Certificate of Need Application
Hospital Projects

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

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

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

Signature and Title of Responsible Officer: Jeff Tomlin, MD, Chief Executive Officer [signature] **Email Address:** jjtomlin@evergreenhealthcare.org	**Date:** October 27, 2022 **Telephone Number:** (425) 899-2490
Legal Name of Applicant: King County Public Hospital District #2 (dba EvergreenHealth/EvergreenHealth Medical Center) **Address of Applicant:** 12040 NE 128th St Kirkland, WA 98034	☐New hospital ☒Expansion of existing hospital (identify facility name and license number) EvergreenHealth Medical Center, License #: HAC.FS.00000164 **Provide a brief project description, including the number of beds and the location:** This application proposes to maintain 36 acute care beds set-up under the Governor's Proclamation 20-36 at EvergreenHealth Medical Center in Kirkland, WA. **Estimated capital expenditure:** $ 125,000

Identify the Hospital Planning Area: East King Hospital Planning Area				
Identify if this project proposes the addition or expansion of one of the following services:				
☐NICU Level II	☐ NICU Level III	☐ NICU Level IV	☐ Specialized Pediatric (PICU)	☐ Psychiatric (within acute care hospital)
☐ Organ Transplant (identify)	☐ Open Heart Surgery	☐ Elective PCI	☐ PPS-Exempt Rehab (indicate level)	☐ Specialty Burn Services

From the office of Jeff Tomlin, MD, Chief Executive Officer

October 27, 2022

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Mr. Hernandez:

Enclosed please find a copy of King County Public Hospital District No. 2, dba EvergreenHealth's certificate of need application proposing to permanently add, to our Kirkland license, 36 beds of additional capacity originally made operational in 2020 under the Governor's COVID Proclamation 20-36.

The required fee of $40,470 was sent separately on October 21, 2022 and was received by DOH on October 24, 2022 at 9:24am. Attached is a copy of the requested tracking information.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

Jeff Tomlin, MD,
Chief Executive Officer

12040 NE 128th Street, Kirkland, WA 98034
evergreenhealth.com

Certificate of Need Application
Make Permanent Acute Care Beds Made Operational Under Proclamation 20-36 at EvergreenHealth Medical Center, Kirkland, WA

October 2022

Section 1
Applicant Description

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

The legal name of the applicant is King County Public Hospital District No. 2, dba EvergreenHealth. This application is being submitted for EvergreenHealth Medical Center in Kirkland (EvergreenHealth Kirkland). The address is:

12040 NE 128th Street
Kirkland, WA 98034

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

Consistent with RCW 70.44, King County Public Hospital District No.2 is a governmental entity, owned by the residents of the District and governed by a board of publicly elected commissioners.

EvergreenHealth Kirkland's UBI number is: 600-068-426.

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

The contact person at EvergreenHealth Kirkland is:

Trisha West, MHA, Director
Strategic Planning
425.899.2642 (P)
twest@evergreenhealthcare.org

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

Jody Carona
Health Facilities Planning & Development
120 1st Avenue West, Suite 100
Seattle, WA 98119
206.441.0971
healthfac@healthfacilitiesplanning.com

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

An organizational chart identifying the business structure is included as Exhibit 1.

Section 2
Facility Description

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

EvergreenHealth Kirkland
12040 NE 128th Street
Kirkland, WA 98034

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

There is no proposed facility. This question is not applicable.

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

EvergreenHealth Kirkland is licensed and certified. The requested information is included below:

HAC.FS.00000164

Medicare #: 50-0124

Medicaid #: 1000823

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

EvergreenHealth Kirkland is fully accredited by the Joint Commission effective October 2, 2021. The next survey is expected in October 2024.

5. **Is the facility operated under a management agreement?**

Yes ☐ No X

6. **Provide the following scope of service information:**

Service	**Currently Offered?**	**Offered Following Project Completion?**
Alcohol and Chemical Dependency	☐	☐
Anesthesia and Recovery	☒	☒
Cardiac Care	☒	☒
Cardiac Care – Adult Open-Heart Surgery	☐	☐
Cardiac Care – Pediatric Open-Heart Surgery	☐	☐
Cardiac Care – Adult Elective PCI	☒	☒
Cardiac Care – Pediatric Elective PCI	☐	☐
Diagnostic Services	☒	☒
Dialysis – Inpatient	☒	☒
Emergency Services	☒	☒
Food and Nutrition	☒	☒
Imaging/Radiology	☒	☒
Infant Care/Nursery	☒	☒
Intensive/Critical Care	☒	☒
Laboratory	☒	☒
Medical Unit(s)	☒	☒
Neonatal – Level II	☒	☒
Neonatal – Level III	☒	☒
Neonatal – Level IV	☐	☐
Obstetrics	☒	☒
Oncology	☒	☒
Organ Transplant - Adult	☐	☐
Organ Transplant - Pediatric	☐	☐
Outpatient Services	☒	☒
Pediatrics	☒	☒
Pharmaceutical	☒	☒
Psychiatric	☐	☐
Skilled Nursing/Long Term Care	☐	☐
Rehabilitation	☒	☒
Respiratory Care	☒	☒
Social Services	☒	☒
Surgical Services	☒	☒

Section 2
Project Description

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

EvergreenHealth proposes to permanently add, to our Kirkland license, 36 beds of additional capacity originally made operational in 2020 under the Governor's COVID Proclamation 20-36. Retention of these beds is necessary to address continuing inpatient acute bed pressures, admission of more and sicker patients, management of patients that are more difficult to discharge, and the increased length of stay currently being experienced. EvergreenHealth Kirkland is currently operating 297 medical/surgical beds. If we were required to return to the pre-pandemic number of beds (261), our midnight census would exceed the 70% target midnight occupancy rate on all but a very few days for a hospital the size of EvergreenHealth Kirkland (based on 2022 YTD 230 days of census). On 60% of all days, we would have operated above 80% midnight occupancy and on 40% of the days, midnight occupancy would have exceeded 85%. Importantly, on 12% of the days, midnight occupancy would have exceeded 95% occupancy. Retaining the beds is necessary for optimizing workflows and staffing and will also help ensure EvergreenHealth's ability to flex and surge as flu, seasonal viruses and other COVID-like conditions require. Finally, it will support the management of EvergreenHealth Kirkland's census caused by the increasing volume of the difficult to discharge patient population that the region has been experiencing. At EvergreenHealth Kirkland, difficult to discharge patients currently average 40 per day and take up 15% of our licensed capacity.

Throughout most of the pandemic, all 36 beds were operational and integrated across several medical/surgical units throughout the hospital. As confirmed by the Department's Construction Review Services, all of the beds are located in spaces that meet applicable codes. The majority of these beds are currently located on older units that are used for overflow/surge capacity, or when we are completing a remodel of other units. This allows us to keep our licensed capacity available to the community, as well as to be able to respond to surge situations, like the COVID-19 pandemic. Four of the rooms have been utilized during the pandemic with surplus beds which need to be replaced for permanent use. This CN request includes the capital to purchase four new beds. There are no other capital expenditures.

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

This project does not involve the addition or expansion of a tertiary service.

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

EvergreenHealth Kirkland has been operating 354 total beds, of which 297 are for medical/surgical/acute care since the early days of the pandemic. Table 1 below reflects our pre-COVID bed set-up, as well as the beds we currently operate under the Governor's waiver and propose to retain as permanent and add to the Hospital's license.

Table 1
EvergreenHealth-Kirkland Licensed Bed Capacity (Pre-COVID and Current)

	Pre -COVID/Currently Licensed Beds	Currently Operational Under 20-36 and Proposed
General Acute Care	261	297
PPS Exempt Psych	0	0
PPS Exempt Rehab	14	14
NICU Level II/III	43	43
NICU Level IV	0	0
Specialized Pediatric	0	0
Skilled Nursing	0	0
Swing Beds (included in General Acute Care)	0	0
Total	318	354

Source: Applicant

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

All 36 beds are currently set-up. As noted in response to Q1 above, four of the rooms are using surplus beds which need to be replaced with new beds for permanent use. This CN request includes the capital to purchase four new permanent beds.

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

The beds are currently operational and per the Powerpoint and the webinars conducted by the Department of Health regarding off-boarding, these beds can remain operational until a decision is made on this application. Table 2 below reflects that the beds are already in operation**.**

Table 2
EvergreenHealth-Kirkland Proposed Timeline

Event	Anticipated Month/Year
Anticipated CN Approval	July 2023
Design Complete	NA
Construction Commenced	NA
Construction Completed	NA
Facility Prepared for Survey	NA
Facility Licensed - Project Complete WAC 246-310-010(47)	July 2023

Source: Applicant

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

The new beds will be general medical/surgical beds. The most common inpatient medical conditions treated at EvergreenHealth Kirkland include respiratory and pulmonary conditions, heart failure, septicemia, stroke, and gastrointestinal conditions. On the surgical side, EvergreenHealth Kirkland's most common surgical inpatient procedures include orthopedics, bariatrics, interventional cardiology, and general surgery (including colon/rectal and gastrointestinal).

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

A copy of the letter of intent is included in Exhibit 2.

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

There is no difference in the space layout of the hospital before or after the project. As stated earlier, the beds are located in older units that were taken offline as new units were opened, ensuring EvergreenHealth Kirkland remained within its pre-pandemic licensed bed capacity. Those older units remain licensable spaces and are used as needed when another unit is being remodeled or for surge needs, such as the COVID-19 pandemic. The drawings included in Exhibit 3 identify where these beds are located.

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

All of the buildings on the EvergreenHealth Kirkland hospital campus comprise a total gross square footage of 2,033,999. This amount includes mechanical, electrical, shell and parking facilities. This project does not change the current square footage.

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

This project does not involve any new square footage.

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

EvergreenHealth Kirkland confirmed with CRS staff in August that no filing is required for this project as there is no change in use of any of the units.

Section 4
A. Need (WAC 246-310-210)

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

Including EvergreenHealth Kirkland, there are a total of four (4) hospitals operational in the East King Hospital Planning Area. The other three hospitals include Overlake Medical Center in Bellevue, Swedish Issaquah and Snoqualmie Valley Hospital.

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

EvergreenHealth Kirkland applied the ten-step acute care bed need projection methodology. The methodology requires incorporation of ten years of historical data for planning area residents trended forward for seven years, from which planning area hospital market share is factored in, and ultimately the set-up and available beds of existing providers are subtracted.

Because inpatient discharges and days for all or portions of the last three years (2020-2022) have been impacted by COVID, EvergreenHealth reviewed data for the period 2019-2021 to understand the impact of COVID on bed need (2022 was excluded because full year CHARS data is not available at this time). Table 3 below details the results of this analysis.

Table 3
East King Hospital Planning Area Bed Need, Based on Three Different Baseline Years

Baseline Year	Projection Year	Planning Area Resident Days Occurring in Planning Area Hospitals	Total Days to Planning Area Hospitals (adjusted for market share and in-migration)	Projected ADC	Set up and Available Beds *Source DOH Acute Care Bed Surveys or DOH Year End Reports*	Net Bed Need
2019	2026	119,060	190,446	521.8	695	71 bed need
2020	2027	116,339	184,041	504.2	747	32 bed surplus
2021	2028	119,139	197,235	540.4	747	20 bed need

Source: Applicant

As Table 3 shows and based on inpatient data for the period of 2013-2019, there is need for more than the 36 beds being requested. In the first year of COVID (2020), days of both planning area residents and planning area hospitals decreased partly in response to the State freezing elective surgeries and other admissions. With 2020 as the baseline year, the bed need converts from a net need to a surplus, largely because of the increase in set-up bed capacity at another planning area hospital. In 2021, and despite the continuation of COVID, resident patient days approached pre-pandemic levels, and planning area hospital days increased 5% over pre-COVID levels. The net need is for 20 beds in 2028, the 7-year planning horizon, and all beds being requested are supported by 2030. This increase in planning area hospitals days means that more non-planning area residents used East King hospitals, and CHARS data shows that EvergreenHealth Kirkland received the predominance of those days, because of our border location with Snohomish County.

If the 2020 COVID year was eliminated from the methodology, all 36 beds are needed by 2028; and the elimination of 2020 data appears a reasonable approach. Even if the Program continues to include 2020, Criterion 2 in the State Health envisioned scenarios wherein a hospital in a specific planning area may have need to expand despite surplus capacity at other hospitals in the same planning area. The market and daily census data provided earlier in this Section provides that rationale.

As recently as mid-October 2022, EvergreenHealth Kirkland was over capacity. The overcapacity was attributed to large numbers of patients pending discharge as well as boarding patients, and a growing list of pending and new surgical patients who needed treatment. Further, daily admissions equaled or exceeded the number of daily discharges; and as a result, both inpatient units and overflow areas were at maximum capacity. Unlike many hospitals, EvergreenHealth Kirkland operates 100% of its licensed bed capacity and has no “banked capacity” that it can make operational without prior CN review and approval.

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

The beds will be medical/surgical beds. Table 4 below provides the location of the beds.

Table 4
EvergreenHealth Kirkland Bed Capacity by Unit

	BEDS PRE-PANDEMIC	LOCATION / UNIT	BEDS CURRENT / TO BE RETAINED	LOCATION/ UNIT
Medical/Surgical/ Acute Care	20	2 Red	20	2 Red
	0	3 Silver	20	3 Silver
	31	4 Silver	31	4 Silver
	31	5 Silver	31	5 Silver
	32	6 Silver	32	6 Silver

	BEDS PRE-PANDEMIC	LOCATION / UNIT	BEDS CURRENT / TO BE RETAINED	LOCATION/ UNIT
	32	7 Silver	32	7 Silver
	32	8 Silver	32	8 Silver
	34	2 Blue	34	2 Blue
	15	4 Blue	15	4 Blue
	34	5 Blue	38	5 Blue
	0	2 Purple	12	2 Purple
Sub-total	**261**		**297**	
PPS Exempt Psych	0	-	0	-
PPS Exempt Rehab	14	4 Purple	14	4 Purple
NICU Level II	29	4 Blue	29	4 Blue
NICU Level III	14	4 Blue	14	4 Blue
NICU Level IV	0	-	0	-
Specialized Pediatric	0	-	0	-
Grand Total	**318**		**354**	

Source: Applicant

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

Table 5 provides the requested information.

Table 5
EvergreenHealth Kirkland Historical Utilization, 2019 2022 (Annualized)

Medical Surgical Beds	2019	2020	2021	2022 YTD August Annualized
Licensed beds	261	261	261	261
Available beds	261	297	297	297
Discharges	14,737	13,312	14,202	14,426
Patient days	62,587	61,150	67,667	74,217
Entire Hospital	**2019**	**2020**	**2021**	**2022 YTD August Annualized**
Licensed beds	318	318	318	318
Available beds	318	354	354	354
Discharges	16,630	15,271	16,517	16,796
Patient days	75,134	73,486	57,791	86,687

Source: Applicant

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

EvergreenHealth Kirkland has very conservatively assumed a 1.5% annual increase in admissions per year for medical/surgical beginning in 2022. This is consistent with population growth and aging in the Planning Area. We have also assumed a decrease in ALOS beginning in 2023 and extending to 2026. The annual length of stay reduction is .05 per year until 2016 and then constant thereafter (see Table 6).

Table 6
EvergreenHealth-Kirkland Projected Utilization, 2023 2029

Medical/Surgical	2023	2024	2025	2026	2027	2028	2029
Licensed beds	297	297	297	297	297	297	297
Available beds	297	297	297	297	297	297	297
Admits	15,265	15,630	16,002	16,382	16,770	16,770	16,770
Patient days	76,784	77,838	78,892	79,945	80,999	80,999	80,999

Source: Applicant

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

A patient origin study, based on 2021 actual inpatient utilization is included as Exhibit 4.

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

While we cannot speak to patient demand in other hospitals in the Planning Area, as shown in Table 7 below, EvergreenHealth Kirkland has averaged over 85% occupancy with nearly 90% of days exceeding 80-85% midnight capacity. During the weekday, 80% of days exceed 80-85% occupancy.

Delays in being able to place ED patients in an inpatient bed is causing the "left without treatment" ED patient volume to increase, which delays or defers necessary care. Approximately 15-20 patients leave our ED without treatment each day due to bed pressures. In addition, and as mentioned earlier, approximately 15% of EvergreenHealth Kirkland's licensed bed capacity is taken up by the difficult to discharge patients that are waiting for post-acute skilled nursing beds. This again places pressure on beds and delays needed inpatient care for others.

Table 7
EvergreenHealth-Kirkland Medical/Surgical Occupancy, First 230 Days of 2022

	Midnight Census
Current Licensed Medical/Surgical Beds	261
Avg. Daily Census (ADC)	228.5
State Health Plan Target Avg. Occupancy	70%
Actual Avg. Occupancy	87.5%
Occupancy	
100%	6
95% - 99%	20
90% - 94%	60
85% - 89%	72
80% - 84%	45
75% - 79%	20
70% - 74%	5
Target Occupancy per SHP: 70%	228
65% - 69%	2
60% - 64%	0
Less than 60%	0

Source: Applicant and based on inpatients who were in a bed at midnight .

This high occupancy, coupled with the lack of post-acute discharge options in the region is restricting patient access. Without making permanent the 36 beds, EvergreenHealth Kirkland will be forced to restrict new admissions and operate significantly above optimal occupancy levels. This leads to inefficiencies and delays as patients are held longer in the ED while awaiting a bed, surgeries are postponed or delayed because no post-recovery beds are available, or patients are transferred to other hospitals (if they have capacity).

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

EvergreenHealth is a Public Hospital District with accountability to serve ALL district residents, including underserved groups. As the admissions policy and charity care/financial assistance policies included in Exhibit 5 demonstrate, admission to EvergreenHealth Kirkland is based on clinical need. Services are made available to all persons regardless of race, color, creed, sex, income, national origin, or disability. EvergreenHealth Kirkland also has a sliding fee schedule as part of its financial assistance program.

For hospital charity care reporting purposes, the Department divides Washington State into five regions. EvergreenHealth Kirkland is located in the King County region. According to 2018-2020 charity care data produced by the Department (the latest data available), the three-year charity care average for the Region excluding Harborview, was 1.18% of gross revenue and 2.65% of adjusted revenue. During the same time frame, EvergreenHealth Kirkland's charity care was 0.37% and 0.76%, respectively. The amount of charity care in the pro forma financials is slightly higher than historical and is based on the most recent experience (0.44% of gross revenue).

As a community owned hospital, led by a community-elected board, EvergreenHealth's mission is to advance the health of the communities it serves through its dedication to high quality, safe, compassionate, and cost-effective health care. The goal is to lower the barriers to high-quality care for <u>everyone</u>. In addition, to providing a full spectrum of health care and access to all community residents, EvergreenHealth Kirkland funds programs that target specific segments of the populations that have the potential for being underserved. Programs in place during 2021 included:

Breaking Barriers to Health and Social Services

Community Healthcare Access Team (CHAT): One of EvergreenHealth's primary programs that serves as a conduit for the underserved is the Community Healthcare Access Team (CHAT). The CHAT team works in partnership with many community organizations to assist low-income, underinsured, and uninsured community residents who face barriers to accessing affordable health and social services. This program focuses on assisting community members in accessing healthcare resources, including long term care solutions, financial assistance, referrals to primary and specialty providers, and connecting members with insurance options. The staff are specifically trained in Medicaid and Medicare eligibility, are certified as navigators for Washington's Healthplanfinder and provide connection and insight into community resources designed to support residents' wellbeing.

Supporting the Community's Youth

Supporting Students in Crisis: EvergreenHealth provides social workers to Lake Washington School District high schools to assess students with high-risk behaviors and mental health concerns. The EvergreenHealth social workers meet with students 1:1, conduct groups, provide support to parents, and coordinate with school officials to keep students safe and connected to community providers. In 2021, our social workers helped 401 high school students during mental health crises.

High School Mental Health Therapists: Community funds also help the Northshore School District provide students access to mental health counselors who meet individually and in small groups to address student needs. Supportive resources are also made available to students grieving the loss of a loved one. In 2021, EvergreenHealth therapists served 1,264 students and responded to 47 crisis visits.

Youth Mental Health First Aid: EvergreenHealth's free Youth Mental Health First Aid training provides educators, coaches and other volunteers who work with students the tools to help adolescents experiencing a mental health crisis or addiction challenge. Participants are taught how to recognize signs and symptoms of mental health challenges and crises, what to say and how to talk with someone, and how to refer to professional resources for help.

STEM Global Health Education Partnership: EvergreenHealth partners with local school districts to give students the opportunity to learn about global health initiatives through job shadowing, attending Grand Rounds and hearing from guest speakers. These kinds of partnerships give students the opportunity to immerse themselves early on in learning about careers in science, health care and so many other industries.

Community Health Needs

EvergreenHealth Nurse Navigator & Healthline: In 2021, our 24/7 Nurse Navigator & Healthline served more than 108,000 community callers, helping with scheduling, referrals and answering health-related questions at no cost. Healthline played a pivotal role in 2021, connecting thousands of community members with accurate information on COVID-19 and pandemic resources. More than 50,000 callers received nursing triage advice, getting help with home remedies for common ailments as well as diagnostic support for various illnesses.

Community Health Education Services: EvergreenHealth's Community Health Education Services provided more than 790 community-funded classes and programs in 2021. Roughly 4,300 community members participated. As a community-owned health system, our curriculum and programs look to address the diverse needs of our region while building a sense of community around common interests.

Hospice Care Center: The Gene & Irene Wockner freestanding hospice center at EvergreenHealth has 15 beds and serves hospice patients in King and Snohomish counties. It is the only hospice center in both counties and provides terminal patients and their families with short-term acute care, with the goal of discharging to home once symptoms have been stabilized.

Palliative Medicine: Our Palliative Medicine program uses levy funds to support a care team that serves families and loved ones who are facing a serious illness. In 2021, these providers helped patients and their families overcome physical and emotional challenges following a concerning diagnosis.

Health Services for Seniors

EvergreenHealth Geriatric Care: This dedicated team develops specialized treatment plans for older adults with complex health needs. This includes expert assessment and treatment of dementia and behavioral health conditions.

The transitional care management program provides expanded support and resources for patients as they transition from the hospital to home, or between clinic visits. The goal of this program is to reduce hospital readmission rates by addressing health issues as they arise.

The Chronic Care Management program is a vital part of the services provided by EvergreenHealth Geriatric Care. It is recognized by Medicare as a program that provides comprehensive and individualized care planning and management of chronic conditions.

Northshore Senior Center: EvergreenHealth funds and provides health and wellness programs to older adults in the local community through the Northshore Senior Center (NSC) and the Adult Day Health Center. The funding includes seven evidence-based programs such as NSC's Enhance® Wellness program, designed to decrease the length of

participants' hospital stays, alleviate symptoms of mood disorders, and encourage older adults to maintain control of their lives through a participant-centered approach.

At the Northshore Senior Center in 2021, more than 230 seniors participated in programs that helped improve their physical and cognitive functioning despite the challenges posed by the pandemic.

Additionally, the community funded NSC Adult Day Health program offered 84 virtual health and wellness classes to encourage movement, fine motor skills, strengthening and other mental and physical rehabilitation services in 2021.

Through EvergreenHealth's community funds, 245 family caregivers were served via programming, consultations, and other services.

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

This question is not applicable.

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

This question is not applicable.

11. Provide a copy of the following policies:

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

All requested policies are included in Exhibit 5.

Section 5
Financial Feasibility (WAC 246-310-220)

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

All requested financial information is included in Exhibit 6.

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

EvergreenHealth Kirkland operates on a calendar year.

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

EvergreenHealth Kirkland is owned by the community and operated by a community-elected board. No such agreements are in place related to the ownership or operation of the licensed beds at the hospital.

