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

March 2, 2022

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

Re: Certificate of Need Request by Mary Bridge Children's Hospital to Transfer Licensure of Neonatal Intensive Care Unit and Intermediate Care Nursery Beds to Mary Bridge Children's Hospital and Modify a Condition of Certificate of Need #1920

Dear Mr. Hernandez:

On behalf of MultiCare Health System, attached, please find a certificate of need ("CN") application for MultiCare Health System ("MultiCare") dba Tacoma General Hospital ("Tacoma General") and dba MultiCare Mary Bridge Children's Hospital ("Mary Bridge"). Based on guidance from the Department, this CN application includes two phases:

- Phase One—a request to transition the 30-bed Level II Intermediate Care Nursery and the 40-bed Level IV Neonatal Intensive Care Unit (collectively referenced as the "NICU" in this application) from the Tacoma General license to the Mary Bridge license.

- Phase Two—a request to modify Condition One from CN #1920, which stated the approval of the relocation included a Project Description wherein Mary Bridge would remain at 82 licensed beds (no change in licensed bed capacity). With the transfer of the 70 beds and tertiary service, requested in Phase One, Mary Bridge would increase its number of licensed bed to 152 licensed beds (82 existing beds + 70 NICU beds).

It is our understanding that if this CN application is approved by the Department, there would be two CNs issued, one for the NICU services and associated bed transfer and a second CN, CN #1920A, an amendment that removes the Condition limiting the number of beds and services.

Thank you for your support and assistance through this process. Please contact me if you have any questions. I can be reached at 253.403.8771 or e.kobberstad@multicare.org

Sincerely,

K. Erin Kobberstad

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

Certificate of Need Application
Hospital Projects

Exclude hospital projects for sale, purchase, or lease of a hospital, or skilled nursing beds. Use service-specific addendum, if applicable.

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

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

Signature and Title of Responsible Officer K. Erin Kobberstad Vice President, Strategic Planning **Email Address** ekobberstad@multicare.org	**Date:** March 2, 2022 **Phone Number:** 253-403-8771
Legal Name of Applicant MultiCare Health System **Address of Applicant** MultiCare Health System 820 A Street Tacoma, WA 98402	☐ New Hospital ☒ Expansion of existing hospital (identify facility name and license number). + Mary Bridge Children's Hospital. License # 175 + Tacoma General Hospital. License #176 ☒ Request to modify Condition One from CN #1920 **Provide a brief description, including the number of beds and the location:** Transfer of 30 Level II Intermediate Care Nursery and 40 Level IV NICU beds from Tacoma General Hospital license to Mary Bridge Children's Hospital license and transfer this tertiary service to Mary Bridge Children's Hospital's license. Modify Condition One from CN #1920, limiting the number of licensed beds and services to those approved in CN 1920, approved December 2021 **Estimated capital expenditure:** $ 103,600

Identify the Hospital Planning Area
The service area is Central Pierce Secondary Hospital Planning Area. However, it should be noted that Mary Bridge, as one of three pediatric hospitals in Washington, serves a much larger geographic area.

Identify if this project proposes the addition of expansion of one of the following services:

☒NICU Level II	☐NICU Level III	☒NICU Level IV	☐Specialized Pediatric (PICU)	☐Psychiatric (within acute care hospital)
☐Organ Transplant (identify)	☐Open Heart Surgery	☐Elective PCI	☐PPS-Exempt Rehab (indicate level)	☐Specialty Burn Services

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.
- Under no circumstance should your application contain any patient identifying information.
- Use non-inflated dollars for all cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.

- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable

Mary Bridge Children's Hospital & Health Network

Certificate of Need Application

Transfer of Licensure of Neonatal Intensive Care Unit beds and Intermediate Care Nursery Beds and Modify a Condition of Certificate of Need #1920

March 2022

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Introduction

Summary of Certificate of Need Request

MultiCare Health System ("MultiCare") dba Tacoma General Hospital ("Tacoma General") and MultiCare Mary Bridge Children's Hospital ("Mary Bridge") submits this certificate of need ("CN") application with a two-phased request: Phase One--to transfer the 30-bed Level II Intermediate Care Nursery and the 40-bed Level IV Neonatal Intensive Care Unit (collectively referenced as the "NICU" in this application) that currently operated under the Tacoma General license to the Mary Bridge license.[1] Phase Two—to request modification of Condition One from CN #1920, which stated the Project Description under the approved relocation would have Mary Bridge remain at 82 licensed beds (no change in licensed bed capacity).[2] With the transfer of the 70 beds and tertiary service, requested in Phase One, Mary Bridge would increase its number of licensed bed to 152 licensed beds (82 existing beds + 70 NICU beds).

In summary, this CN request includes the following:[3]

- Submit one application that covers two goals.
  - Review the NICU and the associated bed transfer at Mary Bridge.
  - Acknowledge that CN #1920 would be amended to reflect the transfer of the NICU beds and the tertiary service to Mary Bridge.

- Assuming the application is approved, two CNs would be issued, one for the NICU services and associated bed transfer and a second amended CN, CN #1920A, modifying Condition One.

Overview to Phase One

Over the years Mary Bridge has grown, offering increasingly sophisticated neonatal and pediatric care. In November 2021, the department issued CN#1920, approving Mary Bridge to relocate and build out an entirely new, specialized children's hospital building.

This request is another step to provide all necessary services and excellent care under Mary Bridge leadership. MultiCare currently provides specialized neonatal care in the

[1] Technical Assistance ("TA") call with representatives from MultiCare Health System, the Certificate of Need program and the Attorney General's Office, January 27, 2022, where MultiCare's plans and different options were discussed. This discussion was followed up with an e-mail, January 28, 2022, from Mr. Eric Hernandez, Manager-Certificate of Need, to Ms. Erin Kobberstad, Vice President, Strategy, MultiCare Health System.
[2] Certificate of Need #1920, issued December 3, 2021, included with letter from Mr. Hernandez to Ms. Kobberstad, December 3, 2021.
[3] As stated by Mr. Hernandez in his e-mail January 28, 2022, to Ms. Kobberstad.

70-bed NICU that operates under the Tacoma General license. This request seeks to align those neonatal services under the Mary Bridge hospital license so that the neonate services are integrated with the pediatric services. The neonatologists and other specialists who provide specialized neonatal care will not change, nor will nursing, but the care planning, delivery, and administration of that care will be organized through Mary Bridge leadership. The proposed transfer of the specialized neonatal services to the Mary Bridge license will enhance the high-quality, essential program provided today by providing operational and administrative alignment, positively impacting patients and their families.

In summary, our requested project will further MultiCare's continued mission to meet the current and future needs of our communities and serve our patients and their families by providing high-quality, safe, and compassionate care, all under Mary Bridge organization and leadership.

Two final important points to note: First, Phase One is "need neutral" as that term is used in CN applications, given there would be no increase in the number of NICU beds within the market and at MultiCare, only a transfer of those beds from one license to another. Second, the NICU is not moving its location or being expanded. There are minor modifications, summarized in this request, to be made to establish the signage and specifically designate the NICU space as Mary Bridge hospital space.

Overview of Phase Two

If the transfer of the NICU tertiary service and beds from Tacoma General's hospital license to Mary Bridge hospital's license is approved, the second step is amending CN #1920 to acknowledge the transfer of NICU beds and tertiary service.

I. Applicant Description

1. **Provide the legal name and address of the applicant(s) as defined in WAC 246-310-010(6).**

   MultiCare Health System ("MultiCare")
   820 A Street
   Tacoma, WA 98402

2. **Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the unified business identifier (UBI).**

   MultiCare is a nonprofit corporation. The UBI Number of MultiCare is 601-100-682.

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

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

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

   Frank Fox, PhD
   Consultant
   511 NW 162nd
   Shoreline, WA 98177
   206-366-1550
   frankgfox@comcast.net

5. **Provide an organizational chart that clearly identifies the business structure of the applicant(s).**

   Please see Exhibit 1 for an organization chart of MultiCare. Mary Bridge is a "Doing Business As" (dba) of MultiCare.

II. Facility Description

1. Provide the name and address of the existing facility

The current address for MultiCare Mary Bridge Children's Hospital and Health Center ("Mary Bridge") is:

317 Martin Luther King Jr Way
Tacoma, WA, 98405-4234

On November 17, 2021, the Department of Health's Certificate of Need program ("Department") approved Mary Bridge to relocate to a new site in Tacoma, within Pierce County. Presented below is a list of affected tax parcels for the new site:

- 2003240010
- 2003240020
- 2003240030
- 2003240040
- 2003240050
- 2003230010
- 2003230020
- 2002220010
- 2003220011
- 2003220012

The address for the neonatal intensive care unit / intermediate care nursery (collectively the "NICU"), located on the Tacoma General Hospital ("Tacoma General") campus, is:

315 M.L.K. Jr Way
Tacoma, WA 98405

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

The NICU will continue to be located on the Tacoma General campus at 315 M.L.K. Jr Way, Tacoma, WA 98405 upon project completion.

3. Confirm that the facility will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing facility, provide the existing identification numbers.

Confirmed, the NICU will continue to be licensed and certified by Medicare and Medicaid upon project completion.

Mary Bridge

- License #: HAC.FS.00000175
- Medicare #: 503301
- Medicaid #: 3300340

4. Identify the accreditation status of the facility before and after the project.

Tacoma General is accredited by the Joint Commission, most recently on 1/25/2020.

Mary Bridge is accredited by the Joint Commission, most recently on 12/20/2019.

5. Is the facility operated under a management agreement?

Yes ☐ No ☒

If yes, provide a copy of the management agreement.

6. Provide the following scope of service information:

Service	Currently Offered?	Offered Following Completion?
Alcohol and Chemical Dependency	☐	☐
Anesthesia and Recovery	☒	☒
Cardiac Care	☒	☒
Cardiac Care – Adult Open Heart Surgery	☐	☐
Cardiac Care – Pediatric Open Heart Surgery	☒	☒
Cardiac Care – Adult Elective PCI	☐	☐
Cardiac Care – Pediatric Elective PCI	☒	☒
Diagnostic Services	☒	☒
Dialysis – Inpatient	☐	☐
Emergency Services	☒	☒
Food and Nutrition	☒	☒
Imaging/Radiology	☒	☒
Infant Care/Nursery	☐	☐

Intensive/Critical Care	☒	☒
Laboratory	☒	☒
Medical Unit(s)	☒	☒
Neonatal – Level II	☐	☒
Neonatal – Level III (1)	☐	☒
Neonatal – Level IV	☐	☒
Obstetrics	☐	☐
Oncology	☒	☒
Organ Transplant - Adult (list types, if applicable)	☐	☐
Organ Transplant - Pediatric (list types, if applicable)	☐	☐
Outpatient Services	☒	☒
Pediatrics	☒	☒
Pharmaceutical	☒	☒
Psychiatric	☒	☒
Skilled Nursing/Long Term Care	☐	☐
Rehabilitation (indicate level, if applicable)	☐	☐
Respiratory Care	☒	☒
Social Services	☒	☒
Surgical Services	☒	☒

(1) Based on Washington Department of Health Prenatal and Neonatal Level of Care (LOC) 2018 Guidelines, if a hospital has a level of care designated as Level IV, Regional NICU, it also has a Level III NICU, as defined by those rules.[4]

[4] https://www.doh.wa.gov/Portals/1/Documents/Pubs/950154.pdf

III. Project Description

1. Provide a detailed description of the proposed project. If it is a phased project, describe each phase separately. For existing facilities, this should include a discussion of existing services and how these would or would not change as a result of the project.

Summary of Certificate of Need Request

This application is a two-phased request:

- Phase One--to transfer the 30-bed Level II Intermediate Care Nursery and the 40-bed Level IV Neonatal Intensive Care Unit (collectively referenced as the "NICU" in this application) that currently operated under the Tacoma General license to the Mary Bridge license.[5] This phase would include an application that covers two goals.
  - Review the NICU and the associated bed transfer to Mary Bridge.
  - Acknowledge that CN #1920 would be amended to allow for the transfer of the NICU beds and the tertiary service.

- Phase Two—to modify Condition One from CN #1920, which stated the Project Description under the approved relocation would have Mary Bridge remain at 82 licensed beds (no change in licensed bed capacity).[6] With the transfer of the 70 beds and tertiary service, requested in Phase One, Mary Bridge would increase its number of licensed bed to 152 licensed beds. This would be the Department's Phase Two evaluation. This would include an amendment to CN #1920 that would acknowledge the transfer of NICU beds and tertiary service to Mary Bridge.

- Assuming the application is approved, it is our understanding that two CNs will be issued, one for the NICU transfer and a second CN, CN #1920A, that modifies the Condition limiting the number of beds and services.

Overview of Phase One

Over the years Mary Bridge has grown, offering increasingly sophisticated neonatal and pediatric care. In November 2021, the department approved the

[5] Technical Assistance ("TA") call with representatives from MultiCare, the Certificate of Need program and the Attorney General's Office, January 27, 2022, discussed this two-phase approach. It was then in an e-mail, January 28, 2022, from Mr. Eric Hernandez, Manager-Certificate of Need, to Ms. Erin Kobberstad, Vice President, Strategy, MultiCare Health System.
[6] Certificate of Need #1920, issued December 3, 2021, included with letter from Mr. Hernandez to Ms. Kobberstad, December 3, 2021.

relocation.[7] This approval allows Mary Bridge to relocate and build out an entirely new, specialized children's hospital building.

This request is another step to provide all necessary services and excellent care under Mary Bridge leadership. MultiCare currently provides specialized neonatal care in the 70-bed NICU that operates under the Tacoma General license. This request seeks to align those neonatal services under the Mary Bridge hospital license so that the neonate services are integrated with the pediatric services. The neonatologists and other specialists who provide specialized neonatal care will not change, nor will nursing, but the care planning, delivery, and administration of that care will be organized through Mary Bridge leadership. The proposed transfer of the specialized neonatal services to the Mary Bridge license will enhance the high-quality, essential program provided today by providing operational and administrative alignment, positively impacting patients and their families.

Approval of Phase One will further MultiCare's continued mission to meet the current and future needs of our communities and serve our patients and their families by providing high-quality, safe, and compassionate care, all under Mary Bridge organization and leadership.

It should also be noted that Phase One is "need neutral" as that term is used in CN applications, given there would be no increase in the number of NICU beds within the market and at MultiCare, only a transfer of those beds from one license to another. Second, the NICU is not moving its location or being expanded. There are minor modifications, summarized in this request, to be made to establish the signage and specifically designate the NICU space as Mary Bridge hospital space.

Overview of Phase Two

If the transfer of the NICU tertiary service and beds from Tacoma General's hospital license to Mary Bridge hospital's license is approved, the second step is amending CN #1920 to acknowledge the transfer of NICU beds and tertiary service.

2. **If your project involves the addition or expansion of a tertiary service, confirm you included the applicable addendum for that service. Tertiary services are outlined under WAC 246-310-020(1)(d)(i).**

   Confirmed, see the addendum at the end of this application for the relevant tertiary services.

[7] Certificate of Need #1920, issued December 3, 2021, included with the letter from Mr. Hernandez to Ms. Kobberstad, December 3, 2021.

3. **Provide a breakdown of the beds, by type, before and after the project. If the project will be phased, include columns detailing each phase.**

	Current	Proposed*
General Acute Care	82	82
PPS Exempt Psych		
PPS Exempt Rehab		
NICU Level II		30
NICU Level III [8]		
NICU Level IV (Includes Level III NICU)		40
Specialized Pediatric		
Skilled Nursing		
Swing Beds (included in General Acute Care)		
Total	**82**	**152**

*Upon project completion, MultiCare Tacoma General Hospital / Allenmore Hospital's licensed bed supply will decrease by seventy (70) beds.

4. **Indicate if any of the beds listed above are not currently set-up, as well as the reason the beds are not set up.**

   All beds are currently set-up.

5. **With the understanding that the review of a Certificate of Need application typically takes six to nine months, provide an estimated timeline for project implementation, below. For phased projects, adjust the table to include each phase.**

Table 1. Project Timeline

Event	**Anticipated Month/Year**
Anticipated CN Approval	September 2022
Design Complete	N/A
Construction Commenced	N/A
Construction Completed	N/A
Facility Prepared for Survey	N/A
Facility Licensed - Project Complete WAC 246-310-010(47)	January 2023

[8] Based on Washington Department of Health Prenatal and Neonatal Level of Care (LOC) 2018 Guidelines, if a hospital has a level of care designated as Level IV, Regional NICU, it also has a Level III NICU, as defined by those rules.

6. **Provide a general description of the types of patients to be served as a result of this project.**

   Phase One of this CN request seeks to continue serving neonatal patients requiring Level II ICN and Level IV NICU care. There is no anticipated change in the types of patients expected to be served because of the transfer of the NICU from Tacoma General's license to the Mary Bridge license. Similarly, approval of Phase Two would not affect current patient care.

7. **Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080.**

   Please see Exhibit 2 for a copy of the letter of intent.

8. **Provide single-line drawings (approximately to scale) of the facility, both before and after project completion. For additions or changes to existing hospitals, only provide drawings of those floor(s) affected by this project.**

   Please see Exhibit 3 for a copy of the single line drawing of the NICU.

   There is no construction involved with Either Phase One or Two of this application. Therefore, an 'after' scenario is not applicable.

9. **Provide the gross square footage of the hospital, with and without the project.**

   The gross square footage for the NICU is collectively 40,423 square feet.

   There is no construction involved with Either Phase One or Two of this application. Therefore, no impact to the gross square footage of the NICU [or Mary Bridge] will result from the proposed project.

10. **If this project involves construction of 12,000 square feet or more, or construction associated with parking for 40 or more vehicles, submit a copy of either an Environmental Impact Statement or a Declaration of Non-Significance from the appropriate governmental authority. [WAC 246-03-030(4)]**

    There is no construction involved with either Phase One or Two of this application. Therefore, this question is not applicable.

11. **If your project includes construction, indicate if you've consulted with Construction Review Services (CRS) and provide your CRS project number.**

The Certificate of Need program highly recommends that applicants consult with the office of Construction Review Services (CRS) early in the planning process. CRS review is required prior to construction and licensure (WAC 246-320-500 through WAC 246-320-600). Consultation with CRS can help an applicant reliably predict the scope of work required for licensure and certification. Knowing the required construction standards can help the applicant to more accurately estimate the capital expenditure associated with a project. Note that WAC 246-320-505(2)(a) requires that hospital applicants request and attend a presubmission conference for any construction projects in excess of $250,000.

There is no construction involved with either Phase One or Two of this application. Therefore, this question is not applicable.

IV. Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services. Documentation provided in this section must demonstrate that the proposed project will be needed, available, and accessible to the community it proposes to serve. Do not skip any questions. If you believe a question is not applicable to your project, explain why it is not applicable.

1. List all other acute care hospitals currently licensed under RCW 70.41 and operating in the hospital planning area affected by this project. If a new hospital is approved, but is not yet licensed, identify the facility.

Please see Table 2 below for a list of acute care hospitals in the Central Pierce Hospital Planning Area. Mary Bridge is the only pediatric hospital in the planning area and greater service area. Tacoma General currently operates a Level II ICN and a Level IV NICU, as stated above. Saint Joseph Medical Center operates Level II/III beds.

Table 2. List of Central Pierce Acute Care Hospitals

Hospital	Hospital License #
Mary Bridge Children's Hospital	175
Saint Anthony Hospital	209
Saint Joseph Medical Center	032
MultiCare Tacoma General	176
MultiCare Allenmore Hospital	*Shares TG license*

2. For projects proposing to add acute care beds, provide a numeric need methodology that demonstrates need in this planning area. The numeric need methodology steps can be found in the Washington State Health Plan (sunset in 1989).

This CN request does not propose adding any beds beyond those for which Mary Bridge and Tacoma General are currently approved. Thus, this question is not applicable.

3. **For existing facilities proposing to expand, identify the type of beds that will expand with this project.**

   This CN request does not propose adding any beds beyond those for which Tacoma General is currently approved. It does propose transferring the existing 30 ICN and 40 Level IV NICU beds from the Tacoma General license to the Mary Bridge license, as discussed above.

4. **For existing facilities, provide the facility's historical utilization for the last three full calendar years. The first table should only include the type(s) of beds that will increase with the project, the second table should include the entire hospital.**

Table 3. Historical Utilization

Tacoma General ICN/NICU (Total)	**CY2018**	**CY2019**	**CY2020**	**CY2021**
Licensed beds	70	70	70	70
Available beds	70	70	70	70
Cases	744	769	749	816
Patient days	15,971	15,678	17,194	17,609
Average Daily Census	43.8	43.0	47.1	48.2
Occupancy	63%	61%	67%	69%
Mary Bridge Entire Hospital	**CY2018**	**CY2019**	**CY2020**	**CY2021**
Licensed beds	82	82	82	82
Available beds	82	82	82	82
Cases	3,806	4,316	3,304	3,592
Patient days	14,610	15,871	12,527	13,052

Source: Applicant.

As demonstrated in Table 3, the Tacoma General ICN/NICU has operated above the 65% occupancy standard[9] for the past two years (2020-2021). Further, based on a review of calendar year 2020 CHARS inpatient utilization for Level II-IV MS-DRGs (789-794), Tacoma General provided the most patient days for these services to Pierce County residents and was the second largest provider of patient days for these services to Washington State residents.

[9] See Washington Department of Health, "Evaluation Dated April 5, 2019 For The Certificate Of Need Application Submitted By MultiCare Health System Proposing To Add 14 Level IV Neonatal Intensive Care Beds To Tacoma General/Allenmore Hospital In Tacoma, Within Pierce County," p. 18. In its evaluation, the Department stated that "In previous evaluations for level III/IV NICU services, the department has concluded that 65% occupancy is reasonable to allow for flexibility and to accommodate for peak usage of the NICU."

5. **Provide projected utilization of the proposed facility for the first seven full years of operation if this project proposes an expansion to an existing hospital. Provide projected utilization for the first ten full years if this project proposes new facility. For existing facilities, also provide the information for intervening years between historical and projected. The first table should only include the type(s) of beds that will increase with the project, the second table should include the entire hospital. Include all assumptions used to make these projections.**

Table 4. Mary Bridge Utilization Projections

ICN/NICU*	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**
Licensed beds	70	70	70	70	70	70	70	70
Available beds	70	70	70	70	70	70	70	70
Cases	761	767	772	778	782	785	788	791
Patient days	17,462	17,597	17,733	17,871	17,942	18,014	18,085	18,157
*The ICN/NICU is under Tacoma General in 2022 and Mary Bridge from 2023 forward.								
Mary Bridge Non-ICN/NICU	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**
Licensed beds	82	82	82	82	82	82	82	82
Available beds	82	82	82	82	82	82	82	82
Cases	3,970	4,053	4,166	4,462	4,758	5,054	5,154	5,257
Patient days	15,376	15,759	16,291	17,671	19,050	20,429	21,406	21,834

Methodology – ICN/NICU

a. Baseline cases set to full year 2020 actuals (749 cases).
b. Case growth based on primary service area 0–4-year-old forecasted population growth (0.78% per year through 2025 and 0.40% per year from 2026-2029) based on OFM GMA projections (2017 release).[10] Primary service area defined as Pierce, King, Thurston, and Kitsap which collectively comprise more than 80% of patient days in 2020.
c. Average length of stay (ALOS) held constant at 2020 value (22.96 days) throughout forecast.
d. Patient days are calculated by multiplying cases by ALOS.

Methodology – Mary Bridge (Non-ICN/NICU)

e. The 2022-2028 utilization for Mary Bridge is consistent with the utilization forecast provided in CN-App 21-63 (approved in CN #1920).
f. 2029 cases assume 2% case growth from 2028.
g. 2029 patient days are calculated by multiplying the 2029 case estimate by 2020 ALOS (4.15 days).

[10] For example, CY2022 cases are two years from the baseline CY2020 (749 cases)---therefore, CY2022 cases = 761 = [749 * (1+0.78%)^2].

6. For existing facilities, provide patient origin zip code data for the most recent full calendar year of operation.

See Exhibits 4A and 4B for CY2021 patient origin statistics for Mary Bridge (hospital-wide) and Tacoma General's NICU.

7. Identify any factors in the planning area that currently restrict patient access to the proposed services.

Phase One of this CN request proposes a change of licensure only, not a net change in supply of beds or access to services. Phase Two is a request for an amendment to CN #1920, to reflect the transfer of the NICU beds and tertiary service from Tacoma General to Mary Bridge. Therefore, this question is not applicable to the proposed project.

8. Identify how this project will be available and accessible to underserved groups.

As a locally based, not-for-profit health care system, MultiCare is committed to serving everyone in the community, without regard to income, race, ethnicity, gender, religion or any other protected class. MultiCare accomplishes its mission through a variety of means, including charity care, health education and outreach programs for underserved populations, free prevention and screening programs, support groups and services for patients and families experiencing chronic and terminal diseases.

Mary Bridge is committed to meeting community and regional health needs and provides charity care consistent with the MultiCare Charity Care Policy, included under Exhibit 5A.

Our financial pro forma forecast for the NICU provided in Exhibit 6 explicitly allocates 1.34% of revenues to be provided for charity care, a figure consistent with the Puget Sound Regional charity care average, less King County, between 2017 to 2019. Please see Table 5 below. Note that while Mary Bridge's 2017-2019 charity care as a percentage of total revenues is below the Puget Sound regional average, the 2019 DOH Charity Care Report shows that 58% of Mary Bridge's total patient service revenues were for Medicaid patients in contrast to the 21% Puget Sound regional average. On an 'Adjusted Revenue' basis where Medicaid and Medicare revenues are excluded, Mary Bridge provided charity care estimated to be 2.27% of adjusted revenues in 2017-2019. This figure is similar to Seattle Children's which has an estimated average charity care of 2.05% of adjusted revenues in 2017-2019.

Table 5. Puget Sound Region (Less King County) Charity Care Statistics, 2017-2019

		% of Total Revenue			
Lic. No	Region/Hospital	2017	2018	2019	3 Year Average, 2017-2019
209	Saint Anthony Hospital	0.78%	0.89%	0.73%	0.80%
32	Saint Joseph Medical Center – Tacoma	1.05%	1.15%	0.78%	1.00%
176	Tacoma General / Allenmore Hospital	1.89%	2.32%	2.03%	2.08%
175	Mary Bridge Children's Health Center	0.93%	1.06%	0.83%	0.94%
	Central Pierce Hospital Average	1.16%	1.35%	1.09%	1.20%
	MultiCare Central Pierce Average	1.41%	1.69%	1.43%	1.51%
	PUGET SOUND REGION TOTALS	1.23%	1.44%	1.35%	1.34%

*Central Pierce and 3-Year averages are calculated based on unweighted average. If a weighted average were used, then MultiCare's average would significantly increase compared to the Planning Area and Regional average.
Source: DOH Charity Care Reports, 2017-2019

9. If this project proposes either a partial or full relocation of an existing facility, provide a detailed discussion of the limitations of the current location.

Phase One of this CN request proposes a change of licensure only, not a relocation of beds. Phase Two is a request for an amendment to CN #1920 to reflect the transfer of the NICU beds and tertiary service from Tacoma General to Mary Bridge. Therefore, this question is not applicable.

10. If this project proposes either a partial or full relocation of an existing facility, provide a detailed discussion of the benefits associated with relocation.

Phase One of this CN request proposes a transfer of licensure only, not a relocation of NICU beds. Phase Two is a request for an amendment to CN #1920. Therefore, this question is not applicable.

11. Provide a copy of the following policies:

- **Admissions policy**
- **Charity care or financial assistance policy**
- **Patient rights and responsibilities policy**
- **Non-discrimination policy**
- **End of life policy**
- **Reproductive health policy**
- **Any other policies directly associated with patient access**

All requested policies are provided in Exhibits 5A – 5F.

B. <u>Financial Feasibility (WAC 246-310-220)</u>
Financial feasibility is based on the criteria in WAC 246-310-220.

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

    See Exhibit 6 for the financial exhibit including the following information:

    - Historical revenue and expense statements
    - Pro forma projections
    - FTE staffing
    - Balance Sheet
    - Assumptions to explain/support key financial models

    Please see Table 4, above, for utilization projections.

2. **Identify the hospital's fiscal year.**

    The hospital's fiscal year is consistent with the calendar year (January to December).

3. **Provide the following agreements/contracts:**
    - **Management agreement**
    - **Operating agreement**
    - **Development agreement**
    - **Joint Venture agreement**

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

The agreements listed above are not applicable to the CN request.

4. **Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site. If a lease agreement is provided, the terms must be for at least five years with options to renew for a total of 20 years.**

   The NICU is located on Tacoma General's campus. See Exhibit 7 for summary property information from the Pierce County Assessor-Treasurer Information Portal demonstrating that MultiCare is the owner of the relevant parcels for the Tacoma General campus.

5. **Provide county assessor information and zoning information for the site. If zoning information for the site is unclear, provide documentation or letter from the municipal authorities showing the proposed project is allowable at the identified site. If the site must undergo rezoning or other review prior to being appropriate for the proposed project, identify the current status of the process.**

   See Exhibit 7 for summary property information from the Pierce County Assessor-Treasurer Information Portal demonstrating that the parcels are under the hospital use code.

6. **Complete the table on the following page with the estimated capital expenditure associated with this project. If you include other line items not listed below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.**

   After thorough evaluation of the areas involved with the proposed project, the equipment expenditures identified in Table 6 below and further detailed in the equipment list (Table 8) have been determined to be needed to convert the ICN and NICU to Mary Bridged licensed space.

Table 6. Total Estimated Capital Expenditures

Item	Cost
a. Land Purchase	---
b. Utilities to Lot Line	---
c. Land Improvements	---
d. Building Purchase	---
e. Residual Value of Replaced Facility	---
f. Building Construction	---

Item	Cost
g. Fixed Equipment (not already included in the construction contract)	---
h. Movable Equipment	$103,600
i. Architect and Engineering Fees	---
j. Consulting Fees	---
k. Site Preparation	---
l. Supervision and Inspection of Site	---
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	---
1. Land	---
2. Building	---
3. Equipment	---
4. Other	---
n. Washington Sales Tax	Included in above line-item
Total Estimated Capital Expenditure	$103,600

7. Identify the entity responsible for the estimated capital costs. If more than one entity is responsible, provide breakdown of percentages and amounts for all.

MultiCare is the sole entity responsible for the estimated capital costs.

8. Identify the start-up costs for this project. Include the assumptions used to develop these costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service.

There are no non-capital start-up costs associated with either Phase One or Phase Two of this CN request. Therefore, this question is not applicable.

9. Identify the entity responsible for the start-up costs. If more than one entity is responsible, provide a breakdown of percentages and amounts for all.

There are no non-capital start-up costs associated with either Phase One or Phase Two of this CN request. Therefore, this question is not applicable.

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

There is no construction associated with either Phase One or Phase Two of this CN request. Therefore, this question is not applicable.

11. Provide a detailed narrative supporting that the costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services in the planning area.

Mary Bridge's reimbursement is not tied to its capital expenditures. Moreover, there are only minor costs required to complete the project. Therefore, the proposed capital expenditures associated with this CN request will not affect costs and charges for health services in the planning area.

12. Provide the projected payer mix for the hospital by revenue and by patients using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."

Table 7. Payer Mix Projections

	Payer Mix	Percentage by Revenue	Percentage by Case
Mary Bridge (Non-ICN/NICU)	Medicaid	48.4%	43.7%
	Commercial	31.9%	42.7%
	Medicare	0.1%	0.2%
	HMO	3.2%	2.6%
	Other Gov't	6.3%	5.6%
	Self-Pay	10.2%	5.1%
	Other / Not Assigned	0.0%	0.0%
	Total	**100%**	**100%**
ICN/NICU	Medicaid	54.1%	52.3%
	Commercial	34.5%	38.5%
	Medicare	0.0%	0.0%
	HMO	1.2%	2.2%
	Other Gov't	10.1%	6.6%
	Self-Pay	0.2%	0.5%
	Other / Not Assigned	0.0%	0.0%
	Total	**100%**	**100%**

13. If this project proposes the addition of beds to an existing facility, provide the historical payer mix by revenue and patients for the existing facility. The table format should be consistent with the table shown above.

The payer mix projections included in Table 7 above are based on the historical 2021 payer mix.

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

After thorough evaluation of the areas involved with the proposed project, the equipment expenditures detailed in Table 8 have been determined to be needed to convert the ICN and NICU as Mary Bridge licensed space.

Table 8. Equipment List

Description	**Cost Estimate***
Signage	$24,000
Access control interface with elevators and safety systems.	$25,000
Badge readers	$45,000
Ambulance wrap	$9,600
Total	**$103,600**
*Inclusive of estimated Washington Sales tax	

15. Identify the source(s) of financing and start-up costs (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

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

MultiCare will finance the project-related capital expenditures from its corporate reserves.

See Exhibit 8 for a letter of financial commitment from Jason Mitchell, Vice President of Finance for MultiCare Health System.

16. Provide the most recent audited financial statements for:

- **The applicant, and**
- **Any parent entity**

See Exhibit 9 for the most recent audited financial statements for MultiCare.

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

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

1. Identify all licensed healthcare facilities owned, operated, or managed by the applicant. This should include all facilities in Washington State as well as any out-of-state facilities. Include applicable license and certification numbers.

Please see Table 9 for a list of MultiCare facilities.

Table 9. MultiCare Facility List

Name	Address	Medicare Provider Number	Medicaid Provider Number	Owned or Managed
MultiCare Mary Bridge Children's Hospital	317 Martin Luther King Jr. Way, Tacoma WA 98403	503301	3300340	Owned
MultiCare Auburn Medical Center	202 North Division St., Auburn WA 98001	500015	2022467	Owned
MultiCare Behavioral Health Inpatient Services- Auburn	202 North Division St., Auburn WA 98001	50-S015	3149101	Owned
MultiCare Deaconess	800 W 5th Ave Spokane, WA 99204-2803	500044	2083493	Owned
MultiCare Valley	12606 East Mission Ave. Spokane Valley 99216-3421	500119	2083493	Owned
MultiCare Tacoma General Hospital	315 Martin Luther King Jr. Way, Tacoma WA 98405	500129	3300332	Owned
MultiCare Tacoma General Behavioral Health Adolescent Inpatient Services	315 Martin Luther King Jr. Way, Tacoma, WA 98405	50-0129	2071315	Owned
MultiCare Allenmore Hospital	1901 South Union Avenue, Tacoma WA 98405	500129	3300332	Owned
MultiCare Good Samaritan Hospital	407 14th Ave. SE Puyallup, WA 98372	500079	3308707	Owned

Name	Address	Medicare Provider Number	Medicaid Provider Number	Owned or Managed
MultiCare Good Samaritan Hospital, Inpatient Rehabilitation	401 15th Ave. SE, Puyallup, WA 98372	50T079	3200094	Owned
Navos	2600 Southwest Holden, Seattle, WA 98126	504009	3500311	Owned
MultiCare Covington Hospital	17700 SE 272nd Street Covington, WA 98042	500154	2102039	Owned
Wellfound Behavioral Health Hospital	3402 S. 19th Street, Tacoma, WA 98405	504016	150453	Owned
MultiCare Capital Medical Center	3900 Capital Mall Dr SW, Olympia, WA 98502	500139	330365	Owned

2. Provide a table that shows full time equivalents (FTEs) by type (e.g. physicians, management, technicians, RNs, nursing assistants, etc.) for the facility. If the facility is currently in operation, include at least the most recent full year of operation, the current year, and projections through the first three full years of operation following project completion. There should be no gaps. All FTE types should be defined.

See Table 10 below for an FTE schedule of historical and projected FTEs. A complete FTE schedule by type is included in Exhibit 6.

Table 10. Historical and Projected Productive FTEs

	2019	2020	2021	2022	2023	2024	2025
Mary Bridge (Non-ICN/NICU)	840	841	849	941	955	1,009	1,053
Mary Bridge (ICN/NICU)	-	-	-	-	145	146	147
Total Productive FTEs	840	841	849	941	1,100	1,155	1,200

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

See the assumptions worksheet included in Exhibit 6 that provides a list of assumptions used to project the number and types of FTEs for Phase One of this CN request.

4. **Identify key staff (e.g. chief of medicine, nurse manager, clinical director, etc.) by name and professional license number, if known.**

Table 11. Key Clinical Staff

NAME	Position	License Number
Mauricio Escobar, MD	Interim Chief Medical Officer	MD60067507
Barbara Thompson, MD	Interim Chief Medical Officer	MD00048103
Margaret Herman, RN	Chief Nursing Officer	RN60949545
Grant Keeney, MD	Med Director-Pediatrics Quality & Safety	MD60448459
Katy Erickson, RN	Nurse Manager – Neonatal Intensive Care Unit	RN00142056
Serena Scott, MD	Medical Director (Contracted) – Neonatal Intensive Care Unit	MD60455485

5. **Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.**

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

Mary Bridge employs over 300 primary and specialty care providers. MultiCare has recruited a large number of new employees each year. This recruiting success, coupled with better-than-average employee retention rates, has enabled MultiCare to staff new programs and open new facilities in both acute-care and outpatient settings.

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

one percent of total new hires. Other recruitment resources include contingent staffing agencies and employment branding consultants.

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

Expanding and developing the healthcare workforce. MultiCare has devoted extensive resources to ensuring a robust pipeline of new healthcare workers. Examples include partnering with local universities, community colleges, and trade schools to provide clinical experiences each year; high school outreach programs including job shadows, Medical Explorers programs at two locations, and health careers camps; a Nurse Technician employment program; and strong residency and apprenticeship programs. MultiCare's workforce development efforts extend to current employees who benefit from residency programs, fellowships, apprenticeships, tuition assistance, and targeted scholarship and training programs. MultiCare also boasts award-winning educational resources including state-of-the-art simulation labs, computer-based learning modules, classroom training and other educational opportunities.

6. **For new facilities, provide a listing of ancillary and support services that will be established.**

   Mary Bridge is not a new facility. Therefore, this question is not applicable.

7. **For existing facilities, provide a listing of ancillary and support services already in place.**

   The ICN/NICU's current list of ancillary and support services includes speech therapy, dietary, PT/OT, lactation, music therapy, social work, case management, and grief and loss services.

   Mary Bridge's existing 'Ancillary, Support, and Other' Services are provided in Table 12 below.

Table 12. List of Ancillary, Support, and Other Services

Description	Internal / External	Vendor
Food & Nutrition	Internal	MultiCare
Imaging	Internal	MultiCare

Description	Internal / External	Vendor
Diagnostic services (CT, Radiation Oncology, MRI, PET)	Internal	MultiCare
Lab & Pathology	Internal	MultiCare
Respiratory Therapy	Internal	MultiCare
Health Information Management	Internal	MultiCare
Biomedical/Clinical Engineering	Internal	MultiCare
Quality Management	Internal	MultiCare
Customer Support	Internal	MultiCare
Security	Internal	MultiCare
Medical Staff Services	Internal	MultiCare
Facilities/Environment of Care	Internal	MultiCare
Utilization Review	Internal	MultiCare
Supply Chain	Internal	MultiCare
Perioperative Services	Internal	MultiCare
Cath Lab	Internal	MultiCare
Pharmacy – Ventilation/Hood Cleaning Services	External	Pentagon Technologies Group, Inc. d/b/a Pentagon Technologies
Interpretation Services Agreement: spoken and sign language interpreters	External	Cross Cultural Communications Inc.
Pathology Services	External	Western Washington Pathology, P.S.
Remote Dosimetry	External	Remote Dosimetrist, LLC
Intraoperative neuromonitoring technical and professional services	External	SpecialtyCare IOM Services, LLC
Neonatal Transport teams in providing critical care transports via air	External	Airlift Northwest (UW Medicine Strategic Outreach)
Perfusion & VAD Program; Pediatric ECMO	External	ECMO Advantage Corp
Organ Procurement	External	Lifecenter Northwest
Blood Products and Services	External	Cascade Regional Blood Services

*External not all inclusive; high-level

See Table 13 below for a description of proposed changes in support services provided by Tacoma General and the MultiCare system as a result of the relocation to the new Mary Bridge hospital approved in CN #1920.

Table 13. Anticipated Mary Bridge Service Changes

Services that are currently under contract from Tacoma General to Mary Bridge, which will change to be services that Mary Bridge provides to itself	• Imaging • Peri Op/Cath Lab • Sterile Processing/Central Supply • Emergency Department (ED) Decontamination Shower

Services that are currently under contract from Mary Bridge to Tacoma General, which we anticipate will stop after Mary Bridge moves to new building	• High Level Disinfectant Scope and Probe Reprocessing • ED – Panda Warmer and C-Arm • Glide Scope • Pediatric Sedation
New services anticipated to be under contract from Mary Bridge to Tacoma General	• Infant formula preparation

8. **Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.**

   There are no changes anticipated to the NICU ancillary and support agreements as result of the proposed transfer from Tacoma General's license to Mary Bridge's license.

9. **If the facility is currently operating, provide a listing of healthcare facilities with which the facility has working relationships.**

   Mary Bridge is an integrated member of the community health system and has developed relationships with many community and regional partners. A summary list includes Seattle Children's, CHI Franciscan, MultiCare Tacoma General/Allenmore, MultiCare Good Samaritan, MultiCare Auburn Regional Medical Center, MultiCare Covington Medical Center, Grays Harbor Community Hospital, and Providence St. Peter Hospital.

   Please see Table 14 below for a list of working relationships for neonatal services.

Table 14. Neonatal Working Relationships

Hospital	City	Miles
Capital Medical Center	Olympia	28mi
Cascade Valley Hospital and Clinics	Arlington	66mi
EvergreenHealth - Kirkland	Kirkland	34mi
FHS - St. Anthony Hospital	Gig Harbor	11mi
FHS - St. Clare Hospital	Lakewood	7.5mi
FHS - St. Elizabeth Hospital	Enumclaw	22mi
FHS - St. Francis Hospital	Federal Way	6.3mi
FHS - St. Joseph Medical Center	Tacoma	0.9mi
Forks Community Hospital	Forks	102mi
Grays Harbor Community Hospital	Aberdeen	68mi
Harborview Medical Center	Seattle	25mi
St. Michael's - Silverdale	Silverdale	29mi
St. Michael's - Bremerton	Bremerton	24mi
St. Ann's (Highline)	Burien	15mi
Jefferson Healthcare Medical Center	Port Townsend	61mi
Madigan Army Medical Center	Lakewood	11mi
Mason General Hospital	Shelton	31mi
MultiCare Allenmore Hospital	Tacoma	1.7mi
MultiCare Auburn Medical Center	Auburn	11mi
MultiCare Bonney Lake OCED	Bonney Lake	15mi

Hospital	City	Miles
MultiCare Covington	Covington	18mi
MultiCare Federal Way OCED	Federal Way	8.4mi
MultiCare Good Samaritan	Puyallup	9.4mi
MultiCare Parkland OCED	Tacoma	7.6mi
MultiCare South Hill OCED	Puyallup	11mi
Morton General Hospital	Morton	49mi
Olympic Medical Center	Port Angeles	74mi
Overlake Medical Center	Bellevue	28mi
PeaceHealth St. John Medical Center	Longview	81mi
PeaceHealth United General Medical Ce	Sedro-Woolley	86mi
PeaceHealth St. Joseph Medical Center	Bellingham	105mi
Providence Centralia Hospital	Centralia	45mi
Providence Regional Medical Center	Everett	53mi
Providence St. Peter Hospital	Olympia	23mi
Seattle Children's	Seattle	29mi
Summit Pacific Medical Center	Elma	47mi
Swedish Cherry Hill	Seattle	25mi
Swedish Issaquah	Issaquah	28mi
UW Medical Center	Seattle	28mi
Valley General Hospital	Renton	17mi
Willapa Harbor Hospital	Willapa Harbor	76mi

10. Identify whether any of the existing working relationships with healthcare facilities listed above would change as a result of this project.

There is no anticipated change to the working relationships as a result of this CN request.

11. For a new facility, provide a listing of healthcare facilities with which the facility would establish working relationships.

Mary Bridge is not a new facility. Therefore, this question is not applicable.

12. Provide an explanation of how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services.

Phase One of this CN request does not propose adding any beds beyond those for which Mary Bridge and Tacoma General are currently approved. The proposed transfer of the specialized neonatal services to the Mary Bridge license will provide enhanced operational and administrative alignment, positively impacting patients and their families. Phase Two of this request includes the Department's evaluation of Phase One, and if approved, the issuance of an

amended CN, CN #1920A, that reflects Phase One changes to the Mary Bridge licensed bed counts and services.

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

Phase One of this CN request does not propose adding any beds beyond those for which Mary Bridge and Tacoma General are currently approved. Phase Two of this request includes the Department's evaluation of Phase One, and if approved, the issuance of an amended CN, CN #1920A, that reflects Phase One changes to the Mary Bridge licensed bed counts and services. Thus, the proposed project will sustain and build upon the relationships with the service area's existing health care system.

14. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements.

a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or
b. A revocation of a license to operate a healthcare facility; or
c. A revocation of a license to practice as a health profession; or
d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

MultiCare has no history with the actions described above. Therefore, this question is not applicable.

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

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

1. **Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.**

   As stated above, there are two phases associated with this CN request.

   - Phase One--to transfer the NICU that currently operates under the Tacoma General license to the Mary Bridge license.

   - Phase Two—to modify Condition One from CN #1920 to reflect the transfer of the NICU beds and tertiary service from Tacoma General's license to Mary Bridge license.

   There were options considered with Phase One, as described below. There were no other options to Phase Two, given the Department's guidance, specifically, the approval of Phase One, required Phase Two.

   Phase One Options
   The following two options were evaluated in the alternatives analysis:

   - Option One: Transfer ICN/NICU to Mary Bridge's license —The Project

   - Option Two: Continue to Operate the NICU at Tacoma General--Do Nothing

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

   Please see the table below for a summary of advantages and disadvantages of each of the two options for Phase One, based on the following evaluative criteria: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

See table on next page

Table 15. Alternatives Analysis

Option:	Advantages (A) / Disadvantages (D) of transferring ICN/NICU to Mary Bridge's license (Option 1, The Project) compared to staying under Tacoma General Hospital's license (Option 2)
Promoting Access to Healthcare Services.	• The pediatric population will continue having high access to neonatal services under either option. (Neutral)
Promoting Quality of Care.	• Care planning, delivery, and administration of that care will be organized through Mary Bridge leadership, unlike presently under the Tacoma General license. The proposed transfer of the specialized neonatal services to the Mary Bridge's license will provide enhanced operational and administrative alignment, positively impacting patients and their families. (A)
Capital Costs and Promoting Cost and Operating Efficiency.	• Minimal capital costs required for The Project compared to No Project. (Neutral) • Enhanced operating efficiency being under Mary Bridge clinical and administrative leadership, as it will be more tightly integrated with other pediatric services. (A)
Staffing Impact.	• The neonatologists and other specialists who provide specialized neonatal care will not change, nor will nursing, but the care planning, delivery, and administration of that care will be organized through Mary Bridge leadership, unlike presently under the Tacoma General license. (A) • There is no expected direct FTE impact as a result of the proposed project. (Neutral)
Legal Restrictions.	• Option 1 requires certificate-of-need approval while Option 2 does not. (Disadvantage for Option 1, since the CN requires time and cost)

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):

- **The costs, scope, and methods of construction and energy conservation are reasonable; and**
- **The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.**

This CN request does not involve construction. Therefore, this question is not applicable.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.

This CN request will foster greater clinical and administrative alignment in the care for pediatrics. Please see Table 15 above for additional discussion of the benefits of the CN request.

Addendum

Hospital Projects Certificate of Need Application
All Tertiary Services EXCEPT Percutaneous Coronary Intervention (PCI)

The following questions are applicable to ALL tertiary service projects except for elective PCI. There are service-specific sections that follow.

General Questions – Applicable to ALL Tertiary Service Projects except for PCI

Project Description

1. **Check the box corresponding with the tertiary service proposed by your project:**

X NICU Level II	**☐ Organ Transplant (identify)**
X NICU Level III[11]	**☐ Open Heart Surgery**
X NICU Level IV	**☐ Elective PCI***
☐ Specialized Pediatric (PICU)	**☐ PPS-Exempt Rehab (indicate level)**
☐ Psychiatric (within acute care hospital)	**☐ Specialty Burn Services**

***If you selected "Elective PCI" above, skip this section and move on to the PCI- specific Addendum.**

Need

2. **If there is a numeric need methodology specific to your service in WAC, provide the WAC-based methodology. If there is no numeric need methodology in WAC, provide and discuss a service-specific numeric need methodology supporting the approval of your project. Include all assumptions and data sources.**

This CN request does not propose adding any beds beyond those for which Mary Bridge and Tacoma General are currently approved. Thus, this question is not applicable.

[11] Based on Washington Department of Health Prenatal and Neonatal Level of Care (LOC) 2018 Guidelines, if a hospital has a level of care designated as Level IV, Regional NICU, it also has a Level III NICU, as defined by those rules.

3. **Are there any service/unit-specific policies or guidelines? If yes, provide copies of the policies/guidelines.**

   Please see Exhibit 5 for a copy of the hospital policies regarding admissions, charity care, non-discrimination, end-of-life, and reproductive health. There are over 80 policies regarding neonatal care. If there is a particular policy or guideline that the Department would like to review, then MultiCare requests it be allowed to provide it in screening.

Financial Feasibility

4. **Provide the proposed payer mix specific to the proposed unit or service. If this project represents the expansion of an existing unit, provide the current unit's payer mix for reference.**

   See Table 7 above for the ICN/NICU's current payer mix based on historical 2021 data.

5. **Provide pro forma revenue and expense statements for the proposed unit or service. If this project proposes the expansion of an existing unit, provide both with and without the project.**

   See Exhibit 6 for the financial exhibit with the pro forma for the ICN/NICU, as well as Mary Bridge with and without the project.

6. **If there is no capital expenditure for this project, explain why.**

   There are capital expenditures required for this CN request. Therefore, this question is not applicable.

Structure and Process of Care

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

   Serena Scott, MD is the medical director for the NICU. Her professional license number is MD60455485. Dr. Scott is a contracted medical director.

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

   The medical director is contracted. Therefore, this question is not applicable.

9. If the medical director is/will be under contract rather an employee, provide the medical director contract.

There is a Professional Service Agreement (PSA) in place between MultiCare and Pediatrix Medical Group of Washington, Inc. P.S. that covers the Medical Director position. This PSA is much broader than a simple, separate Medical Director contract. Consequently, the PSA includes significant proprietary information as well as a confidentiality clause. Because the signed PSA limits its release due to the confidentiality clause, MultiCare has provided in Exhibit 10 the PSA appendix pertaining to the Medical Director, but not the entire PSA.

Please see Exhibit 10 for a copy of Appendix A to the PSA that describes "Neonatal Medical Director Services".

10. Provide the names and professional license numbers of current and proposed credentialed staff for this service/unit.

See Exhibit 11 for the NICU medical staff roster inclusive of physicians, RNs, and advanced practice providers. If the Department would like to see an expanded list of other credential types, then MultiCare requests that it be allowed to provide any additional requested information during screening.

11. If applicable for the service proposed, provide the existing or proposed transfer agreement with a local hospital.

This is not applicable.

12. Will the service/unit proposed comply with any state or national standards? If yes, provide the applicable standard, the rationale for selecting the standard selected, and a detailed discussion outlining how this project will comply with the standard.

The NICU provides care consistent with Level IV of the Washington State Perinatal Level of Care Guidelines (Exhibit 12). Further, NICU care is provided to patients following the National Association of Neonatal Nurses (NANN) scope of practices for Nursing Practice. NANN staffing ratios are in line with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Guideline for Professional Registered Nurse Staffing for Perinatal Units.

13. **After discharge, what steps are taken to ensure continuity of care for each patient?**

Patients are assigned case managers who coordinate care and follow up appointments. Appointments are made prior to discharge and discharge summaries are faxed to the new provider upon discharge. Post discharge phone calls are made by the leadership team to ensure the appointment has occurred.

14. **If the proposed service type is already offered in the same planning area, provide a detailed description of the steps that will be taken to avoid unwarranted fragmentation of care within the existing healthcare system.**

This CN request does not propose adding any NICU services beyond those which Tacoma General currently offers. This CN request proposes a transfer of these NICU beds from Tacoma General to the Mary Bridge license. Thus, this question is not applicable.

Psychiatric Unit Projects ONLY

1. **Confirm that the existing or proposed facility will accept ITA patients.**

Not applicable.

2. **Identify if the existing or proposed facility will provide pediatric or geriatric psychiatric services. If yes, identify the number of beds dedicated to each service.**

Not applicable.

Rehabilitation Unit Projects ONLY

1. **What trauma designation is being proposed for this rehabilitation unit?**

Not applicable.

2. **Will there be separate units for separate diagnoses requiring rehabilitation?**

Not applicable.

NICU Projects ONLY

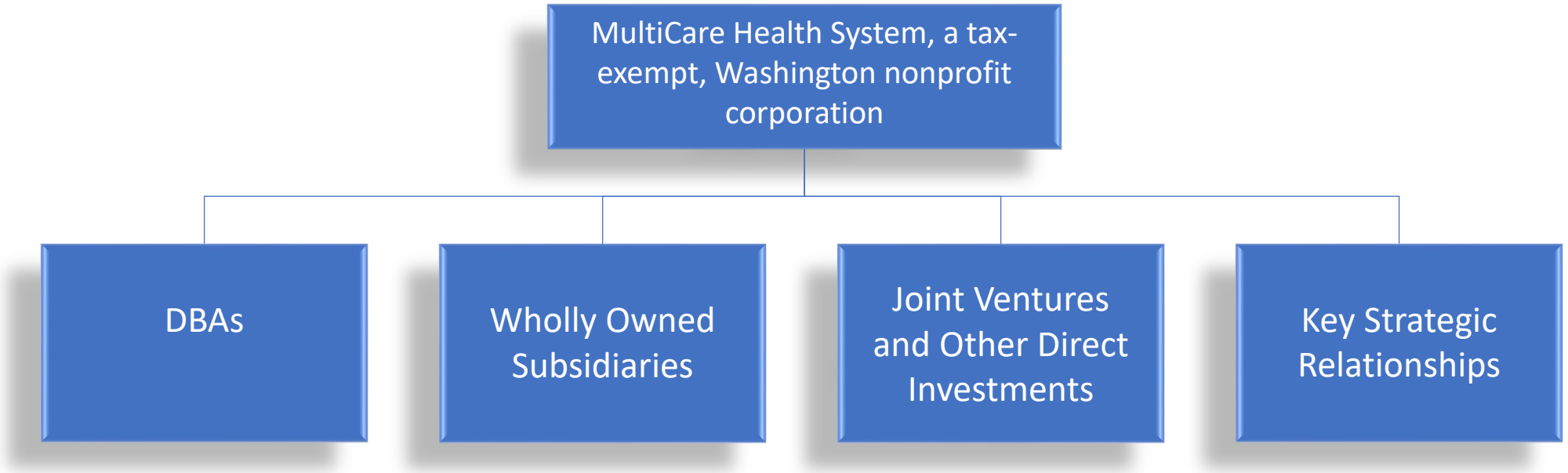
1. Describe how this project will adhere to the most recent Washington State Perinatal Level of Care Guidelines.

As an existing Level II and IV provider, MultiCare adheres to the Washington State Perinatal Level of Care Guidelines (see Exhibit 12).

Exhibit 1.

Organizational Chart

MultiCare – How We Are Organized and Conduct Business



MultiCare Health System "Doing Business As"

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

Region

Puget Sound Region

HOSPITALS

Auburn Medical Center

Covington Medical Center

Good Samaritan Hospital/Off Campus Emergency Departments (OCEDs)

Tacoma General/ Allenmore Hospitals/OCED

Capital Medical Center

CLINICS

Gig Harbor Multi-specialty Medical Center

Primary Care & Specialty Care Clinics

MultiCare Medical Associates

OTHER

New Adventures Daycare

Inland Northwest Region

Deaconess Hospital/North Deaconess OCED

Valley Hospital

Rockwood Clinic

Systemwide

Institute for Research & Innovation
MultiCare Capital Partners

Networks

Retail/Community

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

Pulse Heart Institute*

Mary Bridge

Mary Bridge Children's Hospital Health Network

ABC Pediatrics by Mary Bridge

Woodcreek Pediatrics by Mary Bridge

Treehouse

Behavioral Health

Good Samaritan Behavioral Health
Navos*
Greater Lakes Mental Healthcare*

Population Health

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

* Operates through separate legal entity

MultiCare Health System wholly owned subsidiaries

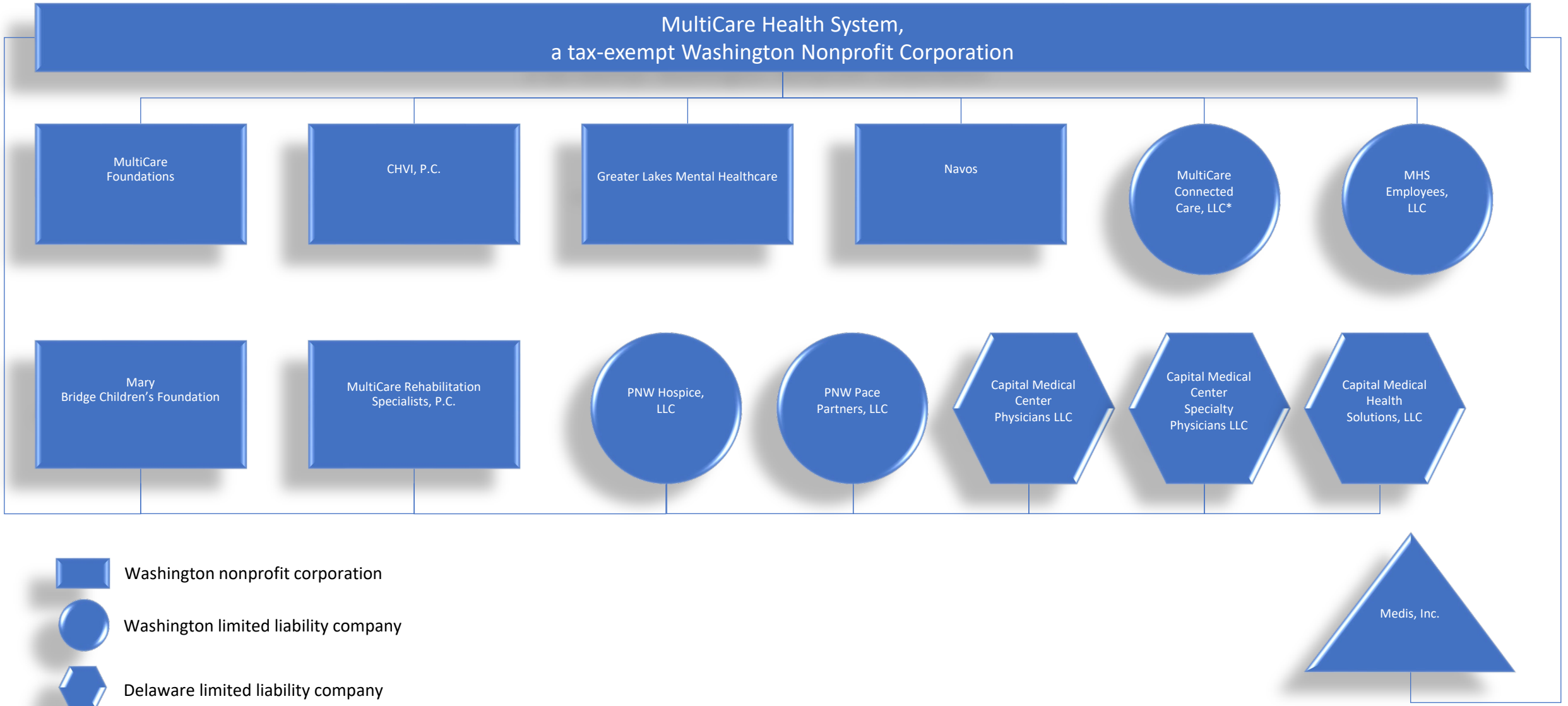


Exhibit 2.

Letter of Intent

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

December 23, 2021

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

Re: Letter of Intent to transition NICU from Tacoma General Hospital to Mary Bridge Children's Hospital

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, MultiCare Health System ("MultiCare") dba Tacoma General Hospital ("Tacoma General") and MultiCare Mary Bridge Children's Hospital ("Mary Bridge") submits this Letter of Intent ("LOI") to transition the 30-bed Level II Intermediate Care and the 40-bed Level IV NICU (collectively the "NICU") from the Tacoma General to the Mary Bridge hospital license.

1. Description of proposed service
   Tacoma General and Mary Bridge are separately licensed hospitals operated by MultiCare on a single campus in Tacoma, Washington. Tacoma General currently operates the NICU and MultiCare proposes to transition those beds from the Tacoma General license to the Mary Bridge license. The physical location of the NICU will not change nor will there be any change in the scope of services provided in the NICU.
2. Estimated cost of the project
   The estimated capital cost of the project is $94,000.
3. Identification of the service area
   The service area is Central Pierce Secondary Hospital Planning Area. However, it should be noted that Mary Bridge, as one of three pediatric hospitals in Washington, serves a much larger geographic area.

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

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

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

Sincerely,

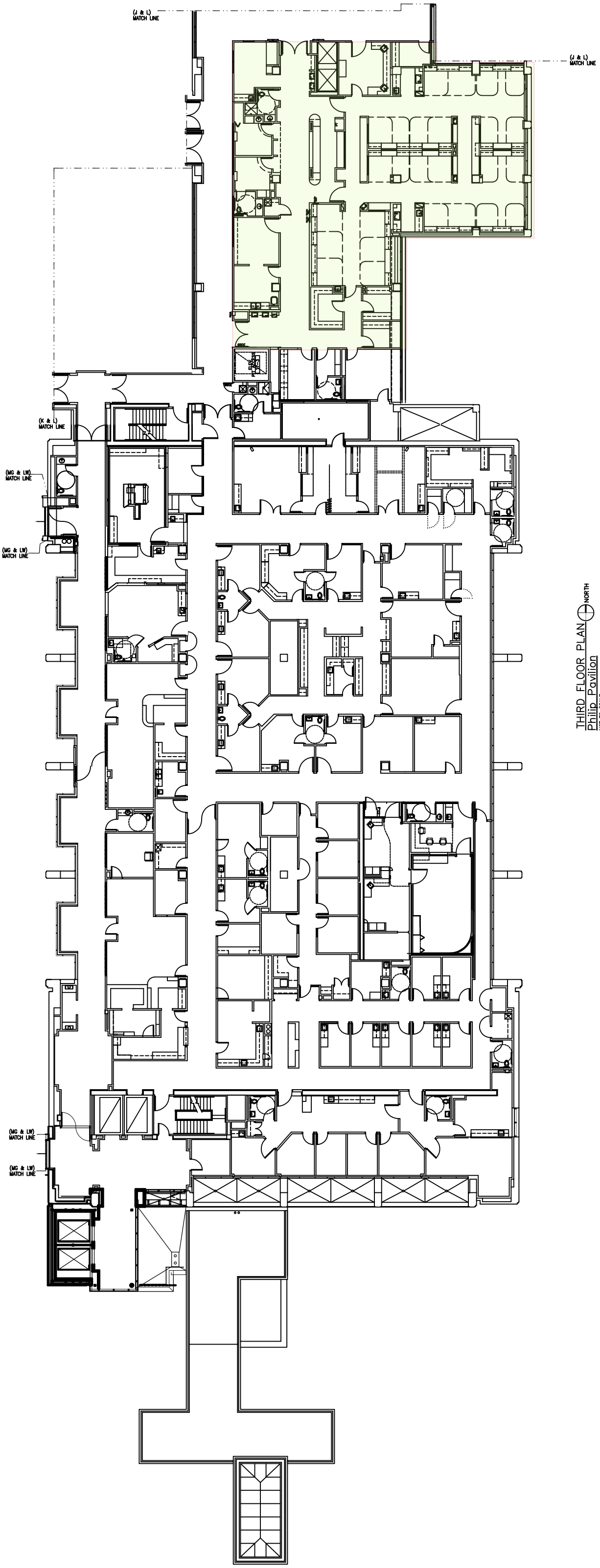
K. Erin Kobberstad

K. Erin Kobberstad
Vice President
Strategic Planning
MultiCare Health System

Exhibit 3A.

Single Line Drawing -

Intermediate Care Nursery



THIRD FLOOR PLAN NORTH
Philip Pavilion
NOT TO SCALE

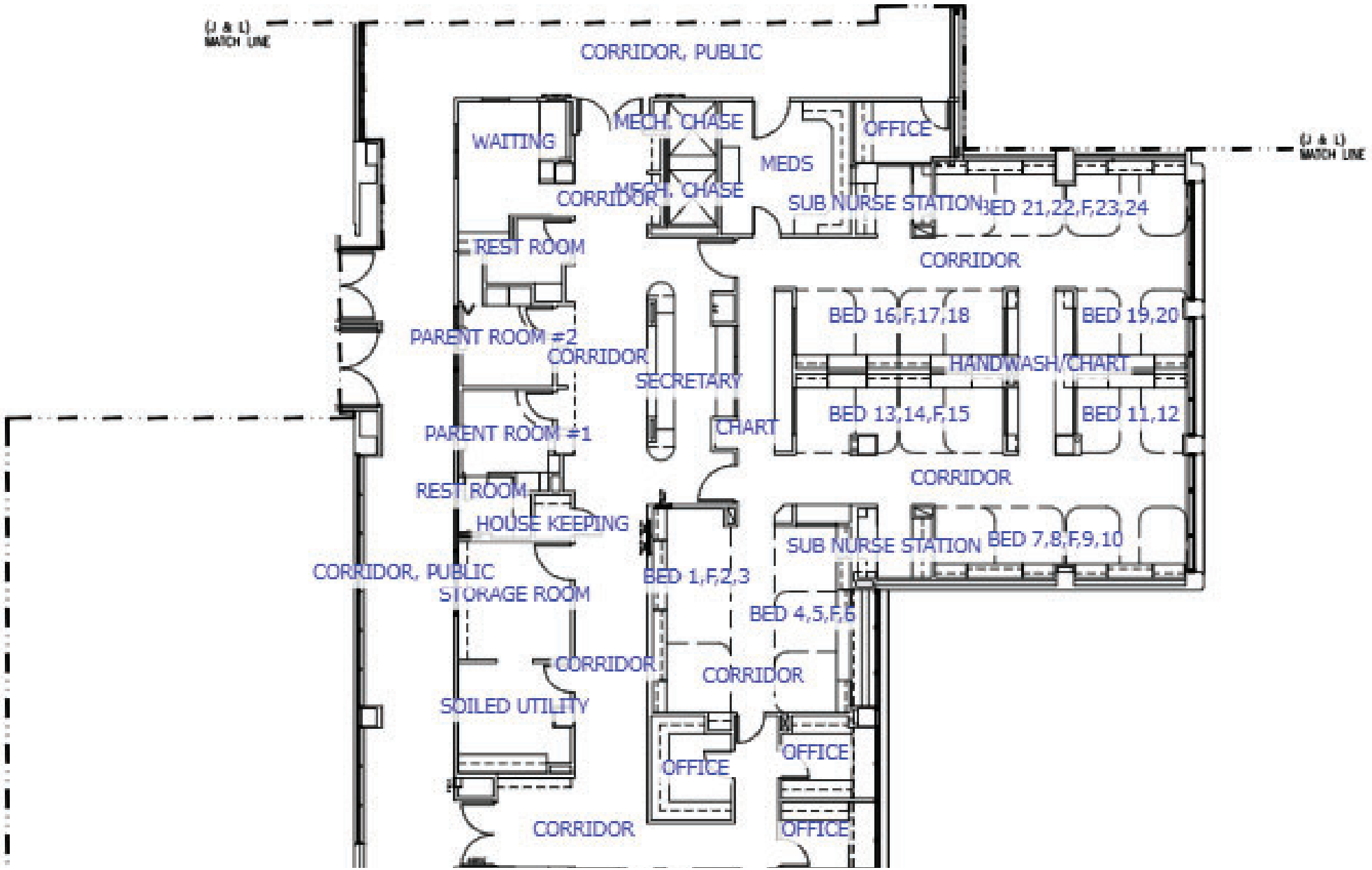
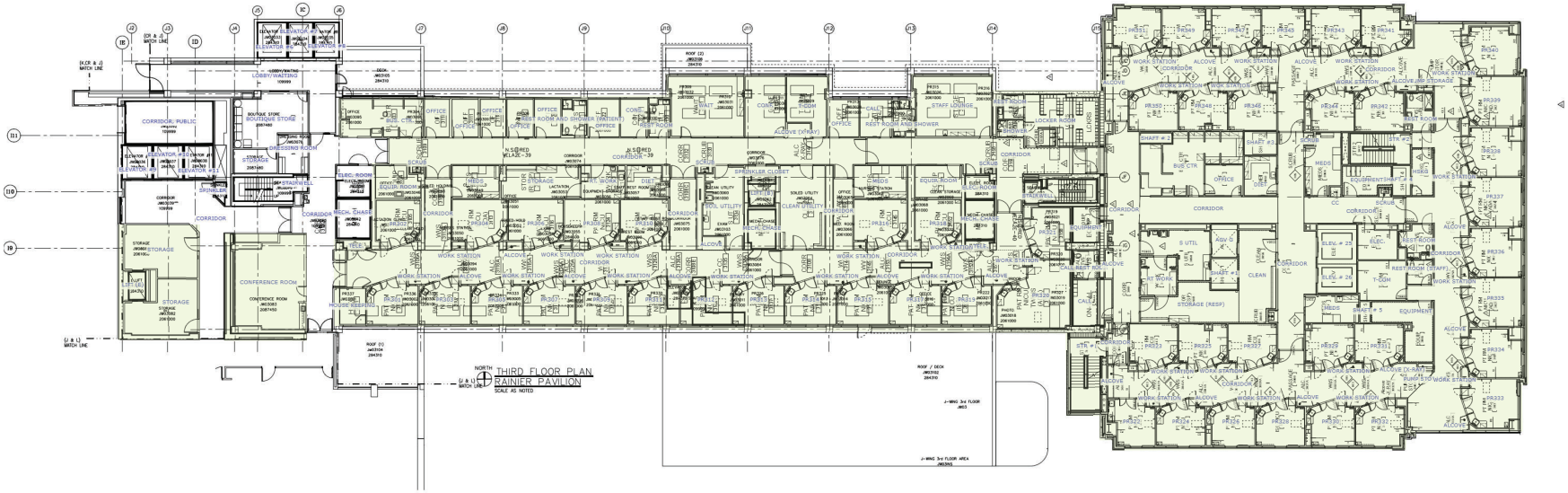

(J & L) MATCH LINE
CORRIDOR, PUBLIC
WAITING
MECH. CHASE
MEDS
OFFICE
(J & L) MATCH LINE
CORRIDOR
MECH. CHASE
SUB NURSE STATION
BED 21,22,F,23,24
REST ROOM
CORRIDOR
BED 16,F,17,18
BED 19,20
PARENT ROOM #2
CORRIDOR
HANDWASH/CHART
SECRETARY
BED 13,14,F,15
BED 11,12
CHART
PARENT ROOM #1
CORRIDOR
REST ROOM
HOUSE KEEPING
SUB NURSE STATION
BED 7,8,F,9,10
CORRIDOR, PUBLIC
BED 1,F,2,3
STORAGE ROOM
BED 4,5,F,6
CORRIDOR
CORRIDOR
SOILED UTILITY
OFFICE
OFFICE
CORRIDOR
OFFICE

Exhibit 3B.

Single Line Drawing -

Neonatal Intensive Care Unit



Property	Tacoma
Building	Tacoma General and Mary Bridge Hospitals
Floor	03 - Third Floor (Rainier)

Exhibit 4A.

Mary Bridge Children's Hospital Patient Origin

MultiCare Mary Bridge Children's Hospital

2021 Unique Inpatient Hospital-Based Inpatient Volumes by Zip Code

Zipcode	City	Unique Patient Count
98387	Spanaway	139
98404	Tacoma	127
98391	Bonney Lake	116
98499	Lakewood	93
98444	Tacoma	91
98003	Federal Way	86
98023	Federal Way	84
98374	Puyallup	83
98375	Puyallup	82
98092	Auburn	79
98338	Graham	70
98366	Port Orchard	66
98584	Shelton	66
98409	Tacoma	65
98405	Tacoma	65
98445	Tacoma	62
98373	Puyallup	60
98531	Centralia	58
98371	Puyallup	56
98367	Port Orchard	55
98002	Auburn	54
98597	Yelm	54
98466	Tacoma	50
98372	Puyallup	50
98501	Olympia	49
98498	Lakewood	49
98408	Tacoma	46
98032	Kent	44
98312	Bremerton	44
98503	Lacey	42
98311	Bremerton	42
98360	Orting	41
98001	Auburn	41
98502	Olympia	37
98516	Olympia	37
98042	Kent	37
98422	Tacoma	36
98335	Gig Harbor	35
98321	Buckley	35
98513	Olympia	34
98512	Olympia	34
98030	Kent	33

MultiCare Mary Bridge Children's Hospital

2021 Unique Inpatient Hospital-Based Inpatient Volumes by Zip Code

Zipcode	City	Unique Patient Count
98390	Sumner	28
98310	Bremerton	28
98446	Tacoma	27
98370	Poulsbo	26
98433	Tacoma	26
98520	Aberdeen	25
98467	University Place	25
98328	Eatonville	24
98022	Enumclaw	24
98403	Tacoma	24
98563	Montesano	24
98550	Hoquiam	23
98532	Chehalis	23
98031	Kent	23
98383	Silverdale	23
98580	Roy	22
98406	Tacoma	22
98332	Gig Harbor	22
98418	Tacoma	22
98424	Tacoma	19
98528	Belfair	19
98439	Lakewood	19
98506	Olympia	19
98198	Seattle	18
98038	Maple Valley	18
98579	Rochester	17
98596	Winlock	16
98465	Tacoma	16
98047	Pacific	16
98407	Tacoma	15
98402	Tacoma	15
98589	Tenino	14
98388	Steilacoom	13
98564	Mossyrock	13
98329	Gig Harbor	13
98327	Dupont	12
98541	Elma	11
98337	Bremerton	10
98359	Olalla	10
98380	Seabeck	10
All Other Zipcodes with < 10 unique patients		318

Exhibit 4B.

NICU/ICN Patient Origin

MultiCare Tacoma General Hospital --- ICN/NICU

2021 Unique Inpatient Hospital-Based Inpatient Volumes by Zip Code

Zipcode	City	Unique Patient Count
98387	Spanaway	34
98404	Tacoma	31
98444	Tacoma	26
98405	Tacoma	26
98409	Tacoma	23
98092	Auburn	23
98445	Tacoma	21
98391	Bonney Lake	19
98374	Puyallup	17
98375	Puyallup	17
98335	Gig Harbor	17
98512	Olympia	16
98408	Tacoma	16
98520	Aberdeen	15
98584	Shelton	15
98513	Olympia	15
98498	Lakewood	15
98499	Lakewood	15
98406	Tacoma	15
98371	Puyallup	14
98422	Tacoma	14
98531	Centralia	14
98503	Lacey	13
98338	Graham	13
98407	Tacoma	13
98501	Olympia	12
98023	Federal Way	12
98532	Chehalis	12
98466	Tacoma	11
98516	Olympia	10
98002	Auburn	10
98433	Tacoma	10
98001	Auburn	10
98332	Gig Harbor	10
98390	Sumner	10
All Other Zipcodes with < 10 unique patients		255

Exhibit 5A.

Charity Care Policy

MultiCare	*Administrative*

Document Title: Financial Assistance – Hospital Based Services

Scope:

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

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

Policy Statement:

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

Definitions:

1. **Collection Efforts** and **Extraordinary Collections Actions** (ECA) are defined by the MHS Collection Guidelines policy.
2. **Charity Care** and/or **Financial Assistance** means medically necessary hospital health care rendered to Eligible Persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. When communicating with patients, the phrase "Financial Assistance" will be used in lieu of "Charity Care." Both terms are synonymous with one another for the purposes of this policy and MHS billing statements.
3. **Eligible Person(s)** is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 500% the federal poverty standards adjusted for family size.
4. **Emergency Medical Conditions** (EMC) are defined by the MHS Emergency Medical Treatment and Active Labor Act (EMTALA), Compliance With policy, which is consistent with WAC 246-453-010.
5. **Family** is defined per WAC 246-453-010 (18) as a group of two or more persons related by birth, marriage or adoption that live together; all such related persons are considered as members of one family.
6. **Income** is defined per WAC 246-453-010(17) as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities.
7. **Medically Necessary** is defined per WAC 246-453-010 (7) as appropriate hospital-

based medical services.

8. **Responsible Party** means that individual who is responsible for the payment of any hospital charges not otherwise covered by a funding source as described below.

Policy Guidelines:

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

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

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

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

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

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

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

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

Procedure:

I. Eligibility Criteria

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

A. *Exhaustion of All Funding Sources*

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

d. Other state, federal or military programs

e. Third party liability situations (e.g., auto accidents or personal injuries)

f. Tribal health benefit programs

g. Health care sharing ministry programs

h. Any other persons or entities having a legal responsibility to pay

i. Health saving account (HSA) funds. MHS may require a Responsible Party to fully utilize any available funds from HSA to satisfy outstanding balances.

j. MHS will pursue payment from any available Funding Source. The remaining patient liability will be eligible for Financial Assistance based on the criteria in this policy.

B. *Accurate Completion of Financial Assistance application*.

1. Incomplete applications will be denied. Patients may appeal the denial and provide the missing information per the guidelines set forth below.

2. If the application places an unreasonable burden, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the Responsible Party's capability of complying with the application procedures on the Responsible Party, then the application process will not be imposed.

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

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

D. *Presumptive determination or Extraordinary Circumstances*

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

E. *Medically Necessary Health Care Services Rendered*

1. The services provided to the patient must be medically necessary and not elective.

2. Scheduled services that appear to not be medically necessary will be reviewed by Utilization Management prior to the date of service to determine medical necessity.

F. *International Patients*

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

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

A. *Income Verification*

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

B. *Calculation of Income*

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

C. *Timing of Determination*

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

III. Process for Determination of Eligibility

A. At the time of registration or as soon as possible following the initiation of services, MultiCare will make an initial determination of eligibility following the patient's review of the FPL grid. If a patient is determined to likely fall below 200% of the FPL, they will not be asked for payment and will be referred to a Patient Financial Navigator (PFN), who will provide additional information about Financial Assistance and other programs that may be available to the patient.

B. Collection activity will cease for 30 calendar days for patients believed to be under 200% of the FPL and the Responsible Party will be asked to complete a Financial Assistance application. If no application is received within 30 days, collection activity will resume.

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

eligibility.

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

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

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

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

IV. Appeals

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

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

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

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

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

V. Application of Financial Assistance Discount Levels

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

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

B. Financial Assistance adjustments will be considered on an individual account

balance basis. Approvals on adjustments will be authorized as follows:

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

C. The volume of applications and adherence to this policy will be tracked and audited on a monthly basis. This report will be reviewed and signed by the Vice President of Revenue Cycle or Executive Director of Patient Access.

VI. Presumptive Eligibility

A. Eligibility may be determined presumptively.

1. MHS may utilize third party vendor software or software applications to determine an account's collectability. This is a "soft" credit check and will not impact the Responsible Party's credit standing.
2. If these reviews determine the patient may be at 200% or below of the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance.

VII. Extraordinary Life Circumstances

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

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

illness and/or their ability to make payments over an extended period of time. All of the debt or a portion of the debt may qualify for Financial Assistance. The Supervisor or Manager of Patient Financial Navigation will assist in making a catastrophic event application determination.

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

VIII. Collection Efforts for Outstanding Patient Accounts

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

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

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

IX. Staff Training

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

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

X. Dissemination of MHS Financial Assistance Policy

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

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

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

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

	system. E. Billing Statements sent to Responsible Parties will contain information regarding the availability of Financial Assistance in both English and Spanish. F. Written materials are available in English, Arabic, Burmese, Cambodian, Chinese – Simplified, Chinese – Traditional, Filipino, Italian, German, Marshallese, Somali, French, Korean, Lao, Punjabi, Russian, Spanish, Ukrainian and Vietnamese. G. Wide-reaching community notifications will occur in the following ways: 1. Available at registration areas of all hospital facilities, 2. On MHS website www.multicare.org 3. Communications provided to our community partners for distribution, and 4. Upon request, by calling 800-919-1936
	Related Forms: Proof of Income for Financial Assistance Instruction Sheet Financial Assistance Application Financial Assistance Letter to Patients Patient Brochure Containing Plain Language Summary
	Appendix A: Financial Assistance
	References: RCW 70.170 WAC 246-453 Federal Register Vol 79, December 31, 2014 Final Rule
	Point of Contact: Executive Director, Patient Access 253-697-2979

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

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

Financial Assistance
Appendix A
2021

FAMILY SIZE	Gross Annual Income	300%	350%	400%	450%	500%
1	$12,880	$38,640	$45,080	$51,520	$57,960	$64,400
2	$17,420	$52,260	$60,970	$69,680	$78,390	$87,100
3	$21,960	$65,880	$76,860	$87,840	$98,820	$109,800
4	$26,500	$79,500	$92,750	$106,000	$119,250	$132,500
5	$31,040	$93,120	$108,640	$124,160	$139,680	$155,200
6	$35,580	$106,740	$124,530	$142,320	$160,110	$177,900
7	$40,120	$120,360	$140,420	$160,480	$180,540	$200,600
8	$44,660	$133,980	$156,310	$178,640	$200,970	$223,300
9	$49,200	$147,600	$172,200	$196,800	$221,400	$246,000
10	$53,740	$161,220	$188,090	$214,960	$241,830	$268,700
EACH ADD'L	$4,540					

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

Exhibit 5B.

Admissions Policy

MultiCare BetterConnected	***Patient Care*** ***Mary Bridge Children's Hospital***

Title: PEDIATRIC PATIENTS, CARE AND PLACEMENT OF

Scope:

This policy applies to the placement of all pediatric patients typically under 18 years of age, within MultiCare Health System (MHS) at Mary Bridge Children's Hospital.

Policy Statement:

This policy establishes the Mary Bridge Children's Hospital procedure for the appropriate placement of pediatric patients.

All patients are admitted without regard to race, ethnicity, national origin, sex, pre-existing condition, physical or mental status

Procedure:

I. Pediatric patients requiring services within MHS:

A. Every effort will be made to admit pediatric patients to Mary Bridge Children's Hospital; however, other specialties and locations may provide services to pediatric patients

B. An adult (greater than or equal to 18 years of age) may receive services and admissions to MBCH based on the department's scope of service and on an individual case-by-case basis.

C. Emancipated minors, behavioral health, minor parents and obstetrical patients will be treated as adults with regard to consent for care. Note see MHS P&P "Informed Consent and Patient Competency."

D. All pediatric patients, regardless of location or service, will receive individualized, age and developmentally-appropriate care

E. Policies and procedures related to the care of pediatric patients will be followed at all locations where pediatric patients receive care

F. A patient must be 18 years or older to execute an Advance Directive. See MHS P & P: *Advance Directives: Living Will and Mental Health*

II. Responsibilities:

A. The Mary Bridge Children's House Supervisor will assist in collaboration with the appropriate Clinical Director and/or designee and the administrator on-call to determine patient placement if needed. Consideration will be given to admission of both pediatric and non-pediatric patients based on individualized care needs and facility capacity status.

III. The following steps assure proper placement of the pediatric patient:

A. Pediatric patients will be given priority consideration over adult patients for admission requests to MBCH.

B. The admission of adult patients to MBCH will be reviewed on a case-by-case basis with approval being coordinated by the MB House Supervisor as appropriate, the Clinical Director and/or designee, the administrator on-call and the pediatric health care team.

C. Re-direction of admissions for identified non-pediatric patients to an adult facility will be coordinated by the MB House Supervisor and adult facility House Supervisor/Manager on Duty as appropriate, the Clinical Director and/or designee, adult and pediatric health care teams, and the administrator on-call as needed.

Definitions:

Pediatric Patient: Determined by patient age, from birth to 18th birthday (relatively, may also be based on patient's medical diagnosis that is being treated by one of the Mary Bridge Specialty physicians).

Emancipated Minor: A minor at least 16 years of age may petition the court for determination of emancipation status. RCW 13.64.060. This status includes the right to provide informed consent for health care. Documentation of this legal status by health care providers may include obtaining a copy of the child's Washington driver's license or identification card, which designates emancipation, or a copy of the court order declaring the minor emancipated See "Informed Consent and Patient Competency".

Related Policies:

MHS P & P: *"Admission of Patient"*

MHS P & P: "Advance Directives: Living Will and Mental Health"

MHS P&P: "Informed Consent and Patient Competency"

Point of Contact: Nurse Executive MB Children's 403-7019

Approval By:	***Date of Approval:***
MHS Pediatrics Committee	***6/12, 6/15, 6/18***
MB Nurse Executive	***5/15, 11/18***
MB Physician Executive	***5/15, 11/18***
Quality Safety Steering Council	***7/12, 7/15, 12/18***
Original Date:	*1/02*
Revision Dates:	*10/03; 8/06; 5/09; 4/12, 5/15, 11/18*
Reviewed with no Changes Dates:	*none*

3/13/19: Removed reference to retired policy "Provision of Care to Adult Patients by Pediatric Licensed Independent Providers (LIP) and Pediatric Staff"

Exhibit 5C.

Patient Rights and Responsibilities Policy

MultiCare	*Administrative*

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

Scope:

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

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

Policy Statement:

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

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

Procedure:

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

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

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

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

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

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

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

Point of Contact: Executive Director, Patient Access 697.1865

Approval By: Patient Registration Leadership CapMC Compliance and Ethics Team Quality Safety Steering Council	Approval Date: 4/19 7/21 4/14, 1/17, 6/19
Original Date: Revision Dates: Reviewed with no Changes Dates:	*9/90* *3/93, 2/95, 5/96, 11/97, 3/99, 2/01, 2/03, 11/05, 3/09, 4/14, 1/17, 4/19* *5/12*

Distribution: MSH Intranet

Scope/locations of services updated March, 2017.

4/11/18 - Approved at SKRB 3/26/18 and QSSC 4/10/18 to apply to Covington Medical Center

Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 5D.

Non-discrimination Policy

Document Title: Patient Nondiscrimination

Scope:

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

Location Scope:

MultiCare Health System adopts the following policy and procedure for the following locations: Tacoma General Hospital/Allenmore Hospital, Mary Bridge Children's Hospital, MultiCare Good Samaritan Hospital, MultiCare Auburn Medical Center, MultiCare Deaconess Hospital, MultiCare Valley Hospital, Covington Medical Center, Capital Medical Center, MultiCare Connected Care, MultiCare Foundations, CHVI, NAVOS, Greater Lakes Mental Healthcare, Home Health and Hospice, and all ambulatory, community-based, administrative, and retail sites.

Policy Statement:

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

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

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

Special Instructions:

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

All reports will be responded to and investigated by the Privacy & Civil Rights Office. The availability and use of this procedure does not prevent a person from filing a complaint of discrimination with the U.S. Department of Health and Human Services, Office for Civil Rights.

No person will suffer retaliation for reporting discrimination, filing a complaint or cooperating in an investigation of a discrimination complaint.

Procedure:

MHS Personnel will:

1. Treat all patients and visitors receiving services from or participating in other programs of MHS, with equality in a welcoming manner that is free from discrimination based on race, color, creed, religion, age, disability, national origin, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, or any other basis prohibited by federal or state law.
2. Provide notices to patients regarding this Nondiscrimination Policy and MultiCare Health System's commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner.
3. Inform patients of the availability of and make reasonable accommodations for patients consistent with federal and state requirements. For example, language interpretation services will be made available for non-English speaking patients and sign language interpretation will be made available for hearing impaired patients.
4. Afford appropriate visitation rights to patients free from discrimination and will ensure that visitors receive equal visitation privileges consistent with patient preferences, safety and other applicable policies. At the time patients are notified of their patient rights, Hospital Personnel will also inform patient, or patient's support person, including the patient's attorney in fact, when appropriate, of the patient's visitation rights, including any clinical or safety restriction on those rights, and the patient's right, subject to the patients consent, to receive visitors whom the patient designates.
5. Determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment of the basis of race, color, creed, religion, age, disability, national origin, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, citizenship or immigration status, or any other basis prohibited by federal or state law.

Related Policies:

Compliance and Ethics Program, Reporting and Investigating Concerns of Violations Patient Grievances

Equal Employment Opportunity and Employment Law

Emergency Medical Treatment and Active Labor (EMTALA), Compliance with Employee Complaint Grievance Procedure

References:

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 if the Patient Protection and Affordable Care Act and Regulations of the U.S. Department of Health and Human Services issued pursuant to:

45 C.F.R. § 80 (2012) – Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964.

45 C.F.R. § 84 (2012) – Enforcement of nondiscrimination on the basis of handicap in

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

Approval By:	***Date of Approval:***
Compliance/Privacy Leadership	***8/19, 8/20***
CapMC Compliance/Privacy	***7/21***
MHS Quality Safety Steering Council	***8/12, 9/17, 9/19, 9/20***
Original Date:	*6/12*
Revision Dates:	*8/17, 8/19, 8/20*
Reviewed with no Changes Dates:	*X/XX; X/XX*

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

Exhibit 5E.

End of Life Policy

Title: WITHHOLDING/WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

Scope

This policy applies to patients receiving care at MultiCare Health System (MHS) in the Puget Sound region including Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Capital Medical Center, and all ambulatory care areas.

The following patients require additional procedures before enacting this policy:

- If the patient has been declared dead by whole brain criteria, refer to the **Brain Death Determination Policy**.
- If the patient is pregnant with a viable fetus, contact the local hospital's Risk Manager and ethics committee.

Policy Statement:

1. MHS recognizes that the decision to withhold or withdraw life-sustaining treatment is ethically and legally appropriate in certain circumstances. It is expected that all involved health care providers will approach the decision-making process with the highest degree of professionalism, engaging in respectful and transparent discussion with the treatment team, the patient or surrogate, and the patient's involved family members.
2. The decision to withhold or withdraw treatment is complex and case-specific, and should be guided by respect for:
    a. the patient's fundamental right to control decisions regarding their health care, including the decision to refuse life-sustaining treatment, and
    b. health care providers' obligations to provide beneficial treatments, restore health, and/or relieve pain and suffering, and
    c. personal values that bear on the decision-making process and the right of a health care provider to elect not to participate in withholding or withdrawing life-sustaining treatment.
3. The goals of this policy are to provide guidelines for withholding or withdrawing life-sustaining medical treatment and may be referred together with the **Medically Ineffective Treatment Policy**.

Procedure:

A. General Considerations

1. A discussion concerning the withholding or withdrawal of life-sustaining treatment may be initiated by the patient, the patient's surrogate or family members, the attending physician, or a consulting physician. The attending physician is responsible for coordinating communication between the patient or surrogate, the patient's involved family members, and members of the treatment team.

2. Under Washington law, the right to refuse, withhold or withdraw life-sustaining treatment includes the right to refuse, withhold, or withdraw artificial nutrition and hydration.
3. A surrogate's decision to withhold or withdraw treatment should be guided by the ***substituted judgment*** standard, which means he or she is relying on known or inferred preferences of the patient when deciding about medical treatment. If the patient's preferences are unknown and cannot be reasonably inferred from the surrogate's knowledge of the patient, an advance directive, or knowledge of others who discussed end of life preferences with the patient, the surrogate must consider the ***best interest*** of the patient. The treatment team should support the surrogate decision-maker in reaching decisions that are guided by the ***appropriate standard*** under the circumstances.

B. Establishing Goals of Care and Treatment Plans

1. The treatment team should establish the patient's goals of care, including goals related to life-sustaining treatments as soon after admission as possible.
2. When the patient lacks decision-making capacity, the treatment team should review the patient's advance directives, if any, and engage the patient's legally qualified surrogate decision-maker in a discussion about goals of care. It is appropriate to involve immediate family members who have knowledge regarding patient preferences to assist the surrogate in exercising substituted judgment.
3. When the patient lacks decision-making capacity and has no surrogate, family, or other legal representative to speak for him or her, notify the local hospital's care continuum director to consider a guardianship process. An ethics consult may also be requested.
4. The role of the treatment team includes providing guidance whether the patient/surrogate's goals of care are attainable based on the best available medical evidence. When requested treatments are deemed medically ineffective, providers must respectfully discuss the rationale for any decision to withhold/withdraw the requested treatment and document the discussion and rationale in the patient's chart.
5. If the goals of care shift to comfort care and/or a decision is made not to escalate treatment, that goal should persist even as attending physicians change. This ensures continuity of care, minimizes the disruption to patients, family and staff, and helps families focus on supporting their dying loved one. The current attending physician should have a conversation with the incoming attending physician to help ensure continuity.
6. If there is clinically significant change in the patient's medical condition, the goals of care should be re-evaluated.
7. Early involvement of the palliative care team is recommended when a patient has a life-limiting or terminal illness, especially when withholding or withdrawing treatment is being considered.

C. Guidelines to Withhold or Withdraw Life-Sustaining Treatment

1. A patient who has decision-making capacity has the right to refuse life-

sustaining treatment, including artificial nutrition and hydration. The request can be made directly by the patient or through his or her advance directive. In such cases, life-sustaining treatment may be withheld or withdrawn, provided conditions of the advance directive are met. Involved family members should be informed of the decision.

2. When the attending physician, with consensus of the treating team, makes a judgment that a life-sustaining intervention is medically ineffective, the attending should commence a patient care conference (as appropriate) to explain the treating team's recommendations, the medical rationale supporting it, the alternatives and their likely outcomes. It is recommended to include members from palliative care, social work and/or spiritual care for added support.
3. The attending physician seeks the patient/surrogate's agreement to withhold or withdraw the interventions. The discussion should be summarized in the patient's chart. Once a decision is made to withdraw or withhold treatment, the preferences of the patient and his or her involved family members should be taken into consideration when they do not harm the patient or complicate the withdrawal process. In certain circumstances the medical interventions may continue to be provided for a brief period of time, such as to allow travel time to reach the patient or to perform cultural or religious ceremonies.
4. Discussion of the option to donate organs is a separate decision from withdrawal of life-sustaining treatment and should be addressed prior to the withdrawal. Tissue donation (including corneas) may be discussed after the patient has died. **Refer to the Organ, Tissue and Eye donation** policy for guidance.

D. Conflict Resolution Procedure

1. Conflicts may arise when parties disagree about the best course of action in the care of a patient when the treating team believes that:
   a. a treatment is medically ineffective, or
   b. a treatment is contrary to generally accepted medical standards, or
   c. the burden of pain, suffering, and/or intrusiveness resulting from treatment significantly outweighs any benefit.
2. Three types of conflict often arise: (a) intra-professional between members of the treating team, (b) between family members or surrogates, and (c) between the treating team and the patient or surrogate. Depending on the source of conflict the following steps should be taken.
3. Conflict between members of the treating team (intra-professional):
   a. Regular team meetings should be held to discuss the patient's prognosis, goals of care, and proposed treatments to achieve consensus among physicians and/or treating team members.
   b. Care should be taken not to engage the family with intra-professional disagreements. This places an unfair burden on them and can provide confusing information regarding treatment options.
   c. If the intra-professional conflict remains unresolved, support from the ethics

committee is recommended. The ethics committee members help to facilitate a fair resolution of the conflict, identify areas of agreement or consensus, and provide recommendations and ethical rationale for various courses of action.

d. If the conflict is not resolved after an ethics consult, the Chief Medical Officer should be enlisted. Final resolution for intra-professional conflicts is an institutional responsibility that includes of the hospital's Chief Medical Officer, MHS service lines and specialties appropriate to the situation, and MHS leadership.

4. Conflict between family members and/or surrogate:

   a. If disagreement arises between family members or surrogate, a family conference should be held with the members of the treating team to discuss the patient's prognosis, goals of care, and proposed treatments to try and achieve consensus. If disagreement persists, an ethics consult should be requested.

   b. Ultimately, with conflicts between family members and/or surrogate, the final decision resides with the legally authorized surrogate. However, every effort should be made by the treating team to help the family reach consensus regarding the withholding or withdrawing of life-sustaining treatment.

5. Conflict between the attending physician/treating team and pt/surrogate:

   a. If the family does not agree with the attending and treating team's recommendation to withhold or withdraw treatment, an ethics consult should be requested. The ethics consultant will meet with all parties to ensure inclusion of all relevant perspectives and provide recommendations and ethical rationale for various courses of action. The process and outcome of the consult will be documented in the patient's chart and communicated to the providers and patient/surrogate/family. The patient/surrogate will be allowed an appropriate amount of time to consider the recommendations.

   b. If disagreement persists after obtaining the ethics consultation, the attending physician may request second opinion from a physician with appropriate expertise. The consulting physician will inform the treatment team and the patient/surrogate regarding their assessment.

   c. Pursuant to Washington code RCW 70.122.030, prior to withholding or withdrawing life-sustaining treatment for patients who lack capacity, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be documented into the patient's medical record.

   d. As a point of information, the attending physicians should notify the CMO about the intractable conflict. It is recommended the CMO informs the Risk and Legal departments about the situation. The patient/surrogate should be offered the opportunity to arrange for transfer to another facility.

   e. Final resolution to withhold or withdraw life-sustaining treatment in situations where there is intractable disagreement is considered an institutional decision that includes the hospital's Chief Medical Officer, MHS service lines and specialties appropriate to the situation, and MHS leadership. The Chief

	Medical Officer or attending physician with support from any relevant clinical staff or MHS representative will inform the patient/surrogate of available options.
	Definitions **Attending Physician:** The physician assigned to the patient who has primary responsibility for the treatment and care of the patient. **Life-Sustaining Treatment**: Any medical or surgical intervention that uses mechanical or other artificial means, including artificial nutrition and hydration, to restore or replace a vital function which when applied to a qualified patient, would serve only to prolong the process of dying. Life- sustaining treatment shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain. **Medical Futility:** the rare circumstance that an intervention cannot accomplish the intended physiological goal. Medical futility may be invoked as the basis for a physician's decision to withhold or withdraw a medical intervention. **Medically Ineffective Treatment:** **See Associated Policy** Any treatment or course of treatment that: 1. holds at least some chance of accomplishing the effect sought by the patient or surrogate, but competing ethical considerations justify not providing it, or 2. would serve only to prolong the patient's irreversible dying process that is actively underway, excluding certain circumstances in which medical interventions are continued for a brief period of time, or 3. would serve only to maintain the patient's life in a permanent, unconscious state or other neurologically devastated state in which the patient is unable to experience the benefits of treatment or survive outside of the hospital's acute care setting, or 4. would impose burdens on the patient grossly disproportionate to any expected benefit. **Surrogate Decision-Maker:** Person legally authorized to provide medical consent for a patient who is not competent or lacks decision-making capacity. Refer to the **MHS Policy Informed Consent Section C: Adult patient's Decisional Capacity** for the updated (2019) priority list. **Treatment or Treating Team:** All of the clinicians assigned to care for the patient, including but not limited to: physicians, nurses, social workers, chaplains, and allied heath staff (respiratory, dieticians, physician therapy, etc.).
	References: American Medical Association. Caring for patients at the end of life. Code of Medical Ethics Opinion E5.1 – E5.5. *AMA principles of medical ethics*. Accessed 12/2019 from: https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-caring-patients-end-life American Medical Association. Medically Ineffective Interventions. Code of Medical Ethics Opinion 5.5. *AMA principles of medical ethics.* Accessed 3/2020 from: https://www.ama-assn.org/delivering-care/ethics/medically-ineffective-

interventions

American Medical Association. Withholding or withdrawing life-sustaining treatment. Code of Medical Ethics Opinion 5.3. *AMA principles of medical ethics.* Accessed 12/2019 from https://www.ama-assn.org/delivering-care/ethics/withholding-or-withdrawing-life-sustaining-treatment

Bosslet GT, Pope TM, Rubenfeld GD, Lo B, Truog RD, et al. An official ATS/AACN/ACCP/ESICM/SCCM policy statement: responding to requests for potentially inappropriate treatments in intensive care units. *Am J Respir Crit Care Med*. 2015;191(11):1318–1330. doi:10.1164/rccm.201504-0750ST

Supreme Court of Washington. Guardianship of Grant 747 P.2d 445 *Justia US Law.* Retrieved 12/2019 from https://law.justia.com/cases/washington/supreme-court/1988/52609-5-1.html

Washington State Legislature. Directive to withhold or withdraw life-sustaining treatment. RCW 70.122.030. Retrieved 12/2019 from https://app.leg.wa.gov/RCW/default.aspx?cite=70.122.030

Washington State Legislature. Informed consent—persons authorized to provide for patients who are not competent-priority (amended 2019). Retrieved 12/2019 from https://app.leg.wa.gov/RCW/default.aspx?cite=7.70.065

Washington State Legislature. Natural Death Act. Chapter 70.122 RCW. Retrieved 12/2019 from https://app.leg.wa.gov/RCW/default.aspx?cite=70.122

Point of Contact: Clinical Ethicist (253) 403-1136

Approval By:	***Date of Approval:***
Tacoma Ethics Committees	***1/20, 3/20***
AMC/CMC Ethics	***3/20***
GS Ethics	***3/20***
GS MEC	***2/20, 4/20***
CMC MEC	***2/20, 4/20***
AMC MEC	***4/20***
Tacoma Med Ops	***2/20, 4/20***
CapMC MEC	***9/21***
CapMC Executive Board of Directors	***9/21***
MHS Quality Safety Steering Council	***3/20, 5/20***
Original Date:	*01/89*
Revision Dates:	*01/05; 10/09; 12/11*
Reviewed with no Changes Dates:	*None*

Distribution: MHS Intranet
4/2017 locations included in scope
7/17, Covington Medical Center added to scope
Approved for Capital Medical Center 9/7/21 by CapMC MEC and Executive Board of Directors
Approved by MHS QSSC e-vote 9/21/2021 to apply to Capital Medical Center

Exhibit 5F.

Reproductive Policy

MultiCare BetterConnected	***Administrative***

Title: REPRODUCTIVE HEALTH

Scope:

All patients needing reproductive health care.

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

Policy Statement:

As an integrated health care system MHS will provide a range of male and female reproductive health services to meet a patient's clinical needs and a patient's choice. Not every procedure is available at all of our hospitals. This policy focuses on services provided in hospital facilities only.

1. Through the primary care settings in hospital facilities, patients have access to a full array of preventive healthcare services including all forms of contraception prevention, and the preventions and treatment of sexually transmitted diseases
2. Through our hospitals patients have access to dedicated birth services. Also available are pre-natal care services with planned deliveries.
3. Our hospitals which routinely deliver babies offer a full scope of services related to prenatal care, birth, maternal fetal medicine consultations and referrals and genetic counseling.
4. Within the MHS system we offer both elective and medically indicated terminations of pregnancy in addition to actively referring patients to community providers.
5. Patients who wish to explore limited services related to male and female fertility can find a range of such services. Which includes actively referring patients to community providers.
    - Note MHS hospitals permit their healthcare professionals to opt/out of participating in serviced that violate their conscience or values. In such circumstances, the hospitals arrange for other healthcare professionals to deliver the care for the patient.

References:
WAC 246-320-141

Point of Contact: Medical Chair OB Collaborative

Approval by:	***Date of Approval:***
OB Collaborative (endorsement)	***3/17***
CapMC Compliance and Ethics Team	***7/21***

Quality Safety Steering Council	***3/17; 7/17***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*2/17* *X/XX; X/XX* *X/XX; X/XX*

Distribution: MSH Intranet

7/17 Covington Medical Center added to scope

Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 6A.

Financial Exhibit – Assumptions

Mary Bridge Children's Hospital & Health Network

Financial Model Key Assumptions

January 2022 Certificate of Need Application

ASSUMPTIONS | Without the Project

2019, 2020, and November Year-to-Date 2021 are actual Mary Bridge financial data. 2022-2025 are financial forecasts based on the assumptions presented below and consistent with the financial model with the relocation to the new Mary Bridge hospital building approved under CN1920.[1]

Volume Assumptions

1. The utilization projections have been established to optimally utilize the new children's hospital based on Mary Bridge's existing licensed bed capacity of 82 beds.
2. Mary Bridge undertook a robust strategic planning process spanning the course of more than 12 months to develop key goals and strategies that are expected to allow it to achieve the target volume growth. Major key strategic initiatives include:
    a. Improve access to Care and Services across the Greater Puget Sound Region to make it easier for patients to get timely appointments
    b. Expand Mary Bridge Specialty Service Lines to provide more services close to home for our patients and their families
    c. Establish and operate a Children's Hospital and Health Network Operating System to create/extend integrated care delivery across both inpatient and outpatient services, such as a comprehensive EMR (electronic medical record) to improve access and communication between patients and providers.
    d. Develop a comprehensive population health model of care delivery to improve the health of the populations Mary Bridge serves
3. The forecast model projects incremental outpatient activity occurring at the hospital including: emergency department, ambulatory surgery, observation, outpatient exam, and radiology patient encounters. Mary Bridge's market share for each ancillary was estimated based on Sg2 utilization reports for Mary Bridge's service area. Mary Bridge is targeting a 16% growth in each of the outpatient ancillaries.
4. Mary Bridge's average length of stay is expected to increase from 3.8 days to 4.1 days as it increases its patient activity mix with higher acuity patients currently leaving the service area.

Capital Expenditures

5. Depreciation at Mary Bridge is based on 2019 Mary Bridge activity, with incremental depreciation added based on the depreciable portion of the $332.68M [non-financing] capital expenditures allocated to the Mary Bridge financial statements for the new hospital spread over an expected 30-year useful life. Depreciation is modeled to begin upon opening of the new Mary Bridge hospital in October 2024.

[1] Mary Bridge CN App #21-63, Screening Responses, July 8, 2021. Exhibits 7 and 14.

6. $2.09M of Mary Bridge's current depreciation will be reallocated back to Tacoma General Hospital upon opening of the new children's hospital. Further, Mary Bridge is expected to incur $2,782,406 of accelerated depreciation expense.

Revenues

7. Models do not include any charge inflation.
8. Mary Bridge's payor mix is based on 2019 Mary Bridge patient activity, with payor mix calculated as a percentage of gross revenues and as a percentage of inpatient discharges.
9. Revenues are based on 2019 figures and are modeled based on forecasted patient encounters by service line and by payor.
10. 2019 Deductions from Revenues were 62% of gross revenues and this percentage has been held constant over the forecast period.
11. Mary Bridge charity care has been modeled at the 2016-2018 Puget Sound Region (Less King County) benchmark at 1.19% of gross revenues.
12. Bad debt represented 0.59% of gross revenues and this percentage has been held constant over the forecast period.
13. Other Patient Services Revenues of $14,018,472 represents additional prescription revenues related to oncology infusion and pharmacy oncology.
14. Other Operating Revenue of $10,809,932 includes revenues associated with Grants and Foundations, Allocated Hospital Services, and Other Revenue.

Expenses

15. Models do not include any expense inflation.
16. Expenses have been modeled using Mary Bridge's 2019 expense structure as the baseline. Expenses have been broken into direct and indirect expenses based on each patient encounter activity type (e.g. inpatient, emergency, radiology, etc.). Each expense is assigned a fixed and variable component based on Mary Bridge actuals in 2019. Fixed expenses are not inflated over the planning period. Variable expenses are calculated as an expense per patient encounter.
17. Other Operating Costs of $18,601,106 are inclusive of costs associated with dues, licenses, malpractice insurance, DME, travel, training, and conferences. These expenses are grown based on the assumptions above.
18. Mary Bridge's corporate services allocation to MultiCare Health System is calculated as 0.5% of Gross Charges based on the 2019 financial statements. This rate has been held constant over the planning period to calculate future corporate service allocations.
19. Mary Bridge has sourced $300,000,000 in bond financing at a rate of 2.803% over a period of 30 years to fund the majority of the hospital construction efforts, with the remaining balance funded through MultiCare reserves. In addition to Mary Bridge's 2019 baseline Interest expense of $3,483,394, Mary Bridge will incur incremental interest related expenses based on its allocated portion of financing for the new hospital. MultiCare will capitalize $8,712,881 of interest expense, but this capitalized interest and bond issuing costs are allocated to MultiCare Health System and not the Mary Bridge statements.
20. Overall variable expenses grow as patient activity grows.

FTEs

21. FTE wage, salary, and benefits by position are based on 2019 actuals and grown based on the forecasted FTEs needed to support the target volume activity.
22. The Non-Productive FTE complement is calculated as 13% of productive FTEs. This percentage figure is held constant over the forecast period.
23. Mary Bridge has also utilized additional staff employed by Tacoma General Hospital that are "under-arrangement" with an allocated portion of time to support Mary Bridge operations. Under-arrangement staff are currently allocated to purchased services.
24. TGH staff "under-arrangement" will transition over to Mary Bridge employment when the new hospital opens, resulting in an increased headcount for Mary Bridge and a shift of expenses from Purchased Services into Salaries and Benefits.
25. Benefits are calculated at 20% of salaries and held constant.

Balance Sheet

26. Cash and Cash Equivalents is used as variable calculation to balance Total Assets to Total Liabilities and Equity.
27. Accounts Receivable is calculated as 16.5 days in A/R[2] and held constant as a ratio throughout the forecast period.
28. Uncollectable Allowances is calculated at 0.3% of NPSR and held constant as a ratio throughout the forecast period.
29. Inventory is calculated based on an inventory turnover of 4,133 and held constant as a ratio throughout the forecast period.
30. Property, Plant, and Equipment assets affected by the new hospital are increased in accordance with the capital costs identified in CN App #21-63, spread to the appropriate asset categories. The capital outlay in the balance sheet is as identified by the construction manager. All physical assets are recorded on the balance sheet when they become operational in FY24 and are recorded as Construction in Progress in the interim. The following increases have been recorded:
    a. Land assets are increased by $1,000,000 for purchase of new land schedule, no subtractions have been assumed.
    b. Land Improvement assets are increased by $5,908,623, including allocated sales tax,, no subtractions have been assumed.
    c. Fixed Equipment assets are increased by $17,839,253, including allocated sales tax, no subtractions have been assumed.
    d. Major Movable Equipment assets are increased by $43,419,406, including allocated sales tax, no subtractions have been assumed.
    e. Building assets are increased by the balance of total project cost [excluding financing3] minus land and equipment assets, for a total of $264,512,443, including allocated sales tax, no subtractions have been assumed.

[2] 16.5 days in A/R calculated based on gross patient services revenue. It is 46 days in A/R if calculated based on net patient services revenue.

[3] Financing costs (e.g. capitalized interest, bond issuance) are allocated to MultiCare Health System and not the Mary Bridge statements.

f. Construction in Progress is grown from FY20 – FY23 based on the allocated incurred expenses, and transitions to the appropriate balance sheet assets in FY24
g. Accumulated Depreciation adds the annual depreciation expense per the depreciation schedule to the prior year's accumulated depreciation.

31. Investment is Other Assets is held constant at $418,485 throughout the forecast period.
32. Accrued expenses is calculated at 9.7 days of Salaries and Wages expenses and held constant as a ratio across the forecast period.
33. Total Equity is calculated by adding the annual net operating margin generated to the prior year's ending balance for Total Equity.

ASSUMPTIONS | The Project

The transfer of the seventy (70) ICN/NICU beds from Tacoma General Hospital's license to Mary Bridge's license ("The Project") is anticipated to be completed by January 2023. Therefore, the first three full years are 2023-2025.

"2021 actuals" defined as rolling 12 months ending September 2021.

Volume Assumptions

1. Baseline cases set to full year 2020 actuals.
2. Case growth based on primary service area 0-4 year old forecasted population growth (0.78%) based on OFM GMA projections (2017 release). Primary service area defined as Pierce, King, Thurston, and Kitsap which collectively comprise more than 80% of patient days in 2020.
3. Average length of stay (ALOS) held constant at 2020 value (22.96 days) throughout forecast.
4. Patient days are calculated by multiplying cases by ALOS.

Capital Expenditures

5. Project-related capital expenditures ($103,600) are depreciated using the straight-line method assuming a 10-year useful life.

Revenues

6. Models do not include any charge inflation.
7. Revenues are based on 2021 actuals calculated on a per patient day basis and are modeled based on forecasted patient days.
8. Contractual adjustments are based on 2021 actuals but adjusted down 0.9% due to expected impact from the ICN/NICU transferring under the Mary Bridge license.
9. Mary Bridge charity care has been modeled at the 2017-2019 Puget Sound Region (Less King County) benchmark at 1.34% of gross revenues.
10. Bad debt represented 0.49% of gross revenues in 2021 and this percentage has been held constant over the forecast period.

Expenses

11. Models do not include any expense inflation.
12. Expenses have been modeled using the 2021 expense structure as the baseline. Each expense is assigned a fixed and variable component based on Mary Bridge actuals in 2021. Fixed expenses are not inflated over the planning period. Variable expenses are calculated as an expense per patient day.
13. Professional Fees include provider contract fees, external medical director stipends, individual contracted providers, etc.
14. Purchased Services include linen services, equipment repairs and maintenance.
15. Other Operating Costs includes dues, books/subscriptions, utilities.
16. Corporate Services is the allocated system level expense bucket.
17. Depreciation includes 2021 actuals (held constant through forecast) and project-related depreciation discussed above.

FTEs

18. FTE wage, salary, and benefits by position are based on 2021 actuals and grown based on the forecasted FTEs needed to support the target volume activity. RN wages are based on 2021 actuals but increased by 10% due to expected impact from the ICN/NICU transferring under the Mary Bridge license.
19. The Non-Productive FTE complement is calculated as 13.2% of productive FTEs. This percentage figure is held constant over the forecast period.
20. Benefits are calculated at 32% of salaries based on 2021 actuals.

Balance Sheet

21. Cash and Cash Equivalents is based on EBIDA less amounts still in Accounts Receivable.
22. Accounts Receivable is calculated as 36 days of net revenue in A/R and held constant as a ratio throughout the forecast period.
23. Inventory is calculated using the starting balance of inventory and adding in average increase in supply expense of 1.17% for project.
24. Property Plant and Equipment increase is the remaining change to balance sheet and assumed that increase is in equipment from major movable equipment.
25. Accumulated Depreciation adds the annual direct depreciation expense to the prior year's accumulated depreciation.
26. Accrued expenses are calculated using starting balance of accrued expenses and adding in average increase in other expenses (professional fees, purchased services and other operating costs) of 2.2% for project.
27. Total Equity is calculated by adding the annual net operating margin generated to the prior year's ending balance for Total Equity.

ASSUMPTIONS | With the Project

- 2019, 2020, and November Year-to-Date 2021 are actual Mary Bridge financial data.
- Since 'The Project' is not anticipated to be complete until January 2023, 2022 "With the Project" is identical to 2022 "Without the Project".
- 2023-2025 "With the Project" projections are the sum of the "Without the Project" and "The Project" forecasts.

Exhibit 6B.

Financial Exhibit – Without the Project

INCOME STATEMENT
WITHOUT THE PROJECT

	2019	2020	Nov 2021 YTD	2022	2023	2024	2025
PATIENT SERVICE REVENUES:							
HB Inpatient	$ 303,260,623	$ 257,659,591	$ 249,656,858	$ 314,879,437	$ 320,688,844	$ 328,553,634	$ 349,467,500
HB Outpatient	$ 520,859,184	$ 485,020,557	$ 449,839,665	$ 555,180,049	$ 572,535,778	$ 596,827,041	$ 659,307,664
PB Outpatient	$ 110,009,437	$ 119,952,161	$ 142,050,521	$ 168,314,424	$ 173,650,277	$ 180,992,512	$ 199,490,696
Other	$ 14,018,472	$ 2,686,704	$ 4,786,979	$ 14,018,472	$ 14,018,472	$ 14,018,472	$ 14,018,472
TOTAL	$ 948,147,715	$ 865,319,013	$ 846,334,023	$ 1,052,392,382	$ 1,080,893,371	$ 1,120,391,659	$ 1,222,284,331
DEDUCTIONS FROM REVENUES:							
Contractual Adjustments	$ 596,130,527	$ 529,857,612	$ 532,332,719	$ 656,064,509	$ 673,821,835	$ 698,454,372	$ 762,012,414
Charity Care	$ 7,862,613	$ 7,660,514	$ 5,430,896	$ 12,523,469	$ 12,862,631	$ 13,332,661	$ 14,545,184
Provision for Bad Debts	$ 5,555,255	$ 4,994,159	$ 6,142,533	$ 6,166,031	$ 6,333,020	$ 6,564,442	$ 7,161,438
TOTAL	$ 609,548,395	$ 542,512,286	$ 543,906,149	$ 674,754,009	$ 693,017,486	$ 718,351,475	$ 783,719,035
NET PATIENT SERVICE REVENUE	$ 338,599,320	$ 322,806,727	$ 302,427,874	$ 377,638,373	$ 387,875,885	$ 402,040,184	$ 438,565,296
OTHER OPERATING REVENUE	$ 10,809,932	$ 27,555,308	$ 12,666,201	$ 10,809,932	$ 10,809,932	$ 10,809,932	$ 10,809,932
TOTAL OPERATING REVENUE	$ 349,409,252	$ 350,362,035	$ 315,094,075	$ 388,448,305	$ 398,685,817	$ 412,850,116	$ 449,375,228
OPERATING EXPENSES							
Salaries and Wages	$ 115,511,392	$ 135,133,742	$ 133,600,299	$ 129,345,785	$ 131,322,371	$ 135,256,598	$ 142,876,672
Employee Benefits	$ 22,724,183	$ 27,734,937	$ 26,990,789	$ 25,445,779	$ 25,834,626	$ 27,139,530	$ 28,321,855
Supplies	$ 16,519,824	$ 24,307,599	$ 18,246,791	$ 18,729,903	$ 19,012,438	$ 19,380,158	$ 20,308,515
Professional Fees	$ 7,539,288	$ 5,000,357	$ 4,462,678	$ 8,547,920	$ 8,676,863	$ 8,844,682	$ 9,268,364
Purchased Services	$ 95,482,570	$ 90,299,009	$ 87,677,025	$ 108,256,558	$ 109,889,576	$ 110,014,327	$ 115,284,282
Other Operating Costs	$ 18,601,106	$ 22,701,529	$ 22,419,557	$ 21,089,626	$ 21,407,757	$ 21,821,805	$ 22,867,122
Lease & Rental Fees	$ 3,151,092	$ 4,722,708	$ 5,439,426	$ 3,572,656	$ 3,626,548	$ 3,696,689	$ 3,873,770
Interest	$ 3,483,394	$ 2,972,912	$ 2,673,199	$ 10,326,652	$ 6,751,069	$ 6,893,870	$ 10,499,833
Depreciation & Amort.	$ 8,324,607	$ 12,408,637	$ 12,084,143	$ 8,378,807	$ 8,378,807	$ 10,614,683	$ 17,322,312
TOTAL	$ 291,337,455	$ 325,281,431	$ 313,593,907	$ 333,693,684	$ 334,900,054	$ 343,662,343	$ 370,622,724
INCOME/(LOSS) FROM OPERATIONS	$ 58,071,797	$ 25,080,604	$ 1,500,168	$ 54,754,621	$ 63,785,763	$ 69,187,773	$ 78,752,504
Corporate Services	$ 4,684,855	$ 4,474,795	$ 4,473,691	$ 5,199,934	$ 5,340,760	$ 5,535,923	$ 6,039,381
OPERATING MARGIN	$ 53,386,942	$ 20,605,809	$ (2,973,523)	$ 49,554,687	$ 58,445,003	$ 63,651,850	$ 72,713,123

FTE SCHEDULE				WITHOUT THE PROJECT			
	2019	2020	Nov 2021 YTD	2022	2023	2024	2025
Productive FTEs							
Management	25.46	30.84	32.29	28.51	28.95	29.41	30.69
RN	190.31	186.26	193.79	213.10	216.36	229.72	239.73
LPN	7.37	4.35	3.80	8.25	8.38	8.34	8.71
Professional	125.12	127.67	132.36	140.10	142.24	141.63	147.80
Technical	48.05	53.13	49.26	53.80	54.62	88.62	92.48
Physician	100.83	106.37	107.03	112.90	114.63	114.18	119.16
Supervision	23.76	19.04	19.70	26.60	27.01	28.07	29.30
Service/Maintenance	21.41	20.19	21.35	23.97	24.34	24.23	25.29
ARNP/PA	37.83	41.49	40.45	42.37	43.01	42.83	44.69
Resident	7.22	9.20	5.16	8.09	8.21	9.23	9.64
Orientation	9.25	6.93	8.76	10.36	10.52	11.12	11.61
Education	5.07	4.36	4.02	5.68	5.76	6.20	6.47
Professional Fixed	47.33	45.43	43.31	53.00	53.81	53.57	55.91
Other Fixed	31.80	32.35	33.99	35.61	36.16	37.37	38.99
Service & Maintenance Fixed	12.54	13.09	14.53	14.04	14.25	14.19	14.81
CNA/MA	62.97	62.59	62.30	70.52	71.59	71.28	74.39
Other	59.30	64.07	66.52	66.41	67.42	68.20	71.17
Outside Wages-Adm Mgmt Temp	1.23	0.19	-	1.37	1.40	1.39	1.45
Outside Wages-RN	16.77	10.04	6.46	18.78	19.07	21.67	22.61
Outside Wages-Other	6.79	3.63	3.78	7.60	7.72	7.69	8.02
Total Productive FTEs	840.41	841.22	848.86	941.06	955.44	1,008.95	1,052.90
Non-Productive FTEs							
Sick Leave	6.33	6.09	1.41	7.09	7.20	7.17	7.48
Vacation	7.46	7.04	8.77	8.36	8.48	8.45	8.82
Bereavement	1.07	0.93	1.61	1.20	1.22	1.27	1.33
Jury Duty	0.29	0.07	0.09	0.32	0.33	0.34	0.36
Paid Time Off (PTO)	83.56	91.45	88.35	93.57	95.00	100.75	105.14
Extended Illness (EIT)	10.62	14.07	12.26	11.89	12.07	12.90	13.46
Total Non-Productive FTEs	109.34	119.65	112.49	122.43	124.30	130.88	136.58
Allocated FTEs	-	189.00	211.52	-	-	-	-
Total FTEs	949.74	1,149.87	1,172.87	1,063.49	1,079.74	1,139.82	1,189.48

FTE SCHEDULE	WITHOUT THE PROJECT

	2019	2020	Nov 2021 YTD	2022	2023	2024	2025
Direct Salaries							
Management	4,180,873	4,538,138	4,471,270	4,681,602	4,753,143	4,849,437	5,012,410
RN	19,891,518	19,207,191	19,560,461	22,273,855	22,614,232	23,380,411	25,133,578
LPN	496,600	409,162	263,018	556,076	564,573	573,915	586,620
Professional	12,460,529	12,913,646	12,611,386	13,952,883	14,166,103	14,400,506	14,719,291
Technical	2,899,919	2,930,336	3,004,387	3,247,232	3,296,854	4,059,310	6,380,570
Physician	35,454,542	38,602,384	37,006,929	39,700,808	40,307,492	40,978,648	41,899,031
Supervision	2,396,641	2,028,554	2,063,261	2,683,679	2,724,689	2,800,740	2,960,348
Service/Maintenance	763,763	779,151	769,609	855,236	868,305	882,673	902,213
ARNP/PA	5,955,256	6,356,484	6,090,096	6,668,496	6,770,400	6,882,428	7,034,785
Resident	532,461	676,156	357,362	596,232	605,343	633,325	703,973
Orientation	731,546	560,442	611,160	819,161	831,679	855,581	906,484
Education	484,678	404,949	340,845	542,726	551,020	571,983	621,985
Professional Fixed	4,852,711	4,712,594	4,148,137	5,433,904	5,516,941	5,608,229	5,732,379
Other Fixed	1,607,067	1,630,682	1,613,747	1,799,539	1,827,039	1,876,113	1,977,039
Service & Maintenance Fixed	628,784	620,055	675,110	704,092	714,851	726,680	742,766
CNA/MA	2,978,109	2,936,609	2,932,000	3,334,787	3,385,747	3,441,770	3,517,961
Other	2,862,056	3,408,090	2,947,359	3,204,834	3,253,809	3,320,919	3,436,266
Premium	1,279,844	1,317,490	1,477,541	1,433,126	1,455,026	1,515,326	1,663,051
Sick Leave	469,117	96,685	87,408	525,301	533,329	542,154	554,155
Vacation	2,271,729	1,979,695	2,530,289	2,543,806	2,582,679	2,625,414	2,683,533
Bereavement	95,782	72,659	117,476	107,254	108,893	112,410	120,306
Jury Duty	26,665	6,771	7,591	29,858	30,315	31,082	32,608
System Initiatives Training	2,317	962	-	2,594	2,634	2,677	2,736
Paid Time Off (PTO)	7,541,000	8,282,744	7,873,683	8,444,158	8,573,197	8,867,582	9,544,665
Extended Illness (EIT)	902,110	1,196,994	998,966	1,010,153	1,025,589	1,062,970	1,150,837
Total Direct Salaries	111,765,617	115,668,624	112,559,089	125,151,391	127,063,882	130,602,281	138,019,591
Contract Labor							
Outside Wages Adm Mgmt Temp	529,142	61,444	-	592,515	601,569	598,967	625,061
Outside Wages RN	2,516,828	1,490,414	1,693,400	2,818,259	2,861,326	3,263,198	3,405,358
Outside Wages-Other	699,806	324,749	577,245	783,619	795,594	792,152	826,662
Total Contract Labor	3,745,775	1,876,607	2,270,645	4,194,393	4,258,490	4,654,317	4,857,081
Allocated Salaries	-	17,588,511	18,770,565	-	-	-	-
Total Salaries	115,511,392	135,133,742	133,600,299	129,345,784	131,322,372	135,256,598	142,876,672

BALANCE SHEET
WITHOUT THE PROJECT

	FY19	FY20	FY21	FY22	FY23	FY24	FY25
ASSETS							
CURRENT ASSETS:							
Cash and Cash Equivalents	$582,475,018	$933,797,382	$978,484,130	$972,952,280	$873,791,566	$834,731,735	$916,581,766
Accounts Receivable	$42,742,128	$44,860,400	$46,149,047	$47,441,437	$48,726,250	$50,506,817	$55,100,099
Less-Estimated Uncollectable & Allowances	$2,712,987	$2,847,440	$2,929,235	$3,011,268	$3,092,819	$3,205,838	$3,497,389
Inventory	$229,404	$240,773	$247,690	$254,626	$261,522	$271,079	$295,732
TOTAL CURRENT ASSETS	**$622,733,563**	**$976,051,114**	**$1,021,951,631**	**$1,017,637,076**	**$919,686,519**	**$882,303,794**	**$968,480,209**
PROPERTY, PLANT AND EQUIPMENT:							
Land	$774,202	$774,202	$774,202	$1,774,202	$1,774,202	$1,774,202	$1,774,202
Land Improvements	$472,407	$503,685	$656,436	$1,987,235	$4,188,509	$6,381,031	$6,381,031
Buildings	$141,185,555	$141,185,555	$141,185,555	$141,185,555	$141,185,555	$405,697,997	$405,697,997
Fixed Equipment - Building Service	$0	$0	$0	$0	$0	$0	$0
Fixed Equipment - Other	$3,354,416	$3,354,416	$3,354,416	$3,354,416	$3,354,416	$21,193,669	$21,193,669
Equipment	$33,164,958	$33,164,958	$33,164,958	$33,164,958	$33,164,958	$76,584,364	$76,584,364
Leasehold Improvements	$6,233,435	$6,233,435	$6,233,435	$6,233,435	$6,233,435	$6,233,435	$6,233,435
Construction In Progress	$0	$1,608,238	$11,158,238	$63,907,815	$219,762,340	$0	$0
TOTAL	$185,184,973	$186,824,489	$196,527,240	$251,607,616	$409,663,415	$517,864,698	$517,864,698
Less Accumulated Depreciation	$80,746,292	$89,070,898	$100,232,111	$108,610,917	$116,989,724	$127,604,407	$144,926,718
NET PROPERTY, PLANT & EQUIPMENT	**$104,438,681**	**$97,753,591**	**$96,295,129**	**$142,996,699**	**$292,673,691**	**$390,260,291**	**$372,937,980**
INVESTMENTS AND OTHER ASSETS:							
Other Assets	$418,485	$418,485	$418,485	$418,485	$418,485	$418,485	$418,485
TOTAL ASSETS	**$727,590,729**	**$1,074,223,190**	**$1,118,665,245**	**$1,161,052,259**	**$1,212,778,695**	**$1,272,982,570**	**$1,341,836,673**
LIABILITIES AND FUND BALANCES-UNRESTRICTED							
CURRENT LIABILITIES							
Other Accrued Expenses	$3,074,247	$3,320,546	$3,366,854	$3,442,439	$3,495,044	$3,599,751	$3,802,553
Current Maturities of Long Term Debt	$0	$0	$7,319,873	$7,493,894	$7,672,440	$7,855,610	$8,043,434
TOTAL CURRENT LIABILITIES	**$3,074,247**	**$3,320,546**	**$10,686,727**	**$10,936,333**	**$11,167,484**	**$11,455,360**	**$11,845,987**
LONG TERM DEBT							
Bonds Payable	$0	$300,000,000	$302,840,806	$295,597,548	$288,826,376	$285,273,694	$281,211,872
Less Current Maturities of Long Term Debt	$0	$0	$7,319,873	$7,493,894	$7,672,440	$7,855,610	$8,043,434
TOTAL LONG TERM DEBT	**$0**	**$300,000,000**	**$295,520,933**	**$288,103,655**	**$281,153,936**	**$277,418,085**	**$273,168,438**
TOTAL LIABILITIES	**$3,074,247**	**$303,320,546**	**$306,207,660**	**$299,039,988**	**$292,321,420**	**$288,873,445**	**$285,014,425**
TOTAL EQUITY	**$724,516,482**	**$770,902,644**	**$812,457,585**	**$862,012,271**	**$920,457,274**	**$984,109,125**	**$1,056,822,248**
TOTAL LIABILITIES AND EQUITY	**$727,590,729**	**$1,074,223,190**	**$1,118,665,245**	**$1,161,052,259**	**$1,212,778,695**	**$1,272,982,570**	**$1,341,836,673**

Exhibit 6C.

Financial Exhibit – The Project

INCOME STATEMENT

THE PROJECT

	2023	2024	2025
PATIENT SERVICE REVENUES:			
HB Inpatient	$ 230,164,965	$ 231,948,946	$ 233,746,754
HB Outpatient	$ -	$ -	$ -
PB Outpatient	$ -	$ -	$ -
Other	$ -	$ -	$ -
TOTAL	$ 230,164,965	$ 231,948,946	$ 233,746,754
DEDUCTIONS FROM REVENUES:			
Contractual Adjustments	$ 158,689,093	$ 159,934,575	$ 161,189,710
Charity Care	$ 3,084,211	$ 3,108,116	$ 3,132,207
Provision for Bad Debts	$ 1,137,887	$ 1,146,707	$ 1,155,595
TOTAL	$ 162,911,191	$ 164,189,397	$ 165,477,511
NET PATIENT SERVICE REVENUE	$ 67,253,775	$ 67,759,549	$ 68,269,243
OTHER OPERATING REVENUE			
TOTAL OPERATING REVENUE	$ 67,253,775	$ 67,759,549	$ 68,269,243
OPERATING EXPENSES			
Salaries and Wages	$ 20,036,938	$ 20,192,515	$ 20,348,102
Employee Benefits	$ 6,470,247	$ 6,506,962	$ 6,543,961
Supplies	$ 2,810,999	$ 2,831,737	$ 2,852,635
Professional Fees	$ 1,640,166	$ 1,643,964	$ 1,647,792
Purchased Services	$ 11,893,172	$ 11,894,995	$ 11,897,951
Other Operating Costs	$ 2,833,644	$ 2,840,206	$ 2,846,818
Lease & Rental Fees	$ -	$ -	$ -
Interest	$ -	$ -	$ -
Depreciation & Amort.	$ 2,379,193	$ 2,379,193	$ 2,379,193
TOTAL	$ 48,064,360	$ 48,289,572	$ 48,516,453
INCOME/(LOSS) FROM OPERATIONS	$ 19,189,415	$ 19,469,977	$ 19,752,790
Corporate Services	$ 614,549	$ 615,972	$ 617,406
OPERATING MARGIN	$ 18,574,865	$ 18,854,004	$ 19,135,383

FTE SCHEDULE	THE PROJECT (NICU-Specific)		
	2023	**2024**	**2025**
Productive FTEs			
Management	0.87	0.88	0.89
RN	109.32	110.17	111.02
LPN	1.41	1.42	1.43
Professional	15.69	15.81	15.93
Technical	0.13	0.13	0.13
Physician	-	-	-
Supervision	2.10	2.12	2.14
Service/Maintenance	-	-	-
ARNP/PA	-	-	-
Resident	1.41	1.42	1.43
Orientation	1.15	1.16	1.17
Education	0.88	0.89	0.90
Professional Fixed	0.17	0.17	0.17
Other Fixed	0.97	0.98	0.99
Service & Maintenance Fixed	6.42	6.47	6.52
CNA/MA	-	-	-
Other	0.35	0.35	0.35
Outside Wages-Adm Mgmt Temp	-	-	-
Outside Wages-RN	3.92	3.95	3.98
Outside Wages-Other	0.15	0.15	0.15
Total Productive FTEs	144.94	146.07	147.20
Non-Productive FTEs			
Sick Leave	0.27	0.27	0.27
Vacation	-	-	-
Bereavement	0.32	0.32	0.32
Jury Duty	-	-	-
Paid Time Off (PTO)	15.44	15.56	15.68
Extended Illness (EIT)	3.05	3.07	3.09
Total Non-Productive FTEs	19.08	19.22	19.36
Allocated FTEs	-	-	-
Total FTEs	164.02	165.29	166.56

FTE SCHEDULE	THE PROJECT (NICU-Specific)		
	2023	**2024**	**2025**
Direct Salaries			
Management	124,195	125,622	127,050
RN	14,008,906	14,117,830	14,226,754
LPN	153,966	155,058	156,150
Professional	1,618,233	1,630,610	1,642,986
Technical	9,779	9,779	9,779
Physician	-	-	-
Supervision	261,667	264,159	266,651
Service/Maintenance	-	-	-
ARNP/PA	-	-	-
Resident	113,345	114,149	114,953
Orientation	101,990	102,877	103,764
Education	102,116	103,276	104,437
Professional Fixed	24,109	24,109	24,109
Other Fixed	41,947	42,379	42,812
Service & Maintenance Fixed	365,811	368,660	371,509
CNA/MA	-	-	-
Other	20,111	20,111	20,111
Premium	250,450	252,404	254,373
Sick Leave	25,847	25,847	25,847
Vacation	-	-	-
Bereavement	29,347	29,347	29,347
Jury Duty	-	-	-
System Initiatives Training	-	-	-
Paid Time Off (PTO)	1,599,122	1,611,550	1,623,979
Extended Illness (EIT)	299,561	301,526	303,490
Total Direct Salaries	19,150,502	19,299,293	19,448,099
Contract Labor			
Outside Wages Adm Mgmt Temp	-	-	-
Outside Wages RN	886,436	893,220	900,004
Outside Wages-Other	-	-	-
Total Contract Labor	886,436	893,220	900,004
Allocated Salaries	-	-	-
Total Salaries	20,036,938	20,192,513	20,348,103

BALANCE SHEET
THE PROJECT

	FY23	FY24	FY25
ASSETS			
CURRENT ASSETS:			
Cash and Cash Equivalents	$7,519,346	$10,127,930	$12,738,393
Accounts Receivable	$6,617,771	$6,667,540	$6,717,694
Less-Estimated Uncollectable & Allowances	$0	$0	$0
Inventory	$32,889	$33,131	$33,376
TOTAL CURRENT ASSETS	**$14,170,005**	**$16,828,601**	**$19,489,463**
PROPERTY, PLANT AND EQUIPMENT:			
Land	$0	$0	$0
Land Improvements	$0	$0	$0
Buildings	$0	$0	$0
Fixed Equipment - Building Service	$0	$0	$0
Fixed Equipment - Other	$0	$0	$0
Equipment	$7,137,579	$7,137,579	$7,137,579
Leasehold Improvements	$0	$0	$0
Construction In Progress	$0	$0	$0
TOTAL	$7,137,579	$7,137,579	$7,137,579
Less Accumulated Depreciation	$2,379,193	$4,758,386	$7,137,579
NET PROPERTY, PLANT & EQUIPMENT	**$4,758,386**	**$2,379,193**	**$0**
INVESTMENTS AND OTHER ASSETS:			
Other Assets	$0	$0	$0
TOTAL ASSETS	**$18,928,391**	**$19,207,794**	**$19,489,463**
LIABILITIES AND FUND BALANCES-UNRESTRICTED			
CURRENT LIABILITIES			
Other Accrued Expenses	$353,527	$353,790	$354,079
Current Maturities of Long Term Debt	$0	$0	$0
TOTAL CURRENT LIABILITIES	**$353,527**	**$353,790**	**$354,079**
LONG TERM DEBT			
Bonds Payable	$0	$0	$0
Less Current Maturities of Long Term Debt	$0	$0	$0
TOTAL LONG TERM DEBT	**$0**	**$0**	**$0**
TOTAL LIABILITIES	**$353,527**	**$353,790**	**$354,079**
TOTAL EQUITY	**$18,574,865**	**$18,854,004**	**$19,135,383**
TOTAL LIABILITIES AND EQUITY	**$18,928,391**	**$19,207,794**	**$19,489,463**

Exhibit 6D.

Financial Exhibit – With the Project

INCOME STATEMENT
WITH THE PROJECT

	2019	2020	Nov 2021 YTD	2022	2023	2024	2025
PATIENT SERVICE REVENUES:							
HB Inpatient	$ 303,260,623	$ 257,659,591	$ 249,656,858	$ 314,879,437	$ 550,853,809	$ 560,502,580	$ 583,214,254
HB Outpatient	$ 520,859,184	$ 485,020,557	$ 449,839,665	$ 555,180,049	$ 572,535,778	$ 596,827,041	$ 659,307,664
PB Outpatient	$ 110,009,437	$ 119,952,161	$ 142,050,521	$ 168,314,424	$ 173,650,277	$ 180,992,512	$ 199,490,696
Other	$ 14,018,472	$ 2,686,704	$ 4,786,979	$ 14,018,472	$ 14,018,472	$ 14,018,472	$ 14,018,472
TOTAL	$ 948,147,715	$ 865,319,013	$ 846,334,023	$ 1,052,392,382	$ 1,311,058,336	$ 1,352,340,605	$ 1,456,031,085
DEDUCTIONS FROM REVENUES:							
Contractual Adjustments	$ 596,130,527	$ 529,857,612	$ 532,332,719	$ 656,064,509	$ 832,510,928	$ 858,388,946	$ 923,202,124
Charity Care	$ 7,862,613	$ 7,660,514	$ 5,430,896	$ 12,523,469	$ 15,946,842	$ 16,440,777	$ 17,677,390
Provision for Bad Debts	$ 5,555,255	$ 4,994,159	$ 6,142,533	$ 6,166,031	$ 7,470,907	$ 7,711,149	$ 8,317,033
TOTAL	$ 609,548,395	$ 542,512,286	$ 543,906,149	$ 674,754,009	$ 855,928,677	$ 882,540,872	$ 949,196,546
NET PATIENT SERVICE REVENUE	$ 338,599,320	$ 322,806,727	$ 302,427,874	$ 377,638,373	$ 455,129,659	$ 469,799,733	$ 506,834,539
OTHER OPERATING REVENUE	$ 10,809,932	$ 27,555,308	$ 12,666,201	$ 10,809,932	$ 10,809,932	$ 10,809,932	$ 10,809,932
TOTAL OPERATING REVENUE	$ 349,409,252	$ 350,362,035	$ 315,094,075	$ 388,448,305	$ 465,939,591	$ 480,609,665	$ 517,644,471
OPERATING EXPENSES							
Salaries and Wages	$ 115,511,392	$ 135,133,742	$ 133,600,299	$ 129,345,785	$ 151,359,309	$ 155,449,113	$ 163,224,774
Employee Benefits	$ 22,724,183	$ 27,734,937	$ 26,990,789	$ 25,445,779	$ 32,304,873	$ 33,646,492	$ 34,865,816
Supplies	$ 16,519,824	$ 24,307,599	$ 18,246,791	$ 18,729,903	$ 21,823,438	$ 22,211,895	$ 23,161,151
Professional Fees	$ 7,539,288	$ 5,000,357	$ 4,462,678	$ 8,547,920	$ 10,317,029	$ 10,488,647	$ 10,916,156
Purchased Services	$ 95,482,570	$ 90,299,009	$ 87,677,025	$ 108,256,558	$ 121,782,747	$ 121,909,322	$ 127,182,232
Other Operating Costs	$ 18,601,106	$ 22,701,529	$ 22,419,557	$ 21,089,626	$ 24,241,401	$ 24,662,011	$ 25,713,941
Lease & Rental Fees	$ 3,151,092	$ 4,722,708	$ 5,439,426	$ 3,572,656	$ 3,626,548	$ 3,696,689	$ 3,873,770
Interest	$ 3,483,394	$ 2,972,912	$ 2,673,199	$ 10,326,652	$ 6,751,069	$ 6,893,870	$ 10,499,833
Depreciation & Amort.	$ 8,324,607	$ 12,408,637	$ 12,084,143	$ 8,378,807	$ 10,758,000	$ 12,993,876	$ 19,701,505
TOTAL	$ 291,337,455	$ 325,281,431	$ 313,593,907	$ 333,693,684	$ 382,964,414	$ 391,951,915	$ 419,139,177
INCOME/(LOSS) FROM OPERATIONS	$ 58,071,797	$ 25,080,604	$ 1,500,168	$ 54,754,621	$ 82,975,177	$ 88,657,750	$ 98,505,294
Corporate Services	$ 4,684,855	$ 4,474,795	$ 4,473,691	$ 5,199,934	$ 5,955,309	$ 6,151,895	$ 6,656,787
OPERATING MARGIN	$ 53,386,942	$ 20,605,809	$ (2,973,523)	$ 49,554,687	$ 77,019,868	$ 82,505,854	$ 91,848,507

FTE SCHEDULE				WITH THE PROJECT			
	2019	2020	Nov 2021 YTD	2022	2023	2024	2025
Productive FTEs							
Management	25.46	30.84	32.29	28.51	29.82	30.29	31.58
RN	190.31	186.26	193.79	213.10	325.68	339.89	350.75
LPN	7.37	4.35	3.80	8.25	9.79	9.76	10.14
Professional	125.12	127.67	132.36	140.10	157.93	157.44	163.73
Technical	48.05	53.13	49.26	53.80	54.75	88.75	92.61
Physician	100.83	106.37	107.03	112.90	114.63	114.18	119.16
Supervision	23.76	19.04	19.70	26.60	29.11	30.19	31.44
Service/Maintenance	21.41	20.19	21.35	23.97	24.34	24.23	25.29
ARNP/PA	37.83	41.49	40.45	42.37	43.01	42.83	44.69
Resident	7.22	9.20	5.16	8.09	9.62	10.65	11.07
Orientation	9.25	6.93	8.76	10.36	11.67	12.28	12.78
Education	5.07	4.36	4.02	5.68	6.64	7.09	7.37
Professional Fixed	47.33	45.43	43.31	53.00	53.98	53.74	56.08
Other Fixed	31.80	32.35	33.99	35.61	37.13	38.35	39.98
Service & Maintenance Fixed	12.54	13.09	14.53	14.04	20.67	20.66	21.33
CNA/MA	62.97	62.59	62.30	70.52	71.59	71.28	74.39
Other	59.30	64.07	66.52	66.41	67.77	68.55	71.52
Outside Wages-Adm Mgmt Temp	1.23	0.19	-	1.37	1.40	1.39	1.45
Outside Wages-RN	16.77	10.04	6.46	18.78	22.99	25.62	26.59
Outside Wages-Other	6.79	3.63	3.78	7.60	7.87	7.84	8.17
Total Productive FTEs	840.41	841.22	848.86	941.06	1,100.39	1,155.01	1,200.12
Non-Productive FTEs							
Sick Leave	6.33	6.09	1.41	7.09	7.47	7.44	7.75
Vacation	7.46	7.04	8.77	8.36	8.48	8.45	8.82
Bereavement	1.07	0.93	1.61	1.20	1.54	1.59	1.65
Jury Duty	0.29	0.07	0.09	0.32	0.33	0.34	0.36
Paid Time Off (PTO)	83.56	91.45	88.35	93.57	110.44	116.31	120.82
Extended Illness (EIT)	10.62	14.07	12.26	11.89	15.12	15.97	16.55
Total Non-Productive FTEs	109.34	119.65	112.49	122.43	143.38	150.10	155.95
Allocated FTEs	-	189.00	211.52	-	-	-	-
Total FTEs	949.74	1,149.87	1,172.87	1,063.49	1,243.77	1,305.11	1,356.07

FTE SCHEDULE				WITH THE PROJECT			
	2019	**2020**	**Nov 2021 YTD**	**2022**	**2023**	**2024**	**2025**
Direct Salaries							
Management	4,180,873	4,538,138	4,471,270	4,681,602	4,877,338	4,975,059	5,139,460
RN	19,891,518	19,207,191	19,560,461	22,273,855	36,623,138	37,498,241	39,360,332
LPN	496,600	409,162	263,018	556,076	718,539	728,973	742,770
Professional	12,460,529	12,913,646	12,611,386	13,952,883	15,784,336	16,031,116	16,362,277
Technical	2,899,919	2,930,336	3,004,387	3,247,232	3,306,633	4,069,089	6,390,349
Physician	35,454,542	38,602,384	37,006,929	39,700,808	40,307,492	40,978,648	41,899,031
Supervision	2,396,641	2,028,554	2,063,261	2,683,679	2,986,356	3,064,899	3,226,999
Service/Maintenance	763,763	779,151	769,609	855,236	868,305	882,673	902,213
ARNP/PA	5,955,256	6,356,484	6,090,096	6,668,496	6,770,400	6,882,428	7,034,785
Resident	532,461	676,156	357,362	596,232	718,688	747,474	818,926
Orientation	731,546	560,442	611,160	819,161	933,669	958,458	1,010,248
Education	484,678	404,949	340,845	542,726	653,136	675,259	726,422
Professional Fixed	4,852,711	4,712,594	4,148,137	5,433,904	5,541,050	5,632,338	5,756,488
Other Fixed	1,607,067	1,630,682	1,613,747	1,799,539	1,868,986	1,918,492	2,019,851
Service & Maintenance Fixed	628,784	620,055	675,110	704,092	1,080,662	1,095,340	1,114,275
CNA/MA	2,978,109	2,936,609	2,932,000	3,334,787	3,385,747	3,441,770	3,517,961
Other	2,862,056	3,408,090	2,947,359	3,204,834	3,273,920	3,341,030	3,456,377
Premium	1,279,844	1,317,490	1,477,541	1,433,126	1,705,476	1,767,730	1,917,424
Sick Leave	469,117	96,685	87,408	525,301	559,176	568,001	580,002
Vacation	2,271,729	1,979,695	2,530,289	2,543,806	2,582,679	2,625,414	2,683,533
Bereavement	95,782	72,659	117,476	107,254	138,240	141,757	149,653
Jury Duty	26,665	6,771	7,591	29,858	30,315	31,082	32,608
System Initiatives Training	2,317	962	-	2,594	2,634	2,677	2,736
Paid Time Off (PTO)	7,541,000	8,282,744	7,873,683	8,444,158	10,172,319	10,479,132	11,168,644
Extended Illness (EIT)	902,110	1,196,994	998,966	1,010,153	1,325,150	1,364,496	1,454,327
Total Direct Salaries	111,765,617	115,668,624	112,559,089	125,151,392	146,214,384	149,901,576	157,467,689
Contract Labor							
Outside Wages Adm Mgmt Temp	529,142	61,444	-	592,515	601,569	598,967	625,061
Outside Wages RN	2,516,828	1,490,414	1,693,400	2,818,259	3,747,762	4,156,418	4,305,362
Outside Wages-Other	699,806	324,749	577,245	783,619	795,594	792,152	826,662
Total Contract Labor	3,745,775	1,876,607	2,270,645	4,194,393	5,144,925	5,547,537	5,757,085
Allocated Salaries	-	17,588,511	18,770,565	-	-	-	-
Total Salaries	115,511,392	135,133,742	133,600,299	129,345,785	151,359,309	155,449,113	163,224,774

BALANCE SHEET
WITH THE PROJECT

	FY19	FY20	FY21	FY22	FY23	FY24	FY25
ASSETS							
CURRENT ASSETS:							
Cash and Cash Equivalents	$582,475,018	$933,797,382	$978,484,130	$972,952,280	$881,310,912	$844,859,665	$929,320,159
Accounts Receivable	$42,742,128	$44,860,400	$46,149,047	$47,441,437	$55,344,021	$57,174,357	$61,817,793
Less-Estimated Uncollectable & Allowances	$2,712,987	$2,847,440	$2,929,235	$3,011,268	$3,092,819	$3,205,838	$3,497,389
Inventory	$229,404	$240,773	$247,690	$254,626	$294,411	$304,210	$329,107
TOTAL CURRENT ASSETS	**$622,733,563**	**$976,051,114**	**$1,021,951,631**	**$1,017,637,076**	**$933,856,525**	**$899,132,395**	**$987,969,671**
PROPERTY, PLANT AND EQUIPMENT:							
Land	$774,202	$774,202	$774,202	$1,774,202	$1,774,202	$1,774,202	$1,774,202
Land Improvements	$472,407	$503,685	$656,436	$1,987,235	$4,188,509	$6,381,031	$6,381,031
Buildings	$141,185,555	$141,185,555	$141,185,555	$141,185,555	$141,185,555	$405,697,997	$405,697,997
Fixed Equipment - Building Service	$0	$0	$0	$0	$0	$0	$0
Fixed Equipment - Other	$3,354,416	$3,354,416	$3,354,416	$3,354,416	$3,354,416	$21,193,669	$21,193,669
Equipment	$33,164,958	$33,164,958	$33,164,958	$33,164,958	$40,302,537	$83,721,943	$83,721,943
Leasehold Improvements	$6,233,435	$6,233,435	$6,233,435	$6,233,435	$6,233,435	$6,233,435	$6,233,435
Construction In Progress	$0	$1,608,238	$11,158,238	$63,907,815	$219,762,340	$0	$0
TOTAL	$185,184,973	$186,824,489	$196,527,240	$251,607,616	$416,800,994	$525,002,277	$525,002,277
Less Accumulated Depreciation	$80,746,292	$89,070,898	$100,232,111	$108,610,917	$119,368,917	$132,362,793	$152,064,297
NET PROPERTY, PLANT & EQUIPMENT	**$104,438,681**	**$97,753,591**	**$96,295,129**	**$142,996,699**	**$297,432,077**	**$392,639,484**	**$372,937,980**
INVESTMENTS AND OTHER ASSETS:							
Other Assets	$418,485	$418,485	$418,485	$418,485	$418,485	$418,485	$418,485
TOTAL ASSETS	**$727,590,729**	**$1,074,223,190**	**$1,118,665,245**	**$1,161,052,259**	**$1,231,707,086**	**$1,292,190,364**	**$1,361,326,135**
LIABILITIES AND FUND BALANCES-UNRESTRICTED							
CURRENT LIABILITIES							
Other Accrued Expenses	$3,074,247	$3,320,546	$3,366,854	$3,442,439	$3,848,571	$3,953,541	$4,156,633
Current Maturities of Long Term Debt	$0	$0	$7,319,873	$7,493,894	$7,672,440	$7,855,610	$8,043,434
TOTAL CURRENT LIABILITIES	**$3,074,247**	**$3,320,546**	**$10,686,727**	**$10,936,333**	**$11,521,011**	**$11,809,150**	**$12,200,066**
LONG TERM DEBT							
Bonds Payable	$0	$300,000,000	$302,840,806	$295,597,548	$288,826,376	$285,273,694	$281,211,872
Less Current Maturities of Long Term Debt	$0	$0	$7,319,873	$7,493,894	$7,672,440	$7,855,610	$8,043,434
TOTAL LONG TERM DEBT	**$0**	**$300,000,000**	**$295,520,933**	**$288,103,655**	**$281,153,936**	**$277,418,085**	**$273,168,438**
TOTAL LIABILITIES	**$3,074,247**	**$303,320,546**	**$306,207,660**	**$299,039,988**	**$292,674,947**	**$289,227,235**	**$285,368,505**
TOTAL EQUITY	**$724,516,482**	**$770,902,644**	**$812,457,585**	**$862,012,271**	**$939,032,139**	**$1,002,963,129**	**$1,075,957,631**
TOTAL LIABILITIES AND EQUITY	**$727,590,729**	**$1,074,223,190**	**$1,118,665,245**	**$1,161,052,259**	**$1,231,707,086**	**$1,292,190,364**	**$1,361,326,136**

Exhibit 7A.

Tax Parcel Map – ICN/NICU

PublicGIS

Disclaimer: The map features are approximate and have not been surveyed. Additional features not yet mapped may be present. Pierce County assumes no liability for variations ascertained by formal survey.

Date: 1/20/2022 06:35 PM

Exhibit 7B.

Tax Parcel Summary Reports – ICN/NICU

Pierce County Assessor-Treasurer
Property Summary

316 S I ST

TACOMA GENERAL HOSPITAL
2003180031

Tax Description

Section 32 Township 21 Range 03 Quarter 43 NEW TACOMA PARCEL "B" OF DBLA 2007-05-10-5007 DESC AS L 7 THRU 9 B 318 TOG/W E 1/2 ALLEY ABUTT VAC BY ORD 1942 & 20089 OUT OF 003-0 SEG 2008-0036 JU 7/19/07JU

Property Details

Parcel Number	2003180031
Site Address	316 S I ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	334,900
Tax Year	2022	**Assessed Land**	334,900
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$334,900

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

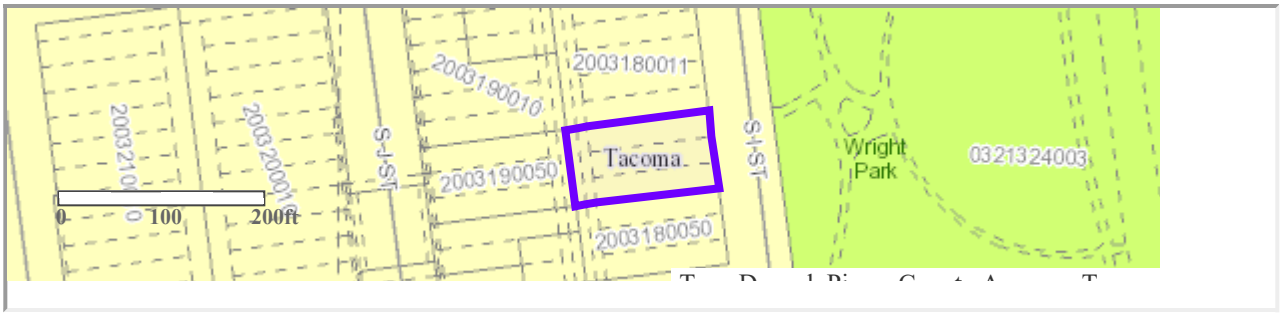
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	10,488
Acres	0.241
Front Foot	0
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

324 S I ST

TACOMA GENERAL HOSPITAL
2003180050

Tax Description

Section 32 Township 21 Range 03 Quarter 43 : NEW TACOMA L 10 THRU 12 B 318 INCL PART ALLEY VAC (DCCAES10-1-84)

Property Details

Parcel Number	2003180050
Site Address	324 S I ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	335,300
Tax Year	2022	**Assessed Land**	335,300
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0

Notice of Value Mailing Date 06/25/2021

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$335,300

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

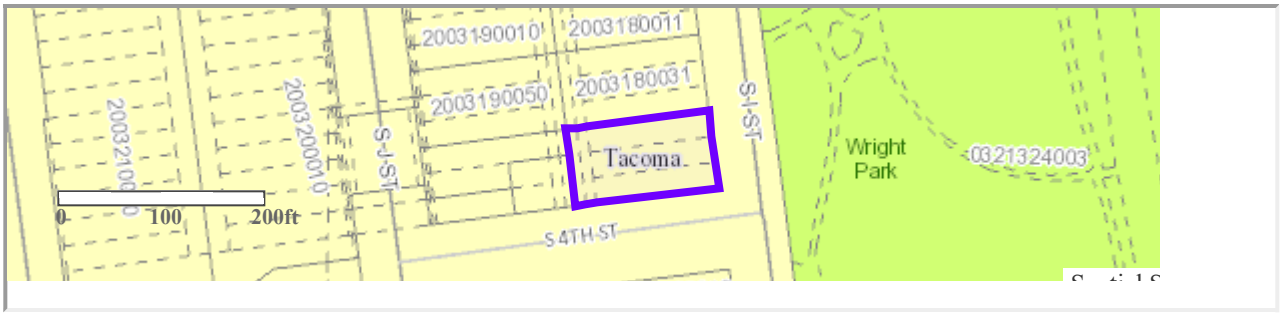
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	10,500
Acres	0.241
Front Foot	225
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

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Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX S J ST

TACOMA GENERAL HOSPITAL
2003190050

Tax Description

Section 32 Township 21 Range 03 Quarter 43 : NEW TACOMA SW OF SE 32-21-03E L 7 THRU 9 B 319 INC PT ALLEY VAC ALSO INC E 3.5 FT J ST VAC TOG/W VAC AIRSPACE PER ORD #20393 & 22971 (DCCBEMS6-17- 81) DC 6/21/99 MA

Property Details

Parcel Number	2003190050
Site Address	XXX S J ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	343,700
Tax Year	2022	**Assessed Land**	343,700
Taxable Value	0	**Assessed Improvements**	0
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$343,700

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

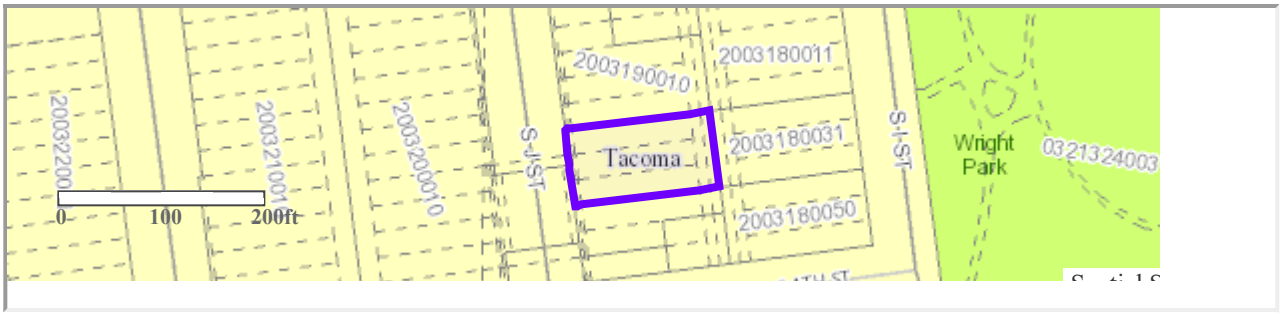
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	10,763
Acres	0.247
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX S 4TH ST

TACOMA GENERAL HOSPITAL
2003190060

Tax Description

Section 32 Township 21 Range 03 Quarter 43 L 10 & WLY 80 FT L 11 B 319 TOG/W E 3.5 FT J ST ABUTT VAC ORD 22971 INCL PT ALLEY VAC 1942 & 20089 TOG/W E 3.5 FT OF S 7 FT L 11 ABUTT VAC ORD #22903 ALSO TOG/W VAC AIRSPACE ORD 20393 (DCGRES8-26-83) DC00179016 12/6/12 KG

Property Details

Parcel Number	2003190060
Site Address	XXX S 4TH ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	181,200
Tax Year	2022	**Assessed Land**	181,200
Taxable Value	0	**Assessed Improvements**	0
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$181,200

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

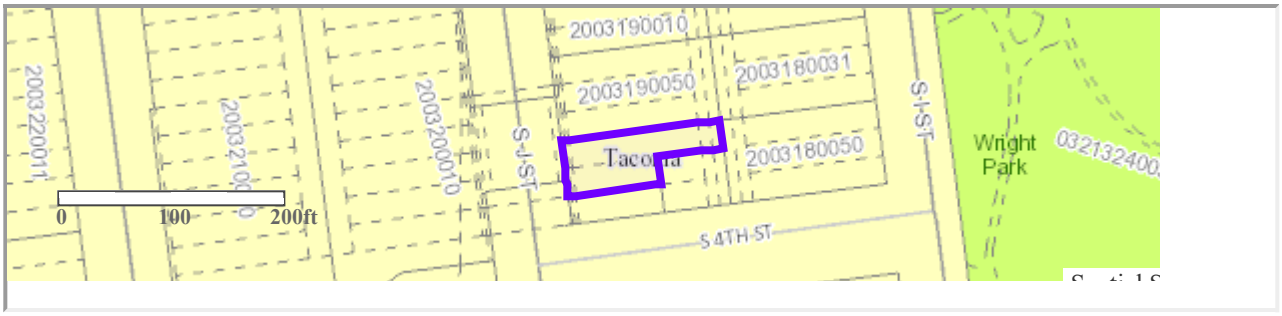
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	5,676
Acres	0.130
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX S 4TH ST

TACOMA GENERAL HOSPITAL
2003190070

Tax Description

Section 32 Township 21 Range 03 Quarter 43 : NEW TACOMA E 40 FT OF L 11 & 12 B 319 INC PT ALLEY VAC

Property Details

Parcel Number	2003190070
Site Address	XXX S 4TH ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	95,800
Tax Year	2022	**Assessed Land**	95,800
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$95,800

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

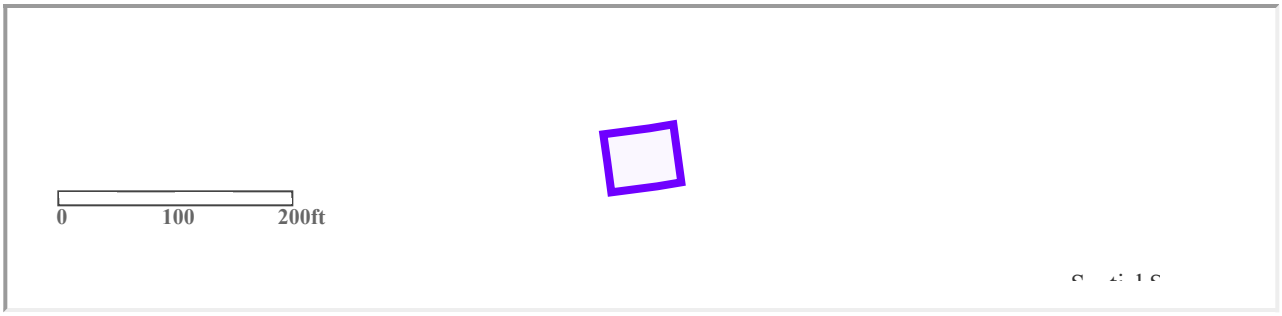
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	3,000
Acres	0.069
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX S 4TH ST

TACOMA GENERAL HOSPITAL
2003190080

Tax Description

Section 32 Township 21 Range 03 Quarter 43 : NEW TACOMA W 80 FT OF L 12 B 319 TOG/W E 3.5 FT OF "J" ST VAC UNDER ORD #22903 SW OF SW 32-21-03E APPROX 2088 SQ FT (DCGRES8-30-83)

Property Details

Parcel Number	2003190080
Site Address	XXX S 4TH ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	66,700
Tax Year	2022	**Assessed Land**	66,700
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$66,700

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

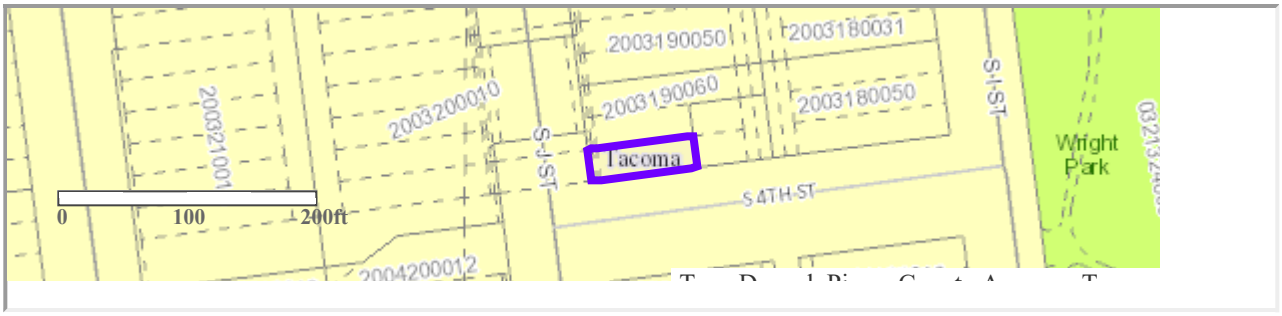
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	2,088
Acres	0.048
Front Foot	450
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

315 MARTIN LUTHER KING J WY

TACOMA GENERAL HOSPITAL
2003200010

Tax Description

Section 32 Township 21 Range 03 Quarter 34 : NEW TACOMA SE OF SW 32-21-03E L 1 THRU 12 B 320 TOG/W VAC 4TH ST & ALLEY PER ORD #17841, #1704, #22495 & 25135 TOG/W 17 FT VAC 3RD ST PER ORD #16573 TOG/W 3.5 FT J ST VAC TOG/W VAC AIRSPACE PER ORD #20393 & #24531 APPROX 51,230 SQ FT DCCBEMS6-17-81 DCPLEMS5-21-82 DCGRES8-31-83 DC8668SG05-27-93 DC6/4/96JU

Property Details

Parcel Number	2003200010
Site Address	315 MARTIN LUTHER KING J WY
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	405 / 830
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	07/13/2021-New Construction
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	1200069713 1200084244 1200112691

Assessed Value

Value Year	2021	**Assessed Total**	182,261,000
Tax Year	2022	**Assessed Land**	1,635,800
		Assessed Improvements	180,625,200
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value $0
Assessed Value $182,261,000

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year 2022
Type Non-Profit Caregivers, Libraries
Expiration Date n/a

Tax Year 2021
Type Non-Profit Caregivers, Libraries
Expiration Date n/a

Land Details

Land Economic Area 2045
RTSQQ 03-21-32-34
Value Area PI5
Neighborhood 405 / 830
Square Footage 51,230
Acres 1.176
Front Foot 740
Electric Power Installed
Sewer Sewer/Septic Installed
Water Water Installed

Building 1 Details

General Characteristics

Property Type	Commercial
Condition	Average
Quality	Good
Neighborhood	405
Occupancy	Medical
Square Feet	443,793
Net Square Feet	443,793
Attached Garage Square Feet	0
Detached Garage Square Feet	0
Carport Square Feet	0
Finished Attic Square Feet	0
Total Basement Square Feet	0
Finished Basement Square Feet	0
Basement Garage Door	0
Fireplaces	0

Built-As

DESCRIPTION	Hospital
YEAR BUILT	1965
ADJUSTED YEAR BUILT	1986
SQUARE FEET	318,473
STORIES	7
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Warm and Cool Air Zone
UNITS	0
SPRINKLER SQUARE FEET	318,473

DESCRIPTION	Hospital
YEAR BUILT	2013
ADJUSTED YEAR BUILT	2013
SQUARE FEET	125,320
STORIES	7
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Fireproof Steel
ROOF	n/a
HVAC	Complete HVAC
UNITS	0
SPRINKLER SQUARE FEET	0

Building 3 Details

General Characteristics

Property Type	Commercial
Condition	Average
Quality	Good
Neighborhood	405
Occupancy	Medical
Square Feet	55,120
Net Square Feet	55,120
Attached Garage Square Feet	0
Detached Garage Square Feet	0
Carport Square Feet	0
Finished Attic Square Feet	0
Total Basement Square Feet	0
Finished Basement Square Feet	0
Basement Garage Door	0
Fireplaces	0

Built-As

DESCRIPTION	Hospital
YEAR BUILT	1994
ADJUSTED YEAR BUILT	1994
SQUARE FEET	55,120
STORIES	2
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Package Unit
UNITS	1
SPRINKLER SQUARE FEET	0

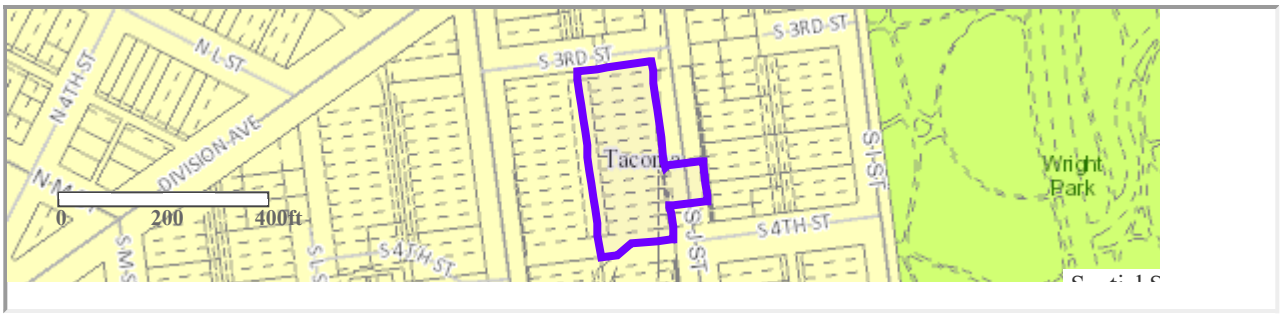
Improvement Details

Type	Description	Units
Basement	Parking	27,560

Sales History

Sorry, no sales available for display

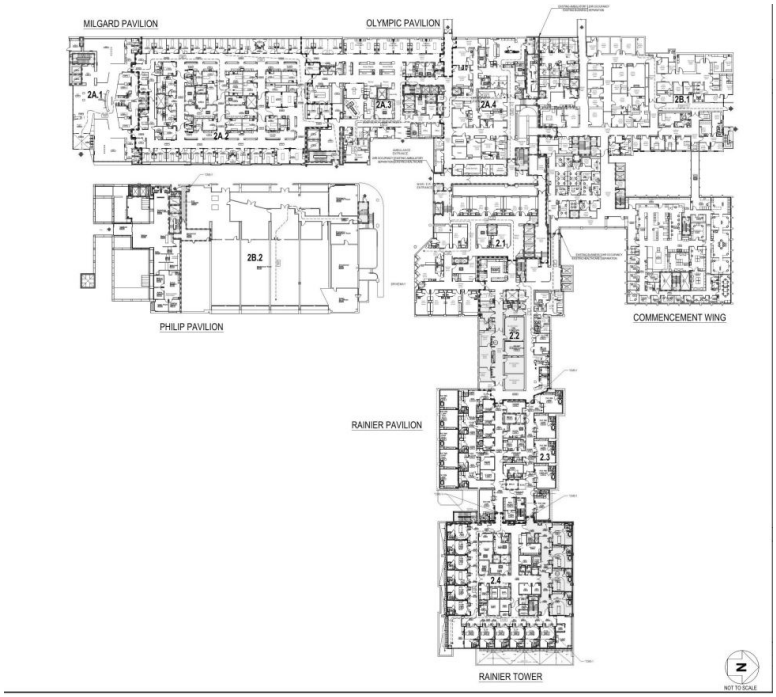
Map



Photos

Sorry, no photo available for display

Sketches



2020_PRI_7-27-2020_TG-Mary Bridge.JPG

Pierce County Assessor-Treasurer
Property Summary

315 MARTIN LUTHER KING J WY

TACOMA GENERAL HOSPITAL
2003210010

Tax Description

Section 32 Township 21 Range 03 Quarter 34 L 1 THRU 12 B 321 TOG/W VAC S 4TH ST & VAC ALLEY PER ORD #17841, #1704 & #22495 TOG/W S 17 FT VAC S 3RD ST PER ORD #16753 TOG/W 4 IN STRIP "K" ST ABUTT VAC PER ORD #22732 APPROX (DCPLEMS5-21-82) DCGRES3-30-83 DC6/3/96JU

Property Details

Parcel Number	2003210010
Site Address	315 MARTIN LUTHER KING J WY
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	405 / 830
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	07/13/2021-New Construction
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	1200203778 2006886717 2099002730 2818070635

Assessed Value

Value Year	2021	**Assessed Total**	134,506,300
Tax Year	2022	**Assessed Land**	1,598,700
		Assessed Improvements	132,907,600
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	09/24/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$134,506,300

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	405 / 830
Square Footage	50,068
Acres	1.149
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Building 1 Details

General Characteristics

Property Type	Commercial
Condition	Average
Quality	Good
Neighborhood	405
Occupancy	Medical
Square Feet	361,000
Net Square Feet	361,000
Attached Garage Square Feet	0
Detached Garage Square Feet	0
Carport Square Feet	0
Finished Attic Square Feet	0
Total Basement Square Feet	0
Finished Basement Square Feet	0
Basement Garage Door	0
Fireplaces	0

Built-As

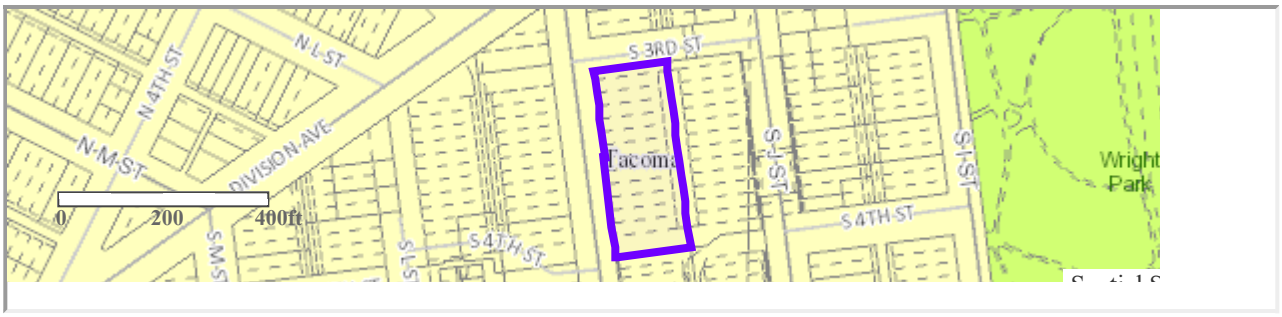
DESCRIPTION	Hospital
YEAR BUILT	1983
ADJUSTED YEAR BUILT	2000
SQUARE FEET	185,000
STORIES	7
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Warm and Cool Air Zone
UNITS	0
SPRINKLER SQUARE FEET	185,000

DESCRIPTION	Hospital
YEAR BUILT	2003
ADJUSTED YEAR BUILT	2006
SQUARE FEET	176,000
STORIES	4
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Complete HVAC
UNITS	0
SPRINKLER SQUARE FEET	176,000

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX S J ST

TACOMA GENERAL HOSPITAL
2004200012

Tax Description

Section 32 Township 21 Range 03 Quarter 34 : NEW TACOMA SE OF SW 32-21-03E L 1 THRU 6 B 420 TOG/W 1/2 4TH ST ABUTT VAC BY ORD 17841 TOG/W 3.5 FT J ST VAC PER ORD 25135 TOG/W 1/2 VAC ALLEY ABUTT SD L 1 & 2 & VAC 4TH ST & ALL OF VAC ALLEY ABUTT SD L 3 THRU 6 PER ETN 980442 APPROX 29,265 SQ FT SEG G-6008 GN DCCBEMS6-17-81 DCPLEMS5-21-82 DC10455SG05-17-94SG DC6/4/96JU DC1/14/00JU

Property Details

Parcel Number	2004200012
Site Address	XXX S J ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	934,500
Tax Year	2022	**Assessed Land**	934,500
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$934,500

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	/
Square Footage	29,265
Acres	0.672
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map

Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

315 S K ST

TACOMA GENERAL HOSPITAL
2004200013

Tax Description

Section 32 Township 21 Range 03 Quarter 34 : NEW TACOMA SE OF SW 32-21-03E L 7 B 420 TOG/W 1/2 ALLEY VAC TOG/W 3.5 FT J ST VAC PER ORD 25135 APPROX 3588 SQ FT SEG G-6008 GN DCCBEMS6-17-81 DC10456 SG 5-17-94SG DC6/4/96JU

Property Details

Parcel Number	2004200013
Site Address	315 S K ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	2700074000

Assessed Value

Value Year	2021	**Assessed Total**	114,600
Tax Year	2022	**Assessed Land**	114,600
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$114,600

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

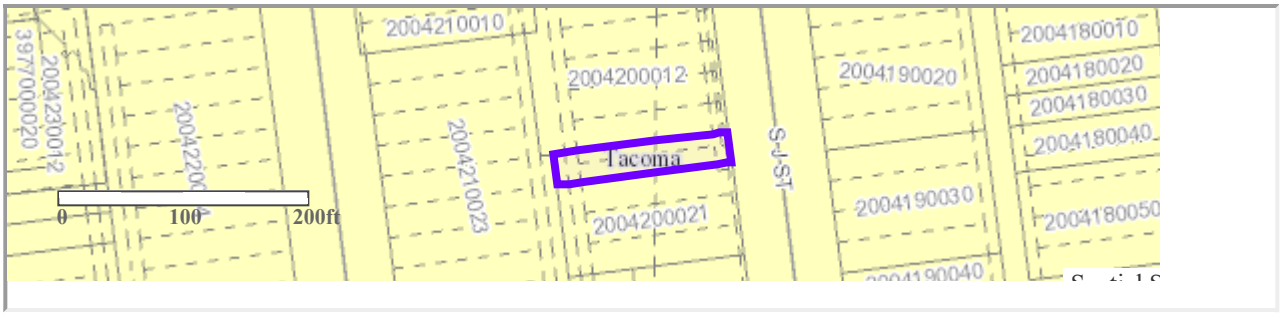
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	/
Square Footage	3,588
Acres	0.082
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

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Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

315 S K ST

TACOMA GENERAL HOSPITAL
2004200021

Tax Description

Section 32 Township 21 Range 03 Quarter 34 : NEW TACOMA SE OF SW 32-21-03E L 8 THRU 10 TOG/W 1/2 ALLEY VAC TOG/W 3.5 FT J ST ABUTT VAC PER ORD 25135 APPROX 10,763 SQ FT SEG G-6008GN DCCBEMS6-17-81 DC10457SG 5-17-94SG DC6/4/96JU

Property Details

Parcel Number	2004200021
Site Address	315 S K ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	343,700
Tax Year	2022	**Assessed Land**	343,700
Taxable Value	0	**Assessed Improvements**	0
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$343,700

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

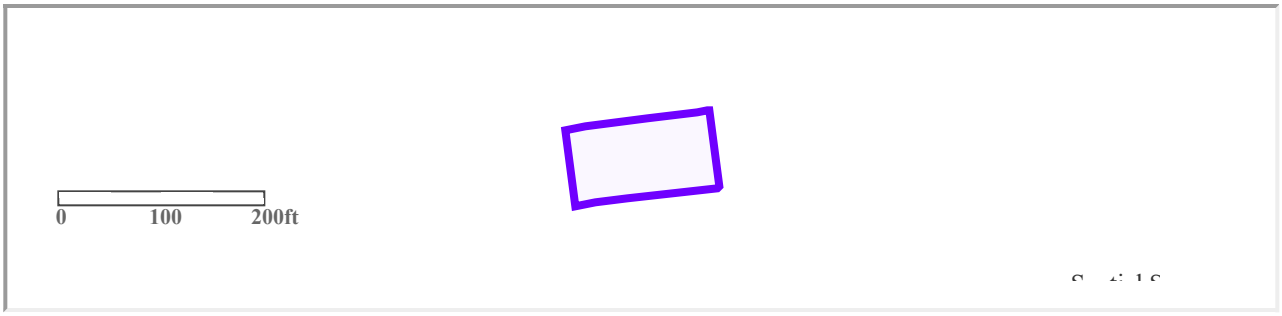
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	/
Square Footage	10,763
Acres	0.247
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

424 S J ST

TACOMA GENERAL HOSPITAL
2004200030

Tax Description

Section 32 Township 21 Range 03 Quarter 43 : NEW TACOMA ELY 93.5 FT OF L 11 & 12 B 420 TOG/W 1/2 5TH ST ABUTT TOG/W 3.5 FT J ST ABUTT VAC PER ORD 25135 APPROX 8685 SQ FTDC6/4/96JU

Property Details

Parcel Number	2004200030
Site Address	424 S J ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	277,300
Tax Year	2022	**Assessed Land**	277,300
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$277,300

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

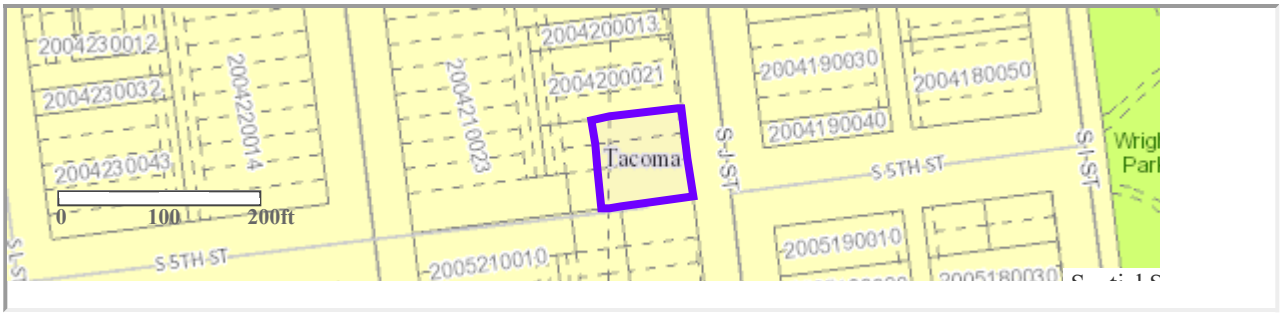
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-43
Value Area	PI5
Neighborhood	/
Square Footage	8,685
Acres	0.199
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

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Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX S 5TH ST

CONSOLIDATED HOSPITALS
2004200040

Tax Description

Section 32 Township 21 Range 03 Quarter 34 : NEW TACOMA SE OF SW 32-21-03E WLY 36.5 FT OF L 11 & 12 B 420 TOG/W 1/2 5TH ST ABUTT TOG/W 1/2 ALLEY VAC PER ORD 25135 APPROX 4285 SQ FT DC10458SG 05-17-94SG DC6/4/96JU

Property Details

Parcel Number	2004200040
Site Address	XXX S 5TH ST
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	CONSOLIDATED HOSPITALS
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	136,800
Tax Year	2022	**Assessed Land**	136,800
Taxable Value	0	**Assessed Improvements**	0
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$136,800

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	/
Square Footage	4,285
Acres	0.098
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map

Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

XXX MARTIN LUTHER KING WY

TACOMA GENERAL HOSPITAL
2004210010

Tax Description

Section 32 Township 21 Range 03 Quarter 34 : NEW TACOMA SE OF SW 32-21-03E L 1 & 2 INCL VAC ALLEY TOG/W S 1/2 4TH ST ABUTT VAC PER ORD 17811 & 22495 TOG/W 4 IN K ST ABUTT VAC PER ORD 22732 APPROX 12,627 SQ FT DCCBMEMS6-17-81 DCPLEMS5-21-82 DCGREMS3-30-83 DC10453SG05-17-94SG DC6/4/96JU

Property Details

Parcel Number	2004210010
Site Address	XXX MARTIN LUTHER KING WY
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	/
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	03/14/2018-Physical Inspection
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	n/a

Assessed Value

Value Year	2021	**Assessed Total**	403,200
Tax Year	2022	**Assessed Land**	403,200
		Assessed Improvements	0
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$403,200

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

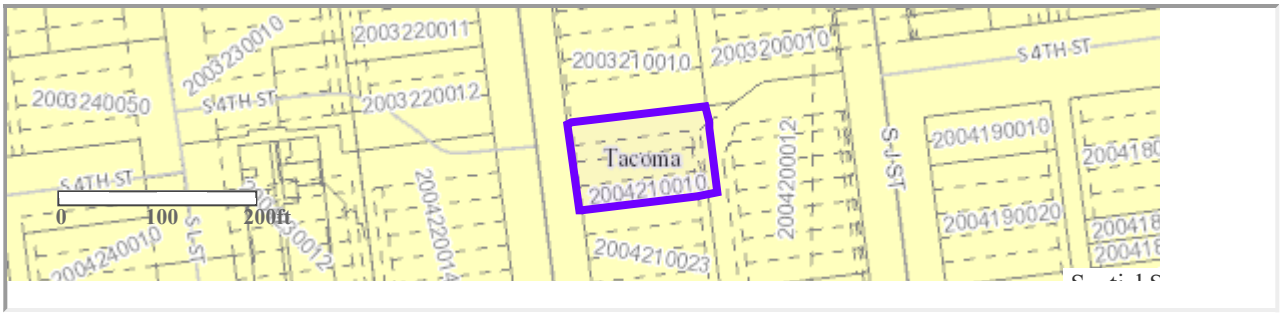
Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	/
Square Footage	12,627
Acres	0.290
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Sales History

Sorry, no sales available for display

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Pierce County Assessor-Treasurer
Property Summary

423 MARTIN LUTHER KING J WY

MULTICARE HEALTH SYSTEMS
2004210023

Tax Description

Section 32 Township 21 Range 03 Quarter 34 NEW TACOMA L 3 THRU 12 B 421 TOG/W 1/2 VAC ALLEY ABUTT S 150 FT THEREOF TOG/W 1/2 VAC ST ABUTT PER CY OF TACOMA ORD 27683 COMB TO RESTORE PARCEL SEGGED FOR TAX PURPOSES ONLY COMB 002-1 & 002-2 SEG L-0496 JU DC10/23/08SK

Property Details

Parcel Number	2004210023
Site Address	423 MARTIN LUTHER KING J WY
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	MULTICARE HEALTH SYSTEMS
Mailing Address	PO BOX 5299 TACOMA, WA 98415-0299

Appraisal Details

Neighborhood	405 / 830
Value Area	PI5
Appr Acct Type	Commercial
Business Name	
Last Inspection	07/29/2019-New Construction
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	1200098372 1200098390 1200140597 1200153899

Assessed Value

Value Year	2021	**Assessed Total**	63,744,000
Tax Year	2022	**Assessed Land**	1,290,000
Taxable Value	0	**Assessed Improvements**	62,454,000
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2021		

Assessment Details

2021 Values for 2022 Tax

Taxable Value	$0
Assessed Value	$63,744,000

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

Tax Year	2022
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Tax Year	2021
Type	Non-Profit Caregivers, Libraries
Expiration Date	n/a

Land Details

Land Economic Area	2045
RTSQQ	03-21-32-34
Value Area	PI5
Neighborhood	405 / 830
Square Footage	40,400
Acres	0.928
Front Foot	740
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Building 1 Details

General Characteristics

Property Type	Commercial
Condition	Average
Quality	Good
Neighborhood	405
Occupancy	Medical
Square Feet	138,020
Net Square Feet	138,020
Attached Garage Square Feet	0
Detached Garage Square Feet	0
Carport Square Feet	0
Finished Attic Square Feet	0
Total Basement Square Feet	0
Finished Basement Square Feet	0
Basement Garage Door	0
Fireplaces	0

Built-As

DESCRIPTION	Hospital
YEAR BUILT	2010
ADJUSTED YEAR BUILT	2010
SQUARE FEET	138,020
STORIES	4
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Warm and Cool Air Zone
UNITS	0
SPRINKLER SQUARE FEET	183,880

Improvement Details

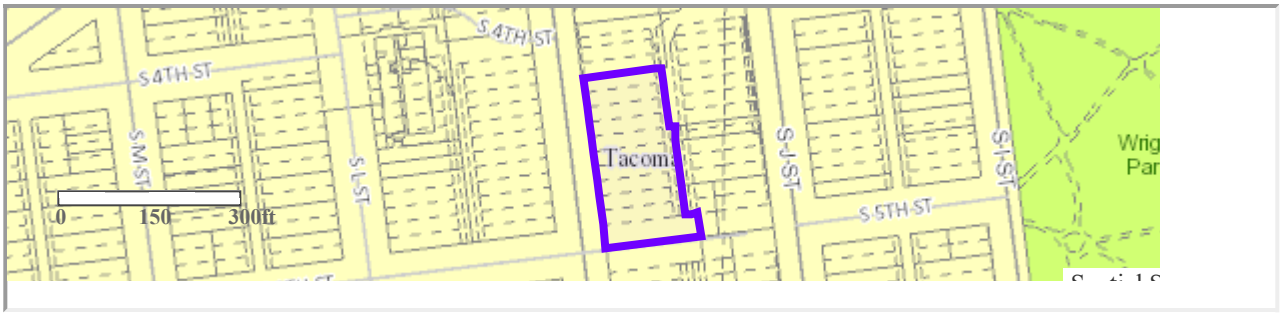
Type	Description	Units
Add On	Canopies DrThru Marquee Steel FR (Gd)	6,200
Basement	Parking	45,860

Sales History

SALE DATE	04/02/2007
ETN	4158815
PARCEL COUNT	1
GRANTOR	FIRST UNITED METHODIST CHURCH
GRANTEE	MULTICARE HEALTH SYSTEMS
SALE PRICE	8,100,000
DEED TYPE	Statutory Warranty Deed
SALES NOTES	Exempt for taxatn Gov nonprof

SALE DATE	04/29/2006
ETN	4124270
PARCEL COUNT	1
GRANTOR	FIRST UNITED METHODIST CHURCH
GRANTEE	MULTICARE HEALTH SYSTEMS
SALE PRICE	8,000,000
DEED TYPE	Statutory Warranty Deed
SALES NOTES	Exempt for taxatn Gov nonprof

Map



Photos

Sorry, no photo available for display

Sketches

Sorry, no sketches available for display

Exhibit 8.

Letter of Financial Commitment

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

December 10, 2021

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

RE: MultiCare Health System Certificate of Need Request to Transfer NICU Beds to Mary Bridge Children's Hospital's License

Dear Mr. Hernandez:

Please accept this letter as evidence of financial support for MultiCare Health System's certificate of need application request to transfer its Neonatal Intensive Care Unit (NICU) Beds from MultiCare Tacoma General Hospital's license to MultiCare Mary Bridge Children's Hospital's license.

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

Please contact me if there are any questions regarding this letter of financial commitment. I can be reached at Jason.mitchell@multicare.org or at 206.304.9458. Thank you for your time and assistance in this important matter.

Sincerely,

Jason Mitchell
Vice President of Finance
MultiCare Health System

Exhibit 9A.

Audited Financial Statements 2019-2020

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2020 and 2019

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

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

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

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

KPMG LLP

Seattle, Washington
March 24, 2021

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2020 and 2019

(In thousands)

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

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2020 and 2019

(In thousands)

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

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2020 and 2019

(In thousands)

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

See accompanying notes to consolidated financial statements.

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

(a) Organization Description

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

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

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

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

(b) Principles of Consolidation

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

(c) Use of Estimates

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

(d) Cash and Cash Equivalents

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

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

(e) Accounts Receivable

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

(f) Supplies Inventory

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

(g) Donor Restricted Assets

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

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

(h) Investments

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

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

(i) Property, Plant, and Equipment

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

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

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

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

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

(j) Leases

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

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

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

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

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

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

(k) Goodwill and Intangible Assets

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

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

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

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

(l) Investment in Joint Ventures

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

(m) Estimated Third-Party Payor Settlements

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

(n) Interest Rate Swaps

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

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

(o) Net Assets with Donor Restrictions

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

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

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

(p) Patient Service Revenue

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

(q) Hospital Safety Net Assessment

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

(r) Uncompensated and Undercompensated Care

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

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

(s) Other Operating Revenue

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

(t) Excess of Revenues over Expenses

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

(u) Federal Income Taxes

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

(v) Self-Insurance Reserves

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

(w) New and Pending Accounting Standards

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

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

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

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

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

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

(2) Coronavirus (COVID-19) Impact

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

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

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

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

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

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

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

(Dollars in thousands)

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

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

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

(3) Revenue from Contracts with Customers

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

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

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

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

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

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

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

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

(Dollars in thousands)

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

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

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

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

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

(Dollars in thousands)

(4) Concentration of Credit Risk

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

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

(5) Fair Value Measurements

(a) Fair Value Hierarchy

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

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

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

(Dollars in thousands)

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

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

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

(Continued)

(Dollars in thousands)

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

(Continued)

(Dollars in thousands)

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

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

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

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

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

(b) Interest Rate Swaps

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

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

(Dollars in thousands)

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

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

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

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

(Continued)

(Dollars in thousands)

(6) Donor Restricted Assets and Investments

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

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

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

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

(Dollars in thousands)

(7) Liquidity and Availability of Financial Assets

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

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

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

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

(Dollars in thousands)

(8) Property, Plant, and Equipment, Net

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

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

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

(9) Other Assets, Net

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

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

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

(Dollars in thousands)

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

(10) Other Liabilities, Net

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

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

(11) Retirement Plans

(a) Defined Benefit Pension Plan

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

(Dollars in thousands)

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

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

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

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

(Dollars in thousands)

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

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

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

(i) Cash Flows – Contributions

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

(ii) Estimated Future Benefit Payments

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

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

(Dollars in thousands)

(iii) Plan Assets

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

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

(Dollars in thousands)

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

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

(Dollars in thousands)

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

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

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

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

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

(Dollars in thousands)

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

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

(iv) Investment Objectives

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

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

(v) Investment Categories

Equities

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

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

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

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

Fixed Income

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

Alternative Investments

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

Real Estate

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

Global Asset Allocation

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

(b) Defined Contribution Plans

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

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

(c) Other

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

(12) Professional Liability

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

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

(13) Workers' Compensation and Employee Health Benefit Programs

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

(Dollars in thousands)

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

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

(14) Long-Term Debt

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

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

(a) 2020 Taxable Bonds

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

(b) 2020 OCED Financing

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

(c) 2019 Term Loan

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

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

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

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

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

(f) 2017 Term Loans

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

(g) WHCFA Revenue Bonds 2015 Series A and B

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

(h) WHCFA Revenue Bonds 2012 Series A

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

(i) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. In August 2019, the 2010 bonds were refinanced with the proceeds from the 2019 Term Loan as described below. This refinancing resulted in a gain of $869 that is recognized in other (loss) income, net in the consolidated statements of operations and changes in net assets.

(j) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued the 2009 Series A and B bonds as variable rate demand bonds for $50,000 each. The bonds were backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds that bear interest ranging from 4.4% to 5.0%. Annual principal payments range from $3,690 in 2040 to $38,890 in 2044.

(k) Other

The other debt listed is primarily made up of debt held by Navos. In April 2020, MHS paid $11,488 of Navos' debt outstanding to third-party creditors. Of the outstanding debt at December 31, 2020, $16,092 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. These provisions state that Navos maintains the assets that were built or purchased with these notes and maintains their usage when the promissory note was signed for the length specified. If these provisions are not met, the note must be repaid based on the terms of the agreement. The forgivable debt is subject to a forgiveness provision in years 2028 through 2068.

(l) 2020 Line of Credit

In April 2020, MHS secured a $200,000 line of credit through JPMorgan Chase Bank, N.A. The term of the line of credit is for 12 months and bears interest at a variable rate based upon the Central Bank Floating Rate. No draws have occurred as of December 31, 2020.

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2020 and 2019.

Each fixed-rate revenue bond requires semiannual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

(Dollars in thousands)

Principal maturities on long-term debt are as follows:

Year ending December 31:	
2021	$ 7,950
2022	45,390
2023	20,616
2024	21,641
2025	22,716
Thereafter	1,453,474
	$ 1,571,787

A summary of interest costs is as follows during the years ended December 31, 2020 and 2019:

	2020	2019
Interest cost:		
Charged to operations	$ 48,464	49,313
Amortization of bond premiums, discounts, and issuance costs	(2,494)	(2,728)
Capitalized	478	1,231
	$ 46,448	47,816

(15) Commitments and Contingencies

Approximately 48% of MHS employees were covered under collective bargaining agreements as of December 31, 2020. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through March 2023.

(16) Leases

(a) Lessee

MHS leases various equipment and facilities under noncancelable operating and finance leases. Lease terms for noncancelable operating leases range from 1 to 18 years, and existing leases have expiration dates through 2036. Lease terms for finance leases range from 3 to 21 years, and existing leases have expiration dates through 2040.

(Dollars in thousands)

The components of lease cost for the years ended December 31, 2020 and 2019 were as follows:

		2020	2019
Operating lease cost	$	37,232	36,532
Finance lease cost:			
Amortization of right-of-use assets		1,550	—
Interest on lease liabilities		388	—
Total finance lease cost		1,938	—
Short term lease cost		1,644	344
Variable lease cost		7,242	7,141
Sublease income		(1,049)	(4,518)
Total lease cost	$	47,007	39,499

Other information related to leases as of December 31, 2020 and 2019 was as follows:

	2020	2019
Weighted average remaining lease term (years)		
Operating leases	6.7	6.8
Finance leases	7.7	N/A
Weighted average discount rate		
Operating leases	4.0 %	4.0 %
Finance leases	4.4	N/A
Operating cash flows from operating leases	(36,707)	(35,619)
Operating cash flows from finance leases	(388)	—
Financing cash flows from finance leases	(1,366)	—
Right-of-use assets obtained in exchange for new operating lease liabilities	19,850	40,717
Right-of-use assets obtained in exchange for new finance lease liabilities	16,739	—

(Continued)

(Dollars in thousands)

Maturities of lease liabilities under noncancelable leases as of December 31, 2020 are as follows:

		Operating Leases	Finance Leases	Total
For year ended December 31:				
2021	$	33,673	3,482	37,155
2022		26,333	3,482	29,815
2023		22,904	3,321	26,225
2024		18,102	3,096	21,198
2025		16,258	1,719	17,977
Thereafter		45,847	3,840	49,687
Total undiscounted lease payments		163,117	18,940	182,057
Less present value discount		(20,255)	(2,904)	(23,159)
Total lease liabilities	$	142,862	16,036	158,898

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS, and is the only asset that MHS leases out as a lessor. The lease has a 20 year initial lease term, with four 5 year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40 year lease. There is no purchase option stated in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. At December 31, 2020, MHS' other assets, net include a net investment in lease of $23,200.

Revenue from leases for the years ended December 31, 2020 and 2019 is as follows:

		2020	2019
Interest income on net investment in finance leases	$	1,136	812
Variable lease income		28	25
Total lease income	$	1,164	837

(Dollars in thousands)

Future lease payments receivable as of December 31, 2020 are as follows:

Year ended December 31:		
2021	$	1,246
2022		1,246
2023		1,246
2024		1,246
2025		1,246
Thereafter		43,495
Total lease payments to be received		49,725
Less: unearned interest income		(26,525)
Net investment in lease	$	23,200

(17) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2020 and 2019:

		2020	2019
Healthcare services	$	52,151	49,866
Endowment funds, perpetual trusts and related receivables		71,651	64,273
Purchase of property, plant and equipment		16,234	6,377
Indigent care		1,533	1,634
Health education		1,192	1,240
Total net assets with donor restrictions	$	142,761	123,390

(18) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

(Dollars in thousands)

The following tables present MHS' endowment net asset composition as well as associated changes therein:

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2019	$ 2,673	39,700	42,373
Investment return:			
Investment income	39	493	532
Net appreciation – realized and unrealized	153	1,989	2,142
Total investment return	192	2,482	2,674
Contributions	—	443	443
Appropriation of endowment assets for expenditure	(40)	(201)	(241)
Endowment net assets, December 31, 2020	$ 2,825	42,424	45,249

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2018	$ 2,923	38,140	41,063
Investment return:			
Investment income	62	782	844
Net appreciation – realized and unrealized	27	334	361
Total investment return	89	1,116	1,205
Contributions	—	1,990	1,990
Appropriation of endowment assets for expenditure	(339)	(1,546)	(1,885)
Endowment net assets, December 31, 2019	$ 2,673	39,700	42,373

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $28,290 and $23,445, respectively, as of December 31, 2020 and 2019. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $937 and $1,128, respectively, as of December 31, 2020 and 2019.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2020 or 2019.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that an annual spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(Dollars in thousands)

(19) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2020 and 2019:

	2020				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 969,456	392,470	51,225	202,870	1,616,021
Employee benefits	119,926	66,759	11,931	49,516	248,132
Supplies	416,964	34,712	54,952	13,750	520,378
Purchased services	98,027	25,874	18,409	155,946	298,256
Depreciation and amortization	110,868	17,914	1,921	37,485	168,188
Interest	41,004	3,936	—	1,030	45,970
Other	226,092	49,321	25,724	68,604	369,741
	$ 1,982,337	590,986	164,162	529,201	3,266,686

	2019				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 918,459	407,097	47,490	175,055	1,548,101
Employee benefits	120,308	69,120	11,259	40,659	241,346
Supplies	424,852	35,609	36,278	4,949	501,688
Purchased services	109,060	34,682	12,763	114,609	271,114
Depreciation and amortization	106,384	20,090	1,425	37,771	165,670
Interest	46,226	2,859	—	(2,500)	46,585
Other	217,900	44,851	16,565	78,170	357,486
	$ 1,943,189	614,308	125,780	448,713	3,131,990

(20) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(21) Subsequent Events

MHS has evaluated the subsequent events through March 24, 2021, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 9B.

Audited Financial Statements 2018-2019

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2019 and 2018

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

We have audited the accompanying consolidated financial statements of MultiCare Health System (a Washington nonprofit corporation), which comprise the consolidated balance sheets as of December 31, 2019 and 2018, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of MultiCare Health System as of December 31, 2019 and 2018, and the results of its operations and changes in net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 1 to the consolidated financial statements, on January 1, 2019, MultiCare Health System adopted Financial Accounting Standards Board Accounting Standard Update (ASU) 2016-02, *Leases,* and ASU 2018-11, *Leases Targeted Improvements*. Our opinion is not modified with respect to these matters.

KPMG LLP

Seattle, Washington
March 19, 2020

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2019 and 2018

(In thousands)

Assets		2019	2018
Current assets:			
Cash and cash equivalents	$	434,854	386,409
Accounts receivable		376,500	375,841
Supplies inventory		41,738	43,387
Other current assets, net		71,397	57,450
Total current assets		924,489	863,087
Donor restricted assets held for long-term purposes		70,783	75,166
Investments		1,797,483	1,490,739
Property, plant, and equipment, net		1,763,345	1,776,259
Right-of-use lease asset, net		144,140	—
Other assets, net		384,004	320,290
Total assets	$	5,084,244	4,525,541
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	195,356	201,304
Accrued compensation and related liabilities		247,971	221,854
Accrued interest payable		15,168	16,364
Current portion of right-of-use lease liability		28,322	—
Current portion of long-term debt		13,668	19,058
Total current liabilities		500,485	458,580
Interest rate swap liabilities		88,311	45,833
Right-of-use lease liability, net of current portion		120,345	—
Long-term debt, net of current portion		1,276,973	1,287,189
Other liabilities, net		155,320	127,406
Total liabilities		2,141,434	1,919,008
Commitments and contingencies (note 14)			
Net assets:			
Without donor restrictions		2,819,420	2,490,997
With donor restrictions		123,390	115,536
Total net assets		2,942,810	2,606,533
Total liabilities and net assets	$	5,084,244	4,525,541

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2019 and 2018

(In thousands)

	2019	2018
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 3,107,525	2,780,371
Other operating revenue	120,355	137,909
Net assets released from restrictions for operations	6,225	4,687
Total revenues, gains, and other support without donor restrictions	3,234,105	2,922,967
Expenses:		
Salaries and wages	1,548,101	1,392,503
Employee benefits	241,346	212,568
Supplies	501,688	465,673
Purchased services	271,114	238,570
Depreciation and amortization	165,670	149,522
Interest	46,585	42,915
Other	357,486	317,815
Total expenses	3,131,990	2,819,566
Excess of revenues over expenses from operations	102,115	103,401
Other income (loss):		
Investment income (loss)	255,460	(95,684)
(Loss) income on interest rate swaps, net	(45,436)	13,467
Other income, net	869	21,669
Total other income (loss), net	210,893	(60,548)
Excess of revenues over expenses	313,008	42,853
Other changes in net assets without donor restrictions:		
Changes in pension asset	13,276	(14,172)
Net assets released from restriction – capital acquisitions	9,689	7,221
Other	(7,550)	—
Increase in net assets without donor restrictions	328,423	35,902
Changes in net assets with donor restrictions:		
Contributions and other	20,032	13,323
Income on investments	1,116	992
Net assets released from restriction – capital acquisitions	(9,689)	(7,221)
Net assets released from restrictions for operations and other	(6,225)	(4,687)
Increase (decrease) in assets held in trust by others	2,620	(3,894)
Increase (decrease) in net assets with donor restrictions	7,854	(1,487)
Increase in net assets	336,277	34,415
Net assets, beginning of year	2,606,533	2,572,118
Net assets, end of year	$ 2,942,810	2,606,533

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2019 and 2018

(In thousands)

	2019	2018
Cash flows from operating activities:		
Increase in net assets	$ 336,277	34,415
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	165,670	149,522
Amortization of bond premiums, discounts, and issuance costs	(2,728)	(2,659)
Net realized and unrealized (gains) losses on investments	(216,859)	123,495
Change in fair value of interest rate swap	42,620	(17,542)
Loss (gain) on disposal of assets, net	824	(198)
Gain on bond refinancing	(869)	—
Undistributed losses (gains) on joint ventures	8,002	(1,741)
Restricted contributions for long-term purposes	(2,795)	(4,477)
Gain on forgiveness of debt	—	(6,425)
Assumption of operating assets and liabilities	—	(15,143)
Changes in operating assets and liabilities:		
Accounts receivable	(659)	(16,007)
Supplies inventory and other current assets	(12,298)	1,700
Right-of-use lease asset	29,282	—
Other assets, net	(16,374)	31,962
Accounts payable and accrued expenses and accrued interest payable	(7,144)	3,821
Accrued compensation and related liabilities	26,117	6,509
Right-of-use lease liability	(24,756)	—
Other liabilities, net	27,675	(13,048)
Net cash provided by operating activities	351,985	274,184
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(195,206)	(233,314)
Cash obtained through affiliation	—	9,335
Proceeds from disposal of property, plant, and equipment	1,157	2,240
Contributions to joint ventures, net	(15,084)	(17,650)
Purchases of investments	(2,342,719)	(2,160,128)
Sales of investments	2,263,097	2,165,472
Change in donor trusts	(5,571)	6,635
Net cash used in investing activities	(294,326)	(227,410)
Cash flows from financing activities:		
Repayment of long-term debt	(12,009)	(32,870)
Restricted contributions for long-term purposes	2,795	4,477
Net cash used in financing activities	(9,214)	(28,393)
Net change in cash and cash equivalents	48,445	18,381
Cash and cash equivalents, beginning of year	386,409	368,028
Cash and cash equivalents, end of year	$ 434,854	386,409
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 47,781	39,204
Noncash activities:		
Increase (decrease) in deferred compensation plans	16,198	(6,735)
(Decrease) increase in accounts payable for purchases of property, plant, and equipment	(3,716)	1,302

See accompanying notes to consolidated financial statements.

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

(a) Organization Description

MultiCare Health System (MHS), a Washington nonprofit corporation, is an integrated healthcare delivery system providing inpatient, outpatient, and other healthcare services primarily to the residents of Pierce, South King and Spokane Counties and, with respect to pediatric care, much of the southwest Washington area. As of December 31, 2019, MHS is licensed to operate 1,992 inpatient hospital beds, including 120 beds associated with Wellfound Behavioral Health Hospital, a 50% owned joint venture located in Tacoma, Washington, which opened in May 2019. On April 1, 2018, Covington Medical Center opened a 58-bed hospital wing on its campus. MHS currently operates eight acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital and Valley Hospital) and one behavioral health hospital (Navos).

Greater Lakes Mental Health (GLMH), a behavioral health services provider located primarily in the South Puget Sound area, affiliated with MHS effective July 1, 2018. No consideration was exchanged and MHS became the sole corporate member of GLMH. The assets and liabilities obtained through the affiliation included property, plant, and equipment, cash and other current and long-term assets offset by accounts payable, accrued compensation and long-term debt and were recorded at their estimated fair value. The net assets without donor restrictions assumed resulted in an inherent contribution of $15,143 and is included in other income, net in the consolidated statement of operations and changes in net assets for the year ended December 31, 2018. The net assets without donor restrictions assumed includes noncash net assets totaling $5,808 for the year ended December 31, 2018.

As of December 31, 2019, MHS also operates eight outpatient surgical sites, three free-standing emergency departments, home health, hospice, and a network of urgent care, primary care and multispecialty clinics located throughout the MHS service areas.

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

(b) Principles of Consolidation

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

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date

of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and assumptions.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid instruments with maturities of three months or less at the date of purchase. Cash equivalents and investments that are held by outside investment managers or restricted per contractual or regulatory requirements are classified as investments on the consolidated balance sheets.

(e) Accounts Receivable

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

(f) Supplies Inventory

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

(g) Donor Restricted Assets

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

Charitable gift annuities, which are included in donor restricted assets, totaled $2,410 and $2,206 at December 31, 2019 and 2018, respectively. MHS has recorded a corresponding payable of $1,222 and $1,246 at December 31, 2019 and 2018, respectively, to pay for estimated future obligations to beneficiaries. The current portion of these obligations is included in accounts payable and accrued expenses and the long-term portions are included in other liabilities, net in the accompanying consolidated balance sheets. According to Washington State law, MHS, as a distinct legal entity holding charitable gift annuities, is required to maintain unrestricted net assets of at least $500, which MHS has done for each of the periods presented.

(h) Investments

MHS accounts for its investment portfolio as a trading portfolio, therefore, investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are recorded at fair value, which are determined based on quoted market prices or prices with observable inputs obtained from national securities exchanges or similar sources. Other investments, including limited partnerships, commingled real estate trust funds, limited liability partnerships, and hedge funds are

carried at net asset value (NAV) provided by the respective investment managers, which management believes approximates fair value. Valuations provided by investment managers consider variables such as valuation and financial performance of underlying investments, quoted market prices for similar securities, recent sale prices of underlying investments, and other pertinent information. Management reviews the valuations provided by investment managers and believes that the carrying values of these financial instruments are reasonable estimates of fair value.

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

(i) Property, Plant, and Equipment

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

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

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

MHS assesses potential impairments to its long-lived assets as well as its intangible assets, as described below, when there is evidence that events or changes in circumstances indicate that an impairment has been incurred. These changes can include a deterioration in operating performance, a reduction in reimbursement rates or a change in business strategy. An impairment charge is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2019 and 2018, there were no impairment charges.

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

(j) Leases

Management reviews contracts in order to identify leases and properly classify leases as either operating or financing. MHS is a lessee of various equipment and facilities under non-cancellable

operating leases. Operating right-of-use (ROU) liabilities are recognized based on the net present value of lease payments over the lease term at the commencement date, and are reduced by payments made on each lease on the straight-line basis. Since most of the leases do not provide an implicit rate of return, MHS uses its incremental borrowing rate based on information available at the commencement date in determining the present value of lease payments. Generally, MHS cannot determine the interest rate implicit in the lease because it does not have access to the lessor's estimated residual value or the amount of the lessor's deferred initial direct costs. Therefore, MHS generally uses its incremental borrowing rate as the discount rate for the lease. MHS' incremental borrowing rate for a lease is the rate of interest it would have to pay on a collateralized basis to borrow an amount equal to the lease payments under similar terms. Leases with an initial term of 12 months or less are not recorded on the balance sheet; rather, rent expense for these leases is recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

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

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

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

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

(k) Goodwill and Intangible Assets

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

If it is more likely than not that goodwill is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment charge. Goodwill is not amortized and along with indefinite-lived intangible assets is evaluated at least annually for impairment. There were no impairment charges recognized during the years ended December 31, 2019 or 2018.

Amortizing intangible assets are comprised of certificates of need, license agreements, trade names and lease arrangements, which all have finite useful lives. Amortization expense is recorded on a straight-line basis over the estimated useful life of the assets, which ranges from three to thirty years, associated with the nature of the intangible asset.

(l) Investment in Joint Ventures

MHS maintains ownership, at varying levels, in certain joint ventures related to imaging, office buildings, behavioral health and other healthcare focused activities. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheet.

(m) Estimated Third-Party Payor Settlements

Medicare cost reports are filed annually by MHS with the Medicare intermediary and are subject to audit and adjustment prior to settlement. Estimates of net settlements due to Medicare were $3,562 and $6,308 as of December 31, 2019 and 2018, respectively, and have been recorded within accounts payable and accrued expenses in the accompanying consolidated balance sheets. Third-party settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined. Patient service revenue increased by $2,746 and $3,792 for 2019 and 2018, respectively, to reflect changes in the estimated Medicare settlements for prior years.

(n) Interest Rate Swaps

MHS maintains several interest rate swap agreements as a means of hedging its exposure to variable-based interest rates and fluctuations in cash flows as part of its overall interest rate risk management strategy. All MHS interest rate swaps are recorded at fair value. The accounting for changes in the fair value of these swaps depends on whether those had been designated as cash flow hedges. As of December 31, 2019 and 2018, none of MHS' interest rate swaps were designated as cash flow hedges and therefore, the changes in fair value are recognized and included in other income (loss) on the consolidated statements of operations and changes in net assets. These swaps have notional amounts totaling approximately $738,000 and expire starting in August 2022 through August 2049. The majority of the swaps have the economic effect of fixing the LIBOR-based variable interest rate on an equivalent amount of MHS' outstanding floating rate principal debt.

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

(o) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by MHS in perpetuity. When restricted funds to be used for operations are expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains, and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant,

and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restriction – capital acquisitions.

MHS applies the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, related to using the present value technique to measure fair value of pledges receivable. In accordance with ASC Topic 820, MHS has applied the expected present value technique to pledges received after January 1, 2009 that adjusts for a risk premium to take into account the risks inherent in those expected cash flows. Pledges of financial support are recorded as pledges receivable when unconditional pledges are made and are stated at net realizable value. Pledges are reported net of an allowance for uncollectible pledges and pledges to be collected in future years are reflected at a discounted value using a weighted average discount rate. As of December 31, 2019, and 2018, MHS has recorded $8,024 and $7,715, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2019, $5,638 of pledges are due in one year or less and $2,386 in two to five years.

(p) Patient Service Revenue

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

(q) Hospital Safety Net Assessment

The State of Washington (the State) has a safety net assessment program involving Washington State hospitals to increase funding from other sources and obtain additional federal funds to support increased payments to providers for Medicaid services. In connection with this program, MHS recorded increases in patient service revenue of $84,831 and $77,375 for 2019 and 2018, respectively, and incurred assessments of $59,460 and $57,324 for 2019 and 2018, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations and changes in net assets. MHS has outstanding receivables of $4,679 and $4,999 associated with this program as of December 31, 2019 and 2018, respectively, which are included with accounts receivable on the consolidated balance sheets.

(r) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated and undercompensated healthcare services to the communities it serves within the purview of its mission. Because MHS does not pursue collection of amounts determined to qualify as charity care, MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its historical collections from these patients. Patients who meet the criteria of MHS' charity care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Such amounts determined

to qualify as charity care are not reported as revenue. The State provides guidelines for charity care provided by hospitals in the state. Hospitals are recommended to provide full charity care to patients who meet 100% of the federal poverty guidelines and a lesser amount to patients who meet up to 200% of the federal poverty guidelines. MHS provides full charity care to patients who meet 300% of the federal poverty guidelines and also provides charity care on a sliding scale for patients whose income is between 301% and 500% of the federal poverty guidelines for true self-pay patients and patients with deductibles and coinsurance amounts. The estimated cost of charity care provided was approximately $58,000 and $47,000 in 2019 and 2018, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $203,000 and $217,000 in 2019 and 2018, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(s) Other Operating Revenue

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

(t) Excess of Revenues over Expenses

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

(u) Federal Income Taxes

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

(v) Self-Insurance Reserves

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

(w) New and Pending Accounting Standards

In January 2016, FASB issued ASU 2016-01, *Financial Instruments – Overall Recognition and Measurement of Financial Assets and Financial Liabilities.* This standard, among other things, eliminates the requirement of entities other than public business entities to disclose the fair value of financial instruments measured at amortized cost on the balance sheet. This standard is effective for fiscal years beginning after December 15, 2018 for all nonpublic business entities. In 2017, MHS adopted the option to remove the fair value of debt disclosure as permitted under the provisions of the standard. MHS has reviewed the details associated with the remainder of this ASU has determined this ASU does not have a material effect on its consolidated financial statements.

In February 2016, FASB issued ASU 2016-02, *Leases (Topic 842)*, which was subsequently updated by ASU 2018-11, issued in July 2018, *Leases Targeted Improvements (Topic 842)*, which provides entities with another transition method in addition to the existing transition method as prescribed in Topic 842 by allowing entities to initially apply the new leases standard at the adoption date and recognize a cumulative-effect adjustment to the opening balance of net assets. In addition, the original standard requires lessees to recognize a lease liability and a right-of-use asset on the balance sheet based upon the present value of the remaining minimum lease payments at the adoption date for all lease obligations with an exception for short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right-of-use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale-leaseback transactions. MHS adopted the standard as of January 1, 2019 using the modified retrospective approach. MHS elected to apply the packages of practical expedients to not reassess prior conclusions related to contracts containing leases, lease classification, and initial direct costs. At the date of adoption, MHS recorded a right-of-use lease liability of $137,114 and corresponding lease asset of $134,412.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*. The amendments in this update require that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total cash amounts shown on the statement of cash flows. The amendments in this update do not provide a definition of restricted cash or restricted cash equivalents. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2019. MHS has reviewed the details of this ASU and has determined that this ASU does not have a material effect on its consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Statement of Cash Flows Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The amendments in this update require that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost as defined in paragraphs 715-30-35-4 and 715-60-35-9 of this standard are required to be presented in the consolidated statement of operations and changes in net assets, separately from the service cost component and are not included in income from operations, if one is presented. If a

separate line item or items are used to present the other components of net benefit cost, that line item or items must be appropriately described. If a separate line item or items are not used, the line item or items used in the consolidated statement of operations and changes in net assets to present the other components of net benefit cost must be disclosed. The amendments in this update also allow only the service cost component to be eligible for capitalization when applicable (for example, as a cost of internally manufactured inventory or a self-constructed asset). The provisions of this ASU are effective for MHS for the year beginning on January 1, 2019. MHS has reviewed the details of this ASU and has determined that this ASU does not have a material effect on its consolidated financial statements.

In June 2018, FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. This standard should assist entities in evaluating whether transactions should be accounted for as contributions (nonreciprocal transactions) or as exchange (reciprocal) transactions, which is subject to other accounting guidance and determining whether a contribution received or made is conditional. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2019. MHS has reviewed the details associated with its contribution transactions and has determined this ASU does not have a material effect on its consolidated financial statements.

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

In April 2019, FASB issued ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments – Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments.* The amendments in this update are divided into four separate topics that discuss the details of the improvement areas and the amendments made to the Codification for these improvement areas. Topics 1, 2 and 5 in this ASU relate specifically to ASU 2016-13, which is effective for MHS for the year beginning January 1, 2023. Topic 3 relates to ASU 2017-12 and other hedging items. Topic 3 is not applicable for MHS. Topic 4 relates specifically to ASU 2016-01, which MHS fully implemented ASU 2016-01 as of January 1, 2019. Topic 4 of this ASU is effective for MHS for the year beginning January 1, 2020. MHS evaluated Topic 4 and noted the four issues and amendments within Topic 4 are not applicable to MHS and their implementation of ASU 2016-01. MHS does not expect the adoption of the remaining topics within this ASU to have a material effect on its consolidated financial statements.

(2) Revenue from Contracts with Customers

Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by MHS and are recognized either over time or at a point in time. Revenue for performance obligations satisfied over time is recognized based on actual charges

incurred through a point in time in relation to total actual charges incurred. MHS believes that this method provides a useful depiction of the provision of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospitals or clinics receiving inpatient or outpatient services. MHS measures an inpatient performance obligation from time of admission to time of discharge and an outpatient performance obligation from the start of the outpatient service to the completion of the outpatient service. Revenue for performance obligations satisfied at a point in time are recognized when goods or services are provided to patients and customers and it is not required to provide additional goods or services.

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

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

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

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

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged

noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from the related programs. There can be no assurance that regulatory or governmental authorities will not challenge MHS' compliance with these laws and regulations, and it is not possible to determine the impact, if any, that such claims or penalties would have upon MHS. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled and no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2019 or 2018.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. MHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. MHS estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for prior years were not significant for 2019 or 2018. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

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

(Dollars in thousands)

MHS has determined that the best depiction of its revenue is by its mix of payors as this shows the amount of revenue recognized from each portfolio. Patient service revenue disaggregated by payor for the years ended December 31, 2019 and 2018 are as follows:

		2019	2018
Payors:			
Medicare	$	833,070	781,842
Medicaid		479,340	494,737
Premera		458,091	359,764
Regence		326,247	303,390
Aetna		195,283	165,488
Kaiser Permanente		128,354	108,539
First Choice		116,867	108,990
Self-pay		15,963	10,924
Other		554,310	446,697
	$	3,107,525	2,780,371

MHS has elected to apply the practical expedient under ASC Topic 606 which allows MHS to not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to MHS' expectations that the period between the time services are provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, MHS, in certain instances, does enter into payment arrangements with patients that allow payments more than one year. These payment arrangements and the associated financing component are not deemed to be significant.

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

(Dollars in thousands)

(3) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are residents of the communities it serves and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2019 and 2018 was as follows:

	2019	2018
Medicare	30 %	33 %
Medicaid	23	24
Regence	6	6
Premera	9	8
First Choice	2	3
Self-pay	8	7
Health Care Exchange	1	2
Other commercial insurance	21	17
	100 %	100 %

(4) Fair Value Measurements

(a) Fair Value Hierarchy

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

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

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

ASC Subtopic 820-10 allows for the use of a practical expedient for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable

(Dollars in thousands)

fair value. The practical expedient used by MHS is the NAV per share, or its equivalent. In some instances, the NAV may not equal the fair value that would be calculated under fair value accounting standards. Valuations provided by investment managers consider variables such as the financial performance of underlying investments, recent sales prices of underlying investments and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the redemption price. MHS reviews valuations and assumptions provided by investment managers for reasonableness and believes that the carrying amounts of these financial instruments are reasonable estimates of fair value. Where investments are not presented at fair value, NAV is used as a practical expedient to approximate fair value.

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2019 and 2018:

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

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2019	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Liabilities:				
Interest rate swaps	$ 88,311	—	88,311	—

		Fair value measurements at reporting date using		
	December 31, 2018	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 487,186	487,186	—	—
Equity securities	118,779	118,779	—	—
Fixed income bond funds	240,191	240,191	—	—
Fixed income governmental obligations	58,186	16,249	41,890	47
Fixed income other	79,015	—	78,661	354
Commingled trust fund – international equity	104,195	—	104,195	—
Interest rate swaps	1,403	—	1,403	—
Donor trusts	22,604	—	—	22,604
Total assets at fair value	1,111,559	$ 862,405	226,149	23,005
Investment assets valued at NAV	425,060			
Total assets at fair value or NAV	$ 1,536,619			
Liabilities:				
Interest rate swaps	$ 45,833	—	45,833	—

There were no significant transfers into or out of Level 1, Level 2, or Level 3 financial instruments during the years ended December 31, 2019 and 2018.

(Dollars in thousands)

The following table presents MHS' activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC Topic 820 for the years ended December 31, 2019 and 2018:

	Level 3 assets Donor trusts
Balance at December 31, 2017	$ 27,414
Net unrealized losses	(4,810)
Balance at December 31, 2018	22,604
Net unrealized gains	3,300
Balance at December 31, 2019	$ 25,904

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2019 and 2018:

	NAV December 31, 2019	NAV December 31, 2018	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 213,291	208,193	500	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	175,882	—	N/A	Daily	1 business day prior to valuation date
Absolute return funds	—	110,646	N/A	Monthly	5 business days prior to valuation date
Limited liability partnerships	—	86,121	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	14,667	20,100	1,800	N/A	N/A
Total investments valued at NAV	$ 403,840	425,060	2,300		

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

Absolute return fund investments consist primarily of listed equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles. These investments use derivatives or other instruments for both investment and hedging purposes and may

take long and/or short positions, and the derivative investments may include but are not restricted to futures, options, swaps, and forward currency contracts.

Limited liability partnership investments include dedicated exposure to global inflation-sensitive equities, commodities, and inflation-linked bonds; and invest in various themes including energy, precious metals, natural resources, and agriculture.

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

(b) Interest Rate Swaps

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

In December 2019, MHS entered into three new swap arrangements with a total notional amount of $158,130 that have the economic effect of fixing the LIBOR-based variable component of the interest rates. At December 31, 2019 the interest rates on these swaps was fixed at 1.39%. In addition, at December 31, 2019 and 2018 these interest rate swaps did not qualify as cash flow hedges and therefore, any changes in the fair value of these swaps are recorded as a gain or loss in the consolidated statements of operations and changes in net assets.

At December 31, 2019 and 2018, the fair value of the interest rate swaps liability was $88,311 and $45,833, respectively, which is included in interest rate swap liabilities on the consolidated balance sheet and the fair value of the interest rate swap asset was $1,263 and $1,403, respectively, which is included in other assets, net on the consolidated balance sheet. The changes in fair value of these interest rate swaps for the years ended December 31, 2019 and 2018 of $42,620 in fair value losses and $17,542 in fair value gains, respectively, are included in income (loss) on interest rate swaps in other income (loss) in the consolidated statements of operations and changes in net assets. Also included in the income (loss) on interest rate swaps is the loss on net cash settlement amounts associated with the swaps of $2,816 and $4,075, respectively, for the years ended December 31, 2019 and 2018.

(Dollars in thousands)

(5) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2019 and 2018 is as follows:

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

	December 31, 2018		
	Donor restricted assets	Investments	Total
Mutual funds	$ 8,329	478,857	487,186
Equity securities	2,030	116,749	118,779
Fixed income securities	6,453	370,939	377,392
Commingled trust fund – international equity	1,781	102,414	104,195
Hedge funds	3,560	204,633	208,193
Absolute return funds	1,892	108,754	110,646
Limited liability partnerships	1,473	84,648	86,121
Limited partnerships	343	19,757	20,100
Donor trusts	22,604	—	22,604
Pledge receivables, net and other	26,701	3,988	30,689
Total	$ 75,166	1,490,739	1,565,905

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

(Dollars in thousands)

(6) Liquidity and Availability of Financial Assets

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

At December 31, 2019 and 2018, MHS' financial resources are as follows:

	2019	2018
Cash and cash equivalents	$ 434,854	386,409
Accounts receivable	376,500	375,841
Other current assets, net	71,397	57,450
Donor restricted assets	70,783	75,166
Investments	1,797,483	1,490,739
	2,751,017	2,385,605
Less prepaid assets included in other current assets, net	(35,222)	(29,610)
Less donor restricted assets	(70,783)	(75,166)
Less investments with redemption limitations of greater than one year	(14,667)	(24,920)
Total financial assets available for general expenditures	$ 2,630,345	2,255,909

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

(Dollars in thousands)

(7) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2019 and 2018 is as follows:

	2019	2018
Land and land improvements	$ 131,635	125,934
Buildings	2,094,270	2,030,190
Equipment	1,020,402	934,127
	3,246,307	3,090,251
Less accumulated depreciation	(1,585,761)	(1,442,014)
	1,660,546	1,648,237
Construction in progress	102,799	128,022
Property, plant, and equipment, net	$ 1,763,345	1,776,259

Depreciation expense charged to operations for the years ended December 31, 2019 and 2018 amounted to $163,826 and $147,125, respectively. Depreciation and amortization expense for the years ended December 31, 2019 and 2018 was $165,670 and $149,522, respectively.

(8) Other Assets, Net

Other assets are as follows at December 31, 2019 and 2018:

	2019	2018
Investment in joint ventures	$ 45,575	38,492
Deferred compensation plan assets held in trust	71,594	55,394
Accrued pension asset (note 10)	45,420	28,085
Self-insured retention receivables, net of current portion (notes 11 and 12)	22,383	21,219
Interest rate swaps (note 4(b))	1,263	1,403
Goodwill and other intangibles	168,284	170,088
Net investment in lease (note 15(b))	25,798	—
Other	3,687	5,609
Other assets, net	$ 384,004	320,290

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

(Dollars in thousands)

(9) Other Liabilities, Net

Other liabilities are as follows at December 31, 2019 and 2018:

		2019	2018
Professional liability, net of current portion (note 11)	$	67,204	55,145
Deferred compensation liability (note 10)		71,594	55,394
Workers' compensation liability, net of current portion (note 12)		12,943	13,077
Other		3,579	3,790
Other liabilities, net	$	155,320	127,406

(10) Retirement Plans

(a) Defined Benefit Pension Plan

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

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the Plan, which has measurement dates of December 31, 2019 and 2018:

		2019	2018
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	576,605	628,996
Service Cost		1,230	—
Interest cost		25,779	25,046
Actuarial loss (gain)		71,704	(41,842)
Benefits paid		(35,325)	(35,595)
Projected benefit obligations at end of year	$	639,993	576,605
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	604,690	669,421
Actual gain (loss) on plan assets		116,048	(29,136)
Benefits paid		(35,325)	(35,595)
Fair value of plan assets at end of year	$	685,413	604,690

(Continued)

(Dollars in thousands)

		2019	2018
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	45,420	28,085
Amount recognized in net assets without donor restrictions:			
Net loss		118,182	131,458

	2019	2018
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	3.70 %	4.60 %
Expected return on plan assets	5.00	6.00

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

The components of net periodic benefit cost are as follows during the years ended December 31, 2019 and 2018:

		2019	2018
Components of net periodic benefit cost:			
Service Cost	$	1,230	—
Interest cost		25,779	25,046
Expected return on plan assets		(36,593)	(37,038)
Amortization of net actuarial loss		5,524	10,159
	$	(4,060)	(1,833)

The accumulated benefit obligation for the Plan was $639,993 and $576,605 at December 31, 2019 and 2018, respectively.

(i) Cash Flows – Contributions

MHS expects to make contributions to the Plan totaling approximately $670 in 2020.

(Dollars in thousands)

(ii) Estimated Future Benefit Payments

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

	Pension benefits
2020	$ 39,734
2021	38,517
2022	40,368
2023	40,291
2024	39,718
2025–2029	194,052

(iii) Plan Assets

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

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

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2019	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker payables	$ (171,268)			
Total assets at fair value	580,953			
Investments valued at NAV	104,460			
Total assets at fair value or NAV	$ 685,413			

		Fair value measurements at reporting date using		
	December 31, 2018	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 9,656	9,656	—	—
Trading securities:				
Mutual funds	65,350	65,350	—	—
Equity securities	18,016	18,016	—	—
Fixed income bond funds	211,938	211,938	—	—
Fixed income governmental obligations	153,164	120,156	33,008	—
Fixed income other	149,718	—	149,718	—
Commingled trust fund – international equity	17,308	—	17,308	—
	625,150	$ 425,116	200,034	—
Broker receivables	19,739			

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2018	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker payables	$ (88,519)			
Total assets at fair value	556,370			
Investments valued at NAV	48,320			
Total assets at fair value or NAV	$ 604,690			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2019 and 2018.

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2019 and 2018:

	Fair value at December 31, 2019	Fair value at December 31, 2018	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 22,333	21,655	N/A	Quarterly	45 days
Hedge funds	—	1,532	N/A	Quarterly	95 days prior to valuation date
Absolute return funds	74,741	15,315	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	7,386	9,818	850	N/A	N/A
Total investments valued at NAV	$ 104,460	48,320	850		

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

(Dollars in thousands)

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

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

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

The defined benefit plan weighted average asset allocations at December 31, 2019 and 2018 by asset category are as follows:

	2019	2018
Asset category:		
Domestic equities	7 %	7 %
International equities	7	6
Emerging markets	1	1
Fixed income securities	79	75
Alternative investments	1	2
Real estate	3	4
Global asset allocation	2	5
	100 %	100 %

(Continued)

(iv) Investment Objectives

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

	2019	2018
Asset category:		
Domestic equities	8 %	8 %
International equities	6	6
Emerging markets	1	1
Fixed income securities	80	77
Real estate	3	3
Global asset allocation	2	5
	100 %	100 %

(v) Investment Categories

Equities

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

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

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

Fixed Income

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

Alternative Investments

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

Real Estate

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

Global Asset Allocation

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

(b) Defined Contribution Plans

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

MHS' funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2019 and 2018 were approximately $47,200 and $40,158, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

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

(11) Professional Liability

MHS maintains a self-insurance program for professional liability with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability as of December 31, 2019 and 2018, which comprises estimated deductibles and retentions for known claims at year-end and a liability for incurred but not reported claims based on an actuarially determined estimate.

At December 31, 2019 and 2018, the estimated gross professional liability (including current and long-term portions) was $85,634 and $71,508, respectively. The current portion is included in accounts payable and accrued expenses and the remainder is included in other liabilities. MHS has recorded a receivable for amounts to be received from the excess insurance carriers for their portion of the claims (including current and long-term portions) of $30,026 and $27,455 as of December 31, 2019 and 2018, respectively. The current amount is included in other current assets, net and the remainder is included in other assets, net in the accompanying consolidated balance sheets.

(12) Workers' Compensation and Employee Health Benefit Programs

MHS maintains a self-insurance program for workers' compensation with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability based on an actuarial estimate of future claims payments. At December 31, 2019 and 2018, the estimated net liability based on future claims cost totaled $16,127 and $15,760, respectively. The gross liabilities (including both current and long-term portions) total $19,135 and $18,526 as of December 31, 2019 and 2018, respectively. The long-term amounts are included in other liabilities and the current portions are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets. These liabilities are secured by a letter of credit with the state of Washington. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,008 and $2,766 as of December 31, 2019 and 2018, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

MHS maintains a self-insurance program for employee medical and dental insurance. Employees can elect to be included in the self-insurance plan as a part of their fringe benefit package. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2019 and 2018 was $12,083 and $9,973, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(Dollars in thousands)

(13) Long-Term Debt

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

	2019	2018
WHCFA Revenue bonds, 2017 Series A and B	$ 325,020	327,990
WHCFA Revenue bonds, 2017 Series C, D, and E	191,010	191,010
WHCFA Revenue bonds, 2015 Series A and B	356,365	360,445
WHCFA Revenue bonds, 2012 Series A	60,000	60,000
WHCFA Revenue bonds, 2010 Series A	—	35,255
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
2017 Term Loans	130,170	130,170
2019 Term Loan	35,255	—
Other	34,839	39,798
	1,230,789	1,242,798
Adjusted for:		
Current portion	(13,668)	(19,058)
Bond premiums, discounts, and debt issuance costs	59,852	63,449
Long-term debt, net of current portion	$ 1,276,973	1,287,189

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

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

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

In November 2017, MHS entered into a $111,010 variable rate private placement agreement (Series C and D) with JPMorgan Chase Bank, National Association and an $80,000 variable rate private placement agreement (Series E) with Wells Fargo Municipal Capital Strategies, LLC. Annual principal payments range from $390 in 2043 to $55,505 in 2049. The interest rates, which were between 1.8% and 1.9% at December 31, 2019, reset monthly and are based on 70% of the one-month U.S. LIBOR plus a spread and a margin rate factor.

(c) WHCFA Revenue Bonds 2015 Series A and B

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

(d) WHCFA Revenue Bonds 2012 Series A

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

(e) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. In August 2019, the 2010 bonds were refinanced with the proceeds from the 2019 Term Loan as described below. This refinancing resulted in a gain of $869 that is recognized in other income, net within other income (loss) in the consolidated statement of operations and changes in net assets.

(f) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued $100,000 of 2009 Series A and B bonds that are backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. 2009 Series A and B bonds were issued as variable rate demand bonds for $50,000 each. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds that bear interest ranging from 4.4% to 5.0%. Annual principal payments range from $3,690 in 2040 to $38,890 in 2044.

(g) 2017 Term Loans

In November 2017, MHS entered into two $65,085 variable rate term loan agreements with Wells Fargo Bank, N.A. The principal balance of $130,170 is due in 2047. The interest rates, which were between 2.5% and 2.6% at December 31, 2019, reset monthly and are based on the one-month U.S. LIBOR plus a spread.

(h) 2019 Term Loan

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

(i) Other

The other debt listed is primarily made up of debt held by Navos. Of this debt at December 31, 2019, $15,665 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. The forgivable debt is subject to a forgiveness provision in years 2020 through 2068. Other debt bears interest ranging from 0.0% to 4.5%. Annual principal payments range from $5,550 in 2020 to $23 in 2036.

At December 31, 2018, $24,745 of debt, that is associated with a new market tax credit arrangement, was forgiven along with a coinciding receivable balance of $18,320, resulting in a gain on the forgiven debt of $6,245 that was realized for the year ended December 31, 2018 and included in other income, net on the consolidated statement of operations and changes in net assets.

(Dollars in thousands)

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2019 and 2018.

Each fixed-rate revenue bond requires semi-annual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

Principal maturities on long-term debt are as follows:

Year ending December 31:		
2020	$	13,668
2021		7,715
2022		47,601
2023		18,465
2024		21,127
Thereafter		1,122,213
	$	1,230,789

A summary of interest costs is as follows during the years ended December 31, 2019 and 2018:

		2019	2018
Interest cost:			
Charged to operations	$	49,313	45,574
Amortization of bond premiums, discounts, and issuance costs		(2,728)	(2,659)
Capitalized		1,231	5,282
	$	47,816	48,197

(14) Commitments and Contingencies

Approximately 44% of MHS employees were covered under collective bargaining agreements as of December 31, 2019. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through December 2022.

(Dollars in thousands)

(15) Leases

(a) Lessee

MHS leases various equipment and facilities under non-cancellable operating leases. Lease terms for non-cancellable operating leases range from 1 to 25 years, and existing leases have expiration dates through 2036.

The components of lease cost for the year ended December 31, 2019 were as follows:

		2019
Operating lease cost	$	36,532
Short term lease cost		344
Variable lease cost		7,141
Sublease income		(4,518)
Total lease cost	$	39,499

Other information related to leases as of December 31, 2019 was as follows:

		2019
Weighted average remaining lease term (years)	$	6.8
Weighted average discount rate		4.0 %
Operating cash flows from operating leases		(35,619)
Right-of-use assets obtained in exchange for new operating lease liabilities		40,717

(Continued)

(Dollars in thousands)

Maturities of lease liabilities under non-cancellable leases as of December 31, 2019 are as follows:

		Operating Leases
For year ended December 31:		
2020	$	33,660
2021		29,750
2022		22,400
2023		19,633
2024		15,004
Thereafter		49,981
Total undiscounted lease payments		170,428
Less present value discount		(21,761)
Total lease liabilities	$	148,667

The following is a schedule by year of future minimum lease payments under operating leases at December 31, 2018, which had initial or remaining lease terms of more than one year:

2019	$	32,288
2020		31,257
2021		27,399
2022		19,984
2023		17,411
Thereafter		58,103
	$	186,442

For the year ended December 31, 2018, total rental expense for operating leases was $44,357.

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS, and is the only asset that MHS leases out as a lessor. The lease has a 20 year initial lease term, with four 5 year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40 year lease. There is no purchase option stated in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. At December 31, 2019, MHS' other assets, net include a net investment in lease of $25,798.

(Dollars in thousands)

Revenue from leases for the year ended December 31, 2019 is as follows:

		2019
Interest income on net investment in finance leases	$	812
Variable lease income		25
Total lease income	$	837

Future lease payments receivable as of December 31, 2019 are as follows:

Year ended December 31:		
2020	$	1,414
2021		1,414
2022		1,414
2023		1,414
2024		1,414
Thereafter		50,029
Total lease payments to be received		57,099
Less: unearned interest income		(31,301)
Net investment in lease	$	25,798

(16) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2019 and 2018:

		2019	2018
Healthcare services	$	49,866	39,785
Endowment funds, perpetual trusts and related receivables		64,273	59,406
Purchase of equipment		6,377	14,559
Indigent care		1,634	785
Health education		1,240	1,001
Total net assets with donor restrictions	$	123,390	115,536

(Dollars in thousands)

(17) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

The following tables present MHS' endowment net asset composition as well as associated changes therein:

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2018	$ 2,923	38,140	41,063
Investment return:			
Investment income	62	782	844
Net appreciation – realized and unrealized	27	334	361
Total investment return	89	1,116	1,205
Contributions	—	1,990	1,990
Appropriation of endowment assets for expenditure	(339)	(1,546)	(1,885)
Endowment net assets, December 31, 2019	$ 2,673	39,700	42,373

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2017	$ 2,872	38,073	40,945
Investment return:			
Investment income	51	645	696
Net appreciation – realized and unrealized	28	347	375
Total investment return	79	992	1,071
Contributions	—	589	589
Appropriation of endowment assets for expenditure	(28)	(1,514)	(1,542)
Endowment net assets, December 31, 2018	$ 2,923	38,140	41,063

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $23,445 and $20,344, respectively, as of December 31, 2019 and 2018. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $1,128 and $922, respectively, as of December 31, 2019 and 2018.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2019 or 2018.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that a spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(18) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization

(Dollars in thousands)

and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2019 and 2018:

	2019				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 918,459	407,097	47,490	175,055	1,548,101
Employee benefits	120,308	69,120	11,259	40,659	241,346
Supplies	424,852	35,609	36,278	4,949	501,688
Purchased services	109,060	34,682	12,763	114,609	271,114
Depreciation and amortization	106,384	20,090	1,425	37,771	165,670
Interest	46,226	2,859	—	(2,500)	46,585
Other	217,900	44,851	16,565	78,170	357,486
	$ 1,943,189	614,308	125,780	448,713	3,131,990

	2018				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 822,476	352,368	69,035	148,624	1,392,503
Employee benefits	100,971	62,505	11,986	37,106	212,568
Supplies	360,578	72,105	27,832	5,158	465,673
Purchased services	103,981	14,925	18,601	101,063	238,570
Depreciation and amortization	98,182	16,630	1,715	32,995	149,522
Interest	41,529	2,551	—	(1,165)	42,915
Other	192,038	52,868	11,829	61,080	317,815
	$ 1,719,755	573,952	140,998	384,861	2,819,566

(19) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(20) Subsequent Events

In December 2019, a strain of coronavirus (2019-nCoV or COVID-19) was identified in Wuhan, China, and has spread to other geographic locations around the world, including more recently in the communities served by MHS. The World Health Organization has described the coronavirus outbreak as a "public health emergency of international concern." Should this pandemic continue to increase in severity in the communities served by MHS, its operations may be adversely affected in patient service volumes and revenues, access to labor, and access to necessary supplies. Additionally, subsequent to December 31, 2019, there has been instability in the global financial markets. MHS has a diverse investment portfolio, including in its defined benefit pension plan portfolio, as detailed in notes 4, 5 and 10. While sharp declines in the broader equities markets will have an adverse impact on MHS, the diversified investment allocation strategy employed by MHS serves to reduce volatility and negativity in performance. As of March 19, 2020, MHS' operations have not been significantly harmed by the COVID-19 outbreak. MHS is not currently able to measure or predict the overall impact that this pandemic, and the related financial market volatility, may have on its future financial results.

MHS has evaluated the subsequent events through March 19, 2020, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 10.

Medical Director Contract

APPENDIX A
NEONATAL MEDICAL DIRECTOR and ASSISTANT MEDICAL DIRECTOR SERVICES

I. Medical Director Neonatal Services. Medical Group will appoint a Member Physician, subject to approval by MHS, to serve as Medical Director, Neonatal Services ("Neonatal Medical Director"). The Neonatal Medical Director shall be board certified in Pediatrics and Neonatal-Perinatal Medicine and an active medical staff member of the TG-AH; GSH; and AMC. The Neonatal Medical Director shall oversee Medical Group's performance of Services under this Agreement and act as Medical Group's spokesperson in matters related to this Agreement. Medical Group has appointed and MHS has approved _____, M.D. as the initial Neonatal Medical Director.

Neonatal Medical Director shall provide, on average, twenty (20) hours per week of Medical Director Services for a total of one thousand (1000) hours annually. He/she shall provide reasonable notice to MHS of vacation or other scheduled absent time and shall provide notice as soon as practicable to MHS of emergency or unplanned absence. Neonatal Medical Director shall communicate directly with NICU leadership to establish coverage for Services during absences. The Neonatal Medical Director may delegate duties as necessary to other Medical Group Member Physicians provided that Medical Group informs NICU administration of such delegation. The Neonatal Medical Director shall remain responsible for these duties. The Neonatal Medical Director shall, without limitation, perform the following duties:

(a) Work with the Chief Medical Officer and other departments as appropriate to promote outreach to surrounding communities, enhancement of referral base and marketing of services.

(b) Evaluate, coordinate and supervise the provision of neonatal intensive care services provided at MHS hospitals;

(c) Work with MHS leadership to facilitate standardization, integration, and coordination of neonatal services among MHS facilities;

(d) Participate in development, and application of standardized evidence-based practice guidelines, clinical protocols, policies, process pathways and practitioner performance improvement monitors throughout MHS facilities;

(e) Collaborate with the NICU/ICN nursing leaders to establish a team-based approach to the provision of services in the NICU/ICN;

(f) Provide input in the development, marketing and budgeting of services in the NICU;

(g) Consult with the MHS administrative team on state and federal regulatory and accreditation requirement related to neonatal services;

(h) Participate in accreditation surveys;

(i) Ensure compliance of Medical Group Member Physicians and Neonatal Nurse Practitioners with state and federal regulations and MHS policies;

(j) Participate on MHS and hospital medical staff committees as reasonably requested;

(k) Meet weekly with the NICU/ICN nursing leaders to address NICU operational and management issues

(l) Meet bi-weekly with the Hospital Chief Medical Officer to discuss clinical and operational issues related to neonatology services provided at MHS hospitals;

(m) Oversee review of the clinical performance, competence and compliance of Member Physicians and Neonatal Nurse Practitioners;

(n) Supervise the development and implementation of and participation by Member Physicians in a quality plan for the Neonatal Care Program that includes specific measures and metrics to be tracked and compared with nationally-recognized benchmarks (e.g. Mednax BabySteps CDW, Vermont Oxford Network, etc.) with the goal of achieving the top 10th percentile;

(o) Collaborate and coordinate with the MHS Medical Director for Pediatric Quality to ensure alignment of the neonatal intensive care program quality plan with MHS pediatric quality objectives;

(p) Participate in MHS and hospital medical staff physician peer review and quality review activities related to neonatal services;

(q) Timely investigate and respond to complaints and unusual/unanticipated events related to NICU, ICN and SCN clinical services documented in a Medical Electronic Quality Improvement Memorandum ("MEQIM") in the MHS quality database system, MIDAS;

(r) Participate, with MHS leaders, in development of a plan for enhancing the marketing and provision of outreach services to surrounding communities;

(s) Supervise the Assistant Medical Director(s) Neonatal Services for GSH and AMC;

(t) In cooperation with MHS' quality, utilization, and risk improvement programs, participate in the development, refinement, and maintenance of such interdisciplinary activities for the SCNs, including but not limited to: (i) standards of care, and auditing those standards; (ii) review of SCN patient care management, including utilization, quality, and customer service; and, (iii) performance measures and neonatal outcome goals; and,

(u) Other duties set forth in the MHS Medical Director and Clinical Service Chief Roles and Responsibilities policy, a copy of which has been provided to Medical Group, as reasonably requested by the Chief Medical Officer.

(v) Embrace and role model the mission, vision and values of MHS.

(w) Contribute to the success of the organization by meeting organizational competency expectations and core values (respect, integrity, stewardship, excellence, collaboration and kindness).

II. Assistant Medical Director(s) Neonatal Services. Medical Group will appoint a Member Physician (or Physicians) acceptable to MHS to serve as Assistant Medical Director(s) ("AMD"). The AMD(s) shall be responsible for overseeing the clinical services provided by Medical Group practitioners in the AMC and GSH special care nurseries and consulting with MHS administrators regarding clinical operations those of those special care nurseries. Medical Group has appointed and MHS has approved _____, M.D. as the initial Assistant Medical Director(s). The AMD(s) shall perform, without limitation, the following duties:

(a) Work collaboratively with the MHS administrators and Hospital Chief Medical Officers to provide leadership, direction and decision-making for the special care nurseries consistent with MHS objectives;

(b) Provide consultation as necessary to maintain the special care nurseries' level 2 designations;

(c) Assist MHS to develop, implement, and update policies for the effective operation of the SCNs. Such policies shall be consistent with licensing, reimbursement, and accreditation regulations, legal requirements, and Medical Staff Bylaws and Rules, and shall promote high quality patient care, standardization of procedures, efficiency of scheduling, and highly trained professional and technical personnel;

(d) Assist MHS in the provision of continuing education programs to properly instruct physicians, nurses and allied health professionals in keeping with such training and continuing education as is customarily provided in hospitals with level 2 nurseries. Such programs shall include, without limitation, a neonatal resuscitation program (NRP) for certification and credentialing of members of nursing and medical staffs;

(e) Advise MHS on cost-control measures and equipment selection;

(f) Participate in MHS' and hospital's planning process as it relates to the operation of the special care nurseries;

(g) In cooperation with MHS' quality, utilization, and risk improvement programs, participate in the development, refinement, and maintenance of such interdisciplinary activities for the SCNs, including but not limited to: (i) standards of care, and auditing those standards; (ii) review of SCN patient care management, including utilization, quality, and customer service; and, (iii) performance measures and neonatal outcome goals;

(h) Evaluate and ensure a response to patient complaints and inquiries concerning physician services in the SCNs, in a professional manner and furnish MHS with an analysis of complaints and recommendations for addressing any deficiencies;

(i) Meet with the special care nursery nursing leadership and Neonatal Nurse Practitioners in person least monthly to review SCN management and operations, including quality metrics, policies, clinical practice issues (e.g. case reviews), and service standards;

(j) Represent MHS and the SCNs in such community education and civic activities as reasonably requested; and

(k) Develop and support an environment that promotes customer service, teamwork, collegiality and open communication between MHS, the hospital, community physicians and SCN staff.

III. Termination of Medical Director. MHS shall have the right to require immediate replacement by Medical Group of the Medical Director or Assistant Medical Director immediately on written notice for cause, which shall include the institution of proceedings against Neonatal Medical Director or Assistant Medical Director that could lead to conviction of a crime; Neonatal Medical Director's or Assistant Medical Director's engaging in actions that MHS in good faith determines may impair the health and safety of patients; the imposition of disciplinary sanctions against Neonatal Medical Director or Assistant Medical Director by any governmental agency having jurisdiction over such physician; and/or the Medical Director's or Assistant Medical Director's failure or refusal to perform the administrative services required under this Appendix A. Termination of Neonatal Medical Director's or Associate Medical Director's performance of services under this Agreement shall be without due process under the MHS Medical Staff Bylaws, or otherwise, which rights Neonatal Medical Director expressly waives; provided, however, any limitation or termination of Neonatal Medical Director's Medical Staff privileges in the treatment of his/her own patients shall be subject to the Medical Staff Bylaws.

Exhibit 11.

NICU Medical Staff Roster

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
Acierno	Stephanie	Pediatric (general) surgery	MD00043770	
Adam	Margaret	Medical Genetics	MD60094938	
Afrassiabi	Ali	Anesthesiology	MD00033503	
Allen-Rich	Jennie	Pediatric Cardiology	MD60217235	
Amos	Janine	Pediatric otolaryngology	OP60958193	
Engel	Amy	Neonatal Nurse Practitioner	AP60833763	RN60288832
Erickson	Katy	Registered Nurse	RN00142056	
Anand-Nichols	Sonia	Neurology	MD60947619	
Anderson	Eric	Anesthesiology	PA60976634	
Anderson	Chelsea	Registered Nurse	RN60619891	
Anderson	Crystal	Registered Nurse	RN60224921	
Peppers	Ann	Neonatal Nurse Practitioner	AP60292018	RN00142598
Archana	Jayaram	Pediatrics Neonatal-Perinatal Medicine	MD60454304	
Armstrong	Kayla	Registered Nurse	RN61087612	
Aube	Paul	Registered Nurse	RN60181390	
Bakalarski	Amy	Registered Nurse	RN60806851	
Baker	Lydia	Registered Nurse	RN60678264	
Balerud	Lauren	Registered Nurse	RN60962850	
Banasky	Sarah	Registered Nurse	RN60159347	
Barlow	Meade	Pediatric (general) surgery	MD60765286	
Bartholomae	Marci	Registered Nurse	RN00130839	
Bartos	Heather	Registered Nurse	RN00152648	
Bauer	Megan	Registered Nurse	RN60441882	
Beasley	Megan	Registered Nurse	RN60927070	
Becker	Megan	Registered Nurse	RN00166405	
Becker	Jennifer	Registered Nurse	RN00171239	
Carter	Becky	Neonatal Nurse Practitioner	AP30005099	RN00095234
Belich	Keja	Registered Nurse	RN00166375	
Bellotti	Christopher	Pediatric Cardiology	MD60349148	
Berdan	Elizabeth	Pediatric (general) surgery	MD60781159	
Bernard	Mary	Anesthesiology	MD00041798	
Bernt	Jennifer	Registered Nurse	RN60096869	
Blackmon	Kevin	Anesthesiology	MD00036968	
Blair	Mackenzie	Registered Nurse	RN61210236	
Bohuta	Lyubomyr	Congenital heart surgery	TR61032442	
Bolster	Kelli	Registered Nurse	RN60025126	
Boseley	Mark	Pediatric otolaryngology	MD00047231	
Bouma	Jana	Registered Nurse	RN00145898	
Bouterse	Phillip	Anesthesiology	MD00035646	
Brantner	Lacey	Registered Nurse	RN60086540	
Braxton	Kimberly	Registered Nurse	RN60791606	
Brookreson	Tonya	Registered Nurse	RN60384336	
Brooks	Jenny	Registered Nurse	RN00165841	
Brundidge	P Kaye	Anesthesiology	MD00045181	
Burini	Amani	Registered Nurse	RN60917610	
Burnbaum	Jake	Pediatric Anesthesiology	MD60671192	
Cameron	Caitlin	Registered Nurse	RN60414802	
Carey	Janet	Registered Nurse	RN00067569	
Chan	KaYee	Neurology	MD60944431	
Chang	Elbert	Anesthesiology	OP60778793	
Chang	Tamara	Pediatric Hem Onc	MD60537839	
Tan-Dy	Cherie	Neonatal-Perinatal Medicine	MD60236067	
Chesemore	Leann	Registered Nurse	RN00166846	
Cheung	Jason C	Pediatric ophthalmology	MD00036111	

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
Christiansen	Michele	Registered Nurse	RN00132194	
Ciullo	Sean	Pediatric (general) surgery	MD61062650	
Miller	Corinne	Neonatal Nurse Practitioner	AP60809280	RN60198950
Weyand	Courtney	Neonatal Nurse Practitioner	AP60413978	RN00160297
Coy	Cherri	Registered Nurse	RN60713574	
Crandall	Ronna	Registered Nurse	RN00089562	
Cunningham	David	Anesthesiology	MD60057683	
Dang	Heather	Registered Nurse	RN60072880	
Davidson	Elizabeth	Registered Nurse	RN60475661	
Day	Sarah	Registered Nurse	RN60957845	
Deacon	Haley	Registered Nurse	RN60464634	
Drake	Elora	Registered Nurse	RN 60662264	
Fielding	Deannita	Neonatal Nurse Practitioner	AP61075184	RN60378918
Lanning	Debra	Neonatal Nurse Practitioner	AP60631212	RN60631207
DeLauder	Natalie	Registered Nurse	RN60774991	
Gries	Delores	Neonatal-Perinatal Medicine	MD60456680	
Demakakos	Jason	Anesthesiology	MD61055423	
DeMars	Adam	Anesthesiology	MD60254019	
Deno	Karaline	Registered Nurse	RN60469104	
DeVault	Monee	Registered Nurse	RN60925493	
Devore	Katherine	Registered Nurse	RN60467680	
DeWalt	Micki	Registered Nurse	RN00105992	
Donohue	Laura	Pediatric Anesthesiology	MD60555639	
Dow	Laura	Registered Nurse	RN60450135	
D'Souza	Rakesh	Pediatric Cardiology	MD60739164	
Du	Veronica	Registered Nurse	RN60158388	
Dunn	Jessica	Registered Nurse	RN60976554	
Dunn	Clara	Registered Nurse	RN60917089	
Dzingle	Dawn	Registered Nurse	RN00120865	
Ellison	Alocasia	Registered Nurse	RN00155486	
Emerson-Glade	Naomi	Registered Nurse	RN60644532	
Engelland	Charlene	Registered Nurse	RN60366041	
Erdman	Kayla	Registered Nurse	RN60570603	
Escobar	Mauricio	Pediatric (general) surgery	MD60067507	
Estill	Bryan	Anesthesiology	MD61057014	
Evans	Jasmine	Registered Nurse	RN60648995	
Everson	June	Registered Nurse	RN60450137	
Falk	Gavin	Pediatric (general) surgery	MD60625361	
Farley	Tanner	Registered Nurse	RN61094495	
Fern	Amanda	Anesthesiology	MD60225909	
Finch	Christopher	Anesthesiology	MD60447551	
Flynn	Kristi	Registered Nurse	RN60000975	
Foulks	Michael	Anesthesiology	MD61053509	
Frazier	Britney	Pediatric Endocrinology	MD60322363	
Frederick	Cheryl	Registered Nurse	RN00160589	
Frost	Nathan	Pediatric orthopedic surgery	MD60143548	
Gagne	Brittney	Registered Nurse	RN60663521	
Galapon	Kathleen	Registered Nurse	RN60811335	
Galinato	Cecilia	Registered Nurse	RN60462558	
Gandhi	Kevin	Pediatric urology	MD00031747	
Garner	Lauren	Registered Nurse	RN61184302	
Garofalo	Michelle	Registered Nurse	RN61242847	
Gehring	Julie	Registered Nurse	RN00117089	
Gernon	Victoria	Registered Nurse	RN60561862	

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
Gillespie	Amy	Registered Nurse	RN00129415	
Goebel	Terri	Registered Nurse	RN00114245	
Gong	Zi	Anesthesiology	MD61049806	
Gore	Kjersten	Registered Nurse	RN61029757	
Graf	Ronald	Endocrinology	MD00013532	
Graves	Carrie	Pediatric Endocrinology	MD60852457	
Greene	Krystal	Registered Nurse	RN60777122	
Grider	Carol	Registered Nurse	RN00083120	
Grondin	Ronald	Pediatric neurosurgery	MD60440903	
Hair	Amelia	Registered Nurse	RN60952110	
Hale	Kara	Registered Nurse	RN60378094	
Han	Julie	Registered Nurse	RN60412228	
Handlan	Gena	Registered Nurse	RN00129293	
Hanevold	Coral	Pediatric Nephrology	MD00048253	
Hart	Wesley	Anesthesiology	MD00028430	
Haynes	Marlo	Registered Nurse	RN60532480	
Helland	Phoebe	Registered Nurse	RN60850792	
Hencke	Kristi	Registered Nurse	RN00173750	
Hencke	Kayla	Registered Nurse	RN61095409	
Henderson	Jacob	Pediatric Hem Onc	MD60958285	
Herd	Heather	Registered Nurse	RN61024732	
Hoang	Khoa	Anesthesiology	MD60927686	
Hoang	Vivian	Neurology	MD60458745	
Hoffman	Stuart	Neurology	OP60886046	
Holder	Susanne	Registered Nurse	RN00148012	
Holland	Randall	Pediatric (general) surgery	MD00031380	
Holley	Katherine	Anesthesiology	OP60481258	
Horton	John	Pediatric (general) surgery	MD60295888	
Hrivnak	Jacqueline	Neurology/SQ Child Neurology	MD00040831	
Hsu	Lilly	Pediatric Anesthesiology	MD00043567	
Hughes	Danielle	Registered Nurse	RN60655417	
Hunter	Joanna	Registered Nurse	RN60552928	
Irwin	Robert	Pediatric Hem Onc	MD00043766	
Jackson	Mercedes	Registered Nurse	RN61168702	
Jahn	Beatrix	Registered Nurse	RN60523214	
Jamieson	Shelby	Registered Nurse	RN60883097	
Clark	Janet	Neonatal Nurse Practitioner	AP60617031	RN00140464
Jenkins	Virginia	Registered Nurse	RN00080138	
Kurtz	Jennifer	Neonatal Nurse Practitioner	AP61016241	RN00124987
Johannsen	Barbra	Registered Nurse	RN60454656	
Johnson	Rebecca	Pediatric Hem Onc	MD00048662	
Jones	Thomas	Pediatric Cardiology	MD00017655	
Judson	Ashley	Registered Nurse	RN60321299	
Jungmann	Julie	Registered Nurse	RN60030842	
Kae	Jacquelin	Anesthesiology	MD00026924	
Kambla	Ilona	Registered Nurse	RN60096865	
Kaminski	Stephen	Anesthesiology	MD00034257	ES60162412
Kandel	Magnum	Registered Nurse	RN60967557	
Karro	Jason	Anesthesiology	MD00044386	
Snyder	Katherine	Neonatal Nurse Practitioner	AP60491309	RN60087477
Kenningham	Katie	Pediatrics Neonatal-Perinatal Medicine	MD60564662	
Katwijk	Karissa	Registered Nurse	RN60231314	
Kaur	Shamsheer	Registered Nurse	RN60883487	
Keegan	Caitlyn	Registered Nurse	RN60844294	

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
Keller	Amanda	Registered Nurse	RN00165318	
Kellner	Leslie	Registered Nurse	RN00176469	
Kelly	Christopher	Pediatric ophthalmology	MD60823724	
Kim	Tiffany	Pediatric Anesthesiology	MD60936506	
Kim	Paul	Anesthesiology	MD60935289	
King	Ericka	Pediatric otolaryngology	MD60906587	
Kintner	Jovilyn	Registered Nurse	RN60225545	
Kish	Nadezhda	Registered Nurse	RN61165328	
Ko	Pin-Yi	Neurology	MD60971559	
Korol	Vera	Neurology	MD00047207	
Krabill	Kimberly	Pediatric Cardiology	MD00037548	
Kravchishin	Yelena	Registered Nurse	RN60829260	
Marbut	Kristie	Neonatal Nurse Practitioner	AP3000331	RN00086197
Ku	Stephen	Anesthesiology	OP60759505	
Kulesza	Caree	Registered Nurse	RN60953769	
Kuri	Scarlett	Registered Nurse	RN60907904	
Kwa	Hian	Anesthesiology	MD00043742	
Lai	David	Anesthesiology	MD00036171	
Langs-Barlow	Allison	Pediatric Infectious Disease	MD60784364	
Langworth	David	Anesthesiology	MD00029427	
Larson	Amanda	Pediatric orthopedic surgery	MD60482537	
Lashley	David	Pediatric urology	MD60817687	
Latendresse	Thomas	Pediatric Anesthesiology	MD00042989	
Le	Chuong	Neurology	MD60213693	
Lee	Andy	Anesthesiology	MD61046623	
Lien	Elizabeth	Infectious Disease	MD00040969	
Liming	Bryan	Pediatric otolaryngology	MD61088418	
Lipowski	Joanna	Registered Nurse	RN00167631	
Lozier	Jordana	Registered Nurse	RN60835955	
Lundberg	Susan	Anesthesiology	MD00048622	
Lynam	Laura	Neurology	MD00046337	
Madden	Kristina	Registered Nurse	RN60470935	
Lutz	Madison	Neonatal Nurse Practitioner	AP61174340	RN61165922
Mahony	Kathleen	Registered Nurse	RN60652185	
Major	Lindenne	Registered Nurse	RN61085364	
Makari	George	Neurology/SQ Child Neurology	MD00027455	
Mangay-Ayam	Lorie Ann	Registered Nurse	RN60851215	
Mann	Kelly	Pediatric Infectious Disease	MD60913660	
Marsh	Danielle	Registered Nurse	RN60081791	
Mathews	Paul	Anesthesiology	MD00028519	
Mattingly	Susan	Registered Nurse	RN00117493	
Mattson	Steve	Anesthesiology	MD00047821	
Mauchley	David	Congenital heart surgery	MD61021349	
Mavin	Stephanie	Registered Nurse	RN00155873	
May	Ashley	Registered Nurse	RN60871543	
McCloskey	John	Pediatric Cardiology	MD00022079	
McClure	Alyssa	Registered Nurse	RN60455721	
McCoy	Brian	Anesthesiology	MD00046744	
McDonald	Abby	Registered Nurse	RN60822177	
McEniry	David	Infectious Disease	MD00025811	
McGrath	Rachael	Registered Nurse	RN60017590	
McMullen	Carl	Anesthesiology	OP60901530	
McMullan	David	Congenital heart surgery	MD00041607	
McNeel	Kenzie	Registered Nurse	RN61016038	

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
McNeley	Hannah	Registered Nurse	RN60866078	
Mebust	Kimberly	Neurology	MD00033517	
Mendoza	Emary Trinna	Registered Nurse	RN61193515	
Metschke	Derrick	Anesthesiology	MD60554441	
Kuluz	Michael	Neonatal-Perinatal Medicine	MD60516236	
Bailey	Michele	Neonatal Nurse Practitioner	AP60114511	RN60114508
Mitchell	Koryne	Registered Nurse	RN61019512	
Mohr	Cynthia	Registered Nurse	RN00114575	
Molacavage	Shanon	Registered Nurse	RN60679304	
Moran	Angela	Registered Nurse	RN60070635	
Mortensen	Sarah	Registered Nurse	RN60658189	
Mott	Jared	Neurology/SQ Child Neurology	OP60460227	
Munumel Garcia	Elixcia	Registered Nurse	RN60091001	
Murphy	Timothy	Pediatric Pulmonology	MD00020806	
Murphy	Jode	Registered Nurse	RN60015000	
Myers	Jalena	Registered Nurse	RN61076888	
Myint	Michael	Infectious Disease	MD00038709	
Neel	Amanda	Registered Nurse	RN00173526	
Neff	Randi	Registered Nurse	RN60693863	
Nelson	MacKenzye	Registered Nurse	RN60870973	
Newgard	Tiffany	Registered Nurse	RN00153075	
Nguyen	Ponney	Registered Nurse	RN60158000	
Nichols	Ericka	Registered Nurse	RN00146568	
Norberg	Shani	Neurology	MD61041339	
Nuri	Muhammad Ataunur Khalid	Congenital heart surgery	MD60433876	
Ogawa	Jessica	Medical Genetics	MD61041303	
Omoruan	Airadion	Anesthesiology	MD60441147	
Park	Matthew	Pediatric Cardiology	MD00049264	
Paul	Madeline	Registered Nurse	RN60878148	
Pearson	Erin	Registered Nurse	RN60757403	
Penalver	Josiah	Pediatric Cardiology	MD60361918	
Permut	Lester	Congenital heart surgery	MD00041731	
Peterson	Lucy	Pediatric plastic surgery	MD00031440	
Peterson	Cathy	Registered Nurse	RN00139986	
Peyfuss	Monica	Registered Nurse	RN61028618	
Phillips	Steven	Neurology/SQ Child Neurology	MD00045897	
Pittard	Melanie	Anesthesiology	OP60906246	
Porta	Kendra	Pediatric Anesthesiology	MD60389023	
Porter	Douglas	Neurology	MD60502147	
Porter	Miranda	Registered Nurse	RN60853699	
Powers	Susan	Pediatric Cardiology	MD60218133	
Prem	Arora	Pediatrics Neonatal-Perinatal Medicine	MD60667080	
Presutti	Monique	Registered Nurse	RN00103442	
Prichard	Jessica	Registered Nurse	RN60969010	
Pruitt	Natalie	Registered Nurse	RN60171610	
Querubin	Jessica	Registered Nurse	RN00169600	
Raff	Michael	Medical Genetics	MD00031657	
Rajacich	Nicholas	Pediatric orthopedic surgery	MD00027445	
Randall	Bailey	Registered Nurse	RN60864575	
Rasco	Haley	Registered Nurse	RN60864708	
Sato	Ray	Neonatal-Perinatal Medicine	MD00033781	
Reams	Mary	Registered Nurse	RN61062129	
Redger	Charles	Anesthesiology	MD60723748	
Ricker	David	Pediatric Pulmonology	MD00028670	

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
Robertson	Cory	Anesthesiology	MD60928192	
Robertson	Rosemary	Registered Nurse	RN60890856	
Robinson	Jeffrey	Anesthesiology	MD00040846	
Rogers	Derek	Pediatric otolaryngology	MD60456988	
Rodrigues	Krystal Faith	Registered Nurse	RN60683142	
Rogers	Alicia	Registered Nurse	RN00134192	
Rossow	Jean-Esther	Registered Nurse	RN60078164	
Rue	Forrest	Anesthesiology	MD00026423	
Ruffner	Cheryl	Registered Nurse	RN00090811	
Running	Sarah	Registered Nurse	RN00142629	
Russell	Michael	Anesthesiology	MD00031927	
Ryan	Traci	Registered Nurse	RN00123973	
Ryckman	Rebecca	Registered Nurse	RN00157878	
Sainato	Rebecca	Pediatric Infectious Disease	MD60805239	
Sanborn	Katherine	Registered Nurse	RN60650991	
Sandeep	Nefthi	Pediatric Cardiology	MD60675977	
Savage	Christopher	Anesthesiology	MD00043662	
Schaan	Megan	Registered Nurse	RN60447616	
Schneider	Patricia	Registered Nurse	RN60276200	
Schneider	Amy	Registered Nurse	RN60459144	
Schoettler	LeeAnn	Registered Nurse	RN00078838	
Schrenk	David	Anesthesiology	MD00029513	
Schroeder	Kathleen	Registered Nurse	RN00094321	
Schwartz	Lawrence	Infectious Disease	MD00029796	
Schwarz	Anisha	Neurology	MD60782568	
Scott	Serena	Neonatal-Perinatal Medicine	MD60455485	
Sessler	Madeline	Registered Nurse	RN61173191	
Shin	Wonita	Anesthesiology	MD60648175	
Shirka	Romina	Neurology	OP60397345	
Siedenburg	Allison	Registered Nurse	RN60884482	
Sinopole	Patrick	Anesthesiology	MD00047487	
Smith	Suzanne	Registered Nurse	RN60446090	
Smith	Alicia	Registered Nurse	RN60287783	
Snider	Teresa	Registered Nurse	RN60287933	
Spevak	Lisa	Registered Nurse	RN00172939	
Sporl	Laura G	Pediatric Gynecology	MD00047209	
Stangl	James	Anesthesiology	MD00032073	
Stead	Ashley	Registered Nurse	RN61070598	
Fox	Stephanie	Neonatal Nurse Practitioner	AP60870200	RN60878484
Stephenson	Roberta	Pediatric Cardiology	MD00034144	
Stowers	Bryanna	Registered Nurse	RN60655418	
Strickland	Nicole	Anesthesiology	MD00046229	
Suchland	Krista	Registered Nurse	RN60398300	
Suetta	Bethany	Registered Nurse	RN00150921	
Suitts	Sarah	Registered Nurse	RN61162328	
Sulik	Victoria	Registered Nurse	RN60176992	
Sutton	Ashley	Registered Nurse	RN60297553	
Ingrao	Suzanne	Pediatric Hospitalist	MD00049333	
Swanson	Veronica	Pediatric Anesthesiology	MD60654357	
Swanson	Marisa	Registered Nurse	RN00142392	
Swanson	Connie	Registered Nurse	RN60939453	
Szczepanik	Ann	Anesthesiology	MD60565948	
Tait	Joanne	Registered Nurse	RN00117576	
Templeton	Genie	Registered Nurse	RN00169073	

NICU Medical Staff Roster

Physicians, RNs, and Advanced Practice Providers

Last Name	First Name	Specialty	License Number	Dual Licensure
Theisen	Michael	Anesthesiology	MD00018370	
Thilo	Evan	Anesthesiology	MD60846738	
Thompson	Barbara	Pediatric Endocrinology	MD00048103	
Titus	Rebecca	Registered Nurse	RN00103182	
Tolbert	Vanessa	Pediatric Hem Onc	MD60953479	
Tomlinson	Jennifer	Registered Nurse	RN00125881	
Tompkins	Jeremy	Anesthesiology	MD00044100	
Trinh	Thuydung	Anesthesiology	MD60456896	
Trippel	Donald	Pediatric Cardiology	MD00019632	
Tucker	Melissa	Registered Nurse	RN61051670	
Turnbull	Saraiah	Registered Nurse	RN61094985	
Tuttle	Lynn	Registered Nurse	RN00103165	
Underwood	Deanna	Registered Nurse	RN00082601	
Upright	Karen	Registered Nurse	RN60915490	
Usach	Tetyana	Registered Nurse	RN60170611	
Uskovich	Julie	Registered Nurse	RN00123923	
Van Devender	Rachel	Registered Nurse	RN60430941	
Van Duker	Brad	Anesthesiology	MD00029600	
Wakefield	Tezra	Registered Nurse	RN60633407	
Wang	Wendy	Pediatric Anesthesiology	MD60926127	
Ware	Ashley	Registered Nurse	RN61167730	
Warriner	Cameron	Registered Nurse	RN60757518	
Warwick	Wendy	Anesthesiology	MD00044569	
Weaver	Jessica	Registered Nurse	RN61106196	
Weier	Kathryn	Registered Nurse	RN60200020	
Wheeler	Kristin	Registered Nurse	RN00074506	
Whelan	Jesse	Registered Nurse	RN60285770	
Whitesell	Rebecca	Pediatric orthopedic surgery	MD60490776	
Williams	Summer	Anesthesiology	MD60883994	
Williams	Rachel	Registered Nurse	RN60861394	
Wilson	Malerie	Registered Nurse	RN60590880	
Wyatt	Janet	Registered Nurse	RN00080220	
Wynn	Teresa	Registered Nurse	RN00155875	
Cervantes	Yazmin	Neonatal Nurse Practitioner	AP61124296	RN60025395
Youngberg	Mark	Anesthesiology	MD60553310	
Yuen	Amy	Clinical Genetics and Genomics	MD00048354	

Exhibit 12.

Washington State Perinatal Level of Care Guidelines

WASHINGTON STATE

Perinatal and Neonatal Level of Care (LOC) 2018 Guidelines

Washington State Department of Health

DOH 950-154 March 2018

For people with disabilities, this document is available on request in other formats.
To submit a request, please call 1-800-525-0127 (TDD/TTY 711).

Contents

Introduction

Washington State Department of Health developed the Washington State Perinatal and Neonatal Level of Care Guidelines in 1988. We have revised them in 1993, 2001, 2005, 2010, and 2013. We want these guidelines to help hospitals assess the type of patients best suited for their facility's capabilities and scope of care. The Level of Care classification allows providers to briefly summarize a given hospital's services while recognizing there can be a broad range of services in each level of care. This revision follows the American Academy of Pediatrics recommendation to use uniform, nationally applicable definitions and consistent standards of service[1,2] to improve neonatal outcomes. The next revision will be in 2023.

The Guidelines don't require individual hospitals to provide the entire scope of service within a Level of Care. We know variation may be needed so both the Guideline objectives and the unique goals of a hospital or region may be met. For example, in some rural hospitals the average daily census of neonates may be lower to ensure access to care.

We hope these guidelines will help:

1. improve the outcome of pregnancy,
2. increase access to appropriate care for pregnant women and newborns, and
3. optimize allocation of resources.

We urge health care providers to remain informed about any updates or revisions of all referenced materials.

This is not a regulatory document. Washington State Certificate of Need program uses this document as a reference for hospitals applying for Level II, Level III, or Level IV designations.

Definitions, Capabilities, and Provider Types[1]

Level of Care	Capabilities	Provider Types
Level I *Well Newborn Nursery*	✔ Provide neonatal resuscitation at every delivery ✔ Evaluate and provide postnatal care to stable term newborn infants ✔ Stabilize and provide care for infants born 35–37 wk gestation who remain physiologically stable ✔ Stabilize newborn infants who are ill and those born at <35 wk gestation until transfer to a higher level of care	✔ Pediatricians ✔ Family physicians ✔ Nurse practitioners ✔ Other advanced practice registered nurses
Level II *Special Care Nursery*	**Level I Capabilities plus:** + Provide care for infants born ≥32 wk gestation and weighing ≥1500 g who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis + Provide care for infants convalescing after intensive care + Provide mechanical ventilation for brief duration (<24 h) or continuous positive airway pressure or both + Stabilize infants born before 32 wk gestation and weighing less 1500 g until transfer to a neonatal intensive care facility	**Level I Providers plus:** + Pediatric hospitalists + Neonatologist + Neonatal nurse practitioners as appropriate
Level III *NICU*	**Level II Capabilities plus:**[3] + Provide sustained life support + Provide comprehensive care for infants born <32 wks gestation and weighing <1500 g and infants born at all gestational ages and birth weights with critical illness + Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists + Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide + Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography	**Level II Providers plus:** + Pediatric medical subspecialists + pediatric anesthesiologists + Pediatric surgeons + Pediatric ophthalmologists with appropriate qualifications
Level IV *Regional NICU*	**Level III Capabilities plus:** + Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions + Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists, and pediatric anesthesiologists at the site + Facilitate transport and provide outreach education	**Level III Providers plus:** + Pediatric surgical subspecialists

Neonatal Patients: Additional Details of Services and Capabilities

Level I

Services and Capabilities of all Level I:

- ✔ Newborn resuscitation per AHA Guidelines including intubation and vascular access for medications and volume
- ✔ Stabilize sick newborns pending arrival of transport team
- ✔ Breastfeeding support per AAP and WHO guidelines[4]
- ✔ Controlled thermal environment
- ✔ Neonatal cardiorespiratory monitor for use during stabilization, assessment, or observation prior to transport
- ✔ Neonatal pulse oximeter
- ✔ Oxygen blender
- ✔ Device for blood glucose screening
- ✔ Gavage feeding
- ✔ Device and appropriate-size cuffs for assessing blood pressure
- ✔ Hood oxygen/nasal cannula
- ✔ Peripheral IV insertion for fluids, glucose, and antibiotics prior to transport
- ✔ Phototherapy equipment available that produces irradiance of at least 30μWcm^2/nm or ability to simultaneously cover body surface under and over baby
- ✔ Irradiance meter to measure light irradiance of equipment[5]
- ✔ Device to measure blood gas in <0.4 mL blood

Level II

Services and Capabilities of Level I plus:
If services are limited to ≥34 wk and ≥2000 g and for newborns whose problems are expected to resolve rapidly and without need for CPAP, assisted ventilation, or arterial catheter:

- + Space designated for care of sick/convalescing neonates
- + Cardiorespiratory monitor for continuous observation
- + Peripheral IV insertion, maintenance and monitoring for fluids, glucose, antibiotics
- + Neonatal blood gas monitoring
- + Average daily census of at least one to two Level II patients
- + Relationship with regional neonatal center for routine and urgent consultation and medical direction advice by phone, videoconference, or regular visits

If caring for 32–33 wk gestation or moderately-ill infants, add:

- + Umbilical or peripheral arterial catheter insertion, maintenance and monitoring
- + Peripheral or central administration and monitoring of total parenteral nutrition and/or medication and fluids
- + High flow nasal cannula
- + Nasal CPAP
- + Average daily census of at least two to four Level II patients

Level III

Services and Capabilities of Level II plus:

- + Conventional mechanical ventilation
- + Cranial ultrasound
- + Pediatric echocardiography with written protocols for pediatric cardiology interpretation and consultation[6]
- + High-risk NICU follow-up program
- + Quality improvement program with comparisons to national benchmarks for Level III NICUs, e.g., VON
- + Complete range of genetic diagnostic services and genetic counselor available, referral arrangement for geneticist and diagnostics per written protocol
- + Arrangement for perinatal pathology services
- + Average daily census of at least 10 Level II/Level III patients

If services include high-frequency ventilation or inhaled nitric oxide, add:

- + NICU respiratory care practitioners continuously present in the NICU during use

If services include major surgical procedure, add: [7]

- + 24/7 pediatric surgeons
- + 24/7 pediatric anesthesiologists
- + 24/7 pediatric diagnostic and interventional radiology
- + NICU nurses trained to care for post-op infants

Level IV

Services and Capabilities of Level III plus:

- + Full spectrum (all possible) of medical and surgical pediatric subspecialists available 24/7
- + Multi-disciplinary teams for management of complex patients, including those with meningomyelocele, hydrocephalus, urogenital anomalies, orthopedic problems, chronic lung disease, congenital diaphragmatic hernia, congenital heart disease, etc.
- + Therapeutic hypothermia program for hypoxic-ischemic encephalopathy, including aEEG, cEEG, pediatric neurologist, and pediatric neuroradiologist
- + Surgical repair of complex conditions that may require cardiopulmonary bypass, ECMO, dialysis, tracheostomy, etc.[8]
- + Neuro-developmental follow-up program
- + Quality improvement program with comparisons to national benchmarks for Level IV NICUs (Children's Hospital Neonatal Consortium (CHNC))
- + Training and educational relationship with referring hospitals

Additional Sites of Perinatal and Neonatal Care

Location	Hospital Without Delivery Service	Non-Hospital Birth Center (37–42 wk gestation; low-risk pregnancies)
Capabilities	Basic newborn support including thermoregulation and resuscitation as needed following AHA Guidelines for Neonatal Resuscitation[9] and stabilization pending transfer to appropriate level of care facility based on maternal and/or neonatal services required.	Manage newborn resuscitation per AHA Guidelines for Neonatal Resuscitation, including thermoregulation, initial steps of resuscitation and mask ventilation and supplemental oxygen if required pending arrival of Emergency Medical Services. ARNPs and medical providers, if present, may provide endotracheal intubation, emergency vascular access and administration of medication and volume if indicated per AHA Guidelines.[7]
Provider Types	Emergency Room Physicians	Licensed Midwives, Certified Nurse Midwives, Naturopathic Physician

Obstetrical Patients: Services and Capabilities

Level I Neonatal

Uncomplicated pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal–fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until patient can be transferred to a facility at which specialty maternal care is available.

Capabilities[10]

- ✔ Ability to begin emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care
- ✔ Available support services, including access to obstetric ultrasonography, laboratory testing, and blood bank supplies at all times
- ✔ Protocols and capabilities for emergency release of blood products, and management of multiple component therapy
- ✔ Ability to establish formal transfer plans in partnership with a higher-level receiving facility
- ✔ Ability to initiate education and quality improvement programs to maximize patient safety, and/or collaborate with higher-level facilities to do so

Types of Healthcare Providers[10]

- ✔ Continuous availability of adequate number of RNs with competence in Level I care criteria and ability to stabilize and transfer high-risk women and newborns
- ✔ Nursing leadership has expertise in perinatal nursing care
- ✔ Anesthesia services available to provide labor analgesia and surgical anesthesia

Level II Neonatal

Level I Facility Capabilities plus:

- + Computed tomography scan and, ideally, magnetic resonance imaging with interpretation available
- + Basic ultrasonographic imaging services for maternal and fetal assessment

Level I Facility Healthcare Providers plus:[10]

- + Continuous availability of adequate numbers of RNs with competence in Level II care criteria and ability to stabilize and transfer high-risk women and newborns who exceed Level II care criteria
- + Nursing leadership and staff have formal training and experience in the provision of perinatal nursing care and should coordinate with respective neonatal care services
- + OB/GYN available at all times
- + Director of obstetric service is a board-certified OB/GYN
- + MFM available for consultation onsite, by phone, or by telemedicine, as needed
- + Anesthesia services available at all times to provide labor analgesia and surgical anesthesia
- + Medical and surgical consultants available to stabilize obstetric patients who have been admitted to the facility

For hospitals prepared to care for newborns >32 0/7 weeks gestation and estimated birthweight >1500 grams, OB capabilities include management consistent with ACOG guidelines of selected high-risk pregnancy conditions such as preterm labor or other complications of pregnancy judged unlikely to deliver before 32 weeks gestation.

Level III Neonatal

Level II Facility Capabilities plus:

- + Advanced imaging services available at all times
- + Medical and surgical ICUs accepts pregnant women and have critical care providers onsite to actively collaborate with MFMs at all times
- + Appropriate equipment and personnel available onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU

Level II Healthcare Providers plus:

- + RNs with competence in Level III care criteria and ability to transfer and stabilize high-risk women and newborns who exceed Level III care criteria, and with special training and experience in the management of women with complex maternal illnesses and obstetric complications
- + OB/GYN available onsite at all times
- + MFM with inpatient privileges available at all times, either onsite, by phone, or by telemedicine
- + Director of MFM service is a board-certified MFM
- + Director of obstetric service is a board-certified ob-gyn with special interest and experience in obstetric care
- + Anesthesia services available at all times onsite
- + Board-certified anesthesiologist with special training or experience in obstetric anesthesia

Level IV Neonatal

If obstetrical services are offered, OB capabilities are the same as for Level III.

Patient Transport

Level I

All hospitals demonstrate capabilities to stabilize and initiate transport of patients in the event of unanticipated maternal-fetal-newborn problems that require care outside the scope of the designated level of care. Access to return transport services may be a necessary capability for Level III and Level IV intensive care nurseries.

Transport patients:

- ✔ Who are anticipated to deliver a neonate of earlier gestational age than appropriate for the facility's designated level of care, but should not transport if the fetus or mother is medically unstable or delivery is imminent
- ✔ Whose illness or complexity requires services with a higher level of care than provided at the admitting facility? For neonatal transport, refer to AAP reference titled, "Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients[11]

A hospital that transports patients to a higher level of care facility should:

- ✔ Demonstrate on-going relationships with referral hospital(s) for education, immediate consultation, urgent transport facilitation, and quality assurance
- ✔ Establish a written policy and procedure for maternal and neonatal transport that includes an established triage system for identifying patients at risk who should be transferred to a facility that provides the appropriate level of care
- ✔ Establish guidelines that ensure a provider's continuing responsibility for and care of the patient until transport team personnel or receiving hospital personnel assume full responsibility for the patient

A hospital that accepts maternal or neonatal transports in order to provide a higher level of care than is offered at the referral hospital, should:

- ✔ Participate in perinatal and/or neonatal case reviews at the referral hospital
- ✔ Maintain a 24 hrs/day, 7 days/week system for reliable, comprehensive communication between hospitals for immediate consultation, initiation, and approval of maternal and newborn transports
- ✔ Provide referring physicians with ongoing communication and recommendations for ongoing patient care at discharge

Level II

Level III criteria excluding obstetrical care if not provided.

Return transport may be necessary to make acute care beds accessible and for discharge planning closer to patient's community.

Level III

Level IV

Medical Director

Level I

Obstetrics: Board-certified in OB/GYN or family medicine

Nursery: Board-certified in pediatrics or family medicine

If the medical director is a family medicine physician, he or she may direct both services.

Level II

Obstetrics: Board-certified in OB/GYN

Nursery: Board-certified in pediatrics

If caring for 32–34 week infants:

Obstetrics: Board-certified in OB/GYN

Nursery: Board-certified in neonatology or pediatric hospitalist who has oversight from neonatologist

Level III

Obstetrics (if provided): Board-certified in maternal-fetal medicine

Nursery: Board-certified in neonatology

Level IV

Healthcare Providers

Level I

- ✔ Physician or credentialed obstetrical provider in-house, immediately available in late stage labor or when fetal or maternal complications are imminent or apparent
- ✔ Every delivery is attended by at least one person whose sole responsibility is the baby, whose Neonatal Resuscitation Program (NRP) provider status is current, and who is capable of initiating newborn resuscitation[12]
- ✔ Another person is in-house and immediately available whose NRP provider status is current and who is capable of assisting with chest compressions, intubation, and administering medications[12]
- ✔ Anesthesiologist or nurse anesthetist available to initiate cesarean section within 30 minutes of decision to do so
- ✔ Consultation arrangement with genetic counselor per written protocol

Level II

Level I Coverage plus:

- ✔ Every **high risk** delivery is attended by at least two people[12] one of whom is a pediatrician, family practice physician, or advanced practice nurse capable of a complete resuscitation, including chest compressions, intubation and administering medications

If providing HFNC or CPAP:

- ✔ Continuous in-house availability of personnel experienced in airway management and the diagnosis and treatment of pneumothorax when a patient is being treated with high flow nasal cannula or nasal CPAP
- ✔ Radiologist on-staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs, and cranial ultrasounds
- ✔ Ophthalmologist with pediatric experience available to do eye exams for neonates who are at high risk for retinopathy of prematurity (ROP) if accepting back transport of such infants; written protocol for referral or treatment
- ✔ Arrangement for neurodevelopmental follow-up or referral per written protocol

Level III

Level II Coverage plus:

- ✔ **Obstetrics:** Immediate availability of an obstetrician with demonstrated competence in the management of complicated labor and delivery patients
- ✔ **Newborn:** Immediate availability of neonatologist or Neonatal Advanced Practice Provider (APP) with demonstrated competence in the management of severely ill neonates, including those requiring mechanical ventilation
- ✔ Obstetrical anesthesiologist or nurse anesthetist immediately available

If services include major surgical procedure, add:

- ✔ Pediatric surgeon available within 30 minutes of request 24/7
- ✔ Pediatric anesthesiologist, with at least 10 infant cases per year, available within 60 minutes of request 24/7

Level IV

Same as Level III Staff plus:

- ✔ Full spectrum of medical and surgical pediatric sub-specialists available 24/7

Nurse:Patient Ratio

Staffing parameters[13] should be clearly delineated in a policy that reflects:

1. staff mix and ability levels;
2. patient census, intensity, and acuity; and
3. plans for delegation of selected, clearly defined tasks to competent assistive personnel.

It is an expectation that allocation of personnel provides for safe care of all patients in a setting where census and acuity are dynamic.[14]

Newborns

- ✔ 1:6 to 8 neonates requiring only routine care*
- ✔ 1:4 recently born neonates and those requiring close observation
- ✔ 1:3 to 4 neonates requiring continuing care
- ✔ 1:2 to 3 neonates requiring intermediate care
- ✔ 1:1 to 2 neonates requiring intensive care
- ✔ 1:1 for unstable neonates requiring multisystem support
- ✔ 1:1 or greater for unstable neonates requiring complex critical care

* *Reflects traditional newborn nursery care. A nurse should be available at all times, but only one may be necessary, as most healthy neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Additional staff is needed to respond to acute and emergency situations. The use of assistive personnel is not considered in the nurse: patient ratios noted here.*

Nursing Management

Level I	Level II	Level III	Level IV
Nurse manager of perinatal and nursery services:* ✔ Maintains RN licensure ✔ Directs perinatal and/or nursery services ✔ Guides perinatal and/or nursery policies and procedures ✔ Collaborates with medical staff ✔ Consults with higher level of care units as necessary	**Same as Level I plus:** + Advanced degree or equivalent experience is desirable		

**One RN may manage both services but additional managers may be necessary based on number of births, average daily census, or number of full-time equivalents (FTEs).*

Pharmacy, Nutrition/Lactation, and OT/PT

Level I	Level II	Level III	Level IV
Pharmacy Services			
✔ Registered pharmacist immediately available for telephone consultation, 24 hrs/day and 7 days/wk ✔ Provision for 24 hr/day and 7 days/wk access to emergency drugs	✔ Registered pharmacist available 24 hrs/day and 7 days/wk **If caring for 32–33 week infants:** ✔ Registered pharmacist with experience in neonatal/perinatal pharmacology available 24 hrs/day, and 7 days/wk, esp. when ordering TPN		
Nutrition/Lactation			
✔ Dietary and lactation services and consultation available[15]	**One healthcare professional who is knowledgeable in:** ✔ Management of special maternal and neonatal dietary needs ✔ Lactation services and consultation available ✔ Diabetic educator for inpatient and outpatient OB services **If caring for 32–33 week infants:** ✔ Registered dietician knowledgeable in parenteral nutrition of low birthweight and other high-risk neonates	**Level II Services Plus:** + At least one registered dietitian who has special training in neonatal/perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates, and oversee TPN orders	
OT/PT Services			
Provide for inpatient consultation and outpatient follow-up services			

Social Services/Case Management, Respiratory Therapy, Nurse Educator/Neonatal Advanced Practice Provider

Level I	Level II	Level III	Level IV
Social Services/Case Management			
✔ Mechanism available for high-risk assessment and provision of social services	**Level I Services plus:** + Personnel with relevant experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process, and home care arrangements **If caring for 32–33 week infants:** + At least one MSW with relevant experience	**Level II Services plus:** + At least one FTE licensed MSW for every 20 NICU patients in delivery hospital[8] and for every 15 NICU patients in children's hospital[8] who has experience with socioeconomic and psychosocial problems of high-risk mothers and babies, available 24 hrs/day and 7 days/wk	
Nurse Educator/Clinical Nurse Specialist			
✔ Phone/TeleHealth/ email consultation /education provided by nurse educator/CNS located at regional Level III or IV NICU ✔ Staff education on maternal or newborn stabilization prior to transport, provided to all staff caring for newborns via TeleHealth Computer technology or onsite	✔ A nurse educator with appropriate training in special care nursery or perinatal care to coordinate staff education and development ✔ If caring for full spectrum of Level II patients, an advanced practice nurse with appropriate training in high risk neonatal care (clinical nurse specialist with graduate education is recommended) for staff development and to effect system-wide changes to improve programs of care	✔ An advanced practice nurse with appropriate training in high risk neonatal care (clinical nurse specialist with graduate education is preferred) for staff development and to effect system-wide changes to improve programs of care	
Respiratory Therapy			
✔ The role of a Respiratory Care Practitioner is prescribed by the medical director and clearly delineated per written protocol. If attending deliveries or providing neonatal respiratory care will have current NRP Provider status	**Same as Level I plus:** + When CPAP in use: in-house and immediately-available RCP with documented competence and experience in the management of neonates with cardiopulmonary disease	**Level II plus:** + One Respiratory Care Practitioner for every six or fewer ventilated neonates with additional staff for procedures + RCP skilled in neonatal airway management immediately available for every high-risk delivery	

X-Ray/Ultrasound

Level I	Level II	Level III	Level IV
✔ Portable x-ray and ultrasound equipment available to Labor and Delivery and Nursery within 30 minutes ✔ Performance and interpretation of neonatal x-rays and perinatal ultrasound available 24 hrs/day and 7 days/wk ✔ Antepartum surveillance techniques available	**Level I Services plus:** + Ultrasound equipment immediately accessible and available to the Labor and Delivery unit 24 hrs/day and 7 days/wk	**Level II Services plus:** + Advanced level ultrasound available to Labor and Delivery and Nursery on-site **If therapeutic hypothermia offered:** + Neonatal MRI with special HIE sequences	

Laboratory and Blood Bank Services

Level I	Level II	Level III	Level IV
Laboratory			
✔ Laboratory technician available 24 hrs/day, and 7 days/wk present in the hospital or within 30 minutes ✔ Capability to report laboratory results in a timely fashion	**Same as Level I plus:** + Lab technician in-house 24 hrs/day and 7 days/wk + Personnel skilled in phlebotomy and IV placement in the newborn immediately available 24 hrs/day and 7 days/wk + Microtechnique for hematocrit and blood gases within 15 minutes	✔ Comprehensive services available 24 hrs/day and 7 days/wk	
Blood Bank			
✔ Blood bank technician on-call and available w/in 30 minutes for performance of routine blood banking procedures ✔ Provision for emergent availability of blood and blood products			

Appendix A: References and Resources

1 American Academy of Pediatrics (2012). Levels of Neonatal Care. *Pediatrics 130(3):* 587–97.
Online at: www.pediatrics.org/cgi/content/full/130/3/587

2 American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2017). Guidelines for Perinatal Care, 7th edition. Riley LE and Stark AR. (eds.) Elk Grove Village, IL: American Academy of Pediatrics.

3 Healthy People 2020. Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or subspecialty perinatal centers. United States Dept of Health and Human Services. Online at: https://www.healthypeople.gov/node/4892/data_details

4 American Academy of Pediatrics Section on Breastfeeding (2012). Breastfeeding and the Use of Human Milk. *Pediatrics 129 (3):* e827–e841.
Online at: http://pediatrics.aappublications.org/content/129/3/e827.full.pdf or UNICEF: Ten Steps to Successful Breastfeeding. Online at: www.unicef.org/newsline/tenstps.htm

5 Neonatal Resuscitation (2015). American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Pediatrics 132 supp 2(5):* S543–560.
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6 Bricker, J.T., Fraser, C.D., Fyfe, D.A., Mahoney L.T., Colegrove, L. (2002). American Academy of Pediatrics Section on Cardiology and Cardiac Surgery Guidelines for Pediatric Cardiovascular Centers. *Pediatrics 109 (3):* 544–549

7 Optimal Resources for Children's Surgical Care v.1.
Online at: www.facs.org/quality-programs/childrens-surgery/childrens-surgery-verification

8 National Association of Perinatal Social Workers—Standards for Social Work Services in the NICU.
Online at: www.napsw.org/assets/docs/NICU-standards.pdf

9 Performance Improvement and Patient Safety (PIPS) Program.
Online at: www.facs.org/~/media/files/quality%20programs/csv/pips%20requirements%20level%20i.ashx

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Online at: www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Levels-of-Maternal-Care

11 Technical report AAP: Phototherapy to prevent severe neonatal hyperbilirubinemia in the newborn infant 35 or more weeks of gestation (2011). *Pediatrics 128(5):* e1046

12 American Academy of Pediatrics and American Heart Association (2016). Textbook of Neonatal Resuscitation, 7th edition. Weiner, G & Zaichkin, J, editors. Elk Grove Village, IL: American Academy of Pediatrics.

13 Association of Women's Health, Obstetric and Neonatal nurses (2010). Guidelines for Professional Registered Nurse Staffing for Perinatal Units.

14 Society for Social Work Leadership in Health Care Standards for Social Work Care and Staffing in Children's Hospitals.
Online at: www.aposw.org/docs/SSWPedsStandards.pdf

15 American Academy of Pediatrics (2016). "Guidelines for Air and Ground Transport of neonatal and Pediatric Patients" 4th edition.

Appendix B: Subcommittee for Perinatal Level of Care (LOC) 2018 Guidelines Document

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