained a separate self-insurance program for employee medical and dental insurance during 2023. Yakima employees were moved into the MHS program as of January 1, 2024. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2023 and 2022 was $25,346 and $12,984, 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, 2023 and 2022:

	2023	2022
WHCFA Revenue bonds, 2022A	$ 49,985	49,985
WHCFA Revenue bonds, 2022B	108,145	108,145
WHCFA Revenue bonds, 2022C	80,000	80,000
WHCFA Revenue bonds, 2022D	130,170	130,170
WHCFA Revenue bonds, 2022 Taxable Private Placement	430,000	430,000
2020 Taxable bonds	300,000	300,000

(Continued)

(Dollars in thousands)

		2023	2022
OCED financing	$	75,642	57,249
WHCFA Revenue bonds, 2017 Series A and B		310,415	314,550
WHCFA Revenue bonds, 2017 Series C and D		111,010	111,010
WHCFA Revenue bonds, 2015 Series A and B		329,345	343,675
Other		17,005	19,085
		1,941,717	1,943,869
Adjusted for:			
Current portion		(22,411)	(18,496)
Bond premiums, discounts, and debt issuance costs		42,643	46,764
Long-term debt, net of current portion	$	1,961,949	1,972,137

(a) Washington Health Care Facility Authority (WHCFA) Revenue Bonds, 2022A

In August 2022, MHS issued $49,985 of 2022 Series A bonds. These bonds were issued as variable rate tax exempt private placement debt with Royal Bank of Canada, with principal payments ranging from $1,845 in 2040 to final payment of $20,365 in 2044. The interest rates reset monthly and are based on SIFMA plus a spread.

(b) WHCFA Revenue Bonds, 2022B

In August 2022, MHS issued $108,145 of 2022 Series B bonds. These bonds were issued as variable rate tax exempt private placement debt with PNC Bank, NA. Principal payments range from $7,035 in 2040 to $22,085 in 2045, with a final payment of $19,715 in 2046 with interest payable semi-annually in February and August, based on SOFR plus a spread.

(c) WHCFA Revenue Bonds, 2022C

In December 2022, MHS issued $80,000 of 2022 Series C bonds. These bonds were issued as variable rate tax exempt private placement debt with Banc of America Preferred Funding Corp. The principal is due in full in 2047 with monthly interest payments based on SIFMA plus a spread.

(d) WHCFA Revenue Bonds, 2022D

In December 2022, MHS issued $130,170 of 2022 Series D bonds. These bonds were issued as variable rate taxable private placement debt with Bank of America, NA. The principal is due in full in 2047 with monthly interest payments based on SOFR plus a spread.

(e) WHCFA Revenue Bonds, 2022 Taxable Private Placement

In August 2022, MHS issued $430,000 of Series 2022 taxable private placement bonds. The bonds were acquired by various private investors. Included in the issuance are $130,000 in bonds bearing 4.48% fixed rate interest with principal due in full in 2037, and $300,000 in bonds bearing 4.75% fixed rate interest with principal due in full in 2052.

(Continued)

(f) 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 2050, with interest only payments made semiannually in February and August of each year.

(g) 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. In October 2022, MHS finalized a sale-leaseback for three additional OCEDs. Due to the specific terms of the agreements, the leases qualified as financing type leases. The agreements did not meet the criteria for sale-leaseback accounting treatment and instead are considered a financing liability. For the agreement finalized in 2022, cash proceeds are not received until construction commences and repayment of the financing liabilities do not start until construction is completed. Construction of the first OCED was completed in December 2023. The 2020 agreement bears an implicit interest rate of 4.64% while the 2022 agreement bears an implicit interest rate of 5.90%. Total annual principal payments range from $1,856 in 2043 to $6,431 in 2039.

(h) 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 $4,310 in 2024 to $62,410 in 2047.

(i) 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. The first annual principal payment of $55,505 is due in 2048, with a final principal payment of $55,505 in 2049. The interest rates reset monthly and are based on SOFR plus a spread.

(j) 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 $4,295 in 2040 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(k) Other

The other debt listed is primarily made up of debt held by Navos. Of the outstanding debt at December 31, 2023, $16,350 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.