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

There is no lease. Exhibit 7 includes documentation that the owner of the property is King County Hospital District No. 2.

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

This information is included in Exhibit 7.

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

The requested information is in Table 8.

Table 8
Capital Expenditure

Item	Cost
a. Land Purchase	$0
b. Utilities to Lot Line	$0
c. Land Improvements	$0
d. Building Purchase	$0
e. Residual Value of Replaced Facility	NA
f. Building Construction	$0
g. Fixed Equipment (not included in the construction contract)	$0
h. Movable Equipment	$112,250
i. Architect and Engineering Fees	$0
j. Consulting Fees	$0
k. Site Preparation	$0
l. Supervision and Inspection of Site	$0
m. Any Costs Associated with Securing the Sources of Financing	
1. Land	$0
2. Building	$0
3. Equipment	$0
4. Other	$0
n. Washington Sales Tax	$12,750
Total Estimated Capital Expenditure	**$125,000**

Source: Applicant

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

The capital expenditure is limited to beds. EvergreenHealth Kirkland's construction department provided the estimate.

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

The beds have been operational since early 2020. There are no start-up costs.

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

There are no start-up costs. This question is not applicable.

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

There is no construction. This question is not applicable.

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

The capital expenditure for the project is minimal at $125,000 and has a negligible impact on costs and charges for health services. If that number is divided across the entire 36 bed project, it amounts to only $3,472 per bed. The beds being retained at EvergreenHealth Kirkland will support efficiencies and timely care delivery. Over time we expect that the additional beds will reduce the total of cost of care by reducing patients leaving without being seen in the ED (who then show up later and sicker); and by allowing our staff to be as efficient as possible in care delivery. Further, reducing the overcrowding situation is expected to help support staff retention. The cost of replacing a staff member who elects to leave is very high at this point; both because of the need for travelers and because of the high cost and time required to recruit.

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

Since these beds are already operational, the projected payer mix is the same as the actual 2021 medical/surgical payer mix, which is provided in Table 9.

Table 9
EvergreenHealth-Kirkland Current and Projected Payer Mix

Payer Mix	Percentage by Gross Revenue	Percentage by Patient
Medicare Traditional	29.2%	23.0%
Managed Medicare	21.3%	15.2%
Medicaid	11.6%	12.1%
Commercial	35.9%	48.1%
Other Government (L&I, VA, etc.)	1.7%	1.2%
Self-Pay	0.3%	0.4%
Other Payers (please list)	0.0%	0.0%
Total	**100.0%**	**100.0%**

Source: Applicant

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

Please see the response to Q12, above.

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

The four beds will be the standard bed that EvergreenHealth uses for medical/surgical units. They are Linet Multicare LE beds.

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

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

The project will be funded from our routine capital budget and thus not require any financing. A letter from EvergreenHealth Kirkland's CFO is included as Exhibit 8.

16. Provide the most recent audited financial statements for:

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

The most recent audited financial statement is included as Appendix 1.

Section 6
Structure and Process of Care (WAC 246-310-230)

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

King County Public Hospital District No. 2 owns and operates EvergreenHealth. In addition, and through a formal alliance agreement, EvergreenHealth operates EvergreenHealth Monroe.

The license and certification numbers for EvergreenHealth Kirkland was provided in Section 1. The information for EvergreenHealth Monroe is below.

License: HAC.FS.00000104

Medicare: 50-00084

Medicaid: 1042500

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

The requested staffing information is included in Exhibit 9.

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

The beds are already operational and staffed. The information provided is based on actual operating experience.

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

The requested information is in Table 10.

Table 10
EvergreenHealth-Kirkland Key Clinical Staff

Name	Position	License Number
Ettore Palazzo, MD, FACP	Chief Medical & Quality Officer	MD00040026
Mary Shepler, RN, BSN, MA, NEA-BC	Chief Nursing Officer	RN60959647
Sandra Kreider, RN	Executive Director, Acute Care & Nursing	RN00114733
Leonora Apigo, RN	Executive Director, Medical Surgical and Nursing Resources	RN00122703
Brandon Au, MD	Medical Director, Adult Hospitalists	MD60399956

Source: Applicant

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

EvergreenHealth is currently staffing all 36 beds. Like all hospitals in the region/nation, EvergreenHealth is experiencing significant wage/benefits competition and workforce shortages in the market. We expect to hire over 1,100 employees this year (compared to 988 in 2021 and 767 in 2020) across the whole organization. Our organizational turnover, excluding per diem employees, of 18.2% as of August 2022 is lower than the national benchmark (18.8% per the Advisory Board Company) and Pacific/West regional benchmark (19.8% per the Advisory Board Company or 23.1% per the NSI Retention Report) for healthcare organizations.

We have instituted a number of recruitment strategies, including increasing the capacity in our RN Residency Program and New-to-Specialty Training Program, closely partnering with local schools, opening our talent pool to incorporate foreign-born RNs, implementing a recruitment platform to increase the number of candidates, assigning dedicated recruiters by nursing specialty, implementing recommendations from an external recruitment and retention assessment, and working towards Magnet designation. In addition, we are supplementing with travel nurses and offering overtime and incentive pay to our employees who pick up additional hours.

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

This question is not applicable.

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

The requested information is in Table 11.

Table 11
EvergreenHealth Kirkland Ancillary and Support Services

Services Provided	Vendor
Linen service	Sterile Surgical Systems
Pathology	Cellnetix
Janitorial services	Provided by in-house staff
Biomedical	Renovo Solutions
Biomedical waste	Trilogy MedWaste; sharps and pharmacy waste handled by Stericyle
Dietary	Management provided by Thomas Cuisine; non-management provided by in-house staff
Respiratory Therapy	Provided by in-house staff
Pharmacy	Provided by in-house staff
Imaging	Technical services provided by in-house staff; professional services provided by Radia

Source: Applicant

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

The beds have been operational for 2.5 years; no changes will result by making them permanent.

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

EvergreenHealth enjoys strong and collegial relationships with other healthcare facilities in the planning area and the region, including hospitals, nursing homes, post-acute and long-term care providers, primary care, and specialty providers. We also have a strong working relationship with public health.

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

No relationships will change. These beds have been operational for 2.5 years.

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

This question is not applicable.

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

The loss of 36 beds of medical/surgical capacity would have a negative impact on continuity of care as we would be forced to delay admissions, divert from the ED and/or transfer patients. Actual 2020-2021 COVID experience demonstrates that delaying admission results in sicker patients, higher acuity, and longer lengths of stay when they are finally admitted. When an ED goes on divert, it has consequences to the larger EMS system, and in our case means that ambulances are out-of-service longer when patients are transported away from the closest hospital, putting at risk timely 911 responses. Transferring patients often means duplicate testing and a new provider; which again is proven to increase costs and length of stay; all of which can and often do impact continuity of care.

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

Without being able to make the beds permanent, on many days EvergreenHealth Kirkland will operate at census levels that approach or exceed 100% occupancy. For all of the reasons noted in response to Q12 above, these levels will have a negative impact on other providers including other hospitals, EMS and long-term care as we seek to divert or transfer.

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

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

No EvergreenHealth facility or provider has any history related to criteria included in this question.

Section 7
Cost Containment (WAC 246-310-240)

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

The impact of maintaining Proclamation 20-36 waiver beds versus reverting back to pre-COVID medical/surgical bed capacity was discussed throughout this application. The State's acute care bed need projection methodology supports making the beds permanent as does the actual operating experience of EvergreenHealth Kirkland. Without the beds, the average midnight occupancy will result in too many days when the facility is at capacity and patients are diverted, delayed or choose to leave without being seen. Over time, these diversions and delays fragment care delivery and increase the total cost of care delivered.

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

The beds are already staffed, and the capital cost is minimal. Data suggests that a loss of these beds will decrease operational efficiency, increase cost and challenge the ability of EvergreenHealth to provide the level of quality that we are known for, and that we demand of ourselves.

3. **If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):**
    - **The costs, scope, and methods of construction and energy conservation are reasonable; and**
    - **The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.**

This project does not involve construction.

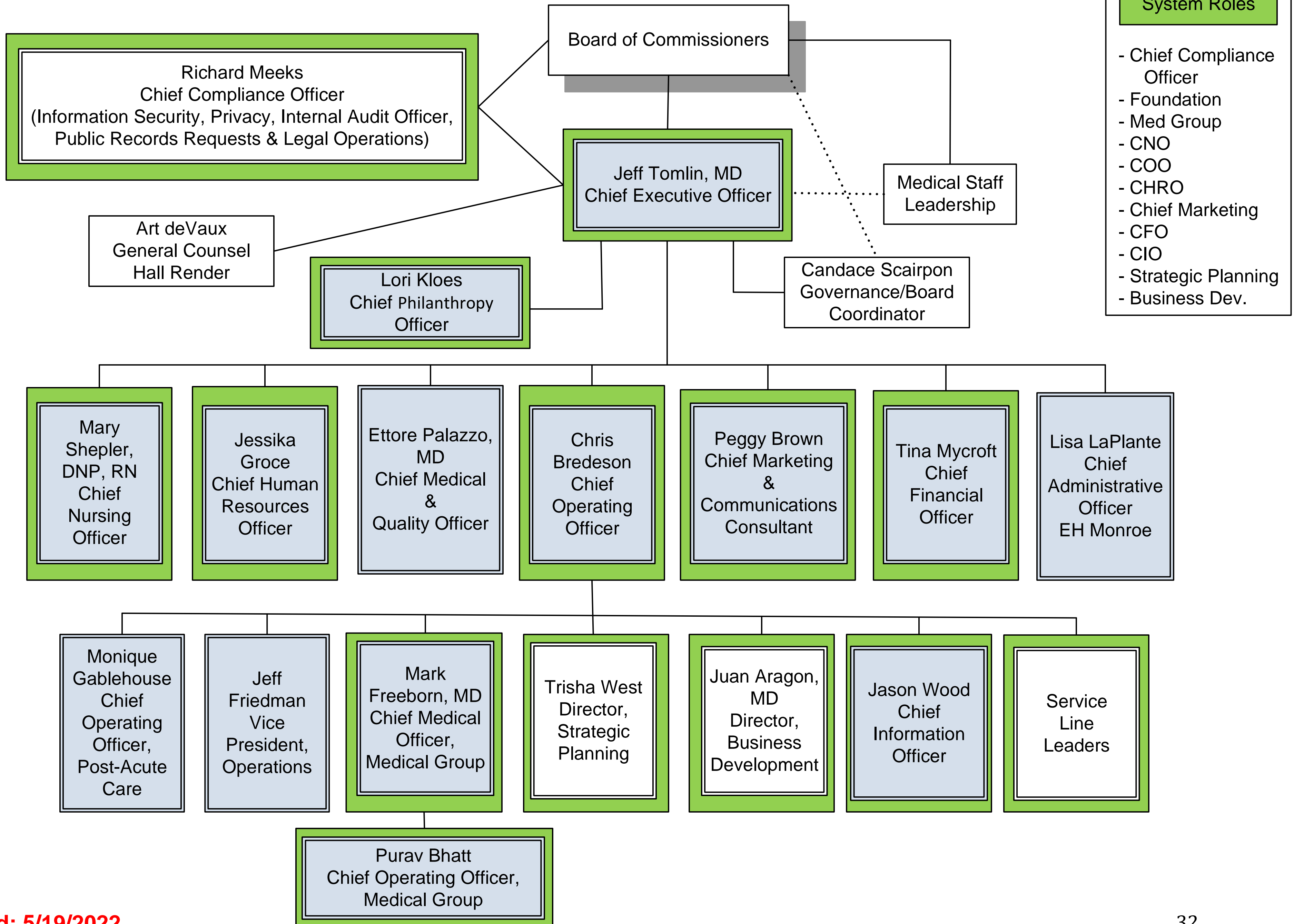
4. **Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.**

This project will support the delivery of high-quality and cost-effective health services. The loss of beds would mean that EvergreenHealth Kirkland operates at occupancy levels that can compromise workflows and processes. The high occupancy would also compromise our ability to retain our quality staff at a time when assuring workforce has optimal conditions is a top priority.

Exhibit 1
Organizational Chart

Org Structure

Senior Leadership Organizational Chart



Legend

- Sr. Leadership Position
- System Roles

- Chief Compliance Officer
- Foundation
- Med Group
- CNO
- COO
- CHRO
- Chief Marketing
- CFO
- CIO
- Strategic Planning
- Business Dev.

Revised: 5/19/2022

Exhibit 2
Letter of Intent

From the office of Jeffrey J. Tomlin, MD, Chief Executive Officer

August 26, 2022

COVID Off-Boarding Program
State of Washington
Department of Health
Olympia, WA

Sent via COVIDwaiver@doh.wa.gov

RE: Letter of Intent in Response to the Governor Rescinding Proclamation 20-36 Waivers of Certificate of Need, Construction Review & Facility Licensing Requirements

Dear COVID Off-Boarding Program:

In accordance with WAC 246-310-080, EvergreenHealth hereby submits a letter of intent proposing to maintain additional bed capacity that was established under the Proclamation 20-36 waivers. The effect would be an increase in the licensed acute care bed capacity at EvergreenHealth which we have determined necessary to address both our continued bed pressure and patient care demands in the region. Below we have provided the information required by WAC, as well as the additional information requested by DOH.

1. A Description of the Services Proposed / A Description of the Increase in Capacity and/or New Locations the Facility Wants to Maintain:
   EvergreenHealth is proposing to maintain an additional 36 acute care beds within existing established patient care units. All but 4 of these beds are currently and actively available to patients in our Kirkland facility (4 of the rooms had equipment redeployed to other areas). All permanent bed locations meet applicable acute care bed facility licensing requirements.

2. Estimated Cost of the Proposed Project:
   The capital expenditure associated with this project is approximately $125,000 to equip four new inpatient rooms to reduce the likelihood of boarding in our Emergency Department. All other areas are already equipped.

3. Description of the Service Area:
   This project will provide services to residents of EvergreenHealth's service area which has historically included portions of East King and Southeast Snohomish Counties.

4. Patient Transition Plan (should the department not approve the application):

   a. *Average number of clients*: On a regular basis, EvergreenHealth exceeds the optimal 70% occupancy rate of our medical/surgical licensed bed capacity by an average of 30 patients. At this time, our occupancy rate is 82%. Our bed pressures are exacerbated when observation patients are included which increases our occupancy rate to 89%. We are requesting the ability to retain the 36 beds to improve patient flow and ensure we continue to have flexibility during peak times and avoid boarding admitted patients in the Emergency Department.

12040 NE 128th Street MS#14 Kirkland, WA 98034 *Phone:* 425 . 899 . 2490 *Fax:* 425 . 899 . 2624
jjtomlin@evergreenhealth.com evergreenhealth.com

b. *List of similar facilities that could provide care to clients*: Similar facilities include acute care hospitals within a 15-mile draw area, such as Overlake, Swedish Edmonds, and the University of Washington Medical Center. We cannot guarantee that these facilities have capacity given the bed pressures facing the entire Puget Sound area.

c. *Steps to be taken for patients to be transitioned, if needed*: EvergreenHealth would close all the waiver/surge units if our application is denied. If inpatient demand continues to exceed our licensed capacity, and there is no additional capacity in the other Puget Sound Area hospitals, we will delay the scheduling of non-emergency inpatient surgeries and continue to board patients in the Emergency Department until capacity opens. We will also use the pre-pandemic surge rules that allow hospitals to exceed licensed bed capacity under certain circumstances. If there is inpatient capacity at other area hospitals, we will transfer emergent patients via ambulance. In addition, and with the state's help, we will aggressively try to discharge long-stay patients that are waiting for a SNF or long-term care bed. It is important to note, that patients do not stop needing inpatient care just because capacity is limited. Even though we have a *No Divert Agreement* along with other King County Hospitals, EvergreenHealth has had to be on divert recently as there were no additional beds for patients to be placed into, including no boarding space in the Emergency Department. This also means progressively longer wait times in the Emergency Department and higher numbers of "left without treatment" patients. That scenario then strains other healthcare providers in the community. Therefore, if the application is denied, EvergreenHealth may be forced into increasing instances of being on divert status or patients waiting for extended periods to be treated.

d. *Transition timeline for clients to CN approved facilities/services if an application is denied*: In order to transition patients to other facilities, EvergreenHealth will need the support of the state to help place patients that are waiting for a SNF or long-term care bed. With that support, and depending on the population admitted at that time, we will need at least two weeks to complete the discharging of those patients, temporarily stop non-emergency inpatient procedures from being scheduled to open capacity, as well as to communicate the unit closures and redeploy staff appropriately within our system. We are not optimistic that the safe discharge and transfer of patients will be possible given the circumstances that currently exist in the healthcare provider community. Some of the circumstances are longstanding issues exacerbated by the pandemic that are not improving and will require further intervention by the legislature or state agencies. Therefore, EvergreenHealth strongly advocates for the additional flexibilities that have been provided under the waivers to continue.

EvergreenHealth appreciates DOH's glidepath to maintain capacity established under the waivers that enables us to continue providing essential acute care services to our community. We will follow the glidepath protocols and submit a second letter of intent by September 27, 2022 to the Certificate of Need department, followed by an application by October 27, 2022.

Please feel free to contact me directly with any questions at (425) 899-2490 or at jjtomlin@evergreenhealthcare.org.

Very respectfully,

Jeff Tomlin, MD
Chief Executive Officer

EvergreenHealth
From the office of Jeffrey J. Tomlin, MD, Chief Executive Officer

September 26, 2022

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852
Sent via fslcon@doh.wa.gov

RE: Letter of Intent to Add Acute Care Beds

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, EvergreenHealth hereby submits a letter of intent proposing to increase licensed acute care beds at EvergreenHealth Medical Center-Kirkland. Throughout the Governor's Proclamation 20-36, EvergreenHealth Medical Center-Kirkland operated beds beyond its licensed capacity. This application will allow the Hospital to make permanent this additional bed capacity. We believe this additional capacity is necessary if we are to address our continued bed pressures and patient care demands.

In conformance with WAC, the following information is provided:

1. A Description of the Services Proposed:
   EvergreenHealth is proposing to increase its acute care capacity by 36 beds.

2. Estimated Cost of the Proposed Project:
   The capital expenditure is approximately $125,000.

3. Description of the Service Area:
   This project will provide services to residents of EvergreenHealth Medical Center-Kirkland's service area which has historically included portions of East King and Southeast Snohomish Counties.

   Consistent with planning area definitions identified in the State Health Plan, EvergreenHealth is located in the East King Hospital Planning Area.

Please feel free to contact me directly with any questions at (425) 899-2490 or at jjtomlin@evergreenhealthcare.org.

Sincerely,

Jeff Tomlin, MD
Chief Executive Officer

12040 NE 128th Street MS#14 Kirkland, WA 98034 *Phone:* 425 . 899 . 2490 *Fax: 425 . 899 . 2624*
jjtomlin@evergreenhealth.com evergreenhealth.com

Exhibit 3
Single Line Drawings

EvergreenHealth Medical Center-Kirkland
Level 2

Pre-Pandemic View

EvergreenHealth Medical Center-Kirkland
Level 2

Post-Pandemic View: Yellow highlighted areas identify post-pandemic beds to maintain, with 20 on 2-Red and 12 on 2-Purple

EvergreenHealth Medical Center - Kirkland
Level 5

Pre-Pandemic View

EvergreenHealth Medical Center - Kirkland
Level 5

Post-Pandemic View: Yellow highlighted area identifies 4 post-pandemic beds to maintain on 5-Blue

Exhibit 4
Patient Origin

Zipcode	2021 Discharges	% of Total
98034	1,604	11.3%
98052	1,164	8.2%
98012	1,110	7.8%
98011	942	6.6%
98021	848	6.0%
98033	810	5.7%
98072	763	5.4%
98028	659	4.6%
98272	553	3.9%
98296	413	2.9%
98077	286	2.0%
98290	285	2.0%
98053	274	1.9%
98208	243	1.7%
98019	236	1.7%
98036	212	1.5%
98294	186	1.3%
98258	172	1.2%
98087	171	1.2%
98074	151	1.1%
98007	128	0.9%
98014	117	0.8%
98004	115	0.8%
98204	112	0.8%
98251	111	0.8%
98037	111	0.8%
98008	100	0.7%
98155	90	0.6%
98270	82	0.6%
98203	76	0.5%
98026	73	0.5%
98275	69	0.5%
98005	66	0.5%
98006	59	0.4%
98043	52	0.4%
98223	51	0.4%
98201	49	0.3%
98271	47	0.3%
98075	41	0.3%
98059	40	0.3%
98133	39	0.3%
98056	38	0.3%
Other	1,454	10.2%
Total	**14,202**	100.0%

Exhibit 5
EvergreenHealth Policies

EvergreenHealth

DocID:	29018
Revision:	1
Status:	Official
Department:	Patient Care
Manual(s):	

Policy : Patient Access

POLICY:

EvergreenHealth will provide patient access to all of its services in accordance with this policy and its Nondiscrimination in Provision of Healthcare Services Policy.

PURPOSE:

To strive to facilitate and assure patient access to EvergreenHealth services and to assure that no person shall be discriminated against in regard to benefits or services. In order to help its patients, EvergreenHealth shall provide upon request Financial Counseling and the estimated cost of services insofar as possible.

DUTIES:

Patient Access Department

EvergreenHealth shall have a Patient Access Department ("Department") under the supervision of the Manager - Patient Access. The Department shall, with regard to EvergreenHealth Medical Center ("Hospital"), among other duties:

1. Provide all necessary and helpful information and assistance to the patient as he/she enters the Hospital.
2. Obtain information from incoming patients to be utilized by Hospital departments and patient care providers.
    a. This includes verification of all demographic information and any necessary Consent for Care or Financial Agreement forms.
    b. Provide Patient or Advocate with Information regarding their Privacy and Patient Rights.
3. Coordinate the time of the patient's arrival with any scheduled surgery or procedure.
4. Facilitate all direct transfers from outside facilities in coordination with the Hospital's Nursing/Patient Flow Supervisor, Care Management team and admitting physician, as necessary.
5. Present a positive and professional first impression to all who enter the Hospital.

Inpatient, Emergency Department, Urgent Care & Outpatient Surgery Registration

The Department shall:

1. Interview incoming patients to obtain required personal, demographic and billing information, and complete the necessary Medicare Admission Inquiry as may be required. The Department shall forward billing information to the Insurance Verification Office prior to the patient's admission to verify eligibility, pre-authorization, and benefits, although the Emergency Department shall comply with all necessary EMTALA requirements.
2. Obtain signatures for Consent for Care and a Financial Agreement with each admission/visit.
3. Screen and provide information to all adult patients concerning Advance Directives. It is EvergreenHealth's policy that each patient have an appropriate Advance Directive insofar as possible.
4. Obtain signatures from the patient or patient's representative on the Important Message from Medicare, MOON acknowledgement and Important Message from Tricare as required. Complete Medicare Secondary Payor screening on all Medicare eligible admissions.
5. Provide information to all patients or their advocate on Patient Rights and Responsibilities.
    a. For Incapacitated patients, Registration will contact any known listed emergency contact at time of admission. If no emergency contact available, Registration will notify Social Work for appropriate follow-up
    b. Coordinate direct admits with the Hospital's House Supervisor.

6. Escort patients needing assistance to their rooms or other Hospital location upon admission.
7. Register and process all outpatients for surgical and special procedures.
8. Maintain safekeeping of patient valuables, including both the securing of items upon admission and the return of the valuables upon discharge or patient request.
9. Collect payments (co-pays, deposits) from patients and issue receipts as needed.

