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By Julianne Kolln at 2:32 pm, Mar 21, 2024

Applicant Description

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

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

   Apex Spine Institute, PLLC
   821 Swift Blvd
   Richland, WA 99352

   Partners:
   Janmeet Sahota
   Allen Shoham

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

   Apex Spine Institute, PLLC

   UBI# 604839169

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

   Alex Linde
   CEO
   509-606-5040
   821 Swift Blvd
   Richland, WA 99352

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

   Lance Baldwin
   ASC Consultant
   318-792-8215
   1320 118 Dr SE
   Lake Stevens, WA 98258

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

Apex Spine Institute, PLLC, is a healthcare entity specializing in spine care, established in May 2022 in the state of Washington. The organization was founded by two managing members and equal partners, Dr. Janmeet Sahota, DO, and Dr. Allen Shoham, MD, each holding a 50% ownership stake. As a Professional Limited Liability Company (PLLC), it operates with a physician-owned structure, underscoring its commitment to providing specialized and expert care in orthopaedics and spine health.

The primary goal of the Apex Spine Institute is to secure a certificate of need for their Ambulatory Surgery Center (ASC). This strategic step is aimed at expanding their service offerings by allowing other orthopaedic physicians to perform surgeries within their facility. Notably, the institute has planned for this expansion without necessitating any changes to the existing infrastructure of the center, indicating a focus on maximizing the utility and efficiency of their current resources.

The organizational structure of Apex Spine Institute encompasses several facilities spread across various locations to optimize accessibility and convenience for patients. The corporate address, which also serves as the principal clinic, is situated at 821 Swift Blvd, Richland, WA. In close proximity, the ASC is located at 985 Goethals Dr, Richland, WA, which is central to their application for the certificate of need. Additionally, another clinic and imaging center are housed at 965 Goethals Dr, Richland, WA, further extending their capacity for specialized care. Moreover, the institute operates a clinic at 614 E Alder St Suite 2, Walla Walla, WA, which is open two days a week, underscoring their commitment to serving a broader patient base.

Project Description

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

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

   Apex Spine ASC

   985 Goethals Dr, Richland, WA, 99352-3527

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

   N/A

3. Provide a detailed description of the proposed project.

   Apex Spine proposes to convert a 3 operating room certificate of need exempt ASC to a certificate of need approved ASC.Apex Spine currently operates a 3 operating room CN-exempt ASC providing orthopedic and pain management services. Apex Spine will not be adding additional service lines as part of this project.

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

Event	Anticipated Month/Year
Design Complete	N/A
Construction Commenced	N/A
Construction Completed	N/A
Facility Prepared for Survey	N/A
CN approval	September 1, 2024
Project Completion	September 1, 2024

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

   □ Ear, Nose, & Throat □ Maxillofacial X Pain Management

□ Gastroenterology	□ Ophthalmology	□ Plastic Surgery
□ General Surgery	□ Oral Surgery	□ Podiatry
□ Gynecology	X Orthopedics	□ Urology

□ Other? Describe in detail:_____

Table 1. Top 30 Procedures performed listed by charge code and brief description

Charge Code	Brief Description
64483	Injection, anesthetic agent/steroid, lumbar/sacral (caudal)
64493	Injection, diagnostic or therapeutic substance, lumbar/sacral spine facet joint, with imaging guidance (fluoroscopy or CT)
64494	Injection, diagnostic or therapeutic substance, lumbar or sacral spine facet joint, second level (List separately in addition to code for primary procedure)
64636	Destruction by neurolytic agent, lumbar or sacral, second facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, lumbar or sacral, first facet joint
64484	Injection, anesthetic agent/steroid, lumbar/sacral spine facet joint, each additional level (List separately in addition to code for primary procedure)
G0260	Injection, sacroiliac joint, anesthetic/steroid, with imaging guidance (fluoroscopy or CT)
64490	Injection, diagnostic or therapeutic substance, cervical or thoracic facet joint, with imaging guidance (fluoroscopy or CT)
64491	Injection, diagnostic or therapeutic substance, cervical or thoracic facet joint, second level (List separately in addition to code for primary procedure)
64634	Destruction by neurolytic agent, cervical or thoracic, second facet joint (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, cervical or thoracic, first facet joint
64495	Injection, diagnostic or therapeutic substance, cervical or thoracic facet joint, third level (List separately in addition to code for primary procedure)

64492	Injection, diagnostic or therapeutic substance, cervical or thoracic facet joint, third level (List separately in addition to code for primary procedure)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with imaging guidance
64772	Decompression of facial nerve
63650	Percutaneous implantation of neurostimulator electrode array, epidural
62323	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, with imaging guidance (i.e., fluoroscopy or CT), cervical or thoracic
64451	Nerve block(s), peripheral nerve(s), by injection of local anesthetic and/or steroid
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, one interspace, lumbar
62321	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, with imaging guidance (i.e., fluoroscopy or CT), lumbar or sacral
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)
64450	Nerve block, other peripheral nerve or branch
64405	Injection, anesthetic agent; greater occipital nerve
22845	Anterior instrumentation; 2 to 3 vertebral segments
22830	Exploration of spinal fusion
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
22551	Arthrodesis, anterior interbody, including disk space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve

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

   □ Endoscopy □ Bariatric Surgery □ Other:_____

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

Clinical Practice: The clinical practice involved in performing these procedures, such as techniques for injections, surgical interventions, and post-operative care, remains consistent. Health professionals' training and qualifications, including surgeons, anesthesiologists, and nursing staff, are determined by professional licensing boards and not by the CON process.
Procedure Codes: The CPT codes (e.g., 64483, 64493, etc.) represent specific medical procedures and services. These codes are used for billing and do not change with the acquisition of a CON. Their definitions and associated reimbursements are determined by the American Medical Association and relevant payer policies. *Apex Spine will continue to perform its existing specialties of orthopedic and pain management. No new specialties will be added.*
Regulatory Compliance: ASCs in Washington must comply with state healthcare facility licensing requirements, federal regulations, and accreditation standards. These compliance requirements ensure facilities maintain high-quality care and patient safety standards, irrespective of CON status.
Quality and Safety: The quality and safety standards for the procedures listed are dictated by clinical guidelines and evidence-based practices. Acquiring a CON does not alter these standards but ensures that the facility providing these services meets specific needs within the community and avoids unnecessary duplication of services.
Access to Care: While a CON may impact the ASC's ability to expand or reduce services based on assessed community needs, it does not affect the inherent nature of the procedures offered. The goal of the CON process is to balance access to care with avoiding overcapacity, without compromising the quality or scope of services provided.

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

   3 Operating rooms

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

   Apex Spine conducts pain management procedures, but none of its three operating rooms are solely reserved for these services.

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

    Apex Spine is committed to addressing a wide spectrum of pain-related conditions, catering to adult patients aged 18 and older. Our comprehensive care extends to individuals suffering from chronic pain, spinal-related injuries, complications arising from motor vehicle accidents, work-related injuries, and pain associated with aging. Our multidisciplinary approach ensures that each patient receives personalized, evidence-based treatment strategies aimed at alleviating pain, improving functionality, and enhancing quality of life. Through a combination of advanced diagnostic techniques and targeted therapies, we are dedicated to providing our patients with the highest standard of care, tailored to meet their unique needs and circumstances. Apex Spine maintains a professional relationship with Lourdes Hospital to ensure patients under the age of 18

can receive similar care in a facility with pediatric capabilities.

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

    See Exhibit 12

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

    See Exhibit 3

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

    License #: ASF.FS.61287220

    Medicare #:1053418137

    Medicaid #: Application applied for, number pending.

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

    The facility is Medicare certified by AAAHC. See Exhibit 6

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

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

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

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

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

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

Table 2. All Surgical facilities in Benton-Franklin Planning Area

Facility	Special Procedure Rooms	Dedicated Outpatient ORs	Mixed Use ORs	Notes	Methodology
Kadlec Regional Medical Center	5		12		Hospital All ORs are counted in methodology
Lourdes Medical Center	5		8		Hospital All ORs are counted in methodology
PMH Medical Center			2		Hospital All ORs are counted in methodology
Trios health			8		Hospital All ORs are counted in methodology
High Desert Surgery Center		**2**			CN approved Surgery Center All ORs are counted in methodology
Hoyeoul Yang MD PS	1			Dedicated to Endoscopy	CN approved Surgery Center Dedicated to Endoscopy Neither ORs nor cases are counted in methodology
Kadlec Ambulatory Surgery Center		**3**			CN approved Surgery Center All ORs are counted in methodology
Northwest Ambulatory Physicians	5			Dedicated to Endoscopy	CN approved Surgery Center Dedicated to Endoscopy Neither ORs nor cases are counted in methodology
Tri-Cities Endoscopy Center	2			Dedicated to Endoscopy	CN approved Surgery Center Dedicated to Endoscopy Neither ORs nor cases are counted in methodology
Mid-Columbia Endoscopy Center	2			Dedicated to Endoscopy	CN-Exempt Dedicated to Endoscopy Neither ORs nor cases are counted in methodology
Northwest Endovascular Surgery		1			CN Exempt Cases, but not ORs, are counted in methodology

Pacific Cataract and Laser Institute		4			CN Exempt Cases, but not ORs, are counted in methodology
Apex Spine Institute		3			Under CN Review Cases, but not ORs, are counted in methodology
The Surgery Center at Tri-City Orthopaedic Clinic (Kennewick)		**4**			CN approved Surgery Center All ORs are counted in methodology
Tri-City Regional Surgery Center	1	3			CN Exempt Cases, but not ORs, are counted in methodology
Total	21	20	30		

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

Table 3. List of Facilities that Provide Similar Services

Facility
Kadlec Regional Medical Center
Lourdes Medical Center
PMH Medical Center
Trios health
High Desert Surgery Center
Kadlec Ambulatory Surgery Center
The Surgery Center at Tri-City Orthopaedic Clinic (Kennewick)
Tri-City Regional Surgery Center

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

Based on need methodology from the Washington Department of Health, there is demonstrated quantitative need for additional outpatient operating suites. Therefore, there will not be a duplication of services.

4. Complete the methodology outlined in WAC 246-310-270, unless your facility will be exclusively dedicated to endoscopy, cystoscopy, or pain management. If your facility will be exclusively dedicated to endoscopy, cystoscopy, or pain management, so state. If you would like a copy of the methodology template used by the department, please contact the Certificate of Need Program.

Table 4. Methodology

Assumption	Data Used	
Planning area	Benton-Franklin	
Population estimates and forecasts	Age Group: All ages Claritas 2024 Year 2022: 273,546 Year 2027: 311,005	
Use rate/1,000 Population	144.440	
Year 2022 total number of surgical cases in the planning area	**Inpatient or mixed use**	**Outpatient**
	20,339	19,172
	Total Cases	39,511
Percent of surgeries: outpatient vs. inpatient (based on survey)	51.48%	48.52%
Average minutes per case (based on survey)	97.43	60.28
OR annual capacity in minutes (per methodology in rule)	94,250 surgery minutes	68,850 surgery minutes
Existing providers/ORs (using DOH survey and ILRS database)	31	9
Department's Methodology Results	**Shortage of dedicated Outpatient ORs: 10.1**	

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

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

To advocate for the approval of a Certificate of Need (CON) for additional outpatient operating rooms (ORs) in the Benton-Franklin Planning Area, it is crucial to address the specific healthcare needs intensified by the recent pandemic. The rationale for expanding outpatient OR capacity encompasses not only pre-existing needs but also those highlighted and exacerbated by the COVID-19 pandemic. This includes the backlog of elective surgeries delayed due to pandemic-related restrictions and a heightened focus on minimizing hospital stays to reduce infection risks. Please consider:

Backlog of Elective Surgeries: The pandemic has significantly impacted the scheduling and completion of elective surgeries, creating a backlog as procedures were postponed to allocate resources to COVID-19 patients. This delay has increased the demand for outpatient surgeries, necessitating an expansion of outpatient OR capacity to address the accumulated needs efficiently.
Shift Towards Outpatient Services: The pandemic has accelerated the shift from inpatient to outpatient surgical care, driven by the necessity to reduce patient exposure to hospital environments and to optimize hospital resources. This shift underscores the need for additional outpatient ORs to accommodate the increased volume of surgeries being transitioned to outpatient settings. (A Positive Trend in Healthcare, see exhibit 9)
Technological Advancements and Patient Preference: The advancements in medical technology and surgical techniques have made it possible to perform a wider range of surgeries on an outpatient basis. Coupled with a patient preference for outpatient settings — due to convenience, lower cost, and perceived lower risk of COVID-19 exposure — there's a clear and growing demand for more dedicated outpatient ORs. (A Positive Trend in Healthcare, see Exhibit 9)
Operational Efficiency and Cost-Effectiveness: Freestanding ambulatory surgery centers (ASCs) have demonstrated greater efficiency and cost-effectiveness, especially important during and following the pandemic. Research shows up to a 43% savings for many orthopedic procedures. (See Exhibit 10). Expanding outpatient OR capacity supports a more sustainable healthcare system by providing cost-effective surgical care and alleviating the financial pressures on the overall healthcare system. Cost savings for performing procedures in an ASC equate to efficient quality care, convenience, and patient satisfaction. See
Public Health Considerations: Enhancing outpatient surgical capacity is also a public health imperative. The Benton and Franklin county's Community Health Improvement Plan (See Exhibit 8) Strategy 1.3.2 is to " Identify and promote services that mitigate barriers to access to healthcare services" By enabling more procedures to be done on an outpatient basis, it reduces the patient load on hospital-based systems, allowing them to better manage infectious disease outbreaks, improved access, and other emergencies.

In conclusion, the expansion of outpatient OR capacity in the Benton-Franklin Planning Area is a critical step towards addressing not only the existing healthcare needs but also those highlighted by the recent pandemic. It aligns with the shifts in healthcare delivery preferences, the need for operational efficiency, and the overarching goal of improving public health outcomes. This expansion is supported by the broader trends in healthcare towards outpatient care, the imperative of addressing surgical backlogs, and the ongoing efforts to optimize healthcare resource utilization in the wake of the pandemic.

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

   Apex Spine ASC was established in May 2022.

Table 5. Historical Utilization

May- Dec 2022	2023
1267	2058

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

Population projections shows growth of 2.6% per year. Apex Spine ASC conservatively shows growth of 2.6% per year.

Table 6. Projected Surgical Volumes for First Three Full Years

	2024	2025	2026	2027
Pain Management	1584	1625	1667	1710
Orthopedic	528	542	556	570
Total	2112	2166	2223	2281

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

   The Benton-Franklin planning area is a significant healthcare hub that attracts patients from across the broader area, underscoring a substantial demand for specialized surgical services. Within this context, the landscape of surgical offerings, particularly in the domain of pain management and orthopedic services, presents a unique scenario. Currently, the Benton-Franklin area boasts a combination of hospitals and outpatient surgery centers that cater to a wide range of surgical needs. Despite the availability of these facilities, only a select few have received Certificate of Need (CN) approval, which is indicative of a rigorous vetting process that ensures the necessity and quality of the services provided.

   Among these, Apex Spine stands out as a specialized center dedicated to pain management and orthopedic services. Unlike the majority of outpatient centers in the region, which often focus on comprehensive services, Apex Spine offers a focused suite of services tailored to address complex pain management and orthopedic conditions. This specialization is particularly significant given the limited number of CN-approved outpatient centers offering such a wide array of services outside of acute care hospital settings.

   The concentration of surgical services within acute care hospitals in the Benton-Franklin area highlights a gap in the availability of outpatient surgical care, especially in specialized fields like pain management and orthopedics. Apex Spine fills this critical gap by providing an accessible, outpatient setting for patients in need of specialized surgical interventions without the need to navigate the more traditional, and often more cumbersome, hospital-based surgical pathways.

   Therefore, in addition to addressing the quantitative demand for surgical services, Apex Spine also mitigates qualitative barriers to accessing care. By offering specialized pain management and orthopedic services in an outpatient setting, Apex Spine enhances the overall healthcare landscape in the Benton-Franklin area, providing vital services that are both in demand and previously underrepresented in the region's outpatient surgical offerings.

9. In a CN-approved facility, WAC 246-310-210(2) requires that “all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and

other underserved groups and the elderly are likely to have adequate access to the proposed health service or services." Confirm your facility will meet this requirement.

Apex Spine Institute is dedicated to meeting the requirements set by WAC 246-310-210(2) to ensure all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups, and the elderly have adequate access to the proposed health services. Here's how we plan to uphold these commitments:

Comprehensive Policy and Procedure: Our policies are designed to ensure equitable access to our services. This includes implementing a non-discrimination policy, ensuring accessibility for individuals with disabilities, and offering financial assistance programs for those who qualify (See Exhibit 7)
Mission and Values: Our mission emphasizes health equity and access for all community members. Our values guide us in creating a welcoming and supportive environment for diverse populations, ensuring everyone receives high-quality care regardless of their background or circumstances.
Financial Assistance: We provide a clear and accessible financial assistance policy to help low-income patients afford the care they need. This policy is widely communicated to patients through various channels, ensuring they are aware of the support available. (See Exhibit 7)
Cultural and Language Services: Recognizing the diversity within our service area, we offer translation and interpretation services to patients who speak languages other than English and ensure our staff are trained in cultural competency.
Accessibility Enhancements: Our facility is designed to be fully accessible to individuals with disabilities, including those who use wheelchairs or have other mobility challenges. We continually assess and improve our physical infrastructure and healthcare delivery processes to enhance accessibility.
Feedback and Continuous Improvement: We actively seek feedback from our patients and community partners to understand how well we are meeting their needs and identify areas for improvement. This feedback informs our ongoing efforts to enhance access and equity in the services we provide.

By adhering to these strategies, Apex Spine Institute is committed to fulfilling the requirements of WAC 246-310-210(2), ensuring that our health services are accessible to all residents of our service area, regardless of their economic status, ethnicity, gender, physical abilities, or age.

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

See Exhibit 7

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

1. Provide documentation that demonstrates that the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:
    - Utilization projections. These should be consistent with the projections provided under "Need" in section A. Include the basis for all assumptions.
    - Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include the basis for all assumptions.

- Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include the basis for all assumptions.
- For existing facilities, provide three years of historical revenue and expense statements, including the current year. Ensure these are in the same format as the pro forma projections. For incomplete years, identify whether the data is annualized.

See Exhibit 1

2. Provide the following applicable agreements/contracts:
   - Management agreement
   - Operating agreement
   - Medical director agreement
   - Development agreement
   - Joint Venture agreement

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

   N/A

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

   Table 7. Planning Area Charity Care

Planning Area Hospital 3-year Average Charity Care as a Percentage of Total Revenue	1.38%
Projected Facility Charity Care as a Percentage of Total Revenue	1.5%

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

   See Exhibit 2

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

   N/A

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

Item	**Cost**
a. Land Purchase	$0
b. Utilities to Lot Line	$0
c. Land Improvements	$0
d. Building Purchase	$0
e. Residual Value of Replaced Facility	$0
f. Building Construction	$0
g. Fixed Equipment (not already included in the construction contract)	$0
h. Movable Equipment	$0
i. Architect and Engineering Fees	$0
j. Consulting Fees	$0
k. Site Preparation	$0
l. Supervision and Inspection of Site	$0
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	$0
1. Land	$0
2. Building	$0
3. Equipment	$0
4. Other	$0
n. Washington Sales Tax	$0
Total Estimated Capital Expenditure	**$0**

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

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

   No start up costs identified. Apex Spine is not adding ORs or service lines with this certificate of need application.

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

   N/A

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

The conversion of Apex Spine ASC from a Certificate of Need (CON) exempt facility to a CON-approved Ambulatory Surgical Center (ASC) represents a strategic enhancement of its operational framework without expanding its current number of operating rooms (ORs) or introducing new service lines. This transition is designed to meet regulatory standards while broadening access to the facility for outside surgeons. The proposed project's structure is carefully planned to ensure that it does not negatively impact the costs and charges to patients for health services. Here's how:

Compliance with WAC 246-310-220

Under Washington Administrative Code (WAC) 246-310-220, any project that undergoes changes requiring CON approval must demonstrate that it will not unnecessarily increase health care costs or affect the charges for health services to the community it serves. The Apex Spine ASC project aligns with these requirements through several key strategies:

Utilization of Existing Infrastructure: By not adding new ORs or service lines, Apex Spine ASC leverages its existing infrastructure. This approach minimizes the need for significant capital expenditures that could otherwise necessitate higher charges to recoup investments.
Efficiency and Specialization: The focus on pain management and orthopedic services, without expansion into new areas, allows Apex Spine ASC to optimize its operations around its core competencies. This efficiency can lead to more cost-effective service delivery, which helps in maintaining or potentially lowering patient charges.
Broadening Access for Surgeons: Allowing outside surgeons to utilize the facility increases the utilization of the existing capacity without altering the facility's cost structure significantly. This efficient use of resources can contribute to maintaining stable pricing for patients by spreading fixed costs over a larger number of procedures.
Regulatory Compliance without Cost Escalation: The project's design to comply with CON requirements focuses on regulatory and quality standards rather than physical expansion. Compliance with these standards ensures patient safety and high-quality care without directly leading to an increase in health service charges.
Strategic Financial Planning: Apex Spine ASC's conversion project includes careful financial planning to ensure that the transition to a CON-approved ASC does not necessitate increased charges to patients. This includes exploring alternative revenue streams, optimizing operational efficiencies, and engaging in strategic pricing practices that align with the community's healthcare affordability.

Patient-Centric Approach

The conversion project is patient-centric, aiming to enhance accessibility and the quality of care through regulatory compliance and operational excellence. By maintaining a focus on efficient service delivery within the facility's existing specialties, Apex Spine ASC ensures that the transition to a CON-approved facility is in the best interest of the patients it serves, without compromising on affordability.

In summary, the proposed project for Apex Spine ASC to become a CON-approved facility is structured to ensure that there is no adverse impact on the costs and charges to patients for health services. Through strategic planning and operational efficiencies, the project aligns with the principles outlined in WAC 246-310-220, fostering an environment that supports both healthcare accessibility and affordability.

11. Provide documentation that the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges to patients for health services in the

planning area. WAC 246-310-220

The project to convert Apex Spine ASC into a Certificate of Need (CON)-approved facility will not involve adding new operating rooms (ORs) or expanding service lines, and it is designed to incur no additional costs. This approach ensures that the conversion process will have no financial implications that could lead to an increase in the costs and charges to patients for health services within the planning area, in compliance with WAC 246-310-220.

Since the project does not require construction or the acquisition of new equipment, it eliminates the potential for significant expenditures that typically necessitate adjustments in service pricing to recoup investment costs. By maintaining the facility's existing infrastructure and focusing on regulatory compliance without physical expansion, the project avoids introducing any factors that would directly impact operational costs. Consequently, this strategy ensures that the conversion will not result in an unreasonable impact on the costs and charges to patients for health services, aligning with the regulatory requirements and preserving the affordability and accessibility of care for the community served.

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

Table 8. Current and Projected Payer Mix

Payer	2022-2023 Percent by Revenue	2022-2023 Percent by Patient	Projected Percent by Revenue	Projected Percent by Patient
Medicare	15.70%	25.50%	15.30%	22.00%
Medicaid	0.00%	0.00%	0.30%	3.50%
Other Payers (please list in individual lines)*	84.30%	74.50%	84.40%	74.50%
Total	100.00%	100.00%	100.00%	100.00%
*All other payers include commercial, HMO, Self-pay				

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

    See above

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

    N/A

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

    N/A

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

N/A

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

See Exhibit 1

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

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

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

821 Swift Blvd, Richland WA 99352- Corporate address and principal clinic

985 Goethals Dr Richland WA 99352- - Location of the ASC

965 Goethals Richland WA 99352- - Another clinic and imaging center

614 E Alder St Suite 2, Walla Walla, WA 99362- Another clinic opened 2 days a week.

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

Table 9. FTE

Position	2022	2023	2024	2025	2026	2027
Administrator	1	1	1	1	1	1
RN's	11	16	17	17	17	17
Surgical Technologists	2	5	6	6	6	6
Receptionist/Scheduler	1	2	2	2	2	2
Total	15	24	26	26	26	26

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

Projecting the number and types of Full-Time Equivalents (FTEs) for Apex Spine Institute, which has been operational for two years, involves analyzing operational data, understanding growth strategies, and adapting to evolving healthcare trends. Here's how these assumptions are grounded:

1. Operational Data Analysis: The foundation starts with examining the past two years of Apex Spine Institute's operations. This review focuses on patient volumes, types of procedures performed, and operation dynamics. Trends from this data help estimate future demands.

2. Strategic Expansion: If Apex Spine Institute plans to introduce new services or specialties, it necessitates additional FTEs with specific expertise. Assumptions regarding expansion are based on comprehensive market research, patient demand, and the institute's strategic objectives. Current projections are limited to 2.6% for the purposes of the application resulting in a stable staffing model.

