STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR CERTIFICATE-OF-NEED
Hospital Projects

(Excluding Sale, Purchase or Lease of Hospital, Nursing Home Related Projects, and CCRC Related Projects)

Certificate-of-need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990 and the instructions on page 2 of this form.

Application is made for a Certificate-of-need in accordance with provisions of Chapter 70.38 Revised Code of Washington (RCW) and Rules and Regulations adopted by the Department (WAC 246-310). I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Project Description:

(PLEASE PRINT OR TYPE)

OWNER:
Name and Title of Responsible Officer:
Theresa Boyle
Senior Vice President, Strategy, Marketing and Communication
Legal Name of Owner:
MultiCare Health System
Address of Owner:
315 Martin Luther King Way
Tacoma WA 98405
Signature of Responsible Officer:
Theresa Boyle
Date: January 10, 2018 Telephone: (253) 403-8770

(PLEASE PRINT OR TYPE)

OPERATOR:
Name and Title of Responsible Officer:
Theresa Boyle
Senior Vice President, Strategy, Marketing and Communication
Name of Operator:
MultiCare Tacoma General Hospital
Address of Operator:
315 Martin Luther King Way
Tacoma WA 98405
Signature of Responsible Officer:
Theresa Boyle
Date: January 10, 2018 Telephone: (253) 403-8770

TYPE OF OWNERSHIP:
- ☐ District
- ☒ Private Non-Profit
- ☐ Proprietary – Corporation
- ☐ Proprietary – Individual
- ☐ Proprietary – Partnership
- ☐ State or County

Proprietor(s) or Stockholder(s) information:
Provide the name and address of each owner and indicate percentage of ownership:

OPERATION OF FACILITY:
- ☒ Owner Operated
- ☐ Management Contract
- ☐ Lease

TYPE OF PROJECT (*check all that apply*):
- ☐ New Health Care Facility
- ☒ Bed Addition
- ☐ New Tertiary Health Service
- ☐ Pre-Development Expenditure
- ☐

Intended Project Start Date:
August 1, 2018

Estimated Capital Expenditures:
$ $6,901,360

Project Description:
MultiCare Tacoma General Hospital submits this application for Certificate of Need approval to add 14 beds to its Level IV neonatal intensive care unit beds, as defined in the Washington State Perinatal and Neonatal Level of Care Guidelines.

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INSTRUCTIONS FOR SUBMISSION: DO NOT bind your application. Bindings, notebooks and other covers are not necessary. Please number the pages at the bottom, and two-hole punch the application material at the top of the pages.

1. Mail two copies of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
PO Box 47852
Olympia, Washington 98504-7852

The application must be accompanied by a check, payable to: ***Department of Health***.

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: $ 40,470 (see the enclosed fee schedule)

APPLICANT NAME: MultiCare Tacoma General Hospital

DATE OF SUBMISSION: January 10, 2018 CHECK NUMBER: #1446208

MultiCare

BetterConnected

MultiCare Tacoma General Hospital

Certificate-of-Need Application to add 14 beds to its Level IV Neonatal Intensive Care Unit

January 10, 2018

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Executive Summary

Introduction

MultiCare Tacoma General Hospital ("Tacoma General") is jointly licensed with MultiCare Allenmore Hospital by the Department of Health to operate 567 beds.[1] Tacoma General Hospital received Washington State Department of Health Certificate of Need approval to operate a total of 40 Level IIIB NICU ("neonatal intensive care unit") beds in 2012. In 2014, the Department issued a Determination of Non-Reviewability that recognized these 40 beds as Level IV [2] beds as defined in the Washington State Perinatal and Neonatal Level of Care ("LOC") Guidelines, February 2013.[3] That unit now operates as a Level IV program on the Tacoma General campus.

MultiCare Health System ("MultiCare") submits this application to add 14 beds to its existing Level IV NICU located at Tacoma General. If approved, Tacoma General would be authorized by the Department to operate a total of 54 Level IV NICU beds. Approval would also increase the licensed bed count by 14 for a total of 581 licensed beds at MultiCare Tacoma General Hospital and MultiCare Allenmore Hospital.

Tacoma General Hospital Level IV NICU

Tacoma General's Level IV NICU is the Southwest Washington regional referral center for care of neonates requiring intensive care, up to and including Level IV services. The Tacoma General Neonatal Program currently includes 70 beds in total, comprising 30 Level II and 40 Level IV NICU beds. The Tacoma General Level IV NICU is the only designated Level IV NICU program between Seattle and Portland, with a service area that includes Grays Harbor, Kitsap, Lewis, Mason, Pacific, Pierce, and Thurston. However, it receives neonates from a much broader catchment area, including all Southwest Washington counties. A dedicated, freestanding MultiCare Neonatal Transport Team supports the transport of neonates born in the service area who require complex neonatal care. Tacoma General is also one of 4 designated hospitals within the Washington State Perinatal Regional Network, along with Yakima Valley Memorial Hospital in Yakima, Sacred Heart Medical Center in Spokane, and University of Washington Medical Center in Seattle.[4] Tacoma General is designated as the Southwest Washington Perinatal Network coordinating hospital to coordinate and implement state and regional quality improvement projects to improve pregnancy and newborn outcomes.

MultiCare Health System

MultiCare is a locally-governed, not-for-profit, integrated health system that owns and operates Tacoma General Hospital, Allenmore Hospital, Good Samaritan Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, and the area's largest network of primary care and specialty clinics. In spring 2012, MultiCare was approved by the Department of Health to develop and operate a new 58-bed hospital in Covington, WA. Further, in June 2017 MultiCare was approved to purchase Deaconess Hospital and Valley Hospital in Spokane, WA. As MultiCare continues to

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[1] This includes 467 acute care beds, 40 Level IV beds, 30 Level II bed and 30 PPS ("Prospective Payment System") exempt psychiatric beds, approved in 2015.

[2] Also referred to as a "Regional Neonatal Intensive Care Unit" or "Regional Level IV NICU." For purposes of this application, we will refer to Tacoma General's program as a "Level IV NICU."

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

[4] https://www.doh.wa.gov/YouandYourFamily/WomensHealth/Perinatal/RegionalNetworks

expand, it is imperative the hospital has the necessary specialized NICU capacity to meet the needs of our communities. Without the proposed expansion of its Level IV NICU, Tacoma General's ability to ensure patients in the region have access to critical neonatal specialty care services will be compromised.

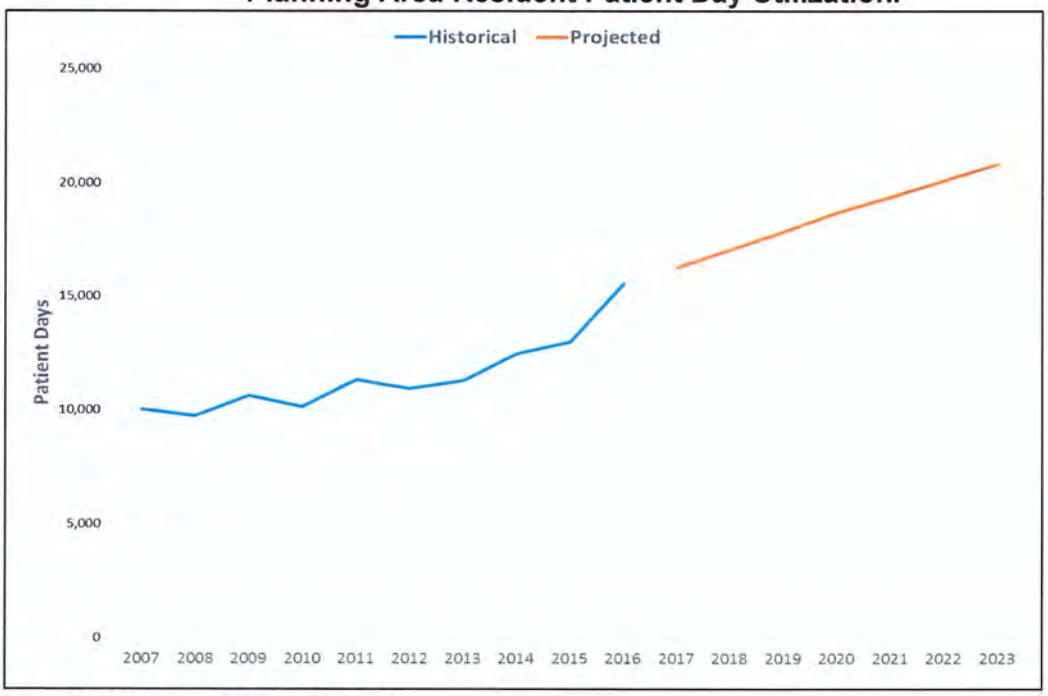
Project Rationale

This request for 14 additional Level IV NICU beds is intended to make the necessary additions to the Tacoma General license to ensure there is adequate, approved capacity to care for area residents over a reasonable forecast horizon, as well as allow for development of a program to enhance services for premature infants. As the only regional Level IV NICU provider, approval of this application is very important. This application is consistent with a 7-year bed need forecast for the planning area, defined as Pierce, Kitsap, Thurston, Grays Harbor, Pacific, Mason, and Lewis counties, further discussed in the application.

Rapid historical and projected growth in patient days for residents in the region

Please see Figure 1 below for a depiction of the historical and projected Level IV NICU utilization, based on patient days, by Planning Area residents. Planning Area (Pierce, Kitsap, Thurston, Grays Harbor, Pacific, Mason, and Lewis counties) patient days for NICU Level IV care grew 4.9% annually from 2007-2016 and 8.8% annually from 2010-2014. Clearly, historic data demonstrates increasing demand for Level IV NICU services from Planning Area residents. Moreover, projected patient days for Planning Area residents, derived from our 7-year bed need forecast model that incorporates the historical experience in the Planning Area and projects it onto the future population projections, demonstrates considerable growth throughout the forecast period.

Figure 1. Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Planning Area Resident Patient Day Utilization.

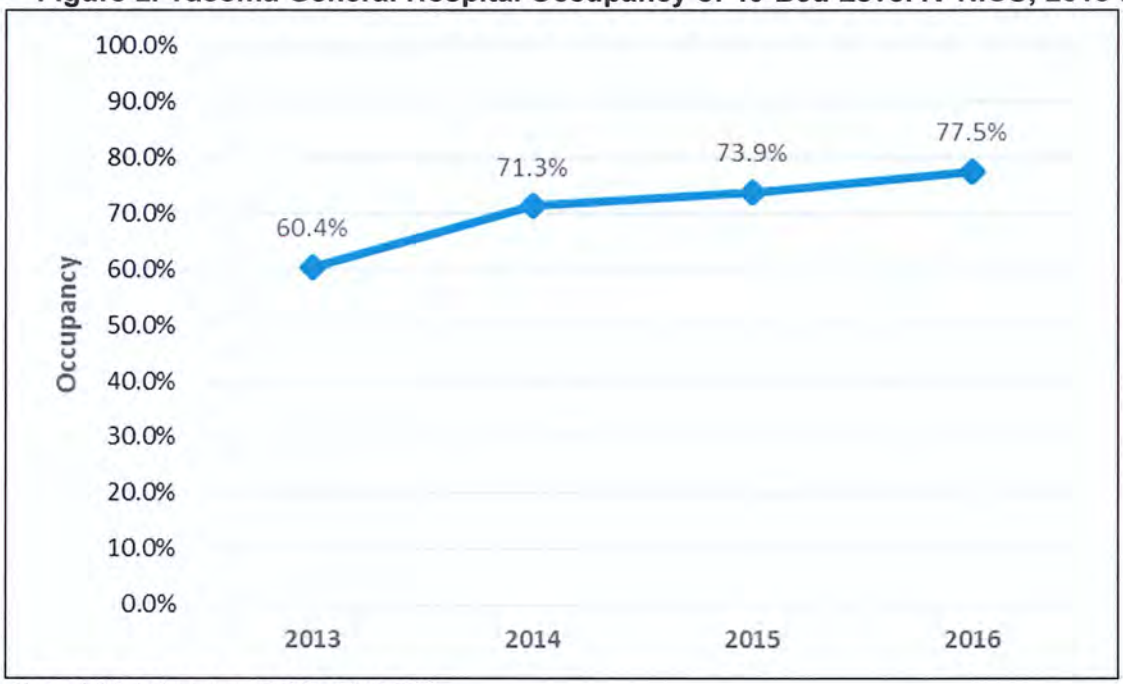


*Level IV defined as DRGs 789-790
Source: CHARS 2007-2016

Current capacity issues at Tacoma General

The need for the additional Level IV beds is related to current operational needs, as well as future space constraints. An historical examination of Tacoma General's occupancy for the past four years clearly illustrates the growing demand placed on its Level IV NICU, as well as its limited capacity to address future demand by regional patients (Figure 1) and others in-migrating to receive Level IV NICU care. As shown in Figure 2, Tacoma General is operating at 77.5% occupancy as of the most recent full year available in CHARS (CY2016). This figure shows that there are sizeable demand pressures on Tacoma General's Level IV NICU; especially given the occupancy standard for a specialty service such as a NICU is 65%.[5] In fact, Tacoma General's Level IV NICU has been operating above the 65% occupancy standard for the past three years. Please note these occupancy figures are based on the average daily census figures. As a result, they do not account for census variations, such as seasonal peaks. At our current trend, without additional capacity, we will be at capacity and diverting patients to other centers in the near future.

Figure 2. Tacoma General Hospital Occupancy of 40-Bed Level IV NICU, 2013-2016



*Level IV defined as DRGs 789-790
Source: CHARS 2013-2016

Small Baby Unit Program Expansion

The requested project will also allow for development of a program to enhance services for premature infants. Tacoma General's youngest and most vulnerable population are patients born at 28 weeks or less. These patients are highest risk and encompass the longest length of stay.

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[5] See Washington Department of Health, "Evaluation dated March 28, 2012 for the Following Two Certificate of Need Applications Proposing to Expand Neonatal Intensive Care Nursery Level III/Obstetric Services Within Pierce County-MultiCare Health System-Tacoma General Hospital; and Franciscan Health System-ST. Joseph Medical Center," p. 18. In its application, MultiCare used 65% as the appropriate occupancy standard for its request and the department agreed with this standard for its Level III request.

We currently have approximately 100 babies born each year that are considered extremely premature, including micro-premies. These patients require hospitalization for up to three months or more, creating hardships for families, compounded by needing to travel out of the area when patients are transferred due to divert status related to no capacity at the local facility.

Additional Level IV NICU beds will allow for the creation of a central location for these premature infants, called a Small Baby Unit, providing the opportunity for focused care, resources, and parental education, which would be a needed complement to the existing Level IV NICU resources and clinical staff. The focus of this unit will be to improve outcomes of our smallest patients in a standardized, best practice approach. Development of Small Baby Units has shown to significantly improve outcomes and has become a national trend to provide the highest quality of care. Research has found that many surviving, very low birth weight premies have neurodevelopmental delays and chronic medical conditions. Small Baby Units that are focused solely on this patient population have been shown to improve outcomes.[6]

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6 Please see American Academy of Pediatrics' research study on Small Baby Units at:

http://pediatrics.aappublications.org/content/136/4/e1007

I. APPLICANT DESCRIPTION

A. Legal name(s) of applicant(s).

The applicant's legal name is MultiCare Health System (MultiCare).

The owning entity is *MultiCare Health System.*

The proposed project will be operational at *MultiCare Tacoma General Hospital.*

B. Address of each applicant.

The applicant's address is:

MultiCare Health System
315 Martin Luther King Jr. Way
Tacoma, WA 98405

The address of *MultiCare Tacoma General Hospital* is the same as the applicant.

C. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

This question is not applicable.

D. Provide separate listings of each Washington and out-of-state health care facility, including name, address, Medicare provider number, Medicaid provider number, owned and/or managed by each applicant or by a related party, and indicate whether owned or managed. For each out-of-state facility, provide the name, address, telephone number and contact person for the entity responsible for the licensing/survey of each facility.

Please see Table 1.

Table 1. MultiCare Health System. Hospital Facility Information

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 99204-2803	500044	2083493	Owned
MultiCare Valley	12606 East Mission Ave. Spokane Valley 99216-3421	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

E. Facility licensure/accreditation status.

MultiCare Health System

MultiCare is licensed by the Washington State Department of Health and accredited by the Joint Commission and also participates in numerous accreditation, licensure and certification reviews by external agencies. MultiCare has the following licensure, certification and accreditation designations:

Washington State Department of Health, Acute Care Hospital License:

- MultiCare Tacoma General/Allenmore Hospital, Expiration:12/31/2017; Renewing effective 12/31/2017
- MultiCare Mary Bridge Children's Hospital, Expiration: 12/31/2017; Renewing effective 12/31/2017
- MultiCare Good Samaritan Hospital, Expiration: 12/31/17; Renewing effective 12/31/2017
- MultiCare Auburn Medical Center Expiration: 12/31/2017; Renewing effective 12/31/2017
- MultiCare Valley Hospital, Expiration: 12/31/2018; Renewing effective 12/31/2018
- MultiCare Deaconess Hospital, Expiration: 12/31/2018; Renewing effective 12/31/2018

Joint Commission Accreditation:

- Hospital Accreditation:

    - MultiCare Tacoma General/Allenmore Hospital, Effective: 2/7/2014
    - MultiCare Mary Bridge Children's Hospital, Effective: 2/7/2014
    - MultiCare Good Samaritan Hospital, Effective: 3/24/2017
    - MultiCare Auburn Medical Center, Effective: 8/4/2017
    - MultiCare Valley Hospital, Effective: 9/9/2015
    - MultiCare Deaconess Hospital, Effective: 1/30/2015
- MultiCare Tacoma General:
    - MultiCare Tacoma General/Allenmore Home Care Program, Effective: 2/7/2017
    - MultiCare Tacoma General/Allenmore Hospital Advanced Primary Stroke Certification, Effective: 3/5/2015
    - MultiCare Tacoma General/Allenmore Hospital Ventricular Assist Device Certification, Effective: 12/11/2015; Re-certification in November 2019
- MultiCare Mary Bridge:
    - MultiCare Mary Bridge Children's Hospital Home Care Program, Effective: 2/7/2014
- MultiCare Good Samaritan
    - MultiCare Good Samaritan Hospital Advanced Primary Stroke Certification: Effective: 6/3/2015
    - MultiCare Good Samaritan Hospital Home Health & Hospice, Effective: 7/17/2017
- MultiCare Auburn:
    - MultiCare Auburn Medical Center Advanced Primary Stroke Certification, Effective: 1/20/2015
- MultiCare Deaconess:
    - MultiCare Deaconess Lab, Effective: 10/17/2017
    - MultiCare Deaconess Hospital, Effective: 1/30/2015
    - MultiCare Deaconess Certified Primary Stroke Center, Effective: 11/21/2016
    - MultiCare Deaconess Certified Knee and Hip Replacement Program, Effective: 8/16/2016
    - MultiCare Deaconess Top Performer on Key Quality Measures, Effective: 2014
- MultiCare Valley Hospital:
    - MultiCare Valley Lab, Effective: 11/7/2017
    - MultiCare Valley Hospital Certified Knee and Hip Replacement Program, Effective November 8, 2017
    - MultiCare Valley Hospital and Laboratory, Effective: 9/11/2015
    - MultiCare Valley Hospital Top Performer on Key Quality Measures for 2010, 2011, 2013, 2014
    - MultiCare Valley Hospital Quality Awards 2010-2011
    - MulitCare Valley Hospital "Gold Standard" for Labs August 8, 2017

Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation:

- MultiCare Good Samaritan Hospital Regional Rehabilitation Center, Effective: April 2015; Recertification April 2018
- Stroke Specialty, Effective: April 2015; Recertification April 2018

Society of Chest Pain Centers (SCPCP) Accreditation:

- MultiCare Tacoma General Hospital: Effective 1/2015, Not Renewing
- MultiCare Good Samaritan Hospital: Effective 1/2015, Not Renewing
- Cardiac Destination: Renewed TGH/AH/GSH, May 2017

American Academy of Sleep Medicine (AASM):

- MultiCare Tacoma General/Allenmore Hospital, Effective: 5/2015
- MultiCare Sleep Center South Hill, Effective: 5/2010, 5/2015
- MultiCare Good Samaritan Sleep Medicine Center, Effective: 5/2015
- MultiCare Auburn Medical Center, Effective: 4/2015
- Clinical Neurophysiology Tacoma General Hospital and Mary Bridge, Effective: 2011 ABRET Lab 5 year Accreditation; Re-Accredited in 2016

American College of Radiology (ACR) Accreditation:

- Mammography Program Accreditation (Auburn Cross Street, Gig Harbor and Covington)
- MultiCare Tacoma General/Allenmore Hospital (US, CT, MRI, PET)
- MultiCare Covington Clinic (US, CT, MRI)
- MultiCare Mary Bridge Pediatric Hospital (with TGAH)
- MultiCare Good Samaritan Hospital (PET, NM, CT, MRI, US),
- MultiCare Auburn Medical Center (US, CT, MRI, NM)

Trauma Designation by the Washington Emergency Medical Services and Trauma System:

- MultiCare Tacoma General Hospital, Level II Trauma Service Designation, Effective: 5/2015
- MultiCare Mary Bridge Children's Hospital, Level IIP Trauma Service Designation, Effective: 6/2015
- MultiCare Good Samaritan Hospital, Level I Rehabilitation Trauma Service Designation, Effective: 6/2015
- MultiCare Auburn Medical Center Level III Trauma Designation, Effective: 10/2014
- MultiCare Good Samaritan Hospital Level III Trauma Designation, Effective: 6/2015
- MultiCare Deaconess Level III Trauma Designation, Effective:
- MultiCare Valley Hospital Washington State Level III Trauma Designation, Effective: 09/2016

CMS for Cardiac Services

- MultiCare Tacoma General Hospital- Carotid Artery Stenting Facility, Effective: 2006 to April 2018
- MultiCare Good Samaritan - Carotid Artery Stenting Facility, 7-2017 to 7-2019

Society of Cardiovascular Patient Care

- MultiCare Deaconess Hospital, Accredited Chest Pain Center (Pending)

Trauma Designation by the Department of Health for Cardiac and Stroke Service

- Cardiac Care
    - MultiCare Tacoma General Hospital/Allenmore, Effective: 10/2014
        - Tacoma General, Level I Designation
        - Allenmore, Level II Designation
    - MultiCare Good Samaritan Hospital, Level I Designation, Effective: 10/2014

- MultiCare Auburn Medical Center Level I Designation, Effective: 10/2014
- MultiCare Valley Hospital Washington State Cardiac Level III EMS Designation Nov. 2017

- Stroke Care
  - MultiCare Tacoma General Hospital, Level I Categorization, Effective: 10/2014 MultiCare Good Samaritan Hospital, Level II Categorization, Effective: 10/2014
  - MultiCare Allenmore Hospital, Level III Categorization , Effective: 10/2014
  - MultiCare Auburn Medical Center Level II Categorization, , Effective: 10/2014
  - MultiCare Valley Hospital Washington State Stroke Level II EMS Designation Nov. 2017

- Stroke Center Certification DNV[7]
  - MultiCare Tacoma General Hospital Comprehensive Stroke Center, initial survey 12-2017-12-2018 DNV-GL
  - MultiCare Good Samaritan Hospital Primary Stroke Center, initial survey 12-2017-12-2018. DNV-GL
  - MultiCare Auburn Medical Center Primary Stroke Center, initial survey 12-2017-12-2018DNV-GL

College of American Pathologists (CAP)- Clinical Laboratory Accreditation

- MultiCare Tacoma General/Allenmore, Effective: 5/2014
- MultiCare Good Samaritan Hospital, Effective: 9/2015
- MultiCare Auburn Medical Center, Effective: 10/2015

American College of Surgeons (ASC) Commission on Cancer-Oncology Program Accreditation; Effective 3/2015

American Society for Metabolic and Bariatric Surgery

- MultiCare Allenmore Hospital MBSAQIP, Effective: 5/19/2017
- Multicare Deaconess Hospital MBSAQIP, Effective: 9/15/2017

Behavioral Health

- Three year CARF Accreditation, Community Employment Services: Job Development, Job Supports, Job-Site Training, Employment Planning Services
- DSHS DBHR "Behavioral Health Agency" License:
  - Outpatient Mental Health Services, including Case Management Crisis Emergency Involuntary Detention, Crisis Outreach Crisis Peer Support, Family Therapy, Group Therapy, Individual Treatment, Less Restrictive Alternative, Psychiatric Medication, Recovery Employment Support, Recovery Medication Support, Recovery Peer Support
  - Asian Counseling Services –expires 2/28/18
  - Puyallup Behavioral Health– expires 2/28/18

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7 Defined as Det Norske Veritas. Please see http://www.heart.org/idc/groups/ahaecc-public/@wcm/@swa/documents/downloadable/ucm_473741.pdf

- Chemical Dependency Treatment, including Alcohol & Drug Information School, DUI Assessment, Level I Outpatient, Level II Intensive Outpatient, Screening & Brief Intervention, Alcohol/Drug Information School. Agency # 160400 – expires 2/28/18
- PACT– expires 2/28/18
- DOH Residential Treatment Facility License
- DSHS DBHR Mental Health Certification as Residential Treatment Facility – Adult – Luckett House– expires 2/28/18
- Adolescent Behavioral Health- expires 2/28/18
- Adult Inpatient Behavioral Health– expires 2/28/18
- Behavioral Health Business License – ID# 601100682

Washington State Emergency Cardiac and Stroke Level I Stroke Center

- MultiCare Deaconess 2/2020

Blue Distinction Center

- MultiCare Deaconess Bariatric Surgery
- MultiCare Deaconess Cardiac Care
- MultiCare Deaconess Knee and Hip
- MultiCare Deaconess Spine Surgery
- MultiCare Deaconess Mother Baby/Labor and Delivery/Neonatal
- MultiCare Valley Knee and Hip Replacement

Certified Sleep Champion

- MultiCare Valley Hospital June 2017

F. Is the applicant reimbursed, or plans to be reimbursed, for services under Titles V, XVIII and XIX of the Social Security Act?

MultiCare Tacoma General Hospital is reimbursed under Titles XVII (Medicare) and XIX (Medicaid) of the Social Security Act.

G. Describe the history of each applicant with respect to criminal convictions related to ownership/operation of health care facility, license revocations and other sanctions described in WAC 248-19-390(5)(a). If there have been no such convictions or sanctions, so state.

There have been no such restrictions or sanctions as described in WAC 248-19-390(5) (a). (Note: the above WAC has been recodified as WAC 246-310-230.)

II. FACILITY DESCRIPTION

A. Name and address of the proposed/existing facility.

The name and address of the existing facility are:

MultiCare Tacoma General Hospital
315 Martin Luther King Way
Tacoma WA 98405

B. Name and address of owning entity at completion of project (unless same as applicant).

The owning entity is *MultiCare Health System*, and its address is:

315 Martin Luther King Jr. Way
Tacoma, WA 98405

The address of *MultiCare Tacoma General Hospital* is the same as the applicant.

Please see Exhibit 1, for the Letter of Intent, filed with the department.

C. Provide the following information about the owning entity (unless same as applicant).

1. **If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnership Division, and a chart showing organizational relationships to any related organizations as defined in Section 405.427 of the Medicare Regulations.**
2. **If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnership Division, and a chart showing organizational relationships to any related organizations as defined in Section 405.427 of the Medicare Regulations.**

This question is not applicable

D. Name and address of operating entity (unless same as applicant).

Please see responses above. MultiCare Tacoma General Hospital is the operating entity.

E. Geographic identity of primary service area

The service area for this project includes the following seven counties: Grays Harbor, Kitsap, Lewis, Mason, Pacific, Pierce, and Thurston. Definition of the service area was determined based on patient origin and market share statistics by total patient days reported in Washington State's Comprehensive Hospital Abstract Reporting System (CHARS) inpatient database. Tacoma General captured greater than 50% market share in all seven counties for DRGs 789-790 from CY2014-2016. Please see Exhibit 4 for the Service Area definition and map,

as well as Exhibit 5 for the patient origin analysis, including patient day utilization and market share by county of patient residence.

F. Peer Group.

This question is not applicable.

G. List physician specialties represented on active medical staff and indicate number of active staff per specialty.

Please see Exhibit 6 for a list of Tacoma General's active Medical Staff, by specialty.

H. List all other generally similar providers currently operating in the primary service area.

There are no other Level IV NICU providers in the service area. However, CHI-Franciscan St. Joseph Medical Center does operate a 5-bed Level III NICU in Pierce County.

I. For existing hospitals, provide:

* **inpatient days/year for the last five years.**
* **total licensed bed capacity at present.**
* **average number of set-up beds in the last twelve months.**

Tacoma General is licensed for 40 Level IV NICU beds, and all beds have been set up and operational for the last 12 months. As shown in Table 2, Tacoma General is operating at 77.5% occupancy as of the most recent full year available in CHARS (CY2016). This figure shows that there are sizeable demand pressures on Tacoma General's Level IV NICU, especially given the occupancy standard for this specialty service is 65%. Please note that these occupancy figures are based on the average daily census figures. As a result, they do not account for census variations, such as seasonal peaks.

Table 2. MultiCare Tacoma General Hospital Level IV Utilization, 2010-2014

	2012	2013	2014	2015	2016
Patient Days	8,457	8,823	10,412	10,791	11,321
Average Daily Census	23.2	24.2	28.5	29.6	31.0
Beds	30	40	40	40	40
Occupancy	**77.2%**	**60.4%**	**71.3%**	**73.9%**	**77.5%**

*Level IV defined as DRGs 789-790
Source: CHARS 2012-2016

J. If this project involves construction of 12,000 square feet or more, or construction associated with parking for forty or more vehicles, submit a copy of <u>either</u> an Environmental Impact Statement <u>or</u> a Declaration of Non-Significance from the appropriate governmental authority.

The project will impact 10,740 square feet. Therefore, this question is not applicable.

III. PROJECT DESCRIPTION

A. Describe the proposed project. This description should include discussion of any proposed conversion or renovation of existing space to other purposes, as well as the construction of new facility space. Also specify any unique services being proposed.

MultiCare Tacoma General Hospital is requesting certificate of need approval to add 14 Level IV NICU beds to its approved 40-bed Level IV NICU. If approved, Tacoma General would be authorized by the Department to operate a total of 54 Level IV NICU beds. Approval would also increase the licensed bed count by 14 for a total of 581 jointly licensed beds at MultiCare Tacoma General Hospital and MultiCare Allenmore Hospital.

This certificate of need request is driven by current and increasing need for Level IV NICU beds in the region. The Tacoma General NICU is the only designated Level IV NICU between Seattle and Portland, with a service or planning area that includes Pierce, Kitsap, Thurston, Grays Harbor, Pacific, Mason, and Lewis counties. However, it receives neonates from a much broader catchment area, including all Southwest Washington counties.

The requested project will also allow for development of a program, a Small Baby Unit, to enhance services for premature infants. Tacoma General's youngest and most vulnerable population are patients born at 28 weeks or less. These patients are highest risk and encompass the longest length of stay. We currently have approximately 100 babies born each year that are considered extremely premature, including micro-premies. These patients require hospitalization for up to three months or more, creating hardships for families, compounded by needing to travel out of the area when patients are transferred due to divert status related to no capacity at the local facility. This planned Small Baby Unit, which will provide care for extremely premature neonates, will improve opportunities for focused care, resources, and parental education. The focus of this unit will be to improve outcomes of our smallest patients in a standardized, best practice approach. Development of Small Baby Units has shown to significantly improve outcomes and has become a national trend to provide the highest quality of care.

B. Type of Project (indicate all that apply):

1. ☐ New Facility or Service
2. ☐ Total Replacement of Existing Facility
3. ☐ Renovation or Modernization
4. ☐ Mandatory Correction of Fire and Life/Safety Deficiencies
5. ☐ Substantial Change in Services
6. ☒ Expansion/Reduction of Facility
7. ☐ Pre-Development Expenditure in Excess of Minimum

C. If the proposed project involves the purchasing of an existing service, identify the present owner(s) of that service.

This question is not applicable.

D. Describe any changes in licensed and/or set-up bed capacity by unit/service which are part of this project.

This project would add 14 Level IV NICU beds at Tacoma General Hospital. These beds will be in addition to Tacoma General's existing license of 40 Level IV NICU beds. If approved, Tacoma General would be authorized by the Department to operate a total of 54 Level IV NICU beds. Approval would also increase the licensed bed count by 14 for a total of 581 jointly licensed beds at MultiCare Tacoma General Hospital and MultiCare Allenmore Hospital.

E. Total estimated capital expenditures.

Estimated capital expenditures are $6,901,360

F. Total estimated additional facility-wide operating expenses for the first and second years of operation (separately shown).

Please see the table below.

Tacoma General Hospital, Total Operating Expenses, With the Project, 2020-2023.

Year	2020 (1st Full year, With the Project)	2021	2022	2023
Total Operating Expense	$585,685,000	$587,415,000	$589,245,000	$591,178,000

Source: Applicant, 2017.

G. General description of types of patients to be served by the project. Describe the extent of any planned limitations to the services offered, either during the initial years of the project or on a permanent basis.

The project seeks to expand Tacoma General's existing Level IV NICU, as defined in the Washington State Perinatal and Neonatal Level of Care Guidelines.[8]

H. Projected utilization of service(s) for the first three years of operation following project completion (shown separately). This should be expressed in appropriate workload units of measure (for hospitals, appropriate workload units of measure and ACMVUs as required in the Accounting and Reporting Manual for Hospitals of the State Hospital Commission should be used) RVU measures should also be expressed in procedure units.

Please see Table 3 below, which includes projected Level IV discharges and patient days at Tacoma General with the project. The additional 14 beds are anticipated to become operational by May 1, 2019.

[8] Washington State Perinatal and Neonatal Level of Care (LOC) Guidelines, [February] 2013

Table 3. MultiCare Tacoma General Hospital. Level IV NICU Utilization Forecast, 2018-2023

	Projected						
	2018	2019 (Jan to Apr)	2019 (May to Dec)	2020	2021	2022	2023
Discharges	327	115	231	366	386	408	432
ALOS	34.7	34.7	34.7	34.7	34.7	34.7	34.7
Patient Days	11,353	4,000	7,999	12,682	13,404	14,167	14,973
Average Daily Census	31.1	32.9	32.9	34.7	36.7	38.8	41.0
Beds	40	40	54	54	54	54	54
Occupancy	**77.8%**	**82.2%**	**60.9%**	**64.3%**	**68.0%**	**71.9%**	**76.0%**

The additional 14 beds are anticipated to become operational by May 1, 2019.
Source: Applicant

I. If applicable, include a copy of the functional program.

Please see Exhibit 7.

J. Existing sources of patient revenue (Medicare, etc.) with percentage of revenue from each source.

Tacoma General's Level IV NICU payer mix by discharge, patient days, and charges, for CY2016, is presented in Table 4 below.

Table 4. MultiCare Tacoma General Hospital. Level IV NICU Payer Mix – CY2016

Payer	Discharges	% of Discharges	Patient Days	% of Patient Days	Charges	% of Charges
Medicaid	179	61.1%	6,752	59.6%	$ 87,491,451	59.5%
HSC	52	17.7%	2,023	17.9%	$ 27,003,899	18.4%
Comm	31	10.6%	1,043	9.2%	$ 13,842,321	9.4%
HMO	16	5.5%	867	7.7%	$ 11,200,666	7.6%
OtherGov	13	4.4%	633	5.6%	$ 7,557,257	5.1%
Self-Pay	2	0.7%	3	0.0%	$ 39,891	0.0%
Total	**293**	**100.0%**	**11,321**	**100.0%**	**$147,135,485**	**100.0%**

*Level IV defined as DRGs 789-790
Source: CHARS 2016

K. Source(s) of financing.

Expenditures associated with this project will be funded from reserves.

L. Equipment proposed:

1. Description of new and replacement equipment proposed.

Please see Exhibit 10.

2. **Description of equipment to be replaced, including cost of equipment and salvage value, if any, or disposal or use of the equipment to be replaced.**

It is not expected there will be equipment replacement. Therefore, this question is not applicable.

M. **Single line drawings to scale of <u>current</u> locations which identify current departments and services.**

Please see Exhibit 11.

N. **Single line drawings to scale of <u>proposed</u> locations which identify proposed services and departments.**

Please see Exhibit 11.

O. **Geographic location of site of proposed project, if other than hospital campus.**

1. **Indicate the number of acres in the site.**
Acres _____.

This question is not applicable.

2. **Indicate the number of acres in any alternate site, if applicable.**
Acres _____.

This question is not applicable.

3. **Indicate if the primary site or alternate site has been acquired, if applicable.**

Yes ☐ No ☐

This question is not applicable.

4. **Address of site:**

MultiCare Tacoma General Hospital
315 Martin Luther King Way
Tacoma WA 98405

5. **If the primary site or alternate site has not been acquired, explain how you will select and acquire a site for the proposed project.**

NOTE: If approved, the Certificate of Need will specify the site and/or alternate site of the project. A change of location of the site authorized by the Certificate of Need may require an amendment to the Certificate of Need.

MultiCare Tacoma General's Level IV NICU is an existing program. Therefore, this question is not applicable.

6. **Describe any of the following which would currently restrict usage of the proposed site and/or alternate site for the proposed project:**

(a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right of ways; (g) building restrictions; (h) water and sewer access; (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) others, please explain.

MultiCare Tacoma General's Level IV NICU is an existing program. Therefore, this question is not applicable.

7. **Provide documentation that the proposed site may be used for the proposed project. Include a letter from any appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project or a written explanation of why the proposed project is exempt.**

MultiCare Tacoma General's Level IV NICU is an existing program. Therefore, this question is not applicable.

8. **Provide documentation that the applicant has sufficient interest in the site or facility proposed. Sufficient interest shall mean one of the following:**

   a. **clear legal title to the proposed site; or**

   b. **a lease for at least five years with options to renew for not less than a total of twenty years in the case of a hospital, psychiatric hospital, tuberculosis hospital, or rehabilitation facilities; or**

   c. **a lease for at least one year with options to renew for not less than a total of five years in the case of freestanding kidney dialysis units, ambulatory surgical facilities, hospices, or home health agencies; or**

   d. **a legally enforceable agreement to give such title or such lease in the event that a Certificate of Need is issued for the proposed project.**

MultiCare Tacoma General's Level IV NICU is an existing program. Therefore, this question is not applicable.