Outpatient/Clinic Registration

The Department shall:

1. Register patients for outpatient services including, but not limited to, lab, diagnostic imaging, primary care and specialty clinics.
2. Direct patients to the care areas and coordinate schedules when the patient is to have services in more than one department.
3. Obtain signatures for Consent for Care and Financial Agreement annually.
4. Provide information to all patients or their advocate on Patient Rights and Responsibilities.
    a. For Incapacitated patients, Registration will contact any known listed emergency contact at time of admission.
    b. If no emergency contact available, Registration will notify Social Work for appropriate follow-up
5. Screen and provide information to all adult patients concerning Advance Directives.
6. Obtain signatures from the patient or patient's representative on the Important Message from Medicare and Tricare as required. Complete Medicare Secondary Payor screening on all Medicare eligible admissions.
7. Provide information to all patients on Patient Rights and Responsibilities.
8. Collect payments (co-pays, deposits) from patients and issue receipts as needed.

Document Owner: Gould, Richard C

Collaborators:

Approvals

- Committees:

- Signers: Richard C Gould

Richard C Gould, Dir-Revenue Cycle (01/11/2018 12:37PM PST)

Original Effective Date: 04/10/2014

Revision Date: [04/10/2014 Rev. 0], [01/11/2018 Rev. 1]

Review Date:

Attachments:
(REFERENCED BY THIS DOCUMENT)

Charity Care Program
Financial Counseling
Nondiscrimination in Provision of Healthcare Services
Nondiscrimination in Provision of Healthcare Services Policy
Self Pay Discount Policies

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at
https://www.lucidoc.com/cgi/doc-gw.pl?ref=everg5:29018.

EvergreenHealth

DocID:	Adm 160
Revision:	11
Status:	Official
Department:	Financial and Materials Management
Manual(s):	Compliance

Policy : Charity Care Program

I. Scope

This policy applies to all EvergreenHealth (EH) hospitals and to all emergent and medically necessary services provided by EH hospitals.

II. Policy Statement

EvergreenHealth is guided by a mission to advance the health of the community it serves through our dedication to high quality, safe, compassionate, and cost-effective health care. In recognition of the need of individuals with limited financial resources to obtain emergent and medically necessary hospital health care services, EH herewith adopts a Charity Care Program (the "**Program**").

III. Reason for Policy (Purpose)

To provide, within reasonable limitations and the financial ability of EH, emergent and medically necessary hospital health care services to patients who do not have sufficient financial resources to pay for services rendered or to be rendered. The Program provides for evaluation, consistent with the criteria stated below, of financial need of the patient or responsible party for the patient.

IV. Who is Affected by this Policy

Including but not limited to the following:

- All EH staff who perform functions relating to registration, admissions, or billing
- EH vendors who perform functions relating to registration, admissions, or billing
- All Emergency Department employees
- Administration, directors, managers and supervisors

V. Who Should Read This Policy

Including but not limited to the following:

- All EH staff who perform functions relating to registration, admissions, or billing
- EH vendors who perform functions relating to registration, admissions, or billing
- All Emergency Department employees
- Administration, directors, managers and supervisors

VI. Definitions

EvergreenHealth (EH): For the purposes of this policy, "EvergreenHealth" includes King County Public Hospital District No. 2 d/b/a EvergreenHealth (EvergreenHealth Medical Center, EvergreenHealth Pain Center and Evergreen Surgical Clinic Ambulatory Surgery Center), and Snohomish County Public Hospital District No. 1 d/b/a EvergreenHealth Monroe.

Charity Care: Medically necessary hospital health care rendered to indigent persons when third-party coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer, as determined by the department. Charity care is also referenced as Financial Assistance.

Indigent Persons: Patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200% 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 payor.

Third-Party Coverage: An obligation on the part of an insurance company, health care service contractor, health maintenance organization, group health plan, government program, tribal health benefits, or health care sharing ministry as defined in 26 U.S.C. Sec. 5000A to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others which have resulted in the medical condition for which the patient has received hospital health care service. The pendency of such settlements, judgments, or awards must not stay hospital obligations to consider an eligible patient for charity care.

Family: A group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family.

Federal Poverty Level (FPL): The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

VII. Policy Procedures

Eligibility Requirements:

A. The patient requesting charity care must be a Washington State resident.

1. For purposes of this policy, a patient is considered a resident of Washington if
    1. the patient is not entering Washington State solely for the purpose of seeking medical care, and

2. prior to the beginning of the course of care, the patient's primary residence is located in the State of Washington.
2. Exceptions to the Washington State residency requirement in the Charity Care Policy are:
   1. A patient who has an emergency medical condition, consistent with applicable federal and state laws and regulations.
   2. A refugee, asylee, or a person seeking asylum who possesses and can present United States Citizenship and Immigration Services (USCIS) documentation.

B. Patient with income within EH's Poverty Guidelines (refer to Hospital's Sliding Fee Schedule) which are based on the Federal Poverty Guideline.

C. Patient has been screened and determined ineligible for Medicaid or other state programs.

D. Patient must first exhaust all other funding sources for which the patient may be eligible.

Criteria for Evaluation:

A. Charity care will be granted to all eligible persons regardless of age, race, color, religion, sex, sexual orientation or national origin in accordance with WAC Chapter 246-453 and RCW 70.170 .

B. Requests for charity care will be accepted from any source. Typically that will be patients, family members, physicians, community or religious groups, social services or financial services personnel. If the hospital becomes aware of factors which might qualify the patient for charity care under this policy, it will advise the patient of this potential and make an initial determination.

C. The patient indicates and appropriately and adequately demonstrates an inability to pay for services rendered or to be rendered. For all purposes of this Policy and the Program, all references to "patient" shall include, as may be applicable, the responsible party for the patient. The Program recognizes, addresses, and is limited to the needs of patients who are "indigent persons" as defined by WAC 246-453-010(4), which may include those who need assistance with medical bills due to temporary or permanent disability or inability to work as a result of catastrophic illness or injury.

D. In the event that there are limited charity care resources due to budgetary constraints, District residents may be granted priority consideration of charity care eligibility for non-emergency care only. Under no circumstances will the Hospital deny access to emergency care to any individuals based on an inability to pay and/or inability to qualify for charity care.

E. Pursuant to RCW 70.170.020(4) services covered under the Program shall include medically necessary hospital health care rendered to indigent persons when third-party coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer, as determined by the department.

F. When a patient wishes to apply for charity care sponsorship in the Program, the Patient shall complete a Charity Care/Financial Assistance Application Form ("**application**") and provide necessary and reasonable supplementary financial documentation to support the entries on the application. The application procedures shall not place an unreasonable burden upon the patient, taking into account any barriers which may hinder the patient's capability of complying with the application procedures. Screening for eligibility for DSHS Medicaid will be coordinated through the EH contracted DSHS Medicaid eligibility vendor, the Social Work Services Department, or through the Community Healthcare Access Team (CHAT).
   1. Any of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status: a "W-2" withholding statement; pay stubs; an income tax return from the most recently filed calendar year; forms approving or denying eligibility for DSHS Medicaid and/or state-funded medical

assistance; forms approving or denying unemployment compensation; or written statements from employers or welfare agencies. In the event the Patient is not able to provide any of the documentation described above, the Hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

2. The Patient may also be asked to provide documentation of outstanding obligations and/or other financial resources (e.g., bank statements, loan documents).

G. Initial review of a patient's application and recommendation for approval of charity care sponsorship shall be the responsibility of appropriate EH personnel. Patient Financial Services representative(s) shall make the "initial determination of sponsorship status," which means an indication, pending verification, that the services provided may or may not be covered by third party sponsorship, or an indication from the patient, pending verification, that he or she may meet the criteria for designation as an indigent person qualifying for charity care. Charity care determinations will preferably be made during pre-admission contacts but will be accepted during admission or at any other time. If the patient is unable to provide supporting documentation, EH will rely upon a written and signed statement from the patient. If it is obvious to EH staff that a patient meets the criteria as an indigent person meeting the above income guidelines, it is not necessary to establish the exact income level or require supporting documentation. Examples of this might include an unemployed or homeless individual. An initial determination of sponsorship shall precede collection efforts directed at the patient, provided the patient is cooperative with EH efforts to reach an initial determination of sponsorship status. During the pendency, EH may pursue reimbursement from any third-party coverage that may be available or identified.

H. A patient who has been initially determined to meet the criteria for Program sponsorship shall be provided with at least fourteen (14) days, or such time as the patient's medical condition may require, or such time as may be reasonably necessary, to secure and present documentation supporting status as an indigent person, in accordance with WAC 246-453-030, prior to receiving a final determination of Program eligibility. If the patient does not respond to the Hospital's reasonable requests for information and/or documentary evidence within fourteen (14) days (or such time as may be necessary considering the patient's medical condition), EH may deem the charity care application incomplete and pursue such collection activity as it deems necessary and appropriate.

I. In determining the status of a patient as an indigent person qualifying for charity care sponsorship in the Program, the Patient Financial Services Representative shall use the criteria set forth in RCW 70.170.060 and WAC 246-453-010 et.seq., which includes a family income (as defined in WAC 246-453-010(17) which is equal to or below 200% of the published federal poverty standards, adjusted for family size, or is otherwise not sufficient to enable payment for the care or to pay deductibles or coinsurance amounts required by a third-party payer. In accordance with WAC 246-453-010(4),the patient must also have exhausted any third party payment sources, including (but not limited to) Medicare and DSHS Medicaid.

1. Patients with family income equal to or below one hundred percent (100%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(1), be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship and provided that such patients are not eligible for other private or public health coverage sponsorship.

2. Patients with family income between one hundred one and two hundred percent (101% - 200%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(2), be determined to be indigent persons qualifying for full or partial charity sponsorship, which allows for discounts from charges related to appropriate

hospital-based medical services that are not covered by private or public third-party sponsorship, in accordance with each EH hospital's sliding fee scheduleand policies regarding individual financial circumstances as set forth herein.

3. Pursuant to WAC 246-453-040(3), the Hospital may, in appropriate circumstances and in its sole discretion, classify a patient whose family income exceeds two hundred percent of the federal poverty standard, adjusted for family size, as an indigent person eligible for a discount from charges based upon the patient's individual financial circumstances.
4. Employment Standard – A patient and/or the account guarantor's employment status and future earning capacity will be evaluated. Patients may be qualified due to reduced future earning potential, even if past income exceeded standards. Alternatively, future earnings sufficient to meet the hospital obligation within a reasonable period (e.g., a patient's returning to work within 6 weeks after service) will also be taken into consideration.

J. When the patient is eligible for and meets the guidelines and requirements for charity care sponsorship in the Program, the Patient Financial Services (PFS) Representative shall forward such recommendation to the authorized designee for review.

1. PFS Manager/Supervisor Up to $10,000
2. FO / Executive Director Revenue Cycle Up to $100,000
3. Sr. Vice President and CFO Up to $1,000,000
4. Chief Executive Officer Over $1,000,000

K. Within fourteen (14) days of receipt of all necessary information to make a final determination of Program eligibility, the PFS designee shall notify the patient of the final determination, including a determination of the amount for which the patient will be held financially accountable.

L. In the event of a recommendation of denial of an application for charity care sponsorship in the Program, the PFS Representative shall forward such recommendation to the PFS authorized designee for review. The PFS designee will, after review of all relevant information, make a final determination of sponsorship status of the patient. The final determination shall be made within fourteen (14) days of receipt of all necessary information.

M. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the PFS department within thirty (30) days of receipt of notification. All appeals will be reviewed by the PFS Administrative Management Team and the Chief Financial Officer or equivalent designee. If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law. The failure of a patient to reasonably complete appropriate application procedures shall be sufficient grounds for EH to initiate collection efforts directed at the patient.

N. Refund: In the event that a patient pays a portion or all of the charges related to medically necessary hospital health care services, and upon submitting an application is subsequently found to have met the Charity Care criteria at the time the payment was made, any payments for services above the qualified amount will be refunded to the patient within 30 days of the eligibility determination.

O. Approval for charity care sponsorship is valid for medically necessary hospital health care services provided within the subsequent one-hundred-eighty (180) day period from application approval date.

Presumptive Charity:

EH may approve a patient for a charity adjustment to their account balance by means other than completing an application. Such determinations will be made on a presumptive basis using an

electronic screening process that evaluates ability to pay based on publically available data sources. The information returned via this electronic screening will constitute sufficient evidence upon which to base the final determination of charity care.

Staff Training:

All relevant and appropriate staff supporting Hospital based locations who perform registration, admission, billing, or other related functions shall participate in standardized training based on this Charity Care Policy and the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about the availability of Financial Assistance. The training shall help ensure staff can answer charity care questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.

Medical Staff and Allied Health Professionals:

Except as provided within this policy, Medical Staff members (and Allied Health Professionals) not employed by EH are encouraged but not obligated to provide charity care in accordance with this Policy, and they may grant full or partial fee waivers in their discretion.

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Approvals

- **Committees:**
- **Signers:** Tina C Mycroft

Tina C Mycroft, Chief Financial Officer (08/12/2020 07:27PM PST)

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Review Date:

Attachments:
(REFERENCED BY THIS DOCUMENT)

Charity Care Schedule A - Sliding Fee Scale
Federal Poverty Guidelines
RCW 70.170
RCW 70.170.020(4)
WAC 246-453-010(4)
WAC 246-453-010(4),
WAC 246-453-040
WAC Chapter 246-453

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

Patient Access
Self Pay Discount Policies
Self Pay Discount Policies
Financial Clearance for Hospital Scheduled Services
Waiver of Patient Financial Responsibility
Patient Access

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=everg5:10070.

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Policy : Nondiscrimination in Provision of Healthcare Services

PURPOSE:

To assure that:

- No person shall be discriminated against at EvergreenHealth on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender, gender identity or expression, disability, veteran or military status, the need to use a trained guide dog or service animal, or on any other basis prohibited by federal (section 1557 of the Affordable Care Act), state, or local law.
- All persons in need receive necessary health care services insofar as EvergreenHealth is able to provide such.
- No person shall be discriminated against in regard to benefits or services to which such person may be entitled.

POLICY:

EvergreenHealth shall provide necessary health care services to persons in need to the extent such person may be entitled to same and such services are available at EvergreenHealth.

EvergreenHealth affords visitation to patients free from discrimination and will ensure that all visitors are able to visit patients consistent with a patient's medical needs, the nature of the healthcare services being provided and the patient's preferences. Visitors may include a spouse, state registered domestic partner (including same-sex state registered domestic partner), another family member, or friend. Patients may withdraw or deny visitation to any person at any time. EvergreenHealth personnel will afford visitors equal visitation privileges consistent with a patient's preferences and medical needs.

Any person who believes that he, she, or another person has been subjected to discrimination which violates this Policy may file a complaint using EvergreenHealth's complaint and grievance procedure. (See Patient Complaints & Grievances, Resolution)

EvergreenHealth personnel will not retaliate against any person who reports suspected or perceived discrimination, files a complaint, or cooperates in an investigation of alleged discrimination.

PROCEDURE:

Responsibilities:

1. Directors, Managers, Supervisors, and staff shall be responsible for implementing and complying with Equal Opportunity, American with Disabilities Act, Rehabilitation Act of 1973 and other federal and state statutes and regulations as applicable to the provision of healthcare and related services.
2. Any EvergreenHealth personnel receiving a patient or visitor allegation of discrimination will advise the complaining individual that he or she may report the problem to Patient Relations at (425) 899-2267 and may file a complaint without fear of retaliation.
3. The Chief Compliance Office services as the Compliance Coordiantor as required by Section 1557 of the Affordable Care Act.

Healthcare Services:

1. In providing healthcare services, EvergreenHealth shall not:
    a. Deny a qualified disabled person benefits or services to which he or she is entitled;

  b. Deny a qualified disabled person an opportunity to receive benefits or services that are offered to others;
  c. Provide a qualified disabled person with benefits or services that are not as effective as the benefits or services provided to others;
  d. Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified disabled persons; or
  e. Provide different or separate benefits or services to disabled persons except where necessary to provide qualified disabled persons with benefits and services that are as effective as those provided to others.
2. Limited English Proficient (LEP) individuals shall be advised of their right to receive appropriate interpreter or auxiliary services at no cost to them. (See Interpretation Program)
3. A notice regarding non-discrimination in admission or access to, or treatment in, its programs and activities shall be provided to patients in the form of “The EvergreenHealth Patient and Client Bill of Rights.”
4. Qualified disabled persons, including those with impaired sensory or speaking skills, will receive effective notice consistent with their disability concerning consent to treatment and/or waivers of rights.
5. A statement shall be printed on materials/pamphlets that informs District residents that, when timely requested by a disabled individual, EvergreenHealth will make a good-faith attempt to provide reasonable accommodation to a person with a disability so as to provide access to services, seminars and classes offered by EvergreenHealth.
6. Appropriate and reasonably available auxiliary aids shall be provided to persons with impaired sensory, manual, or speaking skills, when necessary to afford such persons an equal opportunity to services and/or benefits.
7. There shall be a grievance procedure that provides for prompt and equitable resolution of complaints from all persons who may allege discrimination or a violation of this Policy.

Physical Facility and Program Accessibility:

1. No qualified disabled person shall be denied the benefit of, be excluded from participation in, or otherwise be subjected to discrimination under any program or activity because of EvergreenHealth's facilities being inaccessible to or unusable by disabled persons.
2. EvergreenHealth shall, through the elimination of physical obstacles or through other methods, operate programs and activities which, when viewed in their entirety, are readily accessible to disabled persons.
3. Each facility or part of a facility designed, constructed, altered by, on behalf of, or for the use of EvergreenHealth, shall be designed or constructed in such manner that the facility or part of the facility is readily accessible to and usable by disabled persons.
4. To meet accessibility requirements, EvergreenHealth shall strive to design, construct, and alter its facilities so as to conform to all statutory and regulatory requirements and building standards that provide for accessibility for persons with disabilities as may be applicable at the time of such design, construction and/or alteration.

REFERENCED DOCUMENTS in Lucidoc:

HHS.GOV Section 1557 of the Patient Protection and Affordable Care Act | HHS.gov

Patient and Client Bill of Rights

Patient Complaints & Grievances, Resolution of

Interpretation Program

REFERENCED DOCUMENTS in PolicyTech:

HHS.GOV Section 1557 of the Patient Protection and Affordable Care Act | HHS.gov

Patient Rights and Responsibilities

Patient Complaints & Grievances

Interpreter/Translation Services

Document Owner:	Edgecombe, Dena M
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- Committees:	
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Attachments: (REFERENCED BY THIS DOCUMENT)	Interpretation Program Patient Complaints & Grievances, Resolution of Patient Rights Brochure Patient Rights and Responsibilities Section 1557 of the Patient Protection and Affordable Care Act | HHS.gov
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Patient Access Patient Access

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https://www.lucidoc.com/cgi/doc-gw.pl?ref=everg5:10093.

EvergreenHealth

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Policy : Advance Directives - Living Will & Durable POA for Healthcare

A. **PURPOSE:**

1. All adults receiving health care have certain rights, such as the right to confidentiality of their personal and medical records and to know about and consent to the services and treatments they may receive. "The Patient Self-Determination Act" (PSDA) is a federal law that requires health care providers to give patients written information about their right to make choices about their health care. This information must include a description of the ways in which individuals can make health care decisions in advance.

B. **PHILOSOPHY:**

1. King County Public Hospital District #2 (the "District") is committed to allowing patients to make their own decisions about their healthcare, especially regarding end-of-life decisions. This right is especially significant today because modern medical technology can prolong the lives of people who are terminally ill or permanently unconscious even when there is no hope of recovery. In such circumstances, the District recognizes the right of each patient to decide whether to die without extraordinary treatment or to have life-sustaining treatment instituted to prolong life as long as possible.

2. This policy is intended to provide procedures to ensure that patients' Advance Directives are honored by District staff to the extent permitted by law. It is specifically intended to comply with federal law, "The Patient Self-Determination Act", sections 4206 and 4761 of the Omnibus Budget Reconciliation Act of 1990(OBRA/90), the Washington Natural Death Act (RCW 70.122), and the Washington Mental Health Advance Directives Act (RCW 71.32).

3. The District will not discriminate against any individual based on whether or not the individual has executed an Advance Directive or require that a patient has an Advance Directive as a condition of receiving services.

C. **TYPES OF ADVANCE DIRECTIVES:**

D. **"Advance Directives"** are written instructions to health care providers that are prepared before medical or mental health treatment is actually needed. An Advance Directive describes the type of care or treatment a patient would want if a medical or mental illness or an accident occurs that makes it impossible for him or her to consent to medical or mental illness treatment at the time it is needed. Some types of Advance Directives are meant to be used only if the patient is terminally ill or in a permanent unconscious state. There are several different types of Advance Directives in Washington State:

1. **Living Will** (also known as a Health Care Directive) is allowed under a Washington State statute, the "Washington Natural Death Act", RCW 70.122.010. It is a written document that enables a patient to tell his or her doctor what he or she does or does not want if diagnosed with a terminal condition or is permanently unconscious. The patient may choose not to prolong the process of dying from an incurable and irreversible condition. The patient must sign and date the Living Will in the presence of two witnesses, who must also sign. These two witnesses may not be, at the time of signing, any of the following:

   a. Related to the patient by blood or marriage;

   b. Entitled to inherit the patient's money or property;

   c. A person to whom the patient owes money;

   d. The patient's doctor or the doctor's employees; or an

   e. Employee of the health care facility where the patient is receiving health care.

      i. The patient can change his or her Living Will at any time so long as he or she is mentally capable. If the patient is not mentally capable, he or she can cancel or revoke it, but cannot change it or write a new one. The patient can cancel his or her Living Will by destroying it or having someone else destroy it in their presence; or signing and dating a written statement that he or she is canceling it; or verbally telling his or her doctor, or instructing someone to

tell his or her doctor, that he or she is canceling it. The patient, or someone they have instructed, must tell the attending physician before the cancellation is effective.

2. **Durable Power of Attorney for Healthcare** (DPOAHC) is another type of Advance Directive used in Washington State. It is a written document that allows the patient to designate someone to make "informed consent" health care decisions for the patient if he or she is unable to make them at the time treatment is needed. The patient can also describe what type of health care decisions he or she wants made and under what circumstances the decisions should be made.
A DPOAHC becomes effective only by a court order or if a physician determines the patient is unable to make healthcare decisions for him or herself. It does not need a witness or be notarized in Washington State unless it also includes powers for financial matters.

3. **Physician Orders for Life-Sustaining Treatment (POLST) form** is technically not an Advance Directive and does not take the place of one. It translates an Advance Directive into physician orders. It is a "portable" Physician Order form that describes the patient's code directives. It is intended to go with the patient from one care setting to another. See policy ADM 157.1 Physician Orders for Life-Sustaining Treatmentfor more information.

4. **Organ or Tissue Donation:** The Washington State Uniform Anatomical Gift Act (RCW 68.50) allows individuals to specify whether they wish to donate specific body parts or their entire body upon their death. This can be done via a written statement witnessed by two people, by checking the back of their driver's license, or in their will. See Patient Services policy 728.19 Organ/Tissue Donationfor more information.

