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

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 3:24 pm, Jan 08, 2020

January 6, 2020

CN20-29

Ms. Nancy Tyson
Executive Director
Health Facilities and Certificate of Need
Washington Department of Health
Certificate of Need Program
P.O. Box 47852
Olympia WA 98504-7852

Re: MultiCare Health System dba MultiCare Day Surgery Center of Gig Harbor Certificate of Need ("CN") Request to Convert Two CN-Approved Procedure Rooms to Two Additional Operating Suites

Dear Ms. Tyson:

On behalf of MultiCare Health System, I am pleased to submit a certificate of need ("CN") request to convert two CN-approved procedure rooms to two additional operating rooms (ORs") in addition to the existing two CN-approved ORs at MultiCare Day Surgery Center of Gig Harbor ("MHS-Gig Harbor"). MHS-Gig Harbor is located at 4545 Point Fosdick Dr., Gig Harbor, WA 98335. MHS-Gig Harbor has been in operation since January 2006. It has been CN-approved since May 2012.

The rationale for our request is that MultiCare wishes to shift more of its procedures currently performed in hospitals to more convenient and accessible outpatient settings in the community, so expects significant increases in the utilization of our ambulatory surgery facilities ("ASFs"). Furthermore, the Central Pierce Secondary Health Service Planning Area, where, MHS-Gig Harbor is located, currently demonstrates net need for additional outpatient OR capacity, which MHS-Gig Harbor can help meet through expansion from two CN-Approved ORs to four.

Please let me know if there are any questions regarding this request. Thank you for your assistance. I can be reached at 253.403.8770 or at tmboyle@multicare.org

Sincerely,

Theresa Boyle
Senior Vice President, Strategy, Marketing and Communication
MultiCare Health System
315 Martin Luther King Way
Tacoma WA 98405

Washington State Department of Health

Certificate of Need Application
Ambulatory Surgical Facilities
Ambulatory Surgery Centers

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

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

Name, Title, and Signature of Responsible Officer: Theresa Boyle Senior Vice President, Strategy, Marketing and Communication Signature: Theresa Boyle Dated: 1/6/20	Phone Number: (253) 403-8770 Email Address: tmboyle@multicare.org
Legal Name of Applicant: MultiCare Health System Address of Applicant: 315 Martin Luther King Way Tacoma, WA 98405	Number of Operating Rooms requested – include procedure rooms: MHS-Gig Harbor is CN-Approved to operate 2 operating rooms and 2 procedure rooms. It is requesting approval to convert the 2 procedure rooms to 2 additional operating rooms. Estimated Capital Expenditure: $4, 689,120

Identify the Planning Area for this project as defined in WAC 246-310-270(3): Central Pierce Secondary Health Services Planning Area ("Central Pierce Planning Area" or "Central Pierce")

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Introduction and Rationale

MultiCare Health System dba Day Surgery of Gig Harbor ("MHS-Gig Harbor"), is an ambulatory surgical facility ("ASF") currently certificate of need ("CN") approved to operate two operating rooms and two procedure rooms.[1] MultiCare is requesting approval to convert its two CN-approved procedure rooms to two additional operating rooms in addition to the existing two CN-approved operating rooms. MHS-Gig Harbor is located at 4545 Point Fosdick Dr., Gig Harbor, WA 98335. MHS-Gig Harbor is owned by MultiCare Health System ("MultiCare").

MultiCare is a locally-governed, not-for-profit, integrated health system that owns and operates nine hospitals and over 240 primary, specialty, and urgent care clinics throughout the Puget Sound and Inland Northwest Regions. The organization includes Mary Bridge Children's Hospital & Health Network, Immediate Clinic, MultiCare Indigo Urgent Care, MultiCare Virtual Care, Navos, Pulse Heart Institute and MultiCare Connected Care, our Accountable Care Organization.

MHS-Gig Harbor has been in operation since January 2006, originally as a CN-Exempt Ambulatory Surgical Facility. In May 2012, MHS-Gig Harbor received CN-approval to provide orthopedic, gynecological, ENT, urological, podiatry, eye, general, plastic, and gastroenterological surgical procedures to patients 12 months and older.

With project approval, MHS-Gig Harbor will add two operating rooms to its existing two-operating room suite surgery center and expand utilization to include patients across all age cohorts. The rationale for this request is that MultiCare wishes to shift more of its procedures currently performed in hospitals to more convenient and accessible outpatient settings in the community, so expects significant increases in the utilization of its ASFs. Furthermore, planning area need exists for additional OR capacity, which MHS-Gig Harbor can help meet through expansion from two CN-Approved ORs to four. These two additional ORs presently exist as procedure rooms, so this expansion requires minimal new construction costs and can be executed relatively inexpensively. CN-Approval is requested so that MHS-Gig Harbor may make these additional ORs available to non-MHS physicians across the range of services for which they were CN-Approved in 2012. Improving access by other non-MHS physicians and increasing surgical volumes will increase the efficiency of this existing facility, given higher volumes will reduce average costs.

[1] Certificate of Need #1473

Applicant Description

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

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

   MultiCare Health System ("MultiCare") dba MultiCare Day Surgery Center of Gig Harbor ("MHS-Gig Harbor"). MHS-Gig Harbor is owned and operated by MultiCare.

   The applicant's address is:
   MultiCare Health System
   315 Martin Luther King Jr. Way
   Tacoma, WA 98405

   The address of MHS-Gig Harbor is:

   4545 Point Fosdick Dr.
   Gig Harbor, WA 98335.

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

   MHS-Gig Harbor is solely owned by MultiCare.

   MultiCare Health System is a not-for-profit corporation.

   The UBI Number of MHS-Gig Harbor is 601-100-682

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

   Theresa Boyle
   Senior Vice President, Strategy, Marketing and Communication
   MultiCare Health System
   315 Martin Luther King Way, Tacoma, WA 98405
   (253) 403-8770
   tmboyle@multicare.org

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

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

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

   Please see Exhibit 1 for the MultiCare organizational chart.

Project description

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

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

   MultiCare Day Surgery Center of Gig Harbor
   4545 Point Fosdick Dr.
   Gig Harbor, WA 98335.

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

   This question is not applicable.

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

   MHS-Gig Harbor has been in operation since January 2006, originally as a CN-Exempt Ambulatory Surgical Facility. In May 2012, MHS-Gig Harbor received CN-approval to provide orthopedic, gynecological, ENT, urological, podiatry, eye, general, plastic, and gastroenterological surgical procedures to patients 12 months and older. With project approval, MHS-Gig Harbor will add two operating rooms to its existing two-operating room suite surgery center and expand utilization to include patients 12 months of age and older.

   The rationale for this request is that MultiCare wishes to shift more of its procedures currently performed in hospitals to more convenient and accessible outpatient settings in the community, so expects significant increases in the utilization of its Ambulatory Surgery Facilities. Furthermore, planning area need exists for additional OR capacity, which MHS-Gig Harbor can help meet through expanding from two CN-Approved ORs to four. These two additional ORs presently exist as procedure rooms, so this expansion requires minimal new construction costs and can be executed relatively inexpensively. CN-Approval is requested so that MHS-Gig Harbor may make these additional ORs available to non-MHS physicians across the range of services for which they were CN-Approved in 2012. Improving access by other non-MHS physicians and increasing surgical volumes will increase the efficiency of this existing facility, given higher volumes will reduce average costs.

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

Event	Anticipated Month/Year
Design Complete	October 2020
Construction Commenced	February 2021
Construction Completed	June 2021
Facility Prepared for Survey	July 2021
Project Completion	July 2021

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

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

☐Other? Describe in detail: _____

In May 2012, MHS-Gig Harbor received CN-approval to provide orthopedic, gynecological, ENT, urological, podiatry, eye, general, plastic, and gastroenterological surgical procedures to patients 12 months and older. Currently, MHS-Gig Harbor performs services related to Orthopedic, General Surgery, ENT, Plastics, Podiatry, and basic GYN. Table 1 presents the common procedures performed for each of these different specialties.

Table 1: Procedure List by Specialty

Procedures by Specialty
ENT
Septoplasty & Turbinoplasty
Septorhinoplasty
Hardware Removal Face
Moh's Reconstruction
Soft Tissue Repair
General surgery
Hernia Repair, Umbilical
Cholecystectomy, Laparoscopic, W/Cholangiogram
Rectal General
Cleft Lift Procedure
Hernia Repair, Incisional
Gynecology/OBGYN
Suction D&C
Cervical Cerclage
Tubal Sterilization, Laparoscopic
Endometrial Ablation - Novasure
Hysteroscopy W/Myosure
Orthopedics
Arthroscopy, Knee
Arthroscopic Rotator Cuff Repair
Arthroscopy, Shoulder
Carpal Tunnel Release
Arthroscopic ACL Repair with Autograft
Plastic Surgery
Breast Implant Removal/Replacement
Mammoplasty Augmentation
Mammoplasty Reduction
Abdominoplasty
Fat Grafting
Podiatry
Amputation Digit
Tendon Repair Foot
Calcaneal Osteotomy
Cyst Excision, Orthopedic
Tendon Repair, Achilles

Source: Applicant

Notes:
Urological, eye, and gastroenterological procedures are not currently available as MHS-Gig Harbor performs an insufficient number of procedures within these specialties to separately report.

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

☐ Endoscopy	☐ Bariatric Surgery	☒ Other: will include, but not limited to, diagnostic colonoscopy

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

   MHS-Gig Harbor currently provides ambulatory surgery services related to Ear, Nose, and Throat, General Surgery, Gynecology and OBGYN, Orthopedics, Plastic Surgery, and Podiatry, as well as pediatric surgical services for the specialties of ENT, General Surgery, and Orthopedics. These specialties would continue to be offered, but at greater volumes given approval of the proposed project. Furthermore, given project approval, MHS-Gig Harbor expects to offer all of the services for which it was CN approved in 2012 and those identified above in response to question 5. These are described above.

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

   Given approval of the proposed project, MHS-Gig Harbor would have a total of four (4) operating rooms.

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

   None of the operating rooms at MHS-Gig Harbor would be exclusively dedicated to endoscopy, cystoscopy, or pain management services.

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

    The ASF will continue to serve patients ages 12 months and older who require orthopedic, gynecological, ENT, urological, podiatry, eye, general, plastic, and gastroenterological surgical procedures that can be served appropriately in an outpatient setting.

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

    Please see Exhibit 2 for the letter of intent.

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

Please see Exhibit 3 for single-line drawings of the facility before and after project completion.

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

This facility is currently and will continue to be licensed and certified by Medicare and Medicaid. MHS-Gig Harbor exists under the facility license of Tacoma General/Allenmore Hospital.

License #: HAC.FS.00000176

Medicare #: 50-0129

Medicaid #: 3300332

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

The ASF is currently licensed as part of MultiCare Tacoma General Hospital. As such, it is accredited by the Joint Commission.

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

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

We anticipate meeting with CRS in the first quarter of 2020.

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

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

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

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

   Please see Exhibit 4 for a complete list of hospitals and ambulatory surgery centers in the Central Pierce Planning Area.

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

   Ambulatory surgery centers which provide a service mix of orthopedic, gynecological, ENT, urological, podiatry, eye, general, plastic, and gastroenterological surgical procedures can be considered sufficiently similar to MHS-Gig Harbor. Procedure types by provider are not publicly available in Washington State, but review of planning area ASCs suggests that Gig Harbor Same Day Surgery, Baker Day Surgery of Tacoma, and Soundview ASC all provide similar services to those as MHS-Gig Harbor.

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

   Based on need methodology from the Washington Department of Health, there is demonstrated quantitative need for 5.6 additional outpatient operating suites. Therefore, there would not be an unnecessary duplication of services.

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

   Estimation of numeric need as defined in WAC 246-310-270 requires calculation of current surgical capacity (exclusive of capacity dedicated to endoscopy and pain

management).[2] Hospitals and ASCs voluntarily report OR utilization through an annual utilization survey distributed by the Washington Department of Health. As of November 14, 2019, OR utilization data for 2018 was available for seven planning area hospitals and ASCs. For the remainder, we rely on earlier survey years and prior communication with the Department of Health. In all cases, we prioritize the most recent data available. Table 2 lists the current supply of CN-approved operating rooms in the Central Pierce Planning Area not dedicated to endoscopy or pain management.

Table 2: Supply of CN-Approved Outpatient and Inpatient ORs in the Central Pierce Planning Area

Hospitals, CN-Approved	Mixed Use Operating Rooms	Outpatient Operating Rooms
Allenmore Hospital	8	
Mary Bridge Children's Hospital	4	2
St. Anthony Hospital	6	
St. Joseph Medical Center	10	
Tacoma General Hospital	17	
Walters Same Day Surgery	9	
ASCs, CN-Approved	**Mixed Use Operating Rooms**	**Outpatient Operating Rooms**
[SJMC License] Gig Harbor Same Day Surgery		2
MHS - Baker Day surgery of Tacoma		3
MHS - Gig Harbor ASC		2
Total	**54**	**9**

Sources:
2019 Department of Health ASC Survey, 2018 Department of Health ASC Survey, 2017 Department of Health ASC Survey, DOH Staff Communication, July 2019

From Table 2, there are 63 CN-approved ORs in the Central Pierce Planning Area, including 54 inpatient/mixed use ORs and 9 CN-approved outpatient ORs. Furthermore licensed, CN-exempt outpatient ORs have been identified (listed in Table 3 below) and their outpatient surgery volumes included in the methodology to determine planning area surgery use rates, while their ORs have not been included in the count of ORs within the forecast need model. Operating rooms dedicated to GI/endoscopy pain management are neither counted in the number of planning area ORs nor is their utilization used to determine planning area surgery use rates.[3] Lastly, we have excluded the ORs, surgical volumes, and surgical minutes from the Kaiser

[2] It is our understanding that the Department of Health numeric need methodology excludes these rooms. For example, see "Evaluation Dated October 9, 2018, for the certificate of need application from Virginia Mason Medical Center a subsidiary of Virginia Mason Health System proposing to construct a five operating room ambulatory surgery center in Bellevue within East King County". Department of Health, October 9, 2018, page 9.
[3] WAC 246-310-270(9)(iv)

Permanente Tacoma ASC from the numeric need methodology, since these ORs are available only within the Kaiser Permanente HMO.

Table 3: Supply of CN-Exempt Outpatient ORs in the Central Pierce Planning Area

ASCs, CN-Exempt	Mixed Use Operating Rooms	Outpatient Operating Rooms
Aesthetica Clinique LLC		1
Artistic Plastic Surgery Center		1
Cedar Laser and Surgery Center		2
Harbor Plastic Surgery Center		2
Pacific Cataract and Laser Institute		2
Pacific Northwest Eye Surgery Center		2
Sono Bello		3
Soundview Ambulatory Surgery Center		1
The Eye Surgeons Group Ambulatory Surgery Center		1
Total, CN Exempt ORs	**0**	**15**

Sources:
2019 Department of Health ASC Survey, 2018 Department of Health ASC Survey, 2017 Department of Health ASC Survey, DOH Staff Communication, July 2019

The data and assumptions used in the numeric need calculations are presented in Table 4. These are generated from population forecasts by Claritas and planning area utilization data from the 2019 Department of Health ASC Survey, the 2018 Department of Health ASC Survey, 2017 Department of Health ASC Survey, and communication with DOH Staff in July 2019, where priority is given to the most recent data. For detail on the data sources by hospital, see Exhibit 4.

Table 4: Summary of Data and Assumptions Used in Numeric Need Methodology

Planning area	Central Pierce County
Population estimates and forecasts, all ages	Year 2018: 339,760 Year 2023: 358,271 Source: Claritas 2019
Planning area surgeries	Inpatient or Mixed Use: 40,587 Outpatient: 19,588 Total: 60,175 Source: 2019 & 2018 ASC Surveys
Planning area use rate	Surgeries/2018 Population*1,000 = 177.11 per 1,000 persons
Surgery case mix	Outpatient: 32.55% Inpatient: 67.45%
Average minutes per case	Outpatient: 48.75

	Inpatient: 119.08 Source: 2019 & 2018 ASC Surveys
OR annual capacity (in minutes)	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes
Existing OR capacity (in ORs)	9 dedicated outpatient ORs 54 mixed use ORs See Table 2
Summary of need calculations	Shortage of 5.63 Outpatient ORs

Exhibit 5 presents a step-by-step calculation of net need using the assumptions and data outlined in Table 4. This methodology is described and summarized below.

WAC 246-310-270(9) — Methodology

(a) Existing Capacity

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

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

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

Dedicated outpatient CN-Approved ORs in the planning area=9

Capacity = 68,850 minutes per year per OR

Total annual capacity in minutes: 9*68,850 = 619,650 minutes

Minutes per surgery = 48.75 minutes

Total annual capacity in outpatient surgeries:

619,650 / 48.75 = **12,710 annual [dedicated] outpatient surgeries**

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

Inpatient/mixed use, CN-Approved ORs in the planning area = 54

Capacity = 94,250 minutes per year per OR

Total annual capacity in minutes: 54*94,250 = 5,089,500 minutes **(a)(iv)**

Minutes per surgery = 119.08 minutes

Total annual capacity in inpatient/mixed use surgeries:

5,089,500 / 119.08 = 42,740 annual inpatient/mixed use surgeries

(b) Future need

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

Based on the forecast population in 2023 and the use rate of 177.11 per 1,000 residents, there is a projected total of 63,453 surgeries in the Central Pierce Planning area. [(b) (i)]

An estimated 67.45% of surgeries were performed as inpatient/mixed use and 32.55% as outpatient surgeries. Thus, of the 63,453 forecasted surgeries for 2023, 42,798 would be inpatient/mixed use surgeries and 20,655 outpatient surgeries [(b) (i)].

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

Outstanding demand for outpatient surgeries:

20,655 – 12,710 = 7,945 outpatient surgeries

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

Inpatient/mixed use surgery minutes = 4,833,111

Inpatient/mixed use cases = 40,587

Average inpatient/mixed use minutes per case = 119.08

Outpatient surgery minutes = 954,986

Outpatient cases = 19,588

Average outpatient minutes per case = 48.75

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

Inpatient minutes: 42,798 surgeries * 119.08 minutes/surgery = 5,096,429 minutes, or [(b)(i) * (b)(iii)]

Remaining outpatient minutes: 7,945 surgeries (b)(i) * 48.75 minutes/surgery (b)(iii) = 387,366 minutes, or [(b)(ii) * (b)(iii)]

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

5,096,429 minutes + 387,366 minutes = 5,483,795 minutes (b)(iv)

(c) Net Need

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

This step is not applicable.

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

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

5,483,795 minutes > 5,089,500 minutes.

The model shows net need for 5.63 outpatient ORs in the Central Pierce Planning Area in 2023.

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

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

The model shows numeric need for additional outpatient operating rooms, however there are also important qualitative arguments that support approval of the proposed project. These include an increasing use rate, a limited supply of planning area outpatient providers, and the efficiency and patient preference of outpatient ORs over inpatient ORs.

Increasing use rate and high population growth, particularly among older residents

The model as presented above and in Exhibit 5 assumes a constant use rate. However, it is likely this use rate will increase over the forecast for at least two reasons:

(1) The planning area population is becoming older, with population forecasts projecting average annual growth rates of about 3.73% for persons aged 65+ in the Central Pierce planning area (compared to growth rates of about 0.51% for persons under the age of 65). Since older persons have a higher surgery use rate than younger persons, as the population in the planning area ages, the surgery use rate will rise.

(2) Surgical services are shifting to outpatient settings due to improved clinical practices/technologies that allow surgeries to be performed on an outpatient basis. This change in clinical practice also induces an increase in the outpatient surgery use rate. As such, a 177.1 use rate per 1,000 residents for ambulatory surgeries, held constant, is a conservative approach and may underestimate future demand for outpatient surgeries.

Aside from knowing that it is likely to increase, because data on historical utilization is incomplete and inconsistent across ASC providers, it is difficult to precisely forecast changes in the OR use rate over time. However, using data on planning area providers in 2017 and 2018, it is possible to provide a reasonable estimate for future growth. Data submitted by planning area providers in their 2018 ASC Survey for CY2017 utilization indicates a utilization rate of about 170.75 surgeries per 1,000 persons of all ages. Updating these statistics using the available 2019 ASC surveys, indicates a utilization rate of about 177.1, or a 3.7% annual increase. Assuming Central Pierce utilization will continue to grow at similar rates, we calculate a growth in the use rate for planning area residents from about 177.1 to about 205 surgeries per 1,000 residents between 2018 and 2023. Allowing for this growth would increase estimates of numeric need from a need of 5.63 outpatient ORs to about 7.93 outpatient ORs.

Limited Supply of Outpatient Providers in the Central Pierce Planning Area

Presently MHS-Gig Harbor is one of four CN-approved outpatient facilities in the Central Pierce planning area. As of 2018, only 13 facilities performed non-endoscopy outpatient procedures. Eight of these facilities performed only a limited range of services, with five facilities performing only plastic surgery procedures and three facilities performing only ophthalmological procedures. The limited supply of planning area outpatient facilities, particularly with regard to facilities providing a broad array of services, has resulting in a majority of surgical procedures within Central Pierce being performed on an inpatient basis. In 2018, over 2/3s of surgical procedures in Central Pierce were performed in an inpatient setting. Given the trend towards outpatient care, because the Department's numeric need methodology uses historical shares to predict future distributions of need for mixed use and outpatient ORs, the Department's numeric need methodology understates the demand for outpatient ORs in the Central Pierce Planning Area. Given the evolving landscape shifting more procedures to an outpatient setting, additional outpatient ORs is a critical need in the community.

Efficiency and Patient Preference for Outpatient ORs

If approved, MHS-Gig Harbor can add two additional operating rooms and expand its capacity. This will provide greater accessibility to planning area residents for outpatient surgical services. Given the existing planning area need, without this increase in capacity, planning area residents in need of surgical services will need to either out-migrate to neighboring planning areas, or obtain services in planning area hospitals.

Adding capacity to a local ASF reduces travel time and costs, as well as patient inconvenience and anxiety when they are able to obtain both office care and surgical care in the same location (MultiCare Gig Harbor Medical Park). Furthermore, outpatient facilities can be more efficient and cost-effective in comparison to inpatient surgery departments, leading to lower contractual rates for purchasers and cost savings for patients. Constraints on the supply of outpatient surgical services will push patients into the higher cost inpatient operating rooms, and result in lower planning area efficiency.

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

Please see for the number of surgeries per year between 2016 and 2019 YTD at MHS-Gig Harbor by specialty.

Table 5: MHS-Gig Harbor Case Count, 2016 to 2019 YTD

Specialty	2016	2017	2018	2019 YTD (Jan - Nov)	CAGR (2016-2018)
ENT	162	50	179	211	5.12%
General	34	9	55	56	27.19%
OB/GYN	47	31	109	111	52.29%
Orthopedics	205	75	265	247	13.70%
Plastics	7	0	20	102	69.03%
Podiatry	1	0	7	29	164.58%
TOTAL	456	165	635	756	18.01%

Source: Applicant

Notes:

CAGR stands for "Compound Annual Growth Rate" and equals $\left(\frac{End\ Value}{Start\ Value}\right)^{\frac{1}{\#\ Years}} - 1$

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

   In Table 6 we present projected surgical volumes for two years of current operations (2020 and 2021) and the first three full years of operation given project approval (2022 through 2024). Currently MHS-Gig Harbor provides outpatient services for ENT, general surgery, OB/GYN, orthopedics, plastics, and podiatry procedures. With the additional two ORs, we expect to provide services for the additional specialties of gastroenterological, eye, and urology surgery.

   The specialty-specific case counts presented in Table 6 reflect an aggregation of procedures by ICD-9 grouping. Procedures within a certain specialty may bridge multiple ICD-9 groups, and we apply assumptions regarding *the expected proportion of procedures within a given ICD-9 group to fall within each of the different specialties for MHS-Gig Harbor*. These market share figures are based on the historical utilization of MHS-Gig Harbor, the existing subspecialty expertise of MHS-Gig Harbor physicians, and the number of planning area ASCs performing procedures within the different specialties. These assumptions are:

   - Gastroenterological corresponds to 85% "Operations on the Digestive System"
   - ENT corresponds to 91% of "Operations on the Nose, Mouth and Pharynx" and 7% of "Operations of the Intergumentary System"
   - Eye corresponds to "Operations on the Eye"

- General Surgery corresponds to 9% of "Operations on the Nose, Mouth and Pharynx" and 15% of "Operations on the Digestive System"
- Gynecology corresponds to "Operations on the Female Genital Organs"
- Orthopedics corresponds to "Operations on the Nervous System" and 96% of "Operations on the Musculoskeletal System"
- Plastic corresponds to 93% of "Operations of the Intergumentary System"
- Podiatry corresponds to 4% of "Operations on the Musculoskeletal System"
- Urology corresponds to "Operations on the Urinary System" and "Operations on the Male Genital Organs"

Table 6: MHS-Gig Harbor Projected Case Count, 2020 to 2024

	Project Prior to Project Completion		Future utilization projections given project completion			
Specialty	**2020**	**1Q-2Q 2021**	**3Q-4Q 2021**	**2022**	**2023**	**2024**
# of ORs	2	2	4	4	4	4
Gastroenterological			138	307	326	346
ENT	475	240	250	555	589	626
Eye/Opthalmology			134	298	316	336
General Surgery	123	62	47	104	110	117
Gynecological	140	71	78	173	184	195
Orthopedics	708	358	385	855	908	963
Plastic	230	116	140	310	329	350
Podiatry	7	4	13	29	30	32
Urologic			32	71	75	80
Total	1,683	850	1,215	2,702	2,868	3,044

Sources: Applicant

The forecast model uses the following assumptions and methodologies:

1. The utilization model forecasts an increase in 2020 volumes compared to annualized 2019 cases due to the following reasons: MHS-Gig Harbor has hired a new orthopedic surgeon, is expanding pediatric services, and is expanding hours of operation to now cover all day Monday through Friday.

2. Surgical use rates by ICD-9 procedure code group were derived from the latest National Center for Health Statistics ("NCHS") survey study, "Ambulatory Surgery in the United States." The report analyzed and presented summaries of data from the 2010 National Survey of Ambulatory Surgery ("NSAS").[4] This survey is included in our application as Exhibit 6. For utilization estimates by surgical specialty please see Table 7 below.

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

Table 7: National Center for Health Statistics. Ambulatory Surgery Utilization Estimates

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

Source: "Ambulatory Surgery in the United States, 2010," US Department of Health and Human Services, National Center for Health Statistics, National Health Statistics Reports, Number 102, February 28, 2017.

In this study, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory basis in a hospital or freestanding center's general ORs, dedicated ambulatory surgery rooms, and other specialized rooms. This NCHS survey study is the principal source for published national data on the characteristics of visits to hospital-based and freestanding ASFs. The report was updated and revised in 2017 and contains NCHS estimates on ambulatory surgery case counts for the year 2010.[5] Estimates of population use rates were calculating by dividing the surgery case counts by 2010 U.S. Census population counts and multiplying by 10,000. Please see Exhibit 6 for a copy of the NCHS survey study used in the forecast methodology.

[5] The NCHS survey covers procedures performed in ambulatory surgery centers, both hospital-based and freestanding. Hospitals include non-institutional hospitals exclusive of federal, military, and Department of Veterans Affairs located in the 50 states and the District of Columbia. Only short-stay hospitals—hospitals with an average length of stay less than 30 days—or those whose specialty was general medicine or general surgery were included in the survey. Freestanding facilities included those that were regulated by CMS for Medicare participation. The NSAS sample of facilities was selected using a multistage probability design with facilities having varying selection probabilities.

3. The NCHS use rates were multiplied by 2020-2024 Central Pierce Planning Area population forecasts, and then divided by 10,000 in order to forecast Planning Area resident ambulatory surgeries by procedure type, by year. Table 8 includes these procedure estimates for the planning area.

Table 8: Central Pierce Ambulatory Surgery Forecasts, 2020 to 2024

Procedure (ICD-9-CM Code)	2010 Utiliz. Rate	Total Number of Procedures, Central Pierce Planning Area					
		2020	1Q-2Q 2021	3Q-4Q 2021	2022	2023	2024
All Operations (01-86)	1560.3	54,148	27,359	27,359	55,302	55,900	56,513
Operations on the Nervous System (01-05)	136.6	4,741	2,396	2,396	4,842	4,895	4,948
Operations on the Endocrine System (06-07), operations on the hemic and lymphatic system (40-41), and obstetrical procedures (72-75)	11.3	390	197	197	399	403	407
Operations on the Eye (08-16)	254.7	8,841	4,467	4,467	9,029	9,127	9,227
Operations on the Ear (18-20)	34.1	1,183	597	597	1,208	1,221	1,234
Operations on the Nose, Mouth and Pharynx (21-29)	77.8	2,701	1,364	1,364	2,758	2,788	2,818
Operations on the Respiratory System (30-34)	9.1	316	160	160	323	327	330
Operations on the Cardiovascular System (35–39,00.50–00.51,00.53–00.55,00.61–00.66)	34.7	1,203	608	608	1,228	1,242	1,255
Operations on the Digestive System (42-54)	324.7	11,270	5,694	5,694	11,510	11,634	11,762
Operations on the Urinary System (55-59)	43.6	1,514	765	765	1,546	1,562	1,580
Operations on the Male Genital Organs (60-64)	17.0	589	298	298	602	608	615
Operations on the Female Genital Organs (65-71)	57.1	1,981	1,001	1,001	2,024	2,045	2,068
Operations on the Musculoskeletal System (76–84,00.70–00.73,00.80–00.84)	228.8	7,939	4,011	4,011	8,108	8,196	8,285
Operations of the Integumentary System (85-86)	140.3	4,869	2,460	2,460	4,973	5,027	5,082
Miscellaneous diagnostic and therapeutic procedures and new technologies (87-99, 00)	190.5	6,610	3,340	3,340	6,751	6,824	6,899
Total Planning Area Cases	**1560.3**	**54,148**	**27,358**	**27,358**	**55,302**	**55,900**	**56,513**
Service Area Population		**2020**	**1Q-2Q 2021**	**3Q-4Q 2021**	**2022**	**2023**	**2024**
Central Pierce		347,046	350,698	350,698	354,438	358,271	362,199

Source: Applicant

4. A market share figure was applied to each procedure code group based on current and planned surgeries. These market share figures are based on the historical utilization of the MHS-Gig Harbor, the existing subspecialty expertise of MHS-Gig Harbor physicians[6], and the number of planning area ASCs performing procedures within the different specialties. Table 9 presents our market share assumptions. For those specialties in which MHS-Gig Harbor has not previously performed procedures, the market share figures begin with 3% of the market.

Table 9: MHS-Gig Harbor Market Share Assumptions, 2020-2024

MHS-Gig Harbor Market Share Calculations and Assumptions	2020	1Q-2Q 2021	3Q-4Q 2021	2021	2022	2023
Market Share Growth		1.1%	10.0%	10.0%	5.0%	5.0%
Operations on the Nervous System	1.4%	1.4%	1.5%	1.7%	1.7%	1.8%
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Operations on the Eye	0.0%	0.0%	3.0%	3.3%	3.5%	3.6%
Operations on the Ear	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Operations on the Nose, Mouth and Pharynx	16.9%	16.9%	18.6%	20.5%	21.5%	22.6%
Operations on the Respiratory System	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Operations on the Cardiovascular System	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Operations on the Digestive System	0.8%	0.8%	2.9%	3.1%	3.3%	3.5%
Operations on the Urinary System	0.0%	0.0%	3.0%	3.3%	3.5%	3.6%
Operations on the Male Genital Organs	0.0%	0.0%	3.0%	3.3%	3.5%	3.6%
Operations on the Female Genital Organs	7.1%	7.1%	7.8%	8.6%	9.0%	9.4%
Operations on the Musculoskeletal System	8.2%	8.2%	9.0%	9.9%	10.4%	10.9%
Operations of the Integumentary System	5.5%	5.5%	6.1%	6.7%	7.0%	7.4%
Miscellaneous diagnostic and therapeutic procedures and new technologies	0.2%	0.2%	0.2%	0.2%	0.3%	0.3%

Source: Applicant

5. Estimated planning area surgeries were then multiplied by the presumed market share figures for the ASF, yielding forecasted number of procedures, by year. These projections are included below in Table 10. Assuming project completion to occur by July 2021, Year One is then 2022, since that is the first full year of operations after project completion.

[6] increase in 2020 is based on the shift of inpatient procedures to outpatient settings which MHS-Gig Harbor is able to accommodate with existing capacity.

Table 10: MHS-Gig Harbor Projected Number of Ambulatory Surgeries, by Type, 2020-2024

MHS-Gig Harbor Cases, Historical and Forecast Based on Market Share	2020	1Q-2Q 2021	3Q-4Q 2021	2022	2023	2024
Operations on the Nervous System	65	33	36	80	85	91
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	0	0	-	-	-	-
Operations on the Eye	0	0	134	298	316	336
Operations on the Ear	0	0	-	-	-	-
Operations on the Nose, Mouth and Pharynx	457	231	254	564	599	636
Operations on the Respiratory System	0	0	-	-	-	-
Operations on the Cardiovascular System	0	0	-	-	-	-
Operations on the Digestive System	88	44	163	362	384	408
Operations on the Urinary System	0	0	23	51	54	57
Operations on the Male Genital Organs	0	0	9	20	21	22
Operations on the Female Genital Organs	140	71	78	173	184	195
Operations on the Musculoskeletal System	650	328	361	803	853	905
Operations of the Integumentary System	270	137	150	334	354	376
Miscellaneous diagnostic and therapeutic procedures and new technologies	13	7	7.44	16.54	17.55	18.63
Total Cases	**1,683**	**850**	**1,215**	**2,702**	**2,868**	**3,044**
Central Pierce Planning Area Cases	54,147	27,358	27,358	55,301	55,899	56,511
MHS-Gig Harbor Market Share, Central Pierce Planning Area	3.1%	3.1%	4.4%	4.9%	5.1%	5.4%
Average annual growth, cases	109.6%	22.7%		30.8%	6.1%	6.2%

Source: Applicant

6. Based on the forecasted number of ambulatory surgeries at the ASF, estimated utilization is provided in Table 11, where cases are translated into surgery minutes using the 2019 MHS-Gig Harbor outpatient surgery case per minute figure of 81.3 minutes for surgical cases. Based on WAC 246-310-270(9)(iii), the four ORs at MHS-Gig Harbor would be efficiently utilized. Please refer to Table 11 below.

Table 11: MHS-Gig Harbor, Projected Number of Ambulatory Surgeries and Operating Room Utilization, 2020-2024

Cases	2020	1Q-2Q 2021	3Q-4Q 2021	2022	2023	2024
Operations on the Nervous System	65	33	36	80	85	91
Operations on the Endocrine System, operations on the hemic and lymphatic system, and obstetrical procedures	-	-	-	-	-	-
Operations on the Eye	-	-	134	298	316	336
Operations on the Ear	-	-	-	-	-	-
Operations on the Nose, Mouth and Pharynx	457	231	254	564	599	636
Operations on the Respiratory System	-	-	-	-	-	-
Operations on the Cardiovascular System	-	-	-	-	-	-
Operations on the Digestive System	88	44	163	362	384	408
Operations on the Urinary System	-	-	23	51	54	57
Operations on the Male Genital Organs	-	-	9	20	21	22
Operations on the Female Genital Organs	140	71	78	173	184	195
Operations on the Musculoskeletal System	650	328	361	803	853	905
Operations of the Integumentary System	270	137	150	334	354	376
Miscellaneous diagnostic and therapeutic procedures and new technologies	13	7	7	17	18	19
Total Cases, surgeries	1,683	850	1,215	2,702	2,868	3,044
Cases per Day (assumes 240 days of operation)	7.01	3.54	5.06	11.26	11.95	12.68
Surgery minutes per year (assumes MHS-Gig Harbor outpatient minutes per case)	136,783	69,121	98,771	219,614	233,088	247,425
Estimated Number of Operating Rooms Needed (WAC 246-310-270 (9) (ii)	2.0	2.0	2.9	3.2	3.4	3.6

Source: Applicant

The NCHS use rates in the utilization forecast are based on national data sets and are national estimates. It is possible that local patterns could vary from the survey figures. However, there is no better statistical approach to estimate expected future volumes with procedural specificity. It is arguably reasonable to increase the use rate over time, given population aging and higher ambulatory surgery use rates for older age cohorts. However, we assume a constant use rate over our forecast period.

Table 10 above also provides estimates of MHS-Gig Harbor's Central Pierce Planning Area market share. It is projected to equal 3.1% of all planning area ambulatory surgeries in 2020, increasing to 5.4% by 2024.

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

A relative paucity of outpatient ORs in the Central Pierce planning area limits the ability for further increases in utilization by the planning area population. This limited supply results in excess demand for outpatient services, thereby restricting access for patients. Patients in need of surgical services must then either utilize inpatient services or outmigrate to neighboring planning areas. For those patients which outmigrate, geography and regional traffic patterns may also restrict access, limiting patient ability to access care in neighboring areas such as Seattle.

9. **In a CN-approved facility, WAC 246-310-210(2) requires that "all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services." Confirm your facility will meet this requirement.**

MHS-Gig Harbor is committed to meeting community and regional health needs and provides charity care consistent with the MultiCare Charity Care Policy, included as Exhibit 7.

Our financial pro forma forecast provided in Exhibit 11B-11C explicitly allocates 2.04% of revenues to be provided for charity care, a figure above the Planning Area Hospital and Puget Sound Regional charity care average, less King County, between 2016 to 2018. Please see Table 12 below.

Table 12: Puget Sound Region (Less King County) Charity Care Statistics, 2016-2018

		% of Total Revenue			
Lic. No	**Region/Hospital**	**2016**	**2017**	**2018**	**3 Year Average**
209	Saint Anthony Hospital	0.48%	0.78%	0.89%	0.72%
32	Saint Joseph Medical Center - Tacoma	0.53%	1.05%	1.15%	0.91%
176	Tacoma General Allenmore Hospital	1.71%	1.89%	2.32%	1.97%
175	Mary Bridge Children's Health Center	0.74%	0.93%	1.06%	0.91%
	Central Pierce Hospital Average	0.87%	1.16%	1.35%	1.13%
	MultiCare Central Pierce Average	1.23%	1.41%	1.69%	1.44%
	PUGET SOUND REGION TOTALS	0.91%	1.23%	1.44%	1.19%

*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, 2016-2018

10. Provide a copy of the following policies:

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

Please see Exhibit 8 for the Admissions policy. Our Charity Care Policy, as referenced above, is presented in Exhibit 7. Exhibit 9 includes our Patient Rights and Responsibilities policy, and Exhibit 10 includes our Non-discrimination policy.

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

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

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

Please see Exhibit 11A for historical financial statements, and Exhibit 11B-11C for the Pro Forma financial forecast for the first three years of operations. MHS-Gig Harbor does not keep its own balance sheet since it is essentially a cost center within Tacoma General/Allenmore.

The assumptions used to generate these forecasts are described below. Please note the following:

- There are financial models for Tacoma General/Allenmore, as a whole, and MHS-GH. These are provided with and without the project.

- MHS-GH is a cost center within Tacoma General/Allenmore, thus its actuals are within the overall Income Statement for the combined hospital.

- The Tacoma General/Allenmore financial model only varies over the forecast as the MHS-GH model varies. Thus, for example, in 2020, the Tacoma General/Allenmore Income Statement will vary from 2019 Annualized by the incremental change in MHS-GH over the period 2019-2020. In 2021, with or without the project, The Tacoma General/Allenmore Income Statement will vary from 2020 to 2021 as the MHS-GH Income Statement varies from 2020 to 2021.

- Without the Project, the MHS-GH Income Statement is assumed to remain essentially constant at its 2020 values. There is a slight increase in MHS-GH wages and salaries, even without the project, as detailed below.

- With the Project, MHS-GH volumes and financial performance is forecast to grow based on projections, as detailed in Exhibit 11B-11C. This incremental

growth year-over-year, drives incremental growth in Tacoma General/Allenmore's Income Statement.

Key Assumptions

Volume Assumptions

1. These have been detailed above. Please see Table 10, and the explanation of the methodology and key assumptions, pages 20-26.

2. Either Without or With the Project, there is a relatively large upturn in projected MHS-GH volumes, thus, financial performance due to: (1) an additional recently employed orthopedist utilizing the ASF; (2) increased anesthesia coverage; and (3) opening ORs for five days/week, given increased anesthesia coverage. For example, Table 5 shows ASF volumes of 756 cases through January 1-November 30, 2019, and Table 6 shows a 2020 budgeted ASF volume of 1,683 cases.

3. MHS-GH case volumes, With the Project are detailed in Table 10.

4. MHS-GH case volumes Without the Project are also provided in Table 10, but it is assumed volume growth stops at 2020 and remains constant thereafter.

Capital Expenditures

Tacoma General/Allenmore

5. Routine capital expenditure estimates, for Tacoma General/Allenmore have been held constant at the 2019 Annualized figure. As noted above, however, depreciation costs over the forecast will vary based on incremental depreciation forecasted for the MHS-GH cost center.

MHS-GH

6. Please see the Table below. Incremental capital expenditures of $4,689,120 are expected as part of project.

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	$2,377,329
g. Fixed Equipment (not already included in the construction contract)	$211,679
h. Movable Equipment	$1,168,496
i. Architect and Engineering Fees	$332,826.06
j. Consulting Fees	$71,319,87
k. Site Preparation	
l. Supervision and Inspection of Site	$208,882,50
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	
n. Washington Sales Tax	$319,387.84
Total Estimated Capital Expenditure	***$4,689,120.27***

7. Depreciation at MHS-GH is based on 2019 Annualized figures. Without the project, it is held constant at this value over the forecast period. With the Project, incremental depreciation is added based on the $4.69 million incremental capital expenditure at MHS-GH, depreciated over a 5-year useful life.

Revenues

8. Models do not include any charge inflation.

Tacoma General/Allenmore

9. The Income Statement reflects hospital-wide financial performance. As stated above, revenues and expenses are based on 2019 annualized figures and are held constant over the forecast period except where revenues and expenses vary as incremental MHS-GH revenues and expenses vary, year by year, over the forecast.

10. Overall, Deductions from Revenue, 2019 annualized, were 75% of gross revenues. This percentage has been held constant over the forecast period., With or Without the Project

11. Charity care, 2019 annualized, is 2.04% of gross revenues. This percentage has been held constant over the forecast period. Table 12 indicates this figure is well above the 2016-2018 average, measured as the percentage of charity care divided by total patient services revenues, for either the Puget Sound Region, 1.19%, or the Central Pierce Planning Area, measured at 1.13%. This simply means that Tacoma General/ Allenmore charity care, as a percentage of total patient service revenues, was well above other hospitals in the Planning Area.