P. Space Requirements

1. **Existing gross square feet.**

Please Table 5, below

Table 5. MultiCare Tacoma General Hospital. Level IV NICU Expansion.

Department	Before Project Figures		Remodel		Post Project Figures	
	Gross Square feet ("GSF")	Net Square feet ("NSF")	GSF	NSF	GSF	NSF
Obstetrics	53,820	48,520	-10,740	-10,070	43,080	38,450
NICU	34,240	31,980	10,740	10,070	44,980	42,050

2. Total gross square footage for proposed new addition at existing facility.

Please see Table 5, above.

3. Provide a matrix showing net square feet for all involved services and departments before and after project completion.

Please see Table 5, above.

4. Do the above responses include any shelled-in areas?

Yes ☐ No ☒

Explain the type of shelled-in space proposed (administration, patient beds, therapy space, etc.)

Q. Proposed Timetables for Project Implementation

1. Financing, if project is to be externally funded.

a. Date for obtaining construction financing.

Month _____ Year _____.

This question is not applicable

b. Date for obtaining permanent financing.

Month _____ Year _____.

This question is not applicable

c. Date for obtaining funds necessary to undertake the project.

Month _____ **Year** _____.

This question is not applicable.

2. **Design**

   a. **Date for completion and submittal to Consultation and Construction Review Section of preliminary drawings.**

   Month July 1 **Year** 2018 .

   b. **Date for completion and submittal to Consultation and Construction Review Section of final drawings and specifications.**

   Month September 1 **Year** 2018

3. **Construction**

   a. **Date for construction contract award.**

   Month December 1 **Year** 2018

   b. **Date for 25 percent completion of construction (25% of the dollar value of the contract in place).**

   Month February 1 **Year** 2019

   c. **Date for 50 percent completion of construction.**

   Month February 15 **Year** 2019

   d. **Date for 75 percent completion of construction.**

   Month March 1 **Year** 2019

   e. **Date for completion of construction.**

   Month April 1 **Year** 2019

   f. **Date for obtaining licensure approval**.

   Month May **Year** 2019

   g. **Date for occupancy/offering of service(s).**

   Month June 1 **Year** 2019

R. **As the applicant(s) for this project, describe your experience and expertise in the planning, developing, financing and construction of this type of project.**

MultiCare has successfully undertaken the following large-scale construction projects:

- **Patient Care Tower in Puyallup:** In January 2008, MHS began construction of a 357,000-square-foot Patient Care Tower on the Good Samaritan campus. Now completed, this facility features new emergency, imaging and surgery departments in addition to 80 private patient beds.

- **Emergency Department and Cancer Center Expansion in Tacoma:** On the Tacoma General and Mary Bridge Children's Hospital campus, MultiCare completed a 200,000-square-foot Emergency Department and Cancer Center expansion, with radiation and medical oncology, which opened to the public in April 2010.

- **Adolescent Behavioral Health Unit:**
  In 2016, MHS completed a 17,073 SF - 27 bed inpatient adolescent (13-18 yrs.) psychiatric unit serving voluntary and involuntary clients. The adolescent patient population is under-served in Pierce County; with the completion of this project, this population group now has a new place for care. This unit is located at Tacoma General in the 1st floor of the Rainier Tower. The unit will accommodate a dedicated patient intake space on the 1st floor and has a 1,000 SF indoor activity room.

- **Auburn Behavioral Health Unit:**
  In 2016 MHS completed a 9,949 SF remodel of an existing PCU to convert it into an adult inpatient behavioral health unit. This unit allowed MultiCare to expand its behavioral health service offering in a way that was not previously offered. This is a 20-bed unit with both private and semi-private rooms and features a living area, group therapy rooms and social spaces.

- **Milgard and Rainier Expansion in Tacoma:** In early 2012, MHS began construction on a multi-phased complex expansion project which consists of a two story vertical expansion of 63,000 SF, construction of a new patient tower of 125,000 SF, and full demolition and renovation of three existing patient floors totaling 47,000 SF. The vertical expansion and new patient tower have been successfully completed and are operational at this time. The renovation portion of the project continues with 2 of 3 patient floors completed by end of 2014 with third completing early 2015. Patient services within these expanded and renovated areas in Pediatric ICU and Med Surg, NICU, Women and Newborn, Birth Center, PSCU, PCU, and Adult Med Surg services.

  In addition, over the past several years, MHS has completed several other projects that further represent its commitment to delivering comprehensive and innovative patient care. These include:

- **Covington ED:** In mid-2012 MHS completed a new freestanding 24,000 SF emergency department on the site of the existing MultiCare Covington Clinic to augment existing services as part of a multiyear planning effort cumulating in a MultiCare Covington Hospital. Phase 1 of the Covington Hospital was completed in late 2016.

- **Covington Medical Park:** Since completing the initial construction of the Covington medical clinic in 1993, MultiCare has continually improved and expanded the range of services it provides in Covington. MultiCare's proven

experience, combined with its commitment to serve the community, will ensure that the proposed expansion of services is completed in a timely and cost-effective manner.

- **Tacoma General Expansion:** In 2004, MHS completed an expansion to Tacoma General Hospital to house its full range of operating and surgical capabilities, which ultimately resulted in the establishment of Tacoma General Heart Hospital in 2008.

- **Mary Bridge Expansion:** In 2005, MHS expanded Mary Bridge Children's Hospital. Mary Bridge Health Center, a 63,000-square-foot addition to the hospital, is the foundation for pediatric subspecialty clinics and pediatric support services. This outpatient oriented facility provides direct patient and public access to the surgical, imaging, and care functions of the existing hospital to provide comprehensive inpatient and outpatient service delivery.

- **Gig Harbor Medical Park:** In 2007, MHS completed a 122,000-square-foot Gig Harbor Medical Park, at which MHS provides a comprehensive range of outpatient and outreach services including outpatient surgery.

  In order to support and enhance its efforts, MHS partners with CB Richard Ellis Inc. (CBRE), a global real estate services firm. Together, MHS and CBRE continue to implement a strategic and comprehensive approach to managing MultiCare's real estate portfolio. The partnership provides a combined level of expertise in strategic portfolio planning, finance, and project management.

S. Describe the relationship of this project to the applicant(s)' long-range plan and long-range financial plan (if any).

MultiCare is a not-for-profit integrated health care delivery system with a rich history of serving communities in the Puget Sound region. In Spring 2017, we finalized the purchase of Rockwood Health System to extend our health care service to Washington's Inland Northwest. We are now proud to provide health care services to Eastern Washington residents through 2 hospitals (Deaconess & Valley), 86 clinics, one free-standing ED and 6 Urgent Care Centers. Expanding our geographical footprint, will afford additional brand recognition and market presence, further increasing consumer demand for services within MultiCare. We are dedicated to enhancing the health of the people we serve and supporting our communities. Part of this entails ensuring that we provide the full continuum of care so members of the community can have access to quality health services. As briefly summarized above, and which we will detail in the following section, there is substantial need for additional Level IV NICU services in the Planning Area. According to the quantitative methodology used in our analysis, there is projected need for an additional 27 Level IV NICU bassinets by 2023 in the Planning Area.

Tacoma General is home to the region's only Level IV Neonatal Intensive Care Unit. The proposed project is essential to Tacoma General's long-range strategic and financial plan and will continue and strengthen the existing program and associated clinical services. It is imperative the hospital has the necessary inpatient capacity. Without this capacity, Tacoma General's ability to ensure

patients in the Planning Area have access to critical neonatal specialty care services will be compromised.

IV. PROJECT RATIONALE

A. NEED (WAC 248-19-370)

1. Identify and analyze the unmet health services needs and/or other problems to which this project is directed.

Overview

Tacoma General is the only Level IV NICU provider within the 7-County Planning Area and only one of two Planning Area providers capable of providing Level III care. It is clear there is need for additional Level IV beds at Tacoma General, given the following:

(1) High growth of Level III/Level IV patient days in the Planning area (Figure 1 and Table 6, below);

(2) High average daily census for Tacoma General's Level IV NICU beds, which exceeds occupancy standards (Figure 2 and Table 2, above);

(3) The demonstrated need for Level IV NICU beds when the quantitative need methodology is applied to the Planning Area (Table 8, below, and Exhibit 12).

High Occupancy at Tacoma General

Tacoma General is licensed for 40 Level IV NICU beds, and all beds have been set up and operational for the last 12 months. As previously shown and discussed in Table 2 above, Tacoma General's Level IV NICU unit is operating at 77.5% occupancy as of the most recent full year available in CHARS (CY2016). This figure shows that there are sizeable demand pressures on Tacoma General's Level IV NICU, especially given the occupancy standard is 65%. Please note that these occupancy figures are based on the average daily census figures. As a result, they do not account for census variations, such as seasonal peaks.

Growth in patient days for Planning Area residents

Please see Table 6. Planning Area patient days for NICU Level III/IV care grew 4.9% annually from 2007-2016 and 8.8% annually from 2010-2016. Clearly, historic data demonstrates increasing demand for Level III/IV services from Planning Area residents.

Table 6. Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Resident Level III/IV Historical Utilization, Based on Patient Days, 2007-2016.

											Average Annual Growth	
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2007-2016	2012-2016
Level III/IV Patient Days	10,027	9,738	10,618	10,141	11,299	10,943	11,294	12,458	12,973	15,532	*4.9%*	*8.8%*

Source: CHARS 2007-2016 and OFM SADE 2007-2016
Level III/IV DRGs include 789-790

NICU Bed Need Methodology

Please see Exhibit 12 for the complete need model applied to the Planning Area. Exhibit 12A shows the need model applied to the Planning Area with a use-rate trend adjustment whereas Exhibit 12B includes a forecast model without the use-rate trend adjustment. As will be described below, historical experience justifies application and use of the model with a trend rate adjustment.

NICU Level III/IV services are recognized as tertiary services according to definitions contained in WAC 246-310-010. While some tertiary services (e.g. open heart, percutaneous coronary intervention) have an established methodology, no such methodology exists for NICU Level III/IV services. However, previous applications and Departmental reviews for NICU services can provide guidance on how to model the current and projected demand and how to subtract current supply, thus providing estimates of current and projected net need for Level III/IV services in the Planning Area.

In 2012, the Department evaluated MultiCare's application to expand Tacoma General's Level III NICU,[9] which was subsequently recognized as a Level IV NICU in DOR#14-07-Amended. In particular, in its decision, the Department stated:

> Comprehensive Hospital Abstract Reporting System (CHARS) data is used to assist in demonstrating need for an NICU level III service. CHARS data is reported by each Washington State hospital to the department's Hospital and Patient Data Systems office (HPDS). The CHARS data provides historical trends in discharges and lengths of stay for newborn patients for the major diagnostic category (MDC) #15 - NEWBORNS AND OTHER NEONATES WITH CONDITIONS ORIGINATING IN THE PERINATAL PERIOD. MDC #15 is made up of seven diagnosis related groups (DRGs). For years 2003 through 2006, those DRGS were identified as 385 through 391. Beginning in year 2007, the DRGs are identified as 789 through 795. The chart below provides the DRG and corresponding definition for MDC #15.[10 and 11]

Table 7 below shows a slightly revised chart to reflect the proper classification of Level IV services. Therefore, for the purposes of the application and our quantitative analysis, NICU Level III/IV services are defined as DRGs 789-790.

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[9] See Washington Department of Health, "Evaluation dated March 28, 2012 for the Following Two Certificate of Need Applications Proposing to Expand Neonatal Intensive Care Nursery Level III/Obstetric Services Within Pierce County-MultiCare Health System-Tacoma General Hospital; and Franciscan Health System-St. Joseph Medical Center."

[10] Each DRG corresponding level of care is based on October 3, 2001, testimony provided by Louis Pollack, MD, a board-certified neonatologist and member of Washington State Perinatal Advisory Committee and October 16, 2007 testimony by Dr. Linda Wallen, MD, also a board-certified neonatologist.

[11] Washington Department of Health, Evaluation, March 2012, p. 11.

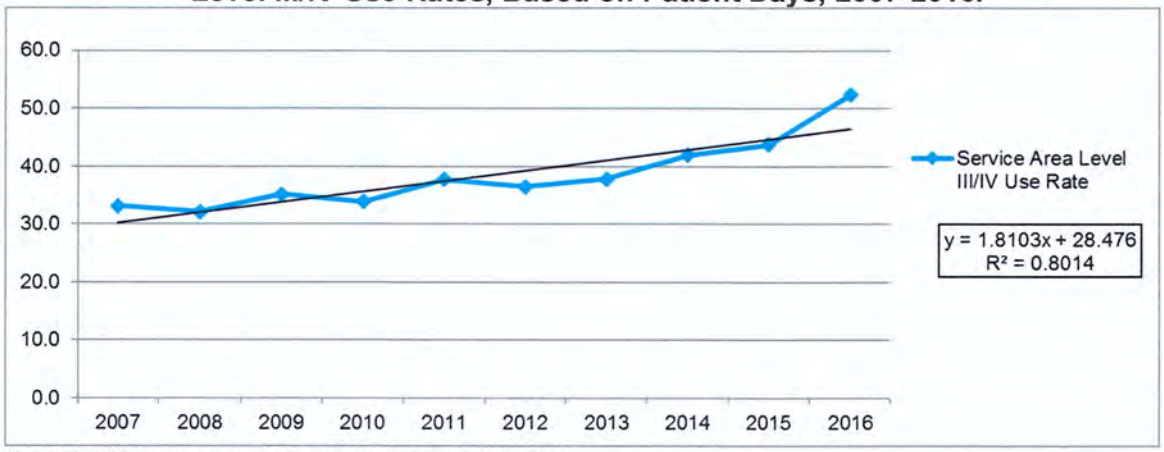
Table 7. Neonatal DRG Definitions and Level of Care Designation.

DRG Definition	Level of Care
789 NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	Level III/IV
790 EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	Level III/IV
791 PREMATURITY WITH MAJOR PROBLEMS	Level II
792 PREMATURITY WITHOUT MAJOR PROBLEMS	Level II
793 FULL TERM NEONATE WITH MAJOR PROBLEMS	Level II
794 NEONATE WITH OTHER SIGNIFICANT PROBLEMS	Level II
795 NORMAL NEWBORN	Level I

Step 1: Identify 10-year historic planning area resident days, discharges and use rates.

Patient day statistics from CHARS 2007-2016 (DRGs 789-790) were used to calculate planning area resident NICU level III/IV patient days and discharges. Average length of stay (ALOS) was calculated by dividing patient days by discharges, for each of the years 2007 through 2016. The number of females within the age cohort of 15-44 (childbearing age) were compiled from OFM small area demographic estimates (SADE) for the 7-county planning area for each year of the historic period. A level III/IV use rate was calculated based on patient days per 1,000 women of childbearing age for each year 2007-2016. Using the same rate estimates for years 2007 - 2016, an annual use rate trend adjustment factor of 1.81 patient days per 1,000 women of childbearing age was calculated (see Figure 3 below).

Figure 3. Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Level III/IV Use Rates, Based on Patient Days, 2007-2016.



*Level III/IV services defined as DRGs 789-790
Source: CHARS 2007-2016 and OFM SADE 2007-2016

Step 2: Calculate planning area provider Level III/IV patient origin, in-migration ratio, and planning area provider market share

Using CHARS data, the 2016 level III/IV patient days to planning area providers (e.g. Tacoma General Hospital and Saint Joseph Medical Center) were estimated. These included patient days from planning area residents as well as from residents from outside the planning area. Using these patient origin figures, the level III/IV in-migration ratio for

the planning area providers was calculated by dividing out-of-area resident patient days to the planning area providers. Planning area resident level III/IV patient days occurring in both Washington and Oregon hospitals were added together to get the total number of level III/IV patient days for planning area residents.[12] The 2016 planning area providers' market share of all planning area resident level III/IV patient days was calculated as 72.5% in 2016.

Step 3: Calculate future total patient days based on forecast use rates and forecast population of women of childbearing age. Apply the market share figures and in-migration ratio from step 2 to calculate future total level III/IV patient days to planning area providers.[13]

The annual use rate trend adjustment factor calculated in Step 1 and shown in Figure 3 clearly shows a consistent, positive increase by Planning Area residents.[14] Therefore, the use rate trend adjustment factor from Step 1 was applied to the 2016 use rate and each subsequent year throughout the 2017-2026 forecast period.[15] The number of women of childbearing age was projected using OFM projections (medium series) for each year of the forecast period. Planning area resident level III/IV patient days were projected by multiplying the projected use rate by the forecast number of women of childbearing age for each year of the forecast period. Using the planning area provider market, the total number of planning area resident level III/IV patient days occurring at the planning area hospitals for each year of the forecast period was calculated. Using the in-migration ratio, the total number of level III/IV patient days from non-planning area residents provided at the planning area hospitals was calculated for each year of the forecast period. Resident and non-resident level III/IV patient days occurring at the planning area's level III/IV providers for each year of the forecast period were summed for total planning area provider patient day forecasts.

Step 4: Use total days projected in Step 3 to determine gross and net Level III/IV bed need for the planning area.

The average daily census (ADC) was calculated for each year of the forecast period. The forecast ADC was adjusted to reflect the occupancy standard of 65% for the level III/IV NICU. These forecasts represent gross demand for NICU level III/IV beds. The supply figure was set at 45 to account for the only two Level III/IV planning area providers,

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[12] Oregon hospital data obtained from the 2015 Oregon Inpatient Database.

[13] At this step, the applicant must choose whether to model future patient days from forecasts of discharges or patient days. Our forecast model uses patient days as the forecast variable, given that the regression equation of patient days is much stronger than discharges, i.e., there is less volatility in the historical patient day statistics, making the projection more reliable.

[14] The R-squared in Figure 3 is 0.8. R-squared figures measure goodness of fit between the fitted line and the actual data in this linear regression equation. R-squared is a statistical measure of how close the actual data are to the fitted regression line. It is also known as the coefficient of determination, or the coefficient of multiple determination for multiple regression. An R-squared figure of 100% indicates that the model explains all the variability of the actual data around its mean. In the case of Figure 3, 80% of the variation of the actual data about its mean is explained by the regression, which simply means the linear fitted line closely approximates the actual data, in this case, patient days. In this case, it can be inferred that: (1) there is a consistent upward trend to the actual patient day figures; and (2), using the fitted line to forecast future patient days will be reasonable. This relatively high R-squared estimate is the basis for trend-adjusting Level III/IV patient days, rather than holding the use rate constant at some value, say, 2016.

[15] We have also included a bed need model applied to the Planning Area without the use-rate trend adjustment in Exhibit 12B.

including Tacoma General's 40 Level IV beds and Saint Joseph Medical Center's 5 Level III beds. Net demand or "need," was calculated by subtracting current planning area supply from gross bed demand each year of the forecast.

In determining bed need for hospital expansion requests, the Department typically uses a "target year," which it currently defines as seven years after the last full year of actual patient day statistics. In this case, the Department would consider 2023 as its "target" year.

Planning Area Forecast Level III/IV Bed Need

As shown in Table 8 below, there is a current (2017) unmet need of just under 12 beds, and projected net need for 27.7 Level III/IV beds by 2023. Please see Exhibit 12A for the complete step-by-step bed need methodology for the Planning Area.[16]

Table 8. Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Planning Area Level III/IV Forecast Bed Need, Based on Patient Days, 2017-2023

	2017	2018	2019	2020	2021	2022	2023
Total Level III/IV Patient Days to Service Area Providers	13,486	14,131	14,794	15,483	16,066	16,657	17,256
ADC	36.9	38.7	40.5	42.4	44.0	45.6	47.3
Gross Beed Need at 65% occupancy	56.8	59.6	62.4	65.3	67.7	70.2	72.7
Current Level III/IV Supply							
MultiCare Tacoma General	40	40	40	40	40	40	40
(CHI-FH) St. Joseph Medical Center	5	5	5	5	5	5	5
Total	**45**	**45**	**45**	**45**	**45**	**45**	**45**
Net bed need	**11.8**	**14.6**	**17.4**	**20.3**	**22.7**	**25.2**	**27.7**

Bed Source: DOH 2016 Acute Care Bed Survey

a. Unmet health services needs of the defined population should be differentiated from physical plant and operating (service delivery) deficiencies which are related to present arrangements.

Tacoma General's Level IV NICU is the only Level IV program in the Planning Area. There is a smaller Level II program at CHI-Franciscan St. Joseph Medical Center. As discussed above, there is projected need for at least 27 beds in 2023. Further, as shown in Table 2, Tacoma General's 40-bed Level IV NICU was operating at 77.5% occupancy in CY2016. Without the project's requested 14-bed expansion, Planning Area residents will increasingly out-migrate as Tacoma General will be forced to effectively close its Level IV NICU to new admits due to occupancy constraints.

[16] Exhibit 12B, the bed need model without a use-rate trend adjustment, shows beds unmet need for 14 beds by 2023.

b. The negative impact and consequences of unmet needs and deficiencies should be identified.

Please see the discussion above.

As of 2017, there is current shortage of just under 12 Level III/IV beds in the Planning Area that grows through the forecast period (Table 8). Without the project, a greater number of Planning Area residents will have to out-migrate for Level III/IV care. Forecast shortages will increase if this request is not approved.

c. The relationship of the project, if any, to the appropriate service specific Performance Standards of the current State Health Plan should be fully documented in this section.

The State Health Plan was "sunset" in 1989. Thus, this question is no longer applicable.

d. The relationship of the project, if any, to the appropriate sections of the regional health council Health Systems Plan or Annual Implementation Plan should be fully documented in this section.

The State Health Plan was "sunset" in 1989. Thus, this question is no longer applicable.

2. In the context of the criteria contained in WAC 248-19-370(2)(a) and (2)(b), document the manner in which:

a. Access of low income persons, racial and ethnic minorities, women and mentally handicapped persons and other underserved groups to the services proposed is commensurate with such persons need for the health services (particularly those needs identified in the applicable Health Systems Plan as deserving of priority)

Table 9 provides Tacoma General's charity care as a percentage of total patient service revenues and adjusted total patient service revenues for 2013-2015. It also provides these percentage figures for the Puget Sound Region average and MultiCare's other hospitals in the region, MultiCare Good Samaritan Hospital and Mary Bridge Children's Health Center.

The Department of Health evaluates hospital charity care based on these percentages and it evaluates a hospital's figures in relation to one of 5 geographic regions. Tacoma General is within the Puget Sound Region, and as Table 9 indicates, all but one of MultiCare's regional hospitals' 3-year (2013-2015) charity care percentages are above those for the Puget Sound Region. The lone exception, Mary Bridge Children's, predominantly treats children and adolescents, including a high proportion of Medicaid-sponsored patients.

Table 9. MultiCare Health System and Puget Sound Regional Average Charity Care, 2013-2015

		% of Total Revenue				% of Adjusted Revenue			
Lic. No	Region/Hospital	2013	2014	2015	3 Year Average, 2013-2015	2013	2014	2015	3 Year Average, 2013-2015
176	Tacoma General Allenmore Hospital	4.27%	2.00%	1.35%	2.48%	8.23%	5.72%	4.01%	6.23%
81	MultiCare Good Samaritan Hospital	3.16%	1.54%	1.29%	1.95%	8.31%	4.20%	1.74%	3.87%
175	Mary Bridge Children's Health Center	0.62%	0.62%	0.59%	0.61%	1.65%	1.55%	1.50%	1.56%
	PUGET SOUND REGION TOTALS	**3.05%**	**1.65%**	**0.92%**	**1.82%**	**6.91%**	**4.60%**	**2.37%**	**4.61%**

Source: Washington Department of Health, Charity Care Reports, 2013-2015.

b. **<u>In the case of the relocation of a facility or service, or the reduction or elimination of a service</u>, the present needs of the defined population for that facility or service, including the needs of underserved groups, will continue to be met by the proposed relocation or by alternative arrangements.**

This question is not applicable.

c. **Applicants should include the following:**

- **copy of admissions policy,**
- **copy of community service policy,**
- **reference appropriate access problems identified in State and regional health council planning documents and discuss how this project addresses such problems,**
- **other information as appropriate.**

Please see Exhibit 13 for Tacoma General's financial assistance (charity care) policy.

Please see Exhibit 14A for Tacoma General's Admission Policy

Please see Exhibit 14B for Tacoma General's Admission Policy for its NICU.

Please see Exhibit 14C for MultiCare's Non-Discrimination Policy.

3. **<u>Define the population that is expected to be served</u> by the specific project proposed. This may require different definitions for each element of the project.**

<u>In all cases</u>, provide regional health council population forecasts for the next ten years, broken down into age and sex categories.

<u>In the case of an existing facility</u>, include a patient origin analysis for at least the most recent twelve month period, if such data is maintained, or provide patient origin data from the last state-wide patient origin study. Patient origin is to be indicated by zip code, zip

codes are to be grouped by city and county, and include a zip code map illustrating the service area.

The population expected to be served can be defined according to specific needs and circumstances of patients (e.g., alcoholism treatment, renal dialysis), or be the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

Please see Exhibit 4 for the Planning Area definition and map. Exhibit 5 provides a patient origin analysis for Tacoma General Level IV NICU inpatients by zip code and county. As shown in that analysis, 83.9% of Tacoma General patient days in the past three years (CY2014-2016) came from residents of the Planning Area.

4. **Provide information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "compete" with the applicant.**

   a. **Identify all existing providers of services similar to those proposed and include sufficient utilization experience of those providers that demonstrates that such existing services are not available in sufficient supply to meet all or some portion of the forecasted utilization.**

      There are only two Level III/IV NICU providers in the Planning Area: Tacoma General's 40-bed Level IV NICU unit and Saint Joseph Medical Center's 5-bed Level III NICU unit.

   b. **If existing services are available to the defined population, demonstrate that such are not accessible to that population. Time and distance factors, among others, are to be analyzed in this section.**

      As noted earlier, the bed need model estimates there is currently a shortage of just under 12 beds for Level IV NICU services, increasing to a shortage of over 27 beds by 2023. If Tacoma General does not expand its capacity to meet current and future needs for Level IV NICU care, access for the most severely-ill neonates will be severely limited, and for some, not available in the Planning Area as Tacoma General's Level IV NICU reaches capacity.

   c. **If existing services are available and accessible to the defined population, justify why the proposed project does not constitute an unnecessary duplication of services.**

      The forecasts presented in Table 8, above, clearly demonstrate there is currently unmet need for Level III/IV beds. Tacoma General is one of only two hospitals in the Planning Area that can meet this need, and the only Planning Area hospital with a Level IV NICU. Without additional beds, Tacoma General will be unable to fully

address the inpatient care needs for the most severely-ill neonates in the Planning Area. By definition, the proposed project will not create unnecessary duplication of services.

5. Provide utilization forecasts for each service included in the project. Include the following:

a. Utilization forecasts for at least three years following project completion.

Please see Tables 10 and 11, for projected utilization without and with the project, respectively. It should be noted, year one for purposes of this request is 2020.

Table 10. Tacoma General Hospital. Level IV NICU Utilization Forecast – Without Project

	Projected					
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Discharges	327	346	366	379	379	379
ALOS	34.7	34.7	34.7	34.7	34.7	34.7
Patient Days	11,353	11,999	12,682	13,140	13,140	13,140
Average Daily Census	31.1	32.9	34.7	36.0	36.0	36.0
Beds	40	40	40	40	40	40
Occupancy	**77.8%**	**82.2%**	**86.9%**	**90.0%**	**90.0%**	**90.0%**

Source: Applicant

Table 11. Tacoma General Hospital. Level IV NICU Utilization Forecast – With Project

	Projected						
	2018	**2019 (Jan to Apr)**	**2019 (May to Dec)**	**2020**	**2021**	**2022**	**2023**
Discharges	327	115	231	366	386	408	432
ALOS	34.7	34.7	34.7	34.7	34.7	34.7	34.7
Patient Days	11,353	4,000	7,999	12,682	13,404	14,167	14,973
Average Daily Census	31.1	32.9	32.9	34.7	36.7	38.8	41.0
Beds	40	40	54	54	54	54	54
Occupancy	**77.8%**	**82.2%**	**60.9%**	**64.3%**	**68.0%**	**71.9%**	**76.0%**

Source: Applicant

b. The complete quantitative methodology used to construct each utilization forecast.

Without the project

1. Use Tacoma General Level IV NICU 2016 discharges as base. (See Table 2)
2. The projected average length of stay is set at 34.7 days, based on the 2012-Q22017 average. It is held constant.

3. Patient days are calculated by multiplying discharges by average length of stay each year of the forecast period.
4. Average daily census ("ADC") is calculated by dividing patient days by 365.
5. Tacoma General's 40 bed supply is held constant throughout the forecast period.
6. Occupancy is calculated by dividing ADC by 40, the Level IV NICU bed supply figure.
7. Growth in discharges, the forecast driver in the model, is based on application of the 2013-2016 average annual growth rate of 5.7%.
8. Maximum occupancy set to 90%. Therefore, as of 2021, discharges are constrained to 379.

With the project

1. Use the same methodology as *Without the project* except 14 additional beds are assumed operational by May 1, 2019.
2. Unlike the *Without the project* forecast, the *With the project* forecast avoids capacity constraints, where 90% occupancy figures were reached, given that there are an additional 14 beds.
3. Because the beds are assumed to become operational by May 1, 2019, the *With the project* forecast splits CY2019 into two time periods (January to April and May to December). Adjustments to average daily census calculations to reflect the respective time periods are made accordingly.

c. Identify and justify all assumptions related to changes in use rate, market share, intensity of service and others.

Please see the discussion above.

d. Evidence of the number of persons now using the service who will continue to use the service(s). Utilization experience for existing services involved in the project should be reported for up to the last ten years, as available. Such utilization should be reported in recognized units of measure appropriate to the service. For hospitals, the workload unit of measure required by the State Hospital Commission should be reported together with the corresponding number of procedures.

It is anticipated that Planning Area residents will continue to receive Level IV NICU care at Tacoma General's Level IV NICU as they historically have. (See Table 2 and Exhibit 5)

e. Evidence of the number of persons who will begin to use the service(s).

Please see the discussion above.

6. Reference all health care facility-related high priority health services needs for your service area which are called for in current health planning documents, including the regional health council HSP and

AIP and the State Health Planning and Development Agency SHP. If the resources required of this project, including health manpower, management personnel, capital and operating funds, do not address those high priority needs, justify why those resources are not reasonably available to be directed to meet such needs.

This question is not applicable.

7. **As applicable, substantiate the following special needs and circumstances which the proposed project is to serve.**

   a. **The special needs and circumstances of entities such as medical and other health professions schools, multidisciplinary clinics and specialty centers which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service area in which the entities are located or in adjacent to health service area.**

      This question is not applicable.

   b. **The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.**

      This question is not applicable.

   c. **The special needs and circumstances of osteopathic hospitals and nonallopathic services.**

      This question is not applicable.

B. FINANCIAL FEASIBILITY (WAC 248-19-380)

NOTE: All cost projections are to be in non-inflated dollars. Use the current year dollar value for all proforma data and projections. Do not inflate these dollar amounts.

NOTE: Capital expenditure estimates should not include contingencies. Certificate of Need statute and regulations allow a 12% or $50,000 (whichever is greater) margin before an amendment to an approved Certificate is required.

1. All Applicable Estimated Capital Costs (Actual or Replacement Costs if a Conversion Project)

Table 12. MultiCare Tacoma General Hospital, Level IV NICU Expansion Project, Estimated Capital Expenditures.

Item	Capital Expenditure Item	Expenditure
a	Land purchase	$ -
b	Utilities to property line	$ -
c	Land/Building improvements	$ -
d	Building purchase	$ -
e	Residual value of replaced facility	$ -
f	Building construction (Tenant Improvement)	$ 3,200,000
g	Fixed equipment (includes furnishings)	$ 2,160,000
h	Moveable equipment	$ -
i	Architect and engineering fees	$ 350,000
j	Consulting fees	$ 430,000
k	Site preparation	$ 10,000
l	Supervision and inspection	$ 30,000
m	Costs of securing financing	$ -
n	Sales tax	$ 541,360
	Building	$ 323,200
	Fixed equipment (includes furnishings)	$ 218,160
	Moveable equipment	$ -
o	Other project costs	$ 180,000
	Permits/fees	$ 140,000
	Real estate commission	$ -
	Other legal fees	$ 40,000
p	**Total Capital Expenditures**	**$ 6,901,360**

Source: Applicant, 2017.

2. **Provide a copy of a signed nonbinding contractor's estimate of the project's construction cost, movable equipment, fixed equipment, consulting fees, site preparation, and supervision and inspection of site (Items e, f, g, i, j, and k, above).**

Please see Exhibit 15.

3. **Using the chart below, break down the estimated capital cost for each service (cost center) affected by this project. For each service (cost center) provide, gross square feet to be impacted by construction, and estimated costs for items e, f, g, i, j, and k above. Separately indicate net square feet for each service (cost center). Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.**

Cost Center	Estimated Incremental Gross Square Feet (GSF)	Construction Cost per GSF (Use e,f,g,i,j, and k)	Total Cost per Bed (use p)	Total Cost per GSF (use p)
Level IV NICU	10,740	$573	$492,954	$643

4. **For an existing facility, indicate the increase in capital costs per patient day that would result from this project:**

	2019	2020	2021	2022--3rd Full year Post Implementation
Patient Days	11,999	12,682	13,404	14,167
Capital Cost/Patient Day	$575.17	$544.19	$ 514.88	$487.15

5. **Anticipated Sources and Amounts of Financing for the Project**

	Amount
a. Public Campaign	
b. Bond Issue	
c. Commercial Loans	
d. Government Loans	
e. Grants	
f. Bequests and Donations	
g. Private Foundations	
h. Accumulated Reserves	$6,901, 360
i. Internal Loans	
j. Capital Allowance	
k. Other – specify	
l. Total (Should Equal Total Project Cost)	**$6,901, 360**

6. **For projects to be totally or partially funded from capital allowance, please indicate the amount(s) of capital allowance and budget year(s) during which the funds would be used.**

   This question is not applicable. Tacoma General will use cash reserves to fund the project.

7. **Indicate the anticipated interest rate on the construction loan. _____%**

   This question is not applicable

8. **Indicate if you will have a fixed or a variable interest rate on the long-term loan and indicate the rate of interest.**

   Fixed interest rate. _____%.

   Variable interest rate beginning at _____% and ending at _____%.

   This question is not applicable

9. **Estimated Start-up and Initial Operating Expenses**

   a. **Total Estimated Start-up costs "$"_____ (Expenses incurred prior to opening such as staff training, inventory, etc., reimbursed in accordance with Medicaid guidelines for start-up costs.)**

   This question is not applicable. The program is an existing service.

b. Estimated Period of Time Necessary for Initial Start-up:

_____ "months" (Period of time after construction completed, but prior to receipt of patients.)

This question is not applicable. The program is an existing service.

c. Total Estimated Initial Operating Deficits "$"_____ (Operating deficits occurring during initial operating period.)

This question is not applicable. The program is an existing service.

d. Estimated initial operating period _____ "months" (Period of time from receipt of first patient until total revenues equal total expenses.)

This question is not applicable. The program is an existing service.

10. <u>Evidence of Availability of Financing for the Project</u>

Please submit the following:

a. Copies of letter(s) from lending institutions which indicate a willingness to finance the proposed project (both construction and permanent financing). The letter(s) should include:

i. **Status of loan application(s)**
ii. **Purpose of the loan(s)**
iii. **Proposed interest rate(s) (Fixed or Variable)**
iv. **Proposed term (period) of the loan(s)**
v. **Proposed amount of loan(s)**
vi. **Verification that the lender has examined the financial position of the borrower and found it to be adequate to support the proposal. The examination should reflect other project activity, actual or proposed, that might relate to this specific proposal**.

This question is not applicable. Tacoma General will use reserves to fund the project. Please see Exhibit 16 for a letter financial commitment from MultiCare's Chief Financial Officer, Ms. Anna Loomis.

b. Copies of letter(s) from the appropriate source(s) indicating the availability of financing for the initial start-up costs. The letter(s) should include the same items requested in 5(a) above, as applicable.

This question is not applicable.

c. Copies of each lease or rental agreement related to the proposed project.

This question is not applicable

d. Amortization schedule(s) for each financing arrangement including long-term, and any short-term start-up or initial operating deficit loans, setting forth the:

i. **Principal**
ii. **Term (number of payment periods) (long-term loans may be annualized)**
iii. **Interest**
iv. **Outstanding balance at end of each payment period**

This question is not applicable

11. Provide a cost comparison analysis, including a discussion of the advantages and costs, of each of the following alternative financing methods: purchase, lease, Capital Allowance, board-designated reserves, interfund loan, and commercial loan. Provide rationale for choosing the financing method selected.

NOTE: All tables, statements, charts, and columns used in responding to the following information requirements should be clearly labeled as to where the data comes from, and what they are meant to convey.

MultiCare evaluates each project in terms of what capital is required and the size of the proposed expenditure. MultiCare evaluates the capital expenditure in terms of its timing, its relative cost, its effect on reserves and the organization's opportunity costs of capital at that time. In the case of this project, given its size and given the availability of reserves to fund it, it was determined to be most prudent, i.e., most cost-effective, to finance the project with reserves.

12. Cost center budgets anticipated revenue, and operating costs for the period from the current fiscal year through and including three full fiscal years following completion of the project, without inflation, with and without the project. In the "with" scenario, include start-up costs, and the anticipated period of deficit operations before the project is utilized at the breakeven point.

For all of the above, provide a narrative of the assumptions used in creating these statements.

Please refer to Exhibit 17A for the Proforma with the Project and Exhibit 17B for the Proforma without the Project.

Key assumptions for the financial models include:

Volume Assumptions

1. The Summary Utilization Statistics worksheet in Exhibit 17 provides total utilization at the hospital ("Total Patient Days"), Intensive Care Department, ("Total Intensive Care Patient Days"), NICU (Level II and Level IV Patient

Days), and Level IV utilization specifically ("Level IV Patient Days). All incremental volume growth is based on Level IV utilization.

2. With project assumes impact of TG approval to add 14 additional Level IV NICU beds and follows the utilization forecast provided in Table 11 above.