5. **Mental Health Advance Directive** is the newest type of Advance Directive allowed under Washington State law (RCW 71.32). It is designed to provide an individual with capacity the ability to control decisions relating to his or her own mental health care. It is a written document that describes the patient's directions and preferences for treatment and care during times when he or she is having difficulty communicating and making decisions regarding his or her mental health care. It can inform mental health providers what treatment the patient does or doesn't want and identify an "agent" who can make decisions and act on behalf of the patient.

   a. It is based on the following concepts:

      i. Some mental illnesses cause individuals to fluctuate between capacity and incapacity;

      ii. During periods when an individual's capacity is unclear, he or she may be unable to access needed treatment due to an inability to give informed consent;

      iii. Early treatment may prevent him or her from becoming so ill that involuntary treatment is necessary; and

      iv. Mentally ill individuals need some method of expressing their instructions and preferences for treatment and providing advance consent to or refusal of treatment.

   b. A mental health advance directive provides the individual with a full range of choices and allows them to document whether they want to be able to revoke a directive during periods of incapacity. The law requires providers to respect an individual's mental health advance directive to the fullest extent possible. It may include:

      i. Consent or, or refusal of, particular medications or inpatient admissions;

      ii. Who can visit the patient in the hospital;

      iii. Who the patient appoints to make his or her decisions regarding mental health treatment, the "agent";

      iv. Anything else the patient wants or doesn't want in his or her future mental health treatment.

   c. The "agent" named by the patient must be at least 18 years old and cannot be the patient's physician, case manager, or residential provider unless that person is also his or her spouse, adult child, or sibling.

   d. A provider may refuse to follow a mental health advance directive under the following instances:

      i. The patient's instructions are against hospital policy or are unavailable;

      ii. Following the directive would violate state or federal law;

      iii. The instructions would endanger the patient or others;

      iv. The patient is hospitalized under the Involuntary Treatment Act or is in jail.

E. **DEFINITIONS:**

1. **"Adult"** means any individual who has attained the age of majority (18 years old) or is an emancipated minor.

2. **"Attending Physician"** means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient [RCW 70.122.020(2)].

3. **"Capacity"** means a patient's ability to make healthcare decision and shall be determined in accordance with Policy ADM 106.1 "Informed Consent on Behalf of Incapacitated Patients".

4. **"Incapacitated"** means an adult who: (a) is unable to understand the nature, character, and anticipated results of proposed treatment or alternatives; understand the recognized serious possible risks, complications, and anticipated benefits in treatments and alternatives, including nontreatment; or communicate his or her understanding or treatment decisions; or (b) has been found to be incompetent pursuant to RCW 11.88.010(1)(e).

5. **"Life-Sustaining Treatment"** means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function which when applied to a patient who is in a terminal or permanently unconscious condition would serve only to prolong the process of dying. Life-sustaining treatment shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain [RCW 70.122.020(5)].

6. **"Permanently Unconscious Condition"** means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state [RCW 70.122.020(6)].

7. **"Terminal Condition"** means an incurable and irreversible condition caused by injury, disease, or illness that within reasonable medical judgment will cause death within a reasonable period of time, in accordance with accepted medical standards and where attempts of resuscitation will serve only to prolong the process of dying [RCW 70.122.020(9)].

F. **POLICY:**

1. No District employee, hospital District volunteer, attending physician, or employee of the attending physician is permitted to witness any patient's Advance Directive. Employees who have been appointed as a notary public may use their notary seal to notarize signatures (RCW 70.122.030].

2. No District employee, hospital District volunteer or attending physician shall be required under any circumstances to participate in the withholding or withdrawing of life-sustaining treatment if such person objects to so doing. No such person shall be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawing of life-sustaining treatment [RCW 70.122.060(4)].

3. Staff and attending physicians may presume that the patient's Advance Directive is legally valid unless the Advance Directive has been revoked. No staff or attending physician will be liable for failing to act upon a revocation unless that person has knowledge of the revocation (RCW 70.122.040).

G. **RESPONSIBILITY:**

1. Staff from several departments have important roles in implementing District policy on Advance Directives. Listed below are summaries of departmental responsibilities.

DEPARTMENT RESPONSIBLE:	RESPONSIBILITY/ACTION:
Patient Registration	Registration personnel are frequently the patient's first point of contact with an Evergreen facility or service. Generally, registration personnel have the following responsibilities: ▪ Determine if the patient has executed an Advance Directive. ▪ Note in Cerner whether the patient has an Advance Directive and whether we have a copy. ▪ Offer each patient information regarding rights and how to create an Advance Directive. ▪ Make copies of Advance Directives and route to appropriate staff and facilities.

	▪ Refer to Social Services those patients expressing interest in establishing an Advance Directive.
Care Management Social Workers	Care Management Social Workers provide information to those patients expressing interest in establishing Advance Directives, including information as to where copies of Advance Directive forms may be obtained. Social workers may refer interested patients to their attending physician, Pastoral Care, their own legal counsel, or other appropriate physicians or personnel for additional information to reach a decision on this matter.
Nursing	Nursing personnel and Health Unit Coordinators are responsible for notifying appropriate staff and physicians regarding the patient's Advanced Directive. As caregivers, nursing personnel also have important roles in ensuring that patients' Advance Directives are implemented.
Attending Physician	**The attending physician's role is crucial to successful implementation of the district's policy on advance directives:** ▪ All attending and primary care physicians are encouraged to raise the issue of Advance Directives with each adult patient at any opportunity (including office visits), preferably when the patient is healthy. ▪ Attending and primary care physicians are encouraged to provide information to those patients expressing interest in establishing Advance Directives, including information as to where they may obtain copies of the brochure "***Who will decide if you can't***". This brochure includes forms for both a Living Will and a Durable Power of Attorney for Health Care. ▪ Each time the physician asks a patient to sign an Informed Consent, the physician is encouraged to ask the patient if he or she has an Advance Directive or would like to discuss establishing an Advance Directive. ▪ Attending physicians will refer interested patients to Social Services, Pastoral Care, their own legal counsel, or other appropriate physicians or personnel. ▪ Attending physicians will honor the patient's revocation of his or her Advance Direct, document the revocation, and notify appropriate District personnel. **When the patient's Advance Directive conflicts with the physician or District's policies:** ▪ The attending physician shall inform a patient or his or her surrogate decision-maker of the existence of any policy or practice of the physician or District (facility or agency) that would preclude the honoring of the patient's Advance Directive at the time the physician becomes aware of the existence of an Advance Directive. If the patient chooses to retain the physician (or facility or agency), the physician shall prepare a written plan to be filed with the patient's Advance Directive that sets forth the physician's (or facility's or agency's) intended actions should the patient's medical status change so that the Advance Directive would become operative. ▪ The physician (and facility or agency) have no obligation to honor the patient's Advance Directive if they have complied with this notification (RCW 70.122.060).
Health Information Management (HIM)	HIM personnel scan the patient's Advance Directive in the Advance Directive portion of the electronic medical record. If the patient has revoked his/her Advance Directive, HIM personnel add the copy of the revocation statement, if signed, to the permanent record.

H. **CROSS REFERENCES OF POLICIES AND PROCEDURES IMPLEMENTING DISTRICT POLICY ON ADVANCE DIRECTIVES:**

I. Other related organizational policies:

1. Organ/Tissue Donation(Patient Services 728.19)

2. Withdrawing or Withholding Life-Sustaining Treatment(**Patient Care 10149**)
3. Informed Consent on Behalf of Incapacitated Patients(**ADM 106.1**)
4. Patient Rights and Responsibilities(**ADM 132**)
5. Guardian Ad Litem (**ADM 152.2**)
6. Physician Orders for Life-Sustaining Treatment(**ADM 157.1**)

Document Owner: Hanson, Joy D

Collaborators:

Approvals

- **Committees:**
- **Signers:**

Mary E Shepler

Mary E Shepler, Senior Vice President, Chief Nursing Officer (10/29/2019 11:53AM PST)

Jeff J Tomlin

Jeff J Tomlin, MD, Chief Executive Officer (10/31/2019 11:38AM PST)

Original Effective Date:

Revision Date: [10/30/2005 Rev. 1], [04/10/2009 Rev. 2], [06/16/2011 Rev. 3], [05/19/2014 Rev. 4], [10/31/2019 Rev. 5]

Review Date: [08/01/2007 Rev. 1], [08/23/2013 Rev. 3]

Attachments:
(REFERENCED BY THIS DOCUMENT)

Living Will & DPOA Form
Patient Rights & Responsibilities
Physician Orders for Life-Sustaining Treatment (POLST)
Guardian Ad Litem
Informed Consent on Behalf of Incapacitated Patients
Omnibus Budget Reconciliation Act of 1990
Organ-Tissue Donation

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

Do Not Attempt Resuscitation
Guideline for Shared Decision Making with Life-Sustaining Treatment
Informed Consent on Behalf of Incapacitated Patients

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=everg5:10075.

EvergreenHealth

DocID: 29017
Revision: 1
Status: Official
Department: Compliance, Ethics and Quality
Manual(s):

Policy : Reproductive Healthcare

POLICY:

EvergreenHealth complies with the Reproductive Privacy Act, a state law that requires a public hospital district that elects to provide maternity care benefits, services or information through a program administered or funded by the public hospital district, to also provide substantially equivalent pregnancy termination benefits, services or information.

EvergreenHealth provides complete maternity care and reproductive health services. These services include, but are not limited to, maternal fetal medicine consultations, genetic level ultrasound for prenatal diagnosis, genetic counseling, social services, termination of pregnancy, birth control, and counseling regarding these services. In the rare case when necessary services are not available at EvergreenHealth, patients are given information regarding alternative sources of care. The EvergreenHealth Healthline (425-899-3000) is available to refer patients to providers who provide these services.

The Reproductive Privacy Act contains a "conscience clause" acknowledging that no person may be required in any circumstance to participate in the performance of a pregnancy termination or certain other services. EvergreenHealth respects each individual's right to refuse to participate in aspects of care that violates his or her beliefs. EvergreenHealth therefore coordinates care so that services are provided with appropriate staff at EvergreenHealth. (See Staff Requests/Non-Participation in Patient Care Policy.)

Document Owner: Kennedy Cunningham, Kelli D

Collaborators:

Approvals

- **Committees:**
- **Signers:**

Mary E Shepler

Mary E Shepler, Senior Vice President, Chief Nursing Officer (11/11/2019 11:57AM PST)

Richard A Meeks

Richard A Meeks, Chief Compliance Officer (11/11/2019 12:34PM PST)

Kelli D Kennedy Cunningham

Kelli D Kennedy Cunningham, Exec Dir-Women/Children's Prog (11/26/2019 12:04PM PST)

Original Effective Date: 03/28/2014

Revision Date: [03/28/2014 Rev. 0], [03/10/2017 Rev. 1]

Review Date: [11/08/2019 Rev. 1]

Attachments: (REFERENCED BY THIS DOCUMENT) Staff Requests/Non-Participation in Patient Care Policy

Other Documents: (WHICH REFERENCE THIS DOCUMENT)

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=everg5:29017.

Exhibit 6
Pro Forma Financials

EvergreenHealth

Income Statement by Division

Hospital Division	Hospital 2019	Hospital 2020	Hospital 2021	Hospital Aug 2022 YTD	Annualized 2022	2023	2024	2025	2026	2027	2028	2029
Volume												
Patient Days	65,407	64,899	70,707	50,418	75,731	76,784	77,838	78,892	79,945	80,999	80,999	80,999
Admits (Exl. NICU)	15,200	13,819	14,650	9,933	14,920	15,265	15,630	16,002	16,382	16,770	16,770	16,770
ALOS (Exl. NICU)	4.30	4.70	4.83	5.08	5.08	5.03	4.98	4.93	4.88	4.83	4.83	4.83
PATIENT REVENUE:												
INPATIENT REVENUE	796,845	769,750	808,685	572,360	859,718	871,679	883,641	895,603	907,564	919,526	919,526	919,526
OUTPATIENT REVENUE	725,600	667,865	761,846	541,556	813,448	824,766	836,084	847,402	858,720	870,038	870,038	870,038
GROSS PATIENT REVENUE	1,522,444	1,437,615	1,570,531	1,113,916	1,673,166	1,696,446	1,719,725	1,743,004	1,766,284	1,789,563	1,789,563	1,789,563
						-	-	-	-	-	-	-
DEDUCTIONS FROM PATIENT REVENUE						-	-	-	-	-	-	-
CONTRACTUAL ADJUSTMENT	1,061,742	1,013,416	1,073,628	752,429	1,130,191	1,145,916	1,161,641	1,177,366	1,193,091	1,208,815	1,208,815	1,208,815
PROVISION FOR BAD DEBT	26,758	13,248	15,088	13,863	20,823	21,113	21,402	21,692	21,982	22,272	22,272	22,272
CHARITY	7,435	7,770	7,941	4,877	7,325	7,427	7,529	7,631	7,733	7,835	7,835	7,835
ADMINISTRATIVE ADJUSTMENT	3,119	4,115	3,130	2,244	3,371	3,418	3,465	3,512	3,559	3,606	3,606	3,606
TOTAL DEDUCTIONS FROM REVENUE	1,099,054	1,038,548	1,099,787	773,413	1,161,710	1,177,874	1,194,037	1,210,200	1,226,364	1,242,527	1,242,527	1,242,527
DEDUCTIONS AS A % OF GROSS PATIENT REV	72.2%	72.2%	70.0%	69.4%	104.3%	105.7%	107.2%	108.6%	110.1%	111.5%	111.5%	111.5%
					0.00							
NET PATIENT REVENUE	423,390	399,067	470,744	340,503	511,456	518,572	525,688	532,804	539,920	547,036	547,036	547,036
JOINT VENTURE REVENUE												
OTHER OPERATING REVENUE	5,771	8,426	9,950	4,895	7,352	7,454	7,557	7,659	7,761	7,864	7,864	7,864
TOTAL OTHER OPERATING REVENUE	5,771	8,426	9,950	4,895	7,352	7,454	7,557	7,659	7,761	7,864	7,864	7,864
						-	-	-	-	-	-	-
TOTAL OPERATING REVENUE	429,161	407,493	480,694	345,398	518,808	526,026	533,245	540,463	547,681	554,900	554,900	554,900
OPERATING EXPENSE:												
SALARIES & AGENCY	167,427	167,517	194,621	153,966	231,266	234,483	237,701	240,919	244,136	247,354	247,354	247,354
MEDICAL BENEFITS	18,766	19,271	18,703	13,355	20,060	20,339	20,618	20,897	21,176	21,455	21,455	21,455
EMPLOYEE BENEFITS	20,767	20,727	22,341	16,208	24,345	24,684	25,023	25,362	25,700	26,039	26,039	26,039
PROFESSIONAL FEES	3,188	5,256	4,238	2,499	3,754	3,806	3,858	3,911	3,963	4,015	4,015	4,015
SUPPLIES	78,908	80,459	83,538	58,067	87,220	88,434	89,647	90,861	92,074	93,288	93,288	93,288
REPAIRS & MAINTENANCE	4,982	4,748	5,166	3,492	5,245	5,318	5,391	5,464	5,537	5,610	5,610	5,610
PURCHASED SERVICES	12,232	13,324	14,414	10,351	15,548	15,765	15,981	16,197	16,414	16,630	16,630	16,630
OTHER OPERATING EXPENSES	3,568	3,083	3,529	1,821	2,735	2,773	2,811	2,849	2,887	2,925	2,925	2,925
OPERATING EXPENSES BEFORE INT.,	309,838	314,386	346,548	259,759	390,173	395,602	401,030	406,459	411,887	417,316	417,316	417,316
OPERATING EBIDA	119,323	93,106	134,146	85,639	128,635	130,425	132,215	134,004	135,794	137,584	137,584	137,584
					-							
DEPRECIATION AND AMORTIZATION	19,180	18,872	20,627	15,502	23,286	23,618	23,942	23,950	23,950	23,950	23,950	23,950
TOTAL OPERATING EXPENSES	329,017	333,258	367,175	275,261	413,458	419,219	424,972	430,409	435,838	441,266	441,266	441,266
NET INCOME (LOSS) FROM OPERATIONS	100,143	74,235	113,519	70,137	105,350	106,807	108,273	110,054	111,844	113,634	113,634	113,634
SHARED SERVICES ALLOCATION	(86,985)	(89,215)	(105,216)	(72,661)	(109,141)	(110,659)	(112,178)	(113,696)	(115,215)	(116,733)	(116,733)	(116,733)
ADJUSTED NET INCOME (LOSS) FROM OPERATION	13,158	(14,980)	8,303	(2,524)	(3,791)	(3,852)	(3,905)	(3,642)	(3,371)	(3,100)	(3,100)	(3,100)
NON-OPERATING REVENUE/(EXPENSE):					-	-	-	-	-	-	-	-
NON-OPERATING TAXATION REVENUE	21,676	-	393	-	-	-	-	-	-	-	-	-
NON-OPERATING INVESTMENT REVENUE	64	-	-	-	-	-	-	-	-	-	-	-
NON-OPERATING INTEREST AND AMORTIZATION E	-	-	(112)	(156)	(234)	(238)	(241)	(244)	(247)	(251)	(251)	(251)
NON-OPERATING-OTHER REVENUE/(EXPENSE)	44	67	2,997	5	7	7	7	7	7	8	8	8
TOTAL NON-OPERATING GAIN OR (LOSS)	21,784	67	3,278	(151)	(227)	(231)	(234)	(237)	(240)	(243)	(243)	(243)
					-	-	-	-	-	-	-	-
NET INCOME / (LOSS)	121,927	74,301	116,798	69,985	105,122	106,576	108,039	109,817	111,604	113,390	113,390	113,390

Assumptions

1) No inflation

2) 2023 - 2030 based on Aug 2022 YTD per unit revenue and expense

3) 2023 - 2030 include $125k capital for hospital beds depreciationed over 15 years

HOSPITAL INFORMATION

BALANCE SHEET - UNRESTRICTED FUND-HOSPITAL AGGREGATE-WITH THE PROJECT

		HISTORICAL			CURRENT	PROJECTED						
					BUDGET							
	ASSETS	**YR 2019**	**YR 2020**	**YR 2021**	**YR (2022)**	**YR 2023**	**YR 2024**	**YR 2025**	**YR 2026**	**YR 2027**	**YR 2028**	**YR 2029**
1	CURRENT ASSETS:											
2	Cash	57,372	79,167	69,831	78,199	79,020	79,782	81,484	83,432	86,704	86,704	86,704
3	Marketable Securities											
4	Accounts Receivable	95,247	86,296	114,017	117,488	123,560	140,984	151,049	160,560	168,537	168,537	168,537
5	Less-Estimated Uncollectable & Allowances											
6	Receivables From Third Party Payors	2,237	3,418	5,325	4,447	4,597	6,490	7,262	7,866	8,176	8,176	8,176
7	Pledges And Other Receivables	9,729	13,462	15,331	12,802	12,802	12,802	12,802	12,802	12,802	12,802	12,802
8	Due From Restricted Funds											
9	Inventory	9,364	8,921	8,096	6,760	7,331	7,954	8,451	8,961	9,465	9,465	9,465
10	Prepaid Expenses	7,916	10,256	8,764	7,318	7,395	10,073	11,165	12,364	13,052	13,052	13,052
11	Current Portion Of Funds Held In Trust	1,362	1,543	3,797	3,171	3,171	3,171	3,171	3,171	3,171	3,171	3,171
12	**TOTAL CURRENT ASSETS**	**183,228**	**203,062**	**225,161**	**230,185**	**237,876**	**261,256**	**275,382**	**289,156**	**301,906**	**301,906**	**301,906**
13												
14	BOARD DESIGNATED ASSETS:											
15	Cash	153,403	201,696	172,446	125,967	132,102	149,400	198,399	288,208	392,232	392,232	392,232
16	Marketable Securities	10,817	2,894	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,626	2,626
17	Other Assets											
18	**TOTAL BOARD DESIGNATED ASSETS**	**164,221**	**204,590**	**175,071**	**128,593**	**134,728**	**152,026**	**201,025**	**290,833**	**394,857**	**394,857**	**394,857**
19												
20	PROPERTY, PLANT AND EQUIPMENT:											
21	Land	4,914	4,914	4,914	4,914	4,914	4,914	4,914	4,914	4,914	4,914	4,914
22	Land Improvements	13,718	13,124	13,121	13,121	13,121	13,121	13,121	13,121	13,121	13,121	13,121
23	Buildings	374,601	380,317	398,182	398,182	398,182	398,182	398,182	398,182	398,182	398,182	398,182
24	Fixed Equipment - Building Service											
25	Fixed Equipment - Other											
26	Equipment	425,026	431,406	426,815	537,751	549,265	593,995	654,711	709,099	760,987	760,987	760,987
27	Leasehold Improvements											
28	Construction In Progress	25,691	24,574	33,286	33,286	44,800	66,503	60,786	60,174	58,286	58,286	58,286
29	TOTAL	843,950	854,334	876,318	987,254	1,010,281	1,076,714	1,131,714	1,185,490	1,235,490	1,235,490	1,235,490
30	Less Accumulated Depreciation	523,121	544,177	549,998	604,577	666,660	730,440	797,780	869,250	944,473	944,473	944,473
31	**NET PROPERTY, PLANT & EQUIPMENT**	**320,829**	**310,157**	**326,320**	**382,677**	**343,622**	**346,274**	**333,934**	**316,240**	**291,017**	**291,017**	**291,017**
32												
33	INVESTMENTS AND OTHER ASSETS:											
34	Investments In Property, Plant & Equipment											
35	Less - Accumulated Depreciation											
36	Other Investments											
37	Other Assets	33,633	28,826	28,332	31,619	31,619	31,619	31,619	31,619	31,619	31,619	31,619
38	**TOTAL INVESTMENTS & OTHER ASSETS**	**33,633**	**28,826**	**28,332**	**31,619**	**31,619**	**31,619**	**31,619**	**31,619**	**31,619**	**31,619**	**31,619**
39												
40	INTANGIBLES ASSETS:											
41	Goodwill											
42	Unamortized Loan Costs											
43	Preopening And Other Organization Costs											
44	Other Intangible Assets											
45	TOTAL INTANGIBLE ASSETS											
46	**TOTAL ASSETS**	**701,910**	**746,635**	**754,884**	**773,074**	**747,845**	**791,174**	**841,960**	**927,848**	**1,019,400**	**1,019,400**	**1,019,400**

HOSPITAL INFORMATION

BALANCE SHEET - UNRESTRICTED FUND - **HOSPITAL AGGREGATE**-WITH THE PROJECT

		HISTORICAL			CURRENT	PROJECTED						
	LIABILITIES AND FUND BALANCES-UNRESTRICTED	**YR 2019**	**YR 2020**	**YR 2021**	**BUDGET YR (2022)**	**YR 2023**	**YR 2024**	**YR 2025**	**YR 2026**	**YR 2027**	**YR 2028**	**YR 2029**
1	CURRENT LIABILITIES:											
2	Notes and Loans Payable											
3	Accounts Payable	28,510	31,038	32,847	38,949	39,358	41,510	42,992	44,654	46,543	46,543	46,543
4	Accrued Compensation and Related Liabilities	53,363	40,399	47,069	45,665	45,665	45,665	45,665	45,665	45,665	45,665	45,665
5	Other Accrued Expenses											
6	Advances from Third Party Payors											
7	Payables to Third Party Payors	8,452	9,747	11,594	9,163	9,472	15,005	17,188	18,860	19,648	19,648	19,648
8	Due to Restricted Funds											
9	Income Taxes Payable											
10	Other Current Liabilities											
11	Current Maturities of Long Term Debt	14,219	14,470	15,389	16,814	7,690	8,353	6,821	7,175	7,670	7,670	7,670
12	**TOTAL CURRENT LIABILITIES**	**104,543**	**95,654**	**106,899**	**110,591**	**102,186**	**110,533**	**112,666**	**116,354**	**119,526**	**119,526**	**119,526**
13												
14	DEFERRED CREDITS:											
15	Deferred Income Taxes											
16	Deferred Third Party Revenue	8,499	38,727	7,840	11,951	11,951	11,951	11,951	11,951	11,951	11,951	11,951
17	Other Deferred Credits											
18	**TOTAL DEFERRED CREDITS**	**8,499**	**38,727**	**7,840**	**11,951**	**11,951**	**11,951**	**11,951**	**11,951**	**11,951**	**11,951**	**11,951**
19												
20	LONG TERM DEBT:											
21	Mortgage Payable											
22	Construction Loans - Interim Financing											
23	Notes Payable											
24	Capitalized Lease Obligations											
25	Bonds Payable	173,354	232,579	266,339	249,525	244,229	255,580	248,759	255,360	247,690	247,690	247,690
26	Notes and Loans Payable to Parent											
27	Noncurrent Liabilities											
28	TOTAL	187,573	247,050	281,728	266,339	251,919	263,934	255,580	262,535	255,360	255,360	255,360
29	Less Current Maturities of Long Term Debt	14,219	14,470	15,389	16,814	7,690	8,353	6,821	7,175	7,670	7,670	7,670
30	**TOTAL LONG TERM DEBT**	**173,354**	**232,579**	**266,339**	**249,525**	**244,229**	**255,580**	**248,759**	**255,360**	**247,690**	**247,690**	**247,690**
31												
32	**UNRESTRICTED FUND BALANCE**											
33												
34	EQUITY (INVESTOR OWNED)											
35	Preferred Stock											
36												
37	Common Stock											
38												
39	Additional Paid In Capital	7,295	11,042	11,042	11,042	11,042	11,042	11,042	11,042	11,042	11,042	11,042
40												
41	Retained Earnings (Capital Account for Partnership	408,219	368,633	362,764	389,965	378,438	402,069	457,543	533,142	629,191	629,191	629,191
42	or Sole Proprietorship)											
43												
44	Less Treasury Stock											
45	**TOTAL EQUITY**	**415,514**	**379,674**	**373,806**	**401,007**	**389,480**	**413,110**	**468,585**	**544,183**	**640,232**	**640,232**	**640,232**
46	**TOTAL LIABILITIES AND FUND BALANCE OR EQUITY**	**701,910**	**746,635**	**754,884**	**773,074**	**747,845**	**791,175**	**841,961**	**927,848**	**1,019,400**	**1,019,400**	**1,019,400**

Exhibit 7
King Count Assessor Information

King County Department of Assessments

Setting values, serving the community, and promoting fairness and equity.