12. Bad debt, 2019 annualized, was 0.78% of gross revenues. It has been held constant at this percent level, over the forecast period.

MHS-GH

13. The MHS-GH gross revenues are based on gross revenues divided by cases for the 2019 annualized period. This revenue per statistic has been held constant and multiplied by forecast cases, with and without the project.

14. Deductions from Revenues have been calculated at 75% of gross revenues. This is an allocation, given that this detail is not kept at the cost center level.

Expenses

Tacoma General/Allenmore

15. Expenses reflect hospital-wide expenses. As stated above, revenues and expenses are based on 2019 annualized figures and are held constant over the forecast period except where revenues and expenses vary as incremental MHS-GH revenues and expenses vary, year by year over the forecast.

MHS-GH

16. There is projected inflation of wages and salaries of 3.5% per year based on existing contractual agreements.

17. There is no other expense inflation in the model.

18. All expenses listed except Wages, Salaries and Benefits, explained below, and depreciation, explained above, flex with volumes, based on an expense per statistic figure calculated from 2019 annualized figures. For example, Supplies were $1.419 million, 2019 annualized. Divided by case volumes for that period at MHS-GH, Supply expenses were $1,720 per case. Then in 2020, with a forecast case volume of 1,683, Supplies would be $2.895 million ($1,770*1,683). This same methodology and calculation has been used for all expenses that flex with volume, With or Without the Project.

19. All expenses, except staffing costs Without the Project, are held constant at 2020 values.

FTEs

20. FTEs at MHS-GH include OR and PACU staff, which have been combined together. Please see Table 16, which includes actuals for 2016-2018, YTD 2019 (January-November) and forecast FTEs With the Project. FTEs Without the Project remain constant at 2020 FTE values.

21. FTE are based on MHS-GH 2019 year to date staffing, as shown in Table 16, by position. Incremental growth is based on growth of cases, and expected need for incremental staff, by position, by year.

22. FTE wage and salary costs as well as benefits are based on 2019 actuals, with annual wage and salary growth, as stated above, which in turn, drives increased benefits each year.

23. Overall, benefits are modeled at 29.5% of wages and salaries. This percentage is held constant over the forecast period.

2. Provide the following applicable agreements/contracts:

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

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

A medical director agreement is the only applicable agreement listed above. See Exhibit 12 for a current copy of the medical director agreement, including a signed first amendment providing automatic renewal terms.

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

   Please see Table 12.

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

   See Exhibit 13A for a Title Guarantee from First American Title Insurance Company that the title is vested to MultiCare Health System for the site located at 4545 Point Fosdick Dr Gig Harbor, WA 98335 (parcel # 400260-0-031[7]). Further, see Exhibit 13B for the property information on the Pierce County Assessor-Treasurer's webtool for parcel 4002600031 that identifies MultiCare Health System as the owner/taxpayer for the site.

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

   Not applicable.

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

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

[7] Exhibit 13A. Schedule A.4

f. Building Construction	$2,377,329
g. Fixed Equipment (not already included in the construction contract)	$211,679
h. Movable Equipment	$1,168,496
i. Architect and Engineering Fees	$332,826.06
j. Consulting Fees	$71,319,87
k. Site Preparation	
l. Supervision and Inspection of Site	$208,882,50
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	
n. Washington Sales Tax	$319,387.84
Total Estimated Capital Expenditure	$4,689,120.27

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

   The project will be financed with MultiCare Health System cash reserves. Please see Exhibit 16 for the letter of financial commitment.

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

   Not applicable

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

   Please see Exhibit 14 for a non-binding contractor's estimate for the project construction costs.

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

    In general, the cost of the project would not be expected to affect costs and charges, as rates are based on fee schedules with CMS and negotiated rates with other payers not directly impacted by project-related costs.

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

    Please our response to Question 10 above.

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

Projected payer mix is anticipated to be consistent with the historical payer mix based on January to October 2019 actuals.

Table 13: Projected Payer Mix by Gross Revenue and by Patients

	Gig Harbor		Tacoma General	
	Cases	Charges	Cases	Charges
Commercial/HCC	46.7%	44.2%	40.1%	28.7%
Medicare	17.1%	14.0%	30.1%	39.5%
Medicaid	16.2%	14.9%	23.5%	26.0%
Other Gov / L&I	7.3%	7.3%	3.3%	3.4%
Self-Pay	12.7%	19.6%	3.0%	2.3%

Source: Applicant, based on Jan-Oct 2019 actuals

Notes:
"Other" includes all other payer sources.

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

Table 14: MHS-Gig Harbor Jan-Oct 2019 Payer Mix, Based on Cases and Charges

	Gig Harbor		Tacoma General	
	Cases	Charges	Cases	Charges
Commercial/HCC	46.7%	44.2%	40.1%	28.7%
Medicare	17.1%	14.0%	30.1%	39.5%
Medicaid	16.2%	14.9%	23.5%	26.0%
Other Gov / L&I	7.3%	7.3%	3.3%	3.4%
Self-Pay	12.7%	19.6%	3.0%	2.3%

Source: Applicant, Jan-Oct 2019 actuals

Notes:
"Other" includes all other payer sources.

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

Please see Exhibit 15 for a listing of new equipment for this project with an estimated cost totaling $1,380,175. This figure includes sales tax assumed at 8.5% of equipment costs.

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

See Exhibit 16 for a letter from MultiCare Health System's Chief Financial Officer, Jim McManus, committing corporate reserves to fully fund the estimated capital expenditures and any working capital requirements associated with the project.

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

This question is not applicable. MultiCare will finance the project with cash reserves.

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

Audited financial statements for MultiCare for the most recent three-year period available (CY2016-CY2018) are provided in Exhibit 17.

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

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

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

Table 15: MultiCare Ambulatory Surgery Center Accreditation Status and Surgical Services, by Facility

Name	Address	Medicare Provider Number	Medicaid Provider Number	Owned or Managed
MultiCare Mary Bridge Children's Hospital	311 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 West 5th Ave Spokane, WA 99204	500044	2083493	Owned
MultiCare Valley	12606 East Mission Ave. Spokane Valley 99216	500119	2083494	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
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	Pending	Pending	Owned

Source: Applicant

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

   Please see Table 16 below for the historical and forecasted number of FTEs and salaries and benefits per FTE, by classification for both productive and non-productive FTEs for MHS-Gig Harbor.

Table 16: MHS-Gig Harbor Ambulatory Surgery Facility FTEs by Type by Year, 2016-2023

Total FTEs, Gig Harbor Ambulatory Surgery Center, With Project	Actual FTE Counts				Projected				
	2016 FTEs	2017 FTEs (OR only operated Sep-Dec)	2018 FTEs	Nov19 FTEs YTD	2020 FTEs	2021 FTEs	2022 FTEs	2023 FTEs	2024 FTEs
Productive FTEs									
Management	(0.01)	0.35	0.12	-	-	-	-	-	-
RN	2.87	1.32	4.45	6.01	13.73	16.91	22.10	23.45	24.84
LPN	0.00	0.10	(0.01)	-	-	-	-	-	-
Technical	1.64	1.35	2.41	2.80	6.36	7.84	10.24	10.86	11.51
Other Salaries/Hours	-	-	-	(0.04)	-	-	-	-	-
Orientation	0.07	0.25	0.18	0.10	0.10	0.12	0.16	0.17	0.18
Education	0.05	0.10	0.08	0.11	0.19	0.23	0.30	0.32	0.34
Technical Fixed	-	-	0.25	0.86	0.69	0.69	0.69	0.69	0.69
Other Fixed	0.73	0.29	0.78	0.90	0.84	0.84	0.84	0.84	0.84
CNA/MA	-	-	-	0.22	-	-	-	-	-
Outside Wages-RN	-	0.17	(0.17)	-	-	-	-	-	-
Total Productive FTEs	**5.35**	**3.92**	**8.10**	**10.95**	**21.90**	**26.63**	**34.33**	**36.33**	**38.39**
Non-Productive FTEs									
Sick Leave	-	-	0.00	0.04	0.07	0.09	0.11	0.12	0.12
Bereavement	0.01	-	-	0.00	-	-	-	-	-
Jury Duty	-	-	-	0.01	-	-	-	-	-
System Initiatives Training	0.00	0.01	-	-	-	-	-	-	-
Paid Time Off (PTO)	0.86	0.65	1.11	1.28	3.04	3.69	4.75	5.03	5.31
Extended Illness (EIT)	0.05	0.21	0.06	0.26	0.23	0.28	0.36	0.38	0.40
Total Non-Productive FTEs	**0.92**	**0.87**	**1.17**	**1.59**	**3.34**	**4.06**	**5.22**	**5.52**	**5.83**
Total FTEs	**6.27**	**4.79**	**9.27**	**12.54**	**25.24**	**30.69**	**39.55**	**41.85**	**44.22**

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

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

As detailed above in Table 16, FTEs With the Project vary, in general, as case volumes vary. As stated earlier, there is a large expected upturn in case volumes over the period 2019-2020, due to: (1) an additional recently employed orthopedist utilizing the ASF; (2) increased anesthesia coverage; and (3) opening ORs for five days/week, given increased anesthesia coverage. Table 5 shows ASF volumes of 756 cases through January 1-November 30, 2019, and Table 6 shows a 2020 budgeted ASF volume of 1,683 cases. This drives productive FTEs up 10.95 FTEs in 2019, to 21.9 FTEs in 2020. Thereafter, as volumes are expected to grow, With the Project, FTEs who provide direct patient care, such an RNs and OR techs (included as "Technical" in Table 16), increase.

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

   The medical director is Dr. Brian McCoy, MD00046744.

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

   The medical director is under contract and is not an employee (see Exhibit 12). Therefore, this question is not applicable.

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

Sharon J. Oxendale	President/COO, MultiCare Tacoma General Allenmore Hospital
Dr. Ugochukwu Uwaoma, MD00039125	Chief Medical Officer, MultiCare Tacoma General Allenmore Hospital
Silje Kennedy	Perioperative Director, MultiCare Tacoma General Hospital

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

   Please see Exhibit 18 for physician names and specialties represented on the MHS-Gig Harbor active medical staff.

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

   Please see Exhibit 18 for names and credential numbers for persons on the MHS-Gig Harbor active medical staff who are not physicians.

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

Overview. MultiCare Health System has an excellent track record in Pierce County for recruiting and retaining qualified staff to meet the needs of their systems that includes 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.

MultiCare Medical Associates employs over 490 primary and specialty physicians. Since 2003, MHS has recruited a large number of new employees each

year. This recruiting success, coupled with better-than-average employee retention rates, has enabled them to staff new programs and open new facilities in both acute-care and outpatient settings.

Extensive recruitment resources. MultiCare Health System'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 MHS' 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. MHS has consistently retained employees at a rate that exceeds other healthcare providers in the region and across the country. 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. Because MHS turnover rates have been low, vacancy rates have also remained lower than industry norms.

Expanding and developing the healthcare workforce. MHS has devoted extensive resources to ensuring an adequate 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. MHS' workforce development efforts extend to current employees who benefit from residency programs, apprenticeships, tuition assistance, and targeted scholarship programs. MHS also boast award-winning educational resources including state-of-the-art simulation labs, computer-based learning modules, classroom training and other educational opportunities

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

Table 17: MHS-Gig Harbor Ambulatory Surgery Facility, Ancillary and Support Services

Acclarent	Latera (Intellis)
Aesculap	LeanTaas
Allergan	LifeNet
Arthrex	Medline (Distributor)
BPI – (Instrument Repair)	MedSpeed (Medical Courier)
Burlington	Medtronic (Covidien)
Cardinal	Mentor
CBRE (Facilities Support)	Mizuho-OSI
Clean Harbors (Waste Disposal)	MTF (Allograft)
ConMed	Paragon
CoMedial	Praxair

DePuy Synthes	Skytron
Deru Medical	Storz
Ethicon	Stryker Endoscopy
GE HealthCare	Stryker Instruments
Hologic	Stryker Sustainability Solutions
Iron Mountain	Tacoma Anesthesia Associates
Johnson & Johnson	TrackCare (Tissue Tracking)
Laboratories Northwest	WL Gore

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

Not applicable.

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

There are no changes expected as a result of the proposed project.

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

MHS-Gig Harbor is operational and currently works with local inpatient health providers, as required. As a member of the MultiCare Health System, it holds an Inter-Facility Patient Transfer Agreement with MHS-affiliated hospitals. This includes the planning area hospital Tacoma General/Allenmore. Please see Exhibit 19 for a copy of this Inter-Facility Transfer Agreement.

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

None of the existing working relationships with healthcare facilities listed above would change.

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

This question is not applicable.

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

Please see Exhibit 19, which includes a copy of MHS-Gig Harbor's Inter-Facility Transfer Agreement with MHS-affiliated hospitals.

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

    MHS-Gig Harbor promotes continuity of care now, since it offers all elements of outpatient care across a wide range of specialties, including diagnoses, treatment and outpatient surgery, if needed. CN approval of two additional ORs will allow MHS-Gig Harbor to meet the increased Planning Area demand for outpatient surgical procedures and continue to support continuity of care in its local market. Without further increases in supply, patients in search of outpatient surgical procedures will need to commute outside the Central Pierce planning area, thereby creating unwarranted fragmentation of services in the future.

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

    MHS-Gig Harbor, as a member of the MultiCare Health System, cooperates with all other MHS-affiliated hospitals. This includes the largest planning area provider of inpatient care in Tacoma General/Allenmore Hospital. Please see Exhibit 19, which includes a copy of MHS-Gig Harbor's Inter-Facility Transfer Agreement with MHS-affiliated hospitals.

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

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

    MultiCare does not have any such convictions as defined in WAC 246-310-230 (5) (a).

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.

MHS-Gig Harbor is requesting certificate of need to operate two (2) additional operating suite in addition to its current two operating suites.

In deciding to submit this application, MHS-Gig Harbor explored the following options: (1) no project—continuing as a licensed, certificate of need approved 2-OR facility and (2) the requested project—seeking certificate approval to expand with two additional CN-approved operating rooms.

Other options, such as additional build-out of operating suites beyond those approved were determined not financially feasible.

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

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

Table 18: Alternatives Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:
No project - remain CN-approved for 2-ORs	• There is no advantage to continuing as is in terms of improving access. (Disadvantage ("D")) • Planning Area supply constraints prevent the potential for further growth in outpatient surgical procedures, leading to reduced access to outpatient surgery services for Planning Area residents. Without the project, these constraints may require patients to out-migrate to non-Planning Area facilities, which harms access. (D)
CN Approval - to expand 2-OR in addition to 2-ORs (Requested project)	• Allows two additional ORs at MHS-Gig Harbor, open to all physicians in the community who are credentialed and privileged as a member of the MHS-Gig Harbor medical staff, improving local access to orthopedic, gynecological, ENT, urological, podiatry, eye, general, plastic, and gastroenterological procedures for Planning Area residents (Advantage ("A"))

Table 19: Alternatives Analysis: Promoting Quality of Care	
Option:	**Advantages/Disadvantages:**
No project - remain CN-approved for 2-ORs	• There are no advantages from a quality of care perspective. However, there are no current quality of care issues. (Neutral ("N"))
CN Approval - to expand 2-OR in addition to 2-ORs (Requested project)	• The requested project meets and promotes quality and continuity of care issues in the Planning Area, given it improves access identified above. (A) • From a quality of care perspective, there are only advantages. (A)

Table 20: Alternatives Analysis: Promoting Cost and Operating Efficiency	
Option:	**Advantages/Disadvantages:**
No project - remain CN-approved for 2-ORs	• Under this option, there would be no impacts on costs or efficiency—the surgery center would continue as presently. (N) • However, without the project, some residents in need of surgical procedures need to either out-migrate or be treated at inpatient facilities as a result of Planning Area supply constraints. (D)
CN Approval - to expand 2-OR in addition to 2-ORs (Requested project)	• The incremental cost of this project will be relatively small, and MultiCare costs and charges are based on fee schedules with CMS and principal payers. Therefore, in general, the proposed project would not be expected to affect costs and charges. (N) • Two additional ORs will provide greater accessibility to planning area residents for outpatient surgical services. Adding capacity to a local ASF reduces travel time and costs, patient inconvenience and anxiety, and is a cost-effective alternative to increased utilization of hospital outpatient surgery departments. (A)

Table 21: Alternatives Analysis: Legal Restrictions.	
Option:	**Advantages/Disadvantages:**
No project - remain CN-approved for 2-ORs	• There are no legal restrictions to continuing operations as presently. (A)
CN Approval -to expand 2-OR in addition to 2-ORs (Requested project)	• Requires certificate of need approval. This requires time and expense. (D)

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

Any proposed changes will meet MultiCare Health System's internal standards which have been engineered and tested to ensure that they support our high quality, efficient and patient-focused standards. Our standards also meet and or exceed all applicable state and local codes.

Exhibit 1.

MultiCare Organizational Chart

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/ Parkland Off Campus ED
- Tacoma General / Allenmore Hospitals

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 Off Campus ED
- Valley Hospital
- Rockwood Clinic
- Neurosciences Institute

System

- Institute for Research & Innovation

Networks

Retail/Community

- Indigo Urgent Care
- Immediate Clinics
- 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 Health*

Population Health

- MultiCare Connected Care, LLC*
- Physicians of Southwest Washington, LLC*
- PNWCIN, LLC* d/b/a Embright

2

* Operates through separate legal entity (see pg.3)

Exhibit 2.

Letter of Intent

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

December 6, 2019

Nancy Tyson, Executive Director
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Tyson:

In accordance with WAC 246-310-080, MultiCare Health System hereby submits this letter of intent to apply for a certificate of need to add two operating rooms to its existing certificate of need approved Ambulatory Surgery Facility (ASF) in Gig Harbor, Washington. In conformance with WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:
   MultiCare Health System proposes to convert two procedure rooms to operating rooms at its existing certificate of need approved ASF located in Gig Harbor, Washington. Upon project completion, the ASF will have four operating rooms.

2. Estimated Cost of the Proposed Project:
   The estimated capital expenditure is $4,689,120.

3. Description of the Service Area:
   Per WAC 246-310-270, the primary service area is the Central Pierce County Secondary Health Service Area. However, because of its location MultiCare Health System anticipates a number of patients will come from other areas of Pierce and Kitsap Counties as well.

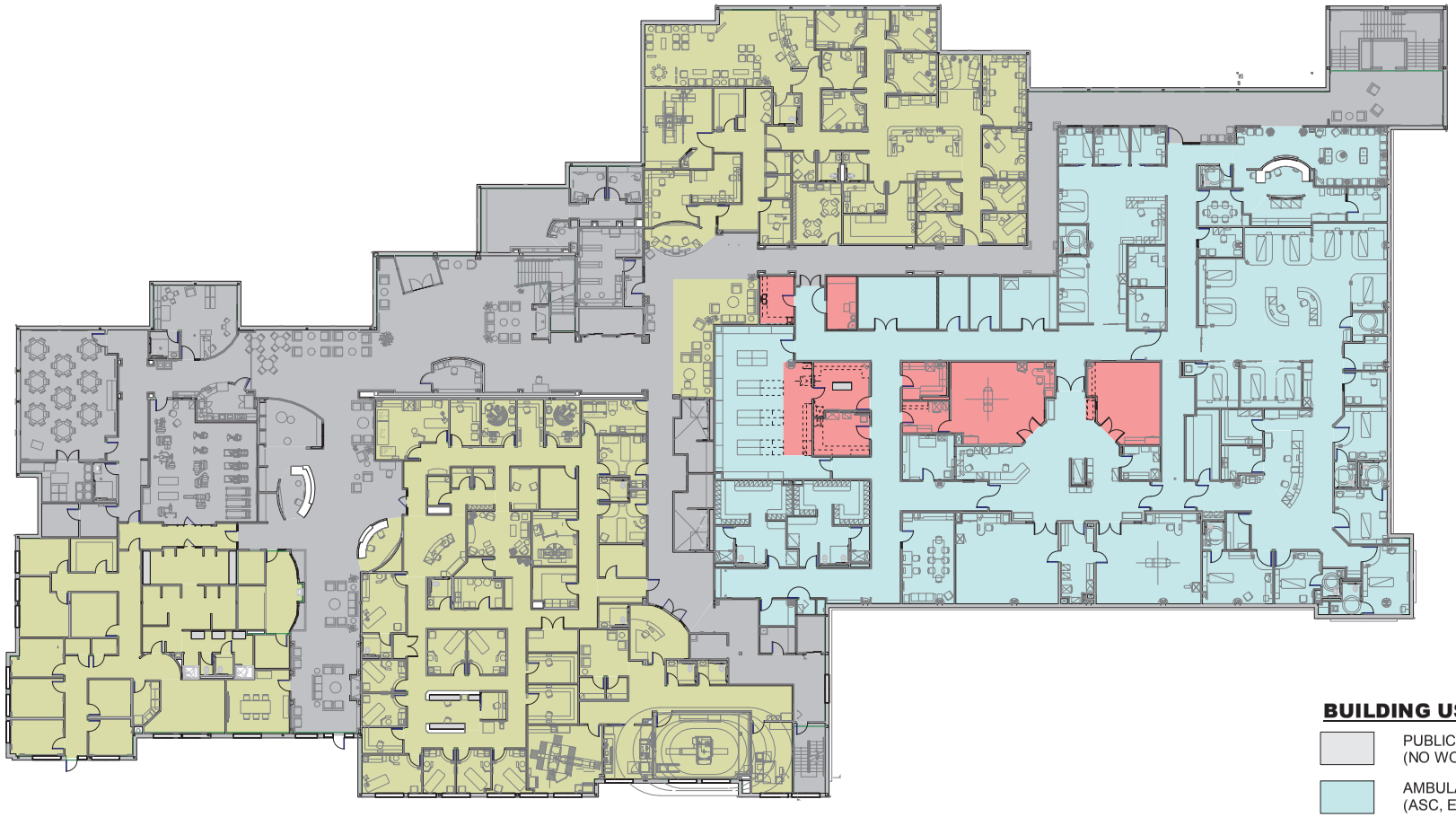
Thank you for your interest in this matter. Please contact me directly with any questions.

Sincerely,

Theresa Boyle, Senior Vice President
MultiCare Health System

Exhibit 3.

Single Line Drawings



BUILDING USE

- PUBLIC / SHARED (NO WORK)
- AMBULATORY SURGICAL CTR. (ASC, EXISTING, NO WORK)
- ASC - AREA OF WORK
- OTHER CLINICAL (NO WORK)

0' 15' 30'

A100

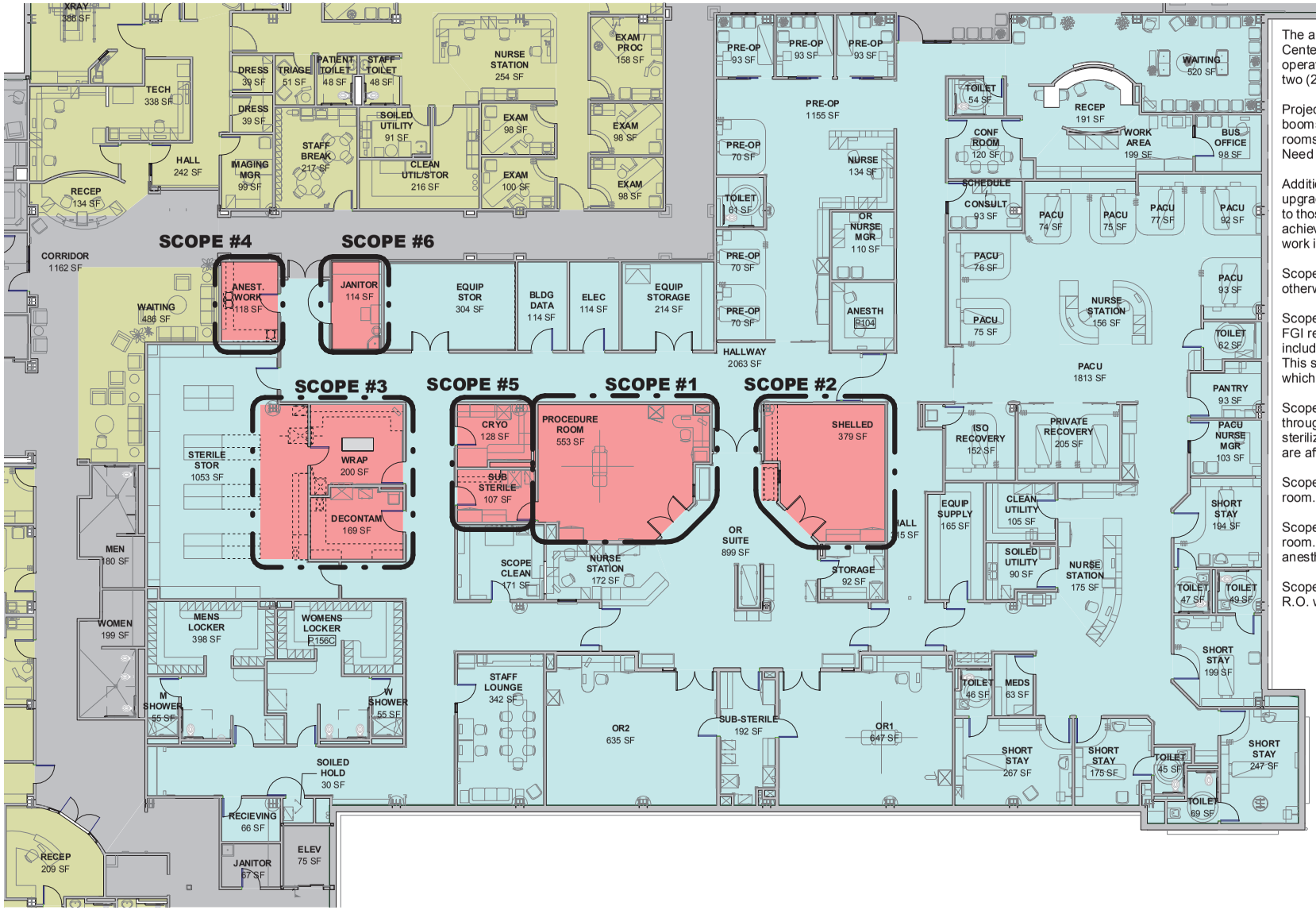
Key Plan - Overall, Level 01

Gig Harbor - Ambulatory Surgical Center, Certificate of Need Submission

Multicare Health System

10/4/19 | 19050 |

CLARK KJOS



General Project Description

The area shown in blue is the existing Ambulatory Surgical Center at Gig-harbor Medical Center. This is an existing, operational ASC with two (2) licensed operating rooms and two (2) procedure rooms, one of which is currently 'shelled'.

Project is to fit-out existing shelled procedure room and add booms to other existing procedure room to classify these two rooms as 'operating rooms' for Gig-Harbor's Certificate of Need application.

Additional work is neccessary to ancillary spaces to add and upgrade sterilization equipment. The areas of work are limited to those shown in red and include only work neccessary to achieve functional charachteristics as required. Description of work is below and additional detail provided on attached plans

Scope #1: Rebalance air-supply system as required, otherwise room is ready as is.

Scope #2: Remove scrub sink to expand room to minimum FGI required dimensions. Fit-out room to match other OR's including HVAC, med. gas, lighting, equipment and finishes. This scope includes the addition of an air-handler, capacity which will be utilized in OR#3 and sterlizer rooms as needed.

Scope #3: Add through wall instrument washer and pas-through window in expanded decontam room. Install larger sterilizer and demo cabinets. Plumbing, electrical and HVAC are affected.

Scope #4: Remove casework and plumbing from existing room. Room to become sterile equipment storage

Scope #5: Relocate low temp sterilizer to existing sub-sterile room. Remove clinical sink from Cryo room to make space for anesthesia supply carts, otherwise room remains as is.

Scope #6: Divide existing housekeeping room and install new R.O. water system to serve sterilizers.

BUILDING USE

- PUBLIC / SHARED (NO WORK)
- AMBULATORY SURGICAL CTR. (ASC, EXISTING, NO WORK)
- ASC - AREA OF WORK
- OTHER CLINICAL (NO WORK)

A200

Existing ASC - Overall Plan / Scoping Plan

Gig Harbor - Ambulatory Surgical Center, Certificate of Need Submission

Multicare Health System

10/4/19 | 19050 |

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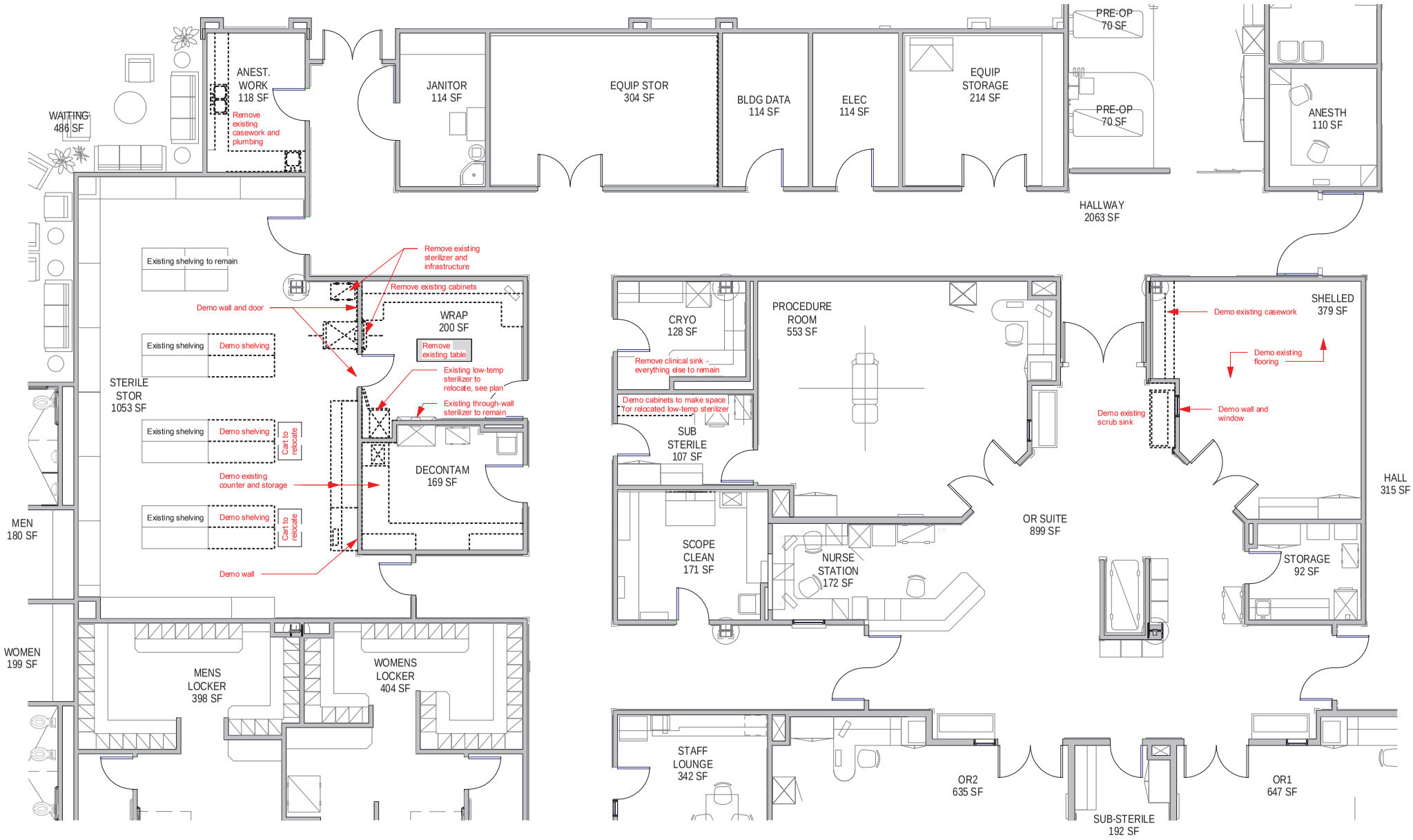

A201

ASC - Existing / Demo Plan

Gig Harbor - Ambulatory Surgical Center, Certificate of Need Submission

Multicare Health System

0' 4' 8'

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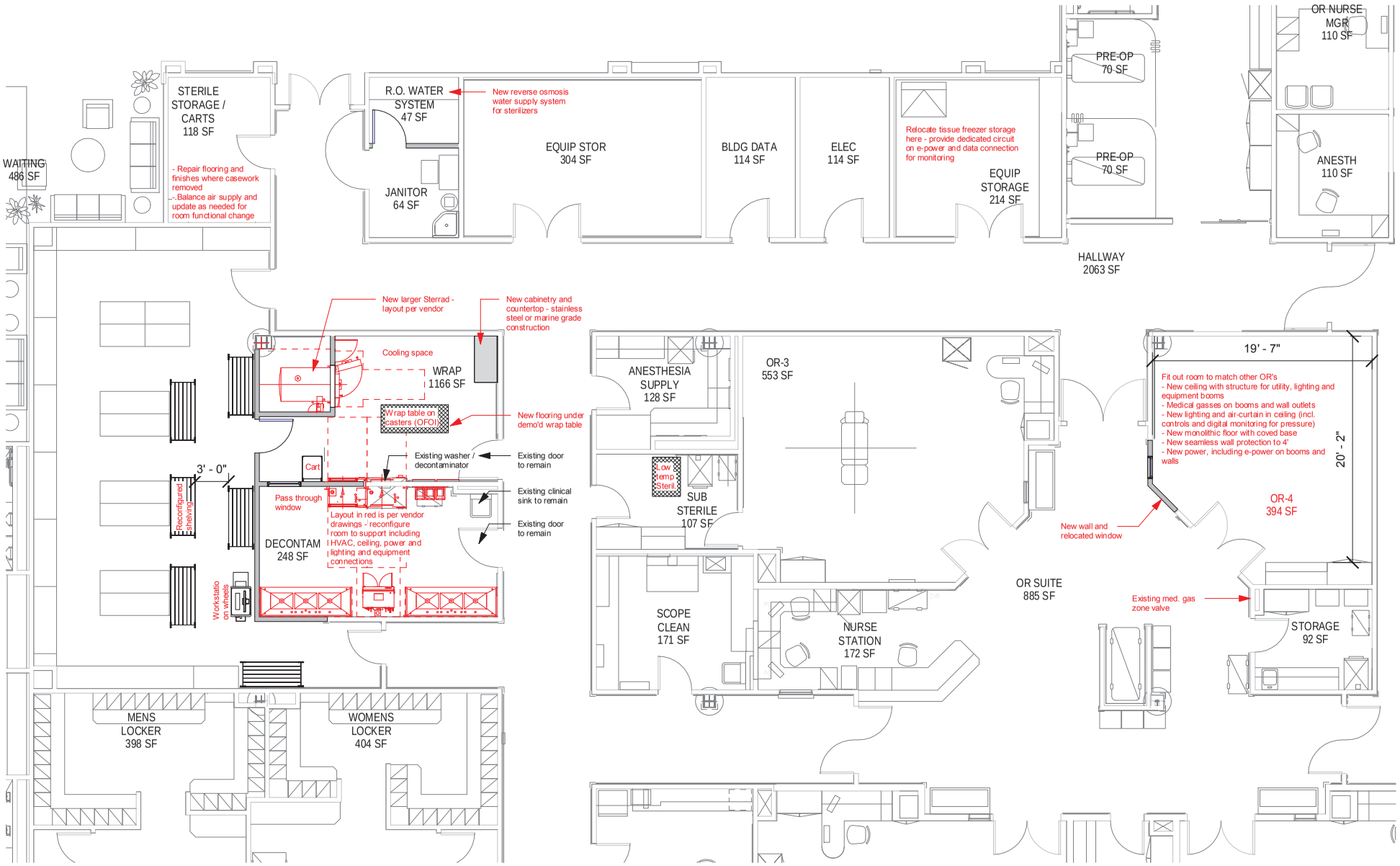

A202

ASC - Proposed

Gig Harbor - Ambulatory Surgical Center, Certificate of Need Submission

Multicare Health System

0' 4' 8'

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Exhibit 4.

Planning Area Supply with Sources

Central Pierce Planning Area Supply with Sources

Facility license	CN-Status	Facility Name	Nbr of ORs			Number of surgeries		Number of Minutes		Minutes/Case		
			Inpatient	Outpatient	Mixed Use	Outpatient	Mixed Use	Outpatient	Mixed Use	Outpatient	Mixed Use	
		Hospitals										
HAC.FS.00000032	CN-Approved	St. Joseph Medical Center			10		7,506		1,089,876		145.20	2018 DOH Survey (CY2017 Utilization) - Hospital Responses
HAC.FS.00000032	CN-Approved	[Part of SJMC License] Walters Same Day Surgery			9		5,718		636,556		111.32	2018 DOH Survey (CY2017 Utilization) - Hospital Responses
HAC.FS.00000032	CN-Approved	[Part of SJMC License] Gig Harbor Same Day Surgery		2		838		73,329		87.50		2018 DOH Survey (CY2017 Utilization) - Hospital Responses
HAC.FS.60075769	CN-Approved	St. Anthony Hospital			6		4,752		481,964		101.42	2018 DOH Survey (CY2017 Utilization) - Hospital Responses
HAC.FS.00000176	CN-Approved	Tacoma General Hospital			17		11,413		1,290,354		113.06	2019 DOH Survey (CY2018 Utilization)
HAC.FS.00000176	CN-Approved	Baker Day surgery of Tacoma		3		1,413		108,856		77.04		2019 DOH Survey (CY2018 Utilization)
HAC.FS.00000175	CN-Approved	Mary Bridge Children's Hospital		2	4	5,279	4,440	64,090	349,211	12.14	78.65	2019 DOH Survey (CY2018 Utilization)
HAC.FS.00000176	CN-Approved	MHS - Gig Harbor ASC		2		635		69,580		109.57		2019 DOH Survey (CY2018 Utilization)
HAC.FS.00000176	CN-Approved	Allenmore Hospital			8		6,758		985,150		145.78	2019 DOH Survey (CY2018 Utilization)
	CN-Approved	Gig Harbor Endoscopy Center	Excluded (Endoscopy Only)									2018 DOH Survey (CY2017 Utilization) - Hospital Responses
	CN-Approved	Tacoma Endoscopy Center	Excluded (Endoscopy Only)									2018 DOH Survey (CY2017 Utilization) - Hospital Responses
		ASF										
ASF.FS.60629909	CN-Exempt	Aesthetica Clinique LLC		1		231		35,700		154.55		2019 DOH Survey (CY2018 Utilization)
ASF.FS.60099774	CN-Exempt	Artistic Plastic Surgery Center		1		215		10,750		50.00		DOH staff - July 2019
ASF.FS.60252056	CN-Exempt	Cedar Laser and Surgery Center		2		2,084		107,732		51.69		2018 DOH Survey (CY2017 Utilization) - ASF Responses
ASF.FS.60278673	CN-Exempt	Harbor Plastic Surgery Center		2		435		21,750		50.00		2018 DOH Survey (CY2017 Utilization) - ASF Responses
ASF.FS.60100949	CN-Exempt	Kaiser Permanente Tacoma Ambulatory Surgery Center	Excluded (HMO)									DOH staff - July 2019
ASF.FS.60101100	CN-Exempt	Pacific Cataract and Laser Institute		2		4,036		201,800		50.00		2018 DOH Survey (CY2017 Utilization) - ASF Responses
ASF.FS.60262678	CN-Exempt	Pacific Northwest Eye Surgery Center		3		2,888		89,203		30.89		2019 DOH Survey (CY2018 Utilization)
ASF.FS.60100194	CN-Exempt	Peninsula Endoscopy Center	Excluded (Endoscopy Only)									2018 DOH Survey (CY2017 Utilization) - ASF Responses
ASF.FS.60386753	CN-Exempt	Sono Bello		3		1,038		147,396		142.00		2018 DOH Survey (CY2017 Utilization) - ASF Responses
ASF.FS.60738149	CN-Exempt	Soundview Ambulatory Surgery Center		1		250		12,500		50.00		DOH staff - July 2019
ASF.FS.60779058	CN-Exempt	The Eye Surgeons Group Ambulatory Surgery Center		1		246		12,300		50.00		DOH staff - July 2019
ASF.FS.60100195	CN-Exempt	Waldron Endoscopy Center	Excluded (Endoscopy Only)									2017 DOH Survey (CY2016 Utilization) - ASF Responses

		Nbr of ORs			Number of surgeries		Number of Minutes		Minutes/Case		
		Inpatient	Outpatient	Mixed Use	Outpatient	Mixed Use	Outpatient	Mixed Use	Outpatient	Mixed Use	
	CN Approved		9	54	8,165	40,587	315,855	4,833,111	38.68	119.08	
	All Other				11,423		639,131		55.95		
	Percent Inpatient				67.4%						
	Percent Outpatient				32.6%						
	Total				19,588	40,587	954,986	4,833,111	48.75	119.08	

Exhibit 5.

Numeric Need Methodology

Central Pierce ASC Need Methodology

Servie Area Population, 2023		358,271		Claritas, 2019: all ages			
Surgeries per, 1,000 residents, 2023 @	177.11	63,453					
a.i.	94,250 minutes per year, mixed use OR						
a.ii.	68,850 minutes per year, outpatient OR						
a.iii.	9 dedicated OP ORs x 68,850 minutes =			619,650	minutes, dedicated OR capacity.	12,710	Outpatient surgeries
a.iv.	54 dedicated mixed use ORs x 94,250 minutes =			5,089,500	minutes, mixed use OR capacity.	42,740	Mixed use surgeries
b.i.	Projected inpatient surgeries =	42,798	=	5,096,429	minutes, mixed use surgeries		
	Projectedoutpatient surgeries =	20,655	=	387,366	minutes, outpatient surgeries		
b. ii.	Forecast # of OP surgeries - capacity,of dedicated OP ORs						
		20,655	minus	12,710	=	7,945	
b.iii.	Average time of mixed use surgeries		=	119.08	minutes		
	Average time of outpatient surgeries		=	48.75	minutes		
b.iv.	mixed use surgeries, 2023 * average minutes/case		=	5,096,429	minutes		
	remianing OP surgeries (b.ii.) * average minutes/case		=	387,366	minutes		
				5,483,795	minutes		
c.i.	if b.iv. < a.iv., divide by (a.iv. - b.iv.) 94,250 to determine surplus of mixed use ORs						
	Not applicable; go to c.ii.						
	5,089,500						
	(5,483,795)						
	(394,295) divided by	94,250	=	(4.18)			
c.ii.	if b.iv. > a.iv., divide (mixed use part of b.iv. - a.iv) by 94,350 to determine shortage of mixed use ORs						
	5,096,429						
	(5,089,500)						
	6,929 divided by	94,250	=	0.07			
	Divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated OP ORs						
	387,366 divided by	68,850	=	**5.63**	**Need**		

Exhibit 6.