(Dollars in thousands)

(l) Line of Credit

In October 2022, MHS entered into a $200,000 revolving credit agreement with JPMorgan Chase Bank, NA. In October 2023, the agreement was amended to $100,000. The line of credit matures October 2024 and bears interest at a variable rate based upon SOFR. The balance outstanding was $62,935 as of December 31, 2023. The line on credit had no draws as of December 31, 2022.

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, 2023 and 2022.

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:		
2024	$	22,456
2025		23,581
2026		24,753
2027		25,993
2028		27,298
Thereafter		1,817,636
	$	1,941,717

A summary of interest costs is as follows during the years ended December 31, 2023 and 2022:

		2023	2022
Interest cost:			
Charged to operations	$	81,941	59,006
Amortization of bond premiums, discounts, and issuance costs		(2,226)	(2,163)
Capitalized		2,486	555
	$	82,201	57,398

(Continued)

(Dollars in thousands)

(16) Commitments and Contingencies

Approximately 42% of MHS employees were covered under collective bargaining agreements as of December 31, 2023. 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 2026.

(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 20 years, and existing leases have expiration dates through 2042. 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, 2023 and 2022 were as follows:

		2023	2022
Operating lease cost	$	42,050	36,768
Finance lease cost:			
Amortization of right-of-use assets		5,922	4,745
Interest on lease liabilities		819	802
Total finance lease cost		6,741	5,547
Short term lease cost		751	1,503
Variable lease cost		—	9,138
Sublease income		(595)	(1,727)
Total lease cost	$	48,947	51,229

Other information related to leases as of December 31, 2023 and 2022 was as follows:

	2023	2022
Weighted average remaining lease term (years):		
Operating leases	8.6	7.2
Finance leases	5.5	6.0
Weighted average discount rate:		
Operating leases	4.0 %	4.0 %
Finance leases	4.4	4.4

(Continued)

(Dollars in thousands)

		2023	2022
Operating cash flows from operating leases	$	(39,882)	(35,805)
Operating cash flows from finance leases		(819)	(802)
Financing cash flows from finance leases		(5,782)	(4,499)
Right-of-use assets obtained in exchange for new operating lease liabilities		62,205	56,322
Right-of-use assets obtained in exchange for new finance lease liabilities		7,676	3,528

Maturities of lease liabilities under noncancelable leases as of December 31, 2023 are as follows:

		Operating leases	Finance leases	Total
For year ended December 31:				
2024	$	45,337	7,278	52,615
2025		41,668	5,215	46,883
2026		37,006	2,420	39,426
2027		30,844	2,154	32,998
2028		27,300	1,305	28,605
Thereafter		106,550	3,045	109,595
Total undiscounted lease payments		288,705	21,417	310,122
Less present value discount		(42,748)	(2,470)	(45,218)
Total lease liabilities	$	245,957	18,947	264,904

(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. The net investment in this lease was $22,459 and $22,655 at December 31, 2023 and 2022, respectively, and is included in other assets, net on the consolidated balance sheets.

(Continued)

(Dollars in thousands)

Revenue from leases for the years ended December 31, 2023 and 2022 is as follows:

		2023	2022
Interest income on net investment in finance leases	$	1,022	1,032
Variable lease income		28	28
Total lease income	$	1,050	1,060

Future lease payments receivable as of December 31, 2023 are as follows:

Year ended December 31:		
2024	$	1,227
2025		1,227
2026		1,227
2027		1,227
2028		1,227
Thereafter		39,346
Total lease payments to be received		45,481
Less unearned interest income		(23,022)
Net investment in lease	$	22,459

(18) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2023 and 2022:

		2023	2022
Healthcare services	$	105,652	51,816
Endowment funds, perpetual trusts and related receivables		71,548	78,231
Purchase of property, plant and equipment		79,602	42,001
Indigent care		2,499	2,459
Health education		1,360	1,006
Total net assets with donor restrictions	$	260,661	175,513

(Continued)

(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, 2021	$ 2,861	44,012	46,873
Investment return:			
Investment income	16	376	392
Net depreciation – realized and unrealized	(85)	(987)	(1,072)
Total investment return	(69)	(611)	(680)
Contributions	—	3,499	3,499
Appropriation of endowment assets for expenditure	(28)	(581)	(609)
Endowment net assets, December 31, 2022	2,764	46,319	49,083
Investment return:			
Investment income	72	933	1,005
Net depreciation – realized and unrealized	334	5,850	6,184
Total investment return	406	6,783	7,189
Contributions	—	18,188	18,188
Appropriation of endowment assets for expenditure	(1,198)	(29,455)	(30,653)
Endowment net assets, December 31, 2023	$ 1,972	41,835	43,807

(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 $18,698 and $27,650, respectively, as of December 31, 2023 and 2022. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $4,020 and $4,262, respectively, as of December 31, 2023 and 2022.