Department of Assessments

201 South Jackson Street, Room 708
Seattle, WA 98104

Office Hours:
Mon - Fri
8:30 a.m. to 4:30 p.m.

TEL: 206-296-7300
FAX: 206-296-5107
TTY: 206-296-7888

Send us mail

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- Map This Property
- Glossary of Terms
- Area Report
- Property Detail

PARCEL

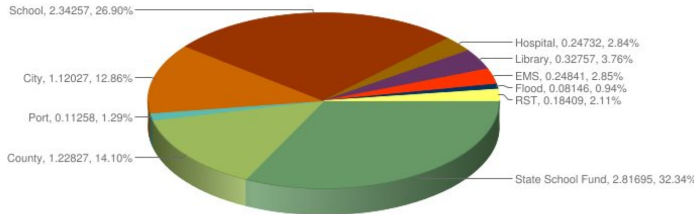
Parcel Number	282605-9144
Name	HOSPITAL DIST 2
Site Address	12040 NE 128TH ST 98034
Legal	S 656.5 FT OF NE 1/4 OF NW 1/4 LESS CO RDS SUBJ TO TRANS LN ESMT LESS POR FOR RD PER REC # 20030829000627 & 20060209001239

BUILDING 1

Year Built	2006
Building Net Square Footage	570472
Construction Class	PREFAB STEEL
Building Quality	AVERAGE/GOOD
Lot Size	757446
Present Use	Hospital
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2022 **Levy Code:** 1806 **Total Levy Rate:** $8.70949 **Total Senior Rate:** $4.79158



51.28% Voter Approved

Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

Valued Year	Tax Year	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total ($)	Appraised Imps Increase ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total ($)
2022	2023	16,663,800	295,673,900	312,337,700	15,519,500	0	0	0
2021	2022	15,148,900	246,307,800	261,456,700	0	0	0	0
2020	2021	15,148,900	248,236,700	263,385,600	0	0	0	0
2019	2020	15,148,900	250,666,900	265,815,800	0	0	0	0
2018	2019	12,876,500	247,571,900	260,448,400	0	0	0	0
2017	2018	12,119,100	241,298,200	253,417,300	0	0	0	0
2013	2014	11,361,600	250,765,500	262,127,100	0	0	0	0
2012	2013	11,361,600	250,319,900	261,681,500	0	0	0	0
2011	2012	11,361,600	252,604,700	263,966,300	0	0	0	0
2010	2011	11,361,600	236,678,100	248,039,700	0	0	0	0
2009	2010	11,361,600	253,056,200	264,417,800	0	0	0	0
2008	2009	10,604,200	239,129,100	249,733,300	0	0	0	0
2007	2008	9,089,300	191,401,700	200,491,000	41,246,600	0	0	0
2006	2007	7,649,100	135,432,400	143,081,500	0	0	0	0
2005	2006	7,649,100	132,422,600	140,071,700	0	0	0	0
2004	2005	6,884,200	121,258,300	128,142,500	3,800,000	0	0	0
2003	2004	7,527,100	129,786,900	137,314,000	0	0	0	0
2002	2003	7,527,100	113,224,300	120,751,400	19,793,000	0	0	0

Reference Links:

- King County Taxing Districts Codes and Levies (.PDF)
- King County Tax Links
- Property Tax Advisor
- Washington State Department of Revenue (External link)
- Washington State Board of Tax Appeals (External link)
- Board of Appeals/Equalization
- Districts Report
- iMap
- Recorder's Office
- Scanned images of surveys and other map documents

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Notice mailing date: 08/18/2022

2001	2002	6,690,800	100,116,800	106,807,600	10,550,500	0	0	0
2000	2001	5,854,500	88,207,900	94,062,400	7,150,700	0	0	0
1999	2000	5,854,500	78,487,400	84,341,900	3,933,000	0	0	0
1997	1998	0	0	0	0	5,854,500	62,177,500	68,032,000
1996	1997	0	0	0	0	5,854,500	62,177,500	68,032,000
1995	1996	0	0	0	0	5,854,500	62,177,500	68,032,000
1994	1995	0	0	0	0	5,854,500	59,920,600	65,775,100
1993	1994	0	0	0	0	5,982,500	40,954,000	46,936,500
1992	1993	0	0	0	0	5,982,500	38,133,000	44,115,500
1991	1992	0	0	0	0	4,203,500	23,733,000	27,936,500
1990	1991	0	0	0	0	4,203,500	17,312,000	21,515,500
1988	1989	0	0	0	0	4,203,500	20,445,200	24,648,700
1986	1987	0	0	0	0	4,181,700	20,467,000	24,648,700
1985	1986	0	0	0	0	4,181,700	5,240,000	9,421,700
1984	1985	0	0	0	0	4,181,700	4,895,000	9,076,700
1982	1983	0	0	0	0	1,463,500	4,895,000	6,358,500

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Updated: July 25, 2022

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Exhibit 8
Financing Letter

October 27, 2022

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

RE: Capital Funding

Dear Mr. Hernandez:

As indicated in our Certificate of Need application to maintain acute care bed capacity that has been made operational under the Governor's Proclamation 20-36, we will incur $125,000 in capital to purchase four (4) inpatient beds.

This equipment will be funded from our routine capital budget and thus not require any financing.

Please feel free to contact me directly with any questions at (425) 899-2606 or at tcmycroft@evergreenhealthcare.org.

Sincerely,

Tina Mycroft
Chief Financial Officer

Exhibit 9
FTE Table

EvergreenHealth
FTE's Report by Labor Category
Hospital Division

	HOSPITAL	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital
Labor Category	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
ANCILLARY FTEs	345.66	332.16	330.16	329.44	329.44	329.44	329.44	329.44	329.44	329.44	329.44
SUPPORT FTEs	72.87	74.15	81.81	85.75	85.75	85.75	85.75	85.75	85.75	85.75	85.75
OTHER FTEs	362.41	362.56	381.76	381.34	381.34	381.34	381.34	381.34	381.34	381.34	381.34
PHYSICIANS FTEs	43.46	40.12	43.71	45.01	45.01	45.01	45.01	45.01	45.01	45.01	45.01
MID LEVEL FTEs	5.65	4.10	4.27	4.57	4.57	4.57	4.57	4.57	4.57	4.57	4.57
CLINICAL STAFF FTEs	799.34	794.42	800.29	784.15	784.15	784.15	784.15	784.15	784.15	784.15	784.15
ADMINISTRATIVE FTEs	66.21	65.28	66.22	63.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45
CONTRACT LABOR	72.14	57.95	111.34	163.33	163.33	163.33	163.33	163.33	163.33	163.33	163.33
TOTAL DEPARTMENT	1,767.76	1,730.73	1,819.56	1,857.05	1,857.05	1,857.05	1,857.05	1,857.05	1,857.05	1,857.05	1,857.05
Total Salaries	167,427.04	167,517.47	194,620.66	231,265.63	234,483.32	237,701.01	240,918.70	244,136.39	247,354.08	247,354.08	247,354.08
Total Benefits	39,532.80	39,997.77	41,043.57	44,404.98	45,022.81	45,640.63	46,258.46	46,876.28	47,494.11	47,494.11	47,494.11
Total Wages and Benefits	206,959.83	207,515.24	235,664.23	275,670.61	279,506.13	283,341.64	287,177.15	291,012.67	294,848.18	294,848.18	294,848.18

Appendix 1
Audited Financials

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Financial Statements

December 31, 2021 and 2020

(With Independent Auditors' Report Thereon)

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

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Statements of Cash Flows	22–23
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KPMG LLP
Suite 2800
401 Union Street
Seattle, WA 98101

Independent Auditors' Report

The Board of Commissioners
King County Public Hospital District No. 2
d/b/a EvergreenHealth:

Opinions

We have audited the financial statements of the business-type activities and the discretely presented component unit of King County Public Hospital District No. 2, d/b/a EvergreenHealth (the District), as of and for the years ended December 31, 2021 and 2020, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and discretely presented component unit of the District, as of December 31, 2021 and 2020, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in

the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

U.S. generally accepted accounting principles require that the management's discussion and analysis on pages 3 through 18 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

KPMG LLP

Seattle, Washington
May 25, 2022

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)
Management's Discussion and Analysis
December 31, 2021 and 2020
(Unaudited)

This discussion and analysis of King County Public Hospital District No. 2, d/b/a EvergreenHealth (the District) provides an overview of the District's financial activities for the years ended December 31, 2021 and 2020. Please read it in conjunction with the District's financial statements, which follow this analysis.

The District is a municipal corporation of the State of Washington formed under the provisions of Chapter 70.44 of the Revised Code of Washington. The District is considered a political subdivision of the State of Washington and is allowed by law to be its own Treasurer.

The District includes the incorporated cities of Kirkland, Redmond, Woodinville, Kenmore, and Duvall, portions of Bothell, Sammamish, and Carnation, as well as adjacent unincorporated areas.

The District's primary operations include Evergreen Hospital Medical Center (the Medical Center), an acute care hospital with 318 licensed beds and a 15-bed freestanding inpatient hospice care center, representing the ninth largest provider in the Puget Sound.

Type of beds	Number of beds	License category
Critical care	20	Acute
Family maternity	36	Acute
Acute rehabilitation	14	Acute rehab
Medical/surgical	205	Acute
Neonatal intensive care unit (Level II = 29 beds; Level III = 14 beds)	43	Acute/newborn
Total beds for hospital acute license	318	
Hospice Care Center	15	Hospice

The Medical Center is accredited by the Joint Commission, a nonprofit organization that accredits more than 21,000 healthcare organizations and programs in the United States. The Medical Center provides clinical excellence in primary care and over 80 specialties, including, heart and vascular care, 24-hour level III trauma emergency care, cancer care, diabetes care, musculoskeletal and spine care, sleep services, oncology, surgical care, orthopedics, neurosciences, women's and children's services, and pulmonary care. Home care and hospice services cover both King and Snohomish counties as the largest provider in the Puget Sound.

The employed physician practices comprise 83 and 78 primary care providers in 2021 and 2020, respectively, and 258 and 266 specialty care providers in 2021 and 2020, respectively. Since 1972, the District's patient and family centered care philosophy, combined with its commitment to advancing medical solutions, has enabled the District to focus on providing excellent patient care.

The District is governed by a board of seven publicly elected commissioners, each elected by district residents to serve a six-year term in accordance with the laws of the State of Washington. The commissioners have delegated day-to-day operations of the District and the Medical Center to the chief executive officer/superintendent.

Utilization Statistics

Historical patient utilization data of the District's facilities is shown in the following table:

Utilization statistics	2021	2020	2019
Hospital Acute Licensed Care Beds	318	318	318
Hospice Care Center Licensed Beds	15	15	15
Acute care admissions	14,650	13,819	15,200
Acute care adjusted admissions	35,449	32,377	36,296
Acute care patient days	66,833	61,292	61,609
Acute care adjusted patient days	189,598	171,258	178,859
Acute care average length of stay	4.8	4.7	4.3
Occupancy (based on acute care licensed beds)	57.6%	52.8%	53.1%
Observation Days	3,425	2,223	2,069
Inpatient surgeries	2,224	2,239	2,944
Outpatient surgeries	12,716	11,716	12,491
Home health episodes and admissions	11,775	11,210	10,740
Home Hospice program days	189,931	184,755	184,678
Emergency room visits	56,652	47,643	59,802
Primary care work relative value units (wRVUs)	370,957	307,851	330,536
Specialty care wRVUs	1,021,184	874,838	959,520

Economic Factors Affecting the Current Environment and Future Direction of the District

The future direction of EvergreenHealth is guided by its vision to "create an inclusive community health system that is the most trusted source for healthcare solutions." The District takes a long-term, strategic view on the future of healthcare in the community and responds with plans that consider that perspective. Challenges and opportunities that face the District are similar to those that face the healthcare industry across the country. Among those issues are:

COVID-19 Pandemic Implications

In December 2019, a novel coronavirus (COVID-19) was identified in China and began to spread to other geographical locations, including the United States. EvergreenHealth was the initial "epicenter" of COVID-19, having reported the first two coronavirus deaths in the nation known at that time. As the result of COVID-19, healthcare organizations were faced with adverse financial impacts, volume-related and otherwise, supply chain disruptions, and difficulties with access to labor.

As a result of the first known COVID-19 deaths, the Governor of the State of Washington declared a state of emergency on February 29, 2020. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic and on March 13, 2020, the President of the United States declared a national emergency.

(Continued)

The District was among the first health systems to proactively postpone elective surgeries to preserve resources and supplies for the potential COVID-19 surge, which was then mandated for all Washington hospitals by Governor Jay Inslee on March 19, 2020. While mandated, the District temporarily suspended all nonurgent in-office visits and moved most outpatient medicine to telehealth and other alternative care options. The Governor modified the restrictions on elective procedures on May 18, 2020. However, the volumes did not resume normal levels, as patients were extremely cautious to return to healthcare environments for fear of contracting COVID-19. Many patients delayed or chose not to pursue healthcare treatment for both chronic and acute care needs. The cancellation of elective and nonurgent services during this period had a significant impact on volumes and financial performance. Additionally, the sentiment of fear impacted emergency and urgent care volumes as well, resulting in significant volume loss across the organization's urgent and emergency care locations.

In addition to the decreased revenue resulting from the mandated shut down, there was an increased cost to delivering patient care due to changes in staffing ratios, requirements for highly specialized nursing staff, Personal Protective Equipment (PPE) and labor carrying costs. With an unprecedented demand for medical supplies, including PPE, testing and other supplies draining inventory through normal supply chain channels, vendors and manufacturers placed premium pricing on some necessary items that exceeded standard costs. At the same time, use of PPE by providers increased, both due to current usage and the need to prepare for surge capacities and unknown patient volumes.

On March 27, 2020, the Coronavirus Aid Relief and Economic Security (CARES) Act was enacted. The CARES Act authorized $100 billion in a Provider Relief Fund for hospitals and healthcare providers. Funding was intended to compensate hospitals and other healthcare providers for lost revenue and increased expenses incurred in order to respond to the COVID-19 impact. Provider Relief Fund distributions are not required to be repaid, so long as the payment can be substantiated by lost revenue and the incremental costs incurred related to responding to the pandemic and certain terms and conditions are met. The District received over $40 million in CARES Act Provider Relief Fund distributions in 2020 and $3.5 million in 2021. Furthermore, the State of Washington distributed funds to healthcare providers through a Coronavirus Relief Fund of which the District received $488 thousand in 2020 and $118 thousand in 2021. Accelerated patient accounts receivable collection initiatives, financial recovery plans and a reduction to capital spend were implemented in an effort to conserve cash.

In addition to direct payments to healthcare providers, the CARES Act provided opportunities to increase cash flow. The CARES Act allowed inpatient acute care hospitals to receive accelerated Medicare payments equivalent up to six months of reimbursement. The accelerated payments are interest free if repaid according to the terms of the advance, which extend up to 29 months from the initial date of receipt. The District received over $41 million in Medicare advance payments in 2020. The payments are excluded from adjusted days cash calculations as a restricted source of funds and represent a deferred revenue liability on the statements of net position.

The CARES Act also provided the deferral of the employer portion of social security taxes as another source of cash flow for employers in need. The District deferred these taxes from March 27, 2020 through the end of the year. This resulted in a $12 million liability, which was repaid 50% by December 31, 2021 and 50% will be repaid by December 31, 2022 in accordance with the CARES Act.

(Continued)

The District also filed insurance claims related to losses sustained due to COVID-19 for Federal Emergency Management Agency (FEMA) assistance. The District received $1 million in insurance proceeds due to business interruption resulting from COVID-19 in 2020 and approximately $2.5 million for FEMA assistance in 2021.

The District and health systems across the United States continue to incur significant unforeseen costs due to the on-going pandemic. With COVID-19 vaccinations now available, hospitals and healthcare providers were tasked with establishing and operationalizing vaccine clinics with minimal upfront labor, financial and other resource support from the state and local government. In 2021, The District incurred significant costs pertaining to community vaccine efforts—first, establishing a vaccine clinic on the Kirkland campus and later, partnering with Overlake Medical Center & Clinics and Microsoft to open a mass vaccination site sponsored by Microsoft on their Redmond campus. The District was also tasked with creating and managing a call center to support the mass vaccination site in Redmond, fielding calls and managing patient communication—requiring substantial investment in new equipment, technology, training, and labor. Call volumes required additional staffing and a significant labor pool, including leadership oversight and third-party expertise.

To help further minimize volume loss, EvergreenHealth expedited implementation of virtual visits across all 12 primary care locations and the majority of specialties. Virtual visits continue to be in demand and offer an opportunity to continue providing patient care in the safest possible environments and conducive to patient preference. As a result, the District saw increased volumes in 2021 as compared to 2020 but still below prepandemic volumes.

Other Economic Factors

- **Financial Performance:** The District continues to implement service enhancement and growth plans, discussed below, which require significant capital outlays. The investment in new and expanded facilities may put initial financial constraints on the organization; however, management believes the District is positioned to better serve the needs of the community.
- **Competition:** The Puget Sound has experienced increased market consolidation and collaboration between healthcare providers over the past several years. In addition, competitors have opened traditional and nontraditional healthcare facilities both within and around the District boundaries with the intention of drawing patients from the service area. Competition includes not only local brick and mortar facilities, but also virtual/telehealth providers funded through venture capital or large organizations such as Amazon.
- **Operating Costs:** The volume indicators for acute care adjusted admissions, including deliveries, increased 9% and surgery counts increased 7% when compared to 2020. The District has continued working to manage its operating costs in line with volumes. Labor is the most significant operating cost for the District, representing approximately 67% of annual expenses. The District continues to implement various cost-saving initiatives, including supply chain standardization and improved labor productivity management.
- **Regulatory Environment:** Continued focus by regulatory agencies on the healthcare industry may impact the District.

(Continued)

- **Labor Availability:** Throughout 2021, the District continued to increase Nurse Tech roles, its New To Specialty programs and Registered Nurse (RN) Residency programs in order to decrease reliance on RN agency personnel and to proactively address expected RN retirements. Labor shortages continued for various positions. Similar to 2020, due to COVID-19, the District again experienced high patient volumes in combination with a significant RN labor shortage resulting in an increase in RN and other clinical agency personnel. Additionally, in an effort to meet the demand in the labor market for more flexible work schedules, the District created more part-time opportunities for staff. Approximately 48% of the District's 4,600 employees are members of one of four labor unions. The International Union of Operating Engineers (IUOE), which represents approximately 20 employees, last negotiated its labor contract in 2018 and is next scheduled to negotiate in early 2022. The United Food and Commercial Workers (UFCW) union, which represents approximately 250 professional/technical employees, last negotiated its labor contract in 2019 and is next scheduled to negotiate in 2023. The Service Employees International Union (SEIU) Healthcare 1199NW, which represents approximately 780 service employees and almost 100 social workers/chaplains, last negotiated its labor contracts in 2020 and is next scheduled to negotiate in the fall of 2022. The Washington State Nurses Association (WSNA), which represents approximately 1,060 registered nurses, last negotiated its labor contract in 2021 and is next scheduled to negotiate in 2024.
- **Contracting/Risk-Sharing Arrangements:** The District has six pay-for-performance contracts in effect as of 2021 with payors; three for the Medical Center and three for the EvergreenHealth Medical Group, a physician-led, physician-designed group of more than 330 primary care doctors and specialists. Via the Eastside Health Network, EvergreenHealth participates in an additional twelve value-based commercial contracts plus five Medicare Advantage contracts. All of these contracts are "layered" on top of existing fee-for-service arrangements between the District and those payors and provides for incentives based upon overall performance against specific goals related to efficiency, quality and patient satisfaction. See additional discussion under partnerships.
- **Payor Reimbursement:** Reimbursement for patient services from federal, state, and private insurance payors continues to be a concern as healthcare costs continue to rise. The District monitors reimbursement closely and works with payors in an effort to maintain payment levels and earn value-based reimbursement model revenue.
- **Partnerships:** During 2021 and 2020, the District continued to develop its strategic alliances with Seattle Cancer Care Alliance (SCCA), EvergreenHealth Monroe (EHM) and Overlake Hospital Medical Center.

  Overlake Hospital Medical Center – In 2016, the Boards of the District and Overlake Hospital Medical Center (Overlake) approved the exploration of a joint venture called *Eastside Health Alliance*. In November 2016, a letter of intent to form the joint venture was signed by the District and Overlake. The joint venture, which is designed to advance the shared mission of improving the health of Puget Sound's Eastside community, was subsequently approved by both Boards in January 2017. Eastside Health Alliance has been focusing on three specific areas guided by a joint venture board, comprising three board members and the CEO from each organization. The three areas include:

  - A coordinated quality and safety program
  - An Eastside-focused clinically integrated network, Eastside Health Network, that combined the Overlake Provider Network and EvergreenHealth Partners, LLC

– Service line collaborations in cardiac services and neurosciences. Both services lines are integrated from a clinical perspective. The cardiac and neurosciences service lines have been financially integrated since 2017 and 2020, respectively.

SCCA – The Halvorson Cancer Center, in collaboration with SCCA, has a shared vision to provide the highest quality, patient-centered, innovative and integrated care for cancer patients at EvergreenHealth. The partnership connects patients to promising new treatments with on-site access to the innovative research programs and breakthrough clinical trials of SCCA. The Halvorson Cancer Center treated 1,256 cancer cases in 2021, a 8% increase from the prior year.

EvergreenHealth Monroe (EHM) – The District's partnership with EHM continues to grow. EHM is governed by the Alliance Governance Board. Both organizations remain independently and separately governed, licensed, and accredited. The purpose of the affiliation is to provide EHM the ability to better serve its community through enhanced clinical services and to adopt the District's approaches to clinical outcomes, patient safety, and patient experience. Governmental Accounting Standards Board (GASB) No. 14 establishes that financial statements of the reporting entity generally should allow the users to distinguish between the primary government and its component units. EHM is reported within the District's financial statements as a discretely presented component unit in accordance with government accounting standards.

