COLUMBIA SURGICAL SPECIALISTS

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 4:04 pm, Apr 14, 2021

April 14, 2021

CN_21-65

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

Re: Application to Establish and Operate a Certificate of Need Approved Four Operating Suite Ambulatory Surgery Facility in Spokane Washington

Dear Mr. Hernandez:

On behalf of Columbia Surgical Specialists, P.S. doing business as ("dba") Columbia Surgery Center, I am pleased to submit this Application for approval to establish and operate a certificate of need ("CN") approved four operating suite ambulatory surgery facility in Spokane Washington.

Columbia Surgery Center ("CSS") operates four operating suites and has operated as a CN-Exempt Ambulatory surgery center ("ASC") since February 2000. Columbia Surgery Center began with six ENT physicians, a practice which grew to include 13 ENT physicians in 2012. In 2013, CSS (then known as Spokane ENT) merged with Surgical Specialists of Spokane, P.S. (DOR 12-42). Since then, CSS has continued to grow such that, to date, it employs 31 surgeons across six different specialties, distributed across six practice sites. These specialties include ENT, Colon and Rectal Surgery , General Surgery, Plastic Surgery, Gynecology, and Urology.

The intent of this certificate of need request is: (1) to expand physician and patient access to CN-approved ambulatory surgery facilities. The Department's ASC need methodology demonstrates there is high net need for outpatient surgery suites in Spokane County. With CN approval, we can help meet that net need. (2) Increase the specialties that practice at CSS. Upon approval, CSS will provide additional surgical services within the specialties of Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, and Podiatry. Currently CSS provides services to patients age 4 months and over who are appropriate candidates for ambulatory surgeries and procedures, and it would continue to do so.

Thank you for your assistance. Please contact me if you have any questions. I can be reached at: 509.789.5777 or at remerson@spokaneent.com

Sincerely,

Rod Emerson
Executive Director
Columbia Surgical Specialists
217 West Cataldo Avenue
Spokane WA 99201

Washington State Department of Health

Date Stamp Here

Certificate of Need Application
Ambulatory Surgical Facilities
Ambulatory Surgery Centers

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

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

Name, Title, and Signature of Responsible Officer: Rod Emerson, CEO, Columbia Surgical Specialists Signature: _____ Dated: April 14, 2021	Phone Number: (509) 789-5777 Email Address: remerson@spokaneent.com
Legal Name of Applicant: Columbia Surgical Specialists, P.S. d/b/a Columbia Surgery Center Address of Applicant: Columbia Surgical Specialists 217 W Cataldo Ave, Spokane, WA, 99201	Number of Operating Rooms requested – include procedure rooms: Four (4) operating rooms Estimated Capital Expenditure: There are no capital expenditures associated with the proposed project. Estimated expenditures include: Not applicable

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

Spokane County Secondary Health Services Planning Area ("Spokane Planning Area")

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Introduction and Rationale

Columbia Surgical Specialists, P.S. Doing Business As ("d/b/a") Columbia Surgery Center ("CSS") is requesting approval to convert its existing four (4) operating room ambulatory surgical center ("ASC") in the Spokane County Planning Area into a Certificate of Need ("CON"; or "CN") approved ambulatory surgery facility ("ASF")with four (4) operating rooms.[1] Upon approval, CSS will provide surgical services within the specialties of ENT, Colon & Rectal Surgery, Gastroenterology, General Surgery, Plastic Surgery, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology. Currently CSS provides services to patients age 4 months and over who are appropriate candidates for ambulatory surgeries and procedures, and it would continue to do so. Columbia Surgery Center is located at 217 W Cataldo Ave, Spokane, WA 99201.

Columbia Surgery Center has operated as a CN-Exempt ASC since February 2000. Originally named Spokane Ear, Nose, and Throat, CSS began with six ENT physicians, a practice which grew to include 13 ENT physicians in 2012. In 2013, CSS (then known as Spokane ENT) merged with Surgical Specialists of Spokane, P.S. (DOR 12-42). Since then, CSS has continued to grow such that, to date, it employs 31 surgeons across six different specialties, distributed across six practice sites. These specialties include Colon & Rectal Surgery, ENT, General Surgery, Plastic Surgery, Gynecology, and Urology.

Under its existing CN-Exempt license, CSS physicians may perform surgical procedures related to ENT, Colon and Rectal Surgery[2], General Surgery, and Plastic Surgery in the CSS ASC, but not Gynecology and Urology. Traditionally, this has meant that Gynecology or Urology patients would receive their pre- and post-operative diagnosis and care at one of the CSS practice sites, but their surgical procedure would be performed at one of the CN-approved planning area ASCs or hospitals. Given that there are only three CN-Approved outpatient ASCs in Spokane County, and only one (Providence Surgery and Procedure Center) which is licensed for procedures that include urology and gynecology, this has meant either fitting the CSS Urology and Gynecology patients into the Providence Surgery and Procedure Center schedule or accessing the relatively higher cost Mixed Use rooms at one of the planning area hospitals.

The intent pf this certificate of need request is to: (1) Expand physician and patient access to CN-approved ambulatory surgery facilities. The Department's ASC need methodology demonstrates there is high net need for outpatient surgery suites in Spokane County. With CN approval, we can help meet that net need. (2) Increase the specialties that practice at CSS, including creating access for current CSS physicians in the specialties of Urology and Gynecology. Upon approval, CSS will provide additional surgical services within the specialties of Gastroenterology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry and Podiatry. Currently CSS provides services to patients age 4 months and over who are appropriate candidates for ambulatory surgeries and procedures, and it would continue to do so.

Recently, with the COVID-19 pandemic and consequent shutdown of Spokane hospitals to non-emergency surgical procedures in mid-2020, CSS additionally performed Urology and

[1] For purposes of this application, ASC and ASF will be used interchangeably.
[2] The Colon & Rectal surgeons also perform a number of gastroenterology procedures, but their subspeciality Board Certification expertise is colon rectal surgery.

Gynecology procedures at its ASC.[3] Knowing that its ASC is fully equipped to handle these and other types of procedures, and knowing of very significant outpatient OR shortages in the Spokane Planning Area, CSS wishes to expand its available specialties beyond the current four for which it is licensed, and "open" its ASF to non-employed physician and their patients, improving access. This would allow CSS physicians across all six of the CSS specialties to perform surgical procedures at the CSS ASC and to add additional specialties and allow access to non-employed physicians. Columbia Surgery Center is often asked by other, non-affiliated physicians if they could use the CSS ASC, as they find it a challenge to obtain adequate OR time in the community. The proposed project will thus increase access to planning area residents, who bear the consequences of these scheduling challenges.

[3] During the COVID-19 crisis, on April 1, 2020, Governor Inslee issued Proclamation 20-36, allowing Certificate of Need Waivers of RCW 70.38.105(4)(a) and WAC 246-310-020(1)(a). This allowed new specialty(s) or outside providers to utilize the ASC for emergent cases pursuant to Proclamation 20-24. This waiver was extended through July 8, 2020.

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)

   Columbia Surgical Specialists P.S. d/b/a as Columbia Surgery Center is the legal name of the applicant. Columbia Surgery center is owned and operated by Columbia Surgical Specialists.[4]

   The applicant's address is:

   Columbia Surgical Specialists PS
   217 W Cataldo Ave,
   Spokane, WA 99201

   The address of Columbia Surgery Center is the same as the applicant.

   Columbia Surgery Center
   217 W Cataldo Ave,
   Spokane, WA 99201

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

   Columbia Surgical Specialists P.S. is a privately held, for-profit entity.

   The UBI number of CSS is 600047769.

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

   Kristie Sudderth
   ASC Manager
   Columbia Surgical Specialists
   217 West Cataldo Ave
   Spokane, WA 99201
   (509) 789-5754
   ksudderth@spokaneent.com

[4] For purposes of this application, CSS will refer to Columbia Surgery Center, but the legal applicant is Columbia Surgical Specialists P.S.

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

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

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

   Please see Exhibit 1 that includes the organizational chart for the applicant.

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.**

   Columbia Surgery Center
   217 W Cataldo Ave,
   Spokane, WA 99201

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

   This question is not applicable.

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

   Columbia Surgery Center requests CN approval to convert its current four (4) operating room (OR) ASC from CN-Exempt to a CN-Approved ASC. It currently operates as a CN-Exempt facility with four ORs providing surgical services within the specialties of ENT, Colon & Rectal Surgery,[5] General Surgery, and Plastic Surgery. As part of the proposed project, CSS will expand its offered specialties to also include Gastroenterology, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology.

   Columbia Surgery Center currently provides care patients who are appropriate candidates for ambulatory surgery, including patients four months and older. It plans to continue this practice post-approval.

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

Event	Anticipated Month/Year
CN Approval	October 1, 2021
Design Complete	October 1, 2021
Construction Commenced	N/A
Construction Completed	N/A
Facility Prepared for Survey	October 1, 2021
Project Completion	October 1, 2021

[5] As noted above, the Colon & Rectal surgeons also perform a number of gastroenterology procedures, but their Board Certification subspeciality expertise is colon rectal surgery.

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

☒ Ear, Nose, & Throat	☒ Maxillofacial	☒ Pain Management
☒ Gastroenterology	☒ Ophthalmology	☒ Plastic Surgery
☒ General Surgery	☒ Oral Surgery	☒ Podiatry
☒ Gynecology	☒ Orthopedics	☒ Urology

☒Other? Describe in detail:

Columbia Surgery Center currently performs cases within the specialties of ENT, Colon & Rectal Surgery,[6] General Surgery, and Plastic Surgery. A list of typical procedures within each of these specialties is presented in Table 1.

Table 1: Typical Procedures at Columbia Surgery Center

Procedure Description	Associated CPT Code
ENT	
Submucous resection inferior turbinate, partial or complete, any method	30140
Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	30520
Nasal/sinus endoscopy, surgical, with frontal sinus exploration	31276
Tonsillectomy and adenoidectomy; younger than age 12	42820
Tonsillectomy and adenoidectomy; age 12 or over	42821
Tympanostomy (requiring insertion of ventilating tube), general anesthesia	69436
Plastic Surgery	
Removal of Breast Lesion	19120
Excision of Breast Lesion	19125
Mastectomy, partial	19301
Placement of breast localization device(s)	19285
Rhinoplasty	30400
Facelift	15828
Blepharoplasty	15823
Bodytite	15876
Colon & Rectal Surgery/Gastroenterology	
Diagnostic colonoscopy	45378

[6] Ibid.

Colonoscopy with biopsy	45380
Lesion removal colonoscopy	45385
Hemorrhoidectomy, internal/external, 2+ columns/groups	46260
Hemorrhoidectomy of internal prolapsed hemorrhoid columns; intersphincteric	46275
Bariatric Surgery – Gastric Bypass	43846
General Surgery	
Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	36561
Upper GI endoscopy with biopsy	43239
Laparoscopy, surgical; cholecystectomy	47562
Repair initial inguinal hernia, age 5 years or older; reducible	49505
Laparoscopy, surgical repair initial inguinal hernia	49650

Source: Applicant

Furthermore, given CN approval, CSS will add the specialties of Gastroenterology,[7] Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology.

Typical Gynecology procedures are expected to include:

- Sterilization procedures
- Pelvic floor repair
- Prolapse repair (vagina and/or uterus)
- Hysterectomy

Typical Maxillofacial procedures are expected to include:

- Facial trauma
- Jaw trauma
- TMJ treatment
- Facial/mandible disorders

Typical Ophthalmology procedures are expected to include:

- Lacrimal duct procedures
- Eye muscle repairs
- Optic nerve decompression
- Orbital Decompression
- Oculo-plastic
- Eye cancer w/ invasion into sinus
- Sinus Cancer w/ invasion into eye orbit
- Orbital fractures

[7] Please see Table 1 for typical procedure types for gastroenterologists.

Typical Oral Surgery procedures are expected to include:

- Tooth extraction
- Root canal
- Bone Grafts
- Dental Implants / caps/ crowns

Typical Orthopedics procedures are expected to include:

- Carpal tunnel release
- Trigger finger release
- Joint arthroscopic surgery – shoulder, knees, hips
- Bone fracture

Typical Pain Management procedures are expected to include:

- Epidural pain injections

Typical Pediatric Dentistry procedures are expected to include:

- Tooth cleaning
- Tooth cavity repair
- Tooth extraction
- Temporary tooth caps

Typical Podiatry procedures are expected to include:

- Bunion removal
- Plantar fasciitis
- Foot & toe trauma / fractures
- Toenail disorders
- Toe amputations

Typical Urology procedures are expected to include:

- Urethral stent placement
- Urethral scopes
- Prostate procedures
- Male sterilization procedures
- Kidney stone treatments
- Incontinence treatments
- Circumcision

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:_____

Columbia Surgery Center plans to offer only a subset of gastroenterological procedures. This would include procedures related to colonoscopy, upper endoscopy and bariatric surgery.

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

   Columbia Surgery Center currently offer surgical services related to ENT, Colon & Rectal Surgery, General Surgery, and Plastic Surgery. Furthermore, CSS employs two physicians who perform procedures related to Urology and Gynecology, however, these two specialists have not performed surgeries in the present ASC since those have not been listed specialties within CSS's CN Exempt approval. With the proposed project, CSS anticipates providing surgical services across all the aforementioned specialties. Furthermore, with the ability to open the ASC to additional physicians, CSS will also anticipate providing services related to Gastroenterology, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology.

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

   Given approval of the proposed project, CSS will have a total of four (4) operating rooms, as currently.

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

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

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

    Columbia Surgery Center will serve patients age four (4) months and older who require Colon & Rectal Surgery, ENT, Gastroenterology, General Surgery, Plastic Surgery, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology surgical procedures that can be provided appropriately in an outpatient setting.

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

    Please see Exhibit 2 for the letter of intent.

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

Please see Exhibit 3 for a floorplan of the CSS facility.

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

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

License #: ASF.FS.60099962

Medicare #: 50C0001176

Medicaid #: 7100738

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

Columbia Surgery Center does not plan to seek accreditation for its facility.

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

No construction is required for the proposed project thus this question is not applicable.

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

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

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

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

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

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

   Columbia Surgery Center is applying for CN Approval of its four OR facility which will provide services including ENT, General Surgery, Colon & Rectal Surgery and Plastic and Reconstructive Surgery as well as planned surgical services in the following specialties: Gastroenterology, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Surgery, Podiatry, and Urology.

   There currently exist three CN-Approved outpatient facilities in the Spokane County Planning area. These include the Chesnut Institute of Cosmetic & Reconstructive Surgery, MultiCare Rockwood Eye Surgery, and Providence Surgery & Procedure Center. Furthermore, a fourth, Empire Eye Surgery, has recently applied for conversion of its CN-Exempt facility to CN-Approved. Of these four facilities, Providence Surgery & Procedure Center appears to provide services most similar to those currently provided by CSS and those proposed in the application. However, the other ASCs in the planning area also provide services, e.g., ophthalmologic surgery, that would be similar to some of the surgical services CSS proposes to provide, once approved.

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.**

Estimation of numeric need as defined in WAC 246-310-270 requires calculation of current surgical capacity (exclusive of capacity dedicated to endoscopy and pain management).[8] Hospitals and ASCs voluntarily report OR utilization through an annual utilization survey distributed by the Washington Department of Health. As of February 2021, OR utilization data for 2019 was available for the five planning area hospitals and five of the seventeen ASCs. Table 2 lists the current supply of operating rooms in the Spokane County Planning Area not dedicated to endoscopy or pain management.

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

Hospitals, CN-Approved	Mixed Use ORs	Outpatient ORs
MultiCare Deaconess Hospital	17	
MultiCare Valley Hospital	8	
Providence Holy Family	19	
Providence Sacred Heart	41	
Shriner's Hospital for Children	2	
ASCs, CN- Approved		
Chesnut Institute of Cosmetic & Reconstructive Surgery		2
MultiCare Rockwood Eye Surgery		2
Providence Surgery & Procedure Center		4
ASCs, CN-Exempt		
Advanced Dermatology and Skin Surgery		6
Carol Hathaway, MD PS		1
Columbia Surgical Specialists		4
Empire Eye Surgery		1
Inland Northwest Surgery Center		1
Northwest Eyelid and Orbital Specialists, P.S.		1

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

Northwest Orthopaedic Specialists		5
Northwest Surgery Center Inc.		2
Pacific Cataract and Laser Institute		3
Shape Cosmetic Surgery and Medspa		2
Spokane Surgery Center		3
Spokane Valley Ear Nose and Throat		2
Seattle Reproductive Medicine Inc PS		2
The Plastic Surgicenter		2
Spokane Eye Clinic PS		8
Total CN-Approved ORs	**87**	**8**

Sources:
2020 Department of Health ASC Survey, 2019 Department of Health ASC Survey, 2019 Department of Health ASC Survey, Appendix A, DOH Eval of CN18-01

From Table 2, there are 95 CN-approved ORs in the Spokane County Planning Area, including 87 inpatient/mixed use ORs and 8 CN-approved outpatient ORs. Furthermore, there are 17 licensed CN-exempt outpatient ASCs whose outpatient surgery volumes are included in the planning area surgery use rate calculations (while their ORs are excluded). Operating rooms dedicated to GI/endoscopy or pain management are neither counted in the number of planning area ORs, nor is their utilization used to determine planning area surgery use rates.[9]

The data and assumptions used in the numeric need calculations are presented in Table 3. These are generated from population forecasts by Claritas, planning area utilization data from the 2018, 2019, and 2020 Department of Health ASC Surveys, and discussions with the Department of Health, where priority is given to the most recent data. For detail on the data sources by hospital, see Exhibit 4.

Table 3: Summary of data and assumptions used in numeric need methodology

Planning area	Spokane County
Population estimates and forecasts, all ages	Year 2019: 535,733 Year 2024 (Forecast Year): 564,611 Source: Claritas 2019
Planning area surgeries	Inpatient or Mixed Use: 61,909 Outpatient: 44,657 Total: 106,566 Sources: 2018, 2019, 2020 ASC Surveys, ILRS, Eval of CN18-01
Planning area use rate	Surgeries/2019 Population*1,000 = 198.92 per 1,000 persons
Surgery case mix	Outpatient: 41.91% Inpatient: 58.09%

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

Average minutes per case	Outpatient: 45.1 Inpatient: 102.3 Sources: 2018, 2019, 2020 ASC Surveys, ILRS, Eval of CN18-01
OR annual capacity (in minutes)	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes
Existing OR capacity (in ORs)	8 dedicated outpatient ORs, 87 mixed use ORs See Table 2
Summary of need calculations	2024 Overall Need. Projected Surplus of 16.16 Mixed Use ORs **Projected Shortage of 22.85 Outpatient ORs**

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

WAC 246-310-270(9) — Methodology

(a) Existing Capacity

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

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

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

Dedicated outpatient CN-approved ORs in the planning area = 8

Capacity = 68,850 minutes per year per OR

Total annual capacity in minutes: 8*68,850 = 550,800 minutes

Minutes per surgery = 45.13 minutes

Total annual capacity in outpatient surgeries:

550,800 / 45.13 = **12,203 annual [dedicated] outpatient surgeries**

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

Inpatient/mixed use, CN-Approved ORs in the planning area = 87

Capacity = 94,250 minutes per year per OR

Total annual capacity in minutes: 87*94,250 = 8,199,750 minutes **(a)(iv)**

Minutes per surgery = 102.33 minutes

Total annual capacity in inpatient/mixed use surgeries:

8,199,750 / 102.33 = **80,128 annual inpatient/mixed use surgeries**

(b) Future need

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

Based on the forecast population in 2024 and the use rate of 198.92 per 1,000 residents, there is a projected total of 112,310 surgeries in the Spokane County Planning area. [(b) (i)]

An estimated 58.09% of surgeries were performed as inpatient/mixed use and 41.91% as outpatient surgeries. Thus, of the 112,310 forecasted surgeries for 2024, 65,246 would be inpatient/mixed use surgeries and 47,064 outpatient surgeries [(b) (i)].

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

Outstanding demand for outpatient surgeries:

47,064 – 12,203 = 34,861 outpatient surgeries

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

Inpatient/mixed use surgery minutes = 6,335,346

Inpatient/mixed use cases = 61,909

Average inpatient/mixed use minutes per case = 102.33

Outpatient surgery minutes = 2,015,579

Outpatient cases = 44,657

Average outpatient minutes per case = 45.13

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

Inpatient minutes: 65,246 surgeries * 102.33 minutes/surgery = 6,676,845 minutes, or [(b)(i) * (b)(iii)]

Remaining outpatient minutes: 47,064 surgeries (b)(i) * 45.13 minutes/surgery (b)(iii) = 1,573,426 minutes, or [(b)(ii) * (b)(iii)]

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

6,676,845 minutes + 1,573,426 minutes = 8,250,271 minutes (b)(iv)

(c) Net Need

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

Not applicable; go to c.ii.

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

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

8,250,271 minutes > 8,199,750 minutes.

The model shows numeric need overall and for an additional 22.85 Outpatient ORs in 2024.

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

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

   The model shows numeric need for additional outpatient operating rooms in the Spokane County Planning Area. Furthermore, there are also qualitative arguments that support approval of the proposed project. These include (1) an increasing use rate; (2) significant shifting of surgical care to outpatient settings, driven by changing clinical practices, improved technology, and patient preference; and (3) lower cost of care for patients and their insurers in freestanding ASFs as compared to hospital-based providers.

   1. Increasing use rate

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

   Higher population growth rates for older persons in the Spokane County Planning Area

   Population forecasts project average annual growth rates over3.65% for persons aged 65+ in the Spokane County planning area. This rate reflects growth about 3 times higher than the rate of population growth for the planning area overall. Please see Table 4, which presents population statistics and associated growth factors across the different planning area age cohorts over the period 2010 to 2024.

Table 4: Spokane County Planning Area Population Growth Rates by Age Group, 2010 to 2024

	Population Estimates			Average Annual Growth	
Age Group	2010	2019	2024	2010 to 2019	2019 to 2024
Total	489,837	535,733	564,611	1.00%	1.06%
Under 15	94,325	98,266	102,035	0.46%	0.76%
15 to 44	198,893	213,228	222,520	0.78%	0.86%
45 to 64	132,939	133,895	131,958	0.08%	-0.29%
65+	63,680	90,344	108,098	3.96%	3.65%

Source: Claritas 2019

Higher surgical use rates for older persons

Surgical utilization by major age group is published within the latest National Center for Health Statistics ("NCHS") survey study, "Ambulatory Surgery in the United States."[10] Table 5 uses this data to present use rates by age group. From Table 5, surgical utilization rates for persons 65+ year of age are about 2.5 times greater than overall population surgical utilization rates.

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

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

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

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

[10] The report analyzed and presented summaries of data from the 2010 National Survey of Ambulatory Surgery ("NSAS").[10] This survey is included in our application as Exhibit 6.

Aside from knowing that the surgical use rate is likely to increase, because data on historical utilization is incomplete and inconsistent across ASC providers, it is difficult to precisely forecast changes in the OR use rate over time. However, it is possible to combine the forecasted demographic changes in the planning area population with the ASC use rates by age group. Given the forecasted shift in the age distribution of the planning area population, the age-specific ASC use rates imply about a 0.45% average annual increase in planning area use rates. Applying these growth rates to the numeric need methodology indicates an increase of the surgery use rate from 198.92 to about 204.35 surgeries per 1,000 residents between 2019 and 2024. Allowing for this growth would increase estimates of numeric need from a need of 22.85 (Table 3) outpatient ORs to a need of about 23.79 outpatient ORs. We note that the overall impact on outpatient OR need from a likely increasing use rate seems small, but only in comparison to the magnitude of the standard need estimate.

2. Significant shift to outpatient-based surgeries

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

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

- Patient Preference for Outpatient ORs.

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

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

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

at freestanding ASCs, more patients will be treated in higher cost, hospital-based operating rooms, which lowers planning area resource efficiency overall.

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

   Please see Table 6 for the number of surgeries and minutes per year between 2018 and 2020 at CSS. Both cases and minutes fell substantially in 2020 due to COVID-19 constraints on elective cases.

Table 6: Columbia Surgery Center Historical Utilization, 2018 to 2020

Columbia Surgical Specialists	2018	2019	2020
Cases	5,313	5,284	4,404
Minutes	328,918	359,492	280,757
Minutes per case	61.91	68.03	63.75

Source: 2018, 2019, and 2020 ASC Surveys and Applicant.
Notes: Demand for ORs is calculated by dividing the number of Surgery Minutes by 68,850. WAC 246-310-270(9)(i).

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

   In Table 7, we present projected surgical volumes for the first three full years of operations given project approval (2022 through 2024), as well as 2021 split between the periods prior to and after project approval (January to September and October to December, respectively). Currently, CSS provides outpatient services for ENT, Colon & Rectal Surgery, General Surgery, and Plastic Surgery in its ASC. Beginning in October 2021, given approval of the proposed project, it plans to add the specialties of Gastroenterology, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology.

   The specialty-specific case counts presented in Table 7 reflect a mapping of procedures by ICD-9 group presented in Table 11. Some ICD-9 groups have a straightforward correspondence to a certain specialty group, while others bridge multiple specialty groups. For this reason, we apply mapping assumptions regarding *the expected proportion of procedures within a given ICD-9 group to fall within each of the different specialties for CSS.* These mapping assumptions are based on review of CPT and ICD-9 procedural classifications and the specialties of CSS and its historical utilization. We emphasize that our mapping assumptions are distinct from our market share assumptions, which are outlined in Table 10. These mapping assumptions are:

- For ICD-9 group “Operations on the Nervous System,” 50% are ENT procedures, 15% are Colon Rectal/Gastroenterology procedures, 30% are General Surgery procedures, and 5% are Pain Management procedures and 10% are pain management procedures. The distribution is based on the historical distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020 and the allowance for a small number of Pain Management cases.
- For ICD-9 group “Operations on the Endocrine System, hemic and lymphatic system, and obstetrical procedures,” 95% are ENT procedures and 2.5% are General Surgery procedures, and 2.5% are gynecology procedures. The distribution is based on the historical distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020 and the allowance for a small number of obstetrical cases.
- For ICD-9 group “Operations on the Eye,” 100% are eye/ophthalmological procedures.
- For ICD-9 group “Operations on the Ear,” 100% are ENT procedures.
- For ICD-9 group “Operations on the Nose, Mouth and Pharynx,” 95% are ENT procedures and 5% are Oral Surgery procedures.
- For ICD-9 group “Operations on the Respiratory System,” 100% are ENT procedures. The distribution is based on the allowance for a small number of Oral Surgery cases.
- For ICD-9 group “Operations on the Cardiovascular System,” 5% are ENT procedures, 85% are general surgery procedures and 10% are Plastic Surgery procedures. vascular procedures. The distribution is based on the historical distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020.
- For ICD-9 group “Operations on the Digestive System,” 38% are Colon Rectal/Gastroenterological procedures and 62% are General Surgery procedures. The distribution is based on the historical distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020.
- For ICD-9 group “Operations on the Urinary System,” 100% are urology procedures.
- For ICD-9 group “Operations on the Male Genital Organs,” 100% are urology Procedures.
- For ICD-9 group “Operations on the Female Genital Organs,” 100% are gynecology procedures.
- For ICD-9 group “Operations on the Musculoskeletal System,” 30% are ENT procedures, 50% are General Surgery procedures, 10% are Orthopedics procedures and 10% are podiatry procedures. The distribution is based on the historical distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020 and the allowance for a small number of Orthopedics and Podiatry cases.
- For ICD-9 group “Operations of the Integumentary System,” 50% are ENT procedures, 20% are Colon Rectal/Gastroenterological Procedures, 15% are General Surgery procedures, 5% are Maxillofacial procedures, and 10% are Plastic Surgery procedures. The distribution is based on the historical

distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020 and the allowance for a small number of Maxillofacial cases.

- For ICD-9 group “Miscellaneous diagnostic and therapeutic procedures and new technologies,” 2% are ENT procedures, 87% are Colon Rectal/Gastroenterological procedures, 6% are General Surgery procedures, and 5% are Pain Management procedures. The distribution is based on the historical distribution of these cases at CSS over the period 3/1/2019 to 2/29/2020, and the allowance for a small number of Pain Management cases.

Table 7: Columbia Surgery Center Projected Case Count, 2021 to 2024

Cases	Jan to Sep 2021	Oct to Dec 2021	2022	2023	2024
ENT	2,257	722	2,920	2,952	2,984
Colon Rectal/Gastroenterology	617	204	824	833	842
General Surgery	1,149	376	1,518	1,535	1,551
Gynecology	-	2	10	10	10
Maxillofacial	-	3	13	13	13
Ophthalmology	-	17	70	71	72
Oral Surgery	-	23	91	92	93
Orthopedics	-	9	36	37	37
Pain Management	-	1	4	4	4
Plastic Surgery	24	9	35	36	36
Podiatry	-	9	36	37	37
Urology	-	8	33	34	34
Total Cases	4,046	1,384	5,592	5,652	5,714
Cases per Day (assumes 240 days of operation)	22.48	23.06	23.30	23.55	23.81
Minutes per case	68.03	68.03	68.03	68.03	68.03
Surgery minutes per year (assumes 2019 CSS minutes per case)	275,275	94,125	380,474	384,544	388,714
Estimated Number of Operating Rooms Needed (WAC 246-310-270 (9) (ii) (Divided minutes by 68,850.	5.33	5.47	5.53	5.59	5.65

Sources: Applicant

The forecast model uses the following assumptions and methodologies:

1. Surgical use rates by ICD-9 procedure code group were derived from the latest National Center for Health Statistics ("NCHS") survey study, "Ambulatory Surgery in the United States." The report analyzed and presented summaries of data from the 2010 National Survey of Ambulatory Surgery ("NSAS").[11] This survey is included in our application as Exhibit 6. For utilization estimates by surgical specialty, please see Table 8, below.

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

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

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

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

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

In this study, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory basis in a hospital or freestanding center's general ORs, dedicated ambulatory surgery rooms, and other specialized rooms. This NCHS survey study is the principal source for published national data on the characteristics of visits to hospital based and freestanding ASFs. The report was updated and revised in 2017 and contains NCHS estimates on ambulatory surgery case counts for the year 2010.[12] Estimates of population use rates were

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

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

The NCHS use rates were multiplied by 2021-2024 Spokane County Planning Area population forecasts and divided by 10,000 to forecast Planning Area resident ambulatory surgeries by procedure type and year. Table 9 presents estimates of these case counts.

Table 9: Spokane County Ambulatory Surgery Forecasts, 2021 to 2024

Service Area Volume of Outpatient Cases	Jan to Sep 2021	Oct to Dec 2021	2022	2023	2024
Number of Months	**9**	**3**	**12**	**12**	**12**
Operations on the Nervous System	5,604	1,868	7,550	7,631	7,714
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	461	154	622	628	635
Operations on the Eye	10,449	3,483	14,078	14,229	14,383
Operations on the Ear	1,398	466	1,883	1,903	1,924
Operations on the Nose, Mouth and Pharynx	3,192	1,064	4,300	4,346	4,393
Operations on the Respiratory System	374	125	504	509	515
Operations on the Cardiovascular System	1,421	474	1,915	1,936	1,957
Operations on the Digestive System	13,319	4,440	17,946	18,138	18,335
Operations on the Urinary System	1,789	596	2,410	2,436	2,462
Operations on the Male Genital Organs	696	232	938	948	958
Operations on the Female Genital Organs	2,342	781	3,155	3,189	3,223
Operations on the Musculoskeletal System	9,382	3,127	12,642	12,777	12,916
Operations of the Integumentary System	5,755	1,918	7,754	7,837	7,922
Miscellaneous diagnostic and therapeutic procedures and new technologies	7,813	2,604	10,527	10,639	10,755
Total	**63,993**	**21,331**	**86,225**	**87,147**	**88,092**

Source: Applicant

Market share figures were applied to each procedure code group based on current and planned surgeries. These market share figures are based on the historical utilization of CSS.