(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 2023 or 2022.

(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 fundraising 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, 2023 and 2022:

	2023				
	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	$ 1,566,478	510,975	162,278	279,047	2,518,778
Employee benefits	159,185	78,846	40,516	102,520	381,067
Supplies	630,578	47,346	124,610	5,171	807,705
Purchased services	184,355	69,179	51,253	181,244	486,031
Depreciation and amortization	110,864	13,849	12,005	26,549	163,267
Interest	69,347	818	77	11,699	81,941
Other	378,173	54,197	155,055	111,272	698,697
	$ 3,098,980	775,210	545,794	717,502	5,137,486

	2022				
	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	$ 1,357,838	464,219	93,787	283,421	2,199,265
Employee benefits	133,164	75,536	20,705	68,208	297,613
Supplies	535,376	48,220	70,994	3,880	658,470
Purchased services	135,500	68,800	32,771	159,676	396,747
Depreciation and amortization	87,289	14,878	7,580	31,145	140,892
Interest	40,631	3,715	70	12,426	56,842
Other	281,895	48,356	121,797	89,198	541,246
	$ 2,571,693	723,724	347,704	647,954	4,291,075

(Continued)

(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 20, 2024, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 9

Pro Forma Financial Statements

MultiCare Yakima Skilled Nursing Facility
Forecast Start-Up Expenses

Category	Startup Amount
Nursing	$ 424,203.19
Central Supply	$ 12,380.22
Briefs & Gloves	$ 2,897.67
Drugs & Pharmacy	$ 44,199.57
Inhalation Therapy	$ 473.01
IV Therapy	$ 449.14
Laboratory	$ 5,761.55
Administrative & General	$ 134,022.22
Admissions Coordinator	$ 10,844.38
Dietary	$ 74,971.80
Housekeeping	$ 19,259.96
Medical Records	$ 6,007.80
Recreation	$ 18,521.69
Social Services	$ 13,110.67
Transportation	$ 2,675.52
Plant Operations & Maint.	$ 31,847.21
Total	**$ 801,625.59**

Note: Reflects 2 months of operating expenses

MultiCare Yakima Skilled Nursing Facility
Forecast Financial Statement ($)