3. Without project assumes growth based on Level IV NICU growth up to capacity constraints [in 2021] which follows the utilization forecast provided in Table 10 above.

4. Ancillary growth for key departments (Pharmacy, Labor and Delivery, Lab, MRI, Radiology, RT, Speech, PT) is based on incremental patient day growth for Level IV neonates, detailed above.

5. Surgical services growth is based on a10% conversion of Level IV patients to surgery and assumes an average of 72 minutes per case. This is based on historical the utilization of Level IV patients.

6. 2017 Projections are based on October 2017 Financial Statements (YTD2017), annualized.

    a. The decrease in patient days from 2016 to 2017 is due to a short term leave of absence of a high-risk delivery provider; and

    b. The annualization projection used.

Capital Expenditures

7. Incremental capital expenditure of $6,901,360 is expected as part of project.

8. Depreciation of incremental capital expenditure is based on 12-year useful life.

9. Routine capital expenditure estimates, by year, have been held constant at $2.7 million each year based on annualized YTD2017 actuals.

Revenues and Expenses

10. Models do not include any charge inflation.

11. Recoveries are reported within Other Direct Expenses.

12. The Income Statement reflects hospital-wide financial performance. Cost Center financials include cost center and departmental-level detail. Models have been prepared at the cost center level and aggregated up to the Hospital's Income Statement.

13. See the Cost Center Forecasts worksheet for Cost Center detail of salaries, professional fees, supplies expense, and other expenses (which includes: benefits, lease/rentals, purchased services, depreciation, less recoveries).

a. Level II and Level IV NICU, which are included in the Intensive Care Department, are shown separately, then combined with Intensive Care Other. The sum of these two units is the Total Intensive Care projection.

b. Other Cost Center summary projections include Surgical Services, and 'Other Departments'. Altogether, these Other Cost Centers combined with the Total Intensive Care comprise the hospital-wide totals.

c. All estimates have been initially based on annualized YTD2017. Revenues, Supplies Expenses, and Other Direct Expenses directly or indirectly linked to the Level IV NICU have been adjusted to reflect Level IV patient day growth. Depreciation is discussed above. Growth in NICU and other indirectly-related salaries, wages, and benefits is discussed below. All other estimates are held constant at their respective annualized YTD2017 estimates.

14. See Income Statement Summary for Interest, Insurance, Taxes, and Corporate Expenses (not shown on Cost Center reports).

    a. Corporate Service expense is based on its value of 25% of total operating expense, YTD2017. This percentage relationship is held constant over the forecast period, with and without the project

    b. Interest, insurance, and tax expenses have been held constant at their annualized YTD2017 estimates.

    c. The marginal difference between Without the Project and With the Project forecasts for any revenue or expense class provides the anticipated effect of the Level IV NICU expansion project.

15. Charity Care has been forecast at 1.70% of gross revenues, with and without the project based on YTD2017 actuals. The 3-year (2013-2015) average for the Puget Sound Region for charity care as a percent of total revenue is 1.82% (see Table 9). However, Charity Care for Puget Sound hospitals as well as Statewide has declined since 2013 (see Table 9). Due to this shift, Tacoma General has projected Charity Care to continue at YTD2017 levels of 1.70%. This is significantly higher than the 2015 Puget Sound regional average of 0.92%.

16. Bad Debt was 0.366 % of gross revenues in YTD2017. The model assumes this bad debt percentage of gross revenues remains constant over the forecast period, with and without the project.

FTEs

17. There is no wage inflation assumed—wages per hour and annual salaries per FTE ("full-time equivalent") are assumed constant at 2017 figures.

18. FTE growth by position (Mgmt., Provider, Nursing, Professional, Support), is based on 2014 - 2017 statistics. Incremental growth is based on growth of Level IV patient days and related Ancillary Services.

19. Salaries and wages and FTE's exclude Corporate Service FTE expenses, which are shown as a purchased expense under corporate service expenses.

13. Provide a proforma balance sheet without inflation, with and without the project. However, if there are no capital costs associated with this project, no proforma balance sheets are necessary. If the project to be totally funded from hospital reserves or capital allowance, a proforma balance with the project is sufficient. Submit these statements for the period from the current fiscal year through and including three full fiscal years following completion of the project. Provide a narrative of the assumptions used in preparing these statements. Explain any extraordinary changes in financial position.

Please see above for a complete discussion of pro forma forecast assumptions and calculations. Please also see Exhibit 18 for audited financial statements for MultiCare, where balance sheets for the system are found. Tacoma General, as a wholly-owned subsidiary, does not maintain an independent balance sheet.

14. Provide a capital expenditure budget covering each year starting with the first year following the last State Hospital Commission budget submittal up through the third year following completion of the project.

There is no planned capital budget for the project above capital costs already identified.

15. The expected sources of revenues for the applicant(s) total operations (e.g., Medicaid, Medicare, Blue Cross, Labor and Industries, etc.) with anticipated percentage of revenue from each source.

Please see Table 4 for CY2016 Level IV NICU payer mix. There is no anticipated change in payer mix with the project.

16. Provide a copy of the latest State Hospital Commission approved rate sheet.

This question is not applicable.

17. Provide the complete audited year-end financial reports for the last three full fiscal years. These should include balance sheets, expense and revenue statements, statements of changes in financial position, and the accompanying notes.

Please see Exhibit 18.

18. The relationship of the project, if any, to the appropriate Cost sections of the State Health Plan, regional health council health systems plan or annual implementation plan should be documented.

The State Health Plan has been sunset. This question is not applicable.

19. Indicate the reduction or addition of FTEs with the salaries, wages, employee benefits for each FTE affected.

Please see Exhibit 17 for detail on the number of FTEs, with the project, with associated salaries, wages and employee benefits over the forecast period.

C. STRUCTURE AND PROCESS (QUALITY) OF CARE (WAC 248-19-390)

1. Document the following:

a. The availability of sufficient numbers of qualified health manpower and management personnel. If staff availability is a problem, describe the manner in which the problem will be addressed.

Our current staffing is sufficient for the care of infants up to a Level IV intensity. We have approximately 130 RN FTEs, and an additional 50 RN's that are available on a per diem basis. Approximately 60 RN's are specialty certified. We would draw from our certified nurses to staff our "Small Baby Unit". With the proposed increase in the number of NICU beds and associated increase in patient days, this unit would require a modest increase in staff. Additional RN's would be brought in and trained through residency to replace our certified nurses that will be working in the new area. We also have Respiratory Therapists, Neonatalogists, Neonatal Nurse Practitioners, Case Managers, Social Workers, Neonatal Registered Dieticians, a Neonatal Pharmacist, Lactation Consultants, Occupational Therapy/Speech Therapy, and ancillary staff available, as required.

b. In the context of the State Health Plan Health Facility/Service General Performance Standard #2h, document the present and future availability of personnel with qualifications appropriate to the level and intensity of care they are and/or will be providing and with training specific to the technologies they are using.

Please see above.

2. Describe the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.

Our multidisciplinary team would continue to support the additional beds as stated above. Modest increases in support may be required, but achievable. We have a longstanding relationship with specialty physician groups and other community resources we could draw upon, as required.

3. In the context of the State Health Plan Health Facility/Service General Performance Standard #2f, document that the facility has and/or will have written policies evidencing a coordination and referral system that assures that patients receive care at the least intensive and restrictive level appropriate to their needs.

MultiCare provides discharge planning to all patients admitted to a hospital unit within our system. The Medical Staff, in collaboration with other MultiCare staff, and the patient's family determine the need for referral, transfer, discharge to another facility or level of care based on the patient's assessed needs and capacity to provide the necessary care or treatment, post-discharge.

Please see Exhibit 19 for the NICU/ICN Discharge Guidelines. Please also see Exhibit 20 for the Scope of Service Policy-Neonatal Intensive Care Unit and Intermediate Care Nursery.

4. **Identify the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health services resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

Adding Level IV NICU beds will support continuity of care and the development of a "Small Baby Unit," as discussed above. It will allow for a standard clinical space with focused patient population, staffing, approach, and guidelines, all of which are instrumental for providing breakthrough results to reduce morbidity and mortality in our youngest patients. It also creates an environment of community for our families.

The multidisciplinary team also includes a wide variety of specialty providers, including a dedicated registered dietician ("RD"), Pharmacist, Case Managers and Social workers that will ensure transition through the continuum of care is smooth. The provision of adequate medical services reduces outmigration and reduces fragmentation of care by ensuring vital medical services are available in the community.

Further, the proposed project requests expansion of Tacoma General's existing Level IV NICU program and Southwest Washington's only regional referral center for care of neonates requiring intensive care, up to and including Level IV NICU services. Therefore, the project strongly promotes continuity of care and will not lead to unwarranted fragmentation of services.

5. **In the context of the State Health Plan Health Facility/Service General Performance Standard #2g, document that your facility ensures and/or will ensure effective continuity of care through discharge planning initiated early in the course of treatment.**

Please see Exhibit 19 for Tacoma General's NICU/ICN Discharge Guidelines and Exhibit 20 for the Scope of Service Policy-Neonatal Intensive Care Unit and Intermediate Care Nursery.

6. **In the context of the State Health Plan Health Facility/Service General Performance Standard #2c, document that your facility has and/or will have a patient priority policy which requires acceptance of patients according to clinical evidence of medical need and potential benefit to patients.**

Please see Exhibit 21 for the Utilization Management Policy, Exhibit 14A and 14B for the Admission Policy and the NICU Admission Policy, respectively, and Exhibit 20 for the Scope of Service Policy-Neonatal Intensive Care Unit and Intermediate Care Nursery.

7. **Fully describe any history of each applicant with respect to the actions noted in Certificate of Need regulations WAC 248-19-390(5)(a). If there is such a history, provide clear, cogent and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.**

There is no history of the applicant with respect to WAC 248-19-390(5)(a).

8. **Demonstrate that services to be provided will be provided (a) in a manner that ensures safe and adequate care, and (b) in accord with applicable federal and state laws and regulations.**

Please see Exhibit 14A and 14B for the Tacoma General Admission Policy and the NICU Admission Policy, respectively, Exhibit 20 for the Scope of Service Policy-Neonatal Intensive Care Unit and Intermediate Care Nursery, Exhibit 21 for the Utilization Management Policy, and Exhibit 19 for Tacoma General's NICU/ICN Discharge Guidelines.

9. **Describe how the project complies with the appropriate Quality and Continuity of Care related criteria of the State Health Plan, regional health council health systems plan or annual implementation plan.**

The State Health Plan has been sunset. This question is not applicable.

10. **In the context of the State Health Plan Health Facility/Service General Performance Standard #2b, document that your facility has and/or will have an active utilization review program.**

Please see Exhibit 21, Utilization Management Policy and Exhibit 20 for the Scope of Service Policy-Neonatal Intensive Care Unit and Intermediate Care Nursery.

D. COST CONTAINMENT (WAC 246-310-240)

Please document the following associated with cost containment.

1. **<u>Exploration of alternatives</u> to the project you have chosen to pursue, including postponing action, shared service arrangements, merger, contract services, and different methods of service provision, including different spacial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:**

   - **Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.*);**
   - **Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria;**
   - **Capital costs;**
   - **Staffing impact**.

The alternatives analysis includes evaluation of the following four options:

- Option One: Add fourteen (14) Level IV NICU beds to the existing facility—The Project
- Option Two: Add eleven (11) Level IV NICU beds to the existing facility
- Option Three: Add twenty-four (24) Level IV NICU beds to the existing facility
- Option Four: Postponing the request—Do Nothing

Please see Tables 13-16 below. They provide a summary of advantages and disadvantages of each of the four options based on the following evaluative criteria: Promoting availability, or access to healthcare services; Promoting Quality of Care; Promoting Cost and Operating Efficiency; and Legal Restrictions.

Table 13. Alternatives Analysis: Promoting Access to Healthcare Services

Option:	Advantages/Disadvantages:
Option One Add fourteen (14) Level IV NICU beds to the existing facility—The Project	• Adds NICU capacity, as warranted by a 7-year time horizon by the bed need forecast, regardless of whether a use rate trend adjustment is applied. An advantage ("A") • Improves number of available beds and improves Planning Area access to services within the Planning Area; thereby preventing patients from having to out-migrate to receive medically necessary care. (A) • Allows sufficient expansion space for current programs and needed new programs/services, most notably the Small Baby Unit Program. (A)
Option Two Add eleven (11) Level IV NICU beds to the existing facility	• Similar advantages to Option 1, yet comparatively less access as Option Two does not fully address bed need even when a constant use rate is applied. Neutral ("N")
Option Three Add twenty-four (24) Level IV NICU beds to the existing facility	• Similar advantages to Option 1. (A) • From an Access perspective, best addresses net need as warranted by the 7-year bed need forecast with the use rate trend adjustment. (A) • Oversupplies Planning Area if constant use rate applied. A disadvantage ("D")
Option Four Postponing the request—Do Nothing	• Would do nothing to promote or improve patient quality of care.(D)

Table 14. Alternatives Analysis: Promoting Quality of Care

Option:	Advantages/Disadvantages:
Option One Add fourteen (14) Level IV NICU beds to the existing facility—The Project	• Would add beds and thus reduce the need for residents to out-migrate—this improves quality inasmuch as it reduces fragmentation of care. (A) • Would add enough beds for Tacoma General to expand its program, including Small Baby Unit Program. (A)
Option Two Add eleven (11) Level IV NICU beds to the existing facility	• Similar advantages to Option One. (A)
Option Three Add twenty-four (24) Level IV NICU beds to the existing facility	• Similar advantages to Option One. (A) • Potential ability to expand service scope beyond the Small Baby Unit Program. (A)
Option Four Postponing the request—Do Nothing	• Would do nothing to promote or improve patient quality of care. (D)

Table 15. Alternatives Analysis: Promoting Cost and Operating Efficiency.

Option:	Advantages/Disadvantages:
Option One Add fourteen (14) Level IV NICU beds to the existing facility—The Project	• This Option provides additional capacity that is clearly needed at Tacoma General and the Planning Area. This creates greater efficiency of care and reduces costs below what they would be otherwise. (A) • Best balances NICU space needs with other competing needs at Tacoma General. (A)
Option Two Add eleven (11) Level IV NICU beds to the existing facility	• Similar advantages to Option One. (A) • Comparatively inefficient compared to Option One given 14 beds are needed according to the bed need model regardless of whether a use rate trend adjustment is applied. Option Two's 11 beds would capture less economies of scale than Option One. (D)
Option Three Add twenty-four (24) Level IV NICU beds to the existing facility	• Would provide greater capacity to meet Planning Area need; in this regard, preferred to Option One. (A) • Would require significant build-out cost in comparison to Option One. (D)
Option Four Postponing the request—Do Nothing	• In the short run, there would be no direct capital cost impacts to Tacoma General. (A) • However, there would be increased costs from staff inefficiencies at the current location, given capacity constraints in the NICU. (D) • NICU patients and their families would bear costs to out-migrate to other providers, given lack of capacity in the Planning Area. Thus, social costs would increase with this Option. (D)

Table 16. Alternatives Analysis: Legal Restrictions.

Option:	Advantages/Disadvantages:
Option One Add fourteen (14) Level IV NICU beds to the existing facility—The Project	• This option requires certificate-of-need approval.
Option Two Add eleven (11) Level IV NICU beds to the existing facility	• This option requires certificate-of-need approval.
Option Three Add twenty-four (24) Level IV NICU beds to the existing facility	• This option requires certificate-of-need approval.
Option Four Postponing the request—Do Nothing	• There are no legal implications with this option.

2. **The specific ways in which the project will promote staff or system efficiency or productivity.**

The proposed project will allow increased staff efficiency with additional Level IV beds. Otherwise, without the project, staff will spend increasing time trying to accommodate additional patients in too few beds. This is inefficient. Without the additional level IV beds for the NICU, the patients of this region will be transported to Portland or Seattle to receive care. This additional, forced out-migration is inefficient since it requires residents to travel further than otherwise for care. This disrupts both patients and their families. Having the proposed additional beds located central to the current NICU and Family Birth center will also support staff efficiency and productivity.

3. **In the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.**

Please see Table 5, above for the net and gross square footage figures for this proposed NICU expansion project.

Guidelines for Design and Construction of Hospitals and Outpatient Facilities (2014 edition), published by the Facility Guidelines Institute, has been followed to ensure appropriate space allocation.

4. **In the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.**

This question is not applicable

Exhibit 1.

Letter of Intent

MultiCare
BetterConnected

MultiCare Allenmore Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Hospital
MultiCare Mary Bridge Children's Hospital & Health Center
MultiCare Tacoma General Hospital
MultiCare Clinics

October 13, 2017

Ms. Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
PO Box 47852
Olympia, WA 98504-7852

RE: Letter of Intent, MultiCare Tacoma General Hospital Level IV Bed Addition

Dear Ms. Sigman:

MultiCare Tacoma General Hospital is jointly licensed with MultiCare Allenmore Hospital by the Department of Health to operate 567 beds.[1] MultiCare Tacoma General Hospital received Washington State Department of Health Certificate of Need approval to operate a total of 40 Level IIIB neonatal intensive care unit ("NICU") in 2012. In 2014, the Department issued a Determination of Non-Reviewability that recognized these 40 beds as Level IV [2] beds as defined in the Washington State Perinatal and Neonatal Level of Care ("LOC") Guidelines, February 2013.[3] That unit now operates as a Level IV program on the MultiCare Tacoma General Hospital campus.

MultiCare Tacoma General Hospital submits this letter of intent for a Certificate of Need to add 14 beds to its Level IV program. If approved, MultiCare Tacoma General Hospital would be authorized by the Department to operate a total of 54 Level IV beds. Approval would also increase the licensed bed count by 14 for a total of 581 licensed beds at MultiCare Tacoma General Hospital and MultiCare Allenmore Hospital.

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

1. **Description of the Services Proposed**
   a. MultiCare Tacoma General Hospital has certificate of need approval to operate 40 Level IV beds.
   b. Approval is requested for 14 additional Level IV beds, allowing expansion to a total of 54 Level IV beds.
   c. Upon approval of this request, the licensed total number of beds at MultiCare Tacoma General/Allenmore Hospitals will increase to 581 beds (567 + 14 additional Level IV beds).

2. **Estimated Cost of the Proposed Project**

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[1] This includes 467 acute care beds, 40 Level IV beds, 30 Level II bed and 30 PPS ("Prospective Payment System") exempt psychiatric beds, approved in 2015.

[2] Also referred to as a "Regional Neonatal Intensive Care Unit."

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

The estimated capital costs associated with this project are $6,661,050.

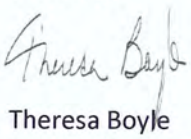
3. **Description of the Service Area**

The service area for this project includes the following seven counties:

- Grays Harbor, Kitsap, Lewis, Mason, Pacific, Pierce and Thurston

If you have any questions, please feel free to contact me directly at 253.403.8770 or Theresa.Boyle@multicare.org.

Sincerely,

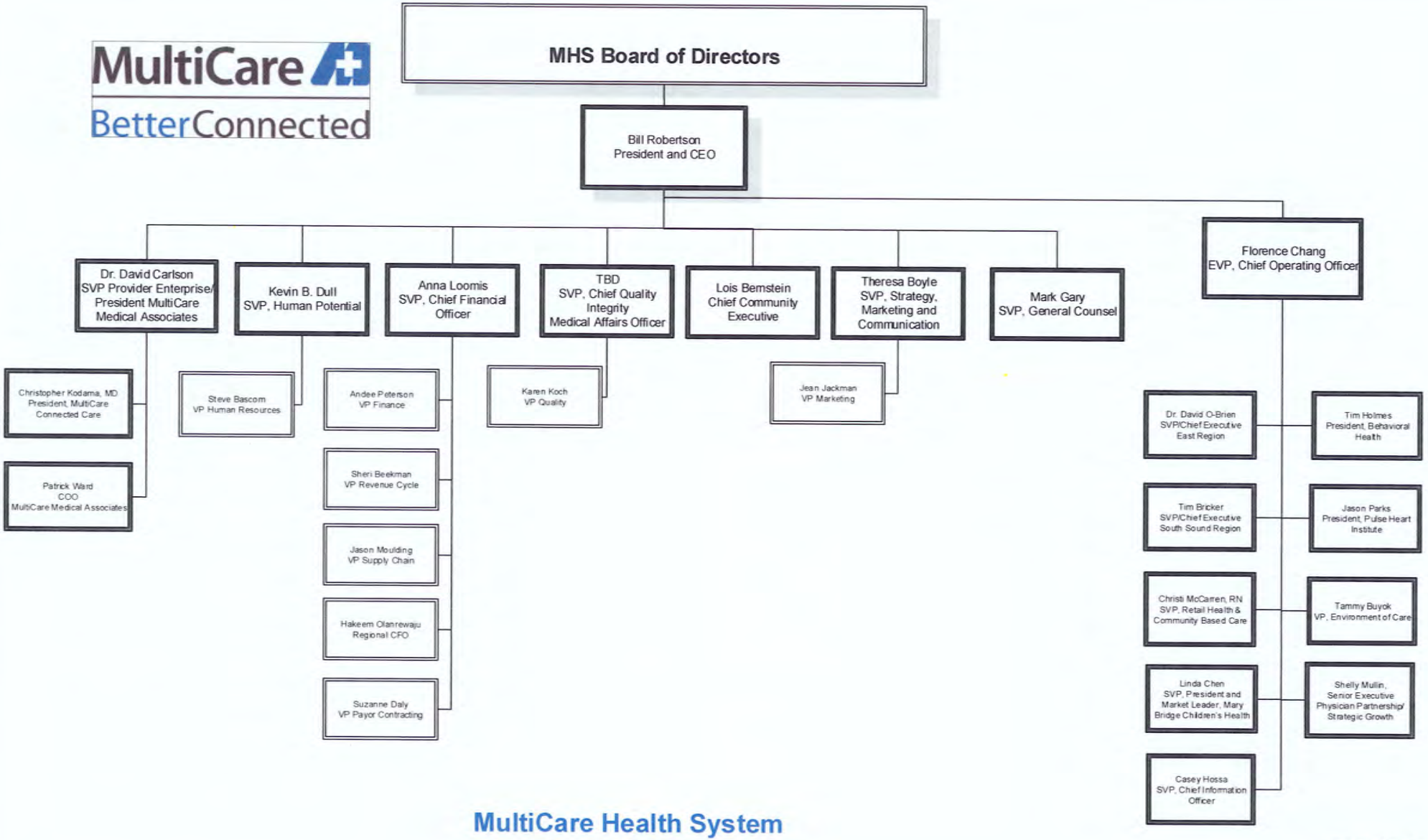


Theresa Boyle
Senior Vice President
MultiCare Health System

Exhibit 2.

MultiCare Health System Organizational Structure

MultiCare
BetterConnected



MultiCare Health System
Organizational Structure

8/29/2017

Exhibit 3.

Tacoma General Licensure

Washington State Department of Health

This organization

Tacoma General/Allenmore Hospital

is authorized by RCW 70.41 to have a

Hospital Acute Care License

Operated by: **Multicare Health System**

Number of Licensed Beds: **567**

Medicare Facility ID #:

Located at: **315 Martin Luther King Jr Way**
Tacoma, WA 98405-4234

Secretary

Credential Number
HAC.FS.00000176

Status	Effective Date	Expiration Date
ACTIVE	**01/01/2016**	**12/31/2018**

THIS LICENSE IS NON-TRANSFERABLE

Exhibit 4.

Planning Area Definition and Map

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Planning Area Definition

County	Level III/IV NICU Providers	CHARS #
Grays Harbor		
Kitsap		
Lewis		
Mason		
Pacific		
Pierce	Tacoma General Hospital (Level IV NICU)	176
	Saint Joseph Medical Center (Level III NICU)	32
Thurston		

Exhibit 5.

Patient Origin Analysis

MultiCare Tacoma General Hospital - Level IV Patient Day Origin by County Residence, CY2014-2016 Totals

	CY2014-2016			
	Patient Days	**% of Total Patient Days**	**County Total Patient Days (All Hospitals)**	**TG Market Share %**
Pierce County	16,484	51%	22,896	72.0%
King County	4,475	14%	51,494	8.7%
Thurston County	3,437	11%	6,193	55.5%
Kitsap County	2,952	9%	5,475	53.9%
Lewis County	2,010	6%	3,023	66.5%
Grays Harbor County	1,729	5%	2,234	77.4%
Mason County	532	2%	860	61.9%
Out-of-State	286	1%	15,528	1.8%
Yakima County	202	1%	8,384	2.4%
Pacific County	152	0%	282	53.9%
Spokane County	121	0%	22,000	0.6%
Douglas County	118	0%	1,209	9.8%
Jefferson County	12	0%	280	4.3%
Grant County	9	0%	4,502	0.2%
Clallam County	5	0%	1,673	0.3%
Benton County	0	0%	6,583	0.0%
Franklin County	0	0%	3,282	0.0%
Skagit County	0	0%	3,116	0.0%
Whatcom County	0	0%	4,680	0.0%
Cowlitz County	0	0%	1,615	0.0%
Total	**32,524**	**100%**	**165,309**	

*DRGs 789-790

Source: CHARS 2014-2016

MultiCare Tacoma General Hospital - Level IV Patient Day Origin by County Residence, CY2014-2016 Totals

*DRGs 789-790

Source: CHARS 2014-2016

MultiCare Tacoma General Hospital - Level IV Patient Day Origin by Zip Code Residence, CY2014-2016 Totals

	CY2014-2016	
Zip Code Residence	**Patient Days**	**% of Total Patient Days**
98405	1799	5.5%
98404	1368	4.2%
98444	1172	3.6%
98445	1070	3.3%
98023	1042	3.2%
98387	954	2.9%
98531	954	2.9%
98409	951	2.9%
98002	831	2.6%
98498	735	2.3%
98499	691	2.1%
98520	617	1.9%
98391	570	1.8%
98466	570	1.8%
98373	569	1.7%
98092	566	1.7%
98408	565	1.7%
98513	559	1.7%
98375	530	1.6%
98367	529	1.6%
98502	523	1.6%
98310	502	1.5%
All Other Zip Codes	14857	45.7%
Total	**32,524**	**100%**

*DRGs 789-790

Source: CHARS 2014-2016

Exhibit 6.

Medical Staff Roster

MultiCare Medical Staff Roster

Primary Practicing Specialty	[MD/DO/DMD/DDS] Provider Count
Pediatrics	103
Family Medicine	100
Anesthesiology	80
Diagnostic Radiology	65
Hospitalist	61
Emergency Medicine	44
Orthopedic Surgery	43
Obstetrics & Gynecology	42
Psychiatry	32
Internal Medicine	32
Gastroenterology	30
Surgery	30
Ophthalmology	28
Neurology	25
Medical Oncology	24
Otolaryngology	20
Physical Medicine & Rehab	19
Urology	18
Cardiovascular Disease	16
Radiation Oncology	15
Pediatric Dentistry	15
Vascular & Interventional Rad	14
Pediatrics/Emerg Med	13
Pediatric Cardiology	12
Surgical Critical Care	12
Pediatric Critical Care Medicine	11
Cardiothoracic Surgery	10
Dermatology	10
Nephrology	10
Vascular Surgery	10
Infectious Disease	9
Pathology	9
Plastic Surgery	9
Allergy & Immunology	9
Neurological Surgery	9
Critical Care Medicine	9
Neonatal/Perinatal Med	8
Rheumatology	8
Pediatric Nephrology	8

MultiCare Medical Staff Roster

Primary Practicing Specialty	[MD/DO/DMD/DDS] Provider Count
Maternal/Fetal Medicine	7
Pulmonary Diseases	7
Endocrinology	6
Hospice & Palliative Medicine	6
Neuroradiology	6
Medical Genetics	5
General Dentistry	5
Pediatric Surgery	5
Urogynecology	4
Nuclear Medicine	4
Interventional Cardiology	4
Pediatric Gastroenterology	4
Neurology/SQ Child Neurology	4
Child Psychiatry	3
Sleep Medicine	3
Gynecologic Oncology	3
Oral Surgery	3
Ped Hematology Oncology	3
Pain Medicine	3
Pediatric Endocrinology	3
Pediatric Radiology	3
Colon & Rectal Surgery	2
Pediatric Rehabilitation Medicine	2
Hematology	1
Weight Loss Obesity Medicine	1
Surgical Assistant	1
Pediatric Pulmonology	1
Neurology/Developmtl Disab.	1
Cardiac Electrophysiology	1
Developmental-Behavioral Peds	1
Geriatrics	1
Pediatric Urology	1
Epileptology	1
General Practice	1
Reproductive Endocrinology	1
Pediatric Infectious Disease	1
Pediatric Rheumatology	1
Orbital Facial Plastic Surgery	1
Clinical Cardiac Electrophysio	1

Includes Active and Courtesy Staff.

Source: MultiCare Health System, 2017.

Exhibit 7.

Functional Program

MultiCare
Tacoma General Hospital
BetterConnected

MultiCare Health System

Neonatal Intensive Care Inpatient Services

Neonatal Intensive Care Unit(NICU)

Functional Program

January 2018

Prepared by:

Raylene Alred, RN

Nurse Manager, Neonatal Intensive Care Unit

MultiCare Tacoma General Hospital

Program Description

The NICU provides care and treatment of critically ill neonates with a variety of diagnoses and requiring respiratory support, cardiac intervention/monitoring, surgical intervention, neurological monitoring/intervention, and/or invasive monitoring. The majority of the diagnoses include, but are not limited to: Severe prematurity, gastroschesis, genetic abnormalities, late preterm, term with medical complications, neurological disorders, severe asphyxia, cardiothoracic problems. Many of our patients are severely premature and very low birth weight. The proposed additional beds will be focused on this patient population only. The care delivery model is a patient and family centered environment with a multidisciplinary holistic approach which includes families, clinical staff, providers, and ancillary staff. The focus of this unit will be to improve outcomes of our smallest patients in a standardized, best practice approach.

The Small Baby Unit will be located on 2 Phillips, within MultiCare Tacoma General Hospital in Tacoma, Washington.

Staffing

The NICU is staffed by specially trained nurses in neonatal intensive care. Many nurses hold the nationally accredited specialty certification(RNC). The residency program for entry into the NICU 14-week course, and ongoing mentorship for 1-year post residency. Didactic training is provided by Board Certified Neonatologists, Neonatal Pharmacists, Neonatal Registered Respiratory Therapists, expert Neonatal Nurses, and other expert ancillary staff. The clinical practicum is monitored by senior nurse liaisons and experienced nurses act as preceptors.

Patient Flow

The patients admitted to this unit will mainly come from the Birth Center which is adjacent to the proposed Small Baby Unit. Other admissions will come from the Emergency Department, or by the Tacoma General NICU transport Team from other hospitals. The new unit will focus on patients born at 28 weeks or less.

Patients born at gestation over 28 weeks will continue to be admitted into our current 70 bed NICU located on 3 Rainier.

Dedicated, qualified staff, specifically trained in neonatal intensive care; to include NRP and BLS, provide the primary care for the patient. Patients will be admitted to the unit appropriate to the assessed patient acuity and provided clinical care by professionals to include, but not limited to: Registered Nurse, Respiratory Therapists, Neonatologists, Neonatal Nurse Practitioners, Personal Health Partners, Social Work, Neonatal Pharmacist, Registered Dietician, Lactation Consultant, and other ancillary support staff.

Waiting Room

A waiting area will be provided for families and visitors when not at the patient's bedside. It is located just outside of the new unit. An additional lounge for families will be available on 3 Rainier in the NICU. It contains a water/ice machine, coffee, comfortable seating and TV.

Patient Rooms

The proposed additional 14 level four beds will be divided into 3 pods on 2 Phillips. Each pod will contain 4 patient bed spaces. There will be space in each of the bed space areas to allow patients to be Kangarooed by family. Each space will be equipped with suction, oxygen, air, monitors, and a computer for documentation. Each pod will contain all required amenities.

Two rooms will be single patient rooms that can be used as isolation rooms. They will have all equipment as stated above.

We currently have 70 beds located on 3 Rainier. These beds are made 52 mixed acuity and 18 bed intermediate care beds. The 52 mixed acuity beds are in private rooms, with one twin room. The use of those beds will not change except as noted above in relation to location based on gestational age.

Clinical Charting Areas

The charting areas will be adjacent to the pods and private rooms with line of sight to the rooms. This will provide privacy for families to spend time with patients.

Team Station

A central area with charting stations for consulting providers and ancillary staff, clinical staff, and central monitoring station will be located in this area. This area will be used for interdisciplinary review of the patient, processing orders, charting. It will serve as an area for the staff to communicate with other areas and each other. Pneumatic tube station is located in this area. This area will be staffed with a Health Unit Coordinator. They will provide reception duties for all visitors, staff, and outside inquiries.

Clean Utility

Provides for storage of clean supplies and patient care equipment. It will include shelving and electrical outlets for pumps as needed.

Soiled Utility

Provides for housing and cleaning dirty equipment and patient care items. This room will include a sink and cabinets.

Housekeeping Closet

Provides space for housecleaning supplies. It is located just outside of the unit, adjacent to the elevators.

Medication Room

Provides space for Pyxis machine and associated medication supplies.

Staff Lounge/Kitchen/Locker Room

Area is located on 3 Rainier in main NICU. Provides place for staff to relax, secure personal items and eat. This area includes lockers, computer, shower, TV. Microwave, refrigerator, and coffee maker are located in this area.

Lactation/Pump Room

Room will be provided in the Small Baby Unit to allow mothers to express breast milk.

Milk Prep Room

Room for the preparation and storage of breastmilk, formula, and other dietary additives. This room will contain sink, freezers, refrigerators, and storage of dietary related supplies.

Equipment Storage

Room to store equipment for patients. This includes respiratory machines, Isolettes, Warmers, and other equipment needed to care for patients.

Conference Room

A conference room space will be in the Small Baby Unit to provide a space for meetings and/or counsel families.

Rest Rooms (2)

There are two ADA compliant restrooms located in the Small Baby Unit.

Exhibit 8.

Planning Area Historical Population

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Planning Area
Historical Female Population, 15 to 44 Years Old

Female Population, 15-44	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Growth Rate 2007-2016
Grays Harbor	12,550	12,386	12,213	12,027	12,021	12,043	12,044	11,981	11,751	11,292	-1.2%
Kitsap	47,041	46,877	46,436	45,705	45,519	44,917	43,263	42,886	42,451	41,948	-1.3%
Lewis	13,132	13,122	13,055	12,886	13,010	13,073	12,996	12,944	12,887	12,777	-0.3%
Mason	9,357	9,450	9,424	9,356	9,388	9,459	9,499	9,494	9,483	9,433	0.1%
Pacific	2,940	2,867	2,836	2,775	2,762	2,722	2,702	2,664	2,623	2,581	-1.4%
Pierce	168,283	168,643	167,751	165,935	166,381	166,496	166,469	165,794	165,569	166,833	-0.1%
Thurston	49,270	49,974	50,401	50,476	50,673	51,017	51,389	51,621	51,661	51,973	0.6%
Total	**302,573**	**303,319**	**302,116**	**299,160**	**299,753**	**299,729**	**298,362**	**297,385**	**296,424**	**296,838**	**-0.2%**

Source: OFM SADE, 2007-2016

Exhibit 9.

Planning Area Forecast Population

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston Planning Area
Projected Female Population, 15 to 44 Years Old

Female Population, 15-44	2017	2018	2019	2020	2021	2022	2023	2024	2025	Growth Rate 2016-2020	Growth Rate 2020-2025
Grays Harbor	11,412	11,533	11,656	11,782	11,835	11,887	11,941	11,994	12,048	1.1%	0.4%
Kitsap	43,401	44,905	46,460	48,182	48,545	48,911	49,279	49,651	50,032	3.5%	0.8%
Lewis	12,970	13,166	13,365	13,573	13,649	13,726	13,803	13,881	13,960	1.5%	0.6%
Mason	9,591	9,751	9,914	10,085	10,241	10,400	10,561	10,724	10,897	1.7%	1.5%
Pacific	2,717	2,861	3,012	3,188	3,118	3,050	2,984	2,918	2,858	5.3%	-2.2%
Pierce	167,937	169,048	170,167	171,308	172,386	173,470	174,561	175,660	176,782	0.7%	0.6%
Thurston	52,918	53,881	54,861	55,895	56,457	57,025	57,598	58,177	58,777	1.8%	1.0%
Total	**300,947**	**305,145**	**309,434**	**314,013**	**316,231**	**318,469**	**320,727**	**323,005**	**325,354**	**1.4%**	**0.7%**

Source: OFM SADE 2016; OFM Medium Series (2012 Release)

Exhibit 10.

List of Planned Equipment

MultiCare Health System
Proposed TG NICU Level 2-Estimate
Budget Forecast by Department and Item Description Report
REVISED: NOV 17, 2017

CAPITAL EQUIPMENT

Description	Status	Funding	Extended Qty	Working Budget
Warmer, Infant, Care System	Draft (New)	Capital	14	672,000
Monitor, Physiologic, Bedside	Draft (New)	Capital	14	420,000
Ventilator, Infant / Neonatal	Draft (New)	Capital	5	170,000
Headwall, Modular, Neonatal	Draft (New)	Capital	14	121,800
Pump, Infusion, Single	Draft (New)	Capital	14	107,800
Monitor, Central Station, Allowance	Draft (New)	Capital	2	50,000
Pump, Enteral	Draft (New)	Capital	14	42,000
Ventilator, Infant / Neonatal, High Frequency	Draft (New)	Capital	1	41,900
Incubator, Infant, Transport	Draft (New)	Capital	1	40,000
Warmer, Infant, Bedded Warrmer & Component	Draft (New)	Capital	1	35,000
Headwall, Allowance, Accessories	Draft (New)	Capital	126	32,035
Light, Treatment, Phototherapy, Infant, Mobile	Draft (New)	Capital	6	25,530
Regulator, Suction, Intermittent/Continuous	Draft (New)	Capital	42	25,200
Humidifier, Heated	Draft (New)	Capital	7	24,500
Refrigerator, Commercial, Compact	Draft (New)	Capital	14	23,800
CPAP Unit, Neonatal -BUBBLE CPAP	Draft (New)	Capital	6	18,000
Blender, Gas, Air/Oxygen	Draft (New)	Capital	14	16,800
Cart, Nurse Server	Draft (New)	Capital	12	15,600
Defibrillator, Monitor, w/Pacing	Draft (New)	Capital	1	15,000
Warmer, Bottle, Neonatal	Draft (New)	Capital	15	15,000
Bracket, Monitor, Wall	Draft (New)	Capital	14	11,704
Refrigerator, Pharmaceutical, 1 door	Draft (New)	Capital	1	7,000
Cart, Supply, Linen	Draft (New)	Capital	2	6,000
Scale, Diaper	Draft (New)	Capital	3	5,400
Ice Machine, Dispenser, Nugget, Countertop	Draft (New)	Capital	1	5,083
Stool, Exam, Cushion-Seat	Draft (New)	Capital	14	4,900
Scale, Diaper	Draft (New)	Capital	2	3,600
Freezer, Commercial, 1 Door	Draft (New)	Capital	1	3,500

Dispenser, Medication, Lock Module	Draft (New)	Capital	2	3,111
Cart, Procedure	Draft (New)	Capital	2	2,600
Monitor, Blood Glucose, Point-of-Care	Draft (New)	Capital	3	2,243
Refrigerator, Commercial, Undercounter	Draft (New)	Capital	1	2,103
Docking Station, Meter, Blood Glucose	Draft (New)	Capital	7	1,365
Resuscitator, Infant	Draft (New)	Capital	1	1,020
Cart, Equipment, Breast Pump	Draft (New)	Capital	2	800
Light, Treatment, Allowance	Draft (New)	Capital	1	450
Cart, Supply, Pillow	Draft (New)	Capital	1	375
Dispenser, Medication, Auxiliary	Draft (Existing)	Capital	1	0
Dispenser, Medication, Host (Main)	Draft (Existing)	Capital	1	0
			CAPITAL EQUIP SUB TOTAL	**1,973,218**

CAPITAL FURNITURE

Description	Status	Funding	Extended Qty	Working Budget
Chair, Clinical, Recliner	Draft (New)	Capital	16	27,200.00
Chair, Interiors, Sleeper/Convertible	Draft (New)	Capital	2	9,000.00
Table, Interiors, End	Draft (New)	Capital	14	7,000.00
Chair, Interiors, Folding	Draft (New)	Capital	14	6,720.00
Chair, Office, Task, w/Arms	Draft (New)	Capital	11	5,720.00
Furniture Delivery/Installation Fee (BiNW)	Draft (New)	Capital	1	3,000.00
Bracket, Chair, Wall	Draft (New)	Capital	14	1,750.00
Furniture Design Fee (BiNW)	Draft (New)	Capital	10	675.00
Furniture PJM Fee (BiNW)	Draft (New)	Capital	10	675.00
			OPERATIONAL EQUIP SUB TOTAL	**61,740**

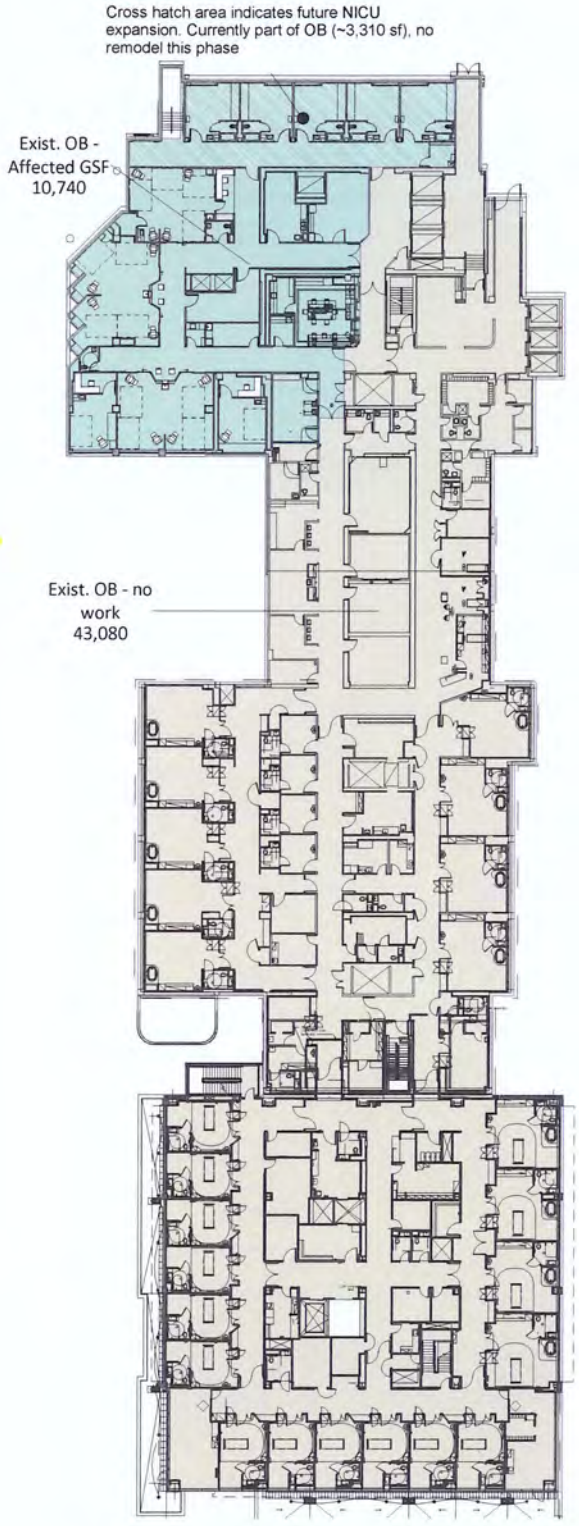
OPERATIONAL EQUIPMENT

Description	Status	Funding	Extended Qty	Working Budget
Bracket, Computer Workstation, Wall	Draft (New)	Operating	14	21,000
Services, Allowance - Jet Ventilator	Draft (New)	Operating	1	4,100
Bracket, Canister, Suction, Wall Mount	Draft (New)	Operating	56	2,800
Monitor, Temperature, Refrigerator/Freezer	Draft (New)	Operating	17	2,550
Hamper, Linen	Draft (New)	Operating	9	2,025
Pump, Breast, General	Draft (New)	Operating	2	2,000
Board, White, Dry Erase, Magnetic	Draft (New)	Operating	15	1,875

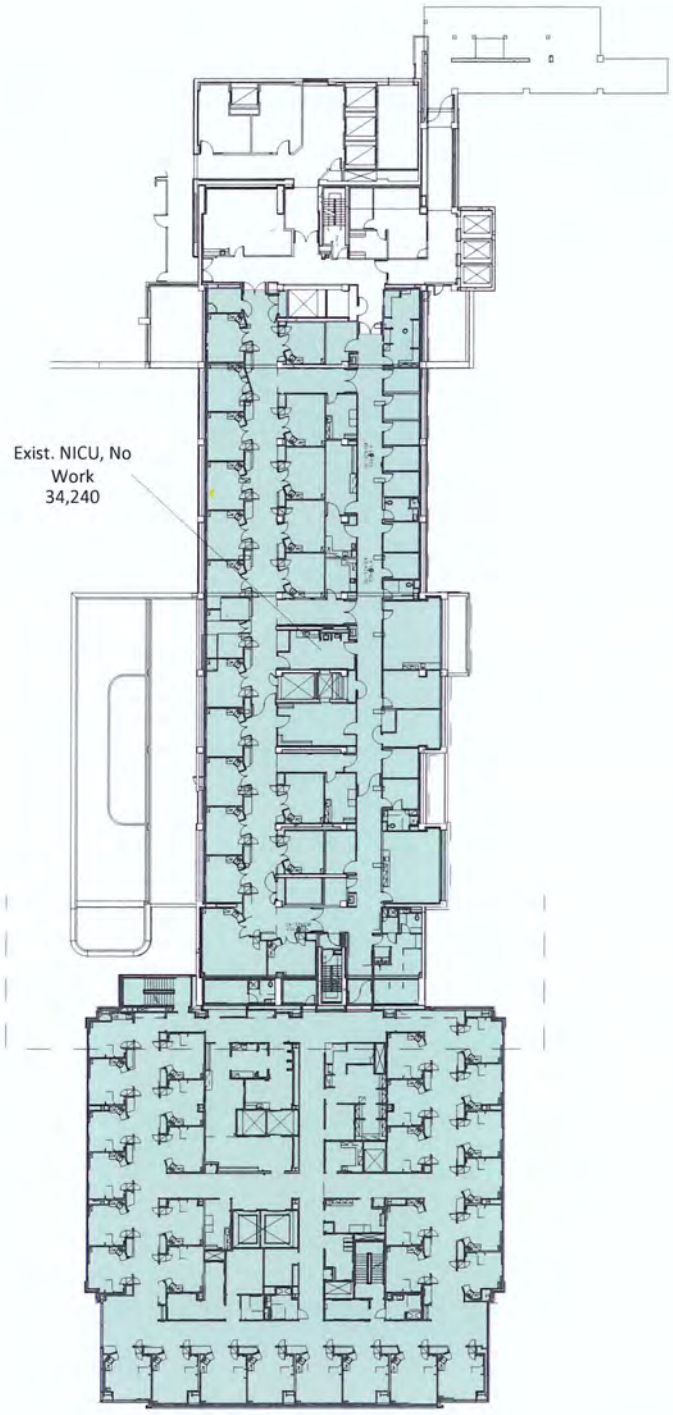
Nurse Call, Speaker, Pillow	Draft (New)	Operating	14	1,820
Cart, Procedure, Resusitation, Neonatal	Draft (New)	Operating	1	1,500
Clock, Analog, Wall	Draft (New)	Operating	11	1,375
Waste Can, Open Top	Draft (New)	Operating	34	1,029
Flowmeter, Air	Draft (New)	Operating	20	1,000
Flowmeter, Oxygen	Draft (New)	Operating	20	1,000
Pump, Suction/Aspirator, General, Portable	Draft (New)	Operating	1	1,000
Bracket, CPU, Wall	Draft (New)	Operating	14	812
Disposal, Sharps, Wall Mount	Draft (New)	Operating	10	600
Cart, Utility, Stainless	Draft (New)	Operating	1	500
Dispenser, Glove, Triple Box	Draft (New)	Operating	11	495
Cover, Cart, Allowance	Draft (New)	Operating	2	400
Allowance, Accessories	Draft (New)	Operating	30	390
Waste Can, Recycle	Draft (New)	Operating	8	362
Waste Can, 20-31 Gallon	Draft (New)	Operating	5	360
Pillow	Draft (New)	Operating	32	320
Cart, Supply, Chrome, 24 inch	Draft (New)	Operating	1	300
Dispenser, Personal Protection, Wall Mount	Draft (New)	Operating	1	300
Basket, Cuff, Wall Mount	Draft (New)	Operating	8	240
Bin, Supply	Draft (New)	Operating	6	240
Board, Message	Draft (New)	Operating	1	200
Waste Can, Bio-Hazardous	Draft (New)	Operating	1	170
Bin, Plastic, Allowance	Draft (New)	Operating	2	80
Bucket, Allowance	Draft (New)	Operating	2	24
Dispenser, Disinfectant Wipes, Wall Mount	Draft (New)	Operating	7	0
Dispenser, Hand Sanitizer, Wall Mount	Draft (New)	Operating	18	0
Dispenser, Paper Towel, Surface Mount	Draft (New)	Operating	12	0
Dispenser, Soap, Wall Mount	Draft (New)	Operating	12	0
			OPERATIONAL EQUIP SUB TOTAL	**50,867**
			TOTAL CAPITAL ESTIMATE	1,973,218
			TOTAL OPERATIONAL ESTIMATE	50,867
			TOTAL FFE ESTIMATE	**2,024,085**

Exhibit 11A.

Single Line Drawings (Existing)



Level 2, Overall Plan - Existing space is currently all Obstetrics



Level 3, Overall Plan for Reference - Existing NICU space to remain

GSF By Department

CLARK KJOS ARCHITECTS, LLC
333 NW 5th Ave. Portland, OR 97209
Phone: 503/224-4848 Fax: 503/224-7116

JOB #: 17045

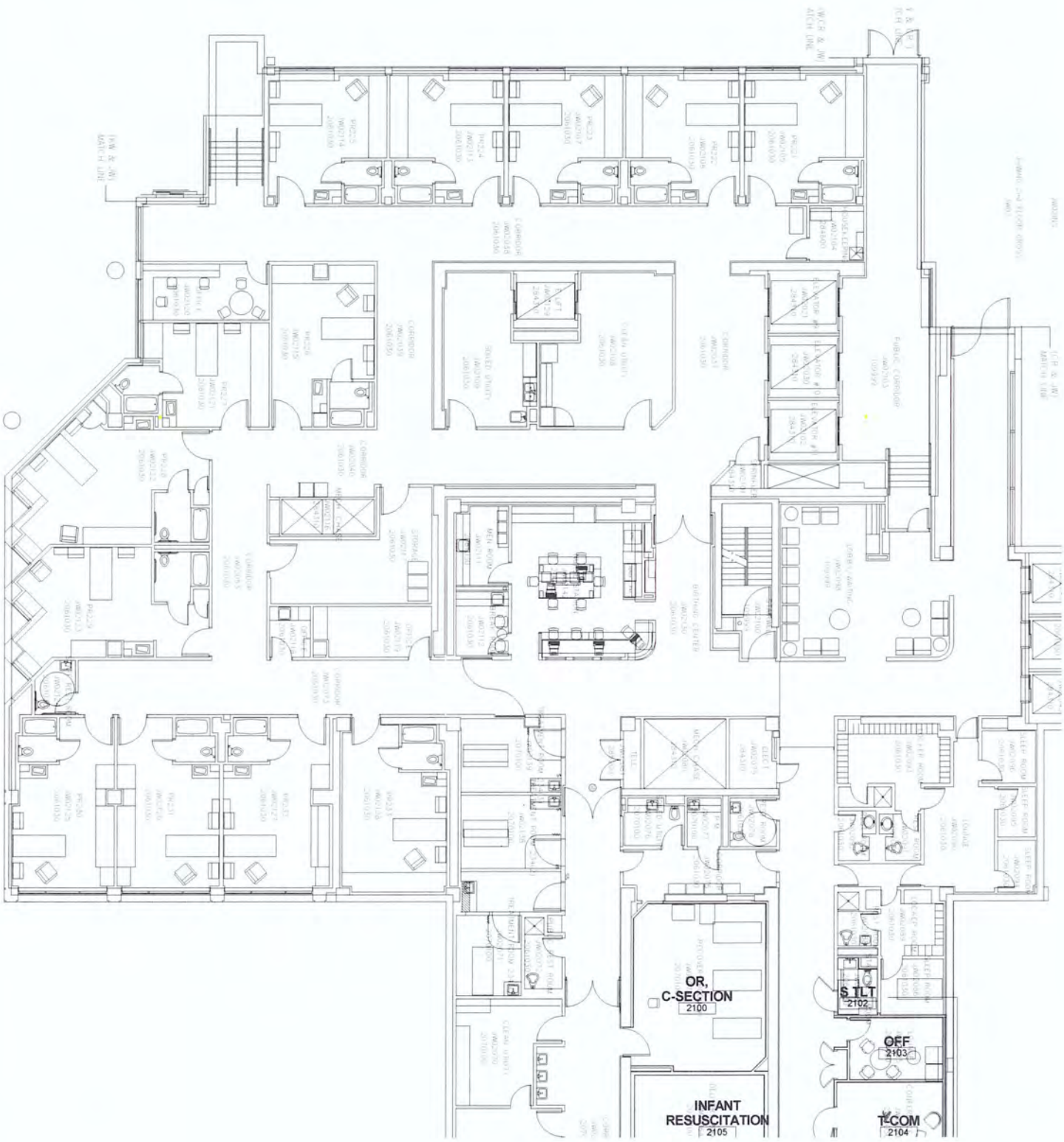
NICU CoN Submission

MultiCare Health System

A2.03

DATE: 11/14/17

REV TYPE: Author



Existing Plan - Vacant

CLARK KJOS ARCHITECTS, LLC
333 NW 5th Ave.
Portland, OR 97209
Phone: 503/224-4848
Fax: 503/224-7116

JOB #: 17045

NICU CoN Submission

MultiCare Health System

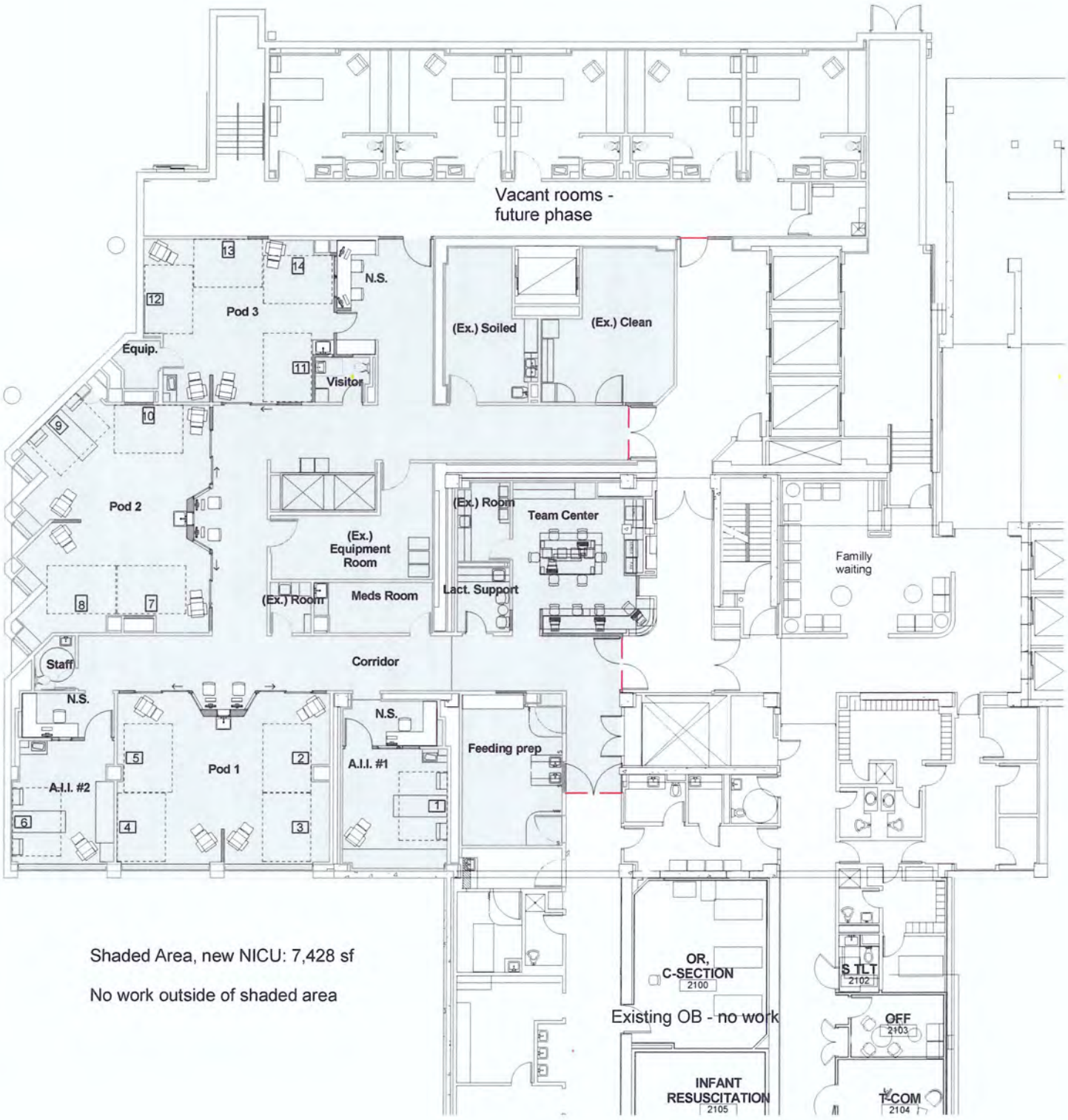
A2.00

DATE: 11/13/17

REV TYPE: Author

Exhibit 11B.

Single Line Drawings (Proposed)



Proposed Plan

C L A R K // K J O S A R C H I T E C T S, L L C 333 NW 5th Ave. Portland, OR 97209 Phone: 503/224-4848 Fax: 503/224-7116	NICU CoN Submission	A2.02
JOB #: 17045	MultiCare Health System	DATE: 11/13/17 REV TYPE: AH

Exhibit 12A.

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston

Level IV Bed Need Forecast Model, 2017-2026

With Trend Adjustment

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston
Service Area Level III/IV Bed Need Model, Based on Patient Days, 2017-2026
With Use-Rate Trend Growth

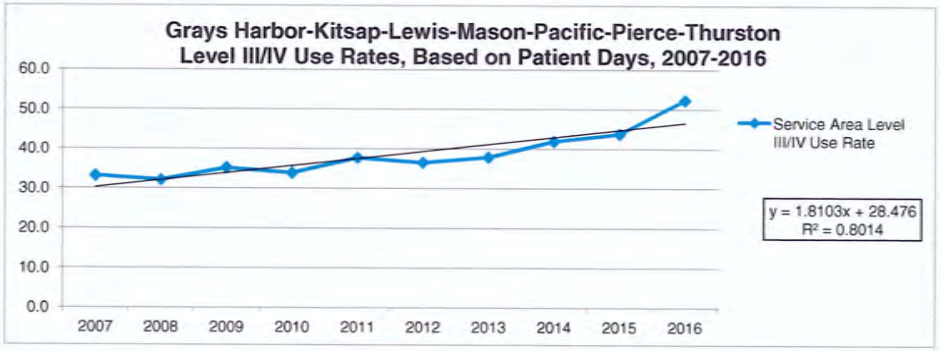
Step 1: Identify 10-year historic planning area resident days, discharges and use rates.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average Annual Growth
Service Area Level III/IV Patient Days	10,027	9,738	10,618	10,141	11,299	10,943	11,294	12,458	12,973	15,532	*4.9%*
Service Area Level III/IV Discharges	506	536	544	461	524	527	540	646	627	684	*3.3%*
ALOS	19.82	18.17	19.52	22.00	21.56	20.76	20.91	19.28	20.69	22.71	*1.5%*
Pop Fem 15-44	302,573	303,319	302,116	299,160	299,753	299,729	298,362	297,385	296,424	296,838	*-0.2%*

Population Source: SADE 2007-2016

											Trend Adjustment
Service Area Level III/IV Use Rates-- patient days per 1,000 females age 15-44	33.1	32.1	35.1	33.9	37.7	36.5	37.9	41.9	43.8	52.3	*1.81*

Source: CHARS 2007-2016 and OFM SADE 2007-2016
Level III/IV DRGs include 789-790



Step 2: Calculate planning area provider Level III/IV patient origin, inmigration ratio, and planning area provider market share

	Total	From Planning Area Residents	From Out of Area	Inmigration Ratio
Service Area Provider Level III/IV Patient Days	13,025	11,410	1,615	0.1415

	In WA	In OR	Total
Service Area Resident Level III/IV Patient Days	15,532	203	15,735

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston
Service Area Level III/IV Bed Need Model, Based on Patient Days, 2017-2026
With Use-Rate Trend Growth

	2016 Actuals
Service Area Provider Market Share of Service Area Resident Level III/IV Patient Days	72.5%

Source: CHARS 2007-2016 and Oregon Discharge Data (2015)
Level III/IV DRGs include 789-790

Step 3: Apply the 2016 use rate from Step 1 plus trend adjustment to the projected future population to calculate future total Patient Days. Apply the market share and inmigration ratio from Step 2 to calculate future total Level III/IV Patient Days to planning area providers.

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Use Rate	54.14	55.95	57.76	59.57	61.38	63.19	65.00	66.81	68.62	70.43
Pop Fem 15-44	300,947	305,145	309,434	314,013	316,231	318,469	320,727	323,005	325,354	326,660
Total Service Area Resident Patient Patient Days	16,292	17,071	17,872	18,705	19,409	20,123	20,846	21,579	22,325	23,006
Resident Patient Days to Service Area Providers	11,814	12,379	12,959	13,563	14,074	14,592	15,116	15,648	16,189	16,682
Out-of-Area Patient Days to Service Area Providers	1,672	1,752	1,834	1,920	1,992	2,065	2,140	2,215	2,291	2,361
Total Level III/IV Patient Days to Service Area Providers	13,486	14,131	14,794	15,483	16,066	16,657	17,256	17,863	18,480	19,044

Source: CHARS 2007-2016 and OFM Medium Series (2012 Release)
Level III/IV DRGs include 789-790

Step 4: Use total days projected in Step 3 to determine gross and net Level III/IV bed need for the planning area.

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Level III/IV Patient Days to Service Area Providers	13,486	14,131	14,794	15,483	16,066	16,657	17,256	17,863	18,480	19,044
ADC	36.9	38.7	40.5	42.4	44.0	45.6	47.3	48.9	50.6	52.2
Gross Beed Need at 65% occupancy	56.8	59.6	62.4	65.3	67.7	70.2	72.7	75.3	77.9	80.3
Current Level III/IV Supply										
MultiCare Tacoma General	40	40	40	40	40	40	40	40	40	40
(CHI-FH) St. Joseph Medical Center	5	5	5	5	5	5	5	5	5	5
Total	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**
Source: 2016 DOH Acute Care Bed Survey										
Net bed need	**11.8**	**14.6**	**17.4**	**20.3**	**22.7**	**25.2**	**27.7**	**30.3**	**32.9**	**35.3**

Exhibit 12B.

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston

Level IV Bed Need Forecast Model, 2017-2026

No Trend Adjustment

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston
Service Area Level III/IV Bed Need Model, Based on Patient Days, No Trend, 2017-2026

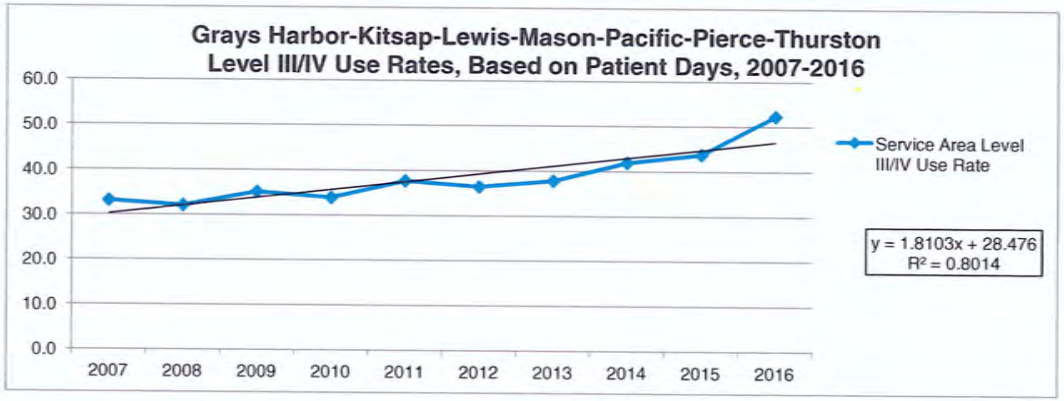
Step 1: Identify 10-year historic planning area resident days, discharges and use rates.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average Annual Growth
Service Area Level III/IV Patient Days	10,027	9,738	10,618	10,141	11,299	10,943	11,294	12,458	12,973	15,532	*4.9%*
Service Area Level III/IV Discharges	506	536	544	461	524	527	540	646	627	684	*3.3%*
ALOS	19.82	18.17	19.52	22.00	21.56	20.76	20.91	19.28	20.69	22.71	*1.5%*
Pop Fem 15-44	302,573	303,319	302,116	299,160	299,753	299,729	298,362	297,385	296,424	296,838	*-0.2%*

Population Source: SADE 2007-2016

											Trend Adjustment
Service Area Level III/IV Use Rates--patient days per 1,000 females age 15-44	33.1	32.1	35.1	33.9	37.7	36.5	37.9	41.9	43.8	52.3	*1.81*

Source: CHARS 2007-2016 and OFM SADE 2007-2016
Level III/IV DRGs include 789-790



Step 2: Calculate planning area provider Level III/IV patient origin, inmigration ratio, and planning area provider market share

	Total	From Planning Area Residents	From Out of Area	Inmigration Ratio
Service Area Provider Level III/IV Patient Days	13,025	11,410	1,615	0.1415

	In WA	In OR	Total
Service Area Resident Level III/IV Patient Days	15,532	203	15,735

Grays Harbor-Kitsap-Lewis-Mason-Pacific-Pierce-Thurston
Service Area Level III/IV Bed Need Model, Based on Patient Days, No Trend, 2017-2026

	2016 Actuals
Service Area Provider Market Share of Service Area Resident Level III/IV Patient Days	72.5%

Source: CHARS 2007-2016 and Oregon Discharge Data (2015)
Level III/IV DRGs include 789-790

Step 3: Apply the 2016 use rate from Step 1 to the projected future population to calculate future total Patient Days. Apply the market share and inmigration ratio from Step 2 to calculate future total Level III/IV Patient Days to planning area providers.

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Use Rate	52.3	52.3	52.3	52.3	52.3	52.3	52.3	52.3	52.3	52.3
Pop Fem 15-44	300,947	305,145	309,434	314,013	316,231	318,469	320,727	323,005	325,354	326,660
Total Service Area Resident Patient Patient Days	15,747	15,967	16,191	16,431	16,547	16,664	16,782	16,901	17,024	17,092
Resident Patient Days to Service Area Providers	11,419	11,578	11,741	11,914	11,999	12,084	12,169	12,256	12,345	12,394
Out-of-Area Patient Days to Service Area Providers	1,616	1,639	1,662	1,686	1,698	1,710	1,722	1,735	1,747	1,754
Total Level III/IV Patient Days to Service Area Providers	13,035	13,217	13,403	13,601	13,697	13,794	13,892	13,990	14,092	14,149

Source: CHARS 2007-2016 and OFM Medium Series (2012 Release)
Level III/IV DRGs include 789-790

Step 4: Use total days projected in Step 3 to determine gross and net Level III/IV bed need for the planning area.

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Level III/IV Patient Days to Service Area Providers	13,035	13,217	13,403	13,601	13,697	13,794	13,892	13,990	14,092	14,149
ADC	35.7	36.2	36.7	37.3	37.5	37.8	38.1	38.3	38.6	38.8
Gross Beed Need at 65% occupancy	54.9	55.7	56.5	57.3	57.7	58.1	58.6	59.0	59.4	59.6
Current Level III/IV Supply										
MultiCare Tacoma General	40	40	40	40	40	40	40	40	40	40
(CHI-FH) St. Joseph Medical Center	5	5	5	5	5	5	5	5	5	5
Total	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**
Source: 2016 DOH Acute Care Bed Survey										
Net bed need	**9.9**	**10.7**	**11.5**	**12.3**	**12.7**	**13.1**	**13.6**	**14.0**	**14.4**	**14.6**

Exhibit 13.

Financial Assistance Policy

Title: Financial Assistance

Scope:

This policy applies to patients who may need Charity Care or Financial Assistance for the services received within the facilities of MultiCare Health System ("MHS"), excluding MultiCare Express Clinics and virtual visits.

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. "Application Period" begins on the date health care services are provided and ends on the 240th day after MHS provides the patient with the first billing statement for care for patients over 200% of the Federal Poverty Limit.

2. "Collection Efforts" and "Extraordinary Collections Actions" (ECA) are defined by the MHS Collection Guidelines policy.

3. "Charity Care" and/or "Financial Assistance" means appropriate medical services provided to Eligible Persons. 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.

4. "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.

5. "Eligible Persons" is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 300% and up to 500% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third party payer.

6. "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.

7. "Medically Necessary" is defined per WAC 246-453-010 (7) as appropriate hospital-based medical services

8. "Notification Period" begins on the date health care services are provided and ends on the 120th day after MHS provides the Responsible Party with the first billing statement for care.

9. "Responsible Party" means that individual who is responsible for the payment of any hospital charges which are not subject to third party sponsorship.

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 health care services (to include emergency care) provided by MHS.

Emergency care will be provided to patients 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 qualifying individuals, 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.

This policy addresses eligibility and qualification regarding Financial Assistance for free and discounted care, including;

a) 100% Financial Assistance - Income levels at or below 300% of the federal poverty limit (FPL); or

b) Sliding Scale Financial Assistance - Income levels between 300.5% and 500% of the FPL

Procedure:

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

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. Any other persons or entities having a legal responsibility to pay
    g. Health saving account (HSA) funds. MHS may require a Responsible Party to fully utilize any available funds from HSA to satisfy outstanding balances.
2. MHS will pursue payment from any available third party payer 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. If the application places an unreasonable burden 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. Medicaid eligibility within (90) days of date of services is equal to or the same as a 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.

2. If a Responsible Party fails to cooperate with the Medicaid determination process, the Responsible Party will not be eligible for Financial Assistance.

D. *Presumptive or Extraordinary Circumstances*

1. The Responsible Party may qualify for Financial Assistance based on presumptive or extraordinary life circumstances, as outlined in the relevant Section, below.

E. *Medically Necessary Health Care Services Rendered*

a. Services given to the patient must be medically necessary and not elective.
b. Scheduled services that appear to not be medically necessary will be reviewed by Utilization Management prior to the date of service.

F. Account Within Application Period

1. An account aged beyond the Application Period will not be considered eligible for Financial Assistance unless they are 200% or below the Federal Poverty Limits.

<u>Proof of Income</u>

In order for the Responsible Party to demonstrate financial eligibility for Financial Assistance, the following criteria shall be used:

A. *Income Verification*

1. One or more 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 may 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 pay

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. Income information should be for the period just prior to the application and in the same year as when the health care services were provided.
    c. Three months of gross income will be multiplied by four.
    d. If the income is inconsistent over the last twelve months, then the quarter with the least amount of earnings will be multiplied by four.
    e. If the income is consistent across the last twelve months, then the previous twelve-month total will be used.
    f. Calculation of income for prior year health care services will be based on prior year tax returns whenever possible or full year W2s

<u>Process for Determination of Eligibility</u>

1. Financial Assistance staff will review the application to determine eligibility.
2. An incomplete application will not immediately result in a denied application. The Responsible Party will be provided a letter specifying missing information and ECA will be suspended for thirty (30) days. The letter will also specify that after thirty (30) days, ECA or collection activity may resume.
3. If approved, a written notice of eligibility will be sent to the applicant within fourteen (14) calendar days from receipt of the complete application. This notice will include the amount for which the Eligible Persons is financially responsible, if any.
4. Approvals will be valid for 90 days and a new application will be required after such time.
5. If denied, a written notice of denial will be sent to the applicant within fourteen (14) calendar days of receipt of application. Applications may be denied due to being incomplete or unsigned or those with information that indicates the applicant's income exceeds guidelines. The Responsible Party will be provided with a reason for the denial and the process for submitting an appeal.
6. Collection efforts <u>may</u> begin if no appeal has been received within thirty (30) calendar days upon receipt of notification, in accordance with the MHS Policy: Collection Guidelines, Patient Accounts

<u>Appeals</u>

The Responsible Party may appeal a denial of eligibility for Financial Assistance by providing additional verification of income or family size

within thirty (30) calendar days of receipt of notification of denial. Within the first fourteen (14) calendar days of this appeal period, the Responsible Party's account will not be referred to an external collection agency. After fourteen (14) calendar days, collection actions in accordance with the MHS Policy: Collection Guidelines, Patient Accounts may be initiated. All appeals will be reviewed and approved or denied by the Manager, Patient Financial Experience. If an appeal is denied, it will be presented to the Administrator of Revenue Integrity, 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.

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".

1. All balances will be given 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 Applications will be considered on an individual account balance basis. Approvals on applications and adjustments will be authorized as follows:

1. Patient Financial Experience Financial Counselors: $0.01 - $4,999
2. Patient Financial Experience Supervisor: $5,000 - $49,999
3. Patient Financial Experience Manager/Revenue Cycle Director: $50,000 - $99,999
4. Administrator Revenue Integrity: $100,000 - $499,999
5. Vice President: $499,999 - $999,999
6. SVP, CFO: $1,000,000 - $2,999,999

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 Administrator of Revenue Integrity.

Presumptive or Extraordinary Financial Assistance Eligibility

Eligibility may be determined presumptively or beyond the guidelines set above on the basis of individual life circumstances:

1. MHS may use outside agencies in pre-determining Financial Assistance eligibility and potential discount amounts.
2. 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. If these reviews determine that the household income meets the guidelines for Financial Assistance, aid will be granted without an application.

Further, 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 all of 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 Experience will assist in making a catastrophic event application determination.

Additionally, 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.

Collection Efforts for Outstanding Patient Accounts

Pending final eligibility determination, 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 120 days after the date of first billing statement. However, an account will be considered for Financial Assistance up to 240 days after the first statement. Accounts beyond this 240 day period will not be considered eligible for Financial Assistance and MHS will pursue collection efforts.

Collection efforts may begin if no appeal has been received within thirty (30) calendar days of receipt of notification, 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.

Failure by the responsible party to reasonably complete the Financial Assistance qualification process shall be sufficient grounds for the hospital to initiate collection efforts directed at the Responsible Party.
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.

Dissemination of MHS Financial Assistance Policy

1. All patients are provided with information about the availability of Financial Assistance upon registration. Additional copies can be requested from the Hospital Financial Counselors or Patient Access Techs within the hospital facilities. Signs advertising Financial Assistance will be posted throughout MHS facilities.
2. This policy, the application, and a plain language summary are available to patients free of charge by contacting the Financial Assistance department at 253-459-8247
3. 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.
4. Billing Statements sent to Responsible Parties will contain information regarding the availability of Financial Assistance.
5. Written materials are available in English and Spanish.

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. Distributed in the MHS Healthy Living magazine 4. Upon request, by calling 253-459-8247
	Related Policies: MultiCare P & P: "Uninsured Prompt Pay Discounts" MultiCare P & P: "Patient Payment Plans- Hospital Billing & Physician Billing" MultiCare P & P: "Emergency Medical Treatment and Active Labor (EMTALA), Compliance with MultiCare P & P: "Collection Guidelines: Patient Accounts" MultiCare P&P: "Authorization: Expenditures and Commitments" MultiCare P&P: "Patient Non-Discrimination Policy"
	Related Forms: **Proof of Income for Financial Assistance Instruction Sheet** **Financial Assistance Application** **Financial Assistance Letter to Patients** **Appendix A- Financial Assistance**
	References: WAC 246-453 Federal Register Vol 77, No 123, June 26, 2012 Proposed Rule
	Point of Contact: Administrator, Revenue Integrity 253-459-8075

Approval By:	***Date of Approval:***
Quality Steering Council	***7/12; 8/13; 7/14; 4/15***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*5/97* *11/00; 8/03; 2/05; 2/06; 9/08; 11/09; 4/11; 6/12; 8/13; 7/14; 3/15* *X/XX; X/XX*

Distribution: MHS Intranet

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

Financial Assistance
Appendix A
2017

FAMILY SIZE	Gross Annual Income	300%	350%	400%	450%	500%
1	$12,060	$36,180	$42,210	$48,240	$54,270	$60,300
2	$16,240	$48,720	$56,840	$64,960	$73,080	$81,200
3	$20,420	$61,260	$71,470	$81,680	$91,890	$102,100
4	$24,600	$73,800	$86,100	$98,400	$110,700	$123,000
5	$28,780	$86,340	$100,730	$115,120	$129,510	$143,900
6	$32,960	$98,880	$115,360	$131,840	$148,320	$164,800
7	$37,140	$111,420	$129,990	$148,560	$167,130	$185,700
8	$41,320	$123,960	$144,620	$165,280	$185,940	$206,600
9	$45,500	$136,500	$159,250	$182,000	$204,750	$227,500
10	$49,680	$149,040	$173,880	$198,720	$223,560	$248,400
EACH ADD'L	$4,180					

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

Exhibit 14A.

Admission Policy

Title: ADMISSION OF A PATIENT

Scope:

This policy applies to the admission/registration of a patient to all MultiCare services.

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, disability status, national origin, sexual orientation, marital status, 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. Patient Access Services will:

A. Provide the standard inpatient admission packet for inpatients and surgical/procedure patients and will create and maintain a supply of standardized admission packets for use.

B. Upon notification, register the patient, generate the Face Sheet and ID Band, document labels, and assure delivery to the patient location.

C. The Patient Access Technician is responsible for obtaining remaining information and signatures on required forms at the time of registration.

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

IV. Procedure for Patient Access Services:

A. The Conditions for Treatment Form (87-5616-5) and The Financial Agreement Form (87-0355-0) will be handed to the patient for review.

1. If the patient cannot read English, interpreter services should be sought and translated forms will be provided.
2. After reviewing the form, any question the patient may have should be answered.

3. When all the patient's questions have been answered, have the patient sign and date each of the forms on the eSignature pad.
4. The Patient Access personnel shall then sign as a witness to the patient's signature.

B. All patients will be given the following brochures at the time of admission:
   1. Managing Pain Brochure
   2. Patient Safety Brochure
   3. The Patient Rights Brochure (87-3018-6)

C. If the patient wishes to request financial assistance:
   1. The patient shall complete, "The Notice of Availability for Uncompensated Care Form (87-0350-6)," with the assistance of the patient access personnel.
   2. This form is NOT the application, but a request for application for assistance.

D. The completed form will either be mailed by the patient when complete or returned to the Financial Assistance Office as indicated on the instructions.

E. Patient Access personnel will refer the in-house Financial Counselor to the patient's room, so a bedside conversation can occur regarding financial assistance.

F. The Health Care Directive form (87-6030-2e) will be completed by the Patient Access and Registered Nursing personnel:
   1. If the patient is an adult and does not have an Health Care Directive or wishes additional information:
      a. The Health Care Directive form (87-6030-2e) is given to the patient and this is documented on the form.

G. For every patient who has Medicare or a Managed Medicare as any insurance, primary, secondary, or tertiary, regardless of age:
   1. The "An Important Message from Medicare" Form (87-0568-3e) must be reviewed with the patient.
   2. If the patient cannot read English, a translated form will be provided or interpreter services sought.
   3. After reviewing the forms, any question the patient may have should be answered.

4. When all patient's questions have been answered, have the patient sign and date the form on the eSignature pad.
5. Provide the patient with a copy of the signed document.

H. If the patient is eligible for TriCare:

1. The form "An Important Message from TriCare" (88-0061-0) must be reviewed with the patient.
2. If the patient cannot read English, a translated form will be provided or interpreter services sought.
3. After reviewing the forms, any question the patient may have should be answered.
4. When all the patient's questions have been answered, have the patient sign and date the form on the eSignature pad and provide the patient with a copy of the signed document.

V. Procedure for Admission to Clinical Care Area:

A. Obtaining 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.
3. Compile chart

C. 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, transcribed, and implemented.

4. Completes the nursing admission record 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. Educated adult admissions on the pneumococcal/influenza vaccine and review protocol using form 88-0670-2e

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

VI. 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

VII. The Standardized Admission Packet will be used for all inpatient and surgical/invasive procedure patients.

A. The admission packet for adults will include the following:

1. Admit Pack:

a. Conditions for Treatment 87-5616-5

b. Notice of Availability for Uncompensated Care 87-0350-6

c. Code Order (purple sheet) 87-016a-7

d. Health Care Directives Form 87-6030-2e

e. Patient Rights Brochure 87-3018-6

f. Managing Pain Brochure 87-9530-0

g. If applicable

1.) Sterilization consent – DSHS forms 13-364, 13-365 or 13364A must be signed 30 days before scheduled procedure, 72 hours before emergency surgery

2.) Special Consent to Medical Treatment, Operation,

	Postoperative Care, Anesthesia, or Other Inpatient Procedure 87-0132-8 3.) Acknowledgement of Notice of Privacy Practice 87-8970-0 (MHS downloadable in various languages) 4.) An Important Message from Medicare 87-0568-3 5.) An Important Message from TriCare 88-0161-0 2. Computer Generated Components (produced by Patient Access Services) a. Face sheet b. Appropriate ID band B. The admission packet for pediatrics at Mary Bridge will include the following: 1. Conditions for Treatment 87-5616-5 2. Notice of Availability for Uncompensated Care 87-9154-1 3. Parent Consent for Participation Special Visitors/Entertainers/Pet Partner Program 4. Pediatric Patient Rights Brochure 87-3019-4 C. There are forms in the adult packets that are not mandatory for every patient (Medicare and TriCare forms, sterilization consent forms, Acknowledgement of Notice of Privacy Practice). The admission packet forms delivered by Patient Access will contain only those forms applicable to the patient.
	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"* Good Samaritan P & P: *"Acute Care Patient Admit Process"* Scope of Service/ADT Criteria
	Related Forms: Conditions for Treatment - Form # 87-5616-5 Important Message from Medicare Form # 87-0568-3e Important Message from TriCare Form # 88-0061-0

	Notice of Uncompensated Care Form # 87-0350-6 or 87-9154-1 (MB) Health Care Directive Form #87-6030-2e Patient Rights and Responsibilities Pamphlet (Adult/Adolescent) # 87-3018-6 Patient Rights and Responsibilities Pamphlet (Pediatric) # 87-3019-4 Patient Safety Brochure # 87-5910-9 Managing Pain Brochure # 87-9530-0e Pneumococcal/Influenza Vaccine Protocol form # 88-0670-2a Financial Agreement Form # 87-0355-0
	References: 45 C.F.R. § 80 (2012) 45 C.F.R. § 84 (2012) 45 C.F.R. § 91 (2012) 29 U.S.C. § 794
	Point of Contact: Administrator Business Operations 459-8266 or Nurse Executives

Approval By: Quality Steering Council	***Date of Approval:*** ***8/12***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*12/00* *8/04; 7/07; 9/09; 06/12* *none*

Distribution: MHS Intranet

Title: PEDIATRIC PATIENTS, CARE AND PLACEMENT OF

Scope:

This policy applies to the placement of all pediatric patients within MultiCare-Health System (MHS).

Policy Statement:

This policy establishes the MHS procedure for the appropriate placement of pediatric patients at any site within MHS.

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

Procedure:

I. Pediatric patients requiring services within MHS:

A. Every effort will be made to admit pediatric patients to Mary Bridge Children's Hospital & Health Center (MBCHC) at Tacoma or Good Samaritan; however, other specialties and locations may provide services to pediatric patients

B. An adult may receive services and admissions to MBCHC or Good Samaritan based on the department's scope of service or on an individual case-by-case basis

C. Emancipated minors and obstetrical patients will be treated as adults with regard to consent for care

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

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

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

II. Responsibilities:

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

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

A. Pediatric patients will be given priority consideration over adult

patients for admission requests to MBCHC at Tacoma and Good Samaritan.

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

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

IV. Definitions

Pediatric Patient: Determined by patient age, from birth to 18th birthday.

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

Related Policies:

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

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

Point of Contact: VP & Administrator, MBCHC - 403-1420

Approval By:	***Date of Approval:***
MGSH Pediatrics Committee	***5/12***
MHS Pediatrics Committee	***6/12***
Quality Steering Council	***7/12***
Original Date:	*1/02*
Revision Dates:	*10/03; 8/06; 5/09; 4/12*
Reviewed with no Changes Dates:	*none*

Distribution: MHS Intranet

Exhibit 14B.

Admission to the Tacoma General Neonatal Intensive Care Unit

Title: ADMISSION TO THE TACOMA GENERAL HOSPITAL NEONATAL INTENSIVE CARE UNIT

Patient Population:

All infants born in the Birth Center or an outlying medical facility who meets the admission criteria listed below.

Policy Statement/Background:

To establish the MultiCare Health System (MHS) policy and procedure for admission to the Neonatal Intensive Care Unit (NICU). To provide appropriate family-centered and developmentally supportive level of care to infants requiring constant acute nursing care and observation.

Special Instructions:

1. Identify admission criteria, including, but not limited to:
   1) Physiological monitoring.
   2) Respiratory therapy.
   3) Intravenous therapy.
   4) Antibiotic therapy.
   5) Nutritional support.
   6) Blood pressure support.

2. Recognize admission conditions, including, but not limited to:
   1) Prematurity.
   2) Respiratory Distress Syndrome.
   3) Cardiac Disease.
   4) Congenital Anomalies.
   5) Hyperbilirubinemia.
   6) Hypoglycemia.

3. Infection prevention:
   1) Clean gloves will be utilized when:
      a) Caring for intubated infants
      b) Caring for infants on nCPAP
      c) Caring for infants with central intravenous (IV) lines
      c) Handling all IV tubing/bags/syringes
      d) Handling feeding tubes/syringes/extension sets
      e) Handling feedings (breast milk/donor breast milk/formula)
      e) Handling bodily fluids (i.e. suctioning, diaper changes)
   2) A clean gown will be utilized when holding an infant (use one clean gown each shift for each infant that will be held)

Procedure:

a. RN responsibilities:
   1) Notify Licensed Independent Practitioner (neonatologist, NNP, or

pediatrician) of admission.
2) Stabilization and/or resuscitation measures.
3) Admit to pre-warmed radiant warmer, Giraffe Omnibed, isolette, or crib.
4) Assess infant and perform admission procedures as indicated by the infant's condition. The physical assessment must be performed and documented within 2 hours of admission.
5) Baseline vital signs:
    a) Apical heart rate and quality of heart sounds.
    b) Respiratory rate and quality of breath sounds.
    c) Axillary temperature.
    d) Blood pressure.
    e) Pain assessment.
6) Baseline measurements:
    a) Weight.
    b) Length.
    c) OFC.
    d) Above measurements plus blood pressure (infants who are intubated or on NCPAP) will be assessed and recorded every Tuesday.
7) Lab work:
    a) Peripheral blood glucose (at 30min, 60min, and 90min).
    b) Lab work as ordered:
        (1) Blood gas.
        (2) Complete blood count (CBC).
        (3) Blood culture.
        (4) Type and Cross/Type and Coombs.
    c) Other lab work as ordered:
        (1) Hematocrit every Wednesday.
        (2) Daily bilirubin if infant is icteric or requires phototherapy.
8) Monitoring:
    a) Cardio-respiratory.
    b) Pulse oximetry.
    c) Thermoregulation.
9) Vitamin K & eye prophylaxis, if not previously given.
10) After initial admission process, provide parent(s) with supportive care and information regarding infant's condition and NICU policies (orientation to the unit, visitation, handwashing, etc.).
11) Obtain the following consents, if applicable:
    a) PICC Placement.
    b) Blood Transfusion.
    c) Hepatitis B
12) Admission note and admission assessment will be charted in the electronic medical record.
13) Provide consultation to Birth Center or Women & Newborn Center for infants requiring limited observation or specific procedures.

	b. RT responsibilities: 1) Assist RN with admission and assessment process. 2) Set up/delivery of respiratory equipment. 3) Chart data in the electronic medical record. **c.** Unit secretary responsibilities: 1) Complete pre-admission process in the computer system. 2) Enter information in NICU admission spreadsheet. 3) Assist in notifying appropriate parties. 4) Assist infant's family members with scrubbing/handwashing and visitation process. 5) Obtain consents (e.g. treatment, financial, privacy). **d.** Environmental Services-Housekeeper responsibilities: 1) Assure that an admission bed is set up and ready at all times. 2) Assist care team with the admission process. 3) Gather equipment and supplies, as requested. 4) Maintain clean environment after initial admission process occurs.
	Related Policies:
	Related Forms:
	References: **a.** Ikuta, L.M. & Beauman, S.S. (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview: National Association of Neonatal Nurses. **b.** Tacoma General Hospital Scope of Services: Neonatal Intensive Care Unit/Intermediate Care Nursery, Revised August 2009. **c.** Washington State Perinatal and Neonatal Level of Care (LOC) Guidelines, Revised February 2013.
	Point of Contact: Neonatal Unit Based Council

Approval By:	***Date of Approval:***
NICU Manager Quality Steering Council	***7/13***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*4/87* *8/07;7/10;7/13* *X/XX; X/XX*

Distribution: MHS Intranet
3/2017 Defined location in title

Exhibit 14C.

Non-Discrimination Policy

Title: PATIENT NONDISCRIMINATION

Scope:

This policy applies to every MultiCare Health System (MHS) staff member, including employees, employed physicians, medical staff members, contracted services staff, and volunteers ("MHS Personnel") vendors, guests/visitors to MultiCare premises, and patients.

Policy Statement:

As a recipient of Federal financial assistance, MHS does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, creed, religion, gender, age, disability status, national origin, sexual orientation, marital status or any other illegal basis 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*."

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin), Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability), the Age discrimination of 1975 (which prohibits discrimination on the basis of age), the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91, and corporate policy (which prohibits discrimination on the other bases).

For questions call the Corporate Compliance Hotline at 459-8300

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 under MHS' Patient Grievance Procedure.

The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination with the U.S. Department of Health and Human Services, Office for Civil Rights.

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

	Procedure: MHS Personnel shall not: 1. Deny an individual service, financial aid or other benefit provided under the program providing federal financial assistance (the program); 2. Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program; 3. Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program; 4. Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program; 5. Treat an individual differently from others in determining whether they satisfy any admission, enrollment, quota, or eligibility that individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program; 6. Deny an individual an opportunity to participate in the program through the provision of services or otherwise afford him an opportunity to do so which is different from that afforded others under the program.
	Related Policies: MHS P & P: *"Equal Employment Opportunity and Employment Law"* MHS P & P: *"Employee Complaint/Grievance Procedure"* MHS P & P: *"Patient Grievances"*
	References: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to: 1. 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. 2. 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. 3. 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.
	Point of Contact: Corporate Compliance & Internal Audit 459-7919

Approval By:	***Date of Approval:***
Quality Steering Council	***8/12; 10/15***
Original Date:	*6/12*

Revision Dates:	*9/15*
Reviewed with no Changes Dates:	*none*

Distribution: MHS Intranet

Exhibit 15.

Non-binding Contractor Estimate

ABBOTT CONSTRUCTION

Friday, November 17, 2017

David Vollmer
MHS/CBRE
315 MLK Jr Way
Tacoma, WA 98405

Subject: MHS TGH OB – NICU Conversion

Dear David:

We are pleased to present this budget proposal for the MultiCare TGH OB-NICU Conversion project located at 315 MLK Jr. Way, Tacoma, WA 98405. This estimate is based on the documents listed below and clarifications provided in this letter. **This estimate excludes Washington State Sales Tax.**

Budget **$2,278,274.00 + WSST**

TWO MILLION TWO HUNDRED SEVENTY EIGHT THOUSAND TWO HUNDRED SEVENTY FOUR DOLLARS and 00/100 plus WSST

Bid Documents

- Schematic Drawing by Clark Kjos dated 11/9/2017
- Schamatic Narrative by Mazzetti dated 11/16/2017

Basic Criteria

Square footage of project estimated to be 6,879 square feet. Construction is anticipated to take 20 weeks after approval and procurement of finishes and equipment. Work area is assumed to be clear of all fixtures, furniture, and equipment prior to mobilizing on site. Project will be completed in 1 phase.

Long Lead Times are expected to be: Possible long lead on the flooring materials, casework, ICU Doors.

Fee on change orders will be 10.0% + GC's and BT&I.

The project will start when permits are in hand and contract is executed. We may require 2 weeks to schedule some trades to be on site after the contract is issued.

We have included a 10% Construction Contingency and 5% in anticipated Escalation Costs.

SEATTLE
3408 1st Avenue South
Seattle, WA 98134
206.467.8500 office
206.447.1885 fax

ABBOTTCONSTRUCTION.COM

Inclusions and Clarifications

The following are clarifications to this proposal. In the event 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

Pre-construction estimating, scheduling and planning
Project administration
Project supervision
Supervision vehicle and project administration mileage
Printing & mailing
Safety measures
Clean-up & disposal
Insurance coverage and limits per Abbott standards unless otherwise clarified by proposed contract documents

Demolition

1. Removal and disposal drywall, ACT, casework, doors, and flooring as indicated.
2. Remove existing MEPs as required to accommodate new layouts and tie ins.
3. Cutting of decking to accommodate new exhaust line to roof.
4. Removal and capping of unused plumbing lines as needed for new layout.

Concrete

1. Patching of holes in concrete deck for demolished plumbing waste lines.

Woods and Plastic

1. Fabricate and install plastic laminate countertops at Nurse Stations as indicated.
2. Modifications to Team Center for new sliding window.
3. Casework in Pod 1 & 2 at window consisting of cabinets with solid surface countertop and integral sink.
4. Pod 3 to receive small solid surface countertop with integral sink in room.
5. Includes upper and lower cabinets with plastic laminate countertop in Nurse Station outside Pod #3.
6. Includes upper and lower cabinets along wall in Pod #2 as indicated.
7. Includes full height casework along window in Pod #1 as indicated.
8. Includes upper and lower cabinets in Feeding Prep as indicated.
9. Includes new solid surface countertop with integral sink in Meds Room as shown.
10. Includes new upper and lower cabinets in Meds Room as shown.

Thermal and Moisture Protection

1. Includes a $5,000 allowance for the repair of roofing due to new rooftop exhaust fan.
2. Includes a $10,000 allowance for miscellaneous firestopping.

Doors, Frames, Hardware & Glazing

1. Supply and install seven single swing doors with associated hardware.
2. Supply and install two pair of corridor doors with power door operators.
3. Includes five sets of 8' single sliding ICU doors with clear glass. No power operation or locking feature included.
4. Includes glazing modifications at Team Center. Design TBD.
5. Includes glazing assemblies at Pod 1 & Pod 2.
6. Includes glazing assembly at Nurse Station at All Rooms.
7. Includes decorative screen at three locations consisting of drywall knee wall with ¼" tempered glazing and film from knee wall to ceiling.
8. Access Control to be supplied and installed by others.

Metal Stud Framing, GWB and Lead Lining

1. New GWB walls as indicated extending to deck.
2. Includes hard lid ceiling in Visitor Toilet and All Rooms.
3. Includes access panels as needed in hard lid ceilings.
4. Includes backing and blocking for larger wall mounted items.
5. Includes a $10,000 allowance for any chase wall modifications for Isolation Exhaust Duct.
6. Includes a $10,000 allowance for any soffits that may be required.
7. Includes a $20,000 allowance for upgrades to GWB for sound resistance.
8. Includes patching of existing GWB partitions to accommodate new MEP tie ins or relocations.

Acoustical Ceilings

1. Supply and install approximately 3,500 sf of ACT grid and ceiling tile.
2. Ceiling tile is anticipated to be 2'x4' tegular second look tile.
3. Includes a $5,000 allowance for the modifications or repair of ACT system in corridor.

Floorcoverings

1. Supply and install approximately 400 sy of Teknoflor sheet vinyl with integral cove base in Pods, All, Toilet Rooms, Feeding Prep, and Nurse Stations.
2. Includes approximately 180 sy of Teknoflor sheet vinyl in corridor.
3. Includes approximately 850 lf of 4" rubber base.
4. Includes typical floor prep as needed for sheet vinyl.
5. Excludes any moisture mitigation or major floor prep.

Painting

1. Painting of all GWB walls and ceilings within construction area.
2. Painting of all hollow metal door frames within area.
3. Tie in to existing drywall will be painted to nearest corner, no more than 8' from new construction.

Specialties

1. Supply and install approximately 70 sheets of Acrovyn wall protection within rooms assumed to be Parchment color.
2. Supply and install approximately 50 sheets of Acrovyn wall protection in corridor assumed to be Parchment color.
3. Supply and install approximately 43 four foot tall Acrovyn corner guards throughout project.
4. Supply and install handrail in corridor.
5. Supply and install bumper guards in Equipment Room.
6. Supply and install grab bars, toilet paper dispenser, seat cover dispenser, and sanitary napkin receptacle in Toilet Rooms.
7. Installation of owner provided paper towel dispenser and soap dispensers at sinks.
8. Installation of owner provided typical items such as glove boxes or instruments.
9. Supply and install two fire extinguisher cabinets with extinguishers.
10. Supply and install double layer manual Mecho shades at exterior windows and skylight.

Infection Control

1. We have included Level IV Infection control procedures with anteroom.
2. Hard Wall Barriers with sticky mats, HEPA machines.
3. Barriers will be inspected and maintained daily during construction.

Fire Sprinkler

1. Includes an $24,000 allowance for the replacement of sprinkler heads and minor relocation of sprinkler lines to accommodate new wall layout.
2. It is assumed existing mains will not be modified and only branch lines and heads are to be relocated as needed.
3. It is assumed existing sprinkler lines have enough pressure to accommodate new layout.

Plumbing

1. Safe off and demolition of plumbing in order to install new systems.
2. Includes relocation of med gas systems to new head walls per Mazzetti narrative.
3. Replacement of all plumbing fixtures.
4. Installation of new plumbing piping to new fixtures.
5. Cutting and capping of existing plumbing lines to mains as needed.

HVAC

1. Safe off and demolition of HVAC system in order to install new systems as indicated.
2. Includes new roof mounted exhaust fan with ductwork for All Rooms.
3. Installation of air pressure monitor systems as indicated in Mazzetti narrative.
4. Replacement of pneumatic HVAC controls for DDC controls.
5. Includes new terminal units as indicated. Existing VAVs are to be reused.
6. Includes a $25,000 allowance for the cleaning of ductwork.
7. Includes a $25,000 allowance for modifications of HVAC pathways.

Electrical

1. Safe off and demolition of Electrical systems in order to install new systems as indicated.
2. Modifications to existing electrical system as indicated in drawings.
3. Supply and install of new 2'x2' LED light fixtures in all rooms within suite.
4. Supply and install of new 2'x2' LED light fixtures in corridor.
5. Includes a $7,000 allowance for the supply of dedicated power for refrigerators in Meds and Feeding Prep.
6. Includes a $20,000 allowance for relocation or addition of electrical circuits to accommodate new layout.
7. Includes new receptacles as indicated by Mazzetti at head wall system.
8. Includes a $75,000 allowance for the upgrade of electrical infrastructure as needed.
9. Excludes any low voltage wiring, nurse call systems, baby monitoring systems, or security systems.
10. Electrical permits.
11. Rough in only for voice/data and nurse call systems.

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. Overtime
3. Architectural, structural and MEP Engineering design or fees.
4. Prevailing or union wages
5. Performance, labor and material payment bond(s)
6. Fire alarm monitoring and phone lines.
7. Testing and inspection unless listed above.
8. Building, mechanical or fire alarm permits and plan check fees unless stated above.
9. Schedule delay due to late procurement of building permits that are by owner.
10. Builders Risk Insurance

Project Specific Exclusions:

1. Cleaning and waxing of floors.
2. Moisture testing and moisture mitigation of existing slab for flooring.
3. Hazardous material testing or mitigation.
4. Terminal clean of space.
5. Interior signage or way finding.
6. Low voltage, data, communication, paging, distributed audio or video, security, card access and low voltage systems, equipment, and wiring.
7. Receiving, uncrating, onsite storage and handling of owner furnished equipment.
8. Setting of equipment and shelving provided by others unless noted in this letter.
9. Repair of damage to building common area, restrooms or corridors not proven to be caused by Abbott Construction or their subcontractors.
10. Unknown structural improvements or 3rd party testing of existing concrete.
11. Schedule delay due to owner provided equipment.
12. Upgrades or modifications to existing MEP equipment to accommodate the added items listed above unless listed on drawings.
13. Access controls, Nurse Call, Security, baby monitoring systems.
14. Major modifications to fire sprinkler system.
15. Supply or installation of headwall systems. MEP rough in is included.
16. Modifications to main lines for med gas systems.

Proposed Payment Terms: Per master agreement.

By acceptance of this proposal, J.R. Abbott Construction, Inc. will perform the work as described above and this proposal will serve as a lump sum project amendment to our A107 MHS Master Contract Agreement dated January 12th of 2012.

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.

Very truly yours,

J.R. ABBOTT CONSTRUCTION, INC.

Matt McKeeby
Project Manager

ABBOTT CONSTRUCTION

Exhibit 16.

Letter of Financing Commitment

MultiCare
BetterConnected

MultiCare Allenmore Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Hospital
MultiCare Mary Bridge Children's Hospital & Health Center
MultiCare Tacoma General Hospital
MultiCare Clinics

November 16, 2017

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

RE: MultiCare Health System Certificate of Need Request for Fourteen Additional Neonatal Intensive Care Level IV Beds at MultiCare Tacoma General Hospital for an Estimated Capital Expenditure of $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 fourteen additional Neonatal Intensive Care Level IV Beds at MultiCare Tacoma General Hospital for an Estimated Capital Expenditure of $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 loomian@multicare.org or at 253.403.8020. Thank you for your time and assistance in this important matter.

Yours truly,

Anna Loomis
Chief Financial Officer
MultiCare Health System

Exhibit 17A.

Financial Forecasts. With the project

Multicare Tacoma General Allenmore Hospital
Selected Utilization and Financial Forecasts, With Project, 2014 - 2023

Volume Indicators

	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Admissions	17,105	20,320	21,153	19,657	19,657	19,675	19,694	19,713	19,734	19,756	19,779
Patient Days	85,386	112,514	115,859	108,076	108,076	108,687	109,334	110,017	110,739	111,502	112,308
ALOS	4.99	5.54	5.48	5.50	5.50	5.52	5.55	5.58	5.61	5.64	5.68
Total ED Visits	73,194	79,796	82,249	82,291	82,291	82,291	82,291	82,291	82,291	82,291	82,291

Depreciation and Interest per Patient Day

Dollars in Thousands	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Total Depreciation	$23,527	$24,422	$24,517	$26,737	$26,737	$26,737	$27,312	$27,312	$27,312	$27,312	$27,312
Total Interest	$9,067	$11,316	$12,081	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512
Total Depreciation & Interest	$32,594	$35,738	$36,598	$38,249	$38,249	$38,249	$38,824	$38,824	$38,824	$38,824	$38,824
Patient Days	85,386	112,514	115,859	108,076	108,076	108,687	109,334	110,017	110,739	111,502	112,308
Total Depreciation & Interest / Patient Day	$382	$318	$316	$354	$354	$352	$355	$353	$351	$348	$346

Projected Capital Expenditures

Dollars in Thousands	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Project Capital Expenditure	$0	$0	$0	$0	$0	$0	$0	$6,901	$0	$0	$0
Routine Capital	$2,800	$4,500	$3,300	$2,700	$2,700	$2,700	$2,700	$2,700	$2,700	$2,700	$2,700
Cost of Securing Sources of Financing	$0	$0	$0	$0	$0	$6,901	$0	$0	$0	$0	$0
Total Estimated Capital Expenditure	$2,800	$4,500	$3,300	$2,700	$2,700	$9,601	$2,700	$9,601	$2,700	$2,700	$2,700

Source: MultiCare Health System, 2014-2017

Multicare Tacoma General Allenmore Hospital
Summary Utilization Statistics, With Project, 2014 - 2023

	Actual	Actual	Actual	Projected	Forecasts							Average Annual
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023	Growth 2017-2023
Total Discharges	17,105	20,320	21,153	19,657	19,657	19,675	19,694	19,713	19,734	19,756	19,779	0.1%
Total Patient Days	85,386	112,514	115,859	108,076	108,076	108,687	109,334	110,017	110,739	111,502	112,308	0.6%
ALOS	4.99	5.54	5.48	5.50	5.50	5.52	5.55	5.58	5.61	5.64	5.68	0.5%
Level II and Level IV Discharges	719	716	746	799	799	817	835	855	876	898	921	2.4%
Level II and Level IV Patient Days	15,361	16,570	17,993	17,698	17,698	18,309	18,955	19,638	20,360	21,123	21,930	3.6%
Level II and Level IV ALOS	21.36	23.14	24.12	22.14	22.14	22.41	22.69	22.96	23.24	23.52	23.81	1.2%
Level II and Level IV ADC	42.00	45.40	49.16	48.51	48.49	50.16	51.93	53.80	55.78	57.87	60.08	3.6%
Level IV Discharges			293	310	310	327	346	366	386	408	432	5.5%
Level IV ALOS			38.6	34.7	34.7	34.7	34.7	34.7	34.7	34.7	34.7	0.0%
Level IV Patient Days			11,321	10,741	10,741	11,353	11,999	12,682	13,404	14,167	14,973	5.5%
Level IV Average Daily Census			31.0	29.4	29.4	31.1	32.9	34.7	36.7	38.8	41.0	5.5%
Level IV Beds			40	40	40	40	47	54	54	54	54	5.0%

Ancillary Volumes

	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Level II and Level IV Patient Days	*15361*	*16570*	*17993*	*17,698*	*17,698*	*18,309*	*18,955*	*19,638*	*20,360*	*21,123*	*21,930*
All Other ICU Patient Days	*23,151*	*27,235*	*27,385*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*
Total Intensive Care Patient Days	38,512	43,805	45,378	44,670	44,670	45,281	45,928	46,611	47,333	48,096	48,902
Operating Minutes	4,109,625	2,122,630	2,072,815	2,159,670	2,159,670	2,159,796	2,159,928	2,160,069	2,160,217	2,160,374	2,160,540
Semi-Intensive Patient Days	6,709	12,000	14,695	18,431	18,431	18,431	18,431	18,431	18,431	18,431	18,431
Acute Care Patient Days	24,750	26,017	24,474	24,985	24,985	24,985	24,985	24,985	24,985	24,985	24,985
Lab Bill Tests	1,172,009	1,788,301	1,230,322	1,219,673	1,219,673	1,226,573	1,233,867	1,241,576	1,249,723	1,258,334	1,267,436
MRI RVUs	127,698	125,889	99,092	104,326	104,326	104,916	105,540	106,200	106,897	107,633	108,412
Imaging RVUs	326,051	275,350	240,657	251,303	251,303	252,725	254,228	255,816	257,495	259,269	261,145
Nuclear RVUs	27,639	23,841	25,657	22,894	22,894	22,894	22,894	22,894	22,894	22,894	22,894
ER Visits	73,194	79,796	82,249	82,291	82,291	82,291	82,291	82,291	82,291	82,291	82,291
Short Stay Outpatients	1,242	1,156	1,077	1,902	1,902	1,902	1,902	1,902	1,902	1,902	1,902

Multicare Tacoma General Allenmore Hospital
Statement of Revenue and Expenses With Project, 2014 - 2023

	Actual	Actual	Actual	Projected	Forecast						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
PATIENT REVENUE											
Inpatient Services	$1,236,309	$1,409,919	$1,428,919	$1,526,126	$1,526,126	$1,538,122	$1,550,801	$1,564,202	$1,578,365	$1,593,335	$1,609,157
Outpatient Services	$1,396,104	$1,380,418	$1,423,421	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378
TOTAL	$2,632,412	$2,790,337	$2,852,340	$3,056,504	$3,056,504	$3,068,500	$3,081,179	$3,094,579	$3,108,743	$3,123,713	$3,139,535
DEDUCTIONS FROM REVENUES											
Contractual Discounts	$1,854,446	$1,967,214	$2,061,539	$2,234,561	$2,234,561	$2,243,331	$2,252,601	$2,262,398	$2,272,753	$2,283,697	$2,295,264
Provision for Charity	$52,976	$37,624	$47,885	$51,904	$51,904	$52,108	$52,323	$52,550	$52,791	$53,045	$53,314
Bad Debt Expense	$39,961	$13,055	$10,326	$11,192	$11,192	$11,236	$11,283	$11,332	$11,383	$11,438	$11,496
TOTAL	$1,947,384	$2,017,893	$2,119,750	$2,297,657	$2,297,657	$2,306,675	$2,316,206	$2,326,280	$2,336,927	$2,348,180	$2,360,074
NET PATIENT REVENUE	$685,028	$772,443	$732,590	$758,846	$758,846	$761,825	$764,972	$768,299	$771,816	$775,532	$779,461
OTHER OPERATING REVENUE											
TOTAL OPERATING REVENUE	$685,028	$772,443	$732,590	$758,846	$758,846	$761,825	$764,972	$768,299	$771,816	$775,532	$779,461
OPERATING EXPENSES											
Salaries and Wages	$234,457	$252,543	$268,969	$278,632	$278,632	$279,380	$280,171	$281,205	$282,088	$283,022	$284,010
Employee Benefits	$57,928	$60,457	$54,370	$59,477	$59,477	$59,652	$59,837	$60,078	$60,284	$60,503	$60,734
Supplies	$118,921	$127,942	$134,111	$141,839	$141,839	$142,338	$142,866	$143,424	$144,014	$144,638	$145,297
Professional fees	$17,870	$17,531	$17,039	$15,970	$15,970	$16,170	$16,170	$16,170	$16,170	$16,170	$16,170
Purchased Services	-$18,248	$15,725	$19,843	$21,217	$21,217	$21,217	$21,217	$21,217	$21,217	$21,217	$21,217
Other Direct Expenses	$6,506	$29,637	$10,790	$11,123	$11,123	$11,171	$11,233	$11,281	$11,331	$11,385	$11,441
Lease and Rental Fees	$3,864	$4,097	$4,288	$4,673	$4,673	$4,673	$4,673	$4,673	$4,673	$4,673	$4,673
Insurance	$6,579	$2,020	$2,173	$2,043	$2,043	$2,043	$2,043	$2,043	$2,043	$2,043	$2,043
Taxes	$6,233	$6,885	$6,962	$6,770	$6,770	$6,770	$6,770	$6,770	$6,770	$6,770	$6,770
Interest	$9,067	$11,316	$12,081	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512
Depreciation & Amort.	$23,527	$24,422	$24,517	$26,737	$26,737	$26,737	$27,312	$27,312	$27,312	$27,312	$27,312
TOTAL	$466,705	$552,575	$555,141	$579,992	$579,992	$581,664	$583,805	$585,685	$587,415	$589,245	$591,178
INCOME/(LOSS) FROM OPERATIONS	$218,324	$219,868	$177,449	$178,854	$178,854	$180,161	$181,167	$182,615	$184,400	$186,288	$188,282
Corporate Services	$148,414	$150,573	$125,242	$145,371	$145,371	$145,818	$146,237	$146,740	$147,203	$147,693	$148,210
OPERATING MARGIN	$69,909	$69,295	$52,207	$33,483	$33,483	$34,343	$34,930	$35,875	$37,197	$38,595	$40,072
NET INCOME	**$69,909**	**$69,295**	**$52,207**	**$33,483**	**$33,483**	**$34,343**	**$34,930**	**$35,875**	**$37,197**	**$38,595**	**$40,072**

Notes: Dollars are in thousands
Source: Multicare Health System 2014-2017

Multicare Tacoma General Allenmore Hospital
Deductions From Revenue, With Project, 2014 - 2023

	ACTUAL	ACTUAL	ACTUAL	Projected	Forecast						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Contractual Allowances											
Medicare	$722,756	$770,515	$795,642	$868,097	$866,484	$869,885	$873,479	$877,278	$881,293	$885,537	$890,022
Medicaid	$452,168	$510,471	$537,368	$558,039	$560,466	$562,666	$564,991	$567,448	$570,045	$572,790	$575,692
Other	$679,522	$686,229	$728,529	$808,425	$807,611	$810,781	$814,131	$817,672	$821,414	$825,370	$829,550
Total Contractual Allowances	**$1,854,446**	**$1,967,214**	**$2,061,539**	**$2,234,561**	**$2,234,561**	**$2,243,331**	**$2,252,601**	**$2,262,398**	**$2,272,753**	**$2,283,697**	**$2,295,264**
Inpatient	$24,880	$19,011	$23,989	$25,916	$25,916	$26,120	$26,335	$26,562	$26,803	$27,057	$27,326
Outpatient	$28,096	$18,613	$23,896	$25,988	$25,988	$25,988	$25,988	$25,988	$25,988	$25,988	$25,988
Total Charity Care	**$52,976**	**$37,624**	**$47,885**	**$51,904**	**$51,904**	**$52,108**	**$52,323**	**$52,550**	**$52,791**	**$53,045**	**$53,314**
Inpatient	$18,768	$6,596	$5,173	$5,588	$5,588	$7,996	$8,100	$8,203	$8,308	$8,444	$8,538
Outpatient	$21,194	$6,458	$5,153	$5,604	$5,604	$7,965	$8,069	$8,172	$8,276	$8,411	$8,505
Total Bad Debt	**$39,961**	**$13,055**	**$10,326**	**$11,192**	**$11,192**	**$11,236**	**$11,283**	**$11,332**	**$11,383**	**$11,438**	**$11,496**
Total Deductions From Revenue	**$1,947,384**	**$2,017,893**	**$2,119,750**	**$2,297,657**	**$2,297,657**	**$2,306,675**	**$2,316,206**	**$2,326,280**	**$2,336,927**	**$2,348,180**	**$2,360,074**

Note: Dollars are in thousands

Source: MultiCare Health System, 2014

Multicare Multicare Tacoma General Allenmore Hospital
Cost Center Forecasts, With Project, 2014 - 2023

Level II and Level IV Intensive Care

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$122,718	$153,245	$154,451	$129,276	$155,132	$155,132	$160,492	$166,157	$172,144	$178,473	$185,161	$192,231
Inpatient	$122,675	$153,230	$154,427	$129,271	$155,125	$155,125	$160,485	$166,150	$172,137	$178,466	$185,155	$192,224
Outpatient	$43	$15	$24	$6	$7	$7	$7	$7	$7	$7	$7	$7
Total FTEs	115.0	119.4	129.0	130.7	130.7	130.7	135.2	140.0	145.0	150.3	156.0	161.9
Total Salaries Expense	$11,029	$11,227	$12,876	$10,481	$12,577	$12,577	$13,012	$13,471	$13,956	$14,470	$15,012	$15,585
Total Supply Expense	$2,262	$3,005	$2,889	$2,460	$2,952	$2,952	$3,054	$3,162	$3,276	$3,397	$3,524	$3,659
Professional Fees	$140	$230	$279	$185	$222	$222	$422	$422	$422	$422	$422	$422
Other Expenses	$3,542	$4,077	$4,195	$3,628	$4,353	$4,353	$4,452	$5,132	$5,242	$5,359	$5,482	$5,613
Total Dept Expense	**$16,973**	**$18,539**	**$20,238**	**$16,754**	**$20,105**	**$20,105**	**$20,940**	**$22,187**	**$22,896**	**$23,647**	**$24,440**	**$25,278**
Total UOS	15,361	16,570	17,993	14,748	17,698	17,698	18,309	18,955	19,638	20,360	21,123	21,930
Ratios												
UOS / FTE	133.60	138.74	139.51	112.86	135.44	135.44	135.44	135.44	135.44	135.44	135.44	135.44
Total Revenue / UOS	$7,988.91	$9,248.34	$8,583.95	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68
Total Salaries / UOS	$718.02	$677.55	$715.61	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67
Total Supplies / UOS	$147.24	$181.37	$160.54	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83

All Other Intensive Care

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$111,588	$132,477	$134,338	$108,696	$130,435	$130,435	$130,435	$130,435	$130,435	$130,435	$130,435	$130,435
Inpatient	$109,389	$131,143	$132,669	$107,304	$128,765	$128,765	$128,765	$128,765	$128,765	$128,765	$128,765	$128,765
Outpatient	$2,199	$1,334	$1,669	$1,392	$1,670	$1,670	$1,670	$1,670	$1,670	$1,670	$1,670	$1,670
Total FTEs	235.8	238.2	269.3	269.1	269.1	269.1	269.1	269.1	269.1	269.1	269.1	269.1
Total Salaries Expense	$19,034	$20,511	$23,730	$19,107	$22,928	$22,928	$22,928	$22,928	$22,928	$22,928	$22,928	$22,928
Total Supply Expense	$1,891	$2,340	$2,431	$2,252	$2,702	$2,702	$2,702	$2,702	$2,702	$2,702	$2,702	$2,702
Professional Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Expenses	$7,413	$7,869	$8,005	$7,146	$8,576	$8,576	$8,576	$8,576	$8,576	$8,576	$8,576	$8,576
Total Dept Expense	**$28,338**	**$30,720**	**$34,166**	**$28,505**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**
Total UOS	23,151	27,235	27,385	22,477	26,972	26,972	26,972	26,972	26,972	26,972	26,972	26,972
Ratios												
UOS / FTE	98.18	114.33	101.69	83.53	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23
Total Revenue / UOS	$4,820.01	$4,864.23	$4,905.53	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88
Total Salaries / UOS	$822.16	$753.11	$866.53	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05
Total Supplies / UOS	$81.67	$85.93	$88.76	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19

Multicare Multicare Tacoma General Allenmore Hospital
Cost Center Forecasts, With Project, 2014 - 2023

Total Intensive Care

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$234,306	$285,722	$288,789	$237,972	$285,567	$285,567	$290,927	$296,592	$302,579	$308,908	$315,597	$322,666
Inpatient	$232,065	$284,373	$287,095	$236,575	$283,890	$283,890	$289,250	$294,915	$300,903	$307,231	$313,920	$320,989
Outpatient	$2,241	$1,349	$1,694	$1,397	$1,677	$1,677	$1,677	$1,677	$1,677	$1,677	$1,677	$1,677
Total FTEs	350.8	357.6	398.3	399.8	399.8	399.8	404.3	409.1	414.1	419.4	425.1	431.0
Total Salaries Expense	$30,063	$31,738	$36,606	$29,588	$35,505	$35,505	$35,940	$36,399	$36,884	$37,398	$37,940	$38,513
Total Supply Expense	$4,152	$5,346	$5,319	$4,712	$5,655	$5,655	$5,757	$5,865	$5,979	$6,099	$6,226	$6,361
Professional Fees	$140	$230	$279	$185	$222	$222	$422	$422	$422	$422	$422	$422
Other Expenses	$10,955	$11,945	$12,200	$10,774	$12,929	$12,929	$13,028	$13,707	$13,818	$13,935	$14,058	$14,188
Total Dept Expense	**$45,311**	**$49,259**	**$54,404**	**$45,259**	**$54,310**	**$54,310**	**$55,146**	**$56,393**	**$57,102**	**$57,853**	**$58,646**	**$59,484**
Total UOS	38,512	43,805	45,378	37,225	44,670	44,670	45,281	45,928	46,611	47,333	48,096	48,902
Ratios												
UOS / FTE	109.79	122.48	113.94	93.12	111.74	111.74	112.00	112.28	112.56	112.85	113.15	113.46
Total Revenue / UOS	$6,083.97	$6,522.60	$6,364.08	$6,392.81	$6,392.81	$6,392.81	$6,424.85	$6,457.79	$6,491.61	$6,526.30	$6,561.83	$6,598.17
Total Salaries / UOS	$780.62	$724.53	$806.69	$794.83	$794.83	$794.83	$793.70	$792.53	$791.33	$790.10	$788.84	$787.55
Total Supplies / UOS	$107.82	$122.03	$117.22	$126.59	$126.59	$126.59	$127.14	$127.69	$128.27	$128.86	$129.46	$130.07

Surgical Services

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$572,067	$588,309	$583,020	$515,070	$618,084	$618,084	$618,120	$618,158	$618,199	$618,241	$618,286	$618,333
Inpatient	$298,420	$327,907	$320,164	$299,570	$359,484	$359,484	$359,520	$359,558	$359,598	$359,641	$359,686	$359,733
Outpatient	$273,647	$260,402	$262,856	$215,500	$258,600	$258,600	$258,600	$258,600	$258,600	$258,600	$258,600	$258,600
Total FTEs	166.0	171.1	164.8	164.0	164.0	164.0	164.0	164.0	164.0	164.0	164.0	164.0
Total Salaries Expense	$15,721	$17,430	$15,916	$12,181	$14,617	$14,617	$14,618	$14,619	$14,620	$14,621	$14,622	$14,623
Total Supply Expense	$33,134	$33,722	$37,386	$32,948	$39,537	$39,537	$39,539	$39,542	$39,544	$39,547	$39,550	$39,553
Professional Fees	$982	$714	$540	$458	$549	$549	$549	$549	$549	$549	$549	$549
Other Expenses	$5,820	$10,584	$10,097	$9,072	$10,887	$10,887	$10,887	$10,887	$10,887	$10,887	$10,888	$10,888
Total Dept Expense	**$55,657**	**$62,450**	**$63,939**	**$54,658**	**$65,590**	**$65,590**	**$65,593**	**$65,597**	**$65,601**	**$65,605**	**$65,609**	**$65,613**
Total UOS	4,109,625	2,122,630	2,072,815	1,799,725	2,159,670	2,159,670	2,159,796	2,159,928	2,160,069	2,160,217	2,160,374	2,160,540
Ratios												
UOS / FTE	24,750.97	12,402.70	12,577.97	10,975.34	13,170.40	13,170.40	13,171.17	13,171.98	13,172.84	13,173.74	13,174.70	13,175.71
Total Revenue / UOS	$139.20	$277.16	$281.27	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19
Total Salaries / UOS	$3.83	$8.21	$7.68	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77
Total Supplies / UOS	$8.06	$15.89	$18.04	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31

Other Other Departments

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	1,826,040	1,916,306	1,980,531	1,794,044	2,152,852	$2,152,852	$2,159,453	$2,166,428	$2,173,801	$2,181,594	$2,189,830	$2,198,535
Inpatient	705,824	797,638	821,660	735,627	882,752	$882,752	$889,352	$896,328	$903,701	$911,493	$919,730	$928,435
Outpatient	1,120,216	1,118,667	1,158,871	1,058,417	1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101
Total FTEs	1,883.9	1,988.1	2,093.0	2,219.0	2,219.0	2,219.0	2,222.6	2,226.2	2,232.1	2,236.3	2,240.8	2,245.3
Total Salaries Expense	188,673	203,375	216,447	190,424	228,509	$228,509	$228,822	$229,153	$229,700	$230,070	$230,461	$230,874
Total Supply Expense	81,634	88,875	91,405	80,539	96,647	$96,647	$97,042	$97,460	$97,901	$98,368	$98,861	$99,383
Professional Fees	16,747	16,587	16,221	12,666	15,199	$15,199	$15,199	$15,199	$15,199	$15,199	$15,199	$15,199
Other Expenses	56,803	111,808	91,510	82,844	99,412	$99,412	$99,536	$99,679	$99,856	$99,996	$100,144	$100,301
Total Dept Expense	**343,857**	**420,645**	**415,583**	**366,473**	**439,766**	**$439,766**	**$440,600**	**$441,491**	**$442,657**	**$443,633**	**$444,665**	**$445,756**

Multicare Tacoma General Allenmore Hospital
Forecast Number of FTE ("full time equivalents") Employees, With Project, 2014 - 2023

	Actual	Actual	Actual	Projected	Forecast						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Total Paid FTEs	2,401	2,517	2,656	2,783	2,783	2,791	2,799	2,810	2,820	2,830	2,840
Total Paid Hours	5,007,161	5,249,732	5,554,903	5,803,937	5,803,937	5,820,923	5,838,418	5,861,315	5,881,107	5,902,248	5,924,135
Average Hourly Wage	$46.82	$48.11	$48.42	$48.01	$48.01	47.99585438	$47.99	$47.96	$47.97	$47.95	$47.94
Total Salaries	$ 234,457	$ 252,543	$ 268,969	$ 278,632	$ 278,632	$ 279,380	$ 280,171	$ 281,205	$ 282,088	$ 283,022	$ 284,010
Employee Benefits	$ 57,928	$ 60,457	$ 54,370	$ 59,477	$ 59,477	$ 59,652	$ 59,837	$ 60,078	$ 60,284	$ 60,503	$ 60,734
Benefits as % Sal & Wages	24.7%	23.9%	20.2%	21.3%	21.3%	21.4%	21.4%	21.4%	21.4%	21.4%	21.4%

	Labor Distribution	Actual	Actual	Actual	Projected	Forecast						
		2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
FTEs	Management FTEs	103	98	105	111	111	111	111	111	111	112	112
	Provider FTEs	210	226	230	230	230	230	230	230	230	230	230
	Nursing FTEs	818	870	953	994	994	1,001	1,009	1,019	1,027	1,036	1,046
	Technologist/Professional FTEs	696	716	742	762	762	762	762	763	763	763	763
	Support FTEs	574	607	627	686	686	687	687	688	689	689	690
	Total	**2,401**	**2,517**	**2,656**	**2,783**	**2,783**	**2,791**	**2,799**	**2,810**	**2,820**	**2,830**	**2,840**
Hours	Management Hours	215,746	205,192	218,810	230,626	230,626	230,960	231,304	231,754	232,143	232,559	232,989
	Provider Hours	438,432	470,823	479,057	479,548	479,549	479,549	479,549	479,549	479,549	479,549	479,549
	Nursing Hours	1,705,414	1,814,890	1,993,938	2,072,697	2,072,699	2,088,030	2,103,822	2,124,489	2,142,354	2,161,437	2,181,193
	Technologist/Professional Hours	1,451,240	1,492,751	1,551,485	1,589,997	1,589,998	1,590,145	1,590,297	1,590,495	1,590,667	1,590,850	1,591,040
	Support Hours	1,196,332	1,265,873	1,311,612	1,431,070	1,431,072	1,432,244	1,433,452	1,435,033	1,436,400	1,437,859	1,439,371
	Total	**5,007,164**	**5,249,529**	**5,554,903**	**5,803,937**	**5,803,943**	**5,820,929**	**5,838,424**	**5,861,321**	**5,881,113**	**5,902,254**	**5,924,141**
Salaries & Wages	Management Salaries & Wages	$ 11,010	$ 10,677	$ 11,561	$ 12,524	$ 12,524	$ 12,532	$ 12,561	$ 12,597	$ 12,618	$ 12,630	$ 12,664
	Provider Salaries & Wages	$ 63,833	$ 69,212	$ 73,188	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526
	Nursing Salaries & Wages	$ 77,950	$ 84,623	$ 92,951	$ 95,726	$ 95,726	$ 96,434	$ 97,163	$ 98,118	$ 98,943	$ 99,824	$ 100,737
	Technologist/Professional Salaries & Wages	$ 56,671	$ 60,837	$ 62,652	$ 65,027	$ 65,027	$ 65,033	$ 65,039	$ 65,047	$ 65,054	$ 65,062	$ 65,070
	Support Salaries & Wages	$ 24,993	$ 27,194	$ 28,617	$ 31,829	$ 31,829	$ 31,855	$ 31,882	$ 31,917	$ 31,948	$ 31,980	$ 32,014
	Total	**$ 234,457**	**$ 252,543**	**$ 268,969**	**$ 278,632**	**$ 278,632**	**$ 279,380**	**$ 280,171**	**$ 281,205**	**$ 282,089**	**$ 283,022**	**$ 284,010**
Employee Benefits	Management Benefits	$ 2,720	$ 2,556	$ 2,337	$ 2,673	$ 2,673	$ 2,676	$ 2,683	$ 2,691	$ 2,697	$ 2,700.03	$ 2,708
	Provider Specific Benefits	$ 15,771	$ 16,569	$ 14,794	$ 15,695	$ 15,695	$ 15,699	$ 15,703	$ 15,708	$ 15,713	$ 15,718	$ 15,723
	Nursing Benefits	$ 19,259	$ 20,258	$ 18,789	$ 20,434	$ 20,434	$ 20,590	$ 20,752	$ 20,962	$ 21,145	$ 21,340	$ 21,542
	Technologist/Professional Benefits	$ 14,002	$ 14,564	$ 12,665	$ 13,881	$ 13,881	$ 13,886	$ 13,891	$ 13,897	$ 13,903	$ 13,909	$ 13,915
	Support Benefits	$ 6,175	$ 6,510	$ 5,785	$ 6,794	$ 6,794	$ 6,802	$ 6,809	$ 6,819	$ 6,827	$ 6,837	$ 6,846
	Total	**$ 57,928**	**$ 60,457**	**$ 54,370**	**$ 59,477**	**$ 59,477**	**$ 59,652**	**$ 59,837**	**$ 60,078**	**$ 60,284**	**$ 60,503**	**$ 60,734**

Note: Dollars are in thousands

FTEs, Salaries and Wages, and Employee Benefits: include allocated amounts from Corporate Services.

Source: MultiCare Health System, 2014-2017

Exhibit 17B.

Financial Forecasts. Baseline without the project

Multicare Tacoma General Allenmore Hospital
Selected Utilization and Financial Forecasts, Without Project, 2014 - 2023

Volume Indicators

	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Admissions	17,105	20,320	21,153	19,657	19,657	19,675	19,694	19,713	19,727	19,727	19,727
Patient Days	85,386	112,514	115,859	108,076	108,076	108,687	109,334	110,017	110,475	110,475	110,475
ALOS	4.99	5.54	5.48	5.50	5.50	5.52	5.55	5.58	5.60	5.60	5.60
Total ED Visits	73,194	79,796	82,249	82,291	82,291	82,291	82,291	82,291	82,291	82,291	82,291

Depreciation and Interest per Patient Day

Dollars in Thousands	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Total Depreciation	$23,527	$24,422	$24,517	$26,737	$26,737	$26,737	$26,737	$26,737	$26,737	$26,737	$26,737
Total Interest	$9,067	$11,316	$12,081	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512
Total Depreciation & Interest	$32,594	$35,738	$36,598	$38,249	$38,249	$38,249	$38,249	$38,249	$38,249	$38,249	$38,249
Patient Days	85,386	112,514	115,859	108,076	108,076	108,687	109,334	110,017	110,475	110,475	110,475
Total Depreciation & Interest / Patient Day	$382	$318	$316	$354	$354	$352	$350	$348	$346	$346	$346

Projected Capital Expenditures

Dollars in Thousands	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Project Capital Expenditure	$0	$0	$0	$0	$0	$0	$0	$6,901	$0	$0	$0
Routine Capital	$2,800	$4,500	$3,300	$2,700	$2,700	$2,700	$2,700	$2,700	$2,700	$2,700	$2,700
Cost of Securing Sources of Financing	$0	$0	$0	$0	$0	$6,901	$0	$0	$0	$0	$0
Total Estimated Capital Expenditure	$2,800	$4,500	$3,300	$2,700	$2,700	$9,601	$2,700	$9,601	$2,700	$2,700	$2,700

Source: MultiCare Health System, 2014-2017

Multicare Tacoma General Allenmore Hospital
Summary Utilization Statistics, Without Project, 2014 - 2023

	Actual	Actual	Actual	Projected	Forecasts							Average Annual
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023	Growth 2017-2023
Total Discharges	17,105	20,320	21,153	19,657	19,657	19,675	19,694	19,713	19,727	19,727	19,727	0.1%
Total Patient Days	85,386	112,514	115,859	108,076	108,076	108,687	109,334	110,017	110,475	110,475	110,475	0.4%
ALOS	4.99	5.54	5.48	5.50	5.50	5.52	5.55	5.58	5.60	5.60	5.60	0.3%
Level II and Level IV Discharges	719	716	746	799	799	817	835	855	869	869	869	1.4%
Level II and Level IV Patient Days	15,361	16,570	17,993	17,698	17,698	18,309	18,955	19,638	20,097	20,097	20,097	2.1%
Level II and Level IV ALOS	21.36	23.14	24.12	22.14	22.14	22.41	22.69	22.96	23.14	23.14	23.14	0.7%
Level II and Level IV ADC	42.00	45.40	49.16	48.51	48.49	50.16	51.93	53.80	55.06	55.06	55.06	2.1%
Level IV Discharges			293	310	310	327	346	366	379	379	379	3.4%
Level IV ALOS			38.6	34.7	34.7	34.7	34.7	34.7	34.7	34.7	34.7	0.0%
Level IV Patient Days			11,321	10,741	10,741	11,353	11,999	12,682	13,140	13,140	13,140	3.4%
Level IV Average Daily Census			31.0	29.4	29.4	31.1	32.9	34.7	36.0	36.0	36.0	3.4%
Level IV Beds			40	40	40	40	47	54	54	54	54	5.0%

Ancillary Volumes

	Actual	Actual	Actual	Projected	Forecasts						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Level II and Level IV Patient Days	*15361*	*16570*	*17993*	*17,698*	*17,698*	*18,309*	*18,955*	*19,638*	*20,097*	*20,097*	*20,097*
All Other ICU Patient Days	*23,151*	*27,235*	*27,385*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*	*26,972*
Total Intensive Care Patient Days	38,512	43,805	45,378	44,670	44,670	45,281	45,928	46,611	47,069	47,069	47,069
Operating Minutes	4,109,625	2,122,630	2,072,815	2,159,670	2,159,670	2,159,796	2,159,928	2,160,069	2,160,164	2,160,164	2,160,164
Semi-Intensive Patient Days	6,709	12,000	14,695	18,431	18,431	18,431	18,431	18,431	18,431	18,431	18,431
Acute Care Patient Days	24,750	26,017	24,474	24,985	24,985	24,985	24,985	24,985	24,985	24,985	24,985
Lab Bill Tests	1,172,009	1,788,301	1,230,322	1,219,673	1,219,673	1,226,573	1,233,867	1,241,576	1,246,745	1,246,745	1,246,745
MRI RVUs	127,698	125,889	99,092	104,326	104,326	104,916	105,540	106,200	106,642	106,642	106,642
Imaging RVUs	326,051	275,350	240,657	251,303	251,303	252,725	254,228	255,816	256,882	256,882	256,882
Nuclear RVUs	27,639	23,841	25,657	22,894	22,894	22,894	22,894	22,894	22,894	22,894	22,894
ER Visits	73,194	79,796	82,249	82,291	82,291	82,291	82,291	82,291	82,291	82,291	82,291
Short Stay Outpatients	1,242	1,156	1,077	1,902	1,902	1,902	1,902	1,902	1,902	1,902	1,902

Multicare Tacoma General Allenmore Hospital
Statement of Revenue and Expenses Without Project, 2014 - 2023

	Actual	Actual	Actual	Projected	Forecast						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
PATIENT REVENUE											
Inpatient Services	$1,236,309	$1,409,919	$1,428,919	$1,526,126	$1,526,126	$1,538,122	$1,550,801	$1,564,202	$1,573,189	$1,573,189	$1,573,189
Outpatient Services	$1,396,104	$1,380,418	$1,423,421	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378	$1,530,378
TOTAL	$2,632,412	$2,790,337	$2,852,340	$3,056,504	$3,056,504	$3,068,500	$3,081,179	$3,094,579	$3,103,567	$3,103,567	$3,103,567
DEDUCTIONS FROM REVENUES											
Contractual Discounts	$1,854,446	$1,967,214	$2,061,539	$2,234,561	$2,234,561	$2,243,331	$2,252,601	$2,262,398	$2,268,968	$2,268,968	$2,268,968
Provision for Charity	$52,976	$37,624	$47,885	$51,904	$51,904	$52,108	$52,323	$52,550	$52,703	$52,703	$52,703
Bad Debt Expense	$39,961	$13,055	$10,326	$11,192	$11,192	$11,236	$11,283	$11,332	$11,365	$11,365	$11,365
TOTAL	$1,947,384	$2,017,893	$2,119,750	$2,297,657	$2,297,657	$2,306,675	$2,316,206	$2,326,280	$2,333,036	$2,333,036	$2,333,036
NET PATIENT REVENUE	$685,028	$772,443	$732,590	$758,846	$758,846	$761,825	$764,972	$768,299	$770,531	$770,531	$770,531
OTHER OPERATING REVENUE	$	$	$	$	$	$	$	$	$	$	$
TOTAL OPERATING REVENUE	$685,028	$772,443	$732,590	$758,846	$758,846	$761,825	$764,972	$768,299	$770,531	$770,531	$770,531
OPERATING EXPENSES											
Salaries and Wages	$234,457	$252,543	$268,969	$278,632	$278,632	$279,380	$280,171	$281,007	$281,568	$281,568	$281,568
Employee Benefits	$57,928	$60,457	$54,370	$59,477	$59,477	$59,652	$59,837	$60,033	$60,164	$60,164	$60,164
Supplies	$118,921	$127,942	$134,111	$141,839	$141,839	$142,338	$142,866	$143,424	$143,799	$143,799	$143,799
Professional fees	$17,870	$17,531	$17,039	$15,970	$15,970	$16,170	$16,170	$16,170	$16,170	$16,170	$16,170
Purchased Services	-$18,248	$15,725	$19,843	$21,217	$21,217	$21,217	$21,217	$21,217	$21,217	$21,217	$21,217
Other Direct Expenses	$6,506	$29,637	$10,790	$11,123	$11,123	$11,171	$11,216	$11,264	$11,296	$11,296	$11,296
Lease and Rental Fees	$3,864	$4,097	$4,288	$4,673	$4,673	$4,673	$4,673	$4,673	$4,673	$4,673	$4,673
Insurance	$6,579	$2,020	$2,173	$2,043	$2,043	$2,043	$2,043	$2,043	$2,043	$2,043	$2,043
Taxes	$6,233	$6,885	$6,962	$6,770	$6,770	$6,770	$6,770	$6,770	$6,770	$6,770	$6,770
Interest	$9,067	$11,316	$12,081	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512	$11,512
Depreciation & Amort.	$23,527	$24,422	$24,517	$26,737	$26,737	$26,737	$26,737	$26,737	$26,737	$26,737	$26,737
TOTAL	$466,705	$552,575	$555,141	$579,992	$579,992	$581,664	$583,213	$584,851	$585,949	$585,949	$585,949
INCOME/(LOSS) FROM OPERATIONS	$218,324	$219,868	$177,449	$178,854	$178,854	$180,161	$181,759	$183,449	$184,582	$184,582	$184,582
Corporate Services	$148,414	$150,573	$125,242	$145,371	$145,371	$145,818	$146,233	$146,671	$146,965	$146,965	$146,965
OPERATING MARGIN	$69,909	$69,295	$52,207	$33,483	$33,483	$34,343	$35,526	$36,778	$37,617	$37,617	$37,617
NET INCOME	**$69,909**	**$69,295**	**$52,207**	**$33,483**	**$33,483**	**$34,343**	**$35,526**	**$36,778**	**$37,617**	**$37,617**	**$37,617**

Notes: Dollars are in thousands
Source: Multicare Health System 2014-2017

Multicare Tacoma General Allenmore Hospital
Deductions From Revenue, Without Project, 2014 - 2023

	ACTUAL	ACTUAL	ACTUAL	Projected	Forecast						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Contractual Allowances											
Medicare	$722,756	$770,515	$795,642	$868,097	$866,484	$869,885	$873,479	$877,278	$879,826	$879,826	$879,826
Medicaid	$452,168	$510,471	$537,368	$558,039	$560,466	$562,666	$564,991	$567,448	$569,096	$569,096	$569,096
Other	$679,522	$686,229	$728,529	$808,425	$807,611	$810,781	$814,131	$817,672	$820,047	$820,047	$820,047
Total Contractual Allowances	**$1,854,446**	**$1,967,214**	**$2,061,539**	**$2,234,561**	**$2,234,561**	**$2,243,331**	**$2,252,601**	**$2,262,398**	**$2,268,968**	**$2,268,968**	**$2,268,968**
Inpatient	$24,880	$19,011	$23,989	$25,916	$25,916	$26,120	$26,335	$26,562	$26,715	$26,715	$26,715
Outpatient	$28,096	$18,613	$23,896	$25,988	$25,988	$25,988	$25,988	$25,988	$25,988	$25,988	$25,988
Total Charity Care	**$52,976**	**$37,624**	**$47,885**	**$51,904**	**$51,904**	**$52,108**	**$52,323**	**$52,550**	**$52,703**	**$52,703**	**$52,703**
Inpatient	$18,768	$6,596	$5,173	$5,588	$5,588	$7,996	$8,100	$8,203	$8,308	$8,444	$8,538
Outpatient	$21,194	$6,458	$5,153	$5,604	$5,604	$7,965	$8,069	$8,172	$8,276	$8,411	$8,505
Total Bad Debt	**$39,961**	**$13,055**	**$10,326**	**$11,192**	**$11,192**	**$11,236**	**$11,283**	**$11,332**	**$11,365**	**$11,365**	**$11,365**
Total Deductions From Revenue	**$1,947,384**	**$2,017,893**	**$2,119,750**	**$2,297,657**	**$2,297,657**	**$2,306,675**	**$2,316,206**	**$2,326,280**	**$2,333,036**	**$2,333,036**	**$2,333,036**

Notes: Dollars are in thousands
Source: MultiCare Health System, 2014-2017

Multicare Tacoma General Allenmore Hospital
Cost Center Forecasts, Without Project, 2014 - 2023

Level II and Level IV Intensive Care

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$122,718	$153,245	$154,451	$129,276	$155,132	$155,132	$160,492	$166,157	$172,144	$176,160	$176,160	$176,160
Inpatient	$122,675	$153,230	$154,427	$129,271	$155,125	$155,125	$160,485	$166,150	$172,137	$176,153	$176,153	$176,153
Outpatient	$43	$15	$24	$6	$7	$7	$7	$7	$7	$7	$7	$7
Total FTEs	115.0	119.4	129.0	130.7	130.7	130.7	135.2	140.0	145.0	148.4	148.4	148.4
Total Salaries Expense	$11,029	$11,227	$12,876	$10,481	$12,577	$12,577	$13,012	$13,471	$13,956	$14,282	$14,282	$14,282
Total Supply Expense	$2,262	$3,005	$2,889	$2,460	$2,952	$2,952	$3,054	$3,162	$3,276	$3,353	$3,353	$3,353
Professional Fees	$140	$230	$279	$185	$222	$222	$422	$422	$422	$422	$422	$422
Other Expenses	$3,542	$4,077	$4,195	$3,628	$4,353	$4,353	$4,452	$4,557	$4,667	$4,741	$4,741	$4,741
Total Dept Expense	**$16,973**	**$18,539**	**$20,238**	**$16,754**	**$20,105**	**$20,105**	**$20,940**	**$21,612**	**$22,321**	**$22,797**	**$22,797**	**$22,797**
Total UOS	15,361	16,570	17,993	14,748	17,698	17,698	18,309	18,955	19,638	20,097	20,097	20,097
Ratios												
UOS / FTE	133.60	138.74	139.51	112.86	135.44	135.44	135.44	135.44	135.44	135.44	135.44	135.44
Total Revenue / UOS	$7,988.91	$9,248.34	$8,583.95	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68	$8,765.68
Total Salaries / UOS	$718.02	$677.55	$715.61	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67	$710.67
Total Supplies / UOS	$147.24	$181.37	$160.54	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83	$166.83

All Other Intensive Care

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$111,588	$132,477	$134,338	$108,696	$130,435	$130,435	$130,435	$130,435	$130,435	$130,435	$130,435	$130,435
Inpatient	$109,389	$131,143	$132,669	$107,304	$128,765	$128,765	$128,765	$128,765	$128,765	$128,765	$128,765	$128,765
Outpatient	$2,199	$1,334	$1,669	$1,392	$1,670	$1,670	$1,670	$1,670	$1,670	$1,670	$1,670	$1,670
Total FTEs	235.8	238.2	269.3	269.1	269.1	269.1	269.1	269.1	269.1	269.1	269.1	269.1
Total Salaries Expense	$19,034	$20,511	$23,730	$19,107	$22,928	$22,928	$22,928	$22,928	$22,928	$22,928	$22,928	$22,928
Total Supply Expense	$1,891	$2,340	$2,431	$2,252	$2,702	$2,702	$2,702	$2,702	$2,702	$2,702	$2,702	$2,702
Professional Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Expenses	$7,413	$7,869	$8,005	$7,146	$8,576	$8,576	$8,576	$8,576	$8,576	$8,576	$8,576	$8,576
Total Dept Expense	**$28,338**	**$30,720**	**$34,166**	**$28,505**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**	**$34,206**
Total UOS	23,151	27,235	27,385	22,477	26,972	26,972	26,972	26,972	26,972	26,972	26,972	26,972
Ratios												
UOS / FTE	98.18	114.33	101.69	83.53	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23
Total Revenue / UOS	$4,820.01	$4,864.23	$4,905.53	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88	$4,835.88
Total Salaries / UOS	$822.16	$753.11	$866.53	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05	$850.05
Total Supplies / UOS	$81.67	$85.93	$88.76	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19	$100.19

Multicare Tacoma General Allenmore Hospital
Cost Center Forecasts, Without Project, 2014 - 2023

Total Intensive Care

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$234,306	$285,722	$288,789	$237,972	$285,567	$285,567	$290,927	$296,592	$302,579	$306,595	$306,595	$306,595
Inpatient	$232,065	$284,373	$287,095	$236,575	$283,890	$283,890	$289,250	$294,915	$300,903	$304,918	$304,918	$304,918
Outpatient	$2,241	$1,349	$1,694	$1,397	$1,677	$1,677	$1,677	$1,677	$1,677	$1,677	$1,677	$1,677
Total FTEs	350.8	357.6	398.3	399.8	399.8	399.8	404.3	409.1	414.1	417.5	417.5	417.5
Total Salaries Expense	$30,063	$31,738	$36,606	$29,588	$35,505	$35,505	$35,940	$36,399	$36,884	$37,210	$37,210	$37,210
Total Supply Expense	$4,152	$5,346	$5,319	$4,712	$5,655	$5,655	$5,757	$5,865	$5,979	$6,055	$6,055	$6,055
Professional Fees	$140	$230	$279	$185	$222	$222	$422	$422	$422	$422	$422	$422
Other Expenses	$10,955	$11,945	$12,200	$10,774	$12,929	$12,929	$13,028	$13,132	$13,243	$13,317	$13,317	$13,317
Total Dept Expense	**$45,311**	**$49,259**	**$54,404**	**$45,259**	**$54,310**	**$54,310**	**$55,146**	**$55,818**	**$56,527**	**$57,003**	**$57,003**	**$57,003**
Total UOS	38,512	43,805	45,378	37,225	44,670	44,670	45,281	45,928	46,611	47,069	47,069	47,069
Ratios												
UOS / FTE	109.79	122.48	113.94	93.12	111.74	111.74	112.00	112.28	112.56	112.74	112.74	112.74
Total Revenue / UOS	$6,083.97	$6,522.60	$6,364.08	$6,392.81	$6,392.81	$6,392.81	$6,424.85	$6,457.79	$6,491.61	$6,513.75	$6,513.75	$6,513.75
Total Salaries / UOS	$780.62	$724.53	$806.69	$794.83	$794.83	$794.83	$793.70	$792.53	$791.33	$790.54	$790.54	$790.54
Total Supplies / UOS	$107.82	$122.03	$117.22	$126.59	$126.59	$126.59	$127.14	$127.69	$128.27	$128.64	$128.64	$128.64
Avg Hourly Rate	**$ 41.09**	**$ 42.55**	**$ 44.07**	**$ 35.48**	**$ 42.58**	**$ 42.58**	**$ 42.62**	**$ 42.66**	**$ 42.71**	**$ 42.73**	**$ 42.73**	**$ 42.73**

Surgical Services

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	$572,067	$588,309	$583,020	$515,070	$618,084	$618,084	$618,120	$618,158	$618,199	$618,226	$618,226	$618,226
Inpatient	$298,420	$327,907	$320,164	$299,570	$359,484	$359,484	$359,520	$359,558	$359,598	$359,626	$359,626	$359,626
Outpatient	$273,647	$260,402	$262,856	$215,500	$258,600	$258,600	$258,600	$258,600	$258,600	$258,600	$258,600	$258,600
Total FTEs	166.0	171.1	164.8	164.0	164.0	164.0	164.0	164.0	164.0	164.0	164.0	164.0
Total Salaries Expense	$15,721	$17,430	$15,916	$12,181	$14,617	$14,617	$14,618	$14,619	$14,620	$14,621	$14,621	$14,621
Total Supply Expense	$33,134	$33,722	$37,386	$32,948	$39,537	$39,537	$39,539	$39,542	$39,544	$39,546	$39,546	$39,546
Professional Fees	$982	$714	$540	$458	$549	$549	$549	$549	$549	$549	$549	$549
Other Expenses	$5,820	$10,584	$10,097	$9,072	$10,887	$10,887	$10,887	$10,887	$10,887	$10,887	$10,887	$10,887
Total Dept Expense	**$55,657**	**$62,450**	**$63,939**	**$54,658**	**$65,590**	**$65,590**	**$65,593**	**$65,597**	**$65,601**	**$65,603**	**$65,603**	**$65,603**
Total UOS	4,109,625	2,122,630	2,072,815	1,799,725	2,159,670	2,159,670	2,159,796	2,159,928	2,160,069	2,160,164	2,160,164	2,160,164
Ratios												
UOS / FTE	24,750.97	12,402.70	12,577.97	10,975.34	13,170.40	13,170.40	13,171.17	13,171.98	13,172.84	13,173.42	13,173.42	13,173.42
Total Revenue / UOS	$139.20	$277.16	$281.27	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19	$286.19
Total Salaries / UOS	$3.83	$8.21	$7.68	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77	$6.77
Total Supplies / UOS	$8.06	$15.89	$18.04	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31	$18.31

Other Other Departments

Dollars in Thousands	Actual	Actual	Actual	YTD	Projected	Forecast						
	2014	2015	2016	2017	2017	2017	2018	2019	2020	2021	2022	2023
Gross Patient Revenue	1,826,040	1,916,306	1,980,531	1,794,044	2,152,852	$2,152,852	$2,159,453	$2,166,428	$2,173,801	$2,178,746	$2,178,746	$2,178,746
Inpatient	705,824	797,638	821,660	735,627	882,752	$882,752	$889,352	$896,328	$903,701	$908,645	$908,645	$908,645
Outpatient	1,120,216	1,118,667	1,158,871	1,058,417	1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101	$1,270,101
Total FTEs	1,883.9	1,988.1	2,093.0	2,219.0	2,219.0	2,219.0	2,222.6	2,226.2	2,230.1	2,232.8	2,232.9	2,232.8
Total Salaries Expense	188,673	203,375	216,447	190,424	228,509	$228,509	$228,822	$229,153	$229,503	$229,738	$229,738	$229,738
Total Supply Expense	81,634	88,875	91,405	80,539	96,647	$96,647	$97,042	$97,460	$97,901	$98,197	$98,197	$98,197
Professional Fees	16,747	16,587	16,221	12,666	15,199	$15,199	$15,199	$15,199	$15,199	$15,199	$15,199	$15,199
Other Expenses	56,803	111,808	91,510	82,844	99,412	$99,412	$99,536	$99,662	$99,794	$99,883	$99,883	$99,883
Total Dept Expense	**343,857**	**420,645**	**415,583**	**366,473**	**439,766**	**$439,766**	**$440,600**	**$441,474**	**$442,398**	**$443,017**	**$443,017**	**$443,017**

MMulticare Tacoma General Allenmore Hospital
Forecast Number of FTE ("full time equivalents") Employees, Without Project, 2014 - 2023

	Actual	Actual	Actual	Projected	Forecast						
	2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
Total Paid FTEs	2,401	2,517	2,656	2,783	2,783	2,791	2,799	2,808	2,814	2,814	2,814
Total Paid Hours	5,007,161	5,249,732	5,554,903	5,803,937	5,803,937	5,820,923	5,838,418	5,857,143	5,869,702	5,869,924	5,869,702
Average Hourly Wage	$46.82	$48.11	$48.42	$48.01	$48.01	47.99585438	$47.99	$47.98	$47.97	$47.97	$47.97
Total Salaries	$ 234,457	$ 252,543	$ 268,969	$ 278,632	$ 278,632	$ 279,380	$ 280,171	$ 281,007	$ 281,568	$ 281,568	$ 281,568
Employee Benefits	$ 57,928	$ 60,457	$ 54,370	$ 59,477	$ 59,477	$ 59,652	$ 59,837	$ 60,033	$ 60,164	$ 60,164	$ 60,164
Benefits as % Sal & Wages	24.7%	23.9%	20.2%	21.3%	21.3%	21.4%	21.4%	21.4%	21.4%	21.4%	21.4%

Labor Distribution		Actual	Actual	Actual	Projected	Forecast						
		2014	2015	2016	2017	2017	2018	2019	2020	2021	2022	2023
FTEs	Management FTEs	103	98	105	111	111	111	111	111	111	111	111
	Provider FTEs	210	226	230	230	230	230	230	230	230	230	230
	Nursing FTEs	818	870	953	994	994	1,001	1,009	1,017	1,022	1,022	1,022
	Technologist/Professional FTEs	696	716	742	762	762	762	762	763	763	763	763
	Support FTEs	574	607	627	686	686	687	687	688	688	688	688
	Total	**2,401**	**2,517**	**2,656**	**2,783**	**2,783**	**2,791**	**2,799**	**2,808**	**2,814**	**2,814**	**2,814**
Hours	Management Hours	215,746	205,192	218,810	230,626	230,626	230,960	231,304	231,672	231,919	231,923	231,919
	Provider Hours	438,432	470,823	479,057	479,548	479,549	479,549	479,549	479,549	479,549	479,549	479,549
	Nursing Hours	1,705,414	1,814,890	1,993,938	2,072,697	2,072,699	2,088,030	2,103,822	2,120,724	2,132,060	2,132,261	2,132,060
	Technologist/Professional Hours	1,451,240	1,492,751	1,551,485	1,589,997	1,589,998	1,590,145	1,590,297	1,590,459	1,590,568	1,590,570	1,590,568
	Support Hours	1,196,332	1,265,873	1,311,612	1,431,070	1,431,072	1,432,244	1,433,452	1,434,745	1,435,612	1,435,628	1,435,612
	Total	**5,007,164**	**5,249,529**	**5,554,903**	**5,803,937**	**5,803,943**	**5,820,929**	**5,838,424**	**5,857,149**	**5,869,708**	**5,869,930**	**5,869,708**
Salaries & Wages	Management Salaries & Wages	$ 11,010	$ 10,677	$ 11,561	$ 12,524	$ 12,524	$ 12,532	$ 12,561	$ 12,581	$ 12,594	$ 12,585	$ 12,595
	Provider Salaries & Wages	$ 63,833	$ 69,212	$ 73,188	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526	$ 73,526
	Nursing Salaries & Wages	$ 77,950	$ 84,623	$ 92,951	$ 95,726	$ 95,726	$ 96,434	$ 97,163	$ 97,944	$ 98,467	$ 98,477	$ 98,467
	Technologist/Professional Salaries & Wages	$ 56,671	$ 60,837	$ 62,652	$ 65,027	$ 65,027	$ 65,033	$ 65,039	$ 65,046	$ 65,050	$ 65,051	$ 65,050
	Support Salaries & Wages	$ 24,993	$ 27,194	$ 28,617	$ 31,829	$ 31,829	$ 31,855	$ 31,882	$ 31,911	$ 31,930	$ 31,930	$ 31,930
	Total	**$ 234,457**	**$ 252,543**	**$ 268,969**	**$ 278,632**	**$ 278,632**	**$ 279,380**	**$ 280,171**	**$ 281,007**	**$ 281,568**	**$ 281,568**	**$ 281,569**
Employee Benefits	Management Benefits	$ 2,720	$ 2,556	$ 2,337	$ 2,673	$ 2,673	$ 2,676	$ 2,683	$ 2,688	$ 2,691	$ 2,689.12	$ 2,691
	Provider Specific Benefits	$ 15,771	$ 16,569	$ 14,794	$ 15,695	$ 15,695	$ 15,699	$ 15,703	$ 15,708	$ 15,711	$ 15,711	$ 15,711
	Nursing Benefits	$ 19,259	$ 20,258	$ 18,789	$ 20,434	$ 20,434	$ 20,590	$ 20,752	$ 20,924	$ 21,040	$ 21,042	$ 21,040
	Technologist/Professional Benefits	$ 14,002	$ 14,564	$ 12,665	$ 13,881	$ 13,881	$ 13,886	$ 13,891	$ 13,896	$ 13,900	$ 13,900	$ 13,900
	Support Benefits	$ 6,175	$ 6,510	$ 5,785	$ 6,794	$ 6,794	$ 6,802	$ 6,809	$ 6,817	$ 6,823	$ 6,823	$ 6,823
	Total	**$ 57,928**	**$ 60,457**	**$ 54,370**	**$ 59,477**	**$ 59,477**	**$ 59,652**	**$ 59,837**	**$ 60,033**	**$ 60,164**	**$ 60,164**	**$ 60,164**

Note: Dollars are in thousands

FTEs, Salaries and Wages, and Employee Benefits: include allocated amounts from Corporate Services.

Source: MultiCare Health System, 2014-2017

Exhibit 18A.

Audited Financial Statements, 2016 and 2015

KPMG

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

(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 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.

(Continued)

(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)

(Continued)

(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.

(Continued)

(Dollars in thousands)

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

(Continued)

(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 18B.

Audited Financial Statements, 2015 and 2014

KPMG

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2015 and 2014

(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, 2015 and 2014, 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, 2015 and 2014, 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 24, 2016

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2015 and 2014

(In thousands)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	207,167	106,864
Accounts receivable, less allowance for doubtful accounts of $43,277 and $58,582 in 2015 and 2014, respectively		265,088	299,809
Supplies inventory		20,493	21,411
Other current assets, net		29,695	30,099
Total current assets		522,443	458,183
Donor restricted assets held for long-term purposes		73,336	74,119
Investments		1,426,358	1,379,041
Bond funds held in trust		93,178	—
Property, plant, and equipment, net		1,281,457	1,298,230
Other assets, net		75,429	70,331
Total assets	$	3,472,201	3,279,904
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	114,574	171,022
Accrued compensation and related liabilities		131,493	148,605
Accrued interest payable		13,731	12,610
Current portion of long-term debt		14,580	11,865
Total current liabilities		274,378	344,102
Accrued pension, professional liability, and other		101,158	147,488
Interest rate swap liabilities		59,029	59,298
Long-term debt, net of current portion		993,686	859,933
Total liabilities		1,428,251	1,410,821
Commitments and contingencies (note 15)			
Net assets:			
Unrestricted		1,955,044	1,788,016
Temporarily restricted		31,696	24,239
Permanently restricted		57,210	56,828
Total net assets		2,043,950	1,869,083
Total liabilities and net assets	$	3,472,201	3,279,904

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2015 and 2014

(In thousands)

	2015	2014
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,913,776	1,832,166
Provision for bad debts	(44,194)	(114,591)
Net patient service revenue less provision for bad debts	1,869,582	1,717,575
Other operating revenue	73,011	60,709
Net assets released from restrictions for operations	4,108	4,357
Total unrestricted revenues, gains, and other support	1,946,701	1,782,641
Expenses:		
Salaries and wages	827,995	785,629
Employees benefits	170,017	154,812
Supplies	241,475	230,554
Purchased services	120,746	116,245
Depreciation and amortization	107,435	105,792
Interest	35,539	34,944
Other	213,702	159,011
Total expenses	1,716,909	1,586,987
Excess of revenues over expenses from operations	229,792	195,654
Other (loss) income:		
Investment (loss) income	(48,513)	39,544
Loss and other expense on interest rate swaps	(5,947)	(31,666)
Loss on bond refinancing	(51,142)	—
Total other (loss) income, net	(105,602)	7,878
Excess of revenues over expenses	124,190	203,532
Other changes in unrestricted net assets:		
Changes in accrued pension liability	39,009	(121,445)
Net assets released from restriction – capital acquisitions	3,779	12,578
Capital assets received and other	50	176
Increase in unrestricted net assets	167,028	94,841
Changes in temporarily restricted net assets:		
Contributions and other	14,955	12,776
Income on investments	389	710
Net assets released from restriction – capital acquisitions	(3,779)	(12,578)
Net assets released from restrictions for operations	(4,108)	(4,357)
Increase (decrease) in temporarily restricted net assets	7,457	(3,449)
Changes in permanently restricted net assets:		
Contributions and other	717	1,199
Income on investments	951	1,469
Decrease in assets held in trust by others	(1,286)	(1,777)
Increase in permanently restricted net assets	382	891
Increase in net assets	174,867	92,283
Net assets, beginning of year	1,869,083	1,776,800
Net assets, end of year	$ 2,043,950	1,869,083

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2015 and 2014

(In thousands)

	2015	2014
Cash flows from operating activities:		
Increase in net assets	$ 174,867	92,283
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	107,435	105,792
Amortization of bond premiums, discounts, and issuance costs	(1,008)	242
Net realized and recognized losses (gains) and change in net unrealized losses (gains) on investments	79,032	(10,328)
Change in fair value of interest rate swap	(356)	25,226
Provision for bad debts	44,194	114,591
Loss (gain) on disposal of assets, net	416	(250)
Loss on bond refinancing	51,142	—
Undistributed losses (earnings) on joint ventures	469	(1,687)
Restricted contributions for long-term purposes	(2,496)	(4,096)
Changes in operating assets and liabilities:		
Accounts receivable	(9,473)	(159,101)
Supplies inventory and other current assets	1,323	4,279
Other assets, net	(7,348)	35,534
Accounts payable and accrued expenses and accrued interest payable	(59,075)	54,746
Accrued compensation and related liabilities	(17,113)	7,548
Accrued pension, professional liability, and other	(49,614)	59,122
Net cash provided by operating activities	312,395	323,901
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(87,678)	(101,666)
Proceeds from disposal of property, plant, and equipment	507	1,938
(Contributions) distributions from joint ventures, net	(1,495)	1,651
Net (purchases) and sales of trading securities	(121,054)	(174,260)
Net increase in bond funds held in trust	(93,178)	—
Change in donor trusts	1,976	1,994
Net cash used in investing activities	(300,922)	(270,343)
Cash flows from financing activities:		
Repayment of long-term debt	(12,945)	(11,295)
Proceeds from bond issuance	99,279	—
Restricted contributions for long-term purposes	2,496	4,096
Net cash provided by (used in) financing activities	88,830	(7,199)
Net increase in cash and cash equivalents	100,303	46,359
Cash and cash equivalents, beginning of year	106,864	60,505
Cash and cash equivalents, end of year	$ 207,167	106,864
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 34,418	34,859
Noncash activities:		
Increase in deferred compensation plans	3,125	4,909
Purchases of property, plant, and equipment included in accounts payable	3,748	312

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 to the residents of Pierce and south King Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2015, MHS operates 1,130 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 respective investment managers or trustees, which management believes approximate fair value.

Charitable gift annuities, which are included in donor restricted assets totaled $2,676 and $3,011 at December 31, 2015 and 2014, respectively. MHS has recorded a corresponding payable of $1,524 and $1,639 at December 31, 2015 and 2014, 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 and equity securities 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. 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 stated 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 2015 and 2014, 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 $8,327 and $5,655 as of December 31, 2015 and 2014, respectively, and have been reflected 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 $4,910 and $4,778 for 2015 and 2014, 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, 2015 and 2014, 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 Measurements*, 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, 2015 and 2014, MHS has recorded $11,950 and $15,328 respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2015, $3,687 of pledges are due in one year or less, $6,394 in two to five years and the remaining amounts within twenty 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, 2015 and 2014:

	2015	2014
Payors:		
Medicare and Medicaid	43%	42%
Regence	14	14
Premera	12	12
First Choice	5	8
Other	26	24
	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 and was included in the 2014 consolidated statement of operations and changes in net assets. Approvals associated with the managed care Medicaid portion were not fully clarified until 2015. As the State moved forward during 2014 with issuing invoices for the assessments associated with the managed care portion of the program, and cash was received associated with this portion, MHS recorded the managed care cash receipts as a payable and the managed care assessments paid by MHS to the State as a receivable awaiting final approvals from Centers for Medicare and Medicaid Services. These transactions were recognized 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 $109,727 and $25,691 for 2015 and 2014, respectively, and incurred assessments of $71,264 and $18,367 for 2015 and 2014, 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 $6,809 and $35,768 associated with this program as of December 31, 2015 and 2014, respectively, which are included with accounts receivable on the consolidated balance sheets, and payables of $0 and $47,366 as of December 31, 2015 and 2014, respectively, which are included with accounts payable and accrued expenses on the consolidated balance sheets.

(o) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated healthcare services to the community 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 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. 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 $19,000 and $24,000 in 2015 and 2014, respectively. The estimated cost of services provided to patients covered under Medicaid in excess of payments received was approximately $127,000 and $101,000 in 2015 and 2014, 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 2015 and 2014, meaningful use revenues were $3,310 and $6,262, 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 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 considered the provisions of this standard and will adopt in the effective fiscal year beginning January 1, 2016. MHS does not believe that the provisions of this standard will have a material impact to its consolidated financial statements.

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 exception to 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.

(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.

(Dollars in thousands)

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, 2015 and 2014 is as follows:

		2015	2014
Gross patient service charges	$	6,541,439	6,190,779
Contractual discounts		(4,545,236)	(4,256,884)
Charity care (gross)		(82,427)	(101,729)
Provision for bad debts (gross)		(44,194)	(114,591)
Net patient service revenue	$	1,869,582	1,717,575

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. During 2015, 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 classify 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 2015 and 2014 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

(Dollars in thousands)

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, 2015 and 2014:

		2015	2014
Change in allowance for doubtful accounts:			
Allowance for doubtful accounts at beginning of year	$	58,582	80,416
Write-offs of accounts due to deemed uncollectibility		(59,499)	(136,425)
Provision for bad debts		44,194	114,591
Allowance for doubtful accounts at end of year	$	43,277	58,582

(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, 2015 and 2014 was as follows:

	2015	2014
Medicare	30%	29%
Medicaid	26	23
Regence	7	7
Other commercial insurance	29	32
Self-pay	8	9
	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 use net asset values (NAV) as a practical expedient to estimate fair value.

  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.

- Level 3 inputs are unobservable inputs for the asset or liability. Level 3 securities include donor trusts where MHS is not the trustee, investments in hedge funds, and limited partnerships – private equity that use NAV as a practical expedient to estimate fair value. The transaction price is initially used as the best estimate of fair value. Accordingly, when a valuation is provided by a private equity fund administrator, the valuation is adjusted so that the value at inception equals the transaction price. The initial valuation is adjusted when changes to inputs and assumptions are corroborated by evidence, such as transactions in similar securities, completed or pending third-party transactions in the underlying securities or comparable entities, offerings in the capital markets, and changes in financial results, data, or cash flows. For positions that are not traded in active markets or are subject to notice provisions, valuations are adjusted to reflect such provisions, and such adjustments are generally based on available market evidence.

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)

The following tables present the placement in the fair value hierarchy of assets and liabilities that are measured at fair value on a recurring basis (including items that are required to be measured at fair value and items for which the fair value option has been elected) at December 31, 2015 and 2014:

		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:				
Information technology	$ 82,979	82,979	—	—
Healthcare	56,747	56,747	—	—
Consumer discretionary	57,826	57,826	—	—
Financials	89,792	89,792	—	—
Other	166,520	166,520	—	—
Subtotal – mutual funds – equity	453,864	453,864	—	—
Equity securities:				
U.S. large cap:				
Information technology	37,944	37,944	—	—
Healthcare	14,550	14,550	—	—
Consumer discretionary	31,041	31,041	—	—
Financials	5,449	5,449	—	—
Other	25,999	25,999	—	—
U.S. small cap:				
Information technology	12,169	12,169	—	—
Healthcare	4,073	4,073	—	—
Consumer discretionary	8,985	8,985	—	—
Financials	7,401	7,401	—	—
Other	17,663	17,663	—	—
Subtotal – equity securities	165,274	165,274	—	—

(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)
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	—
Subtotal – fixed income securities	534,049	420,497	113,552	—
Hedge fund – private investment funds	84,820	—	—	84,820
Commingled trust fund – international equity	71,393	—	71,393	—
Limited liability partnership – international equity	37,905	—	37,905	—
Limited partnership – private equity	111,430	—	—	111,430
Interest rate swaps	1,335	—	1,335	—
Donor trusts	20,302	—	—	20,302
Bond funds held in trust	93,178	93,178	—	—
Total assets	$ 1,573,550	1,132,813	224,185	216,552
Liabilities:				
Interest rate swaps	$ 59,029	—	59,029	—
Total liabilities	$ 59,029	—	59,029	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2014	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:				
Information technology	$ 68,563	68,563	—	—
Healthcare	36,669	36,669	—	—
Consumer discretionary	29,929	29,929	—	—
Financials	76,078	76,078	—	—
Other	173,810	173,810	—	—
Subtotal – mutual funds – equity	385,049	385,049	—	—
Equity securities:				
U.S. large cap:				
Information technology	26,234	26,234	—	—
Healthcare	13,401	13,401	—	—
Consumer discretionary	18,618	18,618	—	—
Financials	3,861	3,861	—	—
Other	23,929	23,929	—	—
U.S. small cap:				
Information technology	8,222	8,222	—	—
Healthcare	3,479	3,479	—	—
Consumer discretionary	7,960	7,960	—	—
Financials	5,134	5,134	—	—
Other	19,217	19,217	—	—
Subtotal – equity securities	130,055	130,055	—	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2014	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Fixed income securities:				
Mutual funds – fixed income	$ 434,051	434,051	—	—
U.S. government obligations	41,916	—	41,916	—
State government obligations	7,276	—	7,276	—
Asset-backed securities	22,172	—	22,172	—
Corporate debt securities:				
Domestic	38,055	—	38,055	—
Subtotal – fixed income securities	543,470	434,051	109,419	—
Hedge fund – private investment funds	75,100	—	—	75,100
Commingled trust fund – international equity	73,462	—	73,462	—
Limited liability partnership – international equity	106,188	—	106,188	—
Limited partnership – private equity	102,393	—	—	102,393
Interest rate swaps	1,248	—	1,248	—
Donor trusts	22,115	—	—	22,115
Total assets	$ 1,439,080	949,155	290,317	199,608
Liabilities:				
Interest rate swaps	$ 59,298	—	59,298	—
Total liabilities	$ 59,298	—	59,298	—

There were no significant transfers into or out of Level 1, Level 2, or Level 3 financial instruments during the years ended December 31, 2015 and 2014.

(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, 2015 and 2014:

	Level 3 assets for the year ended December 31, 2015			
	Hedge funds	Limited partnerships	Donor trusts	Total
Balance at December 31, 2014	$ 75,100	102,393	22,115	199,608
Realized gains	—	2,865	—	2,865
Net unrealized (losses)	(280)	(3,828)	(1,813)	(5,921)
Purchases	10,000	10,000	—	20,000
Balance at December 31, 2015	$ 84,820	111,430	20,302	216,552
The amount of total (losses) included in income attributable to the change in net unrealized gains or losses relating to assets still held at the reporting date	$ (280)	(3,828)	(1,813)	(5,921)

	Level 3 assets for the year ended December 31, 2014			
	Hedge funds	Limited partnerships	Donor trusts	Total
Balance at December 31, 2013	$ 61,939	88,003	24,132	174,074
Realized gains	—	3,502	—	3,502
Net unrealized gains (losses)	3,161	3,888	(2,017)	5,032
Purchases	10,000	7,000	—	17,000
Balance at December 31, 2014	$ 75,100	102,393	22,115	199,608
The amount of total gains or (losses) included in income attributable to the change in net unrealized gains or losses relating to assets still held at the reporting date	$ 3,161	3,888	(2,017)	5,032

(Continued)

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2015 and 2014:

	Fair value at December 31, 2015	Fair value at December 31, 2014	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 84,820	75,100	N/A	N/A	N/A
Commingled trust fund	71,393	73,462	N/A	Bimonthly	5 business days prior to valuation date
Limited liability partnerships	37,905	106,188	N/A	Daily	10 days
Limited partnerships	111,430	102,393	2,961	N/A	N/A

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.

Commingled trust fund is an international equity commingled trust that invests in foreign equity securities. The underlying securities are primarily publicly traded non-U.S. stocks, whose principal markets are outside of the United States.

Limited liability partnerships is a limited liability partnership investing in publicly traded non-U.S. equity securities in emerging markets.

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)

(5) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2015 and 2014 is as follows:

	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

	December 31, 2014		
	Donor restricted assets	Investments	Total
Mutual funds – equity	$ 9,975	375,074	385,049
Equity securities	3,369	126,686	130,055
Fixed income securities	14,079	529,391	543,470
Hedge funds – private investment funds	1,946	73,154	75,100
Commingled trust fund – international equity	1,903	71,559	73,462
Limited liability partnerships – international equity	2,751	103,437	106,188
Limited partnerships – private equity	2,653	99,740	102,393
Donor trusts	22,115	—	22,115
Pledge receivables, net	15,328	—	15,328
Total	$ 74,119	1,379,041	1,453,160

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)

Unrestricted investment (loss) income comprises the following for the years ended December 31, 2015 and 2014:

		2015	2014
Investment (loss) income:			
Interest and dividends	$	30,519	29,216
Net realized gains		23,161	43,607
Net change in unrealized (losses)		(102,193)	(33,279)
Total investment (loss) income	$	(48,513)	39,544

(6) Property, Plant, and Equipment

A summary of property, plant, and equipment at December 31, 2015 and 2014 is as follows:

		2015	2014
Land and land improvements	$	66,378	66,342
Buildings		1,543,351	1,483,534
Equipment		671,682	642,206
		2,281,411	2,192,082
Less accumulated depreciation		(1,054,915)	(962,506)
		1,226,496	1,229,576
Construction in progress		54,961	68,654
Property, plant, and equipment, net	$	1,281,457	1,298,230

Depreciation expense charged to operations for the years ended December 31, 2015 and 2014 amounted to $107,266 and $105,644, respectively.

(Continued)

(Dollars in thousands)

(7) Other Assets

Other assets are as follows at December 31, 2015 and 2014:

	2015	2014
Investment in joint ventures (note 8)	$ 16,294	15,268
Deferred compensation plan assets held in trust	33,564	30,439
Self-insured retention receivables, net of current portion (notes 11 and 12)	14,945	13,497
Interest rate swaps	1,335	1,248
Goodwill and other intangibles	8,718	9,718
Other	573	161
Other assets	$ 75,429	70,331

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.

(8) Investment in Joint Ventures

In 2008, MHS formed 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 $5,882 and $6,814 as of December 31, 2015 and 2014, 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 $7,439 and $7,087 as of December 31, 2015 and 2014, 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 is included in other assets in the accompanying consolidated balance sheets.

(Continued)

(Dollars in thousands)

(9) Accrued Pension, Professional Liability, and Other

Accrued pension, professional liability, and other are as follows at December 31, 2015 and 2014:

	2015	2014
Accrued pension liability (note 10)	$ 9,247	60,623
Professional liability, net of current portion (note 11)	36,237	35,643
Deferred compensation liability (note 10)	33,564	30,439
Workers' compensation liability, net of current portion (note 12)	16,097	14,721
Other	6,013	6,062
Accrued pension, professional liability, and other	$ 101,158	147,488

(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. During 2015, MHS incurred a curtailment gain, which resulted in a decrease of the projected benefit obligation of $19,531, which is recorded in the changes in accrued pension liability in the accompanying consolidated statements of operations and changes in net assets.

(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, 2015 and 2014:

		2015	2014
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	662,410	501,311
Service cost		17,255	15,302
Interest cost		27,138	26,382
Actuarial (gain) loss		(81,086)	145,053
Benefits paid		(33,311)	(25,638)
Projected benefit obligations at end of year	$	592,406	662,410
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	601,787	538,002
Actual (loss) gain on plan assets		(13,417)	57,388
Employer contribution		28,100	32,035
Benefits paid		(33,311)	(25,638)
Fair value of plan assets at end of year	$	583,159	601,787
Accrued benefit cost:			
Funded status	$	(9,247)	(60,623)
Amount recognized in consolidated balance sheets consist of:			
Liability for pension benefits		(9,247)	(60,623)
Amount recognized in unrestricted net assets:			
Net loss		131,004	170,013

	2015	2014
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	4.70%	4.20%
Expected return on plan assets	7.00	7.00
Rate of compensation increase	N/A	3.50

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.

(Dollars in thousands)

During the years ended December 31, 2015 and 2014, pension expenses of $15,734 and $7,903, respectively, were included in employee benefits in the consolidated statements of operations and changes in net assets. The components of net periodic benefit cost are as follows during the years ended December 31, 2015 and 2014:

		2015	2014
Components of net periodic benefit cost:			
Service cost	$	17,255	15,302
Interest cost		27,138	26,382
Expected return on plan assets		(40,877)	(36,287)
Amortization of net actuarial loss		12,218	2,506
	$	15,734	7,903

The accumulated benefit obligation for the Plans was $592,406 and $631,914 at December 31, 2015 and 2014, respectively.

Cash Flows – Contributions

MHS expects to contribute at least $15,000 to the Plans in 2016.

Estimated Future Benefit Payments

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

		Pension benefits
2016	$	26,389
2017		29,329
2018		31,698
2019		33,046
2020		34,795
2021–2025		188,602

(Continued)

(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, 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	—	—
Mutual funds – equity:				
Information technology	25,641	25,641	—	—
Healthcare	16,671	16,671	—	—
Consumer discretionary	16,474	16,474	—	—
Financials	27,524	27,524	—	—
Other	47,392	47,392	—	—
Equity securities:				
U.S. large cap:				
Information technology	13,791	13,791	—	—
Healthcare	5,278	5,278	—	—
Consumer discretionary	11,281	11,281	—	—
Financials	2,053	2,053	—	—
Other	9,406	9,406	—	—
U.S. small cap:				
Information technology	3,832	3,832	—	—
Healthcare	1,937	1,937	—	—
Consumer discretionary	4,502	4,502	—	—
Financials	3,741	3,741	—	—
Other	10,332	10,332	—	—
Commingled trust funds:				
Real estate	34,489	—	34,489	—
International equity	26,489	—	26,489	—
U.S. government securities	110,655	—	110,655	—
Corporate bond fund:				
Domestic	147,110	—	147,110	—
Hedge fund – private investment funds	29,647	—	—	29,647
Limited partnership – private equity	43,433	—	—	43,433
	596,055	$ 204,232	318,743	73,080

(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)
Broker receivables	$ 376			
Broker payables	(13,272)			
Total fair value of plan assets	$ 583,159			

		Fair value measurements at reporting date using		
	December 31, 2014	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	$ 7,176	7,176	—	—
Mutual funds – equity:				
Information technology	22,306	22,306	—	—
Healthcare	12,423	12,423	—	—
Consumer discretionary	9,581	9,581	—	—
Financials	23,570	23,570	—	—
Other	48,061	48,061	—	—
Equity securities:				
U.S. large cap:				
Information technology	11,410	11,410	—	—
Healthcare	5,856	5,856	—	—
Consumer discretionary	8,109	8,109	—	—
Financials	1,779	1,779	—	—
Other	10,439	10,439	—	—
U.S. small cap:				
Information technology	5,062	5,062	—	—
Healthcare	2,069	2,069	—	—
Consumer discretionary	4,825	4,825	—	—
Financials	3,206	3,206	—	—
Other	11,476	11,476	—	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2014	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Commingled trust funds:				
Real estate	$ 38,259	—	38,259	—
International equity	27,509	—	27,509	—
U.S. government securities	107,667	—	107,667	—
Corporate bond fund:				
Domestic	140,589	—	140,589	—
Hedge fund – private investment funds	29,683	—	—	29,683
Limited liability partnership – international equity	26,867	—	26,867	—
Limited partnership – private equity	$ 43,571	—	—	43,571
	601,493	$ 187,348	340,891	73,254
Broker receivables	319			
Broker payables	(25)			
Total fair value of plan assets	$ 601,787			

The following tables set forth a summary of changes in the fair value of the Plans' Level 3 investments for the years ended December 31, 2015 and 2014:

	Level 3 assets for the year ended December 31, 2015		
	Hedge funds	Limited partnerships	Total
Balance, beginning of year	$ 29,683	43,571	73,254
Actual return on plan assets:			
Relating to assets held at year-end	(36)	(138)	(174)
Balance, end of year	$ 29,647	43,433	73,080

(Continued)

(Dollars in thousands)

	Level 3 assets for the year ended December 31, 2014		
	Hedge funds	Limited partnerships	Total
Balance, beginning of year	$ 25,409	39,386	64,795
Actual return on plan assets:			
Relating to assets held at year-end	1,274	2,185	3,459
Purchases	3,000	2,000	5,000
Balance, end of year	$ 29,683	43,571	73,254

There were no significant transfers into or out of Level 1, Level 2, or Level 3 financial instruments during the years ended December 31, 2015 and 2014.

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2015 and 2014:

	Fair value at December 31, 2015	Fair value at December 31, 2014	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 34,489	38,259	N/A	Quarterly	45 days
International equity	26,489	27,509	N/A	Bi-monthly	5 business days prior to valuation date
Fixed income	$ 257,765	248,256	N/A	Daily	3 business days prior to valuation date
Hedge funds	$ 29,647	29,683	N/A	N/A	N/A
Limited liability partnerships	—	26,867	N/A	Daily	7 days
Limited partnerships	43,433	43,571	1,480	N/A	N/A

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

International equity is an international equity commingled trust that invests in foreign equity securities. The underlying securities are primarily publicly traded non-U.S. stocks, whose principal markets are outside of the United States.

Fixed income is a long-duration fixed income portfolio held by a registered investment company. The underlying securities are U.S. corporate and U.S. Treasury fixed-income securities.

(Dollars in thousands)

Hedge funds include investments in hedge fund-of-funds product 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.

Limited liability partnership is a limited liability partnership investing in publicly traded non-U.S. equity securities in emerging markets.

Limited partnerships include 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. It also includes an investment in a hedge fund-of-funds manager. Investments are in underlying managers in equity, credit, merger and acquisition, arbitrage, and commodity funds. The fair values of the investments in this category have been estimated using the NAV of the Plans' 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.

Plan Assets

The defined benefit plan weighted average asset allocations at December 31, 2015 and 2014 by asset category are as follows:

	2015	2014
Asset category:		
Domestic equities	18%	17%
International equities	9	9
Emerging markets	4	4
Fixed income securities	42	42
Alternative investments	14	12
Real estate	4	7
Global asset allocation	9	9
	100%	100%

(Continued)

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:

Asset category:	
Domestic equities	16%
International equities	9
Emerging markets	5
Fixed income securities	40
Alternative investments	15
Real estate	5
Global asset allocation	10
	100%

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. Effective January 1, 2008, the GS 401(k) Plan, which includes both employee and MHS contribution components, was closed to new hires following that date. During 2012, the GS 401(k) Plan was further 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 2015 and 2014 were approximately $27,620 and $24,802, 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, 2015 and 2014, 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, 2015 and 2014, the net professional liability was estimated at $33,345 and $32,869, respectively.

At December 31, 2015 and 2014, the estimated gross professional liability (including current and long-term portions) was $48,740 and $47,132, 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 $15,395 and $14,263 as of December 31, 2015 and 2014, 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, 2015 and 2014, the estimated net liability based on future claims cost totaled $16,891 and $16,468, respectively. The gross liabilities (including both current and long-term portions) total $21,953 and $20,683 as of December 31, 2015 and 2014, 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 $5,062 and $4,215 as of December 31, 2015 and 2014, 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 2015 and 2014 was $9,377 and $8,625, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(Dollars in thousands)

(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, 2015 and 2014, 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, 2015 and 2014 of $356 in fair value gains and $25,226 in fair value losses, respectively, are included in loss and other expense on interest rate swaps in other (loss) 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 $6,303 and $6,440, respectively, for the years ended December 31, 2015 and 2014. As of December 31, 2015 and 2014, the total notional amounts of MHS' outstanding interest rate swap agreements were $415,385 and $424,120, respectively.

(14) Long-Term Debt

MHS adopted the provisions of ASU 2015-03, *Interest – Imputation of Interest*, during 2015 and, accordingly, restated 2014 figures for comparability. ASU 2015-03 requires that bond issuance costs no longer be presented as assets, but instead be presented along with premiums and discounts as an offset to long-term debt. Implementation of this accounting change resulted in a reduction in long-term debt, net of current portion of $12,587 and $18,460 for 2015 and 2014, respectively, with a corresponding reduction in other assets, net.

Long-term debt consists of the following at December 31, 2015 and 2014:

	2015	2014
WHCFA Revenue bonds, 2015 Series A and B	$ 371,330	—
WHCFA Revenue bonds, 2012 Series A and B	140,000	140,000
WHCFA Revenue bonds, 2010 Series A	57,505	64,505
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
WHCFA Revenue bonds, 2008 Series A, B, and C	—	124,720
WHCFA Revenue bonds, 2007 Series A, B, C, and D	301,670	305,475
WHCFA Revenue bonds, 2004 Series A, B, and C	—	150,000
Other	227	317
	968,862	883,147
Adjusted for:		
Current portion	(14,580)	(11,865)
Bond premiums, discounts, and issuance costs	39,404	(11,349)
Long-term debt, net of current portion	$ 993,686	859,933

(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 $2,060 in 2015 to $24,085 in 2034.

The 2015 Series A and B bonds were used in part for the advance refunding of the 2008 Series A, B, and C bonds and the 2004 Series A, B, and C bonds, which resulted in a loss 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. 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 2015 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 2015 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. 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 $7,000 in 2015 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. 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 2015 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. 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 0.01% to 0.12% in 2015. 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 0.13% in 2015. Annual principal payments, including all four series of the 2007 bonds, range from $3,805 in 2015 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. The LOC states that any of the 2007C and D VRDBs purchased and not remarketed will be repaid through semi-annual principal payments for five years starting the first of the month following 367 days after the purchase. Under the terms of the previous standby bond purchase agreement (SBPA), that was in effect until it was replaced by the LOC in October 2011, any of the 2007C and D VRDBs purchased would be repaid through monthly principal payments starting the first of the month following 90 days after the purchase and continuing through February 1, 2017.

(Dollars in thousands)

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, 2015 and 2014.

Principal maturities on long-term debt are as follows:

Year ending December 31:	
2016	$ 14,580
2017	15,178
2018	15,776
2019	16,480
2020	17,178
Thereafter	889,670
	$ 968,862

A summary of interest costs is as follows during the years ended December 31, 2015 and 2014:

	2015	2014
Interest cost:		
Charged to operations	$ 36,547	34,702
Amortization of bond premiums, discounts, and issuance costs	(1,008)	242
Capitalized	415	1,225
	$ 35,954	36,169

(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 2015 and 2014 for all operating leases was approximately $20,877 and $21,153, respectively.

(Continued)

(Dollars in thousands)

The following is a schedule by year of future minimum lease payments under operating leases at December 31, 2015, which have initial or remaining lease terms in excess of one year:

2016	$	13,308
2017		12,389
2018		11,592
2019		9,909
2020		8,208
Thereafter		17,441
	$	72,847

(b) Collective Bargaining Agreements

Approximately 47% of MHS employees were covered under collective bargaining agreements as of December 31, 2015. 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 August 15, 2018. Two of the collective bargaining agreements expired prior to December 31, 2015 and are currently being negotiated. Management does not expect a significant impact to the consolidated financial statements as a result of these negotiations.

(16) Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31, 2015 and 2014:

		2015	2014
Healthcare services	$	18,281	8,250
Endowment fund		56	53
Purchase of equipment		11,540	14,264
Indigent care		967	868
Health education		852	804
Total temporarily restricted net assets	$	31,696	24,239

(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, 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

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment net assets, December 31, 2013	$ 2,876	—	32,671	35,547
Investment return:				
Investment income	89	351	697	1,137
Net appreciation – realized and unrealized	67	32	772	871
Total investment return	156	383	1,469	2,008
Contributions	—	—	1,472	1,472
Appropriation of endowment assets for expenditure	(171)	(330)	(752)	(1,253)
Endowment net assets, December 31, 2014	$ 2,861	53	34,860	37,774

(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 $17,858 and $19,488, respectively, as of December 31, 2015 and 2014. Also excluded from the presentation of permanently restricted net assets are pledge receivables and other totaling $2,162 and $2,480, respectively, as of December 31, 2015 and 2014.

(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 2015 or 2014.

(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, 2015 and 2014:

	2015	2014
Healthcare services	$ 1,191,585	1,057,993
General and administrative	525,324	528,994
	$ 1,716,909	1,586,987

(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) Health Care Reform

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (Reconciliation Act) were both signed into law in the first calendar quarter of 2010. The legislation went into effect upon signing with provisions to become effective over the following seven years. This legislation is expected to broadly impact MHS' operations, including patient access, service reimbursement rates, and reporting requirements in the future.

Effective January 1, 2014, coverage for eligible individuals who elected coverage under the Washington State Health Benefit Exchange (the Exchange) began. The Exchange, along with the expansion of Washington State Medicaid coverage, has reduced the numbers of uninsured patients, but has significantly increased the numbers covered under Medicaid programs, and has begun to create reduced reimbursement rates from some traditional commercial insurance carriers.

(21) Subsequent Events

MHS has evaluated the subsequent events from the balance sheet date through March 24, 2016, the date at which the consolidated financial statements were issued, and determined there are no other items to disclose.

Exhibit 19.

NICU/ICN Discharge Guideline

Title: DISCHARGE GUIDELINE

Patient Population:

All infants in the Tacoma General Neonatal Intensive Care Unit (NICU) and the Intermediate Care Nursery (ICN).

Policy Statement/Background:

To establish the Multicare Health System (MHS) guideline for patient discharge from the NICU/ICN. To identify discharge criteria and to designate job responsibilities to assure that all criteria are met prior to the patient's discharge from the hospital.

Discharge Criteria:

The following criteria for discharge will be evaluated on a case by case basis by the attending Licensed Independent Practitioner (physician, neonatal nurse practitioner) or by the Case Manager.

1. Infants being discharged from the NICU/ICN should meet the following criteria:
   - **a.** Taking all feeds by breast, combination breast/bottle, or bottle as ordered by the LIP.
   - **b.** Gaining weight consistently.
   - **c.** Apnea/bradycardia free for five (5) days. Defined as heart rate <60 for 10 seconds or requiring stimulation and not related to feedings.
   - **d.** Be off Caffeine for seven (7) days.
   - **e.** All parent teaching completed prior to discharge date.

2. Infants with special needs may be discharged:
   - **a.** On a cardio-respiratory monitor with a diagnosis of Gastroesophageal Reflux, oxygen therapy, central apnea, nasogastric feedings, or at the discretion of the LIP.
   - **b.** Home care follow-up by a home-health nursing agency may be needed.

A. Instructions:

1. All infants admitted to the NICU/ICN will have a hearing exam prior to discharge per the Audiology – Newborn Hearing Screening policy. Infant must be at least 34 weeks gestational age.
   - **a.** Case Manager will refer parents to Mary Bridge Speech and Hearing Center for hearing exam to take place as outpatient if unable to

complete prior to discharge or if infant's initial hearing exam was a "refer".

2. Infants <33 weeks gestation and/or <1500gm at birth will have eye exams to rule out retinopathy of prematurity (ROP).
   a. Exam to be done at approximately 4 weeks of age or ≥ 31 weeks gestational age at the time of the initial exam as an inpatient or outpatient.
      1) Infants requiring eye exams will be recorded in the NICU eye log.
      2) If the infant is discharged before the initial ROP exam, facilitate parent/caregiver in making an outpatient appointment and record in the electronic medical record on the After Visit Summary (AVS).

3. Viewing the infant CPR video is required for parents/caregivers of infants meeting the following criteria:
   a. Infant born at 35 weeks gestation or less, or with respiratory distress syndrome requiring mechanical ventilation, or oxygen therapy for greater than 24 hours.
   b. Infant of a mother with a positive drug screen/history.
   c. Member of family with previous SIDS.
   d. Any infant with special health care needs.
   e. Individual CPR demonstration via case managers as needed or requested by parent/caregiver.

4. All infants will be evaluated for immunization needs.
   a. All infants will receive Hepatitis B vaccine prior to discharge, following parental written consent and LIP order.
   b. Infants must be >60 days of age to receive DPT, HIB, IPV, and Pneumococcal, following parental written consent and LIP order.
   c. Infants meeting criteria will receive Synagis as recommended prior to discharge during RSV season (RSV season to be determined yearly).

5. Infants who meet the following criteria will have a car seat SaO2 check (refer to MHS Car Safety Seat, Child Restraint, or Vehicle Seat Belt Use at Discharge – Infants and Children policy for details):
   a. <37 weeks gestation at birth.
   b. Infants discharged with a home apnea monitor or oxygen therapy.
   c. Infants with chronic lung disease.
   d. Infants with neurological disorders or poor tone.
   e. Infants with a 5 minute apgar score of 6 or less.
   f. Term infants that required ≥48 hours of mechanical ventilation.
   g. Contact MB Center for Childhood Safety regarding proper car seat, infant positioning, and placement in vehicle prior to discharge.
   h. Car Seat Safety Technicians are available in the ICN on Monday,

Wednesday, and Friday mornings or by special request as needed.

6. Infants who meet the following criteria will be enrolled in the Neonatal Follow-up Program and have a physical therapy evaluation prior to discharge:
   - **a.** Birth weight less than 1,600gm
   - **b.** Intrauterine Growth Restriction
   - **c.** Asphyxia
   - **d.** Intracranial Hemorrhage
   - **e.** Periventricular Leukomalacia
   - **f.** Neonatal seizures
   - **g.** Structural CNS defects
   - **h.** CNS infections
   - **i.** Symptomatic Hypoglycemia
   - **j.** Hyperbilirubinemia
   - **k.** Congenital malformations of the GI system, musculoskeletal system, dysmorphology syndromes and/or chromosomal disorders
   - **l.** Sensory impairment
   - **m.** Term infants requiring 48 hours of mechanical ventilation
   - **n.** Intrauterine exposure to cocaine, heroin, methadone, or amphetamines
   - **o.** And as referred by the LIP

B. RN/LPN Responsibilities:

1. Review infant and parent progress towards hospital discharge, address unmet criteria daily and document in care plan.

2. Assist family in assuming primary caregiver role for infant.
   - **a.** Review Patient/Family Education Record/Discharge Checklist to assure completion and documentation of the following items, if infant meets criteria:
     - **1)** Audiology – newborn hearing screening
     - **2)** ROP exam
     - **3)** Car seat SaO2 check
     - **4)** Infant CPR video completed by parent/caregiver
     - **5)** Basic infant care
     - **6)** Physical Therapy evaluation completed if enrolled in the Neonatal Follow-up Program.

3. Parents of infants discharging from the NICU/ICN will receive adequate discharge instructions.
   - **a.** Provide parent/caregiver with written discharge information.
   - **b.** Document on Patient/Family Education Record the parent/primary caregiver(s) understanding of the instruction through verbalization

and return demonstration. This sheet will be signed by the parent/primary caregiver(s) at the time of infant's discharge in addition to the AVS.

c. Distribute appropriate parent teaching materials, e.g.: medication information, discharge instructions, car seat information, and immunization information/record.

4. Infants need to be monitored for 90 minutes in the car seat or car bed they will be discharged in.

a. Documentation must include:

1)Date of test

2)Range of SaO2

3)Positioning support needed

b. If infant does not pass car seat SaO2 check, reevaluate in car seat within 2-3 days or obtain appropriate-sized car bed.

5. Complete AVS:

a. Include all discharge medications and follow-up appointments.

b. Document follow-up care provider's phone number(s)

c. Discuss instructions with parents and answer questions.

d. Print two copies of the AVS.

1) Give one copy to parents

2) Placed signed copy in the infant's chart

6. Establish positive Identification of parent/caregiver

a. Ensure that parent/caregiver has signed the hospital footprint sheet:

1) Verify that the band number of the footprint sheet is the same as the infant's ID band number.

2) Tape the infant's ID band to the footprint sheet.

3) In the event of infant export to outlying hospital and parent not present at time of export, transport RN will verify above and indicate as such in lieu of parent signature.

4) Infants born at other hospitals will not have a footprint sheet.

b. Have parent/caregiver provide photo Identification if infant was not born at Tacoma General or if infant is discharged to someone other than parent/caregiver home (foster home, PIC Center). Documentation of photo ID verification will be in the nurses' notes.

7. Infant may be escorted by staff member in appropriate car seat to parent/caregiver vehicle or discharged to parents/caregivers in the NICU/ICN.

8. Parent/caregiver is responsible for placing infant in car seat and in vehicle.

C. Mary Bridge Speech and Hearing Responsibilities:

Administer hearing exam as set up by the NICU Case Manager or designee.

D. Ophthalmologist Responsibilities:

Eye exams will be done at approx. 4 weeks of age for all infants <33 weeks and/or <1500gms at birth.

E. Dietitian Responsibilities:

1. Identify infants eligible for WIC and provide them with formula substitution form, if needed.
2. Prepare formula preparation guidelines and recommended duration of use. Instructions may be provided by dietitian or nurse.
3. Identify infants who need nutritional follow-up, designate where nutrition follow-up will be provided and provide information to parents.
4. Address nutrient supplementation needs for discharge and duration of use.
5. Address expected growth in post-discharge period for high-risk infants.

F. Lactation Responsibilities:

1. All mothers of breastfeeding infants will receive written discharge instructions from the lactation consultant, bedside nurse, or dietitian.

G. Case Manager Responsibilities:

1. Present all infants at weekly NICU discharge rounds.
   a. Verify that those infants that meet criteria are enrolled in the NICU Follow-up Clinic, as per MB Neonatal Follow-up Program criteria.
   b. Infants enrolled in the NICU Follow-up Clinic are to be examined, when able, by MB Physical Therapy prior to discharge.
   c. Ensure social work referrals have been made for appropriate infants.
2. Facilitate parents/caregivers in making follow-up appointments.
3. Review prior to discharge that teaching has been completed and documented.
4. Communicate with secretary appropriate documents to be forwarded to the follow-up care provider(s).

H. Respiratory Care Practitioner Responsibilities:

When inhaled respiratory medications or other respiratory therapies are ordered, the respiratory care practitioner will give instruction to the parent/caregiver prior to discharge.

Related Policies: Audiology – Newborn Hearing Screening	
Related Forms: Patient/Family Education Record (paper) After Visit Summary (electronic) Discharge Checklist (electronic)	
Point of Contact: NICU/ICN Case Managers	
Approval By:	***Date of Approval:***
NICU/ICN Case Managers	*07/10*
Neonatal Unit Based Council	*07/10*
Original Date:	*06/91*
Revision Dates:	*11/03; 08/07; 08/10; 06/12*
Reviewed with no Changes Dates:	
3/2017 location included in scope	

NICU Discharge Guidelines

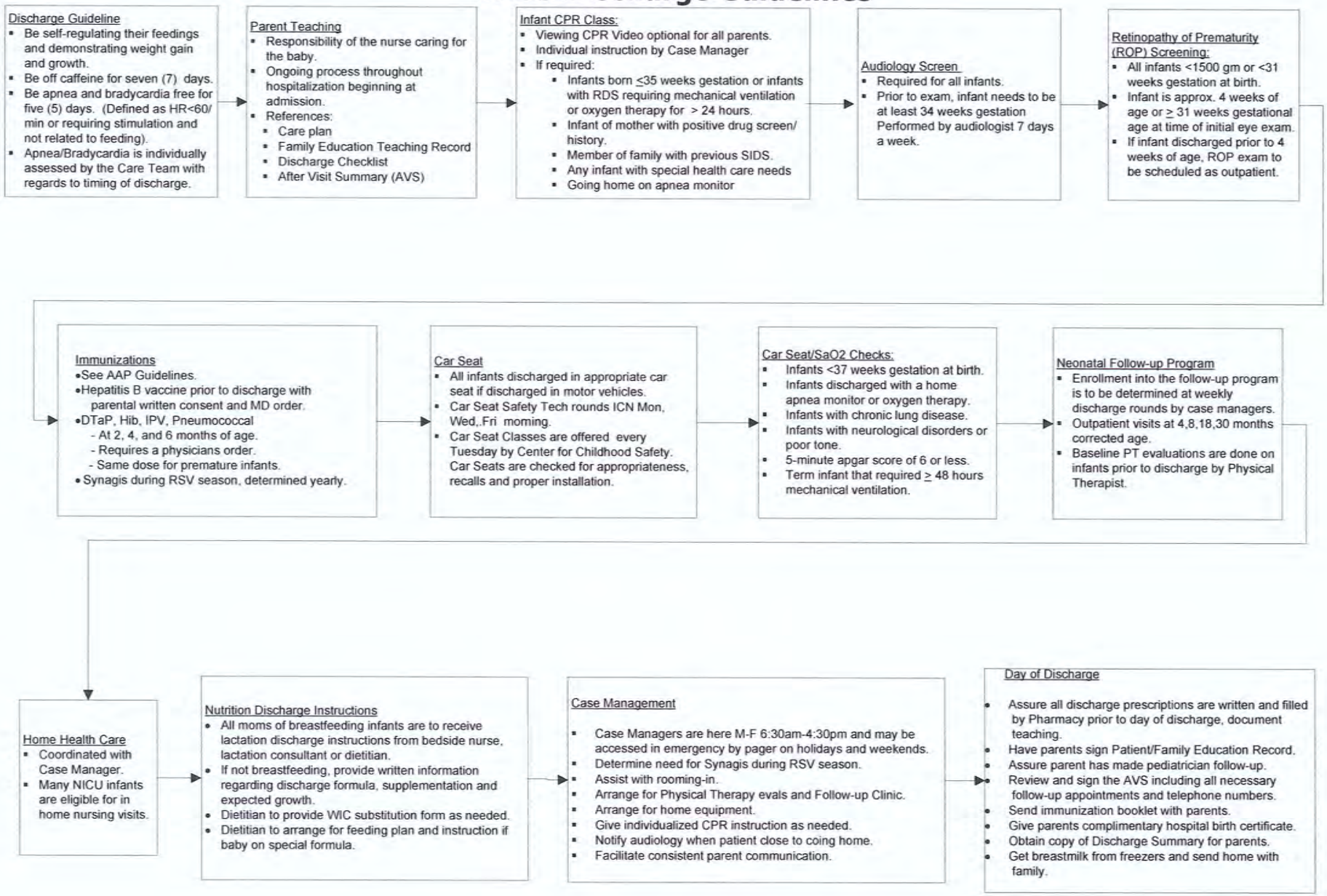


Exhibit 20.

Scope of Services, Neonatal Intensive Care Unit and Intermediate Care Nursery

MultiCare

SCOPE OF SERVICES	LAST REVIEWED/REVISED DATE: May, 2017	NO. OF PAGES: 8
NEONATAL INTENSIVE CARE UNIT INTERMEDIATE CARE NURSERY	POINT OF CONTACT: Raylene Alred, Nurse Manager, NICU	TELEPHONE NUMBER: 403-4841

1. Description of Program / Service:

The Neonatal Intensive Care Unit (NICU) at Tacoma General Hospital (TG) is located on the 3rd floor of the Rainier Tower and the Intermediate Care Nursery is located on the 3rd floor of the Philips Pavilion. There are 70 licensed bassinets. Physical capacity includes 52 beds in the main NICU and 18 bed capacity in the Intermediate Care Nursery. Three rooms in the NICU have the capacity for negative airflow ventilation, room 303,319, 328. All beds are equipped with physiological monitoring capability. Additional support rooms include medication rooms with refrigerators, blood gas analysis rooms, clean and soiled utility rooms, equipment rooms and housekeeping rooms. Staff facilities include a lounge with lockers, mailboxes, kitchen and bathroom. Parent/family facilities include waiting rooms, public restrooms with showers, the option to spend the night in their baby's room (main NICU only) and 2 rooming-in rooms available in the Intermediate Care Nursery in the Philip Pavilion. The TG NICU is a tertiary regional care center serving high risk neonates in the southwest region of Washington State.

Mission and Philosophy

The mission of the NICU is to provide evidenced-based care to acutely ill and convalescing neonates in a neuro-developmentally supportive environment that is based on the family-integrated care philosophy.

2. Patient Population Served:

Age Criteria:

Neonates with high risk conditions born at Tacoma General or transported in from a referral community hospital ranging from 23-weeks gestational age to post-term.

Common Diagnoses:

The top DRGs in the NICU/ICN include:

- DRG 790; Extreme Immaturity or Respiratory Distress Syndrome, Neonate
- DRG 791; Prematurity with Major Problems
- DRG 792; Prematurity without Major Problems

- DRG 793; Full-Term Neonate with Major Problems
- DRG 794; Neonate with Other Significant Problems

Conditions affecting these groups include, but are not limited to, prematurity, respiratory distress syndrome, congenital anomalies, cardiac diseases, hyperbilirubinemia and hypoglycemia.

Common Treatment/Procedures/ Activities:

The clinicians are prepared to provide care and treatment for critically ill babies with a variety of diagnoses requiring physiological monitoring, intravenous therapy, respiratory therapy, and nutritional support.

Surgical procedures performed in the NICU are only performed in situations in which it is deemed by at least two physicians to be more detrimental to move the neonate to the OR, necessitating emergency surgery in the NICU. All surgical post-operative recovery care is performed in the NICU, with the exception of cardiac cases.

Exclusions to scope of service include:

- Patients requiring ECMO. These infants are transferred to the Pediatric Intensive Care Unit (PICU) at Mary Bridge Children's Hospital or transported to Children's Hospital in Seattle.
- Cardiac surgery and post-operative cardiac care is provided at Mary Bridge Children's Hospital

Important Aspects of Care:

The patient's care is delivered with a neurodevelopmental sensitive approach to minimizing negative physical and neurodevelopment effects on the newborn. Families are integrated in the care of their babies with a multidisciplinary approach to care. All clinicians in the unit are prepared to take care of a clinical crisis that can occur quickly and without warning. They are trained with advanced assessment skills that will prepare them to detect changes in patient status and to intervene appropriately. The registered nursing care includes assessment, problem identification, planning, implementation, and evaluation of the delivery of care and the patient's response to medical and nursing therapy. A charge RN is assigned each shift to coordinate the delivery of patient care. Our key customers are patients admitted to the NICU/ICN, their families, other departments and physicians. In collaboration with other support departments, ancillary health care providers include nutritional support, physical therapy, occupational therapy, speech, social work, case management, chaplain staff and others as needed. The Complex Care (formerly known as Palliative Care) team from Mary Bridge is used to coordinate the care required by those patients with complicated or extensive care needs.

Discharge Criteria: See Discharge Guidelines, attached.

3. Location of Program and House of Operation:

The NICU at TG is located on the 3rd floor of Rainier Tower. The Intermediate Care Nursery (ICN) is on the 3rd floor of the Philip Pavilion, adjacent to the NICU.

The NICU/ICN is an inpatient unit and as such provides care on a 24-hour-a-day basis, 7 days a week.

4. Staffing Plan:

Staff Mix: The staff in NICU/ICN includes Registered Nurses, Licensed Practical Nurses, Respiratory Therapists, , Child Life Specialist, Social Work, Pharmacist, Nutritionist, Lactation, and Unit Secretaries. All nursing care is performed under the supervision of a Registered Nurse.

Skill Requirements: NICU/ICN Registered Nurses, Licensed Practical Nurses and Respiratory Therapists must obtain and maintain NRP. The RNs, RTs and LPNs must obtain NRP within 90 days of transfer/employment, In addition, many of the Registered Nurses maintain RNC certification.

Determinates of Staffing Levels: The NICU/ICN is staffed with sufficient professional and non-professional staff to provide the required hours of nursing care based upon acuity or ratio, census and staff ability. The minimum staffing level regardless of census is two Registered Nurses and one respiratory Therapist in the NICU and two Registered Nurses in the ICN.

5. Staffing Models:

Neonatal Intensive Care Unit

Staff	Days	Evenings	Nights
Registered Nurses (RN)*	1:2	1:2	1:2
Respiratory Therapists (RT)*	1:6-7	1:6-7	1:6-7
Licensed Practical Nurse(LPN)*	1:3-4	1:3-4	1:3-4
Unit Secretaries	2	2	1

*RN patient assignments flex based on the acuity of patients. RN will mostly have 2 patients, but on occasion an RN will have 1 or 3 patients.
*LPN patient assignments flex based on the acuity of patients
*RT staffing is based on the number of patients on ventilators and CPAP.

Intermediate Care Nursery

Staff	Days	Evenings	Nights
Registered Nurses (RN)*	1:3-4	1:3-4	1:3-4
Licensed Practical Nurse(LPN)*	1:3-4	1:3-4	1:3-4

*RN/LPN patient assignments flex based on the acuity of patients.
*ICN is supported by the unit secretary in the pavilion business center and the charge nurse in the NICU.

6.Competencies for Each Position (Refer to following grid)

- Clinical Director –.Includes management and leadership competencies, as well as, specifically defined nursing competencies
- Nurse Manager- Includes management and leadership competencies, as well as, specifically defined nursing competencies
- Assistant Nurse Manager – Includes management and leadership competencies, as well as, all competencies for RN staff nurse
- RN charge nurse - Includes all competencies for departmental RN staff nurse, completion of MHS charge nurse educational series, and department specific responsibilities
- RN staff nurse -completion of departmental competency requirements annually (varies based on high risk, low volume, problematic, and new tasks/therapies/equipment
- Health Unit Coordinator - completion of department and MHS requirements
- Lactation Nurse-IBCLC required

	ANM	RN	LPN	RT	HUC
Annual Mandatory Education • Environment of Care • Standardized Emergency Codes • Security • Hazardous Materials • Utilities/Electrical • Compressed Gas Safety • Emergency Management • Fire Safety/Extinguisher • Life Safety • Radiation Safety • Ergonomics • Proper Positioning at Computer Work • Employee Accidents and Injuries • Information Security • Diversity • Disability • Age Specific Care • Code of Conduct • Conflicts of Interest • Fraud Waste and Abuse • Fraud Prevention at MHS • HIPAA • Infection Prevention • EMTALA • Professional and Patient Boundaries • Abuse and Neglect • Quality and Patient Safety • Patient and Family Centered Care • Chest Pain/Stroke/VAD • Bariatric Sensitivity •	X	X	X	X	X

	ANM	RN	LPN	RT	HUC
Clinical Annual Mandatory Education • Change in Patient Condition • Malignant Hyperthermia • Restraints and Seclusion • Safe Patient Handling • Surgical Site Infections • CLABSI • Isolation Precautions • Drug Diversion Training • Malignant Hyperthermia	X	X	X	X	
Blood Administration	X	X	X		
Annual POCT training • Glucometer	X	X	X		
BLS Health Care Provider (every 2 years)	X	X	X	x	
NRP (every 2 years)	x	X	X	X	

7. Professional Standards:

ANA American Nurses Association) Standards for Nursing Practice
NANN (National Association of Neonatal Nurses)
AWHONN (Association of Women's Health, Obstetric, and Neonatal Nurses)
AARC (American Association of Respiratory Care)
AAP (American Academy of Pediatrics)

Discharge Guidelines
Utilization of the Unit

1. **Purpose:**

   The purpose of this document is to identify discharge criteria for the Neonatal Intensive Care Unit and Intermediate Care Nursery, designate job responsibilities, assure that all discharge criteria are met prior to the infant's discharge from the hospital, and set forth criteria for discharge of NICU/ICN infants evaluated on a case-by-case basis by the attending Neonatologists/NNP/Case Manager.

2. **Policy:**

   The infants being discharged from the NICU/ICN should meet the following criteria:

   - Taking all feeds by breast, bottle or as ordered by physician.
   - Gaining weight consistently or per physician and nutritionist.
   - All parent teaching completed prior to discharge
   - Methylxanthines discontinued 7 days prior to day of discharge or as ordered by physician.

   Infants with special needs may be discharged:

   - On a cardio respiratory monitor, O_2 therapy, nasal gastric feedings/GT feedings
   - Home care follow up may be needed by a home health nursing agency.

3. **Infant Discharge Criteria:**

   All infants admitted to the NICU/ICN will have a hearing exam prior to discharge per the Universal Hearing Screen protocol. Case Manager will refer parents to MB Speech and Hearing Center for hearing exam to take place as outpatient if unable to complete prior to discharge or if infants initial hearing exam was a "refer."

   Infants <30 weeks gestation and/or 1500 grams at birth will have an eye exam to rule out ROP.(

   - Exam to be done at 4 weeks of age or 31 weeks GA (whichever is later) as an inpatient or outpatient.
   - Infants requiring eye exams will be recorded in the NICU eye log.
   - If the infant is discharged before the initial ROP exam, facilitate parent/caregiver in making follow up outpatient appointment and record on home instruction sheet.

   All infants will be evaluated for immunization needs:

- All infants receive Hepatitis B immunization before discharge, following parental written consent.
- Infants must be > 60 days of age to receive DPT/HIB/IPV/Pneumococcal, following parental written consent.
- Infants meeting criteria will receive Synagis as recommended prior to discharge during winter months (determined by the DOH).

Infants who meet the following criteria need car seat SaO_2 checks:

- Less than 37 weeks and/or 2500 grams at time of discharge.
- Infants discharged on home apnea monitors and/or oxygen.
- Infants with neurological disorders.
- Contact MB Center for Childhood Safety regarding proper car seat, infant positioning, and placement in vehicle prior to discharge.

Infants who meet the following criteria need to be enrolled in the Neonatal Follow-Up Program and have a physical therapy evaluation prior to discharge:

- Birth weight less than 1600 grams
- Intrauterine Growth Retardation
- Asphyxia neonatorum
- Intracranial Hemorrhage
- Periventricular Leukomalacia
- Neonatal Seizures
- Structural CNS Defects
- CNS Infections
- Symptomatic Hypoglycemia
- Hyperbilirubinemia
- Congenital Malformations of the GI System, Musculoskeletal System, Dysmorphology Syndromes and/or Chromosome Disorders
- Sensory Impairment
- Term Infants requiring 48 hours of Mechanical Ventilation
- Intrauterine exposure to cocaine, heroin, methadone, or amphetamines
- Other: referred by Neonatologist

4. RN/LPN Responsibilities:

Review infant and parent progress towards hospital discharge and address unmet criteria daily.

Assist family in assuming primary caregiver role for infant (refer to Family Centered Care policy). Review Parent Teaching record to assure completion/documentation of the following if infant meets criteria:

- Audiology screen
- ROP exam
- Car seat SaO_2
- CPR completed by parent/caregiver as appropriate
- CHD Screening as appropriate
- Basic infant care completed by parent/caregiver and documented
- Physical therapy evaluation completed if enrolled in the Neonatal Follow-Up Program

Parents of infants discharging from the NICU will receive discharge instructions as listed on parent teaching record:

- Provide parent/caregiver with written discharge information.
- Document on the Discharge Teaching Sheet the parents/primary caregiver(s) understanding of the instruction through teach back.
- Distribute appropriate parent teaching information

Parent/Caregiver is responsible for placing infant in car seat and vehicle.

5. Mary Bridge Speech and Pediatrix Hearing Responsibilities:

Services are contracted and administered by the Pediatrix hearing screen staff for all neonatal patients or Mary Bridge Speech therapists as warranted by infant's condition. Both services are coordinated and tracked by case management for each patient in the NICU

6. Ophthalmologist Responsibilities:

Eye exams will be done for all infants at 4 weeks of age or 31 weeks gestation who were < 30 weeks and/or 1500 grams at birth. Care management coordinates and tracks this service for neonatal patients as warranted. (

7. Dietitian Responsibilities:

- Identify infants eligible for WIC and provide them with formula substitution form as needed.
- Prepare formula preparation guidelines and recommended duration of use. Instructions may be provided by dietician, or designee.

- Identify where dietitian follow up will be provided after discharge (as warranted by patient's condition) and provide information to parents.
- Identify nutrient supplementation needs for discharge and duration of use.
- Identify expected growth in post-discharge period for high risk infants

8. Lactation Responsibilities:

All infants who receive a consult for breastfeeding will have contact with the lactation consultants.

9. Case Manager Responsibilities:

- Verify infants that meet criteria are enrolled in the NICU follow-up clinic, as per Neonatal follow-up program criteria.
- Infants enrolled in the NICU follow-up clinic are to be examined, when able, by Mary Bridge Physical Therapy prior to discharge.
- Ensure social work referrals have been made for appropriate infants.

Facilitate parent/caregivers in making follow-up appointments.

Review prior to discharge that teaching has been documented and completed.

Communicate with secretary appropriate documents to be faxed to the follow-up health care providers.

10. Neonatologist/NNP Responsibilities:

- Ensure patient is medically ready for discharge.
- Coordinate discharge time with the family and other members of the multidisciplinary team
- Write outpatient prescriptions.
- Write discharge order.

Exhibit 21.

Utilization Management Plan

MultiCare
BetterConnected

MultiCare Allenmore Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Hospital
MultiCare Mary Bridge Children's Hospital
MultiCare Tacoma General Hospital

MultiCare Health System

Utilization Management Plan

Purpose, Objectives, and Scope

MultiCare Health System (MHS) will advance its commitment to the community to provide the highest quality of care in a cost effective manner through implementation of an effective Utilization Management (UM) Program in all of the MHS inpatient facilities. The plan provides a framework for addressing under-utilization, over-utilization, and inefficient delivery of care. The program will achieve the following objectives:

- Facilitate the delivery of health care services in the most appropriate setting to meet the patient's needs
- Evaluate delivery of services for timeliness, medical necessity, and appropriate level of care
- Expedite timely discharges through early identification of patient's needs and referrals to community resources for post-hospital care
- Monitor compliance with state and federal regulations for participation in Medicare and Medicaid programs
- Monitor compliance with payer contractual obligations
- Minimize patient, physician, and hospital financial risk through concurrent review and retrospective sampling and audit for appropriateness of care and use of hospital resources and services
- Encourage continuity and coordination of care among practitioners
- Educate medical staff and other health care professionals about utilization management and care delivery issues

The program scope applies to all inpatient and outpatient observation cases regardless of insurance or source of payment.

Authority and Responsibility

Administration

The MHS Board of Directors has the ultimate responsibility and accountability for system wide UM activities and the Utilization Plan, with authority delegated to the UM Committee for the following activities:

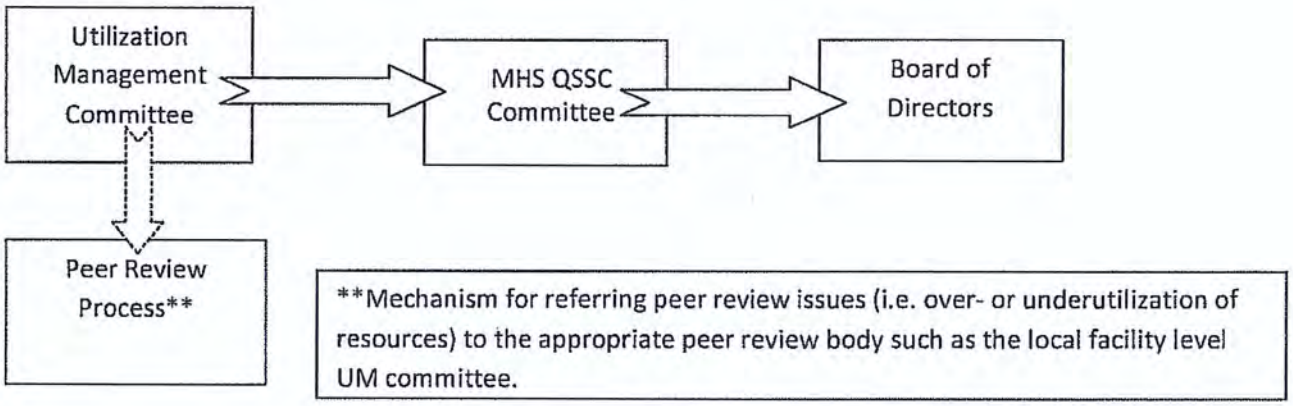
- Developing a committee structure to support implementation, maintenance, and oversight of the UM Program
- Assigning oversight and general supervision of the organization's management of the program, with a focus on regulatory compliance, financial viability, allocation of resources, staffing, and the interdepartmental effectiveness of the Program.

The UM Committee's effectiveness is enhanced under the governance of the Quality Steering Committee for MHS, which includes Medical Staff Leadership representation.

Utilization Management Committee

The Committee reporting relationship is displayed below:

Utilization Management Reporting
Relationship and Flow of Information 2017



The Committee facilitates, monitors, and promotes the effectiveness of the UM Program. The Committee responsibilities and accountabilities include the following:

- Assuring that the UM Plan complies with federal regulations and contractual agreements
- Maintaining a process for reviewing the appropriateness of hospital services, both the initiation of services, and the need for continued delivery of services in the hospital setting. This process will reflect appropriate and germane regulatory guidance or, where appropriate, contractual language to assure correct assignment of billing status.

- Evaluating outlier reports of hospital admissions, avoidable days, length of stay, timeliness of discharges, over- and /or under- utilization of professional services, delay in services, external reviews and medical record documentation
- Recommending actions to improve efficiency of care and appropriate use of resources
- Monitoring the effectiveness of actions to resolve problems and improve delivery of care
- Encouraging prompt and appropriate discharge planning that promotes efficient continuity of care and services
- Reviewing third-party denial trends, making recommendations, and initiating action when appropriate
- Initiating focused reviews in response to specific trends or issues
- Recommending medical staff and staff education programs based on Committee observation, new regulations, or changes in the health care marketplace affecting delivery of care
- Performing an annual review of the effectiveness and function of the UM Program and making recommendations on Program scope, policies, procedures, and practices

Utilization Management Committee

Membership

No less than two members of the UM Committee shall be physicians from the medical staff, one of which will serve as the chair, appointed annually by the system's Chief Executive Officer (CEO), or designee. Other members will include representation from Patient Navigation and Care Coordination (PNCC), MHS leadership, Health Information Management, Finance, Quality Management, Corporate Compliance, Decision Support Analyst, and Nursing.

The Chairman of the UM Committee may appoint physician specialists from the Medical Staff and other experts to serve as non-voting, expert clinical consultants to the Committee.

Each Committee member shall have voting privileges, except when voting occurs regarding clinical issues, such as determination of medical necessity of admission or continued hospitalization. In these situations, only the physician members of the committee shall vote. Attendance by two members shall constitute a quorum.

Individuals who hold financial interest in the system are not eligible for appointment to the Committee. Physician members of the Committee may not review or vote on cases in which they have been or anticipate being professionally involved. Physicians having a direct or indirect financial interest in the case(s) being reviewed may not participate in the UM Committee activities pertaining to the case.

Meetings and Committee Records

The Committee shall meet quarterly or more frequently at the direction of the Chairman. Minutes of each Committee meeting shall be documented (without names of patients or attending physicians) and include:

- Name of the Committee
- Date and duration of each meeting
- Names of Committee members present and absent
- Case reviews
- Summary of findings, conclusions, and recommendations
- Review of key metrics

The Chairman of the Committee shall report findings to the Quality Steering Committee and as appropriate, to other system departments or administration for action or review.

Physician Advisor

The Physician Advisor (PA) is a member of the medical staff or an approved business partner of the hospital and UM Committee. The scope of the PA role may change at the direction and discretion of the Committee to address priorities as it sees fit. The PA responsibilities may include:

- Providing medical leadership and oversight of utilization review and discharge planning functions
- Conducting secondary reviews of cases referred by the Personal Health Partner (PHP) and Utilization Management (UM) staff to assure that the admission, continued stay and professional services are medically necessary and that the billing status of those claims is consistent with applicable regulatory or contractual guidance
- Conferring with attending physicians to promote compliance with applicable state and federal requirements, including discussing the treating physician's expected plan of care and length of stay, the treating physician's rationale for continued stay, and facilitating discharge planning via interface with the PHP or UM staff.
- Reviewing referred retrospective and concurrent denials
- Contacting the attending physician or an approved business partner of the hospital to perform a peer to peer concurrent appeal with a third party payer
- Calling the third party payer physician reviewer for the purposes of performing a peer to peer concurrent review if the attending physician refuses or is unavailable
- Providing recommendations for payer upheld denials to the MHS Clinical Appeal and Audit team or referring the denial to an approved business partner of the hospital.
- Collaborating with MHS leadership to identify trends, and reporting to clinical and administrative leaders for action.

If the PA determines that a case does not meet medical necessity as defined in regulatory guidance for admission to the hospital in either inpatient or observation status or continued stay and agreement cannot be reached with the attending physician, the PA will initiate the following

The PA will refer the case for review to the UM Committee, including at least one other physician. The UM committee will investigate the case including affording the treating physician the opportunity to present their perspective and position. If the case cannot be resolved, two physician members of the Committee will agree on a final determination and notify the treating physician, patient and hospital in a timely manner, consistent with the current regulatory guidance.

Reviews

The Utilization Managers conduct concurrent reviews per regulatory guidance and contractual agreement and obligation as follows:

- *Pre-admission Review:* the UM Committee may designate areas for pre-admission review activities that focus on diagnosis, problems, procedures, or practitioner with identified or suspected utilization-related concerns
- *Admission Review:* the assignment of the appropriate claims status (for example, inpatient, observation, or outpatient) based on the relevant regulatory guidance (such as the CMS 2 - Midnight rule) or contractual agreement and obligation within the first 24 hours of admission
- *Continued Stay Reviews:* in accordance with regulatory or third party payer requirements but no less than every three days, the assessment of the medical necessity and appropriate level of care for a continuing stay at the hospital
- *Professional Services Review:* the UM Committee may designate the assessment of medical necessity, appropriate utilization, and timeliness of physical therapy, laboratory, imaging, pharmaceuticals, and nursing resources

The UM Committee will conduct *extended stay reviews* of outlier cases that exceed parameters set by the committee.

The UM Committee may initiate *retrospective and focused reviews* to address the following:

- Known or suspected concerns
- Cases not captured by concurrent review
- Situations that are new, or to verify that the system is working properly
- Concerns of under-utilization or over-utilization
- Post discharge cases denied by third party payers

Reviews may be conducted via sampling based on diagnoses, procedures, admission, duration of stay, physician, professional services provided, delays of services or denied cases.

Medicare Condition Code 44

Medicare cases which do not meet CMS requirements for inpatient status must be reviewed per guidance provided in the UR standards of the Medicare Conditions of Participation. In addition, all four of the following conditions must be met in order for the episode of care to be converted to an outpatient 13x claim type:

- The patient was not discharged when the decision was rendered
- The bill had not been submitted when the decision was rendered
- The physician responsible for the care of the patient concurred with the decision
- Physician concurrence is documented in the medical record

The UM Committee will review all cases that have utilized Condition Code 44 at regularly scheduled meetings.

Evaluation of UM Program

The effectiveness of the UM Program will be evaluated annually based on quality of care and financial targets set by the hospital. Specific metrics, (e.g. length of stay, denial metrics) will be monitored quarterly by the UM Committee, administration, and Quality Steering Committee.

Revision history:

Original Date:	February 2009
Revised Dates:	March 2010, April 2011, July 2012, January 2015, February 2016

Current Revision Date: March 2017

Related Policies: Medicare Code 44 Process

Approvals:

Maria Granzotti MD — 3/14/17

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Date

J. Mark Maddox MD — 3/17/17

Utilization Management Committee Chair
J. Mark Maddox, MD
Physician Executive Utilization Management

Date