NCHS Survey

National Health Statistics Reports

Number 102 ■ February 28, 2017

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

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

Abstract

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

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

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

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

Introduction

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

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

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

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

Methods

Data source and sampling design

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

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

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

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

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

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

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

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

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

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

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

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

Data collection

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

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

Limitations of NHAMCS Ambulatory Surgery Data

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

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

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

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

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

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

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

Results

Ambulatory surgery procedure and visit overview

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

Ambulatory surgery procedures, by sex and age

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

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

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

NOTE: ASC is ambulatory surgery center.

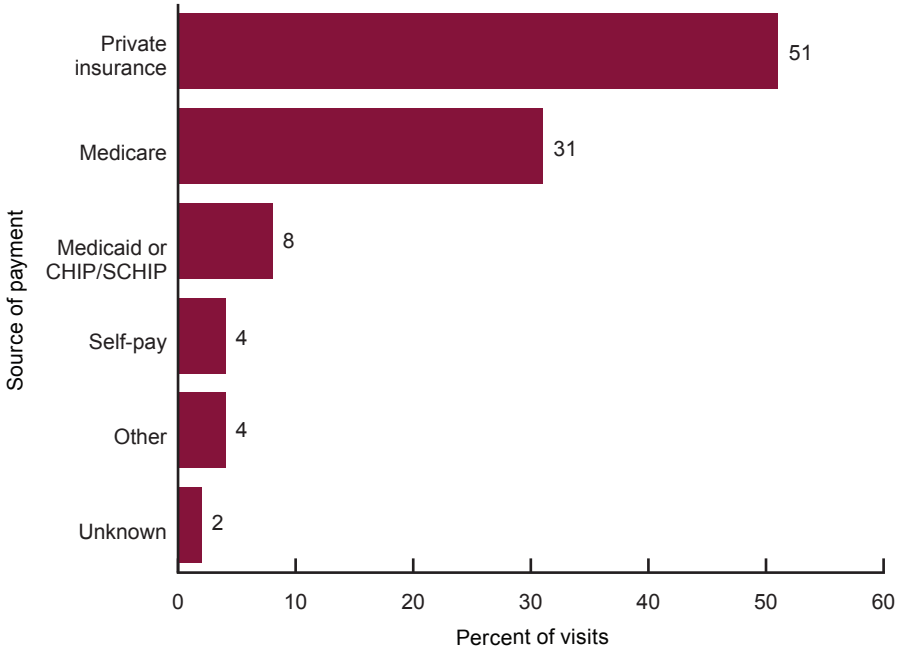
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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

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

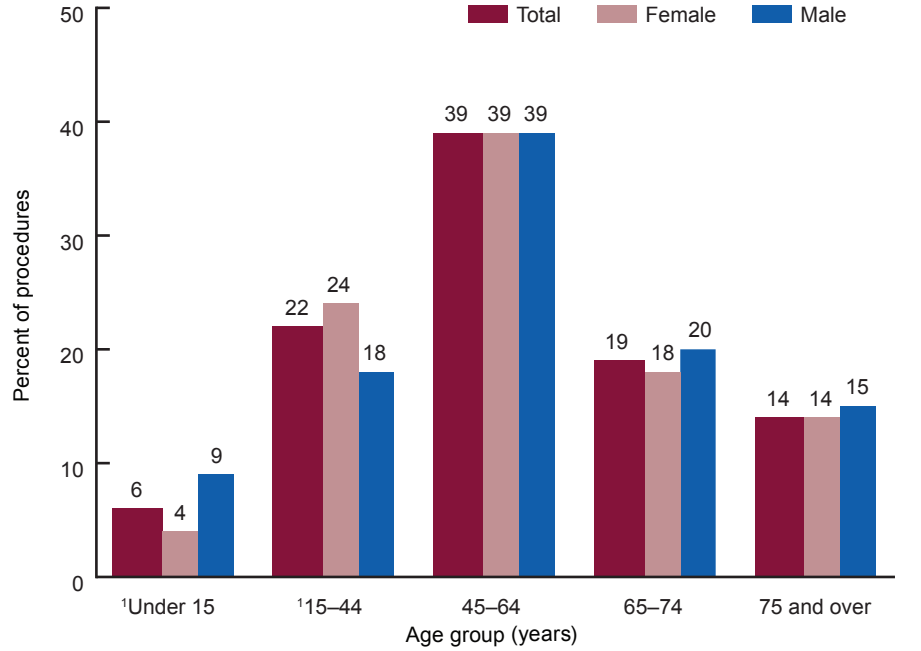
[1]Discharge to customary residence, generally home.
[2]Discharge for further observation without being admitted to a hospital.
[3]Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.
[4]Excludes 1.2 million of the 28.6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

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



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

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



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

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

Types of procedures

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

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

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

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

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

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

Duration of surgery

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

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

Discussion

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

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

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

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

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

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

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

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

Ambulatory Surgery Data

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

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

References

1. Leader S, Moon M. Medicare trends in ambulatory surgery. Health Aff (Millwood) 8(1):158–70. 1989.
2. Cullen KA, Hall MJ, Golosinskiy A. Ambulatory surgery in the United States, 2006. National health statistics reports; no 11. Hyattsville, MD: National Center for Health Statistics. 2009.
3. Davis JE. Ambulatory surgery…how far can we go? Med Clin North Am 77(2): 365–75. 1993.
4. Lumsdon K, Anderson HJ, Burke M. New surgical technologies reshape hospital strategies. Hospitals 66(9):30–6. 1992.
5. Duffy SQ, Farley DE. Patterns of decline among inpatient procedures. Public Health Rep 110(6):674–81. 1995.
6. MEDPAC. Report to the Congress: Medicare payment policy. Section F: Assessing payment adequacy and updating payments for ambulatory surgical center services. Washington, DC. 2003.
7. Durant GD. ASCs: Surviving, thriving into the 1990s. Med Group Manage J 36(2):14. 1989.
8. KNG Health Consulting, LLC. An analysis of recent growth of ambulatory surgical centers: Final report. Prepared for the ASC Coalition. 2009.
9. MEDPAC. Report to the Congress: Medicare payment policy. Chapter 5: Ambulatory surgical center services. Washington, DC. 2013.
10. MEDPAC. Report to the Congress: Medicare payment policy. Washington, DC. 2012.
11. National Center for Health Statistics. 2010 NHAMCS public-use micro-data file documentation. Available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS.
12. Verispan LLC. Healthcare market index, updated July 15, 2006. Hospital market profiling solution, second quarter. Chicago: Healthcare Information Specialists. 2006.
13. Verispan LLC. Freestanding outpatient surgery centers database. Chicago: Healthcare Information Specialists. 2005.
14. Centers for Medicare & Medicaid Services. Provider of services file. Baltimore, MD. 2005.

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

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

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

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

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

15. Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services. International classification of diseases, ninth revision, clinical modification. 6th ed. DHHS Pub No. (PHS) 11–1260. 2011. Available from: https://www.cdc.gov/nchs/icd/icd9cm.htm.
16. Cerner Multum, Inc. Cerner Multum Lexicon. Available from: http://www.multum.com/lexicon.html.
17. Shimizu I. Sampling design for the 2010–2012 National Hospital Ambulatory Medical Care Survey. In: Proceedings from the 2011 JSM Annual Meeting. Alexandria, VA: American Statistical Association. 2012.
18. Hall MJ. The challenges of gathering and interpreting national data on ambulatory surgery over time. Proceedings from the 2013 JSM Annual Meeting. Alexandria, VA: American Statistical Association. 2014.
19. Hall MJ. Comparison of national data on ambulatory surgery from CDC's National Hospital Ambulatory Medical Care Survey, Medicare, the American Hospital Association and SDI. Proceedings from the 2014 JSM Annual Meeting. Alexandria, VA: American Statistical Association. 2015.
20. Alliance for Health Reform Briefing: Trends in health insurance coverage in the U.S.: The impact of the economy. 2010. Available from: http://www.allhealth.org/briefingmaterials/TrendsinHealthInsuranceTranscript12-6-2010-1923.pdf.
21. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. The uninsured: A primer—Key facts about health insurance on the eve of health reform. 2013. Available from: https://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-key-facts-about-health-insurance.pdf.
22. Manchikanti L, Parr AT, Singh V, Fellows B. Ambulatory surgery centers and interventional techniques: A look at long-term survival. Pain Physician 14(2):E177–215. 2011.
23. RTI International. SUDAAN (Release 9.0.1) [computer software]. 2005.

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

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

... Category not applicable.

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

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

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

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

... Category not applicable.

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

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

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

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

See footnotes at end of table.

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

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

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

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

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

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

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

See footnotes at end of table.

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

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

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

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

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

Technical Notes

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

Estimation

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

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

Standard errors

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

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

Testing of significance and rounding

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

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

Nonsampling errors

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

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

Use of tables

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

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

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

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

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

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

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control and Prevention
National Center for Health Statistics
3311 Toledo Road, Room 4551, MS P08
Hyattsville, MD 20782–2064

For more NCHS NHSRs, visit:
https://www.cdc.gov/nchs/products/nhsr.htm.

National Health Statistics Reports ■ Number 102 ■ February 28, 2017

Suggested citation

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DHHS Publication No. 2017–1250 • CS273765

Exhibit 7.

Charity Care Policy

MultiCare	*Administrative*

Title: Financial Assistance – Hospital Based Services

Scope:

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

Location include: Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, Home Health and Hospice and Urgent Care/Immediate Clinic locations.

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 and who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that 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. b) 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 will 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

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.

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: $499,999 - $999,999
6. SVP, CFO: $1,000,000 - $2,999,999

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

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

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:** A 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:** A 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.

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

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.

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.

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 Policies: Can be found on C360
	Related Forms: Proof of Income for Financial Assistance Instruction Sheet (#87-0506-3eB) Financial Assistance Application Financial Assistance Letter to Patients Patient Brochure Containing Plain Language Summary
	Appendix: **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***
Corporate Compliance Leadership	***12/18***
Quality Safety Steering Council	***7/12; 8/13; 7/14; 4/15, 9/19***
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*
Reviewed with no Changes Dates:	*X/XX; X/XX*

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

Appendix A
Financial Assistance

2019

FAMILY SIZE	Gross Annual Income	300%	350%	400%	450%	500%
1	$12,490	$37,470	$43,715	$49,960	$56,205	$62,450
2	$16,910	$50,730	$59,185	$67,640	$76,095	$84,550
3	$21,330	$63,990	$74,655	$85,320	$95,985	$106,650
4	$25,750	$77,250	$90,125	$103,000	$115,875	$128,750
5	$30,170	$90,510	$105,595	$120,680	$135,765	$150,850
6	$34,590	$103,770	$121,065	$138,360	$155,655	$172,950
7	$39,010	$117,030	$136,535	$156,040	$175,545	$195,050
8	$43,430	$130,290	$152,005	$173,720	$195,435	$217,150
9	$47,850	$143,550	$167,475	$191,400	$215,325	$239,250
10	$52,270	$156,810	$182,945	$209,080	$235,215	$261,350
EACH ADD'L	$4,420					

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

Exhibit 8.

Admission Policy

Title: ADMISSION OF A PATIENT

Scope:

This policy applies to the admission/registration of a patient to all MultiCare services. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient once formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed. A patient is considered formally admitted at the time of the physicians order to Admit as Inpatient. Patients who are being admitted for elective inpatient surgery are considered formally admitted once anaesthesia induction has begun.

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, MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Rockwood Clinic

Policy Statement:

Receive the patient/family/caregiver into the system in such a manner that he/she feels welcome and secure while comfort, safety, biopsychosocial, cultural, financial and spiritual needs are addressed; and obtain the key information identified below to process the patient admission.

MHS does not exclude or deny admission to any person on the basis of race, color, creed, religion, gender, age, ethnicity, disability status, national origin, sexual orientation, marital status, pre-existing condition or any other illegal basis.

Procedure:

I. All Members of the Medical Staff with Active Admitting Privileges May Admit Patients

A. All patient admission must be accompanied by appropriate orders called, faxed or sent to the appropriate unit. These orders should include but are not limited to:

1. Admission Statue (inpatient, ambulatory, observation for)
2. Admitting Diagnosis, attending Physician and admitting unit
3. Vital sign parameters

4. Allergies/Reactions
5. Diet orders
6. Activity orders
7. Lab and Imaging orders
8. Medications and IVs to be administered during hospital stay, including Medication Reconciliation of home medications. The written and/or faxed order must include complete list of medications to be administered during hospital stay.
9. Procedure/Treatments
10. Resuscitation status as appropriate

B. The Licensed Independent Practitioner (LIP) will:

1. Determine patient admission needs
2. Coordinate care between the patient's primary care provider and Specialists providing care to the patient
3. Access appropriate care site for admission
4. Provide orders appropriate to patient care needs
5. Assess patient at the bedside within timeframe outlined by Medical Staff Bylaws
6. Specify reasons for admission or treatment
7. Determine diagnosis or diagnostic impression
8. Identify goals of treatment and treatment plan
9. Counsel patient about risks, benefits and alternatives of surgery and/or procedures and obtain informed consent as indicated
10. Complete the patient's History and Physical (H&P) as outlined by Medical Staff Bylaws.
11. Initiate appropriate discharge plan as indicated

II. The Unit Secretary / Health Unit Coordinator is Responsible for Notifying Patient Access Services When Patient Has Arrived.

III. Patient Access Services will:

A. Upon notification, register the patient, generate the Face Sheet, Identification Band, Document Labels, and ensure delivery to the patient location.

B. obtain demographic and insurance information and signatures on applicable forms at the time of registration.

C. Provide and review with the patient the MultiCare Handout entitled “Notice of Privacy Practices, Conditions for Treatment, Financial Disclosures, Patient Rights Materials, Financial Assistance” Form (87-9158-0A)

D. If the patient cannot read English, interpreter services should be sought and translated forms will be provided

E. For every patient who has Medicare or a Managed Medicare as any insurance, primary, secondary, or tertiary, regardless of age the "An Important Message from Medicare" Form (87-0568-3e) must be reviewed with the patient and a signed copy of the document provided to the patient

F. If the patient is eligible for TriCare the form “An Important Message from TriCare” (88-0061-0) must be reviewed with the patient and a signed copy of the document provided to the patient.

IV. Procedure for Admission to Clinical Care Area:

A. Obtain a Bed Assignment:

1. A Licensed Independent Practitioner (LIP) will contact the MMC Operations Logistic Center (OLC) for Tacoma General admissions. For Allenmore or Mary Bridge admissions contact the Hospital Supervisor for bed availability and assignment.
2. The admitting patient care staff will be notified of pending admission and bed assignment.

B. Clerical support responsibilities:

1. Retrieve past medical records, including recent ED or urgent care services, as needed
2. Transcribe physician orders.

C. Compile chart The RN:

1. Obtains report of patient condition and receives patient into appropriate care area.
2. Identifies and prioritized appropriate patient care needs.
3. Obtains physician orders as needed

a. Medication orders received from the physician as "meds per home routine" or any other non-specific fashion will not be administered

b. Medication orders must meet MHS standards prior to medication administration

c. The RN ensures that the orders are accurately acknowledged, and implemented.

4. Completes the nursing admission documentation and verifies that all appropriate admission data are collected and documented

5. Ensures that the Advance Directive information has been obtained and documents the content of the advanced directive in the patient's record if known.

6. Assures that identification bands are placed with appropriate information included

7. Educate adult admissions on the pneumococcal/influenza vaccine and review protocol using form (88-0670-2e)

8. The Health Care Directive form (87-6030-2e) will be completed by Registered Nursing personnel:

a. If the patient is an adult and does not have a Health Care Directive or wishes additional information:

b. The Health Care Directive form (87-6030-2e) is given to the patient and this is documented on the form.

D. The care team initiates a plan of care/clinical pathway

V. Patients will have a Standardized Patient Medical Record (Chart):

A. The type of chart created will be driven by patient location

B. All inpatients will have the blue chart back with the set tabs and outpatient procedure records will follow the Surgical Procedure Record Format outlined in Surgical Services policy

Related Policies:

MHS P &P: *Advance Directive: Living Will and Mental Health*

MHS P &P: *Patient Identification, Using Two Patient Identifiers, Informational Wristbands.*

MHS P &P: *Orders: Written, Faxed, Emailed, Verbal, Telephoned*

MHS P &P: *Medication Administration and Documentation in the Acute Care Setting*

	MHS P &P: *Patient Nondiscrimination* *MHS P&P: Registration and Point of Service Collection Policy* *MHS P & P: Patient Rights and Responsibilities: Adults and Special Rights of Adolescents* Scope of Service/ADT Criteria
	Related Forms: Notice of Privacy Practices, Conditions for Treatment, Financial Disclosures, Patient's Rights Materials, Financial Assistance Form #87-9158-0A Important Message from Medicare Form # 87-0568-3e Important Message from TriCare Form # 88-0061-0 Health Care Directive Form #87-6030-2e Pneumococcal/Influenza Vaccine Protocol form # 88-0670-2a
	References: **CMS Standards:** 45 C.F.R. § 80 45 C.F.R. § 84 45 C.F.R. § 91 29 U.S.C. § 794 Joint Commission Standards: RI 01.01.01 EP2, 5, RI01.02.01, EP 1,2,22
	Point of Contact: Executive Director, Patient Access 253-697-1865

Approval By:	***Date of Approval:***
Revenue Integrity, Compliance, Access Services	***8/12; 7/14; 4/17***
SKRB on behalf of CMC MEC	***4/18***
Quality Steering Council	9/14; 5/17; 8/17; 4/18
Original Date:	*12/00*
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Reviewed with no Changes Dates:	XX

Distribution: MHS Intranet

Scope/locations of services updated March, 2017.
Ethnicity and Pre-existing condition added per non exclusion law 7/17
MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Rockwood Clinic Added to scope 7/21/17
Scope updated (added CMC only) April, 2018.

Exhibit 9.

Patient Rights and Responsibilities

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 and Valley Hospital.

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 Quality Safety Steering Council	Approval Date: 4/19 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

Exhibit 10.

Non-Discrimination Policy

Title: PATIENT NONDISCRIMINATION

Scope:

This policy applies to every MultiCare Health System (MHS) staff and workforce member, including employees, employed physicians, medical staff members, contracted services staff, and volunteers, and to all vendors, representatives, and any other individuals providing services to or on behalf of MultiCare Health System ("MHS Personnel").

Location Scope:

This policy applies to all of MultiCare Health System, to include but not be limited to the following locations: MultiCare Tacoma General Hospital/Allenmore Hospital, MultiCare Mary Bridge Children's Hospital, MultiCare Good Samaritan Hospital, MultiCare Auburn Medical Center, MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Covington Medical Center, Home Health and Hospice Services, and all associated ambulatory and retail sites of care to include primary care and specialty clinics, ancillary services, surgery centers, and urgent care centers.

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, 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 Corporate Compliance at (253) 459-8300, the Integrity Line at (866) 264-6121 or email compliance@multicare.org.

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.

   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.

2. 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. 3. 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. 4. 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, or any other basis prohibited by federal or state law.
	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 MHS Compliance or through the Integrity Line. All reports will be investigated by the Corporate Compliance Department. 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.
	Related Policies: Can be found on C360
	Related Standard Workflows:
	Related Forms:
	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. 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: *HH&H QSSC* *Compliance/Privacy Leadership* Quality Safety Steering Council	***Date of Approval:*** ***8/19*** ***8/19*** ***8/12, 9/17, 9/19***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*6/12* *8/17, 8/19* *X/XX; X/XX*

Distribution: MSH Intranet

Approved at SKRB 4/12/18 and QSSC e-vote 4/18/18 to apply to Covington Medical Center

Exhibit 11A.

Historical Financial Statements

Income Statement (In Thousands)

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

	Gig Harbor Ambulatory Surgery Center			
	2017	2018	Nov 2019 YTD	2019 Annualized
PATIENT SERVICE REVENUES:				
HB Inpatient	0	0	0	0
HB Outpatient	4,134	16,418	22,685	24,748
PB Outpatient	(1)	0	2	3
Other	0	0	0	0
TOTAL	4,133	16,418	22,688	24,750
DEDUCTIONS FROM REVENUES:				
TOTAL	3,099	12,314	17,016	18,563
NET PATIENT SERVICE REVENUE	1,033	4,105	5,672	6,188
OTHER OPERATING REVENUE:				
TOTAL	0	0	0	0
TOTAL OPERATING REVENUE	1,033	4,105	5,672	6,188
Operating Expenses				
Salaries and Wages	402	786	976	1,065
SW - Gainshare/ICP/Severance	8	8	5	5
Employee Benefits	98	209	258	281
EB - FICA Gainshare/ICP/Severance	1	1	0	0
Supplies	253	795	1,301	1,419
Professional Fees	1	542	469	512
Purchased Services	25	55	82	90
PS - System Support Service Allocations	663	658	408	446
PS - Regional Support Service Allocations	0	548	541	590
PS - Shared Operating Costs	0	0	0	0
PS - Provider Sponsorship Fee	0	0	0	0
Other Operating Costs	1	104	95	103
Lease & Rental Fees	0	0	0	0
Interest	0	0	0	0
Depreciation & Amort.	348	336	340	370
TOTAL	1,799	4,041	4,475	4,882
INCOME/(LOSS) FROM OPERATIONS	(765)	64	1,197	1,306
Corporate Services	51	100	74	80
OPERATING MARGIN	(816)	(37)	1,123	1,226
NON-OPERATING REVENUE:				
TOTAL	0	0	0	0
NET INCOME	(816)	(37)	1,123	1,226

Income Statement Multi-Year (In Thousands)
MultiCare Health System - Tacoma General Hospital / Allenmore Hospital

	TG/AH Combined			
	2017	2018	Nov 2019 YTD	2019 Annualized
PATIENT SERVICE REVENUES:				
HB Inpatient	$1,538,039	$1,617,988	$1,595,964	$1,741,052
HB Outpatient	$1,341,150	1,515,950	1,480,289	1,614,861
PB Outpatient	182,776	197,193	201,834	220,183
Other	16,646	16,433	20,790	22,680
TOTAL	3,078,610	3,347,565	3,298,878	3,598,776
DEDUCTIONS FROM REVENUES:				
Contractual Adjustments	2,240,541	2,419,356	2,379,260	2,595,556
Charity Care	58,336	77,579	67,273	73,389
Provision for Bad Debts	9,953	12,746	25,595	27,922
Allocated Deductions	1,104	2,410	2,802	3,057
TOTAL	2,309,934	2,512,090	2,474,930	2,699,923
NET PATIENT SERVICE REVENUE	768,676	835,475	823,948	898,852
OTHER OPERATING REVENUE:				
Hospital Services	8,949	10,485	5,664	6,178
Other	947	703	570	622
Net Assets Released From Restrictions	684	518	349	381
TOTAL	10,581	11,706	6,583	7,181
TOTAL OPERATING REVENUE	779,257	847,180	830,531	906,034
Operating Expenses				
Salaries and Wages	275,700	293,479	293,372	320,042
SW - Gainshare/ICP/Severance	5,115	6,307	7,048	7,689
Employee Benefits	58,984	63,378	63,404	69,168
EB - FICA Gainshare/ICP/Severance	391	482	391	427
Supplies	145,388	156,392	158,814	173,251
Professional Fees	16,772	17,411	17,700	19,309
Purchased Services	20,822	23,362	23,701	25,856
PS - System Support Service Allocations	180,246	107,777	102,393	111,702
PS - Regional Support Service Allocations	0	80,143	80,609	87,937
PS - Shared Operating Costs	(59,436)	(60,111)	(54,253)	(59,185)
PS - Provider Sponsorship Fee	4,302	(1,321)	7,786	8,494
Other Operating Costs	30,815	40,667	40,413	44,087
Lease & Rental Fees	4,646	4,627	4,774	5,208
Interest	11,509	10,341	10,890	11,880
Depreciation & Amort.	26,572	25,449	21,972	23,969
TOTAL	721,828	768,383	779,014	849,833
INCOME/(LOSS) FROM OPERATIONS	57,429	78,797	51,517	56,201
Corporate Services	20,255	14,225	14,318	15,620
OPERATING MARGIN	37,174	64,572	37,199	40,581
NON-OPERATING REVENUE:				
TOTAL	0	0	0	0
NET INCOME	$37,174	$64,572	$37,199	$40,581

Exhibit 11B.

Pro Forma Forecast (Gig Harbor)

Income Statement (In Thousands)

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

WITHOUT THE PROJECT

	Forecast--Not Converting 2 ORs				
	2020	**2021**	**2022**	**2023**	**2024**
PATIENT SERVICE REVENUES:					
HB Inpatient	0	0	0	0	0
HB Outpatient	50,502	50,502	50,502	50,502	50,502
PB Outpatient	6	6	6	6	6
Other	0	0	0	0	0
TOTAL	50,507	50,507	50,507	50,507	50,507
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	36,416	36,416	36,416	36,416	36,416
Charity Care	1,030	1,030	1,030	1,030	1,030
Provision for Bad Debts	392	392	392	392	392
Allocated Deductions	43	43	43	43	43
TOTAL	37,880	37,880	37,880	37,880	37,880
NET PATIENT SERVICE REVENUE	12,627	12,627	12,627	12,627	12,627
OTHER OPERATING REVENUE:					
TOTAL	0	0	0	0	0
TOTAL OPERATING REVENUE	12,627	12,627	12,627	12,627	12,627
Operating Expenses					
Salaries and Wages	2,342	2,665	3,176	3,336	3,507
SW - Gainshare/ICP/Severance	12	13	16	17	18
Employee Benefits	693	788	940	987	1,037
EB - FICA Gainshare/ICP/Severance	1	1	1	1	2
Supplies	2,895	2,895	2,895	2,895	2,895
Professional Fees	1,044	1,044	1,044	1,044	1,044
Purchased Services	183	183	183	183	183
PS - System Support Service Allocations	909	909	909	909	909
PS - Regional Support Service Allocations	1,205	1,205	1,205	1,205	1,205
PS - Shared Operating Costs	0	0	0	0	0
PS - Provider Sponsorship Fee	0	0	0	0	0
Other Operating Costs	211	211	211	211	211
Lease & Rental Fees	0	0	0	0	0
Interest	0	0	0	0	0
Depreciation & Amort.	370	370	370	370	370
TOTAL	9,866	10,286	10,950	11,159	11,381
INCOME/(LOSS) FROM OPERATIONS	2,761	2,341	1,676	1,468	1,245
Corporate Services	80	80	80	80	80
OPERATING MARGIN	2,681	2,261	1,596	1,388	1,165
NON-OPERATING REVENUE:					
TOTAL	0	0	0	0	0
NET INCOME	2,681	2,261	1,596	1,388	1,165

Staffing Worksheet

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

WITHOUT THE PROJECT

	FTEs					Salaries and Wages					Benefits				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Productive															
Management	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
RN	13.73	13.73	13.73	13.73	13.73	$ 1,544,475	$ 1,739,564	$ 2,043,349	$ 2,145,327	$ 2,253,999	$ 455,252	$ 512,757	$ 602,301	$ 632,360	$ 664,392
LPN	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technical	6.36	6.36	6.36	6.36	6.36	$ 372,047	$ 457,154	$ 597,307	$ 633,782	$ 673,131	$ 109,665	$ 134,751	$ 176,063	$ 186,815	$ 198,413
Other Salaries/Hours	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Orientation	0.10	0.10	0.10	0.10	0.10	$ 10,496	$ 12,897	$ 16,852	$ 17,880	$ 19,029	$ 3,094	$ 3,802	$ 4,967	$ 5,270	$ 5,609
Education	0.19	0.19	0.19	0.19	0.19	$ 18,274	$ 19,858	$ 22,182	$ 23,160	$ 24,200	$ 5,386	$ 5,853	$ 6,539	$ 6,827	$ 7,133
Technical Fixed	0.69	0.69	0.69	0.69	0.69	$ 50,676	$ 50,676	$ 50,676	$ 50,676	$ 50,676	$ 14,937	$ 14,937	$ 14,937	$ 14,937	$ 14,937
Other Fixed	0.84	0.84	0.84	0.84	0.84	$ 45,077	$ 45,077	$ 45,077	$ 45,077	$ 45,077	$ 13,287	$ 13,287	$ 13,287	$ 13,287	$ 13,287
CNA/MA	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outside Wages-RN	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Productive	**21.90**	**21.90**	**21.90**	**21.90**	**21.90**	**$ 2,041,045**	**$ 2,325,227**	**$ 2,775,443**	**$ 2,915,902**	**$ 3,066,112**	**$ 601,622**	**$ 685,388**	**$ 818,094**	**$ 859,496**	**$ 903,772**
Non-Productive															
Sick Leave	0.07	0.07	0.07	0.07	0.07	$ 7,385	$ 7,987	$ 8,872	$ 9,243	$ 9,643	$ 2,177	$ 2,354	$ 2,615	$ 2,725	$ 2,842
Bereavement	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Jury Duty	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
System Initiatives Training	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Paid Time Off (PTO)	1.04	1.04	1.04	1.04	1.04	$ 282,056	$ 320,484	$ 381,373	$ 400,385	$ 420,941	$ 83,139	$ 94,466	$ 112,414	$ 118,018	$ 124,077
Extended Illness (EIT)	0.17	0.17	0.17	0.17	0.17	$ 23,659	$ 24,809	$ 26,306	$ 27,215	$ 28,174	$ 6,974	$ 7,313	$ 7,754	$ 8,022	$ 8,305
Total Non-Productive	**1.28**	**1.28**	**1.28**	**1.28**	**1.28**	**$ 313,100**	**$ 353,280**	**$ 416,550**	**$ 436,844**	**$ 458,758**	**$ 92,290**	**$ 104,133**	**$ 122,783**	**$ 128,765**	**$ 135,224**
TOTAL	**23.18**	**23.18**	**23.18**	**23.18**	**23.18**	**$ 2,354,145**	**$ 2,678,507**	**$ 3,191,993**	**$ 3,352,745**	**$ 3,524,870**	**$ 693,912**	**$ 789,521**	**$ 940,877**	**$ 988,261**	**$ 1,038,997**

	% of Salaries and Wages	% of Benefits	Salaries and Wages					Benefits				
			2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Gainshare/ICP/Severance	0.5%	0.1%	$ 11,829	$ 13,459	$ 16,039	$ 16,847	$ 17,712	$ 1,009	$ 1,149	$ 1,369	$ 1,438	$ 1,512

*Percentages based on Gig Harbor January to November 2019 YTD.

	Salaries and Wages					Benefits				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
TOTAL - Excluding Gainshare/ICP/Severance	$ 2,342,316	$ 2,665,048	$ 3,175,954	$ 3,335,899	$ 3,507,159	$ 692,902	$ 788,373	$ 939,508	$ 986,823	$ 1,037,485

Income Statement (In Thousands)

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

WITH THE PROJECT

	Forecast--The Project (Converting Two ORs, for a Total of Four Operating Suites)				
	2020	**2021**	**2022**	**2023**	**2024**
PATIENT SERVICE REVENUES:					
HB Inpatient	0	0	0	0	0
HB Outpatient	50,502	62,054	81,079	86,030	91,371
PB Outpatient	6	7	9	9	10
Other	0	0	0	0	0
TOTAL	50,507	62,061	81,088	86,039	91,381
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	36,416	44,747	58,465	62,035	65,887
Charity Care	1,030	1,265	1,653	1,754	1,863
Provision for Bad Debts	392	481	629	667	709
Allocated Deductions	43	53	69	73	78
TOTAL	37,880	46,546	60,816	64,529	68,536
NET PATIENT SERVICE REVENUE	12,627	15,515	20,272	21,510	22,845
OTHER OPERATING REVENUE:					
TOTAL	0	0	0	0	0
TOTAL OPERATING REVENUE	12,627	15,515	20,272	21,510	22,845
Operating Expenses					
Salaries and Wages	2,342	2,951	3,877	4,167	4,486
SW - Gainshare/ICP/Severance	12	15	20	21	23
Employee Benefits	693	873	1,147	1,233	1,327
EB - FICA Gainshare/ICP/Severance	1	1	2	2	2
Supplies	2,895	3,558	4,649	4,932	5,239
Professional Fees	1,044	1,283	1,676	1,778	1,889
Purchased Services	183	225	294	312	331
PS - System Support Service Allocations	909	1,117	1,460	1,549	1,645
PS - Regional Support Service Allocations	1,205	1,480	1,934	2,052	2,179
PS - Shared Operating Costs	0	0	0	0	0
PS - Provider Sponsorship Fee	0	0	0	0	0
Other Operating Costs	211	259	339	360	382
Lease & Rental Fees	0	0	0	0	0
Interest	0	0	0	0	0
Depreciation & Amort.	370	1,308	1,308	1,308	1,308
TOTAL	9,866	13,070	16,704	17,714	18,811
INCOME/(LOSS) FROM OPERATIONS	2,761	2,445	3,568	3,796	4,034
Corporate Services	80	80	80	80	80
OPERATING MARGIN	2,681	2,365	3,488	3,715	3,954
NON-OPERATING REVENUE:					
TOTAL	0	0	0	0	0
NET INCOME	2,681	2,365	3,488	3,715	3,954

Staffing Worksheet

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

WITH THE PROJECT

	FTEs					Salaries and Wages					Benefits				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Productive															
Management	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
RN	13.73	16.91	22.10	23.45	24.84	$ 1,544,475	$ 1,964,201	$ 2,615,300	$ 2,827,213	$ 3,060,076	$ 455,252	$ 578,971	$ 770,890	$ 833,354	$ 901,993
LPN	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technical	6.36	7.84	10.24	10.86	11.51	$ 372,047	$ 473,154	$ 618,944	$ 656,768	$ 697,545	$ 109,665	$ 139,468	$ 182,441	$ 193,590	$ 205,609
Other Salaries/Hours	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Orientation	0.10	0.12	0.16	0.17	0.18	$ 10,496	$ 13,349	$ 17,462	$ 18,528	$ 19,719	$ 3,094	$ 3,935	$ 5,147	$ 5,461	$ 5,813
Education	0.19	0.23	0.30	0.32	0.34	$ 18,274	$ 23,211	$ 31,065	$ 33,802	$ 36,829	$ 5,386	$ 6,842	$ 9,157	$ 9,963	$ 10,856
Technical Fixed	0.69	0.69	0.69	0.69	0.69	$ 50,676	$ 52,450	$ 52,512	$ 52,514	$ 52,514	$ 14,937	$ 15,460	$ 15,478	$ 15,479	$ 15,479
Other Fixed	0.84	0.84	0.84	0.84	0.84	$ 45,077	$ 46,655	$ 46,710	$ 46,712	$ 46,712	$ 13,287	$ 13,752	$ 13,768	$ 13,769	$ 13,769
CNA/MA	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outside Wages-RN	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Productive	**21.90**	**26.63**	**34.33**	**36.33**	**38.39**	**$ 2,041,045**	**$ 2,573,019**	**$ 3,381,993**	**$ 3,635,537**	**$ 3,913,395**	**$ 601,622**	**$ 758,427**	**$ 996,882**	**$ 1,071,617**	**$ 1,153,519**
Non-Productive															
Sick Leave	0.07	0.09	0.11	0.12	0.12	$ 7,385	$ 9,278	$ 12,266	$ 13,306	$ 14,462	$ 2,177	$ 2,735	$ 3,615	$ 3,922	$ 4,263
Bereavement	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Jury Duty	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
System Initiatives Training	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Paid Time Off (PTO)	3.04	3.69	4.75	5.03	5.31	$ 282,056	$ 354,140	$ 463,396	$ 497,659	$ 535,424	$ 83,139	$ 104,387	$ 136,591	$ 146,691	$ 157,822
Extended Illness (EIT)	0.23	0.28	0.36	0.38	0.40	$ 23,659	$ 29,396	$ 38,561	$ 41,914	$ 45,636	$ 6,974	$ 8,665	$ 11,366	$ 12,355	$ 13,452
Total Non-Productive	**3.34**	**4.06**	**5.22**	**5.52**	**5.83**	**$ 313,100**	**$ 392,814**	**$ 514,223**	**$ 552,880**	**$ 595,522**	**$ 92,290**	**$ 115,786**	**$ 151,573**	**$ 162,968**	**$ 175,537**
TOTAL	**25.24**	**30.69**	**39.55**	**41.85**	**44.22**	**$ 2,354,145**	**$ 2,965,833**	**$ 3,896,216**	**$ 4,188,416**	**$ 4,508,917**	**$ 693,912**	**$ 874,214**	**$ 1,148,455**	**$ 1,234,585**	**$ 1,329,056**

	% of Salaries and Wages	% of Benefits	Salaries and Wages					Benefits				
Gainshare/ICP/Severance			2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
	0.5%	0.1%	$ 11,829	$ 14,903	$ 19,578	$ 21,046	$ 22,656	$ 1,009	$ 1,272	$ 1,671	$ 1,796	$ 1,933

*Percentages based on Gig Harbor January to November 2019 YTD.

	Salaries and Wages					Benefits				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
TOTAL - Excluding Gainshare/ICP/Severance	$ 2,342,316	$ 2,950,930	$ 3,876,639	$ 4,167,370	$ 4,486,260	$ 692,902	$ 872,942	$ 1,146,784	$ 1,232,788	$ 1,327,122

Deductions from Revenue (In Thousands)

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

WITHOUT THE PROJECT

	Gig Harbor Ambulatory Surgery Center				
	2020	2021	2022	2023	2024
Contractual Allowances					
Commercial/HCC	11,478	11,478	11,478	11,478	11,478
Medicare	6,111	6,111	6,111	6,111	6,111
Medicaid	6,854	6,854	6,854	6,854	6,854
Other Gov / L&I	2,981	2,981	2,981	2,981	2,981
Self-Pay	8,993	8,993	8,993	8,993	8,993
TOTAL	36,416	36,416	36,416	36,416	36,416
Charity Care	1,030	1,030	1,030	1,030	1,030
Provision for Bad Debts	392	392	392	392	392
Allocated Deductions	43	43	43	43	43
TOTAL Deductions From Revenue	**37,880**	**37,880**	**37,880**	**37,880**	**37,880**

WITH THE PROJECT

	Gig Harbor Ambulatory Surgery Center				
	2020	2021	2022	2023	2024
Contractual Allowances					
Commercial/HCC	11,478	14,104	18,428	19,554	20,768
Medicare	6,111	7,509	9,811	10,410	11,056
Medicaid	6,854	8,421	11,003	11,675	12,400
Other Gov / L&I	2,981	3,662	4,785	5,077	5,393
Self-Pay	8,993	11,050	14,438	15,319	16,271
TOTAL	36,416	44,747	58,465	62,035	65,887
Charity Care	1,030	1,265	1,653	1,754	1,863
Provision for Bad Debts	392	481	629	667	709
Allocated Deductions	43	53	69	73	78
TOTAL Deductions From Revenue	**37,880**	**46,546**	**60,816**	**64,529**	**68,536**

Income Statement (In Thousands)

MultiCare Health System - Gig Harbor Ambulatory Surgery Center

DIFFERENCE (i.e. "With" minus "Without")

	2019 to 2020 Increment	2020	2021	2022	2023	2024
PATIENT SERVICE REVENUES:						
HB Inpatient	0	0	0	0	0	0
HB Outpatient	25,754	0	11,553	30,577	35,528	40,869
PB Outpatient	3	0	1	3	4	4
Other	0	0	0	0	0	0
TOTAL	25,757	0	11,554	30,580	35,532	40,874
DEDUCTIONS FROM REVENUES:						
Contractual Adjustments	18,571	0	8,330	22,049	25,619	29,470
Charity Care	525	0	236	623	724	833
Provision for Bad Debts	200	0	90	237	276	317
Allocated Deductions	22	0	10	26	30	35
TOTAL	19,318	0	8,665	22,935	26,649	30,655
NET PATIENT SERVICE REVENUE	6,439	0	2,888	7,645	8,883	10,218
OTHER OPERATING REVENUE:						
TOTAL	0	0	0	0	0	0
TOTAL OPERATING REVENUE	6,439	0	2,888	7,645	8,883	10,218
Operating Expenses						
Salaries and Wages	1,277	0	286	701	831	979
SW - Gainshare/ICP/Severance	6	0	1	4	4	5
Employee Benefits	412	0	85	207	246	290
EB - FICA Gainshare/ICP/Severance	1	0	0	0	0	0
Supplies	1,477	0	662	1,753	2,037	2,343
Professional Fees	532	0	239	632	734	845
Purchased Services	93	0	42	111	129	148
PS - System Support Service Allocations	464	0	208	550	640	736
PS - Regional Support Service Allocations	614	0	276	729	847	975
PS - Shared Operating Costs	0	0	0	0	0	0
PS - Provider Sponsorship Fee	0	0	0	0	0	0
Other Operating Costs	108	0	48	128	149	171
Lease & Rental Fees	0	0	0	0	0	0
Interest	0	0	0	0	0	0
Depreciation & Amort.	0	0	938	938	938	938
TOTAL	4,984	0	2,785	5,753	6,555	7,429
INCOME/(LOSS) FROM OPERATIONS	1,455	(0)	104	1,892	2,328	2,789
Corporate Services	0	0	0	0	0	0
OPERATING MARGIN	1,455	(0)	104	1,892	2,328	2,789
NON-OPERATING REVENUE:						
TOTAL	0	0	0	0	0	0
NET INCOME	1,455	(0)	104	1,892	2,328	2,789

Exhibit 11C.

Pro Forma Forecast (Tacoma General / Allenmore Hospital)

Income Statement Multi-Year (In Thousands)
MultiCare Health System - Tacoma General Hospital / Allenmore Hospital

WITHOUT THE PROJECT
TG/AH 2019 Annualized + Gig Harbor 2019-2020 Increment

	TG/AH Combined				
	2020	**2021**	**2022**	**2023**	**2024**
PATIENT SERVICE REVENUES:					
HB Inpatient	$1,741,052	$1,741,052	$1,741,052	$1,741,052	$1,741,052
HB Outpatient	1,640,615	1,640,615	1,640,615	1,640,615	1,640,615
PB Outpatient	220,186	220,186	220,186	220,186	220,186
Other	22,680	22,680	22,680	22,680	22,680
TOTAL	3,624,533	3,624,533	3,624,533	3,624,533	3,624,533
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	2,614,127	2,614,127	2,614,127	2,614,127	2,614,127
Charity Care	73,914	73,914	73,914	73,914	73,914
Provision for Bad Debts	28,122	28,122	28,122	28,122	28,122
Allocated Deductions	3,078	3,078	3,078	3,078	3,078
TOTAL	2,719,241	2,719,241	2,719,241	2,719,241	2,719,241
NET PATIENT SERVICE REVENUE	905,292	905,292	905,292	905,292	905,292
OTHER OPERATING REVENUE:					
Hospital Services	6,178	6,178	6,178	6,178	6,178
Other	622	622	622	622	622
Net Assets Released From Restrictions	381	381	381	381	381
TOTAL	7,181	7,181	7,181	7,181	7,181
TOTAL OPERATING REVENUE	912,473	912,473	912,473	912,473	912,473
Operating Expenses					
Salaries and Wages	321,319	321,319	321,319	321,319	321,319
SW - Gainshare/ICP/Severance	7,695	7,695	7,695	7,695	7,695
Employee Benefits	69,580	69,580	69,580	69,580	69,580
EB - FICA Gainshare/ICP/Severance	427	427	427	427	427
Supplies	174,728	174,728	174,728	174,728	174,728
Professional Fees	19,842	19,842	19,842	19,842	19,842
Purchased Services	25,949	25,949	25,949	25,949	25,949
PS - System Support Service Allocations	112,166	112,166	112,166	112,166	112,166
PS - Regional Support Service Allocations	88,551	88,551	88,551	88,551	88,551
PS - Shared Operating Costs	(59,185)	(59,185)	(59,185)	(59,185)	(59,185)
PS - Provider Sponsorship Fee	8,494	8,494	8,494	8,494	8,494
Other Operating Costs	44,194	44,194	44,194	44,194	44,194
Lease & Rental Fees	5,208	5,208	5,208	5,208	5,208
Interest	11,880	11,880	11,880	11,880	11,880
Depreciation & Amort.	23,969	23,969	23,969	23,969	23,969
TOTAL	854,817	854,817	854,817	854,817	854,817
INCOME/(LOSS) FROM OPERATIONS	57,656	57,656	57,656	57,656	57,656
Corporate Services	15,620	15,620	15,620	15,620	15,620
OPERATING MARGIN	42,036	42,036	42,036	42,036	42,036
NON-OPERATING REVENUE:					
TOTAL	0	0	0	0	0
NET INCOME	$42,036	$42,036	$42,036	$42,036	$42,036

Income Statement Multi-Year (In Thousands)
MultiCare Health System - Tacoma General Hospital / Allenmore Hospital

WITH THE PROJECT
TG/AH 2019 Annualized + Gig Harbor 2019-2020 Increment + Gig Harbor 2021-2024 Difference

	TG/AH Combined				
	2020	**2021**	**2022**	**2023**	**2024**
PATIENT SERVICE REVENUES:					
HB Inpatient	$1,741,052	$1,741,052	$1,741,052	$1,741,052	$1,741,052
HB Outpatient	1,640,615	1,652,167	1,682,744	1,718,273	1,759,142
PB Outpatient	220,186	220,187	220,190	220,194	220,199
Other	22,680	22,680	22,680	22,680	22,680
TOTAL	3,624,533	3,636,087	3,666,667	3,702,199	3,743,073
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	2,614,127	2,622,458	2,644,506	2,670,125	2,699,596
Charity Care	73,914	74,150	74,773	75,497	76,331
Provision for Bad Debts	28,122	28,211	28,448	28,724	29,041
Allocated Deductions	3,078	3,088	3,114	3,144	3,179
TOTAL	2,719,241	2,727,907	2,750,842	2,777,491	2,808,146
NET PATIENT SERVICE REVENUE	905,292	908,180	915,825	924,708	934,927
OTHER OPERATING REVENUE:					
Hospital Services	6,178	6,178	6,178	6,178	6,178
Other	622	622	622	622	622
Net Assets Released From Restrictions	381	381	381	381	381
TOTAL	7,181	7,181	7,181	7,181	7,181
TOTAL OPERATING REVENUE	912,473	915,361	923,007	931,890	942,108
Operating Expenses					
Salaries and Wages	321,319	321,605	322,306	323,137	324,116
SW - Gainshare/ICP/Severance	7,695	7,697	7,700	7,704	7,709
Employee Benefits	69,580	69,664	69,871	70,117	70,407
EB - FICA Gainshare/ICP/Severance	427	427	428	428	428
Supplies	174,728	175,390	177,143	179,180	181,524
Professional Fees	19,842	20,081	20,713	21,447	22,292
Purchased Services	25,949	25,991	26,102	26,231	26,379
PS - System Support Service Allocations	112,166	112,374	112,924	113,564	114,299
PS - Regional Support Service Allocations	88,551	88,826	89,556	90,403	91,378
PS - Shared Operating Costs	(59,185)	(59,185)	(59,185)	(59,185)	(59,185)
PS - Provider Sponsorship Fee	8,494	8,494	8,494	8,494	8,494
Other Operating Costs	44,194	44,243	44,371	44,519	44,690
Lease & Rental Fees	5,208	5,208	5,208	5,208	5,208
Interest	11,880	11,880	11,880	11,880	11,880
Depreciation & Amort.	23,969	24,907	25,845	26,783	27,720
TOTAL	854,817	857,602	863,355	869,910	877,340
INCOME/(LOSS) FROM OPERATIONS	57,656	57,760	59,652	61,979	64,768
Corporate Services	15,620	15,620	15,620	15,620	15,620
OPERATING MARGIN	42,036	42,140	44,032	46,359	49,148
NON-OPERATING REVENUE:					
TOTAL	0	0	0	0	0
NET INCOME	$42,036	$42,140	$44,032	$46,359	$49,148

Deductions from Revenue (In Thousands)

MultiCare Health System - Tacoma General Hospital / Allenmore Hospital

WITHOUT THE PROJECT

	TG/AH Combined				
	2020	2021	2022	2023	2024
Contractual Allowances					
Commercial/HCC	823,980	823,980	823,980	823,980	823,980
Medicare	438,655	438,655	438,655	438,655	438,655
Medicaid	491,983	491,983	491,983	491,983	491,983
Other Gov / L&I	213,956	213,956	213,956	213,956	213,956
Self-Pay	645,553	645,553	645,553	645,553	645,553
TOTAL	2,614,127	2,614,127	2,614,127	2,614,127	2,614,127
Charity Care	73,914	73,914	73,914	73,914	73,914
Provision for Bad Debts	28,122	28,122	28,122	28,122	28,122
Allocated Deductions	3,078	3,078	3,078	3,078	3,078
TOTAL Deductions From Revenue	**2,719,241**	**2,719,241**	**2,719,241**	**2,719,241**	**2,719,241**

WITH THE PROJECT

	TG/AH Combined				
	2020	2021	2022	2023	2024
Contractual Allowances					
Commercial/HCC	823,980	826,606	833,556	841,631	850,920
Medicare	438,655	440,053	443,753	448,052	452,997
Medicaid	491,983	493,551	497,700	502,522	508,068
Other Gov / L&I	213,956	214,638	216,442	218,539	220,951
Self-Pay	645,553	647,610	653,055	659,381	666,659
TOTAL	2,614,127	2,622,458	2,644,506	2,670,125	2,699,596
Charity Care	73,914	74,150	74,773	75,497	76,331
Provision for Bad Debts	28,122	28,211	28,448	28,724	29,041
Allocated Deductions	3,078	3,088	3,114	3,144	3,179
TOTAL Deductions From Revenue	**2,719,241**	**2,727,907**	**2,750,842**	**2,777,491**	**2,808,146**

Exhibit 12.

Medical Director Agreement

ADDENDUM D TO MEDICAL DIRECTOR & PROFESSIONAL SERVICES AGREEMENT REGARDING MEDICAL DIRECTOR

This Medical Director Addendum D ("Addendum"), between MultiCare Health System, a Washington not-for-profit corporation ("MultiCare") and Tacoma Anesthesia Associates, Inc., P.S. ("TAA" and/or "Medical Group"), a Washington professional services corporation, and its employed physician, _____, M.D. (referred to throughout this Addendum as "Medical Director").

WHEREAS, MultiCare and Medical Group have previously entered into a Professional Services Agreement under which Medical Group provides a variety of professional anesthesiology services in support of MultiCare's inpatient and outpatient surgical programs (the "Professional Services Agreement"); and

WHEREAS MultiCare operates acute care hospitals and outpatient ambulatory surgery programs in Tacoma, Washington and surrounding areas, and desires to have a qualified specialist to serve as the Medical Director of the preadmit and preoperative clinic of the combined adult Acute Care Hospital surgical services and associated outpatient surgical services at Gig Harbor surgery center (GH) and Anesthesia Department at Tacoma General Hospital (TG) and Allenmore Hospital (AH)(including the an outpatient surgery center associated with Mary Bridge Children's Hospital and Health Center and a pediatric tertiary care hospital and health center, an ambulatory surgery center at Baker Center) (referred to throughout this Addendum as "the Program") who is able to provide administrative expertise that enhances the quality and efficiency of the preadmission process and delivery of surgical services for patients for the community served by MultiCare, including the poor and medically underserved;

WHEREAS, Medical Group is a physician group practice business entity that employs physicians whom are qualified as specialists in the field of anesthesiology, and Medical Group is interested in performing medical director consulting services; and

WHEREAS, MultiCare believes that this Addendum will effectively fix the responsibilities of each party and contribute to realization of quality patient care by (i) facilitating the administration of the preadmit and preoperative clinic for the Program; (ii) assuring adequate coverage and quality of services contributing to effective scheduling of preadmit services;(iii) ensuring the continuous provision of professional medical staffing and coordination of the staff supporting the preadmit process.

WHEREAS, MultiCare and Medical Group desire to provide a full statement of their respective obligations in connection with these clinical service chief services.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein contained, the parties agree as follows:

I. Services.

A. Term. Effective January 1, 2018 through December 31, 2020, Medical Group shall perform medical director services for the Program, unless this Addendum is earlier terminated as provided herein.

B. Medical Director. _____, M.D. (referred to throughout this Addendum D as "Medical Director") is a member, director, or officer of the Medical Group, and he or she shall discharge the duties of the Program Medical Director, and have general authority to act for and bind Medical Group in all matters relevant to this Addendum. The parties expect that the Medical Director will spend an average of 38.33 hours per month for a total of 460 annual hours or .25 FTE.

C. Administrative Services. Medical Director shall be responsible for consulting as to the clinical aspects of high quality, efficient, responsive preadmit and preoperative operations of the Program. This shall entail, not by way of limitation, the performance of the following general services by the Medical Director, and more particularly described with respect to the Program in ***Appendix B*** hereto:

1. Medical Director shall be responsible for the implementation and oversight of the clinical aspects of high quality, efficient, responsive preadmit and preoperative clinic;

2. Medical Director shall provide consultation as necessary to maintain the Program's accreditation;

3. Medical Director will work cooperatively with the Chief Medical Officer, Chief Nursing Officer, and Manager of the Preadmit clinic for the Program as well as other appropriate management, physicians, and staff personnel;

4. Medical Director shall assist MultiCare develop, implement, and update policies for the effective operation of the Preadmit Program. All 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;

5. Medical Director shall be responsible for review of the medical care provided by the Program;

6. Medical Director shall provide clinical training of preadmit and preoperative staff and shall develop and provide such continuing education materials and instruction as necessary to properly instruct members of the medical, nursing, and allied health professional staffs in keeping with such training and continuing education as is customarily provided in similar hospitals of comparable size and scope;

7. Medical Director shall participate in MultiCare's planning process as it relates to the operation of the preadmit and preoperative process for the Program;

8. In cooperation with MultiCare's quality improvement, utilization, and risk management programs, Medical Director shall participate in the development, refinement, and maintenance of such interdisciplinary activities for the delivery of preoperative services, including but not limited to:

(a) Standards of Care, and auditing those standards;

(b) Concurrent review of Program patient care management including utilization, quality, and customer service; and

(c) Counseling medical staff in a manner consistent with the medical staff bylaws.

9. Medical Director shall participate in evaluation of the Program's interaction with ancillary support departments (such as laboratory, pharmacy, imaging, and central supply), and other MultiCare facilities, shall recommend measures necessary to optimize the smooth and efficient functioning of the patient care delivery process, and shall participate in implementation of MultiCare's recommendations as they relate to the Program;

10. Medical Director will evaluate and ensure a response to all patient complaint and inquires concerning physician services related to the Program, in a manner consistent with MultiCare's customer service philosophy. In addition, Medical Director will furnish MultiCare with an analysis of all complaints and recommendations for addressing any deficiencies;

11. Medical Director shall meet in a private office at least monthly with the Program Director and/or Program Clinical Director to review preadmit operations;

12. Medical Director shall promote good community relations and recognition for the Program, including but not limited to participating in any MultiCare customer relations program;

13. Medical Director shall participate on MultiCare committees and its medical staff committees, at the reasonable request of MultiCare;

14. Medical Director shall support preadmit and preoperative process compliance with The Joint Commission and state and federal regulatory requirements;

15. Medical Director shall support the use of the electronic medical record as it relates to preadmit/perioperative services;

16. Medical Group and Medical Director acknowledge that the Program shall be marketed by MultiCare, and consents during the term hereof to the commercially reasonable use of Medical Director's name and professional credentials in advertisements, provider directories, and similar materials utilized to market the services provided by the Program; provided, however, that MultiCare shall first consult with Medical Director as to the form of such use prior to such use;

17. Medical Director shall perform such other duties as set forth in the MHS *Medical Director and Clinical Service Chief Roles and Responsibilities* policy to the extent they apply to this Program role;

18. Medical Group shall, give MultiCare advance written notice if Medical Director leaves the position (unless the departure is a sudden occurrence where advance notice is not feasible, in which event notice will be given simultaneously) and arrange for and compensate a qualified physician to serve as a temporary or replacement Medical Director of the Program in Medical Director's absence. The appointment of a temporary or replacement Medical Director shall be subject to MultiCare's prior written approval.

D. Qualifications.

1. Medical Group represents and warrants that Medical Director is and shall during the term of this Addendum remain: board certified in anesthesiology; licensed without restriction as a physician to practice medicine in the State of Washington; and in possession of a current unrestricted DEA permit. Medical Group further represents and warrants that, unless disclosed in writing to MultiCare, Medical Director's license to practice medicine in any state has never been suspended, restricted, or revoked; that he or she has never been reprimanded, sanctioned, or disciplined by any licensing board or state or local medical society, or specialty board; that he or she has never been denied membership on or reappointment to any medical staff, and no medical staff membership or clinical privileges of Medical Director have ever been suspended, curtailed as part of a Medical Staff investigation or action, or revoked; that Medical Director has not been the subject of any report or disclosure to the National Practitioner Data Bank; and that there has never been a settlement by or on behalf of Medical Director or a final judgment entered against Medical Director in a malpractice action having an aggregate award to the plaintiff in excess of one hundred thousand dollars, or in a sexual, racial, age, or other civil rights discrimination or harassment action having an award of any amount.

2. Prior to commencing hereunder and during the term of this Addendum, Medical Group represents and warrants that Medical Director is an active member in good standing on the Tacoma General-Allenmore Hospital Medical Staff working primarily at Tacoma General or Allenmore and will adhere to the MultiCare Corporate Compliance Program.

3. Medical Director and Medical Group hereby represent and warrant that neither Medical Director nor Medical Group is and at no time has been excluded from participation in any federally funded health care program, including Medicare and

Medicaid. Medical Director and Medical Group hereby agree to immediately notify MultiCare of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and Medicaid.

4. Medical Group and MultiCare agree to meet no less than annually to assess its efforts and performance and the performance of its Medical Director under this Agreement. The assessment may include discussion of TAA's and its Medical Director's performance measured against the specific Program services as listed on Appendix B. MultiCare, together with the TAA and Medical Director, may also set goals and objectives for performance by TAA and Medical Director.

5. MultiCare may request the termination or replacement of Medical Director without cause with TAA's consent, which consent shall not be unreasonably withheld.

II. MULTICARE'S RESPONSIBILITIES

A. Space, Utilities, Supplies, and Equipment; Obligation of Assets. Subject to budgetary limitations, MultiCare shall provide space, utilities, supplies, and equipment for the proper operation of the Program. Medical Director shall not obligate or commit the assets of MultiCare for the purchase, acquisition, lease, or pilot trial of equipment, supplies, or personnel or encumber, in any other way, such equipment, supplies, or personnel without the express written authorization of MultiCare. Medical Director shall not make any additions, alterations, improvements, or repairs to any space, facilities, or equipment furnished hereunder without the prior written consent of MultiCare.

B. Non-Physician Personnel. MultiCare shall employ all non-physician personnel necessary for the proper operation of the Program. MultiCare shall consult regularly with Medical Director concerning the qualifications and performance of all non-physician personnel in the Program, to include direct oversight of the pre-admission clinic provider.

C. Annual Program Goals. Annually, Medical Director shall suggest measurable goals and standards for the Program. Goals and standards shall relate to at least the following: quality care, Program development, resource utilization, financial performance, and productivity.

D. Administrative Liability Insurance. MultiCare shall maintain errors and omissions liability coverage for services performed by Director pursuant to this Agreement. Such insurance shall be under MultiCare's policy or policies of insurance or self-insurance program which covers other administrators within MultiCare in amounts established by MultiCare. MultiCare shall pay any deductible amounts for claims covered under such policies. If MultiCare enters into an insurance program which will not cover Director's medical administrative duties, MultiCare shall provide at least thirty (30) days written notice to Director, and MultiCare will assist Director in arranging alternative coverage at MultiCare's expense.

III. COMPENSATION

A. For services described herein, MultiCare shall compensate Medical Group One Hundred Eight Thousand Two Hundred Fifty Dollars ($108,250.00) annually, in equal monthly installments of Nine Thousand Twenty Dollars and Eighty-Three Cents ($9,020.83) per month. The parties acknowledge that the compensation provided under this Addendum is intended to reflect the fair market value for the Services which is based on an estimated average number of monthly hours required to perform the Services equating in total to approximately 460 hours or .25 FTE at a per hour rate of $235. In the event this Addendum is terminated sooner than one (1) year after the date Medical Director commenced providing services under this Addendum, the parties may not enter into a new contract for the Services for such physician on economic terms different than set forth herein for a period of one (1) year beginning from the date of the termination. However, should the Medical Director become unable to perform the services, Medical Group may substitute another qualified member of Medical Group to complete the services required under this Addendum.

B. Payments shall be made within fifteen (15) days following the last day of each calendar month in which services are provided. **Payments shall be contingent upon timely receipt of documentation of services required under Section X of this Addendum**. Payment shall be prorated if this Addendum is terminated prior to its scheduled expiration, and also prorated in the first and last months of the term if the services commence on other than the first calendar day of the month.

C. Medical Group and Medical Director shall not bill any patient or any third party payor, including Medicare or any Medicare beneficiary, for Services performed by Medical Group or Medical Director pursuant to this Addendum.

D. Notwithstanding any implication to the contrary herein, it is agreed that Medical Director and Medical Group may maintain a private practice during the term of this Addendum and may refer patients to any facility of their choosing.

E. Medical Group and Medical Director shall cooperate with MultiCare by, among other things, generating, maintaining, and making available all necessary records to ensure compliance with Section 1861 (v)(1)(I) of the Social Security Act. Medical Group and Medical Director shall continue to comply with this Section C for five years following expiration or termination of this Addendum.

IV. NON COMPETE

In recognition of the benefits provided to Medical Group under this Addendum, and in recognition that Medical Director will be responsible for and have access to certain policies, procedures, operational methods, and programs peculiar to MultiCare, Medical Group and Medical Director agree that she/he/it shall not, while serving as the Medical

Director during the term of the Addendum, compete with MultiCare by providing substantially similar services for the benefit of any other provider or healthcare entity.

V. RELATIONSHIP OF PARTIES

When providing services under the terms of this Addendum, Medical Director shall exercise medical judgment free of any direction by MultiCare. In administrative matters, Medical Director shall provide advice that is consistent with laws, regulations, and MultiCare policies, including the MultiCare Corporate Compliance Program. In performing the responsibilities described in this Addendum, Medical Group and Medical Director are at all times acting as independent contractors. Nothing in this Addendum is intended to create an employer/employee or agency relationship between MultiCare and Medical Group or Medical Director. Medical Group shall be responsible for taxes and Social Security withholding, and for filing at the next applicable filing period a schedule with the Internal Revenue Service that includes the payments made by MultiCare pursuant to this Addendum. Medical Group and Medical Director shall have no claim against MultiCare for vacation pay, sick leave, Social Security, retirement, unemployment, or other employee benefits of any kind. Upon request of MultiCare, Medical Group and Medical Director shall provide MultiCare evidence that he/she/it has complied with this Article V.

VI. TERM

This Addendum shall commence on January 1, 2018 and shall continue in effect until December 31, 2020. However, this Addendum shall automatically terminate upon termination of the Professional Services Agreement. Further, with respect to the Medical Director named in Section I.B, this Addendum shall terminate if such individual ceases to be employed by Medical Group, and the parties shall enter into a new Medical Director Addendum pursuant to the Professional Services Agreement to name a new Medical Director. Such termination shall be without further liability to the parties hereto, except as provided in Article VII, Paragraph C.

VII. TERMINATION

A. This Addendum may be terminated by either party upon the occurrence of any of the following events:

1. Immediately, at MultiCare's option, upon the failure of Medical Director to maintain membership on the TG-AH Medical Staff;

2. Immediately upon the death of Medical Director and failure of Medical Group to appoint another physician acceptable to MultiCare; and immediately, at MultiCare's option, upon Medical Group's refusal to perform the terms of this Addendum;

3. Immediately on written notice for cause, which shall include the institution of proceedings against Medical Director that could lead to his or her conviction

of a crime, the Medical Director engaging in actions that MultiCare in good faith determines may impair the health and safety of patients, or the imposition of disciplinary sanctions against Medical Director by any governmental agency having jurisdiction over the Medical Director, such as suspension or disqualification from participation in Medicaid or Medicare or suspension or restriction of license to practice medicine, and the refusal in such circumstances of Medical Group to appoint another qualified physician acceptable to MultiCare; and

4. Immediately if Medical Group is no longer legally organized as a business entity and operated to provide physician and medical director services in a manner consistent with all state and federal laws.

5. Immediately on jeopardy to (i) the participation of MultiCare in, or payment or reimbursement from the Medicare, Medicaid or other reimbursement or payment programs; (ii) MultiCare's full accreditation by any state or nationally recognized accrediting organization; or (iii) the tax exempt status of MultiCare or the status of any financing obligation of MultiCare that is exempt from taxation or interest income.

B. Termination of Medical Director's performance of services under this Addendum pursuant to Section VII, shall be without due process under the TG-AH Medical Staff Bylaws, or otherwise, which rights Medical Director expressly waive; provided, however, any limitation or termination of Medical Director's Medical Staff privileges in the treatment of his or her own patients shall be subject to the Medical Staff Bylaws.

C. Notwithstanding the termination or expiration of this Addendum, the parties shall be required to carry out any provisions hereof that contemplate performance by them subsequent to such termination or expiration; and such termination or expiration shall not affect any liability or other obligation that shall have accrued prior to such termination or expiration, including, but not limited to, any liability for loss or damage on account of default.

VIII. FEDERAL TAX FORM 1099

As required by law, MultiCare shall provide Medical Group with a Federal Tax Form 1099 indicating payment to Medical Group aggregating $600 or more in any calendar year.

IX. CONVERSION

Notwithstanding any other provision of this Addendum, in the event that any payment made to Medical Group hereunder is determined by either party, government agency, or a body having the power to exercise disciplinary authority over one or more of the parties, to be improper for any reason, or is found to threaten the tax exempt status of MultiCare then, if capable of reformation, this Addendum shall be reformed by agreement of the parties negotiating in good faith so as not to violate any such law or be

improper for any reason. If the parties are unable to agree on the terms of such reformation, they shall engage in mediation in good faith at the request of either party with Judicial Arbitration and Mediation Services, Inc. (or such other mediation service or mediator as the parties shall mutually agree). In the event good faith mediation is unsuccessful, payments to Medical Group made during the term of this Addendum shall immediately be converted to loans from MultiCare to Medical Group bearing a commercially reasonable interest rate and repayable in cash over a reasonable time period, or through the provisions of free care over a reasonable time period.

X. RECORD OF SERVICES

Medical Group shall maintain appropriate records relating to all services rendered under this Addendum. Medical Group shall provide MultiCare, within five (5) days following the last day of each calendar month in which services are provided, documentation of the services provided by Medical Group to fulfill the terms of this Addendum, recognizing that the services to be provided under this Addendum are compensated at fair market value but there is no requirement for a specific number of hours. Medical Group is eligible to receive compensation described in Section III only if it has documented services on and submitted forms substantially similar to Appendix A to MultiCare.

XI. ENTIRE AGREEMENT; MODIFICATIONS

This Addendum including Appendix A constitutes the entire agreement between the parties regarding its subject matter and supersedes all prior agreements and understandings, whether oral or written. Medical Group acknowledges that it has relied solely on the covenants and representations set forth in this Addendum and no others. This Addendum may be only modified by a written document signed by the party against whom enforcement is sought. No waiver of any provision of this Addendum shall be valid unless in writing and signed by or on behalf of the party waiving such provision, and no such waiver when executed shall constitute a waiver of any further failure to comply with this Addendum.

XII. SEVERABILITY

If any provision of this Addendum, or the application of such provision to any person or circumstances shall be held invalid, the remaining provisions of this Addendum or the application thereof to persons or circumstances other than those as to which it is held invalid, shall not be affected. However, in the event either party's performance of any provision of this Addendum could jeopardize the full accreditation of MultiCare by The Joint Commission, or by any other regulatory agent, or if such performance would be deemed illegal, either party may at its option give notice of termination; provided, however, that in the event of any such termination under this Section, the parties agree to negotiate in good faith to revise this Addendum in a form consistent with all statutes, ordinances, or other requirements in effect at such time. Nothing in this Section XII limits the right to terminate under other Sections of this Addendum.

XIII. INTERPRETATION

This Addendum shall be interpreted according to, and enforced under, the laws of the State of Washington. Jurisdiction and venue shall lie in Pierce County, Washington.

XIV. PATIENT REFERRAL; INDEPENDENT MEDICAL JUDGMENT

Each party agrees that neither Medical Group, Medical Director, nor MultiCare has a duty or obligation to refer patients to one another and patient referral is not an obligation of this Addendum. Nothing contained herein or in the relationship of MultiCare, Medical Group, and the Medical Director is intended to interfere with the exercise of independent medical judgment by the Medical Director.

XV. PARAGRAPH HEADINGS

The paragraph headings contained in this Addendum are for convenience only and shall be construed as part of this Addendum.

XVI. BINDING EFFECT

This Addendum shall be binding upon and shall enure to the benefit of Medical Group and MultiCare, and to MultiCare's successors and assigns.

XVII. ASSIGNMENT

Nothing contained in this Addendum shall be construed to permit the assignment by Medical Group of any rights or obligations hereunder. Such assignment by Medical Group is expressly prohibited, and shall automatically terminate this Addendum, unless there has been prior written consent of MultiCare. MultiCare may assign this Addendum without the consent of Medical Group in connection with any reorganization or sale, lease, or transfer of MultiCare.

XVIII. TIME OF ESSENCE

Time is of the essence with respect to every term and condition of this Addendum in which time is a factor.

XIX. ARBITRATION

In the event of any dispute under this Addendum, the parties agree to binding arbitration in Tacoma, Washington in accordance with the Commercial Arbitration Rules of the American Arbitration Association and with discovery being governed by the Federal Rules of Civil Procedure applicable in the United States District Court for the Western District of Washington. One arbitrator will be named by each party and a third neutral arbitrator will be named by the arbitrators so chosen. Judgment upon the award rendered

by the arbitrators may be entered into the judgment docket of any court having jurisdiction thereof. The cost of arbitration shall be shared equally by the parties to it. Each party shall be solely responsible for its attorneys' fees, if any. The obligations set forth under this section shall survive the termination of this Addendum.

XX. NOTICES

All notices, requests, demands, and other communications required by or permitted hereunder shall be in writing and shall be deemed to have been given when received in hand or electronically delivered by the party to whom directed; provided, however, that notice shall be conclusively deemed given five (5) days following the time of its deposit in the United States mails when sent certified or registered mail, postage prepaid, return receipt requested, to the other party at the following address, or at an address as shall be given in writing by either party to the other:

MULTICARE HEALTH SYSTEM
315 Martin Luther King Jr. Way
MS: 315-C3-AD

Tacoma, WA 98405
Attn: TG/AH President/Chief Operating Officer

TACOMA ANESTHESIA
ASSOCIATES, INC, P.S.
314 Martin Luther King, Jr. Way,
Suite 300
Tacoma, WA 98405
Attn: President

XXI. OTHER AGREEMENTS BETWEEN THE PARTIES

MultiCare shall document this Addendum and all other personal service arrangements between the Parties (or between MultiCare and a physician member of Medical Group or his or her family member) in a MultiCare master contract list and/or repository that is maintained and updated centrally and available for review upon request by Medical Group or any governmental agency with authority to request the information. MultiCare shall maintain the master list/repository in a manner that preserves the historical record of the past arrangements between the parties.

XXII. AUTHORITY TO SIGN

In witness whereof, the parties have caused this Addendum to be executed and do each hereby warrant and represent that their respective signatory whose signature appears below has been and is on the date of this Addendum duly authorized by all necessary and appropriate corporate action to execute this Addendum.

MULTICARE HEALTH SYSTEM

William G. "Bill" Robertson

MEDICAL GROUP
Tacoma Anesthesia Associates,
Inc., P.S.

David Schrenk, M.D.

Its: President/Chief Executive Officer

Its: President and CEO

MEDICAL DIRECTOR

Feb 28, 2018
_____, M.D.

APPENDIX A

Medical Director :_____, M.D. MONTH

ADMINISTRATION	1	2	3	4	5	6	7	8	9	10	11	12
Medical Direction of Department												
Supervision/Training of Technical Staff												
Physician/Staff In-service												
Eval/approve/imple-ment procedures												
Department Meetings												
Committee Meetings												
Schedules and Planning												
Policies/Procedures												
Budget Activities												
Quality Improvement Utilization Review												
Advisory Duties/Physician Counseling												
Liaison Activities												
Department Development												
Maintain Accrediting Standards												
Evaluate Staff Competency												
Evaluate Quality Control Results												
Other												

THIS IS TO CERTIFY THAT THE ABOVE REPRESENTS A REASONABLE ESTIMATE OF THE HOURS DEVOTED TO TG-AH ANESTHESIA DEPARTMENT SERVICE ADMINISTRATIVE ACTIVITIES DURING THE PERIOD OF THIS REPORT.

Medical Director

_____
, M.D.

Date: _____

Approved for Payment

By: _____
,Clinical Director

Date: _____

APPENDIX B
MEDICAL DIRECTOR PREADMIT PROGRAM-SPECIFIC SERVICES

Medical Director shall be specifically accountable to provide the following for the Program:

1. Maintain updated clinic protocols, algorithms, medication instructions, and order sets for nurse navigators to ensure they are working within their scope of practice and be the nurse triage for surgical patients. Establish new protocols/algorithms for conditions/situations that have not been addressed and get them approved through various hospital committees.

2. Ensure that there is always an anesthesiologist available to review medical charts, see complex patients, address emergencies, and support the nurse navigators. Address and fill in the gaps when needed.

3. Address unique issues/situations that are not covered by the protocols/algorithms and ensure that patients are ready for their surgeries at the appropriate location with all the necessary support and equipment.

4. Maintain a close feedback loop between TAA, the pre-admission nurse navigators, surgeons, their office staff, scheduling, and the day of surgery nurses and staff to review and address any issues/delays/cancellations and improve perioperative patient care.

5. Work with various departmental leaders (Surgical, MIS, Pharmaceutical, PHPs, Administrators) to improve the workflow and ensure that the needs of surgical patients are met and improve the perioperative patient experience.

6. Establish the role and responsibilities of the preadmission clinic nurse practitioner/physician assistant and train him/her for this position. Provide continual support and assist in the management of the complex patients.

AMENDMENT TO MEDICAL DIRECTOR ADDENDUM D TO MEDICAL DIRECTOR & PROFESSIONAL SERVICES AGREEMENT

This Amendment ("Amendment") to Medical Director Addendum D to the Medical Director and Professional Services Agreement for Anesthesiology and Related Services effective July 1, 2018 ("Addendum D"), is made by and between MultiCare Health System ("MHS") and Tacoma Anesthesia Associates, Inc., P.S. ("TAA").

WHEREAS, the parties entered into a Medical Director and Professional Services Agreement for Anesthesiology and Related Services dated January 1, 2018, inclusive of addenda A through D; as amended by that First Addendum dated January 1, 2019 (collectively, the "Agreement");

WHEREAS, Addendum D to the Agreement provides for the terms and conditions under which medical director services for anesthesia are provided to the various Facilities; specifically, TG-AH, MB, Baker Center, and Gig Harbor ASC;

WHEREAS, the parties wish to amend Addendum D to the Agreement to allow for automatic renewal of the medical director services to ensure no contractual gap in coverage;

NOW, THEREFORE, in consideration of the mutual benefits, promises, payments and undertakings of the parties, it is hereby

UNDERSTOOD AND AGREED:

AD-1. **Section I. A. Term** shall be deleted and replaced with the following:

A. Term. Effective January 1, 2018, Medical Group shall perform medical director services for the Program through December 31, 2020 ("Term"), unless this Addendum is earlier terminated as provided herein, or renewed upon expiration of the Term pursuant to Section. VI. herein.

AD-2. **Section VI. TERM** shall be deleted in its entirety and replaced with the following:

This Addendum shall commence on January 1, 2018 and shall continue in effect until December 31, 2020 ("Term"). Upon expiration of the Term, this Addendum D shall automatically renew for additional one (1) year periods ("Renewal Term") unless: (a) either party provides thirty (30) days prior written notice that it does not intend to renew the Addendum, (b) either party terminates pursuant to Section VII. Termination.; or (c) the Agreement has expired or is terminated, with which this Addendum is coterminous. During each Renewal Term, the parties shall examine compensation paid to Medical Group for the provision of Medical Director services and may amend it to ensure it reflects fair market value; provided, however, an amendment to change the compensation on a per unit basis (e.g., per hour or per FTE) cannot be entered into more than once during a twelve (12) month period.

AD-3. This Amendment to Addendum D may be executed in multiple counterparts, each of which is considered an original and will be binding upon the party who executed same, but all of such counterparts, when taken together, shall constitute one and the same Agreement and shall become effective when each party hereto has executed at least one such counterpart. Signatures sent by facsimile or electronic transmission shall be deemed to be originals for all purposes of this Agreement.

AD-4. Except as set forth and amended in this Amendment, all terms and conditions of the Agreement and First Addendum shall remain in full force and effect. Any capitalized terms not herein defined shall be ascribed the meaning as stated in the Agreement, as amended.

[Signatures on the following page]

MultiCare Health System

By: Sharon Oxendale
Its: President & COO, Tacoma General /Allenmore Hospital ~~Its President~~
Date: 12.30, 2019

Tacoma Anesthesia Associates, Inc., P.S.

By: Jeff Robinson, MD
Its: President
Date: 12/27, 2019

Exhibit 13A.

Title Guarantee

GUARANTEE

Issued by

First American Title Insurance Company

920 Fifth Avenue, Suite 1200, Seattle, WA 98104
Title Officer: Lavonne Bowman
Phone: (206)615-3150
FAX:

First American Title Insurance Company

National Commercial Services

920 Fifth Avenue, Suite 1200, Seattle, WA 98104
(206)615-3150 - (800)526-7544 FAX
Lavonne Bowman
(206)615-3269
lavbowman@firstam.com

SUBDIVISION GUARANTEE

LIABILITY	$	2,000.00			ORDER NO.:	NCS-993443-WA1
FEE	$	750.00	TAX $	75.75	YOUR REF.:	4545 Point Fosdick Drive

First American Title Insurance Company
a Corporation, herein called the Company

Subject to the Liability Exclusions and Limitations set forth below and in Schedule A.

GUARANTEES

CBRE

herein called the Assured, against loss not exceeding the liability amount stated above which the Assured shall sustain by reason of any incorrectness in the assurances set forth in Schedule A.

LIABILITY EXCLUSIONS AND LIMITATIONS

1. No guarantee is given nor liability assumed with respect to the validity, legal effect or priority of any matter shown therein.

2. The Company's liability hereunder shall be limited to the amount of actual loss sustained by the Assured because of reliance upon the assurance herein set forth, but in no event shall the Company's liability exceed the liability amount set forth above.

3. This Guarantee is restricted to the use of the Assured for the purpose of providing title evidence as may be required when subdividing land pursuant to the provisions of Chapter 58.17, R.C.W., and the local regulations and ordinances adopted pursuant to said statute. It is not to be used as a basis for closing any transaction affecting title to said property.

Dated: December 03, 2019 at 7:30 A.M.

SCHEDULE A

The assurances referred to on the face page are:

A. Title is vested in:

Multicare Health System, a Washington non-profit corporation

B. That according to the Company's title plant records relative to the following described real property (including those records maintained and indexed by name), there are no other documents affecting title to said real property or any portion thereof, other than those shown below under Record Matters.

The following matters are excluded from the coverage of this Guarantee:

1. Unpatented Mining Claims, reservations or exceptions in patents or in acts authorizing the issuance thereof.

2. Water rights, claims or title to water.

3. Tax Deeds to the State of Washington.

4. Documents pertaining to mineral estates.

DESCRIPTION:

LOT 2 OF UPTOWN GIG HARBOR BINDING SITE PLAN, ACCORDING TO THE PLAT RECORDED UNDER RECORDING NO. 200706015008, IN PIERCE COUNTY, WASHINGTON.

APN: 400260-0-031

RECORD MATTERS:

1. City liens, if any, for the city of Gig Harbor.

   Note: An inquiry has NOT been made concerning the actual status of such liens.

2. Easement, including terms and provisions contained therein:
   Recording Information: 8504110386
   For: Ingress, egress and utilities
   Affects: As described therein

3. The terms and provisions contained in the document entitled "Ordinance No. 515" recorded June 2, 1992 as 9206020307 of Official Records.

4. The terms and provisions contained in the document entitled "Agreement for Dedication of Permanent and Temporary Right-of-Way Easement" recorded August 14, 2000 as 200008140656 of Official Records.

5. Easement, including terms and provisions contained therein:
   Recording Information: 200008170502
   In Favor of: Peninsula Light Company, Telephone Utilities of Washington, Inc. and TCI of Washington
   For: Utilities

6. The terms and provisions contained in the document entitled "Partition Agreement" recorded July 21, 2005 as 200507210116 of Official Records.

7. Terms, covenants, conditions, restrictions and easements as contained in recorded Lot Line Adjustment (Boundary Line Revision) :
   Recorded: August 3, 2005
   Recording Information: 200508035004

8. The terms and provisions contained in the document entitled "Declaration of Covenant" recorded October 4, 2005 as 200510040715 of Official Records.

9. The terms and provisions contained in the document entitled "Easement Agreement" recorded October 6, 2005 as 200510060626 of Official Records.

10. The terms and provisions contained in the document entitled "Storm Water Facilities Maintenance Agreement and Restrictive Covenant" recorded March 15, 2006 as 200603150947 of Official Records.

11. The terms and provisions contained in the document entitled "Sanitary Sewer Facilities Easement and Maintenance Agreement" recorded September 8, 2006 as 200609080551 of Official Records.

12. The terms and provisions contained in the document entitled "Water Right Agreement" recorded September 26, 2005 as 200509261566 of Official Records.

13. Restrictions, conditions, dedications, notes, easements and provisions, if any, as contained and/or delineated on the face of the Uptown Gig Harbor Binding Site Plan recorded June 1, 2007 as 200706015008, in Pierce County, Washington.

14. Easement, including terms and provisions contained therein:
Recording Information: 200710160349
In Favor of: Comcast of Puget Sound, Inc.
For: Broadband communications

15. Easement, including terms and provisions contained therein:
Recording Information: 201112010373
In Favor of: Peninsula Light Company
For: Electric power cables

16. Easement, including terms and provisions contained therein:
Recording Information: 201802050170
In Favor of: Comcast Cable Communications Management, LLC
For: Broadband communications

17. Unrecorded leaseholds, if any, rights of vendors and security agreement on personal property and rights of tenants, and secured parties to remove trade fixtures at the expiration of the term.

INFORMATIONAL NOTES

A. General taxes for the year 2019 which have been paid.

Tax Account No.	400260-0-031
Amount:	$9,556.12
Assessed Land Value:	$5,352,800.00
Assessed Improvement Value:	$18,330,600.00

B. Any sketch attached hereto is done so as a courtesy only and is not part of any title commitment or policy. It is furnished solely for the purpose of assisting in locating the premises and First American expressly disclaims any liability which may result from reliance made upon it.

SCHEDULE OF EXCLUSIONS FROM COVERAGE OF THIS GUARANTEE

1. Except to the extent that specific assurance are provided in this Guarantee, the Company assumes no liability for loss or damage by reason of the following:

(a) Defects, liens, encumbrances, adverse claims or other matters against the title, whether or not shown by the public records.

(b) (1) Taxes or assessments of any taxing authority that levies taxes or assessments on real property; or, (2) Proceedings by a public agency which may result in taxes or assessments, or notices of such proceedings, whether or not the matters excluded under (1) or (2) are shown by the records of the taxing authority or by the public records.

(c) (1) Unpatented mining claims; (2) reservations or exceptions in patents or in Acts authorizing the issuance thereof; (3) water rights, claims or title to water, whether or not the matters excluded under (1), (2) or (3) are shown by the public records.

2. Notwithstanding any specific assurances which are provided in this Guarantee, the Company assumes no liability for loss or damage by reason of the following:

(a) Defects, liens, encumbrances, adverse claims or other matters affecting the title to any property beyond the lines of the land expressly described in this Guarantee, or title to streets, roads, avenues, lanes, ways or waterways to which such land abuts, or the right to maintain therein vaults, tunnels, ramps, or any structure or improvements; or any rights or easements therein, unless such property, rights or easements are expressly and specifically set forth in said description.

(b) Defects, liens, encumbrances, adverse claims or other matters, whether or not shown by the public records; (1) which are created, suffered, assumed or agreed to by one or more of the Assureds; (2) which result in no loss to the Assured; or (3) which do not result in the invalidity or potential invalidity of any judicial or non-judicial proceeding which is within the scope and purpose of the assurances provided.

(c) The identity of any party shown or referred to in this Guarantee.

(d) The validity, legal effect or priority of any matter shown or referred to in this Guarantee.

GUARANTEE CONDITIONS AND STIPULATIONS

1. Definition of Terms.

The following terms when used in the Guarantee mean:

(a) the "Assured": the party or parties named as the Assured in this Guarantee, or on a supplemental writing executed by the Company.

(b) "land": the land described or referred to in this Guarantee, and improvements affixed thereto which by law constitute real property. The term "land" does not include any property beyond the lines of the area described or referred to in this Guarantee, nor any right, title, interest, estate or easement in abutting streets, roads, avenues, alleys, lanes, ways or waterways.

(c) "mortgage": mortgage, deed of trust, trust deed, or other security instrument.

(d) "public records" : records established under state statutes at Date of Guarantee for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without knowledge.

(e) "date": the effective date.

2. Notice of Claim to be Given by Assured Claimant.

An Assured shall notify the Company promptly in writing in case knowledge shall come to an Assured hereunder of any claim of title or interest which is adverse to the title to the estate or interest, as stated herein, and which might cause loss or damage for which the Company may be liable by virtue of this Guarantee. If prompt notice shall not be given to the Company, then all liability of the Company shall terminate with regard to the matter or matters for which prompt notice is required; provided, however, that failure to notify the Company shall in no case prejudice the rights of any Assured under this Guarantee unless the Company shall be prejudiced by the failure and then only to the extent of the prejudice.

3. No Duty to Defend or Prosecute.

The Company shall have no duty to defend or prosecute any action or proceeding to which the Assured is a party, notwithstanding the nature of any allegation in such action or proceeding.

4. Company's Option to Defend or Prosecute Actions; Duty of Assured Claimant to Cooperate.

Even though the Company has no duty to defend or prosecute as set forth in Paragraph 3 above:

(a) The Company shall have the right, at its sole option and cost, to institute and prosecute any action or proceeding, interpose a defense, as limited in (b), or to do any other act which in its opinion may be necessary or desirable to establish the title to the estate or interest as stated herein, or to establish the lien rights of the Assured, or to prevent or reduce loss or damage to the Assured. The Company may take any appropriate action under the terms of this Guarantee, whether or not it shall be liable hereunder, and shall not thereby concede liability or waive any provision of this Guarantee. If the Company shall exercise its rights under this paragraph, it shall do so diligently.

(b) If the Company elects to exercise its options as stated in Paragraph 4(a) the Company shall have the right to select counsel of its choice (subject to the right of such Assured to object for reasonable cause) to represent the Assured and shall not be liable for and will not pay the fees of any other counsel, nor will the Company pay any fees, costs or expenses incurred by an Assured in the defense of those causes of action which allege matters not covered by this Guarantee.

(c) Whenever the Company shall have brought an action or interposed a defense as permitted by the provisions of this Guarantee, the Company may pursue any litigation to final determination by a court of competent jurisdiction and expressly reserves the right, in its sole discretion, to appeal from an adverse judgment or order.

(d) In all cases where this Guarantee permits the Company to prosecute or provide for the defense of any action or proceeding, an Assured shall secure to the Company the right to so prosecute or provide for the defense of any action or proceeding, and all appeals therein, and permit the Company to use, at its option, the name of such Assured for this purpose. Whenever requested by the Company, an Assured, at the Company's expense, shall give the Company all reasonable aid in any action or proceeding, securing evidence, obtaining witnesses, prosecuting or defending the action or lawful act which in the opinion of the Company may be necessary or desirable to establish the title to the estate or interest as stated herein, or to establish the lien rights of the Assured. If the Company is prejudiced by the failure of the Assured to furnish the required cooperation, the Company's obligations to the Assured under the Guarantee shall terminate.

5. Proof of Loss or Damage.

In addition to and after the notices required under Section 2 of these Conditions and Stipulations have been provided to the Company, a proof of loss or damage signed and sworn to by the Assured shall be furnished to the Company within ninety (90) days after the Assured shall ascertain the facts giving rise to the loss or damage. The proof of loss or damage shall describe the matters covered by this Guarantee which constitute the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage. If the Company is prejudiced by the failure of the Assured to provide the required proof of loss or damage, the Company's obligation to such Assured under the Guarantee shall terminate. In addition, the Assured may reasonably be required to submit to examination under oath by any authorized representative of the Company and shall produce for examination, inspection and copying, at such reasonable times and places as may be designated by any authorized representative of the Company, all records, books, ledgers, checks, correspondence and memoranda, whether bearing a date before or after Date of Guarantee, which reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the Assured shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect and copy all records, books, ledgers, checks, correspondence and memoranda in the custody or control of a third party, which reasonably pertain to the Loss or Damage. All information designated as confidential by the Assured provided to the Company, pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the Assured to submit for examination under oath, produce other reasonably requested information or grant permission to secure reasonably necessary information from third parties as required in the above paragraph, unless prohibited by law or governmental regulation, shall terminate any liability of the Company under this Guarantee to the Assured for that claim.

Form No. 1282 (Rev. 12/15/95)

6. Options to Pay or Otherwise Settle Claims: Termination of Liability.
In case of a claim under this Guarantee, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Liability or to Purchase the Indebtedness.

The Company shall have the option to pay or settle or compromise for or in the name of the Assured any claim which could result in loss to the Assured within the coverage of this Guarantee, or to pay the full amount of this Guarantee or, if this Guarantee is issued for the benefit of a holder of a mortgage or a lienholder, the Company shall have the option to purchase the indebtedness secured by said mortgage or said lien for the amount owing thereon, together with any costs, reasonable attorneys' fees and expenses incurred by the Assured claimant which were authorized by the Company up to the time of purchase.

Such purchase, payment or tender of payment of the full amount of the Guarantee shall terminate all liability of the Company hereunder. In the event after notice of claim has been given to the Company by the Assured the Company offers to purchase said indebtedness, the owner of such indebtedness shall transfer and assign said indebtedness, together with any collateral security, to the Company upon payment of the purchase price.

Upon the exercise by the Company of the option provided for in Paragraph (a) the Company's obligation to the Assured under this Guarantee for the claimed loss or damage, other than to make the payment required in that paragraph, shall terminate, including any obligation to continue the defense or prosecution of any litigation for which the Company has exercised its options under Paragraph 4, and the Guarantee shall be surrendered to the Company for cancellation.

(b) To Pay or Otherwise Settle With Parties Other Than the Assured or With the Assured Claimant.

To pay or otherwise settle with other parties for or in the name of an Assured claimant any claim Assured against under this Guarantee, together with any costs, attorneys' fees and expenses incurred by the Assured claimant which were authorized by the Company up to the time of payment and which the Company is obligated to pay.

Upon the exercise by the Company of the option provided for in Paragraph (b) the Company's obligation to the Assured under this Guarantee for the claimed loss or damage, other than to make the payment required in that paragraph, shall terminate, including any obligation to continue the defense or prosecution of any litigation for which the Company has exercised its options under Paragraph 4.

7. Determination and Extent of Liability.
This Guarantee is a contract of Indemnity against actual monetary loss or damage sustained or incurred by the Assured claimant who has suffered loss or damage by reason of reliance upon the assurances set forth in this Guarantee and only to the extent herein described, and subject to the Exclusions From Coverage of This Guarantee.

The Liability of the Company under this Guarantee to the Assured shall not exceed the least of:

(a) the amount of liability stated in this Guarantee;

(b) the amount of the unpaid principal indebtedness secured by the mortgage of an Assured mortgagee, as limited or provided under Section 6 of these Conditions and Stipulations or as reduced under Section 9 of these Conditions and Stipulations, at the time the loss or damage Assured against by this Guarantee occurs, together with interest thereon; or

(c) the difference between the value of the estate or interest covered hereby as stated herein and the value of the estate or interest subject to any defect, lien or encumbrance Assured against by this Guarantee.

8. Limitation of Liability.

(a) If the Company establishes the title, or removes the alleged defect, lien or encumbrance, or cures any other matter Assured against by this Guarantee in a reasonably diligent manner by any method, including litigation and the completion of any appeals therefrom, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused thereby.

(b) In the event of any litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals therefrom, adverse to the title, as stated herein.

(c) The Company shall not be liable for loss or damage to any Assured for liability voluntarily assumed by the Assured in settling any claim or suit without the prior written consent of the Company.

9. Reduction of Liability or Termination of Liability.
All payments under this Guarantee, except payments made for costs, attorneys' fees and expenses pursuant to Paragraph 4 shall reduce the amount of liability pro tanto.

10. Payment of Loss.

(a) No payment shall be made without producing this Guarantee for endorsement of the payment unless the Guarantee has been lost or destroyed, in which case proof of loss or destruction shall be furnished to the satisfaction of the Company.

(b) When liability and the extent of loss or damage has been definitely fixed in accordance with these Conditions and Stipulations, the loss or damage shall be payable within thirty (30) days thereafter.

11. Subrogation Upon Payment or Settlement.
Whenever the Company shall have settled and paid a claim under this Guarantee, all right of subrogation shall vest in the Company unaffected by any act of the Assured claimant.

The Company shall be subrogated to and be entitled to all rights and remedies which the Assured would have had against any person or property in respect to the claim had this Guarantee not been issued. If requested by the Company, the Assured shall transfer to the Company all rights and remedies against any person or property necessary in order to perfect this right of subrogation. The Assured shall permit the Company to sue, compromise or settle in the name of the Assured and to use the name of the Assured in any transaction or litigation involving these rights or remedies.

If a payment on account of a claim does not fully cover the loss of the Assured the Company shall be subrogated to all rights and remedies of the Assured after the Assured shall have recovered its principal, interest, and costs of collection.

12. Arbitration.
Unless prohibited by applicable law, either the Company or the Assured may demand arbitration pursuant to the Title Insurance Arbitration Rules of the American Arbitration Association. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the Assured arising out of or relating to this Guarantee, any service of the Company in connection with its issuance or the breach of a Guarantee provision or other obligation. All arbitrable matters when the Amount of Liability is $1,000,000 or less shall be arbitrated at the option of either the Company or the Assured. All arbitrable matters when the amount of liability is in excess of $1,000,000 shall be arbitrated only when agreed to by both the Company and the Assured. The Rules in effect at Date of Guarantee shall be binding upon the parties. The award may include attorneys' fees only if the laws of the state in which the land is located permits a court to award attorneys' fees to a prevailing party. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction thereof.

The law of the situs of the land shall apply to an arbitration under the Title Insurance Arbitration Rules.

A copy of the Rules may be obtained from the Company upon request.

13. Liability Limited to This Guarantee; Guarantee Entire Contract.

(a) This Guarantee together with all endorsements, if any, attached hereto by the Company is the entire Guarantee and contract between the Assured and the Company. In interpreting any provision of this Guarantee, this Guarantee shall be construed as a whole.

(b) Any claim of loss or damage, whether or not based on negligence, or any action asserting such claim, shall be restricted to this Guarantee.

(c) No amendment of or endorsement to this Guarantee can be made except by a writing endorsed hereon or attached hereto signed by either the President, a Vice President, the Secretary, an Assistant Secretary, or validating officer or authorized signatory of the Company.

14. Notices, Where Sent.
All notices required to be given the Company and any statement in writing required to be furnished the Company shall include the number of this Guarantee and shall be addressed to the Company at 2 First American Way. Bldg. 2, Santa Ana, CA. 92707.

Form No. 1282 (Rev. 12/15/95)

Exhibit 13B.

Pierce County Assessor-Treasurer's electronic Property Information Profile (Parcel 4002600031)

Assessor-Treasurer electronic Property Information Profile

Taxes / Values for 4002600031

12/18/2019 08:44 AM

Have a question?

Property Details

Parcel Number:	4002600031
Site Address:	4545 PT FOSDICK DR
Account Type:	Real Property
Category:	Land and Improvements
Use Code:	6511-MEDICAL OFFICES SERVICES

Taxpayer Details

Taxpayer Name:	MULTICARE HEALTH SYSTEM
Mailing Address:	PO BOX 5299 TACOMA WA 98415-0299

Assessed Values

Value Year	Tax Year	Taxable Value	Assessed Total	Assessed Land	Assessed Improvements	Current Use Land	Personal Property	Notice of Value Mailing Date
2019	2020	1,023,089	23,683,400	5,888,100	17,795,300	0	0	07/12/2019
2018	2019	1,016,186	23,683,400	5,352,800	18,330,600	0	0	07/12/2018
2017	2018	1,059,761	24,929,900	4,866,200	20,063,700	0	0	06/29/2017
2016	2017	969,126	22,663,600	4,866,200	17,797,400	0	0	06/23/2016
2015	2016	695,000	16,547,300	2,577,100	13,970,200	0	0	

Current Charges

Balance Due: 0.00 **Minimum Due: 0.00** **as of 12/18/2019**

Paid Charges

For questions regarding any electronic payments you may have made, please contact **Point & Pay** at **1-877-765-4112**

Tax Year	Charge Type	Amount Paid
2019	Property Tax Principal	9,545.70
	Weed Control Principal	2.46
	Pierce Conservation District Principal	7.96
	Total 2019	**9,556.12**

Exemptions

Tax Year	Exemption
2020	Non-Profit Caregivers, Libraries
2020	Partial Ex Improvement
2020	Partial Ex Land
2019	Non-Profit Caregivers, Libraries
2019	Partial Ex Improvement
2019	Partial Ex Land
2018	Non-Profit Caregivers, Libraries
2018	Partial Ex Improvement
2018	Partial Ex Land
2017	Non-Profit Caregivers, Libraries

2018	Property Tax Principal	10,893.40
	Weed Control Principal	2.46
	Pierce Conservation District Principal	7.00
	Total 2018	**10,902.86**
2017	Property Tax Principal	9,494.08
	Weed Control Principal	2.46
	Pierce Conservation District Principal	6.03
	Total 2017	**9,502.57**
2016	Property Tax Principal	7,287.63
	Weed Control Principal	0.85
	Pierce Conservation District Principal	2.36
	Total 2016	**7,290.84**

2017	Partial Ex Improvement
2017	Partial Ex Land
2016	Non-Profit Caregivers, Libraries
2016	Partial Ex Improvement
2016	Partial Ex Land

Tax Code Areas

Tax Year	TCA	Rate
2020	075	0.000000
2019	075	9.393657
2018	075	10.279102
2017	075	9.796529
2016	075	10.485789

Receipts

Date	Number	Amount Applied
11/04/2019	11005049	4,778.06
05/01/2019	10729849	4,778.06
11/05/2018	10427826	5,451.43
05/08/2018	10157374	5,451.43
11/01/2017	9816703	4,751.29
05/10/2017	9573470	4,751.28
11/08/2016	9255632	3,647.03
05/05/2016	8946332	3,643.81

ULID Information

Click here for ULID information

Pierce County Assessor-Treasurer
Mike Lonergan
2401 South 35th St Room 142
Tacoma, Washington 98409
(253)798-6111 or Fax (253)798-3142
www.piercecountywa.org/atr

WEBSITE INFORMATION

Privacy Policy
Copyright Notices

Exhibit 14.

Contractor's Estimate Letter

ABBOTT CONSTRUCTION

Friday, December 6, 2019

Mike Schaal
MultiCare Health Systems, Inc. | CBRE
1420 5th Ave, Suite 1700
Seattle, WA 98101
Mike.schaal@cbre.com

Re: ROM Budget Proposal
MHS Gig Harbor OR Modifications

Dear Mike:

We are pleased to present this ROM construction budget for the MHS Gig Harbor OR Modifications. This estimate is based on the documents provided by Clark Kjos dated 10/4/2019, Email from Clark Kjos on 10/11/2019 with summary of changes and clarifications provided below. We have provided an estimate summary for your review.

This estimate includes Washington State Sales Tax.

Base Bid **$2,377,329.00**
TWO MILLION THIRTY SEVENTY-SEVEN THREE HUNDRED TWENTY-NINE and 00/100 Dollars

Alternates

Documents
This cost estimate is based upon the drawings and discussions with Clark Kjos and Mike Schaal throughout multiple weeks leading up to the delivery of this budget. Drawings are dated 10/4/2019.

Basic Criteria
We base this proposal on a 13 week construction schedule broken into three phases with multiple phases being performed at the same time. We have included a 4% escalation costs anticipating the work would begin in 12-18 months. We have not anticipated any lead times as material will need to be specified.

Work is priced to be performed during normal weekday working hours with the exception of tie ins that would impact the OR's expected to remain open at the time.

It is assumed we can use the elevators and stairwells for material and labor transportation.

Infection control consists of hard wall barrier ante rooms with negative air machines and sticky mats. We have not included air monitoring.

Includes replacement of three roof top HVAC units feeding the ORs. At the time of this proposal, one is being installed and was not included. This cost is shown at the bottom totals of our proposal.

Includes $263,758 of Owner Contingency.

Inclusions and Clarifications
The following are clarifications to this proposal. In the vent there is a discrepancy between the plans, specifications and these clarifications, then these clarifications shall take precedence.

The following items are included in our cost estimate:

General Requirements

- Project Administration
- Project Supervision
- Supervision Vehicle and Project Administration Mileage
- Printing & Mailing
- Temporary Utilities
- Temporary Facilities
- Safety Measures
- Material Handling
- Layout
- Clean-Up & Disposal

Phase #1 – OR#4

- Demolition of existing flooring, drywall partitions, sink, ACT, and doorway and shown.
- Installation of three procedure light/boom support structures.
- Supply and install of window framing and glazing.
- Installation of drywall ceiling, infill existing door opening, and install of new wall where sink was located.
- Installation of sheet vinyl flooring with integral coved base including patching around new walls.
- Painting of all walls and ceiling modified by construction and within OR#4.
- Includes Acrovyn wall protection up to 4' around the interior of OR#4.
- Setup and tear down of infection control measures.
- Piping of med gas from existing valves to new ports on one wall and to the new boom supplied by others.
- Includes pre and post TAB report, diffuser air curtain system in hard lid ceiling and low wall returns.
- Includes ductwork associated with distribution of air in ceiling.
- Power to booms, wall outlets for equipment, and lighting in hard lid and at procedure lights.
- Includes a $6,000 allowance for data cabling and jacks.

Phase #2 – Decon/Wrap/Sterile Supply

- Demolition of casework, flooring, walls, and doors.
- Includes a $5,000 allowance for adding custom stainless steel trim if needed at equipment.
- Includes stainless steel countertop casework in Wrap area.
- Supply and install new door assembly near sterilizer and at RO Water Supply Room.
- Supply and install automatic pass through window.
- Drywall modification at new wall locations around Decon/Wrap as well as at the RO Water Supply Room.
- ACT modifications in rooms where walls are being modified. Existing tile is to remain in ceilings and only patched.
- Includes sheet vinyl flooring modifications with integral cove.
- Painting of new drywall assemblies.
- Wall protection inside decon and wrap near high traffic areas.
- Setup and tear down of infection control measures.
- Modification of fire sprinkler system
- Plumbing tie in of new pass through washer, sterilizer, floor sinks, wash sinks (provided by others), and instrument air.
- Includes a $10,000 allowance for the relocation of unknown utilities in walls.
- Includes a $50,000 allowance for the installation or piping for a RO system.
- Includes pre and post TAB.
- Includes supplying new power to sterilizers, pass through window, and light fixtures at new ceiling.
- Includes a $10,000 allowance for the relocation of existing unknown utilities.
- Includes a $4,000 allowance for data cabling and jacks.

Phase #3 – Sterile Storage Carts/Sub Sterile Work

- Demolition of casework in Anesthesia Work and Sub Sterile as shown.
- Repair of drywall and flooring within rooms.
- Painting of walls affected by construction.
- Setup and tear down of infection control measures.
- Includes relocation of med air tanks and manifold in Sterile Supply Storage and install in Equipment Storage across the hall.
- Add circuits for tissue freezer and small sterilizer in rooms as shown.
- Add circuit for low temp sterilizer in Sub Sterile.

Exclusions

The following are exclusions from our cost estimate. Owners should carry budgets for these items if required.

General Exclusions:

1. Washington State Sales Tax
2. Architectural and engineering fees
3. Prevailing Wages
4. Property line and control surveys
5. Performance, labor and material payment bonds
6. System development fees, utility connection fees, impact fees, assessments or easements
7. Utility company charges for storm, sewer, water, gas and power services
8. Telephone company service charges, cabling and equipment
9. Utility As Built surveys and "Alta Survey"
10. Any bonds and / or permits as might be required by the City for items such as landscape, grading, public works, street improvements, etc.
11. Right of Way Use Permits (i.e. "Street Use Permits")
12. Building code compliance and ADA upgrades not shown on the documents
13. Building department corrections not shown on the documents
14. Fire alarm monitoring and phone lines
15. Testing and inspection
16. Building permit and plan check fees
17. Builder's "All Risk" property insurance including deductible (to be purchased by Owner)
18. Hazardous material surveys and abatement
19. Escalation

Project Specific Exclusions:

1. Security systems
2. Cleaning and waxing of floors
3. Final keying
4. Custom colors / stains, unless specifically specified
5. Moisture testing for flooring materials if required
6. Non code related signage.
7. Low voltage controls including energy management system
8. Receiving, uncrating, onsite storage and handling of owner furnished equipment
9. Setting of equipment and shelving provided by others
10. Removal of existing or supply/install of Sterilizers, Pass Through Washers, Cart Washers etc. provided by owner vendor
11. Unknown structural improvements unless listed above.
12. Access control system modifications or additions.
13. Commissioning of new equipment.
14. Moisture mitigation
15. Air quality monitoring

16. ACM testing or abatement
17. Relocation of owner supplies
18. Scope associated with Cart Washer installation shown on earlier iterations of drawings.
19. Scope associated with OR#3 Modifications shown on earlier iterations of drawings.
20. Modification to Cryo/Anesthesia Supply Room.

Proposed Payment Terms: Per Master Agreement

Thank you for the opportunity to submit this proposal. We look forward to working together with you toward the successful completion of this project. Should you have any questions, please feel free to give me a call.

If this proposal meets your satisfaction, please issue a notice to proceed.

Sincerely,
J.R. ABBOTT CONSTRUCTION INC.

Matt McKeeby
Project Manager

This proposal is valid for sixty (60) calendar days from date of issuance

Exhibit 15.

Equipment List

MultiCare Gig Harbor CON | Equipment List

Cost estimates include 8.5% item tax

Qty	Description	Manufacturer	Mfr #	Vendor	Model	Ext.Cost
1	Sterilizer, Low Temperature	Advanced Sterilization Products (ASP)	10104-007	Advanced Sterilization Products (ASP)	STERRAD 100NX System w/ALLClear (Single Door)	$195,056.96
1	Sterilizer, Steam, Recessed	STERIS Corporation	SR22122 11011	STERIS Corporation	Amsco 400 Prevac 26x37x48 1Dr (LH slide) 208V	$153,587.85
1	Washer/Disinfector, Electric	STERIS Corporation	FH14072	STERIS Corporation	5052 200-208V Steam	$107,405.71
1	Ultrasonic Cleaner, Floor	STERIS Corporation	IWPCF	STERIS Corporation	InnoWave PCF	$104,792.42
1	Integration System, Surgical, Allowance	Stryker Communications			Switchpoint Infinity 3	$91,432.95
1	Table, Surgical, Major	Skytron	3603	Skytron	3603 UltraSlide	$91,432.95
1	Anesthesia Machine, General	GE Healthcare - Anesthesia Delivery	1006-9113-000	SOMA Technology, Inc.	Aestiva/5 7900 3 Vaporizer	$68,269.94
1	Recorder, CD/DVD, Medical	Stryker Endoscopy	0240-060-921	Stryker Endoscopy	SDC3 Base w/DICOM and SDP1000 Printer Kit	$64,446.82
1	Services, Freight/Shipping/Handling	STERIS Corporation		STERIS Corporation	Freight	$56,522.70
1	Water Treatment System, RO, AmeriWater RO2 System	STERIS Corporation	AW00HC S2051	STERIS Corporation	AmeriWater RO2 withhighflow pump	$48,764.24
2	Sink, Clean-up Workstation (3-sink) - AMSCO 53	STERIS Corporation	SINK5097	STERIS Corporation	AMSCO 50 Reprocessing 97.5'' Adj Height (SINK5097)	$45,838.39
1	Cart, Anesthesia, Controlled Access- Cart	BD - Pyxis	A2MB4	BD - Pyxis	Anesthesia System w/BioID	$39,258.88
1	Waste Disposal, Surgical Fluid Collection	Stryker Instruments	0702-001-000	Stryker Instruments	Neptune 2 Ultra Rover	$39,011.39
1	Boom, Equipment, Single Arm Utility	Stryker Communications	TF 621	Stryker Communications	TELETOM TF 621	$37,624.05
1	Monitor, Physiologic, Bedside	Philips Healthcare - Monitoring Systems	865240	Pacific Medical Supply	Intellivue MX800	$36,573.18
2	Monitor, Video, 26 - 32 inch, Medical Grade	Stryker Endoscopy	0240-031-020	Stryker Endoscopy	VisionPro 26'' LED	$32,630.59
1	Insufflator, CO2	Stryker Endoscopy	0620-040-652	Stryker Endoscopy	PneumoSure XL (45L, for House Gas)	$19,749.52
2	Loading Car, Sterilizer	STERIS Corporation	AX06801 3081	STERIS Corporation	Atlas 36 Loading Car (for AMSCO 400 series)	$13,510.13
1	Cabinet, Warming, Dual, Mobile	Pedigo Products, Inc	P-2145	Pedigo Products, Inc	P-2145 Deluxe Combination Warmer	$12,191.06
2	Table, Instrument, 72 inch	Pedigo Products, Inc	CDS-3072	Pedigo Products, Inc	CDS-3072 Space Station	$11,071.92

MultiCare Gig Harbor CON | Equipment List

Cost estimates include 8.5% item tax

Qty	Description	Manufacturer	Mfr #	Vendor	Model	Ext.Cost
2	Cart, Sterilizer, Transfer Carriage	STERIS Corporation	AX065023083000 0013	STERIS Corporation	Amsco 400 Transfer Carriage (26 x 37.5 x 48'')	$10,907.35
1	Table, Instrument, Assembly	STERIS Corporation	PREP55	STERIS Corporation	AMSCO Prep and Pack Deluxe Electric (PREP55)	$8,777.56
2	Rack, Washer/Disinfector	STERIS Corporation	FD74900	STERIS Corporation	3-Level Vision Manifold [FD74-900]	$7,802.28
5	Cart, Supply, Chrome, 60 inch	InterMetro Industries Corp	A3060NC (x5)/74UPK3(4x)/5MP(2)/5MPB(2)	InterMetro Industries Corp	Super Adjustable Super Erecta 60x30x79	$7,381.69
1	Board, Peg, Stainless Steel	STERIS Corporation	CG76	STERIS Corporation	Pegboard (CG76)	$3,403.74
2	Stool, High, w/Backrest	Herman Miller, Inc.	SA397699 - HIGH	BiNW	Mirra, Drafting Stool	$2,072.48
1	Cart, Supply, Chrome, 72 inch	InterMetro Industries Corp	A2472NC (4x)/74UP(4x)/2472FS(1)/5MP(2)/5MPB(2)	InterMetro Industries Corp	Super Adjustable Super Erecta 72x24x79	$1,822.57
1	Table, Instrument, 55-60 inch	Pedigo Products, Inc	SG-94-SS	Pedigo Products, Inc	SG-94-SS (60x24)	$1,583.62
1	Cart, Supply, Chrome, 48 inch	InterMetro Industries Corp	(4x)A2448NC/(1)2448FG(4x)74UP/5MP/5MPB/EP37C/EP57C	InterMetro Industries Corp	Super Adjustable Super Erecta 48x24x74 (5-Tier)	$1,527.55
2	Stool, Anesthetist	Armstrong Medical Industries	AC-985A	Armstrong Medical Industries	AC-985A (Black, w/Arms)	$975.28
1	Cart, Supply, Chrome, 72 inch	STERIS Corporation	CCM475CHCL	STERIS Corporation	24x72x80	$889.95
1	Cart, Supply, Chrome, 36 inch	InterMetro Industries Corp	N536EC	InterMetro Industries Corp	Super Erecta 36x24x69 [N536EC]	$328.39
2	Allowance, Clinical Integration	TBD		TBD		$24,382.12
1	Services, Storage/Warehousing Ace Relocation	TBD		TBD	Receiving Storage Delivery	$8,988.80
1	Cart, Computer, Workstation	Capsa Healthcare		Capsa Healthcare		$5,851.71
1	Sealer, Heat, Packaging	Rennco Inc.	LS-24D	Rennco Inc.	Lift Seal 24 LS	$2,690.57
1	Monitor, Video, 52 - 58 inch, Display	NEC Display Solutions	V552	NEC Display Solutions	V552 (55'' Commecial-Grade)	$2,619.86

MultiCare Gig Harbor CON | Equipment List

Cost estimates include 8.5% item tax

Qty	Description	Manufacturer	Mfr #	Vendor	Model	Ext.Cost
2	Computer, Desktop	Dell Inc.		Dell Inc.	OptiPlex 3060 SFF i3-8100 500GB HDD 4GB	$2,018.84
1	Speaker, Wall Mount, OR Sound	Bose Corporation		Bose Corporation	Virtually Invisible 191 In-Wall	$1,828.66
2	Positioning Device, Surgical Table, Arm	Hillrom - Allen Medical Systems	A-90002	Hillrom - Allen Medical Systems	LPS Arm Support	$1,704.31
2	Cart, Utility, Stainless	Lakeside Manufacturing, Inc.	492	Medline Industries Inc.	492 (Tubular, 2 shelf, 500 lb)	$1,098.95
3	Stool, Step, Stackable	Pedigo Products, Inc		Pedigo Products, Inc	P-1015	$1,002.11
1	Chair, Office, Task, w/Arms	Herman Miller		Catalyst Workplace Activation	Mirra	$836.31
1	Stand, Mayo, Foot-Operated	Pedigo Products, Inc	P-1065-SS	Pedigo Products, Inc	P-1065-SS	$707.08
1	Clock, Elapsed Time, Wall Mount	American Time & Signal Co.	DSY261R FAE-WEB/ATS TCS-WEB	American Time & Signal Co.	Digital Elapsed Time (Flush, 6 digit)	$693.68
2	Bucket, Kick	Pedigo Products, Inc	P-1020-SS	Owens & Minor	P-1020-SS	$609.55
1	Stool, Exam, w/Backrest	Midmark Corporation	277-201	Midmark Corporation	Ritter 277 Air Lift (Foot Release)	$609.55
1	Printer, Label, Barcode	Zebra Technologies Corp	GK42-202210-000	Zebra Technologies Corp	GK420d (Direct Thermal/Ethernet)	$607.11
2	Clock, Analog, Wall	Innovation Wireless	210001-SM24	Innovation Wireless	13'' Standard 210001-SA24	$519.46
1	Regulator, Suction, Intermittent/Continuous	Ohio Medical Corp	8701-1351-905	Vyaire Medical	8701-1351-905 Push-To-Set Digital	$487.64
2	Stand, IV, Chrome	BD - Alaris Infusion	MDS80600/MDS80600R	Medline Industries Inc.	4 leg, 8 hook [916-0172]	$487.64
3	Hamper, Linen	Medline Industries Inc.	CX402	Centurion Medical Products	MDS80529 18'' Chrome	$479.11
1	Stand, Basin, Double	Pedigo Products, Inc	P-1079-SS	Medline Industries Inc.	P-1079-SS	$426.69
1	Board, Patient Transfer Device	AliMed, Inc.	9183	AliMed, Inc.	9-183 MoveMaster Patient Shifter (22'')	$309.65
1	Clock, Analog, Wall	Innovation Wireless	210001-SM24	Innovation Wireless	13'' Standard 210001-SA24	$262.11
1	Trimmer, Allowance	TBD	TBD	TBD	TBD	$243.82
1	Bracket, Monitor, Wall, Flat Panel	Peerless-AV	ST680	BES	SmartMount ST680 Univ. Tilt (Security, 60''-95'')	$182.87
3	Dispenser, Glove, Triple Box	Bowman Dispensers	GP-330	Grainger	GP-330 Clear PETG Plastic	$153.61

MultiCare Gig Harbor CON | Equipment List

Cost estimates include 8.5% item tax

Qty	Description	Manufacturer	Mfr #	Vendor	Model	Ext.Cost
1	Board, White, Templated, Non-Magnetic, No Markertray	Flex-A-Chart Mfg.		Flex-A-Chart Mfg.		$146.29
1	Telephone, Wall	Nortel		Nortel		$121.91
2	Flowmeter, Oxygen	Amvex Corporation	FM-15UO-OH	Tri Anim	FM-15UO-OH	$112.16
2	Flowmeter, Oxygen, Compact	Amvex Corporation	FM-15UO-OH	Tri Anim	FM-15UO-OH	$112.16
2	Waste Can, 20-31 Gallon	Rubbermaid Commercial Products	FG354000BEIG	Grainger	3540 Slim Jim Beige (23 gal)	$97.53
1	Bracket, CPU, Wall	Ergotron Inc.	97-468-202	MoreDirect	Vertical Universal CPU Holder	$85.34
2	Waste Can, 20-31 Gallon	Rubbermaid Commercial Products	FG354000BEIG	Grainger	3540 Slim Jim Beige (23 gal)	$79.73
1	Flowmeter, Air	Amvex Corporation	FM-15UA-OH	Tri Anim	FM-15UA-OH (Ohmeda)	$58.52
1	Flowmeter, Air, Compact	Amvex Corporation	FM-15UA-OH	Tri Anim	FM-15UA-OH (Ohmeda)	$58.52
1	Dispenser, Glove, Triple Box	Bowman Dispensers	GP-330	Grainger	GP-330 Clear PETG Plastic	$48.69
2	Dispenser, Hand Sanitizer, Wall Mount	GOJO Industries	1920-04	GOJO Industries	Purell LTX-12 White (1920-04)	$0.00
2	Dispenser, Paper Towel, Surface Mount	Georgia Pacific	59407	Professional Hospital Supply	enMotion Automated Touchless	$0.00
1	Dispenser, Soap, Wall Mount	DebMed	4D40-Q5	STERIS Corporation	SDS Dispenser (Manual 1 Liter)	$0.00
1	Services, Freight/Shipping	TBD		TBD	Allowance for Unknown Freight Costs	$2,809.00
Total Equipment Costs						**$1,380,176**

Exhibit 16.

Letter of Financial Commitment

MultiCare Health System
820 A Street, Tacoma, WA, 98402
PO Box 5299 Tacoma, WA 98415-0299 ~ 253-403-1000 ~ multicare.org

December 12, 2019

Washington Department of Health
Certificate of Need Program
Mail Stop 47852
Olympia, WA 98504-7852

RE: MultiCare Health System Certificate of Need Request for Converting Two Procedure Rooms to Two Additional Operating Rooms at Ambulatory Surgical Facility in Gig Harbor, Washington for an Estimated Capital Expenditure of $4.7 Million

Dear Sir or Madam:

Please accept this letter as evidence of financial support for MultiCare Health System's certificate of need application request for converting two procedure rooms to two operating rooms at the Ambulatory Surgical Facility in Gig Harbor, Washington for an Estimated Capital Expenditure of $4.7 Million.

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 jpmcmanus@multicare.org or at 253.403.8020. Thank you for your time and assistance in this important matter.

Yours truly,

Jim McManus
Chief Financial Officer
MultiCare Health System

Exhibit 17A.

MultiCare Health System Audited Financial Statements - 2016

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2016 and 2015

(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, 2016 and 2015, 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 Consolidated 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 audits 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, 2016 and 2015, 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

March 22, 2017

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2016 and 2015

(In thousands)

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	412,077	207,167
Accounts receivable, less allowance for doubtful accounts of $33,931 and $43,277 in 2016 and 2015, respectively		267,858	265,088
Supplies inventory		22,008	20,493
Other current assets, net		37,228	29,695
Total current assets		739,171	522,443
Donor restricted assets held for long-term purposes		66,703	73,336
Investments		1,368,840	1,426,358
Bond funds held in trust		46,738	93,178
Property, plant, and equipment, net		1,332,734	1,281,457
Other assets, net		118,771	75,429
Total assets	$	3,672,957	3,472,201
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	130,278	114,574
Accrued compensation and related liabilities		154,636	131,493
Accrued interest payable		13,565	13,731
Current portion of long-term debt		15,178	14,580
Total current liabilities		313,657	274,378
Accrued pension, professional liability, and other		101,513	101,158
Interest rate swap liabilities		56,265	59,029
Long-term debt, net of current portion		976,920	993,686
Total liabilities		1,448,355	1,428,251
Commitments and contingencies (note 15)			
Net assets:			
Unrestricted		2,131,476	1,955,044
Temporarily restricted		34,665	31,696
Permanently restricted		58,461	57,210
Total net assets		2,224,602	2,043,950
Total liabilities and net assets	$	3,672,957	3,472,201

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2016 and 2015

(In thousands)

	2016	2015
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,898,104	1,913,776
Provision for bad debts	(40,836)	(44,194)
Net patient service revenue less provision for bad debts	1,857,268	1,869,582
Other operating revenue	65,821	73,011
Net assets released from restrictions for operations	3,964	4,108
Total unrestricted revenues, gains, and other support	1,927,053	1,946,701
Expenses:		
Salaries and wages	913,142	827,995
Employees benefits	148,037	170,017
Supplies	259,246	241,475
Purchased services	138,660	120,746
Depreciation and amortization	110,481	107,435
Interest	35,259	35,539
Other	211,497	213,702
Total expenses	1,816,322	1,716,909
Excess of revenues over expenses from operations	110,731	229,792
Other income (loss):		
Investment income (loss)	77,515	(48,513)
Loss and other expense on interest rate swaps, net	(3,849)	(5,947)
Loss on bond refinancing	—	(51,142)
Total other income (loss), net	73,666	(105,602)
Excess of revenues over expenses	184,397	124,190
Other changes in unrestricted net assets:		
Changes in accrued pension liability	(12,473)	39,009
Net assets released from restriction – capital acquisitions	4,508	3,779
Capital assets received and other	—	50
Increase in unrestricted net assets	176,432	167,028
Changes in temporarily restricted net assets:		
Contributions and other	11,299	14,955
Income on investments	142	389
Net assets released from restriction – capital acquisitions	(4,508)	(3,779)
Net assets released from restrictions for operations	(3,964)	(4,108)
Increase in temporarily restricted net assets	2,969	7,457
Changes in permanently restricted net assets:		
Contributions and other	1,792	717
Income on investments	690	951
Decrease in assets held in trust by others	(1,231)	(1,286)
Increase in permanently restricted net assets	1,251	382
Increase in net assets	180,652	174,867
Net assets, beginning of year	2,043,950	1,869,083
Net assets, end of year	$ 2,224,602	2,043,950

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In thousands)

	2016	2015
Cash flows from operating activities:		
Increase in net assets	$ 180,652	174,867
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	110,481	107,435
Amortization of bond premiums, discounts, and issuance costs	(1,588)	(1,008)
Net realized and recognized (gains) losses and change in net unrealized (gains) losses on investments	(54,328)	79,032
Change in fair value of interest rate swap	(1,883)	(356)
Provision for bad debts	40,836	44,194
Loss on disposal of assets, net	201	416
Loss on bond refinancing	—	51,142
Undistributed losses on joint ventures	1,797	469
Restricted contributions for long-term purposes	(1,820)	(2,496)
Changes in operating assets and liabilities:		
Accounts receivable	(43,606)	(9,473)
Supplies inventory and other current assets	(8,777)	1,323
Other assets, net	(24,182)	(7,348)
Accounts payable and accrued expenses and accrued interest payable	11,835	(59,075)
Accrued compensation and related liabilities	23,143	(17,113)
Accrued pension, professional liability, and other	(4,153)	(49,614)
Net cash provided by operating activities	228,608	312,395
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(162,917)	(87,678)
Proceeds from disposal of property, plant, and equipment	4,825	507
Contributions to joint ventures, net	(6,006)	(1,495)
Net sales and (purchases) of trading securities	116,503	(121,054)
Net decrease (increase) in bond funds held in trust	46,440	(93,178)
Change in donor trusts	(9,782)	1,976
Net cash used in investing activities	(10,937)	(300,922)
Cash flows from financing activities:		
Repayment of long-term debt	(14,581)	(12,945)
Proceeds from bond issuance	—	99,279
Restricted contributions for long-term purposes	1,820	2,496
Net cash (used in) provided by financing activities	(12,761)	88,830
Net increase in cash and cash equivalents	204,910	100,303
Cash and cash equivalents, beginning of year	207,167	106,864
Cash and cash equivalents, end of year	$ 412,077	207,167
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 35,425	34,418
Noncash activities:		
Increase in deferred compensation plans	4,344	3,125
Purchases of property, plant, and equipment included in accounts payable	3,701	3,748

See accompanying notes to consolidated financial statements.

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

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 and King Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2016, MHS operates 1,219 licensed inpatient beds, seven outpatient surgical sites, home health, hospice, and several other urgent care, primary care, and multispecialty clinics located throughout MHS' service area.

The consolidated financial statements of MHS include five acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, and Auburn Medical Center) and a medical group that includes MultiCare Clinics, MultiCare Medical Associates, and Urgent Care Centers. MHS includes a wholly owned subsidiary, Medis, Inc. (conducts health related services within the for-profit sector such as consulting, physician joint ventures, facilities management, and leasing), a wholly owned accountable care organization (MultiCare Connected Care), and four foundations (Mary Bridge Children's Foundation, MultiCare Health Foundation, Good Samaritan Foundation, and MultiCare South King Health Foundation).

(a) Principles of Consolidation

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

(b) 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.

(c) Cash and Cash Equivalents

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

(d) Accounts Receivable

Accounts receivable are primarily comprised of amounts due for healthcare services from patients and third-party payors, and are recorded net of allowances for contractual adjustments and bad debts.

(e) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is based on average cost, 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.

(f) Donor Restricted Assets

The majority of the donor restricted assets are invested in MHS' pooled investments and are stated at fair value or estimated fair value. Donor restricted assets that are held outside MHS' pooled investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in cash, 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 available are carried at values provided by the respective investment managers or trustees, which management believes approximate fair value.

Charitable gift annuities, which are included in donor restricted assets totaled $2,385 and $2,676 at December 31, 2016 and 2015, respectively. MHS has recorded a corresponding payable of $1,352 and $1,524 at December 31, 2016 and 2015, 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 the accrued pension, professional liability, and other 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.

(g) Investments

MHS accounts for its investment portfolio as a trading portfolio. Investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are stated 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 trust funds, limited liability partnerships, and hedge funds are carried at net asset value 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.

(h) Bond Funds Held in Trust

Bond funds held in trust include assets held by trustees under bond indenture agreements, which are primarily restricted to fund certain capital projects. These assets are carried at fair value.

(Dollars in thousands)

(i) Property, Plant, and Equipment

Property, plant, and equipment acquisitions 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 or losses upon sale or retirement of property, plant, and equipment are included in other operating revenue. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

MHS assesses potential impairments to its long-lived assets when there is evidence that events or changes in circumstances have made recovery of the carrying value of the assets unlikely. An impairment loss is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2016 and 2015, there were no impairment charges.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, 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 restricted support. 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) 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 $4,825 and $8,327 as of December 31, 2016 and 2015, 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. Net patient service revenue increased by $8,335 and $4,910 for 2016 and 2015, respectively, to reflect changes in the estimated Medicare settlements for prior years.

(k) Interest Rate Swaps

MHS records all interest rate swaps on the consolidated balance sheets at fair value. The accounting for changes in the fair value of these instruments depends on whether those had been designated and qualify as part of a hedging relationship. As of December 31, 2016 and 2015, none of MHS' interest rate swaps have been designated as cash flow hedges and the changes in fair value are recognized within loss and other expense on interest rate swaps in the accompanying consolidated statements of operations and changes in net assets.

(l) Temporarily and Permanently Restricted Net Assets

Gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. Temporarily restricted net assets are those whose use by MHS has been limited by donors to a specific time period or purpose. Permanently restricted net assets 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, these amounts are released from restrictions for operations and are included in unrestricted revenues, gains, and other support. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are reflected in unrestricted net assets 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. As of December 31, 2016 and 2015, MHS has recorded $9,215 and $11,950, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2016, $4,379 of pledges are due in one year or less and $4,836 in two to five years.

(m) Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The basis for payment to MHS under the third-party governmental and private payor agreements includes prospectively determined rates per discharge, discounts from established charges, and per diems.

(Dollars in thousands)

Net patient service revenues were billed to the following payors for the years ended December 31, 2016 and 2015:

	2016	2015
Payors:		
Medicare and Medicaid	41%	43%
Regence	14	14
Premera	12	12
First Choice	4	5
Other	29	26
	100%	100%

(n) 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. During 2014, the fee-for-service portion of the program was approved; however, approvals associated with the managed care Medicaid portion were not fully clarified until 2015. Recognition of these 2014-related amounts were included in the consolidated statement of operations and changes in net assets during 2015.

In connection with the safety net program, MHS recorded increases in net patient service revenue of $58,184 and $109,727 for 2016 and 2015, respectively, and incurred assessments of $38,990 and $71,264 for 2016 and 2015, 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 $7,636 and $6,809 associated with this program as of December 31, 2016 and 2015, respectively, which are included with accounts receivable on the consolidated balance sheets.

(o) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated healthcare services to the communities it serves within the purview of its mission. Patients who meet the criteria of its charity care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Because MHS does not pursue collection of amounts determined to qualify as charity care, these amounts have been excluded from what is reported as patient service 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. MHS 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 $25,000 and $19,000 in 2016 and 2015, respectively. The estimated cost of services provided to patients covered under Medicaid in excess of payments received was approximately

$179,000 and $127,000 in 2016 and 2015, respectively. The cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(p) Other Operating Revenue

Other operating revenue includes revenue from cafeteria sales, retail pharmacy, laboratory revenue from community providers, medical office rental income, unrestricted contributions, grant revenue, and other miscellaneous revenue.

The Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, created an incentive program, beginning in 2011, to promote the "meaningful use" of Electronic Health Records (EHR). Meaningful use revenues are recognized as grant revenue; when there is reasonable assurance that the grant will be received and that the organization will comply with the conditions attached to the grant. During 2016 and 2015, meaningful use revenues were $3,315 and $3,310, respectively, and were recognized in other operating revenue. The amounts recognized are based on management's best estimate and are subject to audit and potential retrospective adjustments.

(q) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses, primarily include changes in accrued pension liability and net assets released from restrictions for capital acquisition.

(r) Federal Income Taxes

ASC Topic 740-10, *Income Taxes*, clarifies the accounting for uncertainty in income taxes recognized in MHS' consolidated financial statements. ASC Topic 740-10 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, ASC Topic 740-10 provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition. ASC Topic 740-10, relating to accounting for uncertain tax positions, did not have a significant impact on the consolidated financial statements of MHS. Other than Medis, Inc., 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.

(s) Reclassifications

Certain prior year amounts have been reclassified to conform to current year presentation.

(t) Recently Issued Accounting Standards

In May 2014, FASB issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers* (Topic 606), to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. MHS is currently evaluating the impact of ASU 2014-09, including the methods of implementation, which is effective for the fiscal year beginning January 1, 2018.

In May 2015, FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820) – Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value per share, or its equivalent, (NAV) using the practical expedient in the FASB's fair value measurement guidance. MHS has adopted the provisions of this standard effective fiscal year beginning January 1, 2016 with retrospective application.

In June of 2015, the FASB issued ASU 2015-10, *Technical Corrections and Improvements*. On adoption of ASU 2015-10, MHS determined that certain investments initially valued using net asset value as a practical expedient actually met the criteria for readily determinable fair value measurement. This presentation has been retrospectively applied.

In February 2016, FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset 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 is currently evaluating the impact of ASU 2016-02, which is effective for the fiscal year beginning January 1, 2019 with retrospective application to the earliest presented period.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, to reduce the diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects; (A) reduces the number of net asset classes presented from three to two: *with donor restrictions* and *without donor restrictions*; (B) requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. MHS is currently evaluating the impact of ASU 2016-14.

(Dollars in thousands)

(2) Net Patient Service Revenue

MHS has agreements with third-party payors that provide for payments to MHS at amounts different from its established rates. A summary of the payment arrangements with major third-party payors 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.

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.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The basis for payment to MHS under the third-party governmental and private payor agreements includes prospectively determined rates per discharge, discounts from established charges, and per diems. MHS evaluates collectability of revenue based on major payor groupings and uses historical experience to make estimates as required regarding expected levels of collection based on contractual rates with third-party payors.

Net patient service revenue for the years ended December 31, 2016 and 2015 is as follows:

		2016	2015
Gross patient service charges	$	6,694,298	6,541,439
Contractual discounts		(4,694,278)	(4,545,236)
Charity care (gross)		(101,916)	(82,427)
Provision for bad debts (gross)		(40,836)	(44,194)
Net patient service revenue	$	1,857,268	1,869,582

(Dollars in thousands)

For receivables associated with self-pay patients (including those with no insurance and those who are paying deductibles or copayments), MHS records a provision for bad debts in the period of service on the basis of past experience, which indicates that many patients are unresponsive or are otherwise unwilling to pay the portion of their bill for which they are financially responsible. For those self-pay patients not meeting the criteria for MHS' charity care policy, MHS has recorded an allowance for doubtful accounts by estimating amounts of outstanding accounts receivable that may become uncollectible based primarily on historical experience. Patients having no insurance were also given a self-pay discount that is reflected as part of contractual discounts in the figures above. MHS information systems configuration classifies accounts receivable in groupings based on who the current balance is expected to be paid by. For example, as amounts are paid by commercial insurance carriers and remaining balances become due from patients to satisfy co-payments or deductibles, those balances are reclassified within the accounts receivable groupings as self-pay after insurance. This grouping of accounts receivable is then evaluated based on historical write-off rates, including age of accounts, and estimates are made regarding expected collectibility of these balances. Less than 1% of patient service revenue (net of contractual allowances and discounts) in 2016 and 2015 was derived from patients without insurance, while all other revenue is derived from patients with governmental or commercial insurance coverage. A portion of third-party receivables also have an associated allowance for uncollectibility as a portion of these balances, based on historical experience, are also periodically found to be uncollectible. Amounts are charged against the allowance for doubtful accounts after reasonable collection efforts have been exhausted. The following reflects the estimates made and changes affecting those estimates for the years ended December 31, 2016 and 2015:

		2016	2015
Change in allowance for doubtful accounts:			
Allowance for doubtful accounts at beginning of year	$	43,277	58,582
Write-offs of accounts deemed uncollectible		(50,182)	(59,499)
Provision for bad debts		40,836	44,194
Allowance for doubtful accounts at end of year	$	33,931	43,277

(Dollars in thousands)

(3) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2016 and 2015 was as follows:

	2016	2015
Medicare	31%	30%
Medicaid	25	26
Regence	7	7
Other commercial insurance	30	29
Self-pay	7	8
	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 identical 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 has the ability to access at the measurement date. Level 1 securities generally include investments in marketable equity securities and mutual funds.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable 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 2 securities also include commingled trusts and limited liability partnerships that have a readily determinable fair value.
- Level 3 inputs are unobservable 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 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 exit 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 market value, NAV is used as a practical expedient to approximate fair market 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, 2016 and 2015:

		Fair value measurements at reporting date using		
	December 31, 2016	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 – equity	$ 409,662	409,662	—	—
Equity securities:				
U.S. large cap	115,226	115,226	—	—
U.S. small cap	61,386	61,386	—	—
Fixed income securities:				
Mutual funds – fixed income	238,824	238,824	—	—
U.S. government obligations	51,221	—	51,221	—
State government obligations	6,798	—	6,798	—
Asset-backed securities	10,532	—	10,532	—
Corporate debt securities:				
Domestic	50,972	—	50,972	—
Commingled trust fund – international equity	93,551	—	93,551	—

(Continued)

(Dollars in thousands)

	Fair value measurements at reporting date using			
	December 31, 2016	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Interest rate swaps	$ 454	—	454	—
Donor trusts	20,860	—	—	20,860
Bond funds held in trust	46,738	46,738	—	—
Total assets at fair value	1,106,224	871,836	213,528	20,860
Investment assets valued at NAV	358,119			
Total assets at fair value or NAV	$ 1,464,343			
Liabilities:				
Interest rate swaps	$ 56,265	—	56,265	—
Total liabilities	$ 56,265	—	56,265	—

	Fair value measurements at reporting date using			
	December 31, 2015	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 – equity	$ 453,864	453,864	—	—
Equity securities:				
U.S. large cap	114,983	114,983	—	—
U.S. small cap	50,291	50,291	—	—
Fixed income securities:				
Mutual funds – fixed income	420,497	420,497	—	—
U.S. government obligations	45,837	—	45,837	—
State government obligations	7,220	—	7,220	—
Asset-backed securities	13,666	—	13,666	—
Corporate debt securities:				
Domestic	46,829	—	46,829	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2015	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Commingled trust fund – international equity	$ 71,393	—	71,393	—
Interest rate swaps	1,335	—	1,335	—
Donor trusts	20,302	—	—	20,302
Bond funds held in trust	93,178	93,178	—	—
Total assets at fair value	1,339,395	1,132,813	186,280	20,302
Investments assets valued at NAV	234,155			
Total investments at fair value or NAV	$ 1,573,550			
Liabilities:				
Interest rate swaps	$ 59,029	—	59,029	—
Total liabilities	$ 59,029	—	59,029	—

The fair values of long-term debt are estimated to be $1,015,417 and $1,052,186 as of December 31, 2016 and 2015, respectively, and are estimated based on dealer quoted market prices and considered Level 2 liabilities. The carrying amounts are $992,098 and $1,008,266 as of December 31, 2016 and 2015, respectively.

There were no significant transfers into or out of Level 1, Level 2, or Level 3 financial instruments during the years ended December 31, 2016 and 2015.

(Dollars in thousands)

The following tables present 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, 2016 and 2015:

	Level 3 assets
	Donor trusts
Balance at December 31, 2014	$ 22,115
Net unrealized gains (losses)	(1,813)
Balance at December 31, 2015	20,302
Net unrealized gains (losses)	558
Balance at December 31, 2016	$ 20,860

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2016 and 2015:

	Net asset value December 31, 2016	Net asset value December 31, 2015	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 94,994	167,243	N/A	Quarterly	95 business days prior to valuation date
Absolute return funds	178,618	—	N/A	Monthly	5 business days prior to valuation date
Limited liability partnerships	57,103	37,905	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	27,404	29,007	2,268	N/A	N/A
Total investments valued at NAV	$ 358,119	234,155	2,268		

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

(Dollars in thousands)

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 it invests 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.

(5) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2016 and 2015 are as follows:

	December 31, 2016		
	Donor restricted assets	Investments	Total
Mutual funds – equity	$ 8,054	401,608	409,662
Equity securities	3,472	173,140	176,612
Fixed income securities	7,045	351,302	358,347
Hedge funds – private investment funds	289	14,398	14,687
Commingled trust fund – international equity	1,839	91,712	93,551
Limited liability partnerships – international equity	4,634	231,087	235,721
Limited partnerships – private equity	2,118	105,593	107,711
Donor trusts	20,860	—	20,860
Pledge receivables, net and other	18,392	—	18,392
Total	$ 66,703	1,368,840	1,435,543

(Dollars in thousands)

	December 31, 2015		
	Donor restricted assets	Investments	Total
Mutual funds – equity	$ 10,074	443,790	453,864
Equity securities	3,668	161,606	165,274
Fixed income securities	11,853	522,196	534,049
Hedge funds – private investment funds	1,883	82,937	84,820
Commingled trust fund – international equity	1,585	69,808	71,393
Limited liability partnerships – international equity	841	37,064	37,905
Limited partnerships – private equity	2,473	108,957	111,430
Donor trusts	20,302	—	20,302
Pledge receivables, net and other	20,657	—	20,657
Total	$ 73,336	1,426,358	1,499,694

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

Unrestricted investment income (loss) comprises the following for the years ended December 31, 2016 and 2015:

	2016	2015
Investment income (loss) :		
Interest and dividends	$ 23,187	30,519
Net realized (losses) gains	(21,702)	23,161
Net change in unrealized gains (losses)	76,030	(102,193)
Total investment income (loss)	$ 77,515	(48,513)

(Dollars in thousands)

(6) Property, Plant, and Equipment

A summary of property, plant, and equipment at December 31, 2016 and 2015 is as follows:

	2016	2015
Land and land improvements	$ 62,453	66,378
Buildings	1,611,664	1,543,351
Equipment	724,210	671,682
	2,398,327	2,281,411
Less accumulated depreciation	(1,162,386)	(1,054,915)
	1,235,941	1,226,496
Construction in progress	96,793	54,961
Property, plant, and equipment, net	$ 1,332,734	1,281,457

Depreciation expense charged to operations for the years ended December 31, 2016 and 2015 amounted to $110,315 and $107,266, respectively.

(7) Other Assets

Other assets are as follows at December 31, 2016 and 2015:

	2016	2015
Investment in joint ventures (note 8)	$ 20,504	16,294
Deferred compensation plan assets held in trust	37,908	33,564
Accrued pension asset (note 10)	9,765	—
Self-insured retention receivables, net of current portion (notes 11 and 12)	16,717	14,945
Interest rate swaps	454	1,335
Goodwill and other intangibles	32,807	8,718
Other	616	573
Other assets	$ 118,771	75,429

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 and are, therefore, classified as Level 1 securities.

(Dollars in thousands)

(8) Investment in Joint Ventures

In 2008, MHS formed the Carol Milgard Breast Center (CMBC) to offer an independent breast screening and diagnostic service for the benefit of the community. MHS is a 50% owner in this joint venture and accounts for it under the equity method. MHS' investment in CMBC was $4,036 and $5,882 as of December 31, 2016 and 2015, respectively, and is included in other assets in the accompanying consolidated balance sheets.

In December 2008, MHS invested $8,350 in Medical Imaging Northwest, LLP (MINW) to operate an outpatient diagnostic imagining center. MHS is a 50% owner in this joint venture and accounts for it under the equity method. MHS' investment in MINW was $7,345 and $7,439 as of December 31, 2016 and 2015, respectively. The investment in MINW is included in other assets in the accompanying consolidated balance sheets.

MHS also maintains ownership, at varying levels, in certain other joint ventures relating to imaging, medical office buildings, and other healthcare focused activities, which are included in other assets in the accompanying consolidated balance sheets.

(9) Accrued Pension, Professional Liability, and Other

Accrued pension, professional liability, and other are as follows at December 31, 2016 and 2015:

		2016	2015
Accrued pension liability (note 10)	$	—	9,247
Professional liability, net of current portion (note 11)		44,228	36,237
Deferred compensation liability (note 10)		37,908	33,564
Workers' compensation liability, net of current portion (note 12)		13,547	16,097
Other		5,830	6,013
Accrued pension, professional liability, and other	$	101,513	101,158

(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.

In November 2012, the Board of Directors of MHS approved an amendment to freeze the Plan as of December 31, 2015 for substantially all eligible employees. In conjunction with the freeze on December 31, 2015, participants no longer accrue service credits under the Plan except for certain groups that continued to accrue service credits through 2016. During 2015, MHS incurred a curtailment gain, which resulted in a decrease of the projected benefit obligation of $19,531, which is recorded in

(Dollars in thousands)

the changes in accrued pension liability in the accompanying consolidated statements of operations and changes in net assets.

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, 2016 and 2015:

		2016	2015
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	592,406	662,410
Service cost		4,642	17,255
Interest cost		27,240	27,138
Actuarial loss (gain)		8,738	(81,086)
Benefits paid		(32,419)	(33,311)
Projected benefit obligations at end of year	$	600,607	592,406
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	583,159	601,787
Actual gain (loss) on plan assets		34,883	(13,417)
Employer contribution		24,750	28,100
Benefits paid		(32,419)	(33,311)
Fair value of plan assets at end of year	$	610,373	583,159
Accrued benefit cost:			
Funded status	$	9,765	(9,247)
Amount recognized in consolidated balance sheets consist of:			
Asset (liability) for pension benefits		9,765	(9,247)
Amount recognized in unrestricted net assets:			
Net loss		143,477	131,004

	2016	2015
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	4.50%	4.70%
Expected return on plan assets	7.00	7.00
Rate of compensation increase	N/A	N/A

(Continued)

(Dollars in thousands)

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. A consulting actuary reviews the assumptions annually for reasonableness.

The components of net periodic benefit cost, which are included in employee benefits in the consolidated statements of operations and changes in net assets, are as follows during the years ended December 31, 2016 and 2015:

		2016	2015
Components of net periodic benefit cost:			
Service cost	$	4,642	17,255
Interest cost		27,240	27,138
Expected return on plan assets		(43,099)	(40,877)
Amortization of net actuarial loss		4,481	12,218
	$	(6,736)	15,734

The accumulated benefit obligation for the Plans was $600,607 and $592,406 at December 31, 2016 and 2015, respectively.

(i) Cash Flows – Contributions

MHS does not currently expect to make a contribution to the Plan in 2017.

(ii) Estimated Future Benefit Payments

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

		Pension benefits
2017	$	33,128
2018		35,475
2019		34,871
2020		36,980
2021		36,846
2022–2026		190,003

(Dollars in thousands)

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

		Fair value measurements at reporting date using			
		December 31, 2016	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	$	11,920	11,920	—	—
Trading securities:					
Mutual funds – equity		123,489	123,489	—	—
Equity securities:					
U.S. large cap		35,471	35,471	—	—
U.S. small cap		22,724	22,724	—	—
Fixed income securities:					
Mutual funds – fixed income		189,397	189,397	—	—
U.S. government obligations		131,577	—	131,577	—
State government obligations		451	—	451	—
Asset-backed securities		4,566	—	4,566	—
Corporate debt securities:					
Domestic		5,282	—	5,282	—
Commingled trust fund – international equity		27,324	—	27,324	—
		552,201	383,001	169,200	—
Broker receivables		7,094			
Broker payables		(55,806)			
Total assets at fair value		503,489			
Investments valued at NAV		106,884			
Total assets at fair value or NAV	$	610,373			

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2015	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	$ 4,377	4,377	—	—
Trading securities:				
Mutual funds – equity	133,702	133,702	—	—
Equity securities:				
U.S. large cap	41,809	41,809	—	—
U.S. small cap	24,344	24,344	—	—
Fixed income securities:				
U.S. government obligations	110,655	—	110,655	—
Domestic	147,110	—	147,110	—
Commingled trust fund – international equity	26,489	—	26,489	—
	488,486	204,232	284,254	—
Broker receivables	376			
Broker payables	(13,272)			
Total assets at fair value	475,590			
Investments valued at net asset value	107,569			
Total assets at fair value or NAV	$ 583,159			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2016 and 2015.

(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, 2016 and 2015:

	Fair value at December 31, 2016	Fair value at December 31, 2015	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 37,013	34,489	N/A	Quarterly	45 days
Hedge funds	33,906	58,837	N/A	Quarterly	95 days prior to valuation date
Absolute return funds	22,702	—	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	13,263	14,243	1,090	N/A	N/A
Total investments valued at NAV	$ 106,884	107,569	1,090		

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.

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.

(Dollars in thousands)

(iii) Plan Assets

The defined benefit plan weighted average asset allocations at December 31, 2016 and 2015 by asset category are as follows:

	2016	2015
Asset category:		
Domestic equities	16 %	18 %
International equities	10	9
Emerging markets	4	4
Fixed income securities	48	42
Alternative investments	8	14
Real estate	6	4
Global asset allocation	8	9
	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:

	2016	2015
Asset category:		
Domestic equities	13 %	16 %
International equities	9	9
Emerging markets	3	5
Fixed income securities	50	40
Alternative investments	11	15
Real estate	5	5
Global asset allocation	9	10
	100 %	100 %

(v) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. 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 international equities is to provide higher expected 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 Plans' 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 through the use of 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.

Alternatives and Other

The strategic role of alternative investments is for diversification relative to equities and fixed-income investments, to add absolute return through the use of 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.

The strategic role of real estate is to diversify the Plans' 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.

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 Good Samaritan (GS) 401(k) Plan. During 2012, the GS 401(k) Plan was amended whereby no further contributions would be allowed into this plan effective December 31, 2015 and all participants would immediately become eligible to participate in the MHS 403(b) Employee Savings Plan and the RAP Plan. The MHS 403(b) Employee Savings Plan is 100% funded by employee contributions and the RAP Plan 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 2016 and 2015 were approximately $32,478 and $27,620, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to defined benefit and the defined contribution plans described above, deferred compensation arrangements are maintained by MHS for the benefit of eligible employees. Substantially all amounts deferred under these arrangements are held by a trustee 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, 2016 and 2015, 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, 2016 and 2015, the net professional liability was estimated at $35,859 and $33,345, respectively.

At December 31, 2016 and 2015, the estimated gross professional liability (including current and long-term portions) was $54,104 and $48,740, respectively, and is recorded in accounts payable and accrued expenses and accrued pension, professional liability, and other. MHS has recorded a receivable for amounts to be received from excess insurance carriers (including current and long-term portions) of $18,245 and $15,395 as of December 31, 2016 and 2015, respectively, which are included in other current assets, net and 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 its actuarial estimate of future claims payments. At December 31, 2016 and 2015, the estimated net liability based on future claims cost totaled $15,990 and $16,891, respectively. The gross liabilities (including both current and long-term portions) total $19,465 and $21,953 as of December 31, 2016 and 2015, respectively. The long-term amounts are included in accrued pension, professional liability, and other 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. MHS has

(Dollars in thousands)

recorded a receivable for amounts to be received from excess insurance carriers of $3,475 and $5,062 as of December 31, 2016 and 2015, respectively, which are 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 2016 and 2015 was $8,323 and $9,377, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(13) Interest Rate Swaps

MHS has several interest rate swap instruments that are used as part of management's strategy to reduce overall interest costs. As of December 31, 2016 and 2015, none of the interest rate swaps qualified for hedge accounting treatment and therefore none were designated as such. The changes in fair value of these interest rate swaps for the years ended December 31, 2016 and 2015 of $1,883 and $356 in fair value gains, respectively, are included in loss and other expense on interest rate swaps in other income (loss) in the consolidated statements of operations and changes in net assets. Also included in the loss and other expense on interest rate swaps is the net cash settlement amounts associated with the swaps of $5,732 and $6,303, respectively, for the years ended December 31, 2016 and 2015. As of December 31, 2016 and 2015, the total notional amounts of MHS' outstanding interest rate swap agreements were $406,230 and $415,385, respectively.

(14) Long-Term Debt

Long-term debt consists of the following at December 31, 2016 and 2015:

		2016	2015
WHCFA Revenue bonds, 2015 Series A and B	$	367,820	371,330
WHCFA Revenue bonds, 2012 Series A and B		140,000	140,000
WHCFA Revenue bonds, 2010 Series A		50,430	57,505
WHCFA Revenue bonds, 2009 Series A and B		98,130	98,130
WHCFA Revenue bonds, 2007 Series A, B, C, and D		297,725	301,670
Other		177	227
		954,282	968,862
Adjusted for:			
Current portion		(15,178)	(14,580)
Bond premiums, discounts, and issuance costs		37,816	39,404
Long-term debt, net of current portion	$	976,920	993,686

(Continued)

(a) Washington Health Care Facility Authority (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 $3,510 in 2016 to $24,085 in 2034.

The 2015 Series A and B bonds were used in part for the advance refunding of 2008 Series A, B, and C bonds and 2004 Series A, B, and C bonds, which resulted in a loss in 2015 of $51,142 as reflected on the consolidated statement of operations and changes in net assets.

(b) WHCFA Revenue Bonds 2012 Series A and B

In November 2012, MHS issued $60,000 of 2012 Series A bonds. The 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 $0 in 2016 to $22,085 in 2045.

Also in November 2012, MHS entered into an $80,000 variable rate private placement agreement (Series B) with Wells Fargo Municipal Capital Strategies, LLC. Annual principal payments range from $0 in 2016 to $30,000 in 2047. The interest rate on the Series B variable rate bonds are reset monthly.

(c) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. The 2010 Series A bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.25%. Annual principal payments range from $7,075 in 2016 to $9,500 in 2022.

(d) 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. The 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 $0 in 2016 to $38,890 in 2044.

(e) WHCFA Revenue Bonds 2007 Series A, B, C, and D

MHS issued $316,000 2007 Series A, B, C, and D bonds in February 2007. The 2007 Series A and B bonds were issued as auction rate securities for $78,725 each and were converted in May 2008 to fixed rated bonds that bear interest ranging from 4.0% to 5.5%. 2007 Series C bonds were issued as variable rate demand bonds for $52,195 and bear interest in the weekly rate mode ranging from 0.02% to 0.83% in 2016. The 2007 Series D bonds were issued as variable rate demand bonds for $105,635 and bear interest in the daily rate mode ranging from 0.01% to 0.74% in 2016. Annual principal payments, including all four series of the 2007 bonds, range from $3,945 in 2016 to $30,225 in 2041.

The 2007 Series C and D variable rate demand bonds (2007C and D VRDBs) include portions that are remarketed both daily and weekly. If any of the remarketings were to fail, the 2007C and D VRDBs would be purchased under a letter of credit facility (LOC) that was entered into in October 2011 and will expire January 2020. The LOC states that any of the 2007C and D VRDBs purchased and not

(Dollars in thousands)

remarketed will be repaid through semi-annual principal payments for five years starting the first of the month following 367 days after the purchase.

The applicable bond indenture agreements require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a debt service coverage ratio of 1.1 to 1.0, and a liquidity covenant of at least 90 days of cash and investments. MHS management believes that MHS is in compliance with these debt covenants at December 31, 2016 and 2015.

Principal maturities on long-term debt are as follows:

Year ending December 31:	
2017	$ 15,178
2018	15,776
2019	16,480
2020	17,178
2021	17,970
Thereafter	871,700
	$ 954,282

A summary of interest costs is as follows during the years ended December 31, 2016 and 2015:

	2016	2015
Interest cost:		
Charged to operations	$ 36,847	36,547
Amortization of bond premiums, discounts, and issuance costs	(1,588)	(1,008)
Capitalized	803	415
	$ 36,062	35,954

(15) Commitments and Contingencies

(a) Operating Leases

MHS leases various equipment and facilities under operating leases expiring at various dates through September 2030. Total rental expense in years 2016 and 2015 for all operating leases was approximately $22,640 and $20,877, respectively.

(Dollars in thousands)

The following is a schedule by year of future minimum lease payments under operating leases at December 31, 2016, which have initial or remaining lease terms in excess of one year:

2017	$	17,922
2018		17,047
2019		15,262
2020		13,429
2021		11,216
Thereafter		23,357
	$	98,233

(b) Collective Bargaining Agreements

Approximately 44% of MHS employees were covered under collective bargaining agreements as of December 31, 2016. 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 January 2020.

(16) Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31, 2016 and 2015:

		2016	2015
Healthcare services	$	23,919	18,281
Endowment fund		67	56
Purchase of equipment		9,115	11,540
Indigent care		797	967
Health education		767	852
Total temporarily restricted net assets	$	34,665	31,696

(17) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both donor-restricted endowment funds and unrestricted funds designated 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:

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment net assets, December 31, 2015	$ 2,933	56	37,190	40,179
Investment return (loss):				
Investment income	41	182	343	566
Net depreciation – realized and unrealized	(35)	(40)	(498)	(573)
Total investment return (loss)	6	142	(155)	(7)
Contributions	—	—	2,204	2,204
Appropriation of endowment assets for expenditure	(102)	(131)	(1,231)	(1,464)
Endowment net assets, December 31, 2016	$ 2,837	67	38,008	40,912

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment net assets, December 31, 2014	$ 2,861	53	34,860	37,774
Investment return:				
Investment income	71	298	577	946
Net appreciation – realized and unrealized	32	23	374	429
Total investment return	103	321	951	1,375
Contributions	—	—	2,472	2,472
Appropriation of endowment assets for expenditure	(31)	(318)	(1,093)	(1,442)
Endowment net assets, December 31, 2015	$ 2,933	56	37,190	40,179

(Continued)

Perpetual trusts that are held and managed by third party trustees are recorded as permanently restricted net assets on the consolidated balance sheets; however, they are not included as permanently restricted endowment net assets in the above presentation. Those perpetual trusts totaled $18,699 and $17,858, respectively, as of December 31, 2016 and 2015. Also excluded from the presentation of permanently restricted net assets are pledge receivables and other totaling $1,754 and $2,162, respectively, as of December 31, 2016 and 2015.

(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 unrestricted net assets. There were no funds with deficiencies in 2016 or 2015.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The majority of the endowment assets are invested in MHS' pooled investments, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all of the board-designated endowment funds. MHS has adopted an investment policy for its pooled investments that attempt to provide income to support its operations and a stream of funding to programs supported by its endowments 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 outside of MHS' pooled investments. Those outside 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.

(Dollars in thousands)

(18) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Expenses related to providing these services are as follows for the years ended December 31, 2016 and 2015:

	2016	2015
Healthcare services	$ 1,248,191	1,191,585
General and administrative	568,131	525,324
	$ 1,816,322	1,716,909

(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 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

MHS has evaluated the subsequent events from the balance sheet date through March 22, 2017, the date at which the consolidated financial statements were issued, and determined there are no other items to disclose.

Exhibit 17B.

MultiCare Health System Audited Financial Statements - 2017

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2017 and 2016

(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, 2017 and 2016, 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 Consolidated 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 audits 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, 2017 and 2016, 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

March 26, 2018

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2017 and 2016

(In thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	368,028	412,077
Accounts receivable, less allowance for doubtful accounts of $41,921 and $33,931 in 2017 and 2016, respectively		358,514	267,858
Supplies inventory		36,432	22,008
Other current assets, net		65,603	37,228
Total current assets		828,577	739,171
Donor restricted assets held for long-term purposes		78,202	66,703
Investments		1,622,901	1,368,840
Bond funds held in trust		—	46,738
Property, plant, and equipment, net		1,680,422	1,332,734
Other assets, net		332,770	118,771
Total assets	$	4,542,872	3,672,957
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	199,363	130,278
Accrued compensation and related liabilities		213,384	154,636
Accrued interest payable		12,653	13,565
Current portion of long-term debt		19,017	15,178
Total current liabilities		444,417	313,657
Accrued pension, professional liability, and other		141,165	101,513
Interest rate swap liabilities		62,484	56,265
Long-term debt, net of current portion		1,322,688	976,920
Total liabilities		1,970,754	1,448,355
Commitments and contingencies (note 14)			
Net assets:			
Unrestricted		2,455,095	2,131,476
Temporarily restricted		52,748	34,665
Permanently restricted		64,275	58,461
Total net assets		2,572,118	2,224,602
Total liabilities and net assets	$	4,542,872	3,672,957

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2017 and 2016

(In thousands)

	2017	2016
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 2,341,695	1,898,104
Provision for bad debts	(36,390)	(40,836)
Net patient service revenue less provision for bad debts	2,305,305	1,857,268
Other operating revenue	105,997	65,821
Net assets released from restrictions for operations	4,817	3,964
Total unrestricted revenues, gains, and other support	2,416,119	1,927,053
Expenses:		
Salaries and wages	1,148,499	913,142
Employees benefits	191,150	148,037
Supplies	349,568	259,246
Purchased services	198,386	138,660
Depreciation and amortization	130,725	110,481
Interest	36,732	35,259
Other	273,971	211,497
Total expenses	2,329,031	1,816,322
Excess of revenues over expenses from operations	87,088	110,731
Other income:		
Investment income	210,963	77,515
Loss and other expense on interest rate swaps, net	(11,709)	(3,849)
Other income, net	8,589	—
Total other income, net	207,843	73,666
Excess of revenues over expenses	294,931	184,397
Other changes in unrestricted net assets:		
Changes in accrued pension liability	26,191	(12,473)
Net assets released from restriction – capital acquisitions	2,497	4,508
Increase in unrestricted net assets	323,619	176,432
Changes in temporarily restricted net assets:		
Contributions and other	25,109	11,299
Income on investments	288	142
Net assets released from restriction – capital acquisitions	(2,497)	(4,508)
Net assets released from restrictions for operations and other	(4,817)	(3,964)
Increase in temporarily restricted net assets	18,083	2,969
Changes in permanently restricted net assets:		
Contributions and other	2,944	1,792
Income on investments	1,032	690
Increase (decrease) in assets held in trust by others	1,838	(1,231)
Increase in permanently restricted net assets	5,814	1,251
Increase in net assets	347,516	180,652
Net assets, beginning of year	2,224,602	2,043,950
Net assets, end of year	$ 2,572,118	2,224,602

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2017 and 2016

(In thousands)

	2017	2016
Cash flows from operating activities:		
Increase in net assets	$ 347,516	180,652
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	130,725	110,481
Amortization of bond premiums, discounts, and issuance costs	(1,529)	(1,588)
Net realized and recognized gains on investments	(182,946)	(54,328)
Change in fair value of interest rate swap	6,160	(1,883)
Provision for bad debts	36,390	40,836
(Gain) loss on disposal of assets, net	(703)	201
Loss on bond refinancing	9,576	—
Undistributed losses on joint ventures	1,515	1,797
Restricted contributions for long-term purposes	(5,555)	(1,820)
Assumption of operating assets and liabilities	(21,719)	—
Changes in operating assets and liabilities:		
Accounts receivable	(55,226)	(43,606)
Supplies inventory and other current assets	(19,767)	(8,777)
Other assets, net	(38,323)	(24,182)
Accounts payable and accrued expenses and accrued interest payable	54,529	11,835
Accrued compensation and related liabilities	27,673	23,143
Accrued pension, professional liability, and other	21,795	(4,153)
Net cash provided by operating activities	310,111	228,608
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(178,727)	(162,917)
Purchase of acquired assets	(429,342)	—
Proceeds from disposal of property, plant, and equipment	704	4,825
Contributions to joint ventures, net	(1,372)	(6,006)
Net (purchases) sales of trading securities	(66,083)	116,503
Net decrease in bond funds held in trust	46,738	46,440
Change in donor trusts	(17,716)	(9,782)
Net cash used in investing activities	(645,798)	(10,937)
Cash flows from financing activities:		
Repayment of long-term debt	(397,373)	(14,581)
Proceeds from bond issuance	683,456	—
Restricted contributions for long-term purposes	5,555	1,820
Net cash provided by (used in) financing activities	291,638	(12,761)
Net (decrease) increase in cash and cash equivalents	(44,049)	204,910
Cash and cash equivalents, beginning of year	412,077	207,167
Cash and cash equivalents, end of year	$ 368,028	412,077
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 37,644	35,425
Noncash activities:		
Increase in deferred compensation plans	17,134	4,344
(Decrease) increase in accounts payable for purchases of property, plant, and equipment	(360)	3,701

See accompanying notes to consolidated financial statements.

(Dollars in thousands)

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

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, 2017, MHS is licensed to operate 1,978 inpatient hospital beds, including 120 beds associated with a joint venture psychiatric hospital that is under construction in Tacoma, Washington and 58 beds associated with the Covington Hospital that is under construction and expected to open in 2018. MHS currently operates seven acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Deaconess Hospital and Valley Hospital) and one behavioral health hospital (Navos).

The acquisition of Deaconess and Valley Hospitals (along with Rockwood Clinic and collectively referred to as the Inland Northwest Region), based in Spokane, Washington, was effective July 1, 2017. The acquisition of the Inland Northwest Region facilities from Community Health Systems (CHS) was valued at approximately $429,342. This acquisition added 511 licensed inpatient hospital beds to MHS. The assets and liabilities purchased included land, buildings, equipment, accounts receivable, inventories, intangibles and other assets offset by accounts payable and accrued compensation and were recorded at their estimated fair values as determined based on standard asset appraisal techniques. MHS hired substantially all of the employees previously employed by CHS in the Inland Northwest Region. The following table summarizes the consideration paid, including associated taxes, for the Inland Northwest Region facilities, along with estimated fair values of assets and liabilities acquired as of the acquisition date:

Recognized amounts of identifiable assets and liabilities acquired:		
Land, buildings and equipment, including taxes thereon	$	249,875
Patient accounts receivable, less allowances for doubtful accounts of $6,568		62,511
Supplies inventory		15,096
Other current assets		6,896
Intangible assets		18,100
Accounts payable and accrued compensation		(37,822)
Total identifiable assets and liabilities acquired		314,656
Recognized amount of goodwill assumed:		
Goodwill		114,686
Total consideration paid in cash	$	429,342

As part of the asset purchase agreement, the value of certain net working capital balances are to be settled with CHS in 2018 and the amounts disclosed above may change accordingly. None of the potential changes will impact revenues or expenses of MHS, but instead will potentially change the total amount of cash paid and certain values of specific assets, liabilities and goodwill, as shown above.

(Dollars in thousands)

Navos, a major behavioral health services provider in Washington state, affiliated with MHS effective May 1, 2017. No consideration was exchanged and MHS became the sole corporate member of Navos. The assets and liabilities obtained through the affiliation included land, buildings, equipment, accounts receivable and notes receivable offset by accounts payable, accrued compensation and long-term debt and were recorded at their estimated fair values as of the date of affiliation as determined based on standard asset appraisal techniques. The following table summarizes the estimated fair values of assets and liabilities assumed as of the affiliation date:

Recognized amounts of identifiable assets and liabilities assumed:		
Land, buildings and equipment	$	50,000
Patient accounts receivable, less allowances for doubtful accounts of $5,994		9,309
Cash		1,826
Other current assets		1,698
Long-term assets		20,983
Intangible assets		3,000
Accounts payable and accrued compensation		(7,309)
Long-term debt		(55,962)
Total net assets assumed	$	23,545

The unrestricted net assets assumed resulted in an inherent contribution of $18,165 and is included in other income, net in the consolidated statement of operations and changes in net assets for the year ended December 31, 2017. The remaining $5,380 contribution was restricted and is included in the restricted net assets in the consolidated statement of operations and changes in net assets for the year ended December 31, 2017.

MHS also operates eight outpatient surgical sites, two 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 the facilities and services described above as well as those of a wholly-owned subsidiary (Medis, Inc.), a wholly-owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly-owned accountable care organization (MultiCare Connected Care), and four fund-raising foundations (Mary Bridge Children's Foundation, MultiCare Health Foundation, Good Samaritan Foundation and MultiCare South King Health Foundation).

(a) Principles of Consolidation

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

(b) 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.

(c) Cash and Cash Equivalents

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

(d) Accounts Receivable

Accounts receivable are primarily comprised of amounts due for healthcare services from patients and third-party payors, and are recorded net of allowances for contractual adjustments and bad debts.

(e) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is based on average cost, 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.

(f) Donor Restricted Assets

The majority of the donor restricted assets are invested in MHS' pooled investments and are stated at fair value or estimated fair value. Donor restricted assets that are held outside MHS' pooled investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in cash, 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 available are carried at values provided by the respective investment managers or trustees, which management believes approximate fair value.

Charitable gift annuities, which are included in donor restricted assets, totaled $2,490 and $2,385 at December 31, 2017 and 2016, respectively. MHS has recorded a corresponding payable of $1,306 and $1,352 at December 31, 2017 and 2016, 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 the accrued pension, professional liability, and other 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.

(g) Investments

MHS accounts for its investment portfolio as a trading portfolio. Investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are stated 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.

(h) Bond Funds Held in Trust

Bond funds held in trust include assets held by trustees under bond indenture agreements, which are primarily restricted to fund certain capital projects. These assets are carried at fair value.

(i) Property, Plant, and Equipment

Property, plant, and equipment acquisitions 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 or losses upon sale or retirement of property, plant, and equipment are included in other operating revenue. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

MHS assesses potential impairments to its long-lived assets when there is evidence that events or changes in circumstances have made recovery of the carrying value of the assets unlikely. An impairment loss is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2017 and 2016, there were no impairment charges.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, 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 restricted support. 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) Goodwill and Intangible Assets

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. Indefinite-lived intangible assets are assets that are not amortized because there is no foreseeable limit to cash flows generated from them.

If it is more likely than not that the asset is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment expense. Goodwill and indefinite-lived assets are evaluated at least annually for impairment. There were no impairment losses recognized during the years ended December 31, 2017 and 2016.

(k) 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 $6,462 and $4,825 as of December 31, 2017 and 2016, 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. Net patient service revenue increased by $4,081 and $8,335 for 2017 and 2016, respectively, to reflect changes in the estimated Medicare settlements for prior years.

(l) Interest Rate Swaps

MHS records all interest rate swaps on the consolidated balance sheets at fair value. The accounting for changes in the fair value of these instruments depends on whether those had been designated and qualify as part of a hedging relationship. As of December 31, 2017 and 2016, none of MHS' interest rate swaps have been designated as cash flow hedges and the changes in fair value are recognized within loss and other expense on interest rate swaps in the accompanying consolidated statements of operations and changes in net assets. Additional disclosure is provided in footnote 12.

(m) Temporarily and Permanently Restricted Net Assets

Gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. Temporarily restricted net assets are those whose use by MHS has been limited by donors to a specific time period or purpose. Permanently restricted net assets 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, these amounts are released from restrictions for operations and are included in unrestricted revenues, gains, and other support. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are reflected in unrestricted net assets 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

(Dollars in thousands)

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. As of December 31, 2017 and 2016, MHS has recorded $7,464 and $9,215, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2017, $4,189 of pledges are due in one year or less and $3,275 in two to five years.

(n) Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The basis for payment to MHS under the third-party governmental and private payor agreements includes prospectively determined rates per discharge, discounts from established charges, and per diems.

Net patient service revenues were billed to the following payors for the years ended December 31, 2017 and 2016:

	2017	2016
Payors:		
Medicare and Medicaid	42%	41%
Regence	13	14
Premera	13	12
First Choice	5	4
Other	27	29
	100%	100%

(o) 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 net patient service revenue of $61,409 and $58,184 for 2017 and 2016, respectively, and incurred assessments of $47,676 and $38,990 for 2017 and 2016, 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 $9,715 and $7,636 associated with this program as of December 31, 2017 and 2016, respectively, which are included with accounts receivable on the consolidated balance sheets.

(p) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated healthcare services to the communities it serves within the purview of its mission. Patients who meet the criteria of its charity care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Because MHS does not pursue collection of amounts determined to qualify as charity care, these amounts have reduced

what is reported as patient service 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. For the year ended December 31, 2017, the Inland Northwest Region facilities offered full charity care to patients up to 150% of the federal poverty guidelines and partial charity care based on a sliding scale for patients up to 300% of the federal guidelines. Effective January 1, 2018, the Inland Northwest Region facilities adopted the MHS policy and are now consistent with the rest of MHS. The estimated cost of charity care provided was approximately $32,000 and $25,000 in 2017 and 2016, respectively. The estimated cost of services provided to patients covered under Medicaid in excess of payments received was approximately $227,000 and $179,000 in 2017 and 2016, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(q) Other Operating Revenue

Other operating revenue includes revenue from cafeteria sales, retail pharmacy, laboratory revenue from community providers, medical office rental income, unrestricted contributions, grant revenue, contracted behavioral healthcare revenue and other miscellaneous revenue.

(r) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses, primarily include changes in accrued pension liability and net assets released from restrictions for capital acquisition.

(s) Federal Income Taxes

ASC Topic 740-10, *Income Taxes*, clarifies the accounting for uncertainty in income taxes recognized in MHS' consolidated financial statements. ASC Topic 740-10 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, ASC Topic 740-10 provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition. Adoption of ASC Topic 740-10 did not have a significant impact on the consolidated financial statements of MHS. Other than Medis, Inc. and Rockwood Clinic, which are taxable corporations, 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.

(t) Reclassifications

Certain prior year amounts contained in note 4 have been reclassified to conform to current year presentation.

(u) New and Pending Accounting Standards

In May 2014, FASB issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The new standard is effective for MHS on January 1, 2018. As part of adopting the standard, MHS will identify revenue streams of like contracts to allow for ease of implementation. MHS will use primarily a portfolio approach to apply the new model to classes of customers with similar characteristics. Management expects the impact of the new pronouncement to be primarily related to disclosures. The new accounting for the estimate of variable consideration will not result in materially different results compared to current practice. MHS will include new disclosures in 2018 in accordance with Topic 606.

In January 2016, the 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 early adopted the option to remove the fair value of debt disclosure as of December 31, 2017 and 2016 as permitted under the provisions of the ASU. When the remaining provisions of this ASU are adopted, a cumulative-effect adjustment to the consolidated balance sheet as of the beginning of the fiscal year of adoption is required. MHS is still evaluating the effects the remaining portions of this standard will have on its consolidated financial statements and accompanying disclosures.

In February 2016, FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right-of-use asset 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 is currently evaluating the impact of ASU 2016-02, which is effective for the fiscal year beginning January 1, 2019, with retrospective application to the earliest presented period.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, to reduce the diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects: (A) reduces the number of net asset classes presented from three to two: *with donor restrictions* and *without donor restrictions*; (B) requires all NFP entities to present expenses by their functional and their natural classifications in one location in the financial statements; (C) requires NFP entities to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) retains the

(Dollars in thousands)

options to present operating cash flows in the statement of cash flows using either the direct or indirect method. MHS is currently evaluating the impact of ASU 2016-14, which is effective for the fiscal year beginning January 1, 2018, and requires retrospective application of its provisions upon adoption.

(2) Net Patient Service Revenue

MHS has agreements with third-party payors that provide for payments to MHS at amounts different from its established rates. 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.

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.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The basis for payment to MHS under the third-party governmental and private payor agreements includes prospectively determined rates per discharge, discounts from established charges, and per diems. MHS evaluates collectability of revenue based on major payor groupings and uses historical experience to make estimates as required regarding expected levels of collection based on contractual rates with third-party payors.

Net patient service revenue for the years ended December 31, 2017 and 2016 is as follows:

		2017	2016
Gross patient service charges	$	8,530,562	6,694,298
Contractual allowances and discounts		(6,056,622)	(4,694,278)
Charity care allowances and discounts (gross)		(132,245)	(101,916)
Provision for bad debts (gross)		(36,390)	(40,836)
Net patient service revenue	$	2,305,305	1,857,268

(Continued)

(Dollars in thousands)

For receivables associated with self-pay patients (including those with no insurance and those who are paying deductibles or copayments), MHS records a provision for bad debts in the period of service on the basis of past experience, which indicates that many patients are unresponsive or are otherwise unwilling to pay the portion of their bill for which they are financially responsible. For those self-pay patients not meeting the criteria for MHS' charity care policy, MHS has recorded an allowance for doubtful accounts by estimating amounts of outstanding accounts receivable that may become uncollectible based primarily on historical experience. Patients having no insurance were also given a self-pay discount that is reflected as part of contractual discounts in the figures above. MHS information systems configuration classifies accounts receivable in groupings based on who the current balance is expected to be paid by. For example, as amounts are paid by commercial insurance carriers and remaining balances become due from patients to satisfy co-payments or deductibles, those balances are reclassified within the accounts receivable groupings as self-pay after insurance. This grouping of accounts receivable is then evaluated based on historical write-off rates, including age of accounts, and estimates are made regarding expected collectability of these balances. Less than 1% of patient service revenue (net of contractual allowances and discounts) in 2017 and 2016 was derived from patients without insurance, while all other revenue is derived from patients with governmental or commercial insurance coverage. A portion of third-party receivables also have an associated allowance for uncollectability as a portion of these balances, based on historical experience, are also periodically found to be uncollectible. Amounts are charged against the allowance for doubtful accounts after reasonable collection efforts have been exhausted. The following reflects the estimates made and changes affecting those estimates for the years ended December 31, 2017 and 2016:

		2017	2016
Change in allowance for doubtful accounts:			
Allowance for doubtful accounts at beginning of year	$	33,931	43,277
Write-offs of accounts deemed uncollectible		(28,400)	(50,182)
Provision for bad debts		36,390	40,836
Allowance for doubtful accounts at end of year	$	41,921	33,931

(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, 2017 and 2016 was as follows:

	2017	2016
Medicare	31%	31%
Medicaid	25	25
Regence	6	7
Other commercial insurance	31	30
Self-pay	7	7
	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 identical 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 has the ability to access at the measurement date. Level 1 securities generally include investments in marketable equity securities and mutual funds.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable 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.

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.

In preparation of the 2017 fair value hierarchy tables below, MHS management reviewed certain investments that were reported as using Level 2 inputs. Upon further consideration of the nature and characteristics of these investments, management determined that such investments are more appropriately reported as using Level 1 inputs. These changes did not affect the fair values reported. Adjustments have been made to correctly present these investments within the fair value hierarchy disclosures.

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 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 exit 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 market value, NAV is used as a practical expedient to approximate fair market value.

(Dollars in thousands)

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2017 and 2016:

		Fair value measurements at reporting date using		
	December 31, 2017	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 – equity	$ 540,709	540,709	—	—
Equity securities:				
U.S. large cap	119,685	119,685	—	—
U.S. small cap	55,935	55,935	—	—
Fixed income securities:				
Mutual funds – fixed income	270,799	270,799	—	—
U.S. government obligations	53,820	19,618	34,202	—
State government obligations	1,209	—	1,209	—
Asset-backed securities	16,816	—	16,816	—
Corporate debt securities:				
Domestic	52,326	—	52,326	—
Commingled trust fund – international equity	104,560	—	104,560	—
Interest rate swaps	512	—	512	—
Donor trusts	27,414	—	—	27,414
Total assets at fair value	1,243,785	1,006,746	209,625	27,414
Investment assets valued at NAV	428,462			
Total assets at fair value or NAV	$ 1,672,247			
Liabilities:				
Interest rate swaps	$ 62,484	—	62,484	—
Total liabilities	$ 62,484	—	62,484	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2016	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 – equity	$ 409,662	409,662	—	—
Equity securities:				
U.S. large cap	115,226	115,226	—	—
U.S. small cap	61,386	61,386	—	—
Fixed income securities:				
Mutual funds – fixed income	238,824	238,824	—	—
U.S. government obligations	51,221	17,715	33,506	—
State government obligations	6,798	—	6,798	—
Asset-backed securities	10,532	—	10,532	—
Corporate debt securities:				
Domestic	50,972	—	50,972	—
Commingled trust fund – international equity	93,551	—	93,551	—
Interest rate swaps	454	—	454	—
Donor trusts	20,860	—	—	20,860
Bond funds held in trust	46,738	46,738	—	—
Total assets at fair value	1,106,224	889,551	195,813	20,860
Investment assets valued at NAV	358,119			
Total assets at fair value or NAV	$ 1,464,343			
Liabilities:				
Interest rate swaps	$ 56,265	—	56,265	—
Total liabilities	$ 56,265	—	56,265	—

There were no significant transfers into or out of Level 1, Level 2, or Level 3 financial instruments during the years ended December 31, 2016 and 2015.

(Dollars in thousands)

The following tables present 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, 2017 and 2016:

	Level 3 assets
	Donor trusts
Balance at December 31, 2015	$ 20,302
Net unrealized gains	558
Balance at December 31, 2016	20,860
Net unrealized gains	6,554
Balance at December 31, 2017	$ 27,414

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2017 and 2016:

	NAV December 31, 2017	NAV December 31, 2016	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 88,085	94,994	N/A	Quarterly	60 or 95 business days prior to valuation date
Absolute return funds	256,010	178,618	N/A	Monthly	5 business days prior to valuation date
Limited liability partnerships	62,399	57,103	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	21,968	27,404	3,868	N/A	N/A
Total investments valued at NAV	$ 428,462	358,119	3,868		

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.

(Dollars in thousands)

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.

(5) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2017 and 2016 is as follows:

	December 31, 2017		
	Donor restricted assets	Investments	Total
Mutual funds – equity	$ 7,044	533,665	540,709
Equity securities	2,288	173,332	175,620
Fixed income securities	5,145	389,825	394,970
Commingled trust fund – international equity	1,362	103,198	104,560
Hedge funds – private investment funds	1,147	86,938	88,085
Absolute return fund	3,335	252,675	256,010
Limited liability partnerships – international equity	813	61,586	62,399
Limited partnerships – private equity	286	21,682	21,968
Donor trusts	27,414	—	27,414
Pledge receivables, net and other	29,368	—	29,368
Total	$ 78,202	1,622,901	1,701,103

(Dollars in thousands)

	December 31, 2016		
	Donor restricted assets	Investments	Total
Mutual funds – equity	$ 8,054	401,608	409,662
Equity securities	3,472	173,140	176,612
Fixed income securities	7,045	351,302	358,347
Commingled trust fund – international equity	1,839	91,712	93,551
Hedge funds – private investment funds	1,868	93,126	94,994
Absolute return fund	3,511	175,107	178,618
Limited liability partnerships – international equity	1,123	55,980	57,103
Limited partnerships – private equity	539	26,865	27,404
Donor trusts	20,860	—	20,860
Pledge receivables, net and other	18,392	—	18,392
Total	$ 66,703	1,368,840	1,435,543

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

Unrestricted investment income was comprised of the following for the years ended December 31, 2017 and 2016:

	2017	2016
Investment income:		
Interest and dividends	$ 28,017	23,187
Net realized gains (losses)	50,268	(21,702)
Net recognized gains	132,678	76,030
Total investment income	$ 210,963	77,515

(Dollars in thousands)

(6) Property, Plant, and Equipment

A summary of property, plant, and equipment at December 31, 2017 and 2016 is as follows:

	2017	2016
Land and land improvements	$ 115,901	62,453
Buildings	1,854,201	1,611,664
Equipment	850,099	724,210
	2,820,201	2,398,327
Less accumulated depreciation	(1,303,257)	(1,162,386)
	1,516,944	1,235,941
Construction in progress	163,478	96,793
Property, plant, and equipment, net	$ 1,680,422	1,332,734

Depreciation expense charged to operations for the years ended December 31, 2017 and 2016 amounted to $130,515 and $110,315, respectively.

(7) Other Assets

Other assets are as follows at December 31, 2017 and 2016:

	2017	2016
Investment in joint ventures	$ 19,291	20,504
Deferred compensation plan assets held in trust	55,042	37,908
Accrued pension asset (note 9)	40,425	9,765
Self-insured retention receivables, net of current portion (notes 10 and 11)	32,619	16,717
Interest rate swaps	512	454
Long-term notes receivable (note 13(h))	13,814	—
Goodwill and other intangibles	170,206	32,807
Other	861	616
Other assets	$ 332,770	118,771

(Dollars in thousands)

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 and are, therefore, classified as Level 1 securities. The increase in deferred compensation plan assets held in trust and goodwill and other intangibles in 2017 was primarily associated with the acquisition of the Inland Northwest Region facilities from Community Health Systems effective July 1, 2017 as described further in note 1.

(8) Accrued Pension, Professional Liability, and Other

Accrued pension, professional liability, and other are as follows at December 31, 2017 and 2016:

		2017	2016
Professional liability, net of current portion (note 10)	$	66,780	44,228
Deferred compensation liability (note 9)		55,042	37,908
Workers' compensation liability, net of current portion (note 11)		13,746	13,547
Other		5,597	5,830
Accrued pension, professional liability, and other	$	141,165	101,513

(9) 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, 2017 and 2016:

		2017	2016
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	600,607	592,406
Service cost		—	4,642
Interest cost		26,288	27,240
Actuarial loss		37,795	8,738
Benefits paid		(35,694)	(32,419)
Projected benefit obligations at end of year	$	628,996	600,607

(Dollars in thousands)

		2017	2016
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	610,373	583,159
Actual gain on plan assets		94,742	34,883
Employer contribution		—	24,750
Benefits paid		(35,694)	(32,419)
Fair value of plan assets at end of year	$	669,421	610,373
Accrued benefit cost:			
Funded status	$	40,425	9,765
Amount recognized in consolidated balance sheets consist of:			
Asset for pension benefits		40,425	9,765
Amount recognized in unrestricted net assets:			
Net loss		117,286	143,477

	2017	2016
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	4.10%	4.50%
Expected return on plan assets	6.30	7.00

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. A consulting actuary reviews the assumptions annually for reasonableness.

(Continued)

(Dollars in thousands)

The components of net periodic benefit cost, which are included in employee benefits in the consolidated statements of operations and changes in net assets, are as follows during the years ended December 31, 2017 and 2016:

	2017	2016
Components of net periodic benefit cost:		
Service cost	$ —	4,642
Interest cost	26,288	27,240
Expected return on plan assets	(38,832)	(43,099)
Amortization of net actuarial loss	8,076	4,481
	$ (4,468)	(6,736)

The accumulated benefit obligation for the Plan was $628,996 and $600,607 at December 31, 2017 and 2016, respectively.

(i) Cash Flows – Contributions

MHS does not currently expect to make a contribution to the Plan in 2018.

(ii) Estimated Future Benefit Payments

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

	Pension benefits
2018	$ 36,161
2019	35,423
2020	38,085
2021	37,885
2022	39,684
2023–2027	195,458

(Dollars in thousands)

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, 2017	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	$ 4,667	4,667	—	—
Trading securities:				
Mutual funds – equity	129,863	129,863	—	—
Equity securities:				
U.S. large cap	41,743	41,743	—	—
U.S. small cap	20,149	20,149	—	—
Fixed income securities:				
Fixed income funds	211,034	211,034	—	—
U.S. government obligations	184,835	78,620	106,215	—
Asset-backed securities	4,931	—	4,931	—
Corporate debt securities:				
Domestic	15,058	—	15,058	—
Commingled trust fund – international equity	36,017	—	36,017	—
	648,297	486,076	162,221	—
Broker receivables	15,430			
Broker payables	(96,663)			
Total assets at fair value	567,064			
Investments valued at NAV	102,357			
Total assets at fair value or NAV	$ 669,421			

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2016	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	$ 11,920	11,920	—	—
Trading securities:				
Mutual funds – equity	123,489	123,489	—	—
Equity securities:				
U.S. large cap	35,471	35,471	—	—
U.S. small cap	22,724	22,724	—	—
Fixed income securities:				
Fixed income funds	189,397	189,397	—	—
U.S. government obligations	131,577	49,521	82,056	—
State government obligations	451	—	451	—
Asset-backed securities	4,566	—	4,566	—
Corporate debt securities:				
Domestic	5,282	—	5,282	—
Commingled trust fund – international equity	27,324	—	27,324	—
	552,201	432,522	119,679	—
Broker receivables	7,094			
Broker payables	(55,806)			
Total assets at fair value	503,489			
Investments valued at NAV	106,884			
Total assets at fair value or NAV	$ 610,373			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2017 and 2016.

(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, 2017 and 2016:

	Fair value at December 31, 2017	Fair value at December 31, 2016	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 39,292	37,013	N/A	Quarterly	45 days
Hedge funds	29,845	33,906	N/A	Quarterly	95 days prior to valuation date
Absolute return funds	22,571	22,702	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	10,649	13,263	940	N/A	N/A
Total investments valued at NAV	$ 102,357	106,884	940		

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.

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.

(Dollars in thousands)

(iii) Plan Assets

The defined benefit plan weighted average asset allocations at December 31, 2017 and 2016 by asset category are as follows:

	2017	2016
Asset category:		
Domestic equities	15 %	16 %
International equities	10	10
Emerging markets	4	4
Fixed income securities	51	48
Alternative investments	6	8
Real estate	6	6
Global asset allocation	8	8
	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:

	2017	2016
Asset category:		
Domestic equities	13 %	13 %
International equities	9	9
Emerging markets	3	3
Fixed income securities	52	50
Alternative investments	8	11
Real estate	5	5
Global asset allocation	10	9
	100 %	100 %

(v) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. 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 international equities is to provide higher expected 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 Plans' 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 through the use of 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.

Alternatives and Other

The strategic role of alternative investments is for diversification relative to equities and fixed-income investments, to add absolute return through the use of 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.

The strategic role of real estate is to diversify the Plans' 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.

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 (formerly the Good Samaritan (GS) 401(k) Plan). Effective July 1, 2017, the GS 401(k) Plan, which was previously amended to not allow future contributions, was further amended and renamed as the MultiCare Health System 401(k) Plan (MHS 401(k) Plan). Most employees assigned to work at Deaconess Hospital, Valley Hospital and Rockwood Clinic became 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 2017 and 2016 were approximately $34,893 and $32,478, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to defined benefit and the defined contribution plans described above, deferred compensation arrangements are maintained by MHS for the benefit of eligible employees. Substantially all amounts deferred under these arrangements are held by a trustee until such time as these funds become payable to the participating employees.

(10) 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, 2017 and 2016, 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, 2017 and 2016, the estimated gross professional liability (including current and long-term portions) was $87,766 and $54,104, respectively, and is recorded in accounts payable and accrued expenses and accrued pension, professional liability, and other. MHS has recorded a receivable for amounts to be received from excess insurance carriers (including current and long-term portions) of $45,092 and $18,245 as of December 31, 2017 and 2016, respectively, which are included in other current assets, net and other assets, net in the accompanying consolidated balance sheets.

(11) 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 its actuarial estimate of future claims payments. At December 31, 2017 and 2016, the estimated net liability based on future claims cost totaled $16,301 and $15,990, respectively. The gross liabilities (including both current and long-term portions) total $19,504 and $19,465 as of December 31, 2017 and 2016, respectively. The long-term amounts are included in accrued pension, professional liability, and other 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. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,203 and $3,475 as of December 31, 2017 and 2016, respectively, which are 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 2017 and 2016 was $15,981 and $8,323, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(12) Interest Rate Swaps

MHS has several interest rate swap instruments that are used as part of management's strategy to reduce overall interest costs. In November 2017, the existing swaps were novated to new counterparties and with these new counterparties MHS restructured the swaps to match the maturity schedules of the underlying debt. As of December 31, 2017 and 2016, none of the interest rate swaps qualified for hedge accounting treatment and therefore none were designated as such. The changes in fair value of these interest rate swaps for the years ended December 31, 2017 and 2016 of $6,160 in fair value losses and $1,883 in fair value gains, respectively, are included in loss and other expense on interest rate swaps in other income in the consolidated statements of operations and changes in net assets. Also included in the loss and other expense on interest rate swaps is the net cash settlement amounts associated with the swaps of $5,549 and $5,732, respectively, for the years ended December 31, 2017 and 2016. As of December 31, 2017 and 2016, the total notional amounts of MHS' outstanding interest rate swap agreements were $596,820 and $406,230, respectively.

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 agreements in other assets, net and in interest rate swap liabilities in the consolidated balance sheets. Additional disclosure is provided in footnote 1(l).

(Dollars in thousands)

(13) Long-Term Debt

Long-term debt consists of the following at December 31, 2017 and 2016:

	2017	2016
WHCFA Revenue bonds, 2017 Series A and B	$ 333,970	—
WHCFA Revenue bonds, 2017 Series C, D, and E	191,010	—
2017 Term Loans	130,170	—
WHCFA Revenue bonds, 2015 Series A and B	364,210	367,820
WHCFA Revenue bonds, 2012 Series A and B	60,000	140,000
WHCFA Revenue bonds, 2010 Series A	43,020	50,430
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
WHCFA Revenue bonds, 2007 Series A, B, C, and D	—	297,725
Other	55,087	177
	1,275,597	954,282
Adjusted for:		
Current portion	(19,017)	(15,178)
Bond premiums, discounts, and issuance costs	66,108	37,816
Long-term debt, net of current portion	$ 1,322,688	976,920

(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. The bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.0%. Annual principal payments range from $5,980 in 2018 to $62,410 in 2047. The 2017 Series B bonds were used for the advance refunding of the 2007 Series A, B, C and D bonds, which resulted in a loss in 2017 of $9,576. This loss on refinancing is included in other income, net on the consolidated statements of operations and changes in net assets.

(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 reset monthly and are based on 70% of one-month U.S. LIBOR.

(c) 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 reset monthly and are based on 100% of one-month U.S. LIBOR.

(d) 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 $3,765 in 2018 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(e) WHCFA Revenue Bonds 2012 Series A and B

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. The 2012 B bonds were refunded in 2017.

(f) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. 2010 Series A bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.25%. Annual principal payments range from $7,765 in 2018 to $9,500 in 2022.

(g) 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.

(h) Other

The other debt listed is primarily made up of debt held by Navos. Of this debt, $37,402 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. At the end of 2018, $23,271 of this debt, that is associated with a new market tax credit arrangement, is expected to be forgiven along with a coinciding receivable balance of $17,206, which is included in other assets, net on the accompanying consolidated balance sheets. The remaining forgivable debt is subject to a forgiveness provision in years 2020 through 2064. The remainder of other debt bears interest ranging from 0.0% to 4.5%. Annual principal payments range from $1,507 in 2018 to $2 in 2033.

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. Management believes that MHS is in compliance with these covenants at December 31, 2017 and 2016.

(Dollars in thousands)

Principal maturities on long-term debt are as follows:

Year ending December 31:	
2018	$ 19,017
2019	19,161
2020	21,970
2021	17,292
2022	22,922
Thereafter	1,175,235
	$ 1,275,597

A summary of interest costs is as follows during the years ended December 31, 2017 and 2016:

	2017	2016
Interest cost:		
Charged to operations	$ 38,261	36,847
Amortization of bond premiums, discounts, and issuance costs	(1,529)	(1,588)
Capitalized	4,080	803
	$ 40,812	36,062

(14) Commitments and Contingencies

(a) Operating Leases

MHS leases various equipment and facilities under operating leases expiring at various dates through September 2030. Total rental expense in years 2017 and 2016 for all operating leases was approximately $36,772 and $22,640, respectively.

The following is a schedule by year of future minimum lease payments under operating leases at December 31, 2017, which have initial or remaining lease terms in excess of one year:

2018	$ 30,119
2019	25,456
2020	22,349
2021	18,795
2022	12,734
Thereafter	40,598
	$ 150,051

(Dollars in thousands)

(b) Collective Bargaining Agreements

Approximately 42% of MHS employees were covered under collective bargaining agreements as of December 31, 2017. 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 January 2020.

(15) Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31, 2017 and 2016:

		2017	2016
Healthcare services	$	42,022	23,919
Endowment fund		86	67
Purchase of equipment		346	9,115
Indigent care		7,914	797
Health education		2,380	767
Total temporarily restricted net assets	$	52,748	34,665

(16) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both donor-restricted endowment funds and unrestricted funds designated 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:

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment net assets, December 31, 2016	$ 2,837	67	38,008	40,912
Investment return:				
Investment income	51	232	436	719
Net appreciation – realized and unrealized	40	56	595	691
Total investment return	91	288	1,031	1,410
Contributions	—	—	163	163
Appropriation of endowment assets for expenditure	(56)	(269)	(1,215)	(1,540)
Endowment net assets, December 31, 2017	$ 2,872	86	37,987	40,945

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment net assets, December 31, 2015	$ 2,933	56	37,190	40,179
Investment return (loss):				
Investment income	41	182	343	566
Net depreciation – realized and unrealized	(35)	(40)	(498)	(573)
Total investment return (loss)	6	142	(155)	(7)
Contributions	—	—	2,204	2,204
Appropriation of endowment assets for expenditure	(102)	(131)	(1,231)	(1,464)
Endowment net assets, December 31, 2016	$ 2,837	67	38,008	40,912

(Continued)

(Dollars in thousands)

Perpetual trusts that are held and managed by third party trustees are recorded as permanently restricted net assets on the consolidated balance sheets; however, they are not included as permanently restricted endowment net assets in the above presentation. Those perpetual trusts totaled $24,557 and $18,699, respectively, as of December 31, 2017 and 2016. Also excluded from the presentation of permanently restricted endowment net assets above are pledge receivables and other totaling $1,731 and $1,754, respectively, as of December 31, 2017 and 2016.

(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 unrestricted net assets. There were no funds with deficiencies in 2017 or 2016.

(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 intend 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 outside of MHS' pooled investments. Those outside 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.

(17) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Expenses related to providing these services are as follows for the years ended December 31, 2017 and 2016:

		2017	2016
Healthcare services	$	1,622,686	1,248,191
General and administrative		706,345	568,131
	$	2,329,031	1,816,322

(Continued)

(18) 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 course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(19) Subsequent Events

MHS has evaluated the subsequent events from the balance sheet date through March 26, 2018, the date at which the consolidated financial statements were issued, and determined there are no other items to disclose.

Exhibit 17C.

MultiCare Health System Audited Financial Statements - 2018

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2018 and 2017

(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, 2018 and 2017, 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 Consolidated 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, 2018 and 2017, 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, in 2018, MultiCare Health System adopted Financial Accounting Standards Board Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts*

with Customers (Topic 606) and ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities, (Topic 958)*. Our opinion is not modified with respect to these matters.

Other Matters

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental schedule consolidating balance sheet on page 44 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

This report is intended solely for the information and use of the Board of Directors and management of MultiCare Health System, and the Washington State Office of the Insurance Commissioner, and is not intended to be and should not be used by anyone other than these specified parties.

KPMG LLP

Seattle, Washington
March 20, 2019

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2018 and 2017

(In thousands)

Assets		2018	2017
Current assets:			
Cash and cash equivalents	$	386,409	368,028
Accounts receivable, less allowance for doubtful accounts of $41,921 in 2017		375,841	358,514
Supplies inventory		43,387	36,432
Other current assets, net		57,450	65,603
Total current assets		863,087	828,577
Donor restricted assets held for long-term purposes		75,166	78,202
Investments		1,490,739	1,622,901
Property, plant, and equipment, net		1,776,259	1,680,422
Other assets, net		320,290	332,770
Total assets	$	4,525,541	4,542,872
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	201,304	199,363
Accrued compensation and related liabilities		221,854	213,384
Accrued interest payable		16,364	12,653
Current portion of long-term debt		19,058	19,017
Total current liabilities		458,580	444,417
Interest rate swap liabilities		45,833	62,484
Long-term debt, net of current portion		1,287,189	1,322,688
Other liabilities, net		127,406	141,165
Total liabilities		1,919,008	1,970,754
Commitments and contingencies (note 14)			
Net assets:			
Without donor restrictions		2,490,997	2,455,095
With donor restrictions		115,536	117,023
Total net assets		2,606,533	2,572,118
Total liabilities and net assets	$	4,525,541	4,542,872

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Revenues, gains, and other support without donor restrictions:		
Patient service revenue		$ 2,341,695
Provision for bad debts		(36,390)
Net patient service revenue	$ 2,780,371	2,305,305
Other operating revenue	137,909	105,997
Net assets released from restrictions for operations	4,687	4,817
Total revenues, gains, and other support without donor restrictions	2,922,967	2,416,119
Expenses:		
Salaries and wages	1,392,503	1,148,499
Employees benefits	212,568	191,150
Supplies	465,673	349,568
Purchased services	238,570	198,386
Depreciation and amortization	149,522	130,725
Interest	42,915	36,732
Other	317,815	273,971
Total expenses	2,819,566	2,329,031
Excess of revenues over expenses from operations	103,401	87,088
Other (loss) income:		
Investment (loss) income	(95,684)	210,963
Income (loss) on interest rate swaps, net	13,467	(11,709)
Other income, net	21,669	8,589
Total other (loss) income, net	(60,548)	207,843
Excess of revenues over expenses	42,853	294,931
Other changes in net assets without donor restrictions:		
Changes in pension asset	(14,172)	26,191
Net assets released from restriction – capital acquisitions	7,221	2,497
Increase in net assets without donor restrictions	35,902	323,619
Changes in net assets with donor restrictions:		
Contributions and other	13,323	28,053
Income on investments	992	1,320
Net assets released from restriction – capital acquisitions	(7,221)	(2,497)
Net assets released from restrictions for operations and other	(4,687)	(4,817)
(Decrease) increase in assets held in trust by others	(3,894)	1,838
(Decrease) increase in net assets with donor restrictions	(1,487)	23,897
Increase in net assets	34,415	347,516
Net assets, beginning of year	2,572,118	2,224,602
Net assets, end of year	$ 2,606,533	2,572,118

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Cash flows from operating activities:		
Increase in net assets	$ 34,415	347,516
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	149,522	130,725
Amortization of bond premiums, discounts, and issuance costs	(2,659)	(1,529)
Net realized and recognized losses (gains) on investments	123,495	(182,946)
Change in fair value of interest rate swap	(17,542)	6,160
Provision for bad debts	—	36,390
Gain on disposal of assets, net	(198)	(703)
Loss on bond refinancing	—	9,576
Undistributed (gains) losses on joint ventures	(1,741)	1,515
Restricted contributions for long-term purposes	(4,477)	(5,555)
Gain on forgiveness of debt	(6,425)	—
Assumption of operating assets and liabilities	(15,143)	(21,719)
Changes in operating assets and liabilities:		
Accounts receivable	(16,007)	(55,226)
Supplies inventory and other current assets	1,700	(19,767)
Other assets, net	31,962	(38,323)
Accounts payable and accrued expenses and accrued interest payable	3,821	54,529
Accrued compensation and related liabilities	6,509	27,673
Other liabilities, net	(13,048)	21,795
Net cash provided by operating activities	274,184	310,111
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(233,314)	(178,727)
Purchase of acquired assets	—	(429,342)
Cash obtained through affiliation	9,335	—
Proceeds from disposal of property, plant, and equipment	2,240	704
Contributions to joint ventures, net	(17,650)	(1,372)
Purchases of investments	(2,160,128)	(1,883,314)
Sales of investments	2,165,472	1,817,231
Net decrease in bond funds held in trust	—	46,738
Change in donor trusts	6,635	(17,716)
Net cash used in investing activities	(227,410)	(645,798)
Cash flows from financing activities:		
Repayment of long-term debt	(32,870)	(397,373)
Proceeds from bond issuance	—	683,456
Restricted contributions for long-term purposes	4,477	5,555
Net cash (used in) provided by financing activities	(28,393)	291,638
Net change in cash and cash equivalents	18,381	(44,049)
Cash and cash equivalents, beginning of year	368,028	412,077
Cash and cash equivalents, end of year	$ 386,409	368,028
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 39,204	37,644
Noncash activities:		
(Decrease) increase in deferred compensation plans	(6,735)	17,134
Increase (decrease) in accounts payable for purchases of property, plant, and equipment	1,302	(360)

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, 2018, MHS is licensed to operate 1,978 inpatient hospital beds, including 120 beds associated with Wellfound Behavioral Health Hospital, a 50% owned joint venture hospital that is under construction in Tacoma, Washington and will open in 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.

The acquisition of Deaconess and Valley Hospitals (along with Rockwood Clinic and collectively referred to as the Inland Northwest Region), based in Spokane, Washington, was effective July 1, 2017. The acquisition of the Inland Northwest Region facilities from Community Health Systems (CHS) was for approximately $429,342 in cash plus the assumption of certain liabilities subject to post closing working capital adjustments as described below. This acquisition added 511 licensed inpatient hospital beds to MHS. The net assets purchased included land, buildings, equipment, accounts receivable, inventories, intangibles and other assets, offset by accounts payable and accrued compensation liabilities and were recorded at their estimated fair values as determined based on standard asset appraisal techniques. MHS hired substantially all of the employees previously employed by CHS in the Inland Northwest Region. The following table summarizes the consideration paid, including associated

(Dollars in thousands)

taxes, for the Inland Northwest Region facilities, along with estimated fair values of assets and liabilities acquired as of the acquisition date:

Recognized amounts of identifiable assets and liabilities acquired:		
Land, buildings and equipment, including taxes thereon	$	249,875
Patient accounts receivable, less allowances for doubtful accounts of $6,568		62,511
Supplies inventory		15,096
Other current assets		6,896
Intangible assets		18,100
Accounts payable and accrued compensation		(37,822)
Goodwill		114,686
Total consideration paid in cash	$	429,342

As part of the purchase agreement, the value of certain net working capital balances were settled with CHS in 2018 and resulted in an additional payment of approximately $500 to CHS. Accordingly, the amount of goodwill as reflected above has been subsequently adjusted by this amount.

Navos, a major behavioral health services provider in Washington state, affiliated with MHS effective May 1, 2017. No consideration was exchanged and MHS became the sole corporate member of Navos. The assets and liabilities obtained through the affiliation included land, buildings, equipment, accounts receivable and notes receivable offset by accounts payable, accrued compensation and long-term debt and were recorded at their estimated fair values as of the date of affiliation as determined based on standard asset appraisal techniques. The following table summarizes the estimated fair values of assets and liabilities assumed as of the affiliation date:

Recognized amounts of identifiable assets and liabilities assumed:		
Land, buildings and equipment	$	50,000
Patient accounts receivable, less allowances for doubtful accounts of $5,994		9,309
Cash		1,826
Other current assets		1,698
Long-term assets		20,983
Intangible assets		3,000
Accounts payable and accrued compensation		(7,309)
Long-term debt		(55,962)
Total net assets assumed	$	23,545

The net assets without donor restrictions assumed resulted in an inherent contribution of $18,165 and is included in other income, net in the consolidated statement of operations and changes in net assets for the year ended December 31, 2017. The remaining $5,380 contribution was restricted and is

included in contributions and other in the consolidated statement of operations and changes in net assets for the year ended December 31, 2017.

MHS also operates eight outpatient surgical sites, two 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 the facilities and services described above as well as those of two wholly owned subsidiaries (Medis, Inc. and MultiCare Rehabilitation Specialists), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned accountable care organization (MultiCare Connected Care), and four fund-raising foundations (Mary Bridge Children's Foundation, MultiCare Health Foundation, Good Samaritan Foundation and MultiCare South King Health Foundation).

During 2018, MHS revised its presentation in the consolidated statement of cash flows related to the purchases and sales of investments. As a result, the 2017 consolidated statement of cash flows has been revised to present separately the purchases of investments of ($1,883,314) and the sales of investments of $1,817,231. MHS previously presented its trading activity on a net basis. This revision does not change the net cash used in investing activities in the consolidated statements of cash flows.

(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.

(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 outside MHS' investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in cash, 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 available are carried at values provided by the respective investment managers or trustees, which management believes approximate fair value.

Charitable gift annuities, which are included in donor restricted assets, totaled $2,206 and $2,490 at December 31, 2018 and 2017, respectively. MHS has recorded a corresponding payable of $1,246 and $1,306 at December 31, 2018 and 2017, 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) Bond Funds Held in Trust

Bond funds held in trust include assets held by trustees under bond indenture agreements, which are primarily restricted to fund certain capital projects. These assets are carried at fair value.

(j) 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 or losses upon sale or retirement of property, plant, and equipment are included in other operating revenue. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring 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 2018 and 2017, 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.

(k) Goodwill and Intangible Assets

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

If it is more likely than not that the asset 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, 2018 and 2017.

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) 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 $6,308 and $6,462 as of December 31, 2018 and 2017, 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. Net patient service revenue increased by $3,792 and $4,081 for 2018 and 2017, respectively, to reflect changes in the estimated Medicare settlements for prior years.

(m) 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, 2018 and 2017, 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 $589,000 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.

(n) 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, 2018, and 2017, MHS has recorded $7,715 and $7,464, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2018, $699 of pledges are due in one year or less and $7,016 in two to five years.

(o) 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.

(p) 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 $77,375 and $61,409 for 2018 and 2017, respectively, and incurred assessments of $57,324 and $47,676 for 2018 and 2017, 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 $4,999 and $9,715 associated with this program as of December 31, 2018 and 2017, respectively, which are included with accounts receivable on the consolidated balance sheets.

(q) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated 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 with 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. For the year ended December 31, 2017, the Inland Northwest Region facilities offered full charity care to patients up to 150% of the federal poverty guidelines and partial charity care based on a sliding scale for patients up to 300% of the federal guidelines. Effective January 1, 2018, the Inland Northwest Region facilities adopted the MHS policy and are now consistent with the rest of MHS. The estimated

cost of charity care provided was approximately $47,000 and $32,000 in 2018 and 2017, respectively. The estimated cost of services provided to patients covered under Medicaid in excess of payments received was approximately $217,000 and $227,000 in 2018 and 2017, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(r) 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.

(s) 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 liability and net assets released from restrictions for capital acquisition.

(t) 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.

(u) 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.

(v) New and Pending Accounting Standards

On January 1, 2018, MHS adopted Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which clarifies the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of the new standard is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to receive in exchange for those

goods or services. MHS adopted this new standard using the modified retrospective method of application to all contracts existing on January 1, 2018. MHS has evaluated the impact of this new standard on its consolidated financial statements and has determined that the impact was not material. However, additional disclosures have been added in note 2 to the consolidated financial statements including the disaggregation of revenue and treatment of implicit price concessions, which includes the provision for bad debt as of the date of adoption of this standard.

In January 2016, FASB issued ASU No. 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 early adopted the option to remove the fair value of debt disclosure as of December 31, 2018 and 2017 as permitted under the provisions of the standard. MHS is currently evaluating the effects the remaining portions of this standard will have on its consolidated financial statements and accompanying disclosures.

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 an 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 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. This standard is effective for MHS as of January 1, 2019. MHS has evaluated the estimated impact that the standard will have on its consolidated balance sheet. At the date of adoption, MHS will record a right-of-use asset and corresponding liability ranging from approximately $130,000 to $160,000.

On January 1, 2018, MHS adopted ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, which reduces the diversity in reporting practice, reduces complexity, and enhances understandability of not-for-profit (NFP) financial statements. This standard contains the following key aspects: (A) reduces the number of net asset classes presented from three to two: *with donor restrictions* and *without donor restrictions*; (B) requires all NFP entities to present expenses by their functional and their natural classifications in one location in the financial statements; (C) requires NFP entities to provide quantitative and qualitative information about liquidity management and availability of financial assets to meet obligations due within one year of the balance sheet date; and (D) retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. This standard has been applied on a retrospective basis except for the disclosures regarding liquidity, which is not required to be applied retrospectively. As part of MHS' adoption of this standard, at December 31, 2017, MHS presented a balance of unrestricted net assets of $2,455,095, temporarily restricted net assets of $52,748 and permanently restricted net assets of

$64,275. At December 31, 2018, MHS presented the 2017 net asset balances as follows: net assets without donor restrictions of $2,455,095 and net assets with donor restrictions of $117,023.

In January 2017, FASB issued ASU 2017-04, *Intangibles-Goodwill and Other (Topic 350) Simplifying the Test for Goodwill Impairment.* This standard eliminates Step 2 from the goodwill test in computing the implied fair value of goodwill. Under this standard, an entity should perform its annual goodwill impairment test by comparing the fair value of the reporting unit with its carrying amount. An entity would then recognize an impairment charge when the carrying amount exceeds the implied fair value of the reporting unit limited to the total amount of goodwill allocated to that reporting unit. An entity should apply the amendments in this standard on a prospective basis and will need to disclose the reason for the change in accounting principle upon transition. This standard is effective for MHS for the year beginning on January 1, 2022. MHS has not yet determined the impact that this standard will have 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 is conditional. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2019. Early adoption of the update is permitted. MHS is currently evaluating the impact this update will have 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

(Dollars in thousands)

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 2018 or 2017.

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 2018 or 2017. 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.

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 year ended December 31, 2018 is as follows:

		2018
Payors:		
Medicare	$	781,842
Medicaid		494,737
Regence		303,390
Premera		359,764
Aetna		165,488
First Choice		108,990
Kaiser Permanente		108,539
Self-pay		10,924
Other		446,697
	$	2,780,371

(Dollars in thousands)

Net patient service revenue for the year ended December 31, 2017 is as follows:

		2017
Gross patient service charges	$	8,530,562
Contractual discounts		(6,056,622)
Charity care (gross)		(132,245)
Provision for bad debts (gross)		(36,390)
Net patient service revenue	$	2,305,305

MHS has elected to apply the practical expedient under ASC Topic 606. This 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 the service is 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.

(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, 2018 and 2017 was as follows:

	2018	2017
Medicare	33 %	31 %
Medicaid	24	25
Regence	6	6
Other commercial insurance	30	31
Self-pay	7	7
	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 observable 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 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.

(Dollars in thousands)

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2018 and 2017:

		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	—

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2017	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	$ 540,709	540,709	—	—
Equity securities	175,620	175,620	—	—
Fixed income bond funds	270,799	270,799	—	—
Fixed income governmental obligations	55,029	19,618	35,411	—
Fixed income other	69,142	—	69,142	—
Commingled trust fund – international equity	104,560	—	104,560	—
Interest rate swaps	512	—	512	—
Donor trusts	27,414	—	—	27,414
Total assets at fair value	1,243,785	$ 1,006,746	209,625	27,414
Investment assets valued at NAV	428,462			
Total assets at fair value or NAV	$ 1,672,247			
Liabilities:				
Interest rate swaps	$ 62,484	—	62,484	—

There were no significant transfers into or out of Level 1, Level 2, or Level 3 financial instruments during the years ended December 31, 2018 and 2017.

(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, 2018 and 2017:

	Level 3 assets Donor trusts
Balance at December 31, 2016	$ 20,860
Net unrealized gains	6,554
Balance at December 31, 2017	27,414
Net unrealized losses	(4,810)
Balance at December 31, 2018	$ 22,604

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2018 and 2017:

	NAV December 31, 2018	NAV December 31, 2017	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 208,193	88,085	N/A	Quarterly	60 or 95 business days prior to valuation date
Absolute return funds	110,646	256,010	N/A	Monthly	5 business days prior to valuation date
Limited liability partnerships	86,121	62,399	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	20,100	21,968	3,193	N/A	N/A
Total investments valued at NAV	$ 425,060	428,462	3,193		

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 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 November 2017, MHS transferred the existing swaps to new counterparties where MHS then restructured the swaps to match the maturity dates of the underlying debt being hedged. However, at December 31, 2018 and 2017, these interest rate swaps still 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, 2018 and 2017, the value of the interest rate swap liability was $45,833 and $62,484, respectively, which is included in other liabilities, net on the consolidated balance sheet and the value of the interest rate swap asset was $1,403 and $512, 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, 2018 and 2017 of $17,542 in fair value gains and $6,160 in fair value losses, 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 net cash settlement amounts associated with the swaps of $4,075 and $5,549, respectively, for the years ended December 31, 2018 and 2017.

(Dollars in thousands)

(5) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2018 and 2017 is as follows:

	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

	December 31, 2017		
	Donor restricted assets	Investments	Total
Mutual funds	$ 7,044	533,665	540,709
Equity securities	2,288	173,332	175,620
Fixed income securities	5,145	389,825	394,970
Commingled trust fund – international equity	1,362	103,198	104,560
Hedge funds	1,147	86,938	88,085
Absolute return fund	3,335	252,675	256,010
Limited liability partnership	813	61,586	62,399
Limited partnerships	286	21,682	21,968
Donor trusts	27,414	—	27,414
Pledge receivables, net and other	29,368	—	29,368
Total	$ 78,202	1,622,901	1,701,103

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, 2018, MHS' financial resources are as follows:

		2018
Cash and cash equivalents	$	386,409
Accounts receivable, net		375,841
Other current assets, net		57,450
Donor restricted assets		75,166
Investments		1,490,739
		2,385,605
Less prepaid assets and bond funds held in trust included in other current assets, net		(29,610)
Less donor restricted assets		(75,166)
Less investments with redemption limitations of greater than one year		(24,920)
Total financial assets available for general expenditures	$	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

A summary of property, plant, and equipment at December 31, 2018 and 2017 is as follows:

	2018	2017
Land and land improvements	$ 125,934	115,901
Buildings	2,030,190	1,854,201
Equipment	934,127	850,099
	3,090,251	2,820,201
Less accumulated depreciation	(1,442,014)	(1,303,257)
	1,648,237	1,516,944
Construction in progress	128,022	163,478
Property, plant, and equipment, net	$ 1,776,259	1,680,422

Depreciation expense charged to operations for the years ended December 31, 2018 and 2017 amounted to $147,125 and $129,127, respectively. Depreciation and amortization expense for the years ended December 31, 2018 and 2017 was $149,522 and $130,725, respectively.

(8) Other Assets

Other assets are as follows at December 31, 2018 and 2017:

	2018	2017
Investment in joint ventures	$ 38,492	19,291
Deferred compensation plan assets held in trust	55,394	55,042
Accrued pension asset (note 10)	28,085	40,425
Self-insured retention receivables, net of current portion (notes 11 and 12)	21,219	32,619
Interest rate swaps	1,403	512
Long-term notes receivable (note 13(h))	2,198	13,814
Goodwill and other intangibles	170,088	170,206
Other	3,411	861
Other assets	$ 320,290	332,770

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

Other liabilities are as follows at December 31, 2018 and 2017:

		2018	2017
Professional liability, net of current portion (note 11)	$	55,145	66,780
Deferred compensation liability (note 10)		55,394	55,042
Workers' compensation liability, net of current portion (note 12)		13,077	13,746
Other		3,790	5,597
Other liabilities, net	$	127,406	141,165

(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.

(Continued)

(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, 2018 and 2017:

		2018	2017
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	628,996	600,607
Interest cost		25,046	26,288
Actuarial (gain) loss		(41,842)	37,795
Benefits paid		(35,595)	(35,694)
Projected benefit obligations at end of year	$	576,605	628,996
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	669,421	610,373
Actual gain (loss) on plan assets		(29,136)	94,742
Benefits paid		(35,595)	(35,694)
Fair value of plan assets at end of year	$	604,690	669,421
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	28,085	40,425
Amount recognized in net assets without donor restrictions:			
Net loss		131,458	117,286

	2018	2017
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	4.60 %	4.10 %
Expected return on plan assets	6.00	6.30

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, which are included in employee benefits in the consolidated statements of operations and changes in net assets, are as follows during the years ended December 31, 2018 and 2017:

	2018	2017
Components of net periodic benefit cost:		
Interest cost	$ 25,046	26,288
Expected return on plan assets	(37,038)	(38,832)
Amortization of net actuarial loss	10,159	8,076
	$ (1,833)	(4,468)

The accumulated benefit obligation for the Plan was $576,605 and $628,996 at December 31, 2018 and 2017, respectively.

(i) Cash Flows – Contributions

MHS does not currently expect to contribute to the Plan in 2019.

(ii) Estimated Future Benefit Payments

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

	Pension benefits
2019	$ 35,299
2020	37,438
2021	37,160
2022	39,047
2023	38,805
2024–2028	191,364

(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, 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			
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			

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2017	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	$ 4,667	4,667	—	—
Trading securities:				
Mutual funds	129,863	129,863	—	—
Equity securities	61,892	61,892	—	—
Fixed income bond funds	211,034	211,034	—	—
Fixed income governmental obligations	184,835	78,620	106,215	—
Fixed income other	19,989	—	19,989	—
Commingled trust fund – international equity	36,017	—	36,017	—
	648,297	$ 486,076	162,221	—
Broker receivables	15,430			
Broker payables	(96,663)			
Total assets at fair value	567,064			
Investments valued at NAV	102,357			
Total assets at fair value or NAV	$ 669,421			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2018 and 2017.

(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, 2018 and 2017:

	Fair value at December 31, 2018	Fair value at December 31, 2017	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 21,655	39,292	N/A	Quarterly	45 days
Hedge funds	1,532	29,845	N/A	Quarterly	95 days prior to valuation date
Absolute return funds	15,315	22,571	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	9,818	10,649	890	N/A	N/A
Total investments valued at NAV	$ 48,320	102,357	890		

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.

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.

(Dollars in thousands)

The defined benefit plan weighted average asset allocations at December 31, 2018 and 2017 by asset category are as follows:

	2018	2017
Asset category:		
Domestic equities	7 %	15 %
International equities	6	10
Emerging markets	1	4
Fixed income securities	75	51
Alternative investments	2	6
Real estate	4	6
Global asset allocation	5	8
	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:

	2018	2017
Asset category:		
Domestic equities	8 %	13 %
International equities	6	9
Emerging markets	1	3
Fixed income securities	77	52
Alternative investments	—	8
Real estate	3	5
Global asset allocation	5	10
	100 %	100 %

(v) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected 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 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.

Alternatives and Other

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.

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.

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 (formerly the Good Samaritan (GS) 401(k) Plan). Effective July 1, 2017, the GS 401(k) Plan was amended and renamed as the MultiCare Health System 401(k) Plan (MHS 401(k) Plan). Most employees assigned to

work at Deaconess Hospital, Valley Hospital and Rockwood Clinic became 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 2018 and 2017 were approximately $40,158 and $34,893, 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, 2018 and 2017, 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, 2018 and 2017, the estimated gross professional liability (including current and long-term portions) was $71,508 and $87,766, respectively. The current amount 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 $27,455 and $45,092 as of December 31, 2018 and 2017, 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, 2018 and 2017, the estimated net liability based on future claims cost totaled $15,760 and $16,301, respectively. The gross liabilities (including both current and long-term portions) total $18,526 and $19,504 as of December 31, 2018 and 2017, 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. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $2,766 and $3,203 as of December 31, 2018 and 2017, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

(Dollars in thousands)

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 2018 and 2017 was $9,973 and $15,981, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(13) Long-Term Debt

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

	2018	2017
WHCFA Revenue bonds, 2017 Series A and B	$ 327,990	333,970
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	360,445	364,210
WHCFA Revenue bonds, 2012 Series A and B	60,000	60,000
WHCFA Revenue bonds, 2010 Series A	35,255	43,020
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
Other	39,798	55,087
	1,242,798	1,275,597
Adjusted for:		
Current portion	(19,058)	(19,017)
Bond premiums, discounts, and debt issuance costs	63,449	66,108
Long-term debt, net of current portion	$ 1,287,189	1,322,688

(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 $2,970 in 2019 to $62,410 in 2047. The 2017 Series B bonds were used for the advance refunding of the 2007 Series A, B, C and D bonds, which resulted in a loss in 2017 of $9,576 from the write-off of certain debt issuance costs. This loss on refinancing is included in other income, net on the consolidated statements of operations and changes in net assets.

(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 2.5% and 2.7% at December 31, 2018, reset monthly and are based on 70% of the one-month U.S. LIBOR plus a spread and a margin rate factor.

(c) 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 3.0% and 3.1% at December 31, 2018, reset monthly and are based on the one-month U.S. LIBOR plus a spread.

(d) 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 $4,080 in 2019 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(e) WHCFA Revenue Bonds 2012 Series A and B

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. The 2012 B bonds were refunded in 2017.

(f) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. 2010 Series A bonds were issued as fixed rate bonds that bear interest ranging from 3.00% to 5.25%. Annual principal payments range from $8,155 in 2019 to $9,500 in 2022.

(g) 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.

(h) Other

The other debt listed is primarily made up of debt held by Navos. Of this debt at December 31, 2018, $15,713 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. 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 $6,425 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. The remaining forgivable debt is subject to a forgiveness provision in years 2020 through 2064. The remainder of other debt bears interest ranging from 0.0% to 4.5%. Annual principal payments range from $3,952 in 2019 to $2 in 2033.

(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, 2018 and 2017.

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:	
2019	$ 19,058
2020	22,063
2021	17,173
2022	22,014
2023	18,534
Thereafter	1,143,956
	$ 1,242,798

A summary of interest costs is as follows during the years ended December 31, 2018 and 2017:

	2018	2017
Interest cost:		
Charged to operations	$ 45,574	38,261
Amortization of bond premiums, discounts, and issuance costs	(2,659)	(1,529)
Capitalized	5,282	4,080
	$ 48,197	40,812

(14) Commitments and Contingencies

(a) Operating Leases

MHS leases various equipment and facilities under operating leases expiring at various dates through September 2030. Total rental expense in years 2018 and 2017 for all operating leases was approximately $44,357 and $36,772, respectively.

(Dollars in thousands)

The following is a schedule by year of future minimum lease payments under operating leases at December 31, 2018, which have 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

MHS accounts for leases that contain fixed-escalation or rent holiday provisions on a straight-line basis.

(b) Collective Bargaining Agreements

Approximately 41% of MHS employees were covered under collective bargaining agreements as of December 31, 2018. 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 January 2020.

(15) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2018 and 2017:

		2018	2017
Healthcare services	$	39,785	42,022
Endowment funds, perpetual trusts and related receivables		59,406	64,361
Purchase of equipment		14,559	7,914
Indigent care		785	2,380
Health education		1,001	346
Total net assets with donor restrictions	$	115,536	117,023

(16) 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, 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

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2016	$ 2,837	38,075	40,912
Investment return:			
Investment income	51	668	719
Net appreciation – realized and unrealized	40	651	691
Total investment return	91	1,319	1,410
Contributions	—	163	163
Appropriation of endowment assets for expenditure	(56)	(1,484)	(1,540)
Endowment net assets, December 31, 2017	$ 2,872	38,073	40,945

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 $20,344 and $24,557, respectively, as of December 31, 2018 and 2017. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $922 and $1,731, respectively, as of December 31, 2018 and 2017.

(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 2018 or 2017.

(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 outside of MHS' pooled investments. Those outside 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.

(17) 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, 2018 and 2017:

	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

	2017				
	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	$ 664,886	284,018	65,602	133,993	1,148,499
Employee benefits	95,762	50,608	10,993	33,787	191,150
Supplies	276,519	41,287	25,285	6,477	349,568
Purchased services	75,291	15,802	17,775	89,518	198,386
Depreciation and amortization	77,713	12,215	1,588	39,209	130,725
Interest	34,428	2,174	—	130	36,732
Other	136,795	43,295	11,126	82,755	273,971
	$ 1,361,394	449,399	132,369	385,869	2,329,031

(18) 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 course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(19) Subsequent Events

MHS has evaluated the subsequent events through March 20, 2019, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

MULTICARE HEALTH SYSTEM

Supplemental Schedule – Consolidating Balance Sheet

December 31, 2018

(In thousands)

Assets		MultiCare Health System	Other consolidated entities	Consolidated
Current assets:				
Cash and cash equivalents	$	371,009	15,400	386,409
Accounts receivable, less allowance for doubtful accounts of $41,921 in 2017		370,794	5,047	375,841
Supplies inventory		43,262	125	43,387
Other current assets, net		51,934	5,516	57,450
Total current assets		836,999	26,088	863,087
Donor restricted assets held for long-term purposes		28,067	47,099	75,166
Investments		1,490,716	23	1,490,739
Property, plant, and equipment, net		1,709,124	67,135	1,776,259
Other assets, net		205,945	114,345	320,290
Total assets	$	4,270,851	254,690	4,525,541
Liabilities and Net Assets				
Current liabilities:				
Accounts payable and accrued expenses	$	176,400	24,904	201,304
Accrued compensation and related liabilities		215,221	6,633	221,854
Accrued interest payable		16,364	—	16,364
Current portion of long-term debt		15,265	3,793	19,058
Total current liabilities		423,250	35,330	458,580
Interest rate swap liabilities		45,833	—	45,833
Long-term debt, net of current portion		1,251,389	35,800	1,287,189
Other liabilities, net		127,406	—	127,406
Total liabilities		1,847,878	71,130	1,919,008
Net assets:				
Without donor restrictions		2,422,973	68,024	2,490,997
With donor restrictions		—	115,536	115,536
Total net assets		2,422,973	183,560	2,606,533
Total liabilities and net assets	$	4,270,851	254,690	4,525,541

See accompanying independent auditors' report.

Exhibit 18A.

Gig Harbor | ASC Active Surgeons

MultiCare Gig Harbor | ASC Active Surgeons

FIRST	LAST	Specialty	License Number
Joseph	Shvidler	ENT	MD00047502
Norman	Burns	General	MD00048958
Moritz	Bartels	GYN	MD60094949
Orestes	Molina	GYN	MD60140048
Nels	Sampatacos	Orthopedic	MD60366024
Mason	Platt	Orthopedic	OP60210160
Ericka	King	Peds ENT	MD60906587
Stephanie	Acierno	Peds General	MD00043770
Meade	Barlow	Peds General	MD60765286
Elizabeth	Berdan	Peds General	MD60781159
Mauricio	Escobar	Peds General	MD60067507
Randall	Holland	Peds General	MD00031380
John	Horton	Peds General	MD60295888
Nicholas	Rajacich	Peds Orthopedic	MD00027445
Amanda	Larson	Peds Orthopedic	MD60482537
Nathan	Frost	Peds Orthopedic	MD60143548
Rebecca	Whitesell	Peds Orthopedic	MD60490776
Michael	Cohen	Plastic	MD60383901
Christopher	Nichols	Plastic	MD00049126
Tarak	Patel	Plastic	MD60042373
Roy	Semlacher	Plastic	MD60572161
Philip	Yearian	Podiatry	PO00000535
Sara	Waversveld	Podiatry	PO60088821

Exhibit 18B.

Gig Harbor | ASC Clinical Staff

MultiCare Gig Harbor | ASC Clinical Staff

Staff	Position	License #
Barnes, Paige	Instrument and Materials Coordinator	ST00000212
Casteneda, Savanna	Patient Care Technician	NC60906028
Abalahin, Julie	OR RN	RN0176771
Anderson, Ann Marie	Pedi PACU RN	RN00166108
Aquino, Alaina	OR RN	RN00166495
Blake, Becky	Pre/Post RN	RN60533261
Boquist, Dahn	Pre/Post RN	RN00132760
DePew, Kathy	OR RN	RN00116244/CNOR 1647213
Durant, Becky	Pedi PACU RN	RN00121653
Farley, Vanessa	Pre/Post RN	RN60158912
Francisconi, Danelle	OR RN	RN60703644
Gremillion, Lindsay	OR/PACU RN	RN60909202
Jackson, Shannon	Pedi PACU RN	RN60092845
Johnson, Deanna	OR RN	RN60074421
Jones, Allie	OR RN	RN60325079/CNOR 1658069
Kreycik, Stacie	OR RN	RN00151090
Lindsey, Mika	Pre/Post RN	RN60971801
Matthies, Jamie	OR RN	RN60878612 /CNOR CCI-1618535
Miller, Diana	Pedi PACU RN	Rn00150200
Moreno, Ernirose	Pre/Post RN	RN60720274
Mulhern, Kristen	Pre/Post RN	RN60120690
Nally, Darla	Pre/Post RN	RN00177529
Piacitelli, Jill	Pedi PACU RN	RN00099331
Powers, Deborah	Pedi PACU RN	rn00103618
Schultz, Martie	OR RN	RN00134339
Starr, Victoria	Pre/Post RN	RN00176853
Swanson, Paula	OR Resource RN	RN00057619/ CNOR 084562
Takara, Aileen	Pedi PACU RN	RN00120741
Tweed, Lauren	Pre/Post RN	RN00163783
Valades, Marcy	Pedi PACU RN	RN00146255
Verhagen, Heather	Pre/Post RN	RN60148046
Walker, Ruth	Pedi PACU RN	RN00150590
Welk, Lisette	Pedi PACU RN	RN0114142
Whitmore, Peggy	Pre/Post RN	RN00121078
Barnes, Jared	Surgical Technologist	ST60431965
Epling, Meghan	Surgical Technologist	ST60783359
Harlan, Louise (travel)	Surgical Technologist	ST00000522
Okkerse(Blunck), Nicole	Surgical Technologist	ST00003282

Exhibit 19.

Transfer Agreements

MULTICARE HEALTH SYSTEM
INTER-FACILITY PATIENT TRANSFER AGREEMENT
AMONG MHS-AFFILIATED HOSPITALS & FACILITIES

This Inter-Facility Patient Transfer Agreement ("Agreement") is made by and between each MHS Affiliated Hospital or Facility listed in Exhibit A ("Facility"). Exhibit A may be modified, from time-to-time, to fully reflect all MHS-Affiliated Facilities and entities covered by this Agreement.

All Facilities wish to establish a coordinated program for the use of the respective skills, resources and physical plant of each other MHS-Affiliated Facility to provide improved and continuous patient care.

NOW, THEREFORE, each MHS-Affiliated Facility agrees as follows:

1. **Term of Agreement.** This Agreement shall be effective April 23, 2018 and shall continue for a term of ten (10) years, or until terminated or replaced by a subsequent agreement among the MHS-Affiliated Health Care Facilities described on Exhibit A below.

2. **Purpose of Agreement.** To provide continuous patient care to meet the needs of patients, each MHS Facility agrees to accept appropriate transfers from any other MHS-Affiliated Health Care Facility for MHS patients in need of the specialized services of the type provided by the receiving Facility, whenever the receiving Facility has the capability to accept such a transfer.

3. **Patient Transfer & Transport Policy.** Each Facility shall follow the guidelines and provisions of the MultiCare Health System Patient Care Policy, entitled: Patient Transfer & Transport to Another Facility, as amended, whenever transferring or transporting an MHS patient between Facilities. In addition:

- Patients transferred for cardiac surgery back-up must meet the requirements on Exhibit B.
- Patients transferred to neuro interventional radiology must meet the requirements set forth on Exhibit C.
- Patients transferred for obstetrics must meet the requirements set forth on Exhibit D.
- Neonate patient transfers must meet the requirements set forth on Exhibit E.

4. **Coordination of Transfer of Patient.** The need to transfer a patient from one MHS-Affiliated Facility to another shall be determined by the patient's attending physician. When such a determination has been made, the transferring Facility shall immediately notify the appropriate physician in the receiving Facility's unit of the proposed transfer. The transferring physician and the receiving physician shall confer and jointly determine the patient's appropriateness for transfer. A patient in an emergency medical condition within the meaning of the Act (defined below) may be transferred only if the receiving Facility has agreed to accept the transfer and to provide appropriate medical treatment and has available space and qualified personnel to treat the patient. Prior to moving the patient, the transferring Facility must receive confirmation from the receiving Facility that it can accept the patient.

To the extent applicable, the Emergency Medical Treatment and Active Labor Act of 1985 (42 USC §1395dd) (the "Act") shall apply its implementing regulations and supersede any contrary provision of this Agreement.

5. Patient Medical Records Not Available In EPIC. The transferring Facility shall send along with each transferred patient an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption including a discharge summary together with essential identifying and administrative information, if that information is not otherwise contained within MHS' electronic patient record system (EPIC). The information shall include, when appropriate, the following:

a) Initial diagnostic impression.
b) Patient's name, address, hospital number and age, and name, address and phone number of next of kin.
c) History of injury or illness. d) Condition at admission.
e) Vital signs (including Glasgow coma score).
f) Pre-hospital condition and treatment.
g) Condition and treatment during stay in emergency department and at time of transfer.
h) Treatment rendered to patient including medications given and route of administration.
i) Laboratory and x-ray findings, appropriate laboratory specimens (when appropriate or indicated) and all x-ray films.
j) Fluids given by type and volume.
k) Name, address and phone number of physician referring the patient.
l) Name of physician at receiving party who has been contacted about the patient.
m) Name, address and phone number of patient's designee who is patient's attorney-in-fact under patient's healthcare power of attorney.
n) The original or a copy of patient's healthcare power of attorney, living will and/or healthcare directives. Additional

information may be required as set forth on the applicable Exhibit.

6. Transportation of Patient. The transferring Facility shall arrange for transportation of the patient to the receiving Facility including selection of the mode of transportation and providing qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transfer unless otherwise agreed between the Facilities. The receiving Facility's responsibility for the patient's care shall begin when the patient is admitted either as an inpatient or an outpatient at the receiving Facility.

7. Transfer of Patient's Personal Property. The transferring Facility is responsible for the transfer or the appropriate disposition of the patient's personal effects including money and valuables and information related to these items. The receiving Facility's responsibility for the Patient's personal effects and belongings shall begin when the receiving Facility has inventoried and documented receipt of such items.

8. Patient's Consent to Transfer. The transferring Facility is responsible for obtaining the patient's consent (or proper substituted or implied consent) to the extent necessary under the Act.

9. Patient Transfer Coordinators. Each Facility shall provide the other Facility with the name and title of persons authorized to initiate, confirm and accept the transfer of a patient on behalf of such Facility. Each receiving Facility shall inform the transferring Facility of the location to which to bring patients in the Facility. The MHS-Affiliated Facilities agree to provide each other information about the patient care services offered by each Facility. The Facilities agree to cooperate and jointly review cases in which either party has questions about appropriateness of transfer.

10. Transfers Arising from Mass Casualties or Natural Disasters: Mutual Aid Pact. In the event of any cause or circumstance arising from a natural disaster or mass casualty, each MHS-Affiliated Facility shall communicate with other MHS-Affiliated Facilities as soon thereafter as is practicable, to ascertain the relative impacts of such disaster or casualty upon one another and their respective capabilities for sending and/or receiving patients under the Agreement. In such situations:

a) Whenever circumstances allow, each Facility, as the receiving Facility, further agrees to accept "block transfers" of as many patients sent from the sending Facility as may be practicable, to free up beds in the Facility most directly impacted by the event, including patients with lower acuity levels or non-emergent needs.

b) Each facility will, in addition to their obligations under the Agreement, establish communications protocols to be triggered in the event of a natural disaster or mass casualty, including the appointment of designated patient transfer coordinators at each facility who shall act as the primary point(s) of contact during any such event or circumstance.

c) At such time as the long-term needs of the sending Facility are better understood in the context of the event, the sending Facility will advise the receiving Facility of its capacity to retrieve patients sent in contemplation of the need for bed space, at which time the parties will evaluate the plan of care for each such patient and determine whether the patient's needs will best be met by returning to the original Facility or remaining at the receiving Facility.

11. Nondiscrimination. No MHS-Affiliated Facility may refuse to receive a patient because of such patient's race, religion, gender, age, national origin, sexual orientation, marital status, handicap, disability or medical diagnosis in providing services under this Agreement.

12. Patient HIV Status. No MHS-Affiliated Facility may refuse to receive a patient because the patient is HIV positive or has AIDS. To the extent that such information is not specially protected within EPIC, the portion of the medical records reflecting the patient's HIV or AIDS status will be transmitted in a secure and sealed envelope with the patient's medical records. The patient's HIV status may be disseminated only to those healthcare providers who have a medical need to know or as provided by law.

13. Confidentiality. Each MHS-Affiliated Facility agrees that the confidentiality of each patient's medical records must be maintained. To achieve that goal, each MHS-Affiliated Facility agrees to transport medical records in a manner designed to maintain the confidentiality of the medical record as required by applicable law, including applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

14. Financial Arrangements- Non-MHS-Owned Facilities. Charges for services performed by each Facility for patient's transfer pursuant to this Agreement shall be collected by the party rendering such services and shall be collected directly from patient, from third party payors or other sources of payment. To the extent that this agreement applies to any Facility which is not wholly owned by MHS, no MHS- Affiliated Facility shall have any liability to any other MHS-Affiliated Facility for the billing, collection or payment of charges for services performed by such other Facility except as otherwise provided in this Agreement or to the extent that such liability would exist separate and apart from this Agreement.

15. Independent Contractor Status – Non-MHS-Owned Facilities. To the extent that any MHS-Affiliated Health Care Facility is not wholly owned by MHS, such Facility may constitute an independent contractor with respect to the other party. In such circumstances, neither party is authorized or permitted to act or to claim to be acting as an agent or employee of the other party. Nothing in this Agreement alters in any way control of the management, assets or affairs of either party. In such circumstances, neither party by this Agreement assumes any liability for any debts or obligations of any kind incurred by the other party to this Agreement. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other Facility on a limited or general basis.

16. Compliance with Laws and Regulations. Each Facility is deemed an instrumentality of the Federal Government [Medicare/Medicaid Providers] and terms of this agreement will be construed in accordance with applicable Federal and State statutes.

17. Termination Without Cause. Any MHS-Affiliated Facility may terminate its participation in this Agreement without cause, upon 30 days' advance written notice to all other participating MHS-Affiliated Facilities identified in Exhibit A, in which event the terminating Facility must complete its duties under the Agreement with respect to any patient who is being transferred at the time of termination.

18. Agreement Remains Valid Between Other MHS-Affiliated Facilities. The termination of this Agreement by any Facility shall not affect the duties and obligations of other MHS-Affiliated Facilities participating in this Agreement.

19. Authorization for Agreement. The execution and performance of this Agreement by each MHS-Affiliated Facility has been duly authorized by MultiCare Health System and this Agreement constitutes the valid and enforceable obligation of each MHS-Affiliated Facility in accordance with its terms.

SIGNATURE PAGE TO FOLLOW

IN WITNESS, WHEREOF, MultiCare Health System hereby affirms the obligation of each MHS-Affiliated Facility identified herein to abide by the terms of this Agreement until terminated.

MultiCare Health System:

By: 

Print Name: Tim Bricker

Title: SVP – Chief Exec. – South Sound Region

Date: 4/17/18

MultiCare Health System:

By: 

Print Name: Bill Robertson

Title: CEO – MHS

Date: 4/17/18

Exhibit A

MHS Affiliated Hospitals & Facilities

The following Facilities are each wholly-owned MHS Facilities subject to this Agreement as MHS Affiliated Hospitals & Facilities ("Facility" and/or "Facilities"):

Tacoma General Hospital

Allenmore Hospital

Good Samaritan Hospital

Auburn Medical Center

Mary Bridge Children's Hospital

Covington Medical Center

Deaconess Hospital

Valley Hospital

Good Samaritan Rehabilitation (Division of Good Samaritan Hospital) Day Surgery of Tacoma

Gig Harbor Ambulatory Surgery Center

Exhibit B

Requirements for Elective PCI Patients

Purpose: This Exhibit B to the MHS Inter-Facility Patient Transfer Agreement applies to patients transferred to MHS Tacoma General Hospital for cardiac surgery back-up and support following elective percutaneous coronary interventions ("PCI Patients") at a facility without the availability of on-site cardiac surgeons.

1. Consent. In addition to the requirements set forth in the Agreement, the Party performing the intervention or PCI, shall obtain consent from PCI Patients which explicitly communicates to such patients that the percutaneous coronary intervention ("PCI") is being performed without on-site surgery back-up and addresses risks related to transfer, the risk of urgent surgery which would require a transfer to MHS Tacoma General Hospital for on-site surgery back-up, and refer to this Agreement.

2. Coordination. Facilities lacking on-site surgery backup shall coordinate, to the extent possible, the availability of surgical teams and operating rooms at MHS so that for all hours that elective PCIs are being performed at Facility, there is a reasonable likelihood that MHS has the capacity to immediately accept a referral. The Parties acknowledge and agree that nothing in this Agreement imposes an obligation on MHS to maintain an available cardiac surgical suite twenty-four hours a day, seven days a week and that the only MHS Hospital with on-site surgery back-up is MHS Tacoma General Hospital.

3. Periods of High Occupancy. During times of high census where a Facility's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), that Facility will notify those MHS Facilities performing PCI procedures, which lack on-site surgical backup, that elective procedures will be rescheduled subject to the attending physician's assessment that such delay does not compromise the patient's care and condition.

4. Transportation of PCI Patients. In addition to the requirements set forth in Section 5 of the Agreement, Facility shall:

a. Maintain a signed transportation agreement with a qualified vendor that provides for expeditious transport for any patient experiencing complications during an elective PCI that requires transfer to another Facility. A qualified vendor is one whose transport staff is ACLS certified. The transferring Facility will provide the experienced and skilled personnel and equipment to monitor and treat the patient en route, including management of an intra-aortic balloon pump (IABP);
b. Document and confirm that emergency transportation begins for each patient within twenty minutes of the initial identification of a complication by the attending physician;
c. Document transportation times from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of receiving Facility and confirm transportation time is less than one hundred twenty minutes; and
d. Participate annually in two timed emergency transportation drills with outcomes communicated to each participating Facility's quality assurance programs. The staff and cost of internal resources used for such drills will be the responsibility of each Facility employing such staff or owning that resource. The cost of any external resources required for such drills will be the responsibility of each Facility.

5. PCI Patient Medical Records. In addition to the information required in Section 6 of the Agreement, transferring Facility shall send to receiving Facility all records (or copies thereof) related to the emergency condition which the patient has presented available at the time of the transfer, along with all diagnostic imaging and videos, if such records, diagnostic imaging and videos are not otherwise directly accessible via EPIC or other electronic systems maintained by MHS at each applicable Facility associated with such transfers.

6. Physician Communication. Transferring Facility will monitor all transfers to assure that the physician performing the elective PCI communicates immediately and directly with receiving Facility's cardiac surgeon(s) about the clinical reasons for the urgent transfer and the PCI Patient's clinical condition.

7. Quality Assurance. The Parties shall schedule cardiac patient care quality assurance conferences at least twice per year that involve case reviews of a significant number of pre-operatives and post-operative PCI cases at Facility including a one-hundred percent (100%) review of all transport cases.

Exhibit C

Requirements for Stroke Patients

Purpose: This Exhibit C to the MHS Inter-Facility Patient Transfer Agreement applies to stroke patients transferred to a MHS neuro-interventional radiology program ("Stroke Program").

1. **Coordination**. Facilities shall coordinate, to the extent possible, transfer process and communication through the MultiCare Health System Transfer and Triage Center. There is a reasonable likelihood that another MHS Facility has the capacity to immediately accept a transfer.

2. **Periods of High Occupancy**. During times of high census where Facility's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), that Facility will notify those MHS Facilities and Facility's elective procedures will be rescheduled subject to the attending physician's assessment that such delay does not compromise the patient's care and condition.

3. **Transportation of Stroke Patients**. In addition to the requirements set forth in Section 5 of the Agreement, Facility shall:

   a. Maintain a signed transportation agreement with a qualified vendor that provides for expeditious transport for any stroke patient that requires transfer to another Facility. A qualified vendor is one whose transport staff is ACLS certified; critical care transport is preferred.

   b. The patient's medical condition and the ability of the transferring hospital to provide necessary stabilizing treatment and the clinical judgment of the transferring and receiving physicians is the determining factor as to when the patient should be transferred.

   c. Provide the following patient care including:
   -IV access (Preference is RAC and Left arm 18 gauge if possible)
   -Use Normal saline for all fluids
   -NPO unless patient passed a documented RN swallow screen (consider gastric tube for medications)

4. **Stroke Patient Medical Records**. In addition to the information required in Section 5 of the Agreement, Facility shall send to MHS all records (or copies thereof) related to the emergency condition which the patient has presented available at the time of the transfer, along with all diagnostic imaging and videos.

5. Physician Communication. Transferring Facility will monitor all transfers to assure that the receiving physician immediately is available to address the clinical reasons for the urgent transfer and patient's clinical condition.

7. Quality Assurance. The receiving Facility shall provide hospital summary after discharge. This is handled by the MHS Transfer and Triage Center. The receiving Facility reviews 100% of transfers, coordinated by the Director of Stroke Quality Management. Summary reports are provided on a quarterly basis to the transferring Facilities.

Exhibit D
Requirements for Obstetric Patients

Purpose: This Exhibit C to the MHS Inter-Facility Patient Transfer Agreement applies to obstetric patients transferred to a MH facility.

1. **Contact Numbers:**
   a. Transfers to TG: (253-403-1034)
   b. Transfers to GSH: (253-697-5900)
   c. Transfers to AMC: (232-333-2522)

2. **Tacoma General Hospital**. Each Facility shall use the following checklist when transferring obstetric patients to Tacoma General Hospital.
   a. Contact the Birth Center Charge Nurse (253-403-1034) to coordinate transfer, to include confirmation of available obstetric bed space, confirmation of available NICU bed space (if applicable), and identification of an accepting provider.
   b. If transferring to Maternal Fetal Medicine service, the Birth Center Charge Nurse will contact the MFM Provider on call and arrange a return call to the transferring provider.
   c. If transferring a low risk patient due to unavailable obstetric services and the patient has no Obstetric provider at Tacoma General Hospital, the Birth Center Charge Nurse will facilitate contact with the MultiCare OB/GYN Associate on call to receive the patient as an obstetric "NO DOC" patient.
   d. If transferring a low risk patient requiring the level of services available at Tacoma General Hospital, but transferring provider is retaining status as attending provider, coordinate transfer with the Birth Center Charge Nurse.
   e. Proceed to Section 4 below, All MHS Obstetrics Transfers.

3. **Good Samaritan Hospital and Auburn Medical Center**. Each Facility shall use the following checklist when transferring obstetric patients to Good Samaritan Hospital or Auburn Medical Center.
   a. Patients must be 34 weeks or greater and deemed low risk prior to transfer. All patients less than 34 weeks or deemed high risk will be transferred to TG.
   b. Contact the Labor and Delivery Charge Nurse at Good Samaritan (253-697-4383) or Auburn Medical Center (232-333-2522) to coordinate transfer, to include confirmation of available obstetric bed space, confirmation of available SCN bed space (if applicable), and identification of an accepting provider.
   c. OBHG will be contacted to assess and accept appropriate transfers. This will be a provider to provider call.
   d. Proceed to Section 4 below, All MHS Obstetrics Transfers.

4. **All MHS Obstetrics Transfers.** After consultation, if the patient is accepted for transfer, follow sending Party's policies for transferring a patient to another facility. For patients whose prenatal course is not documented in EPIC, include copy of the prenatal chart with transport documents.
   a. For patients with diagnosis of preterm labor or active term labor, reassess cervical dilatation prior to transporting the patient, if last exam has been greater than 1 hour (documentation of which shall be provided under Section 4(d) below), to assure that advanced labor has not increased the risk of in transit delivery.

b. For patients with preterm labor or active labor with fetal concerns, where risk for delivery in transit is high, contact the NICU to coordinate attendance of the Neonatal Transport Team to stabilize and transport the neonate.
c. Prior to the patient's departure from the transferring Party, a hand off report to the Birth Center Charge Nurse will occur.
d. In addition to the requirement s of this Agreement, provide the following, if such records are not directly available at the receiving Party through EPIC or other systems maintained by MHS at the receiving Party:
    i. Copy of the patient's hospital chart including:
        1. Prenatal record
        2. Allergies
        3. Past medical history, home medications
        4. Medications and treatment at the transferring Party
        5. Summary of current complaint to include onset, signs and symptoms
        6. Demographic face sheet
        7. Documentation of the (1) labor assessment, (2) last exam, (3) fetal heart rate and (4) vital signs.

Exhibit E

Requirements for Neonates

Purpose: This Exhibit D to the MHS Inter-Facility Patient Transfer Agreement applies to neonate patients transferred to a MHS Facility. MHS and Facility are sometimes referred to in this Exhibit E individually as "Party" or, collectively, as the "Parties."

1. **Contact Numbers:**
    a. Transfers to TG: (253-403-1024)
    b. Transfers to GSH: (253-697-5900)
    c. Transfers to AMC: (253-545-2522 and request the NICU department)
2. **Tacoma General**. Facility shall adhere to the following when requesting a transfer to the Tacoma General NICU:
    a. Consult with the Neonatologist on call in the MHS NICU (253-403-1024).
    b. After consultation, if the patient is accepted for transfer by the neonatologist, the TG NICU Transport Team will be dispatched to transport the infant.
    c. The Transport Team will provide the following documents and request they be completed (the transport team may assist in completing the forms or the physician at the referring hospital may do so):
        i. Signed, dated and timed "Neonatal Transport Consent"
        ii. Signed, dated and timed "Notice of Privacy Practices Acknowledgement Form"
        iii. Signed, dated and timed "Authorization for MultiCare to use or disclose My Health Care Information"
        iv. Provide copies of the patient/maternal chart:
            1. All maternal documentation (i.e. Maternal History/physical; lab values; delivery notes; nurses/physician notes; etc.)
            2. All infant documentation: (i.e. Admission physical, lab values, radiology studies, nursing notes, physician notes, etc.)
3. **Good Samaritan Hospital and Auburn Medical Center.** Facility shall use the following checklist when transferring neonatal patients to Good Samaritan Hospital or Auburn Medical Center.
    a. Patients must be 34 weeks or greater and deemed low risk prior to transfer. Any patient less than 34 weeks or deemed high risk must be transferred to the TG NICU.
    b. Contact the Labor and Delivery Charge Nurse at Good Samaritan (253-697-4383) or Auburn Medical Center (232-333-2522) to coordinate transfer, to include confirmation of available SCN bed space and identification of an accepting provider.
    c. IPS (253-597-4626) will be contacted to assess and accept appropriate transfers. This will be a provider to provider call.
    d. After consultation, if the patient is accepted for transfer, follow sending Party's policies for transferring a patient to another facility.
    e. Prior to the patient's departure from the transferring Party, a hand off report to the Special Care Nursery Nurse must occur.
    f. In addition to the requirements of this Agreement, provide the following, if such records are not directly available at the receiving Party through EPIC or other systems maintained by MHS at the receiving location:
        i. Copy of the patient's hospital chart including:
            1. Birth record
            2. Medications and treatment at the transferring Party
            3. Nursing notes

4. Summary of current complaint to include onset, signs and symptoms (H&P and progress notes)
5. Physician orders
6. Demographic face sheet

Exhibit F

Requirements for Pediatric Patients

Purpose: This Exhibit F to the MHS Inter-Facility Patient Transfer Agreement applies to pediatric patients transferred to Mary Bridge Children's Hospital.

1. **Contact Numbers:**

Transfer to Mary Bridge Children's Hospital:

Contact the Transfer Center (855-647-1010)

2. **Transfers to Mary Bridge:** Facility shall adhere to the following when requesting a transfer to Mary Bridge Children's Hospital:
    a. Contact the transfer center to get in touch with any of the following Inpatient Physician Services (IPS), Emergency Department physician or Pediatric Intensivist. (855-647-1010)
    b. The transfer center will connect the referring physician to the correct MB physician to consult and accept transfer.
    c. If the patient is accepted for transfer by the MB designated physician, the MB physician will offer the pediatric transport team (TT) to come and retrieve the patient.
    d. If the TT is not available, the referral physician and the MB physician will discuss the safest alternative mode of transportation for the patient.
    e. The Transport Team will provide the following documents and request they be completed (the transport team may assist in completing the forms or the physician at the referring hospital may do so):
        1. Signed, dated and timed "Transport Consent"
        2. Signed, dated and timed "Notice of Privacy Practices Acknowledgement Form"
        3. Signed, dated and timed "Authorization for MultiCare to use or disclose My Health Care Information"
        4. Provide copies of the patient's chart:
            1. All pediatric documentation: (i.e. Admission physical, lab values, radiology studies, nursing notes, physician notes, transfer summary, etc.)
        5. Signed, dated and timed "Passenger Release of Liability"
            1. It will be at the TT discretion to allow 1 family member to accompany the patient in the ambulance. So long as the patient's status is stable and the family member will not be a hindrance to the safe transport of the patient.