	2025 Q4	2026	2027	2028
ADC				
Medicaid	4.00	4.00	4.00	4.00
Medicare	14.00	14.00	14.00	14.00
Medicare HMO	8.00	8.00	8.00	8.00
Hospice (Medicaid)	4.00	4.00	4.00	4.00
Total ADC	30.00	30.00	30.00	30.00
Total Patient Days	2,738	10,950	10,950	10,950
Revenue (Net of Contractuals)				
Medicaid Room Revenue	132,859	531,435	531,435	531,435
Medicare Room Revenue	821,246	3,284,984	3,284,984	3,284,984
Medicare HMO	445,819	1,783,277	1,783,277	1,783,277
Hospice	132,859	531,435	531,435	531,435
Medicare B	4,072	16,286	16,286	16,286
Revenue Deductions				
Charity Care	(18,442)	(73,769)	(73,769)	(73,769)
Bad Debt	(15,369)	(61,474)	(61,474)	(61,474)
Total Revenue Deductions	(33,811)	(135,243)	(135,243)	(135,243)
Total Net Revenue	**1,503,043**	**6,012,174**	**6,012,174**	**6,012,174**
Expenses				
Nursing	636,305	2,545,219	2,545,219	2,545,219
Central Supply	18,570	74,281	74,281	74,281
Briefs & Gloves	4,346	17,386	17,386	17,386
Drugs & Pharmacy	66,299	265,197	265,197	265,197
Inhalation Therapy	710	2,838	2,838	2,838
IV Therapy	674	2,695	2,695	2,695
Laboratory	8,642	34,569	34,569	34,569
Medical Equipment Rental	530	2,119	2,119	2,119
Occupational Therapy	46,765	187,060	187,060	187,060
Physical Therapy	63,747	254,987	254,987	254,987
Prosthetics & Pen Therapy	893	3,573	3,573	3,573
Speech Therapy	23,911	95,645	95,645	95,645
X-Ray	2,088	8,352	8,352	8,352
Administrative & General	201,033	804,133	804,133	804,133
Continuing Education and PTO Accrual	3,891	15,562	15,562	15,562
Admissions Coordinator	16,267	65,066	65,066	65,066
Dietary	112,458	449,831	449,831	449,831
Housekeeping	28,890	115,560	115,560	115,560
Laundry	21,868	87,473	87,473	87,473
Medical Records	9,012	36,047	36,047	36,047
MSA Fee	90,183	360,730	360,730	360,730
Recreation	27,783	111,130	111,130	111,130
Social Services	19,666	78,664	78,664	78,664
Transportation	4,013	16,053	16,053	16,053
Plant Operations & Maint.	47,771	191,083	191,083	191,083
Total Operating Expenses	1,456,314	5,825,256	5,825,256	5,825,256
EBITDA	46,730	186,918	186,918	186,918
Depr/Amort	11,722	46,889	46,889	46,889
Net Income	35,007	140,029	140,029	140,029

MultiCare Yakima Skilled Nursing Facility
Depreciation Schedule

	Capital Expenditures	Useful Life	Monthly Depreciation
Buildout	$ -	40	$ -
Equipment	$ 454,892	10	$ 3,791
Architect Fees	$ 14,000	10	$ 117
Total Capital Costs	**$ 468,892**		$ 3,907

	2025	**2026**	**2027**	**2028**
# of Months	**3**	**12**	**12**	**12**
Buildout	$ -	$ -	$ -	$ -
Equipment	$ 11,372	$ 45,489	$ 45,489	$ 45,489
Capitalized Interest	$ 350	$ 1,400	$ 1,400	$ 1,400
Subtotal	**$ 11,722**	**$ 46,889**	**$ 46,889**	**$ 46,889**
Depreciation per month	$ 3,907	$ 3,907	$ 3,907	$ 3,907

MultiCare Yakima Skilled Nursing Facility

Balance Sheet Forecast ($)

		2025 Q4	2026	2027	2028
Months	**2**	**3**	**12**	**12**	**12**
ASSETS	**Pre Op Period**	**12/31/2025**	**12/31/2026**	**12/31/2027**	**12/31/2028**
Current Assets					
Cash and Cash Equivalents	0	0	0	0	0
Accounts Receivable	0	210,528	842,112	842,112	842,112
Total Current Assets	0	210,528	842,112	842,112	842,112
Fixed Assets					
Long-term Assets	468,892	468,892	468,892	468,892	468,892
Accum. Depreciation		(11,722)	(58,612)	(105,501)	(152,390)
Land		0	0	0	0
Total Fixed Assets	468,892	457,170	410,281	363,391	316,502
Other Assets		0	0	0	0
Total Assets	**468,892**	**667,698**	**1,252,392**	**1,205,503**	**1,158,614**
LIABILITIES AND CAPITAL					
Current Liabilities					
Accounts Payable & Accrued Expenses	0	54,954	219,818	219,818	219,818
Accrued Compensation		131,284	131,284	131,284	131,284
Total Current Liabilities		186,238	351,101	351,101	351,101
Long-Term Liabilities		0	0	0	0
Total Liabilities	**0**	**186,238**	**351,101**	**351,101**	**351,101**
Capital Contributed	1,270,518	1,248,078	1,527,881	1,340,963	1,154,044
Retained Earnings/Startup	(801,626)	(766,618)	(626,590)	(486,561)	(346,532)
Capital	468,892	481,460	901,291	854,402	807,513
Total Liabilities & Capital	**468,892**	**667,698**	**1,252,392**	**1,205,503**	**1,158,614**

Exhibit 10

Letter from Avalon Compliance Officer

AVALON HEALTH CARE GROUP

08/28/2024

To Whom It May Concern,

Avalon Care Center - Cottage in the Meadow, L.L.C. (the Facility) and its affiliated entities operate in compliance with all federal and state laws applicable to a skilled nursing facility. The Facility will have and maintain in place policies and procedures to ensure that it remains in compliance with all federal and state laws applicable to a skilled nursing facility.