Other substantial changes anticipated in the U.S. healthcare system include numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers, and the legal obligations of health insurers, providers, and employers. Increasing patient obligations through high-deductible plans and increased premiums may increase bad debt. Management will continue evaluating its response to various healthcare reform components as they develop.

The District recognizes that providing the community with high-quality healthcare goes beyond offering outstanding programs and services. As the community continues to grow and age, the District must keep pace with the need for more types of services. The 2021 population within the District's boundaries is estimated to be 337,131. The population is projected to grow 8.8% over the next five years and reach 366,860 in 2026 according to the Environmental Systems Research Institute. The most recent version of the District's Master Campus Plan filed with the City of Kirkland in February 2017 includes facility and service expansions based on projected needs.

2021 Highlights

- **Governance and Leadership**
  - Welcomed new Chief Information Officer, Jason Wood
- **Initiated or Completed Projects**
  - Commenced the implementation of Epic, a new electronic medical records and billing system
  - Commenced the renovation and construction of Women's & Children's services facilities

(Continued)

- Opened a new Intensive Care Unit
- Opened a Cancer Risk Reduction Clinic
- Opened a new Midwifery practice
- Implemented a Physical Therapy at Home program
- Implemented Code Lavender, a national best practice crisis intervention tool provided by an interdisciplinary group of professionals to support health care workers who are experiencing stress, trauma or challenging events at any point in time
- Implemented Schwartz Rounds®, a national best practice to bring doctors, nurses and other caregivers together to discuss the social and emotional side of caring for patients and families

- **Recognition and Awards**
  - Received a 5-star rating from Centers for Medicare and Medicaid Services (CMS) in the 2021 Hospital Compare overall quality systems rankings (one of 455 hospitals nationwide and one of three within the Puget Sound region)
  - Recognized by Healthgrades as America's 50 Best Hospitals in 2021
  - Recognized by Healthgrades as America's 100 Best Hospitals for Pulmonary, Gastrointestinal Care, Gastrointestinal Surgery, Stroke Care, and Critical Care
  - Recognized by Healthgrades with an Excellence Award for Neurosciences, sixth consecutive year
  - Awarded an "A" rating for patient safety for Spring and Fall 2021 by The Leapfrog Group. Sixth consecutive "A" rating
  - Recognized by the American Heart Association and American Stroke Association for achievement in the Get With The Guidelines® - Stroke Elite Gold Plus Quality Achievement for the fifth consecutive year
  - Received Primary Plus Stroke Center (PSC+) Certification from DNV GL Healthcare
  - Recognized by Practice Greenhealth as a Partner for Change for conservation and recycling programs in 2021. This is the 12th year out of the past 13 years for this award
  - Accredited as a Comprehensive Center with Obesity Medicine Qualifications by the American College of Surgeons and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program in 2021
  - U.S. News recognized EvergreenHealth for high performance in eight specialty areas, placing it in the top 10% of hospitals in patient outcomes. Those specialty areas include:
    - Knee Replacement (fifth consecutive year)
    - Colon Cancer Surgery (fourth consecutive year)
    - Heart Failure (third consecutive year)

- Hip Replacement (third consecutive year)
- Urology (third consecutive year)
- Chronic Obstructive Pulmonary Disease (COPD) (second consecutive year)

Overview of the Financial Statements

The District's financial statements consist of three components: statements of net position; statements of revenue, expenses, and changes in net position; and statements of cash flows. The activities of EvergreenHealth Foundation (the Foundation) are included with the District's financial statements as a blended component unit. These financial statements and related notes provide information about the activities of the District, including resources held by the District designated for specific purposes. The statements of net position includes all of the District's assets and liabilities, using the accrual basis of accounting, as well as an indication about which assets can be utilized for general purposes and which are restricted for a specific purpose. The statements of revenue, expenses, and changes in net position report all of the revenue, expenses, and changes in net position during the time periods indicated. The statements of cash flows report the cash provided by the District's operating activities, as well as other cash sources such as investment income and issuance of new debt, and use of cash such as cash payments for capital asset additions and improvements and repayment of debt.

On March 1, 2015, the District entered into a Strategic Alliance Agreement with EHM. GASB standards require that this entity be presented as a discrete component unit; therefore, its financial position at December 31, 2021 and 2020 and the results of its operations for the years ended December 31, 2021 and 2020 are included with the District in a separate column for financial statement presentation purposes (see further discussion at note 1 to the financial statements).

The analysis presented below represents the District and its blended component unit (the Foundation), but excludes the financial position and results of operations of its discrete component unit (EHM), unless otherwise noted.

Summary of Statements of Net Position

(In thousands)

		2021	2020	2019
Cash and cash equivalents	$	70,149	83,847	57,267
Patient accounts receivable, less allowance for uncollectible accounts		114,017	86,296	95,247
Other current assets		39,960	36,477	30,713
Total current assets		224,126	206,620	183,227

(Continued)

Summary of Statements of Net Position

(In thousands)

		2021	2020	2019
Assets limited as to use, less current portion of amounts required for current liabilities	$	309,361	315,140	164,220
Capital assets, net		326,320	310,158	320,829
Other assets		28,332	28,826	33,634
Total assets		888,139	860,744	701,910
Deferred outflows of resource:				
Deferred loss on refunding		8,184	2,830	2,542
Total assets and deferred outflows of resources	$	896,323	863,574	704,452
Current portion of long-term debt and capital lease obligations	$	15,389	14,470	14,219
Other current liabilities		131,128	99,401	90,324
Total current liabilities		146,517	113,871	104,543
Long-term liabilities		294,087	309,015	184,395
Total liabilities		440,604	422,886	288,938
Net position:				
Invested in capital assets, net of related debt		114,924	86,507	130,714
Restricted		12,851	15,760	8,482
Unrestricted		327,944	338,421	276,318
Total net position		455,719	440,688	415,514
Total liabilities and net position	$	896,323	863,574	704,452

Current Assets

Current assets consist of cash and cash equivalents, current portion of board-designated and restricted assets, and other current assets that are expected to be converted to cash within one year. Current assets also include net patient accounts receivable valued at the estimated net realizable amount due from patients and insurers. Key ratios include:

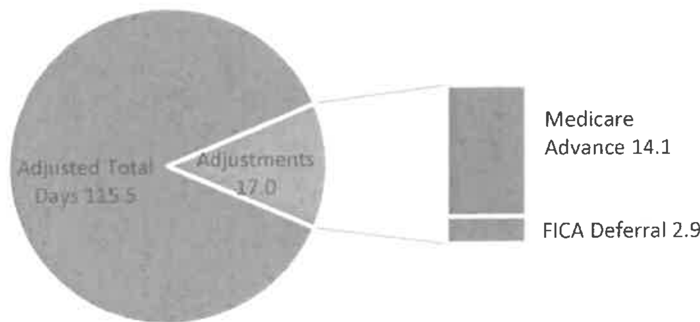
- Current ratio: This is a liquidity ratio that measures the District's ability to pay short-term obligations or debts due within one year. The current ratio is calculated by dividing current assets by current liabilities.

(Continued)

- Days in accounts receivable: This is the number of days it takes the District to collect outstanding patient accounts. The ratio is calculated by dividing the ending accounts receivable by the total operating revenue for the period and multiplying it by 365 days or the number of days in the period.
- Days cash on hand: This demonstrates how long in days the District could meet operating expenses with the amount of cash currently available. This is calculated by adding cash and cash equivalents, board-designated cash and investments, less cash for EvergreenHealth Network and EvergreenHealth Partners, and multiplying by 365 days, then dividing the amount by total operating expenses less annual depreciation.
- Adjusted days cash on hand: This demonstrates how long in days the District could meet operating expenses with the amount of cash currently available, excluding cash intended to be repaid to funding sources. This is calculated by adding cash and cash equivalents, board-designated cash and investments, less cash for the CARES Act deferred payment of the employer portion of social security liability and the CARES Act Medicare Accelerated and Advance Payment Program liability, and multiplying by 365 days, then dividing the amount by total operating expenses less annual depreciation.

Key ratios	2021	2020	2019
Current Ratio	1.5	1.4	1.8
Days in AR (Net)	50.7	38.9	46.9
Days Cash on Hand	132.6	168.4	108.0
Adjusted Days Cash on Hand	115.5	125.3	108.0

Days Cash Composition (days)



■ Adjusted Days Cash ■ Medicare Advance ■ FICA Tax deferral

Total current assets were $224.1 million as of December 31, 2021, compared to $206.6 million as of December 31, 2020.

Current assets in 2021 increased by $17.5 million compared to 2020 primarily due to an increase in net patient accounts receivable resulting from increased volumes. Adjusted days cash on hand decreased to 116 days.

Current assets in 2020 increased by $23.4 million compared to 2019 primarily due to increases of $26.6 million in cash and cash equivalents due to the CARES Act Medicare Advance Payment and the deferral of the employer portion of social security payroll taxes. Adjusted days cash on hand was 125 days.

Noncurrent Assets

Noncurrent assets consist of restricted and board-designated assets held for debt service, capital improvements, community service programs, and other operations. Total noncurrent assets were $664.0 million as of December 31, 2021, compared to $654.1 million as of December 31, 2020.

Capital assets, net of accumulated depreciation increased approximately $16.2 million from 2020 to 2021 and decreased $10.7 million from 2019 to 2020. The District continues to devote resources for capital projects and improvements, including significant components of the master facility plan. During 2021 and 2020, the District invested approximately $55.1 million and $25.6 million, respectively, in buildings, information technology, and equipment. This District recognized $37.8 million and $35.8 million in depreciation expense in 2021 and 2020, respectively.

Restricted and board-designated cash and investments decreased approximately $5.8 million from 2020 to 2021. The decrease in the current year is primarily due $26.1 million of the 2020A Limited Tax General Obligation (LTGO) bonds used for capital improvements to the District's healthcare facilities, in accordance with the long-term master facility plan and $30.0 million defeasance of the 2020 LTGO Series (fixed rate) – direct borrowing, offset by the issuance of new bond funds of $51.6 million related to the financing of Epic. Restricted and board-designated cash and investments increased approximately $150.9 million from 2019 to 2020. The increase from 2019 to 2020 was primarily due to the issuance of $70 million for the 2020A and 2020B LTGO bonds to be used for capital improvements to the District's healthcare facilities, in accordance with the long-term master facility plan. In addition, proceeds from the $30 million 2020 Limited Tax General Obligation and Revenue Bond, issued in August 2020, and other excess cash were transferred from the general fund to the investment account.

Current Liabilities

Current liabilities consist of accounts payable, accrued compensation and other liabilities that are expected to be paid within one year, including current portion of long-term debt and professional liabilities. Total current liabilities were $146.5 million as of December 31, 2021, compared to $113.9 million as of December 31, 2020.

Current liabilities increased approximately $32.6 million from 2020 to 2021 and increased approximately $9.4 million from 2019 to 2020. Accounts payable and accrued expenses increased $3.9 million from 2020 to 2021. In addition, other current liabilities increased $26.2 million, mainly related to the current portion of the accelerated Medicare advance payments received as part of the CARES Act funding. The change in payables and accrued expenses is primarily due to the timing of regular accounts payable cycles.

(Continued)

Noncurrent Liabilities

Noncurrent liabilities consist of long-term debt, capital lease obligations, and professional liability reserves. Total noncurrent liabilities were $294.1 million as of December 31, 2021, compared to $309.0 million as of December 31, 2020.

Noncurrent liabilities decreased approximately $14.9 million from 2020 to 2021 due to the debt issuances and refundings that occurred in 2021 and debt payments in accordance with the established debt service schedule and the noncurrent portion of the Medicare advance payments becoming current in 2021.

Noncurrent liabilities increased approximately $124.6 million from 2019 to 2020 due to the debt issuances that occurred in 2020, offset by debt payments in accordance with the established debt service schedule, and the long-term liabilities associated with the accelerated Medicare advance payments and the payroll tax deferral.

Net Position

The current year net position increase is driven by net income and capital grants and contributions of approximately $15.0 million. The increase from 2019 to 2020 was driven by 2020 net income and capital grants and contributions of approximately $25.2 million, which are accounted for in the net investment in capital asset and restricted categories discussed below.

Investment in capital assets, net of related debt increased approximately $28.4 million, or 33%, from 2020 to 2021 and decreased approximately $44.2 million, or 34%, from 2019 to 2020. The current year increase is primarily attributable to debt obligations of approximately $152 million for the LTGO debt issuances that occurred in 2021, offset by approximately $82 million of unspent bond proceeds and $65 million of refunded bonds. The decrease from 2019 to 2020 is attributable to debt obligations of approximately $100 million for the LTGO debut issuances that occurred in 2020, offset by approximately $56 million of unspent bond proceeds.

Restricted net position (expendable and nonexpendable) decreased approximately $2.9 million from 2020 to 2021 and increased $7.5 million from 2019 to 2020, representing resources with temporary or permanent donor restrictions.

Unrestricted net position, which includes other funds available to the District that do not meet the definition of restricted or net investment in capital assets, decreased approximately $10.5 million, or 3%, from 2020 to 2021 and increased approximately $62.1 million, or 22%, from 2019 to 2020. This decrease from 2020 to 2021 offset the increase in investment in capital assets, net of related debt.

Summary of Revenue, Expenses, and Changes in Net Position

(In thousands)

	2021	2020	2019
Operating revenue:			
Net patient service revenue	$ 768,533	664,008	698,348
Other operating revenue	52,195	46,336	42,768
Total operating revenue	820,728	710,344	741,116
Operating expenses:			
Labor and employee benefits	557,211	489,301	488,168
Supplies, purchased services, and other	238,230	228,059	218,278
Depreciation and amortization	37,830	35,828	35,399
Total operating expenses	833,271	753,188	741,845
Excess (deficit) of revenue over expenses from operations	(12,543)	(42,844)	(729)
Nonoperating income, net of expenses:			
Property taxes	27,968	27,872	26,805
Interest and amortization expense	(9,081)	(9,106)	(7,549)
Investment income (loss)	(371)	6,033	6,698
Federal Stimulus Funding	6,170	40,974	—
Other, net	(492)	62	44
Net nonoperating income	24,194	65,835	25,998
Excess of revenue over expenses	11,651	22,991	25,269
Capital grants and contributions	3,380	2,183	2,835
Total change in net position	15,031	25,174	28,104
Net position, beginning of year	440,688	415,514	387,410
Net position, end of year	$ 455,719	440,688	415,514

(Continued)

Financial Highlights

Revenue

Sources of Patient Revenue

The District derives a substantial portion of its operating revenue from federal and state programs and insurance plans that pay for all or a portion of the healthcare services provided to its patients. As a consequence, the District's operating revenue depends to a great extent on the availability and level of reimbursement or payment under those programs and contracts.

In 2021, gross patient revenue increased by approximately $196.5 million or 10.3%. Gross patient revenue is the total fees charged to patients for services. Total inpatient revenue increased $41.1 million or 5.1% and total outpatient revenue increased $155.4 million or 14.1%. Total outpatient surgery cases increased 8.5% while inpatient surgery cases decreased 0.7%. Overall total surgery cases increased 7.1%. Deliveries increased 8.8% and patient days in the NICU decreased 1.0%. ED visits in the main hospital and in Redmond increased 15.8% and 33.8%, respectively. Total average length of stay (excluding NICU) increased to 4.8 days from 4.7 days in 2020.

In 2020, gross patient revenue decreased by approximately $113.4 million or 5.6%. Gross patient revenue is the total fees charged to patients for services. Total inpatient revenue decreased $30.5 million or 3.6% and total outpatient revenue decreased $82.9 million or 7%. The main driver of revenue declines was related to COVID-19 and the mandated suspension of elective procedures in Spring 2020. COVID-19 negatively impacted most services lines, including surgical services, deliveries, emergency department visits, and overall clinic volumes. Total outpatient surgery cases decreased 6.2% while inpatient surgery cases decreased 23.9%. Overall total surgery cases decreased 9.6%. Deliveries and patient days in the NICU decreased 6.5% and 13.8%, respectively. ED visits in the main hospital and in the Redmond ED decreased 20% and 21.8%, respectively. Total average length of stay (excluding NICU) increased to 4.7 days from 4.3 days in 2019.

The following table sets forth the percentages of the District's gross patient revenue applicable to various programs and plans for the fiscal years ended December 31, 2021, 2020, and 2019.

	2021	2020	2019
Non-Government third-party payors	46.7%	46.2%	47.4%
Medicare	42.4	42.8	42.4
Medicaid	10.0	10.1	9.0
Patient self-pay	0.9	0.9	1.2

In 2021, net patient service revenue increased by approximately $104.5 million or 15.7%. Net patient revenue consists of gross patient revenue less contractual adjustments, bad debt, and charity. This increase was driven by increased volumes compared to the prior year. Other operating revenue increased by approximately $5.9 million, or 12.6%, primarily due to revenue associated with increased research studies completed and revenue from the Evergreen Radia joint venture.

(Continued)

In 2020, net patient service revenue decreased by approximately $34.3 million or 4.9%. Net patient revenue consists of gross patient revenue less contractual adjustments, bad debt, and charity. This decrease was driven by reduced volumes due to COVID-19. Other operating revenue increased by approximately $4.2 million, or 9.9%, primarily due to revenue associated with increased research studies completed and revenue from the Eastside Health Alliance joint ventures.

Operating Expenses

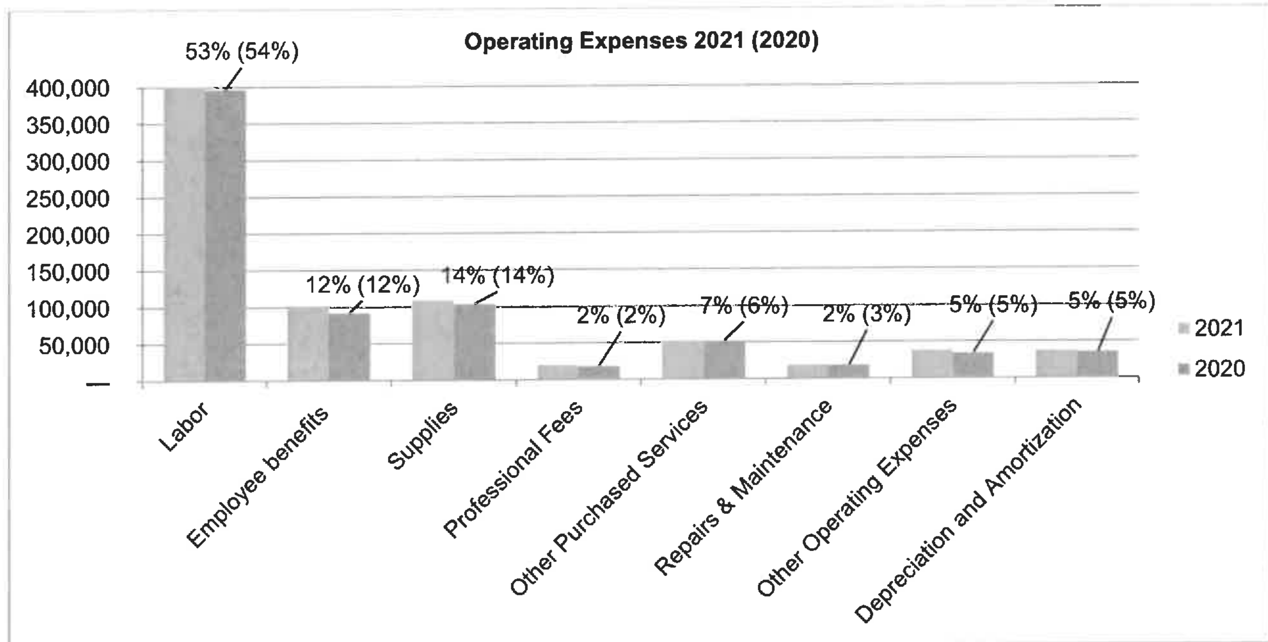
Labor, including contract labor, increased approximately $58.0 million, or 14.6%, and increased $2.5 million, or 0.6%, in 2021 and 2020, respectively. The District's average employed and contracted full-time equivalents increased 5.8% to 3,995 as of December 31, 2021, compared to 3,777 as of December 31, 2020. The 2021 increase is due to increased volumes, employee salary increases as well as premium pay related to contract labor and employee overtime due to labor shortages.

Employee benefit expenses increased $9.9 million, or 10.7%, and $3.6 million, or 4.1%, in 2021 and 2020, respectively. These increases were primarily due to increased number of full-time equivalent employees, medical plan, social security, unemployment and paid time off costs.

Supplies, professional fees, purchased services, repairs and maintenance services, and other operating expenses increased approximately $10.2 million, or 4.5%, and $10.4 million, or 4.8%, in 2021 and 2020, respectively. The increase is due to increased medical supply costs, purchased services, and professional fees due to COVID-19 response and mitigation.

(Continued)

Total operating expenses in 2021 and 2020 of $833.3 million and $753.2 million, respectively, include expenses related to tax-supported community programs for which the offsetting revenue is included in nonoperating income. The table below is presented in thousands.



Nonoperating Income, Net of Expenses

In 2021, nonoperating income, net of expenses decreased $41.6 million, from $65.8 million in 2020 to $24.2 million in 2021. The decrease is due to the recognition of $41.0 million of CARES Act Provider Relief Funds in 2020 whereas $6.2M was recognized in 2021 and losses on investments of $371 thousand compared to investment income of $6.2 million in 2020. There were no significant asset sales in 2021.

In 2020, nonoperating income, net of expenses increased $39.8 million, from $26.0 million in 2019 to $65.8 million in 2020. The increase is due to the recognition of $40 million of CARES Act Provider Relief Funds. There were no significant asset sales in 2020.

Contacting the District's Financial Management

This financial report provides the reader with a general overview of the District's finances and operations. If you have questions about this report or need additional financial information, please contact the Chief Financial Officer or Director of Financial Reporting at EvergreenHealth, 12040 NE 128th Street, Kirkland, Washington 98034.

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Statements of Net Position

December 31, 2021 and 2020

(In thousands)

Assets	2021 District	2021 Component unit EHM	2020 District	2020 Component unit EHM
Current assets:				
Cash and cash equivalents	$ 70,149	11,276	83,847	11,431
Current portion board-designated assets	3,043	1,954	805	214
Current portion of assets restricted as to use	1,290	—	1,318	1,756
Patient accounts receivable, less allowance for uncollectible accounts of $17,924 (District) and $1,304 (EHM) in 2021 and $19,930 (District) and $1,170 (EHM) in 2020, respectively	114,017	8,740	86,296	7,699
Inventory	8,096	845	8,921	1,017
Prepaid expenses and other current assets	22,637	728	22,491	1,147
Third-party payor receivable	4,894	284	2,942	212
Total current assets	224,126	23,827	206,620	23,476
Assets limited as to use, less current portion of amounts required for current liabilities:				
Board-designated cash and investments	304,233	—	310,410	—
Restricted cash and investments	5,128	—	4,730	—
	309,361	—	315,140	—
Capital assets:				
Land	4,914	1,879	4,914	1,879
Construction in progress	33,286	219	24,574	202
Depreciable capital assets, net of accumulated depreciation	288,120	10,885	280,670	12,910
	326,320	12,983	310,158	14,991
Other assets	28,332	—	28,826	—
Total assets	888,139	36,810	860,744	38,467
Deferred outflows of resources:				
Deferred loss on refunding	8,184	—	2,830	—
Total assets and deferred outflows of resources	$ 896,323	36,810	863,574	38,467

(Continued)

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Statements of Net Position

December 31, 2021 and 2020

(In thousands)

Liabilities and Net Position		2021 District	2021 Component unit EHM	2020 District	2020 Component unit EHM
Current liabilities:					
Accounts payable and accrued expenses	$	34,128	4,005	30,257	2,967
Accrued compensation and related liabilities		53,470	3,319	53,201	3,230
Accrued interest payable		731	52	802	55
Current portion of long-term debt and capital lease obligations		15,389	1,421	14,470	2,505
Third-party payor payable		7,328	—	6,070	—
Estimated current portion of professional liability		1,351	—	1,162	—
Other current liabilities (including CARES Act)		34,120	2,522	7,909	1,322
Total current liabilities		146,517	11,319	113,871	10,079
Long-term estimated professional liability		5,082	—	5,477	—
Other noncurrent liabilities (including CARES Act)		11,290	845	38,128	4,002
Long-term debt and capital lease obligations, net of current portion		277,715	19,045	265,410	23,503
Total liabilities		440,604	31,209	422,886	37,584
Net position:					
Investment in capital assets, net of related debt		114,924	(5,818)	86,507	(5,201)
Restricted:					
Expendable for specific activities		9,485	1,664	9,368	1,664
Expendable for debt service		989	206	971	214
Nonexpendable permanent endowments		2,377	—	5,421	—
Unrestricted		327,944	9,549	338,421	4,206
Total net position		455,719	5,601	440,688	883
Total liabilities and net position	$	896,323	36,810	863,574	38,467

See accompanying notes to financial statements.