3. Technological Integration: Anticipating the incorporation of new medical or surgical technologies that may streamline procedures but require specialized skills is crucial. Assumptions here factor in potential technology upgrades and their impact on staffing needs and configurations.

4. Compliance with Standards: The projection takes into account how adherence to healthcare regulations and quality standards influences staffing, particularly in areas like patient safety and infection control. Expected or potential regulatory changes that might affect staffing levels are considered.

5. Benchmarking: By comparing with similar institutions, Apex Spine Institute can gauge whether its staffing levels are in line with industry norms, adjusted for facility size, procedure types, and regional labor market conditions.

6. Quality of Care and Patient Feedback: Patient satisfaction surveys and feedback play a significant role in identifying areas for improvement, possibly leading to adjustments in staffing to elevate care quality.

7. Healthcare and Economic Trends: Broader trends, such as the increasing preference for outpatient care or shifts in healthcare financing, inform staffing projections. Economic factors affecting the labor market, including supply and wage expectations, are also considered.

8. Turnover and Absenteeism: Historical trends in staff turnover and absenteeism offer insights into future staffing requirements, considering the time and resources needed for recruiting and training.

In summary, Apex Spine Institute uses a multi-faceted approach to project future staffing needs, ensuring the institute is prepared to meet demand, uphold quality standards, and adapt to the changing healthcare landscape. This strategic planning ensures the institute remains a leader in spinal care while efficiently managing its workforce.

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

Allen	Shoham	MD60150901

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

   Employed, See Exhibit 7

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

   Alex Linde - Administrator

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

Janmeet	Sahota	OP60220440
Allen	Shoham	MD60150901

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

Table 10. Licensed Personnel

First	Last	License
Amanda	Phillips	RN60205251
Angie	Head	RN60863484
Araceli	Granados	RN60952123
Becky	Frey	RN00160496
Caroline	Jared	RN00155290
Cindy	Mulderig	RN00132130
Courtney	Chestnut	RN60568833
Elizabeth	Lapryntsev	RN61156328
Ivana	Blaskan	RN60222035
Jamie	Robbins	RN60221854
Jessica	Fort	RN60117912
Joanna	Dean	RN60155454
Juanita	Castillo	RN60766270
Leslie	Williams	RN60446213
Melody	Wilkins	RN60069550
Michelle	Thiemens	RN00155868
Nancy	Cruz	RN60850951

Young	Jung	RN61005905
Janmeet	Sahota	OP60220440
Allen	Shoham	MD60150901
Caleb	Ledford	AP60330346
Vanessa	Ratcliff	AP30007386
Tyler	Thornock	AP60203414
Hannah	Burgett	AP60630480

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

Recruitment

Targeted Advertising: Use of specialized job boards, social media platforms, and professional networks to reach potential candidates with the desired skills and experience in orthopedic and pain management care and related fields.
Employee Referral Programs: Encouraging current employees to refer qualified candidates by offering incentives, recognizing that referrals often result in hires who fit well with the organization's culture and have higher retention rates.
Competitive Compensation and Benefits Packages: Offering attractive salary packages, health benefits, retirement plans, and other perks to stand out in the competitive healthcare job market.

Retention

Professional Development and Career Advancement: Providing ongoing education, training programs, and opportunities for professional growth to help staff enhance their skills and advance their careers within the organization.
Recognition and Reward Systems: Programs to recognize and reward employees for their contributions, hard work, and dedication, which can boost morale and job satisfaction.
Flexible Work Arrangements: Offering flexible scheduling options, part-time positions, and telecommuting opportunities where feasible to help staff balance work and personal commitments.
Creating a Positive Work Environment: Fostering a supportive and inclusive culture that values teamwork, communication, and mutual respect, making employees feel valued and engaged.
Open Communication Channels: Encouraging open and transparent communication between staff and management to discuss concerns, feedback, and suggestions, ensuring employees feel heard and involved in decision-making.

By employing these recruitment and retention strategies, Apex Spine Institute has built a dedicated and skilled workforce committed to providing high-quality care and contributing to the institute's success.

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

See Exhibit 5

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

    N/A

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

    No

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

    Lourdes Hospital

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

    None of the above

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

    N/A

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

    See Exhibit 4

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

Promoting Continuity of Care

Enhanced Access to Specialized Care: By maintaining its focus on spine-related surgeries and treatments, the project reinforces Apex Spine Institute's role as a key provider of specialized care. This specialization ensures patients have continued access to high-quality, expert care for spine conditions within the planning area.

Integration with Local Healthcare Systems: The project aims to further integrate Apex Spine Institute's services with the broader local healthcare ecosystem. By fostering partnerships with local hospitals, primary care providers, and rehabilitation centers, the institute ensures a seamless patient care continuum from diagnosis to surgery and post-operative rehabilitation.

Consistent Quality Improvement: Ongoing investments in state-of-the-art surgical technology, staff training, and quality improvement programs under the project will enhance the quality of care. This ensures that patients in the planning area have access to the latest and most effective

treatments for spine conditions, promoting better outcomes and patient satisfaction.

Avoiding Unwarranted Fragmentation of Services

Filling a Critical Niche: By focusing on spine surgery and care, the project fills a critical healthcare niche without duplicating services readily available in the planning area. This approach avoids fragmenting healthcare services and ensures that resources are concentrated where they are most needed.

Community Health Needs Assessment: The project is informed by a thorough assessment of the community's health needs, ensuring that the services provided are tailored to the specific needs of the population. By aligning its services with community needs, the institute ensures that its offerings complement rather than compete with other healthcare services in the area. (See The Benton and Franklin county's Community Health Improvement Plan, Exhibit 8)

In summary, the proposed project by Apex Spine Institute is designed to enhance the continuity and quality of specialized orthopedic and pain management care in the planning area, while avoiding the fragmentation of healthcare services. Through specialized focus, integration with the local healthcare system, and a commitment to quality improvement, the project supports a cohesive healthcare environment that meets the specific needs of the community.

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

Apex Spine Institute's proposed project will enhance the existing healthcare system in its service area by adhering to the requirements set forth in WAC 246-310-230(4), which emphasizes the need for new or expanded health care facilities to have an appropriate relationship to the existing health care system. Here's how the project aligns with this mandate:

Filling Existing Gaps in Care: The project is designed to address specific gaps in the current healthcare system, particularly in specialized orthopedic and pain management care. By focusing on areas of need that are currently underserved, the project supports the overall health ecosystem without unnecessary duplication of services.

Collaborative Care Networks: Apex Spine Institute plans to enhance its collaboration with existing healthcare providers, including hospitals, primary care physicians, rehabilitation centers, and other specialists in the area. This collaborative approach ensures a more integrated healthcare delivery system that facilitates seamless patient transitions between different levels of care, improving patient outcomes.

Complementary Services: The project is structured to complement, rather than compete with, existing services. By providing specialized care that supports the broader health needs of the community, the project contributes to a more comprehensive and efficient healthcare system.

Community Health Needs Assessment: Integral to the project's planning phase is a thorough assessment of the community's health needs. This ensures that the expansion of services is directly responsive to the identified needs of the population, enhancing the relevance and utility of the existing healthcare system.

Access to Specialized Care: By expanding access to high-quality, specialized orthopedic and pain management care, the project addresses a critical need within the community. This increased access is expected to reduce the need for patients to seek care outside the service area, keeping healthcare resources within the community and supporting local health systems.

Use of Advanced Technology: By incorporating advanced medical technologies and surgical techniques, the project supports the service area's health system modernization efforts. This commitment to innovation can lead to better patient outcomes and more efficient use of healthcare resources.

Through these strategies, Apex Spine Institute's proposed project ensures an appropriate relationship to the service area's existing healthcare system. The project aims to enhance the continuum of care, improve access to specialized services, and contribute to the overall health and wellbeing of the community.

19. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or
    b. A revocation of a license to operate a healthcare facility; or
    c. A revocation of a license to practice as a health profession; or
    d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

    None of the above

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

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

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

    - Expanding Existing Hospital Services
    - Partnering with Out-of-Area Specialists
    - Developing Mobile Surgery Center
    - Do Nothing

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

In considering the proposed project by Apex Spine Institute, several alternatives were evaluated and ultimately rejected based on a comprehensive analysis. The primary objective was to enhance patient access to specialized orthopedic and pain management care while ensuring the project's alignment with factors like capital cost, legal constraints, staffing impacts, quality of care, and operational efficiency. Here's how the selected project compares to the alternatives:

Alternative 1: Expanding Existing Hospital Services

Rationale for Rejection:

- Capital Cost: High due to the need for building renovations and specialized equipment, making it financially less viable compared to other options.
- Legal Constraints: Expansion within a hospital setting could face more rigorous regulatory hurdles and compliance requirements, delaying project timelines.
- Staffing Impacts: Requires recruiting or training existing hospital staff for specialized spine care, potentially disrupting current services and increasing operational costs.
- Quality of Care: While potentially high, integrating specialized services into a general hospital environment could dilute the focus on spine care excellence.
- Operational Efficiency: Managing spine care within a larger hospital setting might introduce inefficiencies, such as longer patient wait times and less streamlined care processes.
-

Alternative 2: Partnering with Out-of-Area Specialists

Rationale for Rejection:

- Capital Cost: Lower upfront costs, but potentially higher long-term expenses due to specialist fees and coordination complexities.
- Legal Constraints: Contracting and credentialing specialists from outside the area could introduce legal complexities and administrative burdens.
- Staffing Impacts: Dependency on external specialists might lead to inconsistencies in staff availability and commitment, affecting continuity of care.
- Quality of Care: Potential variability in the quality of care due to differing practices and approaches of various specialists, challenging to standardize care protocols.
- Operational Efficiency: Coordination between the institute and external specialists could complicate scheduling, increase patient wait times, and affect overall service delivery efficiency.
-

Alternative 3: Developing a Mobile Surgical Care Unit

Reason for Rejection:

- Capital Cost: High initial investment in mobile units equipped with necessary medical technologies, alongside ongoing operational and maintenance costs.
- Legal Constraints: Mobile health services face unique regulatory challenges, including licensure across different jurisdictions and adherence to varied health codes.
- Staffing Impacts: Recruiting healthcare professionals willing to work in a mobile setting may be challenging, and maintaining a consistent team could impact service delivery.
- Quality of Care: Limited by the mobile unit's capacity to provide comprehensive spine care, particularly for procedures requiring advanced facilities.
- Operational Efficiency: While offering potential access improvements, the logistical challenges of operating a mobile unit (scheduling, travel between locations, setup) could reduce overall efficiency and increase costs.

Alternative 4: Do Nothing

Reason for Rejection:

- Capital CostWhile this alternative avoids the immediate capital expenditure associated with expansion or updates, it may lead to higher long-term costs. Failing to invest in facility improvements or technology updates could result in inefficiencies, increased maintenance costs, and the potential loss of competitiveness, affecting revenue.
- Legal ConstraintsThe healthcare sector is rapidly evolving, with changes in regulations and standards often necessitating updates to facilities and practices. By doing nothing, the institute risks falling out of compliance with future legal requirements, potentially incurring legal penalties and jeopardizing its license to operate.
- Staffing Impacts: Staff retention and recruitment could be negatively impacted by the decision to maintain the status quo. High-performing staff members often seek dynamic work environments where there are opportunities for professional growth and engagement with advanced treatment methods. Without continual improvement, staff morale and satisfaction may decline, leading to higher turnover rates.
- Quality of Care: The quality of care is likely to suffer over time without investments in new technologies, training, and facility enhancements. As other institutions advance, the gap in service quality and patient outcomes could widen, diminishing the institute's reputation and its ability to attract and retain patients.
- Operational Efficiency: Operational inefficiencies are likely to persist or worsen without action. As patient demands evolve and technologies advance, failing to update or optimize operations will likely result in increased wait times, reduced patient throughput, and an inability to leverage cost-saving innovations.

By choosing the "do nothing" alternative, Apex Spine Institute would likely see a gradual erosion of its competitive position in the healthcare market. The institution would miss opportunities to enhance patient care, improve operational efficiencies, and maintain a satisfied and motivated workforce. These considerations underscore the necessity of pursuing strategic enhancements to stay aligned with industry best practices and meet the evolving needs of patients and staff.

Selected Project: Apex Spine Institute CON

- Patient Access to Healthcare Services: The CON directly addresses the need for localized, specialized orthopedic and pain management care, enhancing patient access within the community and reducing the need for patients to seek care in distant locations.
- Capital Cost: The project requires no investment, it leverages the existing infrastructure of the ASC, optimizing capital outlay compared to building new facilities or extensive renovations elsewhere.
- Legal Restrictions: Operating within the existing legal and regulatory framework of an ASC presents

fewer barriers to expansion and allows for more streamlined implementation of specialized services.
- Staffing Impacts: The project builds on the institute's existing expertise. This approach capitalizes on existing knowledge and minimizes disruption.
- Quality of Care: Specializing in orthopedic and pain management care allows for a high level of expertise, leading to better patient outcomes. The controlled environment of an ASC, dedicated solely to orthopedic and pain management care, supports higher standards of quality and safety.
- Cost or Operation Efficiency: The ASC model is known for its efficiency and cost-effectiveness, benefiting from specialized focus and streamlined operations. This model allows for the provision of high-quality care at a lower cost than hospital-based alternatives.

In conclusion, the Apex Spine Institute's project was deemed superior to the rejected alternatives based on a holistic evaluation of critical factors. The decision reflects a commitment to providing high-quality, accessible, and efficient orthopedic and pain management care tailored to the needs of the local community.

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

Apex Spine Institute's operational efficiency is significantly enhanced through deliberate design choices in patient flow optimization, technology integration, adherence to city and state construction guidelines, and compliance with Medicare regulations for fire safety. Here's an expanded view on how these aspects contribute to efficiency:

Patient Flow Optimization

By meticulously designing the layout to streamline patient movements, Apex Spine Institute minimizes wait times and reduces bottlenecks, enhancing patient satisfaction and staff productivity. Key strategies include:

- Centralized Registration Areas: Streamlining check-in processes to reduce initial wait times.
- Intuitive Signage and Wayfinding: Helping patients navigate the facility easily, reducing stress and improving movement efficiency.
- Dedicated Pathways: Separating patient and supply corridors to minimize congestion and enhance privacy.

Technology Integration

The integration of advanced technologies automates and streamlines operations, leading to better resource management and patient care:

- Electronic Health Records (EHRs): Facilitates seamless access to patient records, reducing paperwork and enabling more informed decision-making by healthcare providers.
- Telemedicine Facilities: Expands access to care, especially for patients in remote areas, reducing the need for physical visits and optimizing the use of space and resources.
- Automated Inventory Systems: Ensures medical supplies are efficiently managed and replenished, reducing waste and ensuring essential items are always available.

Adherence to City and State Construction Guidelines

Complying with local construction codes ensures the facility is built to high standards, promoting safety and sustainability:

- Energy Efficiency: Meeting or exceeding local guidelines for energy use not only lowers operational costs but also aligns with environmental sustainability goals.
- Accessibility Standards: Ensuring the facility meets ADA (Americans with Disabilities Act) standards, facilitating access for all patients and complying with legal requirements.

Medicare Regulations for Fire Safety

Compliance with Medicare's fire safety standards (e.g., NFPA 101: Life Safety Code) is critical for patient safety and operational continuity:

- Fire Detection and Suppression Systems: Advanced systems detect and control fires rapidly, minimizing risk and potential damage.
- Regular Drills and Staff Training: Preparing staff for emergency situations ensures a swift, coordinated response, essential for patient safety during a fire incident.

Through these design and operational strategies, Apex Spine Institute not only meets the regulatory requirements outlined in WAC 246-310-240(2) and (3) but also creates an environment that is safe, efficient, and responsive to the needs of patients and staff. This comprehensive approach to facility design and management underscores the institute's commitment to delivering high-quality care while maintaining operational excellence.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Commonly Referenced Rules for Ambulatory Surgery Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-160	Regular Review Process
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment
246-310-270	Ambulatory Surgery

Certificate of Need Contact Information: Certificate of Need Program Web Page Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Construction Review Services Resources: Construction Review Services Program Web Page Phone: (360) 236-2944
Email: CRS@doh.wa.gov

Licensing Resources:
Ambulatory Surgical Facilities Laws, RCW 70.230 Ambulatory Surgical Facilities Rules, WAC 246-330 Ambulatory Surgical Facilities Program Web Page

Hospital Charity Care and Financial Data (HCCFD) Program Resources
HCCFD Web Page
Email: CharityCare@doh.wa.gov

Exhibit 1

Apex Spine Institute

Profit and Loss

January 2022 - December 2023

	JAN - DEC 2022	JAN - DEC 2023	TOTAL
Income			
4000 Clinic Revenue	2,687,103.91	5,614,015.27	$8,301,119.18
4003 XRay Revenue	128,802.85	213,587.72	$342,390.57
4004 DME Revenue	201,668.20	596,529.39	$798,197.59
4005 ASC Revenue	514,727.80	4,222,932.42	$4,737,660.22
4006 Attny Revenue	110,300.44	862,705.89	$973,006.33
Total Income	**$3,642,603.20**	**$11,509,770.69**	**$15,152,373.89**
Cost of Goods Sold			
5000 Direct Supply/Material Costs	592,812.06	1,144,539.02	$1,737,351.08
Total Cost of Goods Sold	**$592,812.06**	**$1,144,539.02**	**$1,737,351.08**
GROSS PROFIT	**$3,049,791.14**	**$10,365,231.67**	**$13,415,022.81**
Expenses			
6000 Compensation & Benefits	3,357,197.69	5,411,869.63	$8,769,067.32
6100 T,M & E	93,687.34	218,346.56	$312,033.90
6200 General Expenses	479,983.52	935,687.58	$1,415,671.10
6300 Outside Services	280,545.36	392,312.01	$672,857.37
6400 Facility	657,214.59	1,041,515.82	$1,698,730.41
6500 Taxes, Licenses & Interest	103,302.51	275,317.10	$378,619.61
6600 Practice Expenses	380,935.89	414,402.88	$795,338.77
6850 Uncategorized Expense		84.23	$84.23
Total Expenses	**$5,352,866.90**	**$8,689,535.81**	**$14,042,402.71**
NET OPERATING INCOME	**$ -2,303,075.76**	**$1,675,695.86**	**$ -627,379.90**
Other Expenses			
6800 Non Operating Expenses	193,970.00		$193,970.00
Total Other Expenses	**$193,970.00**	**$0.00**	**$193,970.00**
NET OTHER INCOME	**$ -193,970.00**	**$0.00**	**$ -193,970.00**
NET INCOME	**$ -2,497,045.76**	**$1,675,695.86**	**$ -821,349.90**

Apex Spine Institute

Balance Sheet

As of December 31, 2023

	JAN - DEC 2022	JAN - DEC 2023
ASSETS		
Current Assets		
Bank Accounts		
1000 Comm1st Checking (7487)	236,610.86	533,990.96
Total Bank Accounts	**$236,610.86**	**$533,990.96**
Other Current Assets		
1090 Unallocated Payments	51,449.68	-90,787.01
1200 Inventory Asset	67,622.00	46,052.00
Total Other Current Assets	**$119,071.68**	**$ -44,735.01**
Total Current Assets	**$355,682.54**	**$489,255.95**
Fixed Assets		
1500 Fixed Assets	1,133,542.62	1,591,786.15
Total Fixed Assets	**$1,133,542.62**	**$1,591,786.15**
TOTAL ASSETS	**$1,489,225.16**	**$2,081,042.10**
LIABILITIES AND EQUITY		
Liabilities		
Current Liabilities		
Accounts Payable		
2010 Accounts Payable	41,576.58	64,986.74
Total Accounts Payable	**$41,576.58**	**$64,986.74**
Credit Cards		
2020 Capital One Credit Card	9,334.34	0.00
2025 Capital One Mastercard	49,259.27	0.00
2026 Credit Card (9023)-Company		129,381.58
2027 Credit Card (6050)-Sahota		27,519.81
Credit Card (5225)		14,982.34
Total Credit Cards	**$58,593.61**	**$171,883.73**
Other Current Liabilities		
2100 Accrued Liabilities		620.00
Total Other Current Liabilities	**$0.00**	**$620.00**
Total Current Liabilities	**$100,170.19**	**$237,490.47**
Long-Term Liabilities		
2705 Loan (0497)	313,396.66	37,729.37
2710 RASC Loan (0480)	406,781.84	321,922.27
Total Long-Term Liabilities	**$720,178.50**	**$359,651.64**
Total Liabilities	**$820,348.69**	**$597,142.11**
Equity		
3000 Opening balance equity		0.00
3200 Distributions		-1,401,212.93
3300 Contributions	3,165,922.23	3,706,462.82

Apex Spine Institute

Balance Sheet

As of December 31, 2023

	JAN - DEC 2022	JAN - DEC 2023
3900 Retained Earnings		-2,497,045.76
Net Income	-2,497,045.76	1,675,695.86
Total Equity	**$668,876.47**	**$1,483,899.99**
TOTAL LIABILITIES AND EQUITY	**$1,489,225.16**	**$2,081,042.10**

Apex Spine Institute ASC
Pro Forma
January 2022 - December 2027

	ASC 2022	ASC 2023	ASC 2024	ASC 2025	ASC 2026	ASC 2027	
ASC Volume	1,267	2,058	2,112	2,166	2,223	2,281	
Gross Revenue	$ 1,050,465	$ 8,618,229	$ 8,842,303	$ 9,072,203	$ 9,308,081	$ 9,550,091	
Contractual Allowances							
Medicare	$ 80,812	$ 646,109	$ 662,907	$ 680,143	$ 697,827	$ 715,970	
Medicaid			$ 12,998	$ 13,336	$ 13,683	$ 14,039	
Other Payers	$ 433,916	$ 3,564,155	$ 3,656,823	$ 3,751,900	$ 3,849,450	$ 3,949,535	*All other payers include commercial, HMO, Self-pay
Net Revenue	**$ 535,737**	**$ 4,407,966**	**$ 4,509,575**	**$ 4,626,824**	**$ 4,747,121**	**$ 4,870,546**	
Refunds	$ 355	$ 23,830	$ 24,450	$ 25,085	$ 25,738	$ 26,407	Not inflation - grows in relation to prc
Bad Debt	$ 6,429	$ 52,896	$ 54,115	$ 55,522	$ 56,965	$ 58,447	Not inflation - grows in relation to prc
Charity Care				$ 136,083	$ 139,621	$ 143,251	1.5% of Gross Charges
Net revenue	**$ 528,954**	**$ 4,331,240**	**$ 4,431,010**	**$ 4,410,133**	**$ 4,524,797**	**$ 4,642,441**	
Cost of Goods Sold							
5004 COGS-Implants	$ 291,864	$ 567,846	$ 582,610	$ 597,758	$ 613,300	$ 629,245	Not inflation - grows in relation to prc
Gross Margin	**$ 237,090**	**$ 3,763,394**	**$ 3,848,400**	**$ 3,812,375**	**$ 3,911,497**	**$ 4,013,196**	
Expenses							
6010 Salaries/Wages Paid	$ 301,683	$ 1,620,634	$ 1,620,634	$ 1,620,634	$ 1,620,634	$ 1,620,634	
6015 Garnishment	$ -	$ -	$ -	$ -	$ -	$ -	
6060 Medical	$ 31,955	$ 163,109	$ 163,109	$ 163,109	$ 163,109	$ 163,109	
6065 Insurance - MetLife	$ 1,324	$ 49,582	$ 49,582	$ 49,582	$ 49,582	$ 49,582	
6070 Workers Comp	$ -	$ 14,344	$ 14,344	$ 14,344	$ 14,344	$ 14,344	
6075 401(k) Match	$ 6,535	$ 20,623	$ 20,623	$ 20,623	$ 20,623	$ 20,623	
6077 401(k) Plan Expense	$ -	$ 31,578	$ 31,578	$ 31,578	$ 31,578	$ 31,578	
6079 HSA	$ 1,793	$ 12,135	$ 12,135	$ 12,135	$ 12,135	$ 12,135	
6080 Payroll Taxes - Federal	$ 37,734	$ 416,731	$ 416,731	$ 416,731	$ 416,731	$ 416,731	
6082 Payroll Taxes - State	$ 8,419	$ 185	$ 185	$ 185	$ 185	$ 185	
Total 6000 Compensation & Benefits	**$ 389,444**	**$ 2,328,919**	**$ 2,328,919**	**$ 2,328,919**	**$ 2,328,919**	**$ 2,328,919**	
6110 Airfare/Ground Transportation	$ 5,103	$ 47,510	$ 47,510	$ 47,510	$ 47,510	$ 47,510	
6120 Lodging	$ 1,862	$ 14,357	$ 14,357	$ 14,357	$ 14,357	$ 14,357	
6135 Meals - 100% Deductible	$ 4,921	$ 31,158	$ 31,158	$ 31,158	$ 31,158	$ 31,158	
6150 Auto Expense	$ 635	$ 937	$ 937	$ 937	$ 937	$ 937	
6185 Per Diem (deleted)	$ 719	$ -	$ -	$ -	$ -	$ -	
Total 6100 T,M & E	**$ 13,239**	**$ 93,962**	**$ 93,962**	**$ 93,962**	**$ 93,962**	**$ 93,962**	
6220 Bank Charges	$ 7,513	$ 4,670	$ 4,670	$ 4,670	$ 4,670	$ 4,670	
6230 Contributions/Donations	$ 1,691	$ 4,141	$ 4,141	$ 4,141	$ 4,141	$ 4,141	
6235 Merchant Fees	$ 597	$ 6,202	$ 6,202	$ 6,202	$ 6,202	$ 6,202	
6240 Dues & Subscriptions	$ 6,409	$ 15,087	$ 15,087	$ 15,087	$ 15,087	$ 15,087	
6250 Employee Morale	$ 1,052	$ 8,273	$ 8,273	$ 8,273	$ 8,273	$ 8,273	
6260 Insurance - General	$ 3,166	$ 23,463	$ 23,463	$ 23,463	$ 23,463	$ 23,463	
6270 Office Supplies	$ 11,945	$ 58,957	$ 58,957	$ 58,957	$ 58,957	$ 58,957	
6271 Medical Supplies	$ 33,699	$ 281,060	$ 288,368	$ 295,865	$ 303,558	$ 311,450	Not inflation - grows in relation to prc
6285 Postage/Courier	$ 809	$ 806	$ 806	$ 806	$ 806	$ 806	
Total 6200 General Expenses	**$ 66,882**	**$ 402,660**	**$ 409,967**	**$ 417,465**	**$ 425,157**	**$ 433,050**	
6320 Advertising/Marketing	$ 4,869	$ 35,248	$ 35,248	$ 35,248	$ 35,248	$ 35,248	
6350 Legal	$ 2,933	$ 4,789	$ 4,789	$ 4,789	$ 4,789	$ 4,789	
6355 Accounting	$ 5,350	$ 18,635	$ 18,635	$ 18,635	$ 18,635	$ 18,635	
6360 Laundry	$ 14,924	$ 133	$ 133	$ 133	$ 133	$ 133	
6365 Janitorial	$ 10,615	$ 45,949	$ 45,949	$ 45,949	$ 45,949	$ 45,949	
6370 Landscaping Maintenance	$ 1,896	$ 3,313	$ 3,313	$ 3,313	$ 3,313	$ 3,313	
Total 6300 Outside Services	**$ 40,588**	**$ 108,067**	**$ 108,067**	**$ 108,067**	**$ 108,067**	**$ 108,067**	
6410 Telecommunications	$ 1,676	$ 10,044	$ 10,044	$ 10,044	$ 10,044	$ 10,044	
6412 Internet	$ 622	$ 691	$ 691	$ 691	$ 691	$ 691	
6415 Office Expense	$ 3,862	$ 5,903	$ 5,903	$ 5,903	$ 5,903	$ 5,903	
6420 Rent - ASC Portion	$ 48,517	$ 111,100	$ 111,100	$ 111,100	$ 111,100	$ 111,100	
6440 Repairs & Maintenance - Office	$ 4,598	$ 8,827	$ 8,827	$ 8,827	$ 8,827	$ 8,827	
6445 Repairs & Maintenance - Equipment	$ 22,163	$ 142,021	$ 142,021	$ 142,021	$ 142,021	$ 142,021	
6450 Small Tools and Equipment - Under $2,500	$ 4,139	$ 1,447	$ 1,447	$ 1,447	$ 1,447	$ 1,447	
6455 Leases- Equipment	$ 1,053	$ 23,629	$ 23,629	$ 23,629	$ 23,629	$ 23,629	
6495 Utilities	$ 5,896	$ 36,362	$ 36,362	$ 36,362	$ 36,362	$ 36,362	
Total 6400 Facility	**$ 92,526**	**$ 340,024**	**$ 340,024**	**$ 340,024**	**$ 340,024**	**$ 340,024**	
6500 Taxes, Licenses & Interest	$ 31	$ 62	$ 62	$ 62	$ 62	$ 62	
6510 Licenses, Permits & Fees	$ 1,707	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	
6520 Interest Expense	$ 3,033	$ 11,894	$ 11,894	$ 11,894	$ 11,894	$ 11,894	
6530 Excise Tax - B&O Tax	$ 6,204	$ 82,469	$ 82,469	$ 82,469	$ 82,469	$ 82,469	
6540 Property Tax	$ 3,622	$ 19,335	$ 19,335	$ 19,335	$ 19,335	$ 19,335	
Total 6500 Taxes, Licenses & Interest	**$ 14,597**	**$ 118,479**	**$ 118,479**	**$ 118,479**	**$ 118,479**	**$ 118,479**	
6605 Professional Liability Ins	$ 3,762	$ 20,187	$ 20,187	$ 20,187	$ 20,187	$ 20,187	
6630 Reference & Library	$ 141	$ 14	$ 14	$ 14	$ 14	$ 14	
6635 Education	$ 1,633	$ 3,828	$ 3,828	$ 3,828	$ 3,828	$ 3,828	
6640 Software Licenses, Subscriptions & Purchases	$ 23,434	$ 84,069	$ 84,069	$ 84,069	$ 84,069	$ 84,069	
Total 6600 Practice Expenses	**$ 28,970**	**$ 108,098**	**$ 108,098**	**$ 108,098**	**$ 108,098**	**$ 108,098**	
Total Expense	*$ 646,246*	*$ 3,500,208*	*$ 3,507,516*	*$ 3,515,013*	*$ 3,522,706*	*$ 3,530,598*	
Net Income	**$ (117,292)**	**$ 831,032**	**$ 923,494**	**$ 895,120**	**$ 1,002,091**	**$ 1,111,843**	

Exhibit 2

COMMERCIAL LEASE AGREEMENT

This Commercial Lease Agreement (this "**Lease**") is made as of this 19th day of April, 2022, by and between **MH PROPERTIES, L.L.C.**, a Washington limited liability company ("**Landlord**"), and **APEX SPINE INSTITUTE, PLLC**, a Washington professional limited liability company ("**Tenant**").

WITNESSETH:

1. **PREMISES**. In consideration of the covenants and agreements contained herein, Landlord does hereby lease, let and demise unto Tenant, and Tenant does hereby lease from Landlord, that certain premises located at the addresses commonly known as 985 Goethals Drive, Richland, WA 99352 and 821 Swift Boulevard, Richland, WA 99352, and legally described on Exhibit A attached hereto ("**Premises**"), located on the real property, including without limitation the building ("**Building**") and parking areas (collectively, the "**Real Property**").

2. **LEASE TERM**. The Term of this Lease shall commence on April 29, 2022 (the "**Commencement Date**"), and expire at midnight on April 28, 2032.

3. **RENT**.

a) Base Rent. Commencing on the Commencement Date, Tenant shall pay Landlord "**Base Rent**" of Twenty-Five Thousand Dollars ($25,000.00) monthly, provided that the first month's Base Rent shall be due and payable upon mutual execution of this Lease:

b) Operating Expenses. In addition to Base Rent, commencing on the Commencement Date, Tenant shall pay to the applicable third-party service provider each month, Tenant's "**Expenses**" for the Real Property. Expenses shall include without limitation, all costs and expenses incurred in the ownership, use, operation, management and upkeep of the Real Property, including without limitation, real property taxes and assessments, local improvement district costs and assessments, insurance premiums and deductibles, maintenance, repair and replacements costs, utilities (to the extent paid by Landlord), common area, parking lot and sidewalk maintenance and repair, supplies, materials labor and equipment related to operations and maintenance, and a reasonable management fee. On January 1st of each year during the Term, Landlord may increase the monthly Expenses due by Tenant hereunder to cover Landlord's anticipated annual expenses for such year. Base Rent, Expenses, and all other sums due by Tenant hereunder may be collectively referred to herein as "**Rent**."

c) Payment. Base Rent and Expenses shall be due and payable, in advance, on the first (1st) day of each month at such place as shall be designated by Landlord in writing, without any prior demand therefor and without any deduction or set-off whatsoever except as otherwise provided herein. If the Expenses actually paid by Tenant under this Section 3 during the preceding calendar year were less than the actual amount of Tenant's Expenses for such year, Landlord shall so notify Tenant in writing and Tenant shall pay the difference to Landlord within thirty (30) days of receipt of such notice. If Tenant's Expense payments during the preceding calendar year were greater than the actual amount of Tenant's Expenses for such year, then such overpayment shall be paid by Landlord to Tenant within thirty (30) days of such determination or credited against future amounts owed to Landlord. Rent for any partial months during the Term shall be prorated. Any Rent not paid by the date when due shall incur a late fee equal to five percent (5%) of the unpaid amount, and shall accrue interest at the rate of twelve percent (12%) per annum until paid.

4. UTILITIES AND TAXES.

a) Except as otherwise expressly provided herein, Tenant shall be responsible for, and shall timely pay for, all utilities and services serving the Premises, including without limitation, electricity, water, natural gas, HVAC, trash, and janitorial. Unless otherwise instructed by Landlord, Tenant shall contract directly with the applicable utility or service provider and shall timely pay such charges directly to such provider, unless any such utilities or services cannot be separately measured or billed to Tenant, in which event Landlord may pay for such utilities and services and Tenant shall reimburse Landlord the cost thereof within ten (10) days after written notice thereof from Landlord. In no event shall Landlord be liable for any interruption of any utilities or services provided to the Premises nor shall any such interruption be deemed a constructive eviction or entitle Tenant to any abatement of Rent or other damages.

b) Landlord shall pay all real property taxes imposed on or in connection with the Real Property directly to the applicable authority, which amount shall be reimbursed to Landlord as part of the Expenses. Tenant shall cause all taxes, assessments, and other charges levied on or imposed on any of its personal property situated in, on, or about the Premises to be levied on or assessed separately from the Real Property and not as a lien thereon. Tenant shall report and pay, to the appropriate governmental authority, all personal property taxes relating to Tenant's trade fixtures, equipment, and other personal property on the Premises. Tenant shall protect and hold harmless Landlord and the Real Property from liability for any such taxes, assessments, and charges, together with any interest, penalties, and other sums thereby imposed, and from any sale or other proceeding to enforce payment thereof. If any of Tenant's personal property is taxed with the Real Property, Tenant shall pay to Landlord the taxes for such personal property within ten (10) days after written request from Landlord.

5. LIABILITY INSURANCE.

a) Landlord's Insurance. Landlord will maintain (i) all risk (or "special form") property insurance covering the full replacement cost of the Building and all other structures and improvements on the Real Property, and (ii) such other policies in amounts and types that Landlord reasonably deems necessary for the Real Property. The cost of such Landlord's insurance shall be reimbursed to Landlord as an Expense.

b) Tenant's Insurance. Tenant will maintain at all times during the Term, at its sole cost and expense, with companies reasonably acceptable to Landlord: (i) all risk (or "special form") property insurance covering the full replacement cost of Tenant's property installed or placed in the Premises by Tenant; (ii) workers' compensation insurance with no less than the minimum limits required by law; and (iii) commercial general liability insurance covering the Premises and Tenant's use thereof against claims for bodily injury or death and property damage, which commercial general liability insurance shall have limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate. Such liability insurance shall be primary and non-contributing to any insurance maintained by Tenant, and will name Landlord and Landlord's owners and lender(s) as additional insureds. Landlord may from time to time require reasonable increases to the policy limits required hereunder.

Prior to the Commencement Date (or, if applicable, any earlier occupancy of the Premises by Tenant), Tenant shall deliver to Landlord a certificate of insurance, including all endorsements, which Tenant is required to maintain under this Section 5.

c) Waiver of Subrogation. Landlord and Tenant each hereby waive and release any and all rights of recovery against the other, and/or against the officers, employees, agents and representatives of

the other, for loss of or damage to such waiving party or its property (or the property of others under its control) resulting from a fire or other cause that is required to be insured against by the waiving party under this Lease (whether or not actually insured). In addition, each party shall obtain a waiver from its insurance company of any claim, by subrogation or otherwise, against the other party for any such loss or damage which is insured against under any insurance policy in effect at the time of such loss or damage. If such waiver of subrogation is not expressly permitted by any policy of insurance that is required hereunder (or that is otherwise in effect and could cover a loss or damage as described in the foregoing waiver of subrogation), then the party obtaining the policy in question shall obtain from its insurance company an agreement in writing that the waiver will not affect coverage under the policy.

6. **NOTICES**. All notices shall be personally delivered, sent via a nationally recognized overnight courier service (such as Federal Express, UPS or DHL) or sent by certified United States mail (return receipt requested). Notices sent via personal delivery, overnight courier service will be effective upon receipt, and notices sent by mail will be effective three (3) business day after being deposited with the United States Post Office, postage prepaid. The addresses to be used in connection with such correspondence and notices are set forth below, which shall be valid until such time as a party shall otherwise direct by notice given pursuant to this Section 6.

If to Landlord:

MH PROPERTIES, L.L.C.
6703 W. Rio Grande Ave.
Kennewick, WA 99336

If to Tenant:

APEX SPINE INSTITUTE, PLLC
821 Swift Blvd.
Richland, WA 99352

7. **ASSIGNMENT AND SUBLEASE**. Tenant shall not assign this Lease or any interest therein, nor sublet, license or otherwise transfer (including by operation of law) (a "**Transfer**") the Premises or any interest therein without the prior written consent of Landlord, which consent may be granted or withheld in Landlord's sole discretion. "Transfers" shall include a change of control of Tenant.

8. **USE OF PREMISES**. Tenant shall use the Premises for medical and general office use (the "**Permitted Use**"), and for no other purpose without the prior written consent of Landlord, which consent may be granted or withheld in Landlord's sole discretion. Tenant will not permit any unreasonably objectionable noise, light or odor to escape or be emitted from the Premises, or to do anything or permit anything to be done upon or about the Premises in any way tending to create a nuisance or that would increase Landlord's insurance premiums for the Real Property. Tenant shall comply, at Tenant's sole expense, with all applicable federal, state, county, and municipal statutes, ordinances, codes, rules, regulations, and requirements ("**Laws**") and any covenants, conditions, restrictions and other agreements of record affecting the Premises. Tenant shall also abide by any rules and regulations for the Premises that Landlord may from time to time reasonably establish and/or amend. In addition, if as a result of Tenant's use of the Premises for the Permitted Use or any Alteration (as defined below) made by Tenant, Landlord must make any improvement or alteration to any portion of the Real Property to comply with the Americans with Disabilities Act or any other law or regulation, Tenant shall be responsible for the entire cost thereof.

9. **ENTRY ONTO PREMISES**. Upon reasonable prior notice (except in case of bona fide emergency), Landlord shall have the right to access the Premises at reasonable times (and at any time for emergency purposes) for the purpose of making any alterations or repairs to the Premises that Landlord may deem necessary for the safety or preservation of the Premises or Real Property or that Landlord is

required to make hereunder, ensuring Tenant's compliance with the terms of this Lease, or for the purpose of exhibiting the Premises to potential lenders, purchasers or Tenants.

10. INDEMNIFICATION. Tenant shall indemnify, defend and hold harmless, Landlord and Landlord's owners, officers, managers, agents and employees, from and against any and all losses, liabilities, damages, costs, and expenses (including reasonable attorneys' fees) resulting, directly or indirectly, from (i) the use of the Premises and/or Real Property by Tenant and/or its owners, officers, managers, agents, employees, contractors, guests and invitees, (ii) a breach of any representations, warranties and covenants of Tenant in this Lease, and (iii) the negligence or willful misconduct of Tenant or its officers, employees, agents, or contractors, guests or invitees, except to the extent caused by the gross negligence or willful misconduct of Landlord or Landlord's owners, officers, managers, agents, employees and contractors.

Landlord shall indemnity, defend and hold harmless, Tenant and Tenant's owners, officers, managers, agents and employees from and against any and all losses, liabilities, damages, costs, and expenses (including reasonable attorneys' fees) resulting, directly or indirectly, from (i) a breach of any representations, warranties and covenants of Landlord in this Lease, or (ii) the gross negligence or willful misconduct of Landlord or its officers, employees, agents, or contractors, guests or invitees, except to the extent caused by the gross negligence or willful misconduct of Tenant or Tenant's owners, officers, managers, agents, employees and contractors.

Landlord and Tenant's obligations under this Section 10 shall survive termination or expiration of this Lease.

11. CONDITION OF PREMISES. Except as otherwise expressly provided herein, Tenant accepts the Premises and Real Property in their "AS IS" condition as of the date of Landlord's delivery of the Premises to Tenant, and Landlord makes no representations or warranties whatsoever regarding the Premises or the Real Property.

12. ENVIRONMENTAL REQUIREMENTS.

a) Except for standard office cleaning products in de minimis amounts and used in compliance with all Environmental Requirements, Tenant shall not use or permit any Hazardous Material upon the Premises or Real Property, or transport, store, use, generate, manufacture, or release any Hazardous Material in or about the Premises or Real Property. Tenant, at its sole cost, to the extent required by Law, will investigate, remove, monitor, mitigate, and remediate Hazardous Materials released into or on the Premises by Tenant or Tenant's owners, employees, contractors, agents or representatives. "**Environmental Requirements**" means all Laws relating to the protection of human health and the environment or exposure to hazardous substances or hazardous materials, including the Comprehensive Environmental Response, Compensation and Liability Act; the Resource Conservation and Recovery Act; the Occupational Safety and Health Act; all state and local counterparts thereto; and any regulations, policies, permits, or approvals promulgated or issued thereunder. "**Hazardous Materials**" means any substance, material, waste, pollutant, or contaminant listed or defined as hazardous or toxic under any Environmental Requirements.

b) Tenant will indemnify, defend, and hold Landlord harmless from and against any and all losses, liabilities, damages, costs, and expenses (including remediation, removal, repair, corrective action, or cleanup expenses, reasonable attorneys' and consultants' fees, and punitive and/or natural resource damages) (collectively, "**Environmental Claims**") that are brought or recoverable against, or incurred by, Landlord as a result of any release of Hazardous Materials that Tenant is obligated to remediate as provided

in this Section 12 or any other breach of the requirements of this Section 12 by Tenant or Tenant's owners, employees, agents, contractors, representatives or invitees, except to the extent caused by the gross negligence or willful misconduct of Landlord or Landlord's owners, officers, managers, agents or employees. Tenant's obligations under this Section 12 shall survive termination or expiration of this Lease.

13. REPAIRS AND MAINTENANCE.

a) Landlord shall maintain, repair and replace (i) the structural elements of the Premises and Real Property, including the roof, exterior walls and foundation and the parking areas, and (ii) all utility lines to the point of connection with the Premises (but not within the Premises). Tenant shall immediately give Landlord written notice of any repair required by Landlord pursuant to this Section 13. The costs of Landlord's maintenance, repair and replacement obligations shall be reimbursed to Landlord as an Expense.

b) Except as expressly provided in Section 13.a above, Tenant shall, at its sole cost and expense, keep and maintain all parts of the Premises in good, clean, safe and sanitary condition, promptly making all necessary repairs and replacements, including but not limited to the following: windows, glass, interior walls, floors and floor coverings, heating and air conditioning systems, plumbing and electrical systems, lighting facilities and bulbs, sprinkler systems, alarm systems, fire detection systems, landscaping, snow and ice removal, signage and regular removal of trash and debris.

c) Notwithstanding the foregoing to the contrary, Tenant shall immediately reimburse Landlord for the full cost of any maintenance, repair or replacement necessitated by the negligence or willful misconduct of Tenant or Tenant's owners, officers, managers, agents, employees, contractors, invitees or representatives.

14. ALTERATIONS. Tenant shall make no alterations, additions or improvements to the Premises, change the color of the exterior of the Building, or add any lighting to the exterior of the Building ("**Alterations**"), without Landlord's prior written approval, which may be granted or withheld in Landlord's sole discretion. Upon termination of this Lease, any Alterations (but excluding Tenant's trade fixtures and equipment) shall be deemed part of the Premises and belong to Landlord unless otherwise agreed by Landlord and Tenant at the time such Alterations are performed, or unless Landlord requests that part or all of such Alterations be removed, in which case Tenant shall promptly remove such Alterations and restore the affected portion of the Premises to substantially its original condition.

15. PARKING. Tenant acknowledges that parking is available on the Real Property only to the extent allowed by controlling zoning ordinances and other applicable Laws, and that Landlord shall have the right to make such rules and regulations as Landlord deems desirable for the control of parking automobiles on the Real Property, including the right to designate certain areas for parking of the Tenant and its employees.

16. DESTRUCTION OF PREMISES. If fire or other casualty causes damage to the Premises or the Real Property in an amount exceeding thirty percent (30%) of the full replacement cost thereof (whether or not directly affecting the Premises), or that cannot be restored within 180 days after the date of such casualty, Landlord or Tenant may elect to terminate this Lease as of the date of the damage by notice in writing within thirty (30) days after such date, in which event the parties shall have no further obligations hereunder except for those that expressly survive termination. If not so terminated, Landlord shall promptly repair the damage and restore the Premises to substantially its former condition as soon as practicable and to the extent of available insurance proceeds. Rent shall be abated during the period of such restoration to the extent the Premises are reasonably unusable by Tenant for the Permitted Use.

17. CONDEMNATION. If a condemning authority takes the entire Premises or a portion sufficient to render the remainder unsuitable for the Permitted Use (or the Premises are sold under the threat of that power), then either Landlord or Tenant may elect to terminate this Lease, by written notice to the other, effective as of the date that title passes to the condemning authority, in which event the parties shall have no further obligations hereunder except for those that expressly survive termination. Otherwise, Landlord shall proceed as soon as practicable to restore the remaining Premises to a condition comparable to that existing at the time of the taking, subject to, and to the extent of, Landlord's receipt of a condemnation award. Rent shall be abated during the period of restoration to the extent the Premises are reasonably unusable by Tenant for the Permitted Use, and Base Rent shall be reduced for the remainder of the Term in an amount proportionate to the reduction of the size of the Premises. All condemnation proceeds shall belong solely to Landlord, provided that Tenant shall be entitled to bring a separate action to recover any damages separately suffered by Tenant to its business or personal property as a result of the condemnation so long as such award to Tenant does not diminish Landlord's award.

18. TENANT DEFAULT. Any of the following shall constitute a default by Tenant under this Lease (an "**Event of Default**"):

a) Tenant's failure to pay Rent under this Lease within five (5) days after the date when due.

b) Failure to comply with any other term or condition of this Lease, other than payment of Rent, within thirty (30) days following written notice from Landlord specifying the noncompliance; provided that if such noncompliance cannot be cured within such thirty (30) day period, an Event of Default shall not exist if Tenant commences a cure within such 30-day period and thereafter proceeds diligently and in good faith to complete such cure, but in no event to exceed sixty (60) days.

c) Tenant's insolvency, assignment for the benefit of its creditors, voluntary petition in bankruptcy or adjudication as bankrupt, or the appointment of a receiver for Tenant's properties.

d) Tenant's Transfer of the Premises in violation of Section 7.

e) Tenant's abandonment of the Premises without the written consent of the Landlord or failure to occupy the Premises within twenty (20) days after notice from Landlord.

19. REMEDIES. In case of an Event of Default as described in Section 18 above, Landlord shall have the right to the following remedies which are intended to be cumulative and in addition to any other remedies, including all rights and remedies provided under applicable Law:

a) Retake possession of the Premises and relet the Premises upon terms satisfactory to Landlord in its sole discretion. No such reletting shall be construed as an acceptance or a surrender of Tenant's leasehold interest unless otherwise provided in writing.

b) Recover damages caused by or resulting from the Event of Default, including, without limitation, reasonable attorney fees, restoration and renovation of the Premises, broker fees, Tenant inducements, and other reasonable costs of reletting the Premises. Landlord may sue periodically to recover damages as they occur throughout the Term, and no action for accrued damages shall bar a later action for damages subsequently accruing. Landlord may elect in any one action to recover accrued damages plus damages attributable to the remaining Term equal to the difference between the Base Rent due under this Lease and the reasonable rental value of the Premises for the remainder of the Term, discounted to the present value at the time of termination as reasonably determined by Landlord.

c) Make any payment or perform any obligation required of Tenant so as to cure the Event of Default, in which case Landlord shall be entitled to recover from Tenant all amounts so expended, plus interest at the rate of twelve percent (12%) per annum from the date expended until repaid in full (or the maximum interest rate then allowed by Law, if less).

d) Pursue any other remedy now or hereafter available to Landlord at law or in equity.

20. SURRENDER; HOLDING OVER. Upon the expiration or earlier termination of this Lease, Tenant shall deliver up and surrender to Landlord possession of the Premises broom clean and in as good condition and repair as on the Commencement Date, ordinary wear and tear, condemnation and casualty excepted. Tenant shall remove all of Tenant's personal property from the Premises, and shall make any repairs necessitated by such removal. Any such personal property not timely removed shall be deemed abandoned by Tenant and, at Landlord's election, may be treated and/or disposed of by Landlord as Landlord's own property without further right or claim thereto by Tenant. If Tenant remains in possession of the Premises after the expiration or termination of this Lease without the execution of a new lease, Tenant shall be deemed to be occupying the Premises as a tenancy at sufferance, subject to all of the rents and provisions of this Lease in effect on the day before the expiration or termination of this Lease, except those relating to the length of the Term and except that the Base Rent shall be one hundred fifty percent (150%) of the amount payable during the last month of the Term.

21. LIENS. Tenant will pay or cause to be paid all sums legally due and payable by it on account of any labor performed or materials furnished in connection with any work by Tenant on the Premises and will hold Landlord harmless from all losses, costs, or expenses based on or arising out of asserted claims or liens with respect to such work. Tenant will give Landlord immediate notice of any lien or encumbrance against the Premises or Real Property as a result of work by Tenant and cause such lien or encumbrance to be discharged within thirty (30) days of the filing or recording thereof; provided Tenant may contest such liens or encumbrances as long as such contest prevents foreclosure of the lien or encumbrance and Tenant causes such lien or encumbrance to be bonded or insured over in a manner satisfactory to Landlord within such thirty (30)-day period.

22. QUIET ENJOYMENT. Landlord agrees that if Tenant shall faithfully and fully discharge Tenant's obligations herein set forth, then Tenant shall have and enjoy the quiet and undisturbed possession of the said Premises during the Term of this Lease.

23. ESTOPPEL CERTIFICATES. Tenant and Landlord agree, from time to time, but not more often than once in any calendar year (except in connection with a sale or financing, in which case there is no limit), within fifteen (15) days after written request of the other, to execute and deliver to each other, any prospective purchaser, or any lender for the Premises, an estoppel certificate in commercially reasonable form.

24. SUBORDINATION. This Lease and Tenant's interest and rights hereunder are and will be subject and subordinate at all times to any ground lease and the lien of any mortgage or deed of trust now existing or hereafter created on or against the Premises, and to all amendments, restatements, renewals, modifications, consolidations, refinancing, assignments, and extensions thereof. Tenant shall cooperate with Landlord and any lender which is acquiring a security interest in the Premises or the Lease. Tenant shall execute such further documents and assurances as any lender may require.

25. SIGNS. Tenant may erect signs on the exterior of the Building and otherwise on the Premises only after first securing Landlord's prior written approval, which approval may be granted or withheld in Landlord's reasonable discretion. All signs installed by Tenant shall be in compliance with all Laws, and

shall be removed by Tenant upon termination of this Lease, with the sign location restored to its former state, at Tenant's sole cost and expense. Tenant shall be responsible, at Tenant's sole cost and expense, to maintain all of Tenant's signs in good order and neat appearance. If Tenant fails to so maintain any of its signs, Landlord may make required repairs and Tenant shall promptly reimburse Landlord for the expense thereof plus interest at the rate of 12% per annum until fully repaid.

26. FORCE MAJEURE. Neither party shall be held responsible for delays in the performance of its obligations hereunder when caused by industry wide strikes, lockouts or labor disputes, acts of God (including without limitation floods, earthquakes and hurricanes), weather, pandemic or epidemic (including without limitation, COVID-19), governmental orders, restrictions, moratoria, regulations, or controls, terrorism, civil commotion, and other similar causes beyond the reasonable control of such party (a "**Force Majeure Event**"). Notwithstanding the foregoing, in no event will Tenant be excused from its Rent or other monetary obligations hereunder due to a Force Majeure Event.

27. HEIRS AND ASSIGNS. All rights, remedies, and liabilities herein given to or imposed upon either of the parties hereto shall extend to and inure to the benefit of the heirs, executors, administrators, successors, and assigns of such parties.

28. HEADINGS; CONSTRUCTION. The section headings contained in this Lease are inserted for convenience only and shall not affect in any way the meaning or interpretation of this Lease. In construing this Lease, it is understood that Landlord or Tenant may be more than one person; that if the context so requires, the singular pronoun shall be taken to mean and include the plural, the masculine, the feminine, and the neuter, and that generally all grammatical changes shall be made, assumed, and implied to make the provisions hereof apply equally to corporations and individuals.

29. GOVERNING LAW. The validity, performance, construction, interpretation and effect of this Lease shall be governed by and construed in accordance with the internal laws of the State of Washington (excluding its laws related to conflicts of law). The Parties hereby consent to the exclusive jurisdiction of the state courts of the State of Washington and covenant not to file, commence, remove to, or otherwise maintain any judicial proceedings in any federal court or court of any other state.

30. ATTORNEY FEES. If either party brings legal action against the other party to enforce any provision of this Lease, the prevailing party shall be entitled to recover reasonable attorney fees in addition to any other damages awarded at arbitration, trial and upon any appeal. Regardless of whether any suit or action has been filed or brought, Landlord shall be entitled recover its reasonable attorney fees from Tenant to the extent incurred due to, or in connection with, an Event of Default.

31. INTEGRATION. This Lease, including all exhibits hereto, represents the entire agreement among the parties and their affiliates and replaces any and all prior written or oral agreements regarding the subject matter of this Lease.

32. SEVERABILITY. Should any provision of this Lease be found to be illegal or unenforceable, the other provisions shall nevertheless remain effective and shall remain enforceable to the greatest extent permitted by law.

33. COUNTERPARTS. This Lease may be executed in one or more counterparts for the convenience of the parties, each of which shall be deemed an original and all of which together will constitute one and the same instrument. Delivery of an executed counterpart of a signature page to this Lease by facsimile or electronically shall be effective as delivery of a mutually executed counterpart to this Lease.

34. FAILURE OR INDULGENCE NOT WAIVER. No failure or delay on the part of any party hereto in the exercise of any right hereunder shall impair such right or be construed to be waiver of, or acquiescence in, any breach of any representation, warranty or agreement herein, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or any other right. All rights and remedies existing under this Lease are cumulative to, and not exclusive of, any rights or remedies otherwise available.

35. AMENDMENTS AND WAIVERS. This Lease may not be amended or modified except by an instrument in writing signed on behalf of all the parties hereto. No waiver by any party of any provision of this Lease, or of any other party's default, misrepresentation, or breach of any warranty or covenant hereunder, whether intentional or not, shall be valid unless such waiver shall be in writing and signed by the party making such waiver, nor shall any such waiver be deemed to extend to any prior or subsequent default, misrepresentation, breach of any warranty or covenant hereunder or affect in any way any rights arising by virtue of any prior or subsequent occurrence.

36. TIME OF THE ESSENCE. Time is of the essence with respect to all obligations under this Lease.

37. RECORDATION. Neither this Lease nor any memorandum hereof shall be recorded without Landlord's prior written consent, in Landlord's sole discretion.

38. RELATIONSHIP OF THE PARTIES. Nothing contained in this Lease, including the agreement to pay Rent as herein-before provided, shall be construed to create any relationship between the parties other than that of Landlord and Tenant; it being agreed that Landlord shall not be deemed a partner of, or joint venture partner with, or the agent of the Tenant for any purpose whatsoever.

39. AUTHORITY. If Tenant is a legal entity such as a corporation, partnership, or limited liability company, Tenant represents and warrants to Landlord that the person(s) signing this Lease on behalf of such entity has full authority to do so and that this Lease binds Tenant.

40. SURVIVAL. All representations, warranties, and indemnities that by their nature are intended to survive the termination of this Lease shall survive the expiration or early termination of this Lease.

[signature page follows]

IN WITNESS WHEREOF, LANDLORD and TENANT have executed this Lease on this 19 day of April, 2022.

LANDLORD:

MH PROPERTIES, L.L.C., a Washington limited liability company

By: _____
Name: _____
Its: Manager

TENANT:

APEX SPINE INSTITUTE, PLLC, a Washington professional limited liability company

By: _____
Name: _____
Its: ~~Manager~~ CEO

Exhibit A

That portion of Lot 2, Block 637, PLAT OF RICHLAND, according to the Plat thereof recorded in Volumes 6 and 7 of Plats, records of Benton County, Washington, described as follows:

Beginning at the Northeast corner of said Lot 2; thence South 89°09'12" West, 180.02 feet along the North line thereof to a found 5/8" rebar and cap stamped by "Worley;" thence at right angles to said line, South 00°50'48" East, 129.89 feet to a found 5/8" rebar and cap stamped "Worley" on the South line of said Lot 2; thence North 89°10'06" East, 192.51 feet along said South line to the East line of said Lot 2; thence North 06°20'03" West, 130.54 feet along said East line to the point of beginning; TOGETHER WITH that portion of Lot 1, SHORT PLAT NO. 2420 described as follows:

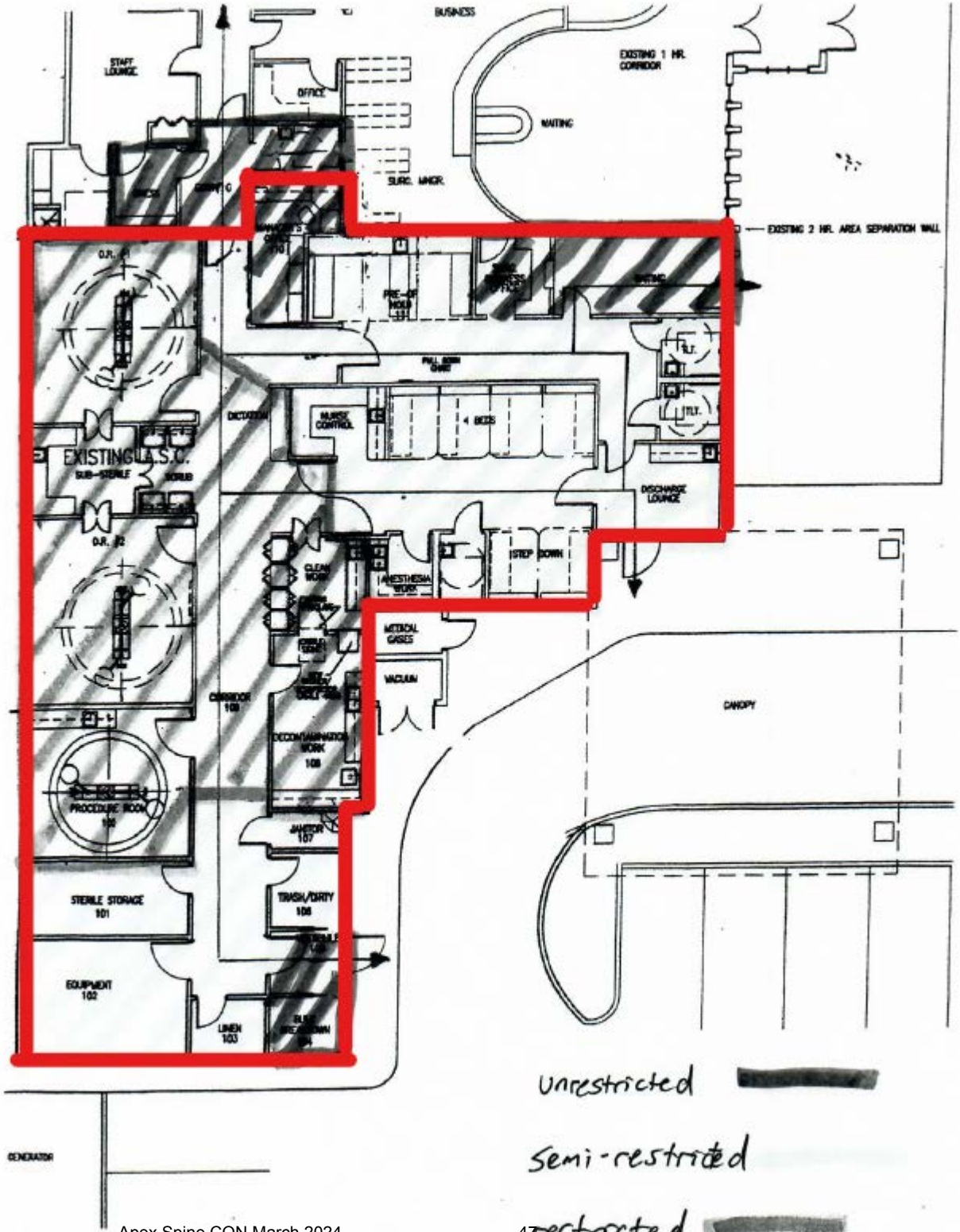
Beginning at the Northeast corner of said Lot 1; thence South 06°21'23" East, 106.02 feet along the Easterly line of said Lot 1; thence South 89°09'09" West, 202.67 feet to the West line of said Lot 1; thence North 00°51'13" West, 105.58 feet to the Northwest corner of said Lot 1; thence North 89°10'06" East, 192.51 feet to the Point of Beginning.

SUBJECT TO covenants, conditions, restrictions, reservations, easements and agreements of record, if any.

More commonly known as 985 Goethals Drive, Richland, WA 99352 and 821 Swift Boulevard, Richland, WA 99352.

Assessor's Property Tax Parcel No. 1-1198-202-0637-010

Exhibit 3



Apex Spine ASC

Exhibit 4

Patient Transfer Agreement

In the event that a patient under care at the Apex Spine ASC requires immediate medical attention and that the required care is not within the scope of services outlined in the Facility's policies, Dr Janmeet Sahota M.D. agrees to admit the patient at a local hospital and receive transfer of care for said patient.

In the event Dr. Janmeet Sahota loses his local hospital admitting privileges, Dr. Sahota agrees to notify the Apex Spine ASC immediately.

This agreement shall last for one year from the date of signature and shall automatically renew for an additional year until one the parties gives 30 days written notice of the cancellation of this agreement.

X_____ Date 8/30/22

Apex Spine ASC

X_____ Date 8/30/22

Janmeet Sahota MD

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement (the "Agreement") is made and executed on the dates set forth below the parties' signatures, to be effective on the last date of signature (the "Effective Date"), by and between Lourdes Hospital, LLC, d/b/a Lourdes Health, and Apex Spine Institure, LLC, d/b/a Apex Spine ASC (the parties are sometimes hereinafter referred to individually as a "Facility" and collectively as the "Facilities").

RECITALS:

WHEREAS, the parties desire to enter into this Agreement governing the transfer of patients between the Facilities; and

WHEREAS, the parties desire to enter into this Agreement in order to specify the rights and duties of each of the parties and the procedure for ensuring the timely transfer of patients between the Facilities.

NOW, THEREFORE, in consideration of the foregoing and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and to facilitate the continuity of care and the timely transfer of patients and records between the Facilities, the parties hereto agree as follows:

AGREEMENT:

Section 1 - Transfer of Patients.

1.1 If either Facility believes that a patient of that Facility (the "Transferring Facility") requires the services of the other Facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the Receiving Facility's admitting office or emergency department to arrange for appropriate treatment as provided herein. All transfers between the Facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and the reasonable policies and procedures of the Facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either Facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

Section 2 - Responsibilities of the Transferring Facility.

2.1 The Transferring Facility shall be responsible to:

2.1.1 Provide, within its capabilities, the medical screening and stabilizing treatment of the patient before the transfer;

2.1.2 Arrange for the appropriate and safe transportation and care of the patient during transfer in accordance with applicable federal and state laws and regulations;

2.1.3 Designate a person who has the authority to represent the Transferring Facility and coordinate the transfer of the patient from the Transferring Facility;

2.1.4 Notify the Receiving Facility's designated representative prior to transfer to confirm availability of appropriate facilities, services and staff necessary to provide care to the patient;

2.1.5 Before the patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

2.1.6 Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

2.1.7 Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

2.1.8 Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including without limitation: records relating to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and, with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of the

transfer. If all necessary and relevant medical records are not available at the time the patient is transferring, then the Transferring Facility shall forward the records as soon as possible;

2.1.9 Transfer the patient's personal effects, including without limitation money and valuables, and information related to those items;

2.1.10 Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare, Medicaid, or a health care assistance program established by a county, public hospital, or hospital district;

2.1.11 Notify the Receiving Facility of an estimated time of arrival for the patient;

2.1.12 Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency medical condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the Transferring Facility at the time of transfer;

2.1.13 Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

2.1.14 Recognize the right of a patient to request a transfer to the care of a physician and hospital of the patient's choosing;

2.1.15 Recognize the right of a patient to refuse consent to treatment or transfer;

2.1.16 Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred to the Receiving Facility under this Agreement; and

2.1.17 Establish policies and/or protocols for (i) maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility.

Section 3 - Responsibilities of the Receiving Facility.

3.1 The Receiving Facility shall be responsible to:

3.1.1 Confirm with the Transferring Facility, as promptly as possible, that the Receiving Facility has available beds and appropriate facilities, services, and staff necessary to treat the patient and that the Receiving Facility has agreed to accept transfer of the patient;

3.1.2 Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred and maintain a call roster of physicians at the Receiving Facility;

3.1.3 Reserve appropriate beds, facilities, and services for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician, unless the Receiving Facility needs them for an emergency;

3.1.4 Designate a person who has the authority to represent and coordinate the transfer and receipt of patients into the Receiving Facility;

3.1.5 When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

3.1.6 Provide the Transferring Facility with a copy of the medical records of the patient that were generated at the Receiving Facility, if the Receiving Facility returns the patient to the Transferring Facility;

3.1.7 Maintain the confidentiality of the patient's medical records in accordance with applicable federal and state law;

3.1.8 Establish policies and/or protocols for (i) maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) the receipt of patients into the Receiving Facility, and (iii) the acknowledgement and inventory of patient valuables transported with patients;

3.1.9 Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending or transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient and, if transferred back to the Transferring Facility, comply with the requirements set forth in Section 2 of this Agreement;

3.1.10 Upon request, provide to the Transferring Facility and patient current information concerning the Receiving Facility's eligibility standards and payment practices;

3.1.11 Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider; and

3.1.12 Complete, execute, and return the memorandum of transfer form to the Transferring Facility.

Section 4 - Billing.

4.1 All charges incurred with respect to any services performed by either Facility for patients received from the other Facility pursuant to this Agreement shall be billed and collected by the Facility providing such services directly from the patient, third party payor, Medicare, Medicaid, or other sources appropriately billed by that Facility. In addition, it is understood that the physicians or other professional providers that may participate in the care and treatment of the patient will bill their professional fees at usual and customary charges. Each Facility shall provide information in its possession to the other Facility and such physicians/providers to enable them to bill the patient, responsible party, or appropriate third-party payor.

Section 5 - Re-Transfer; Discharge.

5.1 At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the Receiving Facility will transfer the patient to the agreed-upon location. If the Receiving Facility is to transfer the patient back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility.

Section 6 - Compliance with Law.

6.1 Each Facility shall comply with all applicable federal and state laws, rules, and regulations, including without limitation those laws and regulations governing the maintenance of medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

Section 7 - Term; Termination.

7.1 Term. This Agreement shall commence on the Effective Date and shall continue for a period of one (1) year thereafter (the "Initial Term"). This Agreement will automatically renew for successive twelve (12) month periods after the expiration of the Initial Term (an "Extended Term"); provided, however, that any Extended Term may be terminated upon (a) the full execution of a new agreement between the parties covering the same services; or (b) not less than sixty (60) days prior written notice of termination by either party to the other party during the Extended Term.

7.2 Termination Without Cause. Either party may terminate this Agreement, without cause, by providing not less than sixty (60) days' prior written notice stating the intended date of termination.

7.3 Termination With Cause. Either party may terminate this Agreement, with cause, upon breach by the other party of any material provision of this Agreement, provided that to effect such termination, the non-breaching party must give the breaching party written notice specifying the nature of the breach after which the breaching party shall then have fifteen (15) days to remedy the breach and conform its conduct to this Agreement. If such corrective action is not taken within the time specified, this Agreement shall terminate at the end of the fifteen (15) day period without further notice or demand.

7.4 Immediate Termination: Either party may also terminate this Agreement immediately by written notice to the other party upon the occurrence of any of the following events: (a) the other Facility's license in the State lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction; (b) the other Facility loses its Medicare certification; or (c) the other Facility closes or ceases patient care operations to such an extent that patient care cannot be carried out adequately.

Section 8 - Insurance; Indemnification.

8.1 Each party hereby agrees to indemnify (the "Indemnifying Party") and hold harmless the other party (the "Indemnified Party") from and against any claim, damage, loss, expense, liability, obligation, action or cause of action, including reasonable attorneys' fees and reasonable costs of investigation, that the Indemnified Party may sustain, pay, suffer or incur by reason of any negligent act or omission of the Indemnifying Party in connection with services provided and duties undertaken under this Agreement, including any claims for personal injury or wrongful death.

8.2 Each party shall (i) maintain in force at all pertinent times at its sole expense a policy of general and professional liability insurance in the minimum amount of $1 million per occurrence, $3 million in the annual aggregate, or such higher amount as

may be required by the laws of the State and (ii) if applicable, participate in the appropriate state compensation fund. Each party shall furnish, at the other party's request, a Certificate of Insurance evidencing the aforementioned coverage.

8.3 Each party agrees, and it is the stated intent of each party, that they shall only be liable to the other party under this Section for the proportionate liability or representative share of negligence allocated to such party based on the negligent acts or omissions of each party. If such allocation is not determined by a court of competent jurisdiction and the parties in good faith are otherwise unable to agree to such allocations, either party hereto may bring an action, including a summary or expedited proceeding, to compel binding arbitration of such matter.

8.4 Each party specifically reserves any common law right of indemnity and/or contribution that either party may have against the other.

Section 9 - Miscellaneous.

9.1 Entire Agreement; Amendment; Counterparts. This Agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof and may not be amended or modified except by the mutual written agreement of the parties. This Agreement may each be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

9.2 Partial Invalidity; Waiver. In the event any provision of this Agreement is found to be legally invalid or unenforceable for any reason, the remaining provisions of the Agreement shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

9.3 Assignment. Neither party shall assign or transfer this Agreement in whole or in part, or assign or delegate any of the party's rights, duties, or obligations under this Agreement, in each case without the prior written consent of the other party, and any assignment, transfer or delegation without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors, and permitted assigns.

9.4 Independent Contractor. The parties are performing services and duties under this Agreement as independent contractors and not as employees, agents, partners of, or joint ventures with the other.

9.5 Regulatory Requirements. The parties expressly agree that nothing contained in this Agreement shall require either party to refer or admit any patients to, or order any goods or services from the other. Notwithstanding any unanticipated effect of any provision of this Agreement, neither party will knowingly or intentionally conduct itself in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 U.S.C. § 1320a-7b).

9.6 Access to Records. As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, each party shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If a party carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, such party agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of 42 U.S.C. § 1395x(v)(1) and the regulations thereto. No attorney-client, accountant-client, or other legal privilege will be deemed to have been waived by either party by virtue of this Agreement.

9.7 Change in Law. In the event that Medicare, Medicaid, any third party payor or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure or interpretation thereof that establishes a material change to the manner of either party's operations under this Agreement and/or the costs related thereto, then upon the request of either party materially affected by any such change in circumstances, the parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the parties are unable to reach an agreement as to how or whether this Agreement shall continue, then either party may terminate this Agreement upon thirty (30) days' prior written notice.

9.8 Notices. Any notice required or permitted to be given hereunder shall be in writing and may be given by: (1) hand delivery and shall be deemed given on the date of delivery; (2) registered or certified mail and shall be deemed given the third day following the date of mailing; or (3) overnight delivery by reputable overnight delivery service such as Federal Express or UPS and shall be deemed given the following day. All notices to a party shall be addressed to the address for such party as set forth on the signature page of Agreement.

9.9 Alternate Dispute Resolution. The parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement shall be settled by arbitration administered by the American Health Lawyers Association in accordance with its rules. The award or decision rendered by the arbitrator will be final, binding, and conclusive, and judgment may be entered upon such award by any court of competent jurisdiction. The arbitration process itself, and any other information or disclosures revealed by either party to the arbitrator or to the other party during the arbitration process will be confidential. No disclosure of the award shall be made by the parties except as required by the law or as necessary or appropriate to effectuate the terms thereof. The location of the arbitration shall be in the City unless the parties mutually agree to another location. The dispute shall be governed by the laws of the State. Further, the prevailing party shall be entitled to recover all costs and expenses associated with arbitration, including reasonable attorneys' fees. If the arbitrator determines that neither party has substantively prevailed, the parties shall bear equally the fees and costs of the arbitrator and the related expense of arbitration. This section specifically survives the termination of this Agreement.

9.10 Third-Party Beneficiaries. This Agreement is entered into for the sole benefit of the parties. Nothing contained herein or in the parties' course of dealings shall be construed as conferring any third-party beneficiary status on any person or entity not a party to this Agreement.

9.11 Governing Law. This Agreement shall be governed by the laws of the State.

9.12 Compliance. Each party represents and warrants to the other that as of the date of this Agreement (i) neither it nor any of its officers, directors, or managing employees is excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) neither it nor any of its officers, directors, or managing employees has been convicted of a criminal offense related to the provision of federal health care items or services that could lead to debarment or exclusion. Each party acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the non-breaching party to immediately terminate this Agreement.

9.13 Non-Discrimination. Neither party shall discriminate against any person on the basis of race, color, national origin, disability or age in admission, treatment, program participation, services, activities or employment.

9.14 Promotion/Publication. Neither party shall use the name of the other party or the name of other party's parent company, subsidiaries, or affiliated facilities in any advertisement, press statement, or release, website, published customer list, or any publication or dissemination similar to the foregoing without receiving in advance the express written permission from the other party. Any request for permission should include the complete text of the publication, statement, or document in which the name usage will appear and be subject to edit by the other party.

[signatures appear on following page]

IN WITNESS WHEREOF, the parties hereto or their duly authorized representatives have executed this Agreement as of the dates set forth below.

Lourdes Hospital, LCC, d/b/a Lourdes Health		
By: Jerry Dooley		
Title: Chief Executive Officer		
Date: 8/18/2022		
Address: 520 N 4th Avenue		
City (the "City"): Pasco	State (the "State"): WA	Zip Code: 99301
Copy to: 330 Seven Springs Way Brentwood, TN 37027 Attention: Chief Legal Officer		

Apex Spine Insitute, LLC, d/b/a Apex Spine ASC		
By: Alex Linde		
Title: Chief Executive Officer		
Date: 08/17/2022		
Address: 821 Swift Blvd		
City: Richland	State: WA	Zip Code: 99352

Exhibit 5

ASC Equipment list

Operating Tables x 2

Blanket Warming Cabinet

Anesthetic Gas Monitor x 3

Anesthesia Cart

Airway Aspirator

Physiological Monitor x 4

Light Source x 2

Electrosurgical unit x 2

Anesthesia Delivery Unit x 1

Patient Warming Unit

Video Monitor x 2

Video Tower

Camera Control Unit

Video Printer

Arthroscopic Shaver System

Syringe Pump

Ultrasonic Surgical Aspirator

Sequential Compression Device

Autoclave Model 16

Autoclave Model 20c

Globus Excelsius Surgical Robot

Crash Cart

Procedure Cart x 2

Small Freezer American Biotech Supply

Surgical Table Steris AMSCO 3085 SP

Washer

Zimmer Intelicart Suction

X-Ray C-Arms x 2

C-Arm Montior x 2

Defibrillator

Zimmer Surgical Smoke Evacuator

Stryker Core 2 Power Console

ValleyLab Electrosurgical Generator

Wheelchairs

Walker

Pre/Post op chairs

Exhibit 6

AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

ACCREDITATION NOTIFICATION

September 22, 2022

Organization #			155864	**Program Type**	Ambulatory Surgery Center
Decision Recipient			Mr. Alex Linde, CMPE, MBA	**CCN**	
Organization Name			Apex Spine Institute PLLC dba Apex Spine ASC		
Address			985 Goethals Dr,		
City	**State**	**Zip**	Richland	WA	99352

Dear Apex Spine Institute PLLC dba Apex Spine ASC,

As an ambulatory surgery center (ASC) that has undergone the AAAHC/Medicare Deemed Status Survey, your ASC has demonstrated its compliance with the AAAHC Standards and all Medicare Conditions for Coverage (CfC).

Survey Date	8/31/2022-9/1/2022		
Type of Survey	EOS/ Initial Medicare Deemed Status Survey		
Acceptable PoC Received	9/19/2022	**Correction Method**	Self Attestation, Plan of Action, Document Review

Congratulations!

The AAAHC Accreditation Committee recommends your ASC for participation in the Medicare Deemed Status program. The Centers for Medicare and Medicaid Services (CMS) has the final authority to determine participation and effective dates in Medicare Deemed Status in accordance with the regulations at 42 CFR 489.13.

Accreditation Type	Full Accreditation	**Recommend Medicare Deemed Status**	Yes
Accreditation Term Begins	9/19/2022	**Accreditation Term Expires**	9/19/2025

Special CC: **CMS CO - Baltimore**
CMS RO X – Seattle

Accreditation Renewal Code: 4EC6E75E155864

Next Steps

1. Leadership and staff of your ASC should take time to thoroughly review your Survey Report and Plan of Correction (PoC).
   - Subsequent surveys by AAAHC will seek evidence that deficiencies from this survey were addressed within the timeframes of your PoC.

5250 Old Orchard Road, SUITE 200
Skokie, Illinois 60077
TEL (847) 853 6060
FAX (847) 853 9028
www.aaahc.org
info@aaahc.org

- The Summary Table provides an overview of compliance for each chapter applicable to your organization.

2. AAAHC requires **notification of any changes** within your organization in accordance with policies and procedures in the front section of the *Accreditation Handbook*. Visit the AAAHC website "I want to" section and select "Notify AAAHC of a change in my organization" and follow instructions.
3. AAAHC Standards, policies and procedures are reviewed and revised on an ongoing basis. You are invited to participate in the review through the periodic public comment process. Your organization will be notified when the proposed changes are available for review. You may also check the AAAHC website for details.
4. Accredited ASCs are required to maintain operations in compliance with the current AAAHC policies and Standards, which include the CMS Conditions for Coverage. Updates are published in the AAAHC *Handbooks*. Any mid-year updates are announced and posted to the AAAHC website, www.aaahc.org.
5. In order to ensure uninterrupted accreditation, your ASC should submit the *Application for Survey* approximately five months prior to the expiration of your term of accreditation. In states for which accreditation is mandated by law, the *Application* should be submitted six months in advance to ensure adequate time for review and scheduling the survey.
   NOTE: You will need the Accreditation Renewal Code found above to submit your renewal application.

Additional Information

Throughout your term of accreditation, AAAHC will communicate announcements via e-mail to the primary contact for your organization. Please be sure to notify us (notifywest@aaahc.org) should this individual or his/her contact information change.

If you have questions or comments about the accreditation process, please contact AAAHC Accreditation Services at 847.853.6060. We look forward to continuing to partner with you to deliver safe, high-quality health care.

Exhibit 7

APEX SPINE INSTITUTE

POLICIES AND PROCEDURES

Operations – Administration

Policy#	Policy
GA021	Patient Rights
Effective Date: 5/1/22	Revision Date:

Policy: To assure that each patient/family or responsible party is informed of his/her rights regarding care and treatment, and to provide a mechanism for patients to present requests, complaints, and ethical issues for consideration. On admission, each patient/family/responsible party will receive a copy of the "Patient's Rights and Responsibilities" document.

Purpose: It is our goal to recognize and respect each patient in the provision of care, treatment, and services in accordance with fundamental human, civil, constitutional, and statutory rights to improve patient outcomes. We believe the staff must function as patient advocates and participate in problem identification and resolution to ensure a high level of quality care. All business relationships with patients and the public are conducted in an ethical manner.

Each patient has the right to receive quality care regardless of disability, race, creed, color, sex, national origin, or age on admission, treatment, or participation in its programs, services, and activities, or in employment. The respect of the individual and dignity of each patient is reflected in the Patient's Right's document which includes participation in decisions regarding his/her care. We encourage the involvement of family/patient representative in all aspects of patient care through communication and education.

Procedure Guidelines:

1. Every patient/family/responsible party will be given a copy of the Patient's Bill of Rights and Responsibilities document upon registration.

2. If the patient/family/responsible party is unable to understand the document, verbal explanation will be given until there is knowledge that the document is understood, or the document will be provided in an understandable language. Alternative communication methods may be used when communicating the patient rights, the facility determines which method is best for each patient.

3. The patient/family/responsible party will sign a statement stating that they have received the information, and this will become part of the medical record.

4. The Patient Bill of Rights will be posted in the Facility Admitting Lobby.

5. The facility respects the rights and privacy of patients in all interactions.

6. The facility discloses in writing financial interest or ownership in the Facility and, when applicable, provide a list of physicians who have financial interest or ownership in the Facility.

Reference:

AAAHC Accreditation Handbook for Ambulatory Health Care 2012
CMS Conditions of Overage, State Operations Manual, *Rev. 76, 12-22-11*

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Receive notice of their rights prior to the surgical procedure in verbal and written notice in a language and manner that ensures the patient, or the patient's representative*, or the patient's surrogate* understand *all of the patient's rights.*
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for afterhours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or patient's surrogate other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions including refusal of treatment or not following the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.
If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES
Be considerate of other patients and personnel and for assisting in the control of noise, eating and other distractions.
Respecting the property of others and the facility.
Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
Providing care givers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition, or any other patient health matters.
Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeit of care at the facility.
Promptly fulfilling his or her financial obligations to the facility.
Identifying any patient safety concerns.

ADVANCE DIRECTIVE NOTIFICATION

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Apex Spine ASC respects and upholds those rights.

Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. We respect your rights to participate in make decisions regarding your care and self determination and will carefully consider your requests. After careful consideration and reviewing the applicable state regulation, the leadership of the facility has established a policy to initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. The majority of procedures performed at Apex Spine ASC are considered to be of minimal risk, hence the risk of you needing such measures are highly unlikely. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

You have the option of proceeding with care at our facility or having the procedure at another location that may not set the same limitations. Having been fully informed of our Statement of Limitations, you choose to proceed with your procedure at Apex Spine ASC

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility Administrator by phone at **509-940-9247** or by mail at:

Alex Linde, CEO
Apex Spine Institute
821 Swift Blvd
Richland, WA 99352

Complaints and grievances may also be filed through:

Washington State Department of Health

HSQA Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
Toll Free: 800-633-6828
Fax: 360-236-2626
Email: mailto:HSQAComplaintIntake@doh.wa.gov

Center for Medicare and Medicaid Services (CMS)

Office of the Medicare Beneficiary Ombudsman:

http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html Medicare Help and Support: 1-800-MEDICARE

APEX SPINE INSTITUTE

POLICIES AND PROCEDURES

Operations - Clinical

Policy#	Policy
PR005	Admission of Patient to Pre-op
Effective Date: 5/1/2022	Revision Date:

ADMISSION OF PATIENT TO PRE-OP

Policy:
The nurse is responsible for ensuring the preparation of the patient is complete. This includes physical and psychosocial needs.

Purpose:
To safely admit the patient to the Preoperative area.

Procedure Guidelines:

The nurse will assess the following:
- Identification of the patient using two different identifiers including bracelet using patient's name and date of birth
- Availability of responsible adult companion to drive patient home and watch next 24 hours.
- NPO status
- Educational needs / Language
- Emotional needs
- Informed consent
- Site validation
- Procedural validation
- Medications taken
- Allergies
- Current level of discomfort
- Current level of wellness
- Vital signs
- Special needs
- Presence and disposition of jewelry, contact lenses, dentures, other prosthetics

Physical preparation:
- Patient will remove personal attire and don facility gown, hair cover, and non-slip booties
- Patient will void if possible
- Jewelry will be removed, including all body piercing
- Contact lenses will be removed, unless otherwise ordered by anesthesia
- Intravenous access will be obtained as indicated for most cases.
- Baseline vitals will be obtained
- Site validation by the patient will be obtained, marked by physician, and Wrong Site Prevention

APEX SPINE INSTITUTE

POLICIES AND PROCEDURES

Operations - Administration

Policy#	Policy
GA041	Charity Care for Patients
Effective Date: 5/1/2022	Revision Date: 02/13/2024

Policy:

It is the desire of Apex Spine Instiute (ASC) to provide financial assistance or charity care to those patients in need of such assistance. The ASC considers each patient's ability to pay for his or her medical care, and is committed to treating patients who have financial needs with the same dignity and consideration that is extended to all of its patients. The ASC intends, with this policy, to establish financial assistance procedures that are compliant with applicable federal, state and local laws.

This policy shall cover health care services provided by the ASC and does not include physician, anesthesia services and other services provided by outside vendors. The ASC has established procedures to aid and assist those patients who have demonstrated financial hardship and cannot meet the costs of the healthcare services they receive at the ASC. The ASC may assist patients in receiving available resources for payment of their services. When such resources are not available, patients will be evaluated for voluntary Charity Care.

Definitions:

Charity Care: The ability to receive free care. It refers to the inability of a patient to pay for medical care. In comparison, bad debt is an unwillingness of a patient to pay for medical care. Charity Care is designed to assist those patients who are unable to pay for all, or part, of their health care expenses. Charity Care is not designed to assist those who are able, yet unwilling, to pay. The patient's willingness to discuss his/her account and disclose pertinent financial information is often relied upon to make the distinction between inability and unwillingness to pay.
Financial Assistance: The ability to receive care at a discounted rate.
Uninsured Patient: An individual who does not have any third-party health care coverage by (a) a third party insurer, (b) an ERISA plan, (c) a Federal Health Care Program (including, without limitation, Medicare, Medicaid, SCHIP and Tricare), (d) Worker's Compensation, Medical Savings Accounts or other coverage for all or any part of the bill, including claims against third parties covered by insurance to which the ASC is subrogated, but only if payment is actually made by such insurance company.
Federal Health Care Program: Any health care program operated or financed at least in part by the federal, state or local government.

Procedure:

1. Eligibility
    a. The Charity Care Policy was established to provide financial relief to those who are unable to meet their financial obligation to the ASC. It applies to any person with the inability to pay all or part of their financial responsibility to the ASC for the ASC's provided services. Patients who are receiving elective cosmetic or plastic surgery are not eligible.

b. Charity Care applies to charges for traditional, non-elective healthcare services to patients meeting the financial criteria set by the ASC using the Federal Poverty Income Guidelines found at https://aspe.hhs.gov/poverty-guidelines.
c. Patients who are uninsured for the relevant service and who are ineligible for governmental or other insurance coverage, and who have family incomes in excess of 200%, but not exceeding 500%, of the Federal Poverty Level, will be eligible to receive Financial Assistance in the form of a partial discount of charge related to procedure and professional fees.

2. Eligibility Determination
   a. The determination of Charity Care eligibility and approval of Charity Care is completed prior to rendering services.
   b. Once a patient is identified as uninsured, the ASC personnel shall give the patient the ASC Charity Care and Financial Assistance Application. The Uninsured Patient must complete the Application for Financial Assistance. Some or all of the following documentation will be required at the time of application: 1. Medical Assistance eligibility /denial notice if applicable.
      i. Income Tax returns for the most recently filed year.
      ii. Proof of income and Adjusted Gross Income such as
         1. Pay stubs from the past six (6) pay periods.
         2. W-2 withholding statement.
         3. Social Security checks, receipts or deposits.
         4. Bank statements – checking and savings.
         5. Any other documentation that may secure as proof of Charity Care or Financial Assistance eligibility.
   c. The financial resources of a parent or guardian may be considered in determining the eligibility of a patient who is dependent on their parents or guardian for financial support.
3. Participation
   a. A competed ASC Charity Care and Financial Assistance Application will be forwarded to the Business Office Manager. When the application for Charity Care is received, the staff will review and determine if the application is complete and whether the documentation supports Charity Care or Financial Assistance eligibility.
   b. Patients extended Financial Assistance in the form of a partial discount must sign a written agreement to pay the amount of the charges remaining after deducting the discount. The patient will receive a bill showing charges, the amount of the discount and the amount due. Physician/Professional, Anesthesia Services and other services provided by outside vendors are not covered by this policy and patients seeking discount for such services should be directed to call the physician or outside vendor directly.
   c. Patients who do not provide the requested information necessary to completely and accurately assess their financial situation and/or who do not cooperate with efforts to secure governmental health care coverage will not be eligible for Charity Care or Financial Assistance. However, in normal circumstances, such cooperation should not be a precondition to the receipt of medically necessary treatment, especially in emergency care.
   d. Applications outside of these guidelines may be approved based upon extraordinary circumstances with the documented approval of the Administrator.
4. Exceptions
   a. It is recognized that there is a small percentage of the uninsured patient population that has substantial assets and could easily afford to pay for health care services, but because

of having tax-exempt income or otherwise, will not have income reflected on a tax return. This policy is not intended to apply to this portion of the uninsured population.

5. Miscellaneous
    a. Confidentiality: Confidentiality of information and preservation of individual dignity will be maintained for all applying for Charity Care. No information obtained in the patient's Application for Charity Care may be released unless the patient gives express permission.
    b. Physician Participation: Physician participation in providing care to charity cases will be strongly encouraged. the ASC will encourage and support staff physicians to provide a certain level of Charity Care for patients that the physician sees at the hospital.
    c. Additional Requestors: Charity care requests may be submitted by persons other than the patient, such as the patient's family, physician, clergy, social worker or hospital personnel. The patient shall be informed of such a request.
    d. Alternative Handling of Charges: Upon denial of a patient's Charity Care application, the ASC administration may consider other alternatives for patient's medical care. Such alternatives may include:
        i. A reduction in the fees charged
        ii. Whole or partial write-off of the patient's account
        iii. Reasonable payment terms for the patient
        iv. Elimination of interest charged on periodic payment

Checklist will be completed
- As required by the physician, the site may be clipped and washed with antimicrobial solution
- Procedural validation
- Medications will be administered if ordered

Psychosocial preparation: the teaching plan will be tailored to the patient's age, physical, mental condition, attitude to surgery, personal traits, past experiences, education, gender, cultural, and religious orientation, and language preference.
Include an overview of the following:
- Preparation
- Approximate length of time in each phase
- Environmental conditions, sights, sounds, equipment
- Opportunity for questions and concerns
- Management of post-operative pain and nausea
- Deep breathing exercises
- Visiting policy
- Discharge criteria, planning
- Discharge instructions

Medical Record
The nurse will document all pertinent information according to facility policy.

Reference: Joint Commission ASC Manual 2014 edition PC.01.02.03.
AAAHC Accreditation Handbook 2014.
CMS §416.52 (a)

Charity Care and Financial Assistance Application Instructions

This is an application for financial assistance (also known as charity care) at Apex Spine Institute.

You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. *Policy GA041 Charity Care for Patients*

What does financial assistance cover? The surgery center financial assistance covers appropriate ASC-based services provided by Apex Spine Institute depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by others.

If you have questions or need help completing this application: Contact the billing office at 509-606-5040. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Attach additional information if needed**
- o **Sign and date the form**

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Submit your completed application in person: Apex Spine Institute
Attn: Business Office Manager
821 Swift Blvd
Richland, WA 99352
(509) 606-5040

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Apex Spine Institute

Charity Care and Financial Assistance Application - confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □**No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____ \	Birth Date		Patient Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Mailing Address City State Zip Code			Main contact number(s) ( ) ( ) Email Address:

Employment status of person responsible for paying bill

o **Employed** (date of hire: _____ } □ **Unemployed** (how long unemployed: }

□ **Self-Employed** o **Student** □ **Disabled** □ **Retired** o **Other** (}

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes/ No
					Yes/ No
					Yes/ No
					Yes/ No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - **SSI** - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other *(please explain* }

Apex Spine Institute

Charity Care/Financial Assistance Application Form - confidential

INCOME INFORMATION

REMEMBER: *You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation. you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (3 *months);* or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $._____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $._____ *(child support, loans, medications, other)*

ASSET INFORMATION

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current checking account balance

$_____

Current savings account balance

$_____

Does your family have these other assets?

Please check all that apply

□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)

□ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income, or persona loss

PATIENT AGREEMENT

I understand that Apex Spine Institute may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false or misleading, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date

Exhibit 8

Benton and Franklin Counties

Community Health Improvement Plan

2023-2025

CHNACHIP
BENTON & FRANKLIN COUNTIES

TABLE OF CONTENTS

CHIP STEERING COMMITTEE

Karen Hayes, MA
Community Health Investment Manager
Kadlec Regional Medical Center

Carla Prock, RN, BSN
Senior Manager
Healthy People & Communities
Benton-Franklin Health District

Kelly Harnish, MPH, MCHES
Healthy Living Program Manager
Benton-Franklin Health District

Kirk Williamson
Program Manager
Benton-Franklin Community Health Alliance

Honor Crawford
Community Health Improvement Plan Coordinator
Benton-Franklin Health District

Patrick Jones, PhD
Executive Director of Public Policy & Economic Analysis
Eastern Washington University

Pernell Hodges
Lead Epidemiologist
Benton-Franklin Health District

Emily Volland
Director of Communications
Kadlec Regional Medical Center/Providence

Hazel Kwak, MPH-Epi, BHSc, NCMA
Epidemiologist
Benton-Franklin Health District

Sean Domagalski, RN, BSN, MHA
Performance Management Manager
Benton-Franklin Health District

Amanda Mason
Communications & Public Affairs Manager & PIO
Benton-Franklin Health District

Kristi Mellema, BSN, RN
Chief Quality and Compliance Officer
Prosser Memorial Health

LETTER TO OUR COMMUNITY

To the Residents of Benton and Franklin counties,

We all seek certain standards of living in the community we call home. The vision of a great community may vary between individuals, yet we all have basic needs that, when met, make our community livable, safe, and thriving. Healthcare is one aspect of what helps communities thrive. However, we know from our research and conversations with residents that the health of our community relies on so much more, including safe and quality childcare, gainful employment opportunities, affordable and sufficient housing, clean air and water, supportive social networks, optimal mental health, and more.

We are fortunate to live in a community where health and service professionals are dedicated to maintaining what works well. However, gaps and disparities in the quality of life for Benton and Franklin county residents remain.

We are pleased to share the 2023 Benton and Franklin counties Community Health Improvement Plan (CHIP), produced by the Benton-Franklin Health District.

The CHIP establishes the groundwork for addressing some of the most pressing public health challenges facing our bi-county region to foster more equitable health outcomes and well-being for all residents in our community.

Local government and community leaders, partners, and members with lived experiences came together to inform this CHIP. A steering committee dedicated to the CHIP process was formed and reviewed community data from the 2022 Benton and Franklin counties Community Health Needs Assessment (CHNA).

The input from the CHNA informed the development of the four CHIP priorities:

- Housing & Homelessness
- Behavioral Health
- Access to Health
- Community Partnership Development

Within this CHIP, you will see how those four priorities are broken down into specific goals, objectives, and strategies. We understand that addressing these priorities takes considerable time, resources, and commitment. Through the power of collective impact, our steering committee and partner agencies have the opportunity to embrace actionable, long-term strategies that will facilitate the development of a vibrant and flourishing community.

You are invited to join us and engage in being part of the solutions. Please reach out to Honor Crawford for opportunities to contribute to these important community initiatives.

Best regards,

The 2023 CHIP Steering Committee

BACKGROUND

Health is variable between individuals and across populations. Optimal health and well-being are impacted by factors beyond genetics and individual traits, choices, and behaviors. The social determinants of health (SDoH) are the conditions in which people are born, grow, live, work, and age, which have a significant impact on their health outcomes. These determinants are influenced by factors such as economic, social, cultural, and environmental conditions. Some examples of social determinants of health include:

1. **Economic status:** Income and employment play a role in determining health outcomes. People who are unemployed, low-income, or live in poverty are at higher risk of poor health outcomes.
2. **Social and community context:** Social support networks can impact an individual's health outcomes, as people who have supportive relationships are less likely to experience stress and have better access to resources that promote health and well-being.
3. **Environmental conditions:** Environmental factors, such as access to clean water and air, safe housing, healthy neighborhood design, and access to healthy food and spaces that encourage physical activity, have a significant impact on health outcomes.
4. **Quality education:** Higher education levels may impact socioeconomic status, knowledge, skills, and access to resources. Individuals with higher levels of education are more likely to live longer, healthier lives.
5. **Access to healthcare:** Access to quality, culturally appropriate healthcare services, including preventive services and treatment for illnesses, may enable individuals to achieve improved health outcomes, quality of life, and productivity.

These social determinants of health are interdependent and can create a cycle of disadvantage that contributes to health disparities and inequities. Therefore, it is essential to break the cycle and address the social determinants of health impacting our community.

Community Health Improvement Process

The Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH) are dedicated to promoting fair and just opportunities for all members of our community to achieve good health and well-being.

Evidence of this commitment is demonstrated through their involvement throughout this community health improvement process which provides the framework for assessment, action planning and assurance to promote and protect the health of all people in Benton and Franklin counties.

The community health improvement process involves collaboration among community members, healthcare providers, public health, and other partners to address the complex and interconnected factors that influence community health.

Partnerships between the local public health system and sectors like education, transportation, and housing are essential to improve the broader environmental conditions that impact health. When our community is aware of and prepared for pressing priorities, we stand to promote more effective programming, avoid duplicative efforts, and bolster a more coordinated response to address larger problems.

The Benton-Franklin Health District, in collaboration with the Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH) collaborated in this community health improvement process that yielded two distinct yet connected phases:

1. Community Health Needs Assessment (CHNA)

The initial phase of the community health improvement process is a Community Health Needs Assessment (CHNA). The CHNA helps determine which critical health needs the community will focus on over the next three years. It is a systematic process for collecting community data to identify and analyze community needs and assets throughout Benton and Franklin counties.

2. Community Health Improvement Plan (CHIP)

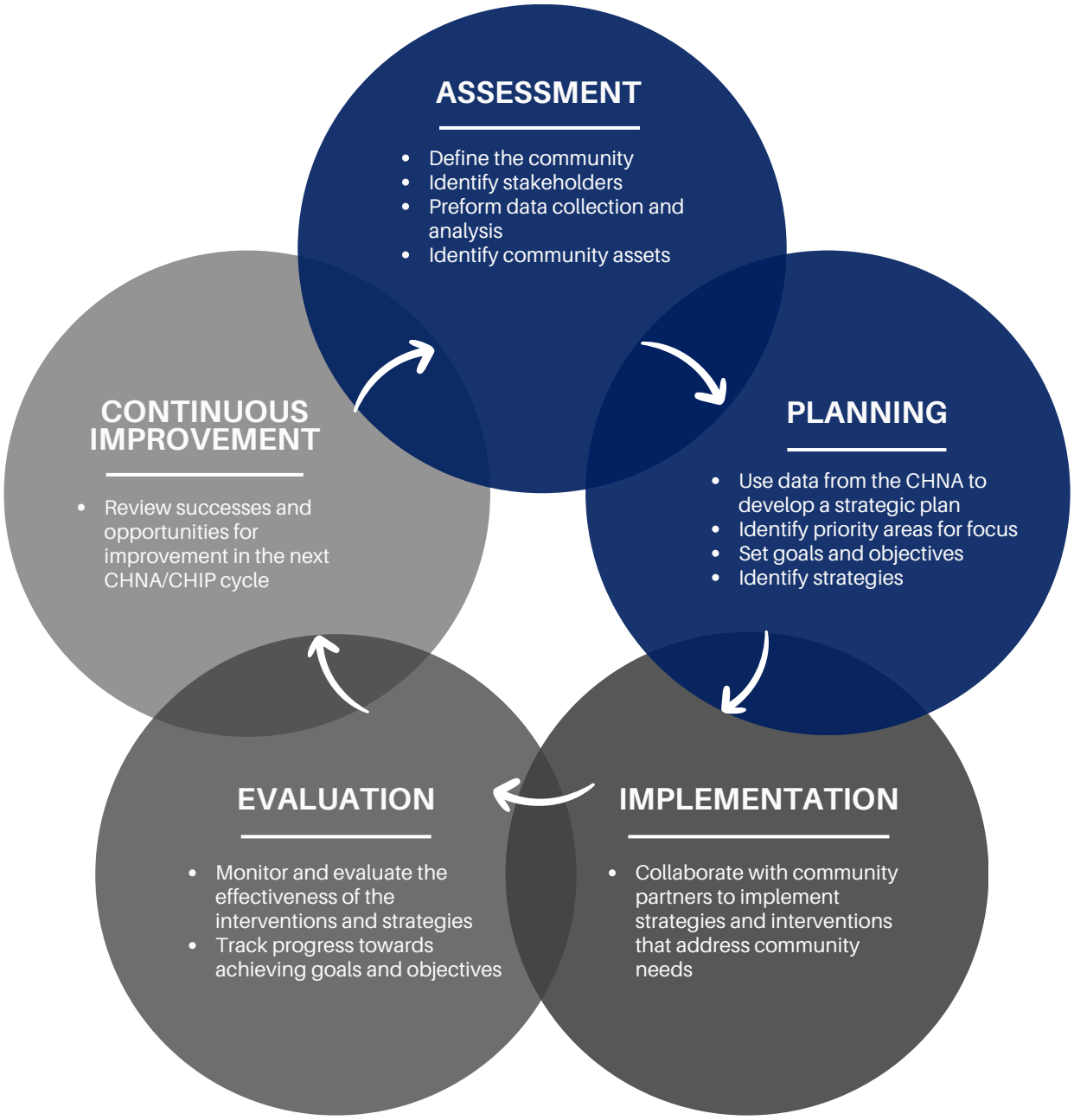
The second phase is the Community Health Improvement Plan (CHIP). The CHIP outlines what community partners, agencies, and the local public health system plan to do about the greatest needs of the community as identified in the CHNA. In other words, the CHIP serves as a roadmap or action plan that community partners interested in and working to improve the health of Benton and Franklin County residents may use to identify local health issues, set priorities, leverage resources, and coordinate efforts.

The goal of these efforts is to improve the health of people living within Benton and Franklin counties by aligning public health-related services, programs, and policies throughout the counties to meet the genuine needs of residents.

PROCESS OVERVIEW

The community health improvement process is a strategic and collaborative approach to identify and address the health needs and concerns of our community and develop a plan of action.

Steps in the Community Health Improvement Process



- Community Health Needs Assessment
- Community Health Improvement Plan

DEMOGRAPHICS

Benton and Franklin counties are situated in south-central Washington near the confluence of the Columbia, Snake, and Yakima rivers. The two counties have a combined population of approximately 312,050 people. The cities of Pasco, Kennewick, and Richland largely define the area and are colloquially referred to as the Tri-Cities. The Tri-Cities represent Washington's third-largest metropolitan area and continue to experience rapid growth. Other principal cities in Benton County are Benton City, Prosser, West Richland, and Finley. Within Franklin County, there are several smaller yet essential cities which include Basin City, Connell, Eltopia, Kahlotus, and Mesa.

The population estimates for the cities and towns within Benton and Franklin counties in 2022:

- Benton City: 3,710
- Connell: 4,840
- Kahlotus: 145
- Kennewick: 85,320
- Mesa: 390
- Pasco: 80,180
- Prosser: 6,195
- Richland: 62,220
- West Richland: 17,410

In 2020, Benton County had a larger proportion of residents 45 years and older (41.53%) compared to Franklin County (31.02%).

Table 1. Benton and Franklin Counties Population by Age

Indicator Age Distribution	Benton County	Franklin County
<1 year	1.27%	1.62%
1-14 years old	20.26%	24.95%
15-24 years old	12.72%	15.37%
25-44 years old	24.40%	27.05%
45-64 years old	24.82%	20.74%
65+ years old	16.53%	10.28%

The two largest ethnic groups in Benton and Franklin County are White (Non-Hispanic) and Hispanic. Other racial and ethnic groups include American Indian and Alaska Native, Asian, Multiracial, Black, and Native Hawaiian or Pacific Islander. These groups make up less than 10% of the population composition by race and ethnicity in both counties.

Benton County had a median household income of $72,847 with 10.2% of residents living below the federal poverty line compared to Franklin County's median household income of $63,575 and 14.2% of residents living below the federal poverty line.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

PURPOSE:

The precursor and foundation for the 2023 CHIP was the 2022 Community Health Needs Assessment (CHNA). Again, the CHNA provided data to suggest which significant health needs the community should focus on over the next three years.

Methods:

The CHNA steering committee began meeting weekly in January 2022. The committee included representatives of Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH). Additionally, Providence Community Health Investment staff provided technical assistance and qualitative data analysis.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach.

Quantitative data sources:

- Benton and Franklin counties community survey
- Behavioral Risk Factor Surveillance System (BRFSS)
- Community Health Assessment Tool (CHAT)
- Healthy Youth Survey (HYS)
- Centers for Disease Control and Prevention (CDC),
- Child Care Aware of America
- County Health Rankings and Roadmaps
- Washington State Department of Children
- Youth & Families (WA DCYF)
- Washington Statistical Analysis Center (WA SAC)
- Washington Association of Sheriffs and Police Chiefs (WASPC)
- Washington Tracking Network (WTN)

Quantitative data is presented through a life course perspective.

Qualitative data sources:

- 21 interviews with working and community partners
- 10 listening sessions
- 2 behavioral health forums,
- 2 housing and homelessness forums
- 2 general forums.

It is important to note pandemic-related challenges may have impacted data collection and caused certain data limitations and information gaps.

Results:

The full results of the CHNA can be found at: 2022 Community Health Needs Assessment-Benton and Franklin counties

CHIP STRUCTURE

The Community Health Improvement Plan (CHIP) is designed with a broad to narrow focus. The broadest components are the priority areas which constitute the principal areas of focus for Benton and Franklin counties. Then, goals are crafted as a broad statement of the desired accomplishment related to a priority area. As the scope becomes narrower, objectives are developed to describe specific, measurable end-products toward the goals. Finally, at the strategy level, action-oriented interventions, programs, and services are designed to fulfill the goals and objectives.

Structure of Implementation Plan

CHIP PROCESS

Prioritization Process and Criteria

Priority Area Selection

The CHNA-CHIP Steering Committee analyzed the results of the 2022 Benton-Franklin Community Health Needs Assessment, and selected the top priority areas using the following criteria as a guideline for selection:

Relevance

- Magnitude, severity, and evidence of worsening trends over time; community concern; community rates worse than the state average

Appropriateness

- Public attitudes and values; human rights considerations; disproportionate impact on low-income and/or Black, Indigenous, and People of Color (BIPOC) communities

Impact

- Opportunity to build on or impact existing efforts

Feasibility

- Community and resource capacity to foster change; political will; socio-cultural considerations

After evaluating the data and applying the selection criteria the following emerged as priority areas:

- **Behavioral Health**
- **Access to Health**
- **Housing and Homelessness**
- **Community Partnership Development**

Next, a subcommittee of the CHNA-CHIP steering committee developed data-driven goals and measurable objectives to inform this report.

Strategy Development

Once the priority areas, goals, and objectives were established, the CHNA-CHIP Steering Committee began the process of developing and identifying efforts designed to fulfill the stated goals and objectives.

Meetings were conducted with a wide array of community partners and vested coalitions and asked the following questions:

- What currently exists to meet the 2023 CHIP priorities and goals?
- Where do gaps and opportunities exist for future efforts to address?
- What initiatives go beyond the individual level of intervention and address policy, organizational or environmental levels of change?

Benton-Franklin Health District staff narrowed down identified strategies by evaluating the following considerations:

- Does it address health equity?
- Do the proposed strategies address the social determinants of health (SDoH)?
- Does the strategy have evidence for effectiveness?
- Is there sufficient capacity for change (e.g. existing resources, assets)?
- Will this strategy be a good fit for our community?
- Does the strategy affect change on multiple levels of the Social Ecological Model of Health?
- Do the proposed strategies fill current gaps?

PRIORITY AREAS

Improving community health and quality of life requires a diverse set of strategies that suit the specific needs of our community. The following section lists proposed community health improvement strategies, including initiatives to address the identified needs in the CHNA.

However, it's important to recognize that these strategies are neither exhaustive nor mutually exclusive, and additional strategies may be added, or existing strategies changed to adapt to changes in resources or opportunities. Additionally, there may be overlap between the strategies for each priority area. For example, many of the strategies listed in Housing and Homelessness are also relevant to Access to Health. The CHNA-CHIP Steering Committee considered the most appropriate placement for strategies that aligned with other work within priority areas.

Addressing complex population health challenges often requires a multi-faceted approach, and successful community health improvement efforts require ongoing collaboration and commitment to tackle the needs of our community.

This CHIP is detailed in a comprehensive work plan, which describes the strategies, tactics, and collaborators for these efforts and will be tracked in a performance management system. This will allow both internal and external stakeholders to access real-time data, feedback and reports on the status of CHIP goals and objectives throughout the CHIP cycle.

PRIORITY AREAS

AREA ONE
HOUSING AND HOMELESSNESS

AREA TWO
BEHAVIORAL HEALTH

AREA FOUR
COMMUNITY PARTNERSHIP DEVELOPMENT

AREA THREE
ACCESS TO HEALTH

Housing and Homelessness

Data from the 2022 CHNA indicated a low supply of affordable housing, a low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Additionally, the housing supply in Benton and Franklin counties has not been keeping up with population growth and demand.

Regarding homelessness, the assessment indicated a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. The Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, and a lack of low-barrier solutions to homelessness. For these reasons, the CHNA-CHIP Steering Committee identified housing and homelessness as priorities.

Goal 1: Benton and Franklin counties have robust and coordinated community support networks to meet housing and homeless needs.

Objective 1.1: Improve resource awareness among community partners and those experiencing or at risk of experiencing homelessness.

- **Strategy 1.1.1:** Identify and promote community resource hubs in Benton-Franklin Counties such as the Kadlec Community Resource Desk, 2-1-1, and the Youth Access and Resource Program (YARP) resource page.
- **Strategy 1.1.2**: Advocate for services and support for community members experiencing or at risk for homelessness such as Homeroom Connect to build relationships between community partners and those experiencing homelessness.

Objective 1.2: Increase services for people experiencing or at risk of experiencing homelessness.

- **Strategy 1.2.1:** Identify isolation and quarantine facilities for the unhoused population in the event of communicable disease outbreaks.
- **Strategy 1.2.2:** Identify and advocate for services to fill gaps for community members experiencing homelessness.

Objective 1.3: Improve data sharing and coordination among community partners serving the population.

- **Strategy 1.3.1:** Identify options, such as Built 4 Zero, to connect housing and homelessness resources and improve data tracking.
- **Strategy 1.3.2:** Develop data dashboards with housing and homelessness metrics.
- **Strategy 1.3.3:** Coordinate with key partners to streamline data-sharing processes.

Objective 1.4: Expand partnerships in Benton and Franklin counties collaborating to address housing and homeless needs.

- **Strategy 1.4.1:** Establish a Housing and Homelessness Coalition.
- **Strategy 1.4.2:** Define and advocate for best-practice anti-displacement housing policies.
- **Strategy 1.4.3:** Develop a toolkit of best practices to promote a regional effort around affordable housing policies and building codes.
- **Strategy 1.4.4:** Advocate for cross-county and cross-municipality collaboration to work towards regional approaches, including rural areas.

Goal 2: Affordable housing is available and accessible to all in our communities.

Objective 2.1: Improve awareness of barriers and successes to zoning and building codes related to affordable housing.

- **Strategy 2.1.1:** Hold community forums on affordable housing.
- **Strategy 2.1.2:** Promote awareness of civic engagement opportunities.
- **Strategy 2.1.3:** Advocate for city zoning to permit low-income housing near basic amenities and needs.

Objective 2.2: Increase support for the establishment of low-barrier, immediate housing opportunities for people experiencing homelessness.

- **Strategy 2.2.1:** Advocate for low-barrier housing located near substance-use recovery facilities.
- **Strategy 2.2.2:** Advocate for reducing or eliminating qualification barriers for people seeking immediate housing.
- **Strategy 2.2.3:** Improve public perception of housing and homelessness issues.

Goal 3: Safe and adequate housing is seen as a basic right for all ages and is embraced by our community.

Objectives 3.1: Increase awareness of the importance of healthy community design.

- **Strategy 3.1.1:** Hire and train staff to perform State Environmental Policy Act (SEPA) plan reviews and provide feedback to local partners.
- **Strategy 3.1.2:** Evaluate new and existing community development policies, zoning, and building codes for effectiveness or gaps in addressing public health issues.
- **Strategy 3.1.3:** Educate policymakers, developers, and other stakeholders on the benefits of healthy community design.

Objective 3.2: Increase the ability of aging adults to safely age in place.

- **Strategy 3.2.1:** Advocate for rent stabilization to support aging in place.
- **Strategy 3.2.2:** Conduct home safety evaluations to identify and meet needs.
- **Strategy 3.2.3:** Promote programs that support mobility and balance improvement.
- **Strategy 3.2.4:** Promote awareness of and access to programs that provide medical equipment and support resources to improve the ability to age in place.

Objective 3.3: Enhance coordinated, community-wide plans for adaptation to climate effects, such as extreme weather.

- **Strategy 3.3.1:** Promote awareness of the public health impact of climate effects such as wildfire smoke and extreme weather events.
- **Strategy 3.3.2:** Support community partners in the provision and awareness of protection from wildfire smoke and extreme weather events, or emerging public health risks.
- **Strategy 3.3.3:** Identify regional climate priorities and develop recommendations for regional climate action.
- **Strategy 3.3.4:** Perform hazard evaluation and identify community members at risk for adverse effects during emergency events.
- **Strategy 3.3.5:** Survey at-risk populations to identify barriers to communication during emergencies.
- **Strategy 3.3.6:** Develop a method to alert vulnerable individuals quickly in emergency events.

Objective 3.4: Establish a policy analysis process related to environmental public health.

- **Strategy 3.4.1:** Identify regional environmental planning and policy priorities.
- **Strategy 3.4.2:** Create a library of model policies to inform community planning efforts on environmental public health best practices.
- **Strategy 3.4.3:** Evaluate new and existing community development policies for effectiveness or gaps in addressing public health issues and evaluate new policies for public health impacts.

Behavioral Health

Data from the CHNA highlighted significant needs for behavioral health response and prevention. With behavioral health workforce shortages, an increase in need, and the benefit of having existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

Goal 1: Benton and Franklin counties have robust and coordinated behavioral health resources.

Objective 1.1: Reduce workforce-related barriers to accessing behavioral health services in Benton and Franklin counties.

- **Strategy 1.1.1:** Advocate for increased opportunities for clinical training.
- **Strategy 1.1.2:** Advocate for policies that improve reimbursement for behavioral health services.
- **Strategy 1.1.3:** Advocate for team-based, integrated care.
- **Strategy 1.1.4:** Educate youth and individuals seeking a career change on opportunities for employment in behavioral health.

Objective 1.2: Improve access to crisis support and recovery services.

- **Strategy 1.2.1:** Advocate for increased quantity and better access to crisis and recovery services.
- **Strategy 1.2.2:** Establish a crisis and recovery center.
- **Strategy 1.2.3:** Establish community supports for individuals and families experiencing substance use disorders, mental illness, or crisis.

Objective 1.3: Enhance understanding of disparities and inequities impacting populations most susceptible to behavioral health challenges.

- **Strategy 1.3.1:** Create a disparities report including data to better understand disparities or racial inequities related to behavioral health.
- **Strategy 1.3.2:** Advocate for broadened access to behavioral health services for Medicaid recipients.
- **Strategy 1.3.3:** Maintain the Benton-Franklin Health District overdose data dashboard.

Goal 2: Our community has access to and awareness of resources and initiatives that promote prevention and resilience.

Objective 2.1: Improve outcomes for pregnant people with substance use disorder and their newborns.

- **Strategy 2.1.1:** Establish a Perinatal Collaborative
- **Strategy 2.1.2:** Maintain and enhance the Benton-Franklin Health District maternal child health data dashboard.
- **Strategy 2.1.3:** Improve access to substance use means restriction and disposal options.

Objective 2.2: Increase the use of positive community norms to reduce stigma and implicit bias, influence language, and increase community support for behavioral health systems.

- **Strategy 2.2.1:** Support partners delivering positive community norms campaigns, programs, and training throughout the community.

Objective 2.3: Increase community awareness of resources.

- **Strategy 2.3.1:** Develop surveys to capture resource awareness.
- **Strategy 2.3.2:** Promote community resources relating to behavioral health.

Objective 2.4: Increase family, school, and community connections.

- **Strategy 2.4.1:** Hold a symposium on the state of the youth in Benton and Franklin counties.
- **Strategy 2.4.2:** Identify programs and policies to address needs raised in the "State of our Youth" symposium.
- **Strategy 2.4.3:** Community partners provide education and prevention practices for families with youth.
- **Strategy 2.4.4:** Support community-building events that combat social isolation and develop a sense of belonging and connectedness.
- **Strategy 2.4.5:** Advocate for increased access to behavioral health specialists in school settings.

Access to Health

The CHNA identified a need for increased access to healthcare as well as community supports that enable health and well-being. This priority, Access to Health, aims to address healthcare-specific needs such as provider-to-patient ratios, along with the broader social determinants of health such as access to safe and nutritious food; safe water for drinking and recreation; transportation; education and employment including safe, licensed, and affordable childcare; and resource awareness.

Goal 1: Individuals and families have access to comprehensive, high-quality health care services in Benton and Franklin counties.

Objective 1.1: Improve dental health access for those on Medicaid and the uninsured or underinsured.

- **Strategy 1.1.1:** Capture and monitor data on dental services for targeted intervention opportunities.
- **Strategy 1.1.2:** Promote awareness of providers who accept Medicaid or provide low-cost or free dental care services in our community.
- **Strategy 1.1.3:** Support an Oral Health Summit: Oral Health Access event.
- **Strategy 1.1.4:** Advocate for Medicaid to accept full mouth disinfection and other care strategies.
- **Strategy 1.1.5:** Promote stronger partnerships between dental providers and schools.

Objective 1.2: Reduce workforce-related barriers to accessing healthcare services in Benton and Franklin counties.

- **Strategy 1.2.1:** Advocate for policies that improve reimbursement for healthcare services.
- **Strategy 1.2.2:** Advocate for increased opportunities for clinical training.
- **Strategy 1.2.3:** Advocate for team-based integrated care.
- **Strategy 1.2.4:** Advocate for lifting the cap on Medicaid residency positions.
- **Strategy 1.2.5:** Support workforce recruitment efforts by promoting regional quality-of-life marketing for healthcare professionals.
- **Strategy 1.2.6:** Educate youth and individuals seeking a career change on opportunities for future employment in healthcare and related fields.

Objective 1.3: Reduce inequities in access to healthcare that may contribute to disparities in health outcomes.

- **Strategy 1.3.1:** Identify inequities through the data-driven disparities report to better understand disparities or racial inequities related to access to healthcare services.
- **Strategy 1.3.2:** Identify and promote services that mitigate barriers to access to healthcare services.
- **Strategy 1.3.3:** Identify the top 10 unnecessary emergency department visits that may increase wait times and barriers to access.

Goal 2: Individuals and families in our communities have access to the support they need to work, learn, and live sustainably.

Objective 2.1: Increase understanding of and opportunities for sustained inclusive, and sustainable economic growth, full and productive employment, and decent work for all.

- **Strategy 2.1.1:** Educate on the health and economic impacts of childcare deserts.
- **Strategy 2.1.2:** Explore models for making childcare more available and more affordable for families.

Objective 2.2: Improve food security and increase access to safe and nutritious food.

- **Strategy 2.2.1:** Promote the concept of food as medicine.
- **Strategy 2.2.2:** Promote nutritious food policies at the community and organizational levels.
- **Strategy 2.2.3:** Improve transportation connections to food resources.
- **Strategy 2.2.4:** Promote the provision and distribution of nutritious foods for low-income community members.

Objective 2.3: Increase equitable access to active and safe transportation.

- **Strategy 2.3.1:** Promote free bus fares for older adults and youth.
- **Strategy 2.3.2:** Advocate for free or reduced bus fares for low-income, income-eligible riders and others.
- **Strategy 2.3.3:** Provide opportunities for community members to learn about options for safe and active transportation.
- **Strategy 2.3.4:** Partner with municipalities to assess mobility and walkability in select locations.

Objective 2.4: Increase access to equitable, safe and reliable water for drinking and recreation.

- **Strategy 2.4.1:** Monitor cyanotoxin levels in high-use recreational water sites and promote public awareness of harmful algal blooms.
- **Strategy 2.4.2:** Collaborate with State and Federal agencies to study factors that may contribute to harmful algal blooms.
- **Strategy 2.4.3:** Advocate for increased reporting of animal and human illnesses related to harmful algal blooms.
- **Strategy 2.4.4:** Explore models to provide private well owners with resources to treat their wells for nitrate contamination or alternative, fresh water sources.
- **Strategy 2.4.5:** Promote safe water recreation.

Objective 2.5: Enhance safe and healthy school environments.

- **Strategy 2.5.1:** Identify and reduce environmental health, safety, and communicable disease risks in schools.
- **Strategy 2.5.2:** Educate community members and decision makers on the impacts of healthy and safe school environments.

Objective 2.6: Increase the ability for individuals and communities to engage in healthy behaviors.

- **Strategy 2.6.1:** Promote opportunities for engagement in healthy behaviors.

Community Partnership Development

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community that supports promoting local health and social initiatives. However, the CHNA indicated that strengthening partnerships, coordinating efforts, and sharing goals and resources may improve outcomes and lead to more long-term, substantive impact for Benton and Franklin counties. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

Goal 1: Groups in Benton and Franklin counties coordinate to respond to the needs identified in the 2022 CHNA and report progress on efforts.

Objective 1.1: Enhance coordination of community coalitions, committees, and other community participatory groups around CHIP goals and objectives.

- **Strategy 1.1.1:** Provide training and technical assistance to support organizing, guiding, evaluating, and sustaining coalitions to improve the health of the public.

Goal 2: Benton and Franklin counties have broad spectrum partnerships between community leaders, the business sector, and other non-traditional public health partners.

Objective 2.1: Increase community and partner understanding of the intersectional nature of public health and other sectors.

- **Strategy 2.1.1:** Raise awareness in the business community about how community health can improve business, and how business policies can improve community health.

Objective 2.2: Increase Community Development Block Grant (CDBG) decision-maker awareness of community health needs and priorities.

- **Strategy 2.2.1:** Support the alignment of Community Development Block Grants (CDBG) with the CHNA and CHIP.

Objective 2.3: Inform community action with the best available data to measure progress and focus community attention on key issues.

- **Strategy 2.3.1:** Support an update to Benton-Franklin Trends to make information and data more accessible.
- **Strategy 2.3.2:** Educate partners on how health is impacted by disparities and inequities.
- **Strategy 2.3.3:** Consolidate data on CHIP-related activities for tracking purposes.
- **Strategy 2.3.4:** Enhance relationships between grant makers and community partners.

Objective 2.4: Establish and strengthen environmental health partnerships.

- **Strategy 2.4.1:** Identify and collaborate with partners working on climate impacts.
- **Strategy 2.4.2:** Identify existing community development policies for effectiveness or gaps in addressing public health impacts.

APPENDICES

Appendix 1: Acronyms and Glossary of Terms

Appendix 2: List of Community Partners and Potential Resources

ACRONYMS AND GLOSSARY OF TERMS

BFCHA: Benton Franklin Community Health Alliance

BFHD: Benton-Franklin Health District

BRFSS: Behavioral Risk Factor Surveillance Survey

CHAT: Community Health Assessment Tool

CHIP: Community Health Improvement Plan. A Community Health Improvement Plan is a long-term, systematic effort to improve health outcomes in a community. The plan outlines actions that key partners plan to take based on the results of Community Health Needs Assessments.

CHNA: Community Health Needs Assessment. A community health needs assessment measures the health of a community at a given point in time. This can include data trends, public perceptions, capacities, and forces of change (funding, support, etc.) that may affect the ability to address health issues.

CDGB: Community Development Block Grant (CDBG) Program provides annual grants on a formula basis to states, cities, and counties to develop viable urban communities by providing decent housing and a suitable living environment, and by expanding economic opportunities, principally for low- and moderate-income persons.

Health Equity: Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

HYS: Healthy Youth Survey

MAPP: Mobilizing for Action through Planning and Partnerships

PMH: Prosser Memorial Health PSJH: Providence St. Joseph Health

SDoH: Social Determinants of Health. The circumstances, in which people are born, grow up, live, and work and age affect their health, functioning, risks, and quality of life. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (World Health Organization).

SEPA: The State Environmental Policy Act process identifies and analyzes environmental impacts associated with governmental decisions.

YARP: Youth Access and Resource Forum

COMMUNITY PARTNERS AND POTENTIAL RESOURCES

The CHIP Steering Committee benefited from community partners' input and involvement throughout the CHNA and CHIP cycle. These partners and future partners will help drive community health improvement. The list below is not exclusive and is likely to grow with additional resources and partners in our community.

2nd Harvest
3 Rivers Community Foundation
Aging and Long-Term Care-Southeast Washington
Amerigroup Washington
Benton County Department of Human Services
Benton-Franklin Behavioral Health Advisory Committee
Benton-Franklin Community Health Alliance
Benton-Franklin Council of Governments
Benton-Franklin Recovery Coalition
Benton-Franklin Youth Suicide Prevention Coalition
Ben Franklin Transit
Chaplaincy Health Care
City of Kennewick
City of Pasco
City of Richland
City of West Richland
Coalition for a Healthy Benton City
Columbia Basin College-School of Health Sciences
Community Action Connections
Comprehensive Healthcare
Communities in Schools Benton-Franklin
Department of Social and Health Services
Eastern Washington University
Educational Service District 123
Grace Clinic
Greater Columbia Behavioral Health
Greater Health Now
Habitat for Humanity
Heartlinks Hospice and Palliative Care
Heritage University
Kadlec Regional Medical Center
KEY Connection
Kennewick Fire Department
Kennewick Housing Authority
Kennewick Police Department
Kennewick Public Hospital District
Kennewick School District
ona-Benton City School District
Lourdes Health
Lutheran Community Services Northwest
Mid-Columbia Libraries
Pacific Northwest National Laboratory
Pasco Chamber of Commerce
Pasco Discovery Coalition
Pasco Emergency Medical Services
Pasco Fire Department
Pasco Police Department
Pasco Prevention Network
Pasco School District
People for People
Prosser Memorial Health
Prosser Emergency Medical Services
Prosser Fire Department
Prosser Police Department
Prosser Thrive
Richland Fire Department
Richland Police Department
Richland School District
Senior Life Resources Northwest
Support, Advocacy & Resource Center (SARC)
TC Futures
Three Rivers Therapy
Trios Health
Tri-Cities Hispanic Chamber of Commerce
Tri-Cities Community Health
Tri-Cities Food Bank
Tri-Cities Washington Economic Development Council (TRIDEC)
Tri-City Regional Chamber of Commerce
United Way of Benton and Franklin Counties
Visit Tri-Cities
Worksource Columbia Basin
World Relief Tri-Cities
WSU Elson Floyd College of Medicine
WSU Extension
WSU Nursing
WSU Tri-Cities
West Richland Police Department
Workforce Development Council
Youth Access and Resource Program (YARP)

CHNACHIP
BENTON & FRANKLIN COUNTIES

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Exhibit 9

ASCA Ambulatory Surgery Center Association

Ambulatory Surgery Centers

A Positive Trend in Health Care

Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting. Since their inception more than four decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

As our nation struggles with how to improve a troubled and costly health care system, the experience of ASCs is a great example of a successful transformation in health care delivery.

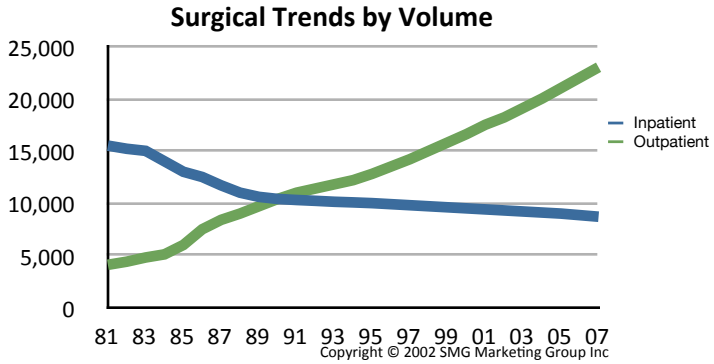
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the US.

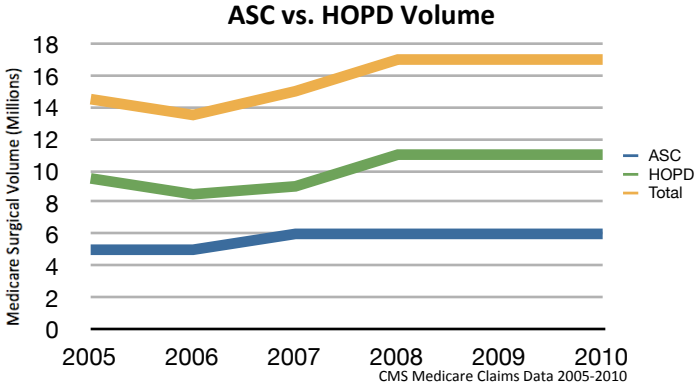
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way—and developed it in ASCs.

Today, physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain increased control over their surgical practices.[1] In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients. Simply stated, physicians are striving for, and have found in ASCs, professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in an ASC (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs and 3% are owned entirely by hospitals.[2]

ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of $90 billion, including more than $5.8 billion in tax payments. Additionally, ASCs employ the equivalent of approximately 117,700 full-time workers.[3]





ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring that patients have the best surgical experience possible, they also provide cost-effective care that save the government, third party payors and patients money. On average, the Medicare program and its beneficiaries share in more than $2.6 billion in savings each year because the program pays significantly less for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures. Accordingly, patient co-pays are also significantly lower when care is received in an ASC.

If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional $2.4 billion a year or $24 billion over the next 10 years. Likewise, Medicaid and other insurers benefit from lower prices for services performed in the ASC setting.

Currently, Medicare pays ASCs 58% of the amount paid to hospital outpatient departments for performing the same services For example, Medicare pays hospitals $1,670 for performing an outpatient cataract surgery while paying ASCs only $964 for performing the same surgery.

This huge payment disparity is a fairly recent phenomenon. In 2003, Medicare paid hospitals only 16% more, on average, than it paid ASCs. Today, Medicare pays hospitals 72% more than ASCs for outpatient surgery. There is no health or fiscal policy basis for providing ASCs with drastically lower payments than hospital outpatient departments.

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as $496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, whereas that same beneficiary's copayment in the ASC would be only $195.

Without the emergence of ASCs as an option for care, health care expenditures would have been tens of billions of dollars higher over the past four decades. Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentivize the movement of patients and procedures to the ASC setting.

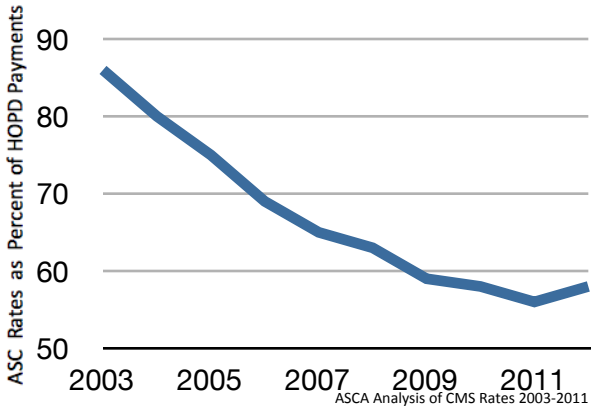
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased by hospitals and converted into hospital outpatient departments. Even if an ASC is not physically located next to a hospital, once it is part of a hospital, it can terminate its ASC license and become a unit of the hospital, entitling the hospital to bill for Medicare services provided in the former ASC at the 72% higher hospital outpatient rates.

Cost Comparison:
ASC v. Hospital Outpatient Department

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	$193	$490	$964	$1,670
Upper GI Endoscopy	$68	$139	$341	$591
Colonoscopy	$76	$186	$378	$655

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

The Gap Between ASC and HOPD Payments Has Widened Significantly

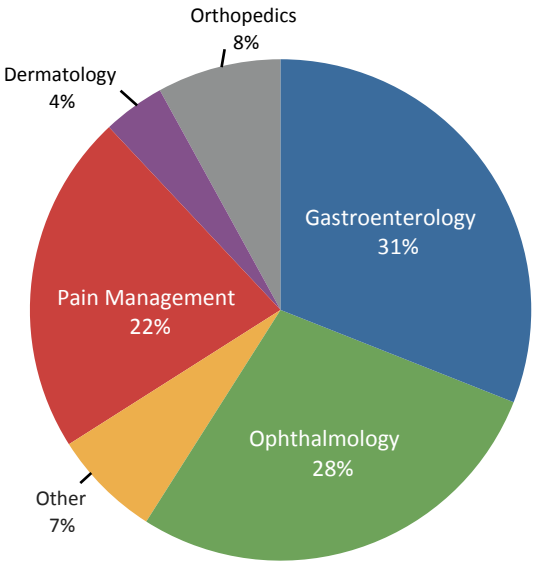


ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

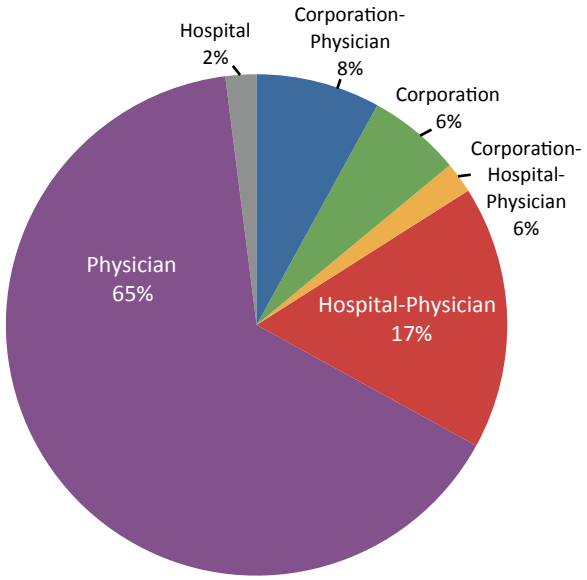
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

The ASC health care delivery model enhances patient care by allowing physicians to:

- Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management
- Intensify quality control processes since ASCs are focused on a smaller space and a small number of operating rooms, and
- Allow patients to bring concerns directly to the physician operator who has direct knowledge about each patient's case rather than deal with hospital administrators who almost never have detailed knowledge about individual patients or their experiences

Physician ownership also helps reduce frustrating wait-times for patients and allows for maximum specialization and patient–doctor interaction. Unlike large-scale institutions, ASCs

- Provide responsive, non-bureaucratic environments tailored to each individual patient's needs
- Exercise better control over scheduling, so virtually no procedures are delayed or rescheduled due to the kinds of institutional demands that often occur in hospitals (unforeseen emergency room demands)
- Allow physicians to personally guide innovative strategies for governance, leadership and most importantly, quality initiatives

As a result, patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs .[4] Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs.

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Forty three states and the District of Columbia, currently require ASCs to be licensed in order to operate. The remaining seven states have some form of regulatory requirements for ASCs such as Medicare certification or accreditation by an independent accrediting organization. Each state determines the specific requirements ASCs must meet for licensure and most require rigorous initial and ongoing inspection and reporting.

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All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC.The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations also require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs. Even though ASCs and hospital outpatient departments are clinically identical, the Center for Medicare & Medicaid Services (CMS) applies different standards to the two settings.

ASCs: A COMMITMENT TO QUALITY

Quality care has been a hallmark of the ASC health care delivery model since its earliest days. One example of the ASC community's commitment to quality care is the ASC Quality Collaboration, an independent initiative that was established voluntarily by the ASC community to promote quality and safety in ASCs.

The ASC Quality Collaboration is committed to developing meaningful quality measures for the ASC setting. Six of those measures have already been endorsed by the National Quality Forum (NQF). The NQF is a non-profit organization dedicated to improving the quality of health care in America, and the entity the Medicare program consults when seeking appropriate measurements of quality care. More than 20% of all ASCs are already voluntarily reporting the results of the ASC quality measures that NQF has endorsed.

Since 2006, the ASC industry has urged the CMS to establish a uniform quality reporting system to allow all ASCs to publicly demonstrate their performance on quality measures. Starting on October 1, 2012, a new quality reporting system for ASCs will begin and will encompass five of the measures that ASCs are currently reporting voluntarily.

Reporting Measures

Measure	Data Collection Begins
Patient Burn	Oct 1, 2012
Patient Fall	Oct 1, 2012
Wrong Site, Side, Patient, Procedure	Oct 1, 2012
Hospital Admission	Oct 1, 2012
Prophylactic IV Antibiotic Timing	Oct 1, 2012
Safe Surgery Check List Use	Jan 1, 2012
Volume of Certain Procedures	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

76 Federal Regulation 74492 - 74517

Specific Federal Requirements Governing ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government to ensure that the facility is operated in a manner that assures the safety of patients and the quality of services.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to take steps to ensure that patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control and Prevention. Thanks to these ongoing efforts, ASCs have very low infection rates.[5]

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event of an emergency. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.[5]

Continuous quality improvement is an important means of ensuring that patients are receiving the best care possible. An ASC, with the active participation of its medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

Medicare Health and Safety Requirements

Required Standards	ASCs	HOPDs
Compliance with State licensure law	☑	☑
Governing body and management	☑	☑
Surgical services	☑	☑
Quality assessment and performance improvement	☑	☑
Environment	☑	☑
Medical staff	☑	☑
Nursing services	☑	☑
Medical records	☑	☑
Pharmaceutical services	☑	☑
Laboratory and radiologic services	☑	☑
Patient rights	☑	☑
Infection control	☑	☑
Patient admission, assessment and discharge	☑	☑

Source: 42 CFR 416 & 482

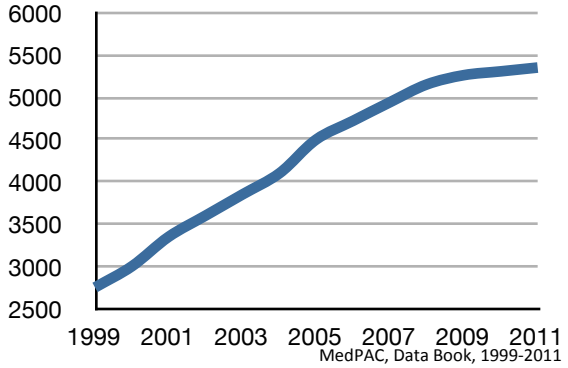
CONTINUED DEMAND FOR ASC FACILITIES

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis (unfortunately, however, Medicare has been slow to recognize these advances and assure that its beneficiaries have access to them). Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers. While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all.

However, in a troubling trend, the growth of ASCs has slowed in recent years. If the supply of ASCs does not keep pace with the demand for outpatient surgery that patients require, that care will be provided in the less convenient and more costly hospital outpatient department. [12]

Number of Medicare Certified ASCs



MedPAC, Data Book, 1999-2011

ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As a leader in the evolution of surgical care that has led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation's health care system can be implemented.

Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation's health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

END NOTES

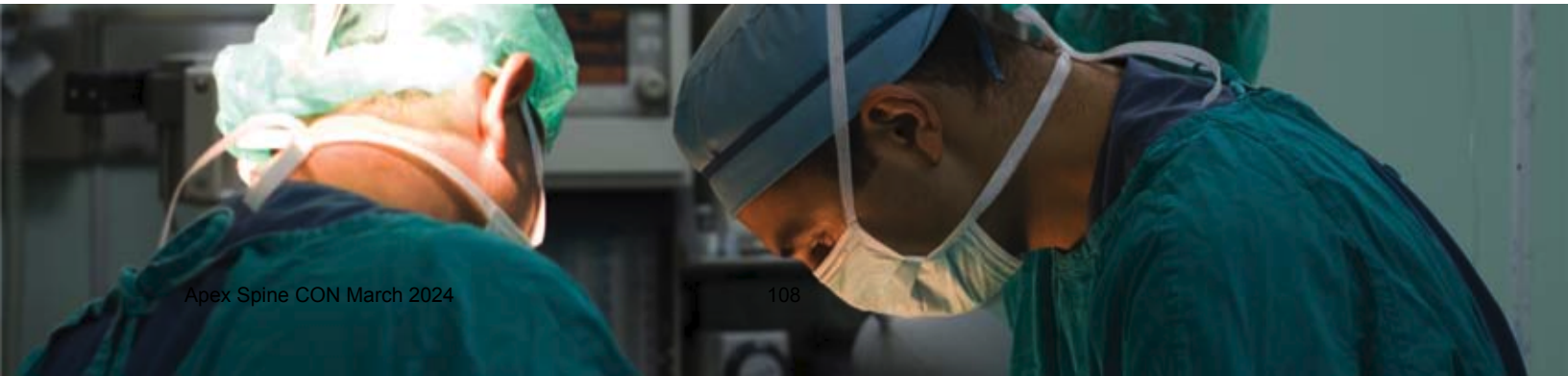
1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.

2 2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.

3 Oxford Outcomes ASC Impact Analysis, 2010.

4 Press-Ganey Associates, "Outpatient Pulse Report," 2008.

5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.



185 Medicare-Certified ASCs in Washington

Ambulatory Surgery Centers (ASCs) Provide High-Quality Care in Washington

ASCs that serve Medicare patients must meet federal requirements to ensure patient safety and the quality of services.

ASCs Save Medicare Money

ASCs **save Medicare approximately $7 billion a year**, according to a recent analysis by KNG Health Consulting, LLC. If current trends in Medicare outpatient surgery continue, procedures performed in ASCs rather than hospitals could **save Medicare $73.4 billion** in the next ten years.

Savings for Top Services Performed in ASCs

Ophthalmology:	$57,425,862
Orthopedics:	$22,049,790
Gastroenterology:	$23,869,991

Total Washington Medicare Savings in 2021:

$150,887,538

www.ascassociation.org

Source for Savings Data: Centers for Medicare and Medicare Services, 2021 Data

Exhibit 10

Research Article

Cost Savings From Utilization of an Ambulatory Surgery Center for Orthopaedic Day Surgery

Peter D. Fabricant, MD, MPH
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Joshua C. Rozell, MD
Evan Fieldston, MD, MBA
John M. Flynn, MD
Lawrence M. Wells, MD
Theodore J. Ganley, MD

Abstract

Introduction: Healthcare providers are increasingly searching for ways to provide cost-efficient, high-quality care. Previous studies on evaluating cost used estimated cost-to-charge ratios, which are inherently inaccurate. The purpose of this study was to quantify actual direct cost savings from performing pediatric orthopaedic sports day surgery at an ambulatory surgery center (ASC) compared with a university-based children's hospital (UH).

Methods: Custom-scripted accounting software was queried for line-item costs for a period of 3 fiscal years (fiscal year 2012 to fiscal year 2014) for eight day surgery procedures at both a UH and a hospital-owned ASC. Hospital-experienced direct costs were compared while controlling for surgeon, concomitant procedures, age, sex, and body mass index.

Results: One thousand twenty-one procedures were analyzed. Using multiple linear regression analysis, direct cost savings at the ASC ranged from 17% to 43% for seven of eight procedures. Eighty percent of the cost savings was attributed to time (mean, 64 minutes/case; $P < 0.001$) and 20% was attributed to supply utilization ($P < 0.001$). Of the time savings in the operating room, 73% (mean, 47 minutes; $P < 0.001$) was attributed to the surgical factors whereas 27% (17 minutes; $P < 0.001$) was attributed to anesthesia factors.

Conclusions: Performing day surgery at an ASC, compared with a UH, saves 17% to 43% from the hospital's perspective, which was largely driven by surgical and anesthesia-related time expenditures in the operating room.

Level of Evidence: Level II

From the Hospital for Special Surgery, New York, NY (Dr. Fabricant), the Geisinger Health System, Danville, PA (Dr. Seeley), the Department of Orthopaedic Surgery, University of Pennsylvania, Philadelphia, PA (Dr. Rozell), and the Children's Hospital of Philadelphia, Philadelphia (Dr. Fieldston, Dr. Flynn, Dr. Wells, and Dr. Ganley).

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US healthcare payment models are experiencing a paradigm shift with implementation of changes in both the public and private sectors. For example, by replacing traditional fee-for-service models, bundled payments provide fixed reimbursement for a surgical intervention and a defined period of postoperative care.[1,2] Healthcare providers are increasingly searching for ways to provide high-quality care that is also cost-efficient. With lower or fixed reimbursement, providers (including hospitals) will be required to decrease costs to maintain or improve their financial position and profits.

To improve the delivery of care using a value-oriented approach, health systems must seek to satisfy the Institute for Healthcare Improvement's (IHI) Triple Aim: decreasing the per capita cost, improving the experience of care, and improving

Table 1

CPT Code Criteria Used to Identify Surgical Encounters for Inclusion

Procedure	CPT Criteria
Shoulder stabilization	29806, 29807
ACL reconstruction	29888
Meniscal repair	29882, 29883
OCD fixation	29887
OCD drilling	29886, 29879
Chondroplasty	29877
Loose body removal	29874
Meniscectomy	29880, 29881

ACL = anterior cruciate ligament, CPT = current procedural terminology, OCD = osteochondritis dissecans

population health.[3] It is known that from the patient and family perspective, care closer to one's home and family is of higher value.[4] Hospital systems have responded by shifting resources into developing satellite centers. Although not all patients are candidates for care in a satellite setting, convenient local care delivered at a reduced cost satisfies two of the three IHI goals.

Previous studies have attempted to quantify costs[5-8] and cost savings[9-12] from the hospital perspective but are limited by existing methodology. To date, many authors have used hospital charges and cost-to-charge ratios as a surrogate for hospital perceived costs.[1,13,14] Unfortunately, this method is known to be inherently inaccurate because of the nature of generating these ratios using estimates and population-level data rather than patient-level data.[13,15-18] To our knowledge, no study has effectively collected and analyzed line-item costs from a hospital accounting system. Although it is generally understood that ambulatory surgery centers (ASCs) are more time efficient than large university hospitals (UHs),[19] to our knowledge, exact quantification of cost savings comparing equivalent patients and procedures has not been reported in the orthopaedic literature to date.

The purpose of this study was to quantify actual cost savings achieved from performing orthopaedic day surgery at an affiliated ASC rather than a UH while controlling for relevant covariables in an epidemiologic analysis. We hypothesized that the overall cost of the same surgeons performing the same surgical cases at an affiliated ASC would be significantly less than at the main UH.

Methods

Data Systems, Patient Selection, and Inclusion Criteria

This study was conducted using the hospital records of human subjects, and thus was first approved by the Institutional Review Board. At our institution, the clinical electronic medical record (EMR; Epic, Epic Systems Corporation) is archived in a data warehouse for administrative and research purposes and stored on a Health Insurance Portability and Accountability Act-compliant server (Epic Clarity, Epic Systems Corporation). This server was queried for clinical care encounters meeting the following potential inclusion criteria: patients undergoing one of eight surgical procedures performed by one of three attending surgeons at either the UH or the ASC defined by Current Procedural Terminology codes outlined in Table 1, patient age of <20 years at the time of surgery, and a surgery date in the time frame of July 2011 to June 2014 (ie, fiscal years 2012 to 2014). All procedures were isolated with the exception of anterior cruciate ligament (ACL) reconstruction, which often included a concomitant meniscal débridement or repair that was controlled for in the statistical analyses. Of note, there is no surgeon financial interest in the ASC; patients and families who are clinically eligible choose the surgical location primarily based on convenience to their home. In addition, all cases at both care locations involve trainee first-assistants (ie, resident or fellow) from the same pool at the affiliated university-based orthopaedic surgery training program. To maintain comparability between groups, patients who required an overnight stay (eg, revision surgeries, complex cases, medically complex patients [body mass index (BMI) >30kg/m^2, airway abnormality, history of malignant hyperthermia, history of cardiopulmonary disease]) were automatically scheduled at the UH and were therefore excluded from the current study because these accommodations do not exist at the ASC (n = 137). Patients who did not require care at the UH were allowed to independently choose their location of care based on availability and convenience. These criteria generated a list of 1,021 unique patient surgical encounter registration numbers, which were

Dr. Fieldston or an immediate family member has stock or stock options held in Johnson & Johnson and Pfizer. Dr. Flynn or an immediate family member has received royalties from Zimmer Biomet and serves as a board member, owner, officer, or committee member of the American Academy of Orthopaedic Surgeons, the American Board of Orthopaedic Surgery, the Pediatric Orthopaedic Society of North America, and the Scoliosis Research Society. Dr. Wells or an immediate family member serves as a board member, owner, officer, or committee member of the Philadelphia Orthopaedic Society. None of the following authors or any immediate family member has received anything of value from or has stock or stock options held in a commercial company or institution related directly or indirectly to the subject of this article: Dr. Fabricant, Dr. Seeley, Dr. Rozell, and Dr. Ganley.

used to extract the corresponding direct hospital costs (ie, variable and fixed costs from line-item expenditures) from the hospital's cost accounting system (Allscripts, Allscripts Healthcare Solutions). Of note, the cost data were not estimated from cost-to-charge ratio estimates; the data represent the hospital's actual cost of service delivery. Operating room (OR) time was divided into that attributed to surgery versus anesthesia. This information was corroborated with time-stamped events in the EMR (OpTime Operating Room Management Module, Epic Systems Corporation), which are recorded in real time during each patient encounter after being mutually agreed on by the circulating nurse and the anesthesia staff. Anesthesia-associated OR time was defined as minutes from the time of arrival in the OR to the start of surgical preparation as well as the time from the application of surgical dressings to the time of departure from the OR. Surgery-associated OR time was defined as minutes from the start of surgical preparation to the application of surgical dressings.

The cost data were merged with demographic variables (ie, age, sex, BMI) and surgical variables (ie, procedures, surgery facility [UH versus ASC], attending surgeon, preprocedure anesthesia-associated OR time, surgery-associated OR time, postprocedure anesthesia-associated OR time, postanesthetic care unit time) to create a dataset for analysis. Direct costs are patient encounter-specific and more accurately reflect the resources used during the patient's encounter. Direct costs were evaluated independently from that of indirect costs to allow for uniform comparison of healthcare delivery in the two settings. Examples of institutional direct and indirect costs are illustrated in Table 2.

Table 2

Examples of Direct and Indirect Costs[a]

Direct Costs	Indirect Costs
Line item supplies and equipment	Support staff wages
Operating room time	Fringe benefits
Anesthesia time	Cost of facility operation and maintenance
PACU time	Utilities overhead
Radiology services	Administrative costs/overhead
Laboratory services	Housekeeping
Pathology services	Facility depreciation
Surgical implants	Other operating revenue
Disposables	
Durable medical equipment, braces	
Drugs	
Implants	

[a] The current study evaluated direct costs only because they are assigned to each patient encounter and more accurately reflect the resources used for the care consumed by each patient.
PACU = postanesthetic care unit

Study Design and Statistical Analysis

The study was designed to primarily investigate the relationship between the surgery facility (UH versus ASC) and cost. Exact hospital costs were compared between facilities while controlling for surgeon, concomitant procedures (for analysis of ACL reconstructions only, because all other procedures were isolated), age, sex, and BMI. Physician salaries and professional fees are equal between sites and were not included in the analyses. Orthopaedic implants were purchased through the same supplier, thus making this cost (per unit) equivalent between the two sites; however, they were included in the analyses because resource utilization may vary between care sites.

Statistical analysis was performed by a member of the research team with advanced training in biostatistics. Descriptive statistics were used to illustrate distributional data. Multiple linear regression was used to perform adjusted analyses for the relationship between the surgery facility and the direct cost while controlling for surgeon, concomitant procedures for analysis of ACL reconstructions, age, sex, and BMI. Cost savings were analyzed as absolute dollar amounts but then converted to normalized percent savings for reporting. Direct costs were further broken down in a multiple linear regression model to evaluate for components that drive differences in cost of care delivery, including surgery-associated OR time, anesthesia-associated OR time, and supply costs. All comparisons were two-tailed and used $P < 0.05$ as the threshold for statistical significance. Because all available patients from the hospital data warehouse were analyzed, an a priori power calculation was not performed.

It is the practice of our institution to treat cost data as proprietary information that cannot be released for publication purposes. Therefore, we present cost differences as adjusted measures and percent differences. Pragmatically, however, the presentation of study data and results as normalized ratios (eg, percent savings)

Table 3

Surgical Procedures Performed in the Study Cohort

Procedure	University Hospital (n)	Ambulatory Surgery Center (n)	Total (n)
Anterior cruciate ligament reconstruction	251	135	386
Arthroscopic meniscectomy	221	128	349
Meniscus repair	161	102	263
Arthroscopic shoulder stabilization	85	50	135
Osteochondral dissecans drilling	72	46	118
Osteochondral dissecans fixation	13	30	43
Removal of loose body (knee)	25	11	36
Chondroplasty (knee)	26	9	35
Total	854	511	1,365

does not affect the conclusions drawn from the study results.

Results

One-thousand twenty-one surgical procedures were included in the final analysis. The mean age was 15.4 ± 2.4 years, and the cohort was 54.1% male. No statistically significant differences in age or sex distribution were noted between patients treated at the UH versus the ASC ($P > 0.05$ for both). Mean BMI for the study cohort was 23.4 ± 6.8 kg/m^2, and although there was a statistically significant difference between patients treated at the UH versus the ASC (23.9 ± 7.9 versus 22.6 ± 3.6, $P = 0.004$), the noted difference of 5.4% is not considered clinically significant (threshold of ≥7%).[20-25] Regardless, BMI was included as a covariate in multiple linear regression analyses to control for any theoretical effect. The surgical case mix of the study cohort is outlined in Table 3.

In multiple linear regression analysis controlling for surgeon, concomitant procedures (for ACL reconstructions only, because all other procedures were isolated), age, sex, and BMI, direct costs associated with seven of eight procedures (all but chondroplasty) were significantly less when performed at the ASC, ranging from 17% to 43% of the cost at the UH depending on the procedure performed (Figure 1). Subanalysis revealed that of this cost savings, 80% was attributed to time savings (mean, 64 minutes per case; $P < 0.001$) and 20% was attributed to supply utilization cost savings ($P < 0.001$) despite same cost-per-item for both care locations. OR time at the ASC was 64 minutes shorter than that at the UH per procedure, on average. Of the time savings in the OR, 73% (47 minutes on average, $P < 0.001$) was attributed to the surgical factors while 27% (17 minutes, $P < 0.001$) was attributed to anesthesia factors.

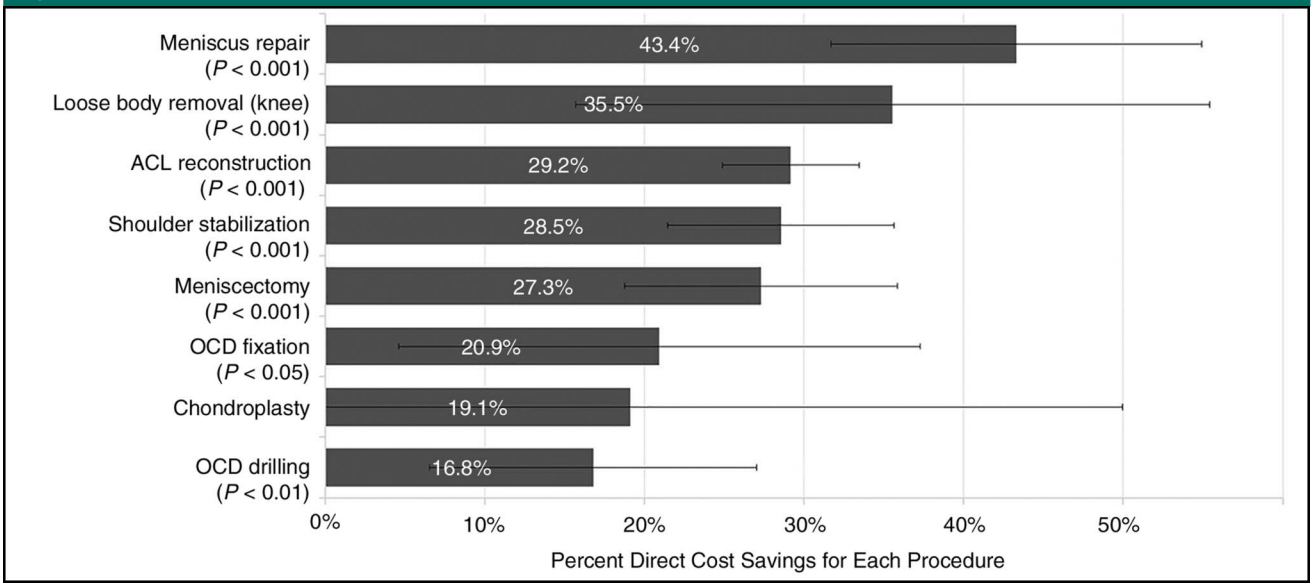
Discussion

Our study noted substantial direct cost savings across seven of eight pediatric orthopaedic sports procedures when performed at an affiliated ASC compared with the main UH. Isolated chondroplasty was the only procedure performed at the ASC that did not result in a significant cost savings. This procedure is less frequently performed in children because they do not experience the same rate or prevalence of degenerative cartilage changes as do adults. The direct cost savings noted for all other procedures were substantial when controlling for surgeon, procedure, and demographic variables in multiple linear regression analysis. Although recent epidemiologic studies have noted time savings from the use of ASCs,[19] to our knowledge, the current study is the only series to directly assess cost savings from the utilization of ASCs. In addition to the large sample size, our study applies a novel methodology of directly measuring cost of care delivery through tabulation of exact expenditures, thus identifying potential avenues for institutional cost savings that may be applied not only at the participating institution but more globally.

Cost accounting databases are accurate and reliably used for hospital financial planning and projections. Analyzing these databases can provide a precise depiction of the resource and cost utilization at any given institution. Historically, cost-to-charge ratios have been used as a surrogate for hospital costs;[1,13,14] however, the inaccuracy of this method is well-known because the estimation of these ratios uses population-level data rather than direct calculation using patient-level data.[13,15-18] To our knowledge, no study has effectively collected and analyzed line-item costs from a hospital accounting system. By identifying unique encounter-level identifiers in an EMR, future research may use the same methodology by linking clinical and accounting hospital databases to evaluate cost and cost savings of a study intervention.

In our study, 80% of direct cost savings was attributed to OR time costs, with 73% of the time savings attributed to surgical factors and

Figure 1



Percent direct cost savings in direct costs (adjusted for surgeon, concomitant procedures, age, sex, and body mass index) of each of eight day surgery procedures performed at an ambulatory surgery center versus a university-based children's hospital. Error bars represent the 95% confidence limits of each effect. Concomitant procedures were included only in the analysis of anterior cruciate ligament reconstruction because all other procedures were isolated. ACL = anterior cruciate ligament, OCD = osteochondritis dissecans

27% to anesthesia factors. The 64 minutes saved intraoperatively are seemingly double the time savings reported from an epidemiologic study of adult multispecialty surgical cases performed at ASCs (31.8 minutes on average).[19] The reasons for the time savings noted in our study are likely multifactorial. The power and precision of conclusions drawn from studies that use large datasets for cost analysis are advantageous; however, quantification of the explanatory variables and reasons to explain these findings are frequently difficult in studies that use large, retrospective datasets. Rather, placing the results in context and using related findings to identify areas of potential improvement in time and resource utilization is vital. From the surgical perspective, university-based programs might consider using a fixed-team structure for OR support staff (eg, circulating nurses, surgical technologists) and similar lean-style improvements to improve UH performance.[26-28] Actions such as these can result in time savings in the OR because of improved staff familiarity with high-volume ambulatory procedures, as well as supply cost savings because of the potential for less material waste and for streamlining of the supply chain. At our institution, during a 6-month period that occurred during the time inclusive of our study, it was noted that a total of 6 unique OR support staff were involved with surgical patient care at the ASC compared with 41 OR support staff at the UH. This finding may explain some of the cost differences noted in our study.

In previous anesthesiology literature, it has been reported that the use of a regional anesthesia "block room" has the potential to provide significant time and cost savings in the OR.[29-31] Efficiency is improved because care is provided in parallel throughout the day rather than in series, thereby saving OR time that would otherwise prolong the length of anesthesia induction. In our study, neither the ASC nor the UH used a block room. Therefore, although it did not contribute to any differences in cost savings, it remains an area of clinical and future research interest for improving efficiency and further decreasing the cost of providing care. Although the use of a block room may require more human resources, the cost may be offset or defrayed by time saved in the OR, the quantification of which is currently under investigation.

Although standalone ASCs, such as that of our institution, tend to be in suburban settings to allow services to be closer to people's homes and capitalize on other non-city advantages (eg, cheaper land, easier parking, less traffic), this may not be available in all regions or practice settings.[32] The internal structures and processes outlined previously (eg, fixed-team structure, anesthesia block rooms) may also be realized in an urban setting, such as the creation

of a day surgery ward within a large urban university hospital. In this manner, an institution may possess some of the benefits of an ASC but not necessarily gain the full advantages of a suburban setting. In addition, in the right setting, an urban ASC may be a viable option for some hospitals or healthcare systems. By designating "centers of excellence" within a larger hospital or health system, especially for high-volume procedures with the potential for cost savings, institutions may streamline and consolidate resources and optimize care delivery in any location.

As with any database research, this study has limitations. Because no clinical outcomes were available in this administrative database, we were unable to determine if there were any differences in quality of outcomes of care between the UH and the ASC. In addition, we were unable to stratify by specific health status or comorbidities as clinical variables (eg, American Society of Anesthesiologists scores were unavailable in compatible institutional databases). However, our study groups, consisting of otherwise healthy, ambulatory sports patients without chronic disease, were well-controlled and comparable for three reasons: (1) we initially excluded any patient who would have been medically or surgically ineligible for care at the ASC, (2) group-wise comparisons on medical covariables of interest were performed to ensure comparability between the ASC and the UC cohorts, and (3) multiple linear regression analyses were performed, controlling for surgeon, concomitant procedures, age, sex, and BMI. Another limitation was that our cost accounting systems did not allow for the investigation of opportunity costs, such as OR turnover time, because these are not actual costs nor are they attributable to the care of patients. It is known that perioperative process redesign, such as those seen in ASCs, can reduce turnover time (eg, the time a patient is not using an OR),[33,34] which may also be the case at our center; however, we were unable to quantify the time not being used by a patient because it was not a direct cost of patient care. In the event that the OR turnover time is shorter at the ASC, the cost savings we found may actually be an underestimate of the true cost savings of performing surgery at the ASC. Finally, although it would have been informative to report procedural cost savings as actual dollar amounts, our institution treats this information as proprietary data and does not allow its publication. However, by reporting the results of the current study as "percent savings," meaningful cost reduction is conveyed that may be used by other institutions and the orthopaedic surgery community to engage in discussions on cost savings at other institutions. Although generalizability of the exact cost savings at other institutions may be limited because of regional differences in healthcare systems, financial and purchasing relationships between ASCs and UHs, and other logistics of performing surgeries in different locations, the unique relationship and healthcare environment at our center (eg, no physician financial stake in the ASC, patient choice in surgery location, single purchaser for instrumentation and implants) provided an excellent setting to investigate this important research question. Pragmatically, the presentation of the study data and results as normalized ratios does not affect the ability to draw conclusions based on the study results.

Conclusions

Performing day surgery at an ASC rather than a UH afforded a direct cost savings of 17% to 43%, depending on the procedure performed, which was largely driven by time expenditures in the OR. These findings may be used to evaluate cost saving methods including fixed surgical teams, regional anesthesia block rooms, optimizing institutional resource utilization, and/or designating "centers of excellence" by building urban UH-linked ASCs or transporting patients to and from satellite suburban ASCs, each serving to potentially decrease cost and optimize value in the setting of bundled payments. Furthermore, this novel methodology may be used by other institutions to perform similar related research. Two of three IHI goals for improving value of care (decreasing per capita cost and improving experience of care) may be met simultaneously if some patients' care can be provided at satellite centers conveniently located in closer proximity to their homes and at a lower cost.

Acknowledgment

We wish to acknowledge Ron Keren, MD, MPH, for his guidance with this research project, and Meaghan Lutts and Tyler Manning for their invaluable assistance with data collection.

References

Evidence-based Medicine: Levels of evidence are described in the table of contents. In this article, references 8, 11, 20, and 23 are level I studies. References 1, 21, 25, and 28 are level II studies. References 5, 7, 13, 22, 26, 27, 30, 31, and 33 are level III studies. References 6, 9, 10, 12, 14, and 19 are level IV studies. References 2-4, 15-18, 24, 29, 32, and 34 are level V expert opinion.

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Exhibit 11

Washington State Department of Health

APPENDIX A
ASC Need Methodology
Benton Franklin County

Service Area Population: 2027		311,005	Claritas	Age 0 - 85+									
Surgeries @147.096/1,000:		44,922											
a.i.	94,250	minutes/year/mixed-use OR											
a.ii.	68,850	minutes/year/dedicated outpatient OR											
a.iii.	9	dedicated outpatient OR's x 68,850 minutes =			619,650	minutes dedicated OR capacity				10,280	Outpatient surgeries		
a.iv.	31	mixed-use OR's x 94,250 minutes =			2,921,750	minutes mixed-use OR capacity				29,989	Mixed-use surgeries		
b.i.	projected inpatient surgeries =		23,124	=	2,252,925	minutes inpatient surgeries							
	projected outpatient surgeries =		21,797	=	1,313,895	minutes outpatient surgeries							
b.ii.	Forecast # of outpatient surgeries - capacity of dedicated outpatient OR's												
	21,797	-	10,280	=	11,517	outpatient surgeries							
b.iii.	average time of inpatient surgeries			=	97.43	minutes							
	average time of outpatient surgeries			=	60.28	minutes							
b.iv.	inpatient surgeries*average time			=	2,252,925	minutes							
	remaining outpatient surgeries(b.ii.)*ave time			=	694,245	minutes							
					2,947,169	minutes							
c.i.	if b.iv. < a.iv. , divide (a.iv.-b.iv.) by 94,250 to determine surplus of mixed-use OR's												
	Not Applicable - Go to c.11. and ignore any value here.												
	2,921,750												
	- 2,947,169												
	-25,419	/	94,250	=	**-0.27**								
c.ii.	if b.iv. > a.iv., divide (inpatient part of b.iv - a.iv.) by 94,250 to determine shortage of inpatient OR's												
	USE THESE VALUES												
	2,252,925												
	- 2,921,750												
	(668,825)	/	94,250	=	**-7.10**								
	divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated outpatient OR's												
	694,245	**/**	**68,850**	**=**	**10.08**								

Washington State Department of Health

APPENDIX A
ASC Need Methodology
Benton Franklin County

Facility	Special Procedure Rooms	Dedicated Inpatient ORs	Dedicated Outpatient ORs	Mixed Use ORs	Mixed Use min/case	Inpatient Cases in Mixed Use ORs	Inpatient Mins. In Mixed Use ORs	Outpatient Min/Case	Outpatient Cases	Outpatient Mins.	Data Source
Kadlec Regional Medical Center	4			**12**	107.9	10,260	1,106,805				2022 data from 2023 survey
Lourdes Medical Center	5			**8**	108.7	3,207	348,447				2018 Survey
PMH Medical Center				**3**	62.1	3,337	207,262				2022 data from 2023 survey
Trios health				**8**	90.3	3,535	319,058				Year 2016 data from 2017 survey
High Desert Surgery Center			**2**					82.5	3,144	259,367	Year 2017 data from 2018 survey
Hoyeoul Yang MD PS	1			Dedicated to Endoscopy							Year 2017 data from 2018 survey
Kadlec Ambulatory Surgery Center - Spaulding			**3**					55.0	2,898	159,409	2022 data from 2023 survey
Kadlec Ambulatory Endoscopy Center - Richland	4			Dedicated to Endoscopy							2022 data from 2023 survey
Northwest Ambulatory Physicians	5			Dedicated to Endoscopy							2022 data from 2023 survey
Tri-Cities Digestive Health Center	2			Dedicated to Endoscopy							2022 data from 2023 survey
Mid-Columbia Endoscopy Center	2			Dedicated to Endoscopy							2022 data from 2023 survey
Northwest Endovascular Surgery			1					48.1	640	30,784	Year 2017 data from 2018 Survey
Pacific Cataract and Laser Institute			4					51.6	6,920	357,400	2022 data from 2023 survey
Apex Spine Institute			3								From ASI
The Surgery Center at Tri-City Orthopaedic Clinic (Kennewick)			**4**					75.1	2,423	181,983	2022 data from 2023 survey
Tri-City Regional Surgery Center			4					53.0	3,147	166,700	2022 data from 2023 survey
Totals	10	**0**	**9**	**31**	**368.9**	**20,339**	**1,981,572**	**365.3**	**19,172**	**1,155,643**	
					Avg min/case inpatient		**97.43**	Avg min/case outpatient		**60.28**	
ORs counted in numeric methodology			**9**	**31**							
ILRS: Integrated Licensing & Regulatory System											
Population data source: Claritas 2024 data											
Total Surgeries	39,511										
Area population 2022 [0 - 85+]	273,546		**Using 2022 population because of 2022 Survey data**								
Use Rate	144.440										
Planning Area projected population Year: 2027	311,005										
% Outpatient of total surgeries	48.52%										
% Inpatient of total surgeries	51.48%										

APEX SPINE INSTITUTE
821 Swift Blvd.
Richland, WA 99352
509-606-5040
www.apexspineinstitute.com.com

Certificate of Need Program
Department of Health
111 Israel Rd SE
Tumwater, WA 98501

RE: Letter of Intent - Apex Spine Institute

In accordance with WAC 246-310-080, Apex Spine Institute, PLLC, hereby submits a letter of intent proposing to establish and operate the Apex Spine Institute at 985 Goethals Dr, Richland, WA, 99352-3527 as a free-standing ambulatory surgery center (ASC) in the Benton-Franklin planning area. Apex Spine Institute historically operates as a certificate of need exempt ASC.

In conformance with WAC 246-310-080, the following information is provided:

1. A description of the extent of services proposed:
    a. Apex Spine Institute proposes to establish and operate the Apex Spine Institute existing three-room surgical center as free-standing ASC.
2. Estimated cost of the proposed project:
    a. The estimated capital expenditures is $0. The ASC is fully built out and operational.
3. Description of the service areas:
    a. The primary service area will be the Benton-Franklin planning area.

Thank you for your interest in this matter. Please contact my office with any questions.

Sincerely,

Alex Linde
CEO