Prosser Memorial Health

Board of Commissioners

Board Packet

September 29, 2022

Vision
Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: To improve the health of our community.

Values
Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

BOARD OF COMMISSIONERS – WORK SESSION
TUESDAY, September 27, 2022
6:00 PM - WHITEHEAD CONFERENCE ROOM
AGENDA

COMMISSIONERS:
Stephen Kenny, Ph.D.
Sharon Dietrich, M.D.
Glenn Bestebreur
Susan Reams
Keith Sattler
Brandon Bowden
Neilan McPartland

STAFF:
Craig Marks, CEO
Merry Fuller, CNO/COO
David Rollins, CFO
Shannon Hitchcock, CCO
Kristi Mellema, CQO
Bryon Dirkes, CHRO
Dr. Brian Sollers, CMO

GUESTS: Paul Kramer, Project Director, NV5
Gary Hicks, Financial Advisor
Brandon Potts, Bouten Construction
Nick Gonzalez, Bouten Construction

I. CALL TO ORDER

II. SERVICES

A. Replacement Facility Update

1. Design Updates

a. CN **(Attachment D)**	**NV5**
b. SVID	**NV5**
c. DOH/USDA/City of Prosser Reviews	**NV5**
d. Furniture Fair	**NV5**

2. Construction/Schedule/Budget

a. Value Engineering Update **(Attachment E)**	**Bouten/All**
b. MACC **(Attachment F)**	**Bouten/NV5**
c. GC/CM Contracts A133 **(Attachment G)**, A201**(Attachment H)**	**NV5/Bouten**
d. Schedule **(Attachment I)**	**NV5/Bouten**
e. Project Budget **(Attachment J) (Attachment K)**	**NV5**

3. Financing **Gary**

a. USDA **(Attachment L) (Attachment M)**

b. Construction Loan

c. Equipment Lease

B. Capital Equipment Request

1. Radiology Equipment for the Replacement Facility **Merry**
(Attachment N) (Attachment O)

III. Executive Session

A. RCW 42.30.110 (l) To consider proprietary or confidential nonpublished information related to the development, acquisition or implementation of state purchased health care services as provided in RCW 41.05.26

B. RCW 42.30.110 (g) To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee.

IV. ADJOURN

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BOARD OF COMMISSIONERS
THURSDAY, September 29, 2022
6:00 PM, WHITEHEAD CONFERENCE ROOM
AGENDA

COMMISSIONERS:
Stephen Kenny, Ph.D.
Sharon Dietrich, M.D.
Glenn Bestebreur
Susan Reams
Keith Sattler
Brandon Bowden
Neilan McPartland

STAFF:
Craig Marks, CEO
Merry Fuller, CNO/COO
David Rollins, CFO
Shannon Hitchcock, CCO
Kristi Mellema, CQO
Bryon Dirkes, CHRO
Dr. Brian Sollers, CMO

I. CALL TO ORDER
A. Pledge of Allegiance

II. PUBLIC COMMENT

III. APPROVE AGENDA
Action Requested – Agenda

IV. CONSENT AGENDA
Action Requested – Consent Agenda
A. Board of Commissioners Meeting Minutes for August 25, 2022, and Special Board Meeting Minutes for September 08, 2022.
B. **Payroll and AP Vouchers** #167133 through #167839 dated 08-18-22 through 09-21-22 in the amount of $7,808,752.65; Board Policies 100.0033-100.0036 **(Attachment AA-DD)**; Surplus Items Resolution #1070 (4) Sleeper Sofas.

V. MEDICAL STAFF DEVELOPMENT
A. Medical Staff Report and Credentialing **Dr. Clifford**
Action Requested - Advancement from Provisional
1. Advancement from Provisional
Peter Himmel, MD – Locum Tenens privileges in Emergency Medicine effective October 1, 2022, through March 31, 2024.

William Lou, MD – Telemedicine Staff privileges in Neurology effective October 1, 2022, through March 31, 2024.

2. New Appointment

Action Requested – New Appointment and Requested Clinic Privileges

Monroe Whitman lll, MD – Provisional/Locum Tenens Staff with requested privileges in General Surgery effective October 1, 2022, through March 31, 2023.

James Wallace, MD – Provisional/Locum Tenens Staff with requested privileges in Emergency Medicine effective October 1, 2022, through March 28, 2023.

Soo Young Kwon, MD – Provisional/Telemedicine staff with requested privileges in Neurology effective October 1, 2022, through March 31, 2023.

3. Reappointment

Action Requested – Reappointment and Requested Clinical Privileges

Stephen Burton, MD – Reappointment to the Telemedicine Staff with requested privileges in Neurology effective October 1, 2022, through September 31, 2024.

Aixa Espinosa-Morales, MD – Reappointment to Telemedicine Staff with requested privileges in Neurology effective October 1, 2022, through September 31, 2024.

George Lopez, MD – Reappointment to Telemedicine Staff with requested privileges in Neurology effective October 1, 2022, through September 31, 2024.

VI. SERVICES

A. Bouten MACC- (Maximum Allowable Construction Cost) **(Attachment F)** **Craig**

Action Requested – Bouten MACC at a cost not to exceed $74,817,419.

B. GC/CM Contract-**(Attachment G) (Attachment H)** **Craig**

Action Requested- GC/CM contract-Bouten Construction

C. Contract Signing-MACC and GC/CM Contract **Craig/Bill Bouten**

D. Radiology Equipment-**GE** MRI and CT at a cost not to exceed **$2,028,830.** **Merry**
(Attachment N) (Attachment O)

Action Requested-Radiology Equipment-GE MRI and CT

VII. FINANCIAL STEWARDSHIP

A. Review Financial Reports for August 2022 **(Attachment V)** **David**

Action Requested – Financial Reports

B. Replacement Facility Project Budget **(Attachment J) (Attachment K)** **Craig/David**

Action Requested-Replacement Facility Total Project cost not to exceed $112,048,033.

C. Board Resolution #1071 (Attachment M) **Craig/David**

Action Requested-Board Resolution #1071-Project Financing

VIII. Employee Development

A. Employee Inflation/Retention Incentive- 3.5% (excluding Leadership and Providers) **(Attachment GG) Craig**
Action Requested-Employee Inflation Retention Incentive at a total cost not to exceed $648,879 (3.5%).

IX. QUALITY

A. Legislative and Political Updates **Commissioner Bestebreur**

B. CEO/Operations Report **Craig**

X. ADJOURN

PMH
Board of Commissioners
Work Plan – FY2022

Vision

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Month	Goals & Objectives	Education
January	QUALITY: • Review/Approve 2022 Strategic Plan and 2022 Patient Care Scorecards • Sign Financial Disclosure and Conflict of Interest Statements • Approve 2022 Risk Management and Quality Assurance Plans • Select and Approve Board Officers • Review Board Committee structure and membership SERVICES: • Approve acquisition of surgical equipment • Approve radiologist contracts • Approve Construction Loan	EMPLOYEE DEVELOPMENT: • Review 2021 Employee Engagement Survey Results • Review 2021 Medical Staff Engagement Survey Results QUALITY: • Review Board Self-Evaluation FINANCIAL STEWARDSHIP: • Review semi-annual financial performance report for PMH Clinics SERVICES: Replacement Facility Update • Construction Loan Schedule Update

Month	Goals & Objectives	Education
February	SERVICES: • Approve construction mini-MACC • Approve construction documents QUALITY: • Approve 2022 Board Action Plan EMPLOYEE DEVELOPMENT: • Review and Approve 2022 Leadership Incentive Compensation Program	EMPLOYEE DEVELOPMENT: • Attend AHA Governance Conference PATIENT LOYALTY: • Patient Loyalty Summary report • Review Patient Engagement Plan SERVICES: Replacement Facility Update: • Construction Documents • Mini-MACC • Schedule
March	QUALITY: • Review/Approve Board Polices • Approve 2022 Corporate Compliance Plan • Approve 2022 Infection Prevention Control Plan EMPLOYEE DEVELOPMENT • Review and Approve 2022 Leadership Incentive Compensation Program MEDICAL STAFF DEVELOPMENT: • Support Providers' Day Celebration FINANCIAL STEWARDSHIP: • Accept 2021 Audit Report SERVICES: • Approve the MACC / GMP for the new facility	PATIENT LOYALTY: • Review 2021 Utilization Review Performance QUALITY: • Review 2021 Corporate Compliance Report • Review 2021 Infection Prevention Summary EMPLOYEE DEVELOPMENT: • Review Employee Performance Report • Review the Communications Calendar FINANCIAL STEWARDSHIP: • Presentation of the 2021 Audit Report by Auditors • Capital Campaign Update

Month	Goals & Objectives	Education
	PATIENT LOYALTY • Approve the 2022 Utilization Review Plan	SERVICES: Replacement Facility Update • MCAA / GMP • USDA Update • Budget
April	QUALITY: • Approve 2022 Community Benefits Report EMPLOYEE DEVELOPMENT • Conduct CEO Evaluation SERVICES: • Approve the MACC / GMP for the new facility	SERVICES: Replacement Facility Update • MCAA / GMP • USDA Update • Budget QUALITY: • Strategic & Patient Care Score Cards • Review 2021 Community Benefits Report EMPLOYEE DEVELOPMENT: • Review 2021 Leadership Performance (LEM) • Review Employee Engagement Plan • Review the Communications Calendar MEDICAL STAFF DEVELOPMENT: • Review 2021 FPPE/OPPE Summary PATIENT LOYALTY: • Review Interpreter Services Plan • Call Center Update

Month	Goals & Objectives	Education
May	EMPLOYEE DEVELOPMENT: • Support Hospital Week	SERVICES: • Replacement Facility Update MEDICAL STAFF • Medical Staff Engagement Plan EMPLOYEE DEVELOPMENT: • Employee Retirement Update PATIENT LOYALTY: • Review Customer Service Program
June	QUALITY: • Review/Approve Board Polices • Approve 2021 CAH Annual Report FINANCIAL STEWARDSHIP: • Approve 2022 Cost Report	QUALITY: • Report 2022 Q1 Utilization Review EMPLOYEE DEVELOPMENT: • Review Leader Assessment and Development Program SERVICES: • Marketing Update • PMH Telehealth Update FINANCIAL STEWARDSHIP: • Accounting Software Update
July	MEDICAL STAFF DEVELOPMENT: • Attend BOC, Medical Staff and Leadership Engagement Activity FINANCIAL STEWARDSHIP: • Approve Single Audit	SERVICES: • Replacement Facility Update MEDICAL STAFF • Review PMH Clinic productivity QUALITY:

Month	Goals & Objectives	Education
		• Quality Committee Report • Strategic & Patient Care Score Cards • Board Judiciary Responsibilities EMPLOYEE DEVELOPMENT: • Human Resources Update • Review Leadership and Exempt Wage Scales FINANCIAL STEWARDSHIP: • Review Semi-Annual Financial Performance Report for PMH Clinics • Foundation Update
August	EMPLOYEE DEVELOPMENT: • Attend end of summer Engagement Activity for BOC, Medical Staff, and all staff	SERVICES: • Replacement Facility Update
September	QUALITY: • Review/Approve Board Polices	EMPLOYEE DEVELOPMENT: • Review Employee Benefit Changes • Review Leadership Development Activities SERVICES: • Replacement Facility update PATIENT LOYALTY: • Nurse Educator Update
October		QUALITY:

Month	Goals & Objectives	Education
		• Conduct 2023 Strategic Planning • Strategic & Patient Care Score Cards EMPLOYMENT DEVELOPMENT: • Review Leadership Accountability Resource Tools PATIENT LOYALTY: • Patient Loyalty Summary
November	FINANCIAL STEWARDSHIP: • Approve Property Tax Request for County Commissioners	QUALITY: • iVantage Update SERVICES: • Review draft 2023 Strategic Plan; 2023 Marketing and IT Plans; and Medical Staff Model/2023 Provider Recruitment Plan • Replacement Facility Update EMPLOYEE DEVELOPMENT: • Review Non-exempt (union) performance evaluation template FINANCIAL STEWARDSHIP: • Review draft 2023 Budget
December	QUALITY: • Complete Board Self-Evaluations • Review/Approve Board Polices • Approve the 2023 Environment of Care Plan	QUALITY: • Review the 2022 Environment of Care Plan

Month	Goals & Objectives	Education
	SERVICES: • Approve 2023 Strategic Plan; 2023 Marketing and IT Plans; and Medical Staff Model/2023 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Approve 2023 Operating and Capital Budgets • Banking relationship Selection EMPLOYEE DEVELOPMENT: • Attend holiday celebration	

Prosser Memorial Health

2022 - Patient Care Scorecard

Major Goal Areas & Indicators	2022 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2022 YTD	2021	2020
Quality																
Left Without Being Seen	<0.80%	2.02%	1.47%	0.88%	2.25%	2.97%	3.88%	2.89%	5.09%					2.79%	1.47%	0.80%
Median Admit Decision Time to ED Departure Time for Admitted Patients	<44 min	53	56	51	51	45	51	53	63					53	60	70
Median Time from ED Arrival to Departure for Discharged ED Patients	<107 min	109	115	114	114	110	134	128	128					119	117	128
Severe Preeclamptic Mothers: Timely Treatment Rate	>90.00%	42.86%	57.14%	86.21%	60.00%	84.62%	90.91%	88.89%	100.00%					70.80%	N/A	N/A
All-Cause Unplanned 30 Day Inpatient Readmissions	<2.70%	10.61%	2.74%	4.92%	3.77%	5.45%	9.09%	5.63%	6.45%					5.98%	5.80%	3.80%
Sepsis - Early Management Bundle	>94.40%	100.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					96.00%	94.40%	72.73%
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.07%	0.00%	0.00%	0.57%	0.00%	0.00%	0.45%	0.00%	0.00%					0.12%	0%	0.29%
Diabetes Management - Outpatient A1C>9 or missing result	<21.89%	22.40%	24.19%	24.53%	21.32%	22.32%	23.35%	26.83%	22.76%					23.45%	21.89%	27.61%
Medication Reconciliation Completed	>90.00%	96.30%	94.74%	90.74%	92.00%	88.00%	85.00%	76.67%	81.67%					87.90%	46%	47.15%
Turnaround time of 30 minutes or less for STAT testing	<30 min	22.0	21.0	21.0	21.0	19.0	19.0	18.0	19.0					20.0	38	37.5
Median Time to ECG for Patients Presenting to the ED with Chest Pain	< 6.3 min	5.0	3.0	5.0	5.0	4.0	4.0	5.0	3.0					4.3	6.3	7
Surgical Site Infection	<0.19%	0.00%	0.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					0.05%	0.19%	0.25%
Bar Code Scanning: Medication Compliance	>93.50%	94.91%	95.77%	95.43%	95.00%	94.54%	93.76%	91.55%	93.34%					94.29%	93.50%	98.90%
Bar Code Scanning: Patient Compliance	>94.70%	96.42%	95.81%	96.17%	96.16%	95.95%	94.83%	92.35%	93.55%					95.16%	94.70%	N/A
*Overall Quality Performance Benchmark (iVantage)	>61	61	61	36	36	36	36	36	36					36	61	53
*Falls with Injury	<2	-	-	-	-	-	1	-	-					1	3	2

Green at or above Goal (4)
Yellow within 10% of Goal (2)
Red More than 10% below Goal (0)

Prosser Memorial Health

2022 - Strategic Plan Scorecard

Major Goal Areas & Indicators	2022 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2022 YTD	2021 Avg	2020 Avg
Patient Loyalty																
IP - "Would Recommend"	>93.1%	94.8%	92.4%	91.7%	92.9%	90.5%	96.4%	79.2%	90.8%					91.1%	93.1%	87.9%
ED - "Would Recommend"	>84.0%	83.9%	81.7%	76.4%	88.0%	88.8%	90.7%	67.7%	85.2%					88.1%	84.0%	81.4%
Acute Care - "Would Recommend"	>91.8%	90.9%	94.4%	87.5%	94.4%	87.5%	91.7%	79.2%	85.0%					89.0%	91.8%	84.1%
OB - "Would Recommend"	>93.6%	99.0%	100.0%	97.7%	100.0%	88.9%	100.0%	75.0%	100.0%					95.7%	93.6%	92.3%
Outpatient Surgery - "Would Recommend"	>96.6%	100.0%	100.0%	97.2%	97.7%	94.4%	95.3%	98.5%	91.4%					95.6%	96.6%	89.8%
Clinic - "Would Recommend"	>91.0%	92.8%	97.5%	91.7%	97.6%	91.8%	94.3%	86.8%	90.6%					92.7%	91.0%	87.3%
Outpatient - "Would Recommend"	>94.1%	98.1%	96.1%	93.5%	96.0%	96.0%	94.8%	94.5%	90.6%					94.8%	94.1%	88.1%
Composite Score	>92.9%	95.7%	95.2%	94.4%	94.1%	93.8%	93.7%	93.2%	94.0%					93.4%	92.9%	N/A
Medical Staff Development																
Medical Staff Turnover	<10%	0%	0%	0%	0%	0%	4%	0%	1%					5%	12%	0.2%
Prosser Specialty Clinic Visits	1,352	1,386	1,429	1,617	1,428	1,366	1,422	1,272	1,681					1,450	1,318	954
Benton City Clinic Visits	868	775	650	822	657	870	730	718	899					765	732	837
Prosser RHC Clinic Visits	1,291	1,063	1,111	1,206	1,106	1,211	1,122	1,152	1,398					1,171	1,227	1,226
Grandview Clinic Visits	969	1,055	833	1,021	873	986	960	904	1,065					962	778	589
Women's Health Center	679	508	600	660	533	611	708	554	648					603	602	601
*# of Active Medical Staff	>51	52	53	53	54	55	54	55	54					54	51	45
Employee Development																
403(B) Participation Rate	>98%	98%	98%	98%	98%	98%	98%	98%	99%					98%	98%	46%
Average Recruitment Time (days)	<21	19	26	40	11	15	19	22	17.5					21	21	32
# of Open Positions (Vacancies)	<23	32	28	35	31	32	39	39	29					33	32	29
Hours of Overtime - Overtime/Total Hours Worked	<4.5%	6.8%	5.3%	4.9%	6.0%	6.3%	6.1%	8.2%	7.1%					6.3%	6.1%	5.9%
Agency - Cost/Total Labor	<7.7%	6.2%	10.6%	6.9%	6.9%	5.7%	7.9%	7.7%	10.5%					7.8%	7.7%	7.6%
Turnover Rate	<0.6%	0.6%	1.2%	0.9%	0.9%	0.9%	1.2%	0.6%	0.0%					0.8%	0.9%	0.6%
Timely Evaluations	>71.8%	95.1%	85.0%	84.2%	93.0%	79.0%	80.0%	81.0%	78.0%					84.4%	71.8%	70.2%
Education Hours/FTE	>2.15	0.64	1.33	1.39	0.95	0.68	0.75	0.44	1.05					0.90	1.05	1.22
New Hire (Tenure) < 1 year	<10%	0.6%	0.6%	0%	0.6%	0.3%	0.3%	1.4%	0.3%					0.5%	10%	0%
* Lost Workdays due to On-the-Job Injuries	<10.25	11	7	7	0	0	6.3	13	15					7	19.49	10.25
Quality																
ED Encounters - Left Without Being Seen	<0.8%	2.0%	1.5%	0.9%	2.3%	3.0%	3.9%	2.9%	5.1%					2.7%	1.4%	0.8%
*Falls with Injury	<2	0	0	0	0	0	1	0	0					0	3	2
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					0.00%	0.0%	0.3%
All-Cause Unplanned Readmissions within 30 Days	<2.7%	10.6%	2.7%	4.9%	3.7%	5.5%	9.1%	5.6%	6.5%					6.1%	6.1%	3.8%
Diabetes Management - Outpatient A1C>9 or missing result	<21.88%	22.40%	24.19%	24.53%	21.32%	22.32%	23.35%	26.83%	22.76%					23.46%	21.88%	27.61%
Services																
ED Visits	1,083	1,287	949	1,138	1,246	1,448	1,419	1,384	1,375					1,281	1,105	805
Inpatient Admissions	96	123	98	115	102	89	120	121	123					111	116	83
OB Deliveries	50	47	41	61	46	41	50	57	55					50	49	41
Surgeries and Endoscopies	187	162	170	268	274	288	337	284	331					264	179	101
Diagnostic Imaging Procedures	2,851	2,462	2,619	3,134	2,915	2,981	3,091	2,691	3,125					2,877	2,992	2,280
Lab Procedures	14,000	14,139	13,806	14,818	13,359	15,075	14,738	13,972	16,271					14,522	14,327	11,768
Adjusted Patient Days	1,900	1,627	1,819	2,016	1,838	2,127	2,461	2,502	2,545					2,117	1,697	1,393
Therapy Visits	1,651	1,225	1,391	1,542	1,339	1,420	1,701	1,540	2,859					1,627	1,453	1,314
Outpatient Special Procedures Visits	325	241	221	332	249	277	306	364	389					297	324	247
Financial Performance																
Net Days in Accounts Receivable	50	55	58	55	56	55	55	55	55					55	51	63
*Total Margin	6.90%	5.2%	13.6%	13.3%	11.2%	5.2%	16.8%	7.4%	23.6%					12.6%	18.40%	4.50%
Net Operating Revenue/FTE	$ 19,431	$ 17,959	$ 18,695	$ 21,800	$ 19,651	$ 20,465	$ 21,737	$ 18,317	$ 23,184					$ 20,226	$ 20,682	$ 17,191
Labor as % of net Revenue	56.30%	63.18%	52.36%	48.39%	62.85%	60.40%	50.97%	59.42%	45.01%					55.32%	57.00%	61.30%
Operating Expense/FTE	$ 18,177	$ 17,959	$ 16,155	$ 17,591	$ 17,598	$ 19,469	$ 17,756	$ 17,086	$ 17,873					$ 17,686	$ 16,940	$ 15,891
*Days Cash on Hand	109	142	150	154	150	148	152	154	161					161	155	183
Commercial %	28.60%	29.90%	30.90%	31.80%	31.70%	31.40%	31.60%	31.60%	31.30%					31.30%	29.00%	29.00%
Total Labor Expense/Total Expense	60.20%	60.73%	60.33%	59.41%	62.99%	62.87%	60.43%	62.50%	58.03%					60.91%	61.00%	61.30%

Green at or above Goal
Yellow within 10% of Goal
Red More than 10% below Goal
*Cumulative Total - goal is year end number

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BOARD WORK SESSION	August 23, 2022	WHITEHEAD CONFERENCE ROOM	
COMMISSIONERS PRESENT	**STAFF PRESENT**	**GUESTS**	**COMMUNITY MEMBERS**
• Dr. Steve Kenny • Keith Sattler • Glenn Bestebreur • Susan Reams • Brandon Bowden • Sharon Dietrich, M.D. • Neilan McPartland	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Shannon Hitchcock, CCO • Kristi Mellema, CCO • Bryon Dirkes, CHRO • Dr. Brian Sollers	• Paul Kramer, NV5 • Kurt Broeckelmann, bcDG • Adam Trumbour, Senior Project Manager, NV5 • Gary Hicks, Financial Advisor • Brandon Potts, Vice President-Bouten Construction	None

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. CALL TO ORDER	Meeting was called to order by Commissioner Kenny at 6:00 p.m.	None.	None.
II. Public Comment		None.	None.
III. SERVICES	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Replacement Facility Update			
1. Design Updates **a. MDNS/SEPA (Attachment E)** **b. SVID** **c. DOH/USDA/City of Prosser Reviews**	Adam reviewed progress being made on the MDNS and with SVID. Kurt provided a brief update on all regulatory reviews.	None.	None.
2. Construction/ Schedule/Budget **a. Bid Process Update**	Brandon provided an update on the bid process with one day to go. The GC/CM contracts are still being negotiated and will not be ready for the August Board Meeting.	None.	The Board will be asked to approve the GC/CM contracts with Bouten

b. GC/CM Contracts A133 (Attachment G) A201 (Attachment H)			Construction A133, A201 at the September Board Meeting.
c. Initial MACC (Attachment JJ), (Attachment K) (Attachment L) **d. Schedule (Attachment D) Budget (Attachment M) (Attachment N)**	Brandon reviewed the concept of an Initial MACC and how it can save PMH money. Paul reviewed a draft schedule and budget for the project.	None.	The Board will be asked to approve the Initial MACC at the August Board Meeting.
3. Financing **a. USDA** **b. Equipment Lease** **c. Construction Loan**	Gary provided an update on all financing activities including the USDA, construction loan and an equipment lease.	None.	None.
B. Capital Equipment Requests **1. Family Birthplace Sofa Sleepers (Attachment P)**	Merry Fuller and Craig Marks reviewed the capital equipment acquisition request-Family Birthplace (4) Sofa Sleepers at a cost not to exceed $28,303.29.	None.	The Board will be asked to approve the capital equipment acquisition request-Family Birthplace (4) Sofa Sleepers at the August Board Meeting.
VI. ADJOURN			
There being no further regular business to attend to, Commissioner Kenny adjourned the meeting at 7:42 p.m.			

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BOARD MEETING	August 25, 2022,	WHITEHEAD CONFERENCE ROOM	
COMMISSIONERS PRESENT	**STAFF PRESENT**	**MEDICAL STAFF**	**GUESTS**
• Steve Kenny Ph.D. • Glenn Bestebreur • Susan Reams • Keith Sattler • Sharon Dietrich, M.D. • Neilan McPartland (absent) • Brandon Bowden	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Shannon Hitchcock, CCO • Kristi Mellema, CCQO • Bryon Dirkes, CHRO	• Dr. Brian Sollers	
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
I. Call to Order	Meeting was called to order by Commissioner Kenny at 6:00 p.m.		
A. Pledge of Allegiance			
II. Public Comment	None.	None.	None.
III. Approve Agenda	None.	Commissioner Sattler made a Motion to approve the July 28, 2022, Agenda. The Motion was seconded by Commissioner Dietrich and passed with 5 in favor, 0 opposed.	None.
IV. APPROVE CONSENT AGENDA **A. Board of Commissioners Meeting Minutes for July 28, 2022.**	None.	Commissioner Dietrich made a Motion to approve the Consent Agenda. The Motion was seconded by Commissioner Reams and passed with 6 in favor, 0 opposed.	None.

B. Payroll & AP Vouchers #166480 through #167132 dated 07.21.22. through 08.17.22 in the amount of $6,446,637.88.			
V. MEDICAL STAFF DEVELOPMENT	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Medical Staff Report and Credentialing			None.
1. Advancement from Provisional	Dr. Brian Sollers presented the following providers for **Advancement from Provisional**: **Jayme Thompson, DO** – Active Staff privileges in Family Medicine effective September 1, 2022, through February 28, 2024. **Michael Chen, MD** – Telemedicine Staff privileges in Neurology effective September 1, 2022, through February 28, 2024. **Mohammad Hirzallah, MD** – Telemedicine privileges in Neurology effective September 1. 2022 through February 28, 2024.	A Motion to approve the Advancement from Provisional Appointment and requested Clinical Privileges that were reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following providers was made by Commissioner Dietrich and seconded by Commissioner Reams. The Motion passed with 6 in favor, 0 opposed. • **Jayme Thompson, DO** • **Michael Chen, MD** • **Mohammad Hirzallah, MD**	None.
2. New Appointments	Dr. Brian Sollers presented the following **New Appointments:** **Jeffrey Johnson, MD** – Provisional/Locum Tenens Staff with requested privileges in General Surgery effective September 1, 2022, through February 28, 2023.	A Motion to approve the New Appointments and requested Clinical Privileges that were reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following providers was made by Commissioner Reams and seconded by Commissioner Bowden. The Motion passed with 6 in favor, 0 opposed.	None.

	Byron Wright, MD – Provisional/Locum Tenens Staff with requested privileges in General Surgery effective September 1, 2022, through February 28, 2023.	• **Jeffrey Johnson, MD** • **Byron Wright, MD**	
3. Reappointment	Dr. Brian Sollers presented the following providers for **Reappointment:** **Richard Unger, DO** – Reappointment to Active Staff with requested privileges in General Surgery effective September 1, 2022, through August 31, 2024. **Katheryn Norris, DO** – Reappointment to Courtesy Staff with requested privileges in Family Medicine effective September 1, 2022, through August 31, 2024. **Flint Orr, MD** – Reappointment to Courtesy Staff with requested privileges in Internal Medicine effective September 1, 2022, through August 31, 2024. **Praveen Korimerla, MD** – Reappointment to Consulting Staff with requested privileges in Cardiology effective September 1, 2022, through August 31, 2024. **Jeffrey Lehr, MD** – Reappointment to Consulting Staff with requested privileges in Cardiology effective September 1, 2022, through August 31, 2024. **Dane Sandquist, MD** – Reappointment to Consulting Staff with requested privileges in Pathology effective September 1, 2022, through August 31, 2024.	A Motion to approve the reappointment and requested Clinical Privileges that were reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following provider was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 6 in favor, 0 opposed. • **Richard Unger, DO** • **Katheryn Norris, DO** • **Flint Orr, MD** • **Praveen Korimerla, MD** • **Jeffrey Lehr, MD** • **Dane Sandquist, MD** • **Joseph Freeburg, MD** • **Yi Mao, MD** • **Kyle Ogami, MD** • **Kishan Patel, MD**	

	Joseph Freeburg, MD – Reappointment to the Telemedicine Staff with requested privileges in Neurology effective September 1, 2022, through August 31, 2024. **Yi Mao, MD** – Reappointment to the Telemedicine Staff with requested privileges in Neurology effective September 1, 2022, through August 31, 2024. **Kyle Ogami, MD** – Reappointment to Telemedicine Staff with requested privileges in Neurology effective September 1, 2022, through August 31, 2024. **Kishan Patel, MD** – Reappointment to Telemedicine Staff with requested privileges in Neurology effective September 1, 2022, through August 31, 2024.		
VI. FINANCIAL STEWARDSHIP	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Review Financial Reports for July 2022 (Attachment X)	David Rollins presented the July 2022 Financial Reports.	A Motion to accept the Financial Reports for July 2022, was made by Commissioner Dietrich, and seconded by Commissioner Bowden. The Motion passed with 6 in favor, 0 opposed.	None.
B. Capital Request Family Birthplace Sofa Sleepers (Attachment P)	Merry presented a Capital Request- Family Birthplace (4) Sofa sleepers at a cost not to exceed $28,303.29.	A Motion to approve the Capital Request- Family Birthplace (4) Sofa Sleepers was made by Commissioner Sattler and seconded by Commissioner Bowden. The Motion passed with 6 in favor, 0 opposed.	None.

VII. SERVICES			
A. Initial MACC (Attachment JJ) (Attachment K) (Attachment L)	Craig presented and passed out revised Initial MACC documents in place of the previous attachments.	A Motion to approve the Initial MACC**,** was made by Commissioner Bestebreur, and seconded by Commissioner Reams. The Motion passed with 6 in favor, 0 opposed	**None.**
VIII. QUALITY	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Legislative and Political Updates	Glenn Bestebreur gave a brief Legislative and Political Update.	None.	None.
B. CEO/Operations Report	Craig provided a brief Operations Report based upon his written report included in the August Board Packet. Craig passed out Legal Manual Handbooks to all Commissioners.	None.	None.
IX. ADJOURN			
There being no further business to attend to, Commissioner Kenny adjourned the meeting at 6:51 p.m.			

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SPECIAL BOARD MEETING	September 8, 2022	WHITEHEAD CONFERENCE ROOM	
COMMISSIONERS PRESENT	**STAFF PRESENT**	**MEDICAL STAFF**	**GUESTS**
• Dr. Steve Kenny • Glenn Bestebreur • Susan Reams Keith Sattler • Sharon Dietrich, M.D. • Brandon Bowden • Neilan McPartland	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO		• Adam Trumbour, Senior Project Manager, NV5 • Kurt Broeckelmann, Architect, bcDG • Brandon Potts, Bouten Construction

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. Call to Order	The Special Meeting of the Board of Commissioners was called to order by Commissioner Kenny at 6:00 p.m. followed by the Pledge of Allegiance.	None	None.
II. Public Comment	No public present.	None.	None.
III. Approve Agenda	Agenda presented for review.	Commissioner Dietrich made a Motion to approve the September 8, 2022, Agenda. The Motion was seconded by Commissioner Reams and passed with 7 in favor, 0 opposed.	None.
IV. Services			
Bid Results (Attachment A) (Attachment B)	A written summary of the bid results was provided for review. Brandon Potts (Bouten Construction) and Adam Tumbour (NV5) provided	None.	None.

	an overview and clarifications as requested.		
A. Draft Budget **(Attachment C)** **(Attachment D)**	A draft budget was presented for review and discussion (summary and detail). Total project cost is estimated at $110,791,288. Value engineering is ongoing to reduce the cost of the project.	None.	None.
B. Draft Schedule **(Attachment E)**	The draft project schedule was reviewed. Although several key elements are pending it is anticipated that groundbreaking still will occur in 2022.	None.	None.
C. GC/CM Contract Update- Bouten Construction	The GC/CM Contract was not available for review at this time but will be provided when the MACC/GMP are finalized.	None.	None.
D. MACC/GMP Update	As noted above, value engineering is ongoing to reduce the cost of the project. Approximately 3M in cost reductions is needed to finalize the MACC/GMP. The intention is to find these cost savings without a reduction in the scope of the project, although some items may be delayed until after the facility is built.	None.	None.
V. Financial Stewardship			
A. Feasibility Study-USDA (DZA) **(Attachment I)**	The Feasibility Study was provided for review.	None.	**None**
Board Resolution #1069-USDA **(Attachment J)**	Board Resolution #1069-USDA was provided for review and discussion. The resolution authorizes Craig Marks, CEO and David Rollins, CFO to prepare, execute and deliver the USD applications, and to execute and deliver the USDA documents.	Commissioner Bestebreur made a Motion to approve the Board Resolution #1069. The Motion was seconded by Commissioner Dietrich and passed with 7 in favor, 0 opposed.	None.
VI. ADJOURN			
There being no further business to attend to, Commissioner Kenny adjourned the meeting at 7:00 p.m.			

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JOINT CONFERENCE COMMITTEE	September 21, 2022	VINEYARD CONFERENCE ROOM

COMMITTEE MEMBERS PRESENT	NON-MEMBERS PRESENT
• Commissioner S. Reams • Commissioner S. Kenny • Commissioner Dr. S. Dietrich • C. Marks, CEO • Dr. D. Carl • Dr. B. Sollers	• K. Mellema, CQO, CCO • M. Fuller, CNO/COO • Dr. S. Hashmi

AGENDA ITEM	DISCUSSION	RECOMMENDATION	FOLLOW-UP
CALL TO ORDER	Meeting was called to order by Commissioner Reams at 7:03 am		
APPROVAL OF MINUTES	July 2022 (August meeting had been canceled) minutes were reviewed and approved by the Committee.	For informational purposes only.	Standing agenda item.
PATIENT LOYALTY			
Patient Satisfaction Data	M. Fuller reported that YTD for the ER is at 88.1% which is better than yearend last year at 84%. Comments for Acute Care have been reviewed to see if there is a common theme and what we are finding is the most complaints are around moving patients multiple times during their visit due to needing beds which we are actively working on to resolve such as cohorting patients right away rather than waiting and avoid moving them at night. Luckily, we have not had a staffing issue like some hospitals are having.	For informational purposes only.	Standing agenda item.
Nurse Educator Update	M. Fuller reported about expanding our nurse educator position. Marla Davis has moved to the clinic side for her RN role and has a passion for patient education. We currently have one nurse educator that focuses on Medicare Wellness checks in Prosser Clinic and a second nurse educator was hired for Benton City Clinic. Now we are looking to hire a third nurse educator for the Grandview	For informational purposes only.	No necessary follow up.

	Clinic. We have recently recruited a per diem nurse Diabetic Educator which is focusing on gestational diabetes at the Women's Health Clinic. We do have an in-house dietician now. The goal with putting this program together with nurse educators, a diabetic educator and a dietician is to have consistent messaging between inpatient and outpatient areas.		
SERVICES			
Replacement Facility Update	C. Marks reported that we have received an approved Certificate of Need (CN) as of September 19, 2022. Based on this CN, we have two years to begin construction of our project. We continue to work with the Sunnyside Valley Irrigation District (SVID) on burying the overflow irrigation canal that runs through our property. We are currently surveying a potential easement on the west and southern borders of our property that would be used to bury the pipe. We hope to complete this in between irrigation seasons (October- March) if we can work out all the details with SVID. We have also submitted an application to the City of Prosser to begin the process to create a development agreement for any improvements that need to be made to or along Gap Road. At this time, we do not have any estimate of how long this process will take. The design team continues to work with the DOH, USDA and the City of Prosser on their review of our construction documents. We continue to struggle with the DOH as the person in charge of our review has left the DOH and has not been replaced. We hope to have an update from the DOH at the September Board Work Session. The final design item we are currently working on is to schedule a furniture fair at PMH for staff to try out various pieces of furniture that were picked-out at the Merchandise Mart in Chicago. The fair will be held the first week of November and will enable our staff to test furniture and give their feedback so that changes can be made if necessary.	For informational purposes only.	Standing agenda item.

	The construction budget is $3 million high on construction cost. The value engineering log has some additional things that can be removed to save on some dollars out of the project. We are currently within $500,000 of goal. Bouten has agreed to look at their numbers as well. Some items that will be removed is the helipad which is $70,000. The outbuilding which is $454,052 and the pneumatic tube system which is $300,000. There is construction and owner's contingency money that could be used later to build the helipad and outbuilding. Unfortunately, once the facility is built, there is no way to add a pneumatic tube system. The GC/CM contract will not be recommended until there is a MACC. The schedule is dependent on the DOH and USDA. We are hoping to have an approval from them by end of October and can then break ground in November. The current new facility budget is $112 million. The feasibility study is complete.		
Radiology Equipment Acquisition	M. Fuller reported that Aurora and her team have been working to evaluate proposals from the top three CT/MRI manufacturers – Phillips, GE and Siemens. We have budgeted for $2 million to replace them. GE is coming in significantly lower at approximately $1.8 million. It is also important to note that this equipment will not be delivered and set up until our new facility is completed. Knowing ahead of time what equipment we will be purchasing allows the design team to complete the drawings for the space where this equipment will be going.	For informational purposes only.	No follow up necessary.
MEDICAL STAFF DEVELOPMENT			
Medical Staff Recruitment	Dr. Sollers reported that we are actively trying to recruit Internal Medicine. We have had one physician interview and will be having a second in the near future. We have had a few PM&R physician interviews but have not yet found one. There is still a need in our Orthopedic program. Dr. Kelly was supposed to start in 2023 but has taken a job in Indiana. We are currently working with a recruitment firm for orthopedics. Ideally, we are looking for someone with sports medicine training. We are close to a signature for a second GI physician that performs ERCP which will be of great value to the surrounding communities.	For informational purposes only.	No follow up necessary.

	We are actively recruiting for a pediatrician since Dr. cooks will be leaving soon. We are also retooling the Behavioral Health program with Diane Hanks leaving soon. We are looking at an expansion of our counseling services as well with a potential partnership with the high school. We have had one ED APC start and another will start full time in October. We are currently working with Merritt Hawkins, a national recruitment firm, to recruit for radiology and orthopedic surgery. We have several visits scheduled in the near future with physicians specializing in emergency medicine, pediatrics, physiatry and internal medicine.		
EMPLOYEE DEVELOPMENT			
Employee Engagement Activities	C. Marks reported that the pool party was a success and had over 400 staff members and family attending. We are now gearing up for Halloween and the Holiday Party which is December 10th at the HAPO center in Pasco. There will be casino night which was a huge hit at the last get together. The Boys and Girls Club had their dunk tank challenge here last Friday. Next year when we have the car wash, we will include a Dunk Your Boss Day!	For informational purposes only.	No follow up necessary.
FINANCIAL STEWARDSHIP			
Financial Performance – August 2022	C. Marks reported that we ended up with $2.1 million in August which is over $2 million in operations. August was an outstanding month. YTD we are just under $8 million in profit. We continue to have high revenue and expenses have remained inline. There was $7 million recognized as PPP money last year. YTD if you pull out both years' worth of covid relief money, we are outperforming last year.	For informational purposes only.	Standing agenda item.
Hospital Financial Struggles	C. Marks shared an article from the Yakima Herald entitled "Yakima Valley Memorial Hospital lost millions during first part of 2022." This article talks about how all the other hospitals in the area have lost significant money. However, the article also states that Prosser	For informational purposes only.	Standing agenda item.

	Memorial Health had a positive total margin of roughly $2.5 million I the first quarter and basically matched it in the second quarter with a year-to-date surplus of $5,139,071		
ADJOURNMENT & NEXT SCHEDULED MEETING			
Meeting adjourned at 0839			
Next scheduled meeting 10/19/2022			

K. Mellema 9/22/2022

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FINANCE COMMITTEE MEETING
Monday – September 26, 2022,
7:00 a.m. – Vineyard Conference Room
AGENDA

MEMBERS:
Keith Sattler
Neilan McPartland
Brandon Bowden

STAFF:
Craig Marks
David Rollins
Stephanie Titus

CALL TO ORDER

I. APPROVE MINUTES
Action Requested – August 22, 2022, Minutes

II. FINANCIAL STEWARDSHIP

A. Review Financials – August 2022 **(Attachment V)** **David**
Action Requested – August 2022 Financial Statements

B. Review Accounts Receivable and Cash Goal **David**

C. Voucher Lists
Action Requested – Voucher List **-** Payroll and AP Vouchers # 167133 through #167839 **David**
Dated 08-18-22 through 09-21-22 in the amount of $7,808,752.65;
Surplus Item Resolution # 1070: (4) Sleeper Sofas.

III. ADJOURN

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FINANCE COMMITTEE MEETING	August 22, 2022	VINEYARD CONFERENCE ROOM	
			GUESTS
• Keith Sattler • ~~Neilan McPartland - absent~~ • Brandon Bowden	• Craig Marks, CEO • David Rollins, CFO • Stephanie Titus, Director of Finance Operations		
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
I. CALL TO ORDER	Keith Sattler called the meeting to order at 7:08 a.m.		
II. APPROVE MINUTES		A motion to approve the Finance Committee Meeting Minutes for July 25, 2022, as presented was made by Brandon Bowden. The motion was seconded by Keith Sattler and approved.	None.
III. FINANCIAL STEWARDSHIP **A. Review Financials – July 2022 (Attachment X)**	David reported Net Income of $533,224 in July and Gross Charges were $20,401,148 which was 15% higher than budget for the month and 21% greater	A motion to recommend acceptance of the July 2022 Financial Statements as presented to the PMH Board	None.

	than the prior year. Net Operating Revenue came in at $7,184,353 (0% over budget). Expenses were $6,701,566 in July and 1% under budget driven by lower professional fees and Purchased Services than budget. Surgeries were 284 vs 191 budget and ER visits were 1,384 vs 1,104 budget. Cash Flow was $311,339 for the month and $696,535 YTD. AR stayed at a net 55 days overall. Continued to discuss and show progress in Revenue Cycle to reduce Days in AR > 90 as well as overall AR.	of Commissioners was made by Brandon Bowden. The motion was seconded by Keith Sattler and approved.	
B. Review Accounts Receivable and Cash Goal	AR stayed at 55 net days overall as Collections were a record $7,574,080 but goal was $8,086,048. POS collections were $67,561 exceeding a budget of $15,000 and prior year $12,115. POS collections YTD are $279,278 versus $105,000 budget and $116,100 prior year.	None.	None.
C. Voucher Lists **Payroll and AP Vouchers #166480 through #167132 Dated 07-21-22 through 08-17-22 in the amount of $6,446,637.88.**		A motion to recommend acceptance of the July 2022 Financial Statements as presented to the PMH Board of Commissioners was made by Brandon Bowden. The motion was seconded by Keith Sattler and approved.	None.

D. Capital Equipment Request – Family Birthplace (4) Sofa Sleepers (Attachment P)		A motion to recommend acceptance of the Capital Equipment request Family Birthplace (4) Sofa Sleepers as presented to the PMH Board of Commissioners was made by Brandon Bowden. The motion was seconded by Keith Sattler and approved.	
IV. ADJOURN			
Having declared no further business, the meeting was adjourned at 7:55 am.			

MEMORANDUM

TO: **BOARD OF COMMISSIONERS**
PROSSER MEMORIAL HEALTH

FROM: **CRAIG J. MARKS, CEO**

DATE: **September 2022**

RE: **CEO REPORT**

SERVICES

1. Replacement Facility Update

While we have had our ups and downs the past couple of years as we worked on our Replacement Facility Project, we can now see a light at the end of the tunnel, and it does not appear to be a train! We have made significant progress on the project and in September we will seek approval to move on to the construction phase of the project. The progress we are making is reflected in the September Monthly Progress Report from our Owner Representatives-NV5 **(Attachment A)**; minutes from our last Project Team Meeting **(Attachment B)**; and the project schedule for the next four months **(Attachment C)**. To assist in compartmentalizing the project, we will continue to use the following areas: Design; Construction/Schedule/Budget; and Financing.

A. Design

It's official, we received our Certificate of Need (CN) from the Department of Health (DOH) for the project on September 19th **(Attachment D)**! Based on this CN, we have two years to begin construction of our project. We continue to work with the Sunnyside Valley Irrigation District (SVID) on burying the overflow irrigation canal that runs through our property. We are currently surveying a potential easement on the west and southern borders of our property that would be used to bury the pipe. We hope to complete this in between irrigation seasons (October- March) if we can work out all the details with SVID. We have also submitted an application to the City of Prosser to begin the process to create a development agreement for any improvements that need to be made to, or along, Gap Road. At this time, we do not have an estimate of how long this process will take. The design team continues to work with the DOH, USDA, and the City of Prosser on their review of our construction documents. We continue to struggle with the DOH as the person in charge of our review has left the agency and has not been replaced. We hope to have an update from the DOH at the September Board Work Session. The final design item we are currently working on is to schedule a furniture fair at PMH for staff to try out various pieces of furniture that were selected at the Merchandise Mart in Chicago. The fair will be held the first week of November and will enable our staff to test furniture and give their feedback so that changes can be made if necessary.

B. Construction/Schedule/Budget

Since receiving the results from the final bid packages on August 25, the entire project team has been working together to identify potential savings. Our goal has been to identify $3 million in construction cost savings. Theses specific savings are detailed in the attached Path Back Log **(Attachment E)**. This log meets our goal and includes a variety of savings that will be discussed at the Board Work Session. It should be noted that several of these items are alternates that can be added back to the project if we have additional funds (unused contingency funds or excess hospital funds/equity) at the 60-80% completion mark. As a result of this effort, Bouten Construction will present a Maximum Allowable Construction Cost (MACC) of $81.5 million dollars ($74,817,419 plus Washington State sales tax) to the PMH Board for approval in September **(Attachment F)** and **(Attachment G)**. Bouten Construction is also planning to donate $150,000 to the PMH Foundation, outside of the MACC. In addition, Garrett Electric and Apollo Mechanical have agreed to match this donation for a total of $300,000 to be paid over the next three years (2022-2024). Based on achieving a satisfactory MACC, GC/CM Contracts with Bouten Construction will also be presented for approval in September **(Attachment H)**. If the Board approves these documents, a notice to all of the contractors that were low bidders will go out indicating the project is a "go!" These documents all seem quite simple, but a tremendous amount of work has gone into them and everyone on the project team is to be commended! Bouten Construction has also developed a detailed construction schedule **(Attachment I)** that will be reviewed at the Board Work Session. The schedule shows construction starting in late October/early November (after approval from the DOH and the notice to proceed is received from the USDA) and completion of the project in January 2025. The Board will also be asked to approve the total project budget of $112,048,033 **(Attachment J)**, which will be reviewed along with a detailed project budget **(Attachment K)** at the September Board Work Session.

C. Financing

As we learned at our September 8th Board Meeting, the USDA has verbally approved us to receive an additional $10 million in the form of a direct loan and $1 million of grant money. This is all contingent on their review of our latest Financial Feasibility Study **(Attachment L)** which looks very good. We expect to hear back from the USDA by the end of September. The Board will be asked to approve Board Resolution #1071 **(Attachment M)** in September to authorize the District to move forward with the following financings:

- $80,500,000 in Direct Loan Financings with the USDA;

- $80,500,000 in interim construction revenue bond anticipation notes with Alliance Bank; and

- $5,000,000 in equipment operating lease financing.

Gary Hicks will be at the September Board Work Session to review the Feasibility Study and the recommended financing options and the Board will be asked to approve the Board Resolution at the September Board Meeting.

2. 2023 Strategic Planning

It is once again time to begin our Strategic Planning process for 2023. We are currently compiling a planning packet that will include external information about the healthcare industry in general and specific information about healthcare in rural America. The packet will also contain information that will focus on the historical performance of PMH and include projections for the future. With all the work we have been doing for the USDA and the Washington State DOH, we will utilize some of the same documents to help tell our current and future story. Our focus in 2023 will be to discuss our Mission, Vision, Values and Standards of Behavior. It has been six years since we developed them, and it is time to review and update them if appropriate. We will also explore ways that PMH can continue to grow to meet the growing and changing healthcare needs of the communities we serve and to discuss the construction of our new facility. We will also continue to focus on maintaining our financial performance, which is critical for the construction of our new hospital. While we have maintained and improved our financial base throughout this pandemic, we must continue to grow our revenue, control expenses, and conserve cash in order to make a new hospital a reality.

Like previous years, the planning process will provide opportunities for everyone in our organization (Staff, Board, Medical Staff) to participate; learn more about PMH and the current healthcare industry; and provide input about how PMH can continue to grow and improve. The planning packets will be distributed directly to you electronically for your review and a few hard copies will be placed throughout PMH in the next few weeks. We will also schedule planning sessions for Staff, Board, and Medical Staff in October and early November. We hope that everyone can attend a planning session, however, for those that are unable, worksheets will be provided to capture your ideas so that we can include your input as we develop the 2023 Strategic Plan. I look forward to meeting with everyone as we continue our journey to become a Top 100 Critical Access Hospital in the country and prepare to build our new facility.

3. Radiology Equipment Acquisition

As we have been planning for our replacement facility, part of that planning was to replace equipment that was nearing its end of life. Two examples of that are our CT unit (7 years old) and our MRI unit (18 years old). We knew that by 2024 both pieces of equipment would need to be replaced. As a result, we budgeted approximately $2 million in aggregate to replace them. Aurora Weddle, Director of Diagnostic Imaging, has been working with her staff to evaluate proposals from the top three CT/MRI manufacturers- Phillips, GE, and Siemens, including making site visits to see several in action. Aurora compiled a matrix for all three companies **(Attachment N)** and as a result of all their research, Aurora and her team are recommending to the Board that we acquire the GE CT and MRI units **(Attachment O)** at a cost not to exceed $2,028,830. The Board's approval of these acquisitions will enable our design team (bcDG) to complete the drawings for this space in the replacement facility and for us to obtain final costs to build the space rather than using estimates. Aurora and Merry will present and explain their recommendation at the September Board Work Session. It is important to note that despite the inflation in healthcare, Aurora and her team were able to keep the cost close to our budget, good job! It is also important to point out that this equipment will not be delivered and set-up until our new facility is completed, and GE will be taking our old equipment as a trade-in, so we do not have to dispose of it.

Medical Staff Development

1. Medical Staff Recruitment

I am pleased to report that with the assistance of Dr. Mitchell Cohen- Gastroenterologist, we have successfully recruited Dr. Michael McDonnell **(Attachment P)** to join the PMH Team as our second Gastroenterologist. Dr. McDonnell joins us with many years of experience (and he is originally from Minnesota!) Including performing endoscopic retrograde cholangiopancreatography (ERCP). Dr. McDonnell will join the PMH Specialty Clinic in January 2023. Please join me in welcoming Dr. McDonnell to PMH as we create one of the strongest Gastroenterology programs in the state! Other specialties we continue to recruit include orthopedic surgery, emergency medicine, physiatry and radiology. To assist us with our recruitment efforts for radiology and orthopedic surgery, we have partnered with Merritt Hawkins, a national recruitment firm, and have several visits scheduled in the near future. We have visits scheduled in the coming months with physicians specializing in emergency medicine, pediatrics, physiatry and internal medicine. It is important to note that we have a very thorough interview process including PMH Medical Staff and Leadership, and we are only interested in providers that provide high quality care and fit our culture. We have recently rejected several candidates that did not fit our culture. I have previously written about the nationwide provider shortage, but I recently read an article that indicated that the State of Washington has the lowest number of primary care providers per population in the country **(Attachment Q)**. This supports some of the challenges we have faced to expand our primary care base.

Patient Loyalty

1. Dunk Tank Challenge

On September 16, Prosser Memorial Health demonstrated how it cares for the youth of our community. We hosted the 3rd Annual Boys and Girls Club Dunk Tank Challenge **(Attachment R)**. The contest pitted 11 local citizens against each other to see who could raise the most money for the Prosser Boys and Girls Club. PMH was represented by Dr. Brian Sollers and me. While Dr. Sollers and I both raised significant funds, neither of us could beat Kippy Brown. As a result of his win and the fact that we raised over $22,000, Kippy was allowed to pick two of the other contestants to dunk. Kippy selected his boss at the Boys and Girls Club, Chris Cisneros, and me, apparently as recommended by several community members. Chris and I both survived the dunking and I want to thank everyone that supported us and more importantly, the children of our community.

2. Patient Engagement

We often talk about our financial success, but even more important is the success we are experiencing with our patient satisfaction. In fact, a strong argument can be made that we are experiencing financial success because of our patient satisfaction success. Year-to-date our composite patient satisfaction score is 93.37% compared to our goal of 92.6% **(Attachment S)**. The only areas lagging behind their goals are acute care and outpatient surgery, but they still have time to exceed their goal with a few strong months. This overall performance is commendable as we experience some of the highest volumes in the history of the hospital. Hats off to everyone that has helped us achieve these great results and here's to a strong finish in 2022!

Employee Development

1. Employee Engagement

It's official, fall has arrived. Temperatures are cooling and the harvests have begun. Before we turn the page on summer, however, we had a great end of summer pool party in August. This year's pool party was the largest we have ever had, with over 400 participants. Outstanding! This was an excellent way to bring summer to a close and begin preparing for fall, and the not-too-distant holiday season. Our next engagement event will include activities centered around Halloween. These activities will include our annual costume contest, chili-cookoff, and a visit from Blissful Bites (local donut truck), and Between the Buns (local hot dog vendor). This year Halloween falls on a Monday and we will celebrate the holiday on Monday, October 31. Save the date on Saturday, December 10 for our Annual Holiday Party. This year's party will be held at the HAPO Center in Pasco and will include dinner, dancing, and a casino night. Invitations will be coming out soon so please RSVP as quickly as possible to assist us in the planning. We're expecting a large group and want to make this the best Holiday Party ever! Included in your packet is a copy of the September Employee Newsletter which highlights activities at PMH in August/September **(Attachment T)**.

2. Employee Benefits

The review of the 2023 Health & Welfare benefits renewal is underway. Our Broker, USI has taken the Prosser Memorial Health enrollment roster to the market to get bids from multiple vendors in effort to ensure that our benefits offerings are both competitive and fiscally responsible. The open enrollment process for 2023 will be performed within UKG (our payroll/ time & attendance system) allowing our employees to use existing information and requiring less data entry. With an initial review of our existing benefits, we do not anticipate making significant changes to the design (what we offer to employees and what is covered), though we do expect rate increases and are eager to understand what they will be. We will finalize our benefits decisions for 2023 in late October.

Also included with this update is a 2023 Health & Welfare Compliance Requirements update provided by our benefits Broker, USI **(Attachment U)**. One of the valuable services provided by USI is their support in monitoring and assistance in complying with the ever-changing legal requirements around offering Health & Welfare benefits. Not all of the outline requirements apply to the plans offered by PMH, many do, and those requirements will be included when introducing the 2023 offerings.

3. Nurse Educator

Our goal this year is to have a Nurse Educator in each primary care clinic, providing one-on-one patient education to those patients with challenging medical conditions. A patient (and support person) who understands their medications and treatment plan are much more successful in managing their disease and staying healthy. The nurse educator makes complex information easy to understand and takes the time to help patients find personalized solutions to any obstacles they may have.

The Nurse Educators will also provide Medicare Wellness Visits. We are currently doing four Wellness Visits a day in the Prosser Clinic. A second RN has been hired for the Benton City Clinic, and we are recruiting for the Grandview Clinic. In addition, we are actively recruiting for a full-time diabetic educator. Our current part-time RN diabetic educator focuses on gestational diabetes in the Women's Health Center, but there is a significant need for this expertise across the organization.

Financial Stewardship

1. Financial Performance-August

For the past six months we have exceeded $20 million in gross charges every month and in August we set another record with $23.4 million in gross charges **(Attachment V)**. Prior to 2022, our best gross revenue month was August of 2021 with $18.8 million of gross charges. This is unprecedented revenue growth for PMH and reflects the volume growth we are seeing. In August we exceeded our budgeted volume goals in virtually every department, well done! As a result, our gross revenue was 27% better than our budget and 24% better than last August. After taking out contractual allowances and deductions from revenue, our net patient services revenue was $9 million compared to our budget of $7.4 million. We then used our final COVID-19 Relief Funds **(Attachment W)** and added in our other operating revenue (nutrition services) for a net revenue total of $9.1 million or 22% better than budget. We have now used all our COVID-19 Relief Funds available for 2022 ($1.8 million) and in total, used $16.3 million over the past three years. Our expenses were 1% over budget driven by increases in purchased labor and professional physician fees, however, considering our revenue was 27% over budget, this is very good expense control. After adding in non-operating income, our net income for the month of August was $2,146,095, 309% better than our budget.

As we continue to add months like this to our year-to-date totals, our financials continue to get stronger. Year-to- date our gross revenue is 12% better than budget. And our expenses are 2% under budget, resulting in a net revenue of $7.8 million compared to our budget of $3.8 million. While it appears that last year was better, that includes over $7 million of COVID-19 Relief Funds. When the Relief Funds are removed from both years, we are outperforming last year. This solid income statement performance is also beginning to impact our cash flow where we experienced a positive cash flow of $1.5 million in August and year-to-date, we are up $2.2 million. This financial success is unusual in the health care industry today as we learn of more and more hospitals struggling across the nation **(Attachment X)**. This is also true locally based on a recent article in the Yakima Herald Republic **(Attachment Y)**. While we often want to be like others, this is one time when we prefer to be the exception!

2. PMH Foundation Update

The 2nd Annual Wine Country Classic was held Friday, September 9 at Canyon Lakes Golf Course. We had beautiful weather, 37 teams participate, and 30 volunteers help with the event. It is safe to say a great time was had by all, and in the process, we raised $36,000 toward the new hospital project! A heartfelt thank you to our sponsors, volunteers, and staff who helped make this a successful event! Save the date for the 3rd annual golf tournament Friday, September 8, 2023. The location will be announced after our Foundation Board Meeting in October.

Quality

1. Board Policies

As outlined in our Board Policy, the Board will be asked to review and approve the following four policies: a) Patient Safety Improvement Projects **(Attachment AA)**; b) Outpatient Ordering Practitioners **(Attachment BB)**; c) Tobacco Usage **(Attachment CC)**; and d) Quality Improvement **(Attachment DD)**. The only changes made to these policies were the correction of typos, title changes, etc. The Board will be asked to approve these policies in the Consent Agenda at the September Board Meeting. If a Board member has any questions regarding these policies, we can discuss them at the September Board Work Session.

2. Rural Hospital Decline

The AHA recently released a report highlighting the variety of causes that resulted in 136 rural hospital closures from 2010 to 2021, and a record 19 closures in 2020 alone **(Attachment EE)**. These include many long-standing pressures, such as low reimbursement, staffing shortages, low patient volume and regulatory barriers, as well as the continued financial challenges associated with the COVID-19 pandemic. Recently, expenses for labor, drugs, supplies and equipment have also increased dramatically, causing difficulties in maintaining access to care for people in rural communities.

The report outlined several pathways for rural hospitals to achieve financial sustainability. Including additional federal support, flexible models of care, decreased regulatory burden, partnership arrangements and state Medicaid expansion. In addition, the AHA and WSHA are advocating to state and federal governments for relief to rural hospitals before more hospitals close and more rural communities are forced to go without needed healthcare services.

5. September Board Meetings

The September Board Work Session (Tuesday, September 27) will include a comprehensive review of our replacement facility project focusing on design; construction/schedule/budget; and financing. The session will also include the review of several capital equipment acquisitions and an executive session. The September Board Meeting will be used for the Board to consider approving Board Policies; radiology equipment, a MACC for the Replacement Facility Project a GC/CM contract with Bouten Construction Board Resolution # 1071 and a Replacement Facility Project Total Budget. If the Board would like any other items on the agenda, please contact me.

If you have any questions regarding this report, or other hospital activities, please contact me at (269) 214-8185 (cell), (509) 786-6695 (office), or stop by and see me at the hospital.

Prosser Memorial Health

NV5

Prosser Public Hospital District
Prosser Memorial Health Replacement Hospital
Progress Report

DATE: September 20, 2022

I. PROJECT TEAM:

Prosser Memorial Health (PMH)	Owner
NV5	Owner's Representative
bcDesignGroup (bcDG)	Architect/Design Team
Henderson Engineering	Security, Low Voltage, Audiovisual Design
Gary Hicks Financial, LLC	USDA Application Consultant
Perkins Coie	General Counsel
R&B | Genesis (Mitchell)	Medical Equipment Planner
GeoProfessional Innovation	Geotechnical Engineering Services and Construction Materials Testing & Inspection Services
CBRE|Heery	Commissioning Agent
OpenSquare	Furniture Vendor
Bouten Construction	General Contractor as Construction Manager

II. PROGRESS:

A. Contracts – The following is a status of professional services agreements:
   a. Agreements, contracts and/or amendments *executed this period*:
      i. Rogers Surveying, surveying proposal for SVID easement relocation.
   b. Agreements, contracts and/or amendments *in process this period*:
      i. Bouten Construction, Contract for Construction Management services (A133 and A201). NV5 is working with Bouten, Perkins Coie, and PMH to finalize contract terms. The team intends to have a contract ready for PMH approval and execution by all parties at the September board meeting.

B. Site Development and Coordination
   a. Sunnyside Valley Irrigation District (SVID) – The project team continues its coordination efforts with SVID to relocate the existing irrigation overflow channel so that it is underground and routed along the western boundary of PMH's property. NV5 and PMH have engaged Rogers Surveying to stake the existing utilities, so that SVID can plan a feasible route. The final route will need to be approved by the US Bureau of Reclamation, so NV5 is gathering the data on what this process entails. In the event the USBR process is too lengthy, the contingency plan would be to maintain the ditch's current routing through the middle of PMH's property.

C. Design – Building
   a. bcDG has been working with Bouten to continue the Value Engineering process, which includes incorporating any design changes necessitated through the process.
   b. Likewise, bcDG has being working to resolve any remaining permit comments, which includes drawing revisions.
   c. bcDG will issue a final "conformed set" of drawings once VE is complete and all permitting items have been resolved. This work is anticipated to be complete before the start of construction.

D. Permitting
   a. State Department of Health (DoH) Certificate of Need (CoN)
      i. On September 18, 2022, the Washington State Department of Health issued an unconditional Certificate of Need to PMH for the replacement facility. This is a major milestone that has been in process for almost two years.
   b. State DOH Plan Review
      i. DoH reviewed the 100% Construction Documents and distributed their comments to the team on April 4, some of which cannot be resolved until final inspections are complete after construction. The design team issued comment responses to the DoH on June 30, 2022 and continues to follow up to reach a resolution. Matthew Campbell was the lead representative from the DoH on this project, but he has left the Department and was replaced by Kevin Scarlett. The team is working to manage this change and minimize any risk to the current review process. The DoH did assure PMH, however, that their review process should not preclude the Team from breaking ground on the project. All comments must be resolved prior to receiving a license to operate as a healthcare facility.
      ii. Henderson Engineers submitted the 100% Construction Documents to the Department of Labor and Industries (DL&I) for a technical review of the electrical systems and has since cleared this review process.
   c. City
      i. On April 20, the City building inspector indicated that they would issue a building permit once DoH (see item II.D.b, above) issued their concurrence for construction.

E. USDA Approval
   a. USDA returned project review comments to the team on August 8, 2022, which include items from the project contracts and the design documents. The project team responded to these comments on September 1, 2022. USDA is currently completing their review of these documents.
   b. Gary Hicks and NV5 are working with USDA representatives to ensure they continue to review the project documents in a timely manner.

F. Pre-Construction
   a. Bouten Construction (BC) is in the final stages of creating their Maximum Allowable Construction Cost (MACC) proposal for the Hospital's review and approval. It is BC's goal to submit this to the project team on September 23, 2022. The project team will review the MACC and present a recommendation to the PMH board at the board work session on September 27, 2022.
   b. BC has also led the project team in a Value Engineering (VE) effort. The items identified for VE were presented to the board at the special meeting on September 8. Additional items that have been recommended will be presented to the board at the work session on September 27 for final concurrence.

G. Operations / Activation
   a. The project team intends to reconvene monthly operations meetings later in 2022. The meetings are intended to plan and strategize for the operational shift that will occur when PMH moves from their existing facility to the new facility in 2024.
   b. NV5 and PMH are working on a structure and objectives for these operations meetings prior to commencing the meeting cadence.

III. PROCUREMENT:

A. Maximum Allowable Construction Cost (MACC) – via BC
B. Upcoming project team members to procure include:
   a. Art Consultant, 2023.
   b. Signage Design and Fabrication vendor, 2023.

IV. SCHEDULE:

See 4-month look ahead schedule, attached herewith.

A. MACC available for team review – September 23, 2022
B. USDA Contracts and Design Review – Ongoing thru September 2022
C. Notice to Proceed (NTP) with Construction – October 2022

V. BUDGET

A. NV5 continues to update the master project budget subsequent to contract approvals and invoicing. It remains unchanged from the version shared with the board at the special meeting on September 8.

VI. PROJECT CHALLENGES / RISKS:

A. **USDA** – As noted in previous reports, Gary Hicks Financial and Health Facilities Planning & Development are providing guidance to the project team for the USDA application process. The project is currently in contract review and design review with local and regional USDA representatives, which is a necessary step in order for USDA to provide final funding approval and concurrence for construction. Despite a concerted effort to provide USDA with information in an organized fashion and in a timely manner, it has been a challenge to understand USDA's expectation of timing needed to complete their review. The team continues to check in with USDA regularly and remind them of PMH's need to move forward expeditiously.

B. **Construction Cost(s)** – As noted in previous reports, the project team continues to experience volatile cost variability and increases in the market for materials and labor. The team is working to mitigate this risk by conducting a thorough value engineering effort and reconsidering the options for general contracting.

C. **Traffic Study** – The City of Prosser indicated that per their development regulations PMH may be required to improve Gap Road in the immediate vicinity of the property in order to accommodate future traffic loads. The extents and scale of the improvements were determined by the outcomes of the City's and PMH's traffic studies. On behalf of PMH, the Project Team continues to advocate that any road improvements due to the Hospital construction, and therefore paid for by the project, should be minimal. Perkins Coie is reviewing the matter and will continue to advise PMH. In addition, the City indicated on May 2, 2022 that PMH will need to comply with WSDOT's requirement that an Intersection Control Evaluation (ICE) study be completed. bcDG is leading this effort with their subconsultant, Transpo Group. The study is complete and as of July 26, 2022, it is with WSDOT for approval, which could take 4 months or more. The finalized MDNS incorporates the ICE as a requirement for the building to be occupied (Certificate of Occupancy). The team is working to minimize any improvement requirements identified through the MDNS and ICE processes.

D. **State Department of Health Review** – The Washington State Department of Health, as noted in item II.D.b. above, is experiencing staffing issues which is currently hampering our ability to receive final approval for construction. With the departure of two staff members, the Department appears to be short-staffed. The project team is working to understand the Department's timeline for completing their review, and is advocating for timely completion. The team may pursue a foundation-only permit if the Department is significantly delayed in their approval process.

VII. NEXT STEPS:

A. Obtain Final Permits and Approvals for Construction (September – October 2022)

VIII. ATTACHMENTS:

A. 4-month look ahead schedule

Prosser Memorial Health Replacement Hospital

Owner Team Meeting Minutes

Meeting #	20220916	Date:	Meeting: Friday, September 16, 2022 Issued: Friday, September 16, 2022
Time & Location:	9:00amCT/8:00amMT/7:00amPT MS Teams Video Call	Prepared by:	Adam Trumbour – NV5
Attendees: ✓ = *Attended Meeting*	PMH Craig Marks ✓ Bryon Dirkes ✓ David Rollins ✓ Rey Rodriguez ✓ Merry Fuller Dr. Brian Sollers Phillip Braem ✓ NV5 Paul Kramer ✓ Adam Trumbour ✓ Braden Demmerly ✓ BCDG Kurt Broeckelmann Brooke Cinalli Hilary Beashore ✓ Lance White Finance Consult. Gary Hicks ✓ Bouten Brandon Potts ✓ Mac McGrath ✓ Sean Gossett ✓ Nick Gonzales		
	Attendees		

PMN = Post Meeting Note *For minutes from prior weeks, please reference previously issued minutes.*

No	Item	Date Due By	Ball in Court
1.	GENERAL / ADMINISTRATION		
1.1.	Project Goals, Objectives, & Strategies 24Jun22 – Adam to send to Hilary; may resolve on site.	IN PROGRESS	Team
1.2.	5Mar21 – Graham Team	CLOSED	
1.3.	5Mar21 – NV5 Transition	CLOSED	
1.4.	Contracting Realignment 17Jun22 – NV5 received comments from Bouten. Both parties are working to reach an agreement. PMH would like a completed contract to recommend to the board at the June work session, for approval at the June 30 board meeting. 24Jun22 – The Bouten preconstruction agreement is fully executed. A201 comments sent to PK on 6/23; PK responded to A133 comments responded this morning. PK and Bouten to agree on approach to deliver contract for board work session, including resolving all comments. 8Jul22 – NV5 to meet with Bouten on contract adjustments/review needed on A201. 22Jul22 – Team hopes to present contract for board approval and execution in August. 28Jul22 – A133 and A201 need to be finalized ASAP for USDA review. A133 is close to completion, A201 needs review by Bouten. Bouten history is that USDA signs the contract with everyone in the room (ie signing party). 12Aug22 – Adam to check with PC on this. Ideally these are ready for the August work session since we need them ready ahead of the September 8 special meeting. 19Aug22 – In Bouten's court for review as of 8/17/2022. Brandon is hoping to review by Monday. 16Sept22 – Final comments should be completed today and final draft out to all parties today.	IN PROGRESS	
2.	SCHEDULE		
2.1.	4 Month Look-Ahead Schedule	INFO	
2.2.	In-Person Meetings As noted at the end of meeting minutes.	INFO	

2.3.	Overall Project Schedule 16Sept22 – NV5 revamped the master schedule.	INFO	
3.	**BUDGET**		
3.1.	Budget Development	INFO	
3.2.	Medical Equipment (Major and Minor) (moved to item 4.12)	INFO	
3.3.	DZA Feasibility Study	CLOSED	
3.4.	Financing 19Aug22 – Gary is working through additional financing. 16Sept22 – USDA additional funding request is submitted and in process.	INFO	
4.	**PROCUREMENT / OWNER-LED ACTIVITIES**		
4.1.	GC/CM RFP	CLOSED	
4.2.	Furniture & Demonstration Furniture 13May22 – OS to prepare final package for next week. OS is also researching the most reasonable procurement timeline (buy furniture upon construction commencement and pay for warehousing vs. risk of inflation year-to-year when purchasing later in the project timeline). Merry and Brian to discuss method for collecting information and feedback on additional demo furniture. Craig requests that Brian be the lead on feedback. Best approach would be a Furniture Fair Friday in a conference room to engage staff. NV5 to facilitate this. 3Jun22 – OpenSquare will present their furniture proposal to the team; need to determine a day/time. Need to include PMH Admin team—30 minutes during Thursday at 2PM – 4PM PT is preferable. **PMN:** Canceled. NV5 to reschedule with PMH and OpenSquare. 17Jun22 – PMH to provide an alternative meeting date/time. 24Jun22 – June 21 does not work for OpenSquare, try 7/28. 8Jul22 – Meeting scheduled for 7/28. 29Jul22 – OpenSquare presented their current furniture proposal to the team on July 28. NV5 to work with OpenSquare to plan a furniture fair with OpenSquare sometime before October. 19Aug22 – OpenSquare is working on this. NV5 will coordinate the dates in October via email.	INFO	NV5, OpenSquare
4.3.	Site Clearing	CLOSED	
4.4.	Geotechnical Engineer	CLOSED	
4.5.	Commissioning Agent	CLOSED	
4.6.	Security Design Consultant	CLOSED	
4.7.	New Facility Operational Meetings 04Mar22 – Team to commence meetings within the coming months.	INFO	NV5, Merry
4.8.	bcDG Contract	CLOSED	

4.9.	Landscape Consultant 11Mar22 – The Foundation would like to incorporate a donor patio/bricks, etc., and would like to know when the landscape contractor will be engaged. As of now, plan is to contract with them during April MACC process. Team to involve the Foundation thereafter. 22Apr22 – Graham received one bid for this work. (PMN) Graham indicates the bid was not compliant and therefore they did not accept it. 6May22 – Close out pending new contractor. 13May22 – PMH requests wildflower planting on fallow parts of the property, as part of the final site landscaping. 17Jun22 – Adam to send plan to Bouten. PMH needs a reasonably landscaped site but understands there might be potential to continue to enhance the landscaping once construction is complete. 5Aug22 – Bouten spoke with prospective landscaping, who recommended that any seeded areas also be irrigated. This is best addressed by the landscape design-build team once they are onboard as a subcontractor, though.	INFO	
4.10.	Telecommunications Provider 6May22 – PMH working on existing facility contract. USAC funding cannot apply until a facility is constructed, so PMH will proceed without USAC financing.	INFO	
4.11.	Flooding from Neighbor	CLOSED	NV5
4.12.	Medical Equipment (Major and Minor) 14Jan22 – We need to competitively bid all new equipment (lights/booms (Stryker), imaging). Note: lights from current ORs will be moved to new Procedure Rooms, for example. RBA advises against bidding the Steris system and Pyxis system. Need to provide specific dates for "required on site" for all equipment. 04Mar22 – NV5 to check in with RBA for next steps. 11Mar22 – NV5 is conducting a meeting with RBA on 3/17. 18Mar22 – Meeting was moved to 3/18. 8Apr22 – Next steps occur after MACC is approved. 6May22 – Adam to check with RBA on updated budget pricing. PMH may increase leased equipment by an additional $1.4MM. 13May22 – RBA will revisit their cost estimate and send to team for review. They will also review lease options to capture the additional $1.4MM in leasing PMH would like to pursue. 20May22 – NV5 to check on RBA progress. 3Jun22 – R&B sent a list of proposed leased equipment. NV5 to send to Steve, Dave, Merry, Craig. PMH is also working on reusing more imaging equipment vs. buying or leasing new. 17Jun22 – Adam to send to Gary. PMH team to review internally and determine which items are appropriate. NV5 to add this review to the on-site agenda for board week. 24Jun22 – NV5 to review lease list from David. 22Jul22 – RBA stresses the importance of executing procurement contracts this year to avoid unpredictable price increases.		
4.13.	Food Service Equipment 29Jul22 – NV5 will procure a FSE vendor once NTP date is set. 5Aug22 – Team reviewed FSE plans with Morrison, who provided minor comments.		
5.	**DESIGN / PERMITTING**		

5.1.	Annexation & Zoning	CLOSED	
5.2.	Certificate of Need 19Aug22 – Health Facilities will appeal to the DoH for the CoN once they have documentation of an approved SEPA. NV5 to follow up with the City and ECE to understand when we might expect an approved SEPA. 16Setp22 – Health Facilities sent the CoN request to the DoH on 9/15; the DoH replied that they will confirm nothing is outstanding and then issue the CoN accordingly.	IN PROGRESS	HFA, DoH
5.3.	Water & Sewer (City)	CLOSED	
5.4.	City Permit Review 12Aug22 – NV5 to check with Nick re building permit status now that MDNS is finalized. **PMN:** Nick is waiting for an "all clear" from the DoH before issuing a building permit. He will contact them ASAP to check on this. He also indicated that a foundation-only permit could be issued ahead of this, though we will need to check with USDA that they will allow us to break ground without a full-fledged building permit.	IN PROGRESS	NV5, PMH
5.5.	State Permit Review 8Jul22 – Team permit review comment meeting scheduled for July 11. 29Jul22 – Matt, our primary contract at DoH, is leaving the DoH. 5Aug22 – Lance to reach out to Ander, John and Noam at DoH to understand who will be the point of contact following Matthew's departure. 12Aug22 – Lance spoke with Kevin Scarlett, who will be our point of contact within the DoH. Team should have a meeting planned moving forward. 19Aug22 – bcDG will talk to Kevin and communicate what Matthew set for expectations re building permit. 16Sept22 – bcDG and NV5 to reach out to Kevin at DoH to inquire about when to expect the A2BC form, which authorizes construction. Team stresses the need to understand where DoH is at in their process subsequent to Matthew's departure.	IN PROGRESS	bcDG, DoH, PMH
5.6.	Electric Service	CLOSED	
5.7.	Program Review	CLOSED	
5.8.	Nurse Server Mockup	CLOSED	
5.9.	NV5 DD Review	CLOSED	
5.10.	Design Progress Update 5Aug22 – Team intends to finalize the front-end specs the week of 8/8/2022. 12Aug22 – bcDG is working with Bouten on this. The last addendum is Friday, August 19. The front-end specs need to be completed before then, with time for Bouten to review and suggest edits if needed. bcDG to verify that all constructability comments were incorporated into the latest drawings, which will be issued as a bid addendum today. 19Aug22 – bcDG will need to revise the drawings to address USDA comments. TBD if this is issued as an addendum or conformed. 16Sept22 – bcDG will provide narratives to confirm accepted VE items before 9/21/22, later, they will issue revised design documents to incorporate all changes.	IN PROGRESS	bcDG, Graham

5.11.	**SVID coordination** 11Feb22 – NV5 to request SVID to complete all work, lateral and culverts included. 11Mar22 – Design for using irrigation water? Hilary to ask ECE. **PMN:** ECE can't provide this service. Graham will investigate working with the landscape contractor to provide this. 18Mar22 – SVID proposes to bury the ditch on PMH property as their preferred option. If SVID is going to underground the entire ditch, which is not PMH's preference, then PMH will not contribute to costs to underground the ditch. 8Apr22 – PMH wants at least a letter from PC to SVID. If the pipe is buried, can it be placed at perimeter and not through the middle of the site? 22Apr22 – Given the cost is less than installing concrete culverts, we should proceed with undergrounding; is along the perimeter better than diagonally through site? NV5 to work with SVID on this and the location of manholes. 6May22 – Adam to send Craig cost info and timing. 13May22 – SVID would charge an additional $30k for a perimeter routing. Team is leaning toward this option, as it clears the center of the site. NV5 to work with ECE and SVID on what this will entail (easement, especially). 3Jun22 – NV5 to maintain progress with SVID on rerouting. bcDG is working with ECE to address the neighboring subdivision's request to tap into the SVID overflow. NV5 to respond to the neighbor to let them know that we are likely rerouting the overflow. 22Jul22 – NV5 to check with SVID today on pricing. NV5 to forward update to PMH prior to board meeting. 29Jul22 – Relocated drainage route needs to be staked/surveyed in order to layout a new easement. NV5 coordinating surveying etc. SVID has notice to proceed for driveway work but needs to finalize the aforementioned reroute before scheduling the work. NV5 to double-check on putting overflow in same easement as supply. NV5 to ask why they need 30' (any legal reasons?). 12Aug22 – NV5 continues to contact the surveyor in an attempt to have the utilities staked per SVID's request. SVID indicated that the USBR will need to approved the ditch relocation, so NV5 is determining what that process entails and any schedule risks. The ditch may need to remain in its current location if the USBR process appears to be too lengthy. 19Aug22 – NV5 continues to work with SVID and USBR to reroute the overflow channel. This includes negotiating the easement locations and widths. 16Sept22 – NV5 to resend surveying proposal to PMH for approval. SVID indicates they will replace the supply pipe under our driveway after irrigation ceases on 10/24. NV5 to check on setting a formal date to lessen impacts on Bouten/construction team.	IN PROGRESS	NV5
5.12.	PAR Process	CLOSED	

5.13.	Traffic Study 5Aug22 – Will the final approval of the ICE push out the SEPA and building permit issuance dates? What is the anticipated duration of the ICE final approval by WSDOT? 12Aug22 – Per Steve Zetz email on 8/8, the MDNS incorporates the ICE as conditions for a Certificate of Occupancy, so we should not be held up on a building permit by the ICE. 16Sept22 – bcDG to check with TranspoGroup on final approval from the State DOT.	IN PROGRESS	ECE/bcDG
5.14.	Helipad	CLOSED	
5.15.	Pneumatic Tube System	CLOSED	
5.16.	USDA Review 20May22 – USDA sent a summary of their status via email. They indicated they need the following prior to concurrence for construction: I show the following is needed prior to construction/bid: • Evidence of the BofA equipment lease $3.6MM secured • Evidence of Applicant contribution $17,300,000 deposited in the construction account. ($2.6 of the funds will be identified in the Out Lay Report as interim financing) • Submittal of evidence of required permits. • Approval by USDA of plans and drawings 100% • R-O-W documents need updated and submitted after permits are received. • Project Manager Resume **(already submitted)** • RFQ, RFQ short list, request for proposal, recommendation of Award, Executed Contract • Final Plans and specification for the project. • AIA contracts: USDA to complete review and approval of new contractor • Civil Rights Compliance Review and Limited English Proficiency review. • Non-Discrimination statement to be added as outlined in the Letter of Conditions • Posters to be posted and pictures submitted to USDA for concurrence • Certificate of Need to be submitted to USDA 17Jun22 – Gary understands we may need to convert to "Buy/Build America Act" (BABA) should we appeal to USDA for additional funding. As of now, this is not part of the design docs/specs, and converting to the Act would incur additional time and cost. Gary to check with USDA to understand the risk of this applying to our project. 29Jul22 – USDA has not indicated this is a requirement and has not answered this question directly. Other precedents indicate we are not bound to this, so we are proceeding as-is without BABA requirements. 12Aug22 – USDA sent comments to the team concerning contracts and design. The team is currently reviewing them, but they appear to be mostly clarifications; there did not seem to be comments mandating additions or deletions of scope. 19Aug22 – bcDG intends to respond to USDA comments the week of 8/29	IN PROGRESS	NV5

5.17.	Bulk Oxygen System 6May22 – Adam to forward drawings as noted above. 20May22 – Oxygen farm is not likely to change due to VE. 17Jun22 – NV5 to facilitate meeting with Oxarc and design team. 22Jul22 – Hyperbaric is still in flux and would change system, so NV5 to request pricing from Oxarc once hyperbaric is resolved.	INFO	
5.18.	New Address	CLOSED	
5.19.	Lot Consolidation of Site	CLOSED	
5.20.	Benton County Noxious Weed Mitigation	CLOSED	
5.21.	Stormwater Permit (SWPPP) 29Jul22 – NV5 working with ECE on this. A newspaper ad was placed and now we are in the 30-day comment period before applying. We need SEPA approval date in order to apply. 12Aug22 – Adam to check on SEPA approval in order to proceed with SWPPP. 19Aug22 – SWPPP application is ready and needs to be signed by Bouten. NV5 to share all supporting info on SWPPP for Bouten to sign. 16Sept22 – Jason submitted to the state; we should have SWPPP approval by early October.	IN PROGRESS	
6.	**PRE-CONSTRUCTION**		
6.1.	Value Engineering (VE) Process 22Jul22 –Bouten presented lighting VE options; HEI is reviewing to ensure equivalency and will provide a recommendation to PMH by 7/25 ahead of final docs being issued next week. 29Jul22 – Bouten team working on proposed bid alternates. 5Aug22 – Bouten will issue alternates to bidders today. 12Aug22 – bcDG and Bouten need to clean up the lighting package to verify which items were approved or rejected and finalize what the most economical lighting package will be. 16Sept22 – Team reviewed VE items with PMH this week. Bouten will send action items this morning on any remaining items. Team continues to work through this list on Friday and Monday.	IN PROGRESS	bcDG, Bouten
6.2.	ECCM/MCCM Procurement	CLOSED	
6.3.	Preconstruction Contract Amendment	CLOSED	
6.4.	CM Estimating	CLOSED	
6.5.	Early Procurement 22Jul22 – Bouten will likely need to commit to early procurement of long-lead equipment (e.g. Air Handling Units) early in the project. The team will work together to facilitate this as appropriate. 12Aug22 – See note 6.2 above re mini-MACCs. Once the EC/MCCM are onboard, they will initiate shop drawing processes for long-lead items e.g., air handlers. 16Sept22 – Submittals on chillers, air handlers, etc. are already in progress. Equipment needs to be released before October in order to hold current prices; Team is headed to meet this date. Bouten is investigating the need for storage space to accommodate early procurement.	IN PROGRESS	bcDG, Bouten

6.6.	MACC prep 24Jun22 – Bouten will issue an advertisement for trade outreach. 8Jul22 – Bouten current working on trade outreach/coming soon announcement. 29Jul22 – Bid openings will occur at NV5 Richland office. 12Aug22 – Bouten hosted a pre-bid meeting on 8/10/2022, with a strong showing (~30 people). We are on-track to have a MACC for the team to review on September 1, 2022. 19Aug22 – Bouten to tell NV5 which bid packages on which Bouten intends to bid. 16Sept22 – MACC will be presented to the board at September work session and on the agenda for approval at board meeting. Bouten is evaluating Fee % etc. to contribute to VE.	IN PROGRESS	Bouten
6.7.	Construction Commencement	CLOSED	
6.8.	Building Permit – See item 5.4 above.	IN PROGRESS	
6.9.	Graham Wind-Down	CLOSED	

The above represents the writer's understanding of the items discussed and/or conclusions reached. It is requested that any questions, comments, omissions, and/or errors to these meeting minutes be directed in writing to this office within three (3) business days. Please contact NV5.

Next Online Meeting
Date: Friday, September 23, 2022, at 9:00am CT / 8:00am MT / 7:00am PT; via TEAMS

Upcoming In-Person Meetings
September 27 – Board Work Session (bcDG, Bouten, NV5)

Prosser Memorial Health
Replacement Hospital

Prosser Memorial Health

4 Month Outlook

SEPTEMBER 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
28	29	30	31	01	02 PROJECT TEAM MEETING	03
04	05	06	07	08 SPECIAL BOARD MEETING	09 PROJECT TEAM MEETING	10
11	12	13 UPDATED FEASIBILITY STUDY FROM DZA	14	15	16 PROJECT TEAM MEETING	17
18	19	20	21	22	23 BOUTEN ISSUES THE MACC PROJECT TEAM MEETING	24
25	26 USDA DECISION ON ADD'L FINANCING	27 TEAM REVIEWS VE AND MACC WITH BOARD BOARD WORKSESSION	28	29 Review and Approve MACC Sign GC Contracts BOARD MEETING	30	01
02	03	04	05	06	07	08

OCTOBER 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
25	26	27	28	29	30	01
02	03	04	05	06	07 PROJECT TEAM MEETING	08
09	10	11	12	13	14 PROJECT TEAM MEETING	15
16	17	18	19	20	21 PROJECT TEAM MEETING	22
23	24	25 BOARD WORKSESSION	26	27 BOARD MEETING	28	29
30	31	01	02	03	04	05

LEGEND

IN PERSON MEETING NVE & BCDD ON SITE UNLESS OTHERWISE NOTED

ONLINE MEETING

DELIVERABLE

PMH MEETING NO ATTENDANCE BY PROJECT TEAM

HOLIDAY

FOR BOARD APPROVAL

Prosser Memorial Health
Replacement Hospital

Prosser Memorial Health

4 Month Outlook

NOVEMBER 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
30	31	01	02	03	04	05
					PROJECT TEAM MEETING	
06	07	08	09	10	11	12
					PROJECT TEAM MEETING	
13	14	15	16	17	18	19
		BOARD WORKSESSION		BOARD MEETING		
20	21	22	23	24	25	26
				THANKSGIVING		
27	28	29	30	01	02	03
04	05	06	07			

Items to be rescheduled:
NEW FACILITY OPERATIONAL MEETING (NVS-Led)
NEW FACILITY OPERATIONAL MEETING (Merry-Led)

DECEMBER 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
27	28	29	30	01	02	03
					PROJECT TEAM MEETING	
04	05	06	07	08	09	10
					PROJECT TEAM MEETING	
11	12	13	14	15	16	17
					PROJECT TEAM MEETING	
18	19	20	21	22	23	24
		BOARD WORKSESSION		BOARD MEETING		
25	26	27	28	29	30	31
	CHRISTMAS (OBS.)					
01	02	03	04	05	06	07

Attachment D

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

September 19, 2022

Craig Marks, CEO
Prosser Memorial Health
e-mail: cmarks@pphdwa.org

RE: Certificate of Need Application #21-69 – and Certificate of Need #1934

Dear Mr. Marks and Ms. Carona:

Thank you for providing the Mitigated Determination of Non-Significance associated with Prosser Memorial Health in Prosser, within Benton County. Attached is Certificate of Need #1943 issued to Benton County Hospital District #1 approving the relocation of Prosser Memorial Health to a new site in Benton County.

The certificate is not an approval for any other local, federal, or state statutes, rules, or regulations. Such a project may also need Department of Health approval for a construction plan and facility licensing or certification, as well as other federal or local jurisdiction permits.

The Certificate of Need is valid for two years. The project must begin during this time. If there is substantial and continuing progress, we may extend the certificate for one six-month period. For an extension, you must submit an extension request at least 120 days before the expiration. You cannot begin a project after the expiration date.

We monitor projects until completed or the expiration date, whichever occurs last. We do this with quarterly progress reports. At least 30 days before the report's due date, you will receive a form to complete and return.

If you have any questions, please contact the Certificate of Need Program at (360) 236-2955.

Sincerely,

Eric Hernandez, Program Manager
Certificate of Need
Office of Community Health Systems

Attachment

Washington State Department of Health

This Certificate is granted under the authority of RCW 70.38. Issuance of this Certificate does not constitute approval under any other local, federal or state statute, implementing rules and regulations. Examples where additional approval may be necessary include, but are not limited to, construction plan approval through the Construction Review Unit of the Department of Health, facility licensing/certification through the Department of Social and Health Services or Department of Health, and other federal or local jurisdiction permits.

Certificate of Need #1943 is issued to:

Applicant's Legal Name:	Benton County Hospital District #1
Applicant's Address:	723 Memorial Avenue, Prosser, Washington 99350
Facility Type	Acute Care Hospital
Project Type	Acute Care Hospital
Facility Name:	Prosser Memorial Health
Facility Address:	Not Yet Assigned – See Parcel Numbers in Project Description

ISSUANCE OF THIS CERTIFICATE OF NEED IS BASED ON THE DEPARTMENT'S RECORD, EVALUATION DATED NOVEMBER 4, 2021 (CN APP # 21-69), AND THE INTENT TO ISSUE A CERTIFICATE OF NEED ISSUED DATED NOVEMBER 18, 2021

Project Description

This certificate approves the relocation of Prosser Memorial Health to a new site in Benton County. The address of the new site has not yet been assigned. Three separate parcel numbers are identified in the application and have been relied upon for this review. The parcel numbers are identified on the Benton County Assessor website and listed below:

135942000010000 135942000011000 135942000012000

Benton County Hospital District #1 states that the following factors will remain with the relocation:

- 25 beds (no change in the licensed bed capacity);
- Prosser Memorial Health will continue to operate at a Critical Access Hospital;
- Prosser Memorial Health will operate with the same Medicare and Medicaid provider numbers;
- No addition of tertiary or other Certificate of Need reviewable services;
- No change in the planning area; and
- The existing hospital will close as an acute care hospital once the replacement hospital opens.

Service Area

Benton County

Conditions

Four Conditions are Listed on Page Two of this Certificate.

Approved Capital Expenditure

The approved capital expenditure associated with the relocation of Prosser Memorial Health is $64,707,545, which includes costs for land purchase, construction and fixed equipment, moveable equipment, associated fees, and taxes.

This Certificate authorizes commencement of the project from September 19, 2022 to September 19, 2024 unless extended, withdrawn, suspended, or revoked in accordance with applicable sections of the Certificate of Need law and regulations.

Date Certificate Issued: September 19, 2022

Eric Hernandez, Program Manager
Community Health Systems

This Certificate is not transferable

Certificate of Need #1943-Page Two
Conditions

1. Approval of the project description as stated above. Benton County Hospital District #1 further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.

2. Prosser Memorial Health will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent policies reviewed and approved by the Department of Health. Prosser Memorial Health will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Central Region. Currently, this amount is 1.30% gross revenue and 3.79% of adjusted revenue. Prosser Memorial Health will maintain records of charity care applications received and the dollar amount of charity care discounts granted. The department requires these records to be available upon request.

3. Prosser Memorial Health has completed its requirement by submitting its updated charity care policy to Department of Health for review and posting to the Department of Health website. Prosser Memorial Health will notify the Certificate of Need Program when the January 13, 2021, Charity Care Policy is approved by DOH's Hospital Financial/Charity Care Program.

4. Benton County Hospital District #1 will finance this project as described in the application.

BOUTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

Current GMP (without deductive VE Allowance):	**$ 78,054,188**
Estimated Cost Reduction (Excluding Markup):	**$ (2,975,586)**
Estimated Cost Reduction (With Markup):	**$ (3,236,769)**
Proposed GMP w/Scope Adjustments:	**$ 74,817,419**

ITEM#	DESCRIPTION	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP02-01	**Shrinkage Reducing Admixture in Concrete Ready-mix** Base Bid Scope: Ready mix includes shrinkage reducing admixture Cost Reduction Description: Eliminate shrinkage reducing admixture requirement (this requirement is more common with exposed concrete floors)	$ (70,000)	$ (76,144)	Accept	9/8: Pricing received from HD Fowler
BP02-02	**Plaza Concrete Planter and Seat Walls** Base Bid Scope: CIP concrete planter walls and seat walls per plan. Cost Reduction Description: Eliminate planter walls and seat walls in Courtyard	$ (50,000)	$ (54,389)	Accept	9/8: Pricing received from HD Fowler
BP09A-01	**Roof Attachment System** Base Bid Scope: Fully adhered roof membrane on mechanically attached insulation Cost Reduction Description: Mechanically attach full roof system	$ (104,258)	$ (113,409)	Accept	
BP09A-02	**Roof Substrate Board** Base Bid Scope: Substrate board included at metal roof deck location Cost Reduction Description: Eliminate substrate board at non-UL fire rates assembly areas- rigid insulation to span deck flutes	$ (76,227)	$ (82,918)	Accept	9/14: Design team has found alternate UL assembly for fire rated roof assembly be needs pricing confirmation from Bouten Team 9/15: Can accept once value is presented 9/19: Updated pricing received from MG Wagner reflecting savings only at non-UL rated areas
BP10-01a	**Column Cover Cladding (Paint Finish)** Base Bid Scope: Column covers with wood-grain painted finish Cost Reduction Description: Standard mono-color paint finish	$ (17,300)	$ (18,819)	Deferred Alt	8/31: John @ Flynn will provide pricing by 9/6 9/7: Received pricing from Flynn
BP10-01b	**Column Cover Cladding (Material Type)** Base Bid Scope: Column covers with wood-grain painted finish Cost Reduction Description: Eliminate column covers. Revise steel canopy support members to square/rectangle tube steel with field painted finish.	$ (202,500)	$ (220,274)	Reject	8/31: If accepted, requires follow up with steel and paint subs 8/31: John @ Flynn will provide pricing by 9/6 9/7: Received pricing from Flynn - this is for column covers only -see BP 22 for offsetting intumescent paint costs 9/14: Previous projects have had bad experiences with exposed intumescent coatings on steel. BCDG recommends keeping the column covers
BP10-02	**Metal Soffit Panels** Base Bid Scope: Soffit panels per drawings & specs Cost Reduction Description: Revise fascia panel profile to ???	$ (43,000)	$ (46,774)	Accept	8/31: John @ Flynn will provide pricing by 9/6 9/6: Flynn to provide a cut sheet for proposed metal panel 9/7: Received pricing from Flynn
BP10-03	**Flashing Detail at Top of Metal Panels** Base Bid Scope: Included 1970lf of flashing at top of metal panel wall at parapet due to bid package requirement for "complete system". This flashing is likely not required due to the parapet cap providing closure. Cost Reduction Description: Eliminate 1970 lf of top-of-wall flashing at metal panel.	$ (12,000)	$ (13,053)	Accept	8/31: John @ Flynn will provide pricing by 9/6 9/7: Received pricing from Flynn
BP11-01	**Exterior Glazing (Glass Types)** Base Bid Scope: Green tinted glass on outside pane with low-e glass on inside pane Cost Reduction Description: Revise outside pane to standard bronze tint / Solarban 60 Low-E.	$ (62,030)	$ (67,475)	Reject	8/31: Bryce @ Perfection to confirm ROMs via email in the next 2-3 days 9/8: Received pricing from Perfection 9/14: Design team is reviewing performance of revised outside pane 9/15: Does not meet energy calcs
BP11-02	**Exterior Glazing Temporary Enclosure** Base Bid Scope: Bid package language requires temporary plywood panels at storefront framing until glass arrives. Cost Reduction Description: Provide guaranteed measurements for storefront to allow early procurement so glazing can be installed with storefront framing at the same time, eliminating temp plywood infill panels.	$ (56,200)	$ (61,133)	Accept	8/31: Bryce @ Perfection to confirm ROMs via email in the next 2-3 days 9/8: Received pricing from Perfection
BP11-03a	**Glass Film (Product Type)** Base Bid Scope: Glass film per plans Cost Reduction Description: Revise glass film to standard (cut sheet coming)	$ (6,500)	$ (7,071)	Reject	9/8: Received pricing from Perfection
BP11-03b	**Glass Film Alternative to Preserve Warranty on Windows (Added Cost)** Base Bid Scope: Glass film per plans at exterior windows Cost Adjustment Description: Revise glass film to factory applied glass frit	$ 4,620	$ 5,026	Reject	9/8: Received pricing from Perfection 9/21: Deferred to further review after MACC

BOULTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP13-01	**Pull Hardware** Base Bid Scope: HD-2 pull hardware (per plans & specs) Cost Reduction Description: Revise pull hardware to PCI Standard Pull	$ (9,852)	$ (10,717)	Accept	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: PCI to provide cut sheet
BP13-02	**Drawer Slides** Base Bid Scope: Soft close slides (per plans & specs) Cost Reduction Description: Revise pull hardware to PCI Standard Slides	$ (2,179)	$ (2,370)	Accept	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: PCI to provide cut sheets
BP13-03	**Solid Surface Countertop (Manufacturer)** Base Bid Scope: Solid Surface Countertop type SS-3 Wilsonart (per plans & specs) Cost Reduction Description: Revise Solid Surface Countertop to Corian Group 2	$ (15,000)	$ (16,317)	Deferred Alt	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: BCDG open to exploring - will review Group 2 colors 9/14: Artic Ice (from Group 2) is acceptable to the Design Team, but is drastically different than the approved finish and needs PMH review/approval.
BP13-04	**PLAM Finish/Color** Base Bid Scope: L-8 Formica, Color: Camel Elm, Finish: WR-Woodbrush (per plans & specs) Cost Reduction Description: Revise to standard plam color & finish	$ (3,267)	$ (3,554)	Reject	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: BCDG recommends rejecting - spent a long time getting the owner to decide
BP13-05	**Dust Panels at Drawers** Base Bid Scope: Dust panel at drawers included per plans and specs Cost Reduction Description: Remove dust panels at all drawers	$ (6,345)	$ (6,902)	Accept	8/31: Received pricing via email from Paul Foresman @ PCI
BP13-06	**PLAM Finish/Color at Die Walls** Base Bid Scope: Die Wall Cladding: P-9 Formica, Compact Laminate; Color: Camel Elm 5795, Finish:TBD Cost Reduction Description: Revise to standard plam color & finish	$ (14,058)	$ (15,292)	Reject	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: BCDG - color needs to remain, but open to revising from compact to standard laminate. 9/6: PCI to find out if this color option is available in standards
BP13-07	**Window Sill Material** Base Bid Scope: Solid Surface Window Sills Cost Reduction Description: Revise window sills to plastic laminate	$ (34,919)	$ (37,984)	Reject	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: BCDG - concern about durability, but open to reviewing. Indicated Owner was not interested in this item in the last bid effort. 9/6: PCI to provide supporting documentation for durability
BP14-01a	**Auto-Door Operators** Base Bid Scope: Besam door operators Cost Reduction Description: Norton 6300 operators	$ (64,438)	$ (70,094)	Reject	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB In our opinion, the Norton operators are not as heavy-duty as the Besam operators specified. (For instance, Norton has a lower door weight limit - 250lbs vs 700lbs). While the Norton may work fine, we would not anticipate it having as long a lifespan as the specified product. (And we'd probably need the Besam operators on the lead-lined doors.)
BP14-01b	**Auto-Door Operators** Base Bid Scope: Besam door operators Cost Reduction Description: Norton 6300 operators (Hold 25% back for select Besam Locations)	$ (48,329)	$ (52,571)	Accept	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB In our opinion, the Norton operators are not as heavy-duty as the Besam operators specified. (For instance, Norton has a lower door weight limit - 250lbs vs 700lbs). While the Norton may work fine, we would not anticipate it having as long a lifespan as the specified product. (And we'd probably need the Besam operators on the lead-lined doors.)
BP14-02	**Wood Door (Manufacturer)** Base Bid Scope: Lynden Door w/no added urea formaldehyde Cost Reduction Description: Masonite door and eliminate the "No Added Urea Formaldehyde" requirement	$ (39,277)	$ (42,725)	Accept	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB: Assuming the 1-3/4" thick version of the LD Series is provided, the additional blocking needed to meet WDMA 1S-1A is provided,, and the species, grain, finish, etc. match the specified finishes, we have no issues with this substitution.

BOULTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP14-03	**Metal Door Frame (Weld Configuration)** 'Base Bid Scope: Door frames have a full profile weld Cost Reduction Description: Eliminate the requirement for "Full profile weld". Frames provided by bidder are die mitered and notched so they only need to be face welded.	$ (15,566)	$ (16,932)	Reject	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB: While face welded frames, as provided in this deduct, comply with the ANSI/SDI Heavy Duty requirements, they are not as stout as the full profile welded frames specified, which is why we don't spec them as our standard. Our recommendation would be to leave full profile welded frames at exterior openings, lead-lined, and double door openings, while switching standard, interior openings to face welded
BP14-03	**Metal Door Frame (Weld Configuration)** 'Base Bid Scope: Door frames have a full profile weld Cost Reduction Description: Eliminate the requirement for "Full profile weld" at 75% of Frame Locations. Frames provided by bidder are die mitered and notched so they only need to be face welded.	$ (11,675)	$ (12,699)	Accept	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB: While face welded frames, as provided in this deduct, comply with the ANSI/SDI Heavy Duty requirements, they are not as stout as the full profile welded frames specified, which is why we don't spec them as our standard. Our recommendation would be to leave full profile welded frames at exterior openings, lead-lined, and double door openings, while switching standard, interior openings to face welded
BP14-04	**Electrified Door Hardware** Base Bid Scope: Electrified lockets hardware per spec (wired through door) Cost Reduction Description: Revise HW Set 8,11, &36 to Storeroom Lock with electric strike (similar to HW Set 8.1)	$ (27,351)	$ (29,752)	Accept	9/8: Need further definition on VE scope (proposed product and locations) 9/13: Pricing received from Yadon Supply
BP17-01a	**Drywall Partition Stud Framing** Base Bid Scope: Partitions per Plans & Specs Cost Reduction Description: Revise (stud) G60 coating to G40 at interior studs in the MOB	$ (11,000)	$ (11,966)	Reject	9/8: ROM $200k (needs further definition and bidder pricing) 9/15: Need revised partition assemblies and/or locations of partition assemblies revisions to provide a biddable deductive price. 9/21: BCC to confirm this is only at the interior of the MOB
BP17-01b	**Drywall Partition Stud Framing** Base Bid Scope: Partitions per Plans & Specs Cost Reduction Description: Revise (stud) G60 coating to G40 at interior studs at all locations	$ (36,500)	$ (39,704)	Accept	9/21: Added to log - pricing provided by Drywall Interiors
BP22-01	**Column Cover Cladding (Material Type)** Reference VE#BP10-01b: Added cost to paint out tube steel at proposed canopy column revision.	$ -	$ -	Reject	
BP24-01a	**Wall Protection - Option A** Base Bid Scope: Wall protection included per drawings & specs Cost Reduction Description: Reduce wall protection by 20% (apx 8,000sf)	$ (79,851)	$ (86,860)	Reject	
BP24-01b	**Wall Protection - Option B** Base Bid Scope: Wall protection included per drawings & specs Cost Reduction Description: Deduct wall protection from all storage rooms except Materials Management Storage Room	$ (31,721)	$ (34,505)	Deferred Alt	9/15: Added to log 9/15: Dupree (vendor) is out of town until Monday 9/19. Anticipating pricing is at least a week out from today (apx 9/22). 9/15: Moved deferred alt 9/21: BCC-SPW provided pricing
BP24-01c	**Wall Protection - Option C** Base Bid Scope: Wall protection included per drawings & specs Cost Reduction Description: Deduct wall protection from all exam rooms and alcoves in the MOB	$ (4,051)	$ (4,407)	Reject	9/15: Added to log 9/15: Dupree (vendor) is out of town until Monday 9/19. Anticipating pricing is at least a week out from today (apx 9/22). 9/21: BCC-SPW provided pricing
BP24-02a	**Operable Partition - Option A** Base Bid Scope: Skyfold operable partition included per plans & specs Cost Reduction Description: Eliminate Skyfold operable partition. Keep steel structure and soffit to allow for future installation.	$ (282,258)	$ (307,033)	Reject	9/21: Room will not function
BP24-02b	**Operable Partition - Option B** Base Bid Scope: Skyfold operable partition (Zenith 52) included per plans & specs Cost Reduction Description: Skyfold operable partition revised to Zenith 48	$ (39,302)	$ (42,752)	Accept	9/14: Added to log 9/15: Dupree (vendor) is out of town until Monday 9/19. Anticipating pricing is at least a week out from today (apx 9/22). 9/21: Rec'd pricing from Dupree

BOUTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP24-02b	**Operable Partition - Option C** Base Bid Scope: Skyfold operable partition included per plans & specs Cost Reduction Description: Manually operated operable partition with same STC rating.		$ -	Reject	9/15: Added to log 9/15: Dupree (vendor) is out of town until Monday 9/19. Anticipating pricing is at least a week out from today (apx 9/22). 9/21: Deferred to further review after MACC
BP26-01	**Elevator Cab Finish** Base Bid Scope: Provide interior elevator finishes as specified. Cost Reduction Description: Provide raised laminate panels from manufacturer standard selection.	$ (20,000)	$ (21,756)	Accept	9/7: Pricing received from Otis, need to review and confirm.
BP26-01	**Pneumatic Tube System** Base Bid Scope: Pneumatic tube system included. Cost Reduction Description: Eliminate pneumatic tube system	$ (319,000)	$ (347,000)	Accept	9/15: PMH proposed and accepted
BP29-01	**Humidifier Condensate Drainage** Base Bid Scope: Dedicated condensate drains for humidifiers Cost Reduction Description: Drain humidifiers to roof drains	$ -	$ -	Reject	9/8: Manufacturer advises against draining units to roof.
BP29-02	**Fire Smoke Damper Monitoring** Base Bid Scope: Fire smoke dampers are monitored in the HVAC control system Cost Reduction Description: Eliminate fire smoke damper monitoring (54 dampers)	$ (57,780)	$ (62,852)	Accept	9/21 Received pricing from Apollo
BP29-03	**Domestic Water (Pipe Material)** Base Bid Scope: Copper piping for domestic water 1" and under in Hospital and MOB Cost Reduction Description: Pex piping for domestic water 1" and under in Hospital and MOB	$ (13,562)	$ (14,752)	Reject	
BP29-04a	**Direct Digital Control System - Occupancy Sensors** Base Bid Scope: DDC points per plans and specs Cost Reduction Description: Occ Sensor Monitoring Deduct	$ (5,313)	$ (5,779)	Accept	9/19: Apollo to provide credit for Zone Occupancy, OSA measurement at AHU's and pulling feedback from controllers. 9/21: Rec'd pricing from Apollo Can be combined with BP29-04b
BP29-04b	**Direct Digital Control System -AHU Monitoring** Base Bid Scope: DDC points per plans and specs Cost Reduction Description: AHU-1,2,4 Monitoring Feedback Deduct	$ (5,021)	$ (5,462)	Reject	9/19: Apollo to provide credit for Zone Occupancy, OSA measurement at AHU's and pulling feedback from controllers. 9/21: Rec'd pricing from Apollo Can be combined with BP29-04a 9/21: Not significant enough savings for impact
BP29-05	**Eliminate Glycol from Water Treatment** Base Bid Scope: Include glycol per water treatment specs Cost Reduction Description: Eliminate glycol including feeders.	$ (102,000)	$ (110,953)	Accept	9/19: Apollo to confirm credit. Henderson to confirm glycol was not intended. Equipment was specified based on water and not glycol. 9/21: Received pricing from Apollo
BP30-01	**Lighting Value Engineering Package (excluded type S2)** Base Bid Scope: Fixture package per drawings Cost Reduction Description: JC Wright light fixture package with VE options reviewed and approved by design team	$ (268,439)	$ (292,001)	Accept	6/22: Excludes Type S2 (strip fixture at perimeter of building - not included in base bid). See next item down. 6/22: Need to follow up an confirm wattage calcs proposed are in line with energy credits. 9/8: Received pricing from Garrett. $146,985 savings is included in the base bid price. Remaining VE includes -$4798 for Type 3C, -$47,067 for Type SB2 bollard, & -$69,589 for type P9 rings
BP30-02	**Lighting Fixture Type S2 (add)** Base Scope: Not included in base proposal (currently still shown on the documents, but priced as an add alternate). This fixture outlines the cap of the building around the 2nd floor Cost Add Description: Cost to add S2 fixture back into the project	$ 82,221	$ 89,438	Reject	6/22: Can be accepted along with item D5 01. 6/22: If rejected, drawings will need to be updated to reflect scope change.
BP30-03	**Lighting Fixture Type WG1 (delete)** Base Scope: Included (apx 7 fixtures, faces into Café seating area) Cost Reduction Description: Removes architectural fixture in café	$ (17,625)	$ -	Reject	9/8: Confirmed with Garrett that this has already been removed in the current plan set.
BP30-04	**Building Ground Ring (excluded excavation)** Base Scope: Not included. Not required by code Cost Add Description: Add grounding system. Would need to be included if a lightning protection system is added.	$ 23,805	$ 25,894	Reject	6/22: If lightning protection system is not required, the grounding system is unnecessary 6/22: Assume ground ring will be installed prior to footing backfill
BP30-05	**Lightning Protection** Base Scope: Not included. Not required by code (details shown in drawings - priced as an add alternate) Cost Add Description: Add lightning protection system	$ 114,088	$ 124,102	Reject	6/22: Need to consult JHA to get clarification on code requirement 6/22: Lightning protection detail shown on Architectural Roof plan will need to be scrubbed, if rejected. 6/22: Must accept item D5.04 Ground System, if this item is accepted.

BOUTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP30-06	**Concrete Warning Planks at Underground Ducts** Base Scope: Not included. (Specified, but priced as an add alternate). CDF fill protection included where required. Cost Add Description: Add concrete planks in secondary power ductbanks	$ 404,695	$ 440,217	Reject	6/22: BCC would need to include CDF backfill at secondary power ductbanks.
BP30-07	**PVC Coated GRC Conduit at Slab Penetrations** Base Scope: PVC runs all the way through the slab in areas not subject to damage (ie inside footprint of equipment) Cost Add Description: Transition from PVC to GRC (per spec - priced as an add alternate)	$ 18,970	$ 20,635	Reject	6/22: Spec requirement. Spec will need to be revised if accepted.
BP30-08	**Extended Light Fixture Cables** Base Scope: Industry standard lengths (does not account for major renovations in the future). Cost Add Description: Spec requirement 6-8' of extra coiled fixture whip cable beyond industry standard whip for future relocations (specified item - priced as an add alternate)	$ 59,174	$ 64,368	Reject	6/22: Spec requirement. Spec will need to be revised if accepted. 6/22: Proposing 6' 6/22: Rejected
BP30-09	**Audio-Video System Reduced Features** Base Scope: Includes specified higher end equipment for conference rooms, etc. Cost Reduction Description: Reduce density of systems as well as providing quality, but lower cost system components. Pricing based on systems in place with similar customers/spaces	$ (78,039)	$ (84,888)	Reject	6/22: ROM pricing 6/22: May require follow-up meeting to run through proposed systems
BP30-10	**Delete TV Distribution Equip Per Spec 27 2133** Base Scope: TV Distribution over twisted pair with provisions for both local cable service AND satellite service distribution. Proposed Alternative: Delete spec section 27 4133 for Z Band Head end equipment/cabling.	$ (134,400)	$ (146,197)	Accept	6/22: ROM pricing 6/22: Base bid system allows a "local channel" option to broadcast menu, hospital information, etc 9/16: Only a single CAT 6 network drop behind each TV is required. No twisted pair or head end equipment is required.
BP30-11	**PA System Control Via OFOI Phone System in Lieu of Stand-Alone Master Controls** Base Scope: Specified stand alone master control station for public address system Cost Reduction Description: Public address functionality handled over Owner provided phone system (ie dial an extension for public broadcast)	$ (12,139)	$ (13,205)	Accept	6/22: ROM pricing 6/22: Specified system allows only operator station to have access to PA station. 9/19: Phillip recommends this VE because phones can be over ridden.
BP30-12	**Sound Masking Over PA System at Hospital Area** Base Scope: Two stand alone (speaker) systems Cost Reduction Description: Utilize PA system speakers for sound masking	$ (12,378)	$ (13,464)	Accept	
BP30-13	**Nurse Call Reduced Duty Stations and Software** Base Scope: Specified Responder 5 system with software features Cost Reduction Description: Stay with Responder 5 system, but reduce quantity of stations and software extra features.	$ (24,279)	$ (26,410)	Reject	6/22: ROM pricing
BP30-14b	**Nurse Call Reduced Duty Stations and Software** Base Scope: Responder 5 system as specified Cost Reduction Description: Nurse Call reduced duty stations and software	$ (22,400)	$ (24,366)	Reject	9/20: Added to log 9/20: Updated pricing based on 9/19 Garrett Quote
BP30-15	**Delete Electrical Power Monitoring** Base Bid Scope: Electrical Power Monitoring Per Spec Cost Reduction Description: Omit separate stand-alone Electrical Power Monitoring system required by specification section 29 09 13. The monitoring and reporting performed by this system is redundant and can be provided via the mechanical BMS system	$ 28,683	$ 31,201	Reject	9/14: Awaiting meeting with Henderson to walk through options (earliest meeting time is 9/19) 9/15: PMH accepts as long as Henderson accepts. 9/19: Apollo to provide add for additional BMS points 9/20: Received pricing from Garrett 9/20: Net add due to $128k added scope from Apollo
BP30-16	**Reduce CAT6 Cable at Each Wall Box from 2 to 1** Base Bid Scope: 2 Data Drops at Each Wall Box Cost Reduction Description: 1 CAT 6 cable at each wall box.	$ (13,584)	$ (14,776)	Accept	9/16: Only 1 CAT 6 cable required at each TV location. GEC to provide credit for second drop. 9/19: Received pricing from Garrett
BP33-01	**Landscape Allowance** Base Scope: Landscaping per Design/Build Bid Proposals Cost Reduction Description: Target $200k Allowance ILO Bid Numbers for Landscape	$ (325,319)	$ (353,874)	Accept	
M-01	**Revise PEMB Maintenance Building to Non-Conditioned Space** Base Scope: Conditioned Space Cost Reduction Description: Eliminate heating/cooling systems in PEMB - this would be a non-conditioned storage building.	$ -	$ -	Reject	

BOULTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
ALT:02	OMMIT PRE-ENGINEERED METAL BUILDING	$ (416,398)	$ (452,947)	Deferred Alt	
ALT-03	ADD HELIPAD	$ 65,589	$ 71,346	Further Review	
ALT-04	REVISE LOADING DOCK GUARDRAIL TO CHAINLINK FENCE	$ (6,399)	$ (6,961)	Reject	
ALT-05	REVISE COURTYARD PAVING TO STANDARD BROOM FINISH			Reject	
ALT-06	REVISE 3Form DIMENSIONAL PANELS TO GYP w/ACCENT PAINT	$ (113,659)	$ (123,635)	Further Review	
ALT-11	FACTORY PRE-INSTALLATION OF DOOR HARDWARE			Reject	
ALT-13	MOISTURE BOARD ILO DENSGLASS AT WALL TOPOUTS	$ (32,500)	$ (35,353)	Accept	
ALT-14	REVISE PATIENT HEADWALLS TO PREFAB	$ 337,886	$ 367,544	Reject	
ALT-15	REVISE ELEVATORS TO HYDRAULIC	$ (135,000)	$ (146,850)	Accept	
ALT-17	OMIT ONCOLOGY BUILDOUT - AREA BECOMES STORAGE	$ (424,821)	$ (462,110)	Deferred Alt	

AIA® Document A133™ – 2019 Exhibit A

Guaranteed Maximum Price Amendment

This Amendment dated the Twenty-Seventh day of September in the year Two Thousand Twenty-Two, is incorporated into the accompanying AIA Document A133™–2019, Standard Form of Agreement Between Owner and Construction Manager as Constructor where the basis of payment is the Cost of the Work Plus a Fee with a Guaranteed Maximum Price dated the Twenty-Seventh day of September in the year Two Thousand Twenty-Two (the "Agreement")
(In words, indicate day, month, and year.)

for the following **PROJECT:**
(Name and address or location)

PROSSER MEMORIAL HEALTH HOSPITAL REPLACEMENT FACILITY
723 Memorial Street
Prosser, WA 99350

THE OWNER:
(Name, legal status, and address)

PROSSER PUBLIC HOSPITAL DISTICT No. 1
d/b/a Prosser Memorial Health
723 Memorial Street
Prosser, WA 99352

THE CONSTRUCTION MANAGER:
(Name, legal status, and address)

Brandon Potts, Vice President
Nick Gonzales, Vice President
BOUTEN CONSTRUCTION COMPANY
P.O. Box 3507
627 N. Napa Street
Spokane, WA 99220-3507
t: 509.535.3531

ADDITIONS AND DELETIONS:
The author of this document has added information needed for its completion. The author may also have revised the text of the original AIA standard form. An *Additions and Deletions Report* that notes added information as well as revisions to the standard form text is available from the author and should be reviewed. A vertical line in the left margin of this document indicates where the author has added necessary information and where the author has added to or deleted from the original AIA text.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

AIA Document A201™–2017, General Conditions of the Contract for Construction, is adopted in this document by reference. Do not use with other general conditions unless this document is modified.