For Spokane County, based on a utilization rate of 1,560.3 and a 2019 population of 535,733, we estimate a total of 83,587 procedures for Spokane County residents in 2019. This same year, Spokane County providers performed 106,566 procedures, resulting in an estimate of resident net in-migration of

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

22,979 procedures. The significant in-migration into Spokane County suggests its presence as a regional center for healthcare services across Eastern Washington and Idaho. The current need for CN- Approved outpatient ORs, and the presence of Spokane County as a regional center for healthcare services indicates significant potential for expansion of planning area providers and subsequent increases in planning area efficiency and resident access.

Table 10 presents our market share assumptions based on the historical utilization of CSS. Columbia Surgery Center historical utilization includes cases in all ICD-9 groups aside from Operations on the Urinary System. Furthermore, the number of cases in the ICD-9 groups Operations on the Nervous System, Operations on the Eye, and Operations on the Female Genital Organs were small enough effectively represent a 0% market share. For these ICD-9 groups in which CSS has not had a meaningful market share, we assume marginal market shares through the forecast. For Operations on the Nervous System and Operations on the Eye, we assume a 0.5% market share. We believe these amounts are reasonable given the existing planning area providers and the current absence of Ophthalmology providers on the CSS staff. For operations on the Urinary System and Operations on the Male Genital Organs, we assume a 1% market share through the forecast period. We believe these amounts are reasonable given that there are already Urology/Gynecology providers on the CSS staff. For all other ICD-9 groups, the forecast market shares are set equal to the 2019 estimates of CSS market share.

Table 10: Columbia Surgery Center Market Share Assumptions, 2021-2024

CSS Market Share Calculations and Assumptions	Jan to Sep 2021	Oct to Dec 2021	2022	2023	2024
Market Share Assumptions					
Market Share annual change	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Operations on the Nervous System	0.0%	0.5%	0.5%	0.5%	0.5%
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	4.8%	4.8%	4.8%	4.8%	4.8%
Operations on the Eye	0.0%	0.5%	0.5%	0.5%	0.5%
Operations on the Ear	46.1%	46.1%	46.1%	46.1%	46.1%
Operations on the Nose, Mouth and Pharynx	42.4%	42.4%	42.4%	42.4%	42.4%
Operations on the Respiratory System	5.9%	5.9%	5.9%	5.9%	5.9%
Operations on the Cardiovascular System	5.2%	5.2%	5.2%	5.2%	5.2%
Operations on the Digestive System	10.8%	10.8%	10.8%	10.8%	10.8%
Operations on the Urinary System	0.0%	1.0%	1.0%	1.0%	1.0%
Operations on the Male Genital Organs	0.0%	1.0%	1.0%	1.0%	1.0%
Operations on the Female Genital Organs	0.3%	0.3%	0.3%	0.3%	0.3%
Operations on the Musculoskeletal System	2.9%	2.9%	2.9%	2.9%	2.9%
Operations of the Integumentary System	3.3%	3.3%	3.3%	3.3%	3.3%
Miscellaneous diagnostic and therapeutic procedures and new technologies	0.4%	0.4%	0.4%	0.4%	0.4%

Source: Applicant

Estimated planning area surgeries were then multiplied by the assumed market share figures for the ASF, yielding forecasted number of procedures, by year. These projections are included below in Table 11. Please note that CN approval is assumed to occur by October 1, 2021, and since, there is no construction required, project implementation can begin immediately thereafter. Thus, from an operations point of view, year one is 2022, since that is the first complete year after CN approval.

Columbia Surgery Center's Spokane County Planning Area market share is estimated to equal 6.3% of all planning area ambulatory surgeries in 2019 and is projected to increase slightly to 6.5% following approval of the proposed project due to the expansion of specialties. We assume market share will be constant at 6.5% throughout the forecast period.

Table 11: Columbia Surgery Center Projected Number of Ambulatory Surgeries, by Type, 2021-2024

CSS Cases, Historical and Forecast Based on Market Share	Jan to Sep 2021	Oct to Dec 2021	2022	2023	2024
Operations on the Nervous System	-	9	38	38	39
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	22	7	30	30	31
Operations on the Eye	-	17	70	71	72
Operations on the Ear	644	215	868	877	886
Operations on the Nose, Mouth and Pharynx	1,354	451	1,825	1,844	1,864
Operations on the Respiratory System	22	7	30	30	31
Operations on the Cardiovascular System	73	24	99	100	101
Operations on the Digestive System	1,436	479	1,935	1,956	1,977
Operations on the Urinary System	-	6	24	24	25
Operations on the Male Genital Organs	-	2	9	9	10
Operations on the Female Genital Organs	7	2	9	9	9
Operations on the Musculoskeletal System	270	90	364	368	372
Operations of the Integumentary System	189	63	254	257	260
Miscellaneous diagnostic and therapeutic procedures and new technologies	27	9	37	37	38
Total Cases	**4,045**	**1,384**	**5,592**	**5,652**	**5,714**
Spokane Planning Area Cases	63,993	21,331	86,225	87,147	88,092
CSS Market Share, Spokane Planning Area	6.3%	6.5%	6.5%	6.5%	6.5%
Average annual growth, cases	22.6%	2.6%	1.1%	1.1%	1.1%

Source: Applicant

2. The forecasted number of ambulatory surgeries at CSS presented in Table 11 are mapped into the specialty groups presented in Table 7 using the methodology outlined above. Cases are translated into surgery minutes using CSS 2019 outpatient surgery case per minute figure of 68.03 minutes. Based on WAC 246-310-270(9)(iii), the four ORs at CSS would be efficiently utilized.

The NCHS use rates in the utilization forecast are based on a 2010 national data set, so are national estimates which do not vary over time. It is possible that local patterns vary from the survey figures and that years such as 2020 deviate from the earlier use rates. However, there is no better statistical approach to estimate expected future volumes with procedural specificity. It is arguably reasonable to increase the use rate over time, given population aging and higher ambulatory surgery use rates for older age cohorts.[13] However, we assume a constant use rate over our forecast period.

[13] Please see our discussion on an increasing use rate in the section Need (WAC 246-310-210).

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 Spokane County Planning Area is a large planning area that draws patients from many areas of Eastern Washington. Consequently, there is a large supply of surgical services, broadly defined, in Spokane County. There currently exist five planning area hospitals and 18 outpatient surgery centers which provide surgical services not limited to endoscopy only. However, only three of these outpatient centers are CN-Approved, and most provide only a limited array of services. For example, we identify 10 of the 18 outpatient centers as providing services limited to either Ophthalmology or Plastic/Cosmetic surgery.[14] In fact, we identify only a single CN-Approved outpatient surgery center offering a diverse array of surgical specialties: Providence Surgery & Procedure Center. As a result, the majority of Spokane planning area surgical supply is concentrated in acute care hospitals, and there are few outpatient surgery locations in which a non-employee surgeon could perform procedures. Thus, in addition to the quantitative need estimated above, there are likely additional barriers to obtaining outpatient surgical care, especially for those specialties beyond eye surgery and plastic/cosmetic surgery.

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.**

   Columbia Surgery Center is committed to meeting community and regional health needs. CSS will provide Charity Care consistent with its financial assistance policy, included as Exhibit 7. This policy states that a charity care discount of up to 100% will be extended to eligible patients, where eligible patients are those whose monthly income falls at or below 200% of the Federal Poverty Level.

   Most indigent individuals in Washington State are insured through Apple Care or other Medicaid providers,[15] and in 2019, CSS wrote off about $3.3 million in charges to these patients.

   Our financial pro forma forecast provided in Exhibit 11 explicitly allocates 0.79% of total revenues to be provided for charity care, a figure equal to the Spokane County

[14] For some surgery centers, it is difficult to determine the actual array of services provided there. Surgery centers limited to Ophthalmological services are identified as MultiCare Rockwood Eye Surgery, Empire Eye Surgery, Northwest Eyelid and Orbital Specialists, Pacific Cataract and Laser Institute, and the Spokane Eye Clinic. Surgery centers limited to Plastic/Cosmetic surgery services are identified as Chesnut Institute of Cosmetic and Reconstructive Surgery, Advanced Dermatology and Skin Surgery, Carol Hathaway, MD PS, Shape Cosmetic Surgery and Medspa, and the Plastic Surgicenter.

[15] The proportion of insured persons residing in Washington State and under 200% of the Federal Poverty Line was approximately 85% between the years 2013 and 2017. (U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates)

Planning Area charity care average over 2016-2018, across hospitals located in Spokane County.[16] Please see Table 12 below.

10. Provide a copy of the following policies:

- **Admissions policy**
- **Charity care or financial assistance policy**
- **Patient Rights and Responsibilities policy**
- **Non-discrimination policy**
- **Any other policies directly related to patient access to care.**

Please see Exhibit 7 for the CSS Financial Assistance Policy. The CSS policies related to patient rights and responsibilities are included in Exhibit 8. These include the policies for Patient Notification of Rights and Responsibilities, Patient Rights, and Patient Responsibilities. Those policies related to non-discrimination are included in Exhibit 9. These include the Anti-Discrimination Policy, the CSS Statement on Non-Discrimination, and the Columbia Surgical Specialists' Grievance Procedure Policy.

[16] Over this period, the hospitals located in Spokane County include MultiCare Deaconess and Valley hospitals, Providence Holy Family and Sacred Heart hospitals, and Shriner's Hospital for Children.

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

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

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

   Please see Exhibit 10 for historical financial statements and the Pro Forma financial forecast for the first three full years of operations.

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

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

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

   Columbia Surgery Center does not hold any of the above agreements. Thus, this question is not applicable.

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

Columbia Surgery Center, in its financial projections for the proposed project, assumes charity care to be 0.79% of total or gross revenue. This figure is consistent with the Spokane County Planning Area Charity Care average of 0.79% over the 2016 to 2018 period (Table 12).

Table 12: Regional and Planning Area Charity Care Statistics, 2016-2018

Hospitals	2016	2017	2018	2016 to 2018 Average
Spokane County PA				
% Total Patient Service Revenue	0.58%	0.74%	1.06%	0.79%
% Adjusted Patient Service Revenue	1.84%	2.39%	2.39%	2.21%

Source: DOH Charity Care Reports, 2016-2018

Notes:
Total patient service revenue includes revenue across all sources. Adjusted patient service revenue reflects total patient service revenue, less revenue from Medicare and Medicaid. Hospitals within the Spokane County Planning Area reporting charity care amounts include MultiCare Deaconess and Valley hospitals, Providence Holy Family and Sacred Heart hospitals, and the Shriner's Hospital for Children.

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

   Please see Exhibit 11 for a copy of the parcel information documenting ownership of the proposed site by Cataldo Medical Building, LLC, and a copy of the lease agreement between Cataldo Medical Building, LLC and Columbia Surgical Specialists, P.S.

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

   Columbia Surgery Center has been operational at its current location since 2000. Thus, this question is not applicable.

6. **Complete the table below with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed below, please include the items with a**

definition of the line item. Include all assumptions used as the basis the capital expenditure estimate.

There are no capital expenditures associated with the proposed project.

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

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

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

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

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

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

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

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

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

    Please see our response to Question 10 above.

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

Projected Payer Mix	Percentage by Revenue WAC 246-310-220(1)	Percentage by Patient WAC 246-310-210(2)
Medicare	21.26%	13.19%
Medicaid	25.32%	29.60%
Commercial/HMO	44.83%	47.58%
Other Government	5.96%	5.35%
Other/Misc.	0.75%	0.88%
Self-Pay	1.87%	3.40%
Total	100.00%	100.00%

Those cases and charges part of the “Other/Misc.” category include 41 cases to persons with Exchange Plan payers, and 4 persons with non-categorizable payers.

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.

Columbia Surgery Center Payer Mix, 2019	Percentage by Revenue WAC 246-310-220(1)	Percentage by Patient WAC 246-310-210(2)
Medicare	21.26%	13.19%
Medicaid	25.32%	29.60%
Commercial/HMO	44.83%	47.58%
Other Government	5.96%	5.35%
Other/Misc.	0.75%	0.88%
Self-Pay	1.87%	3.40%
Total	100.00%	100.00%

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.

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

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

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

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

This question is not applicable.

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

Please see Exhibit 12 for the Columbia Surgical Specialists' audited financials for the period 2017 to 2018.

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.**

   Columbia Surgical Specialists owns only the single ASF, located at 217 W Cataldo Ave, Spokane, WA 99201. In addition, Surgical Specialists operates five satellite clinics in Spokane and Spokane Valley. However, all operate under the same license and certification/credential numbers listed above.

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

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

Table 13: Columbia Surgery Center Productive and Non-Productive FTEs by Type and Year, 2018-2025

FTE Classifications	Historical			Current		Projected		
	2018	2019	2020	2021	2022	2023	2024	2025
ASC Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Assistant Nurse Manager	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Buyer	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Surgical Tech	6.5	6.4	7.4	7.4	7.7	8.0	8.0	8.0
Registered Nurse	17.4	20.2	19.2	17.3	17.9	18.5	19.1	19.1
Licensed Practical Nurse (LPN)	0.0	1.0	1.0	0.0	0.0	0.0	0.0	1.0
Nurse Aid/Pt Care Attendant	0.75	1.0	1.0	2.0	2.0	2.0	2.0	2.0
Health Unit Coordinator (HUC)	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total	**29.6**	**33.6**	**33.6**	**31.7**	**32.6**	**33.5**	**34.1**	**35.1**

Source: Applicant

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

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

   To project staffing increases commensurate with the projected increases in utilization, we added a 3% staffing increase for RNs in 2023 and 2024. Likewise, Surgical Tech FTEs are assumed to increase by 4% between 2022 and 2023 and we anticipate adding 1 LPN FTE in 2025. All other categories are assumed equal to their 2022 levels, and no increases are forecast past 2024 aside from adding a LPN. The FTE levels in 2025 are equal to what it would take to run four rooms five days per week from 7:30am to 5:00pm.

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

   The Columbia Surgery Center's Medical Director is Dr. Carrie Roller (MD00048480). The Medical Director is a shareholder of Columbia Surgical Specialists and is paid a quarterly stipend for the fulfilment of their Medical Director responsibilities. Please see Exhibit 12 for a copy of the November 18, 2020 CSS Board Minutes outlining the Medical Director compensation (Discussion and Decision Items #3), as well as a description of Dr. Roller's responsibilities.

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

Please see Exhibit 12 for a description of the Medical Director's responsibilities.

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

Table 14: Columbia Surgery Center, List of Key ASC Staff

Key Staff	Position	License #
Hart, Kelly	Assistant Nurse Manager	RN00120119
Sudderth, Kristie	Nurse Manager	RN00128341
Tracht, Tricia	Lead Surgical Tech.	ST00001734

Source: Applicant

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

Table 15: List of Current Columbia Surgical Specialists, Physicians and ANRPs

Physicians	Specialty	License #
Ahmad, Rana N	General	MD00034424
Bax, Timothy W	General	MD00036060
Brown, David M.	General	MD60637692
Clyde, Jon C	General	MD00027478
French, Fred P	General	MD60246604
Gilsdorf, Daniel	General	MD60776536
Lin, Paul H.	General	MD00028622
Malladi, Satya V.S.	General	MD60509476
Moore, Michael R.	General	MD00027465
Nickoloff, Jonathan M.	General	MD00044271
Sharbono, Kai L	General	MD60760272
Christante, Dara H.	Colon & Rectal	MD60552600
Juviler, Adam H.	Colon & Rectal	MD00044600
McNevin, M. Shane	Colon & Rectal	MD00040993
Seltman, Ann K.	Colon & Rectal	MD60540308
Guthrie, Carol R.	Breast Surgery	MD00032018
Partoll, Linda M	Urology/ Gynecology/ Pelvic Medicine/ Reconstructive	MD00031122
Hammil, Sarah L	Urology/ Gynecology/ Pelvic Medicine/ Reconstructive	MD60229208
Ahlstrom, Karen K.	Otolaryngology	MD00039605
Bunn, Jeffrey D.	Otolaryngology	MD00041148
Cruz, Michael J	Otolaryngology	MD00038278
Giddings, Neil A	Otolaryngology	MD00031255
Malone, David S	Otolaryngology	MD00036576
McVey, Kevin K.	Otolaryngology	MD00024147
Olds, Michael J	Otolaryngology	MD00033584

Pokorny, Alan T.	Otolaryngology	MD00043413
Qualls, Hannah E	Otolaryngology	MD60960564
Sand, Jordan P	Otolaryngology	MD60681545
Schmitt, William R.	Otolaryngology	MD60436604
Stoddard, David G	Otolaryngology	MD60770094
Roller, Carrie A.	Otolaryngology	MD00048480

ANRPs	Specialty	License #
Bisbee, Megan C.	Otolaryngology	AP60374857
Ledeboer, Karee L.	Otolaryngology	AP60277763

Source: Applicant

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

Table 16: Columbia Surgical Specialists, List of Current Credentialed Physician Assistants

Physician Assistants	Specialty	License #
Gorkovchenko, Ennessa I.	General	PA60901681
Gutsche, Christian J.	General	PA60250429

Source: Applicant

Table 17: Columbia Surgery Center, List of Current Credentialed Nursing Staff

Registered Nurses	Position	License #
Altmeyer, Jody	RN	RN60010712
Bledsoe, Shawn	RN	RN60261933
Bowden, Samantha	RN	RN61052035
Clay, Lynee	RN	RN60879022
Dasovich, Kerry	RN	RN00156453
Erb, Abby	RN	RN60853607
Flood, Shellie	RN	RN60667007
Gibson, Kaycie	RN	RN60835938
Hart, Kelly	Assist. Nurse Mgr.	RN00120119
Howard, Heather	RN	RN60558626
Howard, Kristen	RN	RN00137826
Johnson, Angie	RN	RN60029501
Johnson, Jessica	RN	RN60476775
McCargur, Kayla	RN	RN60651018
Morgan, Samantha	RN	RN61111600
Nelson, Julie Anne	RN	RN61090359
Polishuk, Anna	RN	RN60237255
Schimmels, Jennifer	RN	RN60159489
Ruddach, Jessica	RN	RN6072095

Sharpe, Ericka	RN	RN60732278
Steinhart, Corey	RN	RN00130471
Stellmon, Kelli	RN	RN60019450
Sudderth, Kristie	Nurse Mgr.	RN00128341
VanDinter, Cayce	RN	RN60666010

Nursing Assistants	Position	License #
Spurgin, Christine	Nurse Assistant	NC60163449
Mullin, Megan	Nurse Assistant	NC60878675

Source: Applicant

Table 18: Columbia Surgery Center, List of Current Surgical Technologists

Surgical Technologists	Position	License #
Tracht, Tricia	Surgical Tech.	ST00001734
Oursler, Valerie	Surgical Tech.	ST60365653
Smeltzer, Tawny	Surgical Tech.	ST60453980
Morris, Kristen	Surgical Tech.	ST60469483
Lee, Victoria	Surgical Tech.	ST60729143
Cockle, Bailey	Surgical Tech.	ST60869666
Bates, Ashlee	Surgical Tech.	ST61091944
Gallia, Hannah	Surgical Tech.	ST61100730

Source: Applicant

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

Please see Exhibit 14 for the CSS Recruiting Process policy.

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

Table 19: Columbia Surgery Center, Ancillary and Support Services

Organization Name	Services Provided
NORCO	Medical gases
AMR	Ambulance transport
Heart Clinics NW	EKG Overread services
Henry Schein	General medical supplies
AmeriSource Bergen	Pharmaceutical supplies
Olympus	GI Specialty Supplies, ENT Specialty supplies
Medtronic	ENT specialty supplies
Applied Medical	GS supplies
Boston Scientific	PEG tubes supplies/GI supplies

Stryker	GS specialty supplies, ENT specialty supplies
ABM	Janitorial Services
Kalispel Linen Services	Laundry / linen/ scrubs
InDemand	Interpreter services
SteriCycle	Biomedical and pharmaceutical waste
Devry	Shredding services
CoMedical	Biomed services / maintenance
Steris	OR beds, hand controls, cleaning solutions, service contract
Allied Security	Security
InCyte	Lab/pathology services
Inland Northwest	Fire Protection Services
Anesthesia Associates	Anesthesia services

Source: Applicant

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

Please see our response to Question 10 above.

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)

Columbia Surgery Center does not expect any of the agreements with the organizations listed in Table 19 to change.

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

Columbia Surgery Center currently has a working relationship with Providence Sacred Heart Medical Center (PSHMC). Please see Exhibit 15 for a copy of the transfer agreement between CSS and PSHMC.

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)

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

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

Please see our response to Question 13 above.

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

    Please see Exhibit 15 for a copy of the transfer agreement between Columbia Surgical Specialists and PSHMC.

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)**

    Columbia Surgery Center promotes continuity of care now, since it offers all elements of outpatient Colon & Rectal Surgery, ENT, General Surgery, and Plastic Surgery care, including diagnoses, treatment, and outpatient surgery, if needed. Please also note, as detailed above, there are Gynecology and Urology physicians specialists also currently employed by CSS.

    CN approval of the proposed project will allow CSS physicians across all six of the CSS specialties to perform surgical procedures at the CSS ASC, to add additional specialties and allow non-employed physicians access. Currently there exist only three CN-Approved outpatient ASCs within the Spokane County Planning area, only one of which (Providence Surgery and Procedure Center) is licensed for procedures beyond Plastic Surgery and Ophthalmology. As such, CSS physicians within the Urology and Gynecology specialties, as well as many other planning area providers, must either compete for limited OR time at a single CN-Approved ASC, or access the relatively higher cost Mixed Use rooms at one of the planning area hospitals. The paucity of CN-Approved ASCs in Spokane County has led to current fragmentation of services, which the proposed project will help alleviate. The proposed project will thus promote continuity in the provision of planning area healthcare services.

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).**

    Columbia Surgery Center cooperates with the largest Spokane County inpatient provider, Providence Sacred Heart Medical Center. Please see Exhibit 15 for a copy of the transfer agreement with between Columbia Surgical Specialists (under its old name Spokane ENT) and Providence Sacred Heart Medical Center.

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

    a. **A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or**

b. A revocation of a license to operate a healthcare facility; or
c. A revocation of a license to practice as a health profession; or
d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

Columbia Surgery Center and its parent do not have a history of any of the actions listed above. Thus, this question is not applicable.

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

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

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

In deciding to submit this application, Columbia Surgery Center explored the following options: (1) no project—continuing as a CN-Exempt, four OR facility, and (2) request CN approval for four ORs and an expansion of specialties to include Colon & Rectal Surgery, ENT, Gastroenterology, General Surgery, Plastic Surgery, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology.

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

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

Table 20: Alternatives Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:
No project - remain CN-Exempt with 4 ORs	• There is no advantage to continuing as presently in terms of improving access. (Disadvantage (“D”)) • The Spokane County planning area will continue with only one CN-Approved ASC which provides services to a wide range of specialties. Patients requiring surgical services for specialties outside of plastic surgery and ophthalmology must either contend with scheduling challenges or have their procedure scheduled in a relatively higher cost room at one of the planning area acute care hospitals. (D)
CN Approval for 4 OR ASC (Requested project)	• Allows an expansion of specialties at CSS, open to all physicians in the community who are credentialed and privileged as a member of Proliance’s medical staff, leading to improved access to planning area residents in need of procedures across the additional specialties (Advantage (“A”))

Table 21: Alternatives Analysis: Promoting Quality of Care	
Option:	**Advantages/Disadvantages:**
No project - remain CN-Exempt with 4 ORs	• Continuing as presently conveys no advantages or disadvantages from a quality-of-care perspective. (Neutral ("N"))
CN Approval for 4 OR ASC (Requested project)	• CSS physicians within the Urology and Gynecology specialties will be able to perform surgical procedures at CSS, rather than scheduling surgical time at another facility. This would increase patient and provider convenience and improve scheduling flexibility for these procedures. (A) • CN approval would allow expansion across the requested specialties and utilization of CSS by outside surgeons, thereby improving planning area access across these specialties and reducing the need for outmigration or scheduling at acute care hospitals. This improves quality of care for planning area residents. (A)

Table 22: Alternatives Analysis: Promoting Cost and Operating Efficiency	
Option:	**Advantages/Disadvantages:**
No project - remain CN-Exempt with 4 ORs	• Under this option, there would be no impacts on costs or efficiency of CSS—the surgery center would continue as present. (N) • However, as stated above, without the project, some residents in need of outpatient surgical procedures for certain specialties would likely need to out-migrate or visit inpatient providers due to planning area constraints. This requires otherwise unnecessary travel or usage of relatively expensive inpatient care. (D)
CN Approval for 4 OR ASC (Requested project)	• The incremental cost of this option would be relatively low, and CSS costs and charges are based on fee schedules with CMS and principal payers. Therefore, this option would not be expected to affect costs and charges. (N) • An expansion of services and ability of outside physicians to use the facility would increase access within the planning area for persons needing Colon & Rectal Surgery, ENT, Gastroenterology, General Surgery, Plastic Surgery, Gynecology, Maxillofacial, Ophthalmology, Oral Surgery, Orthopedics, Pain Management, Pediatric Dentistry, Podiatry, and Urology procedures and reduce the need for outmigration or use of acute care inpatient facilities across these specialties. (A)

Table 23: Alternatives Analysis: Legal Restrictions.	
Option:	**Advantages/Disadvantages:**
No project - remain CN-Exempt with 4 ORs	• There are no legal restrictions to continuing operations as presently. (A)
CN Approval for 4 OR ASC (Requested project)	• Requires certificate of need approval. This requires time and expense. (D)

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

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

Exhibit 1
Organizational Chart

Columbia Surgical Specialist

ORGANIZATIONAL CHART

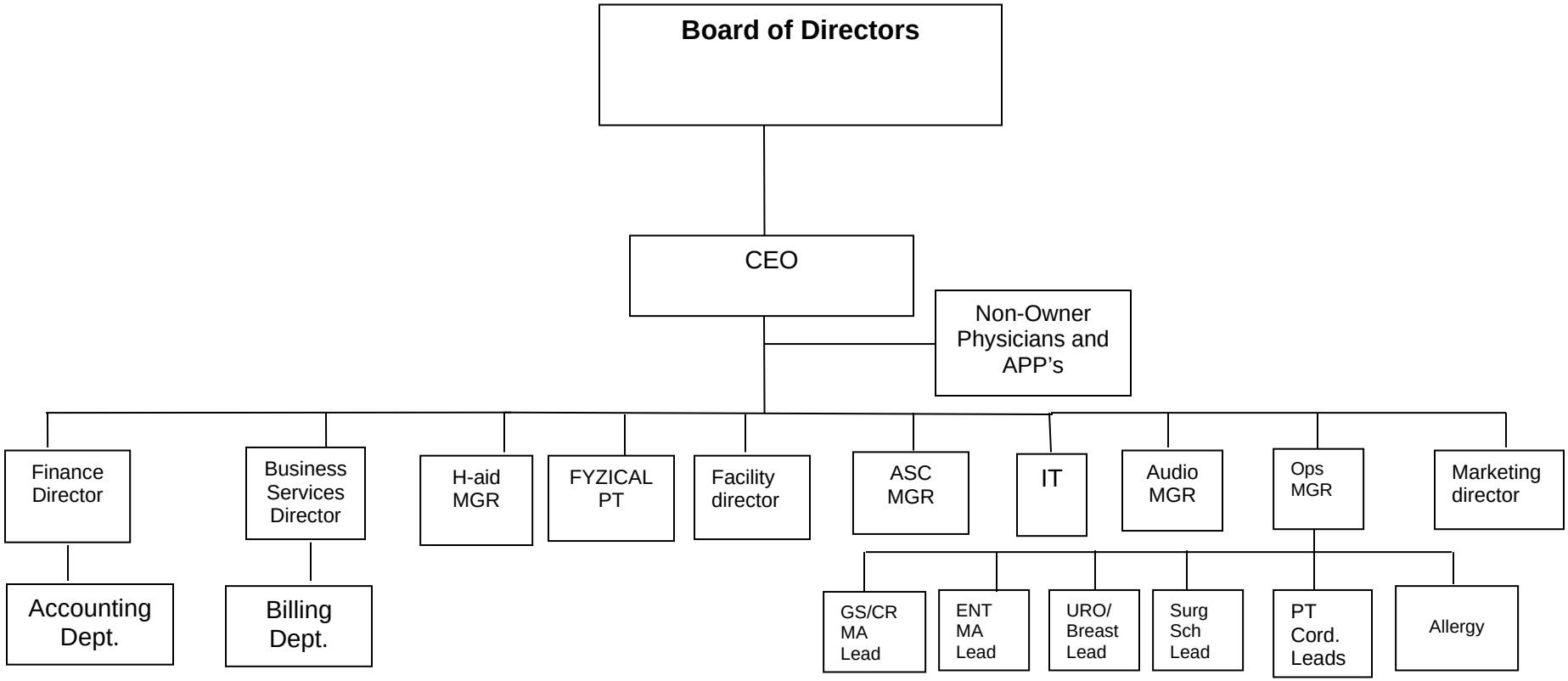

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Exhibit 2
Letter of Intent

COLUMBIA SURGICAL SPECIALISTS

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 12:23 pm, Mar 10, 2021

LOI21-03CoASFS
ex: Sept 10, 2021

March 10, 2021

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

Re: Letter of Intent to Establish and Operate a Certificate of Need Approved Four Operating Suite Ambulatory Surgery Facility in Spokane Washington

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, Columbia Surgical Specialists PS doing business as ("dba") Columbia Surgery Center submits this Letter of Intent "LOI") to establish and operate a certificate of need ("CN") approved four operating suite ambulatory surgery facility in Spokane Washington. Columbia Surgery currently operates four operating suites and is a CN-exempt ambulatory surgery center. Its address is:

Columbia Surgery Center
217 West Cataldo Avenue
Spokane WA 99201

1. Description of proposed service
   Columbia Surgery Center requests approval to establish and operate a CN-approved four operating suite ambulatory surgery facility in Spokane Washington.

2. Estimated cost of the project
   There are no estimated capital costs associated with this project.

3. Identification of the service area
   The service area is Spokane Secondary Health Services Planning Area.

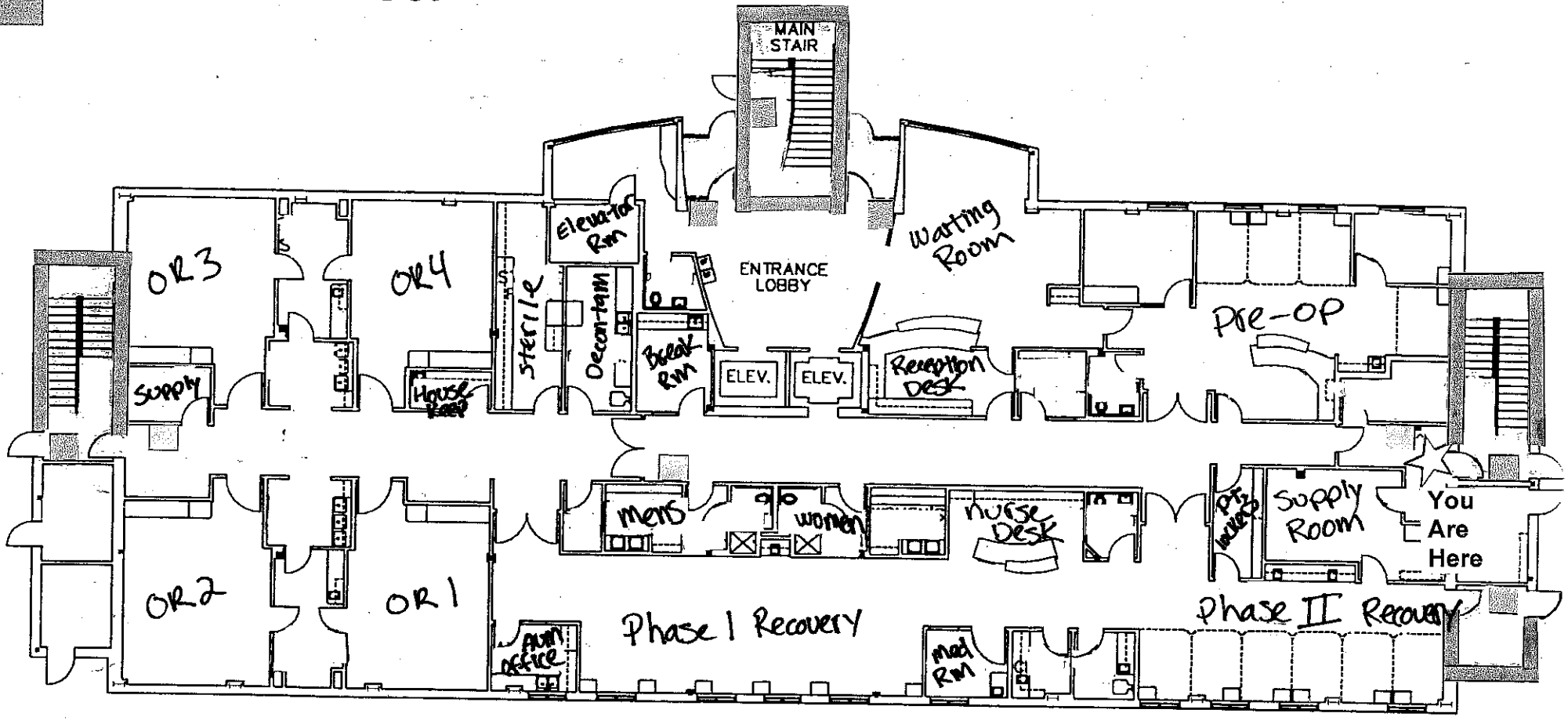
Thank you for your assistance. Please contact me if you have any questions. I can be reached at: 509.789.5777 or at remerson@spokaneent.com

Sincerely,

Rod Emerson
Chief Executive Officer

Exhibit 3
Columbia Surgery Center
Floorplan

Fire Extinguishers
Fire Pulls
Exits / Stairs
Roll Down Door



FIRST FLOOR

Follow Red Arrows To Nearest Exit

Exhibit 4
Planning Area Supply
With Sources

Planning Area Supply
Spokane Planning Area

Facility Name	Exempt/ Approved	Nbr of ORs		Number of surgeries		Number of Minutes		Minutes/Case		Source
		OP	Mixed	OP	Mixed	OP	Mixed	OP	Mixed	
Hospital(s)										
MultiCare Deaconess Hospital	Approved		17		9,929		1,108,500		111.6	2020 DOH Survey (CY2019 Data)
Providence Holy Family	Approved		19		12,861		923,263		71.8	2020 DOH Survey (CY2019 Data)
Providence Sacred Heart	Approved		41		30,624		3,255,300		106.3	2020 DOH Survey (CY2019 Data)
Shriner's Hospital for Children	Approved		2		879		134,513		153.0	DOH 2018 Survey (CY2017 Data)
Valley Hospital	Approved		8		7,616		913,770		120.0	2020 DOH Survey (CY2019 Data)
ASF CN-Approved										
Chesnut Institute of Cosmetic & Reconstructive Surgery	Approved	2		1,266		63,300		50.0		Appendix A, DOH Eval of CN18-01 (ILRS)
MultiCare Rockwood Eye Surgery	Approved	2		1,501		67,825		45.2		2020 DOH Survey (CY2019 Data)
Providence Surgery & Procedure Center	Approved	4		5,960		223,213		37.5		2020 DOH Survey (CY2019 Data)
ASF CN-Exempt										
Advanced Dermatology and Skin Surgery	Exempt	6		2,781		139,050		50.0		ILRS, 2/11/19. K. Nidermayer call, 3/31/20.
Carol Hathaway, MD PS	Exempt	1		90		4,500		50.0		Appendix A, DOH Eval of CN18-01 (ILRS)
Columbia Surgery Center	Exempt	4		5,284		361,525		68.4		DOH 2019 Survey (CY2018 Data)
Empire Eye Surgery	Exempt	1		2,016		100,800		50.0		2020 DOH Survey (CY2019 Data); default minutes
Inland Northwest Surgery Center	Exempt	1		211		18,465		87.5		DOH 2018 Survey (CY2017 Data)
Northwest Eyelid and Orbital Specialists, P.S.	Exempt	1		635		31,750		50.0		DOH 2018 Survey (CY2017 Data)
Northwest Orthopaedic Specialists	Exempt	5		5,513		457,980		83.1		DOH 2019 Survey (CY2018 Data)
Northwest Surgery Center Inc.	Exempt	2		329		16,450		50.0		Appendix A, DOH Eval of CN18-01 (ILRS)
Pacific Cataract and Laser Institute	Exempt	3		3,566		178,300		50.0		2020 DOH Survey (CY2019 Data); default minutes

Planning Area Supply
Spokane Planning Area

Facility Name	Exempt/ Approved	Nbr of ORs		Number of surgeries		Number of Minutes		Minutes/Case		Source
		OP	Mixed	OP	Mixed	OP	Mixed	OP	Mixed	
Hospital(s)										
Shape Cosmetic Surgery and Medspa	Exempt	2		631		32,181		51.0		ILRS, 2/11/19. K. Nidermayer call, 3/31/20.
South Perry Endoscopy, PLLC	Exempt	N/A. Endoscopy Only								
Spokane Digestive Disease Center	Exempt	N/A. Endoscopy Only								
Spokane Surgery Center	Exempt	3		554		24,930		45.0		DOH 2018 Survey (CY2017 Data)
Spokane Valley Ear Nose and Throat	Exempt	2		740		40,331		54.5		DOH 2018 Survey (CY2017 Data)
Seattle Reproductive Medicine Inc PS	Exempt	2		835		41,750		50.0		3/2020 ILRS data, K. Nidermayer, 3/31/2020.
The Plastic Surgicenter	Exempt	2		645		32,250		50.0		11/27/2019 ILRS data, K. Nidermayer, 3/31/2020.
Spokane Eye Clinic PS	Exempt	8		12,100		180,979		15.0		2020 DOH Survey (CY2019 Data)
Total		51	87	**44,657**	**61,909**	**2,015,579**	**6,335,346**	**45.13**	**102.33**	
OR Count in numeric methodology		**8**	**87**							

Exhibit 5
Numeric Need Methodology

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

Service Area Population, 2024			564,611	OFM 2018 GMA Projections - Medium Series			
Surgeries per, 1,000 residents, 2024 @	198.92		112,310				
a.i.	94,250	minutes per year, mixed use OR					
a.ii.	68,850	minutes per year, outpatient OR					
a.iii.	8	dedicated OP ORs x 68,850 minutes =		550,800	minutes, dedicated OR capacity.	12,203	Outpatient surgeries
a.iv.	87	dedicated mixed use ORs x 94,250 minutes =		8,199,750	minutes, mixed use OR capacity.	80,128	Mixed use surgeries
b.i.	Projected inpatient surgeries =		65,246	=	6,676,845	minutes, mixed use surgeries	
	Projected outpatient surgeries =		47,064	=	1,573,426	minutes, outpatient surgeries	
b. ii.	Forecast # of OP surgeries - capacity,of dedicated OP ORs						
			47,064	minus	12,203	=	34,861
b.iii.	Average time of mixed use surgeries			=	102.33	minutes	
	Average time of outpatient surgeries			=	45.13	minutes	
b.iv.	mixed use surgeries, 2024 * average minutes/case			=	6,676,845	minutes	
	remaining OP surgeries (b.ii.) * average minutes/case			=	1,573,426	minutes	
					8,250,271	minutes	
c.i.	if b.iv. < a.iv., divide by (a.iv. - b.iv.) 94,250 to determine surplus of mixed use ORs						
	Not applicable; go to c.ii.						
	8,199,750						
	(8,250,271)						
	(50,521)	divided by	94,250	=	**(0.54)**		
c.ii.	if b.iv. > a.iv., divide (mixed use part of b.iv. - a.iv) by 94,350 to determine shortage of mixed use ORs						
	6,676,845						
	(8,199,750)						
	(1,522,905)	divided by	94,250	=	(16.16)		
	Use This for OP Net Need						
	Divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated OP ORs						
	1,573,426	divided by	68,850	=	**22.85**		

Exhibit 6
NCHS Survey

National Health Statistics Reports

Number 102 ■ February 28, 2017

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

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

Abstract

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

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

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

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

Introduction

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

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

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Centers for Disease Control and Prevention
National Center for Health Statistics

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

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

Methods

Data source and sampling design

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

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

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

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

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

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

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

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

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

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

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

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

Data collection

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

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

Limitations of NHAMCS Ambulatory Surgery Data

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

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

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

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

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

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

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

Results

Ambulatory surgery procedure and visit overview

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

Ambulatory surgery procedures, by sex and age

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

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

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

NOTE: ASC is ambulatory surgery center.

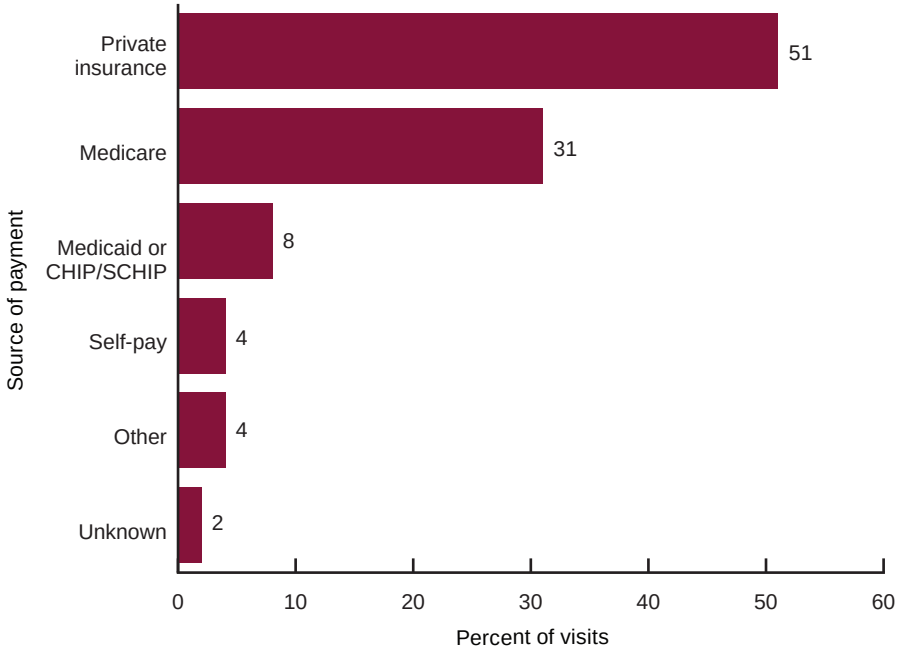
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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

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

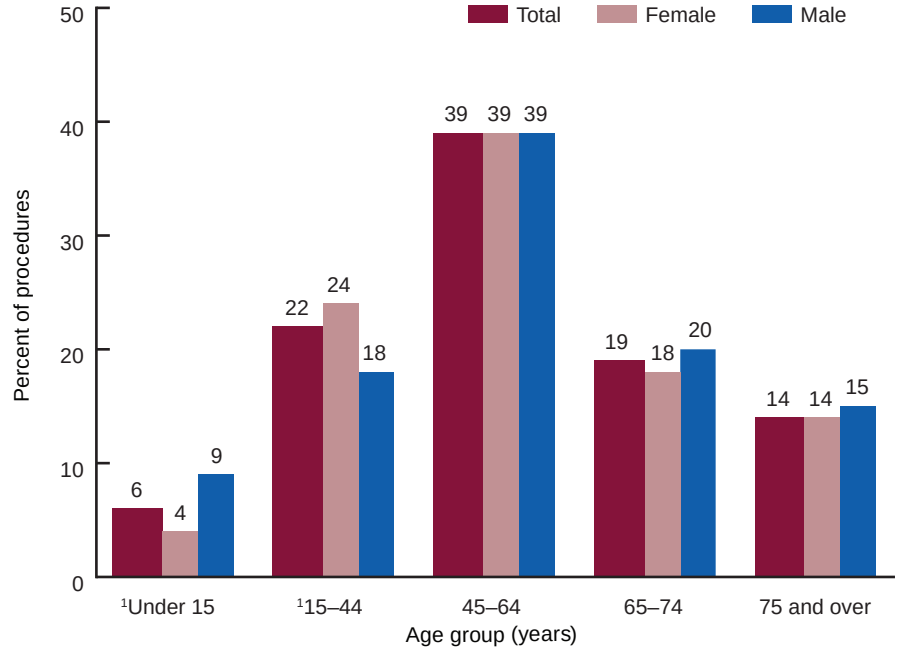
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6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

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



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

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



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

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

Types of procedures

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

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

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

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

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

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

Duration of surgery

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

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

Discussion

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

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

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

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

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

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

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

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

Ambulatory Surgery Data

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

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

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

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

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

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

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

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

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

... Category not applicable.

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

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

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

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

... Category not applicable.

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

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

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

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

See footnotes at end of table.

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

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

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

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

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

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

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

See footnotes at end of table.

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

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

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

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

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

Technical Notes

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

Estimation

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

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

Standard errors

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

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

Testing of significance and rounding

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

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

Nonsampling errors

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

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

Use of tables

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

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

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

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

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

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

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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Exhibit 7
Financial Assistance Policy

Columbia Surgical Specialists, P.S.

Financial Assistance Policy

Purpose:
Columbia Surgical Specialists (CSS) is committed to providing necessary ambulatory surgical services and financial assistance to eligible patients in conformance with federal and state law. This Financial Assistance Policy outlines the criteria and process for patients to receive financial assistance for care received at Columbia Surgical Specialists.

Policy:

1. Financial assistance shall be available and without discrimination regarding race, color, creed, national origin, religion, sex, sexual orientation, disability, age, source of income, or any other class protected by federal or Washington state law.
2. Patients with a gross family income, as compared to Federal Policy Guidelines ("FPG"), defined in the sliding scale income table below, may be eligible for financial assistance, up to a 100% discount**.**
3. Patients must first exhaust all other funding sources for which they may be eligible before they will be eligible for financial assistance from Columbia Surgical Specialists, including, but not necessarily limited to, the following:
    a. Group or individual medical plans; Worker's compensation plans;
    b. Medicaid program;
    c. Medicare;
    d. Other state, federal or military programs;
    e. Third party liability (e.g., personal injury, etc.);
    f. Any other persons or entities who have legal responsibility to pay for the necessary medical care;
    g. Health Savings Account funds.
4. Columbia Surgical Specialists reserves the right to require confirmation a patient is ineligible for alternative funding sources, including without limitation, written denials, (or oral denials followed by documentation) from applicable funding sources. Such documentation decisions will be made by the Columbia Surgical Specialists Administrator.
5. Catastrophic circumstances: any unusual circumstances or extraordinary financial hardships will be considered for extending financial assistance (i.e. full or partial discounts) to patients who do not meet the Financial Assistance Policy, as herein defined. Examples of unusual circumstances include a death or disability in the family. Such circumstances must be approved by the Columbia Surgical Specialists Administrator.

Notification and Communication of Policy:
Information regarding Columbia Surgical Specialists' Financial Assistance Policy will be made widely available across a variety of different mediums, including but not limited to postage and signage in the office, patient brochures and other applicable written materials, digital copies available on our website, and oral information from office staff responsible for patient billing presented in-person and/or by telephone.

Eligibility Criteria and Sliding Fee Schedule:

1. Financial assistance eligibility is dependent on a patient's family's income level, adjusted for family size, compared and measured as a percent of the Federal Poverty Guidelines ("FPG"). Current Federal Poverty Guidelines can be found on the U.S. Department of Health & Human Services' website, available at https://aspe.hhs.gov/poverty-guidelines.
2. Financial assistance means reducing all or some of a patient's financial obligations for the cost of care at Columbia Surgical Specialists that remain after all other funding sources, defined above, are exhausted, as well as patient responsibilities such as deductibles, coinsurance, and copayments that may be required by third-party payers, pursuant to this Financial Assistance Policy.
3. The level of financial assistance that will be provided will be based on a patient's determined family income, in accordance with the following sliding fee schedule:

Patient/Household Income Status	Discount Rate (%)
0-100% FPG	100% Discount to Patient/Family Responsibility
101-200% FPG	50% Discount to Patient/Family Responsibility

*Persons with catastrophic circumstances also qualify for discount to patient/family responsibility. The level of financial assistance will be based on the circumstance and determined by the Columbia Surgical Specialists Administrator.

Income Verification

Income verification is required to determine financial assistance. If a patient cannot provide documentation for the last complete calendar year and documentation for the current year-to-date, he/she may submit a written signed statement describing his/her family's income. Examples of proof of income include:

- A "W-2" withholding statement; or
- Pay stubs (last full year and year-to-date); 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.

Review

The Columbia Surgical Specialists Administrator will make a determination within fourteen (14) calendar days after receiving income verification documentation. If approved, the patient will receive written notice that will include the level of discount allowed. This approval will be valid for 90 calendar days and a new request is required after such time. If denied, written notice will be provided including reason for the denial, payment terms and instructions for any appeals.

Appeals

The patient may appeal the decision by providing additional proof of income or family size within 30 days of the determination to address the reason for denial. Additional documentation needed to support the appeal may be requested and if it is not received the appeal may be denied. The patient will receive written notice of the appeal decision within fourteen days of submitting the additional documentation required for review.

Exhibit 8
Admissions and
Patient Rights and Responsibilities
Policies

SECTION 4.505
Patient Admission, Assessment and Discharge

Columbia Surgical Specialists ASC will ensure that each patient has the appropriate pre-surgical and post-surgical assessments completed and that all elements of the discharge requirements are completed.

Patient Identification: Patients will be identified by their name and date of birth; at admission, at patient hand-off between providers, and prior to administration of any medication.

Admission and Pre-surgical Assessment
Not more than 30 days before the date of the scheduled surgery, each patient will have a comprehensive medical history and physical assessment completed by a physician or a nurse practitioner.

Per WAC 246-330-205, upon admission, each patient will have:

1. Pre-surgical Assessment for risk of falls, skin condition, pressure ulcers, pain, medication use, therapeutic effects and side or adverse effects.
2. Complete and document an initial assessment of each patient's physical condition, emotional, and social needs in the medical record. Initial assessment includes:

(a) Dependent upon the procedure and the risk of harm or injury, a patient history and physical assessment including but not limited to falls, mental status and skin condition;
(b) Current needs;
(c) Need for discharge planning;
(d) When treating pediatric patients, the immunization status;
(e) Physical examination, if within thirty days prior to admission, and updated as needed if patient status has changed; and
(f) Discharge plans when appropriate, coordinated with:
(i) Patient, family or caregiver; and
(ii) Receiving agency, when necessary.

Upon admission, every patient will have a pre-surgical assessment completed by the admitting registered nurse as well as documentation that the patient's condition since completion of the history and physical has not changed; this is to include verifying and/or updating any allergies to drugs and biologicals. The surgeon verifies that the patient continues to be an appropriate candidate for surgery the morning of surgery during the pre-op evaluation and interview. This will be documented in the patients chart indicating "the H&P was reviewed, the patient was examined, and that 'no change' has occurred in the patient's condition since the H&P was completed." A hard printed copy of the H&P and any additional medical records and/or test results will be placed in the patient's chart the day of surgery for review by both the surgeon and anesthesiologist.

Post-Surgical Assessment
The patient's post-surgical condition will be assess and documented in the medical record by either the surgeon or a recovery registered nurse. Registered nurses have specific job training and delegation by the Board of Directors as competent to assess the physical condition of a patient. Specific guidelines have been established (4.510) addressing

Reviewed: 3/01, 3/02,3/03,9/04,5/05,9/08, 9/13
Revised: 01/01, 3/02, 5/09, 2/10, 6/14, 11/14

discharge criteria. Anesthesia assess the patients following administration of anesthesia and documents (dates and times) the adequate recovery from anesthesia. In the event post-surgical needs are identified, the surgeon, anesthesiologist, or on-call surgeon are notified. If a transfer to the hospital is needed policy 4.520 addresses this.

Discharge

Patients are provided with individualized, written discharge instruction and overnight supplies as needed. Follow-up appointments on cards are also provided. Patients are informed prior to leaving the ASC of their prescriptions, post-operative directions and physician contact information for emergency needs and follow-up care.

All patients will have a discharge order prior to leaving the ASC. In some cases, the discharge order may come from the on-call surgeon

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Revised: 01/01, 3/02, 5/09, 2/10, 6/14, 11/14

Section 12.001

Patient Notification of Rights and Responsibilities

Following Medicare Conditions for Coverage requirements, patients for the Ambulatory Surgery Center (ASC) are notified of their rights, responsibilities, policy on advanced directive directives, and physician ownership prior to the date of their surgery; information is provided both verbally and written in their appropriate language. If a patient receives a referral to the ASC the same day as their procedure, the appropriate information is provided at the time of their appointment.

When a patient schedules surgery, the scheduler provides a pamphlet clearly explaining the above mentioned items. (See attached). It is documented in the "*SURG_SCHED_CSS" template patient receipt of this information. Should a patient schedule over the phone, the R&R document is mailed, faxed, or e-mailed along with their other surgical papers. To verify that the patients are in receipt of required notification prior to the date of surgery, patients are again asked to verify receipt of the document during the pre-registration process. In situations where the patient is unsure, the information is then provided both verbally (in their appropriate language) and mailed (time allowing), faxed, or e-mailed.

In the event that a patient is referred to the ASC for surgery on the same day, the rights and responsibilities document is provided and explained at the time of scheduling.

These rights and responsibilities are the same for patients that are minors, wards of the state (regardless of age) and patients judged to be legally incompetent. Legal surrogates, legal guardians/custodians, and family members are also accountable to the same Rights and Responsibilities afforded to patients. Consenting for these patients is addressed in Policy 2.532 to assure their rights are not compromised.

Columbia Surgical Specialists has posted a written notice of patient rights on a main wall likely to be noticed by patients, family members, or representatives waiting for treatment. The notice of rights includes the rights, responsibilities, physician ownership, policy on advanced directives, as well as the name, address and telephone number for the Department of Health Complaint Hotline as well as the web site for the Office of the Medicare Beneficiary Ombudsman.

Reviewed: 11/09, 2/10, 1/12
Revised:11/09, 2/10, 7/14, 11/14, 5/16

Patient Responsibilities

Columbia Surgical Specialists, P.S. ASC (CSS) physicians expect that patients are responsible for cooperating with those providing health care services. The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect.

1. The patient has the responsibility to provide accurate and complete information concerning his present complaints, past medical history, any medications (including over-the-counter products and dietary supplements), any allergies or sensitivities, and other matters relating to his health.
2. The patient is responsible for following the treatment plan established by his physicians, including the instructions of nurses and other health care professionals as they carry out the physician's orders.
3. Columbia Surgical Specialists, P.S. ASC recognizes patient responsibilities according to policies of Columbia Surgical Specialists, P.S. ASC and individual insurance plans, as communicated to patients by the insurance plan in a member services publication.
4. The patient is responsible for keeping their appointments and for notifying the facility or physician when he is unable to do so.
5. The patient is responsible for making it known whether he clearly comprehends the course of his medical treatment and what is expected of him.
6. The patient is responsible for his actions should he refuse treatment or not follow his physician's orders.
7. The patient is responsible for fulfilling the financial obligations of his care as promptly as possible.
8. The patient is responsible for following facility policies and procedures.
9. The patient is responsible for being considerate of the rights of other patients and facility personnel.
10. The patient is responsible for being respectful of his personal property and that of other persons in the facility.
11. The patient is responsible to provide a responsible adult to transport him/her home from the ASC and remain with them for 24 hours, if required by the provider.
12. The patient is responsible to inform CSS about any living will, medical power of attorney, or other directive that could affect their care.

Patient Rights

Columbia Surgical Specialists, P.S. ASC (CSS) physicians and staff members are committed to treating patients in a dignified manner that respects their rights.

1. Patient rights are posted in the waiting area of Columbia Surgical Specialists, P.S. ASC. These rights shall be posted in English. If a patient requests, these rights may be explained via an interpreter.
2. Columbia Surgical Specialists, P.S. ASC recognizes patient rights according to its own policies and the policies of individual insurance plans.
3. Columbia Surgical Specialists, P.S. ASC recognizes patient rights in accordance with state Health and Safety Codes.
4. Patients may express satisfaction or dissatisfaction with Columbia Surgical Specialists, P.S. ASC verbally to any staff member or provider or in writing via the Patient Satisfaction Survey.
5. All, personnel shall observe these patient's rights.

This facility and Medical Staff have adopted the following list of Patient Rights. This list shall include but not be limited to the patient's rights to:

1. Exercise these rights without regard to sex or culture, economic, educational or religious background or the source of payment for his care.

Reviewed: 11/09, 2/10, 1/12
Revised:11/09, 2/10, 7/14, 11/14, 5/16

2. Be treated and cared for with consideration, dignity and respect. Receive confidentiality, privacy, security, complaint resolution, spiritual care, and communication. If communication restrictions are necessary for patient care and safety, restrictions will be explained. Be protected from abuse and neglect. Have access to protective services.
3. Knowledge of the name of the physician who has primary responsibility for coordinating his care and the names and the professional relationships of other physicians who will see him.
4. Receive information from his physicians about his illness, his course of treatment and his prospects for recovery in terms that he can understand.
5. Receive as much information about any proposed treatment or procedure as he may need in order to give informed consent or to refuse his course of treatment. Except in emergencies, this information shall be provided by the surgeon and shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternative courses of treatment or non-treatment and the risks involved, any unanticipated outcomes post-procedure, and to know the name of the person who will carry out the treatment.
6. Participate actively in decisions regarding his medical care. To the extent permitted by law, this includes the right to refuse care and treatment and resolving problems with care decisions. Complain about your care and treatment without fear of retribution or denial of care. Timely complaint resolution.
7. Full consideration of privacy concerning his medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual. Family input in care decisions in compliance with existing legal directives of the patient or existing court-issued legal orders.
8. Confidential treatment of all communications and records pertaining to his care. Written permission shall be obtained before medical records can be made available to anyone not directly related to treatment, payment or operations per HIPPA laws.
9. Reasonable response to any request he may make for services.
10. Leave the facility even against the advice of his physician.
11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
12. Be advised if his physician proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects without hindering access to care.
13. Be informed by his physician or a delegate of his physician of the continuing health care requirements following the discharge from the facility.
14. Examine and receive an explanation of his bill regardless of the source of payment.
15. Know which facility rules and policies apply to his conduct while a patient.
16. Have all patient rights apply to the person who may have legal responsibility to make decisions, surrogate decision makers, regarding medical care on behalf of the patient.

Advanced Directives

Advanced health care directives, also know as advance directives or living will, are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. If you already have an advance directive, please bring it with you to the surgery center. In the event of an emergency / Notice of Limitation. During your time at Columbia Surgery Center, we will always attempt to resuscitate a patient and transfer that patient to the hospital. In the event of deterioration, your advance directive will go with you and your chart to the hospital, should you be admitted. A health care directive, commonly referred to as a 'living will', is a legal document specifying your wishes regarding the care you receive at the end of life, should you become unable to communicate them. In Washington State, the directive is used only if you have a terminal condition where life-sustaining treatment would only artificially prolong the process of dying; or if you are in an irreversible coma and there is no reasonable hope of recovery. Health care directives may also be

called a directive to a physician, declaration or medical directive. They can be accessed via the following website: https://www.wsma.org/media/patients-pdfs/advance-directive-forms.pdf
Information is available to any patient if requested. These documents are provided by the Washington State Medical Association.

Physician Ownership

Columbia Surgical Specialists, P.S. is owned by the physicians. The owners list is posted in the ASC lobby.

Reviewed: 11/09, 2/10, 1/12
Revised:11/09, 2/10, 7/14, 11/14, 5/16

Section 12.100
Patient Rights

Columbia Surgical Specialists, P.S. ASC (CSS) physicians and staff members are committed to treating patients in a dignified manner that respects their rights.

1. Patient rights are posted in the waiting area of Columbia Surgical Specialists, P.S. ASC. These rights shall be posted in English. If a patient requests, these rights may be explained via an interpreter.
2. Columbia Surgical Specialists, P.S. ASC recognizes patient rights according to its own policies and the policies of individual insurance plans.
3. Columbia Surgical Specialists, P.S. ASC recognizes patient rights in accordance with state Health and Safety Codes.
4. Patients may express satisfaction or dissatisfaction with Columbia Surgical Specialists, P.S. ASC verbally to any staff member or provider or in writing via the Patient Satisfaction Survey.
5. All, personnel shall observe these patient's rights.

This facility and Medical Staff have adopted the following list of Patient Rights. This list shall include but not be limited to the patient's rights to:

1. Exercise these rights without regard to sex or culture, economic, educational or religious background or the source of payment for his care.
2. Be treated and cared for with consideration, dignity and respect. Receive confidentiality, privacy, security, complaint resolution, spiritual care, and communication. If communication restrictions are necessary for patient care and safety, restrictions will be explained and documented in NextGen via an alert that will have an expiration date. Be protected from abuse and neglect. Have access to protective services.
3. Knowledge of the name of the physician who has primary responsibility for coordinating his care and the names and the professional relationships of other physicians who will see him. Patients have the right to change providers if other qualified providers are available.
4. Receive information from his physicians about his illness, his course of treatment and his prospects for recovery in terms that he can understand.
5. Receive as much information about any proposed treatment or procedure as he may need in order to give informed consent or to refuse his course of treatment. Except in emergencies, this information will be provided by the surgeon and shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternative courses of treatment or non-treatment and the risks involved, any unanticipated outcomes post-procedure, and to know the name of the person who will carry out the treatment.

Reviewed: 3/01,9/08, 1/12
Revised: 3/01, 7/14, 11/14, 6/15, 5/16

6. Participate actively in decisions regarding his medical care. To the extent permitted by law, this includes the right to refuse care and treatment and resolving problems with care decisions. Complain about your care and treatment without fear of retribution or denial of care. Timely complaint resolution.
7. Full consideration of privacy concerning his medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual. Family input in care decisions in compliance with existing legal directives of the patient or existing court-issued legal orders.
8. Confidential treatment of all communications and records pertaining to his care. Written permission shall be obtained before medical records can be made available to anyone not directly related to treatment, payment or operations per HIPPA laws.
9. Reasonable response to any request he may make for services.
10. Leave the facility even against the advice of his physician.
11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
12. Be advised if his physician proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects without hindering access to care.
13. Be informed by his physician or a delegate of his physician of the continuing health care requirements following the discharge from the facility.
14. Examine and receive an explanation of his bill regardless of the source of payment.
15. Know which facility rules and policies apply to his conduct while a patient.
16. Have all patient rights apply to the person who may have legal responsibility to make decisions, surrogate decision makers, regarding medical care on behalf of the patient.

Reviewed: 3/01,9/08, 1/12
Revised: 3/01, 7/14, 11/14, 6/15, 5/16

Section 12.200
Patient Responsibilities

Columbia Surgical Specialists, P.S. ASC (CSS) physicians expect that patients are responsible for cooperating with those providing health care services. The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect.

1. The patient has the responsibility to provide accurate and complete information concerning his present complaints, past medical history, any medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters relating to his health.
2. The patient is responsible for following the treatment plan established by his physicians, including the instructions of nurses and other health care professionals as they carry out the physician's orders.
3. Columbia Surgical Specialists, P.S. ASC recognizes patient responsibilities according to policies of Columbia Surgical Specialists, P.S. ASC and individual insurance plans, as communicated to patients by the insurance plan in a member services publication.
4. The patient is responsible for keeping their appointments and for notifying the facility or physician when he is unable to do so.
5. The patient is responsible for making it known whether he clearly comprehends the course of his medical treatment and what is expected of him.
6. The patient is responsible for his actions should he refuse treatment or not follow his physician's orders.
7. The patient is responsible for fulfilling the financial obligations of his care as promptly as possible.
8. The patient is responsible for following facility policies and procedures.
9. The patient is responsible for being considerate of the rights of other patients and facility personnel.
10. The patient is responsible for being respectful of his personal property and that of other persons in the facility.

Reviewed: 3/01,9/08, 1/12
Revised: 3/01, 3/14, 6/15

Exhibit 9
Non-Discrimination Policies

Section 5.2001
Anti Discrimination Policy

It is the right of the employees of Columbia Surgical Specialists, P.S. ASC (CSS) to work in an environment free from discrimination on the basis of age, race, religious belief, gender, national origin, or disability. The policy of Columbia Surgical Specialists, P.S. ASC is to provide an employment and business environment free of discrimination and other verbal and/or physical conduct or communications constituting harassment as defined and otherwise prohibited by state and federal law. CSS complies with the Americans with Disabilities Act, Title VII, the Civil Rights Act, Age Discrimination in Employment Act, and other federal, state, and local prohibitions against discrimination.

Discrimination on the basis of age, race, religious belief, gender, national origin, or disability by and between employees, physicians, and patients is prohibited by this policy.

Violations of this policy may result in disciplinary action up to and including termination. Questions about this policy may be directed to the Columbia Surgical Specialists Surgery Center ASC Manager or the Administrator.

COMPLAINTS

A. Employees

Employees who experience discrimination or harassment at work (by a supervisor, fellow employee, or patient) are urged to report such conduct to the direct attention of their immediate supervisor. If the complaint involves the employee's supervisor or someone in the direct line of supervision, or if the employee for any reason is uncomfortable in dealing with his or her immediate supervisor, the employee may go directly to the Clinic Administrator, the CSS ASC Manager, or any CSS physician.

B. Patients

In the event of a patient complaint of discrimination or harassment, employees should report the complaint to surgery center management.

C. General - Applicable to Both Employees and Patients

A committee composed of (1) the Clinic Administrator, (2) the ASC manager, and (3) a designated physician, will investigate all complaints as professionally and expeditiously as possible. Where investigation confirms the allegations, appropriate responsive action will be taken by the committee. Follow up meetings will be held to review any actions at intervals designated appropriate by the committee. The CSS Office phone number is (509) 624-2326.

FAILURE TO REPORT

Supervisors, managers, administrators and physicians who disregard or fail to report allegations of discrimination (whether reported by the person who is the subject of the discrimination or a witness) are in violation of this policy.

Reviewed: 3/01, 5/02, 5/03,9/04,10/05,9/08, 3/11
Revised:6/14

RESPONSIBILITY FOR POLICY ENFORCEMENT

Every CSS employee, manager, and physician must avoid offensive or inappropriate discriminatory or harassing behavior at work. Employees, managers, and physicians are encouraged (but not required) to inform perceived offenders of this policy that the commentary/conduct is offensive and unwelcome.

CONFIDENTIALITY

Records will be maintained in a confidential manner to the extent permitted by law and insofar as they do not interfere with CSS legal obligation to investigate and resolve issues of discrimination.

VIOLATIONS OF LAW

An employee, manager, or physician may be accountable for discrimination under applicable local, state, and/or federal law, as well as under CSS policy. Disciplinary action by CSS may proceed while criminal proceedings are pending and will not be subject to challenge on the grounds that criminal charges involving the same incident have been dismissed or reduced.

FALSE STATEMENTS PROHIBITED

Any individual who knowingly provides false information pursuant to filing a discrimination charge or during the investigation of a discrimination charge, will be subject to appropriate disciplinary action, up to and including, employment termination or dismissal.

RETALIATION PROHIBITED

Retaliation against an employee, manager, patient, or physician for filing a discrimination complaint, or participating in the investigation of a complaint, is strictly prohibited. CSS will take appropriate disciplinary action, up to and including employment termination if evidence of retaliation exists.

_____ _____

Signature Date

Reviewed: 3/01, 5/02, 5/03,9/04,10/05,9/08, 3/11,
Revised:6/14

DISCRIMINATION IS AGAINST THE LAW

COLUMBIA SURGICAL SPECIALISTS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. COLUMBIA SURGICAL SPECIALISTS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

COLUMBIA SURGICAL SPECIALISTS provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and some written information in other formats upon request (large print, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as: qualified interpreters.

If you believe that COLUMBIA SURGICAL SPECIALISTS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with at 217 West Cataldo, Spokane, WA 99201 or (509)624-2326. You can file a grievance in person or by mail or phone. If you need help filing a grievance, OLUMBIA SURGICAL SPECIALISTS is available to assist you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

COLUMBIA SURGICAL SPECIALISTS cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. COLUMBIA SURGICAL SPECIALISTS no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

COLUMBIA SURGICAL SPECIALISTS proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes: intérpretes de lenguaje de señas capacitados. Información escrita en otros formatos (letra grande, formatos electrónicos accesibles, otros formatos). Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes: Intérpretes capacitados. Información escrita en otros idiomas.

Si considera que COLUMBIA SURGICAL SPECIALISTS no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: KRISTIE SUDDERTH alas 217 West Cataldo, Spokane, WA 99201 or (509)624-2326. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, COLUMBIA SURGICAL SPECIALISTS está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

COLUMBIA SURGICAL SPECIALISTS

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-742-3261.	ATENCIÓN **Español (Spanish)**: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-742-3261.
Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-742-3261.	**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-742-3261.
日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-742-3261 まで、お電話にてご連絡ください。	**ខ្មែរ (Cambodian)** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ1-800-742-3261
Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-742-3261	**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-742-3261.
ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-742-3261 'ਤੇ ਕਾਲ ਕਰੋ।	**(Arabic)** رقم 772-398-7336- ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان . اتصل برقم.
ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-742-3261	**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-742-3261.
한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-742-3261. 번으로 전화해 주십시오.	**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-742-3261.
አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-742-3261.	**ภาษาไทย (Thai):** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-742-3261.

Appendix C to Part 92—Sample Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Columbia Surgical Specialists, PLLC not to discriminate on the basis of race, color, national origin, sex, age or disability. Columbia Surgical Specialists, PLLC has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of:

Privacy Officer
217 West Cataldo
Spokane, WA 99201
Phone: (509)624-2326
Fax: (509)329-5838

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Columbia Surgical Specialists, PLLC to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Columbia Surgical Specialists, PLLCr elating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Chief Executive Officer within 15 days of receiving the Section 1557 Coordinator's decision. The Chief Executive Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination. Columbia Surgical Specialists, PLLC will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Dated: October 12, 2016

Privacy Officer

Exhibit 10

Historical Financial Statements and Financial Pro Forma

COLUMBIA SURGICAL SPECIALISTS, P.S.
ASC Revenue and Expense Assumptions

Revenue Category	**Assumption**
Gross revenue	Projected 2021-2024 based on 2019 gross revenue/case equal to $3,293.01
Bad Debt	2018-2020 Actual Bad Debt written-off; Projected 2021-2024 based on ratio of 2019 bad debt/case equal to $17.70
Charity Care	Projections based on 0.79% of Gross Revenue
Contractual Adustments	Projected 2021-2024 based on average 2019 contractual allowance/case equal to $1,701.64
Total Deduction from Revenue	Calculated
Net patient service revenue	Calculated
Expense Category	**Assumption**
Salaries and wages	See FTE Schedule for Projections. Includes the occupational positions ASC Director, Assistant Nurse Manager, Buyer, Surgical Tech, RN, LPN, Nurse Aide, and Health Unit Coordinator.
Employee benefits	Projected 2021-2024 based on 2019 EE Benefits as a % of Salaries/Wages 24.4%
Gen Admin/SS allocated wages	See FTE Schedule for Projections. Includes the occupational positions Administration/Accounting/Marking, Facilities, IT Support, Billing and Collection, and Scheduling Coordinator.
Gen Admin/SS allocated benefits	Projected 2021-2024 based on 2019 EE Benefits as a % of Salaries/Wages 24.4%
Medical/surgical supplies	Projected 2021-2024 based on 2019 exp/case equal to $559.94
Office supplies	Projected 2021-2024 based on 2019 exp/case equal to $12.62
Building/occupancy	Same as 2019 annual equal to $571,121; allocated on sq footage of leased space
Depreciation	Same as 2020 annual equal to $147,709; assuming no change in the projected years (2021-2024)
Professional fees	Projected 2021-2024 based on 2019 exp/case equal to $0.06
Purchased services	Projected 2021-2024 based on 2019 exp/case equal to $20.43
Telephone/communications	Projected 2021-2024 based on 2019 exp/case equal to $4.90
Postage	Projected 2021-2024 based on 2019 exp/case equal to $2.05
Marketing/public relations	Projected 2021-2024 based on 2019 exp/case equal to $1.10
Computer services	Projected 2021-2024 based on 2019 exp/case equal to $15.75
Interest expense	Assumed equal to zero based on historical actuals and absence of debt
Taxes/licenses	Washington State Excise tax = 1.75% of net patient service revenue
Miscellaneous/other	Projected 2021-2024 based on 2019 exp/case equal to $1.16

COLUMBIA SURGICAL SPECIALISTS, P.S.
ASC Income Statement Projections

	Historical Actuals			Forecast				
	2018	2019	2020	Jan - Sep 2021	Oct - Dec 2021	2022	2023	2024
REVENUE:								
Months	12	12	12	9	3	12	12	12
Gross revenue	$ 15,623,840	$ 17,400,261	$ 14,312,520	$ 13,323,516	$ 4,557,525	$ 18,414,508	$ 18,612,088	$ 18,816,255
Bad Debt	$ (97,880)	$ (93,524)	$ (100,808)	$ (71,612)	$ (24,496)	$ (98,975)	$ (100,037)	$ (101,135)
Charity Care					$ (36,004)	$ (145,475)	$ (147,035)	$ (148,648)
Contractual Adustments	$ (7,682,557)	$ (8,991,464)	$ (6,893,210)	$ (6,884,834)	$ (2,355,069)	$ (9,515,569)	$ (9,617,667)	$ (9,723,169)
Total Deductions from Revenue	$ (7,780,437)	$ (9,084,988)	$ (6,994,018)	$ (6,956,446)	$ (2,415,570)	$ (9,760,019)	$ (9,864,740)	$ (9,972,952)
Net patient service revenue	$ 7,843,403	$ 8,315,273	$ 7,318,502	$ 6,367,070	$ 2,141,955	$ 8,654,489	$ 8,747,348	$ 8,843,303
NON PROVIDER EXPENSE:								
Salaries and wages	$ 1,865,297	$ 1,968,175	$ 1,712,582	$ 1,578,033	$ 540,132	$ 2,131,975	$ 2,145,785	$ 2,145,785
Employee benefits	$ 419,860	$ 479,254	$ 428,149	$ 385,040	$ 131,792	$ 520,202	$ 523,572	$ 523,572
Gen Admin/SS allocated wages	$ 454,694	$ 502,953	$ 354,929	$ 374,700	$ 128,253	$ 502,953	$ 502,953	$ 502,953
Gen Admin/SS allocated benefits	$ 115,088	$ 127,463	$ 93,850	$ 91,427	$ 31,294	$ 122,720	$ 122,720	$ 122,720
Medical/surgical supplies	$ 2,730,489	$ 2,958,712	$ 2,598,925	$ 2,265,509	$ 774,954	$ 3,131,173	$ 3,164,769	$ 3,199,485
Office supplies	$ 61,154	$ 66,694	$ 56,619	$ 51,068	$ 17,469	$ 70,582	$ 71,339	$ 72,121
Building/occupancy	$ 552,380	$ 571,121	$ 542,767	$ 425,554	$ 145,567	$ 571,121	$ 571,121	$ 571,121
Depreciation	$ 159,933	$ 121,168	$ 147,709	$ 110,061	$ 37,648	$ 147,709	$ 147,709	$ 147,709
Professional fees	$ 823	$ 326	$ 416	$ 250	$ 85	$ 345	$ 349	$ 353
Purchased services	$ 99,033	$ 107,955	$ 110,444	$ 82,662	$ 28,276	$ 114,248	$ 115,473	$ 116,740
Telephone/ communications	$ 23,434	$ 25,907	$ 23,614	$ 19,837	$ 6,786	$ 27,417	$ 27,711	$ 28,015
Postage	$ 1,841	$ 10,823	$ 2,123	$ 8,287	$ 2,835	$ 11,454	$ 11,577	$ 11,704
Marketing/public relations	$ 3,486	$ 5,790	$ 7,109	$ 4,433	$ 1,517	$ 6,127	$ 6,193	$ 6,261
Computer services	$ 61,280	$ 83,230	$ 95,843	$ 63,730	$ 21,800	$ 88,081	$ 89,026	$ 90,003
Interest expense	$ -	$ -						
Taxes/licenses	$ 116,888	$ 128,769	$ 131,701	$ 111,424	$ 37,484	$ 151,454	$ 153,079	$ 154,758
Miscellaneous/other	$ 6,453	$ 6,116	$ 5,171	$ 4,683	$ 1,602	$ 6,472	$ 6,542	$ 6,614
Total non-provider expense	$ 6,672,133	$ 7,164,456	$ 6,311,951	$ 5,576,697	$ 1,907,494	$ 7,604,033	$ 7,659,918	$ 7,699,914
Income/(loss) from operations	$ 1,171,270	$ 1,150,817	$ 1,006,551	$ 790,372	$ 234,461	$ 1,050,456	$ 1,087,430	$ 1,143,389
Gain/loss on asset disposal								
Non operating income								
Miscellaneous Income								
Net income/(loss)	$ 1,171,270	$ 1,150,817	$ 1,006,551	$ 790,372	$ 234,461	$ 1,050,456	$ 1,087,430	$ 1,143,389
STATISTICS:								
ASC surgical cases	5,315	5,284	4,403	4,046	1,384	5,592	5,652	5,714

COLUMBIA SURGICAL SPECIALISTS, P.S.
ASC Deductions from Revenue Schedule

	2018	2019 Actuals	2020	Jan - Sept 2021	Oct - Dec 2021	2022	2023	2024
Contractual Allowances:								
Medicare	$ 1,334,132	$ 1,561,433	$ 1,197,056	$ 1,195,602	$ 408,975	$ 1,652,448	$ 1,670,178	$ 1,688,499
Medicaid	$ 2,783,123	$ 3,257,294	$ 2,497,170	$ 2,494,135	$ 853,159	$ 3,447,159	$ 3,484,146	$ 3,522,365
Commercial	$ 3,004,864	$ 3,516,815	$ 2,696,129	$ 2,692,852	$ 921,134	$ 3,721,807	$ 3,761,740	$ 3,803,005
Tricare, Triwest	$ 452,225	$ 529,273	$ 405,761	$ 405,268	$ 138,629	$ 560,123	$ 566,133	$ 572,344
Self-Pay	$ 66,847	$ 78,236	$ 59,979	$ 59,906	$ 20,492	$ 82,796	$ 83,684	$ 84,602
Other	$ 41,366	$ 48,414	$ 37,116	$ 37,071	$ 12,681	$ 51,236	$ 51,785	$ 52,353
Total Contractual Allowances	$ 7,682,557	$ 8,991,464	$ 6,893,210	$ 6,884,834	$ 2,355,069	$ 9,515,569	$ 9,617,667	$ 9,723,169
Total Bad Debt	$ 97,880	$ 93,524	$ 100,808	$ 71,612	$ 24,496	$ 98,975	$ 100,037	$ 101,135
Total Charity Care	$ -	$ -	$ -	$ -	$ 36,004	$ 145,475	$ 147,035	$ 148,648
Total Deductions From Revenue	**$ 7,780,437**	**$ 9,084,988**	**$ 6,994,018**	**$ 6,956,446**	**$ 2,415,570**	**$ 9,760,019**	**$ 9,864,740**	**$ 9,972,952**

Note: 2019 contractual allowances by payer reflect historical actuals; 2018 and 2020 reflect total contractual allowances, distributed by 2019 allocations by payer.

COLUMBIA SURGICAL SPECIALISTS, P.S.
ASC Balance Sheet

	Historical Actuals			Forecast				
	2018	2019	2020	Jan to Sep 2021	Jan to Dec 2021	2022	2023	2024
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	1,544,126	1,299,033	1,424,844	1,378,006	1,591,719	1,622,216	1,525,922	1,588,334
Restricted funds	1,544,126	1,299,033	1,424,844	1,378,006	1,591,719	1,622,216	1,525,922	1,588,334
Gross patient receivables	2,108,084	2,249,675	2,058,210	2,022,972	2,326,846	2,350,114	2,373,615	2,397,351
Allowance for uncollectible accounts	(1,106,744)	(1,181,080)	(1,008,523)	(1,055,991)	(1,214,613)	(1,226,760)	(1,239,027)	(1,251,417)
Net patient receivables	1,001,340	1,068,596	1,049,687	966,980	1,112,232	1,123,354	1,134,588	1,145,934
Other current assets	76,551	76,551	76,551	76,551	76,551	76,551	76,551	76,551
Total Current Assets	2,622,017	2,444,179	2,551,081	2,421,537	2,780,502	2,822,122	2,737,061	2,810,819
NON CURRENT ASSETS								
Property, plant & equip - Cost	1,954,049	2,070,999	2,069,226	2,255,570	2,319,320	2,569,320	2,619,320	2,869,320
Accumulated depreciation	(1,544,872)	(1,448,595)	(1,581,100)	(1,691,161)	(1,728,809)	(1,876,518)	(1,824,227)	(1,971,936)
Net Property, plant & equip	409,178	622,405	488,126	564,409	590,511	692,802	795,093	897,384
Other non current assets	-	-	-	-	-	-	-	-
Total non current assets	409,178	622,405	488,126	564,409	590,511	692,802	795,093	897,384
Total Assets	**$ 3,031,194**	**$ 3,066,584**	**$ 3,039,208**	**$ 2,985,946**	**$ 3,371,014**	**$ 3,514,924**	**$ 3,532,154**	**$ 3,708,203**
LIABIILITIES AND SHAREHOLDER EQUITY								
CURRENT LIABILITIES								
Accounts Payable	$ 486,301	$ 420,589	$ 360,687	$ 456,060	$ 586,921	$ 597,002	$ 470,214	$ 481,561
Deferred Unearned Revenue	37,433	35,234	56,435	42,044	56,435	56,435	56,435	56,435
Due to CSS Owners	1,054,143	1,035,735	905,896	711,335	922,350	945,410	978,687	1,029,050
Accrued payroll/ payroll taxes	44,394	44,842	97,899	65,000	65,000	65,650	66,307	66,307
Accrued retirement	17,619	21,661	18,740	15,645	21,000	24,990	25,240	25,240
Accrued employee PTO	35,483	28,488	33,015	39,288	39,288	39,681	40,078	40,078
Accrued claims-self insured medical	62,923	72,053	57,900	68,901	68,901	69,590	70,286	70,286
Total Current Liabilities	1,738,295	1,658,603	1,530,572	1,398,273	1,759,895	1,798,759	1,707,247	1,768,957
NON CURRENT LIABILITIES								
Long term Debt, less current portion								
Total non current liabilities	-	-	-	-	-	-	-	-
Total Liabilities	**1,738,295**	**1,658,603**	**1,530,572**	**1,398,273**	**1,759,895**	**1,798,759**	**1,707,247**	**1,768,957**
SHAREHOLDER'S EQUITY								
Retained earnings-prior year	1,175,772	1,292,899	1,407,981	1,508,636	1,508,636	1,611,119	1,716,165	1,824,908
Current year dividends to CSS Owners	(1,054,143)	(1,035,735)	(905,896)	(711,335)	(922,350)	(945,410)	(978,687)	(1,029,050)
Current year net income/(loss)	1,171,270	1,150,817	1,006,551	790,372	1,024,833	1,050,456	1,087,430	1,143,389
Total Shareholder's Equity	**1,292,899**	**1,407,981**	**1,508,636**	**1,587,673**	**1,611,119**	**1,716,165**	**1,824,908**	**1,939,247**
Total Liabilities and Equity	**$ 3,031,194**	**$ 3,066,584**	**$ 3,039,208**	**$ 2,985,946**	**$ 3,371,014**	**$ 3,514,924**	**$ 3,532,154**	**$ 3,708,203**

COLUMBIA SURGICAL SPECIALISTS, P.S.
ASC Cash Flow Statement

	Historical Actuals			Forecast				
OPERATING ACTIVITIES	2018	2019	2020	Jan to Sep 2021	Jan to Dec 2021	2022	2023	2024
Net income/(loss)	1,171,270	1,150,817	1,006,551	790,372	1,024,833	1,050,456	1,087,430	1,143,389
Non cash items affecting cash flow:								
Depreciation expense	159,933	121,168	147,709	110,061	147,709	147,709	147,709	147,709
Change in patient receivables	(100,134)	(67,255)	18,908	82,706	(62,546)	(11,121)	(11,234)	(11,346)
Change in other current assets	(7,655)	-	-	-	(0)	-	-	-
Change in other assets	-	-	-	-	-	-	-	-
Change in accounts payable and payroll	127,952	(85,870)	(115,483)	(146,478)	209,789	33,792	(92,856)	61,710
Change in other current liabilities	11,603	6,177	(12,547)	14,179	19,534	5,072	1,343	-
Cash flow from operating activities	$ 1,362,968	$ 1,125,037	$ 1,045,138	$ 850,840	$ 1,339,319	$ 1,225,908	$ 1,132,392	$ 1,341,462
INVESTING ACTIVITIES								
Purchase of equipment	(250,000)	(334,395)	(13,431)	(186,344)	(250,094)	(250,000)	(250,000)	(250,000)
Proceeds from sale of equipment								
Cash flow from investing activities	$ (250,000)	$ (334,395)	$ (13,431)	$ (186,344)	$ (250,094)	$ (250,000)	$ (250,000)	$ (250,000)
FINANCING ACTIVITIES								
Dividends	(1,054,143)	(1,035,735)	(905,896)	(711,335)	(922,350)	(945,410)	(978,687)	(1,029,050)
Cash flow from financing actvities	(1,054,143)	(1,035,735)	(905,896)	(711,335)	(922,350)	(945,410)	(978,687)	(1,029,050)
Total cash in/(out) flow	58,825	(245,093)	125,811	(46,839)	166,875	30,498	(96,295)	62,412
Cash and equivalents - beginning of period	1,485,301	1,544,126	1,299,033	1,424,844	1,424,844	1,591,719	1,622,217	1,525,922
Cash and equivalents - end of period	$ 1,544,126	$ 1,299,033	$ 1,424,844	$ 1,378,005	$ 1,591,719	$ 1,622,217	$ 1,525,922	$ 1,588,334

COLUMBIA SURGICAL SPECIALISTS, P.S.
ASC FTE's by Position - Productive & Non-Productive

# of Months:	12	12	12	9	3	12	12	12
FTE's (Productive & Non-Productive)	**2018**	**2019**	**2020**	**JAN-SEP 2021**	**OCT-DEC 2021**	**2022**	**2023**	**2024**
ASC Director	1.0	1.0	1.0	0.7	0.3	1.0	1.0	1.0
Assistant Nurse Manager	1.0	1.0	1.0	0.7	0.3	1.0	1.0	1.0
Buyer	1.0	1.0	1.0	0.7	0.3	1.0	1.0	1.0
Surgical Tech	6.9	7.1	6.1	5.5	1.9	7.7	8.0	8.0
Registered Nurse	16.7	17.5	16.5	14.5	5.0	19.5	19.5	19.5
Licensed Practical Nurse (LPN)	-	0.9	0.5	-	-	-	-	-
Nurse Aid/Pt Care Attendant	1.0	1.0	0.5	1.5	0.5	2.0	2.0	2.0
Health Unit Coordinator (HUC)	2.0	2.0	1.9	1.5	0.5	2.0	2.0	2.0
Administration/Accounting/Marketing	1.0	1.2	0.7	0.9	0.3	1.2	1.2	1.2
Facilities	0.2	0.2	0.1	0.1	0.0	0.2	0.2	0.2
IT Support	0.6	0.5	0.5	0.4	0.1	0.5	0.5	0.5
Billing and Collection	4.4	5.4	3.9	4.0	1.4	5.4	5.4	5.4
Scheduling Coordinator	3.0	3.1	2.2	2.3	0.8	3.1	3.1	3.1
TOTAL	**38.9**	**42.0**	**35.8**	**33.0**	**11.3**	**44.6**	**44.9**	**44.9**

# of Months:	12	12	12	9	3	12	12	12
FTE's (PRODUCTIVE)	**2018**	**2019**	**2020**	**JAN-SEP 2021**	**OCT-DEC 2021**	**2022**	**2023**	**2024**
ASC Director	0.8	0.8	0.8	0.6	0.2	0.8	0.8	0.8
Assistant Nurse Manager	0.9	0.8	0.8	0.6	0.2	0.8	0.8	0.8
Buyer	0.8	0.9	0.8	0.6	0.2	0.9	0.9	0.9
Surgical Tech	6.1	6.0	5.1	4.6	1.6	6.5	6.7	6.7
Registered Nurse	15.4	14.7	13.6	12.2	4.2	16.4	16.4	16.4
Licensed Practical Nurse (LPN)	-	0.8	0.4	-	-	-	-	-
Nurse Aid/Pt Care Attendant	0.9	0.9	0.4	1.3	0.4	1.7	1.7	1.7
Health Unit Coordinator (HUC)	1.8	1.7	1.6	1.3	0.4	1.7	1.7	1.7
Administration/Accounting/Marketing	0.9	1.1	0.7	0.8	0.3	1.1	1.1	1.1
Facilities	0.2	0.2	0.1	0.1	0.0	0.2	0.2	0.2
IT Support	0.6	0.5	0.4	0.4	0.1	0.5	0.5	0.5
Billing and Collection	3.9	4.7	3.4	3.5	1.2	4.7	4.7	4.7
Scheduling Coordinator	2.8	2.7	1.9	2.0	0.7	2.7	2.7	2.7
TOTAL	**35.1**	**35.7**	**30.1**	**28.1**	**9.6**	**37.9**	**38.2**	**38.2**

STAFFING ASSUMPTIONS FOR 2021-2024 PROJECTIONS:	**Hourly Wage**	**# of Hours**	**Benefits %**
ASC Director	$ 59.20	2,080	24.4%
Assistant Nurse Manager	$ 40.30	2,080	24.4%
Buyer	$ 23.67	2,080	24.4%
Surgical Tech	$ 22.13	2,080	24.4%
Registered Nurse	$ 33.65	2,080	24.4%
Licensed Practical Nurse (LPN)	$ 25.43	2,080	24.4%
Nurse Aid/Pt Care Attendant	$ 18.66	2,080	24.4%
Health Unit Coordinator (HUC)	$ 18.99	2,080	24.4%
Administration/Accounting/Marketing	$ 56.45	2,080	24.4%
Facilities	$ 43.90	2,080	24.4%
IT Support	$ 25.87	2,080	24.4%
Billing and Collection	$ 18.30	2,080	24.4%
Scheduling Coordinator	$ 18.04	2,080	24.4%

Exhibit 11
Site Control Documents

Parcel Information

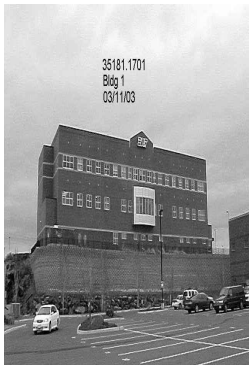
Parcel Number: 35181.1701
Site Address: 217 W CATALDO AVE

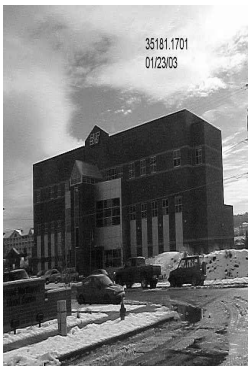
Data As Of: 3/2/2021

Parcel Image









Owner Name: CATALDO MEDICAL BUILDING LLC
Address: 217 W CATALDO AVE, SPOKANE, WA, 99201

Taxpayer Name: CATALDO MEDICAL BLDG, LLC
Address: 217 W CATALDO AVE, SPOKANE, WA, 99201

Site Address

Parcel Type	Site Address	City	Description	Tax Year	Tax Code Area	Status
R	217 W CATALDO AVE	SPOKANE	65 Service - Professional	2021	0010	Active

Assessor Description
CENTRAL ADD L1TO8; L19TO22 B73 AND W1/2 VAC NORMADIE ST E OF & ADJ

Appraisal

Parcel Class	Appraiser	Neighborhood Code	Neighborhood Name	Neighborhood Desc	Appraiser Name	Appraiser Phone
65 Service - Professional	127	546530	4653M	Medical Office	Sam	477-5923

Under Washington State Law (WAC 458-07-015) The Assessor's office is required to make an exterior observation of all properties at least once every six years.
This property is scheduled for inspection between October 2020 and May of 2021.

Assessed Value

Tax Year	Taxable	Market Total	Land	Dwelling/Structure	Current Use Land	Personal Prop.
2021	7,972,920	7,972,920	692,920	7,280,000	0	0
2020	4,917,930	4,917,930	661,430	4,256,500	0	0
2019	5,922,530	5,922,530	661,430	5,261,100	0	0
2018	5,744,130	5,744,130	629,930	5,114,200	0	0
2017	5,713,130	5,713,130	629,930	5,083,200	0	0

Characteristics

Description	Appraiser	Year Built	Year Remodeled	Number of Floors
Medical bldg	127	2000		3

Commercial Details

Description	Area
All Extensions	**32,612**
Medical bldg	32,612

Land Number	Soil ID	Acreage	Sq Ft	Frontage	Depth	Lot(s)
1	CO14	1.45	62,993	0	0	0

Sales

Sale Date	Sale Price	Sale Instrument	Excise Number	Parcel
11/13/1998	580,000.00	COMMERCIAL SALE		35181.1701

Property Taxes

Taxes are due April 30th and October 31st

Total Charges Owing: $94,523.75

Tax Year	Charge Type	Annual Charges	Remaining Charges Owing
	Total Taxes for 2021	**94,523.75**	**94,523.75**
2021	A/V Property Tax	94,511.88	94,511.88
2021	Soil Conservation Principal CNSV1	10.07	10.07
2021	Weed Control Principal WCWEED1	1.80	1.80
	Total Taxes for 2020	**60,518.51**	**0.00**
2020	A/V Property Tax	60,506.64	0.00
2020	Soil Conservation Principal CNSV1	10.07	0.00
2020	Weed Control Principal WCWEED1	1.80	0.00
	Total Taxes for 2019	**70,644.02**	**0.00**
2019	A/V Property Tax	70,637.15	0.00
2019	Soil Conservation Principal CNSV1	5.07	0.00
2019	Weed Control Principal WCWEED1	1.80	0.00
	Total Taxes for 2018	**79,738.90**	**0.00**
2018	A/V Property Tax	79,732.03	0.00
2018	Soil Conservation Principal CNSV1	5.07	0.00
2018	Weed Control Principal WCWEED1	1.80	0.00

Tax Receipts

Tax Year	Receipt Number	Receipt Date	Receipt Amount
2020	8426991	10/28/2020	30,259.26
2020	8360737	06/11/2020	30,259.25
2019	8045877	10/24/2019	35,322.01
2019	7831331	04/12/2019	35,322.01
2018	7654707	10/22/2018	39,869.45
2018	7547582	04/24/2018	39,869.45

Disclaimer

We are pleased to give you online access to the Assessor's Office and Treasurer's Office property tax and valuation information. While we make every effort to produce and publish the most current and accurate information possible, portions of this information may not be current or correct. Neither Spokane County, the Assessor, nor the Treasurer makes any warranty, express or implied, with regard to the accuracy, reliability, or timeliness of information in this system, and shall not be held liable for losses caused by using this information. Any person or entity that relies on any information obtained from this system, does so at his or her own risk. Please feel free to contact us about any error you discover or to give comments and suggestions. Call the Assessor's Office at (509) 477-3698 or the Treasurer's Office at (509) 477-4713.

RCW 42.56.070 (9) prohibits the release of lists of individuals requested for commercial purposes. The requester expressly represents that no such use of any such list will be made by the user or its transferee(s) or vendee(s). I understand, acknowledge, and accept the statements above, and agree to adhere to the prohibitions listed in RCW 42.56.070 (9).

ADDENDUM TO THE
LEASE AGREEMENT
BETWEEN
CATALDO MEDICAL BUILDING, L.L.C.
AND
COLUMBIA SURGICAL SPECIALISTS, P.S.

This Addendum to the Lease agreement between **CATALDO Medical Building, L.L.C.** ("Nevada Medical") and **COLUMBIA SURGICAL SPECIALISTS, P.S.,** amends the Lease agreement dated April 26, 2001 and it's addendums.

This Addendum to the Lease Agreement is to reflect a change to the term of the agreement

A. It is herby agreed that the Lease Agreement is amended as follows:

Term. The Term of the Lease Agreement shall be extended an additional two years with the new term expiring at midnight October 31, 2029.

B. Except as amended herein, the Lease Agreement dated April 26, 2001 and its addendums is hereby confirmed and ratified and shall remain in full force and effect. All related provisions of the Lease Agreement shall be construed to give full force and effect to the amendments made by the Addendum on the effective dates referred to above.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum to the Lease Agreement on this 24TH day of June, 2019.

LESSOR: CATALDO MEDICAL BUIDLING, LLC.

By:_____

Title: Owner

LESSEE:

COLUMBIA SURGICAL SPECIALISTS, P.S.

By:_____

Title: CEO

ADDENDUM TO THE
LEASE AGREEMENT
BETWEEN
CATALDO MEDICAL BUILDING, L.L.C.
AND
SPOKANE EAR, NOSE AND THROAT CINIC, P.S.

This Addendum to the Lease agreement between **CATALDO Medical Building, L.L.C.** ("Nevada Medical") and **Spokane Ear, Nose and Throat Clinic, P.S.,** amends the Lease agreement dated April 26, 2001 and it's addendums.

This Addendum to the Lease Agreement is to reflect a change to the term of the agreement

A. It is herby agreed that the Lease Agreement is amended as follows:

Term. The Term of the Lease Agreement shall commence November 1st, 2012 and shall expire at midnight October 31, 2027.

B. Except as amended herein, the Lease Agreement dated April 26, 2001 and its addendums is hereby confirmed and ratified and shall remain in full force and effect. All related provisions of the Lease Agreement shall be construed to give full force and effect to the amendments made by the Addendum on the effective dates referred to above.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum to the Lease Agreement on this 24th day of October, 2012.

LESSOR: CATALDO MEDICAL BUIDLING, LLC

By: _____

Title: member

LESSEE:

SPOKANE EAR, NOSE & THROAT CLINIC, P.S.

By: _____

Title: Secretary

State of Washington)
) ss.
County of Spokane)

I certify that I know or have satisfactory evidence that Carrie A Roller is the person who appeared before me, and said person acknowledged that he was authorized to sign this instrument as a Member of CATALDO MEDICAL BUILDING, LLC, and acknowledged it to be the free and voluntary act of such entity, for the uses and purposes mentioned in the instrument.

DATED: October 24, 2012 ~~2009~~.

JERI L. HOWARD NOTARY PUBLIC COMMISSION EXPIRES 05-27-13 STATE OF WASHINGTON

Print Name: Jeri L Howard
Notary Public in and for the State of Washington, residing at Spokane
Appointment expires: 5-27-13

Jeri L Howard

State of Washington)
) ss.
County of Spokane)

I certify that I know or have satisfactory evidence that Alan T PoKorny is the person who appeared before me, and said person acknowledged that he was authorized to sign this instrument as a member of SPOKANE EAR, NOSE & THROAT CLINIC, P.S., and acknowledged it to be the free and voluntary act of such entity, for the uses and purposes mentioned in the instrument.

DATED: October 24, 2012 ~~2009~~.

JERI L. HOWARD NOTARY PUBLIC COMMISSION EXPIRES 05-27-13 STATE OF WASHINGTON

Print name: Jeri L Howard
Notary Public in and for the State of Washington, residing at Spokane
Appointment expires: 5-27-13

Jeri L Howard

LEASE ADDENDUM

This Addendum, effective July 1, 2008, amends the Lease dated April 26, 2001, by and between CATALDO MEDICAL BUILDING, L.L.C. ("Lessor") and SPOKANE EAR, NOSE & THROAT CLINIC, P.S. ("Lessee").

In consideration of the mutual covenants contained in the Lease and this Lease Addendum, the parties agree as follows:

1. Provisions in Paragraph 3.a. are modified as follows:

   3. Fixed Monthly Rent.

      a. For the period beginning July 1, 2008. Until further modified, the monthly rental to be paid shall be as follows:

         Seventy Thousand Dollars ($70,000.00) per month. This adjustment to the monthly rental shall be effective beginning with the month of July 1, 2008.

2. Entire Agreement. This Lease modification or Addendum, in conjunction with the Lease, is the entire agreement between the parties. All of the provisions are incorporated into this Lease Addendum and are hereby modified or supplemented to conform with the Lease Addendum, but in all other respects are to be and shall continue in full force and effect between the parties hereto. The Lease, as modified by this Addendum, shall not be altered or modified hereafter except by written agreement signed by the parties.

IN WITNESS WHEREOF, each party to this Lease Addendum has caused it to be executed on the date indicated below.

LESSOR:

CATALDO MEDICAL BUILDING, L.L.C.

By: _____
Title: Member

LESSEE:

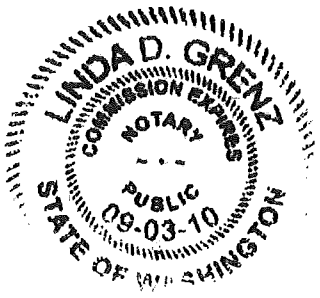
SPOKANE EAR, NOSE & THROAT CLINIC, P.S.

By: _____
Title: owner

State of Washington)
) ss.
County of Spokane)

I certify that I know or have satisfactory evidence that ~~Alan Pokorny MD~~ Michael Olds personally appeared before me, and on oath stated that he was authorized to execute the instrument and acknowledged it, as a Member of **Cataldo Medical Building, L.L.C.**, to be the free and voluntary act of such company, for the uses and purposes mentioned in the instrument.

DATED: July 2, 2008.



Linda D Grenz
Notary Public in and for the State of Washington, residing at Spokane
Appointment expires: 09/03/10

State of Washington)
) ss.
County of Spokane)

I certify that I know or have satisfactory evidence that Alan Pokorny MD personally appeared before me, and on oath stated that he was authorized to execute the instrument and acknowledged it, as owner of **Spokane Ear, Nose & Throat Clinic, P.S.**, to be the free and voluntary act of such corporation, for the uses and purposes mentioned in the instrument.

DATED: July 2, 2008.

Linda D Grenz
Notary Public in and for the State of Washington, residing at Spokane
Appointment expires: 09/03/10

LEASE

THIS LEASE is made and entered into this 26 day of April, 2001, by and between CATALDO MEDICAL BUILDING, L.L.C., hereinafter referred to as "Lessor," and SPOKANE EAR, NOSE AND THROAT CLINIC, P.S., hereinafter referred to as "Lessee."

W I T N E S S E T H

The parties herein do hereby covenant and agree:

1. Premises. Lessor, for and in consideration of the rentals hereinafter provided and the covenants and agreements hereinafter contained, does hereby demise, let and lease unto Lessee all of the real property legally described in Exhibit "A," marked in red on Exhibit "B," including the parking shown on Exhibit "C."

2. Term. The term of this Lease shall commence May 1, 2001 and end at midnight April 30, 2016.

3. Fixed Monthly Rent. Lessee shall and hereby agrees to pay to Lessor as rental for the Leased Premises a fixed monthly rent as follows, which rental shall be payable monthly in advance on the first day of each and every calendar month during this period, at such place as Lessor shall designate from time to time in writing.

a. For the period beginning May 1, 2001 through April 30, 2006. The monthly rental to be paid during this period of time shall be as follows:

Sixty-Five Thousand Dollars ($65,000.00) per month.

b. For the period May 1, 2006 through April 30, 2016. Beginning May 1, 2006 and ever five (5) years thereafter, the monthly rental shall be based on the monthly rental of the prior five (5)-year period increased by the amount of the increase, if any, in the All Items number of the CPI Index for Urban Wage Earners Workers, U.S. city average. The rental payable for the last month of preceding lease year shall be multiplied by a percentage multiple determined in accordance with the provisions hereinafter set forth, which shall result in the monthly rental for the ensuing lease year. (For the purpose of this paragraph, a "lease year" shall commence on May 1 and April 30 of the next year.)

(i) The adjustment in the rental for each lease year shall be determined by using the "Consumer Price Index for Urban Wage Earners and Clerical Workers, U.S. city average for all items" (1982-84 = 100 Published by the Bureau of Labor Statistics of the United States Department of Labor).

(ii) The index number for January of the preceding year shall be the "Base Index Number" and the corresponding index number for the month preceding the adjustment date of which the adjustment is to be made shall be the "Current Index Number."

(iii) The increase in the cost of living shall be determined by dividing the current index number by the base index number in accordance with the following formula:

$$\frac{\text{Current Index Number}}{\text{Base Index Number}} = \text{Percentage Multiple}$$

(iv) The percentage multiple multiplied by the rental for May of the preceding lease year shall be the new monthly rental.

(v) Lessor shall, within a reasonable time after obtaining the appropriate data necessary for computing such new rental, give Lessee notice of the rent so determined and Lessor's computation thereof shall be conclusive and binding unless Lessee shall, within fifteen (15) days after the giving of such notice, notify Lessor of any claimed error therein but shall not preclude any adjustment which may be required in the event of a published amendment of the index figures upon which the computation was based. Within fifteen (15) days of receipt of such notice, Lessee shall pay to Lessor, retroactive to the adjustment date, the increased rental due Lessor for a period subsequent to' the adjustment date for which Lessee should have paid rent at the rate reflected at the then adjusted rental. All rental thereafter until the next adjustment date shall be at the newly computed rental rate.

(vi) If publication of the consumer price index shall be discontinued or if such data is not available, the parties hereto shall thereafter accept statistics on the cost of living as they shall be computed and published by an agency of the United States or by a responsible financial periodical of recognized authority then to be selected by the parties hereto. If the parties cannot agree upon a selection within sixty (60) days after demand by either party, the substitute index shall, upon application of either party, be selected by arbitration in accordance with the rules of the American Arbitration Association. In the event of (1) use of a comparable statistics in place of the consumer price index as above mentioned, or (2) publication of an index figure other than monthly intervals, there shall be made in the method of computation herein provided for, such revisions as the circumstances may require to carry out the intent of this paragraph, and any dispute as to the making of such adjustment shall be determined by arbitration in accordance with the rules of the American Arbitration Association.

(vii) In no case shall the rental as determined be less than the rental for the month of May of the previous lease year and in no event shall the rent be escalated by the cost of living adjustment set forth herein in excess of three percent (3%) over the amount of the monthly rent for the preceding lease year.

4. Additional Rent for Operating Expenses and Real Estate Taxes.

a. Definition. As used in this paragraph, the words and terms that follow mean and include the following:

"Operating costs" shall mean all costs incurred and expenditures of whatever nature made by the Lessor in the operation and management, repair, cleaning, and maintenance of the building, related equipment facilities and appurtenances, cooling and heating equipment, and common areas including, but not limited to, the following:

(1) Water. All charges and rates connected with water supplied to said building and related sewer and refuse use charges, to the extent such charges and rates are paid by Lessor.

(2) Heat and Air Conditioning. All charges connected with heat, lighting and air conditioning supplied to the building common area.

(3) Wages and Fees. Wages and costs of all employee benefits of all employees of the Lessor who are employed in, about or on account of the building together with all accounting costs associated with the allocation of costs between the parties.

(4) Cleaning. The cost of labor and material for cleaning the building, surrounding areaways and windows in the building.

(5) Electricity. The cost of all electric current for the operation of those machines, appliances or devices presently used for the operation of said building, including the cost of electric current for public lights and air conditioning, but not including electric current furnished by Lessor to any lessees within the building.

(6) Insurance, Operation and Maintenance Expenses. Fire, casualty, liability and such other insurance as is required by lending institutions on the entire building and improvements, and all other expenses customarily incurred in connection with the operation and maintenance of

similar buildings in Spokane, Washington, except for maintenance of the roof and exterior walls which shall be the sole obligation of Lessor.

(7) Common Areas. The cost of lighting of the parking lot, exterior of the building, and interior common area, including repair and replacement, repair and maintenance to the common area surfaces, painting of the parking lot, and keeping the common areas reasonably clean, including the removal of snow and ice in inclement weather, and maintaining green areas of the center, including shrubs, trees, lawn, if any, flowers and other plantings.

"Operating costs" shall include only reasonable and bona fide expenses actually incurred by Lessor including accounting fees related to allocation of costs and shall not include any of the following: executive salaries; leasing commissions; interest; depreciation; management or rental agents' fees; legal fees; capital expenditures (which shall be deemed to include, without limitation, the cost of renovating, decorating, or otherwise preparing space in the building for Lessees); or any other expenses relating to the ownership and management, as distinguished from the operation, of the building and common areas. Lessor shall give Lessee notice of any amounts included in operating Expense which are paid to Lessor or any related entity.

b. Lessee shall pay to the Lessor within ten (10) days prior to the date on which each such tax or installment thereof shall be due and payable, as additional rent for the lease year in which such date occurs, the amount of the real property taxes or installment thereof.

c. Lessee shall also pay to Lessor, within ten (10) days prior to the same shall be payable by Lessor and as additional rent for the lease year in which the same shall be so payable, any assessment or installment thereof for public betterments or improvements which may be levied upon said land and building. Lessor shall take the benefit of the provisions of any statute or ordinance permitting any such assessment to be paid over a period of time and Lessee shall be obligated to pay only the said percentage of the installments of any such assessments which shall become due and payable during the term of this Lease.

d. On or before the first day of May, 2001, and no later than the first day of May in each subsequent lease year, Lessor shall furnish to Lessee an estimated cost for operating expenses as herein defined, excluding therefrom taxes which are payable under another provision of this paragraph. Lessee agrees to pay monthly one-twelfth (1/12) of said estimate on the same date as rent is payable. If actual expenses are greater than the estimated expenses, Lessee shall pay a lump sum of the total increase in operating expenses, less the total of the monthly installments of operating expenses paid in the applicable lease year and if the estimated operating expenses exceed the actual expenses, Lessee will receive a credit

toward the next monthly rent falling due. The estimated monthly installment of operating expenses to be paid for each lease year shall be adjusted to reflect the actual operating expenses of the preceding lease year. In the event at any time the parties determine that the budget is not accurate for any reason, the parties agree the budget will be modified to more accurately portray the actual operating expenses. Even though the term has expired and Lessee has vacated the Leased Premises when the final determination is made of Lessee's operating expenses for the year in which the Lease terminates, Lessee shall immediately pay any increase due of actual expenses paid and conversely any overpayment made in the event said expenses are less than the estimated expenses shall immediately be paid by Lessor to Lessee.

e. If the first or final lease years shall contain less than or more than twelve (12) months, the additional rent payable under this article for such lease year shall be prorated. Lessee's obligation to pay additional rent for the final lease year shall survive the expiration of the term of this Lease.

5. Use of Premises.

a. Generally. Lessee will use and occupy the Leased Premises for medical office use, but no other use unless consented to in writing by Lessor. Lessee covenants to execute and comply promptly with all statutes, ordinances, rules, regulations and requirements of federal, state, county and city governments, regulating the use by Lessee of the Leased Premises. Lessee will not use or permit the use of the Leased Premises in any manner that will tend to create a nuisance.

b. ADA Law Compliance. Lessor and Lessee acknowledge that the provisions of the Americans with Disabilities Act (the "ADA") allow allocation of responsibility for compliance with the terms and conditions of the ADA in the Lease. Lessor and Lessee agree that the responsibility for compliance with the ADA shall be allocated as set forth in this Paragraph. Lessee shall be responsible for compliance with the applicable provisions of the ADA with respect to all improvements within the Leased Premises and shall be responsible for compliance with the provisions of Title III of the ADA with respect to the exterior of the building and the land including parking areas, sidewalks and walkways, and the like, together with all common areas of the building. References in this lease to legal requirements shall be deemed to refer to the ADA among other laws.

c. Environmental Law Compliance. For purposes of this Paragraph the term "Hazardous Substances" shall mean and include all hazardous and toxic substances, waste or materials, any pollutant or contaminant, including, without limitation, PCBs, asbestos, asbestos-containing material, and raw materials that are included under or regulated by any Environmental Laws. For purposes of this lease the term "Environmental Laws" shall mean and include all federal, state and local statutes, ordinances, regulations and rules presently

in force or hereafter enacted relating to environmental quality, contamination, and clean-up of Hazardous Substances. References in this lease to legal requirements shall be deemed to refer to Environmental Laws among other laws. Lessor represents that to the best of its current actual knowledge, the building and the land are in compliance with all Environmental Laws respecting Hazardous Substances, and that Lessor has received no notice of any pending or threatened lien, action or proceeding respecting any alleged violation of Environmental Laws respecting Hazardous Substances that has occurred on or near the land or in or about the building. Lessee acknowledges that the expense of compliance with Environmental Laws is an element of Operating Expenses. Lessor shall use reasonable efforts to recover any expense of compliance with Environmental Laws from any third party who is liable for the same and credit any such recovery against Operating Expenses.

d. Indemnity Regarding Legal Violations. Lessee shall indemnify and hold harmless Lessor and its respective partners, directors, officers, agents and employees from and against any and all claims arising from Lessee's breach of its representations, and covenants under this lease respecting compliance with legal requirements including but not limited to the ADA or Environmental Laws; together with all costs, expenses and liabilities incurred or in connection with each such claim, action, proceeding or appeal. Lessor shall indemnify and hold harmless Lessee and its partners, directors, officers, agents and employees from and against any and all claims arising from Lessor's breach of its representations, warranties and covenants under this Lease respecting compliance with legal requirements including but not limited to the ADA or Environmental Laws; together with all costs, expenses and liabilities incurred or in connection with each such claim, action, proceeding or appeal, including, without limitation, all attorneys' fees and expenses.

6. Utilities. All utilities are separately metered to Lessee. Lessee agrees, at its own expense, to pay for all water, power, electricity, gas, air conditioning and janitorial service attributed to its premises at its sole expense.

7. Maintenance and Repair. Lessor shall, at his own expense during the term of this Lease, maintain the roof and exterior walls (except signage and canopies identifying Lessee) in good condition and repair, except Lessor shall not be called upon to make any such repairs occasioned by the negligence of Lessee, its agents or employees. Lessee shall, at its own expense, maintain in good condition all other portions of the Leased Premises except for reasonable wear and tear, damage by fire and/or unavoidable casualty including signage and canopies identifying Lessee. All glass, both exterior and interior, is at the sole risk of Lessee, and any glass broken shall be promptly replaced by Lessee with glass of the same kind, size and quality.

8. Alterations, Additions and Improvements. Lessee accepts said Leased Premises in their present condition and agrees to make no alterations without Lessor's written consent. Any alterations to the Leased Premises shall be made at Lessee's expense and shall become the property -of the Lessor at the termination of this Lease. Upon termination of this Lease, Lessee shall have the right to remove all movable improvements, furnishings, and trade fixtures placed therein by

Lessee which can be removed without material injury to the Leased Premises, and will repair any damage to the Leased Premises occasioned by such removal.

9. Assignment and Subletting. Lessee may not sublease, sublet or assign the Leased Premises, except by written .permission and consent of Lessor, which consent will not be unreasonably withheld. Any such subleasing or assignment, even with the approval of Lessor, shall not relieve Lessee from liability for payment of the rental herein provided or from the obligation to keep and be bound by the terms, conditions and covenants of this Lease. The acceptance of rent from any other person shall not be deemed to have waived any of the provisions of this paragraph or to be a consent to the assignment of this Lease or subletting of the Leased Premises. This prohibition against assigning and subletting shall be construed to include a prohibition against any assignment or subletting by operation of law.

10. Damage or Destruction. In the event the building of which the Leased Premises are a part shall be destroyed or damaged by fire or other causes (and regardless of the extent of the damage to the Leased Premises) to such an extent that the Lessor shall decide to discontinue the operation of the building as a building which is used for offices, which decision shall be communicated to Lessee within thirty (30) days after such damage or destruction, then this Lease shall be terminated as of the date of such damage or destruction. In the event of damage to the Leased Premises by fire or other causes, other than under the circumstances described in the preceding sentence, Lessor shall repair the Leased Premises within a reasonable time and as quickly as circumstances will permit providing Lessee with the same square footage and approximate location. Until the Leased Premises are repaired and put in good and tenantable order, the rents herein provided for, or a fair and just proportion thereof according to the nature and extent of the damages sustained, shall be abated until the Leased Premises shall have been restored to the same condition as they were before such damage or destruction.

11. Waiver or Subrogation. Lessor and Lessee shall mutually release the other from every right, claim and demand which may hereafter arise in favor of either, arising out of or in connection with any loss occasioned by fire and such other perils as are included in the provisions of the normal extended coverage clauses of fire insurance policies, and do hereby waive all rights of subrogation in favor of insurance carriers arising out of any such losses sustained by either the Lessor or the Lessee in and to the premises or any property therein. Lessor and Lessee each agree that they will request the insurance carrier to include in its policy such waiver of subrogation clause.

12. Notices. Whenever under this Lease a provision is made for notice of any kind, notice shall be deemed sufficient if notice to the Lessee is in writing, addressed to the Lessee at the last known post office address of Lessee by certified mail with postage prepaid and if notice to Lessor is in writing, addressed to the last known post office address of Lessor and is sent by certified mail with postage prepaid.

13. Access and Repairs. Lessor's agent shall have free access at all times to said Leased Premises for the purpose of inspection or making repairs, additions, or alterations to Leased Premises, or any property owned by or under control of Lessor. No compensation shall be made to or claimed by the Lessee from the Lessor by reason of inconvenience, annoyance, or damage of any kind whatsoever arising from the making of repairs to or maintenance or alteration of the business or appurtenances on the Leased Premises covered hereby, provided Lessor will not unreasonably interfere with Lessee's use of the Leased Premises during such repair, maintenance or alteration. Lessor reserves the right to make repairs, alterations, connections or extensions when and where the same may be deemed by the Lessor to be necessary.

14. Default and Reentry. If the rent reserved by this Lease, or any part thereof, shall be in arrears for a period of ten (10) days or more after written notice from Lessor to Lessee, or if the Lessee shall breach any one or more of the covenants, conditions, and agreements herein contained on its part to be performed, and if such breach shall continue for thirty (30) days after written notice from Lessor to Lessee of the breach or default complained of, or the leasehold interest of Lessee shall be attached or levied upon under execution, and if such attachment or levy shall not be promptly discharged, or if a petition in bankruptcy shall be filed by or against Lessee, or if the Lessee shall be adjudged bankrupt or insolvent by any court, or if the proceedings be taken by Lessee for reorganization or composition of their indebtedness pursuant to the bankruptcy law of the United States, or a trustee or receiver in bankruptcy or a receiver of any property of Lessee shall be appointed in any suit or proceeding by or against Lessee, the Lessor shall have the right to terminate this Lease and to reenter the Leased Premises or any part thereof, with or without process of law: or, the Lessor at its option, without terminating this Lease, may reenter the Leased Premises and sublet the whole or any part thereof for the account of the Lessee upon such terms and conditions as the Lessor may deem proper. In the latter event Lessor shall have the right to collect any rent which may thereafter become payable under such sublease and to apply the same first to the payment of any expense incurred by the Lessor in dispossessing the Lessee and in subletting the Leased Premises, and, second, to the rentals herein reserved and the fulfillment of the Lessee's covenants hereunder; in such case the Lessee shall be liable for amounts equal to the several installments of rent as they would under the terms of this Lease become due, less any amount actually received by the Lessor and applied as aforesaid. Lessor shall not be deemed to have terminated this Lease by retaking possession of the Leased Premises unless written notice of such termination has been given to the Lessee.

15. Condemnation.

a. Total Condemnation. If all of the entire Leased Premises shall be acquired or condemned by eminent domain, then the term of this Lease shall cease as of the date title or possession shall be transferred in such proceedings, whichever date shall first occur, and all rentals shall be paid up to that date and Lessee shall have no claim against Lessor for the value of any unexpired term of this Lease.

b. Partial Condemnation. If a substantial part of the Leased Premises shall be acquired or condemned by eminent domain, then the term of this Lease and all rights and obligations thereunder shall cease and terminate as of the date of transfer of title or possession in such proceeding, whichever date shall first occur. All rentals shall be paid up to that date and Lessee shall have no claim against Lessor for the value of any unexpired term of this Lease. In the event of a partial taking -or condemnation which is not extensive enough to be determined by Lessor as substantial, this Lease shall continue in full force and effect. To the extent that funds are paid to Lessor out of award in condemnation, they will be used by Lessor to promptly restore the Leased Premises insofar as possible to a condition comparable to the time before such condemnation, less the portion lost in taking.

c. Damages. In the event of any condemnation or taking as hereinabove provided, whether whole or partial, the Lessee shall not be entitled to any part of the award, as damages or otherwise, for such condemnation, and Lessor is to receive the full amount of such award. Lessee hereby expressly waives any claim or right to any part thereof. Although all damages in the event of any condemnation are to belong to the Lessor whether or not such damages are awarded as condemnation for the diminution of value in the leasehold or to the fee of the Leased Premises, Lessee shall have the right to claim and recover from the condemning authority, but not from Lessor, such compensation as may be separately awarded or recoverable by Lessee in Lessee's own right on account of any and all damage to Lessee's business by reason of the condemnation and for and on account of any costs or loss to which Lessee might be put in removing the furniture, fixtures and equipment.

16. Costs and Attorney's Fees. If any legal action is instituted to enforce this Lease, or any part thereof, the prevailing party shall be entitled to recover reasonable attorney's fees and statutory court costs from the other party.

17. Insurance.

a. Lessee. Lessee shall, at its sole cost and expense, cause to be placed in effect immediately upon commencement of the term of this Lease, and shall maintain in full force and effect during such term:

(1) A fire and extended coverage insurance policy covering all Lessee's improvements, and its fixtures, equipment, furniture and inventory in the Leased Premises, on a full replacement cost basis (no deductions for depreciation), insuring against risks covered by an extended coverage form policy;

(2) Bodily injury and property damage comprehensive public liability insurance for the combined single limit coverage of not less than One Million Dollars ($1,000,000.00).

Lessee shall deliver to Lessor a duplicate original of each such policy, or in lieu thereof, a certificate evidencing such coverage issued by the Lessee's insurer. Each such policy or certificate shall provide that the same shall not be cancelled without at least ten (10) days' prior written notice to Lessor, and shall name Lessor and Lessor's designee as an additional insured thereunder.

b. Lessor. Lessor shall cause to be placed in effect immediately upon commencement of the term of this Lease, and shall maintain in full force and effect during such term:

(1) A fire and extended coverage insurance policy covering all improvements, structures and their contents in the entire property of which the Leased Premises are a part, but not including Lessee's leasehold improvements, equipment, fixtures, furniture and inventory, on a basis satisfactory to Lessor's permanent lender or the holder of any first lien mortgage or deed of trust on the land and building insuring against risks covered by an extended coverage form policy;

(2) Bodily injury and property damage comprehensive public liability insurance for the combined single limited coverage of not less than One Million Dollars ($1,000,000.00).

18. Possession on Termination. Lessee shall, upon the expiration or sooner termination of this Lease, peacefully vacate the Leased Premises and remove all goods and effects not belonging to Lessor in a manner so as not to injure permanently the Leased Premises, and will deliver to Lessor the said Leased Premises free and clear and in good repair and condition in all respects, excepting reasonable wear and tear, and excepting damage due to loss, covered by a standard form of fire and extended coverage policy or damage resulting from unavoidable casualty.

19. Holding Over. If Lessee, with the consent, express or implied, of the Lessor, shall hold over after the expiration of the term of this Lease, the Lessee shall remain bound by the terms, covenants and agreements hereof, except the tenancy will be one from month to month.

20. Captions. The captions appearing in this Lease are inserted only as a matter of convenience and in no way define, limit, construe or describe the scope or intent of such sections or in any way affect this Lease.

21. Use of Language and Successors. The rights, liabilities and remedies provided for herein shall extend to the heirs, legal representatives, successors and, so far as the terms of this Lease permit, assigns of the parties hereto; and the words "Lessor" and "Lessee" and their accompanying verbs or pronouns, whenever used in this Lease, shall apply equally to all persons, firms or corporations which may be or become parties hereto.

22. Waiver. Time is made the essence of each and every covenant in this Lease. No waiver or breach of any covenant by either party shall waive any such covenant or future breaches thereof, or be deemed to be or constitute a waiver of any other covenant.

23. Priority. Upon written request of the Lessor, or any mortgagee or beneficiary of Lessor, Lessee will in writing and in form acceptable to Lessor:

a. Subordinate its rights hereunder to the interest to the lien, mortgage or deed of trust, now or hereafter in force against the land and. building of which the Leased Premises are a part, and upon any buildings hereafter placed upon the land of which the Leased Premises are a part, and to all advances made or hereafter to be made upon the security thereof.

b. Agree to attorn and pay rental to such Mortgagee in the event of default by Lessor in the event of foreclosure of such mortgage or deed of trust.

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

24. General.

a. This Lease shall be construed and governed by the laws of the State of Washington.

b. All of the covenants, agreements, terms and conditions contained in this Lease shall apply to and be binding upon Lessor and Lessee and their respective heirs, executors, administrators, successors and assigns.

c. Lessee represents and warrants to Lessor that it has not engaged any broker, finder or other person who would be entitled to any commission or fees in respect of the negotiations, execution or delivery of this Lease and shall indemnify Lessor and hold harmless against any loss, cost, liability or expense incurred by Lessor as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Lessee.

d. This Lease contains all covenants and agreements between Lessor and Lessee relating in any manner to the rental, use and occupancy of the Leased Premises and Lessee's use of the Leased Premises and other matters set forth in this Lease. No prior agreements or understanding pertaining to the same shall be valid or of any force or effect and the covenants and agreements of this Lease shall not be altered, modified or added to except in writing signed by Lessor and Lessee. Any provision of this Lease which shall prove to be

invalid, void or illegal shall in no way affect, impair or invalidate any other provision hereof and the remaining provisions hereof shall nevertheless remain in full force and effect.

e. Any prevention, delay or stoppage due to strikes, lockouts, labor disputes, acts of God, inability to obtain labor or materials or reasonable substitutes therefor, governmental restrictions, governmental regulations, governmental controls, judicial orders, enemy or hostile governmental action, civil commotion, fire or other casualty, and other causes beyond the reasonable control of the party obligated to perform, shall excuse the performance by such party for a period equal to any such prevention, delay or stoppage, except the obligations imposed with regard to rental and other charges to be paid by Lessee pursuant to this Lease.

25. Signs. All exterior signs and their locations shall be approved by Lessor prior to installation.

26. Employee Parking. In order to provide better and closer parking for the customers and invitees of the tenants in the building, Lessee and Lessee's employees shall park at the perimeter of the lot and Lessee agrees to so instruct its employees the same.

IN WITNESS WHEREOF, the parties hereto have executed this Lease the day and year first above written.

LESSOR:

CATALDO MEDICAL BUILDING, L.L.C.

By:_____
Title: Manager

LESSEE:

SPOKANE EAR, NOSE & THROAT CLINIC, P.S.

By:_____
Title: President

State of Washington)
) ss.
County of Spokane)

I certify that I know or have satisfactory evidence that Jan S Connelly is the person who appeared before me, and said person acknowledged that he was authorized to sign this instrument as a Member of CATALDO MEDICAL BUILDING, L.L.C., and acknowledged it to be the free and voluntary act of such entity, for the uses and purposes mentioned in the instrument.

DATED: April 26, 2001.

Jeri L Yapp
Print Name: Jeri L. Yapp
Notary Public in and for the State of Washington, residing at Spokane
Appointment expires: 5-27-01

State of Washington)
) ss.
County of Spokane)

I certify that I know or have satisfactory evidence that Jan S Connelly is the person who appeared before me, and said person acknowledged that he was authorized to sign this instrument as President of SPOKANE EAR, NOSE & THROAT CLINIC, P.S., and acknowledged it to be the free and voluntary act of such entity, for the uses and purposes mentioned in the instrument.

DATED: April 26, 2001.

Jeri L Yapp
Print Name: Jeri L. Yapp
Notary Public in and for the State of Washington, residing at Spokane
Appointment expires: 5-27-01

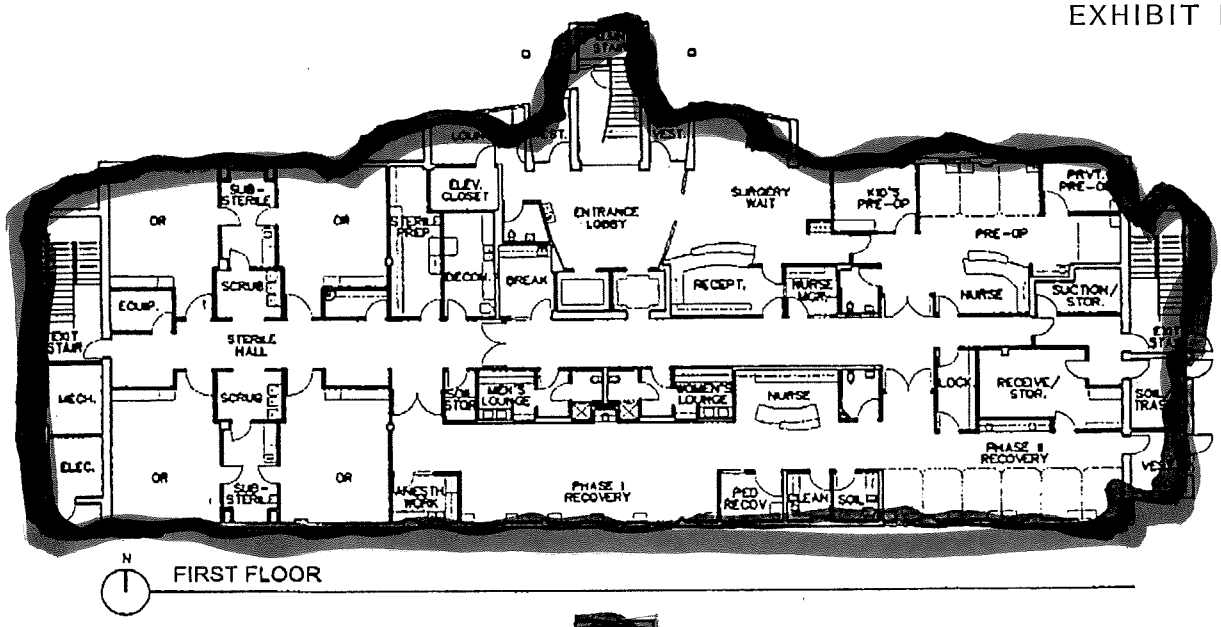
G:\KTC\CATALDO\Lease SENT.wpd

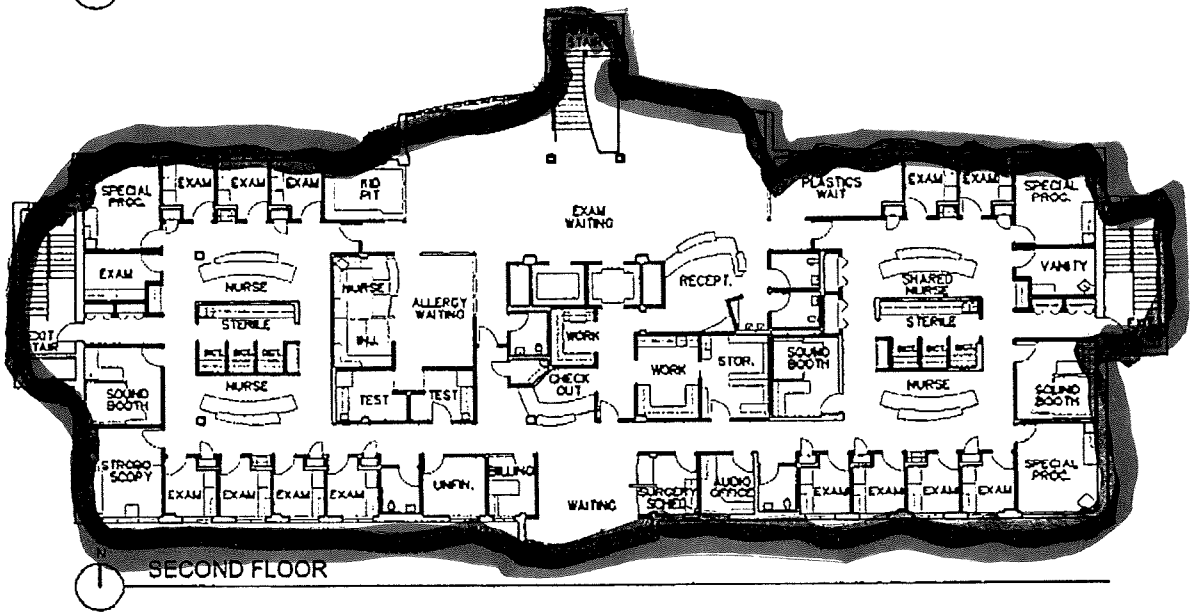
EXHIBIT A

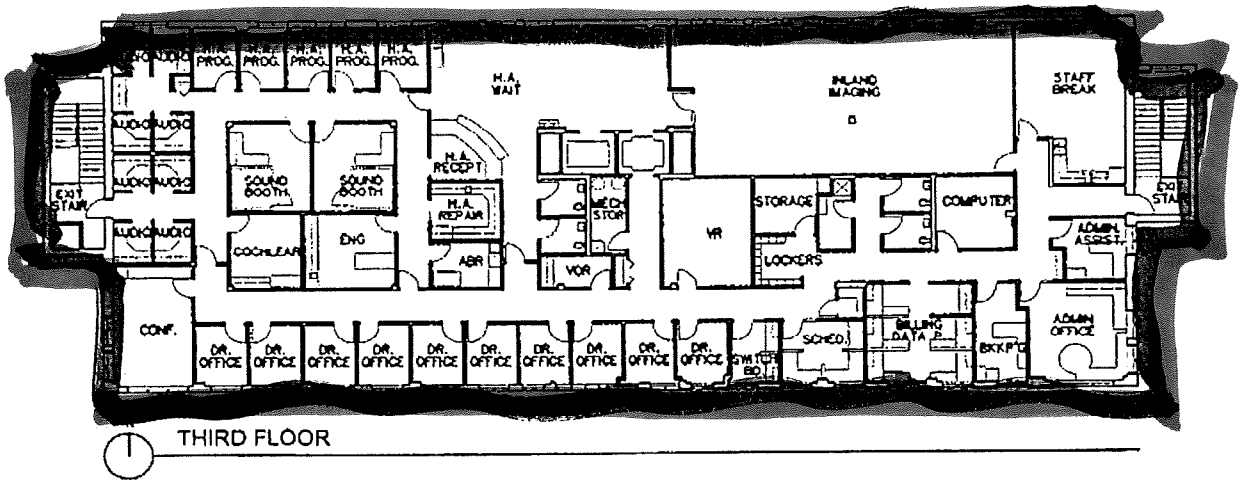
Lots 1, 2, 3, 4, 5, 6, 7 and 8, 19, 20, 21 and 22, Block 73 of Amended Plat of Part of Central Addition, according to plat recorded in Volume B of Plats at page 63, in the City of Spokane, Spokane County, Washington.

Together with the westerly half of vacated Normandie Street adjoining Lots 1, 2, 3 and 4 on the East.

EXHIBIT B





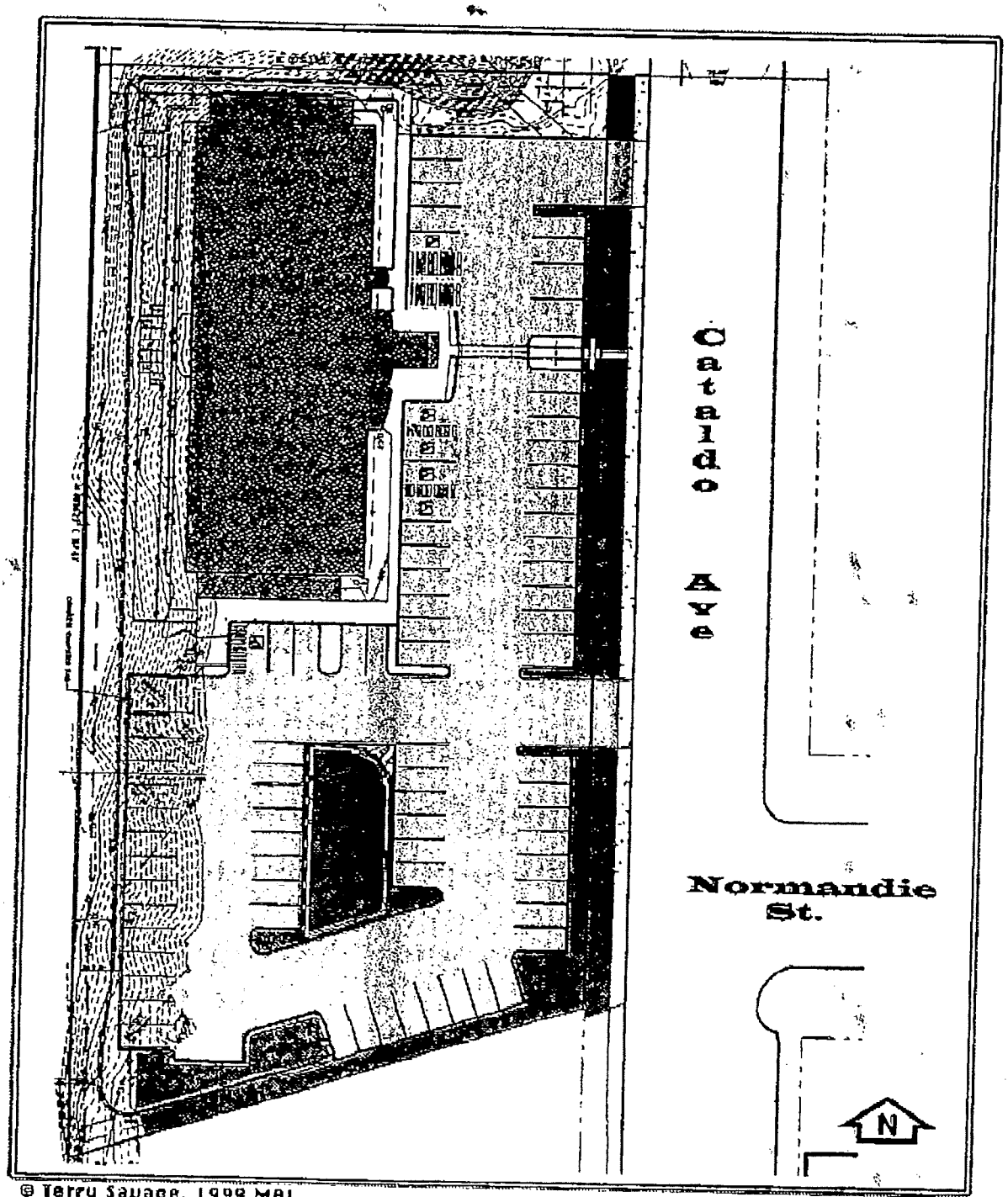


SPOKANE EAR, NOSE & THROAT CLINIC
217 W. CATALDO
SPOKANE, WASHINGTON

OMS
O'Connor, Monaghan & Somers, Inc.
Architecture, Interiors & Planning

RAMEY
CONSTRUCTION CO., INC.

EXHIBIT C



Site Plan

Proposed Spokane Ear, Nose & Throat Clinic
Spokane, Washington
As of March 25, 1999
File #99060-S11

Exhibit 12
Audited Financials, 2017 to 2019

Columbia Surgical Specialists, P.S.

Reviewed Consolidated Financial Statements

For the years ended December 31, 2018 and 2017

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

Columbia Surgical Specialists, P.S.

Reviewed Consolidated Financial Statements
For the years ended December 31, 2018 and 2017

Columbia Surgical Specialists, P.S.

Contents

BDO

Tel: 509-747-8095
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www.bdo.com

601 West Riverside Ave Suite 900
Spokane, WA 99201

Independent Accountant's Review Report

Board of Directors
Columbia Surgical Specialists, P.S.
Spokane, WA

We have reviewed the accompanying consolidated financial statements of Columbia Surgical Specialists, P.S. (the "Clinic"), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, shareholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of the Clinic's management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the consolidated financial statements as a whole. Accordingly, we do not express such an opinion.

Management's Responsibility for the Consolidated Financial Statements

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

Accountant's Responsibility

Our responsibility is to conduct the review engagements in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the American Institute of Certified Public Accountants. Those standards require us to perform procedures to obtain limited assurance as a basis for reporting whether we are aware of any material modifications that should be made to the consolidated financial statements for them to be in accordance with accounting principles generally accepted in the United States of America. We believe that the results of our procedures provide a reasonable basis for our conclusion.

Accountant's Conclusion

Based on our reviews, with the exception of the matter described in the following paragraph, we are not aware of any material modifications that should be made to the accompanying consolidated financial statements in order for them to be in accordance with accounting principles generally accepted in the United States of America.

Known Departure From Accounting Principles Generally Accepted in the United States of America

As disclosed in Note 13 of these consolidated financial statements, accounting principles generally accepted in the United States of America require the recording of deferred tax assets and liabilities within the consolidated financial statements. The Clinic has elected to not record any deferred tax assets or liabilities in the accompanying financial statements. Refer to Note 13 for the impact on the financial statements.

Because of the significance of the matter discussed above, users of the consolidated financial statements should recognize that they might reach different conclusions about the Clinic's financial position, results of operation, and cash flows of the financial statements had they been prepared in conformity with accounting principles generally accepted in the United States of America.

BDO USA, LLP

March 22, 2019
Spokane, Washington

Reviewed Consolidated Financial Statements

Columbia Surgical Specialists, P.S.

Consolidated Balance Sheets

December 31,	2018	2017
Assets		
Current Assets		
Cash and cash equivalents	$ 3,312,150	$ 1,961,810
Restricted cash	105,697	105,697
Accounts receivable from patients, net	3,733,560	2,967,498
Prepaid expenses	407,427	310,319
Income tax receivable	–	73,923
Other receivables	216,337	231,508
Total Current Assets	7,775,171	5,650,755
Property and equipment, net	3,460,795	3,829,217
Total Assets	$ 11,235,966	$ 9,479,972

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Balance Sheets

December 31,	2018	2017
Liabilities and Stockholders' Equity		
Current Liabilities		
Accounts payable	$ 1,261,930	$ 1,147,671
Operating line of credit	298,250	97,603
Accrued payroll and payroll taxes	1,828,933	1,229,096
Accrued vacation	172,918	112,986
Accrued retirement plan contributions	385,689	359,618
Deferred revenue	173,301	25,103
Estimated claims for self-insurance	903,806	605,020
Income tax payable	118,369	–
Current portion of long-term debt	1,055,786	340,689
Total Current Liabilities	6,198,982	3,917,786
Long-term debt, net of debt issuance costs, less current portion	656,757	2,069,403
Total Liabilities	6,855,739	5,987,189
Commitments and Contingencies (Notes 8, 9, and 11)		
Stockholders' Equity		
Common stock, $1 par value, authorized 50,000 shares; issued and outstanding 2018 - 1,002 shares and 2017 - 922 shares	1,002	922
Additional paid-in capital	1,659,294	1,364,493
Retained earnings	2,449,190	1,943,700
Total Columbia Surgical Specialists stockholders' equity	4,109,486	3,309,115
Non-controlling interest	270,741	183,668
Total Stockholders' Equity	4,380,227	3,492,783
Total Liabilities & Equity	$ 11,235,966	$ 9,479,972

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Statements of Operations

Years ended December 31,	2018	2017
Revenues		
Net patient service revenue	$ 31,551,425	$ 28,879,230
Other revenue	519,759	455,312
Total Revenue	32,071,184	29,334,542
Non-Provider Expenses		
Salaries and wages	5,953,996	5,488,664
Employee benefits	1,686,152	1,638,849
Medical supplies and pharmaceuticals	4,219,652	3,853,091
Office supplies	275,179	254,310
Building and occupancy	2,276,605	2,194,953
Depreciation and amortization	499,833	503,427
Professional fees	229,738	182,677
Purchased services	279,407	285,293
Telephone and communication	205,910	211,880
Postage	52,055	48,650
Advertising, marketing, and public relations	176,373	152,622
Data processing	437,990	343,684
Taxes and licenses	466,437	422,872
(Gain) loss on disposal of property and equipment	(141,882)	34,538
Miscellaneous	326,836	302,117
Total Non-Provider Expenses	16,944,281	15,917,627
Provider Expenses		
Physician salaries and wages	7,658,328	6,913,673
Physician benefits	1,813,080	1,684,882
Non-physician salaries and wages	1,652,826	1,574,608
Non-physician benefits	321,034	362,143
Bonuses	2,311,532	2,272,727
Professional liability insurance	378,489	358,666
Physician continuing education	185,428	180,445
Total Provider Expenses	14,320,717	13,347,144
Total Operating Expenses	31,264,998	29,264,771
Income From Operations	806,186	69,771
Other Income (Expense)		
Interest income	—	3,867
Interest expense	(87,040)	(111,248)
Other income, net	151,798	186,809
Total Other Income	64,758	79,428
Income Before Income Tax	870,944	149,199
Income Tax Expense	192,292	120,557
Net Income	$ 678,652	$ 28,642
Net income attributable to non-controlling interest	129,257	29,733
Net (Loss) Income Attributable to Columbia Surgical Specialists	$ 549,395	$ (1,091)

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Statements of Shareholders' Equity

	Common Stock Shares	Common Stock Amount	Additional Paid In Capital	Retained Earnings	Non-Controlling Interest	Total Stockholders' Equity
Balance, January 1, 2017	882	$ 882	$ 1,242,680	$ 1,983,845	$ 191,455	$ 3,418,862
Shareholders distributions	–	–	–	(39,054)	(37,520)	(76,574)
Stock Issuance	40	40	121,813	–	–	121,853
Net income (loss)	–	–	–	(1,091)	29,733	28,642
Balance, December 31, 2017	922	922	1,364,493	1,943,700	183,668	3,492,783
Shareholders distributions	–	–	–	(43,905)	(42,184)	(86,089)
Stock Issuance	80	80	294,801	–	–	294,881
Net income	–	–	–	549,395	129,257	678,652
Balance, December 31, 2018	**1,002**	**$ 1,002**	**$ 1,659,294**	**$ 2,449,190**	**$ 270,741**	**$ 4,380,227**

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Statement of Cash Flows

Years ended December 31,	2018	2017
Operating Activities		
Net income	$ 678,652	$ 28,642
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation and amortization	499,833	503,427
Provision for (recovery of) doubtful accounts	991,599	(164,304)
(Gain) Loss on disposal of property and equipment	(141,882)	34,538
Changes in:		
Accounts receivable from patients	(1,757,661)	178,801
Prepaid expenses	(97,108)	(13,535)
Other receivables	16,485	12,701
Accounts payable and accrued expenses	1,247,083	497,013
Income taxes	192,292	120,557
Net Cash Provided By Operating Activities	1,629,293	1,197,840
Investing Activities		
Proceeds from disposals of property and equipment	756,408	—
Purchase of property and equipment	(741,929)	(692,195)
Net Cash Provided By (Used In) Investing Activities	14,479	(692,195)
Financing Activities		
Loan origination fees	—	(1,000)
Principal payments on long-term debt	(702,871)	(405,042)
Principal payments on line of credit	(10,591,430)	(15,067,882)
Borrowings on long-term debt	—	288,777
Borrowings on line of credit	10,792,077	15,083,635
Stock Issuance	294,881	121,853
Distributions to shareholders	(86,089)	(76,574)
Net Cash Used In Financing Activities	(293,432)	(56,233)
Net Increase in Cash, Cash equivalents, and Restricted Cash	1,350,340	449,412
Cash, Cash Equivalents, and Restricted Cash, Beginning of Year	2,067,507	1,618,095
Cash, Cash Equivalents, and Restricted Cash, End of Year	$ 3,417,847	$ 2,067,507
Supplemental Disclosure of Cash Flow Information		
Cash paid for interest	$ 87,040	$ 111,248

See accompanying independent accountant's review report.

1. Summary of Accounting Policies

Organization and Business

Columbia Surgical Specialists, PS (the "Clinic") is a professional service corporation organized under the applicable laws of the state of Washington. The Clinic provides medical services and specialized surgical care to patients in the Spokane area and the Inland Northwest. In addition to providing medical services and specialized surgical care, the Clinic also sells hearing aids and related items.

Principles of Consolidation

The Clinic is a 51% owner of LYFT, LLC. The purpose of LYFT, LLC is (a) to operate a medical consulting, management consulting, and related business; (b) to carry on any lawful business or activity that may be conducted by a limited liability company; and (c) to exercise all other powers necessary to or reasonably connected with the LYFT, LLC's business, which may be legally exercised by limited liability companies. Executive and other key employees of the Clinic comprise 49% ownership of LYFT, LLC. The Clinic's consolidated financial statements include the accounts of LYFT, LLC, and its subsidiaries YESS Properties, LLC, LYFT 2, LLC, and LYFT 3, LLC. The 49% non-controlling interest in LYFT, LLC, LYFT 2, LLC, LYFT 3, LLC, and YESS Properties, LLC has been classified as a component of equity separate from equity of the Clinic.

Cash and Cash Equivalents

Cash and cash equivalents include cash and short-term investments which have a remaining maturity of three months or less as of the date of purchase. The Clinic maintains cash and money market deposits in financial institutions that may from time to time exceed the amounts insured by the FDIC. To date, the Clinic has not experienced a lack of access to its cash and cash equivalents. However, no assurance can be provided that access to the Clinic's cash will not be impacted by adverse economic conditions in the financial markets.

Restricted Cash

Certain of the Clinic's secured financing arrangements require the Clinic to maintain minimum cash balances in a separate fund. The Clinic currently maintains the funds in a money market fund of which the bank maintains a restricted portion, although previously the funds were held in a CD. As of December 31, 2018 and 2017, the fair value of the accounts were $246,773 and $246,699,respectively, of which $105,697 was restricted in both periods presented.

Patient Accounts Receivable

Patient accounts receivables are unsecured and do not accrue interest. Patient receivables are stated at the amounts billed to patients or third-party payers and others. An allowance for doubtful accounts is provided based on experience and management's evaluation of the current status of accounts. The allowance for doubtful accounts was $507,938 and $424,635 as of December 31, 2018 and 2017, respectively. The allowance for doubtful accounts includes only receivable balances that are determined to be uncollectible. After all attempts to collect a receivable have failed, the receivable is written off against the allowance. The balance of gross accounts receivable older than 90 days was $2,350,548 and $1,676,494 at December 31, 2018 and 2017, respectively.

Patient Service Revenue Recognition

The Clinic recognizes net patient service revenues in the reporting period in which it performs the service based on its current billing rates (i.e., gross charges), less adjustments and estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicaid, other health plans, and self-pay individuals). The Clinic records gross service charges in its accounting records on an accrual basis using its established rates for the type of service provided to the patient. The Clinic recognizes an estimated contractual allowance to reduce gross patient charges to the amount it estimates it will actually realize for the service rendered based upon previously agreed to rates with a payor. Such estimated contractual allowances are based primarily upon historical collection rates. The allowance for contractual amounts was $3,763,285 and $2,854,989 as of December 31, 2018 and 2017, respectively.

The process of estimating contractual allowances requires the Clinic to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on historical paid claims data. Due to the complexities involved in these estimates, actual payments the Clinic receives could be different from the amounts it estimates and records. Because the amount of the eventual settlements and collections are uncertain at the time the financial statements are prepared, management uses judgment based on experience in determining an appropriate reserve for uncollectible receivables. Final settlements under some of these insurance programs are subject to adjustment based on administrative review and audit by third parties. Adjustments are considered in the recognition of revenues on an estimated basis in the period the related services are rendered. The Clinic accounts for adjustments to previous program reimbursement estimates as contractual allowance adjustments and reports them in the periods that such adjustments become known.

From time to time, patients make payments in advance of services being performed. These payments are recorded as deferred revenue and once the services are performed are recognized as revenue by the Clinic.

Revenue from Governmental Programs

The American Recovery and Reinvestment Act of 2009 allocated approximately $19 billion for making incentive payments to hospitals and physicians that implement and meaningfully use electronic health record ("EHR") technology beginning in calendar year 2011 over a five year period. To qualify for the program, participants must successfully demonstrate and certify that they have met a variety of different qualified meaningful use criteria as specified in the program. The Clinic began participating in this program during 2011 and recognized revenue from participating in the program under a grant based model whereby revenue was recognized on a cliff basis during each year of the program when there was reasonable assurance that the Clinic would comply with the criteria of the program and the grants were to be received. During the years ended December 31, 2018 and 2017, the Clinic recognized in other income $88 and $7,840, respectively, related to its participation in the program.

Property and Equipment

Property and equipment, which is stated at cost, is being depreciated by the straight-line method over the expected lives of the various assets. The expected lives for furniture and equipment range from 3 to 7 years, and the expected lives for leasehold improvements range from 7 to 39 years. Depreciation expense amounted to $495,825 and $499,092 for the years ended December 31, 2018 and 2017, respectively.

Valuation of Long-Lived Assets

The Clinic, using its best estimates based on reasonable and supportable assumptions and projections, reviews assets for impairment whenever events or changes in circumstances have indicated the carrying amount of its assets might not be recoverable. At December 31, 2018 and 2017, no assets had been impaired.

Estimated Claims for Self-Insurance

The Clinic is self-insured for employee medical claims. The Clinic records claim expenses and liabilities when it is probable that a loss has been incurred and the amount of that loss can be reasonably estimated. The reported liability includes an estimate of claims that have been incurred but not reported.

Accounting Estimates

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

Significant estimates in the financial statements include the allowance for contractual accounts, allowance for doubtful accounts, depreciation of property and equipment, estimated claims for self-insurance and deferred compensation.

Advertising

The costs of advertising are expensed as incurred. Advertising expense for the years ended December 31, 2018 and 2017, was $176,373 and $152,622, respectively.

Income Taxes

Accounting standards require deferred income tax assets or liabilities be recognized for the expected future income tax consequences of events that have been recognized in the financial statements and are determined based on the temporary differences between the financial statement carrying amounts and tax basis of assets and liabilities. As discussed in Note 13, management has elected not to record any deferred tax assets or liabilities which is not in conformity with accounting principles generally accepted in the United States of America.

The Clinic recognizes the tax benefit from uncertain tax positions only if it is more likely than not the tax positions will be sustained on examination by the tax authorities, based on the technical merits of the position. The tax benefit is measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. The Clinic recognizes interest and penalties related to income tax matters in income tax expense as required.

Reclassifications

Certain amounts disclosed in prior period financial statements have been reclassified to conform to the current period presentation. These reclassifications had no effect on reported income, cash flows, total assets, or shareholders' equity as previously reported.

New Accounting Pronouncements

In February 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2016-02, *Leases (Topic 842)*. The new standard establishes a right-of-use ("ROU") model that requires a lessee to record a ROU asset and a lease liability on the balance sheet for all leases with terms longer than 12 months. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the income statement. The new standard is effective for fiscal years beginning after December 15, 2019. A modified retrospective transition approach is required for lessees for capital and operating leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements, with certain practical expedients available. The Clinic is still in the process of assessing the impact this ASU will have on their financial statements.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)* This ASU supersedes nearly all existing revenue recognition guidance under U.S. GAAP. The core principle of ASU 2014-09 is to recognize revenues when promised goods or services are transferred to customers in an amount that reflects the consideration to which an entity expects to be entitled for those goods or services. ASU 2014-09 defines a five step process to achieve this core principle and, in doing so, more judgment and estimates may be required within the revenue recognition process than are required under existing U.S. GAAP. The standard, issued as ASU 2014-09 and amended by ASU 2015-14, ASU 2016-08, ASU 2016-10 ASU 2016-11, ASU 2016-12, ASU 2016-20, ASU 2017-13, and ASU 2017-14, may be adopted using either of the following transition methods: (i) a full retrospective approach reflecting the application of the standard in each prior reporting period with the option to elect certain practical expedients, or (ii) a retrospective approach with the cumulative effect of initially adopting ASU 2014-09 recognized at the date of adoption (which includes additional footnote disclosure). The standard is effective for annual periods beginning after December 15, 2018, and interim periods within annual periods that begin after December 15, 2019. The Clinic has not yet evaluated the impact this ASU will have on their financials.

In August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments*. This update provides guidance on the eight specific cash flow issues including debt prepayment or debt extinguishment costs, settlement of zero-coupon debt instruments or other debt instruments with coupon interest rates that are insignificant in relation to the effective interest rate of the borrowing, contingent consideration payments made after a business combination, proceeds from the settlement of insurance claims, proceeds from the settlement of corporate-owned life insurance policies, including bank-owned life insurance policies, distributions received from equity method investees and beneficial interests in securitization transactions, separately identifiable cash flows and applications of the predominance principle. The new standard is effective for fiscal years beginning after December 15, 2018. The Clinic does not believe the adoption of this ASU will have a material impact on the financial statements.

In October, the FASB issues ASU No. 2018-17, *Consolidation (Topic 810)*. This update allows a private company to elected not to apply VIE guidance to legal entities under common controls, including common control leasing arraignments, if both the parent and the legal entity being evaluated for consolidate are not public business entities. This new standard is effective for fiscal years beginning after December 15, 2020, with early adoption permitted. The Clinic does not believe the adoption of this ASU will have a material impact on the financial statements.

2. Property and Equipment

Property and equipment is comprised as follows:

December 31,	2018	2017
Medical equipment	$ 4,614,976	$ 4,203,410
Office furniture and equipment	2,151,039	2,111,169
Building	1,394,803	2,238,037
Leasehold improvements	1,394,251	1,281,543
Construction in progress	22,139	—
	9,577,208	9,834,159
Less accumulated depreciation	(6,116,413)	(6,004,942)
Property and Equipment, Net	$ 3,460,795	$ 3,829,217

3. Net Patient Service Revenue

For the years ended December 31, 2018 and 2017, the gross billings for patient services, adjustments for collectability and net patient service revenues were as follows:

Years ended December 31,	2018	2017
Gross billings	$ 60,922,382	$ 56,569,595
Less: Adjustments to accounts receivable and changes in allowance for uncollectible accounts	(29,370,957)	(27,690,365)
Net patient service revenue	$ 31,551,425	$ 28,879,230

4. Lines of Credit

The Clinic maintains an operating line of credit with Wells Fargo. The line of credit provides for a maximum borrowing of $950,000, per the terms of the line of credit agreement, maturing September 5, 2019. Prior to this agreement, the Clinic maintained an operating line of credit, also with Wells Fargo, providing for maximum borrowings of $650,000. This agreement matured on April 30, 2017. The line of credit is collateralized by a second lien on accounts receivable and equipment and is guaranteed by the stockholders. Both agreements bear variable interest payable monthly at the United States prime rate plus 0.50 percentage points (6% at December 31, 2018 and 5.00% at December 31, 2017). The Clinic had an outstanding balance on the line of credit of $298,250 and $97,603 as of December 31, 2018 and 2017, respectively.

5. Long-Term Debt

Long-term debt at December 31, 2018 and 2017, consists of the following:

December 31,	2018	2017
Note payable to Wells Fargo with monthly installments of $4,722 including interest of 4.10%, due April 15, 2019 collateralized by equipment.	$ 776,027	$ 799,891
Note payable to Wells Fargo with monthly installments of $3,699 and a balloon payment at maturity in February 2020 including interest of 3.65%, collateralized by equipment.	—	392,548
Note payable to Wells Fargo with monthly installments of $9,084 including interest of 4.29%, due September 15, 2020, collateralized by real property.	183,456	282,278
Note payable to Wells Fargo with monthly installments of $2,010 and a balloon payment at maturity in May 2020 including interest of 3.90%, collateralized by real property.	349,487	359,571
Note payable to Wells Fargo with monthly installments of $4,670 including interest of 4.29% with a maturity of October 15, 2021 collateralized by equipment.	149,235	197,730
Note payable to Wells Fargo with monthly installments of $4,542 including interest of 4.29%, due March 2018 collateralized by equipment.	—	9,035
Unsecured note payable to Dr. Beyersdorf bearing interest at 1.90% requiring an initial payment of $21,525 on February 1, 2015 followed by monthly installments of $1,505 through February 2020.	20,827	38,316
Unsecured note payable to Dr. Hartnett bearing interest at 1.86% requiring an initial payment of $19,021 on December 1, 2014 followed by monthly installments of $1,329 through December 2019.	15,788	31,284

December 31,	2018	2017
Unsecured note payable to Dr. MacFarlane bearing interest at 1.89% requiring an initial payment of $19,598 on November 1, 2014 followed by monthly installments of $1,370 through November 2019.	**13,585**	29,607
Note payable to Home Street Bank with monthly installments of $6,631 including interest of 4.15%, due November 2021 collateralized by equipment.	**207,528**	273,035
Note payable to US Bank with monthly installments of $620 including interest of 5.30%, due October 2018 collateralized by equipment.	—	5,507
Long-term debt	**1,715,933**	2,418,802
Less: Current portion of long-term debt	**(1,055,786)**	(340,689)
Long-term debt payable, less current maturities	**660,147**	2,078,113
Less: Capitalized debt issuance costs, net of amortization	**(3,390)**	(8,710)
Long-Term Debt, net of debt issuance costs, less current portion	**$ 656,757**	$ 2,069,403

Future maturities of long-term debt, including the line of credit, are as follows:

Years Ending December 31,	
2019	$ 1,354,036
2020	546,371
2021	113,776
	$ 2,014,183

6. Hearing Aid Sales and Cost of Sales

Included in gross patient service revenue are hearing aid sales and included in non-provider expenses are the costs of hearing aids. During the years ended December 31, 2018 and 2017, the Clinic recognized the following sales and costs of hearing aids:

December 31,	2018	2017
Hearing aid sales, net of contractual adjustments	**$ 2,378,875**	$ 2,509,122
Costs of hearing aid sales	**949,010**	1,032,069
	$ 1,429,865	$ 1,477,053

7. Concentration of Credit Risk

Credit is granted without collateral to patients, most of whom are local residents and are insured under third-party payer agreements. The concentration of credit risk with respect to payers of Patient accounts receivable at December 31, 2018 and 2017, is as follows:

December 31,	2018	2017
Payor:		
Medicare	20%	17%
Medicaid	26%	23%

During the years ended December 31, 2018 and 2017, the concentration of net revenue with respect to patient services were approximately as follows:

Years ended December 31,	2018	2017
Payor:		
Medicare	27%	26%
Medicaid	12%	14%

The continuance of Medicare and Medicaid programs is dependent upon governmental policies.

8. Operating Leases

During the years ended December 31, 2018 and 2017, the Clinic occupied facilities owned by Cataldo Medical Building, LLC (CMB), a limited liability company owned by the stockholders of the Clinic. At December 31, 2018 and 2017, the monthly rent charge is $70,000. The lease expires October 31, 2027.

The Clinic is obligated under the terms of a lease for office space related to Columbia Hearing Center, a division of the Clinic, with an original expiration date of December 31, 2017. The Clinic extended the lease, which expires on December 31, 2022. The monthly rent charge is $2,009.

The Clinic is obligated under the terms of a triple net lease with Nevada Medical Building, LLC (NMB), a limited liability company owned by the stockholders of the Clinic, for clinic and office space, which expires October 31, 2027. The monthly rent charge is $13,513.

The Clinic is obligated under the terms of a triple net lease with Valley Medical Building, LLC (VMB), a limited liability company owned by the stockholders of the Clinic, for clinic and office space, which expires October 31, 2027. The monthly rent charge is $14,593.

The Clinic is obligated under the terms of a lease with Washington 910, LLC (910), a limited liability company owned by the stockholders of the Clinic, for office space which expires April 31, 2021. The monthly rent charge is $10,117.

The Clinic is obligated under the terms of a lease with Short Road DP, LLC (Short Road), a limited liability company, for office space which expires October 31, 2023. The monthly rent charge is $5,200.

Minimum future lease payments under noncancelable operating leases with a term of one year or more as of December 31, 2018 are as follows:

Year ending December 31,2016	Related Parties *See Note 12*	Non-Related Parties	
2019	$ 1,298,676	$ 93,823	$ 1,392,499
2020	1,298,676	88,704	1,387,380
2021	1,217,740	92,571	1,310,311
2022	1,177,272	94,567	1,271,839
2023	1,177,272	58,527	1,235,799
Thereafter	4,512,876	—	4,512,876
	$ 10,682,512	$ 428,192	$ 11,110,704

Total rent expense for the years ended December 31, 2018 and 2017, was $1,363,007 and $1,336,303, respectively.

9. Retirement Plans

The Clinic maintains a 401(k) profit sharing plan (the "Plan") that was established effective July 1, 1995. Participation in the 401(k) portion of the Plan requires one year of service and attainment of age 21. In addition to employee elective contributions, the Board of Directors may, at its discretion, make additional employer contributions to the Plan. Participation in the employer approved profit sharing contributions requires two years of service with a 100% vesting upon entry. For the years ended December 31, 2018 and 2017, employer contributions to the Plan totaled $1,145,686 and $1,082,610, respectively.

10. Income Taxes

The Clinic is a professional service corporation and, accordingly, is taxed at an approximate 21% rate on taxable income. As discussed in Note 13, the Clinic has elected not to record any deferred tax assets or liabilities in the financial statements which is not in accordance with accounting principles generally accepted in the United States of America. The Clinic files an income tax return in the U.S. federal jurisdiction. With limited exception, the Clinic is no longer subject to U.S. federal, state and local income tax examinations by taxing authorities for years prior to 2015. The Clinic does not have any uncertain tax positions. As of December 31, 2018 and 2017, there were no accrued interest or penalties recorded in the financial statements.

11. Commitments

Malpractice

Malpractice insurance coverage is provided through a commercial carrier. The Clinic's financial obligation is limited to its premium for malpractice insurance coverage. The insurance carrier provides claims-made coverage, which covers only asserted malpractice claims within policy limits. The Clinic recognizes expenses associated with unasserted claims in the period in which the incidents are expected to have occurred rather than when a claim is asserted. Management believes its insurance coverage is sufficient to cover any potential loss.

Legislation

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare service providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. The Clinic believes it is in compliance with these laws and regulations at December 31, 2018 and 2017.

HIPAA

The Health Insurance Portability and Accountability Act ("HIPAA") was enacted on August 21, 1996, to assure health insurance portability, reduce healthcare fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations were required to be in compliance with HIPAA provisions by April 2004. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. The Clinic believes it is in compliance with HIPAA provisions at December 31, 2018 and 2017.

12. Variable Interest Entities

The Clinic has determined that it is the primary beneficiary of Cataldo Medical Building, LLC ("CMB"), Nevada Medical Building, LLC ("NMB") Valley Medical Building, LLC ("VMB"), Washington 910, LLC ("910"), and Washington 920, LLC ("920") because it has the power to direct activities of the entity that most significantly effects the economic performance of these entities, such as setting rental payment amounts and terms. The Clinic also has exposure to the losses of CMB, NMB, and VMB based on the Clinic's guarantee of debt. The Clinic has no direct ownership in CMB, NMB, VMB, 910, or 920 although it does have common ownership. While the Clinic has no contractual obligation to do so, it may voluntarily elect to provide CMB, NMB, VMB, 910, or 920 with additional direct or indirect financial support based on its business objectives. The adoption of ASU 2014-17 allows the Clinic to opt out of the requirement to consolidate certain common control leasing arrangements and therefore, has treated the leases with the entities as operating leases as discussed in Note 8.

As of December 31, 2018, CMB had approximately $4.5 million of debt outstanding with interest rates ranging from 3.65% to 3.95% and a maturity date of 2020, NMB had approximately $837,000 of debt outstanding with an interest rate of 3.65% and a maturity date of 2020, VMB had approximately $948,000 of debt outstanding with interest rates ranging from 2.25% to 3.65% and maturity dates of 2020, 910 had $1.2 million of outstanding debt with an interest rate of 3.95% and maturity date of 2023, and 920 had approximately $1.1 million of outstanding debt with an interest rate of 3.95% with a maturity date of 2023.

CMB also had two unsecured notes payable with two former members totaling approximately $106,044 at December 31, 2018. NMB, VMB, 910, and 920 LLCs had intercompany notes payable with CMB LLC totaling approximately $1.3 million at December 31, 2018. 910 had notes payable to CSS totaling approximately $163,000 at December 31, 2018.

Additionally, the Clinic has performed an analysis over the VIEs of CSS noting no material commitments or contingencies requiring disclosure or accrual in the financial statements for the years ended December 31, 2018 or 2017.

13. Departures from Accounting Principles Generally Accepted in the United States of America

In accordance with accounting principles generally accepted in the United States of America, the Clinic is required to record deferred tax assets and liabilities as well as income tax expenses or benefits for the expected future income tax consequences of events that have been recognized in the financial statements. Deferred tax assets and liabilities are determined based on the cumulative difference between the tax basis and book basis of assets and liabilities. These differences are tax effected at the enacted tax rates for the years in which the differences are expected to reverse. The Clinic has elected to not record any deferred tax assets or liabilities in the financial statements resulting in a departure from accounting principles generally accepted in the United States of America. Had the Clinic recorded the deferred taxes as of December 31, 2018, deferred tax liabilities would have been approximately $292,000, tax expense would have been approximately $192,000 and retained earnings as of January 1, 2017 would have decreased approximately $26,000. Had the Clinic recorded the deferred taxes as of December 31, 2017, deferred tax liabilities would have been approximately $318,000, tax expense would have been approximately $164,000 and retained earnings as of January 1, 2016 would have decreased approximately $284,000.

14. Subsequent Events

The Clinic has evaluated subsequent events through March 22, 2019, which is the date that these financial statements were available to be issued. The evaluation included the impact on legislation, litigation and HIPPA compliance. On January 9, 2019 the Clinic became aware of the unauthorized access to its electronic systems in the form of a ransomware attack and paid $14,649 to unlock the information. At this time, there is no evidence that patient information has been misused and the Clinic believes that no data was acquired, disclosed or used by any third party. There were no other significant subsequent events identified.

Columbia Surgical Specialists, P.S.

Reviewed Consolidated Financial Statements
As of and for the years ended December 31, 2019 and 2018

Columbia Surgical Specialists, P.S.

Reviewed Consolidated Financial Statements
As of and for the years ended December 31, 2019 and 2018

Columbia Surgical Specialists, P.S.

Contents

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601 West Riverside Ave Suite 900
Spokane, WA 99201

Independent Accountant's Review Report

Board of Directors
Columbia Surgical Specialists, P.S.
Spokane, WA

We have reviewed the accompanying consolidated financial statements of Columbia Surgical Specialists, P.S. (the "Clinic"), which comprise the consolidated balance sheets as of December 31, 2019 and 2018, and the related consolidated statements of income, shareholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of the Clinic's management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the consolidated financial statements as a whole. Accordingly, we do not express such an opinion.

Management's Responsibility for the Consolidated Financial Statements

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

Accountant's Responsibility

Our responsibility is to conduct the review engagements in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the American Institute of Certified Public Accountants. Those standards require us to perform procedures to obtain limited assurance as a basis for reporting whether we are aware of any material modifications that should be made to the consolidated financial statements for them to be in accordance with accounting principles generally accepted in the United States of America. We believe that the results of our procedures provide a reasonable basis for our conclusion.

Accountant's Conclusion

Based on our reviews, with the exception of the matter described in the following paragraph, we are not aware of any material modifications that should be made to the accompanying consolidated financial statements in order for them to be in accordance with accounting principles generally accepted in the United States of America.

Known Departure From Accounting Principles Generally Accepted in the United States of America

As disclosed in Note 12 of these consolidated financial statements, accounting principles generally accepted in the United States of America require the recording of deferred tax assets and liabilities within the consolidated financial statements. The Clinic has elected to not record any deferred tax assets or liabilities in the accompanying financial statements. Refer to Note 12 for the impact on the financial statements.

Because of the significance of the matter discussed above, users of the consolidated financial statements should recognize that they might reach different conclusions about the Clinic's financial position, results of operation, and cash flows of the financial statements had they been prepared in conformity with accounting principles generally accepted in the United States of America.

BDO USA, LLP

April 24, 2020
Spokane, Washington

Reviewed Consolidated Financial Statements

Columbia Surgical Specialists, P.S.

Consolidated Balance Sheets

December 31,	2019	2018
Assets		
Current Assets		
Cash and cash equivalents	$ 3,222,696	$ 3,312,150
Restricted cash	3,323	105,697
Accounts receivable from patients, net	4,229,781	3,733,560
Prepaid expenses	302,459	407,427
Income tax receivable	192,320	—
Other receivables	390,375	216,337
Total Current Assets	8,340,954	7,775,171
Property and equipment, net	3,055,450	3,460,795
Total Assets	$ 11,396,404	$ 11,235,966

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Balance Sheets

December 31,	2019	2018
Liabilities and Stockholders' Equity		
Current Liabilities		
Accounts payable	$ 1,323,968	$ 1,261,930
Operating line of credit	483,494	298,250
Accrued payroll and payroll taxes	1,727,926	1,828,933
Accrued vacation	148,654	172,918
Accrued retirement plan contributions	456,420	385,689
Contract liabilities	163,121	173,301
Estimated claims for self-insurance	914,913	903,806
Income tax payable	—	118,369
Current portion of long-term debt	362,689	1,055,786
Total Current Liabilities	5,581,185	6,198,982
Long-term debt, net of debt issuance costs, less current portion	744,903	656,757
Total Liabilities	6,326,088	6,855,739
Commitments and Contingencies (Notes 7, 8, and 10)		
Shareholders' Equity		
Common stock, $1 par value, authorized 50,000 shares; issued and outstanding 2019 - 1,082 shares and 2018 - 1,002 shares	1,082	1,002
Additional paid-in capital	1,977,152	1,659,294
Retained earnings	2,787,484	2,449,190
Total Columbia Surgical Specialists shareholders' equity	4,765,718	4,109,486
Non-controlling interest	304,598	270,741
Total Shareholders' Equity	5,070,316	4,380,227
Total Liabilities & Shareholders' Equity	$ 11,396,404	$ 11,235,966

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Statements of Income

Years ended December 31,	2019	2018
Revenues		
Net patient service revenue	$ 36,858,220	$ 31,551,425
Other revenue	314,237	519,759
Total Revenue	37,172,457	32,071,184
Non-Provider Expenses		
Salaries and wages	6,678,511	5,953,996
Employee benefits	1,880,673	1,686,152
Medical supplies and pharmaceuticals	4,717,407	4,219,652
Office supplies	385,528	275,179
Building and occupancy	2,508,576	2,276,605
Depreciation and amortization	541,689	499,833
Professional fees	390,297	229,738
Purchased services	354,285	279,407
Telephone and communication	245,148	205,910
Postage	113,791	52,055
Advertising, marketing, and public relations	186,289	176,373
Data processing	540,810	437,990
Taxes and licenses	536,974	466,437
Gain on disposal of property and equipment	(64,421)	(141,882)
Miscellaneous	253,303	326,836
Total Non-Provider Expenses	19,268,860	16,944,281
Provider Expenses		
Physician salaries and wages	9,131,790	7,658,328
Physician benefits	2,119,385	1,813,080
Non-physician salaries and wages	2,173,197	1,652,826
Non-physician benefits	347,160	321,034
Bonuses	3,079,173	2,311,532
Professional liability insurance	429,599	378,489
Physician continuing education	231,539	185,428
Total Provider Expenses	17,511,843	14,320,717
Total Operating Expenses	36,780,703	31,264,998
Income From Operations	391,754	806,186
Other Income (Expense)		
Interest expense	(99,089)	(87,040)
Other income, net	143,204	151,798
Total Other Income	44,115	64,758
Income Before Income Tax	435,869	870,944
Income Tax Expense	—	192,292
Net Income	$ 435,869	$ 678,652
Net income attributable to non-controlling interest	65,079	129,257
Net Income Attributable to Columbia Surgical Specialists	$ 370,790	$ 549,395

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Statements of Shareholders' Equity

	Common Stock Shares	Common Stock Amount	Additional Paid In Capital	Retained Earnings	Non-Controlling Interest	Total Shareholders' Equity
Balance, January 1, 2018	922	$ 922	$ 1,364,493	$ 1,943,700	$ 183,668	$ 3,492,783
Shareholders distributions	—	—	—	(43,905)	(42,184)	(86,089)
Stock Issuance	80	80	294,801	—	—	294,881
Net income	—	—	—	549,395	129,257	678,652
Balance, December 31, 2018	1,002	1,002	1,659,294	2,449,190	270,741	4,380,227
Shareholders distributions	—	—	—	(32,496)	(31,222)	(63,718)
Stock Issuance	80	80	317,858	—	—	317,938
Net income	—	—	—	370,790	65,079	435,869
Balance, December 31, 2019	1,082	$ 1,082	$ 1,977,152	$ 2,787,484	$ 304,598	$ 5,070,316

See accompanying independent accountant's review report.

Columbia Surgical Specialists, P.S.

Consolidated Statement of Cash Flows

Years ended December 31,	2019	2018
Operating Activities		
Net income	$ 435,869	$ 678,652
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation and amortization	541,689	499,833
Provision for doubtful accounts	600,105	991,599
Gain on disposal of property and equipment	(64,421)	(141,882)
Changes in:		
Accounts receivable from patients	(1,096,326)	(1,757,661)
Prepaid expenses	104,968	(97,108)
Other receivables	(174,038)	16,485
Other assets	(6,102)	–
Accounts payable and accrued expenses	8,425	1,247,083
Income taxes receivable/payable	(310,689)	192,292
Net Cash Provided By Operating Activities	39,480	1,629,293
Investing Activities		
Proceeds from disposals of property and equipment	615,178	756,408
Purchase of property and equipment	(677,609)	(741,929)
Net Cash (Used In) Provided By Investing Activities	(62,431)	14,479
Financing Activities		
Loan origination fees	(7,927)	–
Principal payments on long-term debt	(1,176,337)	(702,871)
Principal payments on line of credit	(19,530,269)	(10,591,430)
Borrowings on long-term debt	575,923	–
Borrowings on line of credit	19,715,513	10,792,077
Stock Issuance	317,938	294,881
Distributions to shareholders	(63,718)	(86,089)
Net Cash Used In Financing Activities	(168,877)	(293,432)
Net Increase in Cash, Cash equivalents, and Restricted Cash	(191,828)	1,350,340
Cash, Cash Equivalents, and Restricted Cash, beginning of year	3,417,847	2,067,507
Cash, Cash Equivalents, and Restricted Cash, end of year	$ 3,226,019	$ 3,417,847
Supplemental Disclosure of Cash Flow Information		
Cash paid for interest	$ 99,089	$ 87,040
Cash paid for taxes	$ 310,689	$ –

See accompanying independent accountant's review report.

1. Summary of Accounting Policies

Organization and Business

Columbia Surgical Specialists, PS (the "Clinic") is a professional service corporation organized under the applicable laws of the state of Washington. The Clinic provides medical services and specialized surgical care to patients in the Spokane area and the Inland Northwest. In addition to providing medical services and specialized surgical care, the Clinic also sells hearing aids and related items.

Principles of Consolidation

The Clinic is a 51% owner of LYFT, LLC. The purpose of LYFT, LLC is (a) to operate a medical consulting, management consulting, and related business; (b) to carry on any lawful business or activity that may be conducted by a limited liability company; and (c) to exercise all other powers necessary to or reasonably connected with the LYFT, LLC's business, which may be legally exercised by limited liability companies. Executive and other key employees of the Clinic comprise 49% ownership of LYFT, LLC. The Clinic's consolidated financial statements include the accounts of LYFT, LLC, and its subsidiaries YESS Properties, LLC, LYFT 2, LLC, and LYFT 3, LLC. The 49% non-controlling interest in LYFT, LLC, LYFT 2, LLC, LYFT 3, LLC, and YESS Properties, LLC has been classified as a component of equity separate from equity of the Clinic.

Cash and Cash Equivalents

Cash and cash equivalents include cash and short-term investments which have a remaining maturity of three months or less as of the date of purchase. The Clinic maintains cash and money market deposits in financial institutions that may from time to time exceed the amounts insured by the FDIC. To date, the Clinic has not experienced a lack of access to its cash and cash equivalents. However, no assurance can be provided that access to the Clinic's cash will not be impacted by adverse economic conditions in the financial markets.

Restricted Cash

Certain of the Clinic's secured financing arrangements require the Clinic to maintain minimum cash balances in a separate fund. The Clinic currently maintains the funds in a money market fund of which the bank maintains a restricted portion, although previously the funds were held in a CD. As of December 31, 2019 and 2018, the fair value of the accounts were $246,847 and $246,773, respectively, of which $3,323 and $105,697 was restricted, respectively.

Patient Accounts Receivable

Patient accounts receivables are unsecured and do not accrue interest. Patient receivables are stated at the amounts billed to patients or third-party payers and others. An allowance for doubtful accounts is provided based on experience and management's evaluation of the current status of accounts. The allowance for doubtful accounts was $635,262 and $507,938 as of December 31, 2019 and 2018, respectively. The allowance for doubtful accounts includes only receivable balances that are determined to be uncollectible. After all attempts to collect a receivable have failed, the receivable is written off against the allowance. The balance of gross accounts receivable older than 90 days was $2,759,894 and $2,350,548 at December 31, 2019 and 2018, respectively.

Revenue Recognition

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (Topic 606) ("ASU 2014-09" or "ASC 606"), which amends the existing account standards for revenue recognition. ASU 2014-09 is based on principles that govern the recognition of revenue at an amount an entity expects to be entitled when products are transferred to a customer. The Clinic adopted the guidance under the new revenue standards using the modified retrospective method effective January 1, 2019. Topic 606 requires the Clinic to recognize revenues when control of the promised goods or services and receipt of payment is probable.

Upon adoption, the new standards replaced most existing revenue recognition guidance in U.S. GAAP. The adoption of the new revenue standards did not have a material impact on its consolidated financial statements and all revenue will be recognized pursuant to Topic 606 under the five-step model specified by the new revenue standard.

Patient Service Revenue Recognition

Revenue is recognized in a close time frame after the patient is seen in our clinic for a patient visit or Ambulatory Service Center or Hospital for surgery. This is known as the Date of Service. Gross charges are billed to insurance or the patient and recorded as gross revenue according to services provided upon their visit or surgical date. Columbia Surgical fee schedule is based on a mark-up of the highest paying commercial contract fee schedule. It is our experience this fee schedule is current in the marketplace for similar services. Insurance Companies will reimburse the Clinic according to contract terms with agreed reimbursement at a percentage of gross fees billed. The offset is contractual adjustment, or, patient responsible balance. The contractual adjustment on a gross fee billed is recorded in the general ledger as noted on remittance from Insurance companies. Management also estimates the allowance percentage needed on the monthly Accounts Receivable Balance without bad debt based on historical adjustments and net collections. Each month a reserve for this allowance percentage is recorded to revenue deductions to recognize net revenue according to what is expected to be collected. Such estimated contractual allowances are based primarily upon historical collection rates.

Contract Liabilities

The contract liabilities primarily relate to the advance consideration received from customers for future services being performed. These payments are recorded as contract liabilities and once the services are performed are recognized as revenue by the Clinic. Completion of the services are expected to be performed within a twelve-month period.

Property and Equipment

Property and equipment, which is stated at cost, is being depreciated by the straight-line method over the expected lives of the various assets. The expected lives for furniture and equipment range from 3 to 7 years, and the expected lives for leasehold improvements range from 7 to 39 years. Depreciation expense amounted to $532,197 and $495,825 for the years ended December 31, 2019 and 2018, respectively.

Valuation of Long-Lived Assets

The Clinic, using its best estimates based on reasonable and supportable assumptions and projections, reviews assets for impairment whenever events or changes in circumstances have indicated the carrying amount of its assets might not be recoverable. At December 31, 2019 and 2018, no assets had been impaired.

Estimated Claims for Self-Insurance

The Clinic is self-insured for employee medical claims. The Clinic records claim expenses and liabilities when it is probable that a loss has been incurred and the amount of that loss can be reasonably estimated. The reported liability includes an estimate of claims that have been incurred but not reported.

Accounting Estimates

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

Significant estimates in the financial statements include the allowance for contractual accounts, allowance for doubtful accounts, depreciation of property and equipment, estimated claims for self-insurance and deferred compensation.

Advertising

The costs of advertising are expensed as incurred. Advertising expense for the years ended December 31, 2019 and 2018, was $211,753 and $176,373, respectively.

Income Taxes

Accounting standards require deferred income tax assets or liabilities be recognized for the expected future income tax consequences of events that have been recognized in the financial statements and are determined based on the temporary differences between the financial statement carrying amounts and tax basis of assets and liabilities. As discussed in Note 12, management has elected not to record any deferred tax assets or liabilities which is not in conformity with accounting principles generally accepted in the United States of America.

The Clinic recognizes the tax benefit from uncertain tax positions only if it is more likely than not the tax positions will be sustained on examination by the tax authorities, based on the technical merits of the position. The tax benefit is measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. The Clinic recognizes interest and penalties related to income tax matters in income tax expense as required.

Reclassifications

Certain amounts disclosed in prior period financial statements have been reclassified to conform to the current period presentation. These reclassifications had no effect on reported income, cash flows, total assets, or shareholders' equity as previously reported.

New Accounting Pronouncements

In May 2014, the FASB issued Topic 606 This ASU supersedes nearly all existing revenue recognition guidance under U.S. GAAP. The core principle of ASU 2014-09 is to recognize revenues when promised goods or services are transferred to customers in an amount that reflects the consideration to which an entity expects to be entitled for those goods or services. ASU 2014-09 defines a five step process to achieve this core principle and, in doing so, more judgment and estimates may be required within the revenue recognition process than are required under existing U.S. GAAP. The standard, issued as ASU 2014-09 and amended by ASU 2015-14, ASU 2016-08, ASU 2016-10 ASU 2016-11, ASU 2016-12, ASU 2016-20, ASU 2017-13, and ASU 2017-14, may be adopted using either of the following transition methods: (i) a full retrospective approach reflecting the application of the standard in each prior reporting period with the option to elect certain practical expedients, or (ii) a retrospective approach with the cumulative effect of initially adopting ASU 2014-09 recognized at the date of adoption (which includes additional footnote disclosure). The standard is effective for annual periods beginning after December 15, 2019. The Clinic has implemented this ASU and there is no significant impact to the financials as discussed above.

In August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments*. This update provides guidance on the eight specific cash flow issues including debt prepayment or debt extinguishment costs, settlement of zero-coupon debt instruments or other debt instruments with coupon interest rates that are insignificant in relation to the effective interest rate of the borrowing, contingent consideration payments made after a business combination, proceeds from the settlement of insurance claims, proceeds from the settlement of corporate-owned life insurance policies, including bank-owned life insurance policies, distributions received from equity method investees and beneficial interests in securitization transactions, separately identifiable cash flows and applications of the predominance principle. The new standard is effective for fiscal years beginning after December 15, 2018. The Clinic has implemented this ASU and there is no significant impact to the financials.

In October, the FASB issues ASU No. 2018-17, *Consolidation (Topic 810)*. This update allows a private company to elected not to apply VIE guidance to legal entities under common control, including common control leasing arraignments, if both the parent and the legal entity being evaluated for consolidate are not public business entities. This new standard is effective for fiscal years beginning after December 15, 2020, with early adoption permitted. The Clinic does not believe the adoption of this ASU will have a material impact on the financial statements.

In February 2016, the FASB issued ASU No. 2016-02, Leases (topic 842). The new standard establishes a right-of-use ("ROU") model that requires a lessee to record a ROU asset and a lease liability on the balance sheet for all leases with terms longer than 12 months. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the income statement. The new standard as amended is effective for fiscal years beginning after December 15, 2021. A modified retrospective transition approach is required for lessees for capital and operating leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements, with certain practical expedients available. Management has not yet evaluated the impact this ASU will have on their consolidated financial statements.

2. Property and Equipment

Property and equipment is comprised as follows:

December 31,	2019	2018
Medical equipment	$ 4,935,281	$ 4,614,976
Office furniture and equipment	1,908,574	2,151,039
Building	883,161	1,394,803
Leasehold improvements	1,439,857	1,394,251
Construction in progress	19,187	22,139
	9,186,060	9,577,208
Less accumulated depreciation	(6,130,610)	(6,116,413)
Property and Equipment, Net	$ 3,055,450	$ 3,460,795

3. Net Patient Service Revenue

For the years ended December 31, 2019 and 2018, the gross billings for patient services, adjustments for collectability and net patient service revenues were as follows:

Years ended December 31,	2019	2018
Gross billings	$ 72,269,714	$ 60,922,382
Less: Adjustments to accounts receivable and changes in allowance for uncollectible accounts	(35,411,494)	(29,370,957)
Net patient service revenue	$ 36,858,220	$ 31,551,425

Included in net patient service revenue are hearing aid sales and included in non-provider expenses are the costs of hearing aids. During the years ended December 31, 2019 and 2018, the Clinic recognized the following sales and costs of hearing aids:

December 31,	2019	2018
Hearing aid sales, net of contractual adjustments	$ 2,889,923	$ 2,378,875
Costs of hearing aid sales	(1,135,790)	(949,010)
	$ 1,754,133	$ 1,429,865

4. Lines of Credit

The Clinic maintains an operating line of credit with Wells Fargo. The line of credit provides for a maximum borrowing of $950,000, per the terms of the line of credit agreement, maturing September 5, 2021. The agreement bears variable interest payable monthly at the United States prime rate plus 0.50 percentage points (6% at December 31, 2019 and 6% at December 31, 2018). The Clinic had an outstanding balance on the line of credit of $483,494 and $298,250 as of December 31, 2019 and 2018, respectively.

5. Long-Term Debt

Long-term debt at December 31, 2019 and 2018, consists of the following:

December 31,	2019	2018
Note payable to Wells Fargo with monthly installments of $2,255 including interest of 4.16%, due September 15, 2029 collateralized by equipment.	$ 296,327	$ 776,027
Note payable to Wells Fargo with monthly installments of $6,940 including interest of 5.23%, due April 2023 collateralized by equipment	248,414	—
Note payable to Wells Fargo with monthly installments of $9,084 including interest of 4.29%, due September 15, 2020, collateralized by real property.	80,310	183,456
Note payable to Wells Fargo with monthly installments of $2,010 and a balloon payment at maturity in May 2020 including interest of 3.90%, collateralized by real property.	—	349,487
Note payable to Wells Fargo with monthly installments of $4,670 including interest of 4.29% with a maturity of October 15, 2021 collateralized by equipment.	98,618	149,235

December 31,	2019	2018
Note payable to Wells Fargo with monthly installments of $6,341 including interest of 4.89%, due July 2023 collateralized by equipment.	249,629	–
Unsecured note payable to Dr. Beyersdorf bearing interest at 1.90% requiring an initial payment of $21,525 on February 1, 2015 followed by monthly installments of $1,505 through February 2020.	3,004	20,827
Unsecured note payable to Dr. Hartnett bearing interest at 1.86% requiring an initial payment of $19,021 on December 1, 2014 followed by monthly installments of $1,329 through December 2019.	–	15,788
Unsecured note payable to Dr. MacFarlane bearing interest at 1.89% requiring an initial payment of $19,598 on November 1, 2014 followed by monthly installments of $1,370 through November 2019.	–	13,585
Note payable to Home Street Bank with monthly installments of $6,631 including interest of 4.15%, due November 2021 collateralized by equipment.	139,217	207,528
Long-term debt	1,115,519	1,715,933
Less: Current portion of long-term debt	(362,689)	(1,055,786)
Long-term debt payable, less current maturities	752,830	660,147
Less: Capitalized debt issuance costs, net of amortization	(7,927)	(3,390)
Long-Term Debt, net of debt issuance costs, less current portion	$ 744,903	$ 656,757

Future maturities of long-term debt, including the line of credit, are as follows:

Years Ending December 31,	
2020	$ 846,184
2021	283,254
2022	177,821
2023	98,251
2024	28,489
Thereafter	165,014
	$ 1,599,013

6. Concentration of Credit Risk

Credit is granted without collateral to patients, most of whom are local residents and are insured under third-party payer agreements. The concentration of credit risk with respect to payers of Patient accounts receivable at December 31, 2019 and 2018, is as follows:

December 31,	2019	2018
Payor:		
Medicare	24%	20 %
Medicaid	20%	26 %

During the years ended December 31, 2019 and 2018, the concentration of net revenue with respect to patient services were approximately as follows:

Years ended December 31,	2019	2018
Payor:		
Medicare	25%	27 %
Medicaid	11%	12 %

The continuance of Medicare and Medicaid programs is dependent upon governmental policies.

7. Operating Leases

During the years ended December 31, 2019 and 2018, the Clinic occupied facilities owned by Cataldo Medical Building, LLC (CMB), a limited liability company owned by the stockholders of the Clinic. At December 31, 2019 and 2018, the monthly rent charge is $70,000. The lease expires October 31, 2027.

The Clinic is obligated under the terms of a lease for office space related to Columbia Hearing Center, a division of the Clinic, with an original expiration date of December 31, 2017. The Clinic extended the lease, which expires on December 31, 2022. The monthly rent charge is $2,009.

The Clinic is obligated under the terms of a triple net lease with Nevada Medical Building, LLC (NMB), a limited liability company owned by the stockholders of the Clinic, for clinic and office space, which expires October 31, 2027. The monthly rent charge is $13,513.

The Clinic is obligated under the terms of a triple net lease with Valley Medical Building, LLC (VMB), a limited liability company owned by the stockholders of the Clinic, for clinic and office space, which expires October 31, 2027. The monthly rent charge is $14,593.

The Clinic is obligated under the terms of a lease with Washington 910, LLC (910), a limited liability company owned by the stockholders of the Clinic, for office space which expires April 30, 2021. The monthly rent charge is $11,655.

The Clinic is obligated under the terms of a lease with Short Road DP, LLC (Short Road), a limited liability company, for office space which expires October 31, 2023. The monthly rent charge is $5,200.

The Clinic is obligated under the terms of a lease with Washington 920, LLC (920), a limited liability company owned by the stockholders of the Clinic, for office space which expires April 30, 2024. The monthly rent charge is $16,200.

Minimum future lease payments under noncancelable operating leases with a term of one year or more as of December 31, 2019 are as follows:

Year ending December 31,2019	Related Parties *See Note 11*	Non-Related Parties	
2020	$ 1,511,532	$ 88,704	$ 1,600,236
2021	1,418,292	92,571	1,510,863
2022	1,371,672	94,567	1,466,239
2023	1,371,672	58,527	1,430,199
2024	1,242,072	—	1,242,072
Thereafter	3,335,604	—	3,335,604
	$ 10,250,844	$ 334,369	$ 10,585,213

Total rent expense for the years ended December 31, 2019 and 2018, was $1,552,319 and $1,363,007, respectively.

8. Retirement Plans

The Clinic maintains a 401(k) profit sharing plan (the "Plan") that was established effective July 1, 1995. Participation in the 401(k) portion of the Plan requires one year of service and attainment of age 21. In addition to employee elective contributions, the Board of Directors may, at its discretion, make additional employer contributions to the Plan. Participation in the employer approved profit sharing contributions requires two years of service with a 100% vesting upon entry. For the years ended December 31, 2019 and 2018, employer contributions to the Plan totaled $1,304,896 and $1,145,686, respectively.

9. Income Taxes

The Clinic is a professional service corporation and, accordingly, is taxed at an approximate 21% rate on taxable income. As discussed in Note 12, the Clinic has elected not to record any deferred tax assets or liabilities in the financial statements which is not in accordance with accounting principles generally accepted in the United States of America. The Clinic files an income tax return in the U.S. federal jurisdiction. With limited exception, the Clinic is no longer subject to U.S. federal, state and local income tax examinations by taxing authorities for years prior to 2016 The Clinic does not have any uncertain tax positions. As of December 31, 2019, and 2018, there were no accrued interest or penalties recorded in the financial statements.

10. Commitments

Malpractice

Malpractice insurance coverage is provided through a commercial carrier. The Clinic's financial obligation is limited to its premium for malpractice insurance coverage. The insurance carrier provides claims-made coverage, which covers only asserted malpractice claims within policy limits. The Clinic recognizes expenses associated with unasserted claims in the period in which the incidents are expected to have occurred rather than when a claim is asserted. Management believes its insurance coverage is sufficient to cover any potential loss.

Legislation

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare service providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. The Clinic believes it is in compliance with these laws and regulations at December 31, 2019 and 2018.

HIPAA

The Health Insurance Portability and Accountability Act ("HIPAA") was enacted on August 21, 1996, to assure health insurance portability, reduce healthcare fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations were required to be in compliance with HIPAA provisions by April 2004. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. The Clinic believes it is in compliance with HIPAA provisions at December 31, 2019 and 2018.

11. Variable Interest Entities

The Clinic has determined that it is the primary beneficiary of CMB, NMB VMB, 910, and 920 because it has the power to direct activities of the entity that most significantly effects the economic performance of these entities, such as setting rental payment amounts and terms. The Clinic also has exposure to the losses of CMB, NMB, and VMB based on the Clinic's guarantee of debt. The Clinic has no direct ownership in CMB, NMB, VMB, 910, or 920 although it does have common ownership. While the Clinic has no contractual obligation to do so, it may voluntarily elect to provide CMB, NMB, VMB, 910, or 920 with additional direct or indirect financial support based on its business objectives. The adoption of ASU 2014-17 allows the Clinic to opt out of the requirement to consolidate certain common control leasing arrangements and therefore, has treated the leases with the entities as operating leases as discussed in Note 7.

As of December 31, 2019, CMB had approximately $4.2 million of debt outstanding with interest rates ranging from 3.65% to 3.95% and a maturity date of 2029, NMB had approximately $775,000 of debt outstanding with an interest rate of 3.65% and a maturity date of 2029, VMB had approximately $840,000 of debt outstanding with interest rates ranging from 2.25% to 3.65% and maturity dates of 2029, 910 had $1.1 million of outstanding debt with an interest rate of 3.95% and maturity date of 2029, and 920 had approximately $1.9 million of outstanding debt with an interest rate of 3.95% with a maturity date of 2029.

CMB also had one unsecured note payable with a former member totaling approximately $64,409 at December 31, 2019. NMB, VMB, 910, and 920 LLCs had intercompany notes payable with CMB LLC totaling approximately $1.2 million at December 31, 2019. 910 had notes payable to CSS totaling approximately $156,000 at December 31, 2019. 920 had notes payable to CSS balance of approximately $48,000 at December 31, 2019.

Additionally, the Clinic has performed an analysis over the VIEs of CSS noting no material commitments or contingencies requiring disclosure or accrual in the financial statements for the years ended December 31, 2019 or 2018.

12. Departures from Accounting Principles Generally Accepted in the United States of America

In accordance with accounting principles generally accepted in the United States of America, the Clinic is required to record deferred tax assets and liabilities as well as income tax expenses or benefits for the expected future income tax consequences of events that have been recognized in the financial statements. Deferred tax assets and liabilities are determined based on the cumulative difference between the tax basis and book basis of assets and liabilities. These differences are tax effected at the enacted tax rates for the years in which the differences are expected to reverse. The Clinic has elected to not record any deferred tax assets or liabilities in the financial statements resulting in a departure from accounting principles generally accepted in the United States of America. Had the Clinic recorded the deferred taxes as of December 31, 2019, net deferred tax liabilities would have been approximately $380,000, tax expense would have been approximately $88,000 and retained earnings as of January 1, 2018 would have decreased approximately $318,000. Had the Clinic recorded the deferred taxes as of December 31, 2018, net deferred tax liabilities would have been approximately $292,000, tax expense would have been approximately $192,000 and retained earnings as of January 1, 2017 would have decreased approximately $26,000.

13. Subsequent Events

The Clinic has evaluated subsequent events through April 24, 2020, which is the date that these financial statements were available to be issued.

On January 30, 2020, the World Health Organization ("WHO") announced a global health emergency because of a new strain of coronavirus (the "COVID-19 outbreak") and the risks to the international community as the virus spreads globally beyond its point of origin. In March 2020, the WHO classified the COVID-19 outbreak as a pandemic, based on the rapid increase in exposure globally.

The full impact of the COVID-19 outbreak continues to evolve as of the date of this report. As such, it is uncertain as to the full magnitude that the pandemic will have on the Clinic's financial condition, liquidity, and future results of operations. Management is actively monitoring the global situation on its financial condition, liquidity, operations, suppliers, industry, and workforce. Given the daily evolution of the COVID-19 outbreak and the global responses to curb its spread, the Clinic is not able to estimate the effects of the COVID-19 outbreak on its results of operations and financial condition for fiscal year 2020.

On March 27, 2020, President Trump signed into law the "Coronavirus Aid, Relief and Economic Security (CARES) Act." The CARES Act, among other things, includes provisions relating to refundable payroll tax credits, deferment of employer side social security payments, net operating loss carryback periods, alternative minimum tax credit refunds, modifications to the net interest deduction limitations, increased limitations on qualified charitable contributions and technical corrections to tax depreciation methods for qualified improvement property.

It also appropriated funds for the SBA Paycheck Protection Program ("PPP") loans that are forgivable in certain situations to promote continued employment, as well as Economic Injury Disaster Loans to provide liquidity to small businesses harmed by COVID-19. In April 2020, the Clinic received $2,500,000 of funds under the PPP. There is no assurance we are eligible for additional funds in the future.

We continue to examine the impact that the CARES Act may have on our business. Outside of the above, we are unable to determine the impact that the CARES Act will have on our financial condition, results of operation or liquidity.

Exhibit 13
Columbia Surgical Specialists
Recruiting Process

Recruiting Process

1. The hiring manager will e-mail a completed job requisition to the COO/CEO (depending on the reporting line). The COO/CEO will determine whether or not the requisition meets the staffing model and approve.

2. Upon receipt of an approved requisition from the COO/CEO, the hiring manager will create a job posting using the Job Posting Template.

3. The hiring manager will "post" the position in the following places:

    a. Internally: by sending an email with the job posting to all staff
    b. Craigslist (www.craigslist.com)
       Username: jobs@spokaneent.com
       Password: sent1234
    c. Workforce Washington Site (https://fortress.wa.gov/esd/worksource/Employment.aspx)
       Username: jobs@spokaneent.com
       Password: sent1234
    d. Spokesman Review (email ad to ads@spokesman.com)

    ❖ Other potential recruiting resources (postings in these areas must be pre-approved by the COO/CEO):
    - Local School/College Job Boards
    - Monster.com
    - CareerBuilder.com

4. The hiring manager will collect, review, and save all resumes in the Searches/Year/Month/Position folder. All resumes must be submitted to jobs@spokaneent.com. If resumes/applications are submitted directly to the hiring manager, either by email, fax, or mail, it is the hiring manager's responsibility to scan and save the documents in the appropriate folder.

5. The hiring manager will schedule and conduct interviews. Upon scheduling an interview, the hiring manager should email an application and a background check consent form to the applicant and require that they be completed and returned prior to the interview. If applicant does not have access to a computer, the hiring manager must require the applicant to show up 30 minutes before their interview in order to complete hard copies of the forms. Please review the sample interview questions.

6. Once the hiring manager has deemed a candidate appropriate for hire, he/she will complete two professional reference checks (one of which must be from a prior supervisor) and email the background check consent form to the Accounting Specialist – Payroll for completion.

7. After receiving satisfactory employment reference and criminal background check results, the hiring manager must complete the new hire section of the PAN and offer letter and e-mail both to the COO/CEO for approval along with copies of the reference check and background check results.

8. The CEO/COO will send back the approved PAN and offer letter, cc'ing the Accounting Specialist – Payroll and Accounting Specialist - AP. It will be the hiring manager's responsibility to send the offer letter to the candidate for his/her acceptance.

9. The hiring manager will be responsible for sending thank you emails to all candidates who applied but were not selected for hire.

10. The hiring manager will prepare the new hire packet per the new hire checklist and arrange for orientation of the new employee.

11. The hiring manager will ensure that all new hire paperwork is completed and e-mailed to the Accounting Specialist - Payroll and the Accounting Specialist – AP on the employee's date of hire.

12. The Accounting Specialist – Payroll will be responsible for setting the new employee up in the payroll system. The Accounting Specialist – AP will be responsible for filing the new hire documents in the personnel file and coordinate benefits enrollment when eligible.

SENT/SSS

Recruitment/Hire Checklist for Managers

Department: _____ **Position Title:** _____

JOB POSTING

- ☐ Personnel requisition sent to the COO/CEO for approval — Date: _____
- ☐ Approved personnel requisition received — Date: _____
- ☐ Job Posted — Date: _____

APPLICANT INFORMATION

Applicant: _____ **Interview Date/Time:** _____

- ☐ Application received
- ☐ Background check requested — Date: _____
- ☐ Satisfactory background check results received — Date: _____
- ☐ 2 satisfactory professional references received
  1. _____ (name of reference) — Date: _____
  2. _____ (name of reference) — Date: _____

HIRE

Start Date: _____

- ☐ PAN and offer Letter sent to COO/CEO for approval — Date: _____
- ☐ Approved PAN/offer letter received — Date: _____
- ☐ Offer letter sent to applicant — Date: _____
- ☐ Job postings removed — Date: _____
- ☐ Thank You Emails sent — Date: _____
- ☐ New hire paperwork completed — Date: _____
- ☐ New hire paperwork packet sent to the Accounting Specialist/Payroll & AP — Date: _____

Exhibit 14
Medical Director Job Description and Compensation Schedule

Section 2.200
The Medical Director

Carrie Roller M.D. has been appointed Medical Director of the Spokane EN&T Clinic, P.S. ASC. She will remain in this position until:

I. She is relieved of this position by the Board of Directors, **or**
II. She resigns.

I. Officers of the medical staff shall be the ASC Medical Director, President and Secretary.

II. QUALIFICATION OF OFFICERS:

A. Officers must be practitioners who are members of the active medical staff at the time of appointment, and who remain members of the active staff during their term of office. Failure to maintain such status shall immediately create a vacancy in the office, which may be declared by the Medical Director of the Columbia Surgical Specialists, P.S. ASC, the President of the Board of Directors.

II. APPOINTMENT OF OFFICERS:

A. The Officers are appointed by a majority vote of the Board of Directors. Their term is for a period of two years, and shall remain in effect until they resign or are relieved of their positions by the Board of Directors.

III. DUTIES OF OFFICERS:

A. THE MEDICAL DIRECTOR: serves as the Chief of the medical staff, and in this capacity he:
   1. Acts in coordination with the President of the Board of Directors in all matters of mutual concern within the Columbia Surgical Specialists, P.S. ASC.
   2. Calls, presides at, and is responsible for the agenda of all general meetings of the medical staff.
   3. Is responsible for enforcing or assuring the enforcement of the Medical Staff Rules, Regulations, and Specific Bylaws for the ASC, policies; implementing sanctions where indicated; and assuring the medical staff's compliance with procedural safeguards in all instances where corrective action had been requested against a physician.

4. Approve the requests for privileges of all medical staff members (except their own).
5. Appoints the chairpersons of all standing and special medical staff committees.
7. Is responsible for ensuring that the staff maintains an adequate educational program.
8. Speaks for the medical staff in its external professional and public relations.
9. Performs such other functions as may be assigned to him by the Board of directors or by these rules.

Effective 1/1/2021, this is a compensated position.

Board Meeting

November 18, 2020

Present:

Rana Ahmad, MD	
Tim Bax, MD	x
Courtney Clyde, MD	
Paul Lin, MD	
Jonathan Nickoloff, MD	
Adam Juviler MD	
Shane McNevin, MD	x
S.V. Malladi, MD	x
Michael Moore, MD	
William Schmitt, MD	
Ann Seltman, MD	
Dara Christante, MD	
Fred French, MD	
Linda Partoll, MD	x
Kai Sharbono, MD	
David Stoddard, MD	X
Sarah Hammil, MD	x

Karen Ahlstrom, MD	
Jeff Bunn, MD	X
Michael Cruz, MD	X
Neil Giddings, MD	
David Malone, MD	
Brian Mitchell, DO	
Michael Olds, MD	x
Al Pokorny, MD	x
Carrie Roller, MD	x
David Brown, MD	x
Jordan Sand, MD	x
Daniel Gilsdorf, MD	
Carol Guthrie, MD	
Hannah Qualls, MD	
Lora Wilkinson, Fin. Dir	x
Rod Emerson, CEO	x

A: Call to Order at 6:00 PM
B: Guests Present: Dr. Pasko (HPB) and Craig from Providence
C: Minutes of Previous Meeting were approved.
D: Agenda was reviewed and approved

E: Discussion and Decision items

1. Financials updates and Topics:

    a) Lora reviewed the October Financials. October showed a profit of a little over $200,000. This was lower than budget, but CSS had a large one-time expense with CFO Severance and PTO payout. We did also show a slight gain in our month in reserves for our self-insured plan. We continue to see our volumes down but the reduction in expenses has helped CSS continue to show profits.

    b) We discussed the 2021 budget and the work that Lora is doing. Due to COVID Lora is needing to use more recent months for trending production for 2021. We will have an 8% increase in our health insurance costs as we need to increase those a bit. We will also have around a $50,000 increase in our Malpractice insurance costs over what was budgeted for 2020. We are holding Capital expenses tight for budgeted year. We will have more data on how the budget is shaping up at the December board meeting.

    c) We are now completed with the repricing of the LLC loans, so those rates are lower. We also have all personal guarantees removed for the LLC's and CSS.

    d) We discussed the need to replace a broke UROGYN scope. We discussed what is needed and the board approved a budget up to $12,000 to get a new scope and if enough funds a monitor to go with it.

    e) The Aud Team is requesting 3 more Dragon licenses to be used by their team. Some of the physicians have stated that they do not use Dragon so they could be used by the Aud's.

2. 2021 Board Discussions

    a) Rod has sent out the request for board and director nominations. He will check with all that were nominated prior to starting the voting process.

3. Internal Directorship Recommendation

    a) The finance committee brought forward a recommendation for compensating our internal directors of “profit centers” and how that would work. The board approved this for implementation starting in 2020. Below is the structure approved.

        Profit Centers Included in Directorship oversite:

            Surgery Center
            Allergy
            Audiology / CHC
            FYZICAL
            UROGYN until ownership occurs

        Compensation

            $150 per hour (time sheets to be turned into accounting)
            Maximum of $2,500 per quarter

        Board responsibility

            Not required to go to board meetings
            Report to board as needed
            Do not earn board pay

Exhibit 15
Transfer Agreement with Providence Sacred Heart Medical Center

Providence Health Care

PO Box 2555
101 West Eighth Avenue
Spokane, WA 99220-2555
(509) 474-3335
Fax (509) 474-4925

October 14, 2004

Spokane Ear, Nose & Throat Clinic, P.S.
217 W. Cataldo
Spokane, WA 99201

ATTENTION: Craig Hult, CFO

Dear Mr. Hult:

Please find enclosed one original, fully executed, Patient Transfer Agreement between your facility and Sacred Heart Medical Center. We have retained the other original for our files.

Thank you for your assistance in getting this signed, it is appreciated. If you have any questions or there is ever anything I can do to assist, please do not hesitate to call.

Very truly yours,

Lori Lynn Staley, Paralegal
Office of Legal Affairs
staleyl@psew.org
(509) 474-4900

Enclosure

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Indefinate
see pg 3 para 4
CH7

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is by and between SACRED HEART MEDICAL CENTER, a Washington nonprofit corporation ("Hospital"), and SPOKANE EAR, NOSE & THROAT CLINIC, P.S., a Washington professional service corporation ("Facility"); the transferring facility.

To facilitate continuity of patient care and the timely transfer of patients and records between Facility and Hospital, the parties agree as follows:

(1) If a determination is made by the attending physician that a patient requires transfer from the Facility to the Hospital, Hospital agrees to admit the patient as promptly as possible, as long as it has the available space, qualified personnel and appropriate services for the treatment of the patient, and the requirements of applicable federal and state laws and regulation are met.

(2) Facility has the responsibility for transferring the patient to the Hospital and agrees to use qualified personnel and necessary equipment, including medically appropriate life support measures, during the transfer.

(3) Facility agrees to provide the Hospital with appropriate documentation as necessary to ensure continuity of patient care. This information should include, as a minimum, the patient's medical record (i.e., summary of physician findings, nursing notes, flow sheets, lab and radiology reports, copy of EKG, relevant transfer forms, signed consent for transfer, etc.). This documentation will be sent to the Hospital at the time of transfer unless doing so would jeopardize the patient; in which case, the documentation will be sent as promptly as possible after the transfer.

(4) To the extent possible, patients will be stabilized prior to transfer to ensure the transfer will not, within reasonable medical probability, result in harm to the patient or jeopardize their survival.

(5) All transfers will be done in accordance with applicable federal and state laws and regulations and in accordance with the standards of the Joint Commission on Accreditation of Healthcare Organizations.

(6) Facility will be responsible for the transfer or other appropriate disposition of the patient's personal effects, particularly money and valuables.

(7) Charges for services performed by either party shall be collected by the party rendering the service from the patient, third party payor, or other sources normally billed by the party. Neither party shall have any liability to the other for such charges, except to the extent such liability would exist separate from this Agreement. The parties shall cooperate with each other in exchanging information about financial responsibility for services rendered by them to patients transferred to the Hospital.

(8) Facility shall indemnify, hold harmless and defend the Hospital, its agents and employees from and against any claim, loss damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Facility, its agents and employees of any duty or obligation of the Facility under this Agreement.

(9) Hospital shall indemnify, hold harmless and defend the Facility, its agents and employees from and against any claim, loss damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Hospital, its agents and employees of any duty or obligation of the Hospital under this Agreement.

(10) The parties shall maintain at their own expense comprehensive general and professional liability insurance and property damage insurance adequate to insure them against risks arising out of this Agreement, with limits no less than those customarily carried by similar facilities. Upon request, each party shall furnish the other party with evidence of such insurance. During the term of this Agreement, each party shall immediately notify the other of any material change in such insurance.

(11) The Facility agrees to hold all individually identifiable patient health information that may be shared, transferred, transmitted, or otherwise obtained pursuant to this Agreement ("Protected Health Information") strictly confidential, and provide all reasonable protections to prevent the unauthorized use or disclosure of such information, including, but not limited to the protection afforded by applicable federal, state and local laws and regulations including, but not limited to, regulations, standards, and rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Facility may use and disclose Protected Health Information when necessary for Facility's proper management and administration (if such use or disclosure is necessary), or to carry out the Facility's responsibilities under this Agreement. Specifically, the Facility agrees: (i) to maintain safeguards as necessary to ensure that the Protected Health Information is not used or disclosed except as provided herein; (ii) to ensure that any subcontractors or agents to whom it provides Protected Health Information agree to the

same restrictions and conditions that apply to Facility with respect to such information; (iii) to make available its internal practices, books and records relating to the use and disclosure of Protected Health Information received from Hospital to the Department of Health and Human Services or its agents; (iv) to incorporate any amendments or corrections to Protected Health Information when notified by Hospital that the information is inaccurate or incomplete; (v) to return to Hospital or destroy all Protected Health Information that Facility still maintains in any form and not to retain any such Protected Health Information in any form upon termination of this Agreement; (vi) to adopt and follow policies for providing access to Protected Health Information to the individual who is the subject of the information, or their legally authorized representative; (vii) to report to Hospital any use or disclosure of Protected Health Information which is not permitted under this Agreement; and (viii) to make Protected Health Information and an accounting of disclosures available to the individual who is the subject of the information or Hospital, to the extent required by HIPAA.

(12) Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility or entity on a limited or general basis.

(13) Facility represents and warrants that neither Facility nor Facility's shareholders, owners, principals, partners or members (if applicable) are presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in any federally funded health care program, including Medicare and Medicaid. Facility agrees to immediately notify Hospital of any threatened, proposed, or actual debarment, suspension, or exclusion from any federally funded health care program, including Medicare and Medicaid.

(14) This Agreement shall be in effect on the date it is signed by both parties and shall continue until terminated as follows: (i) either party may terminate this Agreement immediately upon a breach of its terms by the other party, or (ii) either party may terminate this Agreement without cause by giving the other party not less than ninety (90) days written notice.

(15) This Agreement may be signed in counterparts each of which will be considered an original.

(16) This Agreement shall be interpreted and construed in accordance with laws of the State of Washington. Venue for any action to enforce its terms shall be in Spokane County, Washington. This Agreement embodies the entire agreement of the parties relating to transfer of patients from Facility to Hospital, and supercedes all prior agreements, representations and understandings of the parties. This Agreement may only be modified

or amended in writing. All amendments and modifications must be signed by both parties to be effective.

HOSPITAL:

SACRED HEART MEDICAL CENTER, a Washington nonprofit corporation

By: Michael D Wilson
MICHAEL D. WILSON
Its: President & COO
Date: 10/12/04

FACILITY:

SPOKANE EAR, NOSE & THROAT CLINIC, P.S., a Washington professional service corporation

By: Craig Hult
CRAIG HULT
Its: CFO
Date: 10/7/2004

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