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Statements of Revenue, Expenses, and Changes in Net Position

December 31, 2021 and 2020

(In thousands)

	2021		2020	
	District	**Component unit EHM**	**District**	**Component unit EHM**
Net patient service revenue (net of provision for bad debts of $16,930 (District) and $4,023 (EHM) in 2021 and $14,991 (District) and $4,425 (EHM) in 2020, respectively)	$ 768,533	43,538	664,008	38,857
Other operating revenue	52,195	2,097	46,336	2,637
Total operating revenue	820,728	45,635	710,344	41,494
Expenses:				
Labor	454,783	25,528	396,802	24,193
Employee benefits	102,428	5,981	92,499	6,892
Supplies	109,418	6,414	104,116	6,133
Professional fees	19,523	2,056	18,768	2,144
Other purchased services	52,559	6,630	52,263	6,610
Repairs and maintenance	19,053	820	18,716	750
Other operating expenses	37,677	1,958	34,196	1,901
Depreciation and amortization	37,830	2,332	35,828	2,419
Total operating expenses	833,271	51,719	753,188	51,042
Excess (deficit) of revenue over expenses from operations	(12,543)	(6,084)	(42,844)	(9,548)
Nonoperating income, net of expenses:				
Property taxes	27,968	5,048	27,872	4,921
Interest and amortization expense	(9,081)	(741)	(9,106)	(807)
Investment income (loss)	(371)	—	6,033	—
Federal stimulus funding	6,170	291	40,974	6,198
Other, net	(492)	6,153	62	(24)
Net nonoperating income	24,194	10,751	65,835	10,288
Excess (deficit) of revenue over expenses	11,651	4,667	22,991	740
Capital grants and contributions	3,380	51	2,183	37
Total change in net position	15,031	4,718	25,174	777
Net position, beginning of year	440,688	883	415,514	106
Change in accounting principle	—	—	—	—
Net position, end of year	$ 455,719	5,601	440,688	883

See accompanying notes to financial statements.

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Statements of Cash Flows

December 31, 2021 and 2020

(In thousands)

	2021	2020
Cash flows from operating activities:		
Cash received from and on behalf of patients	$ 741,785	670,877
Payments to suppliers and contractors	(235,257)	(191,840)
Payments to employees	(556,941)	(489,464)
Distributions received from / provided to joint ventures	(255)	2,726
Other cash receipts	50,784	46,035
Net payments provided by operating activities	116	38,334
Cash flows from noncapital financing activity:		
Property taxes received for community programs	6,842	5,912
Cash received for CARES Act funding	6,196	41,011
Net cash provided by noncapital financing activity	13,038	46,923
Cash flows from capital and related financing activities:		
Purchases of capital assets	(55,817)	(13,206)
Proceeds from sale of capital assets	470	30
Principal payments on long-term debt and capital lease obligations	(18,732)	(13,849)
Payments for interest on long-term debt	(9,153)	(9,573)
Proceeds from issuance of long-term debt	152,175	132,095
Proceeds from premium on refunding bonds	—	10,603
Payments to refunding bond escrow agent	(118,835)	(40,450)
Payment of debt issuance costs	(1,286)	(1,086)
Proceeds from property taxes related to debt service	21,126	21,960
Net cash (used in) provided by capital and related financing activities	(30,052)	86,524
Cash flows from investing activities:		
Purchases of board-designated assets and assets restricted as to use	(17,185)	(189,277)
Proceeds from sale of board-designated assets and assets restricted as to use	20,756	38,044
Investment income	(371)	6,032
Net cash provided by (used in) investing activities	3,200	(145,201)
Net (decrease) increase in cash, cash equivalents and restricted deposits	(13,698)	26,580
Cash, cash equivalents and restricted deposits, beginning of year	83,847	57,267
Cash, cash equivalents and restricted deposits, end of year	$ 70,149	83,847

(Continued)

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Statements of Cash Flows

December 31, 2021 and 2020

(In thousands)

	2021	2020
Reconciliation of deficit of revenue over expenses from operations to net cash provided by (used in) operating activities:		
Deficit of revenue over expenses from operations	$ (12,543)	(42,844)
Adjustments to reconcile deficit of revenue over expenses from operations to net cash provided by (used in) operating activities:		
Depreciation and amortization	37,830	35,828
Provision for bad debts	16,930	14,991
Other	2,471	(2,032)
Changes in operating assets and liabilities:		
Patient accounts receivable, less provision for bad debt	(44,651)	(6,040)
Inventory	825	443
Prepaid expenses and other assets	(8,096)	1,114
Accounts payable and accrued expenses, net of amounts related to construction in progress	34,207	1,140
Accrued compensation and related liabilities	269	(162)
Third-party payor settlements, net	(1,951)	(1,049)
Professional liability and other liabilities	(25,175)	36,945
Net cash provided by operating activities	$ 116	38,334
Supplemental disclosures of noncash investing, capital, and financing activities:		
Change in capital asset additions included in accounts payable and accrued expenses	$ 4,126	(6,753)
Change in capital asset additions acquired by capital lease	—	(3,489)
Gain (loss) on sale of capital assets	606	—
Donated capital assets	3,380	2,183

See accompanying notes to financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

King County Public Hospital District No. 2, King County, Washington, d/b/a EvergreenHealth (the District) is a municipal corporation established under Chapter 70.44 of the Revised Code of the State of Washington (RCW). The purpose of the District is to own and operate hospitals and other healthcare facilities and provide healthcare services to area residents. The District's primary operations include Evergreen Hospital Medical Center (the Medical Center), an acute care hospital; Evergreen Home Health Services, a home health agency; Evergreen Hospice Services, a program serving the terminally ill; EvergreenHealth Medical Group, a multispecialty practice group consisting of family practice physicians, physician assistants, and certified nurse practitioners; and EvergreenHealth Foundation (the Foundation). Affiliated organizations are evaluated for inclusion in the reporting entity as component units based on the significance of their relationship with the District.

(i) Blended Component Unit

The Foundation is a separate nonprofit foundation. The purpose of the Foundation is to (a) receive grants, bequests, donations, and contributions on behalf of; (b) provide fund-raising and other support to; and (c) make contributions to the District. Consequently, the net financial position and the results of operations of the Foundation are included in the accompanying financial statements. For the years ended December 31, 2021 and 2020, the Foundation raised approximately $5.5 million and $4.9 million in contributions (included in other operating revenue) and its assets comprise 1.6% and 1.5% of total assets of the District in 2021 and 2020, respectively.

(ii) Discrete Component Unit

The District and EvergreenHealth Monroe (EHM), a 72-bed semirural community hospital (together with a 40-bed residential treatment facility license), entered into a Strategic Alliance Agreement effective March 1, 2015. EHM is located in Monroe, Washington and is a separate legal entity governed by the Alliance Governance Board (AGB). The AGB comprises five directors, consisting of two commissioners of the District, two commissioners of EHM, and the District CEO.

The audited financial statements of EHM are available by contacting EHM at 14701 179th Avenue SE, Monroe, Washington 98272 or online at the following address:

www.evergreenhealthmonroe.com/governance-and-leadership-monroe

(b) Basis of Presentation

The financial statements have been prepared on the accrual basis of accounting. Under this method of accounting, revenue is recognized when earned and expenses are recorded when liabilities are incurred without regard to receipt or disbursement of cash.

(Continued)

The District prepares and presents its financial information in accordance with Government Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (GASB 34), known as the "Reporting Model" statement. GASB 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the reporting entity in the form of "management's discussion and analysis" (MD&A). This reporting model also requires the use of a direct method cash flow statement.

(c) Financial Reporting Entity

As required by accounting principles generally accepted in the United States of America (GAAP), these financial statements present the District, the primary government, and its component units, the Foundation and EHM.

Component units are legally separate organizations for which the District is financially accountable. These entities may be reported in the financial statements of the primary government in one of two ways: the component units' amounts may be blended with the amounts reported by the primary government, or they may be shown in a separate column, depending on the application of the criteria of GASB Statement No. 61, *The Financial Reporting Entity: Omnibus*. The Foundation meets the criteria of a blended component unit and has been included in the financial statements. EHM does not meet the criteria of a blended component unit and has been reported as a discretely presented component unit in a separate column of the financial statements.

(d) Use of Estimates

The preparation of financial statements in conformity with 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 financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates in the District's financial statements include patient accounts receivable allowances, third-party payor settlements, professional liabilities, and the fair value of investments.

(e) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid financial instruments with original maturities of three months or less, excluding assets restricted as to use and board-designated assets. Deposits of up to $250 thousand are covered by the Federal Deposit Insurance Corporation and any deposits in excess of $250 thousand are covered by collateral held in a multifinancial institution collateral pool administered by the Washington Public Deposit Protection Commission.

(f) Patients Accounts Receivable

Receivables arising from revenue for services to patients are reduced by an allowance for contractuals and estimated uncollectible accounts based on recent collection experience and other circumstances, which may affect the ability of patients to meet their obligations. There are various factors that can impact the collection trends and the estimation process, such as changes in the economy, the increased burden of copays, and deductibles to be made by patients and business practices related to collection efforts. Accounts deemed uncollectible are charged against this allowance.

(Continued)

(g) Assets Limited as to Use

Assets limited as to use include assets designated by the Board of Commissioners (the Board) for capital improvements and community service programs. The Board retains control of the assets and may, at its discretion, subsequently change the use for other purposes. Assets limited as to use include certain assets of the Foundation that are restricted by donor stipulations. Assets limited as to use also include unexpended proceeds and income generated from certain outstanding bond series restricted for the payment of principal, interest, and expenditures for construction and equipment costs. The assets of the Supplemental Executive Retirement Plan (SERP) are also recorded as assets limited as to use. The SERP is a postretirement plan covering the executive management team. Amounts required to meet related current liabilities have been classified as current assets in the accompanying statements of net position. These assets are carried at fair value with changes in fair value reported as investment income.

(h) Inventory

Inventory consists of pharmaceutical, medical-surgical, and other supplies used in the operation of the District. Inventory is stated at the lower of cost, determined on a first-in, first-out basis, or net realizable value.

(i) Capital Assets

Capital assets are recorded at cost. In accordance with governmental accounting standards, the District has established a capitalization threshold of $3 thousand and a life of three years or more, above which asset acquisitions are added to the capital asset accounts. Donated items are recorded at fair value at the date of the contribution. Depreciation expense is computed using the straight-line method based on the following estimated useful lives of the assets:

Land improvements	10–20 Years
Buildings	25–40 Years
Equipment	3–20 Years

Maintenance and repairs are expensed as incurred. Expenditures that materially increase values, change capacities, or extend useful lives of plant and equipment are capitalized.

Equipment under capital lease is amortized on the straight-line method over the shorter of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying statements of revenue, expenses, and changes in net position.

(j) Compensated Absences

The District's employees earn vacation days at varying rates depending on years of service. Accrued vacation is reported as a current liability as employees utilize their vacation days within the following year.

(k) Net Position

Net position of the District is classified in five components. Investment in capital assets, net of related debt consists of capital assets, net of accumulated depreciation, reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted expendable net position includes expendable for specific activities and expendable for debt service and must be used for a particular purpose, as specified by grantors or contributors external to the District. Restricted nonexpendable net position equals the principal portion of permanent endowments. Unrestricted net position does not meet the definition of investment in capital, net of related debt or restricted. The District will first apply restricted resources when an expense is incurred for purposes for which both unrestricted and restricted net position are available.

(l) Operating Revenue and Expenses

The District's statements of revenue, expenses, and changes in net position distinguish between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing healthcare services — the District's principal activity. Nonoperating income includes property taxes received or grants and contributions received for purposes other than capital asset acquisition. Operating expenses are all expenses incurred to provide healthcare services.

Other operating revenue includes tenant lease receipts, distributions from joint ventures, outreach laboratory service revenue, retail revenue such as gift shop and pharmacy, educational offerings, grant funds to support specific programs, restricted donations, research activities, and other services.

(m) Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(n) Charity Care

The District accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to an established policy of the District. The estimated cost of charity care is determined by calculating the ratio of operating costs to charges, and then applying this ratio to total charity care charges. The estimated costs of charity care provided by the District were $3.3 million and $3.2 million for 2021 and 2020, respectively. Because the District does not pursue collection of amounts determined to qualify as charity care, associated charges are not included in net patient service revenue.

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(o) Nonoperating Income, Net of Expenses

The District received property taxes from regular levy proceeds and voter approved excess levies. These funds were used as follows:

		December 31	
		2021	2020
		(In thousands)	
Amount used for tax-supported programs	$	6,842	5,912
Amounts used for debt service on general obligation bonds		21,126	21,960
	$	27,968	27,872

Of the amount used for debt service on general obligation bonds, $7.3 million and $9.3 million were used for interest payments for the years ended December 31, 2021 and 2020, respectively. The property taxes received are reflected in nonoperating income. Interest expense related to long-term debt is included in nonoperating expenses. All other expenses related to tax supported programs are included in operating expenses.

Investment income includes interest income and realized and unrealized gains and losses on board-designated assets and earnings on cash deposits.

Coronavirus Aid Relief and Economic Security (CARES) Act income includes distributions from both the Federal and State level related to COVID-19 relief programs.

(p) Federal Income Taxes

No provisions have been made for federal income taxes, as the District and EHM are municipal corporations exempt from federal tax, under Section 115 of the Internal Revenue Code.

The Foundation is an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and is generally not subject to federal income taxes. However, the Foundation is subject to income taxes on any net income that is derived from a trade or business, regularly carried on, and not in furtherance of the purposes for which it was granted exemption. No income tax provision has been recorded as the net income, if any, from any unrelated trade or business, in the opinion of management, is not material to the financial statements taken as a whole.

(q) Recently Issued Accounting Standards

In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance* (GASB No. 95). This Statement extends the effective dates of certain accounting and financial reporting provisions to provide temporary relief to governments and other stakeholders in light of the COVID-19 pandemic. The requirements are effective for certain Statements originally effective for reporting periods beginning after June 15, 2018. The District adopted the above GASB statement on January 1, 2019 and delayed the implementation of certain applicable statements accordingly. There are no financial statement impacts or reclassifications associated with adoption of GASB 95.

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In June 2017, the GASB issued Statement No. 87, *Leases* (GASB No. 87). This Statement requires the recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. Therefore, it establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources. GASB No. 95 delays the implementation of this Statement to fiscal years beginning after June 15, 2021. The District has started implementation work and will retroactively adopt on January 1, 2022. The District estimates the financial implication to result in approximately $250-$275 million in additional asset and liability recognition on the statements of net position.

In June 2018, the GASB issued Statement No. 89, *Accounting for interest costs incurred before the end of a construction period (*GASB No. 89). This Statement requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost is incurred for financial statements prepared using the economic resources measurement focus. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of a capital asset but will be reported as an expense. GASB No. 95 delayed the implementation to fiscal years beginning after December 15, 2020. The District adopted in 2021 and considered the above GASB statement noting no financial statement implications or impact upon adoption.

In May 2020, the GASB issued Statement No. 96, *Subscription-Based Information Technology Arrangements (*GASB No. 96). This statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs). This Statement defines a SBITA, establishes that a SBITA results in a right-to-use subscription asset (an intangible asset) and a corresponding subscription liability, provides the capitalization criteria for outlays other than subscription payments (including implementation costs of a SBITA), and requires note disclosures regarding a SBITA. This Statement will be effective for the fiscal year beginning after June 15, 2022. The effects of this Statement on the District's future financial statements have yet to be determined.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans—an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32 (*GASB No. 97). Some requirements of this statement related to defined contribution postemployment benefit plans and fiduciary defined benefit postemployment benefit plans are effective immediately. The District has concluded that these requirements have no material impact on the financial statements. The remaining requirements are effective for the fiscals year beginning after June 15, 2021. This Statement provides guidance intended to increase consistency and comparability related to reporting of fiduciary component units in situations where a potential component unit does not have a governing board and the primary government performs the duties that a governing board would typically perform. The Statement also intends to mitigate costs associated with the reporting of certain defined contribution pension plans, defined contribution other postemployment benefit (OPEB) plans, and employee benefit plans other than pension plans or OPEB plans (other employee benefit plans) as fiduciary component units in fiduciary fund financial statements. Lastly, the Statement seeks to enhance the relevance, consistency, and comparability of the accounting and financial reporting for

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Internal Revenue Code Section 457 deferred compensation plans that meet the definition of a pension plan, and for benefits provided through those plans. The District does not anticipate there will be a future financial statement impact upon adoption of this Statement.

(2) Novel Coronavirus and CARES Act

On March 27, 2020 the Coronavirus Aid Relief and Economic Security (CARES) Act was enacted. The CARES Act authorized $100 billion in a Provider Relief Fund for hospitals and healthcare providers. Funding was intended to compensate hospitals and other healthcare providers for lost revenue and increased expenses incurred in order to respond to the COVID-19 impact. Provider Relief Fund distributions are not required to be repaid, so long as the payment can be substantiated by lost revenue and the incremental costs incurred related to responding to the pandemic and certain terms and conditions are met.

In addition to direct payments to healthcare providers, the CARES Act provided opportunities to increase cash flow. The CARES Act allowed inpatient acute care hospitals to receive accelerated Medicare payments for a period equivalent to up to six months of reimbursement. The accelerated payments are interest free if repaid according to the terms of the advance. The District received $41.7 million in Medicare advance payments between June and September 2020. In 2021, the District repaid $11.0 million and reports the remaining $30 million as a current liability to be repaid in 2022 as reflected on the statements of net position as other current liabilities (including CARES Act).

The CARES Act also provided the deferral of the employer portion of social security taxes as another source of cash flow for employers in need. The District deferred these taxes from March 27, 2020 through the end of 2020. This resulted in a $12.8 million liability, which 50% was repaid December 31, 2021 and the remaining 50% will be repaid by December 31, 2022 in accordance with the CARES Act. The 2022 portion of the liability is reflected on the statement of net position as an other current accrued liability.

The District also filed applications and obtained reimbursement of additional expenses from the Federal Emergency Management Agency (FEMA) based on criteria due to the national emergency declaration made due to COVID-19. The District submitted an expedited application, which allows the District to recover up to 50% of the total funding applied for. The District continues to complete the final reconciliation of the expedited funding application to received the remainder of the funding and will apply for additional funding pertaining to later periods until the national disaster declaration is no longer in effect.

The following table shows the funding that has been received to prepare and respond to COVID-19 and recognized as other nonoperating income for the years ended December 31, 2021 and 2020:

		December 31	
		2021	**2020**
		(In thousands)	
Provider Relief Fund	$	3,552	40,486
Other federal and state COVID-19 relief funding		2,618	488
	$	6,170	40,974

The full impact of the COVID-19 outbreak continues to evolve as of the date of this report. As such, it is uncertain as to the full magnitude the pandemic will have on the District's financial condition, liquidity, and future operations. Management is actively monitoring the global situation on its financial condition, liquidity, operations, suppliers, industry, and workforce.

(3) Net Patient Service Revenue

The District has arrangements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors is as follows:

(a) Medicare

Inpatient acute care services rendered to Medicare program beneficiaries are paid at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. Inpatient nonacute services and defined capital and medical education costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. The District is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The District's cost reports have been reviewed and/or audited by the Medicare fiscal intermediary through 2016. The District recognized interim and final cost report settlements and a Net Payment Reconciliation Award payment from Centers for Medicare and Medicaid Services (CMS) resulting in an increase in net patient service revenue of $238 thousand and $117 thousand in 2021 and 2020, respectively. Most outpatient services to Medicare beneficiaries are paid prospectively based on ambulatory payment classifications (APCs). CMS assigns individual services (Healthcare Common Procedure Coding System codes) to APCs based on similar clinical characteristics and similar costs.

(b) Medicaid

In the spring of 2005, the Washington State Legislature and CMS approved a Medicaid Certified Public Expenditures (CPE) program for inpatient reimbursement. The CPE program uses public expenditures by certain public hospitals to earn federal matching funds. Certified public expenditures are qualifying expenditures made by the hospital to serve Medicaid eligible or uninsured patients. The program was designed to preserve a significant amount of federal match funding for the State of Washington (the State) and maintain the same level of reimbursement to the affected hospitals that they would have received prior to the implementation of the program.

The CPE program uses three payment mechanisms to reimburse hospitals for inpatient care: inpatient hospital claims payments, disproportionate share (DSH) payments, and state grants. Under the program, hospitals are paid an interim payment based on an estimate of the cost to provide services to Medicaid recipients. For each payment to a hospital in the program, only the federal matching portion of the payment is remitted to the hospital; the state portion is funded through DSH payments and state grants.

The intent of the legislature is that hospitals in the program receive no less in combined federal and state payments than the hospital would have received under the methodology that was in place during fiscal year 2005. Any differences between the federal matching and state DSH components on the CPE program payments and this baseline amount are to be paid to the hospitals with state grant funds. Additional legislative appropriations may be required if state grant funds allocated at the start of the year are insufficient to meet the program's hold harmless provision.

Interim state payments based on prospectively estimated experience are retrospectively reconciled to "hold harmless" after actual claims are repriced using the applicable methods. This process takes place at least six months after the end of the fiscal year and results in either a payable to, or receivable from, the state Medicaid program. State inpatient claim and DSH payments are subject to retrospective determination of actual costs once the District's Medicare Cost Report is audited. CPE program payments are not considered final until retrospective cost reconciliation is complete. Final settlement of $977 thousand was paid back in 2021 related to State fiscal year 2016. The District recognized interim settlements resulting in an adjustment to increase net patient service revenue by $1.3 million in 2021 and $200 thousand in 2020.

Inpatient Medicaid charges represented approximately 12.26% and 12.68% of total inpatient charges for the District in fiscal year 2021 and 2020, respectively.

The Medicaid CPE program continues through the State's fiscal year 2021 and 2020. As of December 31, 2021 and 2020, the District has recorded a payable of $1.9 million and $900 thousand for estimated overpayments for state fiscal year 2021 and 2020, respectively, which is included in third-party payor payable in the statements of net position.

Outpatient services are paid on a fee schedule or a percentage of allowed charges based on a ratio of the District's allowable operating expenses to total allowable revenue.

In the July 2009 legislative session, the Washington State legislature enacted the Hospital Safety Net Assessment to help mitigate an estimated $400 million reduction in hospital Medicaid payments. Under this law, nongovernmental Washington hospitals are assessed a fee on all non-Medicare patient days. The fees are used to obtain new federal Medicaid matching funds.