TABLE OF ARTICLES

ARTICLE A.1 GUARANTEED MAXIMUM PRICE

§ A.1.1 Guaranteed Maximum Price

Pursuant to Section 3.2.6 of the Agreement, the Owner and Construction Manager hereby amend the Agreement to establish a Guaranteed Maximum Price. As agreed by the Owner and Construction Manager, the Guaranteed Maximum Price is an amount that the Contract

Sum shall not exceed. The Contract Sum consists of the Construction Manager's Fee plus the Cost of the Work, as that term is defined in Article 6 of the Agreement.

§ A.1.1.1 The Contract Sum is guaranteed by the Construction Manager not to exceed Seventy-Four Million Eight Hundred Eleven Thousand Four Hundred Fifty-Two Dollars and no/100 ($74,811,452.00), subject to additions and deductions by Change Order as provided in the Contract Documents.

§ A.1.1.2 Itemized Statement of the Guaranteed Maximum Price. Provided below is an itemized statement of the Guaranteed Maximum Price organized by trade categories, including allowances; the Construction Manager's contingency; alternates; the Construction Manager's Fee; and other items that comprise the Guaranteed Maximum Price as defined in Section 3.2.1 of the Agreement.
(Provide itemized statement below or reference an attachment.)

Reference Attachment A: Guaranteed Maximum Price (GMP) dated September 27, 2022

§ A.1.1.3 The Construction Manager's Fee is set forth in Section 6.1.2 of the Agreement.

§ A.1.1.4 The method of adjustment of the Construction Manager's Fee for changes in the Work is set forth in Section 6.1.3 of the Agreement.

§ A.1.1.5 Alternates
§ A.1.1.5.1 Alternates, if any, included in the Guaranteed Maximum Price:

Reference Attachment B: Cost Reduction Log dated September 27, 2022

§ A.1.1.5.2 Subject to the conditions noted below, the following alternates may be accepted by the Owner following execution of this Exhibit A. Upon acceptance, the Owner shall issue a Modification to the Agreement.
(Insert below each alternate and the conditions that must be met for the Owner to accept the alternate.)

Reference Attachment B: Cost Reduction Log Item No's:

§ A.1.1.6 Unit prices, if any:
(Identify the item and state the unit price and quantity limitations, if any, to which the unit price will be applicable.)

Reference Attachment A: Guaranteed Maximum Price (GMP) dated September 27, 2022, Note No. 15

ARTICLE A.2 DATE OF COMMENCEMENT AND SUBSTANTIAL COMPLETION
§ A.2.1 The date of commencement of the Work shall be:
(Check one of the following boxes.)

[ ] The date of execution of this Amendment.

[X] Established as follows:
(Insert a date or a means to determine the date of commencement of the Work.)

November 14, 2022

If a date of commencement of the Work is not selected, then the date of commencement shall be the date of execution of this Amendment.

§ A.2.2 Unless otherwise provided, the Contract Time is the period of time, including authorized adjustments, allotted in the Contract Documents for Substantial Completion of the Work. The Contract Time shall be measured from the date of commencement of the Work.

§ A.2.3 Substantial Completion

§ A.2.3.1 Subject to adjustments of the Contract Time as provided in the Contract Documents, the Construction Manager shall achieve Substantial Completion of the entire Work:
(Check one of the following boxes and complete the necessary information.)

[ ] Not later than ( ) calendar days from the date of commencement of the Work.

[X] By the following date: November 14, 2024

§ A.2.3.2 Subject to adjustments of the Contract Time as provided in the Contract Documents, if portions of the Work are to be completed prior to Substantial Completion of the entire Work, the Construction Manager shall achieve Substantial Completion of such portions by the following dates:

Reference Attachment C: Project Schedule dated September 27, 2022

§ A.2.3.3 If the Construction Manager fails to achieve Substantial Completion as provided in this Section A.2.3, liquidated damages, if any, shall be assessed as set forth below.

If Construction Manager fails to substantially complete the entire project on or before the Project Completion Date, which Project Completion Date may be extended pursuant to the Contract Documents, the parties agree that it would be extremely difficult and impractical under the presently known and anticipated facts and circumstances to ascertain and fix the actual damages the Owner will incur by reason of such failure. Accordingly, the parties agree that if the Construction Manager fails to achieve substantial completion on or before the Project completion Date, then the Construction Manager shall be liable to the Owner for liquidated damages until the Date of Substantial Completion of the entire project, as applicable, in accordance with the following scale:

.1 If Construction Manager does not achieve Substantial Completion of the entire Work in accordance with Section A.2.3, no liquidated damages shall be assessed for the first sixty (60) days of delay in Construction Manager's achieving Substantial Completion.

.2 Thereafter, liquidated damages shall be assessed by the Owner and paid by Construction Manager at the rate of $5,265.00 USD for each day sixty-one (61) on, until Construction Manager's achieving Substantial Completion.

.3 Thereafter, liquidated damages shall be assessed by the Owner and paid by Construction Manager at the rate of $1,000.00 USD for each subsequent day of delay in Construction Manager's achieving Final Completion.

The Liquidated Damages provided herein shall be Owner's sole and exclusive damages remedy for Construction Manager's failure to complete the project or the applicable project component within the Contract time provided herein and such liquidated damage payment shall be in lieu of all liability for any and all extra costs, losses, expenses, claims, penalties and any other damages, whether special or consequential and of whatsoever nature incurred by Owner which are occasioned by and delay in achieving substantial completion. Nothing in this Section A.2.3 or otherwise shall limit owner's other rights under the contract documents (e.g., termination).

The parties agree that the above described scale represents a reasonable calculation and amount of liquidated damages based upon the facts presently known and in light of the difficulty in estimating Owner's damages upon the Construction Manager's failure to complete all or any portion of the project on time.

The maximum amount of liquidated damages assessed against the Construction Manager shall not exceed: a) twenty-five percent (25%) of the Construction Manager's fee as set forth in Section A.2.3.

ARTICLE A.3 INFORMATION UPON WHICH AMENDMENT IS BASED

§ A.3.1 The Guaranteed Maximum Price and Contract Time set forth in this Amendment are based on the Contract Documents and the following:

Init.

/

§ A.3.1.1 The following Supplementary and other Conditions of the Contract:

Not applicable

§ A.3.1.2 The following Specifications:

Reference Attachment D: Enumeration of Contract Documents

§ A.3.1.3 The following Drawings:

Reference Attachment D: Enumeration of Contract Documents

§ A.3.1.4 The Sustainability Plan, if any:
(If the Owner identified a Sustainable Objective in the Owner's Criteria, identify the document or documents that comprise the Sustainability Plan by title, date and number of pages, and include other identifying information. The Sustainability Plan identifies and describes the Sustainable Objective; the targeted Sustainable Measures; implementation strategies selected to achieve the Sustainable Measures; the Owner's and Construction Manager's roles and responsibilities associated with achieving the Sustainable Measures; the specific details about design reviews, testing or metrics to verify achievement of each Sustainable Measure; and the Sustainability Documentation required for the Project, as those terms are defined in Exhibit C to the Agreement.)

Not applicable

Other identifying information:

§ A.3.1.5 Allowances, if any, included in the Guaranteed Maximum Price:
(Identify each allowance.)

Reference Attachment A: Guaranteed Maximum Price dated September 23, 2022, Item No's: 36, 37, 38, 39, 40, 41, 42 & 43

§ A.3.1.6 Assumptions and clarifications, if any, upon which the Guaranteed Maximum Price is based:
(Identify each assumption and clarification.)

Reference Attachment A: Guaranteed Maximum Price dated September 23, 2022, Assumptions Item No's 1 – 8 and Exclusions Item No's 1 – 48.

§ A.3.1.7 The Guaranteed Maximum Price is based upon the following other documents and information:
(List any other documents or information here, or refer to an exhibit attached to this Amendment.)

ATTACHMENT A: Guaranteed Maximum Price dated September 27, 2022
ATTACHMENT B: Cost Reduction Log dated September 27, 2022
ATTACHMENT C: Project Schedule dated September 27, 2022
ATTACHMENT D: Enumeration of Contract Documents dated September 27, 2022
ATTACHMENT E: Construction Manager's Equipment Rental Rates

ARTICLE A.4 CONSTRUCTION MANAGER'S CONSULTANTS, CONTRACTORS, DESIGN PROFESSIONALS, AND SUPPLIERS

§ A.4.1 The Construction Manager shall retain the consultants, contractors, design professionals, and suppliers, identified below:

(List name, discipline, address, and other information.)

Not applicable

This Amendment to the Agreement entered into as of the day and year first written above.

PROSSER PUBLIC HOSPITAL DISTICT No. 1	**BOUTEN CONSTRUCTION COMPANY**
Craig T. Marks	Wm O. Bo
OWNER *(Signature)*	**CONSTRUCTION MANAGER** *(Signature)*
Craig T. Marks, CEO	William O. Bouten, CEO
(Printed name and title)	*(Printed name and title)*

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Prosser Memorial Health Replacement Hospital
Prosser Memorial Health
Prosser, WA
Attachment A
Guaranteed Maximum Price
September 27, 2022

ITEM	DESCRIPTION	GMP Total Cost	Notes
BID PACKAGES			
1	Earthwork & Site Utilities (Big D's)	$ 2,172,111	15
2	Building Concrete (Fowler)	5,798,500	
3	Structural Steel Supply (Spokane Metals)	2,066,117	14
4	Structural Steel Erect (AIE)	855,880	14
5	Metal Building (G2)	176,000	
6	Applied Fireproofing (Advanced)	289,700	
7	Masonry (PMI)	168,500	
8	EIFS (Generation)	752,700	
9A	Roofing (MGW)	2,463,976	
9B	Sheet Metal/Flashing (MGW)	583,778	
10	Metal Panel (Flynn)	1,195,000	
11	Glazing, Storefront, ICU Doors (Perfection)	2,402,085	
12	General Works (BCC)	1,459,000	
13	Casework & Millwork (PCI)	2,449,021	
14	Door & Hardware Supply (Yadon)	1,208,269	
15	Door & Hardware Install (BCC)	328,864	
16	Overhead Coiling Doors (Dupree)	50,928	
17	Framing, Drywall, Insulation (DWI)	4,251,400	
18	Floor Covering (Great Floors)	899,409	
19	Terrazzo Flooring (North American Terrazzo)	148,570	
20	Ceramic Tile (Great Floors)	426,146	
21	Acoustical Ceilings & Treatments (ACI)	794,330	
22	Paints & Coatings (Paintmaster)	574,740	
23	Wall Coverings (Paintmaster)	98,365	
24	Interior Specialties (BCC)	1,931,000	10
25	Window Coverings (Valley Shade)	146,271	
26	Elevators (Otis)	510,000	
27	Pneumatic Tube (Swisslog)	315,000	
28	Fire Suppression (Fire Control)	735,000	
29	HVAC & Plumbing (Apollo)	13,254,812	
30	Electrical & Systems (Garrett)	15,504,510	6
31	Asphalt Paving Markings (Inland)	442,000	3
32	Site Concrete (TSS)	446,508	
33	Landscape & Irrigation (Bagley)	497,363	5
34	Fencing (NWF)	137,784	
35	**Subtotal**	**$ 65,533,637**	

BOUTEN CONSTRUCTION COMPANY

Prosser Memorial Health Replacement Hospital
Prosser Memorial Health
Prosser, WA
Attachment A
Guaranteed Maximum Price
September 27, 2022

Prosser Memorial Health

ITEM	DESCRIPTION	GMP Total Cost	Notes
ALLOWANCES (Reference AIA 201, Section 3.8)			
36	Imaging Department Buildout (MRI/CT/X-Ray)	$ 1,000,000	1
37	Unsuitable Soils/Boulders Over 2'	50,000	7
38	Vapor Barrier at Deck Termination	50,000	8
39	Door Hardware Discrepancies	40,000	11
40	Site Concrete Slab Thicknesses at O2 Tank	25,000	12
41	OFCI Unknowns	25,000	13
42	Builders Risk Policy	100,000	16
43	Accepted Cost Reduction Items	(2,962,269)	2
44	**Subtotal**	**$ (1,672,269)**	
	Subtotal	**$ 63,861,368**	
GENERAL CONDITIONS, OVERHEAD, CONTINGENCY			
45	Negotiated Support Services	2,034,352	
46	Specified General Conditions	2,972,814	
47	Construction Manager Bond	434,778	
	Subtotal	**$ 69,303,312**	
48	Construction Manager's Contingency (3.25%)	2,252,358	
	Maximum Allowable Construction Cost (MACC)	**$ 71,555,669**	
49	Fee (4.55%)	3,255,783	4
50	**Guaranteed Maximum Price (GMP) Excluding WSST**	**$ 74,811,452**	

NOTES

1 The design is not complete for the Imaging Department; therefore a contract Allowance is being carried to fund the yet-to-be defined scope of work for this space. Once the design is complete Bouten will submit a final price to reflect the final design and scope of work. An increase or decrease adjustment to the GMP will be made per AIA 201, Section 3.8 once the current Allowance amount is reconciled with the actual cost. The GMP only includes work shown in the Contract Documents for the Imaging Department.

2 Reference Attachment B Cost Reduction Log dated 9/22/22. The Owner has accepted and a portion of the alternate and cost reduction items totaling ($2,975,586). The Architect will incorporate all cost reduction items into the Contract Documents, including the plans and specifications via a narrative and either a conformed set of Contract Documents or an Architectural Supplemental Instruction (ASI) which will be issued to the Construction Manager no later than November 1, 2022. Once issued, the Construction Manager will confirm the ASI includes all items and inform the Owner and Architect if any further information is missing or shall be required. The Construction Manager will then confirm the actual savings amount with 20 working days. The current allowance of ($2,975,586) will be adjusted via Change Order to reflect the actual savings amount. The Schedule of Values will reflect the final line-item costs including accepted the cost reduction amounts.

3 Asphalt paving scope is tied to Asphalt Binder Reference Cost published by the Washington State Department of Transportation pricing for asphalt. The GMP will be adjusted by an additive or deductive Change Order to reflect actual pricing of the asphalt product when the material is installed.

4 Fee includes General Liability Insurance and B&O Tax per contract.

5 Landscape scope has yet to be defined and is being carried as an allowance. See Cost Reduction BP33-01 in Attachment B.

6 Electrical pricing per line item no. 30 excludes the light fixture cost reduction proposed by JC Wright. See cost reduction BP30-01 in Attachment A for approved light fixture savings.

7 Per the Geotech report, bedrock is below the limits of excavation and is excluded. The unsuitable soil allowance (no. 37) includes removal, export and replacement of approximately 1,000 cubic yards of unsuitable soil/boulder excavation over 2'. An additive or deductive Change Order will be issued to adjust the GMP to account for more or less than 1,000 cubic yards of unsuitable material if required.

8 Details for fluid applied membrane at deck termination appear incomplete and may require additional membrane not identified in the Contract Documents. Allowance (no. 38) is included to cover approximately 10,000sf of additional fluid applied membrane if required. An additive or deductive Change Order will be issued to adjust the GMP to account for more or less than 10,000sf of additional material.

9 Pricing is based upon the following documents and information:
a. Bid Set documents as provided by bcDG dated 7/29/2022.
b. Bid packages as issued by Bouten dated August 1, 2022.
c. Addenda 1-3 issued August 5, August 12, and August 19, 2022 respectively.

10 Cubicle curtains are included as CFCI per Contract Documents.

11 Per request from Architect, this allowance (no. 39) is being carried to clean up known hardware group discrepancies that were identified at bid time but not clarified via Addendum.

12 Contract documents show site concrete as 6" thick at all equipment locations. Concrete at the Oxygen Tank will likely need to be thicker than 6". An allowance (no. 40) is being carried to increase the thickness at this location.

13 The allowance (no. 41) is to cover additional OFCI items that are not identified in the Contract Documents but are commonly added towards the end of the project.

14 Medical equipment supports are not shown on architectural or structural drawings. MACC includes supply and install of 35 structural steel supports per medical equipment plans.

15 The following unit prices shall apply to additive/deductive scope for this package and include all markups except Washington State Sales Tax:
Replace Unsuitable Soil with Clean Fill: Add $35.98/cy
Additional Import/Export: Add $29.44/cy
Rock/Boulder Excavation Over 2 Including Import/Export: Add $70.88/cy

16 This allowance (no. 42) is being carried for the Construction Manager to provide the Builders Risk Policy.

ASSUMPTIONS

1 Plumbing proposal is based on using Symmons faucets in lieu of the specific faucets.
2 GMP assumes resolution of AIA 133 and AIA 201 contract comments to mutually agreeable terms.
3 Per specification 05 7000, AF17 is not used and AF6 has been designated as OFOI.
4 The GMP assumes and as discussed with the civil engineer, no export will be required. If the actual conditions differ, a Change Order to adjust the GMP will be issued to cover the additional costs to export soil and the unit rate listed in note 15 will apply.
5 MACC is based on releasing shop drawings for AHU's and Chillers by 9/30/22. There will be a cost increase if released after this date.
6 Utility consumption during construction shall be paid by the Owner.
7 Project schedule assumes a 24 month construction duration as of the Date of Commencement listed in Exhibit A, Article A.2. A start date beyond this may result in additional costs.
8 Per Geotech Report, all test pits for site are within the building footprint. All work outside of test areas is assumed to have same Geotech conditions.

EXCLUSIONS

1. Owner contingency.
2. Design and engineering services including engineering of structural connection details per Note 3/S300 and Specification 051200.15.D.
3. Special inspection and testing fees. Specification 01 400-1.11A.
4. Good Faith survey and HAZ MAT abatement.
5. Owner provided fixtures, furnishings and equipment, mobile exam tables, moveable desks and chairs. Install only by Bouten if listed as OFCI in Contract Documents.
6. Artwork and visual graphics packages.
7. State/Federal or Health Dept safety requirements for construction personnel implemented after 9/8/22.
8. Commissioning.
9. Site Survey and geotechnical studies.
10. Subsurface rock removal and blasting.
11. Furnish and install of all Kitchen Equipment. Utility connections are included as indicated on MEP drawings.
12. Contaminated soils including pesticides or other agriculture-related chemicals if encountered.
13. Permanent or temporary de-watering.
14. Traffic studies.
15. Seismic engineering of equipment. This MACC assumes that the specified equipment meets the seismic requirements for the project.
16. Window coverings other than roller shades & film where required in documents.
17. ABBA requirements for air barrier installation per 07 2726-1.4A & 1.5A.
18. General Facility Charges (GFCs), meter fees and tap fees.
19. Interior/Exterior signage other than indicated on contract documents.
20. Lead or copper shielding (See imaging allowance).
21. Exterior sculptures or wayfinding.
22. The GMP is based upon Benton County Prevailing Wage rates that were published on or before August 30, 2022. If it is determined that the rates in effect after August 30, 2022 apply; an adjustment via Change Order shall be issued to cover the increase in the hourly rate.
23. Bonding of 3rd tier subcontractors.
24. Specification Section 26 4113 - Lightning protection (not required).
25. Building ground ring per Specification Section 26 0526 (not required).
26. Concrete warning planks at underground electrical duct per Specification Section 26 0543-2.2.C.3.
27. Aerosolized duct sealing per specification section 23 3113-3.5D.
28. Pre-occupancy duct cleaning per specification section 23 3113-3.5D. Duct will be protected during construction.
29. Helistop pad and associated lighting. See Attachment B, ALT-3.
30. Cost impacts related to un-answered/incorporated constructability review comments per Comment Review Log dated 7/18/22.
31. Washington State Sales Tax (WSST).
32. Plan review and permit fees including any DOH or L&I fees for document review and permit.
33. Vestibules at AHU 1,2 & 4.
34. Electronic air cleaners per specification section 23 4100-2.1.3.
35. Warranty on exterior insulated glazing units with window film specified. Glazing manufacturer will not warranty units with an added film.
36. Light fixture S2 is excluded from base bid.
37. Unistrut supports for medical equipment, i.e. 9/S303.
38. PVC coated GRC conduit at slab penetrations per specification section 26 0543-3.6.E.
39. TV's will be OFCI.
40. Items noted as OFVI or VFVI per Note #5/G000. Only installation of OFCI or CFCI items are included.
41. 3rd Party Envelope/QC Consultant shall be provided by Owner including 3rd party air and water testing as required by specification section 08 4413-3.5
42. Fireproofing designated for exterior use per Spec 07 8100-2.2.A.2.
43. Elevator fire command center annunciator panel per Spec 14 2123.16-.2.9J. This is not a code requirement except for high rise over 75'.
44. Code required work not specifically shown on the Contract Documents.
45. Rock blasting.

BOUTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

Current GMP (without deductive VE Allowance):	$ 78,028,799
Estimated Cost Reduction (Excluding Markup):	$ (2,962,269)
Estimated Cost Reduction (With Markup):	$ (3,217,347)
Proposed GMP w/Scope Adjustments:	$ 74,811,452

ITEM#	DESCRIPTION	MAX VE	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP-02	**CONCRETE**					
BP02-01	**Shrinkage Reducing Admixture in Concrete Ready-mix** Base Bid Scope: Ready mix includes shrinkage reducing admixture Cost Reduction Description: Eliminate shrinkage reducing admixture requirement (this requirement is more common with exposed concrete floors)	X	$ (70,000)	$ (76,028)	Accept	9/8: Pricing received from HD Fowler
BP02-02	**Plaza Concrete Planter and Seat Walls** Base Bid Scope: CIP concrete planter walls and seat walls per plan. Cost Reduction Description: Eliminate planter walls and seat walls in Courtyard	X	$ (50,000)	$ (54,305)	Accept	9/8: Pricing received from HD Fowler
BP-09A	**ROOFING**					
BP09A-01	**Roof Attachment System** Base Bid Scope: Fully adhered roof membrane on mechanically attached insulation Cost Reduction Description: Mechanically attach full roof system	X	$ (104,258)	$ (113,236)	Accept	
BP09A-02	**Roof Substrate Board** Base Bid Scope: Substrate board included at metal roof deck location Cost Reduction Description: Eliminate substrate board at non-UL fire rates assembly areas- rigid insulation to span deck flutes	X	$ (76,227)	$ (82,791)	Accept	9/14: Design team has found alternate UL assembly for fire rated roof assembly be needs pricing confirmation from Bouten Team 9/15: Can accept once value is presented 9/19: Updated pricing received from MG Wagner reflecting savings only at non-UL rated areas
BP-10	**METAL PANELS**					
BP10-01a	**Column Cover Cladding (Paint Finish)** Base Bid Scope: Column covers with wood-grain painted finish Cost Reduction Description: Standard mono-color paint finish		$ (17,300)	$ (18,790)	Deferred Alt	8/31: John @ Flynn will provide pricing by 9/6 9/7: Received pricing from Flynn
BP10-02	**Metal Soffit Panels** Base Bid Scope: Soffit panels per drawings & specs Cost Reduction Description: Revise fascia panel profile to ???	X	$ (43,000)	$ (46,703)	Accept	8/31: John @ Flynn will provide pricing by 9/6 9/6: Flynn to provide a cut sheet for proposed metal panel 9/7: Received pricing from Flynn
BP10-03	**Flashing Detail at Top of Metal Panels** Base Bid Scope: Included 1970lf of flashing at top of metal panel wall at parapet due to bid package requirement for "complete system". This flashing is likely not required due to the parapet cap providing closure. Cost Reduction Description: Eliminate 1970 lf of top-of-wall flashing at metal panel.	X	$ (12,000)	$ (13,033)	Accept	8/31: John @ Flynn will provide pricing by 9/6 9/7: Received pricing from Flynn
BP-11	**GLAZING**					
BP11-02	**Exterior Glazing Temporary Enclosure** Base Bid Scope: Bid package language requires temporary plywood panels at storefront framing until glass arrives. Cost Reduction Description: Provide guaranteed measurements for storefront to allow early procurement so glazing can be installed with storefront framing at the same time, eliminating temp plywood infill panels.	X	$ (56,200)	$ (61,039)	Accept	8/31: Bryce @ Perfection to confirm ROMs via email in the next 2-3 days 9/8: Received pricing from Perfection
BP-13	**CASEWORK**					
BP13-01	**Pull Hardware** Base Bid Scope: HD-2 pull hardware (per plans & specs) Cost Reduction Description: Revise pull hardware to PCI Standard Pull	X	$ (9,852)	$ (10,700)	Accept	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: PCI to provide cut sheet
BP13-02	**Drawer Slides** Base Bid Scope: Soft close slides (per plans & specs) Cost Reduction Description: Revise pull hardware to PCI Standard Slides	X	$ (2,179)	$ (2,367)	Accept	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: PCI to provide cut sheets
BP13-03	**Solid Surface Countertop (Manufacturer)** Base Bid Scope: Solid Surface Countertop type SS-3 Wilsonart (per plans & specs) Cost Reduction Description: Revise Solid Surface Countertop to Corian Group 2	X	$ (15,000)	$ (16,292)	Deferred Alt	8/31: Received pricing via email from Paul Foresman @ PCI 9/6: BCDG open to exploring - will review Group 2 colors 9/14: Artic Ice (from Group 2) is acceptable to the Design Team, but is drastically different than the approved finish and needs PMH review/approval
BP13-05	**Dust Panels at Drawers** Base Bid Scope: Dust panel at drawers included per plans and specs Cost Reduction Description: Remove dust panels at all drawers	X	$ (6,345)	$ (6,891)	Accept	8/31: Received pricing via email from Paul Foresman @ PCI

BOUTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	MAX VE	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP-14	**DOOR SUPPLY**					
BP14-01b	**Auto-Door Operators** Base Bid Scope: Besam door operators Cost Reduction Description: Norton 6300 operators (Hold 25% back for select Besam Locations)		$ (48,329)	$ (52,490)	Accept	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB In our opinion, the Norton operators are not as heavy-duty as the Besam operators specified. (For instance, Norton has a lower door weight limit - 250lbs vs 700lbs). While the Norton may work fine, we would not anticipate it having as long a lifespan as the specified product. (And we'd probably need the Besam operators on the lead-lined doors.)
BP14-02	**Wood Door (Manufacturer)** Base Bid Scope: Lynden Door w/no added urea formaldehyde Cost Reduction Description: Masonite door and eliminate the "No Added Urea Formaldehyde" requirement	X	$ (39,277)	$ (42,659)	Accept	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB: Assuming the 1-3/4" thick version of the LD Series is provided, the additional blocking needed to meet WDMA 1S-1A is provided,, and the species, grain, finish, etc. match the specified finishes, we have no issues with this substitution
BP14-03	**Metal Door Frame (Weld Configuration)** Base Bid Scope: Door frames have a full profile weld Cost Reduction Description: Eliminate the requirement for "Full profile weld" at 75% of Frame Locations. Frames provided by bidder are die mitered and notched so they only need to be face welded.	X	$ (11,675)	$ (12,680)	Accept	9/2: Received pricing via email from David @ Yardon Specialties 9/6: BCDG-HB: While face welded frames, as provided in this deduct, comply with the ANSI/SDI Heavy Duty requirements, they are not as stout as the full profile welded frames specified, which is why we don't spec them as our standard. Our recommendation would be to leave full profile welded frames at exterior openings, lead-lined, and double door openings, while switching standard, interior openings to face welded.
BP14-04	**Electrified Door Hardware** Base Bid Scope: Electrified lockets hardware per spec (wired through door) Cost Reduction Description: Revise HW Set 8,11, &36 to Storeroom Lock with electric strike (similar to HW Set 8.1)	X	$ (27,351)	$ (29,706)	Accept	9/8: Need further definition on VE scope (proposed product and locations) 9/13: Pricing received from Yadon Supply
BP-17	**DRYWALL & INSULATION**					
BP17-01b	**Drywall Partition Stud Framing** Base Bid Scope: Partitions per Plans & Specs Cost Reduction Description: Revise (stud) G60 coating to G40 at interior studs at all locations	X	$ (36,500)	$ (39,643)	Accept	9/21: Added to log - pricing provided by Drywall Interiors
BP-24	**INTERIOR SPECIALTIES**					
BP24-01b	**Wall Protection - Option B** Base Bid Scope: Wall protection included per drawings & specs Cost Reduction Description: Deduct wall protection from all storage rooms except Materials Management Storage Room		$ (31,721)	$ (34,452)	Deferred Alt	9/15: Added to log 9/15: Dupree (vendor) is out of town until Monday 9/19. Anticipating pricing is at least a week out from today (apx 9/22). 9/15: Moved deferred alt 9/21: RCC-SPW provided pricing
BP24-02b	**Operable Partition - Option B** Base Bid Scope: Skyfold operable partition (Zenith 52) included per plans & specs Cost Reduction Description: Skyfold operable partition revised to Zenith 48		$ (39,302)	$ (42,686)	Accept	9/14: Added to log 9/15: Dupree (vendor) is out of town until Monday 9/19. Anticipating pricing is at least a week out from today (apx 9/22). 9/21: Rec'd pricing from Dupree
BP-26	**ELEVATORS**					
BP26-01	**Elevator Cab Finish** Base Bid Scope: Provide interior elevator finishes as specified. Cost Reduction Description: Provide raised laminate panels from manufacturer standard selection.	X	$ (20,000)	$ (21,722)	Accept	9/7: Pricing received from Otis, need to review and confirm.
BP-27	**PNEUMATIC TUBE**					
BP26-01	**Pneumatic Tube System** Base Bid Scope: Pneumatic tube system included. Cost Reduction Description: Eliminate pneumatic tube system	X	$ (319,000)	$ (346,469)	Accept	9/15: PMH proposed and accepted
BP-29	**HVAC & PLUMBING**					
BP29-02	**Fire Smoke Damper Monitoring** Base Bid Scope: Fire smoke dampers are monitored in the HVAC control system Cost Reduction Description: Eliminate fire smoke damper monitoring (54 dampers)	X	$ (57,780)	$ (62,755)	Accept	9/21 Received pricing from Apollo
BP29-04a	**Direct Digital Control System - Occupancy Sensors** Base Bid Scope: DDC points per plans and specs Cost Reduction Description: Occ Sensor Monitoring Deduct	X	$ (5,313)	$ (5,770)	Accept	9/19: Apollo to provide credit for Zone Occupancy, OSA measurement at AHU's and pulling feedback from controllers. 9/21: Rec'd pricing from Apollo Can be combined with BP29-04b

BOULTEN CONSTRUCTION COMPANY

ATTACHMENT B
COST REDUCTION LOG

Prosser Memorial Health

ITEM#	DESCRIPTION	MAX VE	DIRECT COST	ESTIMATED SAVINGS (GMP)	STATUS	COMMENTS
BP29-05	**Eliminate Glycol from Water Treatment** Base Bid Scope: Include glycol per water treatment specs Cost Reduction Description: Eliminate glycol including feeders.	X	$ (102,000)	$ (110,783)	Accept	9/19: Apollo to confirm credit. Henderson to confirm glycol was not intended. Equipment was specified based on water and not glycol. 9/21: Received pricing from Apollo
BP-30	**ELECTRICAL & LOW VOLTAGE**					
BP30-01	**Lighting Value Engineering Package (excluded type S2)** Base Bid Scope: Fixture package per drawings Cost Reduction Description: JC Wright light fixture package with VE options reviewed and approved by design team	X	$ (268,439)	$ (291,554)	Accept	6/22: Excludes Type S2 (strip fixture at perimeter of building - not included in base bid). See next item down. 6/22: Need to follow up an confirm wattage calcs proposed are in line with energy credits. 9/8: Received pricing from Garrett. $146,985 savings is included in the base bid price. Remaining VE includes -$4798 for Type 3C, -$47,067 for Type SB2 bollard, & -$69,589 for type P9 rings
BP30-10	**Delete TV Distribution Equip Per Spec 27 2133** Base Scope: TV Distribution over twisted pair with provisions for both local cable service AND satellite service distribution. Proposed Alternative: Delete spec section 27 4133 for Z Band Head end equipment/cabling.	X	$ (134,400)	$ (145,973)	Accept	6/22: ROM pricing 6/22: Base bid system allows a "local channel" option to broadcast menu, hospital information, etc 9/16: Only a single CAT 6 network drop behind each TV is required. No twisted pair or head end equipment is required.
BP30-11	**PA System Control Via OFOI Phone System in Lieu of Stand-Alone Master Controls** Base Scope: Specified stand alone master control station for public address system Cost Reduction Description: Public address functionality handled over Owner provided phone system (ie dial an extension for public broadcast)	X	$ (11,200)	$ (12,164)	Accept	6/22: ROM pricing 6/22: Specified system allows only operator station to have access to PA station. 9/19: Phillip recommends this VE because phones can be over ridden.
BP30-16	**Reduce CAT6 Cable at Each Wall Box from 2 to 1** Base Bid Scope: 2 Data Drops at Each Wall Box Cost Reduction Description: 1 CAT 6 cable at each wall box.	X	$ (13,584)	$ (14,754)	Accept	9/16: Only 1 CAT 6 cable required at each TV location. GEC to provide credit for second drop. 9/19: Received pricing from Garrett
BP-33	**LANDSCAPING**					
BP33-01	**Landscape Allowance** Base Scope: Landscaping per Design/Build Bid Proposals Cost Reduction Description: Target $200k Allowance ILO Bid Numbers for Landscape	X	$ (325,319)	$ (353,332)	Accept	
ALT:02	**OMMIT PRE-ENGINEERED METAL BUILDING**	**X**	$ (416,398)	**$ (452,254)**	Deferred Alt	
ALT-03	**ADD HELIPAD**		$ 65,589	**$ 71,237**	Further Review	
ALT-06	**REVISE 3Form DIMENSIONAL PANELS TO GYP w/ACCENT PAINT**	**X**	$ (113,659)	**$ (123,446)**	Further Review	
ALT-13	**MOISTURE BOARD ILO DENSGLASS AT WALL TOPOUTS**	**X**	$ (32,500)	**$ (35,299)**	Accept	
ALT-15	**REVISE ELEVATORS TO HYDRAULIC**	**X**	$ (135,000)	**$ (146,625)**	Accept	
ALT-17	**OMIT ONCOLOGY BUILDOUT - AREA BECOMES STORAGE**	**X**	$ (424,821)	**$ (461,402)**	Deferred Alt	

VE SUMMARY REPORT		
Accepted VE	$ (2,057,029)	$ (2,234,157)
Deferred Alternates	$ (905,240)	$ (983,189)
Add Back Scope	$ -	$ -
Subtotal: Total Estimated Scope Adjustments	**$ (2,962,269)**	**$ (3,217,347)**
Recommended VE	$ -	$ -
Items Requiring Further Review (Deducts)	$ (118,279)	$ (123,446)
Items Requiring Further Review (Adds)	$ 70,209	$ 71,237
Total: Best Case Scenario	$ (3,010,339)	$ (3,269,556)

EXHIBIT A
Guaranteed Maximum Price Amendment

ATTACHMENT D
Enumeration of Contract Documents
Date: September 27, 2022

Drawings as prepared by bcDESIGNGROUP, dated July 29, 2022, including:

- *Bouten Addendum No. 01 issued August 5, 2022*
- *Bouten Addendum No. 02 issued August 12, 2022*
- *Bouten Addendum No. 03 issued August 19, 2022*

Sheet No.	Title	Dated
COVER	PROJECT INFORMATION	7/29/2022
C001	GENERAL NOTES	7/29/2022
C002	TOPOGRAPHIC SURVEY	7/29/2022
C100	DEMOLITION & STORMWATER POLLUTION PREVENTION PLAN	7/29/2022
C200	OVERALL SITE PLAN & VEGETATIVE COVERINGS	7/29/2022
C201	SITE PLAN 1	7/29/2022
C202	SITE PLAN 2	8/19/2022
C203	SITE PLAN 3	7/29/2022
C204	SITE PLAN 4	7/29/2022
C205	CANOPY & MECHANICAL ROOM DROP SIDEWALK BLOWUPS	7/29/2022
C300	OVERALL GRADING PLAN	7/29/2022
C301	GRADING PLAN 1	7/29/2022
C302	GRADING PLAN 2	7/29/2022
C303	GRADING PLAN 3	7/29/2022
C304	GRADING PLAN 4	7/29/2022
C305	DOCK CROSS SECTIONS	7/29/2022
C400	OVERALL UTILITY PLAN	7/29/2022
C401	UTILITY PLAN 1	7/29/2022
C402	UTILITY PLAN 2	7/29/2022
C403	UTILITY PLAN 3	7/29/2022
C404	UTILITY PLAN 4	7/29/2022
C501	ENTRANCE DRIVE PLAN & PROFILE	7/29/2022
C502	NORTH DRIVE PLAN & PROFILE	7/29/2022
C503	STORM SEWER LINE A, B, C & D PLAN & PROFILE	7/29/2022
C504	STORM SEWER LINE E, F, G & H PLAN & PROFILE	7/29/2022
C505	SANITARY SEWER LINE A & WATERLINE A (STA.0+00-10+00) PLAN & PROFILE	7/29/2022
C506	WATERLINE A (STA. 10+00-20+55) PLAN & PROFILE	7/29/2022
C601	DETAIL SHEET 1	7/29/2022
C602	DETAIL SHEET 2	7/29/2022
C603	DETAIL SHEET 3	7/29/2022

Sheet No.	Title	Dated
G000	GENERAL NOTES + LEGEND	07.29.2022
G001	UL DETAILS	07.29.2022
G002	UL DETAILS	07.29.2022
G003	UL DETAILS	07.29.2022
G004	UL DETAILS	07.29.2022
G005	UL DETAILS	07.29.2022
G100	1ST & 2ND FLOOR CODE PLANS	07.29.2022
G101	1ST FLOOR CODE PLAN -AREA A	07.29.2022
G102	1ST FLOOR CODE PLAN -AREA B.1	07.29.2022
G103	1ST FLOOR CODE PLAN -AREA B.2	08.19.2022
G104	1ST FLOOR CODE PLAN -AREA C	07.29.2022
G105	1ST FLOOR CODE PLAN -AREA D	07.29.2022
G201	2ND FLOOR CODE PLAN -AREA A	07.29.2022
G202	2ND FLOOR CODE PLAN -AREA B	07.29.2022
AS100	ARCHITECTURAL SITE PLAN	07.29.2022
AS101	COURTYARD SITE PLAN -ENLARGED PLANS & DETAILS	07.29.2022
AS102	SITE DETAILS	07.29.2022
A110	OVERALL 1ST FLOOR PLAN	07.29.2022
A115	1ST FLOOR NOTED PLAN - A + E	07.29.2022
A116	1ST FLOOR NOTED PLAN - B	07.29.2022
A117	1ST FLOOR NOTED PLAN - C	07.29.2022
A118	1ST FLOOR NOTED PLAN - D	08.18.2022
A120	OVERALL 2ND FLOOR PLAN	07.29.2022
A122	2ND FLOOR NOTED PLAN - A + B	07.29.2022
A130	ENLARGED PLANS	07.29.2022
A131	ENLARGED PLANS	07.29.2022
A132	ENLARGED PLANS	07.29.2022
A133	ENLARGED STAIR + ELEVATOR PLANS AND DETAILS	07.29.2022
A140	ROOF PLAN -AREA A	07.29.2022
A141	ROOF PLAN -AREA B	07.29.2022
A142	ROOF PLAN	07.29.2022
A150	SLAB EDGE	07.29.2022
A200	OVERALL 1ST FLOOR RCP	07.29.2022
A211	1ST FLOOR RCP AREA - A + E	07.29.2022
A212	1ST FLOOR RCP AREA -B	07.29.2022
A213	1ST FLOOR RCP AREA - C	07.29.2022
A214	1ST FLOOR RCP AREA - D	07.29.2022
A220	OVERALL 2ND FLOOR RCP	07.29.2022
A221	2ND FLOOR RCP AREA - A + B	07.29.2022
A230	RCP DETAILS	07.29.2022
A231	RCP DETAILS	07.29.2022
A300	EXTERIOR ELEVATIONS	07.29.2022
A301	EXTERIOR ELEVATIONS	08.18.2022
A302	EXTERIOR ELEVATIONS	07.29.2022
A303	EXTERIOR ELEVATIONS	07.29.2022
A304	EXTERIOR VIEWS	07.29.2022
A400	BUILDING SECTIONS	07.29.2022
A410	WALL SECTIONS	07.29.2022

Sheet No.	Title	Dated
A411	WALL SECTIONS	07.29.2022
A412	WALL SECTIONS	07.29.2022
A413	WALL SECTIONS	07.29.2022
A414	WALL SECTIONS	07.29.2022
A415	WALL SECTIONS	07.29.2022
A416	WALL SECTIONS	07.29.2022
A417	WALL SECTIONS	07.29.2022
A418	WALL SECTIONS	07.29.2022
A419	WALL SECTIONS	07.29.2022
A420	WALL SECTIONS	07.29.2022
A421	WALL SECTIONS	07.29.2022
A422	WALL SECTIONS	07.29.2022
A423	WALL SECTIONS	07.29.2022
A424	WALL SECTIONS	07.29.2022
A425	WALL SECTIONS	07.29.2022
A426	WALL SECTIONS	07.29.2022
A427	STAIR SECTIONS	07.29.2022
A428	STAIR SECTIONS	07.29.2022
A429	STAIR SECTIONS	07.29.2022
A430	ELEVATOR SECTIONS	07.29.2022
A500	PLAN DETAILS	07.29.2022
A501	PLAN DETAILS	07.29.2022
A502	PLAN DETAILS	07.29.2022
A503	PLAN DETAILS	07.29.2022
A504	PLAN DETAILS	07.29.2022
A550	SECTION DETAILS	08.18.2022
A551	SECTION DETAILS	08.18.2022
A552	SECTION DETAILS	08.18.2022
A553	SECTION DETAILS	08.18.2022
A554	SECTION DETAILS	08.18.2022
A555	SECTION DETAILS	07.29.2022
A556	SECTION DETAILS	07.29.2022
A557	SECTION DETAILS	07.29.2022
A558	SECTION DETAILS	07.29.2022
A559	SECTION DETAILS	07.29.2022
A560	MISC. DETAILS	07.29.2022
A600	INTERIOR ELEVATIONS	07.29.2022
A601	INTERIOR ELEVATIONS	07.29.2022
A602	INTERIOR ELEVATIONS	07.29.2022
A603	INTERIOR ELEVATIONS	07.29.2022
A604	INTERIOR ELEVATIONS	07.29.2022
A605	INTERIOR ELEVATIONS	07.29.2022
A606	INTERIOR ELEVATIONS	07.29.2022
A607	INTERIOR ELEVATIONS	07.29.2022
A608	INTERIOR ELEVATIONS	07.29.2022
A609	INTERIOR ELEVATIONS	07.29.2022
A610	INTERIOR ELEVATIONS	07.29.2022
A611	INTERIOR ELEVATIONS	07.29.2022

Sheet No.	Title	Dated
A612	INTERIOR ELEVATIONS	07.29.2022
A613	INTERIOR ELEVATIONS	07.29.2022
A614	INTERIOR ELEVATIONS	07.29.2022
A615	INTERIOR ELEVATIONS	07.29.2022
A616	INTERIOR ELEVATIONS	07.29.2022
A617	INTERIOR ELEVATIONS	07.29.2022
A618	INTERIOR ELEVATIONS	07.29.2022
A700	CASEWORK SECTIONS	07.29.2022
A701	CASEWORK SECTIONS	07.29.2022
A702	CASEWORK SECTIONS	07.29.2022
A800	DOOR SCHEDULE	07.29.2022
A801	DOOR SCHEDULE	07.29.2022
A801.1	DOOR SCHEDULE	07.29.2022
A802	DOOR DETAILS	07.29.2022
A803	DOOR DETAILS	07.29.2022
A804	WINDOW SCHEDULE	07.29.2022
A805	WINDOW SCHEDULE	07.29.2022
A806	WINDOW SCHEDULE	07.29.2022
A807	WINDOW SCHEDULE	08.18.2022
A808	WINDOW SCHEDULE	07.29.2022
A809	WINDOW SCHEDULE	07.29.2022
A900	FINISH PLAN MATERIALS	07.29.2022
A910	FINISH PLAN -1ST FLOOR -AREA A + E	07.29.2022
A911	FINISH PLAN -1ST FLOOR -AREA B	07.29.2022
A912	FINISH PLAN -1ST FLOOR -AREA C	07.29.2022
A913	FINISH PLAN -1ST FLOOR -AREA D	07.29.2022
A914	FIRST FLOOR -FINISH PLAN DETAILS	07.29.2022
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Specifications as prepared by bcDESIGNGROUP, dated July 29, 2022, including:

- *Bouten Addendum No. 01 issued August 5, 2022*
- *Bouten Addendum No. 02 issued August 12, 2022*
- *Bouten Addendum No. 03 issued August 19, 2022*

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00 0101	PROJECT TITLE PAGE	07.29.2022
RD 1942-A, Guide 19	Attachment 1, (1-15-79) "Advertisement for Bids"	07.29.2022
RD 1942-A, Guide 27	Attachment 2, (8-26-98) "Attachment to AIA Document A701-1997	07.29.2022
RD 1942-A, Guide 19	Attachment 3, (1-15-79) "Bid"	07.29.2022
RD 1942-A, Guide 19	Attachment 4, (1-15-79) "Bid Bond"	07.29.2022
RD 1940-Q, Exhibit A-1	(8-21-91) "Lobbying Certification"	07.29.2022
RD Form 400-6,	(Rev 4-00) "Compliance Statement"	07.29.2022
AD-1048	(1-92) "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion"	07.29.2022
RD 1942-A, Guide 27,	Attachment 4, (4/2011) "Attachment to AIA Document A201-2007"	07.29.2022
RD 1901-E, Exhibit D	(Rev 4/2011) "Goals and Timetables for Minorities and Women"	07.29.2022
RD 1942-A, Guide 19,	Attachment 7, (1-15-79) "Notice of Award"	07.29.2022
RD 1942-A, Guide 27	Attachment 3, (4/2011) "Attachment to AIA Document A101-2007"	07.29.2022
RD 1942-A, Guide 19	Attachment 6, (5-23-79) "Payment Bond"	07.29.2022
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RD 1942-A, Guide 18	Page 7, (2-19-86) "Certificate of Owner's Attorney"	07.29.2022
RD 1942-A, Guide 19	Attachment 8, (1-28-81) "Notice to Proceed"	07.29.2022
RD Form 1924-18	(6-97) "Partial Payment Estimate"	07.29.2022
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06 0640	ARCHITECTURAL WOODWORK	07.29.2022
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06 1600	SHEATHING	07.29.2022
06 2023	INTERIOR FINISH CARPENTRY	07.29.2022
06 4116	PLASTIC-LAMINATE-CLAD ARCHITECTURAL CABINETS	07.29.2022
06 6100	HYGIENIC WALL CLADDING	07.29.2022
06 6116	SOLID SURFACE FABRICATIONS	07.29.2022
07 1113	BITUMINOUS DAMPROOFING	07.29.2022
07 1413	HOT FLUID APPLIED WATERPROOFING	07.29.2022
07 2100	THERMAL INSULATION	07.29.2022
07 2419	WATER-DRAINAGE EXTERIOR INSULATION AND FINISH SYSTEM (EIFS)	07.29.2022
07 2726	FLUID-APPLIED MEMBRANE AIR BARRIERS	07.29.2022
07 4293	SOFFIT PANELS	07.29.2022
07 5423	THERMOPLASTIC-POLYOLEFIN (TPO) ROOFING	07.29.2022
07 6200	SHEET METAL FLASHING AND TRIM	07.29.2022
07 7100	ROOF SPECIALTIES	07.29.2022
07 7200	ROOF ACCESSORIES	07.29.2022
07 8100	APPLIED FIRE PROTECTION	07.29.2022
07 8123	INTUMESCENT FIRE PROTECTION	07.29.2022
07 8413	PENETRATION FIRESTOPPING	07.29.2022
07 8443	JOINT FIRESTOPPING	07.29.2022
07 9200	JOINT SEALANTS	07.29.2022
07 9500	EXPANSION JOINT COVER ASSEMBLIES	07.29.2022
08 1113	HOLLOW METAL DOORS AND FRAMES	07.29.2022
08 1416	FLUSH WOOD DOORS	07.29.2022
08 3113	ACCESS DOORS AND FRAMES	07.29.2022
08 3323	OVERHEAD COILING DOORS	07.29.2022
08 4113	ALUMINUM-FRAMED ENTRANCES AND STOREFRONTS	07.29.2022
08 4229.23	SLIDING AUTOMATIC ENTRANCES	07.29.2022
08 4243	INTENSIVE CARE UNIT/CRITICAL CARE UNIT (ICU/CCU) ENTRANCES	07.29.2022
08 4413	GLAZED ALUMINUM CURTAIN WALLS	07.29.2022
08 7100	DOOR HARDWARE	08.19.2022
08 8000	GLAZING	07.29.2022
08 8700	GLAZING SURFACE FILMS	07.29.2022
08 8853	SECURITY GLAZING	07.29.2022
09 2116	GYPSUM BOARD ASSEMBLIES	07.29.2022
09 2116.23	GYPSUM BOARD SHAFT WALL ASSEMBLIES	07.29.2022

Specification Section	Title	Dated
09 3013	CERAMIC TILING	07.29.2022
09 5113	ACOUSTICAL PANEL CEILINGS	07.29.2022
09 5426	SUSPENDED WOOD CEILINGS	07.29.2022
09 6513	RESILIENT BASE AND ACCESSORIES	07.29.2022
09 6516	RESILIENT SHEET FLOORING	07.29.2022
09 6519	LUXURY RESILIENT TILE FLOORING	07.29.2022
09 6623	RESINOUS MATRIX TERRAZZO FLOORING	07.29.2022
09 6723	RESINOUS FLOORING	07.29.2022
09 6813	TILE CARPETING	07.29.2022
09 7200	WALL COVERINGS	07.29.2022
09 7800	SOLID POLYMER FABRICATIONS	07.29.2022
09 8413	SUSPENDED ACOUSTIC PANELS AND BAFFLES	07.29.2022
09 9100	PAINTING	07.29.2022
09 9300	STAINING AND TRANSPARENT FINISHING	07.29.2022
09 9656	EPOXY COATINGS	07.29.2022
10 1100	VISUAL DISPLAY UNITS	07.29.2022
10 1123.16	FABRIC WRAPPED HOMASOTE PANELS	07.29.2022
10 1453	TRAFFIC SIGNAGE	07.29.2022
10 2113.17	PHENOLIC-CORE TOILET COMPARTMENTS	07.29.2022
10 2123	CUBICLE CURTAINS AND TRACK	07.29.2022
10 2126	WATER-PROOF WALL PANEL SYSTEM - WETWALL	07.29.2022
10 2239	VERTICALLY RETRACTABLE ACOUSTIC WALL	07.29.2022
10 2600	WALL AND DOOR PROTECTION	07.29.2022
10 2623.11	DECORATIVE PROTECTION PANELS	07.29.2022
10 2800	TOILET BATH AND LAUNDRY ACCESSORIES	07.29.2022
10 4413	FIRE PROTECTION CABINETS	07.29.2022
10 4416	FIRE EXTINGUISHERS	07.29.2022
10 5129	PHENOLIC LOCKERS	07.29.2022
10 5613	METAL STORAGE SHELVING	07.29.2022
10 7516	GROUND-SET FLAGPOLES	07.29.2022
11 1319	LOADING DOCK LEVELERS AND BUMPERS	07.29.2022
12 2113.23	SWITCHABLE PRIVACY GLASS	07.29.2022
12 2413	ROLLER WINDOW SHADES	07.29.2022
13 3419	METAL BUILDING SYSTEMS	07.29.2022
14 2123.16	MACHINE-ROOM-LESS ELECTRIC TRACTION PASSENGER ELEVATORS	07.29.2022
14 9200	PNEUMATIC TUBE SYSTEM	07.29.2022
20 0548	SEISMIC CONTROLS FOR MEP/F/T SYSTEMS	07.29.2022
21 0010	GENERAL FIRE SUPPRESSION REQUIREMENTS	07.29.2022
21 0500	COMMON WORK RESULTS FOR FIRE SUPPRESSION	07.29.2022
21 0515	BASIC FIRE SUPPRESSION PIPING METHODS AND MATERIALS	07.29.2022
21 0548	SEISMIC CONTROLS FOR FIRE SUPPRESSION	07.29.2022
21 0553	IDENTIFICATION FOR FIRE-SUPPRESSION PIPING AND EQUIPMENT	07.29.2022
21 0880	COMMISSIONING FOR FIRE SUPPRESSION	07.29.2022
21 1100	FIRE SUPPRESSION WATER SERVICE PIPING	07.29.2022
21 1313	WATER BASED FIRE SUPPRESSION SYSTEMS	07.29.2022
22 0010	GENERAL PLUMBING REQUIREMENTS	07.29.2022
22 0015	COORDINATION	07.29.2022
22 0500	COMMON WORK RESULTS FOR PLUMBING	07.29.2022

Specification Section	Title	Dated
22 0513	COMMON MOTOR REQUIREMENTS FOR PLUMBING EQUIPMENT	07.29.2022
22 0515	BASIC PIPING MATERIALS AND METHODS	07.29.2022
22 0519	METERS AND GAUGES FOR PLUMBING PIPING	07.29.2022
22 0523	GENERAL-DUTY VALVES FOR PLUMBING PIPING	07.29.2022
22 0529	HANGERS AND SUPPORTS FOR PLUMBING PIPING	07.29.2022
22 0548	SEISMIC CONTROLS FOR PLUMBING SYSTEMS	07.29.2022
22 0550	VIBRATION ISOLATION FOR PLUMBING PIPING & EQUIPMENT	07.29.2022
22 0553	IDENTIFICATION FOR PLUMBING PIPING & EQUIPMENT	07.29.2022
22 0700	PLUMBING INSULATION	07.29.2022
22 0800	COMMISSIONING FOR PLUMBING	07.29.2022
22 1100	WATER DISTRIBUTION PIPING & SPECIALTIES	07.29.2022
22 1111	MECHANICALLY JOINED PLUMBING PIPING SYSTEMS	07.29.2022
22 1123	DOMESTIC WATER PUMPS	07.29.2022
22 1300	SANITARY DRAINAGE & VENT PIPING & SPECIALTIES	07.29.2022
22 1400	STORM DRAINAGE PIPING & SPECIALTIES	07.29.2022
22 1489	SUMP PUMPS	07.29.2022
22 1500	GENERAL SERVICE COMPRESSED AIR SYSTEMS	07.29.2022
22 3100	WATER SOFTENERS	07.29.2022
22 3300	ELECTRIC DOMESTIC WATER HEATERS	07.29.2022
22 4000	PLUMBING FIXTURES	08.19.2022
22 6100	MEDICAL GAS & VACUUM SYSTEMS FOR HEALTH CARE FACILITIES	07.29.2022
22 6700	PURIFIED WATER SYSTEMS FOR HEALTHCARE FACILITIES	07.29.2022
23 0010	GENERAL MECHANICAL REQUIREMENTS	07.29.2022
23 0015	ELECTRICAL COORDINATION FOR MECHANICAL EQUIPMENT	07.29.2022
23 0500	COMMON WORK RESULTS FOR HVAC	07.29.2022
23 0510	BASIC PIPING MATERIALS AND METHODS	07.29.2022
23 0513	COMMON MOTOR REQUIREMENTS FOR HVAC EQUIPMENT	07.29.2022
23 0514	VARIABLE FREQUENCY DRIVES	07.29.2022
23 0516	EXPANSION FITTINGS AND LOOPS FOR HVAC PIPING	07.29.2022
23 0519	METERS AND GAUGES FOR HVAC PIPING	07.29.2022
23 0523	GENERAL-DUTY VALVES FOR HVAC PIPING	07.29.2022
23 0529	HANGERS AND SUPPORTS FOR HVAC PIPING AND EQUIPMENT	07.29.2022
23 0548	SEISMIC CONTROLS FOR MECHANICAL SYSTEMS	07.29.2022
23 0550	VIBRATION ISOLATION FOR HVAC	07.29.2022
23 0553	IDENTIFICATION FOR HVAC PIPING AND EQUIPMENT	07.29.2022
23 0593	TESTING, ADJUSTING, AND BALANCING FOR HVAC	07.29.2022
23 0700	HVAC INSULATION	07.29.2022
23 0800	COMMISSIONING OF HVAC	07.29.2022
23 0913	INSTRUMENTATION AND CONTROL DEVICES FOR HVAC	07.29.2022
23 0923	DIRECT-DIGITAL CONTROL FOR HVAC	07.29.2022
23 2113	HYDRONIC PIPING	07.29.2022
23 2113.23	MECHANICALLY JOINED HYDRONIC PIPING SYSTEMS	07.29.2022
23 2114	HYDRONIC SPECIALTIES	07.29.2022
23 2123	HYDRONIC PUMPS	07.29.2022
23 2500	HVAC WATER TREATMENT	07.29.2022
23 3113	METAL DUCTS	07.29.2022
23 3300	AIR DUCT ACCESSORIES	07.29.2022
23 3423	HVAC POWER VENTILATORS	07.29.2022

Specification Section	Title	Dated
23 3600	AIR TERMINAL UNITS	07.29.2022
23 3713	DIFFUSERS, REGISTERS & GRILLES	07.29.2022
23 4100	PARTICULATE AIR FILTRATION	07.29.2022
23 5213	ELECTRIC BOILERS	07.29.2022
23 5323	BOILER ACCESSORIES	07.29.2022
23 6426	ROTARY-SCREW WATER CHILLERS	07.29.2022
23 7313	MODULAR CENTRAL STATION AIR HANDLING UNITS	07.29.2022
23 7413	OUTDOOR PACKAGED HEATING AND COOLING UNITS	07.29.2022
23 8126	SPLIT SYSTEM AIR CONDITIONERS	07.29.2022
23 8200	TERMINAL HEATING AND COOLING UNITS	07.29.2022
23 8413	HUMIDIFIERS (DISPERSION TYPE)	07.29.2022
23 8500	ELECTRIC HEATING UNITS	07.29.2022
26 0010	GENERAL ELECTRICAL REQUIREMENTS	07.29.2022
26 0500	COMMON WORK RESULTS FOR ELECTRICAL	07.29.2022
26 0502	EQUIPMENT WIRING SYSTEMS	07.29.2022
26 0519	LOW-VOLTAGE ELECTRICAL POWER CONDUCTORS AND CABLES	07.29.2022
26 0526	GROUNDING AND BONDING FOR ELECTRICAL SYSTEMS	07.29.2022
26 0529	HANGERS AND SUPPORTS FOR ELECTRICAL SYSTEMS	07.29.2022
26 0533	RACEWAY AND BOXES FOR ELECTRICAL SYSTEMS	07.29.2022
26 0543	UNDERGROUND DUCTS AND RACEWAYS FOR ELECTRICAL SYSTEMS	07.29.2022
26 0548	SEISMIC CONTROLS FOR ELECTRICAL SYSTEMS	07.29.2022
26 0553	IDENTIFICATION FOR ELECTRICAL SYSTEMS	07.29.2022
26 0573	OVERCURRENT PROTECTIVE DEVICE COORDINATION STUDY	07.29.2022
26 0800	COMMISSIONING FOR ELECTRICAL	07.29.2022
26 0913	ELECTRICAL POWER MONITORING	07.29.2022
26 0923	LIGHTING CONTROL DEVICES	07.29.2022
26 2200	LOW-VOLTAGE TRANSFORMERS	07.29.2022
26 2413	SWITCHBOARDS	07.29.2022
26 2416	PANELBOARDS	07.29.2022
26 2417	ISOLATION POWER PANELS	07.29.2022
26 2726	WIRING DEVICES	07.29.2022
26 2813	FUSES	07.29.2022
26 2816	ENCLOSED SWITCHES AND CIRCUIT BREAKERS	07.29.2022
26 2913	ENCLOSED CONTROLLERS	07.29.2022
26 3213	PACKAGED ENGINE-DRIVEN GENERATORS	07.29.2022
26 3215	GENERATOR TERMINATION CABINETS	07.29.2022
26 3600	TRANSFER SWITCHES	07.29.2022
26 4113	LIGHTNING PROTECTION FOR STRUCTURES	07.29.2022
26 4313	SURGE PROTECTIVE DEVICES	07.29.2022
26 5100	INTERIOR LIGHTING	07.29.2022
26 5600	EXTERIOR LIGHTING	07.29.2022
27 0010	GENERAL COMMUNICATIONS REQUIREMENTS	07.29.2022
27 0500	COMMON WORK RESULTS FOR COMMUNICATIONS	07.29.2022
27 0543	UNDERGROUND DUCTS AND RACEWAYS FOR COMMUNICATIONS SYSTEMS	07.29.2022
27 0548	SEISMIC CONTROLS FOR COMMUNICATIONS	07.29.2022
27 0800	COMMISSIONING FOR COMMUNICATIONS	07.29.2022
27 1000	STRUCTURED CABLING SYSTEM	07.29.2022
27 1100	TELECOMMUNICATIONS EQUIPMENT ROOM FITTINGS	07.29.2022

Specification Section	Title	Dated
27 1300	COMMUNICATIONS BACKBONE CABLING	07.29.2022
27 1500	COMMUNICATIONS HORIZONTAL CABLING	07.29.2022
27 4100	AUDIO VIDEO SYSTEMS	07.29.2022
27 4110	TELECOMMUNICATIONS REQUIREMENTS FOR AUDIO VIDEO SYSTEMS	07.29.2022
27 4116	AUDIO VIDEO SYSTEMS EQUIPMENT	07.29.2022
27 4133	TELEVISION DISTRIBUTION SYSTEMS	07.29.2022
27 5116	PUBLIC ADDRESS SYSTEMS	07.29.2022
27 5119	SOUND MASKING SYSTEMS	07.29.2022
27 5129.13	RESCUE ASSISTANCE SIGNAL SYSTEMS	07.29.2022
27 5223	NURSE CALL – CODE BLUE SYSTEM	07.29.2022
27 5313	WIRELESS CLOCK SYSTEM	07.29.2022
28 0010	GENERAL ELECTRONIC SECURITY SYSTEM REQUIREMENTS	07.29.2022
28 0501	COMMON WORK RESULTS FOR ELECTRONIC SECURITY SYSTEMS	07.29.2022
28 0548	SEISMIC CONTROLS FOR ELECTRONIC SECURITY	07.29.2022
28 0800	COMMISSIONING FOR ELECTRONIC SAFETY AND SECURITY	07.29.2022
28 1000	ELECTRONIC SECURITY SYSTEMS	07.29.2022
28 1010	CONDUCTORS AND CABLES FOR ELECTRONIC SECURITY	07.29.2022
28 1015	TELECOMMUNICATIONS REQUIREMENTS FOR ELECTRONIC SECURITY	07.29.2022
28 1020	EQUIPMENT ROOM FITTINGS FOR ELECTRONIC SECURITY	07.29.2022
28 1033	NETWORK REQUIREMENTS FOR ELECTRONIC SECURITY	07.29.2022
28 1300	ACCESS CONTROL	07.29.2022
28 1524	VIDEO INTERCOM FOR ELECTRONIC SECURITY	07.29.2022
28 2000	VIDEO SURVEILLANCE	07.29.2022
28 3000	ELECTRONIC INFANT PROTECTION SYSTEM	07.29.2022
28 4600	FIRE DETECTION AND ALARM	07.29.2022
31 1100	SITE CLEARING	07.29.2022
31 2000	EARTH MOVING	07.29.2022
32 1216	ASPHALT PAVING	07.29.2022
32 1313	CONCRETE PAVING	07.29.2022
32 1373	CONCRETE PAVING JOINT SEALANTS	07.29.2022
32 1723	PAVEMENT MARKINGS	07.29.2022
33 1000	WATER DISTRIBUTION	07.29.2022
33 3000	SANITARY SEWER	07.29.2022
33 4000	STORM DRAINAGE	07.29.2022

AIA Document A133-2019

EXHIBIT A
Guaranteed Maximum Price Amendment

ATTACHMENT E
Construction Manager's Equipment Rental Rates
September 27, 2022

Please reference the attached.

BOULTEN
CONSTRUCTION COMPANY

Equipment Rental Rates

June 16, 2022 - June 15, 2023

Category	Description	Model	Replacement Cost	Monthly Rate	Weekly Rate	Daily Rate
Air Conditioners	Air conditioner, 10K BTU	PAC L90 (234229	$542.30	$134.40	$59.00	$14.00
	Air Conditioner, 25K BTU	LRA257ST2	$651.00	$134.40	$59.00	$14.00
Air Tools	Brad Nailer 18Guage, 18V	XNB01Z	$800.91	$150.00	$50.00	$24.00
	Breaker, APT 35 lb		$759.11	$309.94	$139.15	$41.45
	Breaker, CP 90 lb.		$1,135.00	$426.30	$192.10	$58.85
	Chipping gun		$1,026.96	$310.00	$147.50	$41.50
	Compressor, IR 175 cfm #2	P175A-W-W	$11,588.50	$650.00	$217.00	$73.00
	Compressor, IR 185 cfm #6	P185 WIR	$12,853.90	$650.00	$217.00	$73.00
	Compressor, Jenny 7 cfm		$947.65	$416.34	$205.67	$58.00
	Compressor, Sullivan 185 cfm	D185Q11JD	$12,853.90	$1,089.25	$481.25	$153.00
	Duplex Nail Gun, Cordless 36V	NR3675DDM	$719.40	$179.20	$60.00	$20.00
	Impact wrench, 1" IR	285B-6	$646.77	$345.60	$115.00	$40.00
	Rivet Buster, Ikent		$1,218.44	$539.87	$245.87	$84.64
	Rock Drill, CP 14 lb	CP-14RR	$1,547.55	$300.00	$120.00	$30.00
	Rock Drill, IR 55 lb	1J50A	$1,300.00	$270.00	$90.00	$30.00
	Scrabbler, Edco Chip Deck	CD5	$8,107.50	$1,214.40	$540.00	$135.00
	Tanner tank		$507.77	$150.00	$50.00	$24.00
Automobiles	Car, Chev Impala 2006	Impala	$16,202.00	$1,094.00	$330.00	$48.00
	Car, Chevy Equinox 2013	Equinox	$24,998.83	$1,409.60	$412.00	$122.00
	Car, Honda Pilot, 2014	Pilot	$36,139.11	$1,409.60	$412.00	$122.00
	Car, Honda, Pilot, 2012	Pilot	$36,139.11	$1,409.60	$412.00	$122.00
	Car, Suburban, 07		$31,259.05	$1,995.20	$405.00	$80.00
	Grand Cherokee, Jeep	Grand Cherokee	$50,324.83	$1,409.60	$412.00	$122.00
Barricades	Picking Device, Jersey Barrier	KL9K6T12V4	$4,564.80	$450.00	$150.00	$75.00
Compaction Equipment	Compactor, Master plate	P-5000	$2,009.10	$669.01	$289.00	$79.25
	Compactor, Wacker jumping jack	BS-60Y	$2,823.60	$669.74	$298.50	$84.75
Concrete Equipment	Bucket, 1/2 yd side discharge conc		$2,704.14	$240.00	$90.00	$30.00
	Bucket, 1 yd concrete	433-G	$6,081.77	$501.34	$194.00	$77.67
	Bucket, 1/2 yd concrete		$3,146.87	$325.01	$157.50	$57.50
	Bucket, 3/4 yd concrete		$3,532.75	$425.01	$170.00	$67.50
	Bucket, 3/8 yd concrete		$3,054.37	$250.00	$140.00	$55.00
	Chute, Concrete, alum 14'		$515.24	$36.00	$18.00	$6.00
	Column Clamp, Gates Lockfast 12/24	12" - -24"	$299.00	$18.00	$18.00	$3.60
	Column clamps		$33.00	$4.00	$1.20	$0.24
	Column clamps, Gates Lockfast(set)	Lockfast	$299.75	$18.00	$18.00	$3.60
	Concrete Washout Pan	72"X72"X14"	$2,526.19	$280.00	$105.00	$25.00
	Concrete Washout Pan	72"x72"x24"	$2,629.16	$280.00	$105.00	$25.00
	Corner clamp, Jahn		$38.05	$0.48	$0.48	$0.08
	Corner clamp, McGough		$21.00	$1.60	$0.90	$0.16
	Form buttons 1/4"		$4.24	$0.61	$0.20	$0.08
	Form buttons, 1/4" spring loaded	QRC14	$2.36	$0.61	$0.20	$0.08
	Georgia buggy, 30"- 36"		$498.47	$100.00	$65.00	$23.00
	Hopper		$244.59	$12.00	$5.00	$2.00
	Oztec 10' shaft only with head		$675.85	$300.00	$160.00	$60.00
	oztec 14' shaft only with head	14' w head	$753.07	$300.00	$160.00	$60.00
	Oztec 21' shaft only with head	21' w/ head	$400.25	$300.00	$160.00	$60.00
	Oztec. 7' Shaft only with head		$383.76	$300.00	$160.00	$60.00
	She bolts, 16" coarse		$11.96	$0.61	$0.30	$0.08
	She bolts, 9" coarse		$7.47	$0.61	$0.30	$0.08
	She bolts, fine		$11.96	$1.20	$0.60	$0.16
	Trowel, Whiteman 44" power	B-4-8H	$1,965.40	$425.60	$180.00	$44.00
	Vibrator, Oztec 21'		$953.51	$300.00	$160.00	$60.00
	Vibrator, Oztec 7'		$805.81	$511.01	$219.00	$79.00
	Vibrator, Oztec backpack	BP 50	$2,280.37	$451.50	$240.00	$82.00
	Vibrator, Oztec backpack	PB-50A	$2,275.92	$451.50	$240.00	$82.00
	Vibrator, Viberroller external	Model 4 size 2.	$566.87	$52.00	$19.00	$5.00
	Waler brackets		$2.73	$0.61	$0.28	$0.08
Demolition	Dumpster, Crane/Forklift 2-1/4Y	CDF-200 2-1/4Y	$4,000.00	$475.20	$160.00	$64.00
	Self dumping hopper, 1 1/2 yd	FB112G00	$1,206.78	$160.00	$60.00	$20.00
	Self dumping hopper, 1 1/2 yd		$1,206.78	$160.00	$60.00	$20.00
	Tilt truck, 1 yd		$782.00	$60.00	$30.00	$10.00
	Tilt truck, 3/4 yd		$782.64	$60.00	$30.00	$10.00
	Trash box, Cantilever	TB-400	$3,219.37	$400.00	$140.00	$48.00

BOULTEN
CONSTRUCTION COMPANY

Equipment Rental Rates

June 16, 2022 - June 15, 2023

Category	Description	Model	Replacement Cost	Monthly Rate	Weekly Rate	Daily Rate
Drills	Drill press, magnetic Hougen	HMD904C	$1,104.50	$733.90	$289.04	$113.24
	Drill, Diamond Products core	M-2	$2,170.91	$749.01	$328.50	$92.00
	Drill, Hilti Core	DD EC-1	$1,974.54	$630.00	$210.00	$70.00
	Makita, 18v cordless kit 8pc	XT706	$977.00	$150.00	$67.00	$23.00
	Recycle Unit, Hilti	DD-REC 1	$3,513.00	$630.00	$210.00	$70.00
Electrical	Tempower cord, 200'		$600.00	$290.00	$160.00	$80.00
Engineering Equipment	Laser Level PLS-6 - Green	PLS-6G	$597.86	$145.60	$85.00	$40.00
	Laser level, Topcon		$1,059.71	$570.00	$237.50	$82.50
	LINKER ROD WITH BRACKET & EYE	GT1000I	$601.66	$244.80	$100.00	$35.00
	Ranger Data Collector	TDS	$800.00	$300.00	$100.00	$30.00
	Robotic Total Station, Leica	iCR80-5"	$43,265.98	$3,779.20	$1,259.60	$419.84
	Theodolite, Lietz DT5A	DT5A	$2,663.15	$350.00	$140.00	$35.00
	Theodollite, Lietz DT6	DT6	$2,663.15	$350.00	$140.00	$35.00
	Total Station, Geomax Zoom 25-5	ZOOM 25-5	$7,026.25	$785.60	$295.00	$95.00
	Total station, Nikon DTM 350	DTM-350	$8,141.63	$785.60	$295.00	$95.00
	Total station, Sokkia	Set 530 R3	$8,141.63	$785.60	$295.00	$95.00
	Total station, Sokkia	Set 6E	$8,141.63	$785.60	$295.00	$95.00
	Total station, Sokkia	Set530r	$8,141.63	$785.60	$295.00	$95.00
Fans	Air scrubber, PAS 1000HC	PAS 1000HC	$1,835.00	$350.00	$150.00	$50.00
	Air scrubber, PAS 1200HC	PAS1200	$1,975.95	$420.00	$185.00	$60.00
	Air scrubber, PAS 1200HC	PAS-1200HC	$1,975.95	$420.00	$185.00	$60.00
	Air scrubber, PRED600HC	PRED600HC	$1,021.94	$170.00	$75.00	$25.00
	Fan, 36" box		$600.57	$105.34	$104.87	$42.77
	Fan, Abatement Tech neg air	H2000HP	$929.39	$170.00	$75.00	$25.00
	Fan, Advanced negative air	FA2000EC	$929.39	$170.00	$75.00	$25.00
	Fan, Advanced negative air fan	PH2000	$929.39	$170.00	$75.00	$25.00
	Fan, Aerospace American Negative Ai	FA2000EC	$942.62	$170.00	$75.00	$25.00
	Fan, Allegro	9504	$1,100.04	$200.00	$90.00	$30.00
	Fan, Negative air machine	H2KM	$821.77	$472.50	$215.00	$62.50
Forklift	Forklift, Daewoo/Doosan	G25P-5	$15,761.50	$1,420.00	$590.75	$211.00
	Forklift, GEHL RS-42	RS8-42	$100,575.50	$2,792.26	$1,302.50	$444.00
	Forklift, GEHL RS8-42	RS8-45	$100,575.50	$2,792.26	$1,302.50	$444.00
	Forklift, JLG	G6-42A	$97,665.85	$2,559.25	$1,168.75	$408.25
	Forklift, SkyTrak 8042	8042	$101,407.68	$3,254.40	$1,428.80	$447.28
	Forklift, Toyota	7FGU35	$42,377.78	$1,270.00	$535.00	$150.00
	JLG. Picking Device	1001097205	$1,498.75	$300.00	$100.00	$30.00
	Lift-N-Tow	1395B	$1,577.50	$425.60	$190.00	$65.00
Forks	Forks, Crane lifting	A-648	$3,694.83	$360.00	$130.00	$40.00
Form System	10' joist	45004-10	$108.70	$4.80	$1.20	$0.16
	12' joist	45004-12	$130.44	$6.40	$1.60	$0.24
	14' joist	45004-14	$152.18	$8.00	$2.00	$0.24
	15' 6" joist		$173.92	$8.00	$2.00	$0.32
	15' joist		$137.73	$8.00	$2.00	$0.24
	16' 6" joist		$184.79	$9.20	$2.30	$0.32
	16' alum outside corner	47416	$326.10	$16.00	$4.00	$0.56
	16' joist	45004-16	$173.92	$8.00	$2.00	$0.32
	16' x 8" Double alum waler	47016	$473.93	$24.00	$6.00	$0.88
	17' joist	45004-17	$184.79	$9.20	$2.30	$0.32
	18'6" Joist	18'6"	$206.53	$9.60	$2.40	$0.40
	19' joist	45004-19	$206.53	$9.60	$2.40	$0.40
	22' joist	45004-22	$239.14	$11.20	$2.80	$0.40
	4" x 22' joist		$201.63	$11.20	$2.80	$0.40
	4'9" joist		$54.35	$3.20	$0.80	$0.10
	6' joist	45004-06	$65.22	$3.20	$0.80	$0.08
	6' x 8" Double alum waler	47006	$184.79	$9.60	$2.40	$0.32
	7' x 8" Double alum waler		$157.55	$9.60	$2.40	$0.32
	8' alum outside corner		$129.65	$8.00	$2.00	$0.24
	8' joist	45004-08	$86.96	$4.80	$1.20	$0.16
	9' joist	45004-09	$97.83	$4.80	$1.20	$0.16
	9' x 8" Double alum waler	47009	$282.60	$14.40	$3.60	$0.50
	Adj gang jack	H00706	$146.75	$6.40	$1.60	$0.24
	Adj shear wall bkt	H00605	$81.53	$3.20	$0.80	$0.16

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Form System	Alum waler splice plate assy	47100	$146.75	$6.40	$1.60	$0.24
	Core flapper beam	H00108	$777.21	$36.80	$9.20	$1.28
	Cross brace coupler	H00714	$19.57	$1.60	$0.40	$0.08
	Diagonal beam brace	H00712	$59.79	$3.20	$0.80	$0.10
	End beam bkt	H00710	$173.92	$8.00	$2.00	$0.32
	End gr brkt assy	H00738	$68.48	$3.20	$0.80	$0.08
	Flapper tube	H00823	$42.39	$1.60	$0.50	$0.08
	HD pipe brace	H00582	$206.53	$9.60	$2.40	$0.34
	HD scaffold bkt	H00584	$54.35	$3.20	$0.80	$0.08
	Joist clip w/twist bolt	45017	$5.33	$0.22	$0.05	$0.01
	Joist U-bolt assy	H00740	$16.31	$0.74	$0.18	$0.03
	Landing bkt	H00704	$53.26	$3.20	$0.80	$0.08
	Lifting lug	H00578	$39.13	$1.60	$0.40	$0.06
	Pivot plate assy	H00708	$50.00	$3.20	$0.80	$0.08
	Plate washer 1 1/2" hole	HDT190	$4.76	$0.22	$0.06	$0.01
	Plate washer 1 1/4" hole	HDT185	$4.76	$0.22	$0.06	$0.01
	Plate washer 1" hole	HDT180	$4.76	$0.22	$0.06	$0.01
	Platform beam bkt	H00700	$171.75	$8.00	$2.00	$0.32
	Rollback roller assy	H00750	$608.72	$28.80	$7.20	$1.02
	Rollback rolling beam	H00752	$219.57	$11.20	$2.80	$0.40
	Scaffold bracket, corner for form s		$96.64	$4.80	$2.50	$0.48
	Stand off bkt	H00612	$85.87	$3.20	$1.00	$0.16
	Taper tie 54"	HDT150	$65.22	$3.20	$0.80	$0.08
	Taper tie 60"		$52.38	$3.20	$0.80	$0.08
	Taper tie 72"		$52.38	$3.20	$0.80	$0.08
	Wall clips		$4.89	$0.29	$0.07	$0.01
	Washer plates, 5" x 5" x 1/4"		$1.91	$0.18	$0.08	$0.04
	Wing nut 1 1/2"	HDT165	$6.52	$0.34	$0.08	$0.01
	Wing nut 1 1/4"	HDT160	$6.85	$0.34	$0.08	$0.01
	Wing nut 1"	HDT155	$6.52	$0.34	$0.08	$0.01
FRP Panels	12" Panel Assembly, Edge-Guard	4006	$313.50	$52.80	$17.60	$5.84
	24" Panel Assembly, Edge-Guard	4002	$516.00	$86.00	$28.80	$9.56
	24" Panel Assy w/Exhaust port, Edge	4002.1	$600.00	$100.00	$33.20	$11.12
	36" Door Assembly, Edge Guard		$1,250.00	$200.00	$66.00	$22.00
	36" Panel Assembly, Edge-Guard	4001	$605.00	$100.80	$33.60	$11.20
	48" Door Assembly, Edge-Guard	4003BP	$1,250.00	$200.00	$66.00	$22.00
	48" Panel Assembly, Edge-Guard	4000	$696.00	$116.00	$38.80	$12.88
	6' Panel Assembly, Edge-Guard	4005	$291.50	$48.00	$16.80	$5.40
	EdgeGuard Transport Cart		$275.00	$48.00	$16.80	$5.40
	Hinged Corner Assembly, Edge-Guard	4004	$220.00	$36.80	$12.40	$4.12
	Inside Corner Assembly, Edge Guard		$220.00	$36.80	$12.40	$4.12
	Outside Corner Assy, Edge-Guard	4007	$180.00	$30.00	$10.00	$3.34
	T-Post, Edge-Guard	4009	$165.00	$27.20	$9.20	$3.06
Gang Boxes	Field station, Knaak		$2,489.23	$360.00	$170.00	$42.00
	Gang box, cabinet style		$1,699.72	$158.40	$58.00	$19.00
	Gang Box, DataVault	118-02	$5,463.22	$436.80	$147.60	$43.68
	Gang box, large		$868.80	$86.40	$32.00	$10.00
	Gang box, small		$674.58	$67.20	$24.00	$8.00
Generators	Generator, Honda 5000W	EB5000XKT	$2,430.99	$592.67	$255.00	$78.00
	Generator, Honda 6500W	EB6500XAT	$2,444.67	$598.00	$256.50	$70.75
Grinder	Concrete planer, Makita		$645.16	$90.00	$45.00	$15.00
Heaters	Heater, elec furnace		$2,013.12	$494.40	$165.00	$55.00
	Heater, Flagro 400K	F-400T	$1,998.99	$494.40	$165.00	$55.00
	Heater, Flagro Indirct Fired	FVN-400	$5,882.84	$1,121.01	$543.67	$174.00
	Heater, Master 375K BTU Propane	BLP375	$570.15	$385.01	$140.00	$55.00
	Heater, Patron electric 30K		$786.80	$200.00	$95.00	$33.00
	Heater, Sure Flame natural gas	F1500	$4,558.88	$800.00	$270.00	$90.00
	Heater, Sure Flame natural gas	S1500	$4,558.88	$800.00	$270.00	$90.00
	Hose, natural gas 1 1/4" x 50'		$907.98	$44.80	$20.00	$10.00
Ladders	Ladder, 40' extension		$574.98	$360.00	$120.00	$40.00
Lighting	Flood light, 1000 watt		$637.53	$130.00	$50.00	$15.00
	Light stand, CEP 1000 watt		$824.27	$310.34	$149.67	$51.34

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Lighting	Light tower, Allamand diesel	NLPKXZ	$5,755.80	$683.34	$381.67	$135.00
Loaders	Bobcat forks		$909.00	$315.01	$147.00	$49.50
	Bobcat hoe Ram	25006	$8,585.50	$2,210.34	$743.34	$230.00
	Bobcat loader, S130	S130	$49,161.36	$2,057.50	$835.75	$254.75
	Bobcat sweeper	RHB-72	$5,195.00	$93.74	$302.50	$93.75
	Loader, Scoopmobile	HP	$10,713.42	$1,750.00	$700.00	$175.00
Misc Equip	48" Metal Brake - 22 Guage		$521.50	$180.00	$80.00	$20.00
	Airless Paint Sprayer		$1,012.25	$170.00	$75.00	$25.00
	Banding outfit, complete		$576.11	$134.40	$45.00	$15.00
	Bin, 4 x 6 rolling		$1,440.00	$130.00	$72.00	$30.00
	Cabinet jack, Gillift		$867.71	$150.00	$68.00	$16.00
	Cabinets for rental trailer at I080		$898.95	$10.00	$3.00	$1.00
	Chain, 3/8" w 4-20' adjustable legs		$776.69	$129.60	$43.20	$14.40
	Chain, 5/16" W/ 4 20' Legs	5/16x20' 4 leg	$581.12	$97.60	$33.00	$11.00
	Choker, cable, 1' x 15' w/hook		$631.05	$240.00	$120.00	$57.00
	Crane Lift Material Box 1454		$2,218.84	$150.00	$55.00	$18.00
	Cutting outfit, complete		$1,235.82	$360.00	$120.00	$40.00
	Dolly, equipment		$723.82	$76.00	$38.00	$18.00
	Drywall lift		$819.00	$150.00	$68.00	$16.00
	Drywall Tapping Kit		$2,685.00	$360.00	$170.00	$42.00
	Dust control system		$691.35	$262.40	$131.00	$62.00
	Epoxy gun, Hilti cordless	ED3500-A	$578.11	$90.00	$30.00	$15.00
	Ferrodetector, Hilti		$868.65	$126.40	$55.00	$13.00
	Fuel Tank-50 Gal		$598.94	$75.20	$25.00	$8.00
	Hilti anchor system dispenser		$523.94	$130.00	$57.00	$14.00
	Hoist, chain 2 ton		$744.05	$90.00	$45.00	$15.00
	Impact wrench, Makita 3/4"		$590.60	$160.00	$60.00	$20.00
	Leaf Blower, Husqvarna 75.6cc		$683.53	$156.80	$52.40	$17.44
	Lock Mortiser, Rockwell	513	$1,025.00	$250.00	$112.00	$27.00
	Material box	PEB	$1,032.79	$100.00	$38.00	$12.00
	Material platform, 12 x 6		$1,500.00	$150.00	$55.00	$18.00
	Meter, 2" direct read water	HWOPO208	$791.26	$196.80	$87.20	$21.00
	MockWall Systems Kit		$1,805.31	$340.00	$120.00	$40.00
	Monitor, room pressure		$1,492.23	$225.60	$75.00	$25.00
	Oxblue Web Cam	6MP	$5,433.91	$465.60	$150.00	$50.00
	Pallet jack, Jet		$548.62	$292.34	$127.00	$40.34
	Power stripper, National Panther	6280	$8,020.66	$900.00	$450.00	$150.00
	Power stripper, Rambo		$2,868.13	$390.00	$170.00	$42.00
	Power Stripper, Sinclair	1115726	$2,868.13	$390.00	$170.00	$42.00
	Power Stripper, Wolff Duro	Duro	$2,369.08	$360.00	$170.00	$42.00
	Pressure washer		$1,949.37	$360.00	$135.00	$45.00
	Saw, Husquvarna quickie		$1,047.62	$478.50	$195.00	$63.75
	Sheetrock cart		$568.16	$124.80	$60.00	$20.00
	Snow blower, Husqvarna		$1,630.45	$100.00	$44.00	$10.00
	Spreader bar, 21'		$750.00	$75.20	$27.00	$9.00
	Tarp, 30' x 64'	30' x 64'	$1,956.00	$156.00	$53.00	$15.00
	Trash box, steel	1420	$2,757.90	$225.60	$75.00	$25.00
	Trash box, steel		$1,222.88	$50.00	$18.00	$5.00
	Trench Plate 5'x8'	1"x5'x8'	$1,195.50	$262.40	$131.20	$46.00
	Trench Plate 8'x12'	1"x8'x12'	$1,900.00	$348.80	$175.00	$62.00
	Trench Plate 8'x15'	1"x8'x15'	$2,200.00	$450.00	$183.00	$72.00
	Water trailer, 500 gal		$4,223.70	$903.74	$438.75	$136.25
Misc Saws	Quickie saw, Hilti	DSH900-14"	$1,200.05	$345.60	$115.00	$35.00
	Saw, Bosch table	4100-09	$671.22	$224.00	$90.00	$28.00
	Saw, Bosch 10" table	4000	$570.15	$224.00	$90.00	$28.00
	Saw, Bosch table		$654.36	$224.00	$90.00	$28.00
	Saw, compound miter 12"w/stand		$840.02	$160.00	$80.00	$20.00
	Saw, DeWalt 10" compound miter	DW717	$863.44	$160.00	$80.00	$20.00
	Saw, DeWalt 10" table	DW745	$583.29	$224.00	$90.00	$28.00
	Saw, DeWalt 8 1/2" compound miter	DW712	$633.72	$208.00	$104.00	$34.00
	Saw, Hitachi 8" compound miter	C8FB2	$650.46	$208.00	$104.00	$32.00
	Saw, Husquvarna quickie		$990.21	$478.50	$195.00	$63.75
	Saw, Kett Vacuum Saw		$763.99	$105.60	$32.00	$12.50
	Saw, Makita 10" compound slide mite	LS1016L	$541.33	$160.00	$80.00	$20.00
	Saw, Makita 10" slide compound	MALS1019L	$608.95	$160.00	$80.00	$20.00
	Saw, Mongoose concrete	Mongoose 411	$2,820.77	$212.80	$72.00	$21.00

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Misc Saws	Saw, Rockwell Unisaw 1 1/2 HP	34-801	$2,171.44	$224.00	$90.00	$28.00
	Saw, Rockwell Unisaw 2 HP	34-450	$2,171.44	$224.00	$90.00	$28.00
	Saw, Rockwell Unisaw 2 HP	34-761	$2,171.44	$224.00	$90.00	$28.00
	Saw, Rockwell Unisaw 3 HP	34-763	$2,171.44	$224.00	$90.00	$28.00
	Saw, SawStop 10" 3hp	ICS3123052	$4,671.93	$374.40	$126.00	$37.36
	Saw, Soffcut concrete	280	$3,666.60	$292.80	$94.00	$28.00
	Saw, Target 14" concrete	PAC IV 20G D/M	$5,400.00	$604.34	$280.00	$82.00
	Track Saw, Makita	SP60001	$552.70	$118.40	$52.00	$13.00
	Track saw, Makita 36V Cordless	MAXPS01PTJ	$909.70	$137.84	$50.54	$16.85
Nibblers	Nibbler, Makita 18V		$613.80	$160.00	$60.00	$20.00
Office Equipment	Computer - Laptop 450 G8	ProBook 450 G8	$2,249.60	$340.00	$120.00	$40.00
	Computer, Compac desk top	EVO D510	$1,499.00	$302.00	$120.00	$40.00
	Computer, HP w/monitor	d530CMT	$1,722.66	$340.00	$120.00	$40.00
	Computer, HP CPU	dc7600	$2,228.09	$340.00	$120.00	$40.00
	Computer, HP Envy x360m	Envy x360m	$2,249.60	$340.00	$120.00	$40.00
	Computer, HP laptop	440G3	$2,069.00	$340.00	$120.00	$40.00
	Computer, HP laptop	4510s ProBook	$2,146.60	$340.00	$120.00	$40.00
	Computer, HP laptop	8510p	$2,313.05	$340.00	$120.00	$40.00
	Computer, HP laptop	nc6320	$2,288.44	$340.00	$120.00	$40.00
	Computer, HP laptop	nx9600	$2,500.00	$340.00	$120.00	$40.00
	Computer, HP laptop 450	ProBook 450 G2	$2,069.09	$340.00	$120.00	$40.00
	Computer, HP laptop 450G3	ProBook 450 G3	$2,069.00	$340.00	$120.00	$40.00
	Computer, HP Laptop 450G5	ProBook 450 G5	$2,069.00	$340.00	$120.00	$40.00
	Computer, HP Laptop 450G6	ProBook 450 G6	$2,249.60	$340.00	$120.00	$40.00
	Computer, HP Laptop 450G7	ProBook 450 G7	$2,249.60	$340.00	$120.00	$40.00
	Computer, laptop	HP ProBook 450	$4,234.60	$340.00	$120.00	$40.00
	Computer, laptop spare	ProBook 450 G1	$2,069.00	$340.00	$120.00	$40.00
	Computer, laptop, AS	4530s-AS	$4,271.20	$340.00	$120.00	$40.00
	Computer,HP laptop tablet	TC4400	$2,630.00	$340.00	$120.00	$40.00
	Computer-Laptop HP ProBook 450	F2P35UT#ABA	$1,349.99	$340.00	$120.00	$40.00
	Copier, Canon	C2030	$7,077.46	$321.60	$107.00	$42.00
	Copier, canon C3525i	C3525i	$7,077.46	$321.60	$107.00	$42.00
	Copier, Canon C5535i	C5535i	$7,995.00	$321.60	$107.00	$42.00
	Copier, Canon N2225 imagerunner	N2225 Imagerunn	$4,950.20	$321.60	$107.00	$42.00
	Copier, Imagistics	IM4511	$5,623.31	$320.00	$110.00	$30.00
	Copier, Ricoh	MP4001SP	$6,036.80	$294.40	$100.00	$30.00
	Copier, Sharp	AR M350U	$4,659.70	$320.00	$110.00	$30.00
	Copier,HP DesignJet 500 Plan	DesignJet 500	$4,609.34	$138.00	$41.20	$14.00
	Copir, imageRUNNER	ADV C5030	$4,658.70	$320.00	$110.00	$30.00
	Firewall, Cisco ASA	ASA	$816.34	$168.00	$75.00	$25.00
	Firewall, Cisco ASA 5505	ASA 5505	$816.34	$168.00	$75.00	$25.00
	HP Elitebook 850 G6	850 G6	$2,249.60	$340.00	$120.00	$40.00
	ID Card Printer, Color	B22U0000RS	$822.36	$168.00	$75.00	$25.00
	Ipad	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad	IPAD	$961.95	$168.00	$75.00	$25.00
	Ipad - Jim D	4G 32GB	$983.68	$168.00	$75.00	$25.00
	Ipad Mini	Ipad Mini	$1,023.00	$142.40	$64.00	$29.00
	Ipad Mini TonyS	Ipad Mini	$1,023.00	$142.40	$64.00	$29.00
	Ipad Mini, BS	Ipad Mini	$749.97	$142.40	$64.00	$29.00
	Ipad Mini, WB	Ipad Mini	$1,023.00	$142.40	$64.00	$29.00
	Ipad,	4G 32GB	$961.95	$168.00	$75.00	$25.00
	IPad, BobB	4G 32GB	$793.50	$158.00	$71.00	$32.00
	IPad, KB	4G 64GB	$1,012.18	$202.00	$91.00	$40.00
	Ipad, LW	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad, MS	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad, NS	4G 32GB	$961.95	$168.00	$75.00	$25.00
	IPAD, Russ M	IPAD	$961.95	$168.00	$75.00	$25.00
	Ipad, RW	4G32GB	$961.95	$168.00	$75.00	$25.00
	Ipad, SM	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad, SW	4G	$961.95	$168.00	$75.00	$25.00
	Ipad, TM	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad, TT	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad-JoeD	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad-KSD	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad-MacM	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Ipad-MV	4G 32GB	$961.95	$168.00	$75.00	$25.00
	Projector, Portable Multimedia LCD	PLC-XU106	$1,625.01	$162.00	$40.00	$16.00

BOULTEN
CONSTRUCTION COMPANY

Equipment Rental Rates

June 16, 2022 - June 15, 2023

Category	Description	Model	Replacement Cost	Monthly Rate	Weekly Rate	Daily Rate
Office Equipment	PROJECTOR, EPSON	EX522	$551.49	$52.80	$15.00	$5.00
	Telephone conference device	2200-16155-001	$802.58	$80.00	$20.00	$5.00
	Telephone conference device	2201-16200-601	$796.39	$80.00	$20.00	$5.00
	Telephone conference machine	VTX1000	$1,117.44	$120.00	$30.00	$7.50
	Telephone system, Panasonic	KX-TDA50G	$3,584.38	$240.00	$80.00	$30.00
	TV 75", Hisense	75" TV Monitor	$850.89	$141.82	$47.27	$15.76
	TV Sharp 65"		$707.19	$117.87	$39.29	$13.10
Pickups	Pichup, 2020 Chev K2500HD	K2500HD	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2014 Chev K2500HD	2500	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2015 Chev K2500HD	K2500	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2016 Chev K2500HD	Chevrolet/K2500	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2016 Ford F150 Crew Cab	F150 4x4 Crew Cab	$40,000.00	$2,156.50	$714.50	$201.50
	Pickup, 2017 Chev K2500HD	K2500HD	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2018 Chev K2500HD	2500	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2019 Chev K2500 Duramax		$65,728.28	$2,156.50	$714.50	$201.50
	Pickup, 2019 Chev K2500HD	K2500HD	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, 2021 Chev K2500HD	K2500HD	$33,000.00	$2,156.50	$714.50	$201.50
	Pickup, 2022 Chev K1500 Crew Cab	K1500 Crew Cab LT	$55,020.67	$2,156.50	$714.50	$201.50
	Pickup, 2022 Chev K1500 Crew Cab	K1500 Crew Cab	$45,207.78	$2,156.50	$714.50	$201.50
	Pickup, Chev 3/4 ton	2500	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, Chev 3/4 ton	2500HD	$40,487.68	$2,156.50	$714.50	$201.50
	Pickup, GMC SIERRA 1500 SLT	SIERRA 1500 SLT	$49,500.00	$2,156.50	$714.50	$201.50
	Pickup, Toyota Tundra	TUNDRA	$55,445.50	$2,156.50	$714.50	$201.50
Planers	Planer, Dewalt 13" Wood	DW735X	$594.59	$120.00	$45.00	$15.00
Portaband Saws	Portaband, 18V Cordless, Makita	XBP02TX	$641.65	$160.00	$60.00	$20.00
Roto & Electric Hammers	Electric jack hammer		$1,889.55	$480.67	$197.00	$67.67
	Roto hammer, DeWalt cordless		$669.45	$180.00	$60.00	$20.00
	Roto hammer, Hilti TE24-25		$850.34	$180.00	$60.00	$20.00
	Roto hammer, Hilti TE30		$934.00	$380.00	$180.00	$57.50
	Roto hammer, Hilti TE35		$850.34	$380.00	$180.00	$57.50
	Roto hammer, Hilti TE70-76		$1,587.01	$642.00	$207.67	$67.34
	Roto hammer, Hilti TE7C-TE7DRS		$576.53	$90.00	$45.00	$15.00
	Roto hammer, Makita 1/2"		$657.80	$180.00	$60.00	$20.00
	Roto Hammer, Makita Cordless W/ Vac		$1,024.90	$180.00	$60.00	$20.00
Routers & Trimmers	Trimmer, Makita - RotoZip	XOC02Z	$509.99	$144.00	$54.00	$18.00
Safety Equipment	AED, Automated external defibrillat	DDU-100A-EN	$1,825.07	$364.80	$164.40	$54.72
	Belt Respierator Pump, Sundstrom	SR500/SR580	$1,821.96	$364.80	$164.40	$54.72
	Belt Respirator Pump, North	PA710	$1,100.16	$184.00	$61.20	$20.40
	Ceiling Access System 13'	13500	$12,078.60	$2,012.80	$671.20	$178.96
	Flammable liquids cabinet	5530	$1,233.43	$75.20	$27.00	$9.00
	Flammable liquids cabinet	5560	$527.00	$75.20	$27.00	$9.00
	Horizontal Life Line Kit, 100'	7600510	$825.00	$180.00	$80.00	$20.00
	Horizontal Life Line Kit, 60'	7600506	$708.50	$180.00	$80.00	$20.00
	Horizontal Life Line, 100' W/ Tensi	GU04630	$825.00	$180.00	$60.00	$20.00
	Nano-Lok Twin Leg 6' W rebar hook	WFR433006LE-R	$628.96	$209.65	$69.88	$23.30
	Net, safety 50' x 25'		$1,018.13	$110.00	$40.00	$20.00
	Rescue & Decent Device R550	3326300	$2,100.00	$224.00	$90.00	$28.00
	Retractable Leading Edge Life Line	3504500	$1,279.58	$210.00	$90.00	$30.00
	Retractable lifeline Leading E, 20'	3590540	$514.73	$102.40	$45.00	$11.00
	Retractable Lifeline leading E,33'	DI3590543	$619.65	$104.00	$45.00	$11.00
	Retractable lifeline, 11'	10900	$162.51	$40.00	$18.00	$5.00
	Retractable Lifeline, 33'	3590500	$423.71	$180.00	$80.00	$20.00
	Retractable lifeline, 20'	10910	$413.05	$102.40	$45.00	$11.00
	Retractable, Leading Edge 20'	DI3590540	$526.39	$180.00	$80.00	$20.00
	Retractable, Leading Edge 30'	GU10925	$602.83	$180.00	$80.00	$20.00
	Retractable, Leading Edge 50'	GU10968	$833.65	$180.00	$60.00	$20.00
	Retractable, Leading Edge 50'	3590546	$786.50	$180.00	$60.00	$20.00
	Roof anchor, screw down	255	$80.93	$18.00	$6.00	$2.00
	Self Contained Roof Anchor System	26000380	$3,274.88	$545.60	$182.00	$45.52
	Self Contained Roof Anchor System	2100185/2104190	$2,735.97	$545.60	$182.00	$45.52
	Self retracting lifeline, 50'	10987 GAL	$515.89	$180.00	$80.00	$20.00
	Self retracting lifeline, DBI	3101051	$745.68	$180.00	$80.00	$20.00
	Self retracting lifeline, DBI	3504450	$249.19	$60.00	$25.00	$6.00

BOULTEN
CONSTRUCTION COMPANY

Equipment Rental Rates

June 16, 2022 - June 15, 2023

Category	Description	Model	Replacement Cost	Monthly Rate	Weekly Rate	Daily Rate
Safety Equipment	Self retracting lifeline, DBI	L3400	$745.68	$180.00	$80.00	$20.00
	Self retracting lifeline, DBI	L4451C-50	$745.68	$180.00	$80.00	$20.00
	Self retracting lifeline, Miller	M-5550G	$745.68	$180.00	$80.00	$20.00
	Self retracting lifeline, Miller	RL656	$745.68	$180.00	$80.00	$20.00
Scaffolding	Beta Scaff Trac	Gemini Plus	$3,300.00	$800.00	$200.00	$40.00
	Loading Platform Safety Gate	Dock Gate	$2,700.00	$134.40	$45.00	$15.00
	Plank, 20' aluminum	2620	$885.55	$120.00	$45.00	$20.00
	Plank, 20' x 20" aluminum		$885.55	$120.00	$45.00	$20.00
	Plank, 24' aluminum	2624	$1,060.97	$145.60	$50.00	$25.00
	Plank, 32' aluminum		$1,549.80	$190.00	$75.00	$32.00
	Platform, loading		$1,000.00	$100.00	$30.00	$10.00
	QES Alum Stair Tower 16'	16'	$9,237.65	$600.00	$210.00	$42.00
	QES Alum Stair Tower 16', QES	QSTA	$9,237.65	$600.00	$210.00	$42.00
Sheds and Offices	Conex container	NW-1CC-2760R	$2,771.85	$68.80	$17.00	$3.44
	Conex container		$3,695.00	$68.80	$23.20	$7.00
	Conex container	Tex	$4,047.36	$68.80	$17.00	$3.44
	Shed, 8' x 16' tool		$1,450.00	$68.80	$25.00	$7.00
	Shed, 8' x 18' tool		$1,450.00	$68.80	$25.00	$7.00
	Steps, aluminum trailer		$738.07	$35.20	$8.80	$1.76
	Trailer, 10' x 30' office	10' x 30'	$43,498.00	$468.80	$162.40	$54.12
	Trailer, 12' x 56' office	12' x 56'	$62,270.00	$654.40	$203.00	$67.00
	Trailer, 12' x 56' office		$62,270.00	$654.40	$203.00	$67.00
	Trailer, 12' x 56' office	NW Building	$62,270.00	$654.40	$236.00	$78.64
	Trailer, 8' x 40' van		$2,000.00	$68.80	$25.00	$7.00
Stud Guns	Stud gun, Hilti LV		$658.80	$150.00	$60.00	$15.00
Testing Equipment	Air Quality Monitor	IQ-XWY-B-NA	$2,933.11	$732.80	$244.00	$81.00
	Particle Counter, AeroTrak	9303	$2,919.00	$584.00	$194.60	$64.88
	Particle counter, Lighthouse	3016-IAQ	$3,477.66	$2,800.00	$700.00	$175.00
	Sensidyne LFS-113 pump	LFS-113	$689.78	$800.00	$200.00	$50.00
Trucks & Trailers	Ramp, 16' - 2 piece fiberglass	1636AL	$1,804.00	$124.80	$46.00	$15.00
	Ramp, steel		$540.50	$54.00	$20.00	$6.00
	Small job trailer	ORTW714TA2	$4,606.32	$660.00	$260.00	$65.00
	Trailer, 8' x 20' flatbed	820FH	$7,687.50	$660.00	$320.00	$80.00
	Trailer, dump	10SR-12XBK7SIR	$9,865.00	$860.00	$375.00	$125.00
	Trailer, Dump 12'	DT8312	$20,000.00	$1,120.00	$505.50	$154.72
	Trailer, Dump 12'	FT-12DTHD-E	$10,896.32	$1,120.00	$505.50	$154.72
	Truck, GMC 10' flatbed	C3500	$41,880.00	$2,400.00	$915.00	$225.00
	Truck, GMC 16' flatbed	6500	$69,400.00	$3,500.00	$1,250.00	$365.00
	Truck, GMC 16' flatbed	C6500	$69,400.00	$3,500.00	$1,250.00	$365.00
Vacuums & Floor Machines	Floor maintainer, Clarke		$2,809.90	$310.00	$145.00	$45.00
	Scrape-away attachment	15000CC	$815.25	$78.00	$26.00	$8.00
	Vacuum, Dewalt Dust Extract	DWV012	$621.68	$264.00	$115.00	$35.00
	Vacuum, Dewalt Dust Extract		$621.68	$264.00	$115.00	$35.00
	Vacuum, Makita Back Pack	XCV05PT	$1,125.65	$160.00	$80.00	$20.00
	Vacuum, Makita Dust Extraction12gl		$577.50	$134.40	$45.00	$15.00
	Vacuum, Makita Hepa corded/cordless	XCV04PT	$1,013.10	$180.00	$60.00	$20.00
	Vacuum, Milwaukee		$643.80	$134.40	$45.00	$15.00
	Vacuum, Minuteman HEPA		$1,440.43	$134.40	$45.00	$15.00
	Vacuum, PROFORCE upright		$583.74	$75.20	$37.00	$12.50
Water Pumps	Pump, IR 1" daiphragm		$724.13	$120.00	$50.00	$15.00
Welders	Inverter, Thermal Arc Welder		$1,207.78	$180.00	$82.00	$25.00
	Welder, Lincoln 225 AMP elec	AC-225-S	$664.16	$210.00	$76.00	$19.00
	Welder, Lincoln 225 amp gas	Ranger 10,000	$3,390.55	$632.50	$275.50	$95.00
	Welder, Lincoln gas	Ranger 225	$3,555.91	$360.00	$160.00	$40.00
	Welder, Lincoln wire feed		$713.58	$372.58	$186.10	$64.94
	Welder, Miller 225 AMP elec	HG-1B	$664.16	$210.00	$76.00	$19.00
	Welding blanket, 10 x 50	906	$1,409.62	$76.00	$33.00	$8.00

Replacement cost subject to change at any time upon purchase of a new tool.

5/17/2022

Attachment C

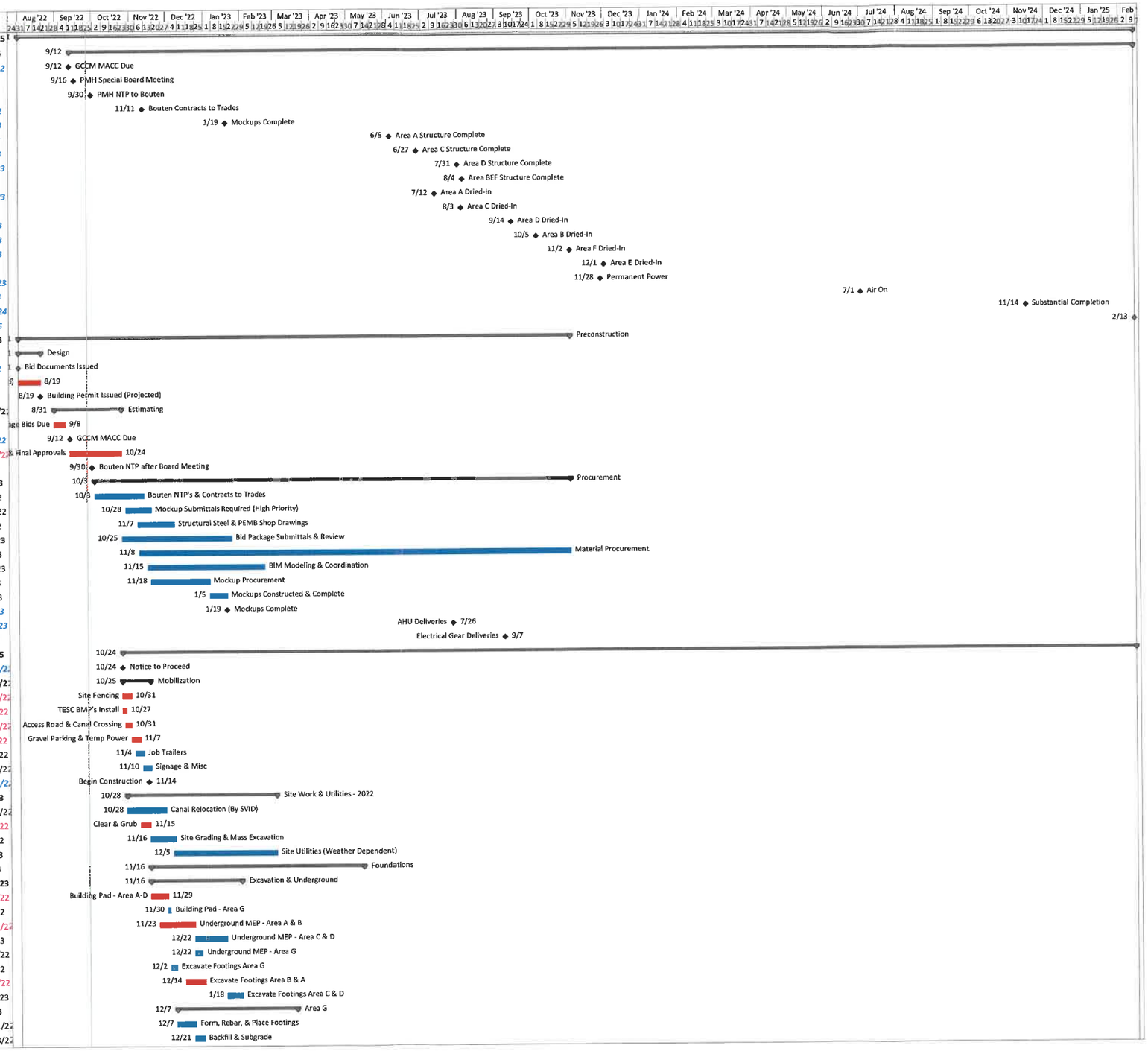
PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

BOULTEN CONSTRUCTION COMPANY

Data Date: Mon 8/1/22

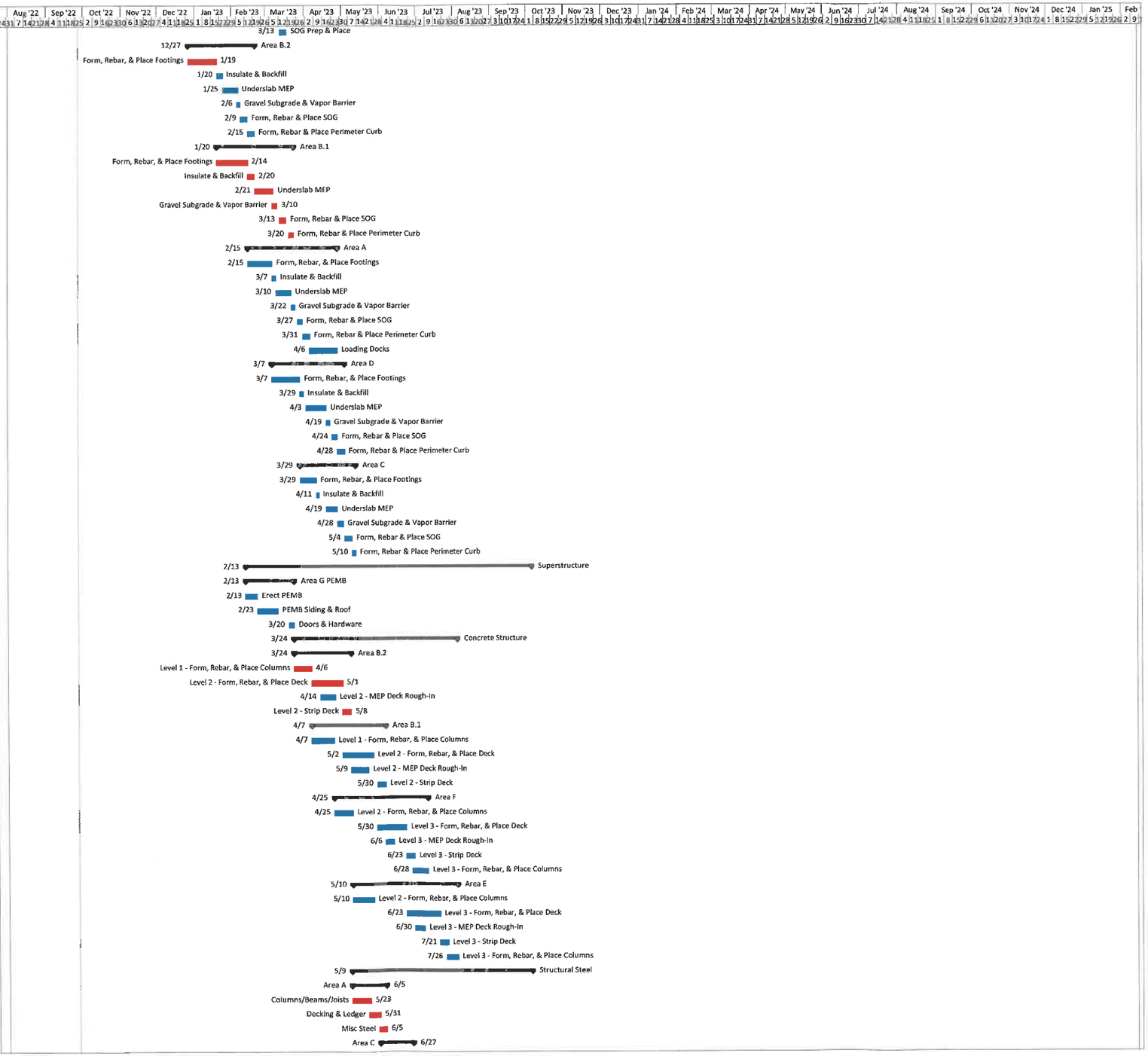
MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
0	PMH HOSPITAL REPLACEMENT	663.81 d	Mon 8/1/22	Thu 2/13/25
1	Project Milestones	612 days	Mon 9/12/22	Thu 2/13/25
2	GCCM MACC Due	0 days	Mon 9/12/22	Mon 9/12/22
3	PMH Special Board Meeting	0 days	Fri 9/16/22	Fri 9/16/22
4	PMH NTP to Bouten	0 days	Fri 9/30/22	Fri 9/30/22
5	Bouten Contracts to Trades	0 days	Fri 11/11/22	Fri 11/11/22
6	Mockups Complete	0 days	Thu 1/19/23	Thu 1/19/23
7	Area A Structure Complete	0 days	Mon 6/5/23	Mon 6/5/23
8	Area C Structure Complete	0 days	Tue 6/27/23	Tue 6/27/23
9	Area D Structure Complete	0 days	Mon 7/31/23	Mon 7/31/23
10	Area BEF Structure Complete	0 days	Fri 8/4/23	Fri 8/4/23
11	Area A Dried-In	0 days	Wed 7/12/23	Wed 7/12/23
12	Area C Dried-In	0 days	Thu 8/3/23	Thu 8/3/23
13	Area D Dried-In	0 days	Thu 9/14/23	Thu 9/14/23
14	Area B Dried-In	0 days	Thu 10/5/23	Thu 10/5/23
15	Area F Dried-In	0 days	Thu 11/2/23	Thu 11/2/23
16	Area E Dried-In	0 days	Fri 12/1/23	Fri 12/1/23
17	Permanent Power	0 days	Tue 11/28/23	Tue 11/28/23
18	Air On	0 days	Mon 7/1/24	Mon 7/1/24
19	Substantial Completion	0 days	Thu 11/14/24	Thu 11/14/24
20	Final Completion	0 days	Thu 2/13/25	Thu 2/13/25
21	Preconstruction	320 days	Mon 8/1/22	Thu 11/2/23
22	Design	15 days	Mon 8/1/22	Fri 8/19/22
23	Bid Documents Issued	0 days	Mon 8/1/22	Mon 8/1/22
24	Bid Phase Addenda (As Needed)	15 days	Mon 8/1/22	Fri 8/19/22
25	Building Permit Issued (Projected)	0 days	Fri 8/19/22	Fri 8/19/22
26	Estimating	38 days	Wed 8/31/22	Mon 10/24/22
27	Bid Package Bids Due	6 days	Wed 8/31/22	Thu 9/8/22
28	GCCM MACC Due	0 days	Mon 9/12/22	Mon 9/12/22
29	MACC Review & Final Approvals	30 days	Tue 9/13/22	Mon 10/24/22
30	Bouten NTP after Board Meeting	0 days	Fri 9/30/22	Fri 9/30/22
31	Procurement	276 days	Mon 10/3/22	Thu 11/2/23
32	Bouten NTP's & Contracts to Trades	30 days	Mon 10/3/22	Fri 11/11/22
33	Mockup Submittals Required (High Priorit	15 days	Fri 10/28/22	Thu 11/17/22
34	Structural Steel & PEMB Shop Drawings	20 days	Mon 11/7/22	Tue 12/6/22
35	Bid Package Submittals & Review	60 days	Tue 10/25/22	Mon 1/23/23
36	Material Procurement	250 days	Tue 11/8/22	Thu 11/2/23
37	BIM Modeling & Coordination	65 days	Tue 11/15/22	Mon 2/20/23
38	Mockup Procurement	30 days	Fri 11/18/22	Wed 1/4/23
39	Mockups Constructed & Complete	10 days	Thu 1/5/23	Thu 1/19/23
40	Mockups Complete	0 days	Thu 1/19/23	Thu 1/19/23
41	AHU Deliveries	0 days	Wed 7/26/23	Wed 7/26/23
42	Electrical Gear Deliveries	0 days	Thu 9/7/23	Thu 9/7/23
43	Construction	582 days	Mon 10/24/22	Thu 2/13/25
44	Notice to Proceed	0 days	Mon 10/24/22	Mon 10/24/22
45	Mobilization	17 days	Tue 10/25/22	Wed 11/16/22
46	Site Fencing	5 days	Tue 10/25/22	Mon 10/31/22
47	TESC BMP's Install	3 days	Tue 10/25/22	Thu 10/27/22
48	Access Road & Canal Crossing	3 days	Thu 10/27/22	Mon 10/31/22
49	Gravel Parking & Temp Power	5 days	Tue 11/1/22	Mon 11/7/22
50	Job Trailers	5 days	Fri 11/4/22	Thu 11/10/22
51	Signage & Misc	5 days	Thu 11/10/22	Wed 11/16/22
52	Begin Construction	0 days	Mon 11/14/22	Mon 11/14/22
53	Site Work & Utilities - 2022	84 days	Fri 10/28/22	Wed 3/1/23
54	Canal Relocation (By SVID)	20 days	Fri 10/28/22	Mon 11/28/22
55	Clear & Grub	6 days	Tue 11/8/22	Tue 11/15/22
56	Site Grading & Mass Excavation	13 days	Wed 11/16/22	Tue 12/6/22
57	Site Utilities (Weather Dependent)	60 days	Mon 12/5/22	Wed 3/1/23
58	Foundations	123 days	Wed 11/16/22	Fri 5/12/23
59	Excavation & Underground	49 days	Wed 11/16/22	Mon 1/30/23
60	Building Pad - Area A-D	8 days	Wed 11/16/22	Tue 11/29/22
61	Building Pad - Area G	2 days	Wed 11/30/22	Thu 12/1/22
62	Underground MEP - Area A & B	19 days	Wed 11/23/22	Wed 12/21/22
63	Underground MEP - Area C & D	16 days	Thu 12/22/22	Tue 1/17/23
64	Underground MEP - Area G	3 days	Thu 12/22/22	Tue 12/27/22
65	Excavate Footings Area G	3 days	Fri 12/2/22	Tue 12/6/22
66	Excavate Footings Area B & A	11 days	Wed 12/14/22	Thu 12/29/22
67	Excavate Footings Area C & D	9 days	Wed 1/18/23	Mon 1/30/23
68	Area G	70 days	Wed 12/7/22	Fri 3/17/23
69	Form, Rebar, & Place Footings	11 days	Wed 12/7/22	Wed 12/21/22
70	Backfill & Subgrade	5 days	Wed 12/21/22	Wed 12/28/22



MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
71	SOG Prep & Place	5 days	Mon 3/13/23	Fri 3/17/23
72	**Area B.2**	**38 days**	**Tue 12/27/22**	**Mon 2/20/23**
73	Form, Rebar, & Place Footings	16 days	Tue 12/27/22	Thu 1/19/23
74	Insulate & Backfill	3 days	Fri 1/20/23	Tue 1/24/23
75	Underslab MEP	9 days	Wed 1/25/23	Mon 2/6/23
76	Gravel Subgrade & Vapor Barrier	3 days	Mon 2/6/23	Wed 2/8/23
77	Form, Rebar & Place SOG	4 days	Thu 2/9/23	Tue 2/14/23
78	Form, Rebar & Place Perimeter Curb	4 days	Wed 2/15/23	Mon 2/20/23
79	**Area B.1**	**45 days**	**Fri 1/20/23**	**Thu 3/23/23**
80	Form, Rebar, & Place Footings	18 days	Fri 1/20/23	Tue 2/14/23
81	Insulate & Backfill	4 days	Wed 2/15/23	Mon 2/20/23
82	Underslab MEP	11 days	Tue 2/21/23	Tue 3/7/23
83	Gravel Subgrade & Vapor Barrier	4 days	Tue 3/7/23	Fri 3/10/23
84	Form, Rebar & Place SOG	5 days	Mon 3/13/23	Fri 3/17/23
85	Form, Rebar & Place Perimeter Curb	4 days	Mon 3/20/23	Thu 3/23/23
86	**Area A**	**52 days**	**Wed 2/15/23**	**Thu 4/27/23**
87	Form, Rebar, & Place Footings	14 days	Wed 2/15/23	Mon 3/6/23
88	Insulate & Backfill	3 days	Tue 3/7/23	Thu 3/9/23
89	Underslab MEP	8 days	Fri 3/10/23	Tue 3/21/23
90	Gravel Subgrade & Vapor Barrier	3 days	Wed 3/22/23	Fri 3/24/23
91	Form, Rebar & Place SOG	4 days	Mon 3/27/23	Thu 3/30/23
92	Form, Rebar & Place Perimeter Curb	4 days	Fri 3/31/23	Wed 4/5/23
93	Loading Docks	16 days	Thu 4/6/23	Thu 4/27/23
94	**Area D**	**42 days**	**Tue 3/7/23**	**Wed 5/3/23**
95	Form, Rebar, & Place Footings	16 days	Tue 3/7/23	Tue 3/28/23
96	Insulate & Backfill	3 days	Wed 3/29/23	Fri 3/31/23
97	Underslab MEP	12 days	Mon 4/3/23	Tue 4/18/23
98	Gravel Subgrade & Vapor Barrier	3 days	Wed 4/19/23	Fri 4/21/23
99	Form, Rebar & Place SOG	4 days	Mon 4/24/23	Thu 4/27/23
100	Form, Rebar & Place Perimeter Curb	4 days	Fri 4/28/23	Wed 5/3/23
101	**Area C**	**33 days**	**Wed 3/29/23**	**Fri 5/12/23**
102	Form, Rebar, & Place Footings	9 days	Wed 3/29/23	Mon 4/10/23
103	Insulate & Backfill	2 days	Tue 4/11/23	Wed 4/12/23
104	Underslab MEP	7 days	Wed 4/19/23	Thu 4/27/23
105	Gravel Subgrade & Vapor Barrier	3 days	Fri 4/28/23	Tue 5/2/23
106	Form, Rebar & Place SOG	4 days	Thu 5/4/23	Tue 5/9/23
107	Form, Rebar & Place Perimeter Curb	3 days	Wed 5/10/23	Fri 5/12/23
108	**Superstructure**	**166 days**	**Mon 2/13/23**	**Thu 10/5/23**
109	**Area G PEMB**	**29 days**	**Mon 2/13/23**	**Thu 3/23/23**
110	Erect PEMB	8 days	Mon 2/13/23	Wed 2/22/23
111	PEMB Siding & Roof	12 days	Thu 2/23/23	Fri 3/10/23
112	Doors & Hardware	4 days	Mon 3/20/23	Thu 3/23/23
113	**Concrete Structure**	**94 days**	**Fri 3/24/23**	**Fri 8/4/23**
114	**Area B.2**	**32 days**	**Fri 3/24/23**	**Mon 5/8/23**
115	Level 1 - Form, Rebar, & Place Colun	10 days	Fri 3/24/23	Thu 4/6/23
116	Level 2 - Form, Rebar, & Place Deck	17 days	Fri 4/7/23	Mon 5/1/23
117	Level 2 - MEP Deck Rough-In	8 days	Fri 4/14/23	Tue 4/25/23
118	Level 2 - Strip Deck	5 days	Tue 5/2/23	Mon 5/8/23
119	**Area B.1**	**41 days**	**Fri 4/7/23**	**Mon 6/5/23**
120	Level 1 - Form, Rebar, & Place Colun	12 days	Fri 4/7/23	Mon 4/24/23
121	Level 2 - Form, Rebar, & Place Deck	19 days	Tue 5/2/23	Fri 5/26/23
122	Level 2 - MEP Deck Rough-In	10 days	Tue 5/9/23	Mon 5/22/23
123	Level 2 - Strip Deck	5 days	Tue 5/30/23	Mon 6/5/23
124	**Area F**	**53 days**	**Tue 4/25/23**	**Mon 7/10/23**
125	Level 2 - Form, Rebar, & Place Colun	11 days	Tue 4/25/23	Tue 5/9/23
126	Level 3 - Form, Rebar, & Place Deck	18 days	Tue 5/30/23	Thu 6/22/23
127	Level 3 - MEP Deck Rough-In	5 days	Tue 6/6/23	Mon 6/12/23
128	Level 3 - Strip Deck	5 days	Fri 6/23/23	Thu 6/29/23
129	Level 3 - Form, Rebar, & Place Colun	8 days	Wed 6/28/23	Mon 7/10/23
130	**Area E**	**61 days**	**Wed 5/10/23**	**Fri 8/4/23**
131	Level 2 - Form, Rebar, & Place Colun	13 days	Wed 5/10/23	Fri 5/26/23
132	Level 3 - Form, Rebar, & Place Deck	19 days	Fri 6/23/23	Thu 7/20/23
133	Level 3 - MEP Deck Rough-In	5 days	Fri 6/30/23	Fri 7/7/23
134	Level 3 - Strip Deck	5 days	Fri 7/21/23	Thu 7/27/23
135	Level 3 - Form, Rebar, & Place Colun	8 days	Wed 7/26/23	Fri 8/4/23
136	**Structural Steel**	**105 days**	**Tue 5/9/23**	**Thu 10/5/23**
137	**Area A**	**19 days**	**Tue 5/9/23**	**Mon 6/5/23**
138	Columns/Beams/Joists	11 days	Tue 5/9/23	Tue 5/23/23
139	Decking & Ledger	6 days	Tue 5/23/23	Wed 5/31/23
140	Misc Steel	4 days	Wed 5/31/23	Mon 6/5/23
141	**Area C**	**19 days**	**Thu 6/1/23**	**Tue 6/27/23**



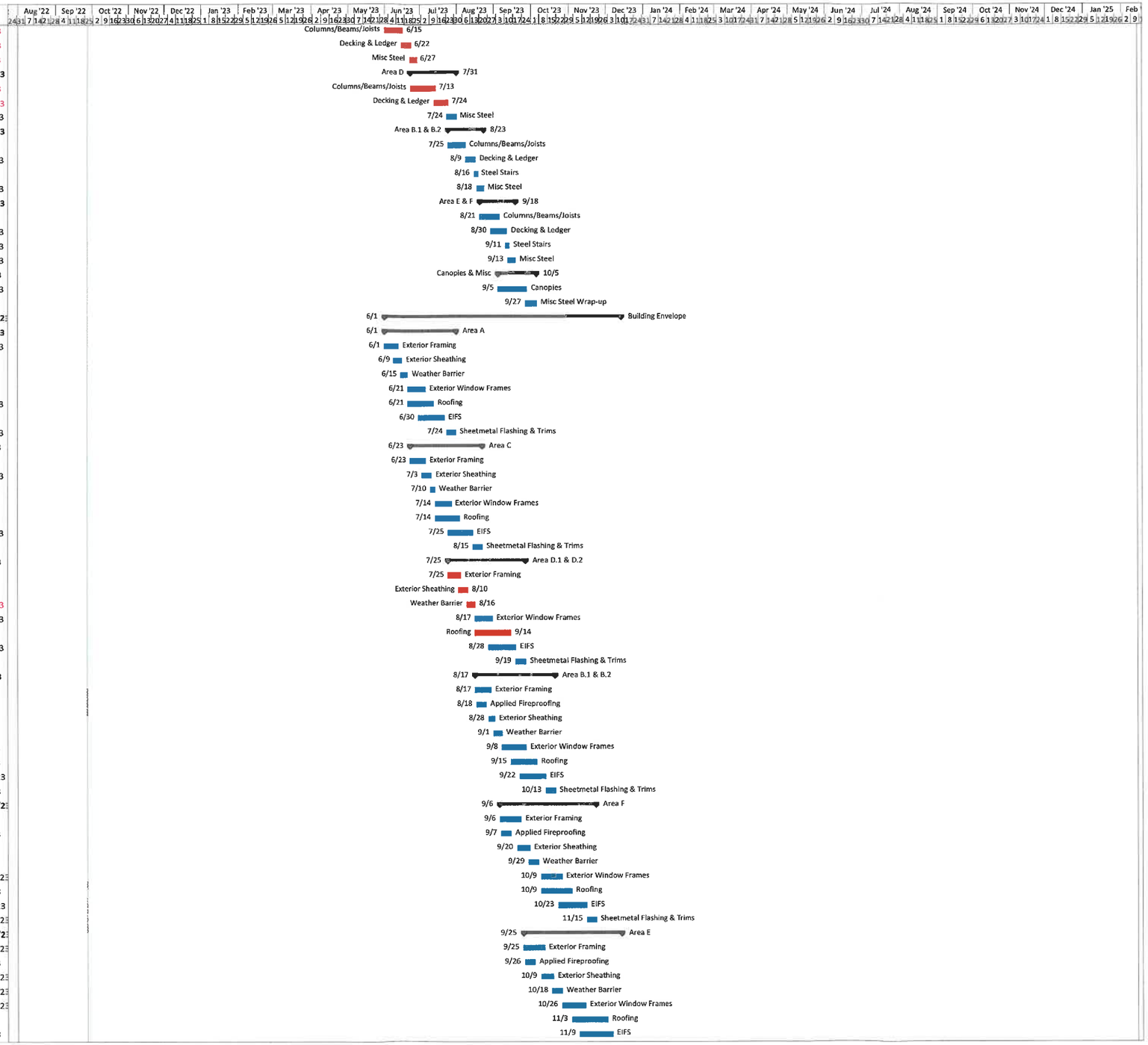
BOUTEN CONSTRUCTION COMPANY

PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

Data Date: Mon 8/1/22

MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
142	Columns/Beams/Joists	11 days	Thu 6/1/23	Thu 6/15/23
143	Decking & Ledger	6 days	Thu 6/15/23	Thu 6/22/23
144	Misc Steel	4 days	Thu 6/22/23	Tue 6/27/23
145	**Area D**	**26 days**	**Fri 6/23/23**	**Mon 7/31/23**
146	Columns/Beams/Joists	14 days	Fri 6/23/23	Thu 7/13/23
147	Decking & Ledger	8 days	Thu 7/13/23	Mon 7/24/23
148	Misc Steel	6 days	Mon 7/24/23	Mon 7/31/23
149	**Area B.1 & B.2**	**22 days**	**Tue 7/25/23**	**Wed 8/23/23**
150	Columns/Beams/Joists	11 days	Tue 7/25/23	Tue 8/8/23
151	Decking & Ledger	6 days	Wed 8/9/23	Wed 8/16/23
152	Steel Stairs	3 days	Wed 8/16/23	Fri 8/18/23
153	Misc Steel	4 days	Fri 8/18/23	Wed 8/23/23
154	**Area E & F**	**20 days**	**Mon 8/21/23**	**Mon 9/18/23**
155	Columns/Beams/Joists	11 days	Mon 8/21/23	Tue 9/5/23
156	Decking & Ledger	8 days	Wed 8/30/23	Mon 9/11/23
157	Steel Stairs	3 days	Mon 9/11/23	Wed 9/13/23
158	Misc Steel	4 days	Wed 9/13/23	Mon 9/18/23
159	**Canopies & Misc**	**23 days**	**Tue 9/5/23**	**Thu 10/5/23**
160	Canopies	17 days	Tue 9/5/23	Wed 9/27/23
161	Misc Steel Wrap-up	7 days	Wed 9/27/23	Thu 10/5/23
162	**Building Envelope**	**136 days**	**Thu 6/1/23**	**Wed 12/13/2**
163	**Area A**	**42 days**	**Thu 6/1/23**	**Mon 7/31/23**
164	Exterior Framing	8 days	Thu 6/1/23	Mon 6/12/23
165	Exterior Sheathing	5 days	Fri 6/9/23	Thu 6/15/23
166	Weather Barrier	4 days	Thu 6/15/23	Tue 6/20/23
167	Exterior Window Frames	10 days	Wed 6/21/23	Wed 7/5/23
168	Roofing	15 days	Wed 6/21/23	Wed 7/12/23
169	EIFS	15 days	Fri 6/30/23	Fri 7/21/23
170	Sheetmetal Flashing & Trims	6 days	Mon 7/24/23	Mon 7/31/23
171	**Area C**	**42 days**	**Fri 6/23/23**	**Tue 8/22/23**
172	Exterior Framing	8 days	Fri 6/23/23	Wed 7/5/23
173	Exterior Sheathing	5 days	Mon 7/3/23	Mon 7/10/23
174	Weather Barrier	4 days	Mon 7/10/23	Thu 7/13/23
175	Exterior Window Frames	10 days	Fri 7/14/23	Thu 7/27/23
176	Roofing	15 days	Fri 7/14/23	Thu 8/3/23
177	EIFS	15 days	Tue 7/25/23	Mon 8/14/23
178	Sheetmetal Flashing & Trims	6 days	Tue 8/15/23	Tue 8/22/23
179	**Area D.1 & D.2**	**45 days**	**Tue 7/25/23**	**Tue 9/26/23**
180	Exterior Framing	9 days	Tue 7/25/23	Fri 8/4/23
181	Exterior Sheathing	6 days	Thu 8/3/23	Thu 8/10/23
182	Weather Barrier	5 days	Thu 8/10/23	Wed 8/16/23
183	Exterior Window Frames	10 days	Thu 8/17/23	Wed 8/30/23
184	Roofing	20 days	Thu 8/17/23	Thu 9/14/23
185	EIFS	15 days	Mon 8/28/23	Mon 9/18/23
186	Sheetmetal Flashing & Trims	6 days	Tue 9/19/23	Tue 9/26/23
187	**Area B.1 & B.2**	**46 days**	**Thu 8/17/23**	**Fri 10/20/23**
188	Exterior Framing	9 days	Thu 8/17/23	Tue 8/29/23
189	Applied Fireproofing	6 days	Fri 8/18/23	Fri 8/25/23
190	Exterior Sheathing	5 days	Mon 8/28/23	Fri 9/1/23
191	Weather Barrier	4 days	Fri 9/1/23	Thu 9/7/23
192	Exterior Window Frames	13 days	Fri 9/8/23	Tue 9/26/23
193	Roofing	15 days	Fri 9/15/23	Thu 10/5/23
194	EIFS	15 days	Fri 9/22/23	Thu 10/12/23
195	Sheetmetal Flashing & Trims	6 days	Fri 10/13/23	Fri 10/20/23
196	**Area F**	**56 days**	**Wed 9/6/23**	**Wed 11/22/2**
197	Exterior Framing	13 days	Wed 9/6/23	Fri 9/22/23
198	Applied Fireproofing	6 days	Thu 9/7/23	Thu 9/14/23
199	Exterior Sheathing	8 days	Wed 9/20/23	Fri 9/29/23
200	Weather Barrier	6 days	Fri 9/29/23	Fri 10/6/23
201	Exterior Window Frames	13 days	Mon 10/9/23	Wed 10/25/2
202	Roofing	19 days	Mon 10/9/23	Thu 11/2/23
203	EIFS	17 days	Mon 10/23/23	Tue 11/14/23
204	Sheetmetal Flashing & Trims	6 days	Wed 11/15/23	Wed 11/22/2
205	**Area E**	**56 days**	**Mon 9/25/23**	**Wed 12/13/2**
206	Exterior Framing	13 days	Mon 9/25/23	Wed 10/11/2
207	Applied Fireproofing	6 days	Tue 9/26/23	Tue 10/3/23
208	Exterior Sheathing	8 days	Mon 10/9/23	Wed 10/18/2
209	Weather Barrier	6 days	Wed 10/18/23	Wed 10/25/2
210	Exterior Window Frames	13 days	Thu 10/26/23	Mon 11/13/2
211	Roofing	19 days	Fri 11/3/23	Fri 12/1/23
212	EIFS	17 days	Thu 11/9/23	Tue 12/5/23



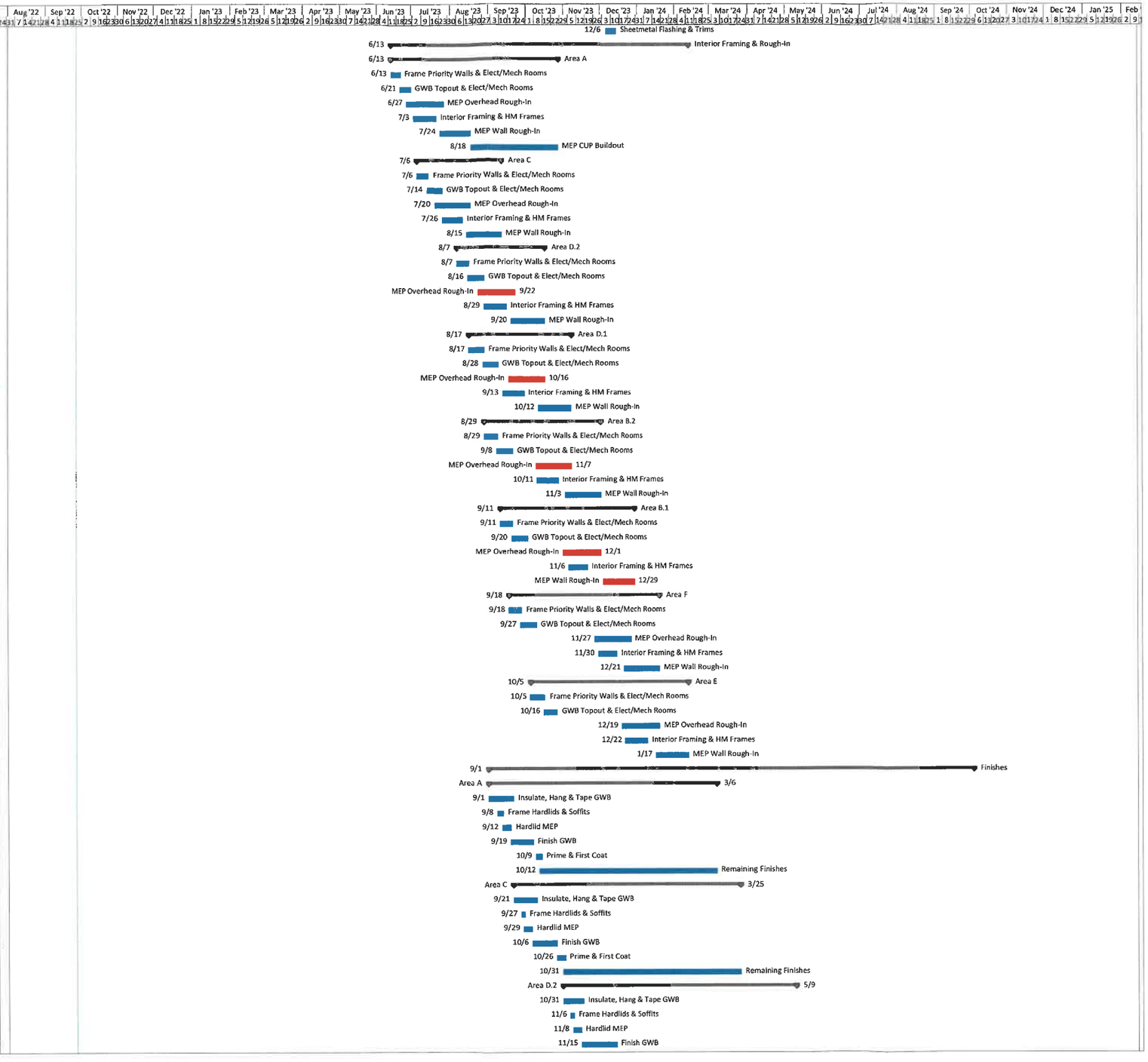
BOULTEN CONSTRUCTION COMPANY

PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

MILESTONE CONSTRUCTION SCHEDULE

Data Date: Mon 8/1/22

ID	Task Name	Dur	Start	Finish
213	Sheetmetal Flashing & Trims	6 days	Wed 12/6/23	Wed 12/13/23
214	**Interior Framing & Rough-In**	**168 days**	**Tue 6/13/23**	**Mon 2/12/24**
215	**Area A**	**97 days**	**Tue 6/13/23**	**Fri 10/27/23**
216	Frame Priority Walls & Elect/Mech Roc	7 days	Tue 6/13/23	Wed 6/21/23
217	GWB Topout & Elect/Mech Rooms	8 days	Wed 6/21/23	Fri 6/30/23
218	MEP Overhead Rough-In	21 days	Tue 6/27/23	Wed 7/26/23
219	Interior Framing & HM Frames	13 days	Mon 7/3/23	Thu 7/20/23
220	MEP Wall Rough-In	19 days	Mon 7/24/23	Thu 8/17/23
221	MEP CUP Buildout	50 days	Fri 8/18/23	Fri 10/27/23
222	**Area C**	**47 days**	**Thu 7/6/23**	**Mon 9/11/23**
223	Frame Priority Walls & Elect/Mech Roc	7 days	Thu 7/6/23	Fri 7/14/23
224	GWB Topout & Elect/Mech Rooms	8 days	Fri 7/14/23	Tue 7/25/23
225	MEP Overhead Rough-In	21 days	Thu 7/20/23	Thu 8/17/23
226	Interior Framing & HM Frames	13 days	Wed 7/26/23	Fri 8/11/23
227	MEP Wall Rough-In	19 days	Tue 8/15/23	Mon 9/11/23
228	**Area D.2**	**50 days**	**Mon 8/7/23**	**Mon 10/16/23**
229	Frame Priority Walls & Elect/Mech Roc	8 days	Mon 8/7/23	Wed 8/16/23
230	GWB Topout & Elect/Mech Rooms	9 days	Wed 8/16/23	Mon 8/28/23
231	MEP Overhead Rough-In	21 days	Thu 8/24/23	Fri 9/22/23
232	Interior Framing & HM Frames	13 days	Tue 8/29/23	Fri 9/15/23
233	MEP Wall Rough-In	19 days	Wed 9/20/23	Mon 10/16/23
234	**Area D.1**	**58 days**	**Thu 8/17/23**	**Tue 11/7/23**
235	Frame Priority Walls & Elect/Mech Roc	8 days	Thu 8/17/23	Mon 8/28/23
236	GWB Topout & Elect/Mech Rooms	9 days	Mon 8/28/23	Fri 9/8/23
237	MEP Overhead Rough-In	21 days	Mon 9/18/23	Mon 10/16/23
238	Interior Framing & HM Frames	13 days	Wed 9/13/23	Fri 9/29/23
239	MEP Wall Rough-In	19 days	Thu 10/12/23	Tue 11/7/23
240	**Area B.2**	**66 days**	**Tue 8/29/23**	**Fri 12/1/23**
241	Frame Priority Walls & Elect/Mech Roc	8 days	Tue 8/29/23	Fri 9/8/23
242	GWB Topout & Elect/Mech Rooms	9 days	Fri 9/8/23	Wed 9/20/23
243	MEP Overhead Rough-In	21 days	Tue 10/10/23	Tue 11/7/23
244	Interior Framing & HM Frames	13 days	Wed 10/11/23	Fri 10/27/23
245	MEP Wall Rough-In	19 days	Fri 11/3/23	Fri 12/1/23
246	**Area B.1**	**77 days**	**Mon 9/11/23**	**Fri 12/29/23**
247	Frame Priority Walls & Elect/Mech Roc	8 days	Mon 9/11/23	Wed 9/20/23
248	GWB Topout & Elect/Mech Rooms	9 days	Wed 9/20/23	Mon 10/2/23
249	MEP Overhead Rough-In	21 days	Wed 11/1/23	Fri 12/1/23
250	Interior Framing & HM Frames	11 days	Mon 11/6/23	Mon 11/20/23
251	MEP Wall Rough-In	19 days	Mon 12/4/23	Fri 12/29/23
252	**Area F**	**85 days**	**Mon 9/18/23**	**Fri 1/19/24**
253	Frame Priority Walls & Elect/Mech Roc	8 days	Mon 9/18/23	Wed 9/27/23
254	GWB Topout & Elect/Mech Rooms	9 days	Wed 9/27/23	Mon 10/9/23
255	MEP Overhead Rough-In	21 days	Mon 11/27/23	Tue 12/26/23
256	Interior Framing & HM Frames	11 days	Thu 11/30/23	Thu 12/14/23
257	MEP Wall Rough-In	19 days	Thu 12/21/23	Fri 1/19/24
258	**Area E**	**88 days**	**Thu 10/5/23**	**Mon 2/12/24**
259	Frame Priority Walls & Elect/Mech Roc	8 days	Thu 10/5/23	Mon 10/16/23
260	GWB Topout & Elect/Mech Rooms	9 days	Mon 10/16/23	Thu 10/26/23
261	MEP Overhead Rough-In	21 days	Tue 12/19/23	Fri 1/19/24
262	Interior Framing & HM Frames	11 days	Fri 12/22/23	Tue 1/9/24
263	MEP Wall Rough-In	19 days	Wed 1/17/24	Mon 2/12/24
264	**Finishes**	**276 days**	**Fri 9/1/23**	**Thu 10/3/24**
265	**Area A**	**128 days**	**Fri 9/1/23**	**Wed 3/6/24**
266	Insulate, Hang & Tape GWB	13 days	Fri 9/1/23	Wed 9/20/23
267	Frame Hardlids & Soffits	3 days	Fri 9/8/23	Tue 9/12/23
268	Hardlid MEP	5 days	Tue 9/12/23	Mon 9/18/23
269	Finish GWB	14 days	Tue 9/19/23	Fri 10/6/23
270	Prime & First Coat	5 days	Mon 10/9/23	Fri 10/13/23
271	Remaining Finishes	100 days	Thu 10/12/23	Wed 3/6/24
272	**Area C**	**128 days**	**Thu 9/21/23**	**Mon 3/25/24**
273	Insulate, Hang & Tape GWB	13 days	Thu 9/21/23	Mon 10/9/23
274	Frame Hardlids & Soffits	3 days	Wed 9/27/23	Fri 9/29/23
275	Hardlid MEP	5 days	Fri 9/29/23	Thu 10/5/23
276	Finish GWB	14 days	Fri 10/6/23	Wed 10/25/23
277	Prime & First Coat	5 days	Thu 10/26/23	Wed 11/1/23
278	Remaining Finishes	100 days	Tue 10/31/23	Mon 3/25/24
279	**Area D.2**	**133 days**	**Tue 10/31/23**	**Thu 5/9/24**
280	Insulate, Hang & Tape GWB	13 days	Tue 10/31/23	Thu 11/16/23
281	Frame Hardlids & Soffits	3 days	Mon 11/6/23	Wed 11/8/23
282	Hardlid MEP	5 days	Wed 11/8/23	Tue 11/14/23
283	Finish GWB	19 days	Wed 11/15/23	Wed 12/13/23



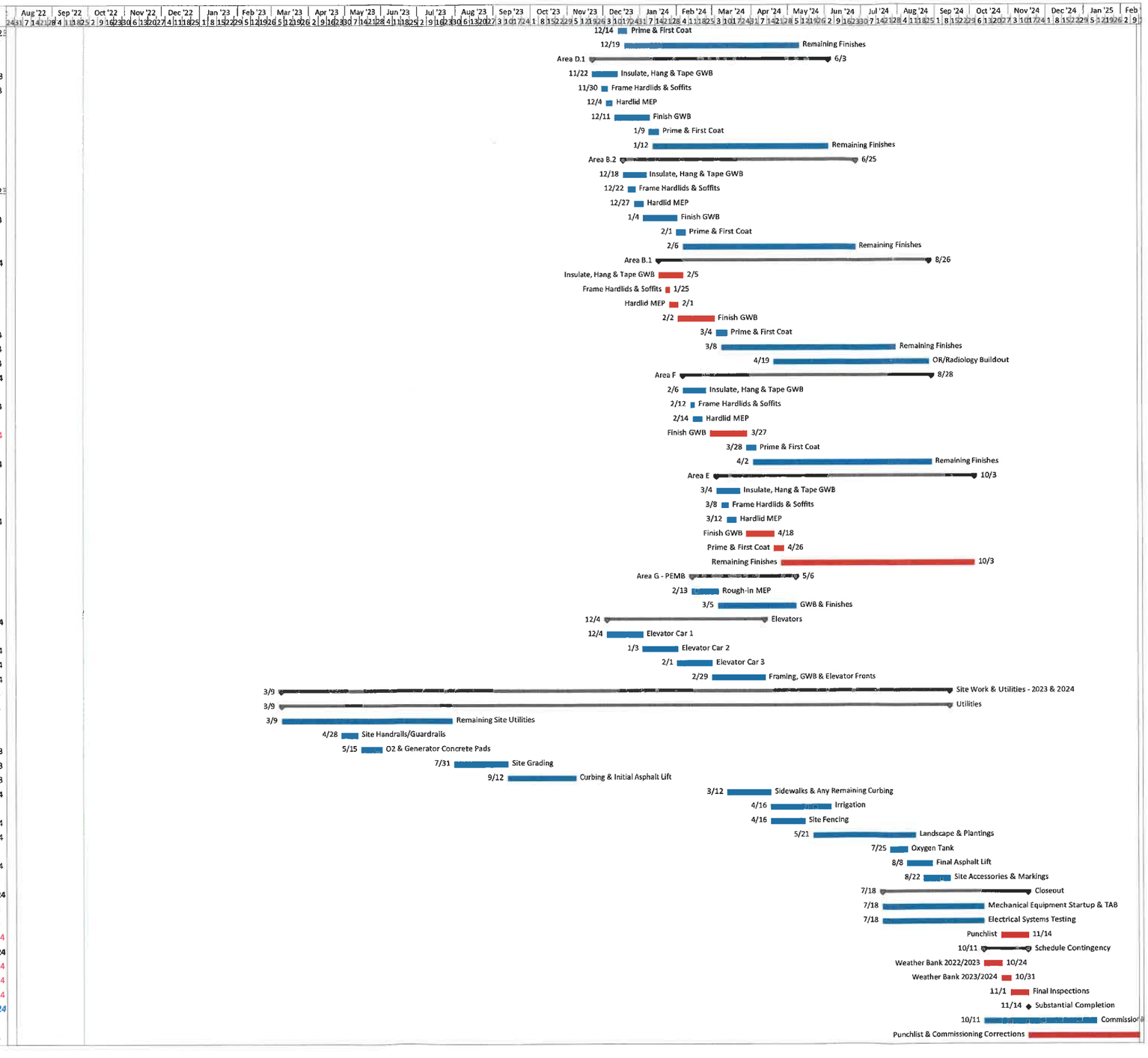
BOUTEN CONSTRUCTION COMPANY

PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

Data Date: Mon 8/1/22

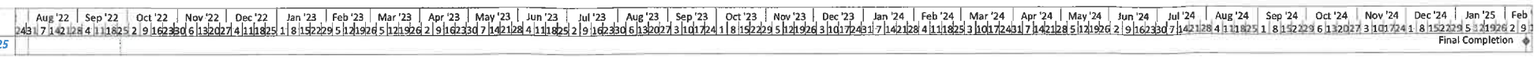
MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
284	Prime & First Coat	5 days	Thu 12/14/23	Wed 12/20/23
285	Remaining Finishes	100 days	Tue 12/19/23	Thu 5/9/24
286	**Area D.1**	**133 days**	**Wed 11/22/23**	**Mon 6/3/24**
287	Insulate, Hang & Tape GWB	13 days	Wed 11/22/23	Tue 12/12/23
288	Frame Hardlids & Soffits	3 days	Thu 11/30/23	Mon 12/4/23
289	Hardlid MEP	5 days	Mon 12/4/23	Fri 12/8/23
290	Finish GWB	19 days	Mon 12/11/23	Mon 1/8/24
291	Prime & First Coat	5 days	Tue 1/9/24	Tue 1/16/24
292	Remaining Finishes	100 days	Fri 1/12/24	Mon 6/3/24
293	**Area B.2**	**133 days**	**Mon 12/18/23**	**Tue 6/25/24**
294	Insulate, Hang & Tape GWB	13 days	Mon 12/18/23	Fri 1/5/24
295	Frame Hardlids & Soffits	3 days	Fri 12/22/23	Wed 12/27/23
296	Hardlid MEP	5 days	Wed 12/27/23	Wed 1/3/24
297	Finish GWB	19 days	Thu 1/4/24	Wed 1/31/24
298	Prime & First Coat	5 days	Thu 2/1/24	Wed 2/7/24
299	Remaining Finishes	100 days	Tue 2/6/24	Tue 6/25/24
300	**Area B.1**	**157 days**	**Wed 1/17/24**	**Mon 8/26/24**
301	Insulate, Hang & Tape GWB	14 days	Wed 1/17/24	Mon 2/5/24
302	Frame Hardlids & Soffits	3 days	Tue 1/23/24	Thu 1/25/24
303	Hardlid MEP	5 days	Fri 1/26/24	Thu 2/1/24
304	Finish GWB	21 days	Fri 2/2/24	Fri 3/1/24
305	Prime & First Coat	6 days	Mon 3/4/24	Mon 3/11/24
306	Remaining Finishes	100 days	Fri 3/8/24	Mon 7/29/24
307	OR/Radiology Buildout	90 days	Fri 4/19/24	Mon 8/26/24
308	**Area F**	**145 days**	**Tue 2/6/24**	**Wed 8/28/24**
309	Insulate, Hang & Tape GWB	14 days	Tue 2/6/24	Fri 2/23/24
310	Frame Hardlids & Soffits	3 days	Mon 2/12/24	Wed 2/14/24
311	Hardlid MEP	5 days	Wed 2/14/24	Tue 2/20/24
312	Finish GWB	21 days	Wed 2/28/24	Wed 3/27/24
313	Prime & First Coat	5 days	Thu 3/28/24	Wed 4/3/24
314	Remaining Finishes	105 days	Tue 4/2/24	Wed 8/28/24
315	**Area E**	**151 days**	**Mon 3/4/24**	**Thu 10/3/24**
316	Insulate, Hang & Tape GWB	14 days	Mon 3/4/24	Thu 3/21/24
317	Frame Hardlids & Soffits	3 days	Fri 3/8/24	Tue 3/12/24
318	Hardlid MEP	5 days	Tue 3/12/24	Mon 3/18/24
319	Finish GWB	16 days	Thu 3/28/24	Thu 4/18/24
320	Prime & First Coat	6 days	Fri 4/19/24	Fri 4/26/24
321	Remaining Finishes	113 days	Thu 4/25/24	Thu 10/3/24
322	**Area G - PEMB**	**60 days**	**Tue 2/13/24**	**Mon 5/6/24**
323	Rough-in MEP	15 days	Tue 2/13/24	Mon 3/4/24
324	GWB & Finishes	45 days	Tue 3/5/24	Mon 5/6/24
325	**Elevators**	**90 days**	**Mon 12/4/23**	**Wed 4/10/24**
326	Elevator Car 1	20 days	Mon 12/4/23	Tue 1/2/24
327	Elevator Car 2	20 days	Wed 1/3/24	Wed 1/31/24
328	Elevator Car 3	20 days	Thu 2/1/24	Wed 2/28/24
329	Framing, GWB & Elevator Fronts	30 days	Thu 2/29/24	Wed 4/10/24
330	**Site Work & Utilities - 2023 & 2024**	**385 days**	**Thu 3/9/23**	**Thu 9/12/24**
331	**Utilities**	**385 days**	**Thu 3/9/23**	**Thu 9/12/24**
332	Remaining Site Utilities	100 days	Thu 3/9/23	Fri 7/28/23
333	Site Handrails/Guardrails	10 days	Fri 4/28/23	Thu 5/11/23
334	O2 & Generator Concrete Pads	12 days	Mon 5/15/23	Wed 5/31/23
335	Site Grading	30 days	Mon 7/31/23	Mon 9/11/23
336	Curbing & Initial Asphalt Lift	40 days	Tue 9/12/23	Mon 11/6/23
337	Sidewalks & Any Remaining Curbing	25 days	Tue 3/12/24	Mon 4/15/24
338	Irrigation	35 days	Tue 4/16/24	Tue 6/4/24
339	Site Fencing	20 days	Tue 4/16/24	Mon 5/13/24
340	Landscape & Plantings	60 days	Tue 5/21/24	Wed 8/14/24
341	Oxygen Tank	10 days	Thu 7/25/24	Thu 8/8/24
342	Final Asphalt Lift	15 days	Thu 8/8/24	Wed 8/28/24
343	Site Accessories & Markings	15 days	Thu 8/22/24	Thu 9/12/24
344	**Closeout**	**85 days**	**Thu 7/18/24**	**Thu 11/14/24**
345	Mechanical Equipment Startup & TAB	60 days	Thu 7/18/24	Fri 10/11/24
346	Electrical Systems Testing	60 days	Thu 7/18/24	Fri 10/11/24
347	Punchlist	15 days	Fri 10/25/24	Thu 11/14/24
348	**Schedule Contingency**	**25 days**	**Fri 10/11/24**	**Thu 11/14/24**
349	Weather Bank 2022/2023	10 days	Fri 10/11/24	Thu 10/24/24
350	Weather Bank 2023/2024	5 days	Fri 10/25/24	Thu 10/31/24
351	Final Inspections	10 days	Fri 11/1/24	Thu 11/14/24
352	***Substantial Completion***	***0 days***	***Thu 11/14/24***	***Thu 11/14/24***
353	Commissioning	60 days	Fri 10/11/24	Wed 1/8/25
354	Punchlist & Commissioning Corrections	60 days	Fri 11/15/24	Thu 2/13/25



MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
355	*Final Completion*	*0 days*	*Thu 2/13/25*	*Thu 2/13/25*



AIA® Document A133™ – 2019

Standard Form of Agreement Between Owner and Construction Manager as Constructor where the basis of payment is the Cost of the Work Plus a Fee with a Guaranteed Maximum Price

AGREEMENT made as of the 29th day of September in the year 2022
(In words, indicate day, month, and year.)

BETWEEN the Owner:
(Name, legal status, address, and other information)

Prosser Public Hospital District No. 1, d/b/a Prosser Memorial Health
723 Memorial St.
Prosser, WA 99350

and the Construction Manager:
(Name, legal status, address, and other information)

Bouten Construction Co.
1060 Jadwin Ave, Suite 300
Richland, WA 99352

for the following Project:
(Name, location, and detailed description)

Prosser Memorial Health Hospital Replacement Facility
723 Memorial St.
Prosser, WA 99350

The Architect:
(Name, legal status, address, and other information)

bcDESIGNGROUP, LLC
12101 W. 110th Street, Suite 100
Overland Park, KS 66201

The Owner and Construction Manager agree as follows.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

AIA Document A201™–2017, General Conditions of the Contract for Construction, is adopted in this document by reference. Do not use with other general conditions unless this document is modified.

TABLE OF ARTICLES

ARTICLE 1.0 DEFINITIONS

§ 1.0 Definitions. These Definitions are often shorthand references to more formal definitions elsewhere in the Contract Documents. When a defined term is described elsewhere in the Contract Documents, the more descriptive definition shall control over any general description in this Section 1.0.

§ 1.0.1 Agreement. The Agreement is this revised A133–2019 Standard Form of Agreement between Owner and Construction Manager as Constructor. All references in this Agreement to the A133-2019 are to the revised Agreement.

§ 1.0.2 Allowance. An Allowance is a stated amount included in the GMP for a stated portion of the Work that is not fully defined and/or quantified at the time the GMP is established. When that part of the Work is adequately defined and/or quantified, the GMP will be adjusted though a Change Order to account for the difference between the Allowance and the actual or estimated Cost of the Work for that item in an amount that is mutually agreeable to the Owner and Construction Manager. Upon execution of the applicable Change Order, that portion of the Work will no longer be an Allowance item.

§ 1.0.3 Application for Payment. An Application for Payment is described in Section 9.3 of the General Conditions and Section 11.1 of this Agreement. An Application for Payment is generally a document the Construction Manager submits to the Owner and Architect itemizing amounts the Construction Manager believes are due and Work completed in accordance with the Contract Documents.

§ 1.0.4 Architect. The Architect, listed above, is the entity with which the Owner has contracted in a separate Owner-Architect agreement. The Architect is described in Section 4.3 of this Agreement and defined in Section 4.1 of the General Conditions.

§ 1.0.5 Change Order. A Change Order is defined in Section 7.2.1 of the General Conditions and is generally a written instrument prepared by the Architect and signed by the Owner, the Construction Manager, and the Architect that modifies the Contract Documents and sets forth their agreement upon a Change in the Work, the amount of the adjustment, if any, in the GMP, and the extent of the adjustment, if any, in the Contract Time.

§ 1.0.6 Claim. A Claim is defined in Section 15.1.1 of the General Conditions and generally consists of a demand or assertion by one of the parties seeking, as a matter of right, adjustments or interpretations of Contract terms, payment of money, an extension of time, or other relief. The term "Claim" includes disputes and matters in question between the Owner and the Construction Manager arising out of or relating to the Contract Documents.

§ 1.0.7 Construction Change Directive. A Construction Change Directive is defined in Section 7.3 of the General Conditions as a written order prepared and signed by the Owner and the Architect, with or without the agreement of the Construction Manager, directing the Construction Manager to perform a change in the Work, or perform Work the Construction Manager contends to be a change in the Work, prior to agreement on the basis for adjustment, if any, to the Contract.

§ 1.0.8 Construction Manager. The Construction Manager is the entity identified above as the party to this Agreement responsible for performing the Preconstruction Services and, upon successful negotiation and execution of the GMP Amendment, responsible for construction of the Project through its own services as well as through Subcontractors. The Construction Manager is identified as the "Contractor" in the General Conditions and shall provide the services of a General Contractor/Construction Manager as defined in Chapter 39.10 RCW.

§ 1.0.9 Construction Phase. The Construction Phase is defined in Section 3.3 of this Agreement and further in the Contract Documents, and generally consists of the period of the Contract during which the Construction Manager performs construction of the Project after the earlier of execution of the GMP Amendment or the Owner's issuance of a Notice to Proceed.

§ 1.0.10 Contingency. The Construction Manager's Contingency is described in Section 3.2.3.1 and generally is an amount stated in the GMP for use by the Construction Manager, with the Owner's approval, for Costs of the Work that are not Changes in the Work. The Construction Manager's Contingency is included in the MACC. The amount of the Construction Manager's Contingency will be negotiated as part of the GMP and will be established in the GMP Amendment.

§ 1.0.11 Contract Documents. The Contract Documents are defined in Section 2.1 of this Agreement and Section 1.1.1 of the General Conditions, and generally consist of this Agreement and its exhibits, the General Conditions (referred to herein as "General Conditions" or "AIA Document A201–2017"), and other conditions of the Contract, the Drawings and Specifications (including documents from Design-Build Subcontractors), Addenda, other documents listed in this Agreement, and Modifications and Amendments issued after execution of the Contract.

§ 1.0.12 Contract. The Contract is the agreement between the Owner and the Construction Manager and is formed by the Contract Documents.

§ 1.0.13 Contract Sum. The Contract Sum is defined in Section 6.1 of this Agreement and Section 9.1 of the General Conditions that the Owner agrees to pay the Construction Manager for its proper performance of the Work under the Contract Documents. The Contract Sum shall not exceed the GMP. Neither the Preconstruction Services Cost nor the Washington State Sales Tax (WSST) due on the Contract Sum is included in the Contract Sum.

§ 1.0.14 Contract Time. The Contract Time is the time defined in Section 8.1 of the General Conditions and set forth in the GMP Amendment for achieving Substantial Completion of the Work.

§ 1.0.15 Contractor. The term Contractor means the Construction Manager.

§ 1.0.16 Cost of the Work. The Cost of the Work is the amount defined in Article 7 of this Agreement reasonably and necessarily incurred by the Construction Manager in the proper performance of the Work under the Contract Documents. Costs of the Work are to be separately recorded. The Cost of the Work includes Subcontractor bid packages, the Specified

General Conditions, and the Negotiated Support Services, but does not include the Construction Manager's Fee or Washington State Sales Tax (WSST) on progress payments made by the Owner to the Construction Manager.

§ 1.0.17 Drawings. The Drawings are defined in Section 1.1.5 of the General Conditions and generally are the graphic and pictorial portions of the Contract Documents showing the design and location of the Work, and generally include plans, elevations, sections, details, dimensions, schedules, and diagrams. The Schematic Design, Design Development, and Construction Documents include all design documents from the conceptual level through completion. The Construction Manager shall review and provide comments on the Construction Documents.

§ 1.0.18 Fee. The Fee is the amount set forth in the GMP Amendment, based on the calculation contained in Section 6.1.2 of this Agreement, that the Construction Manager is to receive under this Agreement in addition to the Cost of the Work for its performance of the Work. The Fee compensates the Construction Manager for all aspects of its performance other than the Cost of the Work, and it includes the Construction Manager's profit and all overhead expenses not otherwise reimbursable under this Agreement, including home office overhead, the cost of the Construction Manager's insurance except builder's risk insurance (which is reimbursable as a Cost of the Work), any licenses, and all taxes (including B&O tax) except Washington State Sales Tax (WSST) due on progress payments made by the Owner to the Construction Manager. The Fee is applied to the MACC (Costs of the Work, including Negotiated Support Services and Specified General Conditions, and Contingency).

§ 1.0.19 Final Completion. Final Completion is defined in Section 9.10.1 of the General Conditions and generally occurs when the Owner finds that the Work has been concluded, any required occupancy permit has been issued, incidental corrective or punch-list Work has been completed, the Construction Manager has submitted or delivered all specified items, the Construction Manager has submitted a final Application for Payment, and the Owner has approved the final Application for Payment.

§ 1.0.20 General Conditions. The General Conditions are defined in Section 2.3 of this Agreement are set forth in the revised A201–2017 General Conditions of the Contract for Construction, which is incorporated herein by reference. All references to the "General Conditions" or to "AIA Document A201-2017" in the Contract Documents are to the revised document.

§ 1.0.21 Guaranteed Maximum Price. The Guaranteed Maximum Price (or "GMP") is defined in Section 3.2 of this Agreement, described in Section 6.2 of this Agreement, and established in the Guaranteed Maximum Price Amendment or GMP Amendment. The GMP consists of the sum established in the GMP Amendment as the fixed limit for the MACC (all Costs of the Work, including Negotiated Support Services and Specified General Conditions, and the Contingency) and the Construction Manager's Fee. As part of establishment of the GMP, the GMP Amendment shall set forth the amount of the Construction Manager's Contingency. The GMP does not include Washington State Sales Tax (WSST) due on the Contract Sum and paid on progress payments made by the Owner to the Construction Manager or the Preconstruction Services Cost. The GMP is the maximum amount the Owner is required to pay the Construction Manager for the performance of the Work. As used in this Agreement, the GMP is intended to be defined as the "total contract cost" per RCW 39.10.370(4).

§ 1.0.22 GMP Amendment. The GMP Amendment is described in Section 3.2.6 of this Agreement and generally is an amendment to this Agreement setting forth the GMP, the information and assumptions upon which the GMP is based, the Contract Time, separate amounts for Negotiated Support Services and Specified General Conditions (included within the Cost of the Work), the amount of the Construction Manager's Contingency, the agreed liquidated damages rate, and other information upon which the parties agree.

§ 1.0.23 MACC. The Maximum Allowable Construction Cost ("MACC") generally consists of the amount to which the Owner, the Architect, and the Construction Manager agree in writing as an estimate of the Cost of the Work reimbursable under Article 7 of this Agreement (including Negotiated Support Services and the Specified General Conditions) and the Construction Manager's Contingency. The MACC does not include the Construction Manager's Fee, the Preconstruction Services Cost, or Washington State Sales Tax (WSST) due on progress payments. A final MACC will be established as part of the GMP negotiation in accordance with this Agreement.

§ 1.0.24 Negotiated Support Services. Negotiated Support Services are defined in Section 7.7.5 of this Agreement and generally are items the Construction Manager normally would manage or perform for the Work, including but not limited to, surveying, maintenance of construction office and facilities, temporary sanitation, including temporary toilets,

equipment and supplies not incorporated in the Work (with the exception of electronic equipment), cranes and hoisting, erosion control, scaffolds and shoring, elevator operations, temporary fire protection, weather protection, temporary heat, power and water use during construction, including hookup, meter and fees, background checks, testing coordination, temporary signs, fences, enclosures, barriers and barricades, refuse collection, cleanup and trash removal (except for final cleaning), street cleaning, dust control, site security (including lighting), document reproductions and delivery, and maintenance of traffic on public street and roads (including flaggers). Approved Negotiated Support Services are reimbursable, consistent with the Contract Documents, to the extent they are Costs of the Work within the GMP. The Construction Manager's management of Negotiated Support Service is included within the Specified General Conditions.

§ 1.0.25 Owner. The Owner is the entity identified on the cover page of this Agreement.

§ 1.0.26 Owner-Architect Agreement. The Owner-Architect Agreement is the separate agreement between the Owner and the Architect relating to the design of the Project.

§ 1.0.27 Owner's Designated Representative. The Owner's Designated Representative, identified in Section 1.1.8, is a representative but not an agent of the Owner. His or her duties and responsibilities are set forth in the Contract Documents. The Owner's Designated Representative is not empowered to waive any terms or conditions of the Contract Documents or to commit the Owner to additional costs or time.

§ 1.0.28 Preconstruction Phase. The Preconstruction Phase is defined in Section 3.1 and generally consists of the initial portion of the Construction Manager's services and performance under the Contract prior to execution of the GMP Amendment or issuance of a Notice to Proceed.

§ 1.0.29 Preconstruction Services. The Preconstruction Services generally consist of those services provided by the Construction Manager under Sections 3.1 and 3.2 of this Agreement. While a substantial portion of the Preconstruction Services is expected to be completed prior to establishing the GMP and the execution of the GMP Amendment, some may occur during the Construction Phase, which shall be treated as Specified General Conditions. Preconstruction Services include construction planning, design review, cost estimating preliminary to the GMP, scheduling, constructability review, Subcontractor cultivation, development of the commissioning plan (including functional testing procedures) and other activities to be performed by the Construction Manager. The process of developing and negotiating the GMP and the related inclusions, qualifications and exclusions for the Construction Manager's Scope of Work to be included in Section 3.3 of the Agreement will be Specified General Conditions.

§ 1.0.30 Preconstruction Services Cost. The Preconstruction Services Cost is defined in Section 5.1.1 of this Agreement and is the compensation payable by the Owner to the Construction Manager for Preconstruction Services.

§ 1.0.31 Project. The Project is identified above and defined in Section 1.1.4 of the General Conditions.

§ 1.0.32 Project Team. The Project Team consists of the Construction Manager, the Owner, and the Architect, and all consultants and Subcontractors of any tier employed or retained by each of them.

§ 1.0.33 Request for Information. A Request for Information ("RFI") means a written request for information made by the Construction Manager to the Architect for the purpose of clarifying or expanding upon the Contract Documents. An RFI does not constitute a notice of Claim.

§ 1.0.34 Specifications. The Specifications are defined in Section 1.1.6 of the General Conditions and generally consist of the portion of the Contract Documents consisting of the written requirements for materials, equipment, systems, standards, and workmanship of the Work, and performance of related services.

§ 1.0.35 Specified General Conditions. Specified General Conditions are further defined in Article 7 and generally mean certain selected general conditions Work and services set forth in the Contract Documents to be provided by the Construction Manager for the fixed Specified General Conditions price as a part of the Cost of the Work. The Specified General Conditions are to be performed by the Construction Manager with its own forces in most instances. The Specified General Conditions include any Preconstruction Services performed after execution of the GMP Amendment. The Specified General Conditions include, but are not limited to, wages or salaries of the Construction Manager's supervisory and administrative personnel, administration and meeting minutes during construction, the process of developing and negotiating the GMP and the related inclusions, qualifications and exclusions for the Construction Manager's Scope of

Work to be included in Section 3.3 of the Agreement, costs associated with the Subcontractor bidding process, including advertising the Project for bids, developing solicitations, conducting site tours, responding to questions from bidders, and conducting pre-bid conferences, Project Manager during construction, Project Superintendent during construction, Project Engineer(s) during construction, including a senior Project Engineer, Quality Control Manager and quality control during construction, start-up coordinator, funding support documentation, estimating during construction, schedule development and updating during construction, subcontract administration and coordinating, on-site storage and handling of materials, Construction Manager accounting and cost accounting, cash flow analysis during construction, administration of the Project safety program, application for payment preparation and negotiation, change order preparation and negotiation, communications and coordination, managing regulatory requirements, review and processing of submittals, shop drawings, and samples, maintaining and updating BIM models during construction, coordination of testing laboratory, equipment, phones and supplies related to management, travel and subsistence for supervision assigned to Project (but only to the extent the Construction Manager's supervisory employees are relocating to the Project from a distance further than 100 miles), company-owned vehicles assigned to staff (company trucks), gas, oil, and maintenance for vehicles assigned to staff, coordination of any separate contractors, contract close-out, punch-list preparation and administration, and project-specific electronic equipment and software at site.

§ 1.0.36 **Subcontracting Plan.** The Subcontracting Plan is defined in Sections 1.1.14 and 3.1.11 and is prepared by the Construction Manager for the Owner's approval prior to conclusion of the Construction Documents phase. It identifies all proposed Subcontractor bid packages, any contemplated alternative Subcontractor selection process permitted by Chapter 39.10 RCW, all Subcontractor bid packages for which the Construction Manager expects to compete, all preliminary Subcontractor scopes of work, the timing of solicitation of Subcontractor bid packages to meet the construction schedule, major coordination issues with other packages, and means to enhance the opportunity for local businesses to participate in performing the Work.

§ 1.0.37 **Subcontractor.** A Subcontractor is defined in Section 5.1 of the General Conditions and is generally a person or entity that has a direct contract with the Construction Manager. A Subcontractor of any tier is a Subcontractor or a lower tier subcontractor that performs a portion of the Work or supplies materials or equipment for the Work. A Design-Build Subcontractor is a Subcontractor that will not only construct a portion of the Work but also will design that portion as specified in the Contract Documents.

§ 1.0.38 **Substantial Completion.** Substantial Completion is defined in Section 9.8.1 of the General Conditions. Substantial Completion generally is the date when the Work (or other portion thereof designated and approved by the Architect and the Owner) when the construction is sufficiently complete, in accordance with the Contract Documents, so the Owner can fully occupy or utilize the Work (or portion thereof designated by the Owner) for its intended use. The required date of Substantial Completion is established in the GMP Amendment. There may be separate required dates of Substantial Completion set forth in the Contract Documents for various portions of the Work.

§ 1.0.39 **Work.** The Work is defined in Section 1.1.3 of the General Conditions and generally means the construction and services performed and materials supplied during the Construction Phase as required by the Contract Documents, whether completed or partially completed, and includes all other labor, materials, equipment, and services provided or to be provided by the Construction Manager to fulfill requirements of the Contract Documents.

ARTICLE 1 INITIAL INFORMATION

§ 1.1 This Agreement is based on the Initial Information set forth in this Section 1.1.
(For each item in this section, insert the information or a statement such as "not applicable" or "unknown at time of execution.")

§ 1.1.1 The Owner's program for the Project, as described in Section 4.1.1:
(Insert the Owner's program, identify documentation that establishes the Owner's program, or state the manner in which the program will be developed.)

The Owner's program will be set forth in specifications prepared by the Architect in coordination with the Owner.

§ 1.1.2 The Project's physical characteristics:
(Identify or describe pertinent information about the Project's physical characteristics, such as size; location; dimensions; geotechnical reports; site boundaries; topographic surveys; traffic and utility studies; availability of public and private utilities and services; legal description of the site, etc.)

The Project involves construction of a 2-story, 70,000 sf replacement hospital and adjoining 30,000 sf medical office building.

§ 1.1.3 The Owner's budget for the Guaranteed Maximum Price, as defined in Article 6:
(Provide total and, if known, a line item breakdown.)

The Owner's budget for the Guaranteed Maximum Price will be established in connection with negotiation of the GMP Amendment.

§ 1.1.4 The Owner's anticipated design and construction milestone dates:

.1 Design phase milestone dates, if any:

TBD

.2 Construction commencement date:

10/24/22

.3 Substantial Completion date or dates:

10/24/24

.4 Other milestone dates:
N/A

§ 1.1.5 The Owner's requirements for accelerated or fast-track scheduling, or phased construction, are set forth below:
(Identify any requirements for fast-track scheduling or phased construction.)

N/A

§ 1.1.6 The Owner's anticipated Sustainable Objective for the Project:
(Identify and describe the Owner's Sustainable Objective for the Project, if any.)

TBD

§ 1.1.6.1 If the Owner identifies a Sustainable Objective, the Owner and Construction Manager ~~shall~~ may complete and incorporate AIA Document E234™–2019, Sustainable Projects Exhibit, Construction Manager as Constructor Edition, into this Agreement to define the terms, conditions and services related to the Owner's Sustainable Objective. If E234–2019 is incorporated into this agreement, the Owner and Construction Manager ~~shall~~ may incorporate the completed E234–2019 into the agreements with the consultants and contractors performing services or Work in any way associated with the Sustainable Objective.

§ 1.1.7 Other Project information:
(Identify special characteristics or needs of the Project not provided elsewhere.)

N/A

§ 1.1.8 The Owner identifies the following representative in accordance with Section 4.2:
(List name, address, and other contact information.)

David Rollins
Chief Financial Officer, Prosser Memorial Health
723 Memorial Street
Prosser, WA 99350
Tel. 509-786-6605

E-mail: drollins@prosserhealth.org

§ 1.1.9 The persons or entities, in addition to the Owner's representative, who are required to review the Construction Manager's submittals to the Owner are as follows:
(List name, address and other contact information.)

NV5, the Owner's Program Manager, as identified in Article 1.1.10.3 below

§ 1.1.10 The Owner shall retain the following consultants and contractors:
(List name, legal status, address, and other contact information.)

.1 Geotechnical Engineer:

GeoProfessional Innovation
5804 Road 90, Suit I
Pasco, WA 99301

.2 Civil Engineer:

Expedient Civil Engineering (as Basic Services through bcDESIGNGROUP, LLC

.3 Other, if any:
(List any other consultants retained by the Owner, such as a Project or Program Manager.)

NV5
Attn: Paul Kramer, Project Director
2650 18th Street, Suite 202
Denver, CO 80211
Tel. 216-225-4273

§ 1.1.11 The Architect's representative:
(List name, address, and other contact information.)

Kurt Broeckelmann
bcDESIGNGROUP, LLC
12101 W 110th Street, Suite 100
Overland Park, KS 66201
Tel. 913-269-3449
E-mail: kurtb@bc-dg.com

§ 1.1.12 The Construction Manager identifies the following representative in accordance with Article 3:
(List name, address, and other contact information.)

Brandon Potts, Vice President
Nick Gonzales, Vice President
Bouten Construction Co.
627 N Napa St.
Spokane, WA 99202
Tel.509.535.3531
E-mail: nickg@boutenconstruction.com

§ 1.1.13 The Owner's requirements for the Construction Manager's staffing plan for Preconstruction Services, as required under Section 3.1.9:
(List any Owner-specific requirements to be included in the staffing plan.)

The Owner's requirements for the Construction Manager's Preconstruction Services staffing are as specified in the Preconstruction Services Agreement executed separately between the Owner and the Construction Manager (Exhibit B).

§ 1.1.14 The Owner's requirements for subcontractor procurement for the performance of the Work:
(List any Owner-specific requirements for subcontractor procurement.)

Prior to negotiation of the GMP, the Owner and the Construction Manager shall negotiate, and the Owner shall approve, the following items, which shall be included with the Subcontracting Plan as an exhibit to the GMP Amendment.

.1 All subcontract bid packages, specifying those upon which the Construction Manager or its affiliates intend to bid;

.2 The scopes of work and timing of solicitation of bids for the packages to meet the construction schedule;

.3 Major coordination issues with other packages;

.4 The scope of work and cost estimates for each subcontract bid package;

.5 The basis used by the Construction Manager to develop all cost estimates;

.6 The allocation of Negotiated Support Services and Specified General Conditions; and

.7 The Construction Manager's updated outreach plan and means to enhance the opportunity to participate in the Project of local businesses, small business entities, disadvantaged business entities, and any other disadvantaged or underutilized businesses as the Owner may designate in the public solicitation of proposals, as Subcontractors and suppliers for the Project (*e.g.*, through development of small and multiple subcontract bid packages).

§ 1.1.15 Other Initial Information on which this Agreement is based:

N/A

§ 1.2 The Owner and Construction Manager may rely on the Initial Information. Both parties, however, recognize that such information may materially change and, in that event, the Owner and the Construction Manager shall appropriately adjust the Project schedule, the Construction Manager's services, and the Construction Manager's compensation. The Owner shall adjust the Owner's budget for the Guaranteed Maximum Price and the Owner's anticipated design and construction milestones, as necessary, to accommodate material changes in the Initial Information.

§ 1.3 ~~Neither the Owner's nor the Construction Manager's representative shall be changed without ten days' prior notice to the other party.~~The Construction Manager's representative shall not be changed without thirty (30) days' prior notice to the Owner. In the event the Construction Manager's representative is being replaced for any reason, the Owner shall be provided an opportunity to interview the proposed replacement, and request an alternate staff member(s), if required.

ARTICLE 2 GENERAL PROVISIONS

§ 2.1 The Contract Documents

The Contract Documents consist of this ~~Agreement, Conditions of the Contract (General, Supplementary and other Conditions),~~ Agreement and its exhibits, the General Conditions of the Contract in the form attached hereto, any Supplementary Conditions, Drawings, Specifications, Addenda issued prior to execution of this Agreement, other documents listed in this Agreement, and Modifications issued after execution of this Agreement, all of which form the Contract and are as fully a part of the Contract as if attached to this Agreement or repeated herein. Upon the Owner's acceptance of the Construction Manager's Guaranteed Maximum Price proposal, the Contract Documents will also include the documents described in Section 3.2.3 and identified in the Guaranteed Maximum Price Amendment and revisions prepared by the Owner with the assistance of the Architect and furnished by the Owner as described in Section 3.2.8. The Contract represents the entire and integrated agreement between the parties hereto and supersedes prior negotiations, representations or agreements, either written or oral. If anything in the other Contract Documents, other than a Modification, is inconsistent with this Agreement, this Agreement shall govern. An enumeration of the Contract Documents, other than a Modification, appears in Article 15.

§ 2.2 Relationship of the Parties

The Construction Manager accepts the relationship of trust and confidence established by this Agreement and covenants with the Owner to cooperate with the Architect and exercise the Construction Manager's skill and judgment in furthering the interests of the Owner to furnish ~~efficient construction administration, management services, and supervision;~~ efficient, professional, and competent construction administration, cost estimating, management services, and supervision with sufficient quantities of fully qualified, competent and experienced personnel; to furnish at all times an adequate supply of workers and materials; and to perform the Work in an ~~expeditious~~ expeditious, workmanlike, and economical

manner consistent with the Owner's interests. The Owner agrees to furnish or approve, in a timely manner, information required by the Construction Manager and to make payments to the Construction Manager in accordance with the requirements of the Contract Documents. The parties shall endeavor to promote harmony, mutual respect, and cooperation among the Owner, the Architect, and the Construction Manager, and other persons or entities employed by them for the Project to the fullest extent possible in order to further the interests of the Owner in the Project and to effect prompt and successful completion of the Project within the requirements of the Contract Documents, the Contract Time, and the GMP.

§ 2.3 General Conditions

§ 2.3.1 For the Preconstruction Phase, AIA Document A201™–2017, General Conditions of the Contract for Construction, in the form attached hereto, shall apply as follows: Section 1.5, Ownership and Use of Documents; Section 1.7, Digital Data Use and Transmission; Section 1.8, Building Information Model Use and Reliance; Section 2.2.4, Confidential Information; Section 3.12.10, Professional Services; Section 10.3, Hazardous Materials; Section 13.1, Governing ~~Law.~~ Law, and any other Sections noted in this Agreement. The term "Contractor" as used in A201–2017 shall mean the Construction Manager.

§ 2.3.2 For the Construction Phase, the ~~general conditions~~ General Conditions of the ~~contract~~ Contract shall be as set forth in the A201–2017, General Conditions of the Contract for Construction, in the form attached hereto, which document is incorporated herein by reference. The term "Contractor" as used in A201–2017 shall mean the Construction Manager.

ARTICLE 3 CONSTRUCTION MANAGER'S RESPONSIBILITIES

The Construction Manager's Preconstruction Phase responsibilities are set forth in Sections 3.1 and 3.2, and in the applicable provisions of A201-2017 referenced in Section 2.3.1. The Construction Manager's Construction Phase responsibilities are set forth in Section 3.3. The Owner and Construction Manager may agree, in consultation with the Architect, for the Construction Phase to commence prior to completion of the Preconstruction Phase, in which case, both phases will proceed concurrently. The Construction Manager shall identify a representative authorized to act on behalf of the Construction Manager with respect to the Project.

The Construction Manager shall perform the Preconstruction Services, shall be responsible for coordinating the activities of construction during the Construction Phase if the GMP Amendment is signed, shall be fully responsible for discharging all of the Construction Manager's obligations under the Contract Documents, and, during the Preconstruction and Construction Phases, shall advise and work with the Project Team to make recommendations for alternate or substitute products and technologies, construction techniques, methods, and practices based on maintainability and durability as well as cost savings, time savings, and/or other related efficiencies. The Construction Manager's obligations herein shall not apply to phases of the Project that were completed prior to execution of this Agreement.

§ 3.1 Preconstruction Phase

§ 3.1.1 Extent of Responsibility

The Construction Manager shall perform the Preconstruction Phase Services required by Sections 3.1 and 3.2 of this Agreement. The Construction Manager shall exercise reasonable care in performing its Preconstruction Services. The Owner and Architect shall be entitled to rely on, and shall not be responsible for, the accuracy, completeness, and timeliness of services and information furnished by the Construction Manager. The Construction Manager, however, does not warrant or guarantee estimates and schedules except as may be included as part of the Guaranteed Maximum Price. The Construction Manager is not required to ascertain that the Drawings and Specifications prepared by the Architect are in accordance with applicable laws, statutes, ordinances, codes, rules and regulations, or lawful orders of public authorities, but the Construction Manager shall promptly report in writing to the Architect and the Owner any nonconformity discovered by or made known to the Construction Manager as a request for information in such form as the Architect may require.

~~**§ 3.1.2** The Construction Manager shall provide a preliminary evaluation of the Owner's program, schedule and construction budget requirements, each in terms of the other.~~

§ 3.1.1.1 The Construction Manager shall promptly report to the Owner and the Architect any error, inconsistency or omission that the Construction Manager may discover in them and shall recommend changes and alternatives. The Construction Manager's review shall be made in the Construction Manager's capacity as a contractor and not as a licensed design professional.

§ 3.1.3 Consultation and Coordination

§ 3.1.3.1 The Construction Manager shall jointly schedule and conduct meetings with the Architect and Owner on a bi-weekly basis or as mutually agreed during the Preconstruction Phase and the Construction Documents Phase to discuss such matters as procedures, progress, coordination, and scheduling of the Work.

§ 3.1.3.2 The Construction Manager shall ~~advise the Owner and Architect on proposed site use and improvements, selection of materials, building systems, and equipment. The Construction Manager shall also~~ actively and collaboratively provide recommendations to the Owner and Architect, consistent with the Project requirements, on ~~constructability;~~ constructability, including through constructability coordination and clash detection using building information modeling (BIM) technology; availability of materials and labor; time requirements for procurement, installation and construction; ~~prefabrication;~~ sequencing, phasing and site work planning; traffic planning; factors related to construction quality, local market trends, bidding strategies, and factors related to construction cost including, ~~but not limited to, costs of alternative designs or materials, preliminary budgets, life-cycle data,~~ and possible cost reductions. The Construction Manager shall consult with the Architect regarding professional services to be provided by the Construction Manager during the Construction Phase.

§ 3.1.3.3 The Construction Manager shall assist the Owner and Architect in establishing building information modeling and digital data protocols for the Project, ~~using~~ using, if agreed among the parties, AIA Document E203™–2013, Building Information Modeling and Digital Data Exhibit, to establish the protocols for the development, use, transmission, and exchange of digital data.

§ 3.1.3.4 Design Review. Design review activities are to be a cooperative and collaborative effort with the Architect, the Owner and their consultants. The Construction Manager shall recommend changes and alternatives to the Architect, without, however, assuming any of the Architect's design responsibilities, except to the extent the Construction Manager or a Subcontractor performs design-build Work. The Construction Manager is not responsible to ascertain that the Drawings and Specifications prepared by the Architect are in accordance with applicable laws, statutes, ordinances, building codes, rules and regulations. If the Construction Manager becomes aware that any specific portion of the Drawings and Specifications conflict with applicable laws, statutes, ordinances, building codes, or rules and regulations, the Construction Manager shall promptly notify the Architect and the Owner in writing.

§ 3.1.3.6 Value Engineering. The Construction Manager will participate in value engineering on a continuing basis with the assistance of the Architect.

§ 3.1.4 Project Schedule

When Project requirements in Section 4.1.1 have been sufficiently identified, ~~the Construction Manager shall prepare and periodically update~~ and by no later than thirty (30) days after execution of this Agreement, the Construction Manager shall prepare a Project schedule for the Architect's and the Owner's input and review and the Owner's acceptance. The Construction Manager shall obtain the Architect's and the Owner's approval for the portion of the Project schedule relating to the performance of the Architect's services. The Construction Manager shall update this schedule on a monthly basis. The Project schedule shall coordinate and integrate the Construction Manager's services, the Architect's services, other Owner consultants' services, and the Owner's responsibilities; and identify items that could affect the Project's timely completion. The updated Project schedule shall include the following: submission of the Guaranteed Maximum Price proposal; components of the Work; times of commencement and completion required of each Subcontractor; ordering and delivery of major critical products, including those that must be ordered in advance of construction; and the occupancy requirements of the Owner. In addition to the Project schedule, the Construction Manager will also be responsible for preparing and updating the construction schedule, including a plan for phased construction defined in the Contract Documents .

§ 3.1.5 Phased Construction

~~The Construction Manager, in consultation with the Architect, shall provide recommendations with regard to accelerated or fast-track scheduling, procurement, and sequencing for phased construction. The Construction Manager shall take into consideration cost reductions, cost information, constructability, provisions for temporary facilities, and procurement and construction scheduling issues.~~

§ 3.1.6 Cost Estimates

§ 3.1.6.1 ~~Based on the preliminary design and other design criteria prepared by the Architect, the Construction Manager shall prepare, for the Architect's review and the Owner's approval, preliminary estimates of the Cost of the Work or the cost of program requirements using area, volume, or similar conceptual estimating techniques. If the Architect or Construction Manager suggests alternative materials and systems, the Construction Manager shall provide cost evaluations of those alternative materials and systems.~~

§ 3.1.6.2 ~~As the Architect progresses with the preparation of the Schematic Design, Design Development and Construction Documents, the Construction Manager shall prepare and update, at appropriate intervals agreed to by the Owner, Construction Manager and Architect, an estimate of the Cost of the Work with increasing detail and refinement. The Construction Manager shall include in the estimate those costs to allow for the further development of the design, price escalation, and market conditions, until such time as the Owner and Construction Manager agree on a Guaranteed Maximum Price for the Work. The estimate shall be provided for the Architect's review and the Owner's approval. The Construction Manager shall inform the Owner and Architect in the event that the estimate of the Cost of the Work exceeds the latest approved Project budget, and make recommendations for corrective action.~~

§ 3.1.6.3 ~~If the Architect is providing cost estimating services as a Supplemental Service, and a discrepancy exists between the Construction Manager's cost estimates and the Architect's cost estimates, the Construction Manager and the Architect shall work together to reconcile the cost estimates.~~

§ 3.1.7 ~~As the Architect progresses with the preparation of the Schematic Design, Design Development and Construction Documents, the Construction Manager shall consult with the Owner and Architect and make recommendations regarding constructability and schedules, for the Architect's review and the Owner's approval.~~

§ 3.1.8 The Construction Manager shall provide recommendations and information to the Owner and Architect regarding equipment, materials, services, and temporary Project facilities.

§ 3.1.9 The Construction Manager shall provide a staffing plan for Preconstruction Phase services for the Owner's review and approval.

§ 3.1.10 If the Owner identified a Sustainable Objective in Article 1, the Construction Manager shall fulfill its Preconstruction Phase responsibilities as required in AIA Document E234™–2019, Sustainable Projects Exhibit, Construction Manager as Constructor Edition, if used by the parties and attached to this Agreement.

§ 3.1.11 Subcontractors and Suppliers

§ 3.1.11.1 If the Owner has provided requirements for subcontractor procurement in section 1.1.14, the Construction Manager shall provide a subcontracting plan, addressing the Owner's requirements, for the Owner's review and ~~approval.~~ approval prior to conclusion of the Construction Documents Phase.

§ 3.1.11.2 The Construction Manager shall use its best efforts to develop bidders' interest in the Project. The Construction Manager shall consider prebid determination of Subcontractor eligibility to the extent permitted by law and shall furnish to the Owner and Architect for their information as a part of the submittal of its Subcontracting Plan a list of possible eligible Subcontractors, including suppliers who are to furnish materials or equipment fabricated to a special design, from whom proposals will be requested for each principal portion of the Work. The Owner will promptly reply in writing to the Construction Manager if the Architect or Owner knows of any objection to such Subcontractor or supplier. The receipt of such list shall not require the Owner or Architect to investigate the qualifications of proposed Subcontractors or suppliers, nor shall it or the lack of any objection waive the right of the Owner or Architect later to object to or reject any proposed subcontractor or supplier.

§ 3.1.11.3 ~~The processes described in Article 9 shall apply if bid packages will be issued during the Preconstruction Phase.~~

§ 3.1.11.4 No more than thirty percent (30%) of the total sum of the GMP (not including Negotiated Support Services) may be performed or supplied by the Construction Manager.

§ 3.1.11.5 If the Owner is unable to negotiate to its satisfaction any aspect of Section 3.1.11.1 and Section 1.1.4 above, then the Owner may terminate negotiations with the Construction Manager. The Owner may, but is not obligated to,

solicit bids or negotiate with the next highest scored proposer and continue until an agreement is reached or terminate the process.

§ 3.1.12 Procurement

The Construction Manager shall prepare, for the Architect's and the Owner's review and the Owner's acceptance, and shall update at least monthly, a procurement schedule for items and/or associated services that must be ordered well in advance of construction. The Construction Manager shall expedite and coordinate the ordering and delivery of materials ~~that must be ordered in advance of construction. If the Owner agrees~~ and/or associated services that must be ordered or bid in advance of construction. The Construction Manager ordinarily will contract directly for these items and/or services. Any such orders shall be subject to the Owner's prior approval. If the Owner agrees, consistent with RCW 39.10.390, to procure any items prior to the establishment of the Guaranteed Maximum Price, the Owner shall procure the items on terms and conditions reasonably acceptable to the Construction Manager. Upon the establishment of the Guaranteed Maximum Price, the Owner shall assign all contracts for these items to the Construction Manager and the Construction Manager shall thereafter ~~accept responsibility for them.~~assume full responsibility for them. If the Construction Manager purchases materials in advance of construction, any such materials shall be separately stored and dedicated for use in connection with the Project.

§ 3.1.12.1 The Construction Manager shall update the Project schedule of all long-lead-time items at least monthly. If the Owner so requests in writing, the Construction Manager shall purchase, expedite and complete the procurement of long-lead-time items to effectuate their delivery by the required dates. The Owner shall be responsible for the Cost of the Work relating to long-lead-time items it directs the Construction Manager to purchase, whether or not the Construction Phase commences. The Construction Manager shall promptly notify the Owner of any anticipated delay with respect to long-lead-time items.

§ 3.1.12.2 The Construction Manager shall identify and estimate the value of any items that require off-site storage, together with proposed locations for storage during the course of the Work acceptable to Owner. These locations shall be selected to provide a maximum of protection and minimum of cost and delay associated with delivery to the site.

§ 3.1.12.3 If authorized by the Owner, an Application for Payment may include a request for payment for material delivered to the Project site and suitably stored, for completed preparatory Work and, provided the Construction Manager complies with or furnishes satisfactory evidence of the following, for material stored off the Project site:

.1 The material will be placed in a bonded warehouse that is structurally sound, dry, lighted, secure and suitable for the materials to be stored;

.2 Only materials for the Project are stored within the warehouse (or a secure portion of a warehouse set aside for the Project);

.3 The Construction Manager furnishes the Owner a certificate of insurance extending the Construction Manager's insurance coverage for damage, fire and theft to cover the full value of all materials stored, or in transit;

.4 The warehouse (or secure portion thereof) is continuously under lock and key, and only the Construction Manager's authorized personnel shall have access;

.5 The Owner shall at all times have the right of access to stored materials in the possession of the Construction Manager;

.6 The Construction Manager assumes total responsibility for the stored materials; and

.7 The Construction Manager furnishes to the Owner proofs of title, satisfactory evidence that the Construction Manager has paid for the materials in question, certified lists of materials stored, bills of lading, invoices and other information as may be required, and shall also furnish notice to the Owner when materials are moved from storage to the Project site.

§ 3.1.13 Compliance with Laws

The Construction Manager shall comply with applicable laws, statutes, ordinances, codes, rules and regulations, and lawful orders of public authorities applicable to its performance under this Contract, and with equal employment opportunity programs, and other programs as may be required by governmental and quasi-governmental authorities.

§ 3.1.14 Other Preconstruction Services

Insert a description of any other Preconstruction Phase services to be provided by the Construction Manager, or reference an exhibit attached to this document

(Describe any other Preconstruction Phase services, such as providing cash flow projections, development of a project information management system, early selection or procurement of subcontractors, etc.)

See Exhibit B. Preconstruction Services Agreement

§ 3.2 Guaranteed Maximum Price Proposal

§ 3.2.1 ~~At a time to be mutually agreed upon by the Owner and the Construction Manager, the Construction Manager shall prepare a Guaranteed Maximum Price proposal.~~ When the Drawings and Specifications are ninety percent (100%) complete. the Owner will submit a "GMP set" or "GMP Model" of Construction Documents to the Construction Manager, and, within thirty (30) days of receipt. the Construction Manager shall, in consultation with the Owner and the Architect. prepare a Guaranteed Maximum Price proposal. including the GMP estimate, for the Owner's and Architect's review, and the Owner's acceptance. As required by RCW 39.10.370, the Construction Manager shall submit a proposed construction management and contracting plan with its GMP proposal. The Guaranteed Maximum Price in the proposal shall be the sum of the Construction Manager's estimate of the Cost of the Work, the Construction Manager's contingency described in Section 3.2.4, and the Construction Manager's Fee described in Section 6.1.2. The Construction Manager shall promptly notify the Owner if it does not consider the Drawings and Specifications to be ninety percent (100%) complete and shall not propose a GMP estimate until the applicable Drawings and Specifications are ninety percent (100%) complete.

§ 3.2.2 ~~To the extent that the Contract Documents are anticipated to require further development, the Guaranteed Maximum Price includes the costs attributable to such further development consistent with the Contract Documents and reasonably inferable therefrom. Such further development does not include changes in scope, systems, kinds and quality of materials, finishes, or equipment, all of which, if required, shall be incorporated by Change Order.~~

§ 3.2.3 The Construction Manager shall include with the Guaranteed Maximum Price proposal a written statement of its basis, which shall include the following:

.1 A list of the Drawings and Specifications, including all Addenda thereto, and the Conditions of the Contract;

.2 ~~A list of the clarifications and assumptions made by the Construction Manager in the preparation of the Guaranteed Maximum Price proposal, including assumptions under Section 3.2.2;~~

.3 A statement of the proposed Guaranteed Maximum Price, including a statement of the estimated Cost of the Work organized by trade categories or systems, including ~~allowances; the Construction Manager's contingency~~ allowances (Specified General Conditions. Negotiated Support Services. and other Article 7 Costs of the Work); the Construction Manager's Contingency set forth in Section 3.2.4; and the Construction Manager's ~~Fee;~~Fee (any Allowances must be limited and pre-approved by the Owner);

.4 The ~~anticipated~~ date of Substantial Completion upon which the proposed Guaranteed Maximum Price is based; and

.5 A date by which the Owner must accept the Guaranteed Maximum ~~Price.~~Price; provided, that the Owner shall have not less than thirty (30) days after the date of the proposal in which to accept the proposal.

§ 3.2.3.1 In preparing the Construction Manager's GMP proposal. the Construction Manager shall include its Contingency as part of the MACC. which will be a negotiated amount acceptable to the Owner and not exceed five percent (5%) of the estimated Cost of the Work. for the Construction Manager's exclusive use to cover those costs considered reimbursable as a Cost of the Work but not qualified for inclusion in a Change Order. The Construction Manager may use the Construction Manager's Contingency to pay for Project issues that are within its control, buy-out errors or shortfalls, buy-out scope gaps, damaged Work not covered by insurance. . Subcontractor performance, and expediting costs for critical materials. The Construction Manager's Contingency may also be used for issues beyond the Construction Manager's control such as lost time. increases in bid contracts. Subcontractor performance or failure. and expediting costs for critical materials. The Construction Manager must give the Owner notice and supporting cost backup when applying to use the Construction Manager's Contingency.. Contingency usage over $75.000 shall require Owner's prior written consent which shall not be unreasonably withheld. Each use of Construction Manager's Contingency shall be shown as a separate line item in the schedule of values submitted with Applications for Payment. Any balance remaining in the Contingency shall be returned to the Owner as a reduction in the GMP via a deductive Change Order as part of Final Payment. Costs that exceed the contingency shall be at the Construction Manager's risk.

§ 3.2.3.2 The MACC shall include all Subcontractor scope of work by bid package consistent with the Subcontracting Plan, including Work the Construction Manager will self-perform through the subcontract bidding process, and other

Article 7 Costs of the Work, including Negotiated Support Services and the Specified General Conditions. It is the intent of the parties that when the GMP is set, the Construction Manager will have participated in and be aware of the proposed design for the Project.. The GMP shall be adjusted principally, including, but not limited to, the following events:

.1 **Scope Changes.** Owner revisions on scope items previously approved by the Owner and incorporated in the pricing of the GMP.

.2 **Concealed or Unknown Conditions** as described in Section 3.7.4 of the General Conditions. For example, during the Construction Phase, substantially differing site conditions are encountered that could not have been reasonably anticipated or discovered by the Construction Manager during the Preconstruction Phase.

.3 **Design Errors or Omissions.** Errors or omissions in the Drawings or Specifications the Construction Manager was not aware of before the GMP was established. However, design errors and omissions do not include, for example: (a) failure to coordinate between trades; (b) requirements of the Specifications that are not specifically shown in Drawings; (c) requirements of the Drawings that are not specifically described in the Specifications; or (d) design changes made at the request of the Construction Manager in order to facilitate the constructability of the Project. The failure of the Architect to specify every detail in the Construction Documents does not eliminate the requirement for the Construction Manager to provide at least a standard commercially available detail that can serve the basic functions of the design.

.4 **Allowance adjustments.**

§ 3.2.3.3 Examples of events for which the GMP shall not be adjusted include but are not limited to:

.1 **Subcontractor gaps.** Gaps in scope coverage between Subcontractors, including self-performed Work, that occur after the GMP is negotiated.

.2 **Scope gaps.** An item indicated in the Drawings or Specifications that was not picked up in the GMP.

.3

.4 **Interdisciplinary Coordination.** Coordination inconsistencies and errors between design disciplines that the Construction Manager was aware of prior to establishing the GMP, including any MC/CM and EC/CM subcontractors.

.5 **Subcontractor Failure.** A Subcontractor fails to perform or goes bankrupt.

.6 **Escalation.** The increased cost of materials, equipment and/or labor prices, unless the increased cost is related to a change in Contract Documents.

.7 The Construction Manager's **estimating errors.**

.8 **Expediting Costs.** Costs to expedite the delivery or completion of materials, whether critical or not.

.9 **Coordination Claims.** Costs related to Subcontractor Claims or charges that result from mistakes or omissions in Subcontractor buyout, or coordination issues between Subcontractors, or interference between Subcontractor and the Construction Manager or among Subcontractors.

§ 3.2.4 In preparing the Construction Manager's Guaranteed Maximum Price proposal, the Construction Manager shall include a contingency for the Construction Manager's exclusive use to cover those costs that are included in the Guaranteed Maximum Price but not otherwise allocated to another line item or included in a Change Order. The Construction Manager's Contingency is described in Section 3.2.3.1.

§ 3.2.5 The Construction Manager shall meet with the Owner and Architect to review the Guaranteed Maximum Price proposal. In the event that the Owner or Architect discover any inconsistencies or inaccuracies in the information presented, they shall promptly notify the Construction Manager, who shall make appropriate adjustments to the Guaranteed Maximum Price proposal, its basis, or both. In connection with reviewing the Guaranteed Maximum Price proposal, the Owner and the Construction Manager have negotiated an agreed liquidated damages rate . The Owner and the Construction Manager agree that the liquidated damages calculation included in §6.1.6 below was informed by the actual, delay-related damages that the Owner anticipates it would suffer in the event of a delay, including but not limited to lost revenue, lost profits, ongoing carrying costs of the Project, storage costs including interest and financing costs, additional consultant expenses, additional staff expenses, and utilities, among other delay-related costs. The Liquidated Damages specified in §6.1.6 below shall be the Owner's sole and exclusive remedy for damages for delays in completion of the project.

§ 3.2.6 If the Owner notifies the Construction Manager that the Owner has accepted the Guaranteed Maximum Price proposal in writing before the date specified in the Guaranteed Maximum Price proposal, the Guaranteed Maximum Price proposal shall be deemed effective without further acceptance from the Construction Manager. Following acceptance of a

Guaranteed Maximum Price, the Owner and Construction Manager shall execute the Guaranteed Maximum Price Amendment amending this Agreement, a copy of which the Owner shall provide to the Architect. The Guaranteed Maximum Price Amendment shall set forth the agreed upon Guaranteed Maximum Price with the information and assumptions upon which it is based.

§ 3.2.7 The Construction Manager shall not incur any cost to be reimbursed as part of the Cost of the Work prior to the ~~execution of the Guaranteed Maximum Price Amendment,~~ commencement of the Construction Phase, unless the Owner provides prior written authorization for such costs.

§ 3.2.8 ~~The Owner shall authorize preparation of revisions to the Contract Documents that incorporate the agreed upon assumptions and clarifications contained in the Guaranteed Maximum Price Amendment. The Owner shall promptly furnish such revised Contract Documents to the Construction Manager. The Construction Manager shall notify the Owner and Architect of any inconsistencies between the agreed upon assumptions and clarifications contained in the Guaranteed Maximum Price Amendment and the revised Contract Documents.~~

§ 3.2.9 ~~The~~ Except to the extent the Owner is exempt from the same, the Construction Manager shall include in the Guaranteed Maximum Price all sales, consumer, use and similar taxes (but not Washington State Sales Taxes (WSST) on the Contract Sum) for the Work provided by the Construction Manager that are legally enacted, whether or not yet effective, at the time the Guaranteed Maximum Price Amendment is executed. The only taxes excluded from the GMP and separately reimbursable by the Owner are Washington State Sales Taxes (WSST) on the Contract Sum and Preconstruction Services Cost.

§ 3.2.10 If, upon establishing the GMP, the GMP varies more than fifteen percent (15%) from the budget specified in the RFP due to changes in the scope requested and approved by the Owner, the percentage applied to the MACC to determine the Fee may be renegotiated when the GMP is negotiated.

§ 3.3 Construction Phase

§ 3.3.1 General

§ 3.3.1.1 For purposes of Section 8.1.2 of ~~A201–2017,~~ the A201–2017 General Conditions, the date of commencement of the Work shall mean the date of commencement of the Construction Phase.

§ 3.3.1.2 The Construction Phase shall commence upon the Owner's execution of the Guaranteed Maximum Price Amendment or, prior to acceptance of the Guaranteed Maximum Price proposal, by written agreement of the parties. The written agreement shall set forth a description of the Work to be performed by the Construction Manager, and any insurance and bond requirements for Work performed prior to execution of the Guaranteed Maximum Price Amendment.

§ 3.3.1.3 Although it will not cause the Construction Phase to commence, the Owner may at any time approve the Construction Manager's (a) award of a subcontract, (b) undertaking construction Work with its own forces, or (c) issue a purchase order for materials or equipment required for the Work. Any work so approved and undertaken shall comply with and be subject to this Agreement and the General Conditions.

§ 3.3.2 Administration

§ 3.3.2.1 The Construction Manager shall schedule and conduct weekly progress meetings during construction to discuss such matters as procedures, progress, coordination, scheduling, and status of the Work. The Construction Manager ~~shall~~ shall, during construction, prepare and promptly distribute minutes of the meetings to the Owner and Architect. During design, the Architect will prepare necessary meeting minutes.

§ 3.3.2.2 Upon the execution of the Guaranteed Maximum Price Amendment, the Construction Manager shall prepare and submit to the Owner and Architect a construction schedule for the Work and a submittal schedule in accordance with Section 3.10 of A201–2017. The Construction Manager shall provide regular monitoring and shall update monthly (or sooner in the event of a substantial change) the construction schedule as the Work progresses.

§ 3.3.2.3 Monthly Report

The Construction Manager shall record the progress of the Project. On a monthly basis, or otherwise as agreed to by the Owner, the Construction Manager shall submit written progress reports to the Owner and Architect, showing percentages of completion and other information required by the Owner. The reports shall:

.1 Include information concerning both the entire Project and each subcontract bid package.

.2 Identify variances between scheduled and probable completion dates, and recommend action required to meet schedule completion dates.

.3 Review the schedule for portions of the Project not started or incomplete and recommend to the Owner alternate procedures or adjustments to meet the scheduled completion dates.

.4 Provide summary reports of each schedule update.

.5 Document all significant changes in the schedule and any Owner's approval of them and reflect the reasons for them.

.6 Record in writing and by photographs the progress of the Project.

.7 Identify significant problems in scheduling together with recommended corrective action.

.8 Maintain and report a quality control log.

.9 Document any outstanding RFIs and risks associated with delayed responses.

.10 List outstanding submittals and risks associated with delayed responses.

.11 Document any outstanding Change Orders and any risks associated with delayed responses.

.12 The status of permits that the Construction Manager is required to coordinate and pickup (the building permit) and obtain (all other permits).

§ 3.3.2.4 Daily Logs

The Construction Manager shall keep, and make available to the Owner and Architect, a daily log containing a record for each day of weather, Subcontractors working on the site, deliveries, Work accomplished, portions of the Work in progress, number and employers of workers on site, identification of equipment on site, problems that might affect progress of the work, accidents, injuries, and other information required by the Owner. The information contained in this log does not constitute notice of a potential or actual Claim to the Owner.

§ 3.3.2.5 Cost Control and Project Status Report

The Construction Manager shall develop a system of cost control for the Work, including regular monitoring of actual costs for activities in progress and estimates for uncompleted tasks and proposed changes. The Construction Manager shall identify variances between actual and estimated costs and report the variances to the Owner and Architect, and shall provide this information in its monthly reports to the Owner and Architect, in accordance with Section 3.3.2.3 above. The Construction Manager shall include a Project status report in a format acceptable to the Owner, listing (i) all pending and/or approved Change Orders and Construction Change Directives (including amounts), (ii) an analysis of the Specified General Conditions and the Negotiated Support Services budget with an explanation of substantial variances from previous budgets, (iii) projected cash flow of construction costs, (iv) an allocation by subcontract bid package and schedule-of-values line item, (v) expenditures to date, (vi) estimates to complete, (vii) forecast at completion, (viii) variances with budget and commitment, and (ix) the items for which the Owner has authorized the Construction Manager to use Contingency, the cost of those authorized items, and the balance of funds remaining in the Contingency account.

§ 3.3.2.6 Subcontractor Work

The Construction Manager shall review and inspect the Work of the Subcontractors on a regular basis and shall stop the Work of Subcontractors if necessary. The Construction Manager shall notify the Owner of any significant material defects or deficiencies and recommend remedial action. The Construction Manager shall take the lead role in negotiating and resolving any disputes with Subcontractors and obtain the Owner's concurrence or approval of all settlements that may affect the GMP before executing change orders with Subcontractors.

§ 3.3.2.7 Records

As part of the Specified General Conditions, the Construction Manager shall maintain, in good order and on a current basis, a record copy of all subcontracts, purchase orders, Drawings marked to record all changes made during construction, Specifications, addenda, Change Orders, and other Modifications; shop drawings; product data; samples; submittals; inspection reports; purchases; materials; equipment; applicable handbooks; maintenance and operating manuals and instructions; other related documents and revisions which arise out of subcontracts or Work. These records shall be available to the Owner, and, at completion of the Project, delivered to the Owner.

§ 3.3.2.8 Staffing

As part of the Specified General Conditions, the Construction Manager shall provide an adequate and experienced staff consistent with or in excess of that specified in its response to the RFP. The staff may include necessary and appropriate project managers, superintendents, field engineers, engineers, quality control specialists, scheduling engineers, cost engineers, clerical, accounting, and data processing personnel, and others so that, among other things:

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.1 The Work is performed and coordinated in a timely manner in compliance with the Contract Documents;

.2 Change Order Proposals and responses to Construction Change Directives are submitted to the Owner within ten (10) days after the Construction Manager's receipt;

.3 Replies to correspondence from the Owner, Subcontractors, and governmental agencies are answered within seven (7) days; and

.4 Substantial and Final Completion are achieved within the time specified in the Contract Documents and consistent with the General Conditions.

§ 3.3.2.9 Equipment

The Construction Manager shall promptly, following the date of execution of the GMP Amendment, prepare a comprehensive list of equipment that it anticipates using on the Project, whether owned or rented. The Construction Manager shall maintain and submit to the Owner monthly a detailed equipment inventory of all equipment it has purchased and charged as a Cost of the Work or job-owned through aggregate rentals and shall prepare an equipment rental report that identifies the equipment rented for the month and identifies the source of the rented equipment. The inventory shall include (i) the original acquisition cost and date, (ii) the Owner-approved fair market value of the equipment when first used on the Project, and (iii) the final disposition.

ARTICLE 4 OWNER'S RESPONSIBILITIES

§ 4.1 Information and Services Required of the Owner

§ 4.1.1 The Owner shall provide information with reasonable promptness, regarding requirements for and limitations on the Project, including a written program which shall set forth the Owner's objectives, constraints, and criteria, including schedule, space requirements and relationships, flexibility and expandability, special equipment, systems, sustainability and site requirements.

§ 4.1.2 Prior to the execution of the Guaranteed Maximum Price Amendment, the Construction Manager may request in writing that the Owner provide reasonable evidence that the Owner has made financial arrangements to fulfill the Owner's obligations under the Contract. After execution of the Guaranteed Maximum Price Amendment, the Construction Manager may request such information as set forth in A201-2017 Section 2.2.

§ 4.1.3 The Owner shall establish and periodically update the Owner's budget for the Project, including (1) the budget for the Cost of the Work as defined in Article 7, (2) the Owner's other costs, and (3) reasonable contingencies related to all of these costs. If the Owner significantly increases or decreases the Owner's budget for the Cost of the Work, the Owner shall notify the Construction Manager and Architect. The Owner and the Architect, in consultation with the Construction Manager, ~~shall~~ may thereafter agree to a corresponding change in the Project's scope and quality.

§ 4.1.4 Structural and Environmental Tests, Surveys and Reports. During the Preconstruction Phase, the Owner shall furnish the following information or services with reasonable promptness. The Owner shall also furnish any other information or services under the Owner's control and relevant to the Construction Manager's performance of the Work with reasonable promptness after receiving the Construction Manager's written request for such information or services. The Construction Manager shall be entitled to rely on the accuracy of information and services furnished by the Owner but shall exercise proper precautions relating to the safe performance of the Work.

§ 4.1.4.1 The Owner shall furnish tests, inspections, and reports, required by law and as otherwise agreed to by the parties, such as structural, mechanical, and chemical tests, tests for air and water pollution, and tests for hazardous materials.

§ 4.1.4.2 ~~The~~ To the extent required by the Contract Documents, the Owner shall furnish surveys describing physical characteristics, legal limitations and utility locations for the site of the Project, and a written legal description of the site. The surveys and legal information shall include, as applicable, grades and lines of streets, alleys, pavements and adjoining property and structures; designated wetlands; adjacent drainage; rights-of-way, restrictions, easements, encroachments, zoning, deed restrictions, boundaries and contours of the site; locations, dimensions and other necessary data with respect to existing buildings, other improvements and trees; and information concerning available utility services and lines, both public and private, above and below grade, including inverts and depths. All the information on the survey shall be referenced to a Project benchmark.

§ 4.1.4.3 The Owner, when such services are ~~requested,~~ requested and approved by the Owner, shall furnish services of geotechnical engineers, which may include test borings, test pits, determinations of soil bearing values, percolation tests,

evaluations of hazardous materials, seismic evaluation, ground corrosion tests and resistivity tests, including necessary operations for anticipating subsoil conditions, with written reports and appropriate recommendations.

§ 4.1.5 During the Construction Phase, the Owner shall furnish information or services required of the Owner by the Contract Documents with reasonable promptness. The Owner shall also furnish any other information or services under the Owner's control and relevant to the Construction Manager's performance of the Work with reasonable promptness after receiving the Construction Manager's written request for such information or services.

§ 4.1.6 If the Owner identified a Sustainable Objective in Article 1, the Owner shall fulfill its responsibilities as required in AIA Document E234™–2019, Sustainable Projects Exhibit, Construction Manager as Constructor Edition, ~~attached to this Agreement.~~if attached to this Agreement and completed by the Owner and the Construction Manager.

§ 4.2 Owner's Designated Representative

The Owner shall identify a representative authorized to act on behalf of the Owner with respect to the Project. The Owner's representative shall render decisions promptly and furnish information expeditiously, so as to avoid unreasonable delay in the services or Work of the Construction Manager. Except as otherwise provided in Section 4.2.1 of A201–2017, the Architect does not have such authority. The term "Owner" means the Owner or the Owner's authorized representative. Any decisions and approvals involving a change in the scope of the Work, in the GMP, and/or in the Contract Time, or involving modification or waiver of the terms of the Contract Documents, must be approved by the Owner's designated representative.

§ 4.2.1 Legal Requirements. The Owner shall furnish all legal, insurance and accounting services, including auditing services, that may be reasonably necessary at any time for the Project to meet the Owner's needs and interests. The Owner is not required to furnish legal, insurance and accounting services for the benefit of the Construction Manager.

§ 4.3 Architect

The Owner shall retain an Architect to provide services, duties and responsibilities ~~as described in AIA Document B133™–2019, Standard Form of Agreement Between Owner and Architect, Construction Manager as Constructor Edition, including any additional services requested by the Construction Manager that are necessary for the Preconstruction and Construction Phase services under this Agreement.~~ appropriate to the Project. The Owner shall provide the Construction Manager with a copy of the scope of services in the executed agreement between the Owner and the ~~Architect,~~ Architect prior to execution of the GMP Amendment, and any further modifications to the Architect's scope of services in the agreement.

§ 4.4 Coordination

The Owner will be responsible for coordinating the activities of the Project Team during the Preconstruction Phase.

ARTICLE 5 COMPENSATION AND PAYMENTS FOR PRECONSTRUCTION PHASE SERVICES

§ 5.1 Compensation

§ 5.1.1 For the Construction Manager's Preconstruction Phase services described in Sections 3.1 and 3.2, the Owner shall compensate the Construction Manager as follows:

(Insert amount of, or basis for, compensation and include a list of reimbursable cost items, as applicable.)

Compensation for the Preconstruction Services (the "Preconstruction Services Cost") shall be as specified in the Preconstruction Services Agreement executed between the Owner and the Construction Manager (Exhibit B). Costs that would cause the lump sum amount to be exceeded shall be paid by the Construction Manager without reimbursement by the Owner. The Construction Manager's Fee in Section 6.1.2 does not apply to Preconstruction Services.

§ 5.1.2 The hourly billing rates for Preconstruction Phase services of the Construction Manager and the Construction Manager's Consultants and Subcontractors, if any, are set forth below.

(If applicable, attach an exhibit of hourly billing rates or insert them below.)

N/A

Individual or Position	Rate
N/A	N/A

§ 5.1.2.1 Hourly billing rates for Preconstruction Phase services include all costs to be paid or incurred by the Construction Manager, as required by law or collective bargaining agreements, for taxes, insurance, contributions, assessments and benefits and, for personnel not covered by collective bargaining agreements, customary benefits such as sick leave, medical and health benefits, holidays, vacations and pensions, and shall remain unchanged unless the parties execute a Modification.

§ 5.1.3 If the Preconstruction Phase services covered by this Agreement have not been completed within ~~( )~~ eighteen (18) months of the date of this Agreement, through no fault of the Construction Manager, the Construction Manager's compensation for Preconstruction Phase services shall be equitably adjusted.

§ 5.2 Payments

§ 5.2.1 Unless otherwise agreed, payments for services shall be made monthly in proportion to services performed.

§ 5.2.2 Payments are due and payable ~~upon~~ within thirty (30) days of presentation of the Construction Manager's invoice. ~~Amounts unpaid ( ) days after the invoice~~ The Construction Manager's invoice will contain detail of and support for the services performed, as required by the Owner and the United States Department of Agriculture (USDA). Amounts unpaid thirty (30) days after the invoice due date shall bear interest at the rate entered below, or in the absence thereof at the legal rate prevailing from time to time at the principal place of business of the Construction Manager.
(Insert rate of monthly or annual interest agreed upon.)

~~%~~ Pursuant to Chapter 39.76 RCW, twelve percent (12%) per annum

ARTICLE 6 COMPENSATION FOR CONSTRUCTION PHASE SERVICES

§ 6.1 Contract Sum

§ 6.1.1 The Owner shall pay the Construction Manager the Contract Sum in current funds for the Construction Manager's performance of the Contract after execution of the Guaranteed Maximum Price Amendment. The Contract Sum is the Cost of the Work as defined in Article 7 plus the Construction Manager's ~~Fee.~~ Fee and the Construction Manager's Contingency, subject to the Guaranteed Maximum Price.

§ 6.1.2 The Construction Manager's Fee:
(State a lump sum, percentage of Cost of the Work or other provision for determining the Construction Manager's Fee.)

The Construction Manager's Fee for the Work during the Construction Phase shall be the fixed, lump sum amount that will be calculated as the percentage specified in response to the RFP (4.55%) 4.multiplied by the MACC.

§ 6.1.3 The method of adjustment of the Construction Manager's Fee for changes in the Work:

In the event a Change Order is issued for a Change in the Work, the change in the Construction Manager's Fee will be the percentage specified in Section 6.1.2.

§ 6.1.4 Limitations, if any, on a Subcontractor's overhead and profit for increases in the cost of its portion of the Work:

The fee for changed Work for which the Owner is responsible and which is directly performed by a Subcontractor of any tier, including overhead and profit, is specified in Section 7.5 of the General Conditions. If a lower-tier Subcontractor performs changed Work, the fee of upper-tier Subcontractors is also specified in Section 7.5 of the General Conditions.

§ 6.1.5 Rental rates for Construction Manager-owned ~~equipment shall not exceed percent (%)~~ equipment, over the full duration of the Project, shall not exceed one hundred percent (100%) of the standard rental rate paid at the place of the Project. Rental rates shall be calculated based on actual days of use and standby and shall not be rounded up in any way.

§ 6.1.6 Liquidated damages, if any:
(Insert terms and conditions for liquidated damages, if any.)

In lieu of actual damages suffered by the Owner as a result of delay and/or loss of use caused by the Contractor, the Owner will assess, and the Contractor will be responsible for, liquidated damages in the amount established in the GMP Amendment for each calendar day beyond the Contract Time, plus sixty (60) days, that Substantial Completion is not timely achieved, and for each calendar day beyond the Contract Time that Final Completion is not timely achieved. In

addition, without limiting any right or remedy under this Agreement or at law, the Owner may take over and complete the Work (or any portion of the Work) at any time more than ninety (90) days following the Contract Time for Final Completion if Final Completion has not been achieved, and charge all direct and indirect costs of completion against the Contractor. Any sums for which the Contractor is liable to the Owner may be deducted at any time by the Owner from any sums due the Contractor. In the event that no amounts are due from the Owner to the Contractor, then the Owner shall notify the Contractor in writing of the liquidated damages amount that is due, and the Contractor shall pay such amount to the Owner within thirty (30) calendar days of such notice.

§ 6.1.7 Other:
(Insert provisions for bonus, cost savings or other incentives, if any, that might result in a change to the Contract Sum.)

If the Project is completed for less than the GMP, any savings shall accrue to the Owner. If the Project is completed for more than the GMP, the additional cost is the responsibility of the Construction Manager.

§ 6.1.8 The Specified General Conditions will be identified in the GMP Amendment.

§ 6.1.9 The amount for Negotiated Support Services will be negotiated as part of the GMP Amendment.

§ 6.2 Guaranteed Maximum Price

The Construction Manager guarantees that the Contract Sum shall not exceed the Guaranteed Maximum Price set forth in the Guaranteed Maximum Price Amendment, subject to additions and deductions by Change Order as provided in the Contract Documents. Costs which would cause the Guaranteed Maximum Price to be exceeded shall be paid by the Construction Manager without reimbursement by the Owner. The GMP shall include the Construction Manager's Contingency.

§ 6.3 Changes in the Work

§ 6.3.1 The Owner may, without invalidating the Contract, order changes in the Work within the general scope of the Contract consisting of additions, deletions or other revisions. The Owner shall issue such changes in writing. The Construction Manager may be entitled to an equitable adjustment in the Contract Time consistent with the requirements of the Contract Documents as a result of changes in ~~the Work.~~the Work; provided, that at the Owner's option and Contractor's mutual agreement, the Owner may instead approve an increase in the GMP (e.g., for overtime) to ensure so as to ensure the Project is completed within the Contract Time.

§ 6.3.1.1 The Architect and the Owner may order minor changes in the Work as provided in Article 7 of AIA Document A201–2017, General Conditions of the Contract for Construction.

§ 6.3.2 Adjustments to the Guaranteed Maximum Price on account of changes in the Work subsequent to the execution of the Guaranteed Maximum Price Amendment may be determined by any of the methods listed in Article 7 of AIA Document A201–2017, General Conditions of the Contract for Construction.

§ 6.3.3 Adjustments to subcontracts awarded on the basis of a stipulated sum shall be determined in accordance with Article 7 of A201–2017, as they refer to "cost" and "fee," and not by Articles 6 and 7 of this Agreement. Adjustments to subcontracts awarded with the Owner's prior written consent on the basis of cost plus a fee shall be calculated ~~in accordance with the terms of those subcontracts.~~consistent with Article 7 of this Agreement.

§ 6.3.4 In calculating adjustments to the Guaranteed Maximum ~~Price,~~ Price or changed Work performed by the Construction Manager, the terms "cost" and "costs" as used in Article 7 of AIA Document A201–2017 shall mean the Cost of the Work as defined in Article 7 of this Agreement and the term "fee" shall mean the Construction Manager's Fee as defined in Section 6.1.2 of this Agreement.

§ 6.3.5 ~~If no specific provision is made in Section 6.1.3 for adjustment of the Construction Manager's Fee in the case of changes in the Work, or if the extent of such changes is such, in the aggregate, that application of the adjustment provisions of Section 6.1.3 will cause substantial inequity to the Owner or Construction Manager, the Construction Manager's Fee shall be equitably adjusted on the same basis that was used to establish the Fee for the original Work, and the Guaranteed Maximum Price shall be adjusted accordingly.~~

ARTICLE 7 COST OF THE WORK FOR CONSTRUCTION PHASE

§ 7.1 Costs to Be Reimbursed

§ 7.1.1 The term Cost of the Work shall mean the costs necessarily incurred by the Construction Manager in the proper performance of ~~the Work.~~ the Work, without embedded overhead, profit, fee or markup (with the exception of Subcontractor overhead, profit, fees, and markup included in subcontracts). The Cost of the Work shall include only the items set forth in Sections 7.1 through 7.7.

§ 7.1.2 Where, pursuant to the Contract Documents, any cost is subject to the Owner's prior approval, the Construction Manager shall obtain such approval in writing prior to incurring the cost. The parties shall endeavor to identify any such costs prior to execution of the GMP Amendment.

§ 7.1.3 Costs shall be at rates not higher than the standard rates paid at the place of the Project, except with prior approval of the Owner.

§ 7.2 Labor Costs

§ 7.2.1 Wages or salaries of construction workers directly employed by the Construction Manager to perform the construction of the Work at the site or, with the Owner's prior approval, at off-site ~~workshops.~~workshops or transporting materials, equipment or personnel to and from the Project site. The Owner and the Construction Manager shall agree upon burdened wage rates for all employees and workers under this Section. The rates established shall be fully burdened and inclusive of all wage-based costs including, but not limited to, taxes, insurance, contributions, assessments, and benefits, including sick leave, medical and health benefits, holidays, paid time off, vacations and pensions. The Construction Manager shall not separately bill any such wage-based costs as Costs of the Work.

§ 7.2.2 Wages or salaries of the Construction Manager's supervisory and administrative personnel ~~when stationed at the site and performing Work, with the Owner's prior approval.~~ are included in the Specified General Conditions and not separately reimbursable.

§ 7.2.2.1 ~~Wages or salaries of the Construction Manager's supervisory and administrative personnel when performing Work and stationed at a location other than the site, but only for that portion of time required for the Work, and limited to the personnel and activities listed below:~~

~~*(Identify the personnel, type of activity and, if applicable, any agreed upon percentage of time to be devoted to the Work.)*~~

§ 7.2.3 ~~Wages and salaries of the Construction Manager's supervisory or administrative personnel engaged at factories, workshops or while traveling, in expediting the production or transportation of materials or equipment required for the Work, but only for that portion of their time required for the Work.~~The labor rates charged for Negotiated Support Services (NSS) shall be the total burdened posted union rate for the work being performed. All other wages and salaries are not separately reimbursable under the terms of the Agreement.

§ 7.2.4 ~~Costs paid or incurred by the Construction Manager, as required by law or collective bargaining agreements, for taxes, insurance, contributions, assessments and benefits and, for personnel not covered by collective bargaining agreements, customary benefits such as sick leave, medical and health benefits, holidays, vacations and pensions, provided such costs are based on wages and salaries included in the Cost of the Work under Sections 7.2.1 through 7.2.3.~~

§ 7.2.5 If agreed rates for labor costs, in lieu of actual costs, are provided in this Agreement, the rates shall remain unchanged throughout the duration of this Agreement, unless the parties execute a Modification.

§ 7.3 Subcontract Costs

Payments made by the Construction Manager to Subcontractors in accordance with the requirements of the subcontracts and this Agreement. The Construction Manager shall maintain a procedure for the review, processing and payment of applications by the Subcontractors for progress and final payments, all in accordance with the terms and conditions of the Contract Documents. The Construction Manager shall verify the completeness of all applications for payment and assemble and check all supporting documentation required by the Contract Documents or by the subcontracts with respect to each Application for Payment, including all lien waivers and releases.

§ 7.4 Costs of Materials and Equipment Incorporated in the Completed Construction

§ 7.4.1 Costs, including transportation and storage at the site, of materials and equipment incorporated, or to be incorporated, in the completed ~~construction.~~construction, except on-site storage and handling of materials, which are included under Specified General Conditions and are not separately reimbursable.

§ 7.4.2 Costs of materials described in the preceding Section 7.4.1 in excess of those actually installed to allow for reasonable waste and spoilage. Unused excess materials, if any, shall become the Owner's property at the completion of the Work or, at the Owner's option, shall be sold or returned by the Construction Manager. Any amounts realized from such sales or returns shall be credited to the Owner as a deduction from the Cost of the Work.

§ 7.4.3 Notwithstanding the foregoing, costs of material and equipment procured by the Construction Manager but not incorporated in the completed construction may be included in the Negotiated Support Services, if approved by the Owner. Electronic equipment is separately addressed as part of the Specified General Conditions.

§ 7.5 Costs of Other Materials and Equipment, Temporary Facilities and Related Items

§ 7.5.1 Costs of transportation, storage, installation, dismantling, maintenance, and removal of materials, supplies, temporary facilities, machinery, equipment (as described in the Contract Documents) and hand tools owned and not customarily owned by construction workers that are provided by the Construction Manager at the site and fully consumed in the performance of the ~~Work.~~ Work are included in Negotiated Support Services and are not otherwise reimbursable. Costs of materials, supplies, temporary facilities, machinery, equipment, and tools, that are not fully consumed, shall be based on the cost or value of the item at the time it is first used on the Project site less the value of the item when it is no longer used at the Project site. Costs for items not fully consumed by the Construction Manager shall mean fair market value.

§ 7.5.2 Rental charges (not to exceed the local fair market rental costs) actually paid to non-related third parties for temporary facilities, machinery, equipment, and hand tools not customarily owned by construction workers that are provided by the Construction Manager at the site, and the costs of transportation, installation, dismantling, minor repairs, and removal of such temporary facilities, machinery, equipment, and hand tools. Rates and quantities of equipment owned by the Construction Manager, or a related party as defined in Section 7.8, shall be subject to the Owner's prior approval. The total rental cost over the full duration of the Project of any such Construction Manager-owned equipment may not exceed the lesser of local fair market rental costs or eighty-five percent (85%) of the purchase price of any comparable item.

§ 7.5.2.1 Rentals from the Construction Manager or any entity in which the Construction Manager or one or more of its owners has a direct or indirect ownership interest ("CM Equipment") shall be separately accounted for and the rental costs shall not exceed Rental Rate Blue Book by Data Quest, San Jose, California, or fair market rental costs, whichever are lower. If more than one rate is applicable, the best available rate will be utilized. The rates in effect at the time of the performance of the Work are the maximum rates allowable for equipment of modern design and in good working condition. Equipment not of modern design and/or not in good working condition will have lower rates. Hourly, weekly, and/or monthly rates, as appropriate, will be applied to yield the lowest total cost. If CM Equipment is required for which a rental rate is not established by the Blue Book, an agreed rental rate shall be established for that equipment, which rate and use must be approved by the Owner prior to performing the Work.

§ 7.5.3 Costs of street cleaning and removal of rubbish and debris from the site of the Work and its proper and legal ~~disposal.~~disposal are included under Negotiated Support Services and are not otherwise reimbursable. While separate contracts for progress cleaning, including removal of rubbish and debris not normally included in a trade subcontract, are Negotiated Support Services, a separate subcontract that specifically requires final cleaning will be reimbursed as an Article 7 Cost of the Work.

§ 7.5.4 Costs of the Construction Manager's site office, including general office equipment and ~~supplies.~~supplies are Negotiated Support Services and are not separately reimbursable.

§ 7.5.5 Costs of materials and equipment suitably stored off the site at a mutually acceptable location, subject to the Owner's prior approval.

§ 7.5.6 Notwithstanding the foregoing, costs of certain material and equipment, temporary facilities and related items procured by the Construction Manager will be included in Negotiated Support Services as set forth in the Contract Documents.

§ 7.6 Miscellaneous Costs

§ 7.6.1 ~~Premiums~~ The actual, net costs of premiums for that portion of builder's risk insurance and mandatory GC/CM and Subcontractor bonds (see Chapter 39.10 RCW) required by the Contract Documents that can be directly attributed to this ~~Contract.~~Contract after taking into consideration cost adjustments including, for example, experience modifiers, premium discounts, policy dividends, rebates, and refunds, retrospective rating plan premium adjustments, and assigned risk pool rebates. All other insurance, bond premiums and Subcontractor risk management tools not explicitly required by the Contract Documents (including Subcontractor bonds beyond those required by Chapter 39.10 RCW, default insurance or Subguard®) are not Costs of the Work but are included within the Fee and are not otherwise reimbursable.

§ 7.6.1.1 Costs for self-insurance, for either full or partial amounts of the coverages required by the Contract Documents, ~~with the Owner's prior approval.~~is not reimbursable as a Cost of the Work.

§ 7.6.1.2 Costs for insurance through a captive insurer owned or controlled by the Construction ~~Manager, with the Owner's prior approval.~~
Manager is not reimbursable as a Cost of the Work.

§ 7.6.2 ~~Sales, use, or similar taxes,~~Use, income, B&O, or similar taxes (with the exception of Washington State Sales Tax (WSST)), imposed by a governmental authority, that are related to the Work and for which the Construction Manager is ~~liable.~~liable are included in the Construction Manager's Fee and are not separately reimbursable. Washington State Sales Tax (WSST) to be paid on the Contract Sum will be calculated by the Owner and paid with each progress payment.

§ 7.6.3 Fees and assessments for ~~the building permit, and for other permits, licenses, and inspections,~~ Project-specific permits, and for other permits, licenses (but not the Construction Manager's business license), and inspections of governmental authorities having jurisdiction, for which the Construction Manager is required by the Contract Documents to pay. The Owner will pay the direct cost of the building permit. The Construction Manager shall coordinate the issuance and pick up of these permits and shall directly pay for (as a Cost of the Work within the GMP) and coordinate all other permits required for the Work.

§ 7.6.4 Fees of laboratories for tests required of the Construction Manager by the Contract Documents; except those related to defective or nonconforming Work for which reimbursement is excluded under Article 13 of AIA Document A201–2017 or by other provisions of the Contract Documents, and which do not fall within the scope of Section 7.7.3. The Construction Manager's testing coordination is included in Negotiated Support Services and is not separately reimbursable as a Cost of the Work.

§ 7.6.5 Royalties and license fees paid for the use of a particular design, process, or product, required by the Contract Documents.

§ 7.6.5.1 The cost of defending suits or claims for infringement of patent rights arising from requirements of the Contract Documents, payments made in accordance with legal judgments against the Construction Manager resulting from such suits or claims, and payments of settlements made with the Owner's consent, unless the Construction Manager had reason to believe that the required design, process, or product was an infringement of a copyright or a patent, and the Construction Manager failed to promptly furnish such information to the Architect as required by Article 3 of AIA Document A201–2017. The costs of legal defenses, judgments, and settlements shall not be included in the Cost of the Work used to calculate the Construction Manager's Fee or subject to the Guaranteed Maximum Price.

§ 7.6.6 Costs for communications services, including computers and cell phones, electronic equipment, and software, directly related to the Work and located at the site, with the Owner's prior ~~approval.~~approval are included in Specified General Conditions and are not separately reimbursable.

§ 7.6.7 Costs of document ~~reproductions and delivery charges.~~reproductions, postage and parcel delivery charges are included in Negotiated Support Services and are not separately reimbursable.

§ 7.6.8 Deposits lost for causes other than the Construction Manager's negligence or failure to fulfill a specific responsibility in the Contract Documents.

§ 7.6.9 Legal, mediation and arbitration costs, including attorneys' fees, other than those arising from disputes between the Owner and Construction Manager, reasonably incurred by the Construction Manager after the execution of this Agreement in the performance of the Work and with the Owner's prior approval, which shall not be unreasonably withheld. Construction Manager will not be entitled to add "Fee" on to such legal, mediation and arbitration costs.

§ 7.6.10 Expenses incurred in accordance with the Construction Manager's standard written personnel policy for relocation and temporary living allowances of the Construction Manager's personnel required for the Work, with the Owner's prior ~~approval.~~approval, are included in Specified General Conditions and are not separately reimbursable.

§ 7.6.11 That portion of the reasonable expenses of the Construction Manager's supervisory or administrative personnel incurred while traveling in discharge of duties connected with the ~~Work.~~Work with the Owner's prior approval, are included in Specified General Conditions and are not separately reimbursable.

§ 7.6.12 The cost of pre-approved warehousing of stored materials or equipment subsequently incorporated into the Work.

§ 7.7 Other Costs and Emergencies

§ 7.7.1 Other costs incurred in the performance of the Work, with the Owner's prior ~~approval.~~approval, including temporary heat and temporary hookups and meter installation for water, utilities, natural gas, sewer and storm sewer, necessary for proper execution and completion of the Work.

§ 7.7.2 Costs incurred in taking action to prevent threatened damage, injury, or loss, in case of an emergency affecting the safety of persons and property, as provided in Article 10 of AIA Document A201–2017.

§ 7.7.3 Costs of repairing or correcting damaged or nonconforming Work executed by the Construction Manager, Subcontractors, or suppliers, provided that such damaged or nonconforming Work was not caused by the negligence of, or failure to fulfill a specific responsibility by, the Construction Manager, and only to the extent that the cost of repair or correction is not recovered by the Construction Manager from insurance, sureties, Subcontractors, suppliers, or others.

§ 7.7.4 The costs described in Sections 7.1 through 7.7 shall be included in the Cost of the Work, notwithstanding any provision of AIA Document A201–2017 or other Conditions of the Contract which may require the Construction Manager to pay such costs, unless such costs are excluded by the provisions of Section 7.9.

§ 7.7.5 Negotiated Support Services are reimbursable as a Cost of the Work up to the not-to-exceed Negotiated Support Services amount.

§ 7.7.6 Specified General Conditions are reimbursable as a Cost of the Work for the fixed Specified General Conditions amount.

§ 7.8 Related Party Transactions

§ 7.8.1 For purposes of this Section 7.8, the term "related party" shall mean (1) a parent, subsidiary, affiliate, or other entity having common ownership of, or sharing common management with, the Construction Manager; (2) any entity in which any stockholder in, or management employee of, the Construction Manager holds an equity interest in excess of ten percent in the aggregate; (3) any entity which has the right to control the business or affairs of the Construction Manager; or (4) any person, or any member of the immediate family of any person, who has the right to control the business or affairs of the Construction Manager.

§ 7.8.2 If any of the costs to be reimbursed arise from a transaction between the Construction Manager and a related party, the Construction Manager shall notify the Owner of the specific nature of the contemplated transaction, including the identity of the related party and the anticipated cost to be incurred, before any such transaction is consummated or cost incurred. If the Owner, after such notification, authorizes the proposed transaction in writing, then the cost incurred shall be included as a cost to be reimbursed, and the Construction Manager shall procure the Work, equipment, goods, or service, from the related party, as a Subcontractor, according to the terms of Article 9. If the Owner fails to authorize the transaction in writing, the Construction Manager shall procure the Work, equipment, goods, or service from some person or entity other than a related party according to the terms of Article 9.

§ 7.9 Costs Not To Be Reimbursed

§ 7.9.1 The Cost of the Work shall not include the items listed ~~below:~~below, as all such items are covered by the Construction Manager's Fee or are at the Construction Manager's risk:

.1 Salaries and other compensation of the Construction Manager's personnel stationed at the Construction Manager's principal office or offices other than the site office, except as specifically provided in Section 7.2, or as may be provided in Article 14;

.2 Bonuses, profit sharing, incentive compensation, and any other discretionary payments, paid to anyone hired by the Construction Manager or paid to any Subcontractor or vendor, unless the Owner has provided prior approval;

.3 Expenses of the Construction Manager's principal office and offices other than the site office;

.4 Overhead and general expenses, except as may be expressly included in Sections 7.1 to 7.7;

.5 The Construction Manager's capital expenses, including interest on the Construction Manager's capital employed for the Work;

.6 ~~Except as provided in Section 7.7.3 of this Agreement, costs~~ Costs due to the negligence of, or failure to fulfill a specific responsibility of the Contract by, the Construction Manager, Subcontractors, and suppliers, or anyone directly or indirectly employed by any of them or for whose acts any of them may be liable;

.7 Any cost not specifically and expressly described in Sections 7.1 to 7.7;

.8 Costs, other than costs included in Change Orders approved by the Owner, that would cause the Guaranteed Maximum Price to be exceeded; ~~and~~

.9 Costs for services incurred during the Preconstruction ~~Phase.~~Phase, except as specifically allowed herein;

.10 Direct payments by the Owner for the building permit, connection fees, GFC fees, state fees and plan-check fees are not a part of the Cost of the Work or the GMP;

.11 Overtime wages, unless pre-approved by the Owner;

.12 Main or home office accounting, data processing, software, hardware or computer-related costs not included in the Specified General Conditions;

.13 Penalties and fines imposed by a governmental entity due to the acts or omissions of the Construction Manager or its subcontractors of any tier;

.14 Safety and warranty administration costs not included in the Negotiated Support Services;

.15 Liquidated damages;

.16 Legal, consultant, or claims-related expenses, except as specifically provided in Section 7.6.9 and 7.6.5.1;

.17 Warehousing in the Construction Manager's facility; and

.18 Business or contractor registration licenses.

.19 Costs related to warranty work performed during the correction period or, as applicable, pursuant to longer extended warranty, unless party obligated by such warranty is insolvent.

ARTICLE 8 DISCOUNTS, REBATES, AND REFUNDS

§ 8.1 Cash discounts obtained on payments made by the Construction Manager shall accrue to the Owner ~~if (1) before making the payment, the Construction Manager included the amount to be paid, less such discount, in an Application for Payment and received payment from the Owner, or (2) the Owner has deposited funds with the Construction Manager with which to make payments; otherwise, cash discounts shall accrue to the Construction Manager.~~ . Trade discounts, rebates, refunds, and amounts received from sales of surplus materials and equipment shall accrue to the Owner, and the Construction Manager shall make provisions so that they can be obtained. The Construction Manager shall notify the Owner in a timely manner of the availability of such cash discounts, rebates, or refunds.

§ 8.2 Amounts that accrue to the Owner in accordance with the provisions of Section 8.1 shall be credited to the Owner as a deduction from the Cost of the Work.

ARTICLE 9 SUBCONTRACTS AND OTHER AGREEMENTS

§ 9.1 Those portions of the Work that the Construction Manager does not customarily perform with the Construction Manager's own personnel shall be performed under subcontracts or other appropriate agreements with the Construction Manager. The ~~Owner may designate specific persons from whom, or entities from which, the Construction Manager shall obtain bids. The Construction Manager shall obtain~~ Construction Manager shall assemble the bidding materials, manage the bidding process, and obtain bids from Subcontractors, and from suppliers of materials or equipment fabricated especially for the Work, who are qualified to perform that portion of the Work in accordance with the requirements of the Contract Documents. The Construction Manager shall comply with the applicable requirements of Chapter 39.10 RCW in soliciting subcontractor bids, the provisions of which shall take precedence over any inconsistent provisions of the

Contract Documents. The Construction Manager shall deliver such bids to the Architect and Owner with an indication and recommendation as to which bids the Construction Manager intends to accept. The Owner then has the right to review the Construction Manager's list of proposed subcontractors and suppliers in consultation with the Architect and, subject to Section 9.1.1, to object to any subcontractor or supplier. Any advice of the Architect, or approval or objection by the Owner, shall not relieve the Construction Manager of its responsibility to perform the Work in accordance with the Contract Documents. The Construction Manager shall not be required to contract with anyone to whom the Construction Manager has reasonable objection.

~~§ 9.1.1 When a specific subcontractor or supplier (1) is recommended to the Owner by the Construction Manager; (2) is qualified to perform that portion of the Work; and (3) has submitted a bid that conforms to the requirements of the Contract Documents without reservations or exceptions, but the Owner requires that another bid be accepted, then the Construction Manager may require that a Change Order be issued to adjust the Guaranteed Maximum Price by the difference between the bid of the person or entity recommended to the Owner by the Construction Manager and the amount of the subcontract or other agreement actually signed with the person or entity designated by the Owner.~~

§ 9.1.1.1 Unless all bids are rejected, subcontract bid packages shall be awarded to the "responsible" and responsive bidder submitting the low responsive bid. Determination of "responsibility" shall comply with the requirements of Chapter 39.10 RCW and Washington law.

.1 Other than Work under the Specified General Conditions and Negotiated Support Services, all Work on the Project shall be competitively bid as required by Chapter 39.10 RCW. Negotiated Support Services shall not be bid as a package, but individual components of Negotiated Support Services may be bid. The Construction Manager may, subject to Chapter 39.10 RCW, organize and solicit bids for the subcontract work in whatever combinations or packages it chooses, but the Construction Manager may not use alternates without approval of the Owner.

.2 The Construction Manager shall bid out the subcontract bid packages in accordance with its approved Subcontracting Plan. The Construction Manager shall document and report bi-weekly to the Owner on its procurement process. The Owner's written approval is required for changes to the Subcontracting Plan.

.3 Before initially soliciting bids for the first subcontract bid package, the Construction Manager shall submit, and the Owner shall reasonably approve, final bid package estimates for all subcontract bid packages in the approved Subcontracting Plan. The sum of the final bid package estimates included in the approved Subcontracting Plan, plus any other Costs of the Work (including Negotiated Support Services and Specified General Conditions) and the Contractor's Contingency shall not exceed the estimated MACC.

.4 When in the best interests of the Project and critical to the successful completion of a subcontract bid package, the Owner and Construction Manager may make a prebid determination of Subcontractor eligibility in accordance with Chapter 39.10 RCW. In addition, if the anticipated subcontract value will exceed $3 million and the Owner consents, the Construction Manager may select a mechanical Subcontractor, an electrical Subcontractor, or both, in accordance with the alternative procedure specified in RCW 39.10.385.

.5 As part of its Subcontracting Plan, the Construction Manager shall promptly notify the Owner of Work (other than Negotiated Support Services and Specified General Conditions) that it will seek to self-perform. The Construction Manager, including its subsidiaries and affiliates, may bid on a subcontract bid package if the Work within the subcontract bid package is customarily performed by the Construction Manager, if the Construction Manager has, in the Owner's reasonable opinion, aggressively sought competition, if the bid opening is managed by the Owner, if notification of the Construction Manager's intention to bid is included in the public solicitation of bids for the bid package, and if the Construction Manager otherwise complies with Chapter 39.10 RCW. The Construction Manager must provide staff to superintend and manage work it performs in subcontract bid packages with individuals separate and distinct from the staff involved in the overall management of this Contract. The Construction Manager shall coordinate subcontract bid package Work it performs with the Work of Subcontractors.

.6 The Construction Manager shall require a bid bond from Subcontractors bidding work expected to cost more than $300,000, and all Subcontractors awarded a subcontract in excess of $300,000 shall provide a performance and payment bond for the subcontract amount.

.7 The Construction Manager's solicitations of subcontract bid packages shall be made in accordance with the following procedures:

- A representative from the Owner will be present at each bid opening to observe the procedure.

- Solicitations for bids will be advertised at least fourteen (14) days in advance in a legal newspaper circulated in the area of the Project.
- Bidders may obtain the bid results by telephone from the Construction Manager.
- Responsiveness requirements and bidding procedures will be described in each solicitation and may be reviewed with the Owner prior to a bid opening.

.8 The Construction Manager shall ensure compliance with Chapter 39.10 RCW and with all the above requirements for Subcontractor solicitation, and subcontracts shall conform to the requirements of Chapter 39.10 RCW.

.9 The services performed by the Construction Manager in soliciting subcontract bid packages are covered under the Specified General Conditions.

.10 The Construction Manager shall promptly contract with the selected bidder and shall promptly deliver a copy of each subcontract to the Owner.

§ 9.2 Subcontracts or other agreements shall conform to the applicable payment provisions of this Agreement, and shall not be awarded on the basis of cost plus a fee ~~without the Owner's prior written approval. If a subcontract is~~ with the exception of any contracts awarded, with the Owner's approval, under the alternative procedure of RCW 39.10.385 on a cost plus fee basis, which shall include a maximum allowable subcontract cost. If mechanical and/or electrical subcontracts are awarded on the basis of cost plus a ~~fee,~~ fee in accordance with the alternative procedure specified in RCW 39.10.385 on a cost plus fee basis, the Construction Manager shall provide in the subcontract for the Owner to receive the same audit rights with regard to the Subcontractor as the Owner receives with regard to the Construction Manager in Article ~~10.~~10 and these Subcontractors shall be audited prior to final payment in accordance with Section 11.2.

ARTICLE 10 ACCOUNTING RECORDS

The Construction Manager and its cost-reimbursable Subcontractors shall keep full and detailed records and accounts related to the Cost of the Work, and exercise such controls, as may be necessary for proper financial management under this Contract and to substantiate all costs incurred. The accounting and control systems shall be satisfactory to the Owner. Substantiation for lump-sum subcontracts shall include the Subcontractors' bid proposals, the Construction Manager's bid tabulation worksheets, invoices to the Construction Manager and monthly schedules of values. The Owner and the Owner's auditors shall, during regular business hours and upon reasonable notice, be afforded access to, and shall be permitted to audit and ~~copy, the Construction Manager's~~ copy (including electronically copy), the Construction Manager's and Subcontractors' original records and accounts, including complete documentation supporting accounting entries, books, ledgers, computerized records, daily reports, job cost reports, correspondence, instructions, drawings, receipts, subcontracts, Subcontractor's proposals, Subcontractor's invoices, purchase orders, vouchers, memoranda, and other data relating to this Contract, including any Claims made under this Contract. The Construction Manager shall preserve these records for a period of three years after final payment, or for such longer period as may be required ~~by law.~~ by law, by any Supplementary Conditions, and/or by USDA.

ARTICLE 11 PAYMENTS FOR CONSTRUCTION PHASE SERVICES

§ 11.1 Progress Payments

§ 11.1.1 Based upon Applications for Payment submitted ~~to the Architect~~ in accordance with the Contract Documents to the Owner by the Construction Manager, and Certificates for Payment issued by the Architect, the Owner shall make progress payments on account of the Contract Sum, to the Construction Manager, as provided below and elsewhere in the Contract Documents. The Application shall be in a form acceptable to the Owner.

§ 11.1.2 The period covered by each Application for Payment shall be one calendar month ending on the last day of the month, or as follows:

N/A

§ 11.1.3 Details regarding the Application for Payment process are addressed in Section 9.3 of the General Conditions. Provided that an Application for Payment is received by the ~~Architect~~ Owner not later than the last day of a month, the Owner shall make payment of the amount certified to the Construction Manager not later than the last day of the following month. If an Application for Payment is received by the Architect after the application date fixed above, payment of the amount certified shall be made by the Owner not later than ~~(--)~~ thirty (30) days after the Architect receives the Application for Payment.

(Federal, state or local laws may require payment within a certain period of time.)

§ 11.1.4 With each Application for Payment, the Construction Manager shall submit lien releases and an itemized listing of all expenses and Costs of the Work that are being billed in such Application for Payment. The Owner shall have the option to request detailed back-up and proof of such expenses and Costs of the Work , including payrolls, petty cash accounts, receipted invoices or invoices with check vouchers attached, and any other evidence reasonably required by the Owner or Architect to demonstrate that payments already made by the Construction Manager on account of the Cost of the Work equal or exceed progress payments already received by the Construction ~~Manager, plus payrolls for the period covered by the present Application for Payment, less that portion of the progress payments attributable to the Construction Manager's Fee.~~Manager.

§ 11.1.5 Each Application for Payment shall be based on the most recent schedule of values submitted by the Construction Manager in accordance with the Contract Documents. The schedule of values shall allocate the entire Guaranteed Maximum Price among: (1) the various portions of the Work; (2) any contingency for costs that are included in the Guaranteed Maximum Price but not otherwise allocated to another line item or included in a Change Order; and (3) the Construction Manager's Fee. Within the Schedule of Values, the Construction Manager's Fee, Negotiated Support Services, Specified General Conditions, and the Contractor's Contingency shall be shown as separate line items.

§ 11.1.5.1 The schedule of values shall be prepared in such form and supported by such data to substantiate its accuracy as the Owner and the Architect may require. The schedule of values shall be used as a basis for reviewing the Construction Manager's Applications for Payment. Each schedule of values prepared by the Construction Manager must be submitted to the Owner and the Architect for review and approval at least thirty (30) days prior to the schedule of values being included in an Application for Payment.

§ 11.1.5.2 The allocation of the Guaranteed Maximum Price under this Section 11.1.5 shall not constitute a separate guaranteed maximum price for the Cost of the Work of each individual line item in the schedule of values.

§ 11.1.5.3 When the Construction Manager allocates costs from a contingency to another line item in the schedule of values, the Construction Manager shall submit supporting documentation to the Owner and the Architect. Contingency usage over $75,000 shall require Owner's prior written consent in a Contingency Use Authorization form, which consent shall not be unreasonably withheld.

§ 11.1.6 Applications for Payment shall show the percentage of completion of each portion of the Work as of the end of the period covered by the Application for Payment. The percentage of completion shall be the lesser of (1) the percentage of that portion of the Work which has actually been completed, or (2) the percentage obtained by dividing (a) the expense that has actually been incurred by the Construction Manager on account of that portion of the Work and for which the Construction Manager has made payment or intends to make payment prior to the next Application for Payment, by (b) the share of the Guaranteed Maximum Price allocated to that portion of the Work in the schedule of values.

§ 11.1.7 In accordance with AIA Document A201–2017 and subject to other provisions of the Contract Documents, the amount of each progress payment shall be computed as follows:

§ 11.1.7.1 The amount of each progress payment shall first include:

.1 That portion of the Guaranteed Maximum Price properly allocable to completed Work as determined by multiplying the percentage of completion of each portion of the Work by the share of the Guaranteed Maximum Price allocated to that portion of the Work in the most recent schedule of values;

.2 That portion of the Guaranteed Maximum Price properly allocable to materials and equipment delivered and suitably stored at the site for subsequent incorporation in the completed construction or, if approved in writing in advance by the Owner, suitably stored off the site at a location agreed upon in writing; and

.3 That portion of Construction Change Directives that the Architect determines, in the Architect's professional ~~judgment,~~ judgment and in coordination with the Owner, to be reasonably justified; and

.4 The Construction Manager's Fee, computed upon the Cost of the Work described in the preceding Sections 11.1.7.1.1 and 11.1.7.1.2 at the rate stated in Section ~~6.1.2 or, if the Construction Manager's Fee is stated as a fixed sum in that Section, an amount that bears the same ratio to that fixed-sum fee as the Cost of the Work included in Sections 11.1.7.1.1 and 11.1.7.1.2 bears to a reasonable estimate of the probable Cost of the Work upon its completion.~~6.1.2.

§ 11.1.7.2 The amount of each progress payment shall then be reduced by:

.1 The aggregate of any amounts previously paid by the Owner;

.2 The amount, if any, for Work that remains uncorrected and for which the Architect or the Owner has previously withheld a Certificate for Payment or the Owner has withheld payment as provided in Article 9 of AIA Document A201–2017;

.3 Any amount for which the Construction Manager does not intend to pay a Subcontractor or material supplier, unless the Work has been performed by others the Construction Manager intends to pay;

.4 For Work performed or defects discovered since the last payment application, any amount for which the Owner or the Architect may withhold payment, or nullify a Certificate of Payment in whole or in part, as provided in Article 9 of AIA Document A201–2017;

.5 The shortfall, if any, indicated by the Construction Manager in the documentation required by Section 11.1.4 to substantiate prior Applications for Payment, or resulting from errors subsequently discovered by the Owner's auditors in such documentation; and

.6 ~~Retainage withheld pursuant to Section 11.1.8.~~Statutory retainage of five percent (5%) of the completed Cost of the Work as a fund for the protection and payment of the claims of any person or entity arising out of the Work and the state with respect to taxes pursuant to Chapter 60.28 RCW (unless Construction Manager has posted a retainage bond pursuant to RCW 60.28.011).

§ 11.1.8 Retainage

§ 11.1.8.1 For each progress payment made prior to Substantial Completion of the Work, the Owner may (subject to the Construction Manager's right to obtain a retainage bond pursuant to RCW 60.28.011) withhold the following amount, as retainage, from the payment otherwise due:

(Insert a percentage or amount to be withheld as retainage from each Application for Payment. The amount of retainage may be limited by governing law.)

See General Conditions, Section 9.3.4

§ 11.1.8.1.1 The following items are not subject to retainage:

(Insert any items not subject to the withholding of retainage, such as general conditions, insurance, etc.)

N/A

§ 11.1.8.2 Reduction or limitation of retainage, if any, shall be as follows:

(If the retainage established in Section 11.1.8.1 is to be modified prior to Substantial Completion of the entire Work, insert provisions for such modification.)

The Construction Manager may request that the Owner release partial retainage on certain subcontractors (e.g., excavation, concrete, earthwork, site utilities) prior to Substantial Completion should there be justification for such early release. The Owner may approve or deny such early release of retainage in its sole discretion.

§ 11.1.8.3 ~~Except as set forth in this Section 11.1.8.3, upon Substantial Completion of the Work, the Construction Manager may submit an Application for Payment that includes the retainage withheld from prior Applications for Payment pursuant to this Section 11.1.8. The Application for Payment submitted at Substantial Completion shall not include retainage as follows:~~

~~*(Insert any other conditions for release of retainage, such as upon completion of the Owner's audit and reconciliation, upon Substantial Completion.)*~~

§ 11.1.9 If final completion of the Work is materially delayed through no fault of the Construction Manager, the Owner shall pay the Construction Manager any additional amounts in accordance with Article 9 of AIA Document A201–2017.

§ 11.1.10 Except with the Owner's prior written approval, the Construction Manager shall not make advance payments to suppliers for materials or equipment which have not been delivered and suitably stored at the site.

§ 11.1.11 The Owner and the Construction Manager shall agree upon a mutually acceptable procedure for review and approval of payments to Subcontractors, and the percentage of retainage held on Subcontracts, and the Construction Manager shall execute subcontracts in accordance with those agreements.

§ 11.1.12 In taking action on the Construction Manager's Applications for Payment the Architect and the Owner shall be entitled to rely on the accuracy and completeness of the information furnished by the Construction Manager, and such action shall not be deemed to be a representation that (1) the Architect ~~has~~ or the Owner have made a detailed examination, audit, or arithmetic verification, of the documentation submitted in accordance with Section 11.1.4 or other supporting data; (2) that the Architect ~~has~~ or the Owner have made exhaustive or continuous on-site inspections; or (3) that the Architect ~~has~~ or the Owner have made examinations to ascertain how or for what purposes the Construction Manager has used amounts previously paid on account of the Contract. Such examinations, audits, and verifications, if required by the Owner, will be performed by the Owner's auditors acting in the sole interest of the Owner. Payment by the Owner shall not constitute final approval of the Work done or the amount due.

§ 11.1.13 The Construction Manager shall obtain Affidavits of Wages Paid from each Subcontractor of any tier within thirty (30) days of each Subcontractor's completion of its Work on the Project.

§ 11.2 Final Payment

§ 11.2.1 Final payment, constituting the entire unpaid balance of the Contract Sum, except statutory retainage, shall be made by the Owner to the Construction Manager within thirty (30) days of the Owner's Final Acceptance of all the Work under the Contract, which shall occur when

.1 the Construction Manager has fully performed the Contract, except for the Construction Manager's responsibility to correct Work as provided in Article 12 of AIA Document A201–2017, and to satisfy other requirements, if any, which extend beyond final payment;

.2 the Construction Manager has submitted a final accounting for the Cost of the Work (including final accountings from cost-reimbursable Subcontractors) and a final Application for Payment; and

.3 a final Certificate for Payment has been issued by the Architect in accordance with Section ~~11.2.2.2.~~ 11.2.2.2;

.4 Final Completion has been achieved and;

.5 The requirements for Final Acceptance in the General Conditions are met.

§ 11.2.2 Within 30 days of the Owner's receipt of the Construction Manager's final accounting for the Cost of the ~~Work, the Owner shall~~ Work (including the final accountings of any mechanical and/or electrical subcontracts under RCW 39.10.385), the Owner shall, at its option, conduct an audit of the Cost of the Work or notify the Architect that it will not conduct an audit.

§ 11.2.2.1 If the Owner conducts an audit of the Cost of the Work, the Owner shall, within 10 days after completion of the audit, submit a written report based upon the auditors' findings to the Architect. The Owner's final accounting shall not preclude or in any way limit the Owner from exercising its rights of audit under other provisions of this Contract.

§ 11.2.2.2 Within seven days after receipt of the written report described in Section 11.2.2.1, or receipt of notice that the Owner will not conduct an audit, and provided that the other conditions of Section 11.2.1 have been met, the Architect will either issue to the Owner a final Certificate for Payment with a copy to the Construction Manager, provided the Owner's auditor's report has substantiated the Construction Manager's final accounting, or notify the Construction Manager and Owner in writing of the Architect's reasons for withholding a certificate as provided in Article 9 of AIA Document A201–2017. The time periods stated in this Section 11.2.2 supersede those stated in Article 9 of AIA Document A201–2017. The Architect is not responsible for verifying the accuracy of the Construction Manager's final accounting.

§ 11.2.2.3 If the Owner's auditors' report concludes that the Cost of the Work, as substantiated by the Construction Manager's final accounting, is less than claimed by the Construction Manager, the Construction Manager shall be entitled to ~~request mediation of the disputed amount without seeking an initial decision pursuant to~~ invoke the dispute resolution procedures of Article 15 of AIA Document A201–2017. ~~A request for mediation~~ Commencement of these dispute resolution procedures shall be made by the Construction Manager within 30 days after the Construction Manager's receipt of a copy of the Architect's final Certificate for Payment. Failure to ~~request mediation~~ commence the dispute resolution procedure within this 30-day period shall result in the substantiated amount reported by the Owner's auditors becoming binding on the Construction Manager. Pending a final resolution of the disputed amount, the Owner shall pay the Construction Manager the undisputed amount certified in the Architect's final Certificate for Payment.

§ 11.2.3 The Owner's final payment to the Construction Manager shall be made no later than 30 days after the issuance of the Architect's final Certificate for Payment, or as follows:

See A201 General Conditions

§ 11.2.4 If, subsequent to final payment, and at the Owner's request, the Construction Manager incurs costs, described in Sections 7.1 through 7.7, and not excluded by Section 7.9, to correct defective or nonconforming Work, the Owner shall reimburse the Construction Manager for such costs, and the Construction Manager's Fee applicable thereto, on the same basis as if such costs had been incurred prior to final payment, but not in excess of the Guaranteed Maximum Price. Notwithstanding the foregoing, the Owner will not reimburse the Construction Manager for costs related to defects covered by an extended warranty unless the applicable subcontractor or supplier providing the extended warranty is insolvent, in which case the Owner will reimburse the Construction Manager as specified this Section. If adjustments to the Contract Sum are provided for in Section 6.1.7, the amount of those adjustments shall be recalculated, taking into account any reimbursements made pursuant to this Section 11.2.4 in determining the net amount to be paid by the Owner to the Construction Manager.

§ 11.3 Interest

Payments due and unpaid under the Contract shall bear interest from the date payment is due at the rate stated below, or in the absence thereof, at the legal rate prevailing from time to time at the place where the Project is located.
(Insert rate of interest agreed upon, if any.)

12 % per annum

ARTICLE 12 DISPUTE RESOLUTION

§ 12.1 ~~Initial Decision Maker~~

§ 12.1.1 ~~Any Claim between the Owner and Construction Manager shall be resolved in accordance with the provisions set forth in this Article 12 and Article 15 of A201–2017. However, for Claims arising from or relating to the Construction Manager's Preconstruction Phase services, no decision by the Initial Decision Maker shall be required as a condition precedent to mediation or binding dispute resolution, and Section 12.1.2 of this Agreement shall not apply.~~

§ 12.1.2 The Architect ~~will serve as the Initial Decision Maker~~ shall play an active role in dispute resolution procedures carried out pursuant to Article 15 of AIA Document ~~A201–2017 for Claims arising from or relating to the Construction Manager's Construction Phase services, unless the parties appoint below another individual, not a party to the Agreement, to serve as the Initial Decision Maker.~~
~~*(If the parties mutually agree, insert the name, address and other contact information of the Initial Decision Maker, if other than the Architect.)*~~

A201-2017. During any dispute resolution procedure, the Owner shall actively and cooperatively solicit the input of the Architect in resolving and Claims and disputes.

§ 12.2 Binding Dispute Resolution

Any Claim between the Owner and the construction Manager shall be resolved in accordance with the provisions set forth in this Article 12 and Article 15 of the General Conditions. For any Claim subject to, but not resolved by mediation pursuant to Article 15 of AIA Document A201–2017, the method of binding dispute resolution shall be as follows:
(Check the appropriate box.)

[ ] Arbitration pursuant to Article 15 of AIA Document A201–2017

[X] Litigation in a court of competent jurisdiction in the County in which the Project is located

[ ] Other: *(Specify)*

If the Owner and Construction Manager do not select a method of binding dispute resolution, or do not subsequently agree in writing to a binding dispute resolution method other than litigation, Claims will be resolved by litigation in a court of competent jurisdiction. As between the parties to this Contract, the prevailing party in any litigation shall be entitled to an award of its reasonable attorneys' fees, costs, and expert fees incurred. Attorneys' fees and expenses covered hereunder

also include, but are not limited to, attorneys' fees and expenses incurred in any bankruptcy proceedings, appeal, post-judgment collection proceedings, and post-judgment enforcement proceedings.

ARTICLE 13 TERMINATION OR SUSPENSION

§ 13.1 Termination Prior to Execution of the Guaranteed Maximum Price Amendment

§ 13.1.1 If the Owner and the Construction Manager do not reach an agreement on the Guaranteed Maximum Price, or if the Owner elects not to proceed with the Project or to use a different contracting structure for any reason, the Owner may terminate this Agreement upon not less than seven (7) days' written notice to the Construction Manager, and the Construction Manager may terminate this Agreement, upon not less than seven (7) days' written notice to the Owner.

§ 13.1.2 In the event of termination of this Agreement pursuant to Section 13.1.1, the Construction Manager shall be compensated for Preconstruction Phase services and Work reasonably and necessarily performed prior to receipt of a notice of termination, in accordance with the terms of this ~~Agreement.~~ Agreement, not to exceed the Preconstruction Services Cost. In no event shall the Construction Manager's compensation under this Section exceed the compensation set forth in Section 5.1.

§ 13.1.3 Prior to the execution of the Guaranteed Maximum Price Amendment, the Owner may terminate this Agreement upon not less than seven days' written notice to the Construction Manager for the Owner's convenience and without cause, and the Construction Manager may terminate this Agreement, upon not less than seven days' written notice to the Owner, for the reasons set forth in Article 14 of A201–2017.

§ 13.1.4 In the event of termination of this Agreement pursuant to Section 13.1.3, the Construction Manager shall be equitably compensated for Preconstruction Phase services and Work reasonably and necessarily performed prior to receipt of a notice ~~of termination.~~ of termination, in accordance with the terms of this Agreement, not to exceed the Preconstruction Services Cost. In no event shall the Construction Manager's compensation under this Section exceed the compensation set forth in Section 5.1.

§ 13.1.5 If the Owner terminates the Contract pursuant to Section 13.1.3 after the commencement of the Construction Phase but prior to the execution of the Guaranteed Maximum Price Amendment, the Owner shall pay to the Construction Manager an amount calculated as ~~follows,~~ follows for Work completed up to the date of termination, which amount shall be in addition to any compensation paid to the Construction Manager under Section 13.1.4:

.1 Take the Cost of the Work incurred by the Construction Manager to the date of termination;

.2 Add the Construction Manager's Fee computed upon the Cost of the Work to the date of termination at the rate stated in Section 6.1 or, if the Construction Manager's Fee is stated as a fixed sum in that Section, an amount that bears the same ratio to that fixed-sum Fee as the Cost of the Work at the time of termination bears to a reasonable estimate of the probable Cost of the Work upon its completion; and

.3 Subtract the aggregate of previous payments made by the Owner for Construction Phase services.

In all cases, the Construction Manager is not entitled to any payment, including, but not limited to, Fee or markup, for Work not performed.

§ 13.1.6 The Owner shall also pay the Construction Manager fair compensation, to the extent permitted in Article 7 of this Agreement, either by purchase or rental at the election of the Owner, for any equipment purchased in connection with the Project for Work performed through the date of termination and now owned by the Construction Manager that the Owner elects to retain and that is not otherwise included in the Cost of the Work under Section 13.1.5.1. To the extent that the Owner elects to take legal assignment of subcontracts and purchase orders (including rental agreements), the Construction Manager shall, as a condition of receiving the payments referred to in this Article 13, execute and deliver all such papers and take all such steps, including the legal assignment of such subcontracts and other contractual rights of the Construction Manager, as the Owner may require for the purpose of fully vesting in the Owner the rights and benefits of the Construction Manager under such subcontracts or purchase orders. All Subcontracts, purchase orders and rental agreements entered into by the Construction Manager will contain provisions allowing for assignment to the Owner as described above.

§ 13.1.6.1 If the Owner accepts assignment of subcontracts, purchase orders or rental agreements as described above, the Owner will reimburse or indemnify the Construction Manager for all costs arising under the subcontract, purchase order or rental agreement, if those costs would have been reimbursable as Cost of the Work if the contract had not been terminated. If the Owner chooses not to accept assignment of any subcontract, purchase order or rental agreement that

would have constituted a Cost of the Work had this agreement not been terminated, the Construction Manager will terminate the subcontract, purchase order or rental agreement and the Owner will pay the Construction Manager the costs necessarily incurred by the Construction Manager because of such termination.

§ 13.2 Termination or Suspension Following Execution of the Guaranteed Maximum Price Amendment

§ 13.2.1 Termination

The Contract may be terminated by the Owner or the Construction Manager as provided in Article 14 of AIA Document A201–2017.

§ 13.2.2 Termination by the Owner for Cause

§ 13.2.2.1 If the Owner terminates the Contract for cause as provided in Article 14 of AIA Document A201–2017, the amount, if any, to be paid to the Construction Manager under Article 14 of AIA Document A201–2017 shall not cause the Guaranteed Maximum Price to be exceeded, nor shall it exceed an amount calculated as follows:

.1 Take the Cost of the Work incurred by the Construction Manager to the date of termination;

.2 Add the Construction Manager's Fee, computed upon the Cost of the Work to the date of termination at the rate stated in Section 6.1 or, if the Construction Manager' Fee is stated as a fixed sum in that Section, an amount that bears the same ratio to that fixed-sum Fee as the Cost of the Work at the time of termination bears to a reasonable estimate of the probable Cost of the Work upon its completion;

.3 Subtract the aggregate of previous payments made by the Owner; and

.4 Subtract the costs and damages incurred, or to be incurred, by the Owner under Article 14 of AIA Document A201–2017.

§ 13.2.2.2 The Owner shall also pay the Construction Manager fair compensation, to the extent permitted in Article 7 of this Agreement, either by purchase or rental at the election of the Owner, for any equipment purchased in connection with the Project for Work performed through the date of termination and now owned by the Construction Manager that the Owner elects to retain and that is not otherwise included in the Cost of the Work under Section 13.2.2.1.1. To the extent that the Owner elects to take legal assignment of subcontracts and purchase orders (including rental agreements), the Construction Manager shall, as a condition of receiving the payments referred to in this Article 13, execute and deliver all such papers and take all such steps, including the legal assignment of such subcontracts and other contractual rights of the Construction Manager, as the Owner may require for the purpose of fully vesting in the Owner the rights and benefits of the Construction Manager under such subcontracts or purchase orders.

§ 13.2.3 Termination by the Owner for Convenience

If the Owner terminates the Contract for convenience in accordance with Article 14 of AIA Document A201–2017, then the Owner shall pay the Construction Manager a termination fee as follows:

(Insert the amount of or method for determining the fee, if any, payable to the Construction Manager following a termination for the Owner's convenience.)

$250.000

§ 13.3 Suspension

The Work may be suspended by the Owner as provided in Article 14 of AIA Document A201–2017; in such case, the Guaranteed Maximum Price and Contract Time shall be increased as provided in Article 14 of AIA Document A201–2017, except that the term "profit" shall be understood to mean the Construction Manager's Fee as described in ~~Sections 6.1 and 6.3.5~~ Section 6.1 of this Agreement.

ARTICLE 14 MISCELLANEOUS PROVISIONS

§ 14.1 Terms in this Agreement shall have the same meaning as those in ~~A201–2017.~~ the A201–2017 General Conditions. Where reference is made in this Agreement to a provision of AIA Document A201–2017 or another Contract Document, the reference refers to that provision as revised and as amended or supplemented by other provisions of the Contract Documents.

§ 14.2 Successors and Assigns

§ 14.2.1 The Owner and Construction Manager, respectively, bind themselves, their partners, successors, assigns and legal representatives to covenants, agreements, and obligations contained in the Contract Documents. Except as provided in Section 14.2.2 of this Agreement, and in Section 13.2.2 of ~~A201–2017,~~ the A201–2017 General Conditions, neither party to the Contract shall assign the Contract as a whole without written consent of the other. If either party attempts to

make an assignment without such consent, that party shall nevertheless remain legally responsible for all obligations under the Contract.

§ 14.2.2 The Owner may, without consent of the Construction Manager, assign the Contract to a lender providing construction financing for the Project, if the lender assumes the Owner's rights and obligations under the Contract Documents. The Construction Manager shall execute all consents reasonably required to facilitate the assignment.

§ 14.3 Insurance and Bonds

§ 14.3.1 Preconstruction Phase

The Construction Manager shall maintain the ~~following insurance~~ insurance required by Article 11 of the General Conditions for the duration of the Preconstruction Services performed under this Agreement. ~~If any of the requirements set forth below exceed the types and limits the Construction Manager normally maintains, the Owner shall reimburse the Construction Manager for any additional cost.~~

§ 14.3.1.1 ~~Commercial General Liability with policy limits of not less than ($) for each occurrence and ($) in the aggregate for bodily injury and property damage.~~

§ 14.3.1.2 ~~Automobile Liability covering vehicles owned, and non-owned vehicles used, by the Construction Manager with policy limits of not less than ($) per accident for bodily injury, death of any person, and property damage arising out of the ownership, maintenance and use of those motor vehicles, along with any other statutorily required automobile coverage.~~

§ 14.3.1.3 ~~The Construction Manager may achieve the required limits and coverage for Commercial General Liability and Automobile Liability through a combination of primary and excess or umbrella liability insurance, provided that such primary and excess or umbrella liability insurance policies result in the same or greater coverage as the coverages required under Sections 14.3.1.1 and 14.3.1.2, and in no event shall any excess or umbrella liability insurance provide narrower coverage than the primary policy. The excess policy shall not require the exhaustion of the underlying limits only through the actual payment by the underlying insurers.~~

§ 14.3.1.4 ~~Workers' Compensation at statutory limits and Employers Liability with policy limits not less than ($) each accident, ($) each employee, and ($) policy limit.~~

§ 14.3.1.5 ~~Professional Liability covering negligent acts, errors and omissions in the performance of professional services, with policy limits of not less than ($) per claim and ($) in the aggregate.~~

§ 14.3.1.6 Other Insurance

(List below any other insurance coverage to be provided by the Construction Manager and any applicable limits.)

Coverage	Limits
See Article 11 of General Conditions for other insurance and bond requirements.	

§ 14.3.1.7 Additional Insured Obligations. To the fullest extent permitted by law, the Construction Manager shall cause the primary and excess or umbrella polices for Commercial General Liability and Automobile Liability to include the Owner as an additional insured for claims caused in whole or in part by the Construction Manager's negligent acts or omissions. The additional insured coverage shall be primary and non-contributory to any of the Owner's insurance policies and shall apply to both ongoing and completed operations.

§ 14.3.1.8 The Construction Manager shall provide certificates of insurance to the Owner that evidence compliance with the requirements in this Section ~~14.3.1.~~14.3.1 in accordance with Article 11 of the General Conditions.

§ 14.3.2 Construction Phase

After execution of the Guaranteed Maximum Price Amendment, the Owner and the Construction Manager shall purchase and maintain insurance as set forth in ~~AIA Document A133™–2019, Standard Form of Agreement Between Owner and Construction Manager as Constructor where the basis of payment is the Cost of the Work Plus a Fee with a Guaranteed Maximum Price, Exhibit B, Insurance and Bonds,~~ Article 11 of the General Conditions, as required by USDA, and elsewhere in the Contract Documents.

§ 14.3.2.1 The Construction Manager shall ~~provide bonds as set forth in AIA Document A133™–2019 Exhibit B, and elsewhere in the Contract Documents.~~provide, as a reimbursable Cost of the Work, statutory payment and performance bonds as set forth in this Section 14.3.2.1 and Article 11 of the General Conditions.

§ 14.3.2.1.1 The Construction Manager shall deliver the required bonds to the Owner within ten (10) days of executing the GMP Amendment. The amount of the Construction Manager's performance and payment bonds shall be equal to one hundred percent (100%) of the GMP pursuant to Chapter 39.10 RCW and Chapter 39.08 RCW, "Contractor's Bond."

§ 14.3.2.1.2 The Construction Manager shall also require each Subcontractor that is awarded a Subcontractor bid package in excess of $300,000 to provide payment and performance bonds in the full amount of the subcontract sum from a surety company acceptable to the Owner and the Construction Manager and authorized to issue bonds in the State of Washington. The Construction Manager may require a performance and payment bond from any other Subcontractor, provided that such requirement is set forth in the Subcontractor bidding documents. Within ten (10) days of entering into a subcontract, and before any payment is due, the Subcontractor on each Subcontractor bid package shall deliver copies of the bonds to the Owner and to the Architect.

§ 14.4 Notice in electronic format, pursuant to Article 1 of AIA Document A201–2017, may be given in accordance with AIA Document E203™–2013, Building Information Modeling and Digital Data Exhibit, if completed, or as otherwise set forth below:
(If other than in accordance with AIA Document E203–2013, insert requirements for delivering notice in electronic format such as name, title, and email address of the recipient and whether and how the system will be required to generate a read receipt for the transmission.)

N/A

§ 14.5 Other provisions:

§ 14.5.1 Project Information. The Construction Manager and all Subcontractors shall submit Project information required by the state Capital Projects Advisory Review Board.

§ 14.6 United States Department of Agriculture (USDA) Requirements

§ 14.6.1 The Owner and the Construction Manager agree that the following USDA Rural Development Program terms and conditions are incorporated into the Agreement by reference:

.1 Exhibit C: USDA RD Instruction 1942-A Guide 27 Attachment 5
.2 Exhibit D: USDA RD Instruction 1942-A Guide 27 Attachment 4

§ 14.6.2 Except as provided in Sections 14.6.3-14.6.4 below and as required by Washington State law, the terms of Exhibit C and Exhibit D shall prevail to the extent there is a conflict between the terms of Exhibit C or Exhibit D and the terms of the Agreement.

§ 14.6.3 The following clarifications shall apply to Exhibit C (USDA RD Instruction 1942-A Guide 27 Attachment 5): With regard to Exhibit C, Sections 11.1.8 and 11.1.8.2, it is understood that retainage shall be as specified by Washington State law. With regard to Exhibit C, Section 11.2.2.3, it is understood that there is no Initial Decision Maker and that dispute resolution proceedings shall be as specified in Article 15 of AIA Document A201-2017, as revised by the Owner and the Construction Manager. With regard to Exhibit C, Section 14.6, it is understood that a reasonable liquidated damages rate shall be established in the GMP Amendment. With regard to Exhibit C, Section 15.2.6, it is understood that a full set of exhibits for the Project will be established in the GMP Amendment.

§ 14.6.4 The following clarifications shall apply to Exhibit D (USDA RD Instruction 1942-A Guide 27 Attachment 4): With regard to Exhibit D, Section 2.3.6, only the first and second sentences of the subparagraph (as modified) are deleted; the remainder of the subparagraph (beginning with "Electronic files may be available...") is retained in its entirety. With regard to Article 9, payment procedures shall be as specified in AIA Document A201-2017, as modified by the Owner and the Construction Manager. With regard to Article 11, USDA insurance requirements set forth in Exhibit D shall supplement the insurance requirements in Article 11 of AIA Document A201-2017, as modified by the Owner and the Construction Manager. Where discrepancies exist between Exhibit D, Article 11 and AIA Document A201-2017, Article

11, the Construction Manager shall purchase the greater coverage amount. With regard to the additional terms added to Section 13 of AIA Document A201-2017, such terms shall supplement and not replace the existing terms of AIA Document A201-2017, as modified by the Owner and the Construction Manager. With regard to Article 15, it is understood that dispute resolution proceedings shall be as specified in Article 15 of AIA Document A201-2017, as revised by the Owner and the Construction Manager.

§ 14.6.5 Pursuant to applicable USDA RD Instructions, USDA has requested that the Project be divided into five (5) phases for monitoring purposes. In accordance with USDA's request, the Owner and the Construction Manager agree to cooperatively report to USDA as the Project is completed in accordance with any phase-by-phase breakdown requested by USDA. The Owner and the Construction Manager agree that concurrence from USDA must be obtained with the product of each Project phase before the next Project phase may begin.

§ 14.6.6 Notwithstanding anything to the contrary in the Agreement, the Construction Manager shall be responsible for (a) any extra cost beyond the GMP that may result from the Construction Manager's errors and omissions in the performance of the Work and related services provided pursuant to the Agreement, and (b) compliance with all Federal, State, and local requirements applicable to the Work and effective on the date of execution of the GMP Amendment.

ARTICLE 15 SCOPE OF THE AGREEMENT

§ 15.1 This Agreement represents the entire and integrated agreement between the Owner and the Construction Manager and supersedes all prior negotiations, representations or agreements, either written or oral. This Agreement may be amended only by written instrument signed by both Owner and Construction Manager.

§ 15.2 The following documents comprise the Agreement:

.1 AIA Document A133™–2019, Standard Form of Agreement Between Owner and Construction Manager as Constructor where the basis of payment is the Cost of the Work Plus a Fee with a Guaranteed Maximum ~~Price~~Price, as modified

.2 AIA Document A133™-2019, Exhibit A, Guaranteed Maximum Price Amendment, if ~~executed~~

~~.3 AIA Document A133™–2019, Exhibit B, Insurance and Bonds~~executed, as modified

.4 AIA Document A201™–2017, General Conditions of the Contract for ~~Construction~~Construction, as modified

.5 AIA Document E203™–2013, Building Information Modeling and Digital Data Exhibit, dated as indicated below:
(Insert the date of the E203-2013 incorporated into this Agreement.)

N/A

.6 Other Exhibits:
(Check all boxes that apply.)

[ ] AIA Document E234™–2019, Sustainable Projects Exhibit, Construction Manager as Constructor Edition, dated as indicated below:
(Insert the date of the E234-2019 incorporated into this Agreement.)

[X] Supplementary and other Conditions of the Contract:

Document	Title	Date	Pages
N/A	N/A	N/A	N/A

.7 Other documents, if any, listed below:
(List here any additional documents that are intended to form part of the Contract Documents. AIA Document A201–2017 provides that the advertisement or invitation to bid, Instructions to Bidders, sample forms, the Construction Manager's bid or proposal, portions of Addenda relating to bidding or proposal requirements, and other information furnished by the Owner in anticipation of receiving bids or proposals, are not part of the Contract Documents unless enumerated in this Agreement. Any such documents should be listed here only if intended to be part of the Contract Documents.)

Exhibit B: Preconstruction Services Agreement
Exhibit C: USDA RD Instruction 1942-A Guide 27 Attachment 5
Exhibit D: USDA RD Instruction 1942-A Guide 27 Attachment 4

This Agreement is entered into as of the day and year first written above.

OWNER *(Signature)*	**CONSTRUCTION MANAGER** *(Signature)*
(Printed name and title)	*(Printed name and title)*

EXHIBIT B

BOUTEN
CONSTRUCTION COMPANY

Building Excellence
Since 1944

June 17, 2022 *(revised)*

Craig Marks, CEO
Prosser Memorial Health
723 Memorial Street
Prosser, WA 99350

RE: PRE-CONSTRUCTION PROPOSAL
REPLACEMENT HOSPITAL
Prosser, WA
Proposal No: 2020-169

Dear Craig:

We are excited about partnering with you on this important project for the Prosser community. In our preconstruction role, we will assist you in coordinating the pre-construction process by providing cost estimating, schedule coordination, and a robust bidding process within the guidelines of the RCW 39.10.

Below you will find a description of the services we offer in our role as general contractor/construction manager:

Pre-Construction Services

1. **Value engineering estimating:** Provide cost estimating services on items that have already been identified. It is anticipated that no additional value engineering effort is needed by Bouten at this time.
2. **Alternate assistance:** Identify additional alternates for the team to consider for the bidding process that will require limited to no redesign effort.
3. **Entitlement assistance:** Lead the effort with the City of Prosser to secure all necessary approvals and permits.
4. **Design team interface:** Collaborate with the design team on design components and details where contractor input is needed.
5. **Schedule development and management:** Create an overall schedule and provide regular updates.
6. **Early trade partner engagement:** Vet the existing MCCM and ECCM contractors bid packages and pricing. Upon approval, coordinate the subcontracting negotiations and early procurement.
7. **Bidding:** Develop a subcontracting plan and associated bid packages per the RCW requirements. Market the project, including public advertising, and secure competitive bids from local trade partners and surrounding areas that serve the Prosser area.
8. **Maximum Allowable Construction Cost (MACC):** Establish and present the final MACC. This may include presenting to the commissioners if requested.

EXHIBIT B

Proposed Fees

1. **Pre-Construction Fee:** Provide pre-construction services above for a lump sum fee of **$99,612**. Pre-construction services to be billed monthly on a percent complete basis. See breakdown on the next page for additional detail.

These preconstruction services will be provided in accordance with the pending AIA A133 contract and A201 General Conditions.

Because we lead the region in healthcare construction, our GC/CM expertise, and our long-term relationships with local trade partners, we are well positioned to lead a robust and successful bidding process. It would be a pleasure partnering with you and your team. Our purpose at Bouten Construction is to "Build places that matter, and relationships that last." This project and your team certainly check all those boxes.

Sincerely,

BOUTEN CONSTRUCTION COMPANY

Nick Gonzales

Nick Gonzales, Vice President

Accepted:

Craig J. Marks

Signature

6/22/22

Date

NAG: nag
J:\PROJECT PURSUIT FILES (2020)\2020-169 (Prosser Memorial Health Replacement Facility)\Estimate\Precon Fee\2022.6.17_Precon Svcs Proposal.docx

ATTACHMENT TO AIA DOCUMENT A133-2019, *Standard Form of Agreement Between Owner and Construction Manager as Constructor* *where the basis of payment is the Cost of the Work Plus a Fee with a Guaranteed Maximum Price.*

The provisions of this Attachment shall delete, modify, and supplement the provisions contained in the "***Standard Form of Agreement Between Owner and Construction Manager as Constructor***", AIA Document A133-2019 Edition. The provisions contained in these Modifications shall supersede any conflicting provisions of the AIA Document. The term "Agency," as used in these Modifications, shall mean the United States of America, acting through the United States Department of Agriculture.

ARTICLE 3, CONSTRUCTION MANAGER'S RESPONSIBILITIES

3.1.5 Phased Construction: Delete the entire paragraph

3.3.2.1 Add a sentence to the end of subparagraph 3.3.2.1 reading "The Construction Manager shall schedule on-site progress meetings no less than once a month during the periods of active construction."

ARTICLE 11, PAYMENTS FOR CONSTRUCTION PHASE SERVICES

11.1.1: Add the following "using AIA Document G702, 'Application and Certificate for Payment,' or Form RD 1924-18, 'Partial Payment Estimate,'" after "Payment issued by the Architect,".

11.1.8 Relace 11.1.11 with the following:

The Owner and Construction Manager shall agree upon a mutually acceptable procedure for review and approval of payments to Subcontractors. Except with the Owner's prior approval, payments to Subcontractors shall be subject to retention of not less than ten percent (10%). The Construction Manager shall execute subcontracts in accordance with those agreements.

11.1.8.2 Insert the following subparagraph:

11.1.8.2 The amount retained shall be 10% of the value of Work until 50% of the Work has been completed. At 50% completion, further partial payments shall be made in full to the Construction Manager and no additional amounts may be retained unless the Architect certifies that the Work is not proceeding satisfactorily, but amounts previously retained shall not be paid to the Construction Manager. At 50% completion or any time thereafter when the progress of the Work is not satisfactory, additional amounts may be retained but in no event shall the total retainage be more than 10% of the value of Work completed.

11.2.2.3 Replace the subparagraph with the following:

If the Owner's auditors report the Cost of the Work as substantiated by the Construction Manager's final accounting to be less than claimed by the Construction Manager, the Construction Manager shall not be entitled to request mediation of the disputed amount without seeking an initial decision pursuant to Section 15.2 of A201-2017 unless the Owner specifically authorizes such action in writing. If such action has been authorized by the Owner, the Construction Manager may make a request for mediation within 30 days after the Construction Manager's receipt of a copy of the Architect's final Certificate for Payment.

11.2.5 Insert the following subparagraph:

11.2.5 Amounts withheld from the final payment to cover any incomplete Work are not considered retainage and shall not be paid to the Construction Manager until the work is actually completed and accepted by the Owner. Such withholdings shall not be less than 150% of the estimated cost to complete the Work.

ARTICLE 14, MISCELLANEOUS PROVISIONS

14.6 Insert the following paragraph:

14.6 If the Work is not substantially complete on or before the date of Substantial Completion established in paragraph 1.1.4, or extension thereof granted by the Owner, the Construction Manager shall pay to the Owner liquidated damages in the sum of $_____ for each calendar day of delay. Any sums that may be due by the Construction Manager to the Owner as liquidated damages may be deducted from any monies due or to become due to the Construction Manager under the Contract or may be collected from the Construction Manager's surety.

14.7 Insert the following paragraph:

14.7 This Agreement shall not become effective until concurred with in writing by the Agency. Such concurrence shall be evidenced by the signature of a duly authorized representative of the Agency in the space provided at the end of the Agency Attachment to this Agreement.

ARTICLE 15, SCOPE OF THE AGREEMENT

15.1 Delete the last sentence of section 15.1 and replace it with the following sentence:

"This Agreement may be amended only by written instrument signed by Agency, the Owner, and the Construction Manager."

15.2.6 The following Documents should be referenced, if applicable:

Attachment to the ***Standard Form of Agreement Between Owner and Construction Manager as Constructor*** (this Attachment)
General Conditions of the Contract for Construction, AIA A201-2007
Attachment to the *General Conditions of the Contract for Construction* (RD Instruction 1942-A, Guide 27, Attachment 4)
Invitation for Bids
Instructions to Bidders (AIA Document A701-1997)
Attachment to *Instructions to Bidders* (RD Instruction 1942-A, Guide 27, Attachment 2)
Bid Form
Bid Bond
Compliance Statement (Form RD 400-6)Payment Bond
Performance Bond
Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions (Form AD 1048)
Disclosure of Lobbying Activities (Form SF-LLL)
Certification for Contracts, Grants and Loans (RD Instruction 1940-Q, Exhibit A-1)

SIGNATURE BLOCK:

The following signature block shall replace the signature block following paragraph 15.2:

IN WITNESS WHEREOF, the parties hereto have executed, or caused to be executed by their duly authorized officials, this Agreement in duplicate on the respective dates indicated below:

OWNER:

ATTEST: _____

Type Name _____

Title _____

Date _____

By _____

Type Name _____

Title _____

Date _____

CONSTRUCTION MANAGER:

ATTEST: _____

Type Name _____

Title _____

Date _____

By _____

Type Name _____

Title _____

Date _____

AGENCY CONCURRENCE:

By _____

Type Name _____

Title _____

Date _____

The concurrence so evidenced by the Agency shall in no way commit the Agency to render financial assistance to the Owner and is without liability to the Agency for any payment hereunder, but in the event such assistance is provided, the concurrence shall signify that the provisions of this Agreement are consistent with Agency requirements.

o0o

ATTACHMENT TO AIA DOCUMENT A201-2017, *General Conditions of the Contract for Construction*

The provisions of this attachment shall delete, modify and supplement the provisions contained in the "*General Conditions of the Contract for Construction*,'' AIA Document A201-2017 Edition. The provisions contained in this attachment will supersede any conflicting provisions of the AIA Document. The term "Agency,'' as used in this Attachment, shall mean the United States of America, acting through the United States Department of Agriculture.

ARTICLE 1, GENERAL PROVISIONS

Add the following subparagraph:

1.2.4 Concurrence of the Contract by the Agency is required before it is effective.

ARTICLE 2, OWNER

Delete subparagraph 2.3.6 and substitute the following:

2.3.6 The Contractor will be furnished, free of charge, _____ copies of the Drawings and Projects Manuals necessary for execution of the Work. Additional copies will be available from the Architect at the cost of reproduction and handling.

ARTICLE 4, ARCHITECT

Add the following to subparagraph 4.1.1:

The term "Architect" means the Architect, or the Engineer when the nature of the work is within the authority granted engineers by the State licensure law, or an authorized representative of the Architect or Engineer.

ARTICLE 5, SUBCONTRACTORS

Add the following to subparagraph 5.2.2:

The Contractor shall not contract with any party who is suspended or debarred by any Federal government agency from participating in Federally assisted construction projects.

ARTICLE 7, CHANGES IN THE WORK

Delete the words ", Construction Change Directive" from subparagraph 7.1.1.

Insert the words ", Agency " after the word "Owner,'' and delete the words "A Construction Change Directive requires agreement by the Owner and Architect and may or may not be agreed to by the Contractor" in subparagraph 7.1.2.

Delete the words "Construction Change Directive" from subparagraph 7.1.3.

Delete subparagraph 7.2.1 and substitute the following:

7.2.1 A Change Order is a written order to the Contractor utilizing Form RD 1924-7, "Contract Change Order," or AIA G-701 signed by the Owner, Architect, Contractor, and the Agency representative. It is issued after the execution of the Contract, authorizing a change in the Work or an adjustment in the Contract Sum or the Contract Time. The Contract Sum and the Contract Time may be changed only by Change Order. The Contractor's signing of a Change Order indicates complete agreement therein.

Add subparagraph 7.2.2:

7.2.2 Methods used in determining adjustments to the Contract Sum may include any of the following:

.1 Mutual acceptance of a lump sum properly itemized and supported by sufficient substantiating data to permit evaluating.

.2 Unit prices stated in the Contract Documents or subsequently agreed upon.

Add the following sentence to paragraph 7.3.1: ''A Construction Change Directive may be used only for a change in response to an emergency as described in paragraph 10.4.

Delete subparagraph 7.3.2.

Add the following, where appropriate, to 7.3.3 through 7.3.10: ''When the use of a Construction Change Directive is justified''

ARTICLE 8, TIME

Add the following subparagraphs:

8.2.4 The Notice to Proceed shall be issued within twenty (20) calendar days of the execution of the Agreement by the Owner. Should there be reasons why the Notice to Proceed cannot be issued within such period, the time may be extended by mutual agreement of the Owner and Contractor, with the concurrence of the Agency. If the Notice to Proceed has not been issued within the twenty (20) calendar day period or within the period mutually agreed, the Contractor may terminate the Agreement without further liability on the part of either party.

8.3.4 As outlined in Article 3 of the Agreement, the Contractor agrees to pay liquidated damages to the Owner for each calendar day the Contractor shall be in default.

ARTICLE 9, PAYMENTS AND COMPLETION

Delete clause 9.3.1.1 and substitute the following:

9.3.1.1 Work performed and materials supplied under a Change Order may be included for payment only after the Change Order has been approved by all appropriate parties, including the Agency.

Add the words ", using AIA Document 702, 'Application and Certificate for Payment' or Form RD 1924-18, 'Partial Payment Estimate'," after "Certificate for Payment" in subparagraph 9.4.1.

Add the following subparagraph:

9.6.9 No progress payments will be made that deplete the retainage, nor place in escrow any funds that are required for retainage, nor invest the retainage for the benefit of the Contractor. Retainage will not be adjusted until after construction is substantially complete.

Replace the word "seven" with the words "fifteen (15)" in the first sentence, second line of subparagraph 9.7.

Delete subparagraph 9.8.5, after the first sentence, and substitute the following:

9.8.5 When the Work has been substantially completed, except for Work which cannot be completed because of weather conditions, lack of materials or other reasons, which, in the judgment of the Owner, are valid reasons for non-completion, the Owner may make additional payments, retaining at all times an amount sufficient to cover the estimated cost of the Work still to be completed. Provide a copy of the Certificate to the Agency.

Delete subparagraphs 9.9.1 and add the following:

9.9.1 The Contractor agrees to the use and occupancy of a portion or unit of the Project before formal acceptance by the Owner under the following conditions:

.1 A ''Certificate of Substantial Completion'' shall be prepared and executed as provided in subparagraph 9.8.4, except that when, in the opinion of the Architect, the Contractor is chargeable with unwarranted delay in completing the Work or other Contract requirements, the signature of the Contractor will not be required. The Certificate of Substantial Completion shall be accompanied by a written endorsement of the Contractor's insurance carrier and surety permitting occupancy by the Owner during the remaining period of the Project Work. Occupancy and use by the Owner shall not commence until authorized by public authorities having jurisdiction over the Work.

.2 Occupancy by the Owner shall not be construed by the Contractor as being an acceptance of that part of the Project to be occupied.

.3 The Contractor shall not be held responsible for any damage to the occupied part of the Project resulting from the Owner's occupancy.

.4 Occupancy by the Owner shall not be deemed to constitute a waiver of existing claims in behalf of the Owner or Contractor against each other.

.5 If the Project consists of more than one building, and one of the buildings is to be

occupied, the Owner, prior to occupancy of that building, shall secure permanent property insurance on the building to be occupied and necessary permits which may be required for use and occupancy.

Add to subparagraph 9.9.3: Use and occupancy by the Owner prior to Project acceptance does not relieve the Contractor of responsibility to maintain all insurance and bonds required of the Contractor under the Contract Documents until the Project is completed and accepted by the Owner.

ARTICLE 11, INSURANCE AND BONDS

Replace the words "the Contract Documents" with the words "subparagraph 11.1.1" in the first sentence of subparagraph 11.1.2.

Add the following subparagraph:

11.1.1. Insurance shall be:

.1 Written with a limit of liability of not less than $500,000 for all damages arising out of bodily injury, including death, at any time resulting therefrom, sustained by any one person in any one accident; and a limit of liability of not less than $500,000 aggregate for any such damages sustained by two or more persons in any one accident. Insurance shall be written with a limit of liability of not less than $200,000 for all property damage sustained by any one person in any one accident; and a limit of liability of not less than $200,000 aggregate for any such damage sustained by two or more persons in any one accident, or

.2 Written with a combined bodily injury and damage liability of not less than $700,000 per occurrence; and with an aggregate of not less than $700,000 per occurrence.

Add the following sentence to the end of subparagraph 11.3.1:

The provisions of this subparagraph shall apply to the Contractor if the Contractor purchases and maintains said insurance coverage.

Delete subparagraph 11.1.2 and substitute the following:

11.1.2 The Contractor shall furnish the Owner bonds covering faithful performance of the Contract and payment of obligations arising thereunder within ten (10) calendar days after receipt of the Notice of Award. The surety company executing the bonds must hold a certificate of authority as an acceptable surety on Federal bonds as listed in Treasury Circular 570, and be authorized to transact business in the State where the Project is located. The bonds (using the forms included in the Bidding Documents) shall each be equal to the amount of the Contract Sum. The cost of these bonds shall be included in the Contract Sum

Add the following subparagraphs:

11.1.3.1 The Contractor shall require the attorney-in-fact who executes the required bonds on behalf of the surety to affix thereto a certified and current power of attorney.

11.1.3.2 If at any time a surety on any such bond is declared bankrupt or loses its right to do business in the State in which the work is to be performed or is removed from the list of surety companies accepted on Federal Bonds, the Contractor shall within ten (10) calendar days after notice from the Owner to do so, substitute an acceptable bond in such form and sum and signed by such other surety or sureties as may be satisfactory to the Owner. The premiums of such bond shall be paid by any Contractor. No further payment shall be deemed due nor shall be made until the new surety or sureties shall have furnished an acceptable bond to the Owner.

ARTICLE 13, MISCELLANEOUS PROVISIONS

Add the following paragraphs:

13.6 LANDS AND RIGHTS-OF WAY

13.6.1 Prior to the start of construction, the Owner shall obtain all lands and rights-of-way necessary for the execution and completion of work to be performed under this contract.

13.7 EQUAL OPPORTUNITY REQUIREMENTS

Non-discrimination in Employment by Federally Assisted Construction Contractors, by Executive Order 11246.

13.7.1 This section summarizes Executive Order 11246, which prohibits employment discrimination and requires employers holding non-exempt Federal contracts and subcontracts and federally-assisted construction contracts and subcontracts in excess of $10,000 to take affirmative action to ensure equal employment opportunity without regard to race, color, religion, sex, or national origin. The Executive Order requires, as a condition for the approval of any federally assisted construction contract, that the applicant incorporate nondiscrimination and affirmative action clauses into its non-exempt federally assisted construction contracts.

13.7.2 Executive Order 11246, is administered and enforced by the Office of Federal Contract Compliance Programs (OFCCP), an agency in the U.S. Department of Labor's Employment Standards Administration. OFCCP has issued regulations at 41 CFR chapter 60 implementing the Executive Order. The regulations at 41 CFR part 60-4 establish the procedures which the Agency, as an administering agency, must follow when making grants, contracts, loans, insurance or guarantees involving federally assisted construction which is not exempt from the requirements of Executive Order 11246. The regulations which apply to Federal or federally assisted construction contractors also are published at 41 CFR part 60-4.

13.7.3 OFCCP has established numerical goals for minority and female utilization in construction work. The goals are expressed in percentage terms for the contractor's aggregate workforce in each trade. OFCCP has set goals for minority utilization based on the percentage of minorities in the civilian labor force in the relevant area. There is

a single nationwide goal of 6.9 percent for utilization of women. The goals apply to all construction work in the covered geographic area, whether or not it is federal, federally assisted or non-federal. A notice advises bidders of the applicable goals for the area where the project is to be located.

13.7.4 Application. This section applies to all of a construction contractor's or subcontractor's employees who are engaged in on-site construction including those construction employees who work on a non-Federal or non-Federally assisted construction site.

13.7.4.1 Agency officials will notify the appropriate Regional Director of OFCCP that an Agency financed construction contract has been awarded, and that the equal opportunity clauses are included in the contract documents.

13.7.4.2 The Regional Director, OFCCP-DOL, will enforce the non-discrimination requirements of Executive Order 11246.

13.7.5 The prospective contractor or subcontractor must comply with the Immigration Reform and Control Act of 1986, by completing and retaining Form I-9, "Employment Eligibility Verification," for employees hired. This form is available from the Immigration and Naturalization Service, and Department of Justice.

13.7.6 The prospective contractor or subcontractor must submit Form RD 400-6, "Compliance Statement," to the applicant and an Agency official as part of the bid package, prior to any contract bid negotiations and comply with the Executive Order 11246 as stated in the contract documents.

13.8 STATUTES

13.8.1 The Contractor and each Subcontractor shall comply with the following statutes (and with regulations issued pursuant thereto, which are incorporated herein by reference):

13.8.1.1 Copeland Anti-Kickback Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR part 3). This Act provides that each Contractor shall be prohibited from inducing, by any means, any person in connection with construction to give up any part of the compensation to which the person is otherwise entitled.

13.8.1.2 Clean Air Act (42 U.S.C. 7414), section 114, and Water Pollution Control Act (33 U.S.C. 1813), section 308. Under Executive Order 11738 and Environmental Protection Agency (EPA) regulations 40 C.F.R. part 15, all Contracts in excess of $100,000 are required to comply with these Acts. The Acts require the Contractor to:

.1 Notify the Owner of the receipt of any communication from EPA indicating that a facility to be utilized in the performance of the Contract is under consideration to be listed on the EPA list of Violating Facilities.

.2 Certify that any facility to be utilized in the performance of any nonexempt Contractor or Subcontractor is not listed on the EPA list of Violating Facilities as of the date of the Contract Award.

.3 Include or cause to be included the above criteria and requirements of paragraphs .1 and .2 in every nonexempt subcontract, and that the Contractor will take such action as the Government may direct as a means of enforcing such provisions.

13.8.1.3 Restrictions on Lobbying (Public Law 101-121, section 319) as supplemented in Department of Agriculture regulations (7 CFR part 3018). This statute applies to the recipients of contracts or subcontracts that exceed $100,000 at any tier under a Federal loan that exceeds $150,000 or a Federal grant that exceeds $100,000. If applicable, the Contractor must complete a certification form on lobbying activities related to the specific Federal loan or grant that is a funding source for this contract. The certification and disclosure forms shall be provided by the Owner.

13.9 RECORDS

13.9.1 If the Contract is based on a negotiated Bid, the Owner, the Agency, the Comptroller General of the United States, or any of their duly authorized representatives, shall have access to any books, documents, papers, and records of the Contractor which are pertinent to a specific Federal loan program for the purpose of making audit, examination, excerpts, and transcriptions. The Contractor shall maintain records for at least three years after the Owner makes final payment and all other pending matters are closed.

13.10 ENVIRONMENTAL REQUIREMENTS

13.10.1 Mitigation Measures - The contractor shall comply with applicable mitigation measures established in the environmental assessment for the project. These may be obtained from the Agency representative.

13.10.2 The Contractor, when constructing a Project involving trenching, excavating, or other earth moving activity, shall comply with the following environmental constraints:

13.10.2.1 Endangered Species, Historic Preservation, Human Remains and Cultural Items, Hazardous Materials, and Paleontology - Any excavation or other earth moving activity by the Contractor that provides evidence of the presence of endangered or threatened species or their critical habitat, uncovers a historical or archaeological artifact, human remains or cultural items, hazardous materials, a fossil or other paleontological materials will require the Contractor to:

.1 Temporarily stop work;

.2 Provide immediate notice to the Architect and the Agency, and in the case of potentially hazardous materials, provide immediate notice to local first responders and take such measures as necessary to protect the public and workers;

.3 Take reasonable measures as necessary to protect the discovered materials or protected resource;

.4 Abide by such direction as provided by the Agency, or Agencies responsible for resource protection or hazardous materials management; and

.5 Resume work only upon notice from the Architect and the Agency.

13.10.3 Lead-Based Paint - The Contractor and Owner shall comply with applicable Agency requirements of the Lead-Based Paint Poisoning Prevention Act, as amended (42 U.S.C. 4821), and the Residential Lead-Based Paint Hazard Reduction Act of 1992 (42 U.S.C. 4851) for rehabilitation work on residential property built prior to 1978.

13.11 DEBARMENT AND SUSPENSION

13.11.1 The Contractor shall comply with the requirements of 7 CFR part 3017, which pertains to the debarment or suspension of a person from participating in a Federal program or activity.

ARTICLE 15 CLAIMS AND DISPUTES

Add the words "may be" after "on the parties but" in the last sentence of subparagraph 15.2.5.

Replace the word "shall" with the word "may" in the first sentence, first occurrence of subparagraph 15.3.2

Add the subparagraph: 15.4.1.2 The arbitrators will select a hearing location as close to the Owner's locale as possible.

o0o

Attachment I

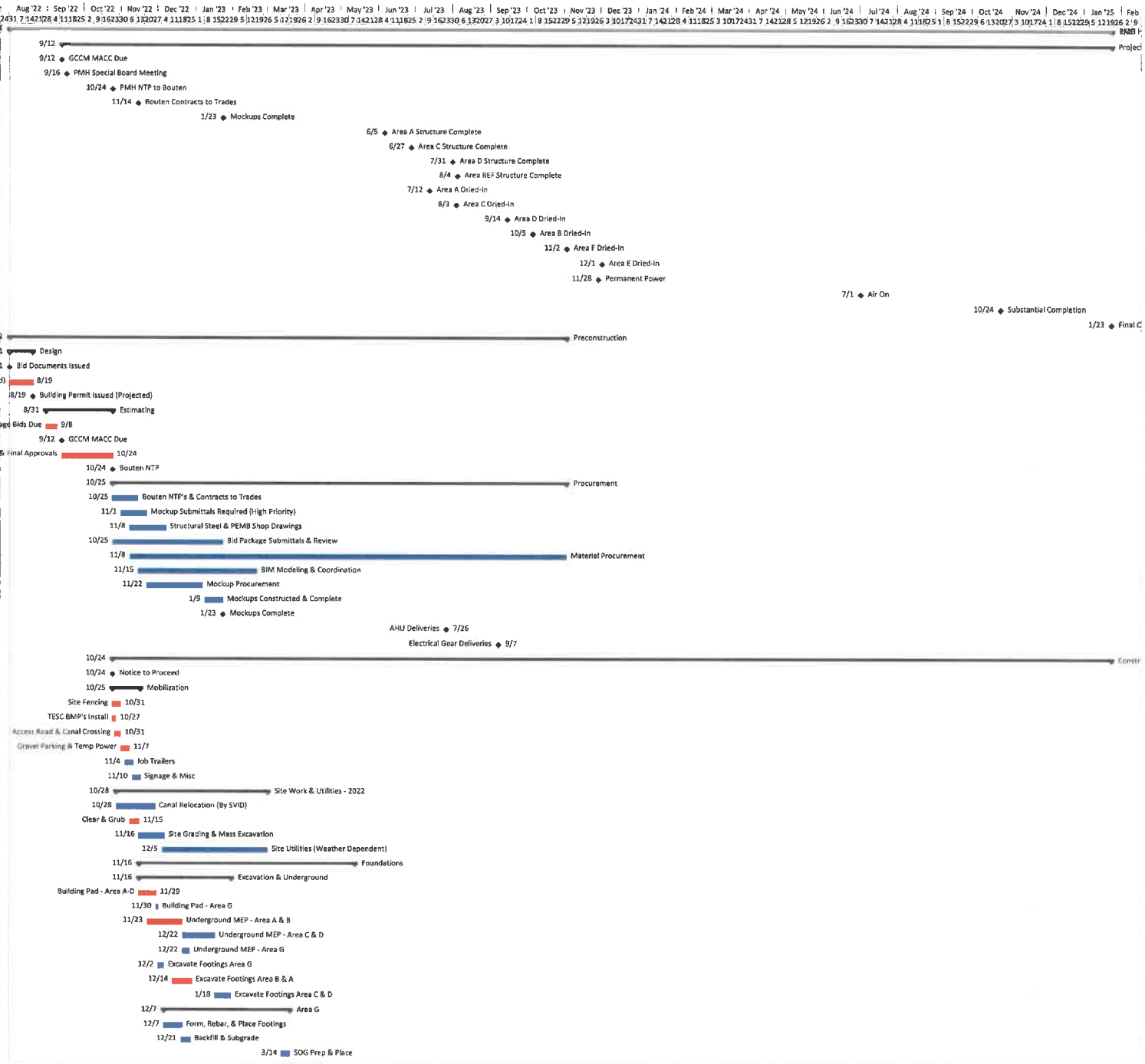
BOULTEN CONSTRUCTION COMPANY

PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

EXHIBIT B
Data Date: Mon 8/1/22

MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
0	PMH HOSPITAL REPLACEMENT	648.81 d	Mon 8/1/22	Thu 1/23/25
1	Project Milestones	597 days	Mon 9/12/22	Thu 1/23/25
2	GCCM MACC Due	0 days	Mon 9/12/22	Mon 9/12/22
3	PMH Special Board Meeting	0 days	Fri 9/16/22	Fri 9/16/22
4	PMH NTP to Bouten	0 days	Mon 10/24/22	Mon 10/24/22
5	Bouten Contracts to Trades	0 days	Mon 11/14/22	Mon 11/14/22
6	Mockups Complete	0 days	Mon 1/23/23	Mon 1/23/23
7	Area A Structure Complete	0 days	Mon 6/5/23	Mon 6/5/23
8	Area C Structure Complete	0 days	Tue 6/27/23	Tue 6/27/23
9	Area D Structure Complete	0 days	Mon 7/31/23	Mon 7/31/23
10	Area BEF Structure Complete	0 days	Fri 8/4/23	Fri 8/4/23
11	Area A Dried-In	0 days	Wed 7/12/23	Wed 7/12/23
12	Area C Dried-In	0 days	Thu 8/3/23	Thu 8/3/23
13	Area D Dried-In	0 days	Thu 9/14/23	Thu 9/14/23
14	Area B Dried-In	0 days	Thu 10/5/23	Thu 10/5/23
15	Area F Dried-In	0 days	Thu 11/2/23	Thu 11/2/23
16	Area E Dried-In	0 days	Fri 12/1/23	Fri 12/1/23
17	Permanent Power	0 days	Tue 11/28/23	Tue 11/28/23
18	Air On	0 days	Mon 7/1/24	Mon 7/1/24
19	Substantial Completion	0 days	Thu 10/24/24	Thu 10/24/24
20	Final Completion	0 days	Thu 1/23/25	Thu 1/23/25
21	Preconstruction	320 days	Mon 8/1/22	Thu 11/2/23
22	Design	15 days	Mon 8/1/22	Fri 8/19/22
23	Bid Documents Issued	0 days	Mon 8/1/22	Mon 8/1/22
24	Bid Phase Addenda (As Needed)	15 days	Mon 8/1/22	Fri 8/19/22
25	Building Permit Issued (Projected)	0 days	Fri 8/19/22	Fri 8/19/22
26	Estimating	38 days	Wed 8/31/22	Mon 10/24/22
27	Bid Package Bids Due	5 days	Wed 8/31/22	Thu 9/8/22
28	GCCM MACC Due	0 days	Mon 9/12/22	Mon 9/12/22
29	MACC Review & Final Approvals	30 days	Tue 9/13/22	Mon 10/24/22
30	Bouten NTP	0 days	Mon 10/24/22	Mon 10/24/22
31	Procurement	260 days	Tue 10/25/22	Thu 11/2/23
32	Bouten NTP's & Contracts to Trades	15 days	Tue 10/25/22	Mon 11/14/22
33	Mockup Submittals Required (High Priority	15 days	Tue 11/1/22	Mon 11/21/22
34	Structural Steel & PEMB Shop Drawings	20 days	Tue 11/8/22	Wed 12/7/22
35	Bid Package Submittals & Review	60 days	Tue 10/25/22	Mon 1/23/23
36	Material Procurement	250 days	Tue 11/8/22	Thu 11/2/23
37	BIM Modeling & Coordination	65 days	Tue 11/15/22	Mon 2/20/23
38	Mockup Procurement	30 days	Tue 11/22/22	Fri 1/6/23
39	Mockups Constructed & Complete	10 days	Mon 1/9/23	Mon 1/23/23
40	Mockups Complete	0 days	Mon 1/23/23	Mon 1/23/23
41	AHU Deliveries	0 days	Wed 7/26/23	Wed 7/26/23
42	Electrical Gear Deliveries	0 days	Thu 9/7/23	Thu 9/7/23
43	Construction	567 days	Mon 10/24/22	Thu 1/23/25
44	Notice to Proceed	0 days	Mon 10/24/22	Mon 10/24/22
45	Mobilization	17 days	Tue 10/25/22	Wed 11/16/22
46	Site Fencing	5 days	Tue 10/25/22	Mon 10/31/22
47	TESC BMP's Install	3 days	Tue 10/25/22	Thu 10/27/22
48	Access Road & Canal Crossing	3 days	Thu 10/27/22	Mon 10/31/22
49	Gravel Parking & Temp Power	5 days	Tue 11/1/22	Mon 11/7/22
50	Job Trailers	5 days	Fri 11/4/22	Thu 11/10/22
51	Signage & Misc	5 days	Thu 11/10/22	Wed 11/16/22
52	Site Work & Utilities - 2022	84 days	Fri 10/28/22	Wed 3/1/23
53	Canal Relocation (By SVID)	20 days	Fri 10/28/22	Mon 11/28/22
54	Clear & Grub	6 days	Tue 11/8/22	Tue 11/15/22
55	Site Grading & Mass Excavation	13 days	Wed 11/16/22	Tue 12/6/22
56	Site Utilities (Weather Dependent)	60 days	Mon 12/5/22	Wed 3/1/23
57	Foundations	123 days	Wed 11/16/22	Fri 5/12/23
58	Excavation & Underground	49 days	Wed 11/16/22	Mon 1/30/23
59	Building Pad - Area A-D	8 days	Wed 11/16/22	Tue 11/29/22
60	Building Pad - Area G	2 days	Wed 11/30/22	Thu 12/1/22
61	Underground MEP - Area A & B	19 days	Wed 11/23/22	Wed 12/21/22
62	Underground MEP - Area C & D	16 days	Thu 12/22/22	Tue 1/17/23
63	Underground MEP - Area G	3 days	Thu 12/22/22	Tue 12/27/22
64	Excavate Footings Area G	3 days	Fri 12/2/22	Tue 12/6/22
65	Excavate Footings Area B & A	11 days	Wed 12/14/22	Thu 12/29/22
66	Excavate Footings Area C & D	9 days	Wed 1/18/23	Mon 1/30/23
67	Area G	71 days	Wed 12/7/22	Mon 3/20/23
68	Form, Rebar, & Place Footings	11 days	Wed 12/7/22	Wed 12/21/22
69	Backfill & Subgrade	5 days	Wed 12/21/22	Wed 12/28/22
70	SOG Prep & Place	5 days	Tue 3/14/23	Mon 3/20/23

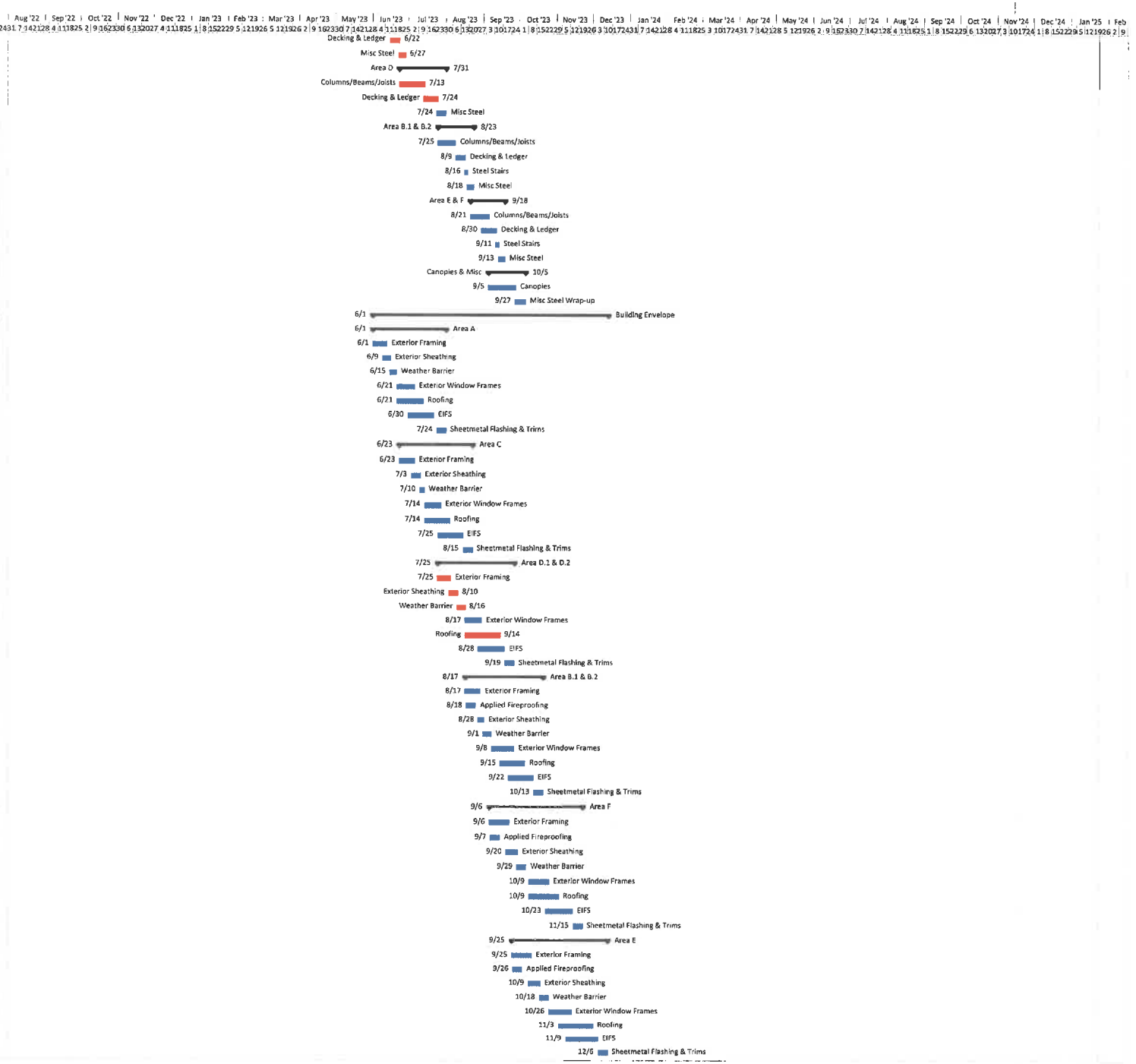


MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
71	**Area B.2**	**38 days**	**Tue 12/27/22**	**Mon 2/20/23**
72	Form, Rebar, & Place Footings	16 days	Tue 12/27/22	Thu 1/19/23
73	Insulate & Backfill	3 days	Fri 1/20/23	Tue 1/24/23
74	Underslab MEP	9 days	Wed 1/25/23	Mon 2/6/23
75	Gravel Subgrade & Vapor Barrier	3 days	Mon 2/6/23	Wed 2/8/23
76	Form, Rebar & Place SOG	4 days	Thu 2/9/23	Tue 2/14/23
77	Form, Rebar & Place Perimeter Curb	4 days	Wed 2/15/23	Mon 2/20/23
78	**Area B.1**	**45 days**	**Fri 1/20/23**	**Thu 3/23/23**
79	Form, Rebar, & Place Footings	18 days	Fri 1/20/23	Tue 2/14/23
80	Insulate & Backfill	4 days	Wed 2/15/23	Mon 2/20/23
81	Underslab MEP	11 days	Tue 2/21/23	Tue 3/7/23
82	Gravel Subgrade & Vapor Barrier	4 days	Tue 3/7/23	Fri 3/10/23
83	Form, Rebar & Place SOG	5 days	Mon 3/13/23	Fri 3/17/23
84	Form, Rebar & Place Perimeter Curb	4 days	Mon 3/20/23	Thu 3/23/23
85	**Area A**	**52 days**	**Wed 2/15/23**	**Thu 4/27/23**
86	Form, Rebar, & Place Footings	14 days	Wed 2/15/23	Mon 3/6/23
87	Insulate & Backfill	3 days	Tue 3/7/23	Thu 3/9/23
88	Underslab MEP	8 days	Fri 3/10/23	Tue 3/21/23
89	Gravel Subgrade & Vapor Barrier	3 days	Wed 3/22/23	Fri 3/24/23
90	Form, Rebar & Place SOG	4 days	Mon 3/27/23	Thu 3/30/23
91	Form, Rebar & Place Perimeter Curb	4 days	Fri 3/31/23	Wed 4/5/23
92	Loading Docks	16 days	Thu 4/6/23	Thu 4/27/23
93	**Area D**	**42 days**	**Tue 3/7/23**	**Wed 5/3/23**
94	Form, Rebar, & Place Footings	16 days	Tue 3/7/23	Tue 3/28/23
95	Insulate & Backfill	3 days	Wed 3/29/23	Fri 3/31/23
96	Underslab MEP	12 days	Mon 4/3/23	Tue 4/18/23
97	Gravel Subgrade & Vapor Barrier	3 days	Wed 4/19/23	Fri 4/21/23
98	Form, Rebar & Place SOG	4 days	Mon 4/24/23	Thu 4/27/23
99	Form, Rebar & Place Perimeter Curb	4 days	Fri 4/28/23	Wed 5/3/23
100	**Area C**	**33 days**	**Wed 3/29/23**	**Fri 5/12/23**
101	Form, Rebar, & Place Footings	9 days	Wed 3/29/23	Mon 4/10/23
102	Insulate & Backfill	2 days	Tue 4/11/23	Wed 4/12/23
103	Underslab MEP	7 days	Wed 4/19/23	Thu 4/27/23
104	Gravel Subgrade & Vapor Barrier	3 days	Fri 4/28/23	Tue 5/2/23
105	Form, Rebar & Place SOG	4 days	Thu 5/4/23	Tue 5/9/23
106	Form, Rebar & Place Perimeter Curb	3 days	Wed 5/10/23	Fri 5/12/23
107	**Superstructure**	**165 days**	**Tue 2/14/23**	**Thu 10/5/23**
108	**Area G PEMB**	**29 days**	**Tue 2/14/23**	**Fri 3/24/23**
109	Erect PEMB	8 days	Tue 2/14/23	Thu 2/23/23
110	PEMB Siding & Roof	12 days	Fri 2/24/23	Mon 3/13/23
111	Doors & Hardware	4 days	Tue 3/21/23	Fri 3/24/23
112	**Concrete Structure**	**94 days**	**Fri 3/24/23**	**Fri 8/4/23**
113	**Area B.2**	**32 days**	**Fri 3/24/23**	**Mon 5/8/23**
114	Level 1 - Form, Rebar, & Place Columns	10 days	Fri 3/24/23	Thu 4/6/23
115	Level 2 - Form, Rebar, & Place Deck	17 days	Fri 4/7/23	Mon 5/1/23
116	Level 2 - MEP Deck Rough-In	8 days	Fri 4/14/23	Tue 4/25/23
117	Level 2 - Strip Deck	5 days	Tue 5/2/23	Mon 5/8/23
118	**Area B.1**	**41 days**	**Fri 4/7/23**	**Mon 6/5/23**
119	Level 1 - Form, Rebar, & Place Columns	12 days	Fri 4/7/23	Mon 4/24/23
120	Level 2 - Form, Rebar, & Place Deck	19 days	Tue 5/2/23	Fri 5/26/23
121	Level 2 - MEP Deck Rough-In	10 days	Tue 5/9/23	Mon 5/22/23
122	Level 2 - Strip Deck	5 days	Tue 5/30/23	Mon 6/5/23
123	**Area F**	**53 days**	**Tue 4/25/23**	**Mon 7/10/23**
124	Level 2 - Form, Rebar, & Place Columns	11 days	Tue 4/25/23	Tue 5/9/23
125	Level 3 - Form, Rebar, & Place Deck	18 days	Tue 5/30/23	Thu 6/22/23
126	Level 3 - MEP Deck Rough-In	5 days	Tue 6/6/23	Mon 6/12/23
127	Level 3 - Strip Deck	5 days	Fri 6/23/23	Thu 6/29/23
128	Level 3 - Form, Rebar, & Place Columns	8 days	Wed 6/28/23	Mon 7/10/23
129	**Area E**	**61 days**	**Wed 5/10/23**	**Fri 8/4/23**
130	Level 2 - Form, Rebar, & Place Columns	13 days	Wed 5/10/23	Fri 5/26/23
131	Level 3 - Form, Rebar, & Place Deck	19 days	Fri 6/23/23	Thu 7/20/23
132	Level 3 - MEP Deck Rough-In	5 days	Fri 6/30/23	Fri 7/7/23
133	Level 3 - Strip Deck	5 days	Fri 7/21/23	Thu 7/27/23
134	Level 3 - Form, Rebar, & Place Columns	8 days	Wed 7/26/23	Fri 8/4/23
135	**Structural Steel**	**105 days**	**Tue 5/9/23**	**Thu 10/5/23**
136	**Area A**	**19 days**	**Tue 5/9/23**	**Mon 6/5/23**
137	Columns/Beams/Joists	11 days	Tue 5/9/23	Tue 5/23/23
138	Decking & Ledger	6 days	Tue 5/23/23	Wed 5/31/23
139	Misc Steel	4 days	Wed 5/31/23	Mon 6/5/23
140	**Area C**	**19 days**	**Thu 6/1/23**	**Tue 6/27/23**
141	Columns/Beams/Joists	11 days	Thu 6/1/23	Thu 6/15/23

MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
142	Decking & Ledger	6 days	Thu 6/15/23	Thu 6/22/23
143	Misc Steel	4 days	Thu 6/22/23	Tue 6/27/23
144	Area D	26 days	Fri 6/23/23	Mon 7/31/23
145	Columns/Beams/Joists	14 days	Fri 6/23/23	Thu 7/13/23
146	Decking & Ledger	8 days	Thu 7/13/23	Mon 7/24/23
147	Misc Steel	6 days	Mon 7/24/23	Mon 7/31/23
148	Area B.1 & B.2	22 days	Tue 7/25/23	Wed 8/23/23
149	Columns/Beams/Joists	11 days	Tue 7/25/23	Tue 8/8/23
150	Decking & Ledger	5 days	Wed 8/9/23	Wed 8/16/23
151	Steel Stairs	3 days	Wed 8/16/23	Fri 8/18/23
152	Misc Steel	4 days	Fri 8/18/23	Wed 8/23/23
153	Area E & F	20 days	Mon 8/21/23	Mon 9/18/23
154	Columns/Beams/Joists	11 days	Mon 8/21/23	Tue 9/5/23
155	Decking & Ledger	8 days	Wed 8/30/23	Mon 9/11/23
156	Steel Stairs	3 days	Mon 9/11/23	Wed 9/13/23
157	Misc Steel	4 days	Wed 9/13/23	Mon 9/18/23
158	Canopies & Misc	23 days	Tue 9/5/23	Thu 10/5/23
159	Canopies	17 days	Tue 9/5/23	Wed 9/27/23
160	Misc Steel Wrap-up	7 days	Wed 9/27/23	Thu 10/5/23
161	Building Envelope	136 days	Thu 6/1/23	Wed 12/13/23
162	Area A	42 days	Thu 6/1/23	Mon 7/31/23
163	Exterior Framing	8 days	Thu 6/1/23	Mon 6/12/23
164	Exterior Sheathing	5 days	Fri 6/9/23	Thu 6/15/23
165	Weather Barrier	4 days	Thu 6/15/23	Tue 6/20/23
166	Exterior Window Frames	10 days	Wed 6/21/23	Wed 7/5/23
167	Roofing	15 days	Wed 6/21/23	Wed 7/12/23
168	EIFS	15 days	Fri 6/30/23	Fri 7/21/23
169	Sheetmetal Flashing & Trims	5 days	Mon 7/24/23	Mon 7/31/23
170	Area C	42 days	Fri 6/23/23	Tue 8/22/23
171	Exterior Framing	8 days	Fri 6/23/23	Wed 7/5/23
172	Exterior Sheathing	5 days	Mon 7/3/23	Mon 7/10/23
173	Weather Barrier	4 days	Mon 7/10/23	Thu 7/13/23
174	Exterior Window Frames	10 days	Fri 7/14/23	Thu 7/27/23
175	Roofing	15 days	Fri 7/14/23	Thu 8/3/23
176	EIFS	15 days	Tue 7/25/23	Mon 8/14/23
177	Sheetmetal Flashing & Trims	6 days	Tue 8/15/23	Tue 8/22/23
178	Area D.1 & D.2	45 days	Tue 7/25/23	Tue 9/26/23
179	Exterior Framing	9 days	Tue 7/25/23	Fri 8/4/23
180	Exterior Sheathing	6 days	Thu 8/3/23	Thu 8/10/23
181	Weather Barrier	5 days	Thu 8/10/23	Wed 8/16/23
182	Exterior Window Frames	10 days	Thu 8/17/23	Wed 8/30/23
183	Roofing	20 days	Thu 8/17/23	Thu 9/14/23
184	EIFS	15 days	Mon 8/28/23	Mon 9/18/23
185	Sheetmetal Flashing & Trims	6 days	Tue 9/19/23	Tue 9/26/23
186	Area B.1 & B.2	46 days	Thu 8/17/23	Fri 10/20/23
187	Exterior Framing	9 days	Thu 8/17/23	Tue 8/29/23
188	Applied Fireproofing	6 days	Fri 8/18/23	Fri 8/25/23
189	Exterior Sheathing	5 days	Mon 8/28/23	Fri 9/1/23
190	Weather Barrier	4 days	Fri 9/1/23	Thu 9/7/23
191	Exterior Window Frames	13 days	Fri 9/8/23	Tue 9/26/23
192	Roofing	15 days	Fri 9/15/23	Thu 10/5/23
193	EIFS	15 days	Fri 9/22/23	Thu 10/12/23
194	Sheetmetal Flashing & Trims	6 days	Fri 10/13/23	Fri 10/20/23
195	Area F	56 days	Wed 9/6/23	Wed 11/22/23
196	Exterior Framing	13 days	Wed 9/6/23	Fri 9/22/23
197	Applied Fireproofing	6 days	Thu 9/7/23	Thu 9/14/23
198	Exterior Sheathing	8 days	Wed 9/20/23	Fri 9/29/23
199	Weather Barrier	6 days	Fri 9/29/23	Fri 10/6/23
200	Exterior Window Frames	13 days	Mon 10/9/23	Wed 10/25/23
201	Roofing	19 days	Mon 10/9/23	Thu 11/2/23
202	EIFS	17 days	Mon 10/23/23	Tue 11/14/23
203	Sheetmetal Flashing & Trims	6 days	Wed 11/15/23	Wed 11/22/23
204	Area E	56 days	Mon 9/25/23	Wed 12/13/23
205	Exterior Framing	13 days	Mon 9/25/23	Wed 10/11/23
206	Applied Fireproofing	6 days	Tue 9/26/23	Tue 10/3/23
207	Exterior Sheathing	8 days	Mon 10/9/23	Wed 10/18/23
208	Weather Barrier	6 days	Wed 10/18/23	Wed 10/25/23
209	Exterior Window Frames	13 days	Thu 10/26/23	Mon 11/13/23
210	Roofing	19 days	Fri 11/3/23	Fri 12/1/23
211	EIFS	17 days	Thu 11/9/23	Tue 12/5/23
212	Sheetmetal Flashing & Trims	6 days	Wed 12/6/23	Wed 12/13/23



MILESTONE CONSTRUCTION SCHEDULE

ID	Task Name	Dur	Start	Finish
213	**Interior Framing & Rough-In**	**168 days**	**Tue 6/13/23**	**Mon 2/12/24**
214	**Area A**	**97 days**	**Tue 6/13/23**	**Fri 10/27/23**
215	Frame Priority Walls & Elect/Mech Roon	7 days	Tue 6/13/23	Wed 6/21/23
216	GWB Topout & Elect/Mech Rooms	8 days	Wed 6/21/23	Fri 6/30/23
217	MEP Overhead Rough-In	21 days	Tue 6/27/23	Wed 7/26/23
218	Interior Framing & HM Frames	13 days	Mon 7/3/23	Thu 7/20/23
219	MEP Wall Rough-In	19 days	Mon 7/24/23	Thu 8/17/23
220	MEP CUP Buildout	50 days	Fri 8/18/23	Fri 10/27/23
221	**Area C**	**47 days**	**Thu 7/6/23**	**Mon 9/11/23**
222	Frame Priority Walls & Elect/Mech Roon	7 days	Thu 7/6/23	Fri 7/14/23
223	GWB Topout & Elect/Mech Rooms	8 days	Fri 7/14/23	Tue 7/25/23
224	MEP Overhead Rough-In	21 days	Thu 7/20/23	Thu 8/17/23
225	Interior Framing & HM Frames	13 days	Wed 7/26/23	Fri 8/11/23
226	MEP Wall Rough-In	19 days	Tue 8/15/23	Mon 9/11/23
227	**Area D.2**	**50 days**	**Mon 8/7/23**	**Mon 10/16/23**
228	Frame Priority Walls & Elect/Mech Roon	8 days	Mon 8/7/23	Wed 8/16/23
229	GWB Topout & Elect/Mech Rooms	9 days	Wed 8/16/23	Mon 8/28/23
230	MEP Overhead Rough-In	21 days	Thu 8/24/23	Fri 9/22/23
231	Interior Framing & HM Frames	13 days	Tue 8/29/23	Fri 9/15/23
232	MEP Wall Rough-In	19 days	Wed 9/20/23	Mon 10/16/23
233	**Area D.1**	**58 days**	**Thu 8/17/23**	**Tue 11/7/23**
234	Frame Priority Walls & Elect/Mech Roon	8 days	Thu 8/17/23	Mon 8/28/23
235	GWB Topout & Elect/Mech Rooms	9 days	Mon 8/28/23	Fri 9/8/23
236	MEP Overhead Rough-In	21 days	Mon 9/18/23	Mon 10/16/23
237	Interior Framing & HM Frames	13 days	Wed 9/13/23	Fri 9/29/23
238	MEP Wall Rough-In	19 days	Thu 10/12/23	Tue 11/7/23
239	**Area B.2**	**66 days**	**Tue 8/29/23**	**Fri 12/1/23**
240	Frame Priority Walls & Elect/Mech Roon	8 days	Tue 8/29/23	Fri 9/8/23
241	GWB Topout & Elect/Mech Rooms	9 days	Fri 9/8/23	Wed 9/20/23
242	MEP Overhead Rough-In	21 days	Tue 10/10/23	Tue 11/7/23
243	Interior Framing & HM Frames	13 days	Wed 10/11/23	Fri 10/27/23
244	MEP Wall Rough-In	19 days	Fri 11/3/23	Fri 12/1/23
245	**Area B.1**	**77 days**	**Mon 9/11/23**	**Fri 12/29/23**
246	Frame Priority Walls & Elect/Mech Roon	8 days	Mon 9/11/23	Wed 9/20/23
247	GWB Topout & Elect/Mech Rooms	9 days	Wed 9/20/23	Mon 10/2/23
248	MEP Overhead Rough-In	21 days	Wed 11/1/23	Fri 12/1/23
249	Interior Framing & HM Frames	11 days	Mon 11/6/23	Mon 11/20/23
250	MEP Wall Rough-In	19 days	Mon 12/4/23	Fri 12/29/23
251	**Area F**	**85 days**	**Mon 9/18/23**	**Fri 1/19/24**
252	Frame Priority Walls & Elect/Mech Roon	8 days	Mon 9/18/23	Wed 9/27/23
253	GWB Topout & Elect/Mech Rooms	9 days	Wed 9/27/23	Mon 10/9/23
254	MEP Overhead Rough-In	21 days	Mon 11/27/23	Tue 12/26/23
255	Interior Framing & HM Frames	11 days	Thu 11/30/23	Thu 12/14/23
256	MEP Wall Rough-In	19 days	Thu 12/21/23	Fri 1/19/24
257	**Area E**	**88 days**	**Thu 10/5/23**	**Mon 2/12/24**
258	Frame Priority Walls & Elect/Mech Roon	8 days	Thu 10/5/23	Mon 10/16/23
259	GWB Topout & Elect/Mech Rooms	9 days	Mon 10/16/23	Thu 10/26/23
260	MEP Overhead Rough-In	21 days	Tue 12/19/23	Fri 1/19/24
261	Interior Framing & HM Frames	11 days	Fri 12/22/23	Tue 1/9/24
262	MEP Wall Rough-In	19 days	Wed 1/17/24	Mon 2/12/24
263	**Finishes**	**261 days**	**Fri 9/1/23**	**Thu 9/12/24**
264	**Area A**	**128 days**	**Fri 9/1/23**	**Wed 3/6/24**
265	Insulate, Hang & Tape GWB	13 days	Fri 9/1/23	Wed 9/20/23
266	Frame Hardlids & Soffits	3 days	Fri 9/8/23	Tue 9/12/23
267	Hardlid MEP	5 days	Tue 9/12/23	Mon 9/18/23
268	Finish GWB	14 days	Tue 9/19/23	Fri 10/6/23
269	Prime & First Coat	5 days	Mon 10/9/23	Fri 10/13/23
270	Remaining Finishes	100 days	Thu 10/12/23	Wed 3/6/24
271	**Area C**	**128 days**	**Thu 9/21/23**	**Mon 3/25/24**
272	Insulate, Hang & Tape GWB	13 days	Thu 9/21/23	Mon 10/9/23
273	Frame Hardlids & Soffits	3 days	Wed 9/27/23	Fri 9/29/23
274	Hardlid MEP	5 days	Fri 9/29/23	Thu 10/5/23
275	Finish GWB	14 days	Fri 10/6/23	Wed 10/25/23
276	Prime & First Coat	5 days	Thu 10/26/23	Wed 11/1/23
277	Remaining Finishes	100 days	Tue 10/31/23	Mon 3/25/24
278	**Area D.2**	**133 days**	**Tue 10/31/23**	**Thu 5/9/24**
279	Insulate, Hang & Tape GWB	13 days	Tue 10/31/23	Thu 11/16/23
280	Frame Hardlids & Soffits	3 days	Mon 11/6/23	Wed 11/8/23
281	Hardlid MEP	5 days	Wed 11/8/23	Tue 11/14/23
282	Finish GWB	19 days	Wed 11/15/23	Wed 12/13/23
283	Prime & First Coat	5 days	Thu 12/14/23	Wed 12/20/23

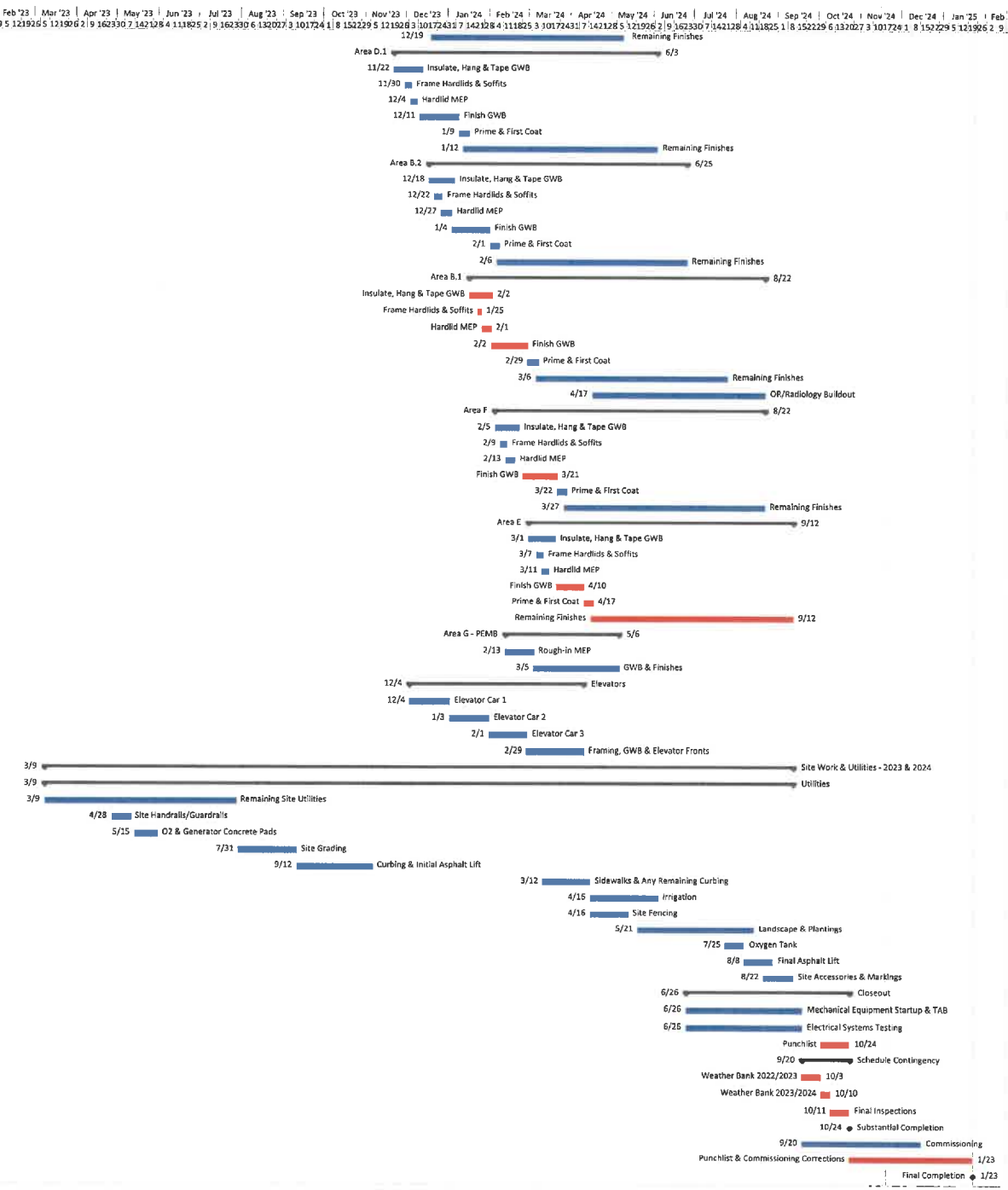
BOULDEN CONSTRUCTION COMPANY

PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

MILESTONE CONSTRUCTION SCHEDULE

EXHIBIT B
Data Date: Mon 8/1/22

ID	Task Name	Dur	Start	Finish
284	Remaining Finishes	100 days	Tue 12/19/23	Thu 5/9/24
285	Area D.1	133 days	Wed 11/22/23	Mon 6/3/24
286	Insulate, Hang & Tape GWB	13 days	Wed 11/22/23	Tue 12/12/23
287	Frame Hardlids & Soffits	3 days	Thu 11/30/23	Mon 12/4/23
288	Hardlid MEP	5 days	Mon 12/4/23	Fri 12/8/23
289	Finish GWB	19 days	Mon 12/11/23	Mon 1/8/24
290	Prime & First Coat	5 days	Tue 1/9/24	Tue 1/16/24
291	Remaining Finishes	100 days	Fri 1/12/24	Mon 6/3/24
292	Area B.2	133 days	Mon 12/18/23	Tue 6/25/24
293	Insulate, Hang & Tape GWB	13 days	Mon 12/18/23	Fri 1/5/24
294	Frame Hardlids & Soffits	3 days	Fri 12/22/23	Wed 12/27/23
295	Hardlid MEP	5 days	Wed 12/27/23	Wed 1/3/24
296	Finish GWB	19 days	Thu 1/4/24	Wed 1/31/24
297	Prime & First Coat	5 days	Thu 2/1/24	Wed 2/7/24
298	Remaining Finishes	100 days	Tue 2/6/24	Tue 6/25/24
299	Area B.1	155 days	Wed 1/17/24	Thu 8/22/24
300	Insulate, Hang & Tape GWB	13 days	Wed 1/17/24	Fri 2/2/24
301	Frame Hardlids & Soffits	3 days	Tue 1/23/24	Thu 1/25/24
302	Hardlid MEP	5 days	Fri 1/26/24	Thu 2/1/24
303	Finish GWB	19 days	Fri 2/2/24	Wed 2/28/24
304	Prime & First Coat	6 days	Thu 2/29/24	Thu 3/7/24
305	Remaining Finishes	100 days	Wed 3/6/24	Thu 7/25/24
306	OR/Radiology Buildout	90 days	Wed 4/17/24	Thu 8/22/24
307	Area F	142 days	Mon 2/5/24	Thu 8/22/24
308	Insulate, Hang & Tape GWB	14 days	Mon 2/5/24	Thu 2/22/24
309	Frame Hardlids & Soffits	3 days	Fri 2/9/24	Tue 2/13/24
310	Hardlid MEP	5 days	Tue 2/13/24	Mon 2/19/24
311	Finish GWB	19 days	Mon 2/26/24	Thu 3/21/24
312	Prime & First Coat	5 days	Fri 3/22/24	Thu 3/28/24
313	Remaining Finishes	105 days	Wed 3/27/24	Thu 8/22/24
314	Area E	137 days	Fri 3/1/24	Thu 9/12/24
315	Insulate, Hang & Tape GWB	14 days	Fri 3/1/24	Wed 3/20/24
316	Frame Hardlids & Soffits	3 days	Thu 3/7/24	Mon 3/11/24
317	Hardlid MEP	5 days	Mon 3/11/24	Fri 3/15/24
318	Finish GWB	14 days	Fri 3/22/24	Wed 4/10/24
319	Prime & First Coat	5 days	Thu 4/11/24	Wed 4/17/24
320	Remaining Finishes	105 days	Tue 4/16/24	Thu 9/12/24
321	Area G - PEMB	60 days	Tue 2/13/24	Mon 5/6/24
322	Rough-in MEP	15 days	Tue 2/13/24	Mon 3/4/24
323	GWB & Finishes	45 days	Tue 3/5/24	Mon 5/6/24
324	Elevators	90 days	Mon 12/4/23	Wed 4/10/24
325	Elevator Car 1	20 days	Mon 12/4/23	Tue 1/2/24
326	Elevator Car 2	20 days	Wed 1/3/24	Wed 1/31/24
327	Elevator Car 3	20 days	Thu 2/1/24	Wed 2/28/24
328	Framing, GWB & Elevator Fronts	30 days	Thu 2/29/24	Wed 4/10/24
329	Site Work & Utilities - 2023 & 2024	385 days	Thu 3/9/23	Thu 9/12/24
330	Utilities	385 days	Thu 3/9/23	Thu 9/12/24
331	Remaining Site Utilities	100 days	Thu 3/9/23	Fri 7/28/23
332	Site Handrails/Guardrails	10 days	Fri 4/28/23	Thu 5/11/23
333	O2 & Generator Concrete Pads	12 days	Mon 5/15/23	Wed 5/31/23
334	Site Grading	30 days	Mon 7/31/23	Mon 9/11/23
335	Curbing & Initial Asphalt Lift	40 days	Tue 9/12/23	Mon 11/6/23
336	Sidewalks & Any Remaining Curbing	25 days	Tue 3/12/24	Mon 4/15/24
337	Irrigation	35 days	Tue 4/16/24	Tue 6/4/24
338	Site Fencing	20 days	Tue 4/16/24	Mon 5/13/24
339	Landscape & Plantings	60 days	Tue 5/21/24	Wed 8/14/24
340	Oxygen Tank	10 days	Thu 7/25/24	Thu 8/8/24
341	Final Asphalt Lift	15 days	Thu 8/8/24	Wed 8/28/24
342	Site Accessories & Markings	15 days	Thu 8/22/24	Thu 9/12/24
343	Closeout	85 days	Wed 6/26/24	Thu 10/24/24
344	Mechanical Equipment Startup & TAB	60 days	Wed 6/26/24	Fri 9/20/24
345	Electrical Systems Testing	60 days	Wed 6/26/24	Fri 9/20/24
346	Punchlist	15 days	Fri 10/4/24	Thu 10/24/24
347	Schedule Contingency	25 days	Fri 9/20/24	Thu 10/24/24
348	Weather Bank 2022/2023	10 days	Fri 9/20/24	Thu 10/3/24
349	Weather Bank 2023/2024	5 days	Fri 10/4/24	Thu 10/10/24
350	Final Inspections	10 days	Fri 10/11/24	Thu 10/24/24
351	*Substantial Completion*	*0 days*	*Thu 10/24/24*	*Thu 10/24/24*
352	Commissioning	50 days	Fri 9/20/24	Mon 12/16/24
353	Punchlist & Commissioning Corrections	60 days	Fri 10/25/24	Thu 1/23/25
354	*Final Completion*	*0 days*	*Thu 1/23/25*	*Thu 1/23/25*



Prosser Memorial Hospital

Hospital Replacement Project

Project Cost Budget Summary

September 8, 2022

Cost Category	*Current Budget Estimate*	*Comments*
SITE COSTS	1,725,375	*Cost of Land, Environmental Survey & Title Support*
SOFT COSTS (General Project Costs)	8,180,115	*Fees, Permits & other Professional Services*
CONSTRUCTION	81,500,000	*Construction by Contractor & Owner*
MEDICAL EQUIPMENT	7,000,000	*Major & Minor Medical Equipment & Purchasing Support*
IT and TELECOMMUNICATIONS	451,500	*IT Closet Equipment, Computers & Phones*
FURNITURE FIXTURES and EQUIPMENT	2,100,000	*Furniture, Signage, Artwork & Miscellaneous Equipment*
CONTINGENCY	4,526,045	*4.6% of all Categories above less SITE COSTS*
Project Cost Before Financing	105,483,036	
FINANCING	6,564,997	
TOTAL PROJECT COST	112,048,033	
Proposed MACC Value	74,818,895	

Prosser Memorial Hospital

Hospital Replacement Project

Project Cost Budget Detail

September 8, 2022

Cost Category	*Current Budget Estimate*	*Comments*
SITE COSTS		
Acquisition		
Real Estate		
Property Cost	1,700,000	*Actual Costs from*
Brokerage / Transaction Fees	0	*None included in Current GL*
Municipal Fees	0	*None included in Current GL*
Real Estate Costs	1,700,000	
Due-Diligence		
Property Survey(s)	0	*None included in Current GL*
Environmental Study(s)	18,875	*Meier Associates 'Due-Diligence' report*
Title Research / Support	6,500	*Market Research Study; no specific invoice - Health Facilities costs???*
Legal Support	0	*None included in Current GL*
Due Diligence Costs	25,375	
ACQUISITION COSTS	1,725,375	
Development Cost(s)		
Platting & Zoning Costs	0	*None included in Current GL*
Site Improvement Costs	0	*None included in Current GL*
Real Estate Costs	0	*None included in Current GL*
DEVELOPMENT COSTS	0	
SITE COSTS	**1,725,375**	*Cost of Land, Environmental Survey & Title Support*
SOFT COSTS (General Project Costs)		
Professional Fees & Expenses		
Pre-Design Services	0	*None required / included in Current GL*
A-E Team Basic Services		
Basic Services Value	3,965,132	*Fee fixed as a percentage off 2/22/22 MACC Estimate of $59.5M*
Site / Civil Engineer	0	*Included in 'Basic Services' above*
Structural Engineer	0	*Included in 'Basic Services' above*
Plumbing Systems Engineer	0	*Included in 'Basic Services' above*
Mechanical Systems Engineer	0	*Included in 'Basic Services' above*
Electrical Systems Engineer	0	*Included in 'Basic Services' above*
IT / Low-Voltage Systems Engineer	0	*Basic Cabling & Systems Design Included*
Fire-Protection / Code Consulting Services	0	*None anticipated required; Fire Protection in 'Basic Services'*
A-E Team Basic Services	3,965,132	
Reimbursable Expenses		
A-E Team Reimbursables	198,257	*5.0% of Services Cost directly above, ESTIMATE*
Consultant Reimbursables	0	*Included directly above*
Reimbursable Expenses	198,257	
Additional Services	0	
Other Consultant Services		
Miscellaneous Consultant Allowance	0	*Original Budget Value listed in 'Sources & Uses' Document(s)*
Environmental Engineer	20,000	*Value for Fulcrum Associates to support USDA submittal(s)*
Interiors	0	*General selection(s) included in 'A/E Basic Services' above*
Acoustics Consultant	0	*None assumed required*
Lighting Consultant	0	*None assumed required*
Furniture Design & Specification	0	*Included with Furniture cost below*
Graphics & Signage	35,000	*$0.35 / s.f. Allowance for 'Current Estimate'; Coordinate w/Shannon*
Artwork Consultant	20,000	*Lump Sum Allowance for 'Current Estimate'*
Medical Equipment Planning	115,000	*Lump Sum Allowance w/Expenses for 'Current Estimate'*
Radiation Shielding Consultant	15,000	*Lump Sum Allowance for 'Current Estimate'*
Elevator / Vertical Transportation	0	*None assumed required*
Mechanical Plant Commissioning	120,000	*$1.20 / s.f. Allowance for 'Current Estimate'*
Security Systems Consultant	187,047	*0.25% of 'Construction' below per contract; less 'Sales Tax' & 'Fee' value(s)*
Materials Management Consultant	5,000	*Allowance for 'Current Estimate'*

Prosser Memorial Hospital

Hospital Replacement Project

Project Cost Budget Detail

September 8, 2022

Cost Category	*Current Budget Estimate*	*Comments*
A-V Consultant	0	*Included with 'Security Systems' above*
Telecommunications / IT Systems	0	*Assume through Hospital IT Team; Look @ FutureCasting*
Other Consultant Services	517,047	
PROFESSIONAL FEES & EXPENSES	4,680,436	
Miscellaneous Owner's Responsibilities		
Agency and Permit Fees		
A.H.J. Plan Review Fees	160,000	*Plan Review Fee + Plan Check Fee using Prosser City Calculator*
Inspection Fees, if separate from Plan Review	100,000	*Allowance for 'Current Estimate'*
State of Washington Project Review Fee	38,735	*Fee Estimate generated from DOH Calculator*
Notice of Commencement	0	*Verify if required in Washington State*
Department of Health / CON Fees	10,000	*Budget Allowance for review(s)*
USDA Financial Consultant	0	*Included in 'Financing' below*
USDA Financial Consultant Reimbursables	0	*Included in 'Financing' below*
CON Application Consultant	25,000	*Health Facilities Fee for CON Application based on final invoices.*
CON Legal & Filing Fees	80,000	*Perkins Coie Fee(s) allowance + $40K Filing Fee*
Utility Assessment Fees	200,000	*Budget value for Electric, Internet & SVID Services*
Agency and Permit Fees	613,735	
Testing and Inspection Fees		
Geotechnical (Soils) Testing	30,000	*Allowance for ten (10) Borings @ $1,000 ea. + Construction Inspections*
Materials Testing & Inspection	150,000	*$1.50 / s.f. Allowance for 'Current Estimate'*
Hazardous Materials Consulting	0	*New Construction, assume none required*
Hazardous Materials Abatement / Remediation	0	*New Construction, assume none required*
Air Balance Testing	20,000	*Allowance to support Cx Effort, independent of Construction*
Testing and Inspection Fees	200,000	
Project Management Fees and Expenses		
Internal Staffing Costs	0	*No specific costs anticipated*
Out-Sourced Services	1,117,000	*NV5 proposed Contract Value*
Out-Sourced Services Expenses	111,700	*10.0% of Services Cost directly above, ESTIMATE*
RCW 39.10 Consultant	15,000	*Lump Sum estimate for 'Current Budget'*
Estimating Services	0	*Included in BCDG 'Basic Services' above*
CM Pre-Design Services	991,307	*Graham final precon fees + Bouten INCL Taxes*
Construction Supervision	0	*Included in 'Construction' below*
Field Office & associated Reimbursables	0	*Included in 'Construction' below*
Project Management Fees and Expenses	2,235,007	
Insurance Costs	0	
Other Owner Responsibilities		
Project Specific Accounting Fees	0	*Assume to be Operational Expense 'Current Estimate'*
Project Specific Legal Fees	100,000	*Allowance for 'Current Estimate'*
Appraisal Fee for USDA	18,500	*Valbridge & Associates actual cost*
Temporary Utilities	53,437	*Allowance for 'Current Estimate'*
Document Reproduction	10,000	*Allowance for 'Current Estimate'*
Staff Relocation / Temporary Facilities Cost(s)	0	*No specific costs anticipated*
Moving Costs	200,000	*Allowance for 'Current Estimate'*
Operations 'Start-Up' & Supplies	0	*Assume to be Operational Expense 'Current Estimate'*
Clinical Cleaning / Final 'White Glove' Cleaning	50,000	*Allowance for 'Current Estimate'*
Staff Training	0	*Assume to be Operational Expense 'Current Estimate'*
Newspaper Procurement Advertisements	5,000	*Allowance for 'Current Estimate'*
Owner Reimbursables	14,000	*Allowance in 'Current Estimate' for Miscellaneous Costs*
Community Events / Public Relations	0	*Assume to be Operational Expense 'Current Estimate'*
Other Owner Responsibilities	450,937	
MISCELLANEOUS OWNER'S RESPONSIBILITIES	3,499,679	
SOFT COSTS (General Project Costs)	**8,180,115**	

Prosser Memorial Hospital

Hospital Replacement Project

Project Cost Budget Detail

September 8, 2022

Cost Category	*Current Budget Estimate*	*Comments*
CONSTRUCTION		
Construction by Contractors		
Contractor Direct Cost(s)	74,818,895	*Per Bouten Bid Package Breakout*
Contractor Indirect Cost(s)	0	*Included in 'Direct Cost(s) above*
Alternate # / Description	0	*Included in 'Direct Cost(s) above*
Washington State Sales Tax	6,509,244	*8.7% of 'Direct' + 'Indirect Costs' above*
Facility Adjustment Factor	0	*New Construction, none required*
Alternates / Adjustments Cost(s)	6,509,244	
Construction 'Base Contract' / GMP	***81,328,138***	
Contract / GMP Modifications	0	
CONSTRUCTION BY CONTRACTORS	81,328,138	
Construction by Owner		
Mock-Up Room Construction	17,500	*Actual costs for Boutten Construction Services*
Tree Clearing for Geotech & Survey Work	60,000	*Estimate for 'Current Budget'*
Graham Direct Cost Close-Out	94,362	*Consistent with final billing value, including Tax*
CONSTRUCTION BY OWNER	171,862	
CONSTRUCTION	**81,500,000**	
MEDICAL EQUIPMENT		
Medical / Clinical Equipment		
Direct Costs		
Building Support Services	828,774	*Per Mitchell/R&B February 22, 2021 Estimate*
Imaging & Diagnostic Services	2,911,802	*Per Mitchell/R&B February 22, 2021 Estimate*
Cardiovascular Services	435,910	*Per Mitchell/R&B February 22, 2021 Estimate*
Surgical & Special Procedures	1,342,251	*Per Mitchell/R&B February 22, 2021 Estimate*
Central Sterile & Decontamination	0	*Included in 'Building Support Services' directly above*
Pharmacy	91,447	*Per Mitchell/R&B February 22, 2021 Estimate*
Medication / Supply Dispensing System(s)	0	*Included in specific Department Totals*
Central Lab	123,376	*Per Mitchell/R&B February 22, 2021 Estimate*
Emergency Services	381,315	*Per Mitchell/R&B February 22, 2021 Estimate*
Patient Care Units	227,285	*Per Mitchell/R&B February 22, 2021 Estimate*
Family Maternity Center	344,391	*Per Mitchell/R&B February 22, 2021 Estimate*
Specialty Clinic(s)	80,567	*Per Mitchell/R&B February 22, 2021 Estimate*
Oncology Clinic	91,636	*Per Mitchell/R&B February 22, 2021 Estimate*
Miscellaneous Equipment Allowance	0	*None specifically included in 'Current Estimate', fund from 'Contingency'*
Medical / Clinical Equipment Direct Cost(s)	6,858,756	
Indirect Costs		
Freight / Shipping	137,175	*2.0% of 'Direct Costs' above as an allowance for 'Current Estimate'*
Temporary Storage	0	*Included in 'Installation' below*
Purchasing Coordination	125,000	*MR&B Costs to Coordinate P.O.'s w/PMH*
Installation	240,056	*3.5% of 'Direct Costs' above as an allowance for 'Current Estimate'*
Washington State Sales Tax	596,712	*8.7% of 'Direct Costs' above*
Contingency	0	*Fund from 'Project Contingency' below*
Escalation	548,700	*8% Forecasted by NV5 July 2022. Need to verify with RBA*
Savings / Deferment	(1,506,399)	*Final Budget Adjustment*
Medical / Clinical Equipment Indirect Cost(s)	141,245	
MEDICAL / CLINICAL EQUIPMENT	7,000,000	
MEDICAL EQUIPMENT	**7,000,000**	
IT and TELECOMMUNICATIONS		
IT and Telecommunications		
Direct Costs		
Desktop Hardware and Services	20,000	*Allowance of $200 per monitor for 100 new monitors + bracket(s)*
Telephone Hardware and Services	60,000	*Allowance for switching / Head End in two (2) Closets @ new building*
TV's and Cabling	0	*Included in 'Communications / Non-Clinical' below*
Network Hardware and Services	170,000	*Allowance for two (2) Closets @ $75,000 ea.*

Prosser Memorial Hospital

Hospital Replacement Project

Project Cost Budget Detail

September 8, 2022

Cost Category	*Current Budget Estimate*	*Comments*
Wireless Hardware and Services	180,000	*Allowance for 'Vocera' Equipment etc.*
Licensing	0	*None Included for 'Current Budget'; verify if to be capital or operating cost*
Miscellaneous Items	0	*None Included for 'Current Budget'*
IT / Telecom Direct Costs	430,000	
Indirect Costs		
Freight / Shipping	10,750	*2.5% of 'Direct Costs' as an allowance for 'Current Estimate'*
Project Management Service Fees	0	None assumed required; by internal staff
Installation	10,750	*2.5% of 'Direct Costs' as an allowance for 'Current Estimate'*
Contingency	0	*Fund from 'Project Contingency' below*
Escalation	0	*Fund from 'Project Contingency' below, if required*
IT / Telecom Indirect Costs	21,500	
IT AND TELECOMMUNICATIONS	451,500	
IT and TELECOMMUNICATIONS	**451,500**	
FURNITURE FIXTURES and EQUIPMENT		
Communications and Non-Clinical Equipment		
Kitchen Equipment	600,000	*FSE estimate per Kitchen Equipment designer 7/2021*
Nurse Call System	0	*Included in 'Construction' above*
Overhead Paging / 'Musak' System	0	*None assumed required*
Dedicated Paging System(s)	0	*Included in 'Construction' above*
Dedicated Intercom	0	*None assumed required*
Sound Masking Systems	0	*None included in 'Current Estimate'*
Wireless Phone System / 'Voicera'	0	*Included in 'IT' above*
Copiers, Faxes & Office Machines	0	*Leased Equipment; no specific capital cost(s)*
Pneumatic Tube System	0	*Early Bid Package included in 'Construction' above*
Patient / Staff Television & Cable	75,000	*Allowance for 75 TV's + brackets @ $1,000 ea.*
Security Equipment	70,000	*Allowance for CCTV & 'Headend' not in 'Construction'*
Time & Attendance Clock System	10,000	*Allowance for duplicate devices; move balance*
Master Clock System	0	*None included in 'Current Estimate'*
COMMUNICATIONS AND NON-CLINICAL EQUIPMENT	755,000	
Furniture		
Direct Costs		
Waiting Area Furniture	175,000	*Allowance for Primary Waiting @ ED, DI, Surgery, Patient Care & Lobby*
Patient Area(s) Loose Furniture	200,000	*Allowance of $8,000 / Room x 25-Rooms*
Modular Nurses' Station	60,000	*Allowance for Chairs & Files; assume built-in Casework*
Modular Office(s)	0	*In 'Office Furniture' below*
Office Furniture	0	*Assume re-use for 'Current Budget'*
Staff Work Area(s) Furniture	100,000	*Allowance for Chairs & Files; assume built-in Casework*
Computer Support Accessories	0	*Assume included in 'IT' above*
Staff Lounge Furniture / Appliances	100,000	*Assume $25,000 ea. for ED/DI, Physicians, Surgery & Inpatient/FamMat*
Café / Dining Room Furniture	75,000	*Allowance for 75-seats, Tables & Chairs @ $1,000 ea.*
Conference Room Furniture not in 'Construction' above	112,500	*Allowance for 150-person Capacity @ $750 / Person*
Privacy Curtains	100,000	*Allowance for multiple Curtains for 'Current Budget'*
Window Treatments	0	*Included in 'Construction' above*
Furniture Allowance(s)	0	*None included in 'Current Budget'*
Furniture Direct Cost(s)	922,500	
Indirect Costs		
Freight / Shipping	23,063	*2.5% of 'Direct Costs' as an allowance for 'Current Estimate'*
Temporary Storage	50,000	*Allowance for 'Current Budget'*
Installation	23,063	*2.5% of 'Direct Costs' as an allowance for 'Current Estimate'*
Contingency	0	*Fund from 'Project Contingency' below*
Escalation	138,375	*15% Forecasted by NV5 July 2022*
Savings / Deferment	(452,000)	*Final Budget Adjustment*
Furniture Indirect Cost(s)	(217,500)	
FURNITURE	705,000	

Prosser Memorial Hospital

Hospital Replacement Project

Project Cost Budget Detail

September 8, 2022

Cost Category	*Current Budget Estimate*	*Comments*
Other Fixtures, Furnishing(s) & Equipment		
Interior Wayfinding, Signage & Graphics	90,000	*$1.00 / s.f. allowance for 'Current Budget'*
Exterior Signage	300,000	*Allowance for Ground & Building Signage*
Original Artwork	150,000	*Allowance for 'Current Budget'*
General Artwork	100,000	*Allowance for 'Current Budget'*
Trash Cans, Magazine Racks & Planters	0	*Assume in Equipment & Furniture Allowance above*
Plantscaping	0	*Operational cost and/or none anticipated*
Start-Up Supplies	0	*Operational cost*
OTHER FIXTURES, FURNISHINGS & EQUIPMENT	640,000	
F. F. & E. ADJUSTMENTS	0	*Included in specific Categories above*
FURNITURE FIXTURES and EQUIPMENT	**2,100,000**	
Owner's / Project Contingency		
Original / Approved Value	4,526,045	*4.6% Owner's Contingency Only, $3.1M / 3.1%; Construction Contingency $2.46M / 3.5% in 'Construction' above' - TOTAL Contingency is $5.56M or 5.3%*
(Expenditures) / Unallocated Funds	0	*Preliminary Budget, none required*
PROJECT CONTINGENCY REMAINING	4,526,045	
CONTINGENCY	**4,526,045**	
Project Cost Before Financing	**105,483,036**	
FINANCING	**6,564,997**	
TOTAL PROJECT COST	**112,048,033**	
Proposed MACC Value	74,818,895	

Prosser Public Hospital District
doing business as
Prosser Memorial Health

Forecasted Financial Statements
for the Years Ending
December 31, 2022 through 2026

Prosser Public Hospital District
doing business as Prosser Memorial Health
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DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

INDEPENDENT ACCOUNTANTS' REPORT

Board of Commissioners
Prosser Public Hospital District
doing business as Prosser Memorial Health
Prosser, Washington

We have examined the accompanying forecast of Prosser Public Hospital District doing business as Prosser Memorial Health (the District), which comprises the forecasted statements of net position as of December 31, 2022, 2023, 2024, 2025, and 2026; the related statements of forecasted revenues, expenses, and changes in net position, the statements of forecasted cash flows, the forecasted debt coverage ratios and days cash on hand, and the historical and forecasted schedules of ratios for the years then ending based on the guidelines for the presentation of a forecast established by the American Institute of Certified Public Accountants. The District's management is responsible for preparing and presenting the forecasts in accordance with the guidelines for the presentation of a forecast established by the American Institute of Certified Public Accountants. Our responsibility is to express an opinion on the forecast based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the forecast is presented in accordance with the guidelines for the presentation of a forecast established by the American Institute of Certified Public Accountants, in all material respects. An examination involves performing procedures to obtain evidence about the forecast. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risks of material misstatement of the forecast, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

In our opinion, the accompanying forecast is presented, in all material respects, in accordance with the guidelines for the presentation of a forecast established by the American Institute of Certified Public Accountants, and the underlying assumptions are suitably supported and provide a reasonable basis for management's forecast.

There will usually be differences between the forecasted and actual results because events and circumstances frequently do not occur as expected, and those differences may be material. We have no responsibility to update this report for events and circumstances occurring after the date of this report.

Management is responsible for the accompanying historical information in the historical and forecasted statements of net position, statements of historical and forecasted revenues, expenses, and changes in net position, and the statements of historical and forecasted cash flows of the District, as of and for the years ended December 31, 2017, 2018, 2019, 2020, and 2021, in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement 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.

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We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

Management has elected to omit from the 2017, 2018, 2019, 2020, and 2021 historical financial statements substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the District's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of the financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
September 12, 2022

Prosser Public Hospital District
doing business as Prosser Memorial Health
Forecasted Statements of Net Position
December 31, 2022 through 2026

ASSETS	Forecast Year 2022	Forecast Year 2023	Examined Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Current assets					
Cash and cash equivalents	$ 6,536,000	$ 9,304,000	$ 10,494,000	$ 10,975,000	$ 12,920,000
Investments	592,000	592,000	592,000	592,000	592,000
Receivables:					
Patient accounts, net	11,850,000	12,568,000	13,320,000	14,732,000	15,626,000
Taxes	27,000	28,000	29,000	29,000	30,000
Other	50,000	50,000	50,000	50,000	50,000
Inventories	795,000	819,000	849,000	880,000	912,000
Physician advances	84,000	77,000	88,000	79,000	67,000
Prepaid expenses	697,000	940,000	778,000	697,000	940,000
Total current assets	20,631,000	24,378,000	26,200,000	28,034,000	31,137,000
Noncurrent assets					
Cash and cash equivalents limited as to use for capital acquisitions	2,986,000	4,261,000	6,277,000	8,077,000	9,872,000
Cash and cash equivalents restricted by bond agreement for capital acquisitions	767,000	767,000	767,000	767,000	767,000
Cash and cash equivalents restricted by debt agreement for USDA debt reserve	-	-	-	339,000	678,000
Investments limited as to use for capital acquisitions	10,771,000	12,225,000	13,214,000	17,275,000	21,615,000
Physician advances	48,000	75,000	71,000	54,000	50,000
Prepaid expenses, net of current portion	325,000	81,000	-	325,000	81,000
Right-of-use assets, net	5,398,000	4,746,000	4,198,000	3,846,000	3,494,000
Capital assets, net	36,161,000	86,991,000	116,432,000	110,274,000	103,443,000
Total noncurrent assets	56,456,000	109,146,000	140,959,000	140,957,000	140,000,000
Total assets	**$ 77,087,000**	**$ 133,524,000**	**$ 167,159,000**	**$ 168,991,000**	**$ 171,137,000**
LIABILITIES AND NET POSITION					
Current liabilities					
Accounts payable	$ 1,871,000	$ 1,923,000	$ 1,981,000	$ 2,041,000	$ 2,103,000
Accrued payroll and related liabilities	2,322,000	2,514,000	2,750,000	3,019,000	3,173,000
Accrued leave	1,503,000	1,623,000	1,772,000	1,941,000	2,036,000
Accrued interest payable	-	-	-	-	-
Current portion of long-term debt	1,163,000	1,206,000	2,196,000	2,549,000	2,628,000
Current portion of lease obligations	872,000	784,000	1,101,000	1,142,000	1,038,000
Total current liabilities	7,731,000	8,050,000	9,800,000	10,692,000	10,978,000
Noncurrent liabilities					
Long-term debt, net of current portion	8,971,000	60,791,000	86,012,000	83,460,000	80,829,000
Lease obligations, net of current portion	4,337,000	3,553,000	7,452,000	6,310,000	5,272,000
Total noncurrent liabilities	13,308,000	64,344,000	93,464,000	89,770,000	86,101,000
Total liabilities	21,039,000	72,394,000	103,264,000	100,462,000	97,079,000
Net position					
Net investment in capital assets	26,983,000	26,170,000	24,636,000	21,426,000	17,937,000
Restricted for debt service	-	-	-	339,000	678,000
Unrestricted	29,065,000	34,960,000	39,259,000	46,764,000	55,443,000
Total net position	56,048,000	61,130,000	63,895,000	68,529,000	74,058,000
Total liabilities and net position	**$ 77,087,000**	**$ 133,524,000**	**$ 167,159,000**	**$ 168,991,000**	**$ 171,137,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Forecasted Revenues, Expenses, and Changes in Net Position
Years Ending December 31, 2022 through 2026

	Examined				
	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Operating revenues					
Net patient service revenue	$ 86,506,000	$ 91,747,000	$ 97,239,000	$ 107,547,000	$ 114,070,000
Grants	150,000	250,000	250,000	250,000	250,000
Other	186,000	186,000	186,000	186,000	186,000
Total operating revenues	86,842,000	92,183,000	97,675,000	107,983,000	114,506,000
Operating expenses					
Salaries and wages	37,565,000	40,579,000	44,297,000	48,533,000	50,911,000
Employee benefits	8,884,000	9,699,000	10,698,000	11,842,000	12,550,000
Professional fees	8,548,000	8,805,000	9,069,000	9,341,000	9,621,000
Purchased services	7,808,000	8,019,000	8,235,000	8,458,000	8,687,000
Supplies	11,159,000	11,497,000	11,913,000	12,350,000	12,808,000
Insurance	509,000	519,000	529,000	540,000	551,000
Utilities	605,000	623,000	642,000	661,000	681,000
Depreciation and amortization	3,716,000	3,489,000	2,979,000	7,358,000	8,031,000
Repairs and maintenance	962,000	981,000	1,001,000	1,021,000	1,041,000
Licenses and taxes	734,000	749,000	764,000	779,000	795,000
Leases and rentals	413,000	422,000	430,000	439,000	447,000
Other	1,781,000	1,816,000	1,852,000	1,890,000	1,927,000
Total operating expenses	82,684,000	87,198,000	92,409,000	103,212,000	108,050,000
Operating income	4,158,000	4,985,000	5,266,000	4,771,000	6,456,000
Nonoperating revenues (expenses)					
Taxation for maintenance and operations	916,000	934,000	953,000	972,000	991,000
Investment income	31,000	211,000	266,000	308,000	371,000
Interest expense	(552,000)	(1,712,000)	(4,041,000)	(2,173,000)	(2,349,000)
Gift shop revenue	172,000	179,000	186,000	125,000	131,000
Gift shop expenses	(108,000)	(112,000)	(117,000)	(85,000)	(89,000)
Contributions made to others	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
Fundraising events and other Foundation expenses, net	(113,000)	(55,000)	(41,000)	(42,000)	(42,000)
Contributions	51,000	53,000	56,000	59,000	61,000
CARES Act Provider Relief Fund	1,522,000	-	-	-	-
Debt issuance costs	(400,000)	(400,000)	(262,000)	(300,000)	-
Total nonoperating revenues (expenses), net	1,518,000	(903,000)	(3,001,000)	(1,137,000)	(927,000)
Excess of revenues over expenses before capital grants	5,676,000	4,082,000	2,265,000	3,634,000	5,529,000
Capital grants and contributions	500,000	1,000,000	500,000	1,000,000	-
Change in net position	6,176,000	5,082,000	2,765,000	4,634,000	5,529,000
Net position, beginning of year	49,872,000	56,048,000	61,130,000	63,895,000	68,529,000
Net position, end of year	**$ 56,048,000**	**$ 61,130,000**	**$ 63,895,000**	**$ 68,529,000**	**$ 74,058,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Forecasted Cash Flows
Years Ending December 31, 2022 through 2026

	Examined				
	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Increase (Decrease) in Cash and Cash Equivalents					
Cash flows from operating activities					
Cash received from and on behalf of patients	$ 85,019,000	$ 91,029,000	$ 96,487,000	$ 106,135,000	$ 113,176,000
Cash received from other revenue	186,000	186,000	186,000	186,000	186,000
Cash received from operating grants	150,000	250,000	250,000	250,000	250,000
Cash paid to and on behalf of employees	(46,035,000)	(49,966,000)	(54,610,000)	(59,937,000)	(63,212,000)
Cash paid to suppliers and contractors	(31,938,000)	(33,422,000)	(34,171,000)	(35,668,000)	(36,511,000)
Net cash provided by operating activities	7,382,000	8,077,000	8,142,000	10,966,000	13,889,000
Cash flows from noncapital financing activities					
Taxes received for maintenance and operations	913,000	933,000	952,000	972,000	990,000
Gift shop revenue	172,000	179,000	186,000	125,000	131,000
Gift shop expenses	(108,000)	(112,000)	(117,000)	(85,000)	(89,000)
Fundraising and other Foundation expenses	(113,000)	(55,000)	(41,000)	(42,000)	(42,000)
Contributions received	51,000	53,000	56,000	59,000	61,000
Contributions to others	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
CARES Act Provider Relief Fund refund of overpayment	(25,000)	-	-	-	-
Net cash provided by noncapital financing activities	889,000	997,000	1,035,000	1,028,000	1,050,000
Cash flows from capital and related financing activities					
Purchase of capital assets	(16,220,000)	(53,667,000)	(26,872,000)	(848,000)	(848,000)
Proceeds from capital grants and contributions	500,000	1,000,000	500,000	1,000,000	-
Proceeds from issuance of interim financing for construction	50,000	53,030,000	27,420,000	-	-
Principal payments on 2014 LTGO bonds	(305,000)	(325,000)	(345,000)	(365,000)	(385,000)
Principal payments on Bank of America conditional sales agreement	(567,000)	(583,000)	(599,000)	(617,000)	(634,000)
Principal payments on GE Government Finance, Inc. loan	(248,000)	(255,000)	(262,000)	(89,000)	-
Principal payments on lease liabilities	(932,000)	(872,000)	(784,000)	(1,101,000)	(1,142,000)
Principal payments on USDA loan	-	-	-	(1,125,000)	(1,530,000)
Interest paid	(576,000)	(1,716,000)	(4,044,000)	(2,176,000)	(2,352,000)
Debt issuance costs	(400,000)	(400,000)	(262,000)	(300,000)	-
Net cash provided by (used in) capital and related financing activities	(18,698,000)	(3,788,000)	(5,248,000)	(5,621,000)	(6,891,000)
Cash flows from investing activities					
Purchase of investments	-	(1,454,000)	(989,000)	(4,061,000)	(4,340,000)
Sale of investments	6,767,000	-	-	-	-
Interest received	31,000	211,000	266,000	308,000	371,000
Net cash provided by (used in) investing activities	6,798,000	(1,243,000)	(723,000)	(3,753,000)	(3,969,000)
Net increase (decrease) in cash and cash equivalents	(3,629,000)	4,043,000	3,206,000	2,620,000	4,079,000
Cash and cash equivalents, beginning of year	13,918,000	10,289,000	14,332,000	17,538,000	20,158,000
Cash and cash equivalents, end of year	**$ 10,289,000**	**$ 14,332,000**	**$ 17,538,000**	**$ 20,158,000**	**$ 24,237,000**
Reconciliation of Cash and Cash Equivalents to the Statements of Net Position					
Cash and cash equivalents	$ 6,536,000	$ 9,304,000	$ 10,494,000	$ 10,975,000	$ 12,920,000
Cash and cash equivalents, limited as to use for capital acquisitions	2,986,000	4,261,000	6,277,000	8,077,000	9,872,000
Cash and cash equivalents, restricted by bond agreement	767,000	767,000	767,000	767,000	767,000
Cash and cash equivalents, restricted by debt agreement for USDA debt reserve	-	-	-	339,000	678,000
Total cash and cash equivalents	$ 10,289,000	$ 14,332,000	$ 17,538,000	$ 20,158,000	$ 24,237,000

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Forecasted Cash Flows (Continued)
Years Ending December 31, 2022 through 2026

	Examined				
	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Reconciliation of Operating Income to Net Cash Provided by Operating Activities					
Operating income	$ 4,158,000	$ 4,985,000	$ 5,266,000	$ 4,771,000	$ 6,456,000
Adjustments to reconcile operating income to net cash provided by operating activities					
Depreciation and amortization	3,716,000	3,489,000	2,979,000	7,358,000	8,031,000
Provision for bad debts	3,953,000	4,269,000	4,650,000	5,027,000	5,405,000
(Increase) decrease in assets:					
Receivables:					
Patient accounts, net	(4,202,000)	(4,987,000)	(5,402,000)	(6,439,000)	(6,299,000)
Other	691,000	-	-	-	-
Inventories	(212,000)	(24,000)	(30,000)	(31,000)	(32,000)
Physician advances	71,000	(20,000)	(7,000)	26,000	16,000
Prepaid expenses	(65,000)	1,000	243,000	(244,000)	1,000
Increase (decrease) in liabilities:					
Accounts payable	96,000	52,000	58,000	60,000	62,000
Accrued payroll and related liabilities	701,000	192,000	236,000	269,000	154,000
Accrued leave	(287,000)	120,000	149,000	169,000	95,000
Estimated third-party payor settlements	(1,238,000)	-	-	-	-
Net cash provided by operating activities	**$ 7,382,000**	**$ 8,077,000**	**$ 8,142,000**	**$ 10,966,000**	**$ 13,889,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Forecasted Debt Coverage Ratios and Days Cash on Hand
Years Ending December 31, 2022 through 2026

	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Debt service coverage					
Net income available for debt service					
Excess of revenues over expenses before capital grants	$ 5,676,000	$ 4,082,000	$ 2,265,000	$ 3,634,000	$ 5,529,000
Add back:					
Depreciation and amortization	3,716,000	3,489,000	2,979,000	7,358,000	8,031,000
Interest expense	552,000	1,712,000	4,041,000	2,173,000	2,349,000
Bond issuance costs	400,000	400,000	262,000	300,000	-
Net income available for debt service	10,344,000	9,683,000	9,547,000	13,465,000	15,909,000
Annual debt service requirements:					
Debt service payments:					
Principal payments	2,052,000	2,035,000	1,990,000	3,297,000	3,691,000
Interest expense	552,000	1,712,000	4,041,000	2,173,000	2,349,000
Total annual debt service payments	$ 2,604,000	$ 3,747,000	$ 6,031,000	$ 5,470,000	$ 6,040,000
Number of times annual debt service covered	**4.0**	**2.6**	**1.6**	**2.5**	**2.6**

	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Days unrestricted cash and cash equivalents on hand					
Cash and cash equivalents	$ 6,536,000	$ 9,304,000	$ 10,494,000	$ 10,975,000	$ 12,920,000
Cash and cash equivalents limited as to use for capital acquisitions	2,986,000	4,261,000	6,277,000	8,077,000	9,872,000
Investments limited as to use for capital acquisitions	10,771,000	12,225,000	13,214,000	17,275,000	21,615,000
Total cash and investments on hand	$ 20,293,000	$ 25,790,000	$ 29,985,000	$ 36,327,000	$ 44,407,000
Total operating expenses	$ 82,684,000	$ 87,198,000	$ 92,409,000	$ 103,212,000	$ 108,050,000
Interest expense	552,000	1,712,000	4,041,000	2,173,000	2,349,000
Less depreciation and amortization	(3,716,000)	(3,489,000)	(2,979,000)	(7,358,000)	(8,031,000)
Operating expenses	$ 79,520,000	$ 85,421,000	$ 93,471,000	$ 98,027,000	$ 102,368,000
Days unrestricted cash and cash equivalents on hand	**93**	**110**	**117**	**135**	**158**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Historical and Forecasted Schedules of Ratios
Years Ended December 31, 2017 through 2021
Years Ending December 31, 2022 through 2026

	State of Washington CAH Median	United States CAH Median	Historical (Compiled)					Forecasted (Examined)				
	2019	2019	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Profitability Indicators												
Total margin	4.17	2.40	3.2	1.5	5.2	4.6	12.5	6.9	5.4	2.8	4.2	4.8
Return on equity	9.83	5.76	7.5	6.1	13.4	11.5	22.8	15.2	15.8	18.3	14.4	14.2
Operating margin	1.15	0.72	1.9	(0.6)	3.7	(3.1)	7.6	4.8	5.4	5.4	4.4	5.6
Liquidity Indicators												
Current ratio	3.24	2.52	2.7	2.0	2.1	2.4	2.8	2.7	3.0	2.7	2.6	2.8
Days cash on hand	77.45	71.23	113.4	109.2	103.0	164.2	163.1	93.1	110.2	117.1	135.3	158.3
Days in net patient accounts receivable	52.11	50.54	62.8	57.9	66.3	60.7	54.4	50.0	50.0	50.0	50.0	50.0
Days in gross patient accounts receivable	58.99	47.57	58.7	62.8	57.9	66.3	57.8	62.1	62.1	62.1	62.1	62.1
Capital Indicators												
Equity financing	52.9%	59.6%	68.8	67.6	62.7	55.5	72.2	72.7	45.8	38.2	40.6	43.3
Debt service coverage	6.05	3.95	9.1	7.5	10.1	6.2	7.6	4.0	2.6	1.6	2.5	2.6
Long-term debt to capitalization	38.00%	29.97%	20.1	19.8	27.0	34.5	16.8	19.2	51.3	59.4	56.7	53.8
Revenue Indicators												
Outpatient revenue to total revenue	79.84%	80.20%	70.37%	74.92%	77.21%	76.25%	78.91%	75.53%	75.53%	75.53%	75.53%	75.53%
Patient deductions	45.37%	46.23%	54.08%	55.50%	56.48%	58.78%	60.62%	60.53%	60.86%	61.92%	61.04%	61.57%
Medicare inpatient payer mix	74.05%	69.80%	67.56%	67.67%	61.59%	54.89%	54.79%	61.30%	61.30%	61.30%	61.30%	61.30%
Medicare outpatient payer mix	37.69%	36.36%	24.29%	22.31%	22.57%	21.82%	22.46%	22.69%	22.69%	22.69%	22.69%	22.69%
Medicare outpatient cost to charge	44.10	42.51	32.46	31.78	28.22	30.24	30.68	30.68	30.68	30.68	30.68	30.68
Cost Indicators												
Salaries to net patient revenue	48.27%	45.39%	43%	45%	46%	49%	43%	43%	44%	46%	45%	45%
Average age of plant	12.35	12.28	11.2	12.2	10.9	10.6	13.6	9.4	11.0	13.9	6.6	7.1
Average salary per FTE	$ 76,368	$ 61,605	$ 72,267	$ 77,624	$ 86,729	$ 90,851	$ 95,258	$ 98,881	$ 103,071	$ 108,226	$ 112,920	$ 116,742

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Summary of Significant Forecast Assumptions and Accounting Policies
For Years Ending December 31, 2022 through 2026

1. **Nature and Limitation of Forecast:**

   This financial forecast presents, to the best of management's knowledge and belief, Prosser Public Hospital District doing business as Prosser Memorial Health's (the District) expected results of operations, financial position, and cash flows for the forecast period, assuming the District obtains $86,500,000 in proposed financing to build a new hospital building (the Project).

   Accordingly, the forecast reflects management's judgment of the expected conditions and management's expected course of action as of the date of this forecast assuming management's assumptions occur. The financial forecast is based on management's assumptions concerning future events and circumstances. The assumptions disclosed herein are those which management believes are significant to the forecast or are key factors upon which the financial results of the District depend.

   There will be differences between the forecasted and actual results because events and circumstances frequently do not occur as expected and those differences may be material. Management does not intend to revise this forecast to reflect changes in present circumstances or the occurrence of anticipated events. The forecast was prepared on September 12, 2022.

   In addition to the forecast's underlying assumption that the District obtains the proposed financing and builds a new hospital building, the following are additional key factors and assumptions which affect the overall forecast:

   - Forecasted volumes, payor mixes, and government payment policies for the various types of services offered by the District.
   - Continuation of current state and federal laws as they relate to the District.
   - Staffing and operating assumptions, as well as rates of inflation related to key expense elements such as wages and benefits, utilities, medical supplies, purchased professional medical services, repairs and maintenance, and insurance.
   - Forecasted property tax revenue.

   Any material deviation from these assumptions could have an adverse effect on the forecasted statements of net position, statements of forecasted revenues, expenses, and changes in net position, and statements of forecasted cash flows. Although all assumptions are important to the understanding of this forecast, the above are highlighted here to emphasize their significance.

2. Reporting Entity:

The District, serving the residents of Prosser, Washington, and the surrounding communities, is organized as a municipal corporation pursuant to the laws of the state of Washington. The primary purpose of the District is to operate Prosser Memorial Health, a 25-bed critical access hospital. The District also operates several clinics, including rural health clinics in Prosser, Grandview, and Benton City, Washington. The majority of the District's patients are geographically concentrated in Prosser, Washington, and the surrounding communities.

As required by accounting principles generally accepted in the United States of America, the forecast financial statements present the District – the primary government – and its component unit. The component unit discussed below is included in the District's reporting entity because of the significance of its operations and financial relationship with the District.

PMH Medical Center Foundation doing business as Prosser Memorial Health Foundation (the Foundation) is a component unit of the District since its Board of Directors are appointed by the District's Board of Commissioners. The Foundation was formed in 2017 and began operations in 2018 as a supporting organization for the District. The Foundation is a nonprofit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Foundation's stated purpose is to support, benefit, perform the functions and carry out the purposes of the District, and the Foundation intends to fulfill this purpose by raising funds to support the operations and activities of the District, including raising $2,000,000 for the Project.

The District is the sole corporate member of the Foundation. In order to ensure that the Foundation remains responsive to the District's needs, the District appoints all of the Foundation's directors and can remove directors with or without cause.

Governance

The District is governed by a seven-member Board of Commissioners. These commissioners are elected to six-year terms. The principal members of the Board of Commissioners of the District and their qualifications are listed below:

- Stephen Kenny, PhD – Chairman – Dr. Kenny has served on the Prosser Memorial Health Board of Commissioners for 35 years. He was recently re-elected as the Board Chairman. His term expires in 2025. He is a Professor at Yakima Valley Community College Grandview campus.

- Keith Sattler – Vice Chairman – Keith Sattler has served on the Prosser Memorial Health Board of Commissioners for the last 8 years. He currently serves as the Vice Chairman of the Board. His term expires in 2023. Keith grew up in Clarkston, WA, and graduated from Washington State University with a degree in accounting. He is a Certified Public Accountant and owner of Sattler & Associates, CPAs with offices in Prosser and Sunnyside. Keith has lived with his family in Prosser for the past 26 years. Keith is active in Sacred Heart Parish. He is a past president of the Prosser Chamber of Commerce, Prosser Economic Development Association, Rotary, and Historic Downtown Prosser Association. He serves on the board of the Chamber of Commerce, Depot Inc., Prosser Economic Development Association, and is a Rotary member. He is a former Chairman of the Board of AmericanWest Bank and State Director of the Farmers Home Administration of the United States Department of Agriculture.

2. **Reporting Entity (continued):**

Governance (continued)

- Glenn Bestebreur – Secretary/Treasurer – Glenn Bestebreur has served on the District's Board for 10 years. He currently serves as the Secretary/Treasurer on the Board. His term expires in 2025. He was born and raised in the Yakima Valley and has been a member of the Prosser community since 1999. He has a degree in Construction Management from Central Washington University and is employed in the family construction business.

- Susan Reams – Susan Reams has served on the Prosser Memorial Health Board for 6 years. Her term expires in 2023. Originally raised in Venezuela and fluent in Spanish, she has worked in the field of Human Resources, Compliance, and Safety/Security for 49 years in an executive capacity. Susan holds two degrees: Business Administration and Sociology/Psychology. She has resided in Prosser since 1993.

- Sharon Dietrich, MD – Dr. Dietrich has served on the Prosser Memorial Health Board for 7 years. She retired from family medicine in 2011 after serving the community at the Yakima Valley Farm Workers Clinic in Grandview for more than 25 years. Dr. Dietrich has been a long-time active member/volunteer leader for the Seattle Mountaineers, a club that is involved in a variety of outdoor activities and issues. Her involvement has been primarily in hiking and leading hikes, a life-long activity. She is also a member of the Tri-Cities Digital Photography Club, with a long history in taking interesting and notable photos. Dr. Dietrich has lived in Prosser for almost 30 years.

- Brandon Bowden – Brandon has served on the Prosser Memorial Health Board for 3 years. His term expires in 2025. He is a Training Captain at West Benton Fire Rescue based in Prosser, Washington.

- Neilan McPartland – Neilan joined the Prosser Memorial Health Board in November 2020. He serves as AVP Regional Director at Numerica Credit Union. Neilan received his bachelor's degree in social sciences at Washington State University and Western CUNA Management School through Pomona College.

Key Management Personnel

- Craig Marks – Chief Executive Officer – Craig Marks has served as the Chief Executive Officer of Prosser Memorial Health since 2016, and as CEO in various acute care hospitals in Michigan, Missouri, California, and Washington for over 31 years. Craig graduated from Concordia College with a Bachelor of Arts degree in Healthcare Administration and Finance, and he earned his Master of Healthcare Administration from the University of Minnesota. Craig has been in a senior leadership role in healthcare since 1982. He has extensive experience in all facets of managing the daily operations of acute care hospitals, remodel, and new construction projects. Craig has been the key driver of the growth by the District over the last five years as the District has grown its operating revenue by 66 percent and increased its active medical staff by over 300 percent.

2. **Reporting Entity (continued):**

   Key Management Personnel (continued)

   - David Rollins – Chief Financial Officer – David Rollins has served as the Chief Financial Officer of Prosser Memorial Health since 2019 and as CFO in various acute care hospitals in Kansas, Oregon, Iowa, Idaho, Illinois, Colorado, and Washington for over 16 years. David graduated from Wichita State University with a Bachelor of Arts degree in Political Science and Bachelor of Arts degree in Economics, along with a Master of Business Administration. David has been in a senior leadership role in various organizations since 1999. He has extensive experience in all facets of revenue cycle in acute care hospitals, remodel, and new construction projects.

   - Merry Fuller, MSN, RN, CPHQ, CPHRM, Chief Nursing Officer, and Chief Operating Officer – Merry Fuller has been the Chief Nursing Officer and Chief Operating Officer at Prosser Memorial Health for 4 years. She has been employed in healthcare since 1982, an RN since 1986 (practicing in both the inpatient and outpatient setting), and has held various hospital leadership roles since 2005. Her areas of expertise include Labor & Delivery, Quality Assurance, Hospital Risk Management, and Regulatory Readiness.

   - Brian Sollers, MD, Chief Medical Officer – Dr. Brian Sollers has served as the Chief Medical Officer of Prosser Memorial Health since 2017, and he has worked in the Prosser Women's Health Clinic since 2013. Dr. Sollers graduated from Western University of Health Sciences in Pomona, CA, and completed his OB/GYN residency in 2013 at Arrowhead Regional Medical Center in Colton, CA. Dr. Sollers has been instrumental in the growth of the District and has aided Craig Marks, CEO, in recruiting and retaining quality providers in his role as CMO.

3. **Project Overview:**

   The cost of the Project is approximately $105,483,000. The expected draws on the construction line of credit are expected to be approximately $80,500,000. Total permanent financing, including municipal lease financing of $5,000,000, will be approximately $85,500,000. The District is also expected to receive a USDA Emergency Rural Health Care grant for $1,000,000.

   In the month of October 2020, in support of the District's relocation project, the District filed a request for exemption from the State of Washington Certificate of Need (CON) process, as the new facility remains a Critical Access Hospital, with similar services, in the same market demographic. This request was formally denied by the State in late January 2021, and the District immediately filed both an appeal to this decision and a Letter of Intent (LOI) to submit a CON Application. The District also engaged Health Facilities Planning & Development to support the Project team in the CON Application process. The CON application was approved in 2021 and is expected to be issued in October 2022.

4. Financing Plan:

The District intends to finance the Project with interim financing totaling $80,500,000. The interim financing is expected to close November 3, 2022. Payments will be interest only and the interim financing is expected to bear interest at 5.25 percent. The interim financing is expected to be refinanced to permanent financing on March 1, 2025.

The total amount of permanent financing will be $85,500,000. It is intended that permanent financing will be comprised of loans totaling $80,500,000 from the United States Department of Agriculture (USDA) and $5,000,000 in municipal lease financing for capital equipment for the new building. The USDA loans are expected to include $13,000,000 that are secured by a pledge of the District's limited tax general obligation and $67,500,000 that are secured by a pledge of revenue. Principal and interest payments will be due quarterly through February 2060. $57,500,000 of the USDA loans are expected to bear interest at 2.25 percent. $13,000,000 of the USDA loans are expected to bear interest at 2.125 percent. $10,000,000 of the USDA loans are expected to bear interest at 3.25 percent. Payments on the municipal lease financing will be made through December 2034 and the loan will bear interest at 4.23 percent.

The sources and uses of the funds will be as follows:

Estimated sources of funds:	
USDA loan proceeds	$ 80,500,000
USDA Emergency Rural Health Care grant	1,000,000
Municipal lease financing	5,000,000
Equity contribution (includes $2,000,000 in capital campaign contributions)	25,548,000
Total estimated sources of funds	$ 112,048,000
Estimated uses of funds:	
Project costs	$ 105,483,000
Interest during construction period	5,203,000
Bond issuance costs	1,362,000
Total estimated uses of funds	$ 112,048,000

5. **Summary of Significant Accounting Policies:**

Forecasted financial statement presentation – The forecasted financial statements have been presented in accordance with accepted reporting practices for the healthcare industry.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America 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.

Enterprise fund accounting – The District's accounting policies conform to accounting principles generally accepted in the United States of America as applicable to proprietary funds of governments. The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

Cash and cash equivalents – Cash and cash equivalents include highly liquid investments with an original maturity of three months or less.

Investments and investment income – Investments are stated at fair value primarily using quoted market prices. Investment income includes dividend and interest income and realized and unrealized gains and losses on investments.

Inventories – Inventories are stated at lower of cost or market value using the first-in, first-out method. Inventories consist of pharmaceutical, medical-surgical, and other supplies used in the District's operations.

Assets limited as to use – Assets limited as to use include assets set aside by the Board of Commissioners for future capital improvements and other uses over which the Board retains control and could subsequently use for other purposes.

Patient accounts receivable – Receivables arising from patient services revenue are reduced by an allowance for uncollectible accounts and contractual adjustments based on experience, third-party contractual payment arrangements, and unusual circumstances which may affect the ability of patients to meet their obligations. Accounts deemed uncollectible are charged against these allowances.

Capital assets – Capital assets are assets with an initial, individual cost of more than $5,000 and an estimated useful life in excess of one year; lesser amounts are expensed. Donated capital assets are stated at estimated fair value at the date of donation. Expenditures for maintenance and repairs are charged to operations as incurred; betterments and major renewals are capitalized. When such assets are disposed of, the related costs and accumulated depreciation are removed from the accounts and the resulting gain or loss is classified in nonoperating revenue or expenses. All capital assets, other than land and construction in progress, are being depreciated by the straight-line method of depreciation over the shorter period of the lease term, if applicable, or the estimated useful life of the equipment.

Accrued leave – The District's employees earn vacation days at varying rates depending on years of service. Vacation days accumulate up to a specified maximum depending on length of service. Employees are paid for accumulated vacation days upon termination. Vacation days are accrued as earned. Employees also earn sick leave benefits based on varying rates depending on years of service. Employees may accumulate sick leave days up to a specified maximum.

5. Summary of Significant Accounting Policies (continued)

Cash and cash equivalents restricted for capital acquisitions – Cash and cash equivalents restricted for capital acquisitions is cash and cash equivalents restricted by the District's existing long-term debt to be used for capital acquisitions.

Cash and cash equivalents restricted for debt reserve – Cash and cash equivalents restricted for debt service is cash and cash equivalents restricted as a reserve for the USDA loan payments. It is expected that the District will be required to fund a reserve account over ten years until the reserve account balance is equal to one-year's debt service amount on the loan.

Operating revenues and expenses – The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing healthcare services—the District's principal activity. Nonexchange revenues, including grants and contributions received for purposes other than capital asset acquisition or taxes for uses other than repayment of long-term debt, are reported as other operating revenues. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs paid by specific tax proceeds.

Net position – Net position of the District is classified into three components. *Net investment in capital assets* consists of capital assets, net of accumulated depreciation, and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* is noncapital assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District. Restricted net position is reduced by any liabilities payable from restricted assets. *Unrestricted net position* is remaining net position that does not meet the definition of net investment in capital assets or restricted net position.

Foundation gift shop operations, fundraising activities, and other activities are reported as nonoperating revenues and expenses.

Restricted resources – When the District has both restricted and unrestricted resources available to finance a particular program, it is the District's policy to use restricted resources before unrestricted resources.

Grants and contributions – From time to time, the District receives grants from the state of Washington as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital purposes. Grants that are unrestricted or that are restricted to a specific operating purpose are reported as operating revenue. Grants that are used to subsidize operating deficits are reported as nonoperating revenue. Contributions, except for capital contributions, are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenues and expenses.

Income taxes – The District is a municipal corporation and is exempt from federal income tax. Accordingly, no provision for taxes has been made.

Tax revenue for maintenance and operations and emergency medical services – Property taxes are levied by Benton County on the District's behalf and are intended to finance the District's activities of the same calendar year. Amounts levied are based on the assessed property values.

Assessed values are established by the Benton County Assessor at 100 percent of fair market value. Property taxes are recorded as receivables when levied. Since state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

5. Summary of Significant Accounting Policies (continued)

Bond issue costs – Bond issue costs are expensed when incurred.

Future accounting standards – The District's forecasted financial statements include the implementation of the following change in accounting standards:

- Governmental Accounting Standards Board (GASB) Statement No. 87, *Leases*, which requires lessees to recognize a right-of-use asset and related lease liability for all leases other than leases with terms of less than one year. This pronouncement is effective for the District's year ending December 31, 2022. Beginning in the year ending December 31, 2022, and for each subsequent year, the portion of leases and rentals expense related to leases that will be required to be recognized as lease liabilities under GASB No. 87 is included in depreciation and amortization and interest expense. On the forecasted statements of net position, the right-of-use assets, net balance is calculated as the present value of future payments on the leases that will be required to be recognized as lease liabilities under GASB No. 87, net of accumulated amortization.

- In June 2018, the GASB issued Statement No. 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period*, which requires interest cost incurred during a construction period to be expensed when incurred. This pronouncement was first effective for the District's year ended December 31, 2021. The interest expense on the statements of forecasted revenues, expenses, and changes in net position includes interest incurred during the construction period in 2022, 2023, and 2024.

6. Net Patient Service Revenue:

The District recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients who do not qualify for charity care, the District recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the District's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the District records a significant provision for bad debts related to uninsured patients in the period the services are provided.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

- *Medicare* – The District has been designated a critical access hospital by Medicare and is reimbursed for inpatient and outpatient services on a cost basis as defined and limited by the Medicare program. Physician services outside the rural health clinic are paid on a fee schedule. The District is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare administrative contractor. Rural health clinic services are paid on a prospectively set rate per visit.

6. Net Patient Service Revenue (continued):

- *Medicaid* – Medicaid beneficiaries receive coverage through either the Washington State Health Care Authority (HCA) or Medicaid managed care organizations (MCOs). The District is reimbursed for MCO covered inpatient and outpatient services on a prospectively determined rate that is based on historical revenues and expenses of the District. The District is reimbursed by the HCA for inpatient and outpatient services under a cost reimbursement methodology. The District is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the District and review by HCA. Rural health clinic services are paid on a prospectively set rate per visit.

- *Other commercial payors* – The District also has entered into payment agreements with certain commercial insurance carriers, managed care organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations governing the Medicare, Medicaid, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

The District provides charity care to patients who are financially unable to pay for the healthcare services they receive. The District's policy is not to pursue collection of amounts determined to qualify as charity care. Accordingly, the District does not report these amounts in net operating revenues or in the allowance for uncollectible accounts.

Payor mix – Utilization by payor mix has been forecasted based on revenues generated by historical patient days and outpatient procedures and the results of the market study prepared for the District by Health Facilities Planning and Development. The prospective financial statements assume that the population base will have approximately the same payor mix during the forecast years.

Payor mix based net patient service revenues are as follows:

	Years Ending December 31,				
	Examined				
	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Medicare	$ 25,319,000	$ 26,923,000	$ 28,320,000	$ 32,273,000	$ 33,889,000
Medicaid	21,549,000	22,313,000	22,386,000	24,763,000	25,644,000
Other commercial	40,758,000	43,779,000	47,897,000	51,964,000	56,071,000
Self pay	6,477,000	6,937,000	7,574,000	8,209,000	8,855,000
	94,103,000	99,952,000	106,177,000	117,209,000	124,459,000
Bad debt	(3,953,000)	(4,269,000)	(4,650,000)	(5,027,000)	(5,405,000)
Charity care	(3,644,000)	(3,936,000)	(4,288,000)	(4,635,000)	(4,984,000)
Net patient revenue	**$ 86,506,000**	**$ 91,747,000**	**$ 97,239,000**	**$ 107,547,000**	**$ 114,070,000**

7. Summary of Significant Forecast Assumptions:

This financial forecast is based on assumptions concerning future events and circumstances. The assumptions disclosed herein are those which management believes are significant to the forecast or are key factors on which the financial results of the District depend. Some assumptions inevitably will not materialize and unanticipated events and circumstances may occur subsequent to the date of the forecast. Therefore, the actual results achieved during the forecast period will vary from the forecast and the variations may be material.

Service and Patient Volumes Assumptions

The District has predicted the following departments will see the following volume increases each year based on population growth and expanded services:

Year Ending	Acute Care Patient Days	Nursery Patient Days	Surgeries	Emergency Department Visits
2022	8.5%	8.4%	10.3%	2.0%
2023	1.5%	1.5%	3.0%	1.5%
2024	1.5%	1.5%	5.0%	3.0%
2025	1.5%	1.5%	5.0%	2.0%
2026	1.5%	1.5%	5.0%	1.5%

In addition, the District predicts the clinics will have the following volume increases and decreases:

Year Ending	Benton City RHC	Prosser RHC	Grandview RHC	Specialty Clinic	Dermatology Clinic
2022	14%	1%	40%	7%	0%
2023	35%	27%	16%	6%	5%
2024	14%	17%	3%	58%	5%
2025	19%	8%	11%	25%	5%
2026	3%	8%	20%	6%	5%

The significant increases noted above in 2022 are due to the District hiring several new providers in 2020 and 2021.

The significant increases noted in the clinic volumes are due to plans to hire new providers as detailed below in the salaries and wages assumptions.

The following departments' volumes are generally driven by acute care volumes and will have the same percentage increases each year: respiratory therapy and pharmacy.

The following departments' volumes are generally driven by nursery volumes and will have the same percentage increases each year: labor and delivery.

The following departments' volumes are generally driven by emergency department volumes and will have the same percentage increases each year: radiology, laboratory, and observation.

7. **Summary of Significant Forecast Assumptions (continued):**

The following departments' volumes are generally driven by surgery volumes and will have the same percentage increases each year: anesthesia, blood administration, medical supplies, and implantable supplies.

The following departments' volumes are generally driven by the clinic volumes and will have the same percentage increases each year as the average increases in the clinics: physical therapy, occupational therapy, speech therapy, and IV therapy.

The District ceased pain clinic operations in March 2021. The pain clinic became the dermatology clinic.

Net Patient Revenue Assumptions

Net patient revenue is based on the forecasted charge structure, the forecasted occupancy levels and anticipated units of service, and the forecasted reimbursement rates from third-party payors and forecasted collection rates from patients. The forecasted utilization is based on the District's assumptions for each of the existing service areas. Forecasted charge structure is developed by applying assumed annual rate increases to the average charges per unit of service.

Net patient revenue is reported as the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors.

It is assumed that the payor mix for these services will be approximately the same as the overall District's current payor mix.

No service line will be materially realigned, expanded, or reduced except as noted above in the Service and Patient Volumes Assumptions section.

Patient service charge rates are forecasted to increase each year from 2022 – 2026 by 2 percent for acute care, nursery, blood administration, respiratory therapy, and speech therapy. For surgery and anesthesia, forecasted charge rate increases are 5 percent per year. For radiology, laboratory, IV therapy, and the emergency department, forecasted charge rate increases are 4 percent per year. For all other departments, forecasted charge rate increases are 3 percent per year.

Medicare and Medicaid reimbursement are as described in Note 6. These reimbursement methods are expected to continue during the forecast period. Fee based reimbursement for Medicare and Medicaid services are expected to remain consistent with historical percentages over the forecast period.

Various insurance companies reimburse the District based on a percentage of charges or on a fixed-fee basis. This forecast assumes that insurance companies will not significantly change payment rates or methodologies for the forecast period.

Medicaid HMOs and PPOs are forecasted to pay at the same rates as Medicaid throughout the period of the forecast.

Other Operating Revenue Assumptions

Other operating revenue consists mainly of cafeteria revenue, rental income, and grants for operations. This revenue is expected to be consistent with historical levels during the forecast period. Operating grant revenue is expected to decrease in 2022 and then to remain at a consistent amount through 2025.

7. Summary of Significant Forecast Assumptions (continued):

Tax Revenue

Annual tax revenue is expected to increase by 2 percent per year for the years 2022 – 2026.

Other Nonoperating Revenue Assumptions

Other nonoperating revenue consists of investment income, gain on disposal of assets, gift shop revenue, CARES Act Provider Relief Fund, and capital grants and contributions.

Investment income consists of interest income on the District's cash reserves. No significant changes in interest rates are expected over the forecast period. The District has historically had very little interest income; therefore, interest income is not expected to increase during the forecasted years.

Gift shop revenue is expected to remain consistent with 2021 revenue throughout the forecast period.

The District expects to recognize an additional $1,522,000 of revenue in 2022 from the CARES Act Provider Relief Fund grants it received in 2020 and 2021 based on allowable costs and lost revenues it will incur in 2022 related to the COVID-19 pandemic.

Capital grants and contributions are expected to increase during the forecast period due to a capital campaign to help fund the Project. The District expects to receive $500,000 from the capital campaign in 2022, $1,000,000 in 2023, and $500,000 in 2024.

The plan for the existing hospital building will be to demolish it and sell the land after the new building is completed. However, it is expected to take two or more years to complete this process. During 2024 – 2026, the building will continue to be used for storage.

Operating Expense Assumptions

Salaries and wages – Salaries and wages are forecasted on an average per full-time equivalent employee (FTE). Estimates were developed by the District based on forecasted staffing patterns. The following is a summary of the forecasted FTEs:

	Compiled						Examined			
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Historical Year 2020	Historical Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Average total FTEs	282.9	300.0	316.8	322.1	349.9	379.9	393.7	409.3	429.8	436.1
Average salaried physician FTEs	21.9	26.9	32.9	36.6	38.3	42.3	45.1	49.6	52.3	53.3
Average non-physician FTEs	261.0	273.1	283.9	285.5	311.6	337.6	348.7	359.8	377.5	382.8
Average annual salary	$ 72,267	$ 77,624	$ 86,729	$ 90,851	$ 95,258	$ 98,881	$ 103,071	$ 108,226	$ 112,920	$ 116,742
Benefits as a percent of salary	23.1%	26.3%	22.8%	22.1%	22.5%	23.6%	23.9%	24.2%	24.4%	24.7%

7. **Summary of Significant Forecast Assumptions (continued):**

Operating Expense Assumptions (continued)

The average salaries and wages are expected to increase by approximately 3.5 percent for the forecasted years 2022-2026, not including changes for additional FTEs. The District plans to hire the following new providers during the forecast years:

- 2022 – An internal medicine physician, an endocrinologist, and a neurologist
- 2023 – Two family practice physicians, an oncologist, and a rheumatologist
- 2024 – A pulmonologist, a nephrologist, an ophthalmologist, a neurosurgeon, and an endocrinologist
- 2025 – a family practice physician and two nurse practitioners
- 2026 – a family practice physician and two nurse practitioners

The District also plans to hire additional support staff for these providers and to hire additional staff in other departments to keep up with the increases in volumes during the forecast period.

Employee benefits – Employee benefits include social security taxes, unemployment insurance compensation, workers' compensation, self-insured health insurance, retirement contribution, and other employee related expenses. The totals of these items have been forecasted to change proportionately with salaries and wages during the forecast period as the benefits are generally driven by the number of employees and the amounts of salaries and wages. However, as health insurance costs generally increase at a faster rate than salaries and wages, employee benefits as a percentage of salaries is expected to increase 0.25 percent per year. The District does not expect to implement any additional major fringe benefit programs during the forecast period.

Professional fees and purchased services – Professional fees and purchased services including contract providers, agency nursing, agency radiology staff, physical therapists, occupational therapists, speech therapists, and other are expected to increase by 3 percent per year for the forecasted years 2022-2026. The District does not plan on changing the mix between employed employees and contracted employees. The approximate annual fees for these services, based on fees for 2020, are as follows:

		Annual Fees	FTEs
Clinic physicians	$	133,000	0.85
Physical therapy		1,361,000	10.92
Occupational therapy		263,000	1.23
Speech therapy		210,000	1.94
Contract nursing		642,000	3.82
Radiology services		43,000	0.21
Hospital physician services		1,868,000	2.99
Hospitalists		1,060,000	3.50
Business office staffing		78,000	1.00
Total	**$**	**5,658,000**	**26.46**

7. **Summary of Significant Forecast Assumptions (continued):**

Operating Expense Assumptions (continued)

Supplies – Supply expense includes both billable and nonbillable patient care supplies, pharmaceuticals, and office supplies. The District is not anticipating any significant changes to supplies; therefore, supplies expense is forecasted to increase by an inflation factor of 2 percent for the forecasted years 2022-2026.

Insurance – Insurance includes professional and general liability, auto, property, and other insurance. The professional liability policy provides $1,000,000 per claim with an annual aggregate limit of $5,000,000. Settled claims have not exceeded coverage in the preceding three years. The coverage limits are adequate for the District. This expense is expected to increase by 2 percent per year during the forecast.

Utilities – Utilities expenses have historically only increased by a small percentage each year, on average. They are expected to increase by 3 percent per year during the period of the forecast.

Depreciation and amortization – Depreciation and amortization expense for the forecasted capital additions is computed using the following average useful lives and the straight-line method:

	Years
Buildings and improvements	5 – 40
Land improvements	5 – 25
Equipment	3 – 20

Repairs and maintenance – Repairs and maintenance expenses have historically only increased by a small percentage each year, on average. They are expected to increase by 2 percent per year during the period of the forecast.

Licenses and taxes – Licenses and taxes expenses have historically only increased by a small percentage each year, on average. They are expected to increase by 2 percent per year during the period of the forecast.

Leases and rentals – Leases and rentals expenses have historically only increased by a small percentage each year, on average. They are expected to continue to increase by 2 percent per year during the forecast. Noncancelable operating leases were converted to lease liabilities for year 2022 in order to recognize the implementation of GASB No. 87.

Other expenses – Other expenses are comprised of continuing education, association dues and fees, and recruiting expenses. These costs have historically only increased by a small percentage each year, on average. They are expected to continue to increase by 2 percent per year during the forecast.

Bond issuance costs – Bond issuance costs associated with issuing the interim construction loan, the USDA direct loans, and the municipal lease are expected to be $1,362,000 in total with the costs spread over the years 2022-2025.

Interest expense – Interest expense is forecasted based on the assumed interest rates and amounts of the interim construction loan, the USDA direct loans, and the municipal lease used for the Project, as well as the scheduled interest payments of the District's existing debt and lease obligations. See debt summary schedules for interest expense by forecast year.

7. **Summary of Significant Forecast Assumptions (continued):**

Operating Expense Assumptions (continued)

Capital acquisitions – The District expects to make the following major capital purchases in 2022: four colonoscopes, a blood flow monitor, and an electrocardiogram machine. For the years 2023, 2025, and 2026, the District estimates $1.2 million of capital purchases per year based on expected need and historical capital purchases. For 2024-2025, the District estimates $9.6 million of expenditures for furniture, fixtures, and equipment for the new hospital building. These assets will be purchased in the fourth quarter of 2024 and will be put into service in March 2025 when the new building opens. This will include a computed tomography machine, a magnetic resonance imaging machine, x-ray machines, surgical cameras and lighting, sterilizers, a hyperbaric chamber, and many other pieces of equipment.

Provision for doubtful accounts and bad debt expense – Doubtful accounts and bad debts are netted against patient revenue on the statements of forecasted revenues, expenses, and changes in net position. Bad debts for forecast years 2022 through 2026 are based on the average of bad debt expense as a percentage of gross patient revenue from uninsured patients for 2021.

Charity care – Charity care writeoffs as a percent of total gross patient revenue are expected to remain consistent with the 2021 percentage throughout the forecast period.

Forecasted Statements of Net Position Assumptions

A summary of forecasted statements of net position assumptions follows:

Cash and cash equivalents and assets limited as to use – Assets limited as to use include assets set aside by the District for future capital improvements, other uses over which the District retains control, and funds restricted for bond debt service.

Short-term investments – The short-term investments balance is not expected to change during the forecast period.

Net patient accounts receivable – Net patient accounts receivable is expected to be 50 days of net patient service revenues for all forecast years.

Taxes receivable – Taxes receivable is estimated to be 3 percent of tax revenue each year.

Other receivables – Other receivables is estimated to be $50,000 each year.

Inventories – The inventories balance is expected to be 26 days of supplies expense for all forecast years.

Physician advances – Physician advances are advances paid to physicians when they are hired that are forgiven over time to encourage physicians to remain employed at the hospital. The forecast balances are based on the amortization of the existing balances and an expected $25,000 advance for new physicians or a $15,000 advance for new nurse practitioners, amortized over 36 months.

Prepaid expenses – The prepaid expenses balance is expected to change based on the amortization of the software contract entered into in 2019. The contract is expected to be renewed at similar terms in 2022 and in 2025.

Accounts payable – Accounts payable are expected to be 21 days of all operating expenses excluding salaries, benefits, depreciation, and interest.

7. Summary of Significant Forecast Assumptions (continued):

Forecasted Statements of Net Position Assumptions (continued)

Accrued compensation and related liabilities – These balances are expected to be 5 percent of salary and benefit expense.

Accrued leave – Accrue leave is expected to be 4 percent of salaries.

Accrued interest payable – This balance is calculated based on the timing of draws on the construction loan as the interest will be paid at the end of the construction period.

The above assumptions are based on historical averages for the respective items except where noted above.

Long-term debt and interest expense – The financial forecast was prepared based on the proposed issuance of $80,500,000 in long-term debt for the Project. The District forecasts its principal payments and interest expense to be as follows:

Years Ending	Construction Loan		Project Long-term Financing		Other Long-term Debt	
December 31,	Principal	Interest	Principal	Interest	Principal	Interest
2022	$ -	$ -	$ -	$ -	$ 1,119,984	$ 361,969
2023	-	1,230,000	-	-	1,162,834	326,919
2024	-	3,621,000	-	-	1,206,325	290,428
2025	80,500,000	352,000	1,125,000	1,257,000	1,070,457	253,853
2026	-	-	1,530,000	1,855,000	1,019,302	222,913
Thereafter	-	-	77,845,000	34,700,000	5,598,995	809,331
Total	**$ 80,500,000**	**$ 5,203,000**	**$ 80,500,000**	**$ 37,812,000**	**$ 11,177,897**	**$ 2,265,413**

Years Ending	Combined		
December 31,	Principal	Interest	Total Debt Service
2022	$ 1,119,984	$ 361,969	$ 1,481,953
2023	1,162,834	1,556,919	2,719,753
2024	1,206,325	3,911,428	5,117,753
2025	82,695,457	1,862,853	84,558,310
2026	2,549,302	2,077,913	4,627,215
Thereafter	83,443,995	35,509,331	118,953,326
Total	**$ 172,177,897**	**$ 45,280,413**	**$ 217,458,310**

7. Summary of Significant Forecast Assumptions (continued):

Forecasted Statements of Net Position Assumptions (continued)

Lease obligations and interest expense – The District is anticipating entering into lease obligations in 2024. The 2024 lease obligations in the amount of $5,000,000 will be for equipment for the new building. In addition, GASB No. 87 will be implemented in 2022, which will require additional lease obligations to be recognized. The District forecasts its principal payments and interest expense on its lease obligations to be as follows:

Years Ending December 31,	Lease Obligations Principal	Interest
2022	$ 931,809	$ 184,219
2023	871,909	155,292
2024	783,928	129,698
2025	1,100,763	310,523
2026	1,142,442	271,256
Thereafter	6,309,791	842,317
Total	**$ 11,140,642**	**$ 1,893,305**

Capital expenditures

The following is a summary of major capital expenditures by year for the years 2017-2021:

Year	Property and Equipment Expenditures	Category	Cost
2017	Land for new hospital	Land	$ 1,745,440
	Electronic health records software	Equipment	702,474
	Prosser clinic furnishing	Equipment	262,093
2018	Surgery clinic expansion	Renovation	867,114
2019	Grandview clinic purchase	Land, building, and furnishings	4,854,052
	Prosser clinic expansion	Renovation	553,299
	X-ray machine	Equipment	117,831
	Obstetrics clinic medical equipment	Equipment	177,709
	Phone infrastructure	Equipment	495,318
	Mobile MRI machine	Equipment	450,000
	Mammography machine	Equipment	417,786
2020	CT scanner	Equipment	234,424
	Ambulance	Equipment	118,984
	C-arm	Equipment	165,631
2021	Patient monitoring system	Equipment	816,268
	Nuclear medicine department remodel	Renovation	334,224
	Virtual desktop	Equipment	325,794
	Nuclear medicine imaging system	Equipment	312,932
	Patient monitoring system	Equipment	285,441
	Ultrasound machine	Equipment	251,256
	Colonoscopes	Equipment	200,951
	Immunochemsitry unit	Equipment	104,256

For purposes of this summary, a major expenditure is considered to be any expenditure over $100,000.

7. Summary of Significant Forecast Assumptions (continued):

Forecasted Statements of Net Position Assumptions (continued)

Capital expenditures (continued)

Forecasted capital expenditures are based on estimates from management and on capital budgeting. The District develops its budget on an annual basis, and in 2021 it forecasted its capital needs through 2026. This process includes soliciting department directors and service leaders for proposed equipment, renovations, maintenance, and new construction needs; multiple reviews; prioritization of the proposed items and projects by a budget review committee; and the development of a ranked order of the highest prioritized capital items. The list is reviewed and approved by senior leadership and forwarded to the Board of Commissioners for final review and approval of the annual capital budget. The District targets capital purchases at 2-3 percent of operating expenses with the capital purchases amounts in 2022-2023 reduced due to the large purchases planned for 2024 related to the Project that will go live in 2025.

Laws and regulations – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of various statutes and regulations by healthcare providers. 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. Management believes that the District will be in compliance with fraud and abuse as well as other applicable government laws and regulations during the period covered by this forecast. If the District is found in violation of these laws, the District could be subject to substantial monetary fines, civil and criminal penalties, and exclusion from participation in the Medicare and Medicaid programs.

The laws and regulations, including reimbursement regulations that the healthcare industry is subject to, are continually changing from year to year. This forecast has been completed based on the laws and regulations including the reimbursement regulations that are in effect as of the date of this forecast. No consideration has been given to any proposed laws or regulations, or laws or regulations with delayed effective dates, if any, that may have future impact on the District's operations.

Additionally, these forecasts have been prepared under the assumption that the District will continue to operate as a critical access hospital. The loss of this designation for any reason would have a material, adverse effect on the financial results of the District.

8. Sensitivity Analysis:

Because forecasts are based on assumptions about circumstances and events that have not yet occurred, they are subject to unanticipated events and circumstances that may arise as future operations actually occur. Accordingly, the actual results achieved during the forecast periods will vary from the forecasts, and the variations may be material.

Some events or conditions may occur which would adversely affect the forecast results and affect the District's ability to meet debt service requirements. Events may include, among other things, changes in utilization, competition, payor rates, payor mix, financing terms, operating costs, and legislative changes.

8. **Sensitivity Analysis (continued):**

Utilization and competition – The District has forecasted volume based on its marketing plan and historical relationships. There are several factors that could adversely affect the District's ability to obtain the forecasted volume. Competition from other healthcare facilities, the District's rates, and marketing are among these factors.

Rates and payor mix – The District has forecasted net revenues based on expected rates that it will negotiate or obtain from the various payors and the percentage of business it will do with each payor. Gross rates are forecasted to increase as described in Note 7.

Operating costs – The District has forecasted operating expenses using various assumptions, including staffing and other costs as detailed in the forecast. Expenses are forecasted to increase based on utilization and estimated inflation rates. If expenses are higher than expected, the District may experience difficulty in meeting its working capital requirements.

Legislative changes – Governmental legislation and regulation, particularly Medicare and Medicaid, may affect revenues and expenses of the District. If future legislation or regulations related to the District's operations are enacted, such legislation or regulations could have a material effect on the forecasted financial statements.

Change in utilization – The forecast was prepared assuming the District attains certain levels of utilization, payor rates, and payor mix. The following table shows the effects of a 10 percent decrease in inpatient discharges on the debt coverage ratio, assuming all other factors remain static.

	Debt Coverage Ratio	
Years	**As Forecasted**	**Sensitivity**
2021	4.0	3.7
2022	2.6	2.4
2023	1.6	1.5
2024	2.5	2.3
2025	2.6	2.5

Change in Medicare and Medicaid reimbursement – The forecast was prepared assuming the District maintains certain levels of reimbursement from Medicare and Medicaid. The following table shows the effects of a 1 percent decrease in Medicare and Medicaid reimbursement on the debt coverage ratio, assuming all other factors remain static.

	Debt Coverage Ratio	
Years	**As Forecasted**	**Sensitivity**
2021	4.0	3.7
2022	2.6	2.4
2023	1.6	1.4
2024	2.5	2.3
2025	2.6	2.5

8. **Sensitivity Analysis (continued):**

Financing – The forecast assumes that long-term debt will be obtained at interest rates as discussed in Note 4. If the long-term debt is issued at an interest rate higher than the assumed rate, it may affect the District's ability to meet debt service requirements. The following table shows the effects of a 0.5 percent increase in the interest rates for the Project loans on the debt coverage ratio, assuming all other factors remain static.

	Debt Coverage Ratio	
Years	**As Forecasted**	**Sensitivity**
2021	4.0	4.0
2022	2.6	2.4
2023	1.6	1.5
2024	2.5	2.0
2025	2.6	2.3

9. **Summary of Significant Demand Forecast Assumptions:**

In the spring of 2019, the District retained Health Facilities Planning & Development (HFPD) to produce a market assessment. This process involved defining and then collecting, analyzing, summarizing, and reporting the District's service area demographic, socioeconomic, health status, inpatient and outpatient data, use patterns, and volumes.

In early fall 2020,when the District made the final decision to replace the current hospital and pursue United States Department of Agriculture (USDA) financing, the District asked HFPD to update the report with the latest available data and add estimates of future service area inpatient and outpatient volumes, as well as the District's market share thereof. This report is divided into three sections, as follows:

- Section 1: Overview of the District and the Service Area;
- Section 2: Service Area Resident Inpatient and Outpatient Volumes, District Market Shares, and Competitor Profiles; and
- Section 3: Future Service Area Demand (Inpatient and Outpatient) and Estimated District Volumes.

HFPD, per the request of Dingus, Zarecor & Associates, PLLC (DZA), has updated the tables from the January 2021 Market Overview and Assessment to include, when available, 2020 utilization data. The updated data includes updates to inpatient utilization and market share. Outpatient data has been updated to include 2020 estimates. Actual 2020 data for the District has been used to estimate the District's market share. Due to COVID-19, HFPD has not updated any future volumes and has instead relied upon the previously estimated 2019 use rates.

The main data sources used in this report include inpatient hospital discharge data supplied by the State of Washington Comprehensive Hospital Abstract Reporting System (CHARS) for the period of 2014-2019, Claritas 2019/2020 population estimates (current and projected), IBM Watson/Truven outpatient estimates, U.S. Census data, Robert Wood Johnson's Community Health Rankings, the Center for Disease Control's Behavioral Risk Factor Surveillance System, UDS Mapper, American Community Survey data, and the Washington Employment Security Department.

9. Summary of Significant Demand Forecast Assumptions (continued):

Where possible, data is provided for just the Service Area, which, based on patient origin data, is defined as the District (Prosser, Benton City, and Paterson) as well as Grandview and Mabton (Yakima County). HFPD also defined an Emerging Market, the zip code of Sunnyside, located in adjacent Yakima County. For some data points, the only source data available is at the County level (Benton County and Yakima County) and is so noted.

In summary, the data shows that:

- The Service Area is growing and is slightly younger than the state at large. Since the 2010 Census, the Service Area's total population (46,000 today) grew by 9.3 percent, while the Hispanic population grew at double the rate (20 percent), and the population age 65+ grew by 40.3 percent. The population of females of childbearing age (15-44) grew by nearly 9 percent. The Service Area is expected to continue to grow (11.6 percent) through 2030. The growth in the Service Area far surpasses the average growth rate in communities served by the State's other critical access hospitals (CAHs) (4.9 percent).

- The zip code of Sunnyside, referred to in this report as an Emerging Market, has a total population of about 23,000, of which more than 80 percent is Hispanic. The community is exceptionally young with only 9.6 percent over the age of 65. Since the 2010 census, Sunnyside's total population grew by just over 4 percent, while the Hispanic population grew by almost 11 percent, and the population age 65+ grew by nearly 12 percent. Sunnyside is expected to continue to grow (7.4 percent) through 2030, with the fastest growth continuing to be in the 65+ cohort and Hispanic populations.

- Combined, the Service Area and the Emerging Market (Sunnyside) communities have a population of almost 70,000, projected to be just over 75,000 by 2030.

- The District, Service Area, and the Emerging Market all have higher percentages of households struggling to meet basic needs (ALICE households[1]) and of adults who did not graduate from high school

- The Service Area's self-reported rates of diabetes and being overweight were higher than the Counties and the State.

- Total inpatient days for patients residing in the Service Area totaled 13,801 in 2020[2]. Days in the Service Area have grown a total of 12 percent since 2014. The District's days in the Service Area grew even faster (+35 percent). The District's total days (regardless of where the patient resides) increased by 50 percent during the same time period.

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[1] ALICE is an acronym for Asset Limited, Income Constrained, Employed -- households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the county (the ALICE Threshold).

[2] Please note that Astria Sunnyside did not report any inpatient data for the five months of the second half of 2018; likely due to issues related to its electronic medical record conversion. In addition, Astria Sunnyside's 2019 data is also underreported. HFPD has adjusted Astria Sunnyside's 2019 using total discharges and days from its Department of Health Year End Report.

9. Summary of Significant Demand Forecast Assumptions (continued):

- There has been considerable volatility and change in the market related to other hospital providers. Over the past 4 years, two providers (representing four hospitals) filed for bankruptcy and another hospital provider recently unwound its affiliation from a larger health system. Three hospitals (including one that filed for bankruptcy) became part of for-profit LifePoint Health, based in Tennessee. The data in this Assessment shows that during this same time frame, the District has been a stable and growing force.

- Inpatient days, assuming use rates remain at 2019 levels, are expected to grow by 23 percent by 2030, just due to growth and aging of the population. Assuming the District's market share and immigration remain at 2020 levels, an additional 1.0 average daily census (ADC) is expected. Observation days are estimated to grow as well but slightly less (+20 percent). If the District's market share were to increase; as it has historically, by 2030, a total ADC of 10.4 is estimated for the District (including immigration) or an additional 2.2 ADC higher than assuming no market share increase.

- The Service Area is also expected to see growth in outpatient volumes due to population growth.

Section 1: Overview of the District and the District Service Area:

A. Brief History:

The Prosser Hospital Association was established in 1943 to raise funds for a community hospital. In 1945, after intense community-led fundraising, construction crews broke ground on a new 19-bed hospital. Two years later, on December 26, 1947, Prosser Memorial Hospital, as it was then named, opened, and was dedicated to the memory and service of veterans of World War II. The Prosser Public Hospital District was formed in 1948, and the Prosser Hospital Association was disbanded.

Over the years, there have been numerous additions and expansions to the District's facilities and services. Most recently, there has been significant outpatient and clinic development. The District's mission is "to improve the health of our community." Its vision is to become one of the top 100 critical access hospitals in the country.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued):

B. Prosser Memorial Health Today:

The District is a 25-bed critical access hospital (CAH): It is rural, operates 25 or fewer beds, meets other applicable requirements and is paid allowable costs from Medicare and Medicaid HCA. The intent of the CAH program is to mitigate financial vulnerability of rural hospitals, thereby assuring that essential services exist in rural communities.

Today, the District is a robust rural healthcare system providing a broad array of primary care, specialty care, acute care, outpatient care, and post-acute care services, including:

- Level 4 Trauma Center
- Emergency Cardiac Level II
- Emergency Stroke Level III
- Inpatient & Outpatient Surgery
- Obstetrics
- Swing Beds
- Primary Care
- Behavioral Health
- Teleradiology

C. The Service Area:

A Service Area is typically defined as the contiguous geography from which approximately 70-80 percent of a hospital's patients reside. For the District, Washington State's Inpatient CHARS database along with internal outpatient data was used to make this determination.

Patient origin data for the District's inpatients for the period of 2016-2020 is depicted in Table 1. The Service area logically includes all three of the zip codes contained within the legal boundaries of the District, as well as several adjacent communities. The three communities within the legal boundaries of the District: Prosser, Benton City and Paterson, are all located in Western Benton County; the other zip codes are located in adjacent Yakima County.

As seen in **Table 1**, in 2020, approximately 33 percent of Prosser's patients came from the District. In 2016 this percentage was 44 percent. The adjacent Yakima County cities of Grandview and Mabton consistently account for another 31-34 percent of discharges. Collectively, these communities account for about 70 percent of all the District inpatient discharges (decreasing from 70 percent in 2016).

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 1: Overview of the District and the District Service Area (continued):

C. The Service Area (continued):

For the purposes of this report, HFPD has elected to identify the growing community of Sunnyside in Yakima County as an 'emerging' market for several reasons. First, Astria Sunnyside Hospital has experienced declining inpatient volumes over the last three years (2018-2020). In addition, as can be identified in Table 1, the percentage of the District's inpatients coming from Sunnyside increased in 2019 and 2020 (with nearly 22 percent of the District's inpatients coming from Sunnyside in 2020, up from about 15 percent from 2016-2018). Additional data provided directly by the District also identifies a significant bump up from Sunnyside in 2020 compared to 2019 (71 percent); with nearly 12 percent of the District's outpatient volume coming from residents of the Sunnyside zip code.

Table 1
The District's Patient Origin, by Zip Code and City-2016-2020

Zip Code	City	2016	2017	2018	2019	2020
99350	Prosser	39.2%	41.7%	39.4%	34.2%	30.1%
99320	Benton City	4.8%	3.8%	3.1%	3.9%	3.0%
99345	Paterson			0.1%	0.3%	.3%
	Subtotal -District	**44.0%**	**45.4%**	**42.7%**	**38.4%**	**33.3%**
98930	Grandview	29.8%	23.2%	25.3%	26.3%	26.8%
98935	Mabton	4.2%	5.5%	5.9%	5.1%	5.6%
	Service Area	**78.0%**	**74.1%**	**73.8%**	**69.7%**	**65.7%**
	Emerging Market -Sunnyside					
98944	Sunnyside	14.6%	15.3%	14.8%	18.2%	21.9%
	Service Area and Emerging Market	**92.6%**	**89.4%**	**88.6%**	**87.9%**	**87.7%**
	Other	7.4%	10.6%	11.4%	12.1%	12.3%
	Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: 2016-2020 Inpatient CHARS Data, excludes newborns and swing bed patients

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued):

C. The Service Area (continued):

As defined by the Federal Health Resources & Services Administration (HRSA), the entirety of Benton and Yakima Counties are Health Professional Shortage Areas, (HSPA) with designations for primary care, mental health, and dental care. **Table 2** reflects the Service Area HPSA designations and scoring. The highest score (greatest shortage) for a HPSA is 25.

Table 2
HPSA Designation by Select County

Geography	HPSA	Designation Type	Designation Date	Score
Benton County	Primary Care	Low Income Population HPSA	10/02/2017	16
	Dental Care	Low Income Population HPSA	8/31/2017	18
	Mental Health	Geographic: Entire County	8/27/2017	17
Yakima County	Primary Care	Low Income Population HPSA	09/24/2017	17
	Dental Care	Low Income Population HPSA	07/26/2017	19
	Mental Health	Geographic: Entire County	08/23/2017	18

Source: HPSA Find (https://datawarehouse.hrs.gov/tools/analyzers/hspafind.aspx).

D. Demographics – Service Area:

Throughout the report, the **Service Area** is defined by five communities: Prosser, Benton City, Patterson, Mabton and Grandview. When Sunnyside is added, we refer to the area as the **Service Area + Emerging Market.**

As depicted in **Table 3**, in 2020, the Service Area had a population of nearly 46,000, of which 56.7 percent is Hispanic. Since the 2010 Census, the Service Area's total population has grown by 9.3 percent, while the Hispanic population grew at double the rate (19.9 percent), and the population age 65+ grew by 40.3 percent. The Service Area is slightly "younger" than the rest of the State, with 12.7 percent aged 65+ in the Service Area vs 16.3 percent statewide.

In comparison to the Service Area's 9.3 percent total population growth, the state grew by nearly 13 percent; however, the growth in the Service Area far surpasses the average growth rate in communities served by the state's other CAHs (4.9 percent). The Service Area is expected to continue to grow (11.6 percent) through 2030, with the fastest growth continuing to occur in the 65+ and Hispanic populations. Again, and for comparison, the state is expected to grow by 13.5 percent between 2020-2030.

Table 3 also shows that the population of females of childbearing age (15-44) grew by nearly 9 percent between 2010 and 2020 and is expected to grow another 14.5 percent by 2030.

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 1: Overview of the District and the District Service Area (continued):

D. Demographics – Service Area (continued):

Table 3
Service Area Population

	2010	Pct of Tot Pop	2020 Est	Pct of Tot Pop	Pct Chg. 2010-2020	2030 Proj	Pct of Tot Pop	Pct Chg. 2020-2030
Tot. Pop.	**41,910**	**100.0%**	**45,811**	**100.0%**	**9.3%**	**51,129**	**100.0%**	**11.6%**
Pop. By Age								
0-17	13,552	32.3%	14,071	30.7%	3.8%	15,069	29.5%	7.1%
18-44	14,497	34.6%	16,153	35.3%	11.4%	18,453	36.1%	14.2%
45-64	9,708	23.2%	9,762	21.3%	0.6%	9,812	19.2%	0.5%
65-74	2,457	5.9%	3,654	8.0%	48.7%	4,657	9.1%	27.5%
75-84	1,224	2.9%	1,636	3.6%	33.7%	2,564	5.0%	56.7%
85+	472	1.1%	536	1.2%	13.5%	575	1.1%	7.3%
Tot. 0-64	37,757	90.1%	39,986	87.3%	5.9%	43,333	84.8%	8.4%
Tot. 65 +	4,153	9.9%	5,825	12.7%	40.3%	7,796	15.2%	33.8%
Hispanic	21,674	51.7%	25,988	56.7%	19.9%	31,625	61.9%	21.7%
Fem. 15-44	8,236	19.7%	8,962	19.6%	8.8%	10,261	20.1%	14.5%

Source: Nielsen Claritas 2020 and includes: Prosser, Benton City, Paterson, Grandview and Mabton

In further support of the growth, and perhaps even in addition to the growth estimated in Table 3, more than 350 new home applications are currently under review at the City of Prosser. The City of Prosser has also indicated that it has had conceptual discussions for an additional 650 new homes over the next few years and we understand that about 400 of the proposed 650 had a 'good chance' of resulting in actual development applications.

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 1: Overview of the District and the District Service Area (continued):

D. Demographics – Service Area (continued):

Table 4 demonstrates that the communities of Prosser and Grandview have a higher percentage of Hispanic residents than the Service Area as a whole. The District proper is also growing faster than the communities of Grandview and Mabton as well as Yakima County. The Service Area is growing slightly slower than Benton County.

Table 4
Service Area Population Comparisons

	2020 Total Population	2030 Total Population	% Change 2020-2030	2020 Hispanic Population	% of Total	2030 Hispanic Population	% Change 2020-2030
99350 – Prosser	14,889	16,997	14.2%	7,019	47.1%	9,002	28.2%
99320 – Benton City	10,334	11,863	14.8%	2,545	24.1%	3,546	39.3%
99345 – Paterson *	PO Box, No Data						
Subtotal District	**25,223**	**28,860**	**14.4%**	**9,564**	**37.9%**	**12,548**	**31.2%**
98930 – Grandview	16,225	17,723	9.2%	12,808	78.9%	15,114	18.0%
98935 – Mabton	4,360	4,622	6.0%	3,613	82.9%	**4,007**	**10.9%**
Subtotal Service Area[3]	**45,808**	**51,205**	**11.8%**	**25,985**	**56.7%**	**31,669**	**21.9%**
Benton County	204,751	235,725	15.1%	46,821	22.9%	64,816	38.4%
Yakima County	257,195	277,954	8.1%	131,097	51.0%	158,998	21.3%
Washington	7,661,468	8,143,617	6.3%	1,012,383	13.2%	1,159,778	14.6%

*Source: Nielsen Claritas 2019. *Patterson is a PO Box and is reported with Prosser (99350).*

[3] *numbers may not match Table 3 exactly due to rounding.

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 1: Overview of the District and the District Service Area (continued):

E. Demographics - Emerging Market: Sunnyside:

As seen in **Table 5**, in 2020, Sunnyside has a total population of nearly 23,000, of which more than 80 percent is Hispanic. The community is exceptionally young with only 9.6 percent over the age of 65. Since the 2010 census, Sunnyside's total population grew by just over 4 percent, while the Hispanic population grew by almost 11 percent and the population age 65+ grew by nearly 12 percent. The growth in Sunnyside is less than the growth rate of the Service Area.

Sunnyside is expected to continue to grow (7.4 percent) through 2030, with the fastest growth continuing to be in the 65+ cohort and Hispanic populations. Again, and as with the Service Area, women of childbearing age are expected to continue to grow as well.

Table 5
Emerging Service Area – Sunnyside

	2010	Pct of Tot Pop	2020 Est	Pct of Tot Pop	Pct Chg. 2010-2020	2030 Proj	Pct of Tot Pop	Pct Chg. 2020-2030
Tot. Pop.	**21,879**	**100.0%**	**22,809**	**100.0%**	**4.2%**	**24,505**	**100.0%**	**7.4%**
Pop. By Age								
0-17	8,077	36.9%	8,115	35.6%	0.5%	8,355	34.1%	3.0%
18-44	8,034	36.7%	8,447	37.0%	5.1%	9,119	37.2%	8.0%
45-64	3,805	17.4%	4,054	17.8%	6.5%	4,487	18.3%	10.7%
65-74	999	4.6%	1,228	5.4%	22.9%	1,424	5.8%	16.0%
75-84	634	2.9%	642	2.8%	1.2%	833	3.4%	29.8%
85+	330	1.5%	323	1.4%	-2.1%	287	1.2%	-11.3%
Tot. 0-64	19,916	91.0%	20,616	90.4%	3.5%	21,962	89.6%	6.5%
Tot. 65 +	1,963	9.0%	2,193	9.6%	11.7%	2,543	10.4%	16.0%
Hispanic	16,939	77.4%	18,715	82.1%	10.5%	21,345	87.1%	14.1%
Fem. 15-44	4,505	20.6%	4,711	20.7%	4.6%	5,104	20.8%	8.3%

Source: Nielsen Claritas 2020

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 1: Overview of the District and the District Service Area (continued):

F. Demographics Service Area + Emerging Market:

Combined, the Service Area and the Emerging Market (Sunnyside) communities have a population of almost 70,000. Since 2010, the Service Area + Emerging Market has grown by nearly 8 percent. The Service Area + Emerging Market is younger than the state (12 percent age 65+) and is 65 percent Hispanic. Growth by 2030 is estimated to be 10.2 percent with the 65+ age cohort growing more than twice as fast. Females 15-44 are expected to continue to grow.

Table 6
Service Area + Sunnyside

	2010	Pct of Tot Pop	2020 Est	Pct of Tot Pop	Pct Chg. 2010-2020	2030 Proj	Pct of Tot Pop	Pct Chg. 2020-2030
Tot. Pop.	**63,789**	**100.0%**	**69,270**	**100.0%**	**7.6%**	**75,602**	**100.0%**	**10.2%**
Pop. By Age								
0-17	21,629	33.9%	22,186	32.3%	2.6%	23,421	31.0%	5.6%
18-44	22,531	35.3%	24,600	35.8%	9.2%	27,565	36.5%	12.1%
45-64	13,513	21.2%	13,816	20.1%	2.2%	14,290	18.9%	3.4%
65-74	3,456	5.4%	4,882	7.1%	41.3%	6,078	8.0%	24.5%
75-84	1,858	2.9%	2,278	3.3%	22.6%	3,389	4.5%	48.8%
85+	802	1.3%	859	1.3%	7.1%	859	1.1%	0.0%
Tot. 0-64	57,673	90.4%	60,603	88.3%	5.1%	65,277	86.3%	7.7%
Tot. 65 +	6,116	9.6%	8,019	11.7%	31.1%	10,325	13.7%	28.8%
Hispanic	38,613	60.5%	44,705	65.1%	15.8%	52,952	70.0%	18.4%
Fem. 15-44	12,741	20.0%	13,673	19.9%	7.3%	15,361	20.3%	12.3%

Source: Nielsen Claritas 2019

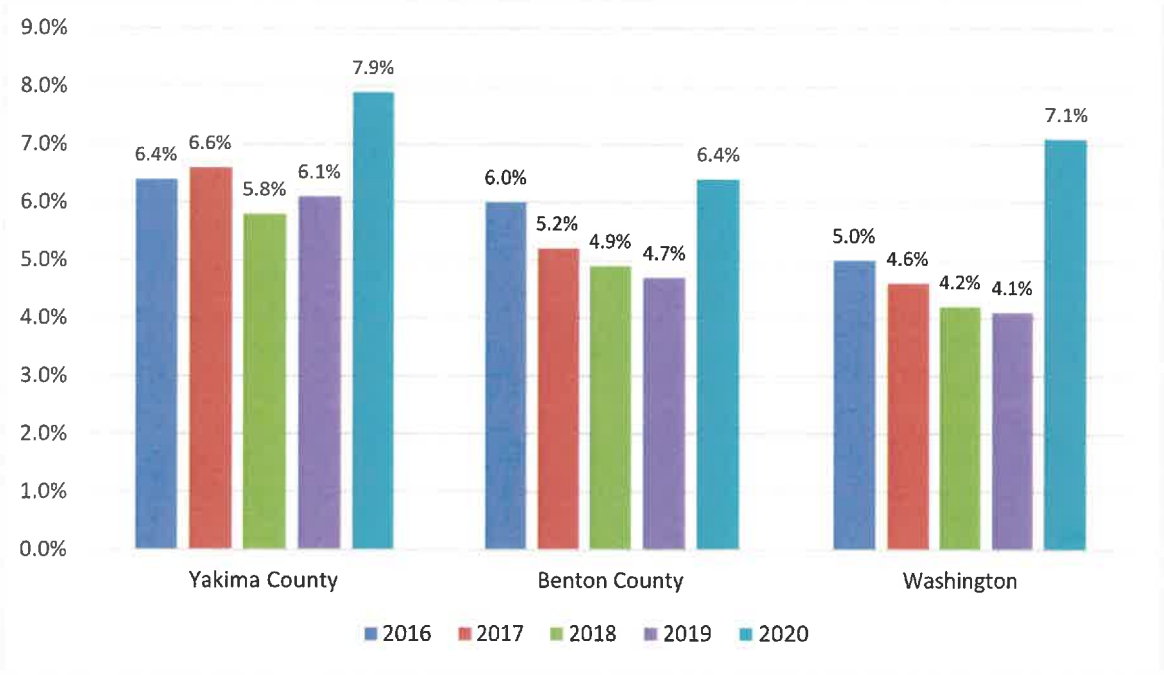
9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued):

G. Socioeconomic Characteristics and Social Determinants:

Unemployment data is available only at the County level. While unemployment rates had generally improved between 2016-2019, rates in Benton and Yakima Counties were still higher than that of Washington State. Benton County's unemployment decreased by 22 percent between 2016 (6.0 percent) and 2019 (4.7 percent). Comparatively, Washington State's unemployment rate decreased from 5.0 percent in 2016 to 4.1 percent in 2019 (a decrease of 18 percent). Yakima County's unemployment rate had also decreased since 2016, from 6.4 percent to 6.1 percent (a decrease of 5 percent). COVID-19 dramatically impacted these rates, but the December 2020 rates are better than they were in the early months of COVID. The data is summarized in **Figure 1**.

Figure 1
Unemployment Rates 2016- 2020*



Source: U.S. Bureau of Labor Statistics, Not Seasonally Adjusted,
**2020 data is December data from the WA State Employment Security Department*

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 1: Overview of the District and the District Service Area (continued):

G. Socioeconomic Characteristics and Social Determinants (continued):

Table 7 identifies the Service Area's major employers, which, except for the large Walmart distribution center, are generally agricultural, viticultural, or public.

Table 7
Employers, by Number of Employees within the Service Area

Employer	Employees
Ste. Michelle Wine Estates	1,100
Walmart Grocery Distribution Center	719
Grandview School PSA	562
FruitSmart	368 (218 in Prosser)
Prosser School PSA	316
PMH	300
WSU/Irrigated Agriculture Research and Extension Center	207
Benton County Government	144
Tree Top, Inc.	125
Milne Fruit	120
Yakima Valley Farm Worker's Clinic	116
Conrad Adams Fruit	100 + 316 seasonal
Chukar Cherries	100
Bleyhel Farm Services	89
J M Smucker Company	75
Yakima Valley College	70
Welch Grape	60
Zirkle Fruit	60 (in Prosser)
City of Grandview	58
Benton Rural Electric	54
City of Prosser	50
Shonan (USA)	50

Source: www.trytricitiessites.org; www.portofgrandview.org; www.prosser.org

In the Emerging Market, large employers include healthcare entities, the school district, agriculture, and local government.

Other social and economic factors including poverty levels, educational attainment, and income are typically referred to as the Social Determinants of Health.

The average household income for the entirety of Benton County, Yakima County, and the Service Area is lower than the state **(Table 8)**. All the communities within the Service Area have lower household incomes than Benton County and the state.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued):

G. Socioeconomic Characteristics and Social Determinants (continued):

Table 8
Average Household Income by Zip Code, Service Area and Emerging Market, 2019

	Average HH Income
Service Area	
99350 – Prosser (District)	$79,626
99320 – Benton City (District)	$83,538
99345 – Paterson (District)	PO Box Not Reported
98930 – Grandview	$62,868
98935 – Mabton	$62,457
Emerging Market	
98944- Sunnyside	$69,537
County and State	
Benton County	$90,475
Yakima County	$71,263
Washington	$101,633

*Source: Nielsen Claritas 2019. *Reported with Prosser (99350).*

The United Ways of the Pacific Northwest's ALICE report provides county-level estimates of ALICE households and households in poverty. ALICE is an acronym for Asset Limited, Income Constrained, Employed – households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the county (the ALICE Threshold). Combined, the number of ALICE and poverty-level households equals the total population struggling to afford basic needs. As **Table 9** indicates, the District, Service Area, and the Emerging Market all have higher percentages of ALICE households and a higher percentage of adults who did not graduate from high school, with Sunnyside reporting the highest percentage of population at or below poverty.

Table 9
Education and Income Indicators

	District	Service Area	Emerging Sunnyside	Benton County	Yakima County	WA
% at or below poverty*	10%	12%	22%	11%	17%	14%
% of Households either at or below poverty or ALICE (Asset Limited, Income Constrained, Employed)**	38%	39%	50%	31%	45%	33%
% of adults who reported that they did not graduate high school	13%	19%	23%	6%	19%	5%

*Source: *UDS Mapper, 2020, *American Community Survey Data, 2014-2018 *, all other sources from WA State BRFSS Data, 2014-2019*

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued):

H. Health Status:

The Robert Wood Johnson Foundation's County Health Rankings compares and ranks counties (relative to the health of other counties in the same state) on more than 30 health status indicators. 2020 summary composite scores for Benton County and Yakima County, compared to the state, are identified in **Table 10**.

Benton County is among the middle-tier of the 39 counties in Washington State regarding health outcomes and health factors, meaning they are similar to Washington State on many measures while Yakima County is in the lowest quartile. Out of Washington's 39 Counties, Benton County ranks 17th in health outcomes and 20th in health factors while Yakima County is ranked 34th in health outcomes and 36th in health factors. Health outcomes include mortality and morbidity and include such factors as premature death, poor or fair health, poor physical or mental health days, and low birthweight. Health factors include: clinical care (uninsured adults, primary care provider rates, preventable hospital stays, and diabetic screenings) and health behaviors (adult smoking, obesity, binge drinking, motor vehicle deaths, teen pregnancy, and sexually transmitted diseases).

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued):

H. Health Status (continued):

Table 10
County Health Status Indicators

	Washington	Benton	Yakima
Health Measures			
% of adults reporting poor or fair health	16%	16%	24%
% of adults who are current smokers	13%	13%	14%
% of adults (age 20+) that reports BMI greater or equal to 30	28%	31%	35%
Health Risks			
% of adults who report no leisure-time physical activity	17%	17%	23%
% Excessive Drinking (% of adults reporting binge or heavy drinking)	17%	18%	16%
Access to Care			
Primary Care Ratio	1,180:1	1,470:1	1,500:1
Dentist Ratio	1,230:1	1,430:1	1,490:1
Mental Health Ratio	270:1	390:1	320:1
Percent Uninsured	7%	10%	13%
Preventive Measures			
Preventable Hospitalization Stays (Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees)	2,969	4,336	3,770
% Flu Vaccinations (% fee-for-service Medicare enrollees that had an annual flu vaccination)	46%	50%	48%
% Mammography screening (% female Medicare enrollees ages 65-74 that received an annual mammography screening)	39%	44%	38%
Community Measures			
% of the ninth-grade cohort that graduates from high school in four years	79%	77%	79%
% Unemployed (civilian labor force, ages 16 and older, that is unemployed but seeking work)	4.5%	5.2%	6.3%
% Children in Poverty (people under the age of 18 in poverty)	13%	14%	21%
% Single-Parent Households	28%	29%	40%
Teen Birth Rate (per 1,000)	18	25	42

Source: County Health Rankings 2020

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 1: Overview of the District and the District Service Area (continued)

H. Health Status (continued):

In addition to the above, the Service Area was evaluated for various chronic disease metrics. As **Table 11** indicates, the self-reported rates of having diabetes or being overweight or obese were higher in the Service Area and Emerging Market. These two areas also self-reported that they were less likely to exercise.

Table 11
Health Risk Factor by Geography

	District	Service Area	Emerging - Sunnyside	Benton County	Yakima County	WA
% of Adults ever told that they have angina or coronary heart disease?	3%	3%	4%	5%	6%	5%
% of Adults ever told that they have diabetes	14%	17%	20%	12%	15%	12%
% of Adults ever told that they have asthma	12%	13%	12%	16%	14%	15%
% of Adults ever told that they have a depressive disorder	20%	18%	13%	21%	20%	22%
% of Adults ever told that they are obese	30%	32%	30%	29%	31%	26%
% of Adults who are binge drinkers	16%	12%	10%	13%	10%	12%
% of Adults who report they smoke	9%	9%	7%	10%	11%	11%
% of Adults who report during the past month, other than at their regular job, did not participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise.	24%	29%	27%	18%	26%	18%

WA State BRFSS 2011-2019

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles:

A. Service Area Inpatient Volumes:

Hospital inpatient data was obtained from the Washington State Comprehensive Hospital Abstract Reporting System (CHARS) for the period of 2014 to 2020[4].This data represents every hospitalization (defined as a patient in a bed at midnight) occurring in a Washington hospital regardless of payer.

As identified in **Figure 2**, Total inpatient days for patients residing in the Service Area totaled 13,801 in 2020[5]. Days in the Service Area have grown a total of 11.8 percent since 2014, the District's days from the Service Area grew even faster (27 percent). In addition, the District's total days (regardless of where the patients resided) increased by 60 percent during the same time period.

Figure 2
Service Area Patient Days and the District's (PMH) Patient Days from Service Area: 2014-2020

Source: Washington CHARS State database, 2014-2020, excludes all newborns, swing beds and observation. 2018 and 2019 adjusted for Astria Sunnyside underreporting

[4] Less than 1% of Service Area discharges went to an Oregon Hospital.
[5] Please note that Astria Sunnyside did not report any inpatient data for the five months of the second half of 2018; likely due to issues related to its electronic medical record conversion. In addition, Astria Sunnyside's 2019 data is also underreported. HFPD has adjusted Astria Sunnyside's 2019 data using total discharges and days from its Department of Health Year End Report.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

B. Hospitals Serving the Service Area:

Table 12 depicts the hospitals providing the predominance of care to Service Area residents. It also depicts their total inpatient days between 2014 and 2020. The top hospitals include the District, Kadlec Regional Medical Center (Richland), and Astria Sunnyside Hospital (Sunnyside). Additionally, there are other providers in the Tri-Cities to which Service Area residents are admitted, including Trios Health and Lourdes Medical Center; as well as other Yakima County providers, primarily Virginia Mason Memorial.

The District experienced a nearly 3 percent average annual increase in market share of patient days from the Service Area between 2014-2020 (an increase of 1.0 in ADC).

On any given day in 2020, a total of 38 residents of the Service Area were hospitalized as an inpatient in a Washington hospital; this is an increase in ADC of 4.2 over 2014. The District's market share was about 12 percent. Over the same period, Astria Sunnyside Hospital, other Yakima hospitals, and Seattle tertiary providers lost market share.

Table 12
Market Share of Service Area Inpatient Days
2014 to 2020

Hospital Name	2014 ADC	2014 Market Share	2015 Market Share	2016 Market Share	2017 Market Share	2018 Market Share	2019 Market Share	2020 Market Share	2020 ADC	Average Annual change
The District	3.5	10.5%	12.4%	11.2%	12.9%	11.5%	12.8%	11.9%	4.5	2.8%
Astria Sunnyside	5.9	17.3%	15.4%	14.9%	15.1%	11.6%	13.9%	10.7%	4.0	-6.5%
Kadlec Regional Medical Center	12.8	37.9%	39.7%	40.0%	40.9%	40.2%	41.4%	43.0%	16.3	2.1%
Trios Health	1.0	2.9%	4.5%	3.8%	3.3%	3.5%	4.2%	4.8%	1.8	11.1%
Spokane Tertiary[6]	0.9	2.8%	4.3%	3.1%	4.6%	5.6%	5.9%	8.4%	3.2	22.9%
Seattle Tertiary[7]	4.9	14.6%	10.9%	14.3%	12.1%	13.0%	9.0%	10.4%	3.9	-2.9%
Other Yakima County[8]	2.4	7.2%	6.3%	6.2%	4.9%	5.1%	6.2%	3.9%	1.5	-7.8%
All Other	2.3	6.8%	6.5%	6.5%	6.2%	9.50%	6.60%	6.9%	2.7	4.0%
Total Service Area	**33.8**[9]	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**37.9**	**3.2%**

Source: Washington CHARS State database, 2014-2020, excludes all newborns, swing beds and observation.

[6] Spokane Tertiary includes: Providence Sacred Heart Medical Center, Deaconess Hospital, Providence Holy Family Hospital and Valley Hospital.
[7] Seattle Tertiary includes: UW/Harborview Medical Center, UWMC, Seattle Cancer Care Alliance, Seattle Children's Hospital, Swedish First Hill, Swedish Cherry Hill, Virginia Mason Medical Center and Mary Bridge Children's Hospital (Tacoma).
[8] Other Yakima includes: Astria Yakima Regional Medical and Cardiac Center (which closed in January 2020), Astria Toppenish and Yakima Valley Memorial Hospital.
[9] Numbers may not add exactly due to rounding.

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

B. Hospitals Serving the Service Area (continued):

Table 13 provides detail regarding patient days and ADC by age cohort (0-64 and 65+) for the Service Area. This analysis is provided to understand the different utilization between the two age groups. As Table 13 indicates, the 65+ age cohort (which is about 13 percent of the total population) accounted for more than 46 percent of the patient days in 2020.

As depicted in **Table 13**, the average daily census (ADC) of Service Area patients increased from 33.8 to 37.9 in 2020.

Table 13
Days and ADC by Age Cohort for the Service Area, 2014-2020

		Patient Days	ADC
2014	0 to 64	7,655	21.0
	65 plus	4,694	12.9
	Total	**12,349**	33.8
2015	0 to 64	6,885	18.9
	65 plus	5,416	14.8
	Total	**12,301**	33.7
2016	0 to 64	7,411	20.3
	65 plus	5,546	15.2
	Total	**12,957**	35.5
2017	0 to 64	7,415	20.3
	65 plus	5,948	16.3
	Total	**13,363**	36.6
2018	0 to 64	7,589	20.8
	65 plus	6,083	16.7
	Total	**13,672**	37.5
2019	0 to 64	7,526	20.6
	65 plus	6,028	16.5
	Total	**13,554**	37.1
2020	0 to 64	7,428	20.4
	65 plus	6,373	17.5
	Total	**13,801**	37.8

Source: Washington CHARS State database, 2014-2020, excludes all newborns, swing beds and observation.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued)

B. Hospitals Serving the Service Area (continued):

Service Area residents' highest volume service lines were General Medicine, General Surgery, OB/Delivery, Orthopedics, Gastroenterology, and Medical Cardiology. The same is true for the Emerging Market. **Table 14** shows Service Area resident patient days by service line from 2014 to 2020. The fastest growing services lines (since 2014), in terms of number of days, were general medicine, medical cardiology, and psychiatry[10].

Table 14
Service Area Resident Days by Service Line, 2014, 2019, and 2020

Service Line	2014 Patient Days	2020 Patient Days	Change 2014-2020	PMH 2014 Market Share	PMH 2020 Market Share	PMH Change 2014-2020
General Medicine	2,945	4,521	53.5%	15.1%	16.4%	8.7%
General Surgery	2,062	1,767	-14.3%	1.5%	5.9%	292.4%
OB/Delivery	1,382	1,045	-24.4%	19.8%	45.8%	131.5%
Orthopedics	1,051	1,011	-3.8%	13.3%	5.4%	-59.1%
Gastroenterology	997	690	-30.8%	11.9%	10.4%	-12.3%
Medical Cardiology	606	769	26.9%	13.9%	9.1%	-34.5%
Other	390	598	53.3%	5.6%	3.7%	-34.3%
Psychiatry	476	644	35.3%	2.1%	1.9%	-11.3%
Neurosciences	549	728	32.6%	8.2%	5.2%	-36.3%
Oncology	440	513	16.6%	3.2%	3.3%	3.6%
Rehabilitation	461	484	5.0%	8.9%	0.0%	-100.0%
Cardiac Surgery	423	581	37.4%	0.0%	0.0%	0.0%
Interventional Cardiology	209	196	-6.2%	0.0%	0.0%	0.0%
Other OB	96	84	-12.5%	22.9%	14.3%	-37.6%
Gynecology	135	28	-79.3%	28.9%	10.7%	-62.9%
Urology	127	142	11.8%	5.50%	9.2%	66.5%
Total	**12,349**	**13,801**	**11.8%**	**10.5%**	**11.9%**	**13.1%**

Source: Washington CHARS State database, 2014-2020 excludes all newborns, swing beds and observation.

C. Service Area Resident Inpatient Market Share by Provider:

Table 15 depicts market share and top competitors for each major inpatient service line. The data shows that Kadlec Regional Medical Center (Kadlec), a tertiary regional provider located in Richland, has the largest market share in the Service Area at 41 percent; about three times that of the District. The District enjoys the second largest market share, and its market share increased from 10.5 percent in 2014 to 11.9 percent in 2020; an increase of 13 percent. During the same period, it is estimated that Astria Sunnyside lost nearly 20 percent of its market share.

[10] Excludes other as this is a 'catch all' category.

Table 15
Service Area Market Share by Hospital & Service Line, 2014 & 2020, (Patient Days)

		ADC	PMH	Kadlec Regional Medical Center	Astria Sunnyside Hospital	Trios Health	Other Yakima County	Spokane Tertiary	Seattle Tertiary	All Other
Cardiac Surgery	**2014**	1.2	0.0%	54.8%	0.0%	0.0%	22.2%	20.1%	2.8%	0.0%
	2020	1.6	0.0%	40.4%	0.2%	0.0%	0.0%	29.6%	28.6%	1.2%
Cardiology	**2014**	1.7	13.9%	28.9%	28.9%	3.3%	10.7%	3.6%	4.0%	10.0%
	2020	2.1	9.1%	59.0%	15.5%	6.2%	4.4%	3.5%	1.7%	0.6%
Gastroenterology	**2014**	2.7	11.9%	43.4%	20.8%	3.0%	9.1%	0.9%	9.2%	5.1%
	2020	1.9	10.4%	51.9%	19.4%	3.0%	4.8%	4.6%	3.6%	2.3%
General Medicine	**2014**	8.1	15.1%	44.3%	22.5%	2.8%	6.0%	1.9%	5.1%	5.1%
	2020	12.4	16.4%	41.8%	14.3%	6.3%	4.15%	8.5%	4.4%	4.2%
General Surgery	**2014**	5.6	1.5%	33.3%	9.8%	1.8%	4.8%	2.9%	44.4%	3.9%
	2020	4.5	5.9%	53.0%	6.6%	2.7%	5.4%	11.2%	12.6%	2.6%
Gynecology	**2014**	0.4	28.9%	23.7%	34.1%	3.7%	7.4%	0.0%	1.5%	5.9%
	2020	0.1	10.7%	53.6%	14.3%	0.0%	0.0%	0.0%	21.4%	0.0%
Interventional Cardiology	**2014**	0.6	0.0%	57.9%	0.0%	1.9%	37.8%	0.0%	2.4%	1.9%
	2020	0.5	0.0%	60.7%	3.6%	8.2%	4.1%	5.1%	11.7%	6.6%
Neurosciences	**2014**	1.5	8.2%	37.3%	13.1%	2.8%	2.7%	3.8%	29.7%	5.5%
	2020	2.0	5.2%	40.8%	2.9%	5.4%	0.0%	15.7%	22.5%	7.5%
OB/Delivery	**2014**	3.8	19.8%	30.4%	37.3%	6.5%	3.5%	0.1%	2.2%	6.7%
	2020	2.9	45.8%	31.6%	13.8%	4.3%	3.5%	0.0%	1.0%	0.0%
Oncology	**2014**	1.2	3.2%	57.5%	3.9%	10.0%	14.3%	2.0%	9.1%	10.9%
	2020	1.4	3.3%	53.2%	2.7%	3.5%	6.2%	11.7%	17.0%	2.4%
Orthopedics	**2014**	2.9	13.3%	35.7%	13.2%	1.6%	6.9%	1.6%	11.6%	18.8%
	2020	2.8	5.4%	39.8%	8.9%	8.1%	1.9%	7.8%	23.3%	4.8%
Other	**2014**	1.1	5.6%	27.7%	10.0%	0.3%	7.9%	6.7%	41.0%	1.0%
	2020	1.6	3.7%	20.6%	19.7%	8.4%	0.7%	7.2%	27.1%	12.6%
Other OB	**2014**	0.3	22.9%	37.5%	28.1%	4.2%	5.2%	0.0%	2.1%	4.2%
	2020	0.2	14.3%	65.5%	1.2%	0.0%	9.5%	0.0%	9.5%	0.0%
Psychiatry	**2014**	1.3	2.1%	4.2%	4.8%	2.9%	2.5%	2.7%	2.9%	82.6%
	2020	1.8	1.9%	17.4%	9.3%	1.9%	8.5%	3.9%	0.2%	56.9%
Rehabilitation	**2014**	1.3	8.9%	55.7%	0.0%	0.0%	1.7%	0.0%	8.0%	25.6%
	2020	1.3	0.0%	56.8%	0.0%	0.0%	0.0%	0.0%	16.7%	26.5%
Urology	**2014**	0.3	5.5%	16.5%	8.7%	3.9%	15.7%	18.9%	28.3%	7.1%
	2020	0.4	9.2%	41.5%	0.0%	3.5%	18.3%	8.5%	19.0%	0.0%
Total	**2014**	**33.8**	**10.5%**	**37.9%**	**17.3%**	**2.9%**	**7.2%**	**2.8%**	**14.6%**	**10.1%**
	2020	**37.8**	**11.9%**	**43.0%**	**10.7%**	**4.8%**	**3.9%**	**8.4%**	**10.4%**	**10.8%**

Source: Washington CHARS State database, 2014-2020, excludes all newborns, swing beds and observation.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

D. Inpatient Payer Mix of Service Area Residents:

Data in **Table 16** shows that Medicare is the primary payer for patient days in the Service Area, followed by Commercial & HMO. Nearly two-thirds of all patient days are paid for by Medicare and Medicaid. Both Medicare (7 percent) and Medicaid (21 percent) increased as a payor from 2014-2020. However, that could be attributable to some hospitals reporting Medicaid Managed Care as commercial or HMO. The available data shows that the District's percentage Medicaid increased significantly and surpassed the Service Area rate in 2020.

Table 16
Provider Inpatient Payer Mix (Days) of Service Area Residents, 2014 and 2020

	Commercial & HMO		Medicaid		Medicare		Self-Pay & Other	
	2014	**2020**	**2014**	**2020**	**2014**	**2020**	**2014**	**2020**
The District	48%	19%	10%	31%	41%	43%	1%	7%
Kadlec Regional Medical Center	32%	20%	11%	21%	52%	52%	5%	7%
Astria Sunnyside Hospital	15%	10%	44%	30%	37%	59%	4%	2%
Trios Health	54%	21%	8%	24%	37%	54%	1%	1%
Other Tri-Cities	30%	22%	1%	23%	67%	55%	2%	1%
Other Yakima County	45%	33%	21%	25%	32%	38%	1%	4%
Spokane Tertiary	34%	11%	26%	50%	37%	37%	3%	1%
Seattle Tertiary	22%	31%	49%	36%	24%	31%	5%	2%
All Other	22%	11%	35%	40%	39%	21%	5%	4%
Service Area Total	**30%**	**21%**	**24%**	**29%**	**42%**	**45%**	**4%**	**5%**

Source: Washington CHARS State database, 2014-2020, excludes all newborns, swing beds and observation.
NOTE: Astria Sunnyside Hospital is actual data as submitted

The emerging market has less commercial (24 percent in 2014 and 22 percent in 2020), higher Medicaid (32 percent), and the same self-pay (5 percent) in comparison to the Service Area in 2020.

E. Service Area Swing Bed Volumes:

There were 66 swing bed discharges associated with Service Area residents in 2020 and 97 percent occurred at the District, which is logical as the District operates the most robust swing bed program in Benton or Yakima County. Astria Sunnyside has five swing beds but has not consistently provided swing bed services. Discharges in the Service Area peaked in 2017 (**Figure 3**) and have declined in the past three years. In 2020, swing bed census represented an ADC of 3.0.

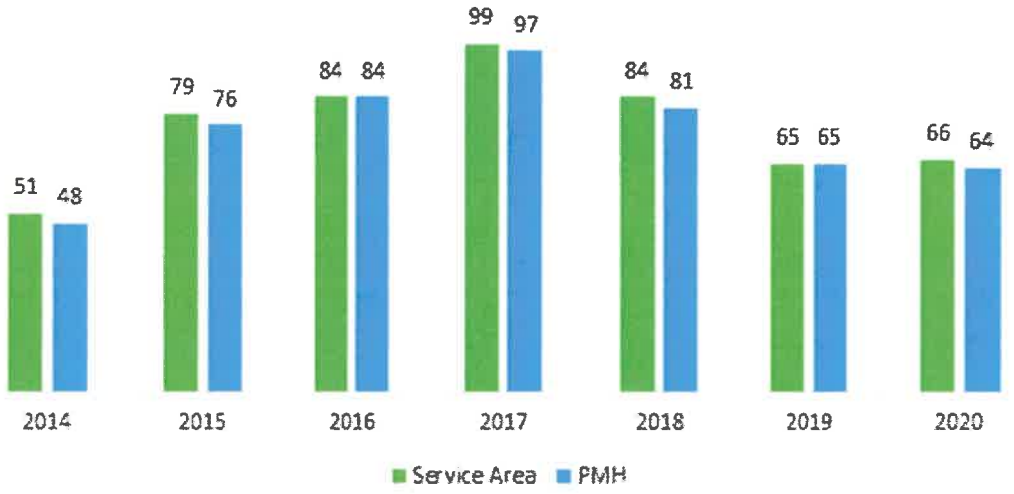
In the emerging market, swing bed discharges are small in number (ranging from a low of 4 in 2014 to a high of 15 in 2015 and 2020). The District has by far the largest market share of these discharges, which ranged from a low of 83 percent (2018) to a high of 100 percent (2014 and 2016).

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

E. Service Area Swing Bed Volumes (continued):

Figure 3
Service Area Swing Bed Discharges, 2014-2020



Source: Washington CHARS State database, 2014-2019. Distinct swing bed unit only.

F. Service Area Outpatient Volumes:

To estimate outpatient Service Area volume, HFPD obtained outpatient estimates from IBM Truven (Truven) Analytics' Outpatient Profiles, Code Profiles. Truven collects governmental and select commercial outpatient claims data at the CPT code level, and then develops a proprietary algorithm for unavailable claims and produces zip code level estimates at the CPT level. **Table 17** shows the largest service lines (by volume) in the Service Area, which include lab, physical therapy, X-Ray, emergency department (ED), and outpatient surgery (minor[11]). The largest service lines by market share include, CT, ultrasound, mammography, echocardiography, and ED.

[11] Truven defines minor surgery as those occurring in Hospital Outpatient Departments and Physician offices; while major surgery is defined as those procedures occurring in ORs.

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

F. Service Area Outpatient Volumes (continued):

Table 17
Service Area Market Outpatient Volumes & the District's (PMH) Market Share, 2016-2020

Service Line	2016 PMH Market Share	2017 PMH Market Share	2018 PMH Market Share	2019 PMH Market Share	2020 PMH Market Share	2020 Service Area Volumes
Lab Tests	20.3%	19.5%	22.1%	21.7%	19.1%	330,354
Physical Therapy sessions	20.7%	24.2%	25.6%	22.5%	18.9%	95,797
X-Ray Procedures	20.9%	21.9%	22.5%	29.7%	35.8%	24,264
Emergency Department	65.9%	70.7%	78.2%	81.1%	60.5%	22,078
Outpatient Surgery procedures, minor	5.9%	5.8%	6.2%	6.6%	6.6%	15,568
Outpatient Surgery procedures, major	11.5%	14.2%	15.0%	15.7%	14.4%	7,893
CT Procedures	23.0%	24.1%	41.3%	59.5%	55.0%	7,516
Ultrasound - Other procedures	22.2%	30.3%	45.1%	67.4%	56.4%	6,796
Mammography procedures	28.2%	31.7%	44.9%	70.0%	64.7%	5,263
MRI Procedures	9.9%	12.1%	22.1%	31.4%	29.3%	4,185
Ultrasound - OB procedures	46.6%	35.9%	65.3%	100.4%*	83.0%	3,511
Gastroenterology Endoscopy Procedures	10.7%	12.3%	11.4%	13.5%	7.0%	2,998
Echocardiography	28.8%	30.6%	39.3%	38.8%	45.4%	2,121
Chemotherapy visits	0.0%	0.0%	0.0%	0.0%	0.8%	1,450
Cardiac Rehab visits	0.0%	0.0%	0.0%	0.0%	0.0%	1,321
Occupational Therapy sessions	0.0%	0.0%	0.0%	0.0%	0.0%	445
Nuclear Medicine	0.0%	0.0%	0.0%	0.0%	0.0%	295

Source: IBM Watson/Truven Analytics outpatient estimates

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

F. Service Area Outpatient Volumes (continued):

Table 18 shows the current Service Area volumes for new and established patient office visits. The District's market share is comparable to what HFPD has seen in other rural markets.

Table 18
Service Area Outpatient Office Visit by Type & the District's (PMH) Market Share 2016-2020

Office Visit Type	2016 PMH Market Share	2017 SA Volumes	2017 PMH Market Share	2018 SA Volumes	2018 PMH Market Share	2019 SA Volumes	2019 PMH Market Share	2020 SA Volumes	2020 PMH Market Share
New Patient	12.0%	21,185	17.8%	21,929	19.6%	22,131	15.3%	22,364	23.4%
Established Patient	6.8%	140,312	7.5%	141,795	10.3%	143,102	9.1%	144,611	13.8%
Total	**7.5%**	**161,497**	**8.9%**	**163,724**	**11.6%**	**165,233**	**9.9%**	**166,975**	**15.1%**

Source: IBM Watson/Truven Analytics outpatient estimates

The District's volumes from the emerging market for outpatient services have increased consistently since 2016, with a slight decrease from 2019 to 2020; growth is seen across the board in nearly all service lines, again, with a slight decrease from 2019 to 2020.

G. Other Providers and Competitors Serving the Service Area and Emerging Market:

An overview of each of the major providers in the market is below:

Kadlec Regional Medical Center

Kadlec Regional Medical Center (Kadlec), located in Richland, WA, opened in 1944 to care for Hanford workers and their families. Today Kadlec is currently licensed for 337 beds, with 254 available (having received certificate of need approval to add 68 beds in August 2019)[12]. Over the past 10 years, Kadlec has increased its licensed bed capacity from 203 to 337.

Approximately 58 percent of Kadlec's patients come from Benton County and 7.7 percent from the Service Area. Kadlec's market share of Benton County is nearly 53.7 percent and its market share of the Service Area is 42 percent. Another 1 percent of its patients come from the Emerging Market and it has a 3 percent market share of this area.

[12] Kadlec's 2019 Department of Health Year End Report (the most recent available) reported 254 available beds.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

G. Other Providers and Competitors Serving the Service Area and Emerging Market (continued):

Kadlec Regional Medical Center (continued)

In 2014, Kadlec became part of Providence Health & Services. Organizationally, Kadlec operates under Western HealthConnect, which is the entity that allows Providence Health & Services to affiliate with non-religious secular organizations.

Kadlec offers primary and specialty care including open-heart surgery and interventional cardiology, the region's only level III Neonatal Intensive Care Unit, acute rehabilitation, and an all-digital outpatient imaging center, as well as a number of other services and programs. Kadlec also operates express clinics, and a total of 48 other clinics in six communities, offering 26 specialties.

Kadlec is 26.7 miles and 31 minutes from the District under normal drive times.

Astria Sunnyside Hospital

Astria Sunnyside Hospital was formed with the consolidation of two hospitals (Valley Memorial Hospital and Sunnyside General Hospital) in 1986. Astria Sunnyside became a CAH in 2004 and offers a Level IV Emergency Room, Intensive Care Unit, a Level 1 Cardiac facility, a Cancer Center, a Family Birth Center, Nephrology, inpatient and outpatient surgical services, wound care including a hyperbaric chamber, intensive outpatient behavioral health services, and outpatient speech and hearing services. In December 2020, Astria Sunnyside received certificate of need approval to establish an adult elective PCI program.

Astria Sunnyside's 2019 market share of Benton County is less than 1 percent and its market share of the Service Area is 14 percent. Its market share of the District's Emerging Market, the geography in which it is physically located, was 47.7 percent in 2014 and was approximately 41.8 percent in 2019.

Astria Sunnyside received a determination of nonreviewability from the Department of Health to replace its current hospital in 2015. Astria Sunnyside became an affiliate of nonprofit Astria Health in September 2017. In May 2019, Astria Health filed for Chapter 11 bankruptcy citing issues with an electronic health records system and the company it hired to manage its revenue cycle in 2018. Astria Health was expected to emerge from bankruptcy at the end of 2019; however, it is now expected in Quarter 1, 2021. In December 2020, it was announced that MultiCare Health System would provide Astria Health with a $75 million loan that would be used to pay off creditors and allow it to exit from bankruptcy, subject to approval by the bankruptcy court.

In addition to the hospital, Astria Sunnyside also operates several clinics including one in Prosser (the Astria Health Center, located on Chardonnay Avenue). This clinic provides primary care/family medicine and walk-in/urgent care. Astria Sunnyside also operates a clinic in Grandview, offering primary care/family medicine, internal medicine, and orthopedics.

Astria Sunnyside Hospital is 17.3 miles and 23 minutes from the District under normal drive times.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

G. Other Providers and Competitors Serving the Service Area and Emerging Market (continued):

Trios Health

Trios is a 110-bed acute care hospital, operating two campuses (Southridge, which opened in 2014 and Auburn Campus, which offers women's and children's services). Formerly Kennewick General Hospital, it was owned and operated by Kennewick Public Hospital District. In the Spring of 2018, the District filed for bankruptcy, and the Hospital was acquired by LifePoint in August 2018. In February of 2021, Trios received CN approval to consolidate the two campuses at the Southridge location.

Trios' 2019 market share of Benton County is 17.2 percent and its market share of the Service Area is 4.2 percent. Its market share of the District's Emerging Market is 1.3 percent.

Lourdes Medical Center/Lourdes Counseling Center

LifePoint Health also acquired Lourdes Medical Center and Lourdes Counseling Center in late 2018. Lourdes Medical Center is a 25-bed critical access hospital with a 10-bed acute rehab unit. It is located in Pasco in Franklin County (adjacent to Benton County). Lourdes Medical Center's 2019 market share of Benton County is 4.3 percent and its market share of the Service Area is 2.2 percent. Its market share of the emerging market is 1.0 percent. Lourdes Medical Center is 36 miles and 36 minutes from the District under normal drive times.

Lourdes Counseling Center is a 32-bed psychiatric hospital located in Richland. Lourdes Counseling Center's overall 2019 market share of Benton County is 4.2 percent (but it had a 50 percent market share of psychiatric patient days). Its overall market share of the Service Area is 2.0 percent (but it had a 42 percent market share of psychiatric days). Its market share of the emerging market just for psychiatric days is about 16 percent (and 1.0 percent for its overall market share). Lourdes Counseling Center is 27.9 miles and 30 minutes from the District under normal drive times.

Yakima Valley Memorial Hospital (Yakima Valley Memorial)

Yakima Valley Memorial is a 226-bed acute-care, not-for-profit community hospital that has served Central Washington's Yakima Valley for nearly 70 years. With the closure of Astria Regional in 2020, Yakima Valley Memorial is the only hospital in the City of Yakima. In 2016, Yakima Valley Memorial merged with Virginia Mason Medical Center in Seattle and became Virginia Mason Memorial. The merger was designed to bring resources from Virginia Mason in Seattle to Virginia Mason Memorial including expanded services. In late 2020, the board of Virginia Mason Memorial decided to end the relationship with Virginia Mason and to become Yakima Valley Memorial again. The reason cited was the pending merger/affiliation between Virginia Mason and CHI Franciscan. Yakima Valley Memorial says that it will remain independent but continue its relationship with Virginia Mason for referrals and other health-related matters.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 2: Service Area Resident Inpatient and Outpatient Volumes, the District's Market Shares and Competitor Profiles (continued):

G. Other Providers and Competitors Serving the Service Area and Emerging Market (continued):

Yakima Valley Memorial Hospital (Yakima Valley Memorial) (continued)

Yakima Valley Memorial operates six primary care clinics including two outside of the City of Yakima (one in Selah and one in Zillah).

Yakima Valley Memorial is 53 miles and 56 minutes from the District under normal drive times.

Yakima Valley Farm Workers Clinics

Yakima Valley Farm Workers (YVFW) Clinic operates 25 medical and 13 dental community health centers. Within the Service Area, their clinics include Valley Vista Medical Group in Prosser (offering primary care, internal medicine, pre-natal and post-partum care, MAT treatment, and behavioral health services) and Mountainview Women's Health Center and Grandview Medical/Dental Clinic in Grandview. In the Emerging Market, their clinics include Sunnyside Immediate Care and Community Dental Care.

Annually, YVFW services nearly 200,000 patients; resulting in nearly 750,000 patient encounters. According to UDS Mapper, YVFW is the dominant provider of community health center patients in the Service Area and its market share ranges from a low of 60 percent (Benton City) to a high of 94 percent (Prosser).

The District signed a Memorandum of Understanding with YVFW in June 2020 to share on-call coverage for the District's pediatric hospital admissions and OB/GYN between the District's providers and YVFW's providers. As YVFW had been referring many of its patients to Astria Sunnyside Hospital in recent years, this agreement is expected to increase referrals to the District and to thereby increase patient volumes during the forecast period.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 3: Future Service Area Demand (Inpatient and Outpatient) and Estimated District Volumes:

This section estimates inpatient and outpatient utilization for the Service Area as well as the District. The target year for the projections is 2030.

A. Inpatient:

Use rates for the Service Area were calculated from the 2019 State's CHARS inpatient database and Claritas 2019 population data. The use rates were applied to population estimates for 2020, 2025 and 2030 to estimate future patient days. Patient day utilization and use rates were estimated separately for the 0-64 and 65+ age cohorts as these sub-populations have different rates of inpatient use (**Table 19**). 2019 use rates were used to project future utilization because they have been relatively flat since 2016.

Current acute care use rates for the Service Area are low (275.1 per 1,000 population) and are lower than Benton County (321.9 per 1,000 population), Yakima County (297.1 per 1,000 population), and the State (303.6 per 1,000 population).

HFPD ran two scenarios. In the first scenario, the District's Service Area market share was held constant at actual 2020 levels as was in-migration from the Emerging Market and other areas.

In a second scenario, the District's Service Area market share was trended through 2025 at the rate of growth from 2014 to 2020. The rate of in-migration to the District was held at 2019 levels.

Under Scenario 1, acute care inpatient days for the Service Area are expected to increase by 23 percent and observation days by 20 percent by 2030. Even with no increases in market share or in-migration, the District would expect 550 more acute care days (ADC +1.5) and an additional 159 observation days (ADC +.4) by 2030. Table 19 reflects this information. Swing bed use rates and market share were held at 2019 levels and by 2030 a total ADC of 7.6 for the District is estimated. (Table 19).

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 3: Future Service Area Demand (Inpatient and Outpatient) and Estimated District Volumes (continued):

A. Inpatient (continued):

Table 19 (Scenario 1)
District (PMH) Service Area Inpatient 2019 Use Rates, 2025 and 2030 Projections

Service	2019 PMH SA Use Rate (per 1,000)	2019 PMH Service Area Volumes	2019 PMH ADC	2019 PMH Market Share	2025 Projected District Volumes	2025 PMH Projected Volumes	2025 PMH ADC	2030 Projected PMH SA Volumes	2030 PMH Projected Volumes	2030 PMH ADC
Med/Surg										
0-64	137.9	471	1.3	8.6%	5,739	609	1.7	5,971	634	1.7
65+	1,002.3	770	2.1	13.6%	6,740	1,104	3.0	7,780	1,275	3.5
Total	1,140.2	1,241	3.4	22.2%	12,479	1,713	4.7	13,751	1,909	5.2
OB/Delivery & Other OB										
Total	149.7	495	1.4	37.4%	1,436	918	2.5	1,536	982	2.7
Acute Care Total										
0-64	171.3	970	2.7	14.3%	7,175	1,527	4.18	7,508	1,616	4.4
65+	1,002.3	770	2.1	13.6%	6,740	1,104	3.03	7,780	1,275	3.5
Total	275.1	1,740	4.8	14.0%	13,915	2,631	7.21	15,287	2,891	7.9
Observation										
0-64	36.0	342	0.9	15.9%	1,500	361	0.99	1,561	376	1.03
65+	163.9	262	0.7	28.0%	1,102	372	1.02	1,272	429	1.18
Total	**52.0**	**604**	**1.6**	**20.7%**	**2,602**	**733**	**2.01**	**2,833**	**805**	**2.21**
Swing Beds										
0-64	2.4	96	0.3	100%	101	133	0.36	105	139	0.38
65+	140.4	795	2.2	100%	944	2,281	6.25	1,090	2,633	7.21
Total	**19.7**	**891**	**2.4**	**100%**	**1,045**	**2,414**	**6.61**	**1,195**	**2,771**	**7.6**

Source: WA CHARS Inpatient Database 2019. Population data from Claritas 2019, 2025, and 2030 Excludes all newborns, psychiatry, and rehabilitation service lines.

In Scenario 2, use rates are the same as Scenario 1, but market share for acute care only is trended and increased to 16.4 percent and in-migration is held flat at acute 2020 levels. In Scenario 2, total acute care ADC at the District increases in 2030 to 10.4 (or +2.2 ADC increase over the projections from Scenario 1). Observation market share was not trended because, despite some ups and downs, it was virtually unchanged between 2014 and 2020.

9. Summary of Significant Demand Forecast Assumptions (continued):

Section 3: Future Service Area Demand (Inpatient and Outpatient) and Estimated District Volumes (continued):

A. Inpatient (continued):

Table 20 (Scenario 2)
District (PMH) Total Inpatient Days Assuming 2019 Use Rates, Trended Market Share, 2025 and 2030 Projections

Service	2025 Patient Days	2025 ADC	2030 Patient Days	2030 ADC
Med/Surg	**2,194**	6.0	2,443	6.7
OB/Other OB	1,175	3.2	1,257	3.4
Acute Care Total	**3,368**	**9.2**	**3,700**	**10.1**

Source: WA CHARS Inpatient Database 2019. Population data from Claritas 2019, 2025, and 2030 Excludes all newborns, psychiatry, and rehabilitation service lines., and swing beds.

B. Outpatient:

Outpatient use rates were computed for the Service Area using available outpatient data from IBM Watson/Truven and Claritas population estimates for 2020 and 2025. Because IBM Watson/Truven provides only overall use rates, the data in this section is not age-specific. Use rates were calculated for select service lines in 2020 and conservatively held constant throughout the projection period such that incremental growth in volume is due solely to population change. Details are provided in **Table 21**. In-migration was held flat at 2020 levels and ranged from a low of 8 percent (physical therapy) to a high of 35 percent (outpatient surgery). The growth in population results in additional volumes for the District by 2025.

9. **Summary of Significant Demand Forecast Assumptions (continued):**

Section 3: Future Service Area Demand (Inpatient and Outpatient) and Estimated District Volumes (continued):

B. Outpatient (continued):

Table 21
District Outpatient 2020 Use Rates and 2030 Projections

Service	2020 Estimated PMH @ Use Rate (per 1,000)	2020 Estimated Service Area Volumes	2025 Projected Volumes	2025 Estimated PMH Service Area Volumes	2025 Total PMH Volumes
ED Visits (urgent and emergent)	481.9	21,848	23,297	11,798	15,417
Surgery Cases (Major Only)	172.3	7,810	8,329	359	552
X-Ray Exams	529.7	24,011	25,604	5,818	7,549
CT Scan	164.1	7,437	7,931	3,166	4,170
MRI Scan	91.4	4,141	4,416	903	1,243
Ultrasound – Other	148.3	6,725	7,171	3,117	4,194
Ultrasound – OB	76.6	3,474	3,705	2,335	3,308
Mammography Scan	114.9	5,208	5,553	2,431	2,853
Physical Therapy	2,091.1	94,798	101,086	5,818	17,129
Gastroenterology Endoscopy Procedures	65.4	2,967	3,164	275	351
Echocardiography	46.3	2,099	2,238	685	876
Clinic Visits (New & Est.)	3,644.9	165,233	176,193	17,495	24,184

Source: IBM Watson/Truven Analytics outpatient estimates

10. The District's Medical Staff:

The District operates a CAH providing acute medical and rehabilitation inpatient services as well as select surgical specialties.

The top admitting physicians, who have admitted more than 80 percent of the District's inpatients from 2017 to 2021, are as follows:

Physician	2017 Admits	2018 Admits	2019 Admits	2020 Admits	2021 Admits
Hashmi, Syed Farhan T.	242	211	240	226	327
Joshi, Sandeep	167	176	182	168	257
Weaver, Derek S.	188	169	153	157	172
Gupta, Ridhima	-	12	11	66	146
Collingham, Shelli Lynn	-	-	-	-	127
Sollers, Brian G.	146	137	231	143	119
Carl, David	26	67	91	83	117
Weaver, Heidi S.	-	-	12	113	97
Marsh, Kevin L.	58	30	101	89	75
Smith, Coke R.	137	139	135	146	51
Moran, Patrick James	-	3	17	58	50
Min, Sarah	-	27	67	85	-

The District has focused the last several years on increasing the number of providers available to its community in family practice, behavioral health, women's health, and specialty providers such as surgeons, orthopedics, and cardiac health. The District has added 12 providers between 2017 and 2020, with an additional 12 providers targeted for hire between 2022 and 2026 with the goal of having a robust medical staff who can meet the vast majority of the community's needs.

- 2017 – The District hired six Rural Health Clinic providers for the Benton City and Prosser Clinic locations and replaced one orthopedic surgeon.
- 2018 – The District continued building up its Rural Health Clinic provider staffing by hiring five providers with a focus on increasing its behavioral health capacity, replacing its two General Surgeons with new providers and started up a new Pain Management Clinic to help patients with chronic pain. The District also hired an onsite Radiologist to improve quality and efficiency.
- 2019 – The District hired an additional provider to its Women's Health program in its Prosser Clinic to increase capacity, replaced an Orthopedic Surgeon with one focused on joints and hips and purchased a new MAKO joint replacement robot to ensure maximum quality. The District also hired a new Cardiologist for its new cardiac program in its specialty clinic. Additional providers for behavioral health for the Grandview Clinic were added, and the clinic expanded its hours to include evenings and weekends which required additional providers.

10. The District's Medical Staff (continued):

- 2020 – The District continued its focus on increasing its capacity in its Women's Health program by hiring two additional mid-wife providers. It also started a new Urology program in its Specialty Clinic by hiring a new Urologist as well as replacing its retiring ENT Surgeon. The Prosser Clinic took the primary role of COVID testing in 2020 due to its central location and facility design and expanded its hours to evenings and weekends, and the Grandview Clinic reduced its operating hours to Monday – Friday, 8am – 5pm.
- 2021 – The District focused on increasing its surgical capacity by replacing its general surgeons with providers with greater capabilities and adding a gastroenterologist. The Pain Management Clinic was discontinued in early 2021 due to poor performance and was replaced with an active Dermatology Program. Adding additional providers to the Grandview Clinic is critical to the District's growth, and three additional providers were hired in 2021. The Grandview Clinic's operating hours were also expanded.
- 2022 – The District will be focusing on increasing its Specialty Clinic capabilities through an expansion of telehealth capabilities for Endocrinology and Neurology.
- 2023 – The District will be preparing for the new hospital building opening by hiring a new Oncologist for its new Oncology Program and a Pulmonologist for its new Pulmonology/Sleep Medicine program that are both slated to operate out of the new hospital building as part of an expanded Specialty Clinic.
- 2024 – The District will be adding additional providers to the Specialty Clinic in the new hospital to include Nephrology (kidneys), Ophthalmology (eyes), and Neurosurgery (spine); Endocrinology (diabetes) will be added at the Prosser Clinic.
- 2025 – The District will be adding an additional family practice physician to the Benton City clinic, a nurse practitioner to the Prosser clinic, and a nurse practitioner to the Grandview clinic.
- 2026 – The District will be adding an additional nurse practitioner to the Benton City clinic, a family practice physician to the Prosser clinic, and a nurse practitioner to the Grandview clinic.

11. Physician Support for the Project

To evaluate the medical staff's attitudes and perspectives regarding the Project, the District held a public meeting in February 2021 to present information on the Project. Several physicians were in attendance and made comments in favor of the Project. The physician comments indicate the physicians support the District and believe the District's construction of a new hospital building using USDA loan financing helps to address the primary needs of the community. Key responses from the meeting included the following:

- All responding physicians supported the District and the USDA financing transaction.
- The new hospital building is necessary as the existing building does not have adequate capacity. The responding physicians indicated that patients are currently having to go further away for medical care due to limitations in the current hospital building that will be addressed in the new building. The physicians expect the new building to allow more patients in the community to use the District's medical services. The new building will allow for more growth in volume and services and will better serve the community.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Historical and Forecasted Statements of Net Position
December 31, 2017, 2018, 2019, 2020, and 2021 (Historical)
December 31, 2022, 2023, 2024, 2025, and 2026 (Forecasted)

	Compiled					Examined				
ASSETS	Historical Year 2017	Historical Year 2018	Historical Year 2019	Historical Year 2020	Historical Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Current assets										
Cash and cash equivalents	$ 2,282,799	$ 1,279,823	$ 817,760	$ 9,379,362	$ 10,931,985	$ 6,536,000	$ 9,304,000	$ 10,494,000	$ 10,975,000	$ 12,920,000
Investments	-	335,780	437,638	512,731	592,319	592,000	592,000	592,000	592,000	592,000
Receivables:										
Patients accounts, net	8,121,908	8,166,553	10,744,795	9,878,800	11,601,410	11,850,000	12,568,000	13,320,000	14,732,000	15,626,000
Estimated third-party payor settlements	-	622,040	-	-	-	-	-	-	-	-
Taxes	23,124	24,789	26,908	31,706	23,641	27,000	28,000	29,000	29,000	30,000
Other	477,058	30,756	195,041	120,637	739,363	50,000	50,000	50,000	50,000	50,000
Inventories	291,763	357,940	413,831	496,349	583,000	795,000	819,000	849,000	880,000	912,000
Physician advances	-	192,798	220,234	165,854	151,026	84,000	77,000	88,000	79,000	67,000
Prepaid expenses	304,717	304,724	902,449	940,146	956,968	697,000	940,000	778,000	697,000	940,000
Total current assets	11,501,369	11,315,203	13,758,656	21,525,585	25,579,712	20,631,000	24,378,000	26,200,000	28,034,000	31,137,000
Noncurrent assets										
Cash and cash equivalents limited as to use for capital acquisitions	11,999,425	1,376,480	1,250,261	2,233,842	2,986,028	2,986,000	4,261,000	6,277,000	8,077,000	9,872,000
Cash and cash equivalents restricted by bond agreement for capital acquisitions	976,204	-	346,920	1,660,627	-	767,000	767,000	767,000	767,000	767,000
Cash and cash equivalents restricted by debt agreement for USDA debt reserve	-	-	-	-	-	-	-	-	339,000	678,000
Investments limited as to use for capital acquisitions	-	12,534,987	13,880,674	15,448,177	17,537,681	10,771,000	12,225,000	13,214,000	17,275,000	21,615,000
Physician advances	-	190,267	156,015	102,799	52,169	48,000	75,000	71,000	54,000	50,000
Prepaid expenses, net of current portion	-	-	324,504	-	-	325,000	81,000	-	325,000	81,000
Right-of-use assets, net	-	-	-	-	-	5,398,000	4,746,000	4,198,000	3,846,000	3,494,000
Capital assets, net	13,367,798	14,313,800	18,314,760	18,758,895	22,913,579	36,161,000	86,991,000	116,432,000	110,274,000	103,443,000
Total noncurrent assets	26,343,427	28,415,534	34,273,134	38,204,340	43,489,457	56,456,000	109,146,000	140,959,000	140,957,000	140,000,000
Total assets	**$ 37,844,796**	**$ 39,730,737**	**$ 48,031,790**	**$ 59,729,925**	**$ 69,069,169**	**$ 77,087,000**	**$ 133,524,000**	**$ 167,159,000**	**$ 168,991,000**	**$ 171,137,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Historical and Forecasted Statements of Net Position (Continued)
December 31, 2017, 2018, 2019, 2020, and 2021 (Historical)
December 31, 2022, 2023, 2024, 2025, and 2026 (Forecasted)

	Compiled					Examined				
LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND NET POSITION	**Historical Year 2017**	**Historical Year 2018**	**Historical Year 2019**	**Historical Year 2020**	**Historical Year 2021**	**Forecast Year 2022**	**Forecast Year 2023**	**Forecast Year 2024**	**Forecast Year 2025**	**Forecast Year 2026**
Current liabilities										
Accounts payable	$ 1,160,673	$ 915,866	$ 1,192,142	$ 1,369,231	$ 1,774,984	$ 1,871,000	$ 1,923,000	$ 1,981,000	$ 2,041,000	$ 2,103,000
Accrued payroll and related liabilities	1,105,709	1,586,757	2,282,536	1,134,162	1,620,595	2,322,000	2,514,000	2,750,000	3,019,000	3,173,000
Accrued leave	845,705	953,506	1,233,493	1,329,277	1,790,013	1,503,000	1,623,000	1,772,000	1,941,000	2,036,000
Estimated third-party payor settlements	856,120	1,148,700	472,704	901,118	1,237,660	-	-	-	-	-
Accrued interest payable	21,099	20,307	19,670	19,670	19,670	-	-	-	-	-
Unearned CARES Act Provider Relief Fund	-	-	-	3,166,415	1,546,716	-	-	-	-	-
Current portion of long-term debt	245,000	255,000	806,614	1,170,080	1,119,984	1,163,000	1,206,000	2,196,000	2,549,000	2,628,000
Current portion of lease obligations	-	673,075	418,578	-	-	872,000	784,000	1,101,000	1,142,000	1,038,000
Total current liabilities	4,234,306	5,553,211	6,425,737	9,089,953	9,109,622	7,731,000	8,050,000	9,800,000	10,692,000	10,978,000
Noncurrent liabilities										
Long-term debt, net of current portion	6,571,624	6,312,292	11,152,228	11,145,077	10,087,868	8,971,000	60,791,000	86,012,000	83,460,000	80,829,000
Paycheck Protection Program loan	-	-	-	6,350,235	-	-	-	-	-	-
Lease obligations, net of current portion	-	336,449	-	-	-	4,337,000	3,553,000	7,452,000	6,310,000	5,272,000
Total noncurrent liabilities	6,571,624	6,648,741	11,152,228	17,495,312	10,087,868	13,308,000	64,344,000	93,464,000	89,770,000	86,101,000
Total liabilities	10,805,930	12,201,952	17,577,965	26,585,265	19,197,490	21,039,000	72,394,000	103,264,000	100,462,000	97,079,000
Deferred inflow of resources										
Deferred electronic health records incentive revenue	990,600	660,400	330,200	-	-	-	-	-	-	-
Net position										
Net investment in capital assets	7,506,279	6,716,677	6,264,590	8,084,695	11,686,198	26,983,000	26,170,000	24,636,000	21,426,000	17,937,000
Restricted for debt service	-	-	-	-	-	-	-	-	339,000	678,000
Unrestricted	18,541,987	20,151,708	23,859,035	25,059,965	38,185,481	29,065,000	34,960,000	39,259,000	46,764,000	55,443,000
Total net position	26,048,266	26,868,385	30,123,625	33,144,660	49,871,679	56,048,000	61,130,000	63,895,000	68,529,000	74,058,000
Total liabilities, deferred inflow of resources, and net position	**$ 37,844,796**	**$ 39,730,737**	**$ 48,031,790**	**$ 59,729,925**	**$ 69,069,169**	**$ 77,087,000**	**$ 133,524,000**	**$ 167,159,000**	**$ 168,991,000**	**$ 171,137,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Historical and Forecasted Revenues, Expenses, and Changes in Net Position
December 31, 2017, 2018, 2019, 2020, and 2021 (Historical)
December 31, 2022, 2023, 2024, 2025, and 2026 (Forecasted)

	Compiled					Examined				
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Historical Year 2020	Historical Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Operating revenues										
Net patient service revenue	$ 47,220,568	$ 51,512,050	$ 59,133,934	$ 59,413,374	$ 77,839,294	$ 86,506,000	$ 91,747,000	$ 97,239,000	$ 107,547,000	$ 114,070,000
Electronic health records incentive payments	991,835	330,200	330,200	330,200	-	-	-	-	-	-
Grants	15,480	19,341	1,040,213	589,335	215,316	150,000	250,000	250,000	250,000	250,000
Other	595,059	451,283	343,701	305,410	213,423	186,000	186,000	186,000	186,000	186,000
Total operating revenues	48,822,942	52,312,874	60,848,048	60,638,319	78,268,033	86,842,000	92,183,000	97,675,000	107,983,000	114,506,000
Operating expenses										
Salaries and wages	20,444,314	23,287,263	27,475,681	29,263,038	33,330,871	37,565,000	40,579,000	44,297,000	48,533,000	50,911,000
Employee benefits	4,714,799	6,118,772	6,260,013	6,452,514	7,491,310	8,884,000	9,699,000	10,698,000	11,842,000	12,550,000
Professional fees	7,530,166	7,565,035	7,399,636	7,462,624	8,534,247	8,548,000	8,805,000	9,069,000	9,341,000	9,621,000
Purchased services	4,050,206	4,093,715	4,568,821	4,917,920	5,520,071	7,808,000	8,019,000	8,235,000	8,458,000	8,687,000
Supplies	4,750,644	4,960,397	5,566,480	6,656,675	9,845,710	11,159,000	11,497,000	11,913,000	12,350,000	12,808,000
Insurance	255,248	241,381	312,599	417,756	518,437	509,000	519,000	529,000	540,000	551,000
Utilities	465,846	520,065	535,779	575,775	531,967	605,000	623,000	642,000	661,000	681,000
Depreciation and amortization	2,063,342	1,988,410	2,443,594	2,754,873	2,299,357	3,716,000	3,489,000	2,979,000	7,358,000	8,031,000
Repairs and maintenance	489,253	309,142	279,995	374,544	642,224	962,000	981,000	1,001,000	1,021,000	1,041,000
Licenses and taxes	284,240	343,191	425,776	474,816	532,079	734,000	749,000	764,000	779,000	795,000
Leases and rentals	1,859,223	1,998,258	2,157,531	2,075,213	2,087,856	413,000	422,000	430,000	439,000	447,000
Other	967,318	1,176,943	1,161,324	1,109,273	975,206	1,781,000	1,816,000	1,852,000	1,890,000	1,927,000
Total operating expenses	47,874,599	52,602,572	58,587,229	62,535,021	72,309,335	82,684,000	87,198,000	92,409,000	103,212,000	108,050,000
Operating income (loss)	$ 948,343	$ (289,698)	$ 2,260,819	$ (1,896,702)	$ 5,958,698	$ 4,158,000	$ 4,985,000	$ 5,266,000	$ 4,771,000	$ 6,456,000

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Historical and Forecasted Revenues, Expenses, and Changes in Net Position (Continued)
December 31, 2017, 2018, 2019, 2020, and 2021 (Historical)
December 31, 2022, 2023, 2024, 2025, and 2026 (Forecasted)

	Compiled					Examined				
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Historical Year 2020	Historical Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Nonoperating revenues (expenses)										
Taxation for maintenance and operations	$ 784,095	$ 821,455	$ 846,680	$ 856,225	$ 896,165	$ 916,000	$ 934,000	$ 953,000	$ 972,000	$ 991,000
Investment income	17,530	192,001	423,827	297,783	(108,953)	31,000	211,000	266,000	308,000	371,000
Interest expense	(178,423)	(167,241)	(351,114)	(386,610)	(402,151)	(552,000)	(1,712,000)	(4,041,000)	(2,173,000)	(2,349,000)
Gain (loss) on disposal of assets	1,000	(150,726)	61,850	(47,321)	-	-	-	-	-	-
Gift shop revenue	-	63,687	81,282	144,610	190,776	172,000	179,000	186,000	125,000	131,000
Gift shop expenses	-	(62,863)	(83,634)	(138,102)	(149,215)	(108,000)	(112,000)	(117,000)	(85,000)	(89,000)
Contributions made to others	-	(15,327)	(19,263)	(28)	(1,195)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
Fundraising events and other Foundation expenses, net	-	(12,910)	(4,613)	(54,643)	(91,144)	(113,000)	(55,000)	(41,000)	(42,000)	(42,000)
Contributions	-	441,741	39,406	43,071	211,096	51,000	53,000	56,000	59,000	61,000
CARES Act Provider Relief Fund	-	-	-	3,738,633	3,599,160	1,522,000	-	-	-	-
COVID-19 grants	-	-	-	464,119	273,547	-	-	-	-	-
Debt issuance costs	-	-	-	-	-	(400,000)	(400,000)	(262,000)	(300,000)	-
Total nonoperating revenues (expenses), net	624,202	1,109,817	994,421	4,917,737	4,418,086	1,518,000	(903,000)	(3,001,000)	(1,137,000)	(927,000)
Excess of revenues over (under) expenses before capital grants	1,572,545	820,119	3,255,240	3,021,035	10,376,784	5,676,000	4,082,000	2,265,000	3,634,000	5,529,000
Capital grants and contributions	28,401	-	-	-	-	500,000	1,000,000	500,000	1,000,000	-
Change in net position before gain on forgiveness of Paycheck Protection Program loan	1,600,946	820,119	3,255,240	3,021,035	10,376,784	6,176,000	5,082,000	2,765,000	4,634,000	5,529,000
Gain on forgiveness of Paycheck Protection Program loan	-	-	-	-	6,350,235	-	-	-	-	-
Change in net position	1,600,946	820,119	3,255,240	3,021,035	16,727,019	6,176,000	5,082,000	2,765,000	4,634,000	5,529,000
Net position, beginning of year	24,447,320	26,048,266	26,868,385	30,123,625	33,144,660	49,872,000	56,048,000	61,130,000	63,895,000	68,529,000
Net position, end of year	**$ 26,048,266**	**$ 26,868,385**	**$ 30,123,625**	**$ 33,144,660**	**$ 49,871,679**	**$ 56,048,000**	**$ 61,130,000**	**$ 63,895,000**	**$ 68,529,000**	**$ 74,058,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Historical and Forecasted Cash Flows
December 31, 2017, 2018, 2019, 2020, and 2021 (Historical)
December 31, 2022, 2023, 2024, 2025, and 2026 (Forecasted)

	Compiled					Examined				
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Historical Year 2020	Historical Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Increase (Decrease) in Cash and Cash Equivalents										
Cash flows from operating activities										
Cash received from and on behalf of patients	$ 45,691,638	$ 51,137,945	$ 56,501,736	$ 60,707,783	$ 76,453,226	$ 85,019,000	$ 91,029,000	$ 96,487,000	$ 106,135,000	$ 113,176,000
Cash received from electronic health records incentive payments	356,141	305,494	-	-	-	-	-	-	-	-
Cash received from other revenue	498,933	451,283	343,701	305,410	213,423	186,000	186,000	186,000	186,000	186,000
Cash received from operating grants	15,480	19,341	1,040,213	589,335	215,316	150,000	250,000	250,000	250,000	250,000
Cash paid to and on behalf of employees	(24,771,082)	(28,817,186)	(32,759,928)	(36,768,142)	(39,875,012)	(46,035,000)	(49,966,000)	(54,610,000)	(59,937,000)	(63,212,000)
Cash paid to suppliers and contractors	(21,051,286)	(21,762,494)	(23,235,560)	(23,502,337)	(29,438,785)	(31,938,000)	(33,422,000)	(34,171,000)	(35,668,000)	(36,511,000)
Net cash provided by operating activities	739,824	1,334,383	1,890,162	1,332,049	7,568,168	7,382,000	8,077,000	8,142,000	10,966,000	13,889,000
Cash flows from noncapital financing activities										
Taxes received for maintenance and operations	787,036	819,790	844,561	851,427	904,230	913,000	933,000	952,000	972,000	990,000
Contributions received	-	425,580	34,716	26,910	211,096	51,000	53,000	56,000	59,000	61,000
Gift shop revenue	-	60,006	77,601	140,929	190,776	172,000	179,000	186,000	125,000	131,000
Gift shop expenses	-	(59,571)	(83,634)	(134,810)	(149,215)	(108,000)	(112,000)	(117,000)	(85,000)	(89,000)
Fundraising and other Foundation expenses	-	(9,968)	(27,738)	(51,729)	(91,144)	(113,000)	(55,000)	(41,000)	(42,000)	(42,000)
Contributions to others	-	(600)	(19,263)	14,727	(1,195)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
Proceeds from Paycheck Protection Program loan	-	-	-	6,350,235	-	-	-	-	-	-
COVID-19 grants	-	-	-	464,119	273,547	-	-	-	-	-
CARES Act Provider Relief Fund	-	-	-	6,905,048	1,979,461	-	-	-	-	-
CARES Act Provider Relief Fund refund of overpayment	-	-	-	-	-	(25,000)	-	-	-	-
Net cash provided by noncapital financing activities	787,036	1,235,237	826,243	14,566,856	3,317,556	889,000	997,000	1,035,000	1,028,000	1,050,000
Cash flows from capital and related financing activities										
Purchase of capital assets	(3,342,653)	(2,075,614)	(6,300,773)	(3,246,329)	(6,454,041)	(16,220,000)	(53,667,000)	(26,872,000)	(848,000)	(848,000)
Proceeds from capital grants and contributions	28,401	-	-	-	-	500,000	1,000,000	500,000	1,000,000	-
Proceeds from issuance of long-term debt	-	-	6,000,000	1,254,257	-	-	-	-	-	-
Proceeds from issuance of interim financing for construction	-	-	-	-	-	50,000	53,030,000	27,420,000	-	-
Principal payments on 2014 LTGO bonds	(230,000)	(245,000)	(255,000)	(270,000)	(285,000)	(305,000)	(325,000)	(345,000)	(365,000)	(385,000)
Principal payments on Bank of America conditional sales agreement	-	-	(349,202)	(446,018)	(596,204)	(567,000)	(583,000)	(599,000)	(617,000)	(634,000)
Principal payments on GE Government Finance, Inc. loan	-	-	-	(177,808)	(222,128)	(248,000)	(255,000)	(262,000)	(89,000)	-
Principal payments on lease liabilities	-	-	(673,075)	(418,578)	-	(932,000)	(872,000)	(784,000)	(1,101,000)	(1,142,000)
Principal payments on USDA loan	-	-	-	-	-	-	-	-	(1,125,000)	(1,530,000)
Interest paid	(182,827)	(172,365)	(355,999)	(390,726)	(406,124)	(576,000)	(1,716,000)	(4,044,000)	(2,176,000)	(2,352,000)
Debt issuance costs	-	-	-	-	-	(400,000)	(400,000)	(262,000)	(300,000)	-
Net cash provide by (used in) capital and related financing activities	(3,727,079)	(2,492,979)	(1,934,049)	(3,695,202)	(7,963,497)	(18,698,000)	(3,788,000)	(5,248,000)	(5,621,000)	(6,891,000)
Cash flows from investing activities										
Purchase of investments	-	(12,800,607)	(1,322,395)	(1,512,678)	(2,357,045)	-	(1,454,000)	(989,000)	(4,061,000)	(4,340,000)
Sale of investments	-	-	-	-	-	6,767,000	-	-	-	-
Interest received	17,530	121,841	298,677	167,865	79,000	31,000	211,000	266,000	308,000	371,000
Net cash provided by (used in) investing activities	17,530	(12,678,766)	(1,023,718)	(1,344,813)	(2,278,045)	6,798,000	(1,243,000)	(723,000)	(3,753,000)	(3,969,000)
Net increase (decrease) in cash and cash equivalents	(2,182,689)	(12,602,125)	(241,362)	10,858,890	644,182	(3,629,000)	4,043,000	3,206,000	2,620,000	4,079,000
Cash and cash equivalents, beginning of year	17,441,117	15,258,428	2,656,303	2,414,941	13,273,831	13,918,000	10,289,000	14,332,000	17,538,000	20,158,000
Cash and cash equivalents, end of year	**$ 15,258,428**	**$ 2,656,303**	**$ 2,414,941**	**$ 13,273,831**	**$ 13,918,013**	**$ 10,289,000**	**$ 14,332,000**	**$ 17,538,000**	**$ 20,158,000**	**$ 24,237,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Prosser Public Hospital District
doing business as Prosser Memorial Health
Statements of Historical and Forecasted Cash Flows (Continued)
December 31, 2017, 2018, 2019, 2020, and 2021 (Historical)
December 31, 2022, 2023, 2024, 2025, and 2026 (Forecasted)

	Compiled					Examined				
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Historical Year 2020	Historical Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024	Forecast Year 2025	Forecast Year 2026
Reconciliation of Cash and Cash Equivalents to the Statements of Net Position										
Cash and cash equivalents	$ 2,282,799	$ 1,279,823	$ 817,760	$ 9,379,362	$ 10,931,985	$ 6,536,000	$ 9,304,000	$ 10,494,000	$ 10,975,000	$ 12,920,000
Cash and cash equivalents, limited as to use for capital acquisitions	11,999,425	1,376,480	1,250,261	2,233,842	2,986,028	2,986,000	4,261,000	6,277,000	8,077,000	9,872,000
Cash and cash equivalents, restricted by bond agreement	976,204	-	346,920	1,660,627	-	767,000	767,000	767,000	767,000	767,000
Cash and cash equivalents, restricted by debt agreement for USDA debt reserve	-	-	-	-	-	-	-	-	339,000	678,000
Total cash and cash equivalents	$ 15,258,428	$ 2,656,303	$ 2,414,941	$ 13,273,831	$ 13,918,013	$ 10,289,000	$ 14,332,000	$ 17,538,000	$ 20,158,000	$ 24,237,000
Reconciliation of Operating Income (Loss) to Net Cash Provided by Operating Activities										
Operating income (loss)	$ 948,343	$ (289,698)	$ 2,260,819	$ (1,896,702)	$ 5,958,698	$ 4,158,000	$ 4,985,000	$ 5,266,000	$ 4,771,000	$ 6,456,000
Adjustments to reconcile operating income (loss) to net cash provided by operating activities										
Depreciation and amortization	2,063,342	1,988,410	2,443,594	2,754,873	2,299,357	3,716,000	3,489,000	2,979,000	7,358,000	8,031,000
Provision for bad debts	2,281,127	2,325,567	4,031,596	3,323,931	3,087,123	3,953,000	4,269,000	4,650,000	5,027,000	5,405,000
(Increase) decrease in assets:										
Receivables:										
Patient accounts, net	(3,524,224)	(2,370,212)	(6,609,838)	(2,457,936)	(4,809,733)	(4,202,000)	(4,987,000)	(5,402,000)	(6,439,000)	(6,299,000)
Estimated third-party payor settlements	72,844	(622,040)	622,040	-	-	-	-	-	-	-
Electronic health records incentive payments	(305,494)	305,494	-	-	-	-	-	-	-	-
Other	(96,126)	156,969	(189,891)	94,246	(618,726)	691,000	-	-	-	-
Inventories	(90,547)	(66,177)	(43,683)	(82,518)	(86,651)	(212,000)	(24,000)	(30,000)	(31,000)	(32,000)
Physician advances	-	(383,065)	6,816	107,596	65,458	71,000	(20,000)	(7,000)	26,000	16,000
Prepaid expenses	70,673	(7)	(919,620)	286,807	(16,822)	(65,000)	1,000	243,000	(244,000)	1,000
Increase (decrease) in liabilities and deferred inflow of resources:										
Accounts payable	(379,268)	(262,087)	318,759	156,128	405,753	96,000	52,000	58,000	60,000	62,000
Accrued payroll and related liabilities	353,846	481,048	695,779	(1,148,374)	486,433	701,000	192,000	236,000	269,000	154,000
Accrued leave	34,185	107,801	279,987	95,784	460,736	(287,000)	120,000	149,000	169,000	95,000
Estimated third-party payor settlements	(358,677)	292,580	(675,996)	428,414	336,542	(1,238,000)	-	-	-	-
Deferred electronic health records incentive revenue	(330,200)	(330,200)	(330,200)	(330,200)	-	-	-	-	-	-
Net cash provided by operating activities	**$ 739,824**	**$ 1,334,383**	**$ 1,890,162**	**$ 1,332,049**	**$ 7,568,168**	**$ 7,382,000**	**$ 8,077,000**	**$ 8,142,000**	**$ 10,966,000**	**$ 13,889,000**

See accompanying summary of significant forecast assumptions and accounting policies and independent accountants' report.

Attachment M

PROSSER PUBLIC HOSPITAL DISTRICT
BENTON COUNTY, WASHINGTON

RESOLUTION NO. 1071

A RESOLUTION of the Board of Commissioners (the "Commission") of Prosser Public Hospital District, Benton County, Washington (the "District"), relating to contracting indebtedness; authorizing the Chief Executive Officer and the Chief Financial Officer of the District to move forward with the current revised plan of finance to fund the construction of a new hospital and related facilities.

WHEREAS, the District applied for, received, and approved a Letter of Conditions for a USDA Community Facilities Program loan in the aggregate principal amount of not to exceed $70,500,000 (the "USDA Loan") to fund the construction of (i) a new 75,000 square foot, 25 bed critical access hospital, (ii) a 15,000 square foot education center and medical office building attached to the hospital, (iii) a 1,500 square foot maintenance support building, and (iv) a helipad (the "Project"); and

WHEREAS, pursuant to Resolution No. 1069 adopted by the Commission on September 8, 2022, the District determined that there is a need to apply for additional financial assistance in the amount of $11,000,000 from United States of America, acting through the United States Department of Agriculture, Community Facilities Program in Rural Housing Service, an agency in Rural Development ("USDA") to provide sufficient funds to complete the financing of the Project, and is in the process of completing the application for such additional financial assistance in the form of a supplemental application for $10,000,000 in Direct Loan Financing and $1,000,000 in Emergency Rural Health Care Grant funds; and

WHEREAS, the District's current revised plan of finance for the Project (the "Revised Plan of Finance"), is expected to include a hospital revenue bond anticipation note or notes, USDA direct loans or bonds, and an operating lease; and

WHEREAS, the Commission wishes to authorize the Chief Executive Officer and Chief Financial Officer of the District to take such actions and to execute such documents as in their judgment may be necessary or desirable to carry out the transactions contemplated in connection with the Revised Plan of Finance and this Resolution; NOW, THEREFORE,

BE IT RESOLVED BY THE BOARD OF COMMISSIONERS OF PROSSER PUBLIC HOSPITAL DISTRICT, BENTON COUNTY, WASHINGTON, as follows:

Section 1. Approval of Revised Plan of Finance. The Commission hereby approves the Revised Plan of Finance, which currently includes the following:

A. A hospital revenue bond anticipation note or notes (the "Note") expected in the aggregate principal amount of $80,500,000, or such amount as determined by the Commission, to provide interim financing during the construction phase of the Project;

B. USDA direct loans or bonds (the "Bonds") to repay the Note expected in the aggregate principal amount of $80,500,000 or such amount as determined by the Commission; and

C. An operating lease (the "Operating Lease") in the approximate principal amount of $5,000,000.

Section 2. Authorization to Carry out the Revised Plan of Finance. The Commission hereby authorizes and directs the Chief Executive Officer and the Chief Financial Officer of the District (each, an "Authorized Officer" and, together, the "Authorized Officers"), each of whom is authorized to act alone, to take such actions and to execute such documents as in their judgment may be necessary or desirable to carry out the Revised Plan of Finance.

Section 3 Ratification of Prior Acts. All actions heretofore taken by the officers, agents, attorneys, and employees of the District in connection with the transactions contemplated herein are hereby ratified and approved.

Section 4. Effective Date of Resolution. This resolution shall take effect and be in force from and immediately after its passage.

ADOPTED and APPROVED by the Commission of Prosser Public Hospital District, Benton County, Washington, at an open public meeting thereof this 29th day of September, 2022, the following Commissioners being present and voting.

_____
President and Commissioner

_____
Commissioner

_____
Commissioner

_____
Commissioner

_____
Commissioner

_____
Commissioner

_____
Secretary and Commissioner

CERTIFICATION

I, the undersigned, Secretary of the Board of Commissioners (the "Commission") of Prosser Public Hospital District, Benton County, Washington (the "District"), hereby certify as follows:

1. The attached copy of Resolution No. 1071 (the "Resolution") is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Commission held on September 29, 2022, as that resolution appears on the minute book of the District; and the Resolution is now in full force and effect.

2. That such meeting was duly convened, held and included an opportunity for public comment, in all respects in accordance with law; due and proper notice of such meeting was given; that a legal quorum was present throughout the meeting; and a majority of the members of the Commission of the District voted in the proper manner for the adoption of the Resolution.

3. That all other requirements and proceedings incident to the proper adoption of the Resolution have been duly fulfilled, carried out and otherwise observed, and that I am authorized to execute this Certificate.

Dated: September 29, 2022.

PROSSER PUBLIC HOSPITAL DISTRICT,
BENTON COUNTY, WASHINGTON

_____

Secretary, Board of Commissioners

Attachment N

Prosser
Memorial Health

Excecutive Summary
CT & MRI Proposals

Vendor	Siemens	GE	Phillips	Budget
CT	$ 625,000	$ 604,976	$ 500,706	
MRI	1,299,911	1,261,473	1,355,095	
Sub Total	1,924,911	1,866,449	1,855,801	
Sales Tax (8.7%)	167,467	162,381	161,455	
Grand Total	**$ 2,092,378**	**$ 2,028,830**	**$ 2,017,256**	**$ 1,968,190**

Computed tomography (CT)

*Note: The competitive information found in this file is based on interpretation of the publicly available material and is filled out to the best of our knowledge. Last Updated 3/10/22

System Name	Revolution Ascend	SOMATOM go.Top	Incisive
Manufacturer	General Electric	Siemens Healthineers'	Phillips
Image			
Gantry			
Power	72kW 55 kW optional	75 kW	
Bore Size	75 cm	70 cm	
Touchpanel	yes	Scan&GO Tablet enabled mobile workflow	
Moodlighting	No	Yes, standard	
Patient visualization camera	Option	Yes	
Tilt	Yes	Yes	
Tilted Spiral	up to ± 30	VA30 up to ± 30	
Maximum Field of View	50 cm	70 cm with HD Field of View	
X-ray Tube			
X-ray Tube	Performix 40 Plus X-ray Tube	Athlon	
Heat Storage	7 MHU, 1.07 MHU/min	7MHU	
kV Selections	80, 100, 120, 140	70, 80, 90, 100, 100 SN, 110, 110 SN, 120, 120 SN, 130, 130 SN, 140, 140 SN (Tin Filter Technology standard)	
10 kV Steps	No	Yes, standard	
70kV Capabilities	No	Yes, standard	

Automated kV Selection	No	CARE kV (automatically selects optimal kV based on topogram and protocol selected)	
max mA	560 mA max (600 mA max only available for one scan mode)	825 mA @ 70 kV	
max mA @ 70 kV	No	825 mA at 70 kV with optional High Power 70 mode	
max mA @ 80 kV	400 @ 80kV	825 mA	
Focal Spot	Small: 0.9 mm x 0.7 mm Large: 1.2 mm x 1.1 mm	Small: 0.8 mm x 0.8 mm Large: 1.0 mm x 1.2 mm	
Detector			
Detector	4 cm Clarity DAS	38.4 mm STELLAR Integrated detector	
Slices	64 /128	64/128	
Minimum Slice Thickness	0.625 mm	0.6 mm (always on)	
Reconstruction Matrix Sizes	1024x1024	512 x 512	
Resolution in lp/cm (High Contrast) x/y	18.3 lp/cm	13 lp/cm @ 50% MTF	
Radiation dose			
Iterative Reconstruction	ASiR-V, True Fidelity	SAFIRE	
Max IR Recon Speed	35	Inline Automatic Post Processing reconstruction time includes direct to PACS, zero-click reformatting rate of 23 IPS for FBP / 20 IPS for SAFIRE with Ultras FAST IRS or 40 fps for FBP and 29 fps for IR with Ultra FAST IRS II	

Dose Modulation Technologies	Smart mA, Organ Dose Modulation	Adaptive Dose Shield, CAREDose 4D, X-CARE, Tin Filter Technology, CARE kV, 10 kV steps, SAFIRE	
Adaptive Dose Shield for superior dose reduction	no	Yes	
Acquisition Speed			
Pitch selections	0.531:1 (20mm Detector), 0.516:1,0.969:1 0.941:1,(40mm Detector) ,1.375:1 and 1.531:1 (20mm and 40mm Detector) 1.375:1 and 1.531:1 pitch are not valid with Ped Head or Head SFOV	0.03-1.5	
Rotation Time	0.35 (Optional), 0.4, 0.5, 0.6, 0.7,0.8s, 0.9s, 1.0s	0.33 s	
Native Temporal Resolution	175 ms	165 ms	
Fastest Cardiac Scan Time	0.35s	0.33s	
Patient scan coverage in detail mode		175 mm/sec (0.33s rotation, 1.5 pitch)	
Max. Z-coverage per rot. in mm	61mm	57.6mm	

Scan time for 50 cm sub mm scanning (e.g. Chest) in s	2.9s	2.85s	
Table			
Maximum Table Weight	500lb (675lb optional)	676 lbs	
Scan Range	1700 mm, up to 2000 mm optional	2000 mm	
Advanced Functionality			
Metal Artifact Reduction SW	SMART MAR (not compatible with 7.5mm and 10 mm slices.) Interval can be greater than or equal to 0.312mm	iMAR optional	
Tin Filter / Additional beam filtration	No	Standard Tin Filter	
Dual Energy spectral imaging Acquisition	Yes	Twin Spiral DE standard TwinBeam Dual Energy (optional) [Note allows for full utilization of all of Siemens real time dose reduction technology such as CARE Dose4D for dose modulation and dose-neutral dual energy.]	
Dual Energy spectral imaging - PACS Ready Workflow	No	Yes, Recon&Go DE Inline results for Twin Spiral & TBDE DE applications *optional	
Automated Cardiac Phase Detection	Yes	Cardio BestPhase	
Neuro Perfusion Coverage	8 cm	8.49cm with Flex 4D Spiral	
Body / Extended Perfusion Coverage	8 cm	Dynamic CTA for Head & Neck up to 26.6cm Up to 40cm Extended Dynamic CTA Up to 18.5mm Body Perfusion	
Intervention Modes	Smart 3D Interventional	My Needle with flouro	

Intervention Control Method	SmartStep, 3D Guidance and needle tracking	My Needle with flouro	
Injector Synchronization	Enhanced Xtream Injector (optional)	CARE Contrast III	
Workflow & Automation			
Automated Patient Positioning	Yes	FAST 3D Camera	
Automated Scan Range Selection	Intelligent protocoling & Smart Plan & Auto Prescription	Yes, standard	
AI-Validated workflows	Yes. AI-based workflow solution called- Effortless workflow	myExam Companion is an AI-validated user guidance that is designed to help technologists navigate complex clinical tasks by providing a streamlined, visually oriented approach to assist in complex clinical decision making points.	
Mobile Workflow	No true mobile tablet workflow but user can access certain scan set-up including protocols on gantry touch screen	Yes	
Automated Anatomical Alignment	yes	Inline Anatomical Ranges, included	
Automated Spine Labeling & Alignment	no	Yes	
Automated rib labeling	no	Yes	
Siting			
Electrical requirements	~150 kVA	≤115 kVA	
Cooling requirements (BTU/HR) all components	air-cooled	28,800	
Flexible Siting	Yes	Yes, Integrated computers, control room optional	
System Upgradeability / Investment Protection			
Computer non-obsolescence	Yes	Window 10 software with embedded virus protection	
Data security	Yes	Window 10 software with embedded virus protection	
Warranty	Yes	24 months	

Warranty tube coverage	Yes	included with tube inclusive contract	
MISC			
Table limit	500/675 lbs	676lbs	
Slice thickness	.625, 1.25, 2.5, 3.75, 5.0, 7.5, 10mm	.6mm	
Uptime	CTDI	97%	
Applications # of days			
	10 Days	9 Days	
Service			
Customer service response time	Same day	Next day	Pending
Service agreement cost	110,665	$76,000.00	$55,297.00
Subtotal			
	$734,976	$625,000	
Trade			
	$130,000 Deducted from price	$60,000 Deducted from price	Pending Deducted from price
Price			
Total	**$604,976**	**$625,000**	**$500,706**

MRI

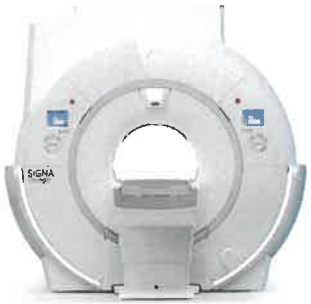
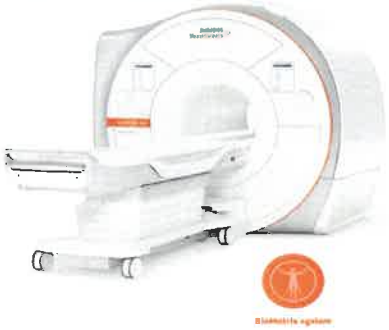
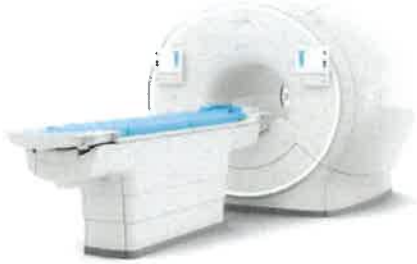
System Name	GE Voyager	MAGNETOM Altea	Phillips Ambition
Maufacturer	General Electric	Siemens Healthineers	Phillips
Image			
Gantry			
	Flared opening with accent lights	FDA Cleared 2018	70 cm; Bore is 70cm in the center of the magnet and flairs to wider opening at both ends up to 95cm.
Gantry user interface	In-Room Operator Console and Control (IROC) - IntelliTouch one touch landmarking - AIR Touch intelligent auto-coil selection	FDA Cleared 2018 New Magnet with larger FOV New Gradients New Gantry & Controls with Dual Touchscreens New Patient Table New Computer / User Interface / Applications Very short overall magnet size and length. Altea is 157cm cover to cover at 5'1"	Vital Screen Option; VitalScreen provides the MR operator with patient identification details and guidance on exam set-up. Information is provided for patient orientation, VCG positioning, coil, examination name, number of scans, and total exam time. VitalScreen is multi-touch and allows the operator the change patient position or enter patient weight. It provides access to basic exam controls like ventilation, sound and light. The integrated workflow of VitalScreen means no exam adaptations are necessary on the MR console before starting the exam, allowing the MR exam to automatically start as soon as the scanner room door is closed.
		Select&GO - touch display based on the underlying BioMatrix Body Model. Artificial intelligence is employed to accelerate patient positioning by up to 30%. Color TFT-LCD (LED backlight), Projective Capacitive Touch Technology 	

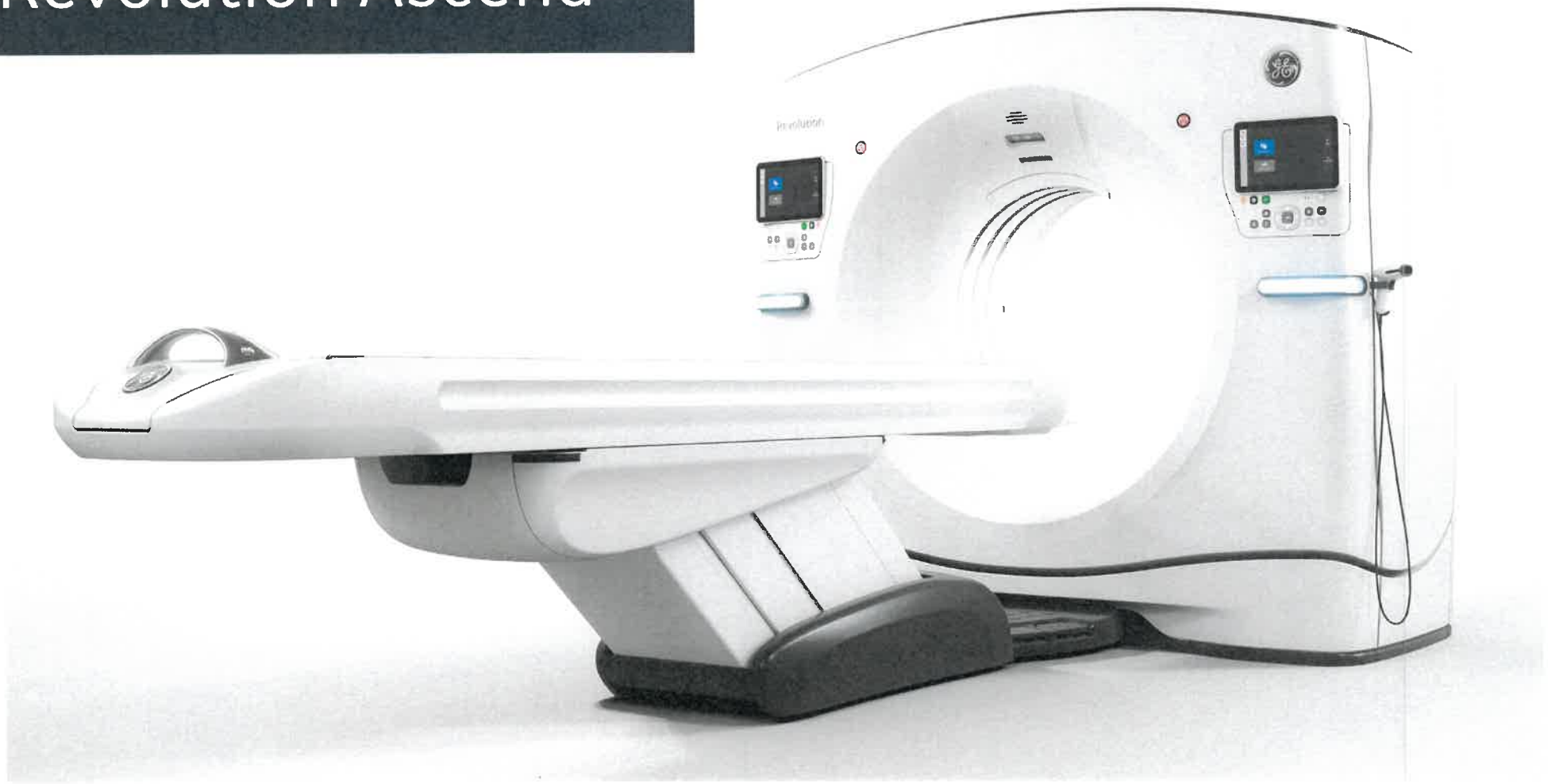
Table docking/Pedals/maneuverability	Detachable and mobile table with integrated arm-boards and IV pole - IntelliTouch landmarking sensors - 32 channel integrated posterior array coil, that never needs to be handled by the technologist 	Fast automated push-button AutoDock and undock functionality. Motorized vertical movement and power eDrive. 	FlexTrak Trolley; Ultra-thin, curved to the patient anatomy, table top that maximizes bore space. Includes coil connections directly on the table top for fast and easy setup. • Ultra-thin design ensures minimal distance between patient and FlexCoverage Posterior coil for optimal SNR • Ultra-strong design supports patients up to 250 kg (550 lbs) • Wide table for enhanced patient space and comfort • Easily removed for patient transport using the optional FlexTrak patient transport system; • Dockable patient transport system for simplified patient preparation, handling and transportation from preparation room to the MR scanner, without repositioning the patient. • Lightweight, easy to maneuver FlexTrak patient support system docks and undocks quickly and easily with patient support and tabletop. • Patient and coils can be prepared outside the MR room. No need to remove coils to reposition patients. • Integrated coil connections on the table and FlexConnect connectors for efficient patient management and rapid evacuation. • Easy-to-use foot pedal, locks wheel direction during transport or brakes the FlexTrak while standing still.
Table weight Limit	550 lbs.	550lbs.	550 lbs
Minimum Table Height	70cm	20", No need for a stepstool to load patients.	59 cm
Gradient Strength	36 mT/m 150 T/m/s UHE Gradient (see page #5 if Voyager Datasheet	33 m/T/m, 125 T/M/S	33/120
Helium usage	Zero Boil Off Magnet effectively eliminates helium fills	Zero Helium Boil off	less than 7 liters total, for the lifetime of the system; Type of cryogen: liquid helium (~7 liters). Uses Micro-cooling technology and is fully sealed. Philips' Ingenia Ambition 1.5T X MRI uses zero-boil off. Refilling, boil-off and vent pipes are not applicable for this fully sealed magnet. The magnet does not have to be refilled with liquid helium
FOV	50cm X 50cm X 50cm	The Altea has a 50 x 50 x 50 FOV.	55 X 55 X 50; Largest usable FOV means best homogeneity, better off-centered imaging
R/F System			
Number of R/F Channels	Up to 65 channels, each generating an independent partial image - Up to 65 simultaneous RF receivers (A/D Converters)	(180ch x 32ch per FOV)	The number of potential channels is unlimited. Philips industry only Unique digital broadband MR architecture capturing the purest MR signal, DirectDigital RF receive technology samples the MR signal directly in the RF coil on the patient. Then transfers the data via fiber-optic technology, creating: • Up to 40% greater signal-to-noise ratio (DirectDigital). DirectDigital RF receive technology samples the MR signal directly in the RF coil on the patient. • As much as 30% improvement in throughput (FlexStream). FlexStream workflow increases system versatility and throughput. • NO CHANNEL UPGRADES. Easy expandability of clinical capabilities without the need for major system upgrades (EasyExpand)
Amplifier	Water cooled/Small footprint	29.2kW	Solid state, microprocessor controlled; The 18 kW High-performance solid-state RF power amplifier affords the energy necessary to manage even very large patients. Both RF transmit and reception are synchronized by the
Coils (how many Channels)			
Coil Combinations	Multiple AIR coils can be combined and combine with PA and HNU Coil	The Tim 4G coils are designed for highest image quality in combination with easy handling. High element coils. Increase SNR and reduce examination times. Directconnect and SlideConnect technology reduce patient set up time. Light weigth, ergonomically designed coils enable highest patient comfort. Any of the coils quoted combine seamlessly	Unlimited; The number of potential channels is unlimited. Philips industry only Unique digital broadband MR architecture capturing the purest MR signal, DirectDigital RF receive technology samples the MR signal directly in the RF coil on the patient. Then transfers the data via fiber-optic technology, creating: • Up to 40% greater signal-to-noise ratio (DirectDigital). DirectDigital RF receive technology samples the MR signal directly in the RF coil on the patient. • As much as 30% improvement in throughput (FlexStream). FlexStream workflow increases system versatility and throughput. • NO CHANNEL UPGRADES. Easy expandability of clinical capabilities without the need for major system upgrades (EasyExpand)
Proprietary coils	AIR Coil Technology	Self Shimming coils	dStream digital technology is proprietary to Philips. Philips has smart element combinations where it looks at all elements in the area and turns on the best element groups for the best image quality.
Head Coil	21ch Head/Neck Unit (can utilize up to 45ch in FOV when combined with PA and AA	Head/Neck 20 channel with tilt and our exclusive Coil Shim technology.	dS HeadSpine* Integrated; 15 Channel Head, 30 cm Coverage 51 Channel (Total Neuro) 90 cm Coverage (Total Neuro); Head, Brain, Total neuro, Total spine (CTL)
Spine Coil	32ch Posterior Array with Digital Micro Switching	Spine with Exclusive Respiratory Sensors. *OPTIONAL	dS TotalSpine; Integrated; 90 cm total coverage; 44 total channels; Total spine, C-Spine, T-Spine, L-Spine
Body/Torso Coils	AIR AA (40ch when combined with Posterior Array)	New Biomatrix Body coil is extremely flexible and light. This coil has an Exclusive BEAT Sensor for ECG gating integrated into the coil. The coil contains ventilation holes for patient comfort.	dS Torso; Integrated, 60 cm coverage; 32 channels, Chest, Pelvis, Heart, Peripheral-vascular dS Whole Body* Integrated, 200 cm total coverage, 108 channels, Whole Body, Chest, Pelvis, Heart, Peripheral-vascular
Knee Coil	16ch T.R Knee Coil and 21ch/20ch AIR MP Coils	18ch Tx/Rx – 170mm at isocenter and flares to 190mm at thigh and 177mm at calf.	dS 16 channel dedicated Knee coil; Main application Knee; Coverage 20 cm
Shoulder Coil	16ch Shoulder Coil and 21ch/20ch AIR MP Coils	16ch Shoulder Shape made of flex coil material to adapt to patient anatomy. The coil can be freely positioned	dS 16 channel dedicated Shoulder Coil; Main applications Shoulder. Coverage 18 cm in LR direction.
Foot/Ankle Coil	8-channel hard shell and 21 channel AIR MP + holder	Foot/Ankle 16ch with tilt for patient comfort.	dS 16 channel dedicated Foot/Ankle coil; Main applications Foot, ankle, toes. Coverage 32 cm in AP direction, 24 cm in FH direction.
Breast Coil	8 channel biopsy compatible or 16 channel biopsy compatible	16 Channer Sentinel Coil	dS 16 Channel dedicated Breast Coil Coverage Bilateral; Maximum numberof channels 16; Main applications Breast; Coil solution type Integrated; Data sampling dStream digital broadband; Coil connection Single Flex Connect; SENSE parallel imaging dS SENSE enhanced parallel imaging performance
Flex Coils	AIR AA (40ch when combined with Posterior Array), AIR MP Lg (21ch), AIR MP Med (20ch) also available 16ch Flex Sm/md/lg	New UltraFlex 18 Lg & Sm. 3 rings of 6 elements allows for high iPAT acceleration	Flex M coil included; Coverage 15 cm Maximum number of channels 6, Main applications: Shoulder, Foot, Ankle, Knee, Pediatrics; Coil solution type Integrated; Data sampling dStream digital broadband; Coil connection dStream Interface; SENSE parallel imaging dS SENSE enhanced parallel imaging performance
T/R Coils available	T/R Head-T/R Knee-T/R Hand Wrist	T/x/Rx 18 Channel Knee Coil + Head coil	Yes - Integrated Posterior coil and T/R dS Head Coil
User Interface			
Monitors/How many?	Only single monitor needed	MR.syngo XA31 user interface is an intuitive platform with Dual Monitors.	1 Standard, 2 Optional

Work Station	READYView integrated post processing and advanced visualization included on scan console	*Optional Dual Monitor	Reduce operator workload by automating exam planning, scanning and processing. Achieve standardized results supporting confident diagnoses and increased throughput while automated patient coaching enhances patient experience. With SmartWorkflow you can confidently offer imaging to patients with MR Conditional implants through guided and automated workflow support.
Misc.	One-touch protocols		R5.7; Optional: New MR Workspace
Clinical Applications			
Autoalign	Deep-learning based AIRx	DotGO – the latest generation of Dot – is setting the standard in exam configuration. For true	SmartWorkflow; Auto-patient centering. Allow your staff to focus less on technology, and fully engage with patients. By reducing and simplifying the number of steps needed for patient preparation, even new operators who have never worked with the scanner can proceed with confidence. SmartWorkflow guides and coaches where required, and automates where possible achieving high productivity while enabling your staff to focus on patients.
AI(Air Recon DL, Deep Resolve, Compress Sense)	AIR Recon DL - Deep Learning based reconstruction	**Siemens Deep Resolve** is a growing family of acceleration solutions as AI technologies are not one size fits all. The Siemens deep neural networks need to be trained on large datasets (over 10,000 pairs of data samples) to deliver excellent image quality and improved levels of acceleration at the same time. Deep Resolve solutions allow for high resolution, sharp images acquired and reconstructed faster than ever before.	SmartWorkflow; SmartExam Card; SmartSpeed; Scanwise; MR Workspace
Applications Training			
	Complete onsite and remote training package included - with HQ training and Jumpstart training options	**Online and On-site**	Customizable; On Demand Clinical Support; Virtual, in-person, onsite, offsite etc. available. Please refer to pages 27 - 30 on quote for greater detail -
Mechanical Components			
Chiller	Seismic Chiller included	Low Ambient	Provide KKT Standard Chiller
Equipment room necessities in size and HVAC	Please see PIM Manual	Siemens equipment cabinets are sealed and water-cooled so they do not dump a large amount of heat into a small equipment room.	**Technical room** Floor space (Recommended) 5.0 m × 2.0 m Floor space (Minimum) 3.8 m × 1.8 m Ceiling height (Recommended) 3.2 m Ceiling height (Minimum) 2.6 m Temperature 15-24 °C
Patient Comfort			
Quiet Scanning?	Silenz/Silent Propeller/Acoustic Reduction Technology (AKT)	yes	ComforTone 80% reduction: ComforTone is a scan technique that brings noise reduction. ComforTone ExamCards will be available for routine exams (Brain, Spine, MSK) including the reference scans.
Room Ambience	Caring Suite Option	optional	Optional Ambient Experience; Options; Tier 1: In bore Connect + Integrated Perimeter Lighting; Tier 2: In bore Connect + Integrated Perimiter Lighting + Wall Projection ; Tier 3: In bore Connect + Integrated Perimeter Lighting
Table Padding	Variable density patient comfort pads and Comfort Tilt on HNU for improved patient comfort	n/a	Ingenia Ambition S offers a table mattress set that brings patient comfort and compliance to the next level. The 60 mm thick viscoelastive foam makes the patient comfortably sink towards the posterior coil adapting to the shape of the body. The bielastic special knitwear offers an exceptional texture that is easy to clean, durable, and pleasant to the patient's skin. The head positioning support offers stability and comfort making it easy for the patient to lie still throughout the whole MR exam.
Music	Wireless sound system included in quote	Mri patient audio system	Yes; Also AutoVoice - 32 preprogammed languages and 8 open fields, providing automated patient guidance and engagement
Anything for Pediatrics	oZTEo cortical bone imaging has peds applications	Pediatric suite- included in the quote	In-bore Connect with Pediatric Themed Content; Option: New partnership with Disney: https://www.usa.philips.com/a-w/about/news/archive/standard/news/press/2021/20210303-philips-and-disney-
Anything for Pediatrics	AIR Coils are ideal for pediatric imaging - Stanford/Lucille Packard Children's Hospital were key in helping develop this technology		
Service			**Protection Service Plan**
Service Contract	Full Service - FE Labor, PM coverage and Repair Parts included. GE supplied coils covered. Remote technical and applications support included. FE Labor and PM	Full service	98%
Uptime	97%	97%	4 hours
Service Response Time	FE onsite - 4 hours; Insite & ILinq remote support- 30 minutes	Warranty- 4 Hours. After Warranty 8 Hours	1 year
Warranty	12-months	24 months	TechMax provides Service Upgrade Path

Upgrade path	Lifecycle management of Software and select Hardware upgrades available for an additonal cost through the service contract via specific offerings (Continuity, AP Refresh).	EVOLVE is a Hardware & Software non-obsolescence program included on your service contracts.	
Cost	146,690/year	142,474/year	
Exam Cards			
Standard Sequences	NeuroWorks/BodyWorks/CVWorks/OrthoWorks/OncoWorks + MAVRIC - metal artifact reduction - Inhance Suite for Non-Con MRA - SWAN for susceptibility weighted Imaging	See Datasheet	We match your existing Exam Cards and help build new ones for additional service lines, etc. We have the North America database, and easy to share protocols.
Additional Sequences price	Comprehensive portfolio of MR applications will be configured and proposed after validation at upcoming site visit		Need to refine configuration further to determine price.
Service			
Customer service response time			
Service agreement cost	$115,400	$103,000	pending
Subtotal			
	$1,396,473	$1,424,911	$1,355,095
Trade			
	$135,000	$125,000	No-Trade in
Price			
Total	**$1,261,473**	**$1,299,911**	**$1,355,095**

Attachment O

Revolution Ascend

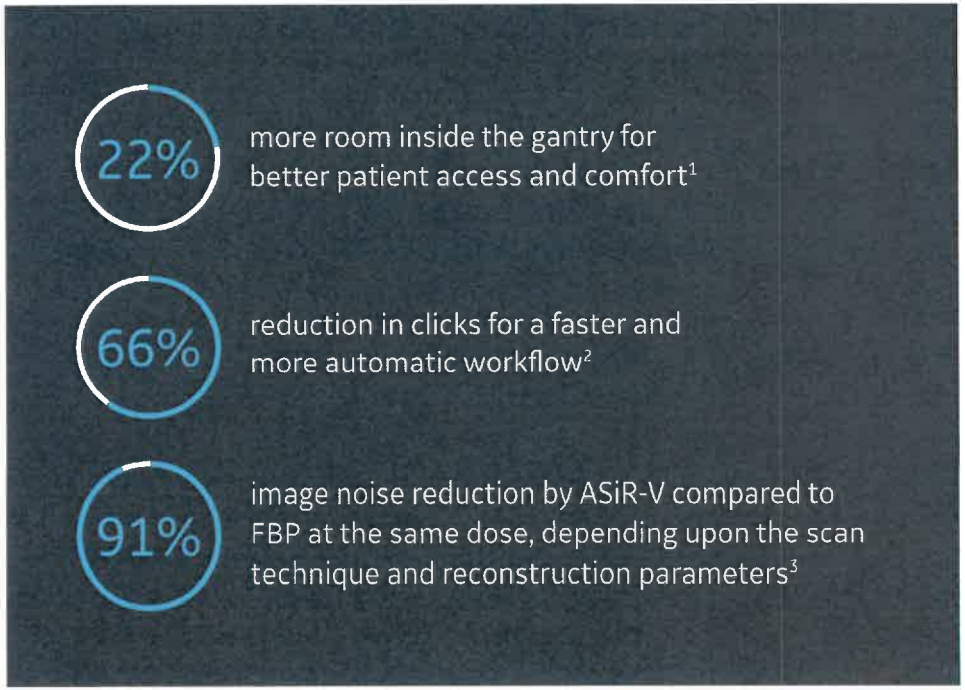


gehealthcare.com

Faster workflow, clearer images

The number one challenge faced by CT departments worldwide is finding a way to efficiently manage increased CT procedure volume. Even though the CT scan itself is the fastest in diagnostic imaging, the sequence from referral to report needs to be faster to meet the challenge. To accomplish exactly that, we have redefined the entire CT experience with Revolution™ Ascend, a 75 cm wide-bore CT system that makes the CT process faster, more intuitive and more approachable, while also providing the image quality you expect.

Revolution Ascend uses an AI-based workflow solution, a smart user interface, cutting-edge technology and access to Smart Subscription to substantially simplify, streamline and automate the entire CT experience from both inside and outside the scan room.



Effortless Workflow

Pre-scan

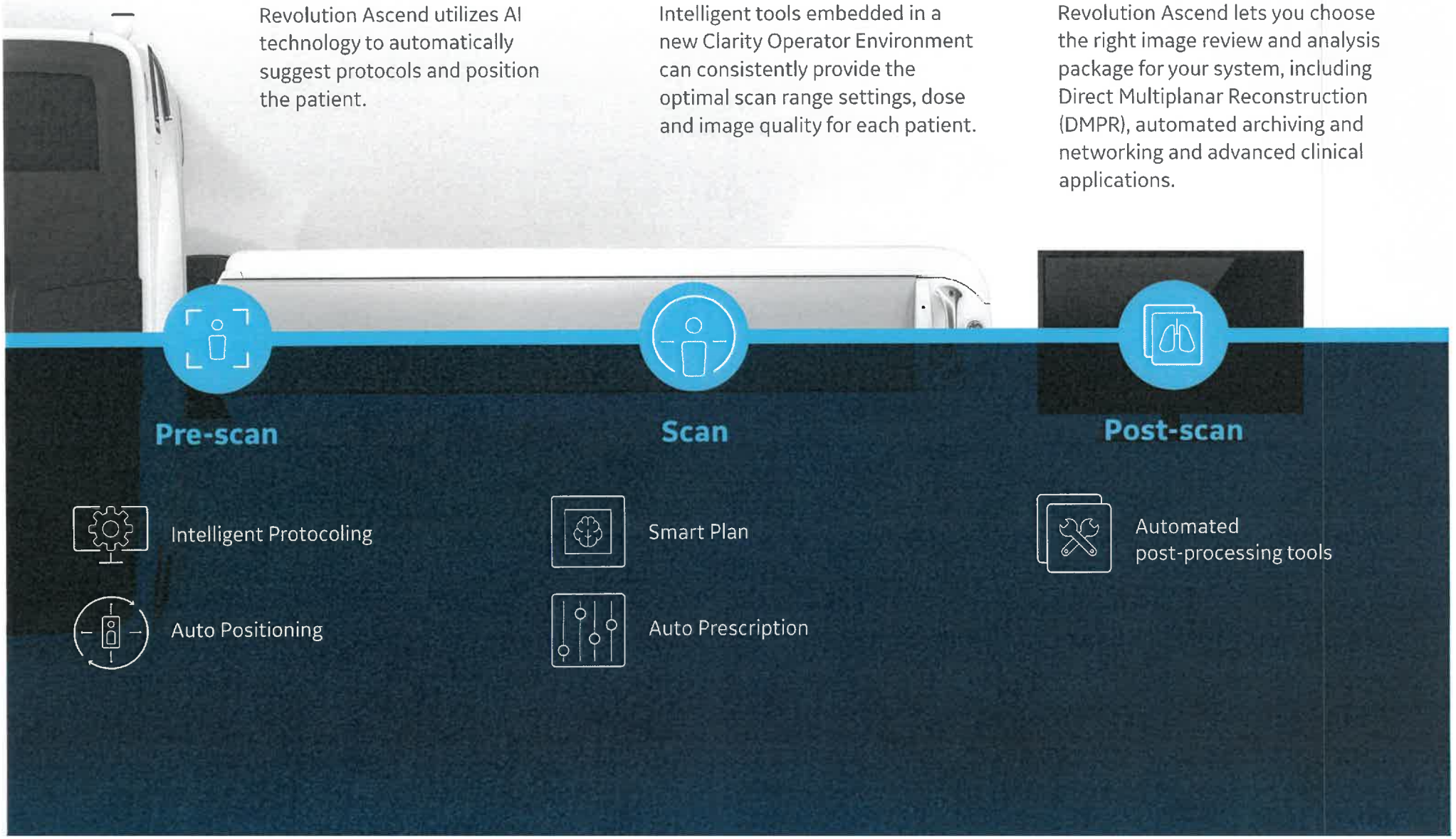
Revolution Ascend utilizes AI technology to automatically suggest protocols and position the patient.

Scan

Intelligent tools embedded in a new Clarity Operator Environment can consistently provide the optimal scan range settings, dose and image quality for each patient.

Post-scan

Revolution Ascend lets you choose the right image review and analysis package for your system, including Direct Multiplanar Reconstruction (DMPR), automated archiving and networking and advanced clinical applications.



Effortless Workflow includes AI-based features such as Intelligent Protocoling and Auto Positioning in addition to automated features such as Smart Plan, Auto Prescription and automated post-processing tools on the console. These intelligent applications are a key component of what transforms the CT experience, enabling Revolution Ascend to accurately and automatically personalize scans for each patient while requiring significantly less effort from the technologist.

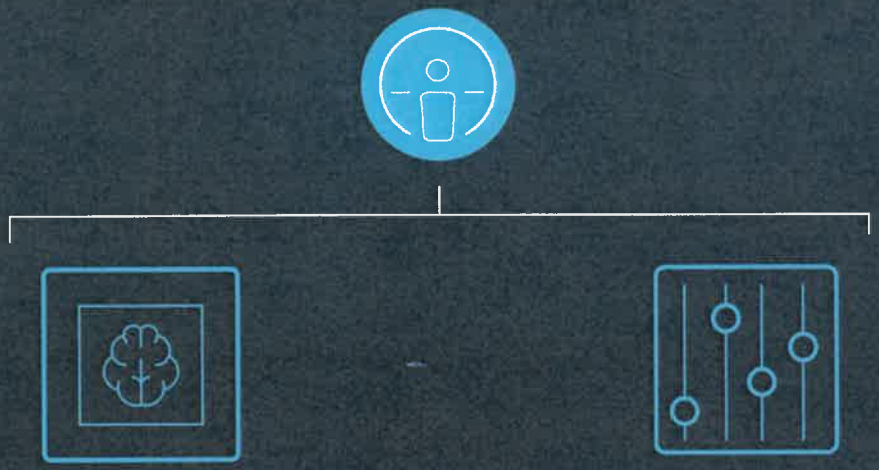
Thinks fast. Works even faster.

Intelligent Protocoling

Intelligent Protocoling uses machine learning to automatically suggest a protocol for each exam. Learning from each site's individual behaviors, Intelligent Protocoling reduces the time spent searching for protocols and may help in reducing errors in protocol selection.

Auto Positioning

AI-based Auto Positioning streamlines patient positioning workflow by minimizing actions into a single-click operation. It first detects landmark locations and displays scout scan range on the Xtream tablet and then determines the correct table elevation and cradle movements to align the scan range center to the CT isocenter.

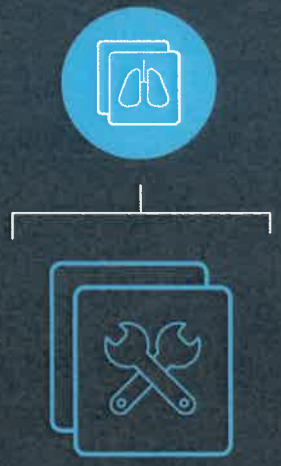


Smart Plan

Smart Plan uses information from the patient scout to automatically provide the correct scan range for head, chest, abdomen and pelvis scans, including multigroup scans.

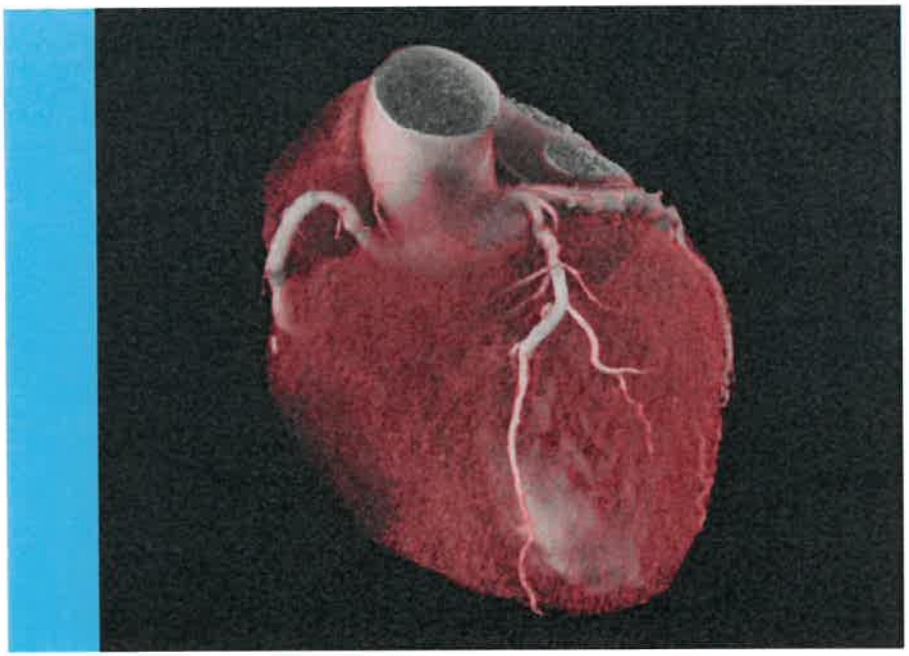
Auto Prescription

Auto Prescription delivers an auto-adjustment of scan settings, balances dose and image quality, facilitates the optimal trade-off between scan speed and mAs and provides re-usable, customizable patient profiles. Auto Prescription technology reduces scan time adjustments and eliminates the need for size-based protocols.



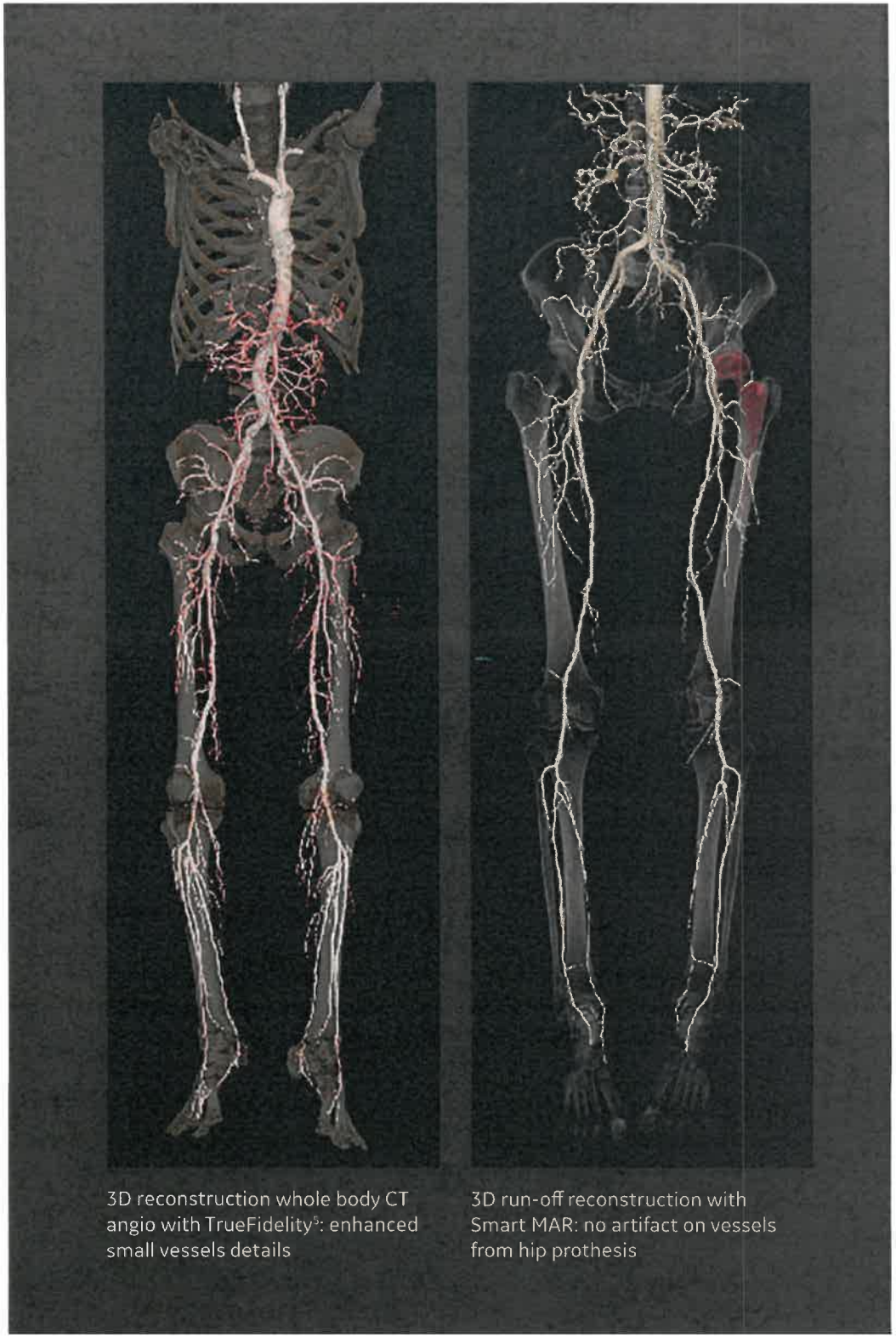
Automated post-processing tools

Revolution Ascend streamlines your post-processing tasks through Prospective Multiple Reconstruction, automated reformatted view generation and a suite of intelligent applications designed to deliver high efficiency and high quality CT imaging in all clinical areas.



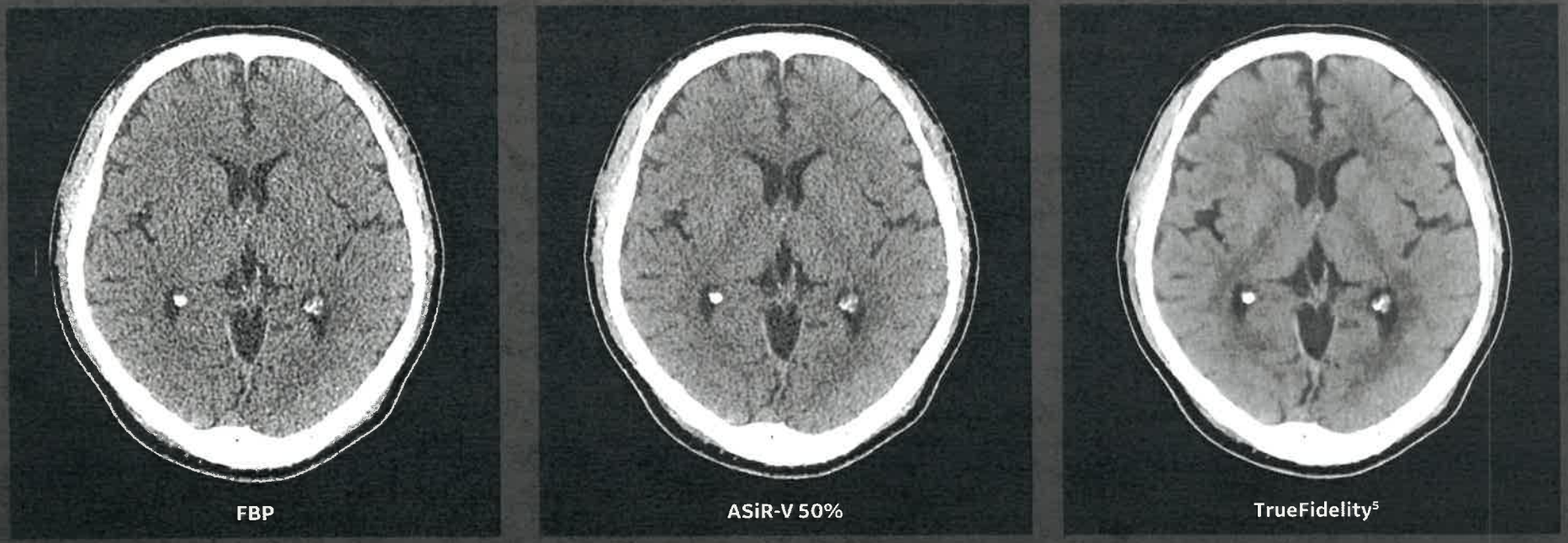
Clearly a faster way to quality images

Performance imaging is a careful balance of the right amount of image quality combined with speed and accuracy. Revolution Ascend makes it easier to strike the right balance with key advancements like the best-in-class 0.28 mm spatial resolution[4] and ASiR-V iterative reconstruction technology, which offers an advanced noise reduction capability. In addition, our Deep Learning Image Reconstruction technology uses a dedicated deep neural network to generate TrueFidelity™ CT images.

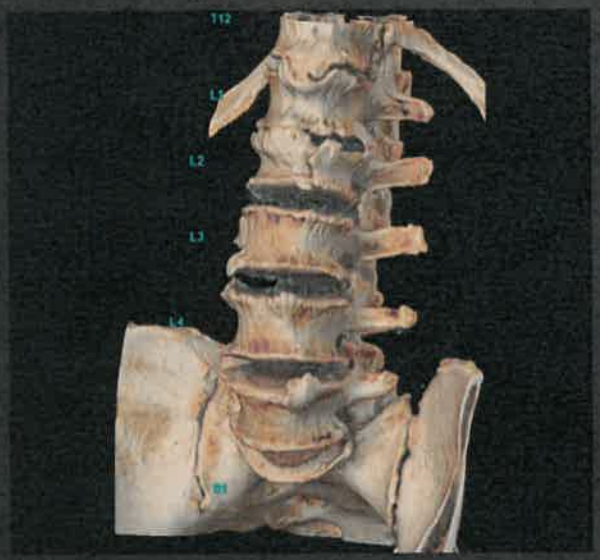


3D reconstruction whole body CT angio with TrueFidelity[5]: enhanced small vessels details

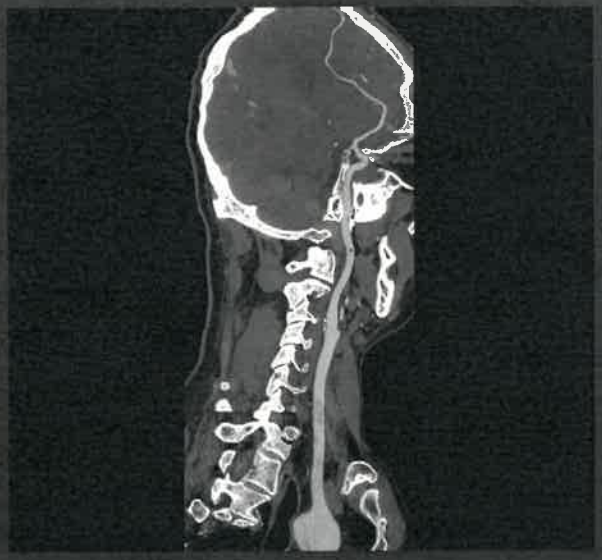
3D run-off reconstruction with Smart MAR: no artifact on vessels from hip prothesis



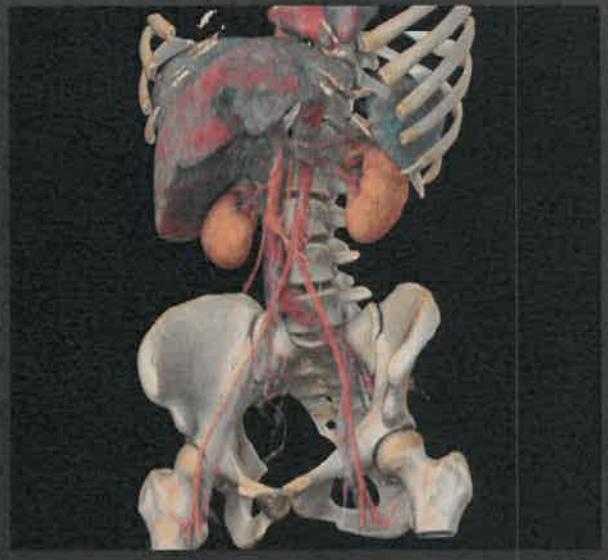
Routine head scan: three reconstruction algorithms comparison



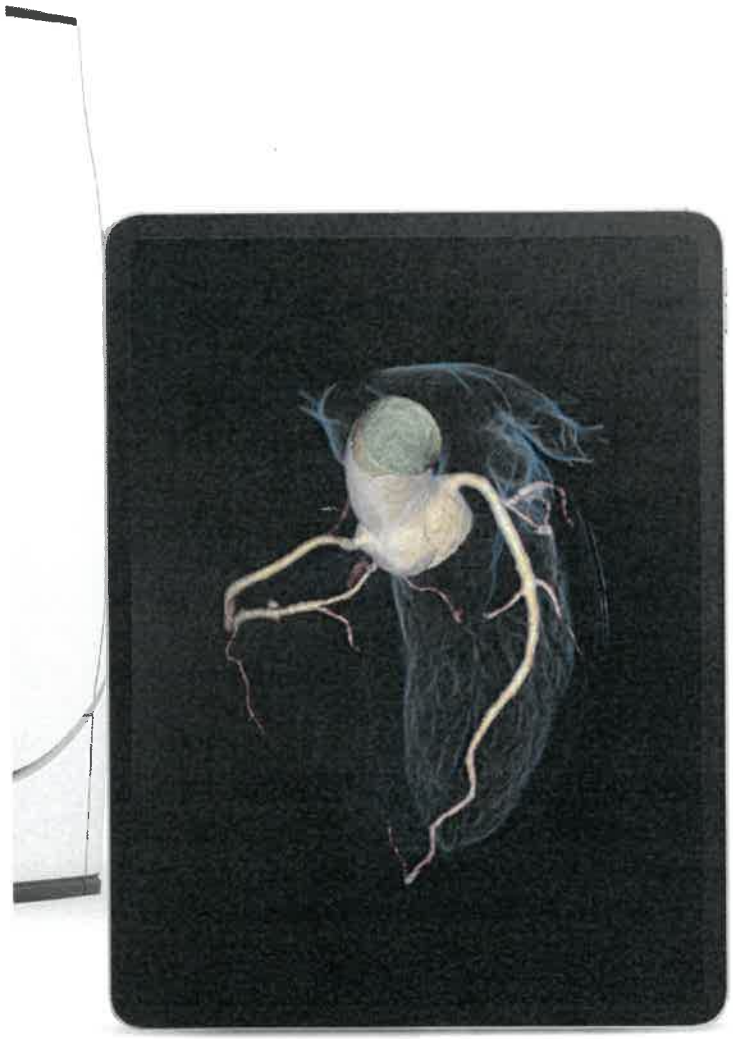
Lumbar spine 3D Volume Illumination showing a vertebral collapse



Curved reformatted view of left internal carotid



Abdominal 3D Volume Illumination reconstruction



Welcome to the new standard for CT

CT departments around the world face operational challenges that require a completely new approach to performance imaging. In order to manage an increasing procedure volume, you need accurate results faster than ever before. With Revolution Ascend, we provide an innovative CT experience.

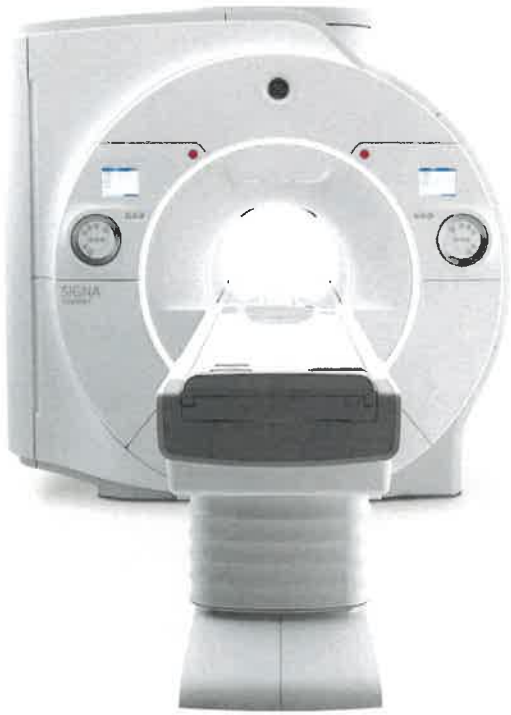
Revolution Ascend features our new Effortless Workflow model, which uses AI technology to streamline the entire CT process. Revolution Ascend empowers you to get the right diagnosis, efficiently and precisely, for more patients in less time.


TOMORROW TODAY
SIGNA™ Voyager
AIR™ IQ Edition
gehealthcare.com/mr

Exceptional imaging in a compact, high-efficiency scanner

SIGNA™ Voyager AIR™ IQ Edition gives technologists and radiologists quick, patient-friendly exams with consistent, optimal image quality. Administrators love the rapid return on investment (ROI) this scanner can deliver, with the potential to save up to $100,000 over 10 years with up to 46% less power consumption*.

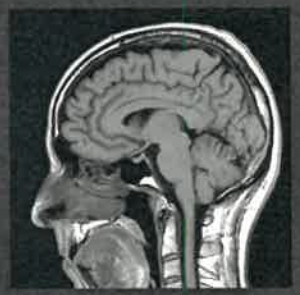
Whether your interest is efficiency, image quality or cost-effciency, this intelligent 1.5T wide bore scanner delivers. It's designed to be a masterful balance of comfort and productivity, with features that improve the patient experience and software that can optimize image quality and reduce exam time. And for hospitals looking for the flexibility of a dockable table, SIGNA™ Voyager AIR™ IQ Edition also offers the eXpress Patient Table option. It's built for improved patient handling, maneuverability and durability.



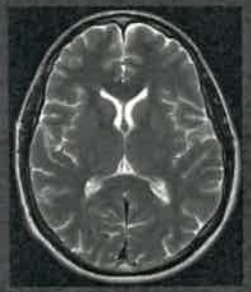
** Compared to conventional 1.5T wide bore designs*

AIR™ Recon DL

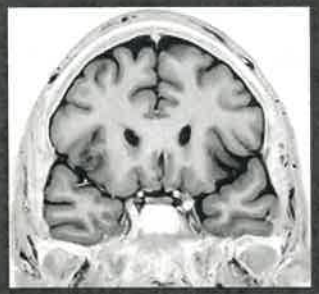
With AIR™ Recon DL, radiologists can have higher consistency and quality in the images they interpret. And technologists can acquire higher SNR without a time penalty. Scan time may also be reduced without compromising detail or SNR.



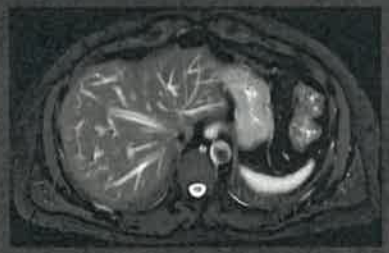
AIR™ Recon DL for Speed
Sagittal T1 FLAIR
0.8 x 1.2 x 5.0 mm
0:31 sec./23 slices



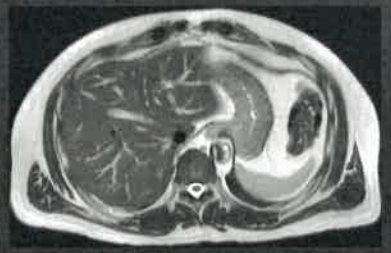
AIR™ Recon DL for Speed
Axial T2
0.8 x 1.2 x 5.0 mm
0:22 sec./24 slices



AIR™ Recon DL
Coronal STIR temporal lobes (inverted)
0.8 x 0.9 x 3.0 mm
0:52 sec./22 slices

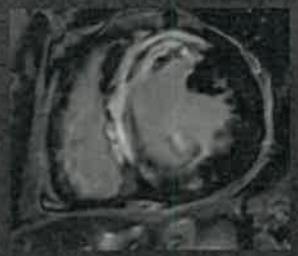


AIR™ Recon DL
Axial T2 SSFSE ASPIR
SnapShot Navigated
1.3 x 1.7 x 5.0 mm
1:13 min./35 slices

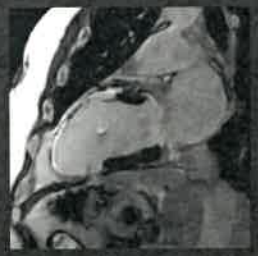


AIR™ Recon DL
Axial T2 SSFSE
SnapShot Navigated
1.3 x 1.7 x 5.0 mm
0:57 sec./35 slices

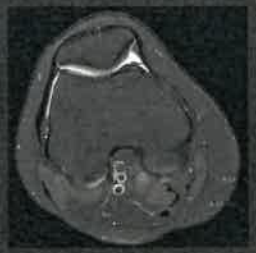
AIR™ Recon DL
Sagittal DWI FOCUS b800
1.5 x 3.7 x 2.3 mm
3:27 min./21 slices



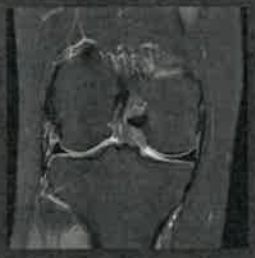
AIR™ Recon DL
Short Axis Single Shot MDE
Free Breathing
1.6 x 1.9 x 8.0 mm
0:09 sec.



AIR™ Recon DL
2ch Long Axis 2D MDE
1.8 x 2 x 8 mm



AIR™ Recon DL
Axial PD Fat Sat
0.4 x 0.6 x 3.0 mm
1:50 min.

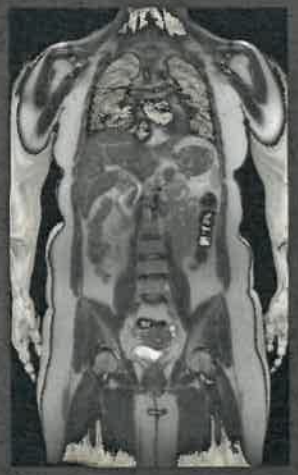


AIR™ Recon DL
Coronal PD Fat Sat
0.4 x 0.6 x 3.0 mm
1:57 min.

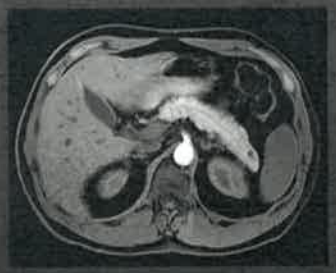
BodyWorks

Eliminate the variable of patient-breath holding and conquer timing challenges when conducting whole-body, abdominal and pelvic scans with our suite of simple, push button dynamic imaging applications that give you speed and the flexibility to adapt to different patient types and conditions.

The suite includes sensor-free motion correction and navigators that enable free-breathing exams with a broad range of contrast weighting like diffusion, SnapShot SSFSE, PROPELLER MB, MRCP and dynamic multi-phase T1 imaging.

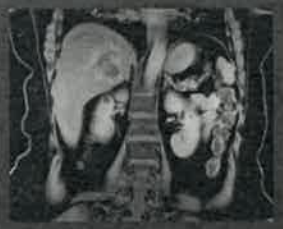


Coronal SSFSE
Whole body - 50 cm FOV, pasted
0:15 sec. and 0:18 sec.



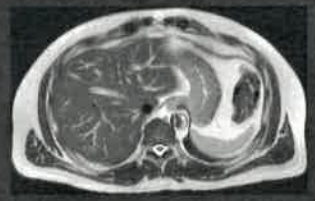
Axial LAVA-Flex Water Image
Breath Hold
1.0 x 1.8 x 3.4 mm
0:20 sec.

Axial LAVA Breath Hold
1.3 x 2.0 x 3.8 mm
0:17 sec.



Coronal LAVA Flex
with Auto Navigator
320 x 192
2.2 mm
1:04 min.

Axial T2 SSFSE ASPIR
SnapShot Navigated
1.3 x 1.7 x 5.0 mm
1:13 min./35 slices

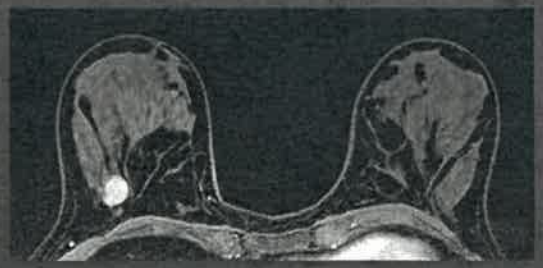


Axial T2 SSFSE
SnapShot Navigated
1.3 x 1.7 x 5.0 mm
0:57 sec./35 slices

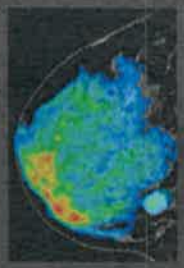
OncoWorks

This extensive library of techniques captures anatomic data to uniquely enable oncological assessment of the anatomy. OncoWorks includes diffusion techniques, robust tissue contrast and motion-insensitive, high temporal and spatial resolution imaging.

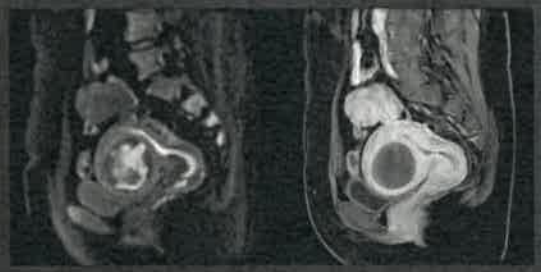
3D volumetric imaging with an optimized adiabatic fat suppression, combined with ARC or ASSET, provides high spatial and temporal resolution to capture contrast uptake patterns.



Axial DISCO Water Image and sagittal reformat
0.7 x 0.7 x 1.0 mm
1:01 min. per phase

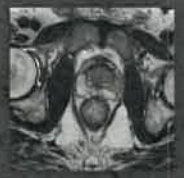


Sagittal DISCO reformat fused
with sagittal DWI FOCUS



Sagittal DWI MUSE b800
2.7 x 2.7 x 4 mm
3:20 min.

Sagittal 3D DISCO Dynamic
2.4 mm slices
12 phases, 11.6s/phase



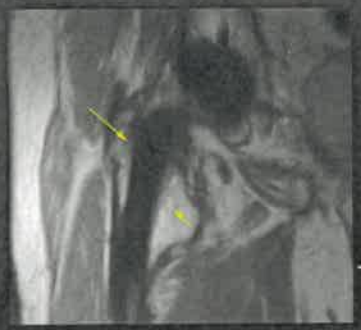
Axial T2 FSE
Ax T2 FSE w/ AIR™ Recon DL
0.4 x 0.7 x 3 mm
1:46 min.

FOCUS DWI
b50 / b800
4mm 100x50
4:23 min./26 slices

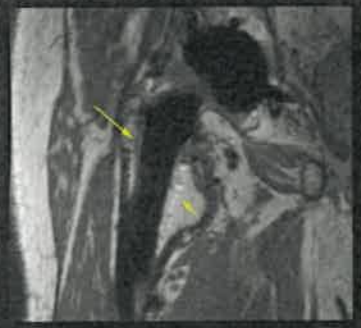
Motion correction and bone imaging

MAVRIC SL and HyperMAVRIC SL*

Use MAVRIC SL with HyperMAVRIC SL, which automatically tailors the acquisition to the patient's MR-Conditional implant, scanning 40% faster with higher resolution. It also enables isotropic imaging.



MAVRIC SL PD
0.4 x 0.6 x 4 mm

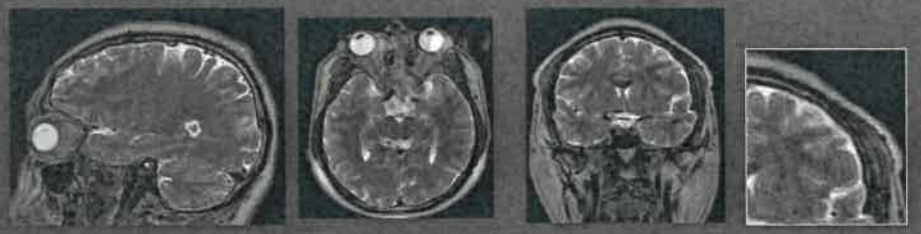


HyperMAVRIC SL PD
1.3 mm isotropic

Fibrous membrane formation in femur that was not appreciated in a conventional acquisition or same scan time.

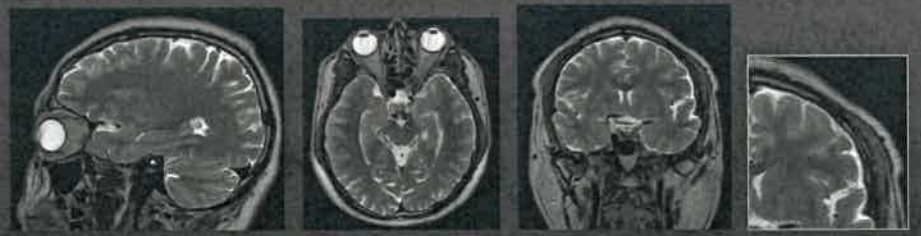
PROMO*

Minimize the effects of motion on routine imaging with an enhanced version of PROMO for motion robust neuro imaging and motion-corrected time course for cardiac perfusion imaging.



Without PROMO

T2 Cube
288 x 288
FOV 25 cm
1.2 mm slice
4:13 min.

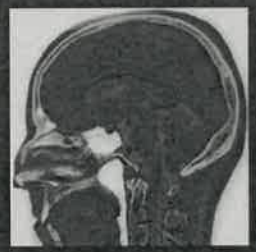


With PROMO

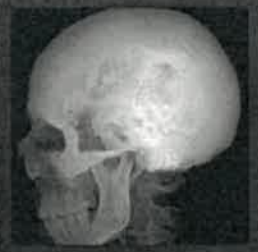
T2 Cube
with PROMO
288 x 288
FOV 25 cm
1.2 mm slice
4:20 min.

oZTEo*

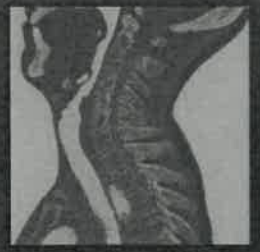
oZTEo, for imaging cortical bone surfaces, is inherently motion-insensitive and complements a conventional MR soft-tissue exam to deliver 3D isotropic imaging with familiar bright bone contrast.



Sagittal oZTEo skull
1.2 x 1.2 x 1.2 mm
3:00 min./140 slices

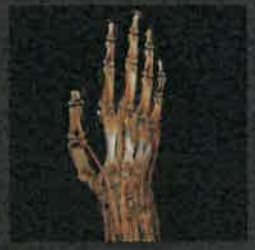


Skull in weighted MIP

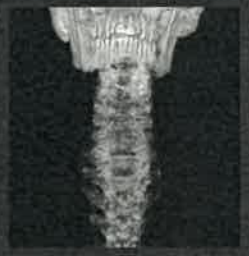


Sagittal oZTEo cervical vertebrae in MIP
1.2 x 1.2 x 1.2 mm
3:09 min./80 slices

Shoulder
1.0 x 1.0 x 1.0 mm
3:25 min.



Hand
0.8 x 0.8 x 0.8 mm
4:57 min.



Cervical vertebrae in volume rendering

*Purchasable option.

You no longer need to choose between consistent image quality, productivity and efficiency

Multiply the value of advanced 1.5T imaging in a smaller, more efficient MR with SIGNA™ Voyager AIR™ IQ Edition. With patient-friendly AIR™ Coils that maximize comfort and intelligent AIR™ Workflow applications that reduce exam time, this wide-bore system makes use of UHE technology and Total Digital Imaging to consistently deliver premium imaging performance with a low-running cost.

Patient-friendly design maximizes comfort and versatility

- Adaptive AIR™ Coils provide 360° degree of coverage to accommodate all types of scans and patients
- Comfort Plus Table offers more room for all patients
- Optional lightweight, detachable eXpress Patient Table improves patient handling and comfort and allows for faster patient setup
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Efficient with streamlined imaging performance

- 25% efficiency gain with Ultra High Efficiency (UHE) gradient system
- Fast, clear Total Digital Imaging (TDI) increases SNR by 25%
- 80% of cases get improved IQ without added time with AIR™ Recon*
- Acquire higher SNR without a time penalty and get images virtually free of artifact with AIR™ Recon DL

Consistently accurate. Consistently quick.

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- 5x faster set-up time & 4x fewer mouse clicks with AIR x™*
- 50% faster acquisition time with HyperWorks

** Results may vary.*

CURRICULUM VITAE

PERSONAL DATA

Name:	W. Michael McDonnell
Place of birth	Evanston, IL
Citizenship	US

EDUCATION

1975 - 1979	College of St. Thomas, St. Paul, Minnesota; B.A.
1979 - 1983	St. Louis University School of Medicine, St. Louis, Missouri; M.D.

POSTGRADUATE TRAINING

1983 - 1984	Intern, University of Michigan, Department of Internal Medicine, Ann Arbor, MI
1984 - 1986	Resident, University of Michigan, Department of Internal Medicine, Ann Arbor, MI
1986 - 1987	Research Fellow, University of Michigan, Division of Pediatric Infectious Diseases, Ann Arbor, MI
1987 - 1990	Fellow, University of Michigan, Department of Internal Medicine, Division of Gastroenterology, Ann Arbor, MI

ACADEMIC APPOINTMENTS

1990 - 1992	Instructor of Internal Medicine, University of Michigan, Ann Arbor, MI
1992 - 1997	Assistant Professor of Internal Medicine, University of Michigan, Ann Arbor, MI
1999-2001	Clinical Assistant Professor of Medicine, University of Washington, Seattle, WA
2001- 2008	Clinical Associate Professor of Medicine, University of Washington, Seattle
2008- present	Clinical Professor of Medicine, University of Washington, Seattle

HOSPITAL POSITIONS

1990-1997	Staff Physician University of Michigan Medical Center

1993 - 1997	Chief, Endoscopy Unit, Ann Arbor Veteran's Affairs Medical Center
1996 -1997	Interim Chief, Gastroenterology Section, Ann Arbor VAMC
1997-2014	Staff Physician Providence Everett Medical Center
2014-present	Associate Chief of Gastroenterology Puget Sound VAMC

HONORS AND AWARDS

1979	Delta Epsilon Sigma Honor Society
1990	Winner-Clinical Research Competition, 71st Annual Meeting, American College of Physicians, Chicago, IL
1990	Career Development Award, Department of Veterans Affairs
1994	Resource Award, Glaxo Institute for Digestive Health
2018	Seattle Met Top Doctor-Gastroenterology
2019	Seattle Met Top Doctor-Gastroenterology
2020	Seattle Met Top Doctor-Gastroenterology

BOARD CERTIFICATION

Board Certification:	Internal Medicine (ABIM) 1986 Gastroenterology (ABIM) 1989

LICENSURE

Medical Licensure:	Michigan medical license 1984 Permanent I.D. No. 4301048746 (exp 1-31-2001) Washington State license 1997 Number: MD00035287 (exp 11-2020) DEA BM3319539 (expiration 1-31-2022)
Medicare	UPIN A78418

PROFESSIONAL ORGANIZATIONS

1985-present	American College of Physicians Fellow (00055798)
1987-present	American Gastroenterology Association, Fellow (0000157794)
1990	American Federation of Clinical Research
1991-present	American Association for the Study of Liver Disease (000967)
1991-present	American Association for the Advancement of Science (10009491)
1997-1999	Membership Task Force Committee. American Association for the Study of Liver Disease
1997-2000	Membership Committee. American Association for the Study of Liver Disease
2004	Secretary, Pacific Northwest Gastroenterology Society
2005	President, Pacific Northwest Gastroenterology Society
2006-present	Chairperson of Board, Pacific Northwest Gastroenterology Society

2014-present	WSMA CME committee member

TEACHING RESPONSIBILITIES

1992 - 1993	Lecturer, Introduction to Clinical Sciences 601; a. April 1992, Occult Gastrointestinal Bleeding (1 hour), b. April 11, 1993, Gastrointestinal bleeding (1 hour)
1992 - 1997	Instructor, Comprehensive Clinical Assessment of M-3 students; a. July 25, 1992, 8:00 AM-12:00 PM, b. July 17, 1993, 8:00 AM-12:00 PM, c. July 19, 1995, 7:30 AM-12:00 PM, d. July 18, 1996, 7:30 AM-12:00 PM
1992 - 1997	Lecturer, Introduction To The Patient (ITTP), M1 students Small group leader for weekly two hour sessions; a. 1992 (8-27-92, 9-3-92, 9-24-92, 10-1-92, 10-8-92, 10-22-92); b. 1993 (9-9-93, 10-7-93, 10-28-93, 11-11-93, 11-18-93, 12-9-93); c. 1994 (9-1-94, 9-15-94, 10-27-94, 11-10-94, 12-1-94); d. 1995 (8-31-95, 9-14-95, 9-21-95, 10-5-95); e. 1996 (9-5-96, 9-19-96, 9-26-96, 10-10-96, 10-31-96)
1994 - 1997	Lecturer, Introduction to Clinical Sciences 601; a. January 12, 1994, Viral Hepatitis (1 hour), b. January 5, 1994, small group case discussion (2 hour), c. January 12, 1995, Viral Hepatitis (1 hour), d. January 3, 5, 10, 12, 17 1995. Small group case discussion (10 hours), e. January 5, 1996, screening for colon cancer (2 hours), f. January 11, 1996, Viral Hepatitis (1 hour), g. January 10, 1997, screening for colon cancer (2 hours), h. January 16, 1997, Viral Hepatitis (1 hour), i. January 7, 9, 14 1997, Small group cases discussions (10 hours).
1994 - 1997	Physical Diagnosis Final Exam preceptor; a. 1994 (4-28, 2:00-5:00 PM); b. 1995; c. 1996 (4-16, 2:00-5:00 PM)
2009-2014	Providence Everett Medical Center: Teaching 3rd year medical students, one hour per month
2014-present	Clinical teaching; one month per year Puget Sound VA GI consultation service; Endoscopy teaching of GI fellows and surgical residents two days per week.
2019	"Time for a change up: Proton Pump Inhibitors" Spring Training for Primary Care. Seattle, WA April 11-12, 2019

National Invitational lectures

International

1994	Invited Speaker, Update in Gastroenterology, Hanoi, Vietnam, March 1-5, 1994. Ho Chi Minh City, Vietnam, March 14-17; Acute liver disease 3/1, 3/7; Chronic liver disease 3/1, 3/7; Hepatitis C virus 3/5, 3/10; Truth and fiction in the medical literature 3/3, 3/7; Daily CPC's done March 14-17
1995	Invited Speaker, International North-South Dialog: Therapeutic strategies for ulcus pepticum. "Induction of CYP1A gene in the human alimentary tract", Institute for Biochemical Pharmacology, Innsbruck, Austria, June 30-July 2, 1995

EDITORIAL RESPONSIBILITIES

2000-2003	Journal of Clinical Outcomes Medicine (Editorial Board)
2012- 2018	Clinical Liver Disease, AASLD (Editorial Board)

SPECIAL NATIONAL RESPONSIBILITIES

SPECIAL LOCAL RESPONSIBILITIES

1993-1997	Ann Arbor VA Endoscopy Committee (Chair)
1993-1997	Ann Arbor VA Invasive Procedures Committee
1994-1997	Ann Arbor VA Drug Usage Evaluation Committee
1997-2014	Providence Everett Medical Center Education Committee
2014-present	Puget Sound VA SOIP Committee
2008-present	Chair, Pacific Northwest GI Society
2014- present	WSMA CME Committee member

RESEARCH FUNDING

PAST

Title: "P450 gene expression and the effect of tobacco in human alimentary tract"
Funding Agency: Veterans Administration, Career Development Award
PI: W.M. McDonnell
Amount: $57,669 direct cost/year
Funding Period: 7/90 to 6/93

Title: "Gastroenterology Training Grant"
Funding Agency: National Institutes of Health, Center Training Grant
PI: Tadataka Yamada, M.D.
Trainee: W.M. McDonnell
Funding Period: 7/89 to 6/90

Title: "Gene transfer of HCV core region: a model for anti-viral vaccination"
Funding Agency: U of M Cancer Center, Pilot Feasibility Project
PI: W. Michael McDonnell
Amount: $10,000, total cost
Funding Period: 2/1/94 to 1/31/95

Title: "P450 expression in the human intestine"
Funding Agency: American Cancer Society IRG 40-33, U of M Cancer Center's Institutional Grant

PI: W.M. McDonnell
Amount: $7,500, total cost
Funding Period: 11/91 to 10/92

Title: "Gene transfer of HCV core region: a model for anti-viral vaccination"
Funding Agency: Glaxo Institute for Digestive Health, Resource Award
PI: W.M. McDonnell
Amount: $10,000, total cost
Funding Period: 7/1/94 to 6/30/95

Title: Unrestricted Research and Education Gift
Funding Agency: Hoffman LaRoche, Inc.
PI: W.M. McDonnell.
Amount: $80,000
Funding Period: 1/95

Title: "Placebo controlled study of lamivudine and interferon in patients with chronic HBV who are interferon nonresponders"
Funding Agency: Glaxo Research Institute, Protocol #NUCAB3011
PI: W.M. McDonnell
Amount: $10,000 per patient
Funding Period: 3/1/95 to (no specific end date)

Title: "A study of lamivudine or placebo in patients with chronic HBV who are treatment naive"
Funding Agency: Glaxo Research Institute, Protocol #NUCAB3010
PI: W.M. McDonnell
Amount: $10,000 per patient
Funding Period: 3/1/95 to (no specific end date)

Title: "HCV DNA transfer: immune response as a marker of cellular processing"
Funding Agency: University of Michigan GI Peptide Research Center
PI: W.M. McDonnell
Amount: $15,000
Funding Period: 9/1/95 to 8/31/96

Title: "A sensor for spatial imaging of colonscopes"
Funding Agency: National Institutes of Health, NIDDK, 1R43DK48579-02, SBIR phase II
PI: Yansong Shan
Co-Investigator: W.M. McDonnell
Amount: Direct costs $707,240
Funding Period: 11/1/95 to 10/30/97

Title: Unrestricted Research and Education Gift
Funding Agency: Astra Merck Inc.
PI: W.M. McDonnell
Amount: $24,500
Funding Period: 1/96

Title: Unrestricted Research and Education Gift
Funding Agency: Astra Merck Inc.
PI: W.M. McDonnell
Amount: $25,000
Funding Period: 9/96

Title: "Phase II clinical trial of difluoromethylornithine (DFMO) in Barretts esophoagus"
Funding Agency: National Institutes of Health CN-65000
PI: Dean Brenner, M.D.
Co-Investigator: W.M. McDonnell
Amount: Total Direct costs $890,000
Funding Period: 10/2/95 to 9/30/97

Title: "HCV DNA transfer: Immune response as a marker of cellular processing
Funding Agency: Blowitz Ridgeway Foundation
PI: W.M. McDonnell
Amount: $25,600
Funding Period: 10/1/96 to 9/30/97

Title: "A study of extended lamivudine treatment for hepatitis B patients previously enrolled in phase 2 or 3 lamivudine trials"
Funding Agency: Glaxo Research Institute , Protocol # NUCAB3017
PI: W.M. McDonnell
Amount: $9,715 per patient
Date of Submission: 8/1/96 to 7/31/02

Title: "A randomized double blind, controlled safety study of multiple ascending doses of recombinant human IL-12 in adults with chronic hepatitis C virus infection previously treated with alpha-interferon."
Funding Agency: Wyeth-Ayerst Research Department and Genetics Institute, Inc, Protocol 0879A3-111-US, Phase I study
PI: W.M. McDonnell
Amount: $120,000
Date of Submission: 1-1-97 to 12-31-97

BIBLIOGRAPHY

a. Publications in Refereed Journals

1. McDonnell WM, Roth MS, Sheagren JN: *Hemophilis influenzae* type b cellulitis in the adult. Am J Med 81:709-12, 1986.
2. McDonnell WM, Gilsdorf JR, Kent JB, Sheagren JN: Relationship of health-related variables to levels of anti-PRP antibodies in adults. J Clin Micro 26:1202-1206, 1988.

3. McDonnell WM, Ryan JA, Seeger DM, Elta GH: Effect of iron on the guaiac reaction. Gastroenterology 96:74-79, 1989.

4. Traber PG, Wang W, McDonnell M, Gumucio JJ: Expression and regulation of P450IIB genes in rat small intestine: identification and cloning of intestinal mRNA using the polymerase chain reaction. Molec Pharmacol 37:810-819, 1990.

5. Gilsdorf JR, McDonnell WM: Mucosal antibodies to *Haemophilus influenza* type b capsular polysaccharide. Ped Res 29:420-423, 1991.

6. McDonnell WM, Van Dyke RW: Transgenic approach to hepatitis B virus liver damage. (Hepatology Elsewhere) Hepatology 13:191-3, 1991.

7. Barnett JL, McDonnell WM, Appelman HD, Dobbins WO: Familial visceral neuropathy with neuronal intranuclear inclusions; diagnosis by rectal biopsy. Gastroenterology 102:684-691, 1992.

8. McDonnell WM, Elta GH: Acute hepatitis C infection; interferon finally succeeds. Gastroenterology 103:1359-1360, 1992.

9. McDonnell WM, Scheiman JM, Traber PG: Induction of cytochrome P450IA genes (CYP1A) by omeprazole in the human alimentary tract. Gastroenterology 103:1509-1516, 1992.

10. Traber PG, McDonnell WM, Wang W, Florence R: Expression and regulation of P450I genes in rat alimentary tract. Biochim Biophys Acta 1171(2):167-175, 1992.

11. McDonnell WM, Lucey MR: Alpha-fetoprotein elevation associated with loss of HBeAg in patients with chronic hepatitis B. Am J Gastroenterol 88, 1993.

12. McDonnell WM, Lucey MR: Hepatitis C viral transmission during organ transplantation. (Hepatology Elsewhere) Hepatology 17:162-164, 1993.

13. McDonnell WM: Gene transfer as a new mode of vaccination: implications for hepatitis C virus. Hepatology 18:696-698, 1993.

14. Carethers JC, McDonnell WM: Extraintestinal manifestations of Crohn's disease. N Engl J Med 330:1870, 1994.

15. Hitomi Y, McDonnell WM, Baker Jr. JR, Askari FK: High efficiency prokaryotic expression and purification of a portion of the hepatitis C core protein and analysis of the immune response to recombinant protein in BALB/c mice. Viral Immunol 8:109-119, 1995.

16. McDonnell WM, Owyang C: Effects of smoking on interdigestive gastrointestinal motility. Dig Dis Sci 40:2608-2613, 1995.

17. McDonnell WM, Lucey ML: Hepatitis C infection. Curr Opin Infect Dis 8:384-390, 1995.

18. Kohagen KR, Kim MS, McDonnell WM, Chey WD, Owyang C, Hasler WL: Nicotine effects on prostaglandin-independent gastric slow wave rhythmicity and antral motility in non-smokers and smokers. Gastroenterology 110:3-11, 1996.

19. McDonnell WM, Hitomi E, Askari FK: Identification of bilirubin UDP-GTs in the human alimentary tract in accordance with the gut as a putative metabolic organ. Biochem Pharmacol 51:483-488, 1996.

20. Carethers JC, McDonnell WM, Scheiman JM, Owyang C: Massive secretory diarrhea and pseudoobstruction as the initial presentation of Crohn's disease. J Clin Gastroenterol 23:55-59, 1996.

21. Hitomi Y, McDonnell WM, Killeen AA, Askari FK: HCV core gene sequence fidelity confirms core protein as an appropriate target for HCV vaccine strategies. J Viral Hep 2:235-241, 1996.

22. McDonnell WM, Chensue SW, Askari FK, Moseley RH: Hepatic fibrosis in Ahr-/- mice. Science 271:223-224; 1996.

23. McDonnell WM, Lok AS, Fendrick AM: Decisions in the treatment of chronic HCV infection. J Clin Out Med 3:15-24; 1996.

24. McDonnell WM, Askari FK: Molecular Medicine: DNA vaccines. N Engl J Med 334:42-45, 1996.

25. Askari FK, McDonnell WM: Molecular Medicine: Anitsense oligonucleotides in clinical medicine. N Engl J Med 334:316-318, 1996.

26. McDonnell WM, Lok ASF: GBV-C and HGV, a new hepatitis virus? Gastroenterology 111:1776-1778, 1996.

27. McDonnell WM, Lok ASF: Testing for HCV RNA in serum: when and how [editorial]. Vir Hep Rev 2:81-83, 1996.

28. Jung F, McDonnell WM. Barium impaction in the sigmoid colon. N Engl J Med 337:1278, 1997 .

29. McDonnell WM, Lok ASF. Viral hepatitis. Current Opinion in Gastro. 13:228-234, 1997

30. McDonnell WM, Askari FK. Immunization. J Am Med Assoc. 278:2000-2007, 1997.

31. McDonnell WM. Screening for colon cancer: where basic science meets randomized control trials [editorial]. JCOM 4:56-57, 1997

32. Jefferies MA, McDonnell WM, Tworek JA, Merion RM, Moseley RH: Veno-occlusive disease of the liver following renal transplant. Dig Dis Sci. 43, 229-234, 1998.

33. McDonnell WM, Jung F. Prevention of barium impaction. (letter reply) N Engl J. Med. 338:624, 1998

34. McDonnell WM. Is PBC a complication of pregnancy? Hepatology 28:593-594, 1998

35. Ladabaum U, McDonnell WM. Images in clinical medicine: Barrett's esophagus with high grade dysplasia. N Eng J Med. 341:1439, 1999

36. McDonnell WM, Lucey MR. Hepatitis C: Approaching the patient. J Clinical Outcomes Medicine. 7:50-59, 2000.

37. Stern MA, Fendrick AM, McDonnell WM, Gunaratnam N, Moseley R, Chey WD: A randomized, controlled trial to assess a novel colorectal cancer screening strategy: the conversion strategy--a comparison of sequential sigmoidoscopy and colonoscopy with immediate conversion from sigmoidoscopy to colonoscopy in patients with an abnormal screening sigmoidoscopy. Am J Gastroenterol. 2000 Aug;95(8):2074-9

38. McDonnell WM. Liver stem cells from bone marrow. Hepatology. 2000 Nov;32(5):1181.
39. Johnson KL, Samura O, Nelson JL, McDonnell M, Bianchi DW. Significant fetal cell microchimerism in a nontransfused women with hepatitis C: Evidence of long-term survival and expansion. Hepatology 2002; 36:1295-1297
40. Stevens AM, McDonnell WM, Nelson JL. Male cells in female recipients. N Engl J Med. 2002 Jul 18;347(3):218-20.
41. McDonnell WM, Dominitz JA. CT colonography. Gastroenterology 127:693; 2004
42. Stevens AM, McDonnell WM, Mullarkey ME, Pang JM, Leisenring W, and Nelson JL. Liver biopsies from human females contain male hepatocytes in the absence of transplantation. Laboratory Investigation 2004;84:1603-9
43. Mullarkey ME, Stevens AM, McDonnell WM, Loubiere LS, Brackensick JA, Pang JM, Porter AJ, Galloway DA, Nelson JL. Human leukocyte antigen class II alleles in Caucasian women with primary biliary cirrhosis. Tissue Antigens 2005;65:199-205
44. McDonnell WM, Loura, F, Pointen M, Greenson JL, Catscratch Colon. Endoscopy 2007; 39:459-61
45. McDonnell WM, Bhattacharya R, Halldorson JB. Fulminant hepatic failure after use of the herbal weight-loss supplement Exillis. Ann Intern Med 2009; 151:673-4

b. Book Chapters

1.McDonnell WM: Intestine. Chapter 3. In: Yamada T, Alpers D, Owyang C, Powell D, Silverstein FE (eds): Textbook of Gastroenterology Self Assessment Test (Philadelphia, PA: J.B. Lippincott Company), 1993.

2.McDonnell WM, Dawson D: Pathophysiology of Diarrhea. Chapter 5. In: Hendersen J (ed): Gastrointestinal Pathophysiology (Philadelphia, PA: J.B. Lippincott Company), pgs 71-109, 1996.

3.Kolars JC, McDonnell WM: Gastroenterology and Hepatology. In: Wooliscoft JO (ed) Current Diagnosis and Treatment, 2nd edition (Current Medicine, Inc, Philadelphis PA and Mosby-Yearbook, Inc St. Louis, MO) 1998

c. Published Books

None

d. Other Publications

1. McDonnell M, Elta G: More on oral iron and the Hemoccult test. N Engl J Med 321:1684, 1989.
2. Carpenter SL, McDonnell WM: Misuse of veterinary phenylbutazone. Arch Int Med 155:1229-1231, 1995.
3. McDonnell WM, Loura F. Complications of colonoscopy [letter]. Ann Intern Med. 2007 Aug 7;147(3):212-3

4. McDonnell WM. "Cat scratch" colon: an impressive but innocent endoscopic finding. [response] Endoscopy 2007; 39
5. McDonnell M. Cat scratch colon is caused by barotraumas secondary to insufflation during colonoscopy. [response] Endoscopy 2008; 40:878
6. McDonnell WM. That Cursed Dyspepsia [letter] Clin Gastroenterol Hepatol. 2018; Oct 16(10)1679

e. Manuscripts submitted

f. Abstracts.

1.McDonnell WM, Elta GH, Ryan J: *In vitro* effects of ferrous sulfate on the Hemoccult II test. Gastroenterology 90:1542, 1986. (Presented at the American Gastroenterological Association meeting in San Francisco, May, 1986).

2.McDonnell WM, Elta GH: Ingestion of oral iron does not produce false positive Hemoccult II or HemoQuant tests for occult blood. Gastroenterology 90:1542, 1986.

3.Gilsdorf JR, McDonnell WM: Mucosal antibodies to *H. influenzae b* (Hib) capsular polysaccharide. 15th Michigan-Northwest Ohio Society for Infectious Diseases, Detroit, MI, February 20, 1988.

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HEALTH INSURANCE

Amid a Physician Shortage, 51% of Primary Care Providers Are Nurse Practitioners and Physician Assistants

by Maggie Davis

updated Aug 22, 2022

Nurse practitioners (NPs) and physician assistants (PAs) are filling the primary care physician gap. Here's which states have the highest percentage of NPs and PAs in primary care.

A doctor speaks to a patient. Source: Getty Images

The COVID-19 pandemic spotlighted America's health care workers, as well as staffing shortages in an industry where people are increasingly overworked. Although the pandemic caused significant health care staff shortages, it also exacerbated those developing before the crisis struck — namely, an increasing lack of physicians in the U.S.

There's an increasing demand for health care professionals. America is an ever-growing and aging nation — the U.S. Census Bureau even projects that the number of older adults will be higher than the number of children for the first time in 2034. Older adults need regular health care, particularly with 6 in 10 adult Americans having a chronic disease.

However, other health care professionals are stepping in to provide primary care. According to ValuePenguin health insurance expert Robin Townsend, the emergence of these professionals in primary care has benefits.

"Nurse practitioners and physician assistants are (at least partially) filling the primary care provider gap left by physicians," Townsend says. "That's good for patients across the U.S. — especially those without insurance — as it gives them better access to affordable care."

On this page

Key findings

- **There are 168.7 primary care providers (PCPs) for every 100,000 Americans**. The District of Columbia has the highest rate of PCPs at 464.1 per 100,000 residents.

On the other hand, Washington state has just 107.9 PCPs per 100,000 residents — making it the state with the lowest rate of PCPs.

- **Nurse practitioners (NPs) and physician assistants (PAs) help fill those primary care gaps**. In fact, NPs and PAs make up a larger portion of primary care providers than physicians. While 48.8% of PCPs in the U.S. are physicians (including doctors specializing in internal medicine, family medicine and pediatrics), 42.9% are NPs and 8.2% are PAs.
- **Kansas has the highest percentage of NPs and PAs in PCP roles (80.9%)**. That's followed by Louisiana (77.5%) and North Dakota (72.9%). Meanwhile, the District of Columbia has the highest percentage of physicians in PCP roles (76.3%), followed by Hawaii (68.2%) and Pennsylvania (63.1%).
- **Since 2016, the number of nurse practitioners has jumped by 56.2%**. Similarly, the number of those in PA roles has increased by 27.8%. Meanwhile, physicians in the combined specialties of internal medicine, family medicine and pediatrics have dropped by 0.21%.
- **NPs and PAs are among the 10 fastest-growing professions, according to U.S. Bureau of Labor Statistics (BLS) projections**. From 2020 to 2030, NP jobs are predicted to grow by 52.2%, while PA roles are expected to grow by 31.0%. At the same time, the predicted growth for all occupations is 7.7%.

Rate of primary care providers varies widely by state

For every 100,000 Americans, there are 168.7 primary care providers (PCPs), but those figures vary extensively by state. Washington state ranks lowest, at 107.9 PCPs per 100,000 residents.

Following that, the states with the lowest rates include:

- **Nevada:** 114.2 PCPs per 100,000 residents
- **Oregon:** 115.6 PCPs per 100,000

On the other hand, the District of Columbia has the highest rate of PCPs at 464.1 per 100,000 residents. That's followed by:

- **Alaska:** 281.2 PCPs per 100,000 residents
- **Tennessee:** 260.1 PCPs per 100,000

Many states with the lowest rate of PCP providers have more countywide primary care shortages than the states with the highest rates. An earlier ValuePenguin study on health care workforce shortages found that 41% of counties within Washington state have a lack of PCPs — the third-highest. Meanwhile, Nevada ranked first, with 63% of counties in the state facing a shortage of PCPs.

> Primary care health professional shortage areas (HPSAs) are determined using the following factors:
>
> - Population-to-provider ratio
> - Percentage of population below 100% of the federal poverty level
> - Infant Health Index, which factors infant mortality rates or low birth weight rates
> - Travel time to the nearest source of care outside the HPSA area

On the opposite end of the list, just 8% of counties in Tennessee have a PCP shortage. And while the District of Columbia wasn't included in the original study, three of the next four states with the highest rate of PCPs had deficiencies in 20% or less of their counties.

Still, there are some exceptions. Oregon (third-lowest PCP rate) had a notably smaller shortage of PCPs — affecting just 25% of counties in the state — while Alaska (second-highest PCP rate) ranked notably higher, with 79% of counties facing a PCP shortage.

Full rankings: States with the fewest primary care providers per capita

Rank	State	Population	Total PCPs	Rate of PCPs per 100,000 residents
1	Washington	7,738,692	8,350	107.9
2	Nevada	3,143,991	3,590	114.2
3	Oregon	4,246,155	4,910	115.6
4	Hawaii	1,441,553	1,700	117.9
5	Alabama	5,039,877	6,090	120.8
6	Illinois	12,671,469	15,510	122.4
7	Utah	3,337,975	4,520	135.4
8	Texas	29,527,941	40,110	135.8
9	Louisiana	4,624,047	6,350	137.3
10	Kansas	2,934,582	4,050	138.0
11	New Mexico	2,115,877	2,930	138.5
12	California	39,237,836	54,750	139.5

Show All Rows

Source: ValuePenguin analysis of U.S. Bureau of Labor Statistics (BLS) and U.S. Census Bureau data

51.1% of PCPs are nurse practitioners and physician assistants

When thinking about primary care, a doctor likely comes to mind. And that may be the case for some Americans — internal medicine, family medicine and pediatrics are primary care specialties in which physicians practice.

But a PCP doesn't necessarily need to be a physician — in fact, more than half of PCP providers aren't physicians at all. Rather, when comparing the number of physicians

specializing in PCP roles with the number of nurse practitioners (NPs) and physician assistants (PAs) in the U.S., ValuePenguin researchers found:

- 48.8% of PCPs are physicians
- 42.9% are NPs
- 8.2% are PAs

Townsend believes that varying levels of education likely play a role in the difference between the type of providers in PCP roles.

> "NPs and PAs finish school and become licensed more quickly than physicians, which means they can start practicing sooner," Townsend says. "Educational costs are lower, too, making the NP and PA fields open to more people. And fewer medical school graduates are choosing primary care as their specialty."

Only 29.2% of U.S. physicians practice in a primary care specialty, according to a ValuePenguin analysis of a 2019 report from the Association of American Medical Colleges (AAMC). This rate has been declining over the past decade. Though many factors may contribute to the decline in physicians in primary care specialties, pay, burnout and an increasing number of physicians leaving likely contribute.

Primary care is among the lowest-paid specialties at an average of $255,000 annually, according to a 2022 Medscape report. In comparison, those in plastic surgery earn an average of $576,000 — the highest among those examined. Although primary care physician salaries are still well above the national median salary of $45,760, many physicians may prefer working within a higher-earning specialty — particularly those with hefty medical school debt.

Meanwhile, an analysis of studies on PCP burnout — emotional exhaustion and reduced feelings of accomplishment at work — found that the prevalence of self-reported burnout among PCPs range from 13.5% to 60%, according to a study published in the Medical Care Research and Review journal. Coupled with that, 1 in 3 primary care clinicians reported in March 2021 that they expected to leave primary care within five

years, according to a survey from the Larry A. Green Center, a Richmond, Va.-based research, development and advocacy firm.

Which states have the lowest percentage of physicians in primary care roles?

The percentage of physicians in PCP roles varies by state, too. Overall, Kansas has the lowest percentage of physicians in PCP roles. Of the PCP providers in the state, just 19.1% are physicians, while 72.0% are NPs and 8.9% are PAs. That's followed by:

- **Louisiana:** 22.5% of PCPs are physicians
- **North Dakota:** 27.1%

Meanwhile, the District of Columbia has the highest percentage of physicians in PCP roles (76.3%), followed by:

- **Hawaii:** 68.2% of PCPs are physicians
- **Pennsylvania:** 63.1%

With NPs and PAs earning significantly less than physicians, cost of living may have something to do with the varying percentages of physicians in primary care. The states with the lowest percentage of physicians in PCP roles generally have a lower cost of living. In comparison, those with the highest percentage of physicians in PCP roles generally have a higher cost of living.

Full rankings: States with the lowest percentage of physicians in PCP roles

Rank	State	Percentage of PCPs who are NPs	Percentage of PCPs who are PAs	Percentage of PCPs who are physicians
1	Kansas	72.0%	8.9%	19.1%
2	Louisiana	70.5%	7.1%	22.5%
3	North Dakota	63.1%	9.8%	27.1%

Rank	State	Percentage of PCPs who are NPs	Percentage of PCPs who are PAs	Percentage of PCPs who are physicians
4	West Virginia	61.3%	8.7%	29.9%
5	Alabama	67.4%	2.4%	30.2%
6	Mississippi	67.0%	2.1%	30.9%
7	North Carolina	52.8%	15.5%	31.7%
8	New Jersey	56.9%	11.0%	32.2%
9	Utah	54.6%	12.3%	33.2%
10	Tennessee	61.8%	4.7%	33.5%
11	Washington	48.9%	11.3%	39.8%
12	Georgia	47.0%	13.1%	40.0%

Show All Rows

Source: ValuePenguin analysis of BLS and Census Bureau data

While NP and PA roles are growing, physician roles are shrinking

Since 2016, the number of people employed as nurse practitioners has jumped from 150,230 to 234,690 — an increase of 56.2%. PA roles have grown, too: The number of PAs has risen 27.8%, jumping from 104,050 in 2016 to 132,940 in 2021.

Meanwhile, the number of physicians in primary care specialties has dropped 0.21% in the same period.

Growth rate of U.S. physicians, NPs and PAs (2016 to 2021)

Year	Physicians	NPs	PAs
2016	195,220	150,230	104,050
2017	197,710	166,280	109,220
2018	180,440	179,650	114,710
2019	183,720	200,600	120,090
2020	176,740	211,280	125,280
2021	194,810	234,690	132,940
Growth rate (2016-2021)	-0.21%	56.2%	27.8%

Source: ValuePenguin analysis of BLS data

However, the demand for physicians is growing. The BLS predicts that the U.S. will need 91,400 physicians by 2026, according to a 2020 report from Human Resources for Health — a 13% increase from 2016. And as the physician shortage worsens, some areas in the U.S. will be more impacted than others. By 2030, the regions with the largest estimated shortage ratios — according to the same report — will be:

- The West (69 unfilled physician roles per 100,000 people)
- The South (62 unfilled physician roles per 100,000 people)
- The Midwest (41 unfilled physician roles per 100,000 people)

On the other hand, the Northeast will have a surplus of 50 physicians per 100,000 people.

In light of this, Townsend says NPs and PAs will play an increasingly vital role in primary care — but that's not necessarily a bad thing.

"More and more NPs and PAs are caring for patients in all stages of life, including older Americans, and this trend will continue," Townsend says. "NPs and PAs are well-equipped to manage chronic diseases with outcomes similar to medical doctors. In fact, NPs and PAs provide health care at a lower cost than medical doctors and are more

likely to treat patients directly, rather than refer them for unnecessary follow-up health services. This is good for the patient and saves on health care costs, especially for Medicare."

Plus, notably, a study published in 2020 in the journal Medical Care suggests that patients of NPs and PAs have lower odds of inpatient hospital admissions and require less frequent emergency department visits. Not only does that indicate a higher level of care, but it suggests millions of dollars saved in patient care.

NP and PA jobs are among the 10 fastest-growing professions

While there's a stark discrepancy between the growth rates of NPs and PAs compared to physicians, it's only projected to get wider. In fact, NP and PA jobs are among the 10 fastest-growing jobs in the U.S. From 2020 to 2030, the BLS predicts that NP jobs will grow by 52.2%, while PA roles will grow by 31.0%.

Meanwhile, all physicians and surgeon jobs are projected to grow just 3.0% from 2020 to 2030, slower than the average of 7.7% for all occupations. Notably, it's also slower than the predictions for employment in health care occupations overall, which are projected to grow by 16.0%.

With physicians growing at a much slower rate, Townsend says NPs and PAs will play a vital role in preventing a shortage of PCPs.

"With fewer medical doctors choosing the primary care field, it's important that NPs and PAs continue filling their role," Townsend says. "Primary care providers act as medical 'gatekeepers.' Without them, patients are more likely to go directly to the hospital for their medical needs. This puts a greater burden on the U.S. health care system."

Top factors to consider when choosing a new provider

Whether you visit a physician, NP or PA, having a PCP is vital to your long-term health. To determine the PCP that's right for you, Townsend offers the following advice:

- **Keep your needs in mind**. For example, those with a heart condition should look for a primary provider who can meet those needs and is connected with specialists and facilities in the field. You should also ensure that the provider accepts your insurance — including Medicare or Medicaid.
- **Determine your compatibility**. Townsend recommends calling the office to get a first impression of the practice your potential PCP runs. Do you feel comfortable and welcomed as a potential new patient? How far in advance do you have to make appointments? Is this a group or individual practice?
- **Use the government resources available to you**. Townsend recommends using the Physician Compare tool to find primary care providers in your area, which also allows you to read about quality issues that may have been reported. It's a Medicare tool, but anyone can use it.

Methodology

Researchers determined the number of primary care providers ("PCPs") by analyzing May 2021 data from the U.S. Bureau of Labor Statistics (BLS) to determine the number of employed physicians in the primary care specialties.

Specifically, researchers looked at the number of physicians specializing in internal medicine, family medicine and pediatrics. Researchers then determined the number of people employed as nurse practitioners (NPs) and physician assistants (PAs) in each state.

To calculate the rate of PCPs per 100,000 residents, researchers compared the number of PCPs in each state with population data from the Census Bureau 2020 American Community Survey (with five-year estimates).

Editorial Note: The content of this article is based on the author's opinions and recommendations alone. It has not been previewed, commissioned or otherwise endorsed by any of our network partners.

Craig Marks

From: Shannon Hitchcock
Sent: Thursday, September 15, 2022 9:50 AM
To: !All Staff
Subject: Craig Will Be Dunked @ 3pm Tomorrow!

Shannon Hitchcock
Chief Communications Officer / E.D. of the Foundation | Community Relations
PROSSER MEMORIAL HEALTH
723 MEMORIAL ST | PROSSER, WA 99350
o: (509) 786 6601
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Prosser Memorial Health

Attachment S

Prosser Memorial Health

Patient Loyalty Summary Report: "Would Recommend" Mean

Data pulled: 9.19.22 mf

Survey Group	2022 Goal	Aug 2022	# Of Surveys	YTD 2022	# Of Surveys	% Rank	Patient Survey Comments
Emergency Depart.	>84.0%	85.23	22	88.05	159	59	"Excellent job and I feel so confident going into this hospital." "Thank you all for what you do! We're so blessed to have you!"
HCAHPS-Inpatient	>93.1%	90.79	19	91.06	161	76th	"The hospital is like a well-oiled machine. I'm so happy I choose Prosser."
Acute Care	>91.8%	85	5	88.99	84	60	"I can not say anything bad about my stay. Everything was fantastic!"
Family Birthplace	>93.6%	100	5	95.74	47	91st	"OB staff was amazing, as well as the lactation consults"
Out-Patient Surgery	>96.6%	91.35	26	95.61	114	21st	"There was knowledgeable staff at admitting front desk, Receptionist was very professional and quick. I recommend this hospital to others." "I felt very special the way I was treated. I lost an earring and nurse Esther made sure I got I back. Extremely happy. Thank you so much."
Clinic Network	>91.0%	90.63	48	92.67	375	22nd	"Some of the best care I have ever received. I truly felt cared for and valued. Will recommend to everyone."
Out-Patient Services	>94.1%	90.63	48	94.81	376	55th	"DI staff were amazing. I was nervous at first by their ability to make me feel at ease and comfortable was effortless. The had me laughing and interacting with me, asking me questions and were very informative while getting my X-rays done. Thank you for being so kind ladies."

	2022 Goal	YTD Score	Equation				*Composite score based on 2020 departmental revenue contributions
Composite Score	92.6%	**93.37%**	ED	0.13x	88.05	11.45	ED: 13%
			IP	0.16x	91.06	14.66	IP: 16% (Includes AC, OB)
			OR	0.23x	95.61	21.99	OP-Surgery: 23%
			Clinics	0.11x	92.67	10.19	Clinic: 11%
			OP	0.37x	94.81	35.08	Outpatient: 37%

Press Ganey_Facility Scorecard_(Specific service line)_Mean (Last month or YTD)_x9152810overall assessment Likelihood of Recommending_

PROSSER MEMORIAL HEALTH EMPLOYEE NEWSLETTER

THE PULSE

Prosser Memorial Health

SEPTEMBER | 2022

News & Events

Annual Pool Party

Prosser Memorial Health employees and families came together to enjoy the annual pool party!

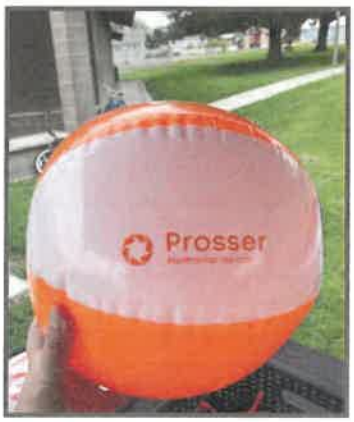

















U-HAUL










News & Events

Mask Burning Cermony

Prosser Memorial Health employees gather around to witness the burning of Craig's old mask and raising $1,100 for the Foundation!

Prosser National Night Out

PMH was represented at the 1st Annual National Night Out in Prosser. It was a great time to get to support our community with a fun event. The Benton City Clinic was at their National Night Out too!

Benton Franklin Fair

Congratulations to our Benton Franklin Fair raffle winners! Bonnie Bair enjoyed her annual corndog and lemonade!

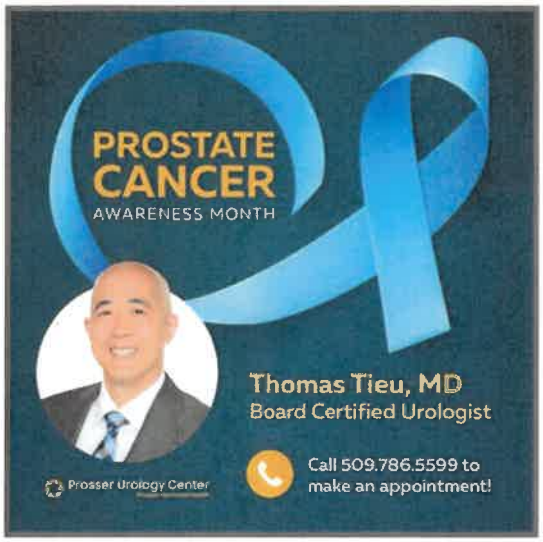
Surgery Team Throwback

The surgery team at PMH recreated throwback photos from 2014!

This is how we care.

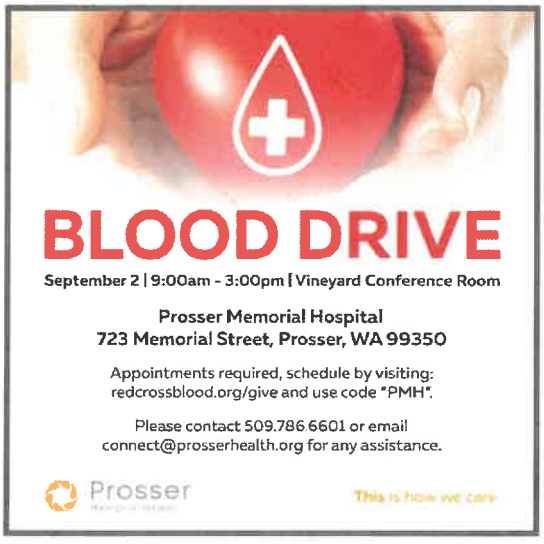
Yakima Valley Fair & Rodeo Livestock Auction

Craig Marks, Merry Fuller, Rosemary Mendoza, and Annie Tiemersma represented Prosser Memorial Health at the YVFR Livestock Auction. Prosser Memorial Health purchased Vanessa Robin's goat, Peyton Robinson-Hollenbeck's lamb, Connor Bowden's lamb and Cassie Smithyman's steer! This is one of the many ways PMH supports our local youth.



September is Prostate Cancer Awareness Month

September is Prostate Cancer Awareness Month, a time to help people learn about prostate cancer and the importance of screenings. Prostate cancer is the second most common cancer among men. To schedule an appointment with Dr. Thomas Tieu, please call 509.786.5599.



Blood Drive

Prosser Memorial Health will hold a blood drive on September 2 at 9:00am - 3:00pm.

Wine Country Classic

Join us on Friday, September 9 for the Wine Country Classic at Canyon Lakes Golf Course in Kennewick. Event starts at 8:00am.

Football Season

Thank you to Dr. Strebel, Dr. Halvorson, and Dr. Proctor for representing Prosser Memorial Health at local varsity and junior varsity games in Prosser and Grandview this year!

ASPIRE Awards

Our ASPIRE program recognizes team members who demonstrate our core values of Accountability, Service, Promoting Teamwork, Integrity, Respect and Excellence.

Maryann Hildebrant

Congratulations to Maryann Hildebrant, RN in our Acute Care Department, for receiving a Gold ASPIRE Award! Maryann took on the monumental task of reviewing, reformatting, and uploading ALL of our hospital and clinic policies to a new platform. This was a huge undertaking that took hours and hours and hours of time and attention to detail to accomplish. Great job! On behalf of your PMH team THANK YOU Maryann!

Denise Guillen

Congratulations to Denise Guillen, RN at the Specialty Clinic, for receiving the Silver ASPIRE Award! Denise jumped in and helped cover rooming patients and other duties when the clinic was very short staffed. She also went above and beyond by driving to Benton City to ensure a patient could get their prescription since they did not drive. She then drove to Grandview to deliver a new wound pump to a patient. All with a smile on her face! On behalf of your PMH Team and our patients, thank you!

Justin Herzog

Congratulations to Justin Herzog, CT Technologist in our Diagnostic Imaging Department, for receiving a Bronze ASPIRE Award! Justin was recognized by a co-worker for his compassion during a very stressful time. Justin went above and beyond to help another employee access assistance through our employee support programs and took the time to listen to her. It meant a great deal to this employee and she wanted to make sure everyone knew how amazing Justin is, not only with his patients, but with his teammates as well. Thank you Justin!

Anniversaries

Happy Anniversary!

Thank you for being an essential part of Prosser Memorial Health's success.

Happy 1 Year

- **Katelyn Greene**
  EMS EMT - B
- **Rachel Voegele**
  EMS Paramedic
- **Susan Graf**
  Medical/Surgical RN
- **Ke'Andre Striegel Hardy**
  Diagnostic Imaging Ultrasonographer - R
- **Elvira Jasso**
  Collector/Cash Posting/Credit Balance
- **Cecilia Barraza**
  Environmental Services Technician
- **Dr. Brian Proctor**
  Grandview Clinic
- **Jocelyn Martinez**
  Prosser Clinic CMA
- **Reymundo Rodriguez**
  Maintenance Mechanic

Happy 2 Years

- **Rachel Castillo**
  Surgical Services RN
- **Oscar Vela**
  Emergency Services ED Technician
- **Isabel Jimenez**
  Prosser Women's Health Center CMA
- **Gabriela Guel**
  Family Birthplace RN
- **Ana Garcia**
  Prosser Specialty Clinic CMA
- **Becky Morris**
  Grandview Clinic CNM-WHNP

Happy 3 Years

- **Edith Nateras**
  Emergency Services ED Technician
- **Rosalinda Mendoza**
  Grandview Clinic Patient Services Rep
- **Katy Davis**
  Nursing Administration
  RN Resources Nurse
- **Steven Rode**
  ER Physician

Happy 5 Years

- **Peter Lewis**
  Laboratory Medical Technologist

Happy 6 Years

- **Stephanie Turner**
  Nursing Administration
  RN Resource Nurse
- **Olena Larsen**
  Surgical Services
  Central Sterilizing Technician

Happy 7 Years

- **Amy Shook**
  Surgical Services RN First Assist
- **Maria Rivera**
  Medical/Surgical Acute Care Technician
- **Brittney Derderian**
  Emergency Services RN
- **Maryann Hildebrant**
  Nursing Administration
  RN Resource Nurse
- **Kathleen Atkinson**
  Medical/Surgical RN

Happy 9 Years

- **Allison Young**
  Medical/Surgical RN
- **Sofia Flores**
  Laboratory Assistant II

Happy 11 Years

- **Sasha Thomasson**
  Director of Co-ordination

Happy 14 Years

- **Rusti Wilson**
  Director of Cardiopulmonary

Happy 15 Years

- **Jennifer Smith**
  Diagnostic Imaging CT Technologist - R

Happy 16 Years

- **Rita Galvan**
  Prosser Specialty Clinic Surgery
  Scheduler Coordinator

Birthdays

Free 20oz Busy Bean Coffee on your birthday!

On your birthday, we just want to let you know that it is a great pleasure working with truly inspirational figures like yourselves. Thank you for all the incredible support you give towards Prosser Memorial Health. Happy Birthday to you all! #ThisIsHowWeCare

September 1
- **Gaylin Griffits**
  EMS Paramedic

September 3
- **Yolanada Montiel**
  Staff Accountant
- **Amanda Hibbs**
  CT Technologist - R
- **Irene Chavez**
  Medical/Surgical Acute Care Tech
- **Glenn Bestebreur**
  Board Member

September 4
- **Robert Wenger**
  ER Physician
- **Maria Persinger**
  Medical/Surgical RN
- **Rebecca Hernandez**
  Health Information Management Technician II

September 7
- **John McPartland**
  Board Member
- **Angela Garcia**
  Cook

September 8
- **Amber Guthrie**
  Nuclear Medicine Technologist
- **Brandon Bowden**
  Board Member

September 9
- **Oscar Vela**
  Emergency Services ED Technician

September 12
- **Kristi Shoman**
  RN Resource Nurse
- **Dr. Jared Clifford**
  Prosser Orthopedic Center

September 17
- **Crystal Blanco**
  HR Generalist
- **Esmeralda Arroyo Onate**
  Medical/Surgical Acute Care Technician
- **Dr. Jayme Thompson**
  Prosser Clinic
- **Tracy Von Moos**
  Collector/Cash Posting/ Credit Balance

September 18
- **Margarita Sanchez**
  Cook

September 19
- **Jay Boyle**
  Wound Care Nurse

September 20
- **Alma Gonzalez**
  OR Scheduler Technician

September 21
- **Annie Barrera**
  Environmental Services Technician
- **Evelia Galvez**
  Medical/Surgical Acute Care Technician
- **Stephanie Turner**
  RN Resource Nurse
- **Dr. Brian Proctor**
  Grandview Clinic

September 23
- **Maria Cardenas**
  Outpatient Hospital Scheduler

September 24
- **Andrea Valle**
  Director of Health Information Management
- **Bailey Padilla**
  Prosser Women's Health Center CNM

September 25
- **Timothy Shipley**
  EMS EMT - B

September 26
- **Kayla Coder**
  Lab Assistant II

September 27
- **Karla Greene**
  RN Resource Nurse

September 28
- **Heather S. Morse**
  Prosser Clinic
- **Chantal Thornburg**
  Emergency Services RN

September 29
- **Rosalinda Mendoza**
  Grandview Clinic Patient Services Rep
- **Jacobo Rivero**
  ER Physician

September 30
- **Lucia Ramirez**
  Prosser Women's Health Center CMA
- **Alejandra Arteaga Martinez**
  Medical/Surgical RN

Twenty 22

September

REACH

THE SAVER'S TAX CREDIT -- CAN YOU BENEFIT?

It's not always easy to keep contributing to your employer-provided retirement plan. Bills and unexpected expenses can eat up most of your salary, leaving little for retirement savings. You might be tempted to forget about it until you start earning more money.

But before you stop or cut back (or never start) contributing to your plan, understand that you could be entitled to a federal tax credit called the Retirement Savings Contributions Credit, or Saver's Credit, if you meet certain income requirements. In effect, the credit repays a percentage of the contributions you make to your 401(k) or other retirement savings plan by reducing your income tax liability for the year. It may be just the thing that enables you to keep participating in your retirement plan or increase your contributions..

What It Is

The credit is a percentage -- 50%, 20%, or 10% -- of up to $2,000 in qualified retirement savings contributions for a maximum credit of $1,000 (or twice that amount for a married couple filing jointly who each contribute $2,000). The percentage depends on adjusted gross income (AGI) and filing status. The credit is available for contributions to a 401(k), 403(b), governmental 457(b), SIMPLE IRA, or salary reduction SEP, as well as for traditional and Roth IRA contributions.

To claim the credit, you must be at least age 18, not claimed as a dependent on another person's return, and not a full-time student. You will not be able to claim the credit if your AGI exceeds the top of the range for the 10% credit.

2022 Tax Credit				
	50% of Contribution	**20% of Contribution**	**10% of Contribution**	**0% of Contribution**
Tax Filing Status	**Adjusted Gross Income**			
Married filing jointly	$41,000 or less	$41,001-$44,000	$44,001-$68,000	> $68,000
Head of household	$30,750 or less	$30,751-$33,000	$33,001-$51,000	> $51,000
All other filers*	$20,500 or less	$20,501-$22,000	$22,001-$34,000	> $34,000
*Single, married filing separately, or qualifying widow(er)				
Source: IRS.gov, "Retirement Savings Contributions Credit (Saver's Credit)"				

If you have questions regarding your retirement plan, please contact Nora Newhouse in Human Resources, ext. 6688.

SUGAR-FREE PALEO APPLE CRISP

Ingredients:

- 4 apples (use Granny Smith if desired)
- 2 tsp lemon juice
- 2 tsp + 1 tsp vanilla extract, divided
- 2 tsp + 1/2 tsp cinnamon, divided
- 1/2 tsp nutmeg
- 1/3 cup coconut oil
- 1 cup almond flour
- 2–4 tbsp swerve or erythritol, optional
- 1/2 cup pecans, chopped
- 1/2 cup shredded coconut

Instructions:

1. Preheat your oven to 400 degrees.
2. Core, peel, and thinly slice the apples. Toss the apples with the lemon juice, 2 tsp vanilla extract, 2 tsp cinnamon, and nutmeg. Dump into an 8×8" baking dish.
3. Melt the coconut oil, then mix in the almond flour, Monk Fruit if desired, pecans, shredded coconut, and 1/2 tsp cinnamon. Sprinkle over the apples, then sprinkle the remaining 1 tsp vanilla extract over everything.
4. Bake at 400 degrees for 20 minutes covered, then another 10-20 uncovered. The apples should be somewhat soft and bubbling when it's finished.

- **Prep Time: 15 min**
- **Cook Time: 30 min**
- **Yield: 9 servings**

Prosser
Memorial Health

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2023 Health & Welfare Compliance Requirements

The following should be carefully reviewed for plan years that begin in 2023. This chart is not exhaustive and does not include many ongoing compliance requirements. Please work with your service team to review USI's full Compliance Checkup for a broader picture of your employee benefits compliance requirements.

This chart also includes temporary changes as a result of the COVID-19 pandemic. Provisions that are no longer relevant have been removed. We will continue to update this tool as necessary.

Temporary Health and Welfare Compliance Requirements Related to the COVID-19 Pandemic

Important Definitions

Emergency Period. HHS issued a Public Health Emergency beginning January 27, 2020. This *Emergency Period* is now set to expire **October 13, 2022** (unless further extended or shortened by HHS).[1]

Outbreak Period. The *Outbreak Period* started on March 1, 2020. The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, or 2) 60 days after the announced end of the COVID-19 National Emergency.[2]

✓	Topic	Applies to:	Description
	COVID-19 Testing	All group health plans	**Temporary: March 18, 2020 through the end of the *Public Health Emergency Period*** All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing, prior authorization, or medical management. ▪ Includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered, including drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing. ▪ Includes at-home testing when ordered by an attending heath care provider who has determined the test is medically appropriate. ▪ Includes antibody testing. ▪ No balance billing with respect to the COVID-19 test – does not preclude balance billing for items and services that are not the COVID-19 tests (however state law or other agreements may control). ▪ For OON providers, plan must pay listed cash price (or, negotiated lower price) for the COVID-19 testing (not for other items and services). ▪ Plans must provide coverage for testing without cost-sharing for asymptomatic individuals when the purpose for testing is individualized diagnosis or treatment. Cannot use medical screening criteria to deny (or impose cost-sharing on) a claim for COVID-19 diagnostic testing for an asymptomatic person who has no known or suspected exposure to COVID-19. ▪ Does not include testing for employment or surveillance purposes.

[1] For more information, visit https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

[2] For purposes of the Outbreak Period, on March 13, 2020, President Trump declared a National Emergency concerning the COVID-19 pandemic effective beginning March 1, 2020. A national emergency generally extends for one year. On February 18, 2022, President Biden issued a Notice continuing the National Emergency beyond March 1, 2022, for an effective extension to February 28, 2023 (unless an earlier termination is announced). The announced end date of the National Emergency may not be the same date as the end of the Public Health Emergency period announced by HHS. For more information, see USI's Compliance Update, "Guidance Issued on Outbreak Period" (February 26, 2021).

✓	Topic	Applies to:	Description
			▪ Effective for OTC COVID-19 tests purchased on or after January 15, 2022 through the end of the Emergency Period, plans must cover diagnostic OTC COVID-19 tests without requiring a health care provider's order or prescription. – Limits of 8 test/member/month (covered family of 4 can receive up to 32 tests/month) – If there is an established network to access free OTC tests at point of sale (both online and at retailers), then reimbursement for tests provided out-of-network may be limited to $12/test (or the actual cost of the test if less). Otherwise, the plan must reimburse the actual cost of the test. – May require substantiation for the reimbursement – Does not include testing for employment purposes
	Preventive Care – COVID-19 Vaccine	All non-grandfathered group health plans	**Permanent** ▪ Non-grandfathered group health plans must cover, without cost-sharing (both in-network and out-of-network[3]), *qualifying coronavirus preventive services* (including immunizations) immediately once the particular vaccine becomes authorized under an Emergency Use Authorization ("EUA") or approved under a Biologics License Application ("BLA"), and according to the scope of the applicable EUA or BLA.[4] So far, three vaccines have received this approval: – Pfizer BioNTech (full FDA approval on August 23, 2021) – Moderna (full FDA approval on January 31, 2022) – Johnson & Johnson ▪ This includes any amendment to the EUA or BLA for a particular vaccine, including the administration of an additional dose to certain individuals, booster doses or the expansion of the age demographic for whom the vaccine is authorized or approved. ▪ Grandfathered group health plans are encouraged to provide similar coverage. ▪ Plans should not deny coverage of a recommended COVID-19 vaccine because the participant or beneficiary is not in the specific category recommended for early vaccination. ▪ The U.S. government has paid for the cost of the vaccine and its distribution. Group health plans will be responsible for paying for the administration of the vaccine. For vaccine administration out-of-network, a group health plan must reimburse providers an amount that is reasonable determined in comparison to prevailing market rates for such service. The amount that would be paid under Medicare is considered reasonable.[5] Providers are prohibited from balance billing patients. ▪ Self-funded plans may be asked to opt in to covering the administration costs through the medical plan, pharmacy benefit, or both.

[3] Must provide out-of-network coverage without cost-sharing during the Public Health Emergency Period for COVID-19

[4] This change is effective January 5, 2021. Earlier guidance indicated coverage must be provided within 15 business days following an applicable recommendation by the Advisory Committee on Immunization Practices ("ACIP") and adopted by the CDC. Due to confusion, this timing requirement will only be enforced prospectively.

[5] Effective for services furnished on or after March 15, 2021, the new Medicare Payment rate for administering a COVID-19 vaccine is approximately $40 to administer each dose of a COVID-19 vaccine. This means that starting on March 15, 2021, for single dose COVID-19 vaccines, Medicare pays approximately $40 for its administration. Starting on March 15, 2021, for COVID-19 vaccines requiring multiple doses, Medicare pays approximately $40 for each dose in the series. Before March 15, 2021, the Medicare payment rate for administering a COVID-19 vaccine was $28.39 for a single dose. In cases where two or more doses are needed (the expectation for several of the vaccines), the initial rate of administration was $16.49, and the final dose was $28.39. These rates will be geographically adjusted. ***See*** *Toolkit on COVID-19 Vaccine: Health Insurance Issuers and Medicare Advantage Plans* (updated Dec. 23, 2021).

✓	Topic	Applies to:	Description
	Deadline Extensions	All ERISA group health and welfare benefit plans Government plans are encouraged, but not required, to comply	**Temporary** Must disregard the *Outbreak Period* for the following: ▪ COBRA* – Timeframe for the employer to provide a COBRA election notice – 60-day election period for a qualified beneficiary to elect COBRA – COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments) – Deadline to notify the plan of qualifying events or disability determinations ▪ HIPAA Special Enrollment Rights (*major medical plans only*) – 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage or marriage, birth* or adoption* ▪ ERISA Claims Deadlines* – Timeframe to submit a claim and appeal of an adverse benefit determination (includes health FSAs and HRAs) For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request ▪ Example: Joe terminated employment resulting in a loss of group health plan coverage after April 30, 2020. This triggered a COBRA qualified event. Joe would have been required to elect COBRA by June 29, 2020. However, under this relief, Joe has until the earlier of the following dates to timely elect COBRA: – June 29, 2021; or – the end of the Outbreak Period **Important Note:** ▪ These deadline extensions may extend beyond the current plan year, in some cases with coverage going into effect retroactively for many months. There are concerns about what gaps in insurance coverage there could be. This may be an issue if the employer changes carriers, including stop loss carriers, at renewal. It is important to review your policies (especially stop loss) to understand whether such coverage would be available. ▪ Consider providing notice regarding the end of the relief period to affected individuals. This may be a best practice in light of the guidance. ▪ Reissue or amend any plan disclosures that were issued prior to or during the pandemic if the earlier disclosures failed to provide accurate information regarding the time in which participants and beneficiaries were required to take action, (e.g., COBRA election notices and claims procedure notices). ▪ ERISA group health plans should consider ways to ensure that participants and beneficiaries who are losing coverage under their group health plans are made aware of other coverage options that may be available to them, including the opportunity to obtain coverage through the Health Insurance Marketplace in their state. * Retroactive application for COBRA, birth, adoption, and claims.

✓	Topic	Applies to:	Description
	Fiduciary Relief of Certain Notification and Disclosure Deadlines	All ERISA plans	**Temporary** With respect to documents and disclosures due to be furnished during the *Outbreak Period* ▪ A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document[6] if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable. ▪ Good faith includes use of alternative electronic means for communicating with participants and beneficiaries where the plan and fiduciary reasonably believes the individual has effective access to electronic communications including emails and text message. ▪ Example. If a plan would have been required to furnish a notice or disclosure by March 1, 2020, the relief would end with respect to that notice or disclosure on February 28, 2021. The plan fiduciary would be required to ensure that the notice or disclosure was furnished on or before March 1, 2021.
	Enforcement	All ERISA plans	**Temporary** ▪ Plan fiduciaries should make reasonable accommodations to prevent the loss of benefits or undue delay in benefit payments in such cases and should attempt to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established timeframes (as reinforced in Notice 2021-1). ▪ The approach to enforcement will emphasize compliance assistance and include grace periods and other relief where appropriate, including when physical disruption to a plan or service provider's principal place of business makes compliance with pre-established timeframes for certain claims' decisions or disclosures impossible.
	Revoking Required COVID-19 Changes	Grandfathered health plans	**Temporary** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the *Emergency Period* (for example, added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status solely because the changes are later reversed when the *Emergency Period* expires and the terms of the plan that were in effect prior to the *Emergency Period* are restored.
	Enhanced Benefits During COVID-19 Pandemic	HDHPs and HSAs	**Temporary** ▪ The following may be provided to individuals before the minimum statutory deductible is satisfied without jeopardizing HSA eligibility: – Required coverage for COVID-19 testing and related services without cost-sharing, as described above. – For plan years that begin before December 31, 2021, telehealth and remote care services. **This relief expires for plan years that begin on or after January 1, 2022 except for telehealth or other remote care services provided in April – December 2022. The relief expires again after December 31, 2022.** o Calendar year plans will have a 3-month gap (January - March 2022) where telehealth or other remote care services provided before satisfaction of the deductible may be disqualifying coverage. ▪ May provide coverage for COVID-19 treatment before satisfaction of the minimum statutory deductible without cost-sharing. Relief applies until further guidance is issued.

[6] Various ERISA notices are affected by this relief, including SPDs, SMMs, SBCs. For more information, see USI's May 5, 2020 National Compliance Update, "New Guidance Offers Relief and Extends Deadlines for Benefit Plans."

✓	Topic	Applies to:	Description
	Excepted Benefits and COVID-19 Testing	EAPs	Temporary An EAP will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis, testing and/or vaccinations (including administration) for COVID-19 during the *Emergency Period*. Therefore, an EAP that offers benefits for diagnosis of, or testing for, or vaccination for COVID-19 may still qualify as an excepted benefit. Note, to preserve this status, no cost-sharing is permitted and the EAP must comply with other applicable rules.
	Expanded Telehealth and Remote Care Services	Large employers (at least 51 employees)	Temporary The following are available with respect to plan years that begin before the end of the *Emergency Period*. ▪ Large employers may offer telehealth or other remote care services only to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer. ▪ The arrangements must comply with the prohibition on preexisting condition exclusions, discrimination based on a health status, prohibition on rescissions, and mental health and substance use disorder parity.
	SBC Changes	Group health plans	Temporary ▪ Notify participants as soon as reasonably practicable of any mid-year changes to the SBC related to COVID-19 (as opposed to the 60 days advance notice requirement). ▪ If, at the end of the *Emergency Period* the plan reverses changes related to COVID-19 mid-plan year, the 60-day advance notice requirement does not apply, and notice of the change as soon as reasonably practicable is permissible, so long as the plan: – had previously notified the participants that the changes were temporary (such as through the COVID-19 public health emergency); or – notifies participants within a reasonable timeframe in advance of the reversal of the changes.
	COVID-19 Testing: Employment Practices	Employers with at least 15 employees	Temporary **EEOC Guidance (FAQs)** ▪ *Temperature Testing*. The Equal Employment Opportunity Commission ("EEOC") has stated in previous guidance that an employer may take the body temperature of employees during the COVID-19 pandemic. (FAQ. A.3). ▪ *Diagnostic Testing*. The EEOC has stated that an employer may administer a COVID-19 test before permitting employees to enter the workplace during the COVID-19 pandemic if the employer can show it is job-related and consistent with business necessity. (FAQ A.6). ▪ *Screening*. Employers may ask employees who will be physically entering the workplace if they have COVID-19 or symptoms associated with COVID-19 during the COVID-19 pandemic. (FAQ A.8). ▪ *Antibody Testing*. The Centers for Disease Control and Prevention ("CDC") and the EEOC have indicated that employers should not use antibody testing as part of a return to work strategy. (FAQ A.7).

✓	Topic	Applies to:	Description
	COVID-19 Vaccine: Employment Practices	Employers with at least 15 employees Special rules apply to Federal Contractors and Entities that are Medicare and Medicaid Certified Facilities	▪ The EEOC issued guidance specific to COVID-19 vaccines. According to the guidance, a mandatory vaccination program may be permissible unless: – a disability prevents the employee from taking the vaccine (ADA); or – an employee's sincerely held religious belief, practice, or observance prevents him from taking the vaccine (GINA, Title VII). ▪ Pre-screening questions related to the administration of the vaccine may be impermissible disability related inquiries under the ADA unless job-related and consistent with business necessity. Exceptions for voluntary programs[7] and administration by a non-contracted third party. ▪ Must offer a reasonable accommodation for those with disability or religious objection. ▪ Incentives are permissible. – Exception: If the employer (or the employer's agent) administers the vaccine then the incentive cannot be substantial as to the employee, and no incentive is permitted with respect to family members of the employee. ▪ Incentives offered under a group health plan will need to comply with HIPAA health contingent wellness program requirements for activity-only programs (30% limits on incentive, reasonable alternative standard offered to those who cannot be vaccinated for medical reasons). ▪ OSHA's Emergency Temporary Standard ("ETS") requiring employers with at least 100 employees to adopt a mandatory vaccination policy or for unvaccinated workers, weekly testing and masking, was overturned by the courts and does not apply. ▪ Employers that are federal contractors (Fed. Contractor Mandate) or Medicare and Medicaid certified facilities (CMS Mandate) must ensure their employees are fully vaccinated, subject to reasonable accommodations under the ADA and Title VII. – Supreme Court held CMS mandate is valid. – Fed. Contractor mandate currently not enforced nationwide pending litigation.
	Election and Plan Design Changes	Health FSA	**Temporary and Required.** ▪ Claims deadlines for a health FSA that occur during the *Outbreak Period* are disregarded and any submission deadline applies as of the end of the *Outbreak Period*. – Includes any appeals
	State or Local COVID-19-Related Leave	Various	▪ Employers should review whether any state or local laws (such as earned sick leave or family leave laws) require additional leave or protections for workers due to COVID-19. ▪ A comprehensive discussion or list of these state and local requirements is beyond the scope of this checklist.

[7] Meaning that employees can choose whether or not to get the COVID-19 vaccine from the employer or its agent.

Other Requirements Affecting Health and Welfare Plans

✓	Topic	Applies to	Description
	Transparency in Coverage – Machine-Readable Files	Non-grandfathered medical plans	Plans and carriers must make public three machine-readable files disclosing **(1)** in-network rates, **(2)** out-of-network ("OON") allowed amounts and billed charges, and **(3)** negotiated rates and historical net prices for covered prescription drugs. ▪ Deadline to publish **(1)** and **(2)** above is: – For a plan year that begins between January 1, 2022 and July 1, 2022, July 1, 2022. – For plan years that begin after July 1, 2022, the month in which the plan year begins. ▪ Requirement to publish machine-readable files for prescription drugs **(3)** delayed pending further rulemaking. Employers sponsoring a fully insured arrangement can rely on the carrier to post this information when there is an agreement between the plan and the carrier. If the carrier fails to provide full or timely information, the carrier (not the plan/employer) is liable. While a self-funded health plan may contract with a TPA to provide the required disclosure, the plan is ultimately responsible. If a group health plan does not have its own public website, nothing in the final rules requires the plan to create its own website for the purposes of providing a link to where the MRFs are publicly available. A plan may satisfy the disclosure requirement by entering into a written agreement under which a TPA posts the machine-readable files on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable. Plan sponsors should confirm whether carriers and/or TPAs will prepare and publicly post files as required under the law. Files must be updated monthly on an ongoing basis.
	Transparency in Coverage ("TiC") – Price Comparison Tools (including CAA[8] requirements)	All group medical plans[9]	For plan years that begin on or after January 1, 2023, plans must provide for the disclosure of cost sharing information in advance of receiving care through an internet-based self-service tool, in paper form or by telephone (added by CAA). The initial compliance deadline applies to 500 identified items and services. Full compliance required for plan years beginning on or after January 1, 2024. The CAA included similar disclosure requirements that are largely duplicative and set to take effect for plan years beginning on or after January 1, 2022. Enforcement of CAA requirements are deferred until the first plan year on or after January 1, 2023 to align with the TiC rules. Plans are encouraged to continue to make existing price comparison tools available to participants and beneficiaries and works toward full compliance.

[8] Consolidated Appropriations Act, 2021.
[9] While the specific transparency in coverage price comparison regulations only apply to non-grandfathered plans, based on guidance in FAQ 49 the requirements under the CAA are largely duplicative and will apply to all group health plans (regardless of grandfathered status).

✔	Topic	Applies to	Description
	No Surprises Act ("NSA") – Balance billing protection	All group medical plans	Applies to group health plans that begin on or **after** January 1, **2022.** ▪ Self-funded plans are subject to the NSA unless the self-funded plan choses to "opt-in" to an available state program. ▪ Fully insured plans are subject to the NSA unless state law[10] or the All-Payer Model Agreement[11] applies. With respect to OON emergency services, non-emergency services furnished by an OON provider in an in-network facility and OON air ambulance services, the NSA requires the services be provided: ▪ without cost-sharing requirements that are greater than those that would apply if the services were provided in-network; ▪ by calculating cost-sharing requirements as if the total amount that would have been charged for the services were equal to the "recognized amount" for such services; and ▪ by counting any cost-sharing payments toward any in-network deductible or out-of-pocket maximum ("OOPM") (including the annual limit on cost-sharing). There is a prescribed process for plan and payer payment, including an Independent Dispute Resolution ("IDR") process when the payment is disputed. **Notice requirement.** Plans must make publicly available, post on a public website of the plan or issuer and include on each EOB for an item or service with respect to which the NSA applies a notice of the protections under the NSA. The model NSA disclosure has been updated for use by group health plans and carriers for plan years beginning on or after January 1, 2023. Before this date, a plan may use either the original model notice or the updated version. If the group health plan does not have a website, the plan may satisfy the public posting requirement through agreement with a carrier/TPA to post the information on its public website where information is normally made available to participants. **Emergency services.** Final rules clarify that a determination of what constitutes an emergency medical condition cannot be based on final diagnosis code. Rather all pertinent documentation must be considered and should focus on the presenting symptoms. Plan sponsors should discuss compliance with carriers/TPAs. For additional details, see USI's National Compliance Update, First Guidance on Surprise Medical Billing Issued (July 22, 2021).
	Air Ambulance Disclosure	All group medical plans	**Air Ambulance Disclosure.** Plans must submit data regarding air ambulance services on a calendar year ("CY") basis for 2022 and 2023 within 90 days of the end of the calendar year. ▪ For CY 2022, by March 31, 2023, regardless of plan year. ▪ For CY 2023, by March 31, 2024 regardless of plan year. At this time, no guidance has been issued.

[10] According to the regulations, 33 states that have enacted balance billing protections. For more information, see the Commonwealth Fund, State Balance billing Protections, https://www.commonwealthfund.org/sites/default/files/2021-03/Hoadley_state_balance_billing_protections_table_02052021.pdf. New Jersey, Nevada, Virginia, and Washington permit a self-funded plan to "opt-in" to the state's balance billing law.

[11] The All-Payer Model Agreement ("APMA") under Sec. 1115A of the Social Security Act. According to the regulations, Maryland, Pennsylvania and Vermont use the APMA.

✓	Topic	Applies to	Description
	Continuity of Care	All group medical plans	For plan years beginning on or after January 1, 2022, a patient in a course of treatment[12] with an in-network provider/facility that becomes OON must be notified and given an opportunity to receive coverage on the same terms for up to 90 days. Regulations are expected, but not until after January 1, 2022. Plans should implement this requirement using good faith, reasonable interpretation of the statute.
	Compensation Transparency	ERISA-covered group health plans	▪ Effective for contracts issued on or after December 27, 2021. ▪ Fiduciaries of a group health plan (regardless of size) must obtain a written disclosure of services and compensation from "brokers" and "consultants" earning at least $1,000 in direct or indirect compensation. ▪ Definition of broker/consultant appears broad, may include parties who are not considered traditional brokers/consultants (e.g., pharmacy benefit managers, wellness vendors, and third-party administrators). ▪ Fiduciaries should receive the disclosure reasonably in advance of each contract date and renewal date. ▪ Fiduciaries will be required to report brokers/consultants to the DOL if they do not comply.
	ID Cards Transparency	All group medical plans	For plan year beginning on or after January 1, 2022, group health plan ID cards (physical or electronic) must include (in clear writing): ▪ Any applicable deductibles ▪ Any applicable out-of-pocket maximum limitations, and ▪ A telephone number and website address for individuals to seek consumer assistance. Regulations are expected, but not until after January 1, 2022. Plans should implement this requirement using good faith, reasonable interpretation of the statute. The Departments will not deem a plan out of compliance where the ID card is issued to participants and beneficiaries with the following: ▪ the applicable major medical deductible and applicable out-of-pocket maximum, ▪ a telephone number and website address for consumer assistance, and to access additional applicable deductibles and maximum out-of-pocket limits (including a QR code on the ID card).

[12] Generally, this provision applies to serious and complex conditions, pregnancy, terminal illness, individuals undergoing a course of institutional or inpatient care, or scheduled to undergo nonelective surgery (or post-operative care related to the surgery).

✓	Topic	Applies to	Description
	Prohibition on Gag Clauses on Price and Quality Data	All group medical plans	Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from: ▪ providing provider-specific cost or quality of care information or data; ▪ electronically accessing de-identified claims and encounter data for each participant or beneficiary; and ▪ sharing such information, consistent with applicable privacy regulations. **Disclosure.** Annually plans must submit an attestation of compliance. Future guidance expected as to how plans will submit this information and collection will begin in 2022. At this time, no guidance has been issued. Plans should implement this requirement using good faith, reasonable interpretation of the statute.
	Provider Directories	All group medical plans	For plan years beginning on or after January 1, 2022, group health plans must update and verify the accuracy of provider directory information (every 90 days) and establish a protocol for responding to requests by telephone and email from a member about a provider's network participation status. Members who are provided with inaccurate information by the plan or issuer under the required provider directory or response protocol that stated that the provider or facility was a participating provider or facility, the plan or issuer cannot impose a cost-sharing amount that is greater than the in-network cost-sharing amount and must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum. Regulations are expected, but not until after January 1, 2022. Plans should implement this requirement using good faith, reasonable interpretation of the statute.
	Pharmacy Benefits and Cost Reporting	All group medical plans	▪ Effective December 27, 2021, group health plans and carriers will be required to report annually to the government specific information on pharmacy benefits and costs. ▪ This includes the 50 most common brand dispensed prescriptions, the 50 most costly drugs, and the 50 drugs with the greatest year-over-year costs. This is in addition to other information including the impact of rebates on premiums and out-of-pocket costs. ▪ Reporting for calendar year 2020, 2021 is due by December 27, 2022. ▪ For subsequent calendar years, reporting is due by the following June 1. For calendar year 2022, the reporting is required by June 1, 2023. ▪ Fully insured plans may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier (recommended). ▪ Self-funded plans may enter into a written agreement with their TPAs or PBMs to fulfill reporting function on behalf of the plan, however plan (and plan sponsor) remain liable for failures. Coordination with TPAs and PBMs is needed to facilitate accurate and timely reporting.

✓	Topic	Applies to	Description
	Grandfathering	Grandfathered medical plans	▪ Employers should revisit grandfathered status requirements, weighing the restrictions of remaining grandfathered against the additional requirements that apply to non-grandfathered plans. ▪ An employer must look back to the coverage in effect on March 23, 2010 to know whether a change results in a loss of this status. ▪ If grandfathered status is retained, provide appropriate notice to participants and beneficiaries in all materials describing the group health plan and maintain records documenting the retention of this status for as long as it is claimed. ▪ Once grandfathered status is lost, even if inadvertently, it cannot be regained. This is true even if the defect causing the loss of grandfathered status can be cured.
	Cost-sharing limits	Non-grandfathered medical plans	For plan years beginning on or after **January 1, 2023**, non-grandfathered plans cannot impose out-of-pocket limits on EHBs that exceed the following limits: ▪ **$9,100** for self-only coverage; and ▪ **$18,200** for coverage other than self-only. Additionally, with respect to family coverage, an individual out-of-pocket maximum of $9,100 applies to each person with family coverage.
	Cost-sharing limits	Reference-based price programs (or other similar arrangements)	Plans with this type of structure should carefully review whether there is adequate access to quality providers willing to accept the reference price as a payment in full.[13] Otherwise the plan may be required to count an individual's out-of-pocket expenses and pay amounts that exceed the OOPM even if provided "out-of-network" (including balance billing amounts for the provider who did not accept the reference price toward the out-of-pocket maximum limitation). There is ongoing litigation, the result of which may impact these arrangements.
	Cost-sharing limits	Qualified HDHPs	For plan years beginning on or after **January 1, 2023**, qualified HDHPs are subject to the following limits: ▪ Minimum deductible: **$1,500** self-only coverage and **$3,000** coverage other than self-only; ▪ Maximum out-of-pocket: **$7,500** self-only coverage and **$15,000** family coverage.[14]
	HSA contributions	HSAs	The maximum contribution to an HSA for calendar/tax year **2023** is: ▪ **$3,850** for self-only coverage; ▪ **$7,750** for coverage other than self-only. Account holders who are at least 55 years of age may make a $1,000 catch-up contribution.
	Preventive care	All non-grandfathered group health plans	Various new preventive care benefits must be covered without cost-sharing in-network, including ones related to condoms, double-electric breast pumps, suicide risk screening for adolescents, and diabetes screenings for certain populations. For further information, see USI's July 14, 2022 Compliance Update. Departments are stepping up enforcement activity around plans that fail to provide contraceptive benefits in compliance with the ACA.

[13] The Departments have issued various FAQs specifying factors that will be considered to determine whether the reference-based price structure (or similar network design) is a reasonable method. Notably, FAQ 21 lays out five specific requirements the Departments will look at including the type of services, whether there is reasonable access, whether the providers meet quality standards, whether there is an exceptions process and disclosure regarding the pricing structure and providers. *See FAQ 21* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxi.pdf *and FAQ 31* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf.

[14] This is lower than what is required under the ACA. Non-grandfathered HDHPs must follow both sets of out-of-pocket maximum rules.

<table>
<tr><th>✓</th><th>Topic</th><th>Applies to</th><th>Description</th></tr>
<tr><td></td><td>Preventive items and services</td><td>Self-funded qualified HDHPs</td><td>Employers should consider adding coverage of allowed pre-deductible expenses, including beta-blockers, insulin, and inhalers for individuals with chronic conditions.</td></tr>
<tr><td></td><td>Preventive items and services</td><td>Employers with religious or moral objection to providing some or all contraceptive services</td><td>Employers with sincerely held religious or moral objection to providing some (or all) contraceptives services under the ACA, may be able to exclude such coverage from their group health plans.
Litigation in this area is ongoing.
Employers should discuss such exclusions with counsel.
Fully insured plans may be subject to state insurance laws requiring such coverage (and therefore exclusion not permitted).</td></tr>
<tr><td></td><td>Health FSA limits</td><td>Health FSAs</td><td>The 2023 limits have not been announced yet.
For plan years beginning in 2022, the limit on annual salary reduction contributions to a health flexible spending arrangement ("health FSA") provided under a cafeteria plan is $2,850.
Inflation adjustment for health FSA carryovers.
A health FSA with a 2022 plan year may carryover up to $570 (amount carried over into 2023). Plan amendment and notification required.</td></tr>
<tr><td></td><td>PCOR fee</td><td>All medical plans and HRAs</td><td>Health plans have been assessed an annual fee to fund a Patient-Centered Outcomes Research (PCOR) program.
Insured plans: Insurance carriers pay the fee directly.
Self-insured plans, including HRAs: The employer pays the fee to the IRS each year by July 31 using the 2nd quarter Form 720 (quarter ending 6/30).
While this fee was scheduled to sunset, legislation signed into law on December 20, 2019 extended the PCOR fee through September 30, 2029 for insured and self-funded plans.
The next payment is due on July 31, 2023, as follows:
<table>
<tr><th>Plan Year END Date</th><th>Amount of PCOR Fee</th></tr>
<tr><td>January 31, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>February 28, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>March 31, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>April 30, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>May 31, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>June 30, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>July 31, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>August 31, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>September 30, 2022</td><td>$2.79/covered life/year</td></tr>
<tr><td>October 31, 2022</td><td>$TBA/covered life/year</td></tr>
<tr><td>November 30, 2022</td><td>$TBA/covered life/year</td></tr>
<tr><td>December 31, 2022</td><td>$TBA/covered life/year</td></tr>
</table>
Note that special rules apply to short plan years.</td></tr>
</table>

✓	Topic	Applies to	Description
	MHPAEA	Employers with more than 50 employees offering group health plan coverage that includes Mental Health and/or Substance Use Disorder (MH/SUD) benefits Non-grandfathered insured plans, including small group coverage	Review the plan to determine whether there are provisions that may raise MHPAEA issues, such as: ▪ Exclusions of ABA therapy for the treatment of autism as an experimental treatment. ▪ Dosage limits on prescription drugs which are more restrictive on MH/SUD conditions than other medical conditions. ▪ Exclusion of in-patient or out-patient treatment for eating disorders based on facility type. Review FAQ 39 for additional information: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-39-proposed.pdf An updated self-compliance tool is now available https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf. Group health plans must conduct a comparative analysis of the design and application of Non-Quantitative Treatment Limits (NQTLs) and provide to the DOL (or participants and beneficiaries) upon request. Further regulations expected. Self-funded plans and/or carveout arrangements (i.e., PBM carveout) will need to work with third-party administrators to determine capabilities for providing such a report.
	Health plan benefit design – Abortion coverage post-*Dobbs*	Group health plans	▪ Laws regulating abortions services falls to the states. ▪ At least 26 states are (or are expected to) limit or prohibit abortions. ▪ Employers should review what group health plans currently provide, where employees work and reside, and what if any next steps to consider, which may include: – Removing coverage for abortion. – Do nothing or wait and see. – Adding a travel reimbursement benefit for individuals who cannot access care within a certain radius. ▪ There are significant legal implications for both the group health plan and the employer to consider; changes should be discussed with counsel.
	Health plan benefit design – Discrimination based on sexual orientation or gender identity	Employers with at least 15 employees	In 2020, the Supreme Court held that sex discrimination under Title VII of the Civil Rights Act includes discrimination based on an employee's sexual orientation and gender identity. ▪ Employers sponsoring health and welfare programs should assess whether their health programs may discriminate against employees who are gay or transgender. ▪ This may include exclusions for medically necessary medical services associated with health care for transgender participants (e.g., surgical benefits, hormone therapy, mental health care). ▪ Employers should consult with legal counsel and proceed with caution if implementing plan designs or eligibility rules based on sexual orientation or gender identity. Recent district court decisions have ruled against employers/plans with such exclusions. ▪ State insurance and employment laws may also prohibit such discrimination.

✓	Topic	Applies to	Description
	Health plan benefit design -- Sec. 1557 Discrimination	Providers, insurance carriers and other entities that receive financial assistance from the federal government relating to a health program or activity such as Medicare or Medicaid	▪ HHS has proposed new rules for Section 1557 entities. ▪ Carriers and TPAs who receive financial assistance from the government (e.g., premium tax subsidies for Marketplace coverage) are subject to these provisions. ▪ Consider removing any exclusions based on HHS announcement that it will interpret and enforce Section 1557's prohibition on discrimination on the basis of sex to include discrimination on the basis of (1) sexual orientation and (2) gender identity.
	Employer penalty: Understand potential penalty exposure	ALEs	*The 2023 limits have not been formally published; estimated indexed amounts included below.* **"A" Penalty.** Applies if the ALE does not offer at least 95% of all ACA FTEs and their children to age 26 minimum essential coverage ("MEC") and one FTE receives a subsidy in the Marketplace. ▪ $2,000 (as adjusted for inflation, *estimated* $2,880 for 2023) X total number of FTEs in excess of 30. **"B" Penalty.** Applies if the ALE offers coverage to at least 95% of all ACA FTEs (and their children to age 26), but that coverage is *unaffordable* or does not provide *minimum value* (or as to any excluded 5% of ACA FTEs and one FTE receives a subsidy in the Marketplace. ▪ $3,000 (as adjusted for inflation, *estimated* $4,320 for 2023) X the total number of ACA FTEs who receive the subsidy in the Marketplace (maximum penalty is capped at the "A" penalty).
	Employer penalty: Identify application and method of compliance	Employers	▪ Determine ALE status (i.e., whether the employer has at least 50 full-time employees ("FTEs") each calendar year, considering all common law employees in the entire controlled group and counting each part-time employee as a fraction of an FTE). ▪ Determine full-time status using the monthly measurement method or look-back measurement method. ▪ Offer coverage to FTEs and dependent children. ▪ Evaluate minimum value. ▪ Evaluate affordability and elect a safe harbor.[15] ▪ Ensure that all plan language accurately reflects the selections.

[15] An employer will not be subject to a penalty with respect to an FTE if the employer meets the 95% MEC offer requirement and that employee's required contribution for 2023 for the employer's lowest cost self-only coverage that provides MV does not exceed:
- 9.12% of W-2 wages (Box 1 on Form W-2); or
- 9.12% of the employee's rate of pay (either $/hour multiplied by 130 hours or monthly salary); or
- 9.12% of applicable FPL:
  - Jan. 1, 2023 renewals use $103.28/mo. (9.12% of 2022 FPL for 48 contiguous states). Alaska $129.12/mo.; Hawaii $118.78/mo.
  - All other 2023 renewals use 9.12% of the applicable 2023 FPL, *once announced.*

✓	Topic	Applies to	Description
	Employer penalty: Reporting	All ALEs, with additional requirements for ALEs with self-insured health plans	All ALEs must use Forms 1095-C and 1094-C to report offers of coverage (or no offer of coverage) to ACA FTEs. ▪ For calendar year 2022, Forms 1095-C are due to ACA FTEs by, **March 2, 2023.** ▪ For calendar year 2022, Forms 1094-C and all Forms 1095-C must be filed electronically with the IRS by **March 31, 2023** (unless filing by paper, then **February 28, 2023**). ▪ Electronic filing is required if filing 250 or more forms. *Note, the IRS proposed a rule that will require electronic filing for most ALEs in the future. If finalized, most ALEs will need to file electronically.* **ALEs with self-funded health plans** must also report MEC information for each covered member on these Forms, including covered non-ACA FTEs (e.g., part-time employees and COBRA qualified beneficiaries). Information on family members who have coverage through the covered member (e.g., a spouse or child) must be included. Corrections may be filed on paper if submitted in batches of less than 250 forms. *Note, the IRS proposed a rule that would require corrections to be submitted in the same manner as the originally filed document.*
	MEC reporting	Non-ALEs with self-insured plans	▪ Employers that are not considered ALEs but offer a self-funded group health plan are responsible for MEC reporting on behalf of covered members. ▪ Small employers with self-insured plans may use Forms 1094-B and 1095-B. This report includes individuals who receive coverage through the covered member (e.g., spouse, children). The timeframe for submitting these reports is the same as described above for Forms 1094-C and 1095-C.
	Employer penalty: Reporting and penalty assessments	Employers	▪ The IRS has notified certain employers regarding missing or incomplete Form 1094-C and 1095-C filings (Letter 5699). ▪ The IRS has issued Letter 226J notifying employers of potential penalty assessments for CYs 2015, 2016, 2017, and 2018. ALEs should ensure that they review and handle them timely. ▪ Employers should continue to comply with the employer mandate until and unless guidance is issued. ▪ Resources are available for USI clients to assist with the response to the IRS.
	Marketplace notices	Employers	▪ The Marketplace is supposed to issue a notice if any employee of an employer receives a subsidy in the Marketplace. ▪ If an applicable large employer ("ALE") receives this notice on an ACA full-time employee, the employer should verify whether there is any penalty exposure (i.e., inquire as to whether the individual was offered affordable health insurance coverage). ▪ The Marketplace Notice is NOT a notice that a penalty is imminent. Any penalty assessment notice will come from the IRS. ▪ Ensure good recordkeeping processes to demonstrate offers of coverage, acceptance, waivers, affordability and minimum value as applicable.

✓	Topic	Applies to	Description
	ACA's integration requirement and prohibition of employer payment of individual insurance policies	HRAs	*The 2023 limits have not been announced yet.* HRAs must be integrated with group health plans and generally may not reimburse individual policy premiums, except as permitted: 1. **Qualified Small Employer HRA (QSEHRA).** A small employer (fewer than 50 full-time employees) with no group health plan can offer reimbursements up to indexed amounts ($5,450 self-only / $11,050 family for 2022). Reimbursement of individual policies permissible. 2. **Retiree HRA.** An HRA covering fewer than two participants who are active employees. 3. **Individual Coverage HRA.** Beginning 2020, an HRA can be integrated with an individual policy if the employer does not offer a group plan to same class of employees. ALEs must evaluate affordability for Employer Penalty purposes. 4. **Excepted Benefit HRA.** Employers can offer an EB HRA offering reimbursements up to $1,800 for 2022. A group medical plan must be offered, but the employee doesn't have to enroll in it. 5. **Stand-Alone HRA for Dental and/or Vision Expenses.**
	Wellness incentives	Employers using incentives with wellness programs	▪ Incentive based wellness programs continue to be complicated. ▪ Effective January 1, 2019, the court vacated the ADA and GINA Title II rules regarding wellness incentives. ▪ The most conservative approach is to remove incentives associated with employee or spousal medical exams or spousal completion of health risk assessments. ▪ Some employers may be comfortable continuing programs with reward thresholds at or below the pre-2019 rules which generally limit the incentive to no more than 30% of the total cost of self-only coverage in the lowest cost health plan option offered by the employer to any employee. ▪ Employers looking at rewards beyond the 30% limits should consult with their own counsel. ▪ Proposed rules that would permit only *de minimis incentives* (very low monetary value) when a wellness program uses medical exams or disability related inquiries, have been withdrawn.[16]
	Transportation benefits	Employers offering transportation benefits	*The 2023 limits have not been announced yet.* For calendar year 2022, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass and qualified parking expenses is **$280**. Parity between these accounts is permanent. *The employer deduction for all transportation fringe benefits was unavailable beginning January 1, 2018.*
	Highly Compensated and Key Employee Definitions	Cafeteria plans, life insurance discrimination (Sec. 79)	The compensation threshold for a **highly compensated individual** or participant (for purposes of Section 125 nondiscrimination testing) is **$135,000** in CY 2022 for 2023. The dollar limitation concerning the definition of a **key employee** is **$200,000** in CY 2022 for 2023.

[16] There withdrawn proposed rule included an exception under the ADA safe harbor to the de minimis incentive level for a wellness program that is a group health plan and complied with the HIPAA requirements for a heath contingent program (outcomes or activity based).

✓	Topic	Applies to	Description
	Cross-Plan Offsetting	Self-funded medical plans	Cross-plan offsetting is a mechanism used by TPAs to resolve overpayments to a provider made through one plan by withholding (or reducing) payment to the same provider through another plan. Based on a recent court ruling, employers should review and understand whether their TPA engages in cross-plan offsetting and whether there is language in the plan documents to support this practice. Further, it is advisable to review whether to continue cross-plan offsetting or "opt out" of this practice.
	State Individual Mandate Reporting	Employers providing health insurance coverage to employee in California, D.C., Massachusetts, New Jersey, Rhode Island, and Vermont	As described below, providing information to residents of the affected states as well as filing with certain state government agencies is generally required annually for compliance. If fully insured, determine whether the carrier satisfies these obligations. If self-funded, coordinate with the TPA for support in meeting these obligations. ▪ **California** employers that sponsor a health plan must file Forms 1095-C or 1095-B with the state's Franchise Tax Board on all CA residents covered by the plan. ▪ **D.C.** employers with at least 50 employees (including one resident of D.C.), must sign up and file information returns with the Office of Tax and Revenue. Third party vendors may facilitate this reporting. ▪ **Massachusetts** Form MA 1099-HC remains in effect and employers with at least 6 MA resident/employees must file a HIRD with the Commonwealth. ▪ **New Jersey** – Forms reporting on offers of coverage to employees are to be sent to the NJ Division of Taxation. Reporting deadlines align with ACA requirements. ▪ **Rhode Island** employers must file federal Forms with the RI Division of Taxation. ▪ **Vermont** residents report coverage status on state tax returns. No employer obligations provided the federal requirement to distribute 1095-C forms remains.
	State Fees on Self-Insured Plans	Self-funded plans	▪ Self-insured plans may see surcharges applied to their benefit programs with respect to certain state assessments (e.g., 1% tax on claims paid in Michigan and the New York public goods pool for claims incurred in New York). ▪ Washington PAL assessment. ▪ Idaho, New Mexico, New Hampshire, Alaska, and Rhode Island have mandatory annual vaccine assessments.
	State Required Paid Sick Leave	Various	Many states already require (or will soon require) paid sick leave for employees; specifically, Arizona, California, Colorado, Connecticut, D.C., Maryland, Massachusetts, Michigan, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.
	State Required Paid Family Leave	Various	Many states require paid family leave, including California, Colorado (2024), Connecticut, Delaware (2026), D.C., Maryland (2025), Massachusetts, New Hampshire, New Jersey, New York, Oregon (2023), Rhode Island, and Washington.
	State Required Paid Time Off	Employers with employees in Maine or Nevada	Nevada employers that have been in operation for at least two years with at least 50 employees in Nevada must allow their employees to accrue and use paid time off for any reason. Maine employers with 10 or more employees in Maine are required to offer their employees paid leave which may be used for any reason.

✔	Topic	Applies to	Description
	City and Other Required Paid Leave	Various. ***This summary does not address all applicable city or other local mandates.***	**Some cities that have passed sick leave laws include Los Angeles, New York City, Philadelphia, Pittsburgh, Chicago, and Seattle. One county that passed a sick leave law is Westchester County, New York.** **These are a few examples only.**
	Good Faith Estimate ("GFE") and Advance EOBs	Providers and facilities ("GFEs") and all group medical plans (Advance EOBs)	▪ Upon the scheduling of items or services (or upon patient request) providers are required to (1) inquire whether the individual has health insurance coverage and (2) provide GFE of the expected charges for furnishing those items and services to the group health plan. ▪ The group health plan, after receiving the GFE, must send the participant or beneficiary an Advance EOB.[17] **Enforcement Relief.** While set to take effect for plan years beginning on or after January 1, 2022, *enforcement has been deferred until further guidance is issued*, including establishing appropriate data transfer standards between providers and plans. Any future guidance will include a prospective applicability date to provide additional time for compliance.

[17] Specifically, the Advance EOB must include:
- the network status of the provider or facility;
- the contracted rate of the item or service;
- the good faith estimate received from the provider;
- a good faith estimate of the amount the plan is responsible for paying for the item or service and the amount of any cost-sharing the individual will be responsible for paying; and
- disclaimers explaining whether the item or service is subject to any medical management techniques.

Attachment V

Balance Sheet
August 31, 2022

Assets

	8/31/2022	7/31/2022	8/31/2021	12/31/2021
Cash & Temporary Investments	12,089,835	10,747,477	*6,337,951*	*9,316,646*
COVID Cash Holding	-	38,580	*2,580,034*	*1,546,716*
Gross Patient Accounts Receivable	40,568,933	38,080,535	*34,777,364*	*31,324,657*
Less Allowances for Uncollectible	(25,667,000)	(24,120,000)	*(21,331,000)*	*(19,716,000)*
Net Patient Receivables	14,901,933	13,960,535	*13,446,364*	*11,608,657*
Taxes Receivable	403,193	412,039	*392,756*	*23,641*
Receivable from 3rd Party Payor	256,224	384,105	*306,233*	*241,933*
Inventory	587,606	545,300	*299,813*	*570,651*
Prepaid Expenses	1,097,362	909,131	*1,259,580*	*1,152,815*
Other Current Assets	14,425	13,870	*3,199*	*4,746*
Total Current Assets	29,350,578	27,011,037	*24,625,930*	*24,465,805*
LEOFF Net Pension Asset	1,106,851	1,106,851		*1,106,851*
Whitehead Fund - LGIP	1,221,419	1,219,093	*1,214,492*	*1,214,855*
Funded Depreciation - Cash	2,773,430	2,542,755	*1,089,805*	*1,003,653*
Funded Depreciation - TVI	16,768,158	16,768,158	*16,791,856*	*17,537,681*
Bond Obligation Cash Reserve	767,546	767,543	*767,507*	*767,520*
USDA Debt Reserve Fund	-	-	-	-
Tax Exempt Lease Funds	-	-	-	-
Board Designated Assets	22,637,404	22,404,400	*19,863,660*	*21,630,560*
Land	478,396	478,396	*478,396*	*478,396*
Property Plant & Equipment	47,651,779	47,620,690	*43,966,812*	*46,165,427*
Construction In Progress	6,041,978	5,682,682	*4,667,447*	*4,226,277*
Accumulated Depreciation	(32,422,352)	(32,200,334)	*(29,878,244)*	*(30,725,767)*
Net Property Plant & Equipment	21,749,801	21,581,434	*19,234,411*	*20,144,333*
Investment & Other Non Current Assets	1,000,679	1,002,212	*1,030,168*	*1,023,805*
Land - Gap Road	1,745,440	1,745,440	*1,745,440*	*1,745,440*
Net Investments & Other Non Current Assets	2,746,119	2,747,652	*2,775,608*	*2,769,245*
Total Assets	**$ 76,483,902**	**$ 73,744,523**	***$ 66,499,609***	***$ 69,009,943***

Liabilities & Fund Balance

	8/31/2022	7/31/2022	8/31/2021	12/31/2021
Current Portion of Bonds Payable	882,266	880,908	*846,383*	*871,489*
Current Portion of USDA	-	-	-	-
Current Portion Capital Leases	252,836	252,329	*247,120*	*248,495*
Accounts Payable	2,496,957	1,985,418	*1,879,946*	*1,797,177*
Payroll & Related Liabilities	3,822,873	3,597,049	*3,313,209*	*3,410,607*
Cost Report Payable	425,494	404,568	*1,192,427*	*510,126*
Other Payables to 3rd Parties	1,346,364	1,346,364	*969,467*	*969,467*
Deferred LEOFF Pension	483,233	483,233	-	*483,233*
Deferred Tax Revenue	304,787	380,983	*287,324*	-
Deferred EHR Medicare Revenue	-	-	-	-
Deferred COVID Revenue	-	38,580	*2,580,034*	*1,546,716*
Accrued Interest Payable	56,235	37,952	*57,659*	*19,670*
Other Current Liabilities	-	-	-	-
Total Current Liabilities	10,071,045	9,407,384	*11,373,569*	*9,856,980*
Non Current Liabilities				
Bonds Payable net of CP	9,092,843	9,141,892	*9,931,290*	*9,482,042*
USDA Financing Payable net of CP	-	-	-	-
Capital Leases net of CP	436,502	457,830	*668,562*	*605,826*
Total Non Current Liabilities	9,529,345	9,599,722	*10,599,852*	*10,087,868*
Total Liabilities	19,600,390	19,007,106	*21,973,421*	*19,094,572*
Fund Balance				
Current YR Unrestricted Fund Balance	7,818,417	5,672,321	*11,948,204*	*16,487,111*
Prior YR Unrestricted Fund Balance	49,065,095	49,065,096	*32,577,984*	*32,577,984*
Restricted Fund Balance	-	-	-	-
Total Fund Balance	56,883,512	54,737,417	*44,526,188*	*49,065,095*
Total Liabilities & Fund Balance	**$ 76,483,902**	**$ 73,744,523**	***$ 66,499,609***	***$ 69,009,943***

Prosser
Memorial Health

Statement of Operations
August 31, 2022

Month Ending Actual	Budget	Variance	%	*Prior Year*	%		Year to Date Actual	Budget	Variance	%	*Prior Year*	%
						Gross Patient Services Revenue						
$ 4,156,328	$ 3,894,671	$ 261,657	7%	$ *4,327,455*	-4%	Inpatient	$ 29,728,737	$ 30,620,175	$ (891,438)	-3%	$ *27,919,434*	6%
19,301,817	14,536,402	4,765,415	33%	*14,529,135*	33%	Outpatient	132,853,820	114,286,193	18,567,627	16%	*102,224,626*	30%
23,458,145	18,431,073	5,027,072	27%	*18,856,590*	24%	**Total Gross Patient Services Revenue**	162,582,557	144,906,368	17,676,189	12%	*130,144,060*	25%
						Deductions from Revenue						
						Contractual Allowances						
4,915,032	3,786,015	(1,129,017)	-30%	*3,603,120*	36%	Medicare	34,663,457	29,765,911	(4,897,546)	-16%	*27,074,388*	28%
4,985,014	4,048,757	(936,257)	-23%	*4,364,148*	14%	Medicaid	35,183,053	31,831,606	(3,351,447)	-11%	*28,419,833*	24%
3,416,698	2,305,051	(1,111,647)	-48%	*2,645,102*	29%	Negotiated Rates	23,054,047	18,122,471	(4,931,576)	-27%	*16,550,811*	39%
598,097	360,629	(237,468)	-66%	*308,420*	94%	Other Adjustments	5,504,768	2,835,289	(2,669,479)	-94%	*2,110,398*	161%
13,914,841	10,500,452	(3,414,389)	-33%	*10,920,790*	27%	**Gross Contractual Allowances**	98,405,325	82,555,277	(15,850,048)	-19%	*74,155,430*	33%
287,801	306,454	18,653	6%	*303,523*	-5%	Charity Care	3,091,590	2,409,363	(682,227)	-28%	*1,804,758*	71%
204,558	332,479	127,921	38%	*287,566*	-29%	Bad Debt	931,883	2,613,976	1,682,093	64%	*3,129,214*	-70%
14,407,200	11,139,385	(3,267,815)	-29%	*11,511,879*	25%	**Total Deductions From Revenue**	102,428,798	87,578,616	(14,850,182)	-17%	*79,089,402*	30%
9,050,945	7,291,688	1,759,257	24%	*7,344,711*	23%	**Net Patient Services Revenue**	60,153,759	57,327,752	2,826,007	5%	*51,054,658*	18%
38,580	126,814	(88,234)	-70%	*6,628,311*	-99%	COVID Net Revenue	1,785,036	1,014,512	770,524	76%	*7,257,479*	-75%
15,458	15,480	(22)	0%	*26,327*	-41%	Other Operating Revenue	187,722	198,840	(11,118)	-6%	*152,207*	23%
9,104,983	**7,433,982**	**1,671,001**	**22%**	***13,999,349***	**-35%**	**Net Revenue**	**62,126,517**	**58,541,104**	**3,585,413**	**6%**	***58,464,344***	**6%**
						Operating Expenses						
3,030,073	3,103,762	73,689	2%	*2,838,758*	7%	Salaries	24,192,929	24,401,989	209,060	1%	*21,200,016*	14%
614,207	802,611	188,404	23%	*573,865*	7%	Benefits	6,185,634	6,310,183	124,549	2%	*5,326,436*	16%
429,131	288,085	(141,046)	-49%	*308,636*	39%	Purchased Labor	2,540,865	2,264,944	(275,921)	-12%	*2,283,988*	11%
4,073,411	4,194,458	121,047	3%	*3,721,259*	9%	Sub-Total Labor Costs	32,919,428	32,977,116	57,688	0%	*28,810,440*	14%
533,096	348,831	(184,265)	-53%	*375,128*	42%	Professional Fees - Physicians	3,341,242	2,790,649	(550,593)	-20%	*2,905,338*	15%
58,784	78,344	19,560	25%	*103,477*	-43%	Professional Fees - Other	398,737	622,695	223,958	36%	*523,346*	-24%
1,198,991	1,217,919	18,928	2%	*1,328,441*	-10%	Supplies	9,121,043	9,721,531	600,488	6%	*7,793,399*	17%
58,004	47,475	(10,529)	-22%	*49,501*	17%	Purchased Services - Utilities	352,304	379,803	27,499	7%	*359,591*	-2%
459,142	452,325	(6,817)	-2%	*365,859*	25%	Purchased Services - Other	3,051,606	3,618,603	566,997	16%	*2,342,890*	30%
210,436	161,302	(49,134)	-30%	*194,310*	8%	Rentals & Leases	1,465,020	1,290,418	(174,602)	-14%	*1,432,537*	2%
83,089	103,587	20,498	20%	*81,749*	2%	Insurance License & Taxes	753,678	828,701	75,023	9%	*650,233*	16%
223,551	196,422	(27,129)	-14%	*185,801*	20%	Depreciation & Amortization	1,735,301	1,571,375	(163,926)	-10%	*1,445,471*	20%
120,741	141,737	20,996	15%	*80,833*	49%	Other Operating Expenses	887,349	1,132,043	244,694	22%	*541,685*	64%
2,945,834	2,747,942	(197,892)	-7%	*2,765,099*	7%	Sub-Total Non-Labor Expenses	21,106,280	21,955,818	849,538	4%	*17,994,490*	17%
7,019,245	**6,942,400**	**(76,845)**	**-1%**	***6,486,358***	**8%**	**Total Operating Expenses**	**54,025,708**	**54,932,934**	**907,226**	**2%**	***46,804,930***	**15%**
2,085,738	**491,582**	**1,594,156**	**324%**	***7,512,991***	**-72%**	**Operating Income (Loss)**	**8,100,809**	**3,608,170**	**4,492,639**	**125%**	***11,659,414***	**-31%**
						Non Operating Income						
76,197	76,314	(117)	0%	*75,744*	1%	Tax Revenue	630,446	610,508	19,938	3%	*586,977*	7%
10,012	2,935	7,077	241%	*466*	2048%	Investment Income	(724,807)	23,476	(748,283)	-3187%	*(27,858)*	2502%
(30,052)	(46,681)	16,629	-36%	*(32,572)*	-8%	Interest Expense	(265,569)	(373,449)	107,880	-29%	*(287,616)*	-8%
4,200	347	3,853	1110%	*4,200*	0%	Other Non Operating Income (Expense)	77,538	2,778	74,760	2691%	*17,287*	349%
60,357	**32,915**	**27,442**	**83%**	***47,838***	**26%**	**Total Non Operating Income**	**(282,392)**	**263,313**	**(545,705)**	**-207%**	***288,790***	**-198%**
$ 2,146,095	**$ 524,497**	**$ 1,621,598**	**309%**	**$ *7,560,829***	**-72%**	**Net Income (Loss)**	**$ 7,818,417**	**$ 3,871,483**	**$ 3,946,934**	**102%**	**$ *11,948,204***	**-35%**

Prosser Memorial Health

Statement of Operations 13-month Trend

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Gross Patient Services Revenue													
Inpatient	$ 4,327,455	$ 3,536,125	$ 3,463,893	$ 3,043,354	$ 3,406,566	$ 3,605,247	$ 3,288,747	$ 3,726,370	$ 4,138,763	$ 3,310,749	$ 3,857,898	$ 3,644,634	$ 4,156,328
Outpatient	14,529,135	13,294,650	12,964,572	13,593,213	14,195,193	13,346,293	14,047,763	17,199,727	16,039,568	17,523,148	18,638,990	16,756,514	19,301,817
Total Gross Patient Services Revenue	18,856,590	16,830,775	16,428,465	16,636,567	17,601,759	16,951,540	17,336,510	20,926,097	20,178,331	20,833,897	22,496,888	20,401,148	23,458,145
Deductions from Revenue	*39%*	*38%*	*41%*	*39%*	*40%*	*38%*	*40%*	*38%*	*33%*	*38%*	*36%*	*35%*	*39%*
Contractual Allowances													
Medicare	3,603,120	3,526,574	3,000,655	3,266,390	3,200,913	3,393,158	3,902,405	3,785,864	4,551,851	4,308,246	5,205,426	4,601,476	4,915,032
Medicaid	4,364,148	3,880,351	3,619,215	3,668,725	3,909,940	4,012,377	2,920,563	4,802,755	4,652,839	4,548,393	4,701,779	4,559,333	4,985,014
Negotiated Rates	2,645,102	2,028,743	2,278,447	2,412,022	2,549,312	2,379,307	2,584,862	2,978,601	2,714,651	2,834,178	3,257,683	2,888,068	3,416,698
Other Adjustments	308,420	442,001	648,306	368,145	398,392	199,926	624,993	626,880	1,328,948	654,495	818,520	652,908	598,097
Gross Contractual Allowances	10,920,790	9,877,669	9,546,623	9,715,282	10,058,557	9,984,768	10,032,823	12,194,100	13,248,289	12,345,312	13,983,408	12,701,785	13,914,841
Charity Care	303,523	375,097	285,889	296,306	599,602	341,961	354,814	452,226	343,536	438,650	521,022	351,581	287,801
Bad Debt	287,566	114,155	(144,638)	103,191	(114,798)	214,560	(24,155)	243,688	(92,400)	221,628	(133,838)	297,843	204,558
Total Deductions From Revenue	11,511,879	10,366,921	9,687,874	10,114,779	10,543,361	10,541,289	10,363,482	12,890,014	13,499,425	13,005,590	14,370,592	13,351,209	14,407,200
Net Patient Services Revenue	7,344,711	6,463,854	6,740,591	6,521,788	7,058,398	6,410,251	6,973,028	8,036,083	6,678,906	7,828,307	8,126,296	7,049,939	9,050,945
COVID Grant Revenue	6,628,311	1,106,281	337,283	1,496,853	25,046	455,985	107,900	50,843	712,772	52,506	249,375	107,208	38,580
Other Operating Revenue	26,327	16,804	206,955	19,922	28,650	118,972	(76,453)	23,220	50,187	23,821	15,152	27,206	15,458
Net Revenue	**13,999,349**	**7,586,939**	**7,284,829**	**8,038,563**	**7,112,094**	**6,985,208**	**7,004,475**	**8,110,146**	**7,441,865**	**7,904,634**	**8,390,823**	**7,184,353**	**9,104,983**
Operating Expenses	*51%*	*65%*	*55%*	*59%*	*52%*	*63%*	*52%*	*48%*	*63%*	*60%*	*51%*	*59%*	*45%*
Salaries	2,838,758	3,349,881	2,742,169	2,734,884	3,303,928	2,972,517	2,772,043	2,865,229	2,980,200	3,595,919	3,007,956	3,130,198	3,030,073
Benefits	573,865	578,262	832,824	685,761	68,030	827,743	492,813	753,577	929,136	864,394	805,166	737,393	614,207
Purchased Labor	308,636	270,875	152,018	427,135	310,891	250,000	386,545	269,484	288,146	267,672	328,737	321,151	429,131
Sub-Total Labor Costs	3,721,259	4,199,018	3,727,011	3,847,780	3,682,849	4,050,260	3,651,401	3,888,290	4,197,482	4,727,985	4,141,859	4,188,742	4,073,411
Professional Fees - Physicians	375,128	368,393	344,807	333,691	399,338	407,364	333,806	386,705	382,778	391,045	482,125	424,354	533,096
Professional Fees - Other	103,477	39,174	62,259	82,246	30,749	41,222	61,379	103,229	64,244	(26,169)	54,282	41,765	58,784
Supplies	1,328,441	1,114,451	1,255,438	877,373	1,080,455	1,134,236	1,003,996	1,100,475	961,608	1,416,520	1,182,777	1,122,439	1,198,991
Purchased Services - Utilities	49,501	44,629	34,396	26,701	33,590	49,802	23,513	49,904	37,431	33,429	46,709	53,512	58,004
Purchased Services - Other	365,859	400,511	277,356	423,787	458,116	335,478	381,919	365,468	382,103	477,295	319,531	330,670	459,142
Rentals & Leases	194,310	215,090	147,779	180,858	111,591	181,248	191,423	236,771	216,425	119,924	159,032	149,762	210,436
Insurance License & Taxes	81,749	120,304	90,770	97,105	92,103	99,053	87,858	87,811	101,813	94,344	112,234	87,476	83,089
Depreciation & Amortization	185,801	186,122	195,247	204,290	268,228	212,599	211,565	215,248	220,087	207,039	222,140	223,071	223,551
Other Operating Expenses	80,833	96,773	109,760	152,045	92,216	158,066	105,914	110,506	100,267	78,539	133,508	79,775	120,741
Sub-Total Non-Labor Expenses	2,765,099	2,585,447	2,517,812	2,378,096	2,566,386	2,619,068	2,401,373	2,656,117	2,466,756	2,791,966	2,712,338	2,512,824	2,945,834
Total Operating Expenses	**6,486,358**	**6,784,465**	**6,244,823**	**6,225,876**	**6,249,235**	**6,669,328**	**6,052,774**	**6,544,407**	**6,664,238**	**7,519,951**	**6,854,197**	**6,701,566**	**7,019,245**
Operating Income (Loss)	**7,512,991**	**802,474**	**1,040,006**	**1,812,687**	**862,859**	**315,880**	**951,701**	**1,565,739**	**777,627**	**384,683**	**1,536,626**	**482,787**	**2,085,738**
Non Operating Income													
Tax Revenue	75,744	71,831	73,342	71,831	73,097	74,817	80,262	88,426	77,100	74,594	80,517	78,534	76,197
Investment Income	466	2,347	11,834	(24,802)	(146,092)	476	476	(571,938)	11,722	8,769	(186,482)	2,158	10,012
Interest Expense	(32,572)	(33,739)	(32,265)	(32,361)	(20,143)	(31,143)	(60,844)	(21,572)	(30,723)	(39,532)	(21,447)	(30,255)	(30,052)
Other Non Operating Income (Expense)	4,200	-	-	-	6,000	-	81,261	14,920	(2,497)	(20,347)	-	-	4,200
Total Non Operating Income	**47,838**	**40,439**	**52,911**	**14,668**	**(87,138)**	**44,150**	**101,155**	**(490,164)**	**55,602**	**23,484**	**(127,412)**	**50,437**	**60,357**
Net Income (Loss)	**$ 7,560,829**	**$ 842,913**	**$ 1,092,917**	**$ 1,827,355**	**$ 775,721**	**$ 360,030**	**$ 1,052,856**	**$ 1,075,575**	**$ 833,229**	**$ 408,167**	**$ 1,409,214**	**$ 533,224**	**$ 2,146,095**
Total Margin	53.8%	11.1%	14.9%	22.7%	11.0%	5.1%	14.8%	14.1%	11.1%	5.1%	17.1%	7.4%	23.4%
Margin (Non Operating Income)	53.7%	10.6%	14.3%	22.5%	12.1%	4.5%	13.6%	19.3%	10.4%	4.9%	18.3%	6.7%	22.9%
Salaries as a % of Net Revenue	20.3%	44.2%	37.6%	34.0%	46.5%	42.6%	39.6%	35.3%	40.0%	45.5%	35.8%	43.6%	33.3%
Labor as a % of Net Revenue	26.6%	55.3%	51.2%	47.9%	51.8%	58.0%	52.1%	47.9%	56.4%	59.8%	49.4%	58.3%	44.7%
Operating Expense change from prior month	7%	5%	-4%	-4%	-4%	3%	-7%	1%	3%	16%	6%	10%	8%
Gross Revenue change from prior month	12%	-11%	-13%	-12%	-7%	-10%	-8%	11%	7%	10%	19%	21%	24%
Net Revenue change from prior month	112%	-46%	-48%	-43%	-49%	-50%	-50%	-42%	-47%	-44%	-40%	9%	-35%

Prosser
Memorial Health

Statement of Cash Flows
August 31, 2022

CURRENT MONTH Actual	NET INCOME TO NET CASH BY OPERATIONS	YEAR TO DATE Actual
2,146,095	**NET INCOME (LOSS)**	**7,818,417**
223,551	Depreciation Expense	1,735,301
-	Amortization	-
-	Loss (Gain) on Sale of Assets	-
2,369,646	**TOTAL**	**9,553,718**
	WORKING CAPITAL	
(1,035,763)	Decrease (Increase) in Assets	(3,658,300)
663,661	Increase (Decrease) in Liabilities	214,065
1,997,544	**NET CASH PROVIDED BY OPERATIONS**	**6,109,483**
	CASH FLOWS FROM INVESTING ACTIVITIES	
(390,385)	Capital Purchasing	(3,302,053)
-	Proceeds on Capital Assets Sold	-
(70,377)	Investment Activity	(574,113)
(460,762)	**NET CASH USED BY INVESTING ACTIVITIES**	**(3,876,166)**
1,536,782	**NET CHANGE IN CASH**	**2,233,317**
	CASH BALANCE	
33,190,457	**BEGINNING**	**32,493,922**
34,727,239	**ENDING**	**34,727,239**
1,536,782	**NET CASH FLOW**	**2,233,317**

Prosser
Memorial Health

Direct Cash Flow Statement
August 31, 2022

	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	Year to Date 2022
CASH FLOWS FROM OPERATING														
PAYMENTS RECEIVED														
Commercial	2,898,177	3,130,632	3,153,931	2,875,267	3,330,492	2,870,461	2,644,488	3,345,808	3,083,155	3,080,772	3,456,092	3,664,670	3,459,009	25,604,455
Medicaid	1,588,232	2,103,782	1,687,063	1,529,067	1,709,233	1,527,015	1,438,583	1,933,332	1,793,945	1,717,575	1,999,159	1,776,093	1,922,625	14,108,327
Medicare	1,879,928	1,638,399	1,603,757	1,599,329	1,813,966	1,682,223	1,406,927	1,706,618	1,682,098	1,847,438	2,223,897	1,689,671	2,244,129	14,483,001
VA	88,287	56,918	52,706	66,281	119,229	83,053	37,616	94,447	100,585	74,713	18,848	46,441	74,217	529,920
Worker's Comp	100,236	109,063	145,456	130,592	154,764	154,456	80,761	125,210	100,871	123,467	196,392	274,009	213,343	1,268,509
Self Pay	121,182	163,813	108,110	129,044	97,535	65,480	93,400	120,387	66,663	98,505	69,161	123,196	84,611	721,403
Other Non Patient Payments	435,091	101,670	1,465,202	2,014,478	112,073	266,052	212,934	467,464	425,160	996,244	538,087	218,554	253,270	3,377,765
Cash Received (Patients, Insurance, Other)	**7,111,133**	**7,304,347**	**8,216,225**	**8,344,058**	**7,337,292**	**6,648,740**	**5,914,709**	**7,793,266**	**7,252,477**	**7,938,714**	**8,501,636**	**7,792,634**	**8,251,204**	**60,093,380**
Patient Refunds	(1,590)	(35,193)	(28,515)	(30,265)	(30,265)	(37,922)	(9,381)	(52,430)	(26,079)	(30,262)	(15,402)	(15,948)	(12,661)	(200,085)
AP Expenses	(3,291,615)	(3,276,658)	(3,837,948)	(3,398,633)	(1,628,648)	(3,425,965)	(2,483,587)	(4,162,503)	(4,176,244)	(4,332,217)	(3,764,079)	(3,055,432)	(3,345,398)	(28,745,425)
Settlement LumpSum Payments	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Payroll Expenses	(2,646,771)	(2,640,425)	(3,402,985)	(2,684,405)	(4,109,423)	(2,878,211)	(2,861,203)	(2,826,391)	(3,848,358)	(2,937,045)	(3,013,974)	(4,355,448)	(2,911,511)	(25,632,141)
Loan/Interest Expense	(57,467)	(114,934)	(57,467)	-	(456,436)	(57,467)	(57,467)	(57,467)	(57,467)	(57,467)	(224,627)	(54,467)	(54,467)	(620,896)
NET CASH PROVIDED BY OPERATING	**1,113,690**	**1,237,137**	**889,310**	**2,230,755**	**1,112,520**	**249,175**	**503,071**	**694,475**	**(855,671)**	**581,723**	**1,483,554**	**311,339**	**1,927,167**	**4,894,833**
CASH FLOWS FROM INVESTING ACTIVITIES														
Capital Purchasing	(337,064)	(421,857)	(175,878)	(772,834)	(386,876)	(641,743)	(216,418)	(134,128)	(249,106)	(371,445)	(658,291)	-	(390,385)	(2,661,516)
NET CASH USED BY INVESTING ACTIVITIES	**(337,064)**	**(421,857)**	**(175,878)**	**(772,834)**	**(386,876)**	**(641,743)**	**(216,418)**	**(134,128)**	**(249,106)**	**(371,445)**	**(658,291)**	**-**	**(390,385)**	**(2,661,516)**
NET CHANGE IN CASH	**776,626**	**815,280**	**713,432**	**1,457,921**	**725,644**	**(392,568)**	**286,653**	**560,347**	**(1,104,777)**	**210,278**	**825,263**	**311,339**	**1,536,782**	**2,233,317**
CASH BALANCE														
BEGINNING	**28,005,019**	**28,781,645**	**29,596,925**	**30,310,357**	**31,768,278**	**32,493,922**	**32,101,354**	**32,388,007**	**32,948,354**	**31,843,577**	**32,053,855**	**32,879,118**	**33,190,457**	**32,493,922**
ENDING	**28,781,645**	**29,596,925**	**30,310,357**	**31,768,278**	**32,493,922**	**32,101,354**	**32,388,007**	**32,948,354**	**31,843,577**	**32,053,855**	**32,879,118**	**33,190,457**	**34,727,239**	**34,727,239**
NET CASH FLOW	**776,626**	**815,280**	**713,432**	**1,457,921**	**725,644**	**(392,568)**	**286,653**	**560,347**	**(1,104,777)**	**210,278**	**825,263**	**311,339**	**1,536,782**	**2,233,317**

Prosser Memorial Health

Key Operating Statistics
August 31, 2022

Month Ending Actual	Budget	Variance	%		Year to Date Actual	Budget	Variance	%	Prior Year	Change
				Key Volumes						
318	256	62	24%	Inpatient Acute Days	2,302	2,009	293	15%	2,315	-1%
133	153	(20)	-13%	Inpatient Swing Days	783	1,198	(415)	-35%	643	22%
451	409	42	10%	**Total Inpatient Days**	3,085	3,207	(122)	-4%	2,958	4%
123	153	(30)	-20%	Inpatient Admissions	890	1,198	(308)	-26%	942	-6%
117	153	(36)	-23%	Inpatient Discharges	874	1,198	(324)	-27%	941	-7%
12	12	0	2%	Swing Bed Discharges	47	92	(45)	-49%	56	-16%
2,545	1,936	609	31%	Adjusted Patient Days	16,871	15,176	1,695	11%	13,788	22%
14.55	13.20	1.35	10%	Average Daily Census	12.70	13.20	(0.50)	-4%	12.17	4%
660	723	(63)	-9%	Adjusted Discharges	4,780	5,671	(891)	-16%	4,386	9%
2.72	1.68	1.04	62%	Average Length of Stay - Hospital	2.63	1.68	0.96	57%	2.46	7%
14.00	13.04	0.96	7%	Average Length of Stay - Swing Bed	14.00	13.04	0.96	7%	11.48	22%
58%	53%	5%	10%	Acute Care Occupancy (25)	51%	53%	-2%	-4%	49%	4%
55	51	4	8%	Deliveries	386	399	(13)	-3%	396	-3%
331	191	140	73%	Total Surgical Procedures	2,114	1,497	617	41%	1,359	56%
121	67	54	81%	GI Procedures	716	524	192	37%		
1,375	1,104	271	25%	Emergency Dept Visits	10,246	8,655	1,591	18%	8,494	21%
16,271	14,268	2,003	14%	Laboratory Tests	116,178	111,847	4,331	4%	116,269	0%
3,125	2,906	219	8%	Radiology Exams	23,018	22,779	239	1%	24,011	-4%
1,681	1,378	303	22%	PMH Specialty Clinic	11,601	10,803	798	7%	10,085	15%
899	885	14	2%	PMH - Benton City Clinic Visits	6,121	6,934	(813)	-12%	6,081	1%
1,398	1,316	82	6%	PMH - Prosser Clinic Visits	9,369	10,317	(948)	-9%	10,585	-11%
1,065	987	78	8%	PMH - Grandview Clinic Visits	7,697	7,739	(42)	-1%	5,527	39%
648	692	(44)	-6%	PMH - Women's Health Clinic Visits	4,822	5,427	(605)	-11%	4,987	-3%
				LABOR FULL-TIME EQUIVALENT						
327.19	345.07	17.88	5%	Employed Staff FTE's	318.23	345.07	26.84	8%	265.34	20%
34.04	34.75	0.71	2%	Employed Provider FTE	33.86	34.75	0.89	3%	29.15	16%
361.23	379.82	18.59	5%	All Employee FTE's	352.09	379.82	27.73	7%	294.49	20%
317.68	303.86	(13.82)	-5%	Productive FTE's	308.26	303.86	(4.40)	-1%	260.55	18%
14.15	18.65	4.50	24%	Outsourced Therapy FTE's	14.06	18.65	4.59	25%	15.32	-8%
8.36	11.65	3.29	28%	Contracted Staff FTE's	8.39	11.65	3.26	28%	7.41	13%
22.51	30.30	7.79		All Purchased Staff FTE's	22.45	30.30	7.85	26%	22.73	-1%
8.99	12.00	3.01	25%	Contracted Provider FTE's	8.16	12.00	3.84	32%	7.24	13%
392.73	422.12	29.39	7%	All Labor FTE's	382.70	422.12	39.42	9%	324.46	18%

Prosser
Memorial Health

Financial Operations

August 31, 2022

	YTD 2021	YTD 2022	YTD Budget 2022
Utilization			
Admissions	942	890	1,198
Adjusted Admissions	4,391	4,867	5,671
Average Daily Census	9.5	9.5	8.3
Adjusted Occupied Beds	44.4	51.8	39.1
Average Length of Stay (days)	2.5	2.6	1.7
Outpatient Revenue %	78.5%	81.7%	78.9%
Total Yield (net patient revenue)	31.3%	9.2%	31.5%
Hospital Case Mix Index	0.99	0.99	1.00
Average Charge Per Patient Day	9,439	9,637	9,548
Financial Performance ($000)			
Net Patient Revenue	51,055	60,154	57,328
Total Operating Revenue	58,464	62,127	58,541
Total Operating Expense	46,805	54,026	54,933
Income (Loss) from Operations	11,659	8,101	3,608
Excess of Revenue Over Expenses	11,948	7,818	3,871
EBIDA (Operating Cash Flow)	13,105	9,836	5,180
Additions to Property, Plant, and Equipment	4,687	3,302	496
Balance Sheet ($000)			
Unrestricted Cash and Investments	8,918	12,090	16,686
Accounts Receivable (gross)	34,777	40,569	26,541
Net Fixed Assets	19,234	21,750	31,774
Current and Long-Term Liabilities (excluding LT debt)	11,374	10,071	7,884
Long-Term Debt	9,931	9,093	8,928
Total Liabilities	21,305	19,164	16,812
Net Worth	44,526	56,884	55,460

	YTD 2021	YTD 2022	YTD Budget 2022
Key Ratios			
Operating Margin (%)	19.9%	13.0%	6.2%
Excess Margin (%)	20.3%	12.6%	6.6%
Operating EBIDA Margin (Operating Cash Flow)	22.4%	15.8%	8.8%
Average Expense per Adjusted Patient Days	3,394	3,202	3,620
Average Net Revenue per Adjusted Patient Days	3,703	3,565	3,777
Net Accounts Receivable (days)	60.67	55.36	57.00
Current Ratio (x)	2.17	2.91	3.80
Cash on Hand (days)	140	161	109
Cushion Ratio (x)	100.07	130.77	43.67
Return on Equity (%)	26.83%	13.74%	11.01%
Capital Spending Ratio	6.02	2.89	0.61
Average Age of Plant (Years)	13.78	12.46	10.52
Debt Service	10.93	6.89	6.55
Debt-to-Capitalization (%)	21%	16%	12.78%
Patient Revenue Sources by Gross Revenue (%)			
Medicare	32.2%	31.5%	32.2%
Medicaid	30.8%	30.8%	30.8%
Commercial Insurance	29.3%	31.3%	29.3%
Self-pay and Other	4.4%	3.0%	4.4%
Labor Metrics			
Productive FTE's (incl contract labor)	290.52	338.87	346.16
Total FTE's (incl contract labor)	324.46	382.70	422.12
Labor Cost (incl benefits) per FTE - Annualized	133,193	129,028	117,184
Labor Cost (incl benefits) as a % of Net Operating Revenue	49.3%	53.0%	56.3%
Net Operating Revenue per FTE - Annualized	270,285	243,506	208,025
Operating Expense per FTE - Annualized	216,382	211,755	195,204

Contacts:			
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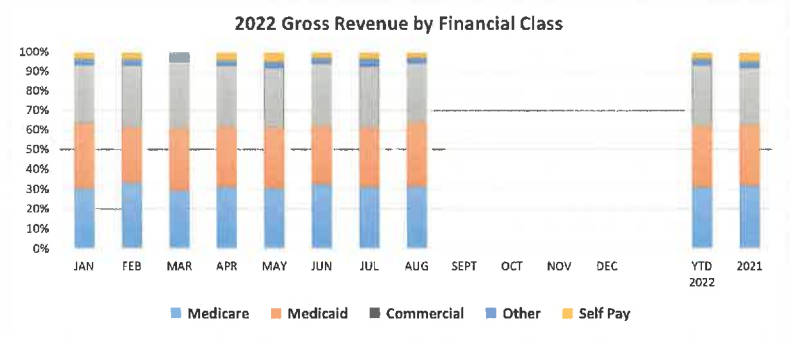
Stephanie Titus	Director of Finance	(509) 786-5530	stitus@prosserhealth.org

Prosser Memorial Health

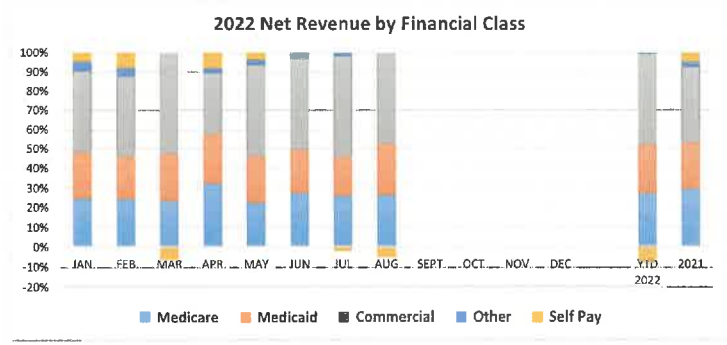
Revenue by Financial Class
August 31, 2022

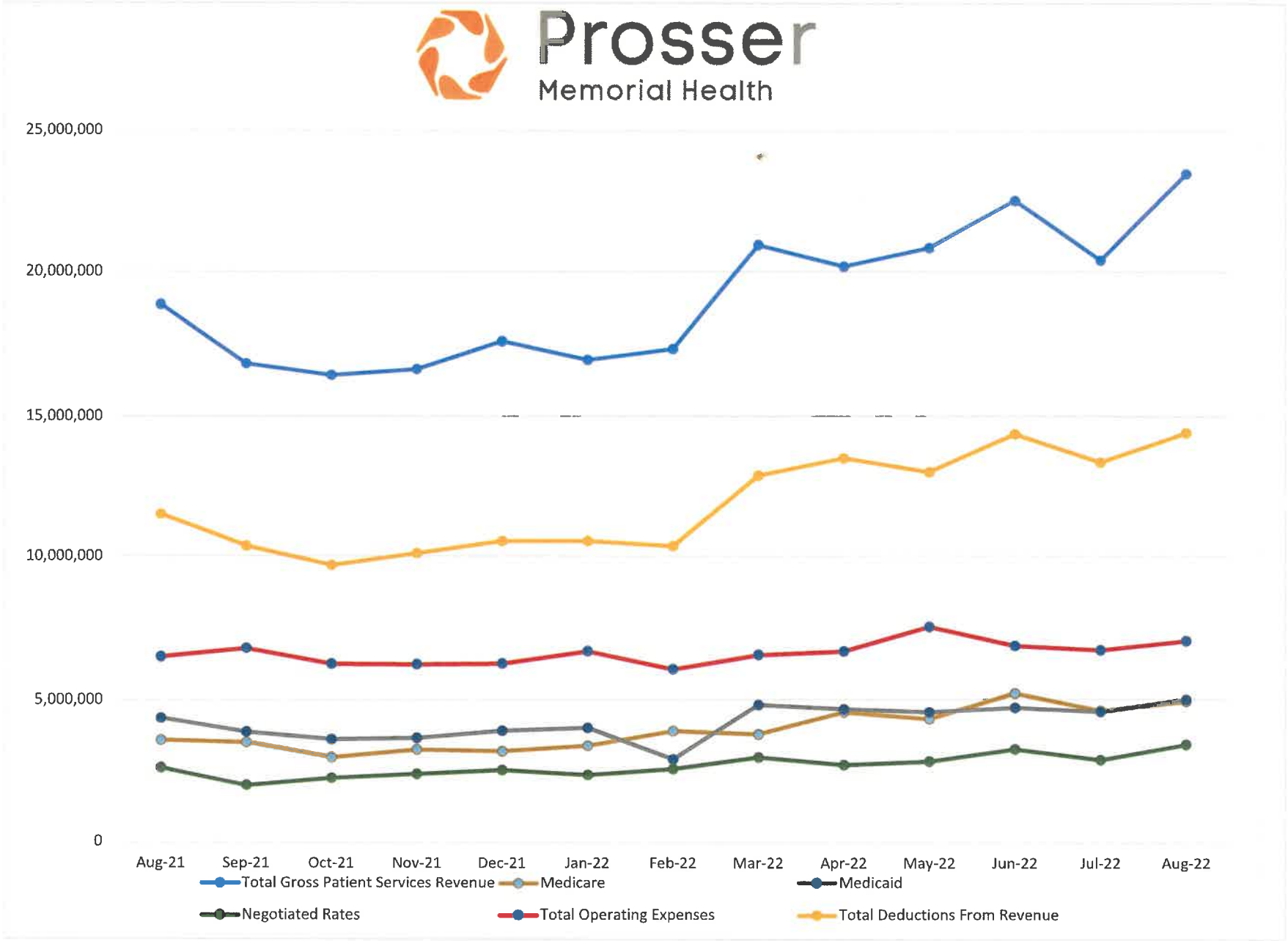
Month	Medicare	Medicaid	Commercial	Other	Self Pay	Total
JAN	30.6%	33.1%	29.9%	3.4%	3.0%	100.0%
FEB	33.6%	28.3%	31.5%	3.4%	3.2%	100.0%
MAR	29.6%	31.8%	33.6%	3.5%	1.5%	100.0%
APR	31.5%	30.2%	31.5%	2.9%	3.9%	100.0%
MAY	30.9%	30.8%	30.5%	3.4%	4.5%	100.0%
JUN	32.8%	29.7%	31.8%	3.0%	2.6%	100.0%
JUL	31.6%	29.9%	31.5%	4.0%	3.0%	100.0%
AUG	31.7%	32.7%	30.0%	3.2%	2.4%	100.0%
SEPT						
OCT						
NOV						
DEC						
YTD 2022	31.5%	30.8%	31.3%	3.3%	3.0%	100.0%
2021	32.2%	30.8%	29.3%	3.3%	4.4%	100.0%



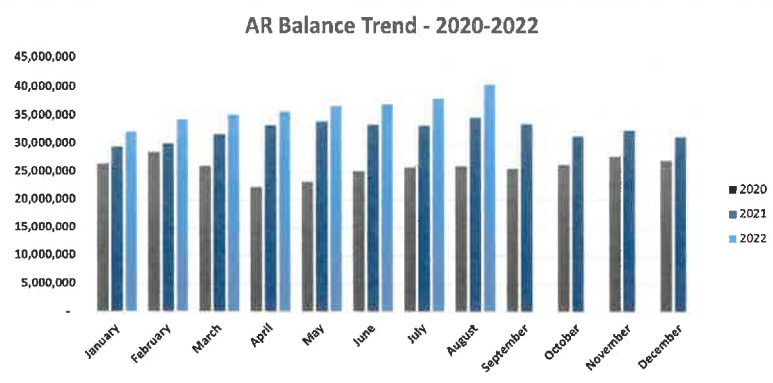
Net Revenue by Financial Class
August 31, 2022

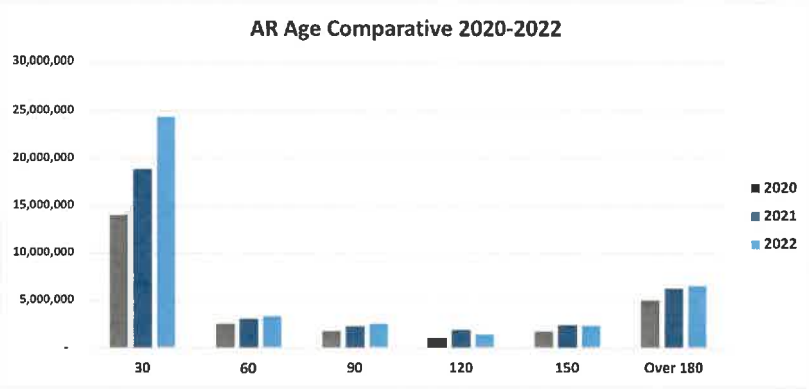
Month	Medicare	Medicaid	Commercial	Other	Self Pay	Total
JAN	24.9%	23.6%	42.0%	5.2%	4.3%	100.0%
FEB	24.7%	21.6%	41.5%	4.6%	7.6%	100.0%
MAR	23.6%	24.0%	54.5%	3.8%	-6.0%	100.0%
APR	32.6%	25.2%	31.8%	2.7%	7.7%	100.0%
MAY	22.7%	23.9%	47.1%	3.1%	3.3%	100.0%
JUN	27.6%	22.2%	46.8%	2.5%	0.8%	100.0%
JUL	26.3%	19.8%	52.1%	3.4%	-1.6%	100.0%
AUG	26.6%	26.2%	50.5%	1.4%	-4.6%	100.0%
SEPT						
OCT						
NOV						
DEC						
YTD 2022	27.6%	24.8%	47.3%	8.1%	-7.8%	100.0%
2021	29.8%	23.5%	39.5%	2.7%	4.5%	100.0%




Prosser
Memorial Health
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
0
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Total Gross Patient Services Revenue
Medicare
Medicaid
Negotiated Rates
Total Operating Expenses
Total Deductions From Revenue

Prosser
Memorial Health





AR Balance Trend

	2017	2018	2019	2020	2021	2022	% Change
January	13,660,199	16,931,510	19,428,531	26,540,403	29,542,976	32,260,939	*9%*
February	14,529,841	16,911,324	19,146,130	28,567,785	30,120,411	34,474,143	*14%*
March	15,115,376	14,989,166	19,513,147	26,130,696	31,816,016	35,287,961	*11%*
April	15,752,955	15,852,894	19,692,139	22,350,961	33,444,324	35,889,741	*7%*
May	15,131,907	16,812,980	19,455,887	23,319,876	34,107,637	36,813,211	*8%*
June	15,446,995	16,291,895	21,223,053	25,197,275	33,577,529	37,192,042	*11%*
July	15,918,959	15,979,415	20,206,074	25,943,825	33,378,224	38,080,535	*14%*
August	17,412,422	16,633,907	20,028,246	26,144,421	34,777,364	40,568,933	*17%*
September	17,547,651	17,129,789	23,681,156	25,640,562	33,643,597		
October	15,948,473	16,950,256	25,724,222	26,432,788	31,514,355		
November	16,292,336	17,374,013	25,655,024	27,862,474	32,541,479		
December	16,777,361	17,137,550	25,486,600	27,102,309	31,324,657		

AR Age Balance Comparative

	30	60	90	120	150	Over 180
2016	6,930,389	2,199,852	1,275,351	848,568	1,644,539	2,913,857
2017	8,538,041	2,208,941	1,608,359	891,034	1,204,910	2,961,137
2018	10,881,112	1,284,863	1,213,005	633,350	922,007	1,699,571
2019	11,534,270	1,933,906	1,502,503	1,017,686	1,481,418	2,558,464
2020	14,020,817	2,549,366	1,799,479	994,916	1,760,353	5,019,490
2021	18,870,616	3,077,949	2,255,795	1,930,797	2,390,923	6,251,284
2022	24,341,816	3,335,770	2,581,755	1,438,437	2,325,675	6,545,481

AR Percentage of Total Balance

2016	44%	14%	8%	5%	10%	18%
2017	49%	13%	9%	5%	7%	17%
2018	65%	8%	7%	4%	6%	10%
2019	58%	10%	8%	5%	7%	13%
2020	54%	10%	7%	4%	7%	19%
2021	54%	9%	6%	6%	7%	18%
2022	60%	8%	6%	4%	6%	16%

Prosser
Memorial Health

Lease Schedule
As of:
August 31, 2022

Building Rentals

Lease	Effective Date	Term Date	Auto Renew	Payment Amount		2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total
Prosser Professional Center	May-17	April-32		20,687.55	RHC	253,240	255,698	260,838	263,369	263,369	268,663	271,270	276,722	282,174	287,790	45,020		3,222,270
Prosser Professional Center	May-17	April-32		9,583.00	Therapy	115,000	116,650	120,000	121,188	123,600	124,824	127,308	128,568	131,127	132,425	95,930		1,566,620
Prosser Family Fitness Pool	Jul-15	Jul-22		32,812.50	Therapy	73,625	16,000	16,000	16,000	16,000	8,000							408,125
Benton City Professional Center	May '12	2027		14,000.00	Family Med	168,000	168,000	168,000	168,000	168,000	56,000							1,232,000
Benton City Professional Center	May '12	2027		4,775.00	Pain Clinic	57,300	57,300	57,300	57,300	57,300	19,100							420,200
Yakima Valley Farmworkers	Oct-06	Oct-47		16,539.93	Spec Clinic	190,400	62,400	63,960	65,559	67,198	68,878	70,600	72,365	74,174	76,028	77,929	79,877	1,366,327
Chardonnay Building with Builder	Jun-13	Jun-28		9,082.00	OB/GYN	108,984	108,984	108,984	108,984	108,984	108,985	49,951						921,824
					Total Building Leases	966,549	785,032	795,082	800,400	804,451	654,449	519,129	477,656	487,475	496,244	218,880	79,877	9,137,366

A -
41770060 BUILDING RENTAL -PT
41770721 BUILDING RENTAL -ST
41770722 BUILDING RENTAL -OT

Leased Equipment

Lease	Effective Date	Term Date		Payment Amount														Total
Stryker - Fee per Case agreeement	Mar-18	Mar-23		7,739.16		92,870	23,217											394,697
Biomerieux	Dec-19	Dec-24		798.70		9,584	9,584	8,786										47,922
Flex Financial (MAKO)	Oct-19	Oct-24		21,157.04		233,779	233,779	175,335										1,168,897
Karl Storz	Mar-21	Aug-23		5,838.37		70,060	46,707											175,151
Leaf	Sep-16	Sep-20	Renewed	7,807.00		93,684	93,684	93,684										336,000
Baxter - Infusion Pumps	Aug-17	Aug-22		193.80		1,550												6,202
Baxter - Spectrum SW	Aug-17	Aug-22		60.00		480												1,920
Quadient	Apr-20	Jul-25		282.00		3,384	3,384	3,384	1,974									17,766
					Total Equipment Leases	505,393	410,356	281,188	1,974	-	-	-	-	-				2,701,560
					Total Future Leases	1,471,942	1,195,388	1,076,270	802,374	804,451	654,449	519,129	477,656	487,475	496,244	218,880	79,877	11,838,926

Prosser
Memorial Health

Capital Expenditure Budget

GL #	DEPARTMENT	YEAR	DESCRIPTION	APPROVED COST	Anticipated by YE	Spent To Date	Purchase Date
60700	Med/Surg	**2022**	Sit to Stand Chair	10,000	Yes		
		2022	Blanket warmer	6,000	Yes		
		2022	Child Cribs (x2)	18,000	Yes		
		2022	Sleeper Sofa - Room 4	5,500	Yes		
		2022	Zoll Monitor	50,000	Yes		
70100	Family Birthplace	**2022**	Draeger Infant Warmer	13,224	Yes	14,298	8/1/2022
70200	Surgical Services	2021	Colonoscope Sterilizer	80,000	Yes	86,166	5/1/2022
		2022	Erbe	72,062	Yes	49,320	1/1/2022
		2022	Olympus Colonoscopes (x4)	185,038	Yes	185,038	11/24/2021
		2022	Stryker SPY-PHI (blood flow monitor)	115,000	Yes	121,951	6/1/2022
		2022	Megadyne Ace Blade	13,500	Yes		
		2022	Gastroscopes (x2)	46,000	Yes	50,662	7/1/2022
		2022	Flexible Uteroscope	15,500	Yes		
70700	Laboratory	2021	Nova Biomedical Stat Profile	13,227			
		2022	Chemistry Freezer	6,658	Yes	6,332	5/1/2022
		2022	RALS middleware interface	29,363			
		2022	Bugsy - EPIC module IC surveillance	90,000			
71400	Diagnostic Imaging	2021	TEE Service Line	132,234	Yes	31,480	*ongoing
		2022	i-STAT blood analyzer	11,868			
71800	Cardiopulmonary	**2022**	Philips V60 BiPAP Interface	43,322			
		2022	PFT Interface (Easy Pro)	15,000			
		2022	Hamilton Ventilator Interface	15,000	Yes	34,852	7/1/2022
72000	Physical Therapy	**2022**	Chattanooga Vectra GENSYS	5,736			
72300	Emergency Dept	**2022**	Stryker Stretchers (x3)	22,300	Yes		
		2022	ED EHR Module	10,000	Yes		
		2022	Metro Carts (x2)	15,000	Yes		
		2022	Altrix Unit	30,000	Yes		
		2022	Level 1 Unit	8,000	Yes		
		2022	Zoll Monitor	50,000	Yes		
72500	OSP	2021	Exam Chair	11,000			
		2021	Blanket Warmer	5,000			
		2022	New Patient Care divider curtains	7,000			
72600	Benton City	2021	Security Cameras	12,000			
		2022	Repainting of Building	38,622			
		2022	Remodel for Provider Office	7,020			
72630	Grandview	**2022**	Venue Go Ultrasound	44,890	Yes		
		2022	Cabinet and Desk Remodel	15,000	No		
72640	Women's Health	**2022**	Blanket Warmer	5,000	Yes		
		2022	Fluid Warmer	5,000	Yes		
72700	Specialty Clinic	**2022**	Medtronic Pill Capsule	17,889	Yes	16,019	1/1/2022
		2022	Provation Prof Fees Documenting SW	26,405	Yes	26,405	1/31/2022
		2022	Olympus Scopes	56,104			
84600	Environmental Services	**2022**	Carpet Shampooer	13,000			
		2022	Floor Scrubber	15,000			
85400	Information Technology	**2022**	Virtual Desktop Expansion	91,471			
		2022	Replacement Firewall	33,201	Yes	42,975	6/1/2022
		2022	Server Storage Archiving	14,000			
		2022	Interpretor Compliance HW/SW	20,000	Yes	24,998	*ongoing
85600	Scheduling Call Center	**2022**	Call Center Cubicle Set up	30,000		813	4/30/2022
87400	Employee Health	**2022**	@Net Health Agility	18,500			
			2022 Capital Items	**1,401,400**		*$ 65,339*	
			2021 Carryover Approved Capital Items	**212,234**		*$ 31,480*	
			TOTAL	**$ 1,613,634**		**$ 691,309**	
NON BUDGETED CAPITAL - BOARD APPROVED DURING 2022							
70200	Surgery	2022	Universal Driver (Stryker)			26,728	1/1/2022
70200	Surgery	2022	WM-DP# Mobile Workstation			70,539	2/1/2022
70200	Surgery	2022	Neptune 3 Rover			17,157	3/1/2022
85100	Accounting	2021	Kronos			7,500	8/1/2022
85300	Patient Financial Svcs	2021	COVID Business Office Remodel			78,491	4/1/2022
85400	Information Technolo	2022	Cooling System			9,291	8/1/2022
						$ 209,706	
						$ 901,015	

Prosser
Memorial Health

As of:
August 31, 2022

Capital Project Expenditures

Project Name	Budget	Jun-22	Jul-22	Aug-22
CIP - New Prosser Hospital		4,762,150	5,236,150	5,597,075
CIP - Gap Rd Land Improvement		118,571	118,571	118,571
	78,400,000	4,880,721	5,354,721	5,715,646
CIP - DI TEE Project	132,234	-	-	-
CIP - Dermatology Clinic	235,000	245,439	260,157	260,157
CIP - Beaker Lab System	788,596	-	-	-
CIP - Call Center	30,000	813	813	813
CIP - 1511 Meade Ave		12,378	12,378	12,378
CIP - PFS Office Remodel	35,328	-	-	-
Asset Clearing:				
TD100 System Additional Cost		2,216	2,216	2,216
Stryker Ceiling Exam Lights		-	-	-
Zoll Medical - Remote View X-series		5,000	5,000	5,000
Additional Cost to Firewall		209	209	209
16 Ipads (CDW Intrep Project)		5,780		
Core 2 (US)			20,431	20,431
Infant Resuscitative Warmer			14,298	-
Aquaplus Steamcleaner			12,459	12,459
Megadyne Elect gen/Smoke Evac				12,668
	81,093,614	5,152,556	5,682,682	6,041,977

Prosser Memorial Health

Organization	Purpose	Award	Date Rec'd	Amount Recognized in FY2020	Amount Recognized in FY2021	Amount Recognized in FY2022	Balance Remaining	Repayment	Other Notes
Greater Columbia Accountability of	Telehealth Application Funding for relief	$ 6,000	4/3/2020	$ **6,000**			$ -	$ -	Received for initial telehealth expenditures
CMS Medicare Advanced Benefits	Advance of Medicare Payments	$ 6,591,980	4/21/2020	$ -			$ -	$ 6,591,980	Three months worth of Medicare payments advanced to PMH. **REPAID 11/30/2020**
US Bank SBA Economic Injury Disaster	Payroll Protection Forgiveness Loan	$ 10,000	4/30/2020	$ 10,000			$ -	$ -	US Bank SBA grant deposited into our account.
US Bank SBA Payroll Protection Program Loan (PPPL)	Payroll Protection Forgiveness Loan	$ 6,350,235	5/4/2020	$ -	$ 6,350,235		$ -	$ -	SBA PPP - To be forgiven and recognized in 2021
HHS	Provider Relief Payment	$ 760,801	4/10/2020	$ 760,801			$ -	$ -	CARES Act: Stimulus for highly effected areas
HHS	Provider Relief Payment	$ 271,197	4/24/2020	$ 271,197			$ -	$ -	CARES Act: Stimulus for highly effected areas
HHS	CARES Provider Relief Fund - Rural Allocation	$ 4,170,732	5/6/2020	$ 2,353,778	$ 1,816,954		$ 0	$ -	Each CAH will receive at least $1,000,000 with the average CAH/Rural Hospital to receive $4,000,000 and each Rural Health Clinic to receive at least $100,000 with the average to be about $160,000. NARHC.ORG (National Association of Rural Health Clinics)
HHS	Provider Relief Payment	$ 150,680	6/15/2020	$ 150,680			$ -	$ -	CARES Act: Phase 1 (2% Net Income)
HHS	Provider Relief Payment	$ 103,253	6/25/2020	$ 103,253			$ -	$ -	CARES Act: Safety Net Distribution
HHS	RHC COVID-19 Testing Program	$ 49,461	5/20/2020	$ 49,461			$ -	$ -	HHS - RHC COVID-19 Testing Program
WSHA	ASPR PPE purchase from WSHA	$ 20,000	5/21/2020	$ **20,000**			$ -	$ -	Grant funds thru WSHA for Staff PPE
Medicaid SRDSH	SRDSH reallocation of addt'l funds	$ 29,382	5/22/2020	$ **29,382**			$ -		The SRDSH amount that is funded by the HSNA fund, is set by RCW at $1,909,000, and the federal matching funds has historically been 50%. Due to the current COVID-19 pandemic, congress passed the CARES ACT, which increase the federal matching percentage to 56.2% effective 1/1/2020.
HHS	RHC COVID-19 Testing Program	$ 49,461	6/9/2020	$ 49,461			$ -	$ -	HHS - RHC COVID-19 Testing Program
HHS	Provider Relief Payment	$ 1,300,000	7/20/2020	$ -	$ 1,300,000		$ -		CARES Act: ($100,000 per RHC, $1,000,000 for CAH)
HRSA (WA DOH)	SHIP Grant Hospital COVID Funding	$ 83,136	7/27/2020	$ 83,136			$ -	$ -	HRSA Rural Hospital SHIP Grant COVID Funding
Molina	PCP Stabilization Payment	$ 25,434	8/4/2020	$ **25,434**			$ -	$ -	Molina Healthcare provided COVID pmt to providers
HHS	RHC COVID-19 Testing Program	$ 49,461	12/7/2020	$ -	$ 49,461		$ -	$ -	HHS - RHC COVID-19 Testing Program
WHSA	HCA CARES COVID Funding	$ 370,982	12/31/2020	$ 370,982			$ -	$ -	WSHA - CARES funding distributed to hospitals
WHSA	HCA CARES COVID Funding	$ 7,913	1/25/2021	$ -	$ 7,913		$ -	$ -	WSHA - CARES funding distributed to hospitals
HCA	HCA CARES COVID Funding - RHC	$ 9,439	4/15/2021	$ -	$ 9,439		$ -	$ -	HCA - CARES funding distributed to RHCs
HCA	HCA CARES COVID Funding - RHC	$ 3,511	4/15/2021	$ -	$ 3,511		$ -	$ -	HCA - CARES funding distributed to RHCs
HHS Stimulus - RHC	RHC COVID-19 Testing Program	$ 200,000	6/10/2021	$ -	$ 200,000		$ -	$ -	HHS - RHC COVID-19 Testing Program
HHS Stimulus - RHC	RHC COVID-19 Testing Program	$ 100,000	8/17/2021	$ -	$ 100,000		$ -	$ -	HHS - RHC COVID-19 Testing Program
HCA	HCA CARES COVID Funding - RHC	$ 252,684	10/12/2021	$ -	$ 252,684		$ -	$ -	HCA - CARES funding distributed to RHCs
HHS	Provider Relief Payment	$ 1,679,462	11/23/2021	$ -	$ 132,745	$ 1,546,717	$ -	$ -	HHS - Phase 4 PRF Funds Distribution
HHS	Provider Relief Payment	$ 228,453	1/26/2022	$ -	$ -	$ 228,453	$ -	$ -	HHS - Phase 4 PRF Funds Distribution Bonus payment
Medicaid SRDSH	SRDSH reallocation of addt'l funds	$ 35,586	3/11/2022	$ -	$ -	$ 35,586	$ -	$ -	SRDSH 56.2% Additional Allocation of Funds
Medicaid SRDSH	SRDSH reallocation of addt'l funds	$ 16,674	3/11/2022	$ -	$ -	$ 16,674	$ -	$ -	SRDSH 56.2% Additional Allocation of Funds
	Totals	$ 22,925,919		$ 4,283,567	$ 10,222,942	$ 1,827,430	$ 0	$ 6,591,980	

Attachment X

HOSPITALS

Industry Voices—Facing unprecedented challenges, America's hospitals and health systems need help now

By **Stacey Hughes** Aug 26, 2022 03:08pm

American Hospital Association (AHA) | Industry Voices | Supply Chain | COVID-19

Congress must act quickly to help hospitals and health systems address current challenges, writes AHA's Stacey Hughes. (VILevi/Getty)

When has inflation ever been so high in recent decades, cost increases so steep for drugs, supplies and equipment and workforce challenges so widespread, all amid a global health emergency? Never, which is why hospitals and health systems on the front lines are now facing unprecedented challenges and pressures.

With one-third of hospitals operating in the red and another one-third barely breaking even prior to the

pandemic, hospitals now face severe staffing shortages, supply chain breakdowns, skyrocketing prices for drugs and supplies and near-historic levels of inflation. This tsunami of challenges is exerting tremendous pressure on hospitals and health systems' ability to provide access to care to their patients and communities. While hospitals appreciate the pandemic relief from Congress, it is essential that Congress help support hospitals to shore up the cornerstone of our nation's medical care.

First, COVID-19 delivered shock waves, overwhelming our staff and caregivers, while forcing hospitals to spend tremendous amounts to secure personal protective equipment (PPE) and other needed supplies and equipment. Many hospitals also had to shut down nonemergency care—some due to government orders—to continue to provide emergency care and to treat large influxes of COVID-19 patients. Hospitals and health systems quickly set up alternative sites of care, hospital-at-home programs, testing centers and deployed other innovative strategies to care for patients during the pandemic.

However, the pandemic was just the beginning of the operational challenges. According to the U.S. Department of Labor, hospital employment is still down over 40,000 from March of 2020. Simultaneously, per-patient labor expenses rose by nearly 20% from 2019 to 2021. Keep in mind that over 50% of a hospital's expenses are workforce costs, so even minor changes in labor expenses can have a spiraling impact on a hospital's budget.

Workforce shortages also intensified during over the last two and a half years. In 2019, hospitals spent an average of 4.7% of their total nurse labor expenses for contract travel nurses, which skyrocketed to 38.6% in January 2022. While staffing agencies have helped hospitals fill gaps during the pandemic, hourly rates of contract staffing agencies shot up by an incredible 213% compared to pre-pandemic times, further straining hospital resources.

According to a report released by the HHS Office of Health Policy, persistent labor shortages are anticipated in the health care sector––and they might get worse. Primary care physicians may be in short supply across 37 states by the year 2025. Not surprisingly, rural areas are projected to be the worst affected in terms of provider availability. An aging health care workforce remains a significant concern—nearly 50% of registered nurses are over 50 years old, and 44% of physicians in 2019 were at least 55 years old. A dearth of clinical sites and qualified faculty to train the next generation of clinical care providers will further exacerbate the access to care issue.

It does not end with workforce issues. Non-labor costs have also escalated:

- Per-patient drug expenses rose by nearly 37% compared to pre-pandemic levels.
- Hospitals spent over 20% more on supplies in 2021 per patient than before the pandemic.

- ICUs and respiratory care departments directly involved in COVID-19 patient care saw a 31.5% and 22.3% jump, respectively, in medical supply costs.
- The average length of hospital stays for patients increased by nearly 10% in 2021 compared to 2019.

Any one of these challenges is alarming on its own. But all of them occurring at once —in tandem with the highest inflation rate in nearly half a century — is a real crisis. Just as policymakers stepped up to help keep hospitals afloat during the early days of the pandemic so they could continue to provide care to patients, so too must our nation's leaders rise to the occasion now.

To help protect patients' access care, we continue to call for Congress to:

- Halt cuts to Medicare payments to hospitals, health systems and other providers;
- Extend or make permanent critical waivers that have improved patient care; and
- Hold commercial health insurers accountable for improper business practices —especially those that take caregivers away from the bedside to deal with burdensome administrative hurdles.

These necessary steps will provide critical support as the hospital field contends with a financial crisis, staffing shortages and increasing labor costs. Safeguarding the workforce and financial stability of our frontline care organizations means continued access to quality care for our patients and the wider community. Congress must act quickly to help hospitals and health systems address current challenges — and ensure they can provide needed care in the years to come.

Stacey Hughes is the executive vice president for government relations and public policy for the American Hospital Association.

Hospitals

Attachment Y

https://www.yakimaherald.com/news/local/yakima-valley-memorial-hospital-lost-millions-during-first-part-of-2022/article_e535c44c-3618-11ed-bd5a-1351986daaf4.html

FEATURED | SPOTLIGHT

Yakima Valley Memorial Hospital lost millions during first part of 2022

JOEL DONOFRIO Yakima Herald-Republic
Sep 19, 2022

Yakima Valley Memorial on Friday, March 12, 2021, along Tieton Drive in Yakima, Wash.

Amanda Ray / Yakima Herald-Republic

Unprecedented. Massive. Unsustainable. These words have been used to describe the financial crisis facing hospitals in the Yakima Valley, the state of Washington and the nation for the first portion of 2022.

Quarterly reports filed with the state's Department of Health by Yakima Valley Memorial Hospital officials have added a number to go with those words: $28.1 million.

That figure is the budget shortfall Yakima's only full-service hospital and trauma center reported for the first and second quarters of 2022, through June 30, according to the DOH.

The Yakima Valley's other two hospitals, Astria facilities in Sunnyside and Toppenish, also reported first-quarter losses, with second-quarter numbers not yet available.

All three hospitals reflect the grim reality facing health care providers throughout the state and nation, said Cassie Sauer, president and CEO of the Washington State Hospital Association.

Sauer and the WSHA reported in July that a statewide membership survey showed a net loss of $929 million for Washington hospitals during January, February and March. Several WSHA officials and hospital administrators across the state said the financial crisis is the worst they've ever seen in their decades of work in the health care industry.

"We don't yet have second-quarter financial results (we are surveying now), but what we are hearing anecdotally is not encouraging," Sauer wrote in an email to the Yakima Herald-Republic.

"For many hospitals, things have gotten worse (since the first quarter of 2022)," she wrote. "The cost of staff and supplies keeps going up, and the inability to get patients out who do not need hospital care (into long-term care facilities) is crushing."

Carole Peet, CEO and president of Virginia Mason Memorial, speaks at a press conference in front of the hospital's emergency entrance on Saturday, March 21, 2020, in Yakima, Wash.

Evan Abell / Yakima Herald-Republic

Memorial's reports

Yakima Valley Memorial's financial situation was referenced earlier this month as the hospital announced it would reduce the use of traveling nurses by Oct. 1 and update its staffing plan in response to "large financial losses" it is facing in 2022.

While the hospital did not provide specific data, hospital officials stated "massively inflated costs for travelers" — RNs, often provided by health care staffing agencies, who sign a contract to fill temporary positions — was among the reasons expenses outpaced revenue in the first half of 2022.

In July, Memorial Vice President and Chief Financial Officer Susan Sauder said the hospital "has suffered unsustainable negative margins and cash flow through the first two quarters of 2022."

Sauder said the struggle to find employees and the use of temporary workers to fill some of those openings have contributed to Memorial's financial problems, with temporary labor costs escalating by 201% during the past year.

The quarterly reports filed with the state Department of Health confirmed the observations of Sauder and other Memorial officials.

As seen in the adjacent chart, Memorial had an operating margin of minus-$6.9 million in the first quarter of 2022. When nonoperating losses from investments and other sources are added, the total margin for January, February and March of this year is minus-$10 million.

The second quarter was worse, with a total margin of minus-$18.1 million, bringing the 2022 shortfall through June 30, 2022 to minus-$28.1 million, according to the DOH figures.

Memorial has 222 licensed beds, according to the state hospital association's website. It was founded in 1950 and is governed by the private, nonprofit Yakima Valley Memorial Hospital Association.

Other area hospitals

Astria hospitals in Sunnyside and Toppenish also lost money in the first quarter of 2022, with the DOH reports showing a $182,352 deficit at Astria Sunnyside Hospital and a $1.3 million shortfall at Astria Toppenish Hospital. Second-quarter financial data was not available.

Both hospitals are smaller than Yakima Valley Memorial. Astria Sunnyside is a critical access hospital with 25 beds, while Astria Toppenish is a 63-bed community hospital, according to www.astria.health.

It was a different story for Prosser Memorial Hospital, on the western edge of Benton County.

The 25-bed critical access hospital had a positive total margin of roughly $2.5 million in the first quarter and basically matched it in the second quarter, with a year-to-date surplus of $5,139,071 reported through June 30.

Prosser Memorial announced in February plans to build a new facility on 33 acres north of Interstate 82. Hospital officials recently reported that the project has been slowed by inflation and supply chain issues, causing its estimated cost to increase to $103 million and timeline to be delayed. Groundbreaking is expected sometime this fall, with the new facility expected to open in late 2024.

Yakima Valley Memorial also could see changes soon. On May 9, officials with Memorial and MultiCare Health Systems of Tacoma said the two health organizations were considering a merger.

A "due diligence and information sharing process" that originally was estimated to take several months has been extended through the summer.

Hospital officials said the nursing and other staffing decisions being made at Memorial are not tied to the potential merger.

State, national trends

Staffing shortages and the cost to fill those positions with traveling employees remains a major issue for hospitals across Washington and across the country.

Earlier this month, Yakima Valley Memorial officials noted Washington state has 6,800 open RN positions across the health care spectrum, with 35 RN positions currently open at the Yakima hospital.

Sauer, with the WSHA, said Washington's problems are the same faced by other hospitals across the country, although "our Medicaid reimbursement rates are really low, and our difficult to discharge patient problem is worse."

An August report from the data analytics division of the Kaufman Hall health care management consulting company showed lower outpatient volumes and rising expenses have caused financial difficulties for the nation's hospitals through July.

The report by Kaufman Hall's Erik Swanson showed a median year-to-date operating margin of nearly minus-1% through July for U.S. hospitals, underscoring the continuing losses many facilities have experienced in 2022.

"An increasing number of patients continued to choose ambulatory centers over hospital settings for surgical procedures, a sign of a larger shift to ambulatory care and new ways of accessing care outside of the hospital," Swanson wrote in his report summary. "As outpatient activity and revenue sank, labor expenses, which have remained well above pre-pandemic levels throughout 2022, rose."

The WHSA's Sauer believes the best solutions to hospitals' financial woes could be addressed by public policy.

Tops on her list is providing more rehabilitation center and long-term care capacity so state-sponsored patients can leave hospitals after their acute care needs are met.

"Caring for them is very expensive, and once they've completed their acute care treatment, the hospital gets little to no money," Sauer wrote in an email to the Herald-Republic.

"We also need to increase our abysmally low Medicaid rates — which would be particularly helpful in Yakima, with a high Medicaid population — and grow the pipeline for health worker staff," she added.

A complete list of quarterly financial data for hospitals across the state is available at the Department of Health's website, doh.wa.gov. Go to the "Data and Statistical Resources" tab, click "Healthcare in Washington" then "Hospital and Patient Data" and go to the quarterly reports listed under hospital financial data.

Contact Joel Donofrio at jdonofrio@yakimaherald.com.

First quarter hospital finances

Financial data for Yakima Valley hospitals from the first quarter of 2022, as reported to the state's Department of Health. Most figures listed in millions, rounded to the nearest $100,000.

FACILITY Memorial Sunnyside Toppenish Prosser

Revenue

Total charges $425.9 $71.7 $49.9 $55.1

Other operating revenue $8 $177,900 $347,346 $528,505

Expenses

Total contractuals $291 $45.8 $34.1 $32.2

Charity care $7.8 $0.3 $0.2 $1.2

Bad debt $2.6 $0.9 $2 $0.4

Total operating expenses $139.4 $25.1 $15.2 $19.4

Operating margin -$.6.9 -$174,372 -$1.3 $2.5

Net nonoperating loss $3.1 $7,890 0 0

Total margin -$10 -$182,352 -$1.3 $2.5

Prosser Memorial Health	Title: Patient Safety Improvement Projects
	Department Manual(s): Board of Commissioners
Owner: CEO	Review date: The last review date will be automatically printed on the last page of the policy when a printed version is required.
Implementation date: 3/1/2022	

PURPOSE
To set forth a systematic process for conducting patient safety improvement projects that are intended to reduce the risk of adverse patient events or conditions that represent potential patient safety hazards while maintaining confidentiality protection.

POLICY
Safety risks to patients stem primarily from system breakdowns and poorly designed processes. To improve the safety of health care services, physicians and staff members at Prosser Memorial Health (PMH) work collaboratively to design systems and processes that minimize the risk of failures. These failures increase the likelihood that patients will be harmed by the effects of health care services.

An effective patient safety program cannot exist without error reduction projects, otherwise known as patient safety improvement projects. What differentiates a patient safety improvement project from other improvement initiatives is the focus and intent. The purpose of a patient safety improvement project is to analyze and understand the risks inherent in-patient care activities so that safer systems and processes can be designed. Ideally, all patient safety improvement projects use proactive risk assessment techniques to identify ways that system and process weaknesses can be corrected. At the present time, the standards of Regulatory Agencies require that at least one proactive risk assessment be conducted annually for a high-risk patient care process. PMH may choose to exceed the Regulatory Agency standards.

The Quality Committee (QC) will introduce patient safety improvement projects. The topics or processes chosen for these will be selected according to the priorities established by the Committee with input from the Board of Commissioners, PMH Medical Staff Committee, PMH Administration, the QC, and PMH employees as appropriate. To be considered a proactive risk assessment project that meets the regulatory agency standards, the project should conduct a Risk Assessment.

PROCEDURE
The QC may initiate a patient safety improvement project at any time in response to:

- The improvement priorities of the organization;
- Findings from internal root cause analysis;
- Recommendations received from the Safety Committee and other Medical Staff or PMH committees or groups;
- Safety alerts issued by external groups such as the Food and Drug Administration, and the Institute for Safe Medication Practices, etc.;
- National patient safety goals established by external groups; and
- Literature sources and knowledge-based information on patient safety improvement.

Since improvement projects are resource-intensive, the QC and Chief Quality Officer will consider many factors before initiating a patient safety improvement project. Issues to be considered include but are not limited to:

- Does the issue represent a high priority for improvement for the organization?
- Does the issue represent a substantial risk for patient safety?
- If the concern is not addressed, is there a high probability that a sentinel or critical event will occur?
- Will the organization receive substantial negative publicity or loss of accreditation if the concern is not addressed?

- Will failure to conduct an improvement project result in deterioration of staff or physician morale and/or loss of trust in the leadership's commitment to patient safety?

When the decision is made to initiate a patient safety improvement project, the QC & Chief Quality Officer shall:

- Initiate a DRAFT Business Case to be completed by the team; and
- Establish the team of people responsible for completing the project.

The team shall be comprised of physicians and staff members personally involved in the system and process to be improved. Recommendations for team members may be solicited from other Medical Staff Committees, PMH Departments, and Administration. Ideally the team includes 5-7 individuals who are "subject matter experts" and who have different levels and types of knowledge about the system and process to be improved. The team will report directly to the Quality Committee. A team facilitator, knowledgeable in proactive risk assessment techniques or performance improvement methods, will be named to support the project team activities and establish a deadline for project completion.

ACTIONS AND FOLLOW-UP

The Quality Committee is responsible for evaluating the thoroughness and credibility of patient safety improvement projects and the merits of the recommended risk reduction strategies and actions. The thoroughness and credibility are evaluated by considering the following questions:

- Did the project have multidisciplinary participation and input from those closest to the processes and systems under review?
- Did the team follow logical and systematic processes to arrive at recommended risk reduction strategies and/or action plans?

The Quality Committee reviews the patient safety improvement projects report of the recommendations as well as the thoroughness and credibility of the project. If the Quality Committee does not agree with the report, the team will reconvene to address the questions or concerns of the committee and make necessary changes. Upon completion of their changes, the team will present a new report to the Quality Committee for final review. A summary report of approved patient safety improvement projects will be incorporated into the performance improvement reports that are presented to the Medical Staff Committee and the Board of Commissioners.

The Quality Committee will receive regular reports on the progress of risk reduction strategies and/or actions and measures of the effectiveness of actions for each patient safety improvement project that is conducted. The department director is responsible for providing this report to the Quality Committee. The department director will monitor implementation of the actions. The department director will monitor the effectiveness of actions until such time as the group is reasonably assured that the desired results were achieved. The Quality Committee will periodically share general information relating to the improvement of patient safety that is derived from improvement projects with leadership, staff, and Medical Staff members.

Documents related to quality improvement projects, are considered confidential and protected from discovery in most states. The following steps can be taken to enhance statutory confidentiality protection:

- Follow policies and procedures for controlling access to quality improvement documents.
- Reference State statutes on quality improvement documents, for example CONFIDENTIALITY STATEMENT, STATE OF WASHINGTON: All records, data, and information collected and maintained by the Quality Assurance Department are to be used strictly for peer/professional

review as defined by the Medical Staff Bylaws and Board-approved professional staff committees involved in quality improvement activities. Data, records, and knowledge, including minutes, collected for or by individuals on committees assigned peer review functions are confidential, not public records, and are not available for court subpoena in accordance with WA and other state and federal laws. No one shall have access to or the right to release documents collected or prepared by the risk management staff without authority.

Prosser Memorial Health	Title: Outpatient Ordering Practitioners
	Department Manual(s): Board of Commissioners
Owner: CEO	Review date: The last review date will be automatically printed on the last page of the policy when a printed version is required.
Implementation date: 3/1/2022	

POLICY

Prosser Memorial Health (PMH) will allow the following practitioners to order outpatient procedures that are within their scope of practice: physicians (MD or DO), podiatrists, chiropractors, dentists, nurse practitioners and veterinarians. Physician Assistants (PA) may also order outpatient procedures as long as they provide the name of their sponsoring physician.

PROCEDURE

1. Any of the following practitioners: physicians (MD or DO), chiropractors, veterinarians, and advanced practice clinicians (APC) who are not members of PMH Medical Staff or allied health practitioner staff may order outpatient procedures at our facility, if those procedures are within the scope of practice of the practitioner.
2. Prior to any outpatient procedures being performed, the practitioner's credentials, to include verification of Washington license and the OIG exclusion list, will be verified by the Organization.
3. If the outpatient procedures are ordered by a physician's assistant, the credentials of both the PA and the sponsoring physician will be verified prior to the procedure being completed.

Prosser Memorial Health	Title: Tobacco Usage
	Department Manual(s): Board of Commissioners
Owner: CEO	Review date: The last review date will be automatically printed on the last page of the policy when a printed version is required.
Implementation date: 3/1/2022	

PURPOSE

Prosser Memorial Health (PMH) is committed to providing a safe and healthy environment and supports the findings of the Surgeon General that tobacco use in any form is a significant health hazard and that there is no risk-free level of exposure. The personal health hazards related to tobacco and nicotine delivery products include non-tobacco smoking substances and devices that simulate the use of tobacco including using smokeless tobacco.

POLICY

Smoking or the use or sale of tobacco and nicotine delivery products is not permitted on the PMH campus or its affiliated clinics and is restricted at other District owned or leased facilities as indicated below. Employees may not use these products on hospital property during work time except as defined below. For the purposes of this policy the term smoking also includes vaping.

PROCEDURE

The campus of PMH, clinics and its affiliated District properties and leased facilities are considered to be "smoke free" zones. Smoking is strictly prohibited. The use of tobacco or non-tobacco products that simulate tobacco use is not permitted inside PMH, campus out buildings, clinics and District properties and leased facilities. Smoking is not permitted in PMH owned or leased vehicles. Patients will be informed of this policy prior to admittance by their medical provider or at the time of admission.

Signage shall be posted at facility entrances regarding smoking restrictions in compliance with prevailing regulations. Smoking is not permitted within twenty-five (25) feet of any door, operable window or outside air intake on all hospital campus, clinics, District properties and leased facilities per Washington State Legislature RCW 70.160.

ORGANIZATIONAL RESPONSIBILITY:

Human Resources will assist in this communication by:

- Informing all applicants for employment at PMH of the Tobacco Free Environment policy prior to applicant accepting an offer of employment.
- Review the policy at New Employee Orientation.
- Publishing an article regarding the policy and the importance of enforcement on an annual basis.
- Assist employees, medical staff and patients with resource information and their understanding of the policy.

Prosser Memorial Health	Title: Quality Improvement
	Department Manual(s): Board of Commissioners
Owner: CEO	Review date: The last review date will be automatically printed on the last page of the policy when a printed version is required.
Implementation date: 3/1/2022	

SUPPORTIVE DATA

Change in health care is inevitable. Health care organizations must continually monitor and respond to the many changes in market conditions, customer expectations, regulations, and reimbursements just to name a few. In order to remain a viable provider of health care services for our service area, Prosser Memorial Health (PMH) must also strive to continuously improve our organization's performance thereby enabling us to meet its Mission, Vision and Values.

The current Strategic Plan will be the initial document that will identify Quality Improvement opportunities.

POLICY

PMH is taking the lead in the transformation from a pure quality assurance approach to a process/quality improvement function. The integration of the following functions is a reflection of that forward, proactive approach of PMH to become one of the top 100 Critical Access Hospitals in the country:

- Quality Improvement
- Compliance
- Infection Prevention

This Policy will focus on Quality Improvement functions.

Quality Improvement Policy:

PMH is committed to continuous improvement of services, as well as patient outcomes and preventing medical errors. This continuous effort will be interdisciplinary in nature and will involve all departments at PMH. Departmental programs should be evaluated by measuring, analyzing, and tracking quality indicators that assess the processes of care, services, and operations of departments. The data will be used to monitor the effectiveness, safety, and quality of care; as well as identify opportunities for improvement.
To facilitate the process of continuous quality improvement by departments, a systematic reporting system has been established. Quality Improvement Plans/ Goals should be updated annually into the Leadership Evaluation Management (LEM) Database.

In accordance with 42 CFR 485.641, a Critical Access Hospital (CAH) Annual Review is required as a tool for periodic evaluation of the total facility. Additionally, Washington State Legislature RCW 43.70.510 & RCW 70.41.200 requires an Annual Quality Program Plan as a tool for prospective quality improvement. The CAH Annual Review and Annual Quality Program Plan will be updated by the facility's Quality Assurance Department and made available for overseeing governing bodies, e.g. the Department of Health, when necessary.

Departmental Quality Improvement Plans, CAH Annual Review, and Annual Quality Program Plan will be presented to the Joint Conference Committee. Updated reports from the Joint Conference Committee will be presented to the Board of Commissioners.

OBJECTIVES

- To ensure that departments participate in performance improvement and contribute to quality and services related activities;
- To ensure that PMH and its departments are committed to the ongoing evaluation of customer's needs, expectations and requirements;
- To implement a process that will result in a customer focus and quality values being integrated into management approaches and day-to-day activities; and
- To provide a commitment to the continuous assessment and improvement of patient care, services, outcomes and customer satisfaction.

AUTHORITY AND ACCOUNTABILITY

The governing body has ultimate responsibility for the quality of care provided by PMH. The Quality Committee (QC) has overall accountability for assuring effective implementation of the continuous improvement process. The QC possesses the authority to act on recommendations made by any of the PMH employees, Medical Staff, auxiliary, customers and any recommendation they make on their own based on evaluation of results and the effectiveness of the continuous quality improvement processes.

Directors are responsible for the implementation of this plan and the development of a systematic process for monitoring and evaluation the quality and appropriateness of care and services provided or performed within their department and effective performance of department employees; directors are responsible for assuring that this process is objective, timely and consistent throughout the quality improvement process.

Directors have responsibility to act on recommendations made by employees based on a review and evaluation of identified opportunities for improvement that involve process within their department or within one discipline. Directors are responsible for the implementation and effective management of a quality improvement program within their departments that selects areas for improvement based on outcomes and identified through the analysis of internal and external data.

Directors have responsibility for communication of their department's quality improvement activities to the Quality Committee (QC) and the Chief Quality Officer.

ORGANIZATON AND RESPONSIBILITIES

The Board of Commissioners and Medical Staff, through the Joint Conference Committee, will be informed of departmental and interdepartmental quality improvement activities.

Quality improvement teams will submit findings, conclusions, recommendations, actions and results demonstrating effectiveness to the QC on an annual basis or as requested.

Information submitted to the QC will be integrated with other organizational quality information and data as reflected on the Strategic Plan Score Card and the Patient Care Score Card.

The Quality Committee (QC) will submit significant conclusions, actions and results to the governing board through the Joint Conference Committee semi-annually.

RESPONSIBILITIES

Joint Conference Committee

- Demonstrate top level commitment to quality improvement by providing direction and guidance in the pursuit of organizational excellence;
- Identify ongoing insights and expectations from the community as they relate to quality improvements;
- Provide approval and oversight of the organization-wide Quality Improvement Program Plan;
- Provide sufficient resources and systems for quality improvements;
- Support mechanisms to determine the quality requirements and expectations of those we serve to meet or exceed those requirements and expectations of quality care, service outcomes and satisfaction;
- Request, review and evaluate regular reports on quality improvement, including at least the process selected for improvement achieved and customer requirements. Provide support when there are unresolved quality issues presented in the reports; and
- Utilize the information and data from the quality improvement and incorporate improvement goals and objectives into the strategic planning process.

Administration/Quality Assurance

- To coordinate and/or present, in addition to interpreting accurate and adequate quality information and data for the Joint Conference Committee;
- Provide adequate resources and support for activities related to quality improvements;
- Assure the integration of concepts, systems and activities of process/performance improvements;
- Assure adequate systems for the identification of opportunities for improvement, data collection and measurement, and continuous monitoring of results;
- Provide support, not control, for a quality work environment by implementing actions, removing barriers to improvement, facilitating problem-solving activities and resolving concerns that cross departmental lines;
- Role model behaviors, actions and attitudes demonstrating concepts, principles and problem-solving methodologies of an effective quality improvement environment; and
- Set expectations, develop plans, and implement procedures to assess and improve the performance of the organization's governance, management, clinical and support processes.

Directors

- Assess departmental quality improvement needs based on data collected;
- Collect input from employees regarding their views of current opportunities for quality improvement through a regular, systematic process;
- Assess departmental quality improvement needs based on the current Strategic Plan;
- Collect and/or analyze data about the needs and expectations of patients and/or customers and degree to which these needs and expectations have been met;
- Identify department processes (clinical and non-clinical) that affect a large percentage of patients, place patients at risk if not performed well, performed when not indicated or not performed when indicated, have been or are likely to be opportunities for improvement and direct improvement activities toward those processes;
- Collect data about quality control activities in the clinical Laboratory, Cardiopulmonary, Diagnostic Imaging, Pharmacy, Environmental Services, Nutritional Service, etc., as appropriate;
- Assure that department staff are involved in the department quality improvement activities and promote a collaborative approach;
- Encourage and empower employees to solve problems utilizing quality improvement tools and methodologies; and
- Identify and utilize benchmarks (i.e. published data, professional standards, and data collected from internal and external sources) to target and measure departmental performance.

QUALITY COMMITTEE (QC) STRUCTURE

Members of the Quality Committee (QC) include individuals from the following functions:

- Administrative Team; and
- Leadership Team

Quality Committee (QC) Procedure:

The QC will function in accordance to its approved Purpose, Composition and Functions document (aka. Charter; to be located in the Organization and Functions Manual).

Quality Improvement Project Selection:

- Any employee, Medical Staff member, Board member or volunteer may submit suggestions for quality improvement projects;
- Suggestions should be submitted to the QC and/or the Chief Quality Officer; and

- The QC and the Chief Quality Officer will prioritize suggestions by considerations of the following:
    - Estimated resources required for project and availability
    - Appropriateness of suggested project for a team approach
    - Input from the affected process owners
    - Relationship to the current Strategic Plan
    - Relationship to the Mission, Vision, and Values
    - The magnitude of the opportunity for improvement

Quality Improvement Teams will be selected based upon the following:

- Availability;
- Willingness to seek out improvements and willingness to improve the process;
- As recommended by their functional managers;
- Ability to work in a team environment;
- Ability to openly communicate with others; and/or
- Willingness to act as a liaison between the team and the QC.

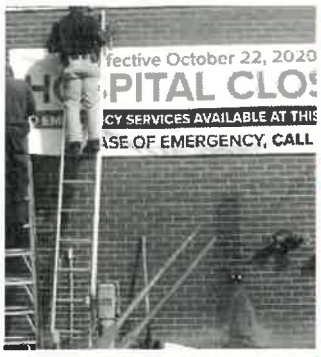
Attachment EE

















American Hospital Association™

Advancing Health in America

Rural Hospital Closures Threaten Access

Solutions to Preserve Care in Local Communities

Table of Contents

American Hospital Association™

Advancing Health in America

Rural Hospital Closures Threaten Access

In rural communities across America, hospitals and health systems are cornerstones for the health and well-being of the patients and communities they serve. Rural hospitals and health systems provide much needed access to affordable, quality health care for patients close to home, and operate as economic anchors in their local communities, supporting good paying jobs and infusing the local economy with spending on goods and services. In 2020, rural hospitals supported one in every 12 rural jobs in the U.S. as well as $220 billion in economic activity in rural communities.

The vital role of rural hospitals has never been more apparent than during the COVID-19 pandemic, which has hit rural areas especially hard. Since the start of the pandemic, rural hospitals and health systems have been on the front lines in providing health care to their communities. Their perseverance is crucial to the nearly 46 million people – 14% of all Americans – living in rural areas across the U.S. who currently face a significant shortage of health care services.

Yet 136 rural hospital and health systems have closed from 2010 to 2021 (see Figure 1 below), according to the UNC Cecil G. Sheps Center for Health Services Research, which has had a detrimental impact on their communities in a variety of ways. While rural hospitals were partially buoyed by the Provider Relief Fund and other sources of COVID-19 assistance that limited closures in 2021, the financial outlook for many rural hospitals moving forward is precarious. These closures — whether due to declining financial performance, geographic isolation or low patient volume — have an outsized impact on the health and economic well-being of rural communities. Additionally, rural hospitals are disproportionately impacted by issues such as coverage trends, workforce and regulatory barriers.

Key Findings

- **Between 2010 and 2021, 136 rural hospitals have closed, according to the UNC Cecil G. Sheps Center. Nineteen of these closures occurred in 2020, the most of any year in the past decade.**
- **The majority (74%) of rural closures happened in states where Medicaid expansion was not in place or had been in place for less than a year.**
- **Rural hospitals face significant staffing shortages. Only 10% of physicians in the United States practice in rural areas despite rural populations accounting for 14% of the population. Nearly 70% of the primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.**
- **An AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 shows that slightly more than half of the hospitals that have been closed were independent.**
- **Despite facing ongoing challenges, a number of pathways exist for rural hospitals' financial sustainability.**

Figure 1 – Overview of Rural Hospital Closures 2010-2021

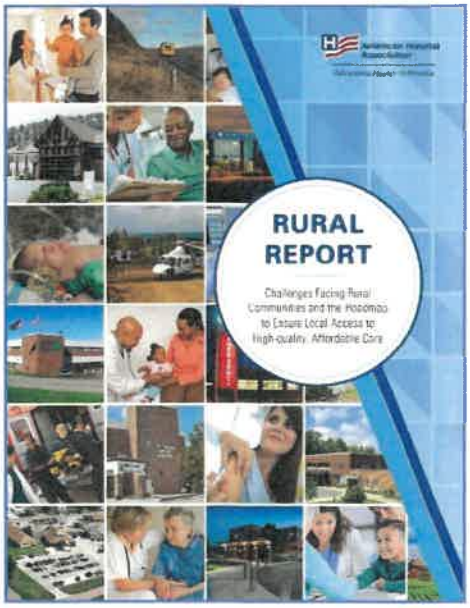
YEAR	FULL CLOSURES	CONVERTED CLOSURES	TOTAL CLOSURES
2010	1	2	3
2011	2	3	5
2012	5	4	9
2013	5	8	13
2014	8	8	16
2015	11	6	17
2016	5	5	10
2017	8	2	10
2018	9	5	14
2019	9	9	18
2020	10	9	19
2021	0	2	2
Total	73	63	136

Source: The Cecil G. Sheps Center for Health Services at the University of North Carolina at Chapel Hill

Given their unique constraints, rural hospitals and health systems often need to be resourceful in pursuing opportunities that improve financial stability and viability. Participation in innovative payment models that provide additional investment and flexibilities can be a helpful resource to rural hospitals. Access to capital is important to stabilizing a vulnerable hospital or advancing an innovative one. For some rural hospitals, partnerships, collaborations, mergers or affiliations also can be a good option. Research indicates that these options are important lifelines for rural hospitals, increasing access to **much-needed capital**. It's also shown not to drive closures – contrary to some claims that rural closures are driven by consolidation. An estimated 40% of hospitals may be **financially challenged or distressed** prior to an M&A transaction. These acquisitions are associated with a **3.3% reduction** in annual operating expense per adjusted admission at the acquired hospitals.

Challenging Demographics

Rural hospitals make up about **35%** of all hospitals in the U.S. Nearly **half** of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby. As a result, in rural hospitals, the acute care occupancy rate (37%) is less than **two-thirds** of their urban counterparts (62%).



Compared to their non-rural counterparts, a significantly higher percentage of rural hospitals are owned by state and local governments — 35% compared to just 13% of urban hospitals. Moreover, a significantly lower percentage of rural hospitals are investor-owned. In 2020, just **11%** of rural hospitals operated as for-profit compared to 34% of urban hospitals.

The COVID-19 pandemic has increased existing pressures on rural hospitals, contributing to declining financial margins and patient volumes. Despite the documented importance of rural hospitals, these continued financial pressures caused a record number of rural hospital closures in 2020. A variety of factors have contributed to these closures, most notably, financial pressures, challenging patient demographics and staffing shortages. The risk of increased closures has now returned as hospitals deal with the mounting financial challenges created by the pandemic, longstanding difficulties facing rural hospitals and new economic pressures, including rapidly increasing input costs.

Rural Hospital Closures 2010-2021

Between 2010 and 2021, **136 rural hospitals closed**, with 73 complete closures[1] and 63 converted closures[2] (see Figure 1 above). Nineteen of these closures occurred in 2020, the most of any year in the past decade. Many rural hospitals were in precarious financial positions even before the COVID-19 pandemic, and the pandemic has exacerbated the challenges that many rural hospitals were already experiencing, including workforce shortages, limited access to critical supplies and aging infrastructure.

Trends Affecting Rural Hospital Financial Sustainability

There are a number of trends driving rural closures, forcing hospitals to take a wide variety of approaches in addressing them. Despite myriad challenging circumstances, there are many pathways for rural hospitals' sustainability. Flexible models of care, decreased regulatory burden and state Medicaid expansion can all support rural hospitals in maintaining access to care for their communities.

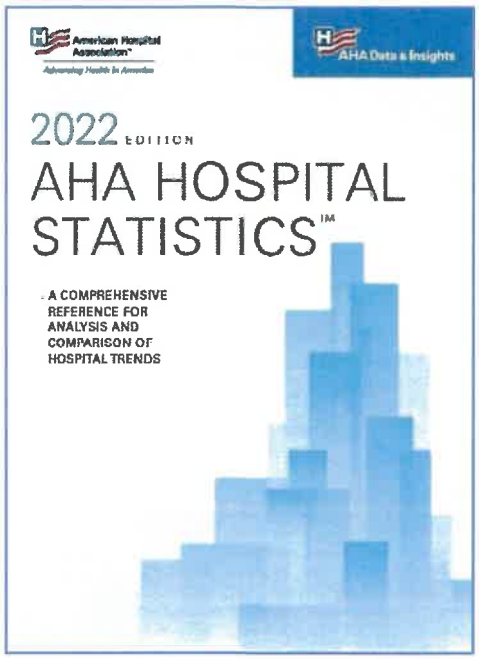
Patient Volume and Health

Population densities are categorically lower in rural areas, and as a consequence, rural hospitals have much lower patient volumes. Lower patient volumes makes it challenging for rural hospitals to maintain fixed-operating costs. This has been especially true during the COVID-19 pandemic as patient volumes and patient acuity have been more volatile.

Lower patient volumes also can impede rural hospitals participation in performance measurement and quality improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement. Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. This can limit rural hospitals' participation in innovative payment models that can help improve patient outcomes and provide alternative streams of revenue.

In addition to lower patient volumes, rural hospitals often treat patient populations that are older, sicker and poorer compared to the national average. For example, a higher percentage of patients in rural areas are uninsured. A 2016 Department of Health and Human Services Assistant Secretary for Planning and Evaluation issue brief found that 26% of uninsured, rural

patients delayed seeking care due to cost. These delays contribute to sicker, and subsequently more costly, patients seeking care. These delays in care are further worsened by the fact that people in rural areas face geographic isolation and limited access to transportation to receive care at medical facilities. Indeed, this challenging patient mix and lower volumes strains rural health systems as the resources needed to provide care are more varied and intense than those in other regions.



Overcoming Low Reimbursement

The bulk of rural hospital revenue comes from government payers, of which Medicare comprises nearly half. Yet, both Medicare and Medicaid reimburse less than the cost of providing these services. This resulted in rural hospitals incurring $5.8 billion in Medicare underpayments and $1.2 billion in Medicaid underpayments in 2020, on top of $4.6 billion in uncompensated care provided by rural hospitals. For Medicare reimbursements in particular, these underpayments grew by nearly 40% from 2016 to 2020. Medicare sequester cuts, which to fully resumed July 1, will further strain rural hospital finances.

Because rural hospitals are more likely to serve a population that relies on Medicare and Medicaid, rural hospitals are not able to offset low public program payment rates with revenue from patients with commercial coverage, which often has higher reimbursement rates than government payers. Additionally, two programs designed to address these issues, the Medicare-dependent Hospital (MDH) and enhanced Low-volume Adjustment (LVA) program, which provide vital support to rural hospitals to offset financial vulnerabilities associated with being rural, geographically isolated and low-volume, are scheduled to expire Sept. 30, 2022. COVID-19 relief prevented many closures in 2021 but as that assistance expires, the financial position of many rural hospitals, especially MDH and LVA hospitals, is grim. In 2020, one in five rural closures were MDHs. Extending these programs or making them permanent will be critical to these rural hospitals moving forward. In 2020, one in five rural closures were MDHs.

In the commercial insurance market, rural hospitals are often forced to accept below average rates or are left out of plan networks entirely. Rural hospitals with low commercial patient volume and a lack of market power are often forced to "take it or leave it" when large insurers refuse to negotiate. In cases where rural hospitals are, in effect, excluded from certain plan networks due to unfair insurer negotiation tactics, patient access can be negatively affected. Many patients residing in rural areas may already have to drive long distances to seek in-network care. Plan practices that restrict access to network providers in rural areas further exacerbate these challenges by impeding timely patient access to care, compromising the stability of rural health care providers, and circumventing the intent of network adequacy requirements.

Additionally, affordable coverage remains a pressing challenge facing the health care system. Lack of health insurance coverage in rural areas results in high uncompensated care costs for hospitals. Medicaid expansion is one policy that has helped rural hospitals remain viable. The majority (74%) of rural closures happened in states where Medicaid expansion was not in place or had been in place for less than a year. Research has found that Medicaid expansion has been associated with improved hospital financial performance and lower likelihood of closure, especially in rural areas that had many uninsured adults prior to expansion.

Managing Staffing Shortages

Rural hospitals face significant staffing shortages. Only 10% of physicians in the United States practice in rural areas despite rural populations accounting for 20% of the population. Nearly 70% of the primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.

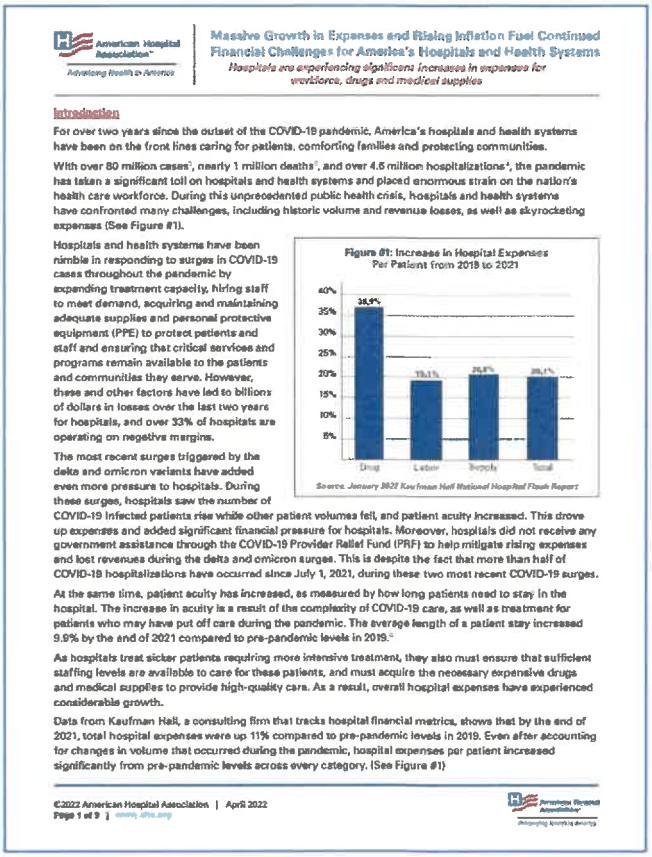
The shortage of primary care services has detrimental effects on the overall health of rural populations. For example, health outcomes in rural areas are significantly lower compared to more densely populated regions. Additionally, while clinical care shortages exist across the care continuum, the shortage of behavioral health and substance abuse professionals in rural populations is immense. Recent research finds that 65% of rural counties do not have a psychiatrist; 47% do not have a psychologist; and 81% do not have a psychiatric nurse practitioner. Clinician shortages are difficult to fill as rural hospitals find it challenging to recruit and retain qualified practitioners.

The COVID-19 pandemic has only worsened existing staffing shortages. At the height of the January 2022 omicron surge, nearly one-third of hospitals indicated that they were anticipating critical staffing shortages. These shortages have pushed hospitals to utilize incredibly expensive contract labor firms to bolster staffing when there are surges in patient volume. Average pay for hospital contract nurses has more than doubled over the course of the pandemic, increasing labor expenses by more than 50% on a per adjusted discharge basis compared to pre-pandemic levels. For rural hospitals, the rising costs for labor can be especially challenging when close to half of rural hospitals already have negative operating margins.

Recruitment and retention of health professionals has long been a persistent challenge for rural providers. Acute workforce shortages and increasing labor expenses resulting from the pandemic have placed additional pressure on rural hospitals. Many rural providers are seeking novel approaches to recruit and retain staff. Existing federal programs, such as the National Health Service Corps, work to incentivize clinicians to work in rural areas. Other programs, such as the Rural Public Health Workforce Training Network Program, help rural hospitals and community organizations expand public health capacity through health care job development, training and placement. Additional and continued support to help recruit and retain health care professionals in rural areas is needed from state and federal governments.

Navigating COVID-19 and Rising Input Costs

Hospitals and health systems are facing significant financial instability due to the COVID-19 pandemic. Expenses for labor, drugs, purchased services and personal protective equipment have all increased compared to pre-pandemic levels. For example, drug expenses have increased dramatically, **36.9%** on per patient bases, compared to pre-pandemic levels. Hospitals also are seeing sicker patients requiring longer hospital stays, with average length of stay up **9.9%** compared to pre-pandemic levels. However, patient volume, particularly among outpatient centers, has not returned to pre-pandemic levels. Discharges are down **16%** compared to pre-pandemic levels. Hospitals are continuing to utilize more expensive labor, drugs and other supplies and seeing higher acuity patients, while patient volume continues to fluctuate with COVID-19 surges.



American Hospital Association™
Advancing Health in America

Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems

Hospitals are experiencing significant increases in expenses for workforce, drugs and medical supplies

Introduction

For over two years since the outset of the COVID-19 pandemic, America's hospitals and health systems have been on the front lines caring for patients, comforting families and protecting communities.

With over 80 million cases[1], nearly 1 million deaths[2], and over 4.6 million hospitalizations[3], the pandemic has taken a significant toll on hospitals and health systems and placed enormous strain on the nation's health care workforce. During this unprecedented public health crisis, hospitals and health systems have confronted many challenges, including historic volume and revenue losses, as well as skyrocketing expenses (See Figure #1).

Hospitals and health systems have been nimble in responding to surges in COVID-19 cases throughout the pandemic by expanding treatment capacity, hiring staff to meet demand, acquiring and maintaining adequate supplies and personal protective equipment (PPE) to protect patients and staff and ensuring that critical services and programs remain available to the patients and communities they serve. However, these and other factors have led to billions of dollars in losses over the last two years for hospitals, and over 33% of hospitals are operating on negative margins.

Figure #1: Increase in Hospital Expenses Per Patient from 2019 to 2021

Source: January 2022 Key Issues Hall National Hospital Flash Report

The most recent surges triggered by the delta and omicron variants have added even more pressure to hospitals. During these surges, hospitals saw the number of COVID-19 infected patients rise while other patient volumes fell, and patient acuity increased. This drove up expenses and added significant financial pressure for hospitals. Moreover, hospitals did not receive any government assistance through the COVID-19 Provider Relief Fund (PRF) to help mitigate rising expenses and lost revenues during the delta and omicron surges. This is despite the fact that more than half of COVID-19 hospitalizations have occurred since July 1, 2021, during these two most recent COVID-19 surges.

At the same time, patient acuity has increased, as measured by how long patients need to stay in the hospital. The increase in acuity is a result of the complexity of COVID-19 care, as well as treatment for patients who may have put off care during the pandemic. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019.[4]

As hospitals treat sicker patients requiring more intensive treatment, they also must ensure that sufficient staffing levels are available to care for these patients, and must acquire the necessary expensive drugs and medical supplies to provide high-quality care. As a result, overall hospital expenses have experienced considerable growth.

Data from Kaufman Hall, a consulting firm that tracks hospital financial metrics, shows that by the end of 2021, total hospital expenses were up 11% compared to pre-pandemic levels in 2019. Even after accounting for changes in volume that occurred during the pandemic, hospital expenses per patient increased significantly from pre-pandemic levels across every category. (See Figure #1)

At the same time, rural communities were especially hit **hard** by the pandemic with sicker patients seeking care. Rural hospitals have been forced to cancel or postpone non-emergent procedures to adjust for the influx of COVID-19 patients. The loss of outpatient revenue significantly impacts how rural hospitals can remain viable, especially given that the national median for outpatient revenue, as a percentage of total revenue, is **77%**. Indeed, under this pressure, some rural hospitals have **struggled** to maintain access to health care services. By the fall of 2020, more than **three dozen** hospitals had already gone bankrupt.

The federal government developed funding programs to help rural hospitals sustain services during the COVID-19 pandemic. Rural hospitals received COVID-19 relief funds from the Coronavirus Aid, Relief and Economic Security (CARES) Act and the American Rescue Plan Act. As these funding streams run out, however, rural hospitals will once again shoulder the brunt of the costs incurred by the pandemic, putting them in a financially precarious position moving forward. Of particular note is that in 2021 only two rural hospitals closed. The critical support from the Provider Relief Fund and sources of COVID-19 relief certainly proved to be a lifeline to many rural hospitals, contributing to a temporary slowdown of the alarming trend of rural closures. Without additional relief and halting payment cuts, we will likely see more years of record rural closures, with devastating impacts to the communities they serve.

Additionally, the Centers for Medicare & Medicaid Services (CMS) utilized waiver authority tied to the Public Health Emergency to enable the expansion of telehealth services during the COVID-19 pandemic. These flexibilities have had a huge impact on rural hospitals, who used

these telehealth waivers to increase access, avoid hospitalizations and improve outcomes. Without congressional action, however, these waiver flexibilities will expire, jeopardizing the progress made to increase patient access over the last two years.

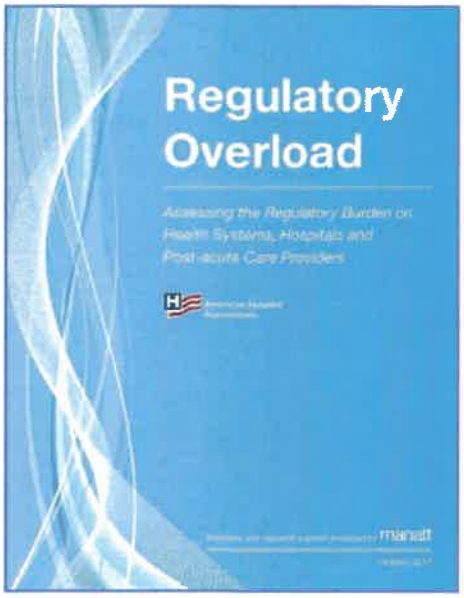
Implementing Flexible Models of Care

Rural hospitals can employ new models of care and embark on pathways to transformation, but they need flexibility and resources to be successful. In 2020, the CMS **announced** a new value-based payment model for rural health care providers called the Community Health Access and Rural Transformation (CHART). The new payment model would provide increased financial stability through predictable upfront payments, as well as increased operational and regulatory flexibility for care delivery.

Additionally, new legislation in 2020 also established the Rural Emergency Hospital designation under Medicare allowing critical access hospitals and certain small, rural hospitals to meet a community's need for emergency and outpatient services without also providing inpatient care. This designation would help ensure patients in rural communities maintain access to essential emergency and outpatient services and support rural hospitals' ability to remain financially viable, serving as a critical access point for their communities. These models are promising, but additional opportunities are needed to develop and expand successful models for rural communities.

Overcoming Regulatory Barriers

Rural hospitals face a number of regulatory burdens that impact their ability to provide care. According to a 2017 AHA **study**, the nation's hospitals, health systems and post-acute care providers spend $39 billion each year on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for larger facilities. For example, while Medicare's Conditions of Participation (CoPs) and other compliance metrics are important to ensure the safe delivery of care, future CoPs should be developed with more flexibility and alignment with other laws and industry standards. Rural hospitals can protect their communities' access to health care by receiving relief from outdated and unnecessary regulations.



Exploring Partnerships, Collaborations, Mergers, and Affiliations

For some rural hospitals, partnerships, collaborations, mergers and affiliations can be effective options to preserve access to care in their communities. Hospital partnership, collaboration, merger and affiliation activity has **increased significantly** in the past decade, with hospitals and health systems looking to create operational, strategic and financial value to help them meet

their mission of caring for patients and communities. A main driver is the pursuit of economies of scale, the ability to decrease unit costs, or to improve productivity and outcomes through increased volumes. For example, a hospital that does not offer a particular service line may seek a joint venture partnership with a leading organization in the field. A hospital in severe financial distress with little prospect of significant capital investments may look to engage in a merger and acquisition arrangement. Having this access to capital is particularly important for rural hospitals, since they face additional challenges such as aging infrastructure and new technology investments for telehealth and broadband.

Increasingly, rural hospitals and health systems have sought varying forms of integration. Despite claims by some that consolidation drives rural closures, the data clearly show that system affiliation is not driving this trend. For example, even though most rural community hospitals are affiliated with a health system, an AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 shows that less than half of the hospitals that have been closed were system affiliated. This would indicate that of all the challenges facing rural hospitals that contribute to closures, being part of a system is likely not one of them.

These integrations cannot only preserve patient access to care, but they also can enhance quality of care. They have given rural hospitals the ability to provide resources for patient support and engage in partnerships with larger employers to increase access. Additionally, they also have given rural hospitals the ability to obtain capital at an affordable cost when traditional funding from state and federal capital programs has been difficult to secure.

Conclusion

To mitigate rural hospital closures, hospitals continue to explore strategies that allow them to remain viable within the community. Although rural hospitals have long faced circumstances that have challenged their survival, we will most likely see more rural hospital closures as they attempt to adapt to the unprecedented challenges brought on by the COVID-19 pandemic. Rural hospitals also require increased attention from state and federal government to address barriers and invest in new resources in rural communities. The AHA continues to support policies that would help address these challenges, including:

1. Extending the MDH program (Rural Hospital Support Act, S.4009, and Assistance for Rural Community Hospitals Act, H.R.8747).
2. Extending the LVA program (Rural Hospital Support Act, S.4009, and Assistance for Rural Community Hospitals Act, H.R.8747).

Without the appropriate support and evaluation of existing policies by the state and federal government, rural hospitals will continue to be on life support.

Attachment GG

Prosser Memorial Health

September 29, 2022

Re: Retention Inflation Incentive for Union and Exempt Non-Leadership Staff

Payment Date: Pay Period Ending 10/16/2022 and Paid on Friday 10/21/2022

Rules for determining Retention Inflation Incentive

- Employee must be an active employee at the time of payment
- Employees that are excluded:
  - Exempt in a Leadership position (Director or higher)
  - Exempt Providers: Physician, APC, ARNP, Licensed Mental Health Counselor
- Earnings based on paid amounts: 26 pay periods beginning 09/20/2021 and ending 09/18/2022
- Earnings include all wages for hours worked, sick, vacation, holidays, overtime, shift differentials
- Earnings excluded but not limited to the following categories:
  - Bonus
  - FMLA
  - PFML
  - Gift Card
  - GTL Income
  - Housing Allowance
  - Incentive Payments
  - Medical Taxable Fringe
  - Moving Allowances
  - Rewards & Recognition
  - Cash Outs for Sick & Vacation
  - Sign-On Bonus
  - Student Loan Repayments
  - Tail Insurance

Incentive %	AFSCME	Exempt Non-Leadership	IAFF	SEIU	Grand Total
3.5%	340,732	39,700	28,377	240,070	$ 648,879
Employee #	224	20	21	107	372