Should you have questions about the commitment and assurances expressed in this letter, please contact me directly using the information below. Thanks.

Ryan D. Nelson, Esq.
Compliance Officer
Avalon Health Care Management, Inc.
206 North 2100 West, Salt Lake City, UT 84116
O 801.325.0126 | M 385.552.1466 | F 801.596.9001
Ryan.Nelson@AvalonHealthCare.com

Exhibit 11

Example Hospital Transfer Agreement

Transfer Agreement Example

This agreement is made and entered into by and between YOUR FACILITY NAME, CITY, STATE, a nonprofit corporation (hereinafter called "YOUR FACILITY") and RECEIVING FACILITY NAME, CITY, STATE, a nonprofit corporation, (hereinafter called "RECEIVING FACILITY"):

WHEREAS, both YOUR FACILITY and RECEIVING FACILITY desire, by both means of this Agreement, to assist physicians and the parties hereto in the treatment of trauma patients (e.g., burn, traumatic brain injuries, spinal cord injuries, pediatrics); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of trauma patients transferred, (b) the continuity of the care and treatment appropriate to the needs of trauma patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of trauma patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

1. PATIENT TRANSFER: The need for transfer of a patient from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a trauma patient at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING FACILITY will be made pursuant to admission policies and procedures of RECEIVING FACILITY.

2. YOUR FACILITY agrees that it shall:

    a. Notify RECEIVING FACILITY as far in advance as possible of transfer of a trauma patient.
    b. Transfer to RECEIVING FACILITY the personal effects, including money and valuables and information relating to same.
    c. Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, YOUR FACILITY shall either establish that the transfer is the result of an informed written request of the patient or his or her surrogate or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.
    d. Affect the transfer to RECEIVING FACILITY through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

3. YOUR FACILITY agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

4. RECEIVING FACILITY agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

5. Bills incurred with respect to services preformed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

6. This agreement shall be effective from the date of execution and shall continue in effect indefinitely. Either party may terminate this agreement on thirty (30) days notice in writing to the other party. If either party shall have its license to operate revoked by the state, this Agreement shall terminate on the date such revocation becomes effective.

7. Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

8. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.

9. Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

10. This agreement shall be governed by the laws of the State of INSERT STATE. Both parties agree to comply with the Emergency Medical Treatment and Active Labor Act of 1986, and the Health Insurance Portability and Accountability Act of 1996 and the rules now and hereafter promulgated thereunder.

11. This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

YOUR FACILITY	RECEIVING FACILITY
SIGNED BY:	SIGNED BY:
DATE:	DATE:

Exhibit 12

Facility Discharge and Continuity of Care Policies

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **COMPREHENSIVE CARE PLANS** **Discharge Planning**	**NUMBER** **660**

PURPOSE: To have a discharge planning process which addresses the resident's discharge goals and needs, including caregiver support and referrals to local agencies, as needed, in an effort to reduce readmissions.

POLICY: The facility will develop an individualized discharge care plan through an Interdisciplinary Team Process (IDT), as part of the comprehensive care plan. The process will include the resident and/or resident representative and will be re-evaluated and updated as changing needs are identified throughout the resident's stay. The discharge plan will consider the resident's discharge goals and needs to make a smooth and safe transition from the facility to the post-discharge setting. Consideration will be given to the resident's post-discharge care needs and caregiver/support person availability and capability. This process will begin at the time of admission.

GUIDELINES:

1. Discharge planning will begin at the time of admission and include the resident and/or the resident representative.

2. The discharge plan will be based on the resident's assessment and goals for care, desire to be discharged and the resident's capacity for discharge.

3. The discharge plan will be re-evaluated and updated to reflect changes in the plan if the resident's condition changes.

4. The discharge plan will include needs that must be addressed before the resident can be discharged (e.g. resident and caregiver education, rehabilitation and caregiver availability).

5. Identify post-discharge needs such as medical equipment, nursing and therapy services, ADL assistance or home modifications.

6. The facility will document the resident's interest in referrals to local support agencies, ombudsman or other entities and any referrals that have been made.

7. If the resident wishes to discharge to the community, the facility will determine if appropriate and adequate supports are in place and are capable of meeting the resident's needs. This determination will be made with the involvement of the resident and/or resident representative as well as other family members and/or significant others. This includes, but is not limited to home health, hospice, or assisted living.

8. If it is determined that discharge to the community is not feasible, the facility will document, in the medical record, information related to who made the decision and the rationale for the decision.

9. If the resident and/or resident representative wishes to be discharged to a destination that does not appear to meet his/her post-discharge needs or appears unsafe, the facility will:
    a. Discuss and document the implications and/or risks and attempt to ascertain why the resident is choosing that location
    b. Document that other, more suitable, options were presented and discussed
    c. Document that despite other more suitable options, the resident refused other settings
    d. Determine if a referral to Adult Protective Services or other State agency is needed
    e. If a referral to a state agency is needed, it will be made at the time of discharge.

10. If a resident will be discharged to another SNF/NF, IRF, LTCH or HHA, the facility will assist the resident to accomplish a smooth transition of care. To accomplish this, the facility will provide names of other providers who can meet the resident's needs and provide information and data related to the other providers. This information will be in a manner that the resident and/or resident representative can understand. The facility will document evidence that this was completed.

11. If a resident's condition changes the physician will be notified. The physician will determine if a resident's care needs cannot be met in the facility, and if the resident should be transferred to a higher level of care.

References	
Regulation(s)	483.21(c)(1)
FTag(s)	F660
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **PHYSICIAN SERVICES**	**NUMBER** **710**

PURPOSE: To support medical supervision of the care of each resident is provided by a physician and that orders for the resident's immediate care and needs are provided throughout the resident's stay.

POLICY: The medical care of each resident is supervised by a physician.

GUIDELINES:

1. The Attending physician refers to the primary physician who is responsible for managing the medical care of the resident. This does not include other physicians whom the resident may see periodically, such as specialists.

2. Another physician supervises the medical care of residents when their physician is unavailable.

3. The written recommendation for admission must be provided by a physician.

4. A hospital transfer summary written by a physician, paperwork completed by the resident's physician in the community, or other written form by a physician can serve as the written recommendation for admission to the facility.

5. The physician admission orders for the resident's immediate care can serve as the physician's "personal approval" of the admission if the orders are provided by a physician.

6. The Non-Physician Provider (NPP) cannot provide the recommendation for admission or admission orders.

7. An NPP can provide admission orders if a physician personally approved in writing a recommendation for admission to the facility prior to admission.

8. The facility will provide or arrange for the provision of physician services 24 hours a day, in case of emergency. If a resident's attending physician is unavailable, the facility will attempt to contact the physician covering for the attending physician before assuming the responsibility of contacting another physician.

9. Arranging for physician services may include arranging resident transportation to a hospital emergency room or other medical facility if the facility is unable to meet the particular medical need at the facility. The facility remains responsible to have a physician available and to respond to emergencies that do not require medical care in another setting.

References	
Regulation(s)	483.30(a)(1)-(2), (d)
FTag(s)	F710, F713
Other References	
Version	

	CLINICAL SERVICES POLICY AND GUIDELINES FOR IMPLEMENTATION
SUBJECT **PHYSICIAN SERVICES** **Physician Visits and Physician Delegation of Visits**	**NUMBER** **711**

PURPOSE: Physician visits are to include an evaluation of the resident's condition and total program of care, including medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen.

POLICY: The physician takes an active role in supervising the care of the residents.

GUIDELINES:

1. Except where the regulation specifies that the task must be personally completed by the physician, the term "attending physician" or "physician" also includes a non-physician practitioner involved in the management of the resident's care to the extent permitted by State law.

2. ***During required visits***, the physician must document a review of the resident's total program of care, including the resident's current condition, progress and problems in maintaining or improving their physical, mental and psychosocial well-being and decisions about the continued appropriateness of the resident's current medical regimen.

3. Progress notes must be written, signed and dated at each physician visit, which can be done in a physical chart or electronic record.

4. During visits, the physician must sign and date orders, with the exception of influenza and pneumococcal vaccination orders which can be administered per physician approved facility policy after an assessment for contraindications. This includes cosigning orders written by an NPP, qualified dietitians, other clinically qualified nutrition professionals and qualified therapists as required by state law.

5. SIGNATURES
    a. Electronic signatures are acceptable in facilities who have adopted electronic health records.
    b. Physician orders can be transmitted via facsimile when the following conditions are met:
    c. If a facility management authorizes the use of rubber stamp signatures, the individual whose signature the rubber stamp represents shall place in the administrative offices of the facility a signed statement to the effect that s/he is the only one who has the stamp and uses it.
    d. A list of computer codes, identification numbers and/or written signatures must be readily available and maintained under adequate safeguards. Adequate safeguards may include, but are not limited to locked in a drawer, locked in a location that is accessible only by appropriate staff as defined by the facility, or available on a protected electronic site accessible by appropriate staff as defined by the facility.

6. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

7. The timing of the physician visits is based upon the admission date of the resident.

8. In a SNF:
    a. The first physician visit (includes the initial comprehensive visit) is conducted within 30 days after admission.
    b. The residents are seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.
    c. All required physician visits must be made by the physician personally, except in the following instance: At the option of the physician, required visits in the SNF, after the initial visit, may alternate between personal visits by the physician and visits by a nurse practitioner, physician assistant or clinical nurse specialist.
    d. The physician cannot delegate the responsibility for conducting the initial visit in a SNF.
    e. NPPs may perform other medically necessary visits prior to and after the physician's initial visit, as allowed by state law.
    f. Where allowed by state law, NPPs may conduct every other required visit. These alternate visits, as well as medically necessary visits may be performed and signed by the NPP. (Physician co-signature is not required, unless required by State law).

9. In a NF:

a. The requirement for physician visits can be satisfied in accordance with state law by an NPP who is not an employee of the facility but who is working in collaboration with a physician and who is licensed by the State and performing within the state scope of practice.
b. Medically necessary visits performed by an NPP employed by the facility may not take the place of physician required visits, nor may the visit count towards meeting the physician visit schedule prescribed.

10. In SNFs and NFs, facility policy that allows NPPs to conduct required visits, and/or allows a 10-day slippage in the time of the required visit, does not relieve the physician of the obligation to visit a resident personally, when the resident's medical condition makes that visit necessary.

11. An NPP can provide admission orders if a physician personally approved in writing a recommendation for admission to the facility prior to admission.

12. In a facility where beds are dually certified under Medicare and Medicaid, the facility will determine how the particular resident stay is being paid in order to identify whether the physician delegation of tasks is permissible and an NPP can perform the tasks.

13. It is preferred to have the physician visits occur at the facility, unless equipment is needed, or a resident specifically requests an office visit.

14. If the facility may establish a policy that residents leave the premises for medical care as long as the resident does not object and the policy does not infringe on the resident's rights (including the right to privacy).

15. NPPS who are not employed by the facility and who are working in collaboration with a physician may sign the required initial certification and re-certifications when permitted under scope of practice for the State.

See Tools: Table 1 Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Re-certifications when Permitted by the State

References	
Regulation(s)	483.30(b)(1)-(2); 483.30(c)(2)-(4)
FTag(s)	F711 - 712
Other References	Tools: Table 1 Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Re-certifications when Permitted by the State
Version	

Table 1: Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Re-certifications when Permitted by the State

	Initial Comprehensive Visit/Orders	**Other Required Visits^**	**Other Medically Necessary Visits & Orders+**	**Certification / Recertification±**
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State Requirements
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable
PA, NP, & CNS not a facility employee	May perform/ May sign*	May perform	May perform and sign	Not applicable

**A NPP may provide admission orders if a physician personally approve in writing a recommendation for admission to the facility prior to admission. For additional requirements on physician recommendation for admission and admission orders, see §483.30(a)., F710.*

^Other required visits are the physician visits required by 483.30(c)(1) other than the initial comprehensive visit.

+Medically necessary visits are independent of required visits and may be performed prior to the initial comprehensive visit.

±Though not part of a compliance determination for this section, this requirement is provided for clarification and relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.