The safety net assessment was subject to approval by CMS before it took effect. In 2010, CMS approved the two amendments required to fully enact the safety net assessment program. The initial safety net program expired in June 2013 and the State passed a new safety net assessment program that was approved by CMS in April 2014. The new law is retroactive to July 1, 2013 and will sunset on July 1, 2025. The District is not subject to the assessment but is a recipient of funding through the program. The District received safety net payments totaling $800 thousand in 2021 and $863 thousand in 2020.

(c) Other Third-Party Reimbursement

The District has entered into payment agreements with certain commercial insurance carriers and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

The following are the components of net patient service revenue for the years ended December 31, 2021 and 2020:

	2021	
	District	Component unit
	(In thousands)	
Gross patient service charges	$ 2,101,010	134,897
Adjustments to patient service charges:		
Contractual adjustments	1,302,369	86,496
Provision for bad debts	16,930	4,023
Charity care	8,445	840
Administrative adjustments	4,733	—
	1,332,477	91,359
Net patient service revenue	$ 768,533	43,538

	2020	
	District	Component unit
	(In thousands)	
Gross patient service charges	$ 1,904,525	120,473
Adjustments to patient service charges:		
Contractual adjustments	1,212,050	76,286
Provision for bad debts	14,991	4,421
Charity care	8,243	909
Administrative adjustments	5,233	—
	1,240,517	81,616
Net patient service revenue	$ 664,008	38,857

(4) Assets Limited as to Use

Assets limited as to use include board-designated cash and investments and restricted cash and investments.

Board-designated cash and investments represent unrestricted resources that have been designated by the Board for funded depreciation and community service programs. In addition, the Board has the authority to establish a regular property tax levy within statutory restrictions, with the proceeds being used for purposes designated by the Board.

Restricted cash and investments include certain assets of the Foundation that are restricted by donor stipulations, assets related to the postretirement plan covering the executive management team, and other restricted cash and investments.

Assets limited as to use are carried at fair value. Fair value is based on 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. The three levels of the fair value hierarchy under GASB Statement No. 72, *Fair Value Measurement and Application*, are described below:

- Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that a government can access at the measurement date
- Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly
- Level 3 – Unobservable inputs for an asset or liability

The following methods and assumptions were used to estimate the fair value of each class of financial instruments for which it is practicable to estimate that value:

(a) Cash and Cash Equivalents – The carrying value approximates fair value because of the short maturity of those instruments.

(b) Assets Limited as to Use – Fair values are estimated based on quoted market prices for those or similar investments. Maturities for securities are based on the weighted average maturity date, or reset date for adjustable rate mortgages.

The following tables present the composition, fair value, ratings and maturity of board-designated cash and investments for the District at December 31, 2021 and 2020:

Board-Designated Assets

December 31, 2021

Investment type		Fair value amount		Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Ratings
				(In thousands)		
U.S. treasuries	$	108,834		—	108,834	AAA
U.S. government agencies		5,199		—	5,199	AA-
Mutual fund – bonds		894		894	—	Not rated
Credit		58,603		—	58,603	A+
Taxable municipal bonds		2,726		—	2,726	AA
U.S. government agency – mortgage backed		59,453		—	59,453	AAA
Government-related securities		7,543		—	7,543	AAA
King County Investment Pool		2,446		2,446	—	Not rated
Total investments		245,698	$	3,340	242,358	
Cash and cash equivalents		58,521				
Total cash and investments		304,219				
Property tax, interest receivable, and other		3,057				
Total board-designated assets	$	307,276				

(Continued)

Board-Designated Assets

December 31, 2021

Investment type		Fair value amount	Investment maturities (in years) N/A or less than 1	1–5
			(In thousands)	
U.S. treasuries	$	108,834	9,518	99,316
U.S. government agencies		5,199	—	5,199
Mutual fund – bonds		894	894	—
Credit		58,603	5,886	52,717
Taxable municipal bonds		2,726	1,096	1,630
U.S. government agency – mortgage backed		59,453	4,359	55,094
Government-related securities		7,543	1,490	6,053
King County Investment Pool		2,446	2,446	—
Total investments	$	245,698	25,689	220,009

Board-Designated Assets

December 31, 2020

Investment type		Fair value amount		Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Ratings
				(In thousands)		
U.S. treasuries	$	190,354		—	190,354	AAA
U.S. government agencies		13,802		—	13,802	AA-
Mutual fund – bonds		680		680	—	Not rated
Credit		49,525		—	49,525	A+
Taxable municipal bonds		4,169		—	4,169	AA
U.S. government agency – mortgage backed		26,923		—	26,923	AAA
Government-related securities		7,895		—	7,895	AAA
King County Investment Pool		152		152	—	Not rated
Total investments		293,500	$	832	292,668	

(Continued)

Board-Designated Assets

December 31, 2020

Investment type		Fair value amount	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Ratings
			(In thousands)		
Cash and cash equivalents		14,347			
Total cash and investments		307,847			
Property tax, interest receivable, and other		3,368			
Total board-designated assets	$	311,215			

Board-Designated Assets

December 31, 2020

Investment type		Fair value amount	Investment maturities (in years) N/A or less than 1	1–5
			(In thousands)	
U.S. treasuries	$	190,354	8,968	181,386
U.S. government agencies		13,802	277	13,525
Mutual fund – bonds		680	680	—
Credit		49,525	16,889	32,636
Taxable municipal bonds		4,169	1,140	3,029
U.S. government agency – mortgage backed		26,923	1,726	25,197
Government-related securities		7,895	3,387	4,508
King County Investment Pool		152	152	—
Total investments	$	293,500	33,219	260,281

(Continued)

The following tables present the composition, fair value, ratings and maturity of restricted cash and investments of the District for the years ended December 31, 2021 and 2020:

Restricted Cash and Investments

December 31, 2021

Investment type		Fair value amount		Quoted prices in active markets for identical assets (Level 1)	Ratings		Investment maturities (in years) N/A or less than 1
				(In thousands)			
King County Investment Pool	$	921		921	Not rated		921
Mutual fund – bonds		1,812		1,812	Not rated		1,812
Mutual fund – equity		3,448		3,448	Not rated		3,448
Total investments		6,181	$	6,181		$	6,181
Cash and cash equivalents		104					
Total cash and investments		6,285					
Property tax, interest receivable, and other		133					
Total assets restricted as to use	$	6,418					

(Continued)

Restricted Cash and Investments

December 31, 2020

Investment type		Fair value amount		Quoted prices in active markets for identical assets (Level 1)	Ratings		Investment maturities (in years) N/A or less than 1
				(In thousands)			
King County Investment Pool	$	916		916	Not rated		916
Mutual fund – bonds		1,936		1,936	Not rated		1,936
Mutual fund – equity		2,942		2,942	Not rated		2,942
Total investments		5,794	$	5,794		$	5,794
Cash and cash equivalents		104					
Total cash and investments		5,898					
Property tax, interest receivable, and other		150					
Total assets restricted as to use	$	6,048					

Interest Rate Risk – The District's investment policy limits investment maturities as a means of managing its exposure to fair value losses arising from changing interest rates. Shares of mutual funds with portfolios consisting of only U.S. government bonds or U.S. government bonds issued by federal agencies must have average maturities of less than four years. Unless matched to a specific cash flow, the District does not invest in securities maturing more than five years from the date of purchase. However, assets whose use is limited may be invested in securities exceeding 10 years if the maturity of such investments is timed to coincide with the expected use of funds.

Credit Risk – Statutes authorize the District to invest in obligations of the U.S. Treasury, agencies, and instrumentalities, public funds investment accounts, state, or local government bonds with one of the three highest credit ratings of a nationally recognized agency, money markets with investments in authorized securities, and mutual funds of only U.S. government bonds and agencies. The U.S. Treasury, agency, and agency mortgage backed are considered to be of high quality; and the U.S. Treasury carry the long-term sovereign rating of the United States of America. The District's policy requires that all certificates of deposit be collateralized.

The District utilizes an investment adviser as well as the King County Investment Pool (the Pool), an external investment pool. The Pool is not registered with the Securities and Exchange Commission as an investment company. Oversight of the Pool is provided by the King County Executive Finance Committee

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pursuant to RCW 36.29.020. Participation in this pool is voluntary. The intent of this policy is to balance reasonable security with reasonable investment return, seeking to maximize both while meeting the daily cash flow requirements of the District and conforming to all applicable laws and regulations governing the investment of public funds.

Concentration of Credit Risk – In October 2017, the District's Board of Commissioners adopted a revised investment policy, which includes the ability to invest in Commercial Paper and Corporate Notes in accordance with RCW 39.59.040 and Washington State Investment Board policy number 2.05.500.

The following table sets forth the percentages by investment type of the District's total investment portfolio as of December 31, 2021 and 2020:

	2021	2020
U.S. treasuries	43%	60%
Mutual fund/U.S. government securities	3	7
Federal National Mortgage Association	6	3
Federal Home Loan Bank	2	1
Federal Home Loan Mortgage Corporation	16	10
Government National Mortgage Association	2	—
King County Investment Pool	1	—
Credit	23	16
Taxable municipal bonds	1	1
Government-related securities	3	2
	100%	100%

(5) Capital Assets

The schedule of capital asset activity for the years ended December 31, 2021 and 2020 is as follows:

		January 1, 2021	Additions and adjustments	Sales and retirements	Account transfers	December 31, 2021
				(In thousands)		
Assets at cost:						
Nondepreciable capital assets:						
Land	$	4,914	—	—	—	4,914
Construction in progress		24,574	55,100	—	(46,388)	33,286
Total nondepreciable capital assets		29,488	55,100	—	(46,388)	38,200
Depreciable capital assets:						
Land improvements		13,124	—	(3)	—	13,121
Buildings		368,348	—	(840)	18,705	386,213
Equipment		431,406	—	(32,273)	23,805	422,938
Equipment and property under capital lease		11,969	—	—	3,878	15,847
Total depreciable capital assets		824,847	—	(33,116)	46,388	838,119
Less accumulated depreciation:						
Land improvements		11,308	356	(3)	—	11,661
Buildings		198,516	13,647	(840)	—	211,323
Equipment		326,440	23,502	(31,638)	—	318,304
Equipment and property under capital lease		7,913	798	—	—	8,711
Total accumulated depreciation		544,177	38,303	(32,481)	—	549,999
Depreciable capital assets, net		280,670	(38,303)	(635)	46,388	288,120
Capital assets, net	$	310,158	16,797	(635)	—	326,320

(Continued)

	January 1, 2020	Additions and adjustments	Sales and retirements	Account transfers	December 31, 2020
			(In thousands)		
Assets at cost:					
Nondepreciable capital assets:					
Land	$ 4,914	—	—	—	4,914
Construction in progress	25,691	24,996	—	(26,113)	24,574
Total nondepreciable capital assets	30,605	24,996	—	(26,113)	29,488
Depreciable capital assets:					
Land improvements	13,718	—	(594)	—	13,124
Buildings	362,282	—	—	6,066	368,348
Equipment	422,214	636	(14,653)	23,209	431,406
Equipment and property under capital lease	15,131	—	—	(3,162)	11,969
Total depreciable capital assets	813,345	636	(15,247)	26,113	824,847
Less accumulated depreciation:					
Land improvements	11,543	359	(594)	—	11,308
Buildings	185,493	13,023	—	—	198,516
Equipment	309,153	22,124	(14,653)	9,816	326,440
Equipment and property under capital lease	16,931	798	—	(9,816)	7,913
Total accumulated depreciation	523,120	36,304	(15,247)	—	544,177
Depreciable capital assets, net	290,225	(35,668)	—	26,113	280,670
Capital assets, net	$ 320,830	(10,672)	—	—	310,158

(Continued)

The schedule of capital asset activity for EHM for the years ended December 31, 2021 and 2020 is as follows:

		January 1, 2021	Additions and adjustments	Sales and retirements	Account transfers	December 31, 2021
				(In thousands)		
Assets at cost:						
Nondepreciable capital assets:						
Land	$	1,879	—	—	—	1,879
Construction in progress		202	241	(224)	—	219
Total nondepreciable capital assets		2,081	241	(224)	—	2,098
Depreciable capital assets:						
Land improvements		1,234	—	—	—	1,234
Buildings		30,112	—	224	—	30,336
Equipment		2,731	—	—	—	2,731
Equipment and property under capital lease		19,382	83	—	—	19,465
Total depreciable capital assets		53,459	83	224	—	53,766
Less accumulated depreciation:						
Land improvements		938	63	—	—	1,001
Buildings		21,791	1,115	—	—	22,906
Equipment		2,462	50	—	—	2,512
Equipment under capital lease		15,358	1,104	—	—	16,462
Total accumulated depreciation		40,549	2,332	—	—	42,881
Depreciable capital assets, net		12,910	(2,249)	224	—	10,885
Capital assets, net	$	14,991	(2,008)	—	—	12,983

(Continued)

	January 1, 2020	Additions and adjustments	Sales and retirements	Account transfers	December 31, 2020
			(In thousands)		
Assets at cost:					
Nondepreciable capital assets:					
Land	$ 1,879	—	—	—	1,879
Construction in progress	4,508	111	—	(4,417)	202
Total nondepreciable capital assets	6,387	111	—	(4,417)	2,081
Depreciable capital assets:					
Land improvements	1,234	—	—	—	1,234
Buildings	27,173	12	—	2,927	30,112
Equipment	19,543	718	(2,369)	1,490	19,382
Equipment and property under capital lease	2,731	21	(21)	—	2,731
Total depreciable capital assets	50,681	751	(2,390)	4,417	53,459
Less accumulated depreciation:					
Land improvements	883	55	—	—	938
Buildings	20,660	1,131	—	—	21,791
Equipment	16,433	1,162	(2,237)	—	15,358
Equipment under capital lease	2,412	70	(20)	—	2,462
Total accumulated depreciation	40,388	2,418	(2,257)	—	40,549
Depreciable capital assets, net	10,293	(1,667)	(133)	4,417	12,910
Capital assets, net	$ 16,680	(1,556)	(133)	—	14,991

(Continued)

(6) Other Assets

Evergreen Radia, LLC

During 2003, the District formed a limited liability company with a local radiology group for the purpose of providing outpatient diagnostic imaging services to individuals within the community. The District had a 50% interest in this joint venture at December 31, 2021 and 2020, which is accounted for using the equity method of accounting. During the years ended December 31, 2021 and 2020, the District recognized its proportionate share of the Evergreen Radia, LLC's net income, as other operating revenue.

The following represents the summary financial information of Evergreen Radia, LLC as of December 31, 2021 and 2020:

		2021	2020
		(In thousands)	
Current assets	$	5,643	5,627
Noncurrent assets, net		3,096	3,288
	$	8,739	8,915
Current liabilities	$	3,066	2,721
Long-term liabilities		2,274	2,416
Equity		3,399	3,778
	$	8,739	8,915
Revenue	$	17,598	15,033
Expenses		12,976	11,513
Net income	$	4,622	3,520

Eastside Health Alliance, LLC

During 2017, the District formed a limited liability company with Overlake Medical Center to create a clinically integrated network of providers to deliver value-based care on the Eastside. The District had a 50% interest in this joint venture at December 31, 2021 and 2020, which is accounted for using the equity method of accounting. During the years ended December 31, 2021 and 2020, the District recognized its proportionate share of the Eastside Health Alliance, LLC's net loss, as a reduction to other operating revenue.

(Continued)

The following represents the summary financial information of Eastside Health Alliance, LLC as of December 31, 2021 and 2020:

		2021	2020
		(In thousands)	
Current assets	$	6,210	4,785
Noncurrent assets, net		—	—
	$	6,210	4,785
Current liabilities	$	5,334	—
Long-term liabilities		—	—
Equity		876	4,785
	$	6,210	4,785
Revenue	$	4,460	5,106
Expenses		6,845	7,326
Net loss	$	(2,385)	(2,220)

(Continued)

(7) Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations of the District consist of the following:

	December 31	
	2021	2020
	(In thousands)	
Limited Tax General Obligation (LTGO) Series 2015 (fixed rate), payable annually through 2031, interest at 3.63% to 5.00%	9,610	46,195
LTGO Series 2015 B (fixed rate), payable annually through 2037, interest at 4.00% to 5.00%	—	54,000
LTGO Series 2020 (fixed rate) – direct borrowing, payable annually through 2030, interest at 1.87% to 2.16%	—	30,000
LTGO Series 2020 A (fixed rate), payable annually through 2045, interest at 4.00% to 4.00%	59,940	59,940
LTGO Series 2020 B (fixed rate), payable annually through 2035, interest at 1.30% to 2.54%	36,790	39,210
LTGO Series 2021 (fixed rate), payable annually through 2044, interest at 0.57% to 3.11%	152,175	—
Unlimited Tax General Obligation Refunding Bonds (UTGO), Series 2013 (fixed rate), payable semiannually through 2023, interest at 3.00% to 5.00%	15,425	22,590
Capital lease obligations, $8,919 (fixed rate), payable monthly including interest at 0.18% to 10.0%, collateralized by equipment	7,788	9,418
	281,728	261,353
Plus bond discounts and premiums	11,376	18,527
	293,104	279,880
Less current portion	(15,389)	(14,470)
	$ 277,715	265,410

(Continued)

Long-term debt and capital lease obligations 2021 and 2020 activity summary for the District is as follows (in thousands):

		January 1, 2021	Additions	Reductions	December 31, 2021	Amounts due within one year
Limited general obligation bonds:						
2015 series	$	46,195	—	36,585	9,610	3,365
2015 series B		54,000	—	54,000	—	—
2020 series - direct borrowing		30,000	—	30,000	—	—
2020 series A		59,940	—	—	59,940	—
2020 series B		39,210	—	2,420	36,790	2,760
2021 series		—	152,175	—	152,175	—
Unlimited general obligation bonds:						
2013 series		22,590	—	7,165	15,425	7,525
Total long-term debt		251,935	152,175	130,170	273,940	13,650
Capital lease obligations		9,418	—	1,630	7,788	1,739
Total long-term debt and capital lease obligations		261,353	152,175	131,800	281,728	15,389
Bond discounts and premiums		18,527	—	7,151	11,376	4,045
Total long-term debt and capital lease obligations	$	279,880	152,175	138,951	293,104	19,434

		January 1, 2020	Additions	Reductions	December 31, 2020	Amounts due within one year
Limited general obligation bonds:						
2010 series	$	20,835	—	20,835	—	—
2011 series		18,910	—	18,910	—	—
2015 series		49,295	—	3,100	46,195	3,255
2015 series B		54,000	—	—	54,000	—
2020 series - direct borrowing		—	30,000	—	30,000	—
2020 series A		—	59,940	—	59,940	—
2020 series B		—	42,155	2,945	39,210	2,420
Unlimited general obligation bonds:						
2013 series		29,455	—	6,865	22,590	7,165
Total long-term debt		172,495	132,095	52,655	251,935	12,840

(Continued)

	January 1, 2020	Additions	Reductions	December 31, 2020	Amounts due within one year
Capital lease obligations	6,868	3,489	939	9,418	1,630
Total long-term debt and capital lease obligations	179,363	135,584	53,594	261,353	14,470
Bond discounts and premiums	10,752	10,604	2,829	18,527	1,925
Total long-term debt and capital lease obligations	$ 190,115	146,188	56,423	279,880	16,395

A summary of the District future maturities on long-term debt for the next five years and thereafter as of December 31, 2021 for both principal and interest is presented below (in thousands):

	Bonds	
	Principal	Interest
2022	$ 13,650	8,777
2023	14,960	7,814
2024	5,715	7,193
2025	6,250	7,014
2026	6,705	6,924
Amounts due 2027–2031	41,070	32,623
Amounts due 2032–2036	55,985	27,332
Amounts due 2037–2041	71,685	18,116
Amounts due 2042–2046	57,920	4,901
	$ 273,940	120,694

Total unamortized bond discounts and premiums are $11.4 million as of December 31, 2021.

(a) Overview of Bonds

UTGO bonds are secured by the irrevocable pledge of the District to levy taxes annually, without limitation as to rate or amount based on a vote of the electors, on all taxable property within the District. LTGO are secured by the irrevocable pledge of the District to levy taxes annually, within the constitutional and statutory limitations provided by law without a vote of the electors, upon property in the District, as well as the net revenue of the District for amounts that exceed that available through the levy.

(Continued)

(b) Series 2021 Bond Issue

The 2021 LTGO bonds were issued for the principal amount of $152.2 million. The proceeds were used to retire, defease and refund the direct borrowing with JPMorgan, refund a portion of the 2015 LTGO series, and refund all of the 2015 B LGTO series; as well as fund the project for the District to implement a new electronic medical record and billing system, Epic. The difference between the cash flows required to service the new debt and complete the refunding was $2.9 million. The economic gain was $5.8 million.

The District has pledged tax revenues to secure the bonds.

(c) Component Unit – EHM

Long-term debt and capital lease obligations of EHM consist of the following:

		December 31	
		2021	2020
		(In thousands)	
LTGO Refunding Bonds, 2019, payable semiannually through 2034, interest at 2.95%	$	15,665	16,460
LTGO Bonds, 2019, payable semiannually through 2029, interest at 3.25%		4,949	5,483
Paycheck Protection Program (PPP) Loan Coastal Bank any amounts not forgiven convert to term loan payable monthly beginning August 2021 through 2022, interest at 1%		—	4,152
Capital lease obligations, payable monthly, including interest at 6.70%, collateralized by equipment		29	114
		20,643	26,209
Plus bond discounts and premiums		(177)	(201)
		20,466	26,008
Less current portion		(1,421)	(2,505)
	$	19,045	23,503

(Continued)

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Long-term debt and capital lease obligations 2021 and 2020 activity summary of EHM is as follows (in thousands):

	January 1, 2021	Additions	Reductions	December 31, 2021	Amounts due within one year
Limited general obligation bonds:					
2019 refunding series	$ 16,460	—	(795)	15,665	840
2019 series	5,483	—	(534)	4,949	552
PPP Loan (forgiven)	4,152	—	(4,152)	—	—
Total long-term debt	26,095	—	(5,481)	20,614	1,392
Capital lease obligations	114		(85)	29	29
Total long-term debt and capital lease obligations	26,209	—	(5,566)	20,643	1,421
Bond discounts and premiums	(201)	—	24	(177)	—
Total long-term debt and capital lease obligations	$ 26,008	—	(5,542)	20,466	1,421

	January 1, 2020	Additions	Reductions	December 31, 2020	Amounts due within one year
Limited general obligation bonds:					
2019 refunding series	$ 17,235	—	775	16,460	795
2019 series	6,000	—	517	5,483	534
PPP Loan	—	4,152	—	4,152	1,091
Total long-term debt	23,235	4,152	1,292	26,095	2,420
Capital lease obligations	194	—	80	114	85
Total long-term debt and capital lease obligations	23,429	4,152	1,372	26,209	2,505
Bond discounts and premiums	(227)	—	(26)	(201)	—
Total long-term debt and capital lease obligations	$ 23,202	4,152	1,346	26,008	2,505

A summary of EHM's future maturities on long-term debt for the next five years and thereafter as of December 31, 2021 for both principal and interest is presented below (in thousands):

		Principal	Interest
2022	$	1,392	623
2023		1,459	580
2024		1,563	535
2025		1,637	488
2026		1,707	437
Amounts due 2027–2031		8,290	1,379
Amounts due 2032–2035		4,566	274
	$	20,614	4,316

Total unamortized bond discounts and premiums are $177 thousand as of December 31, 2021.

(d) Capital Leases

The District acquired certain equipment under capital lease obligations. The leases are collateralized by the related equipment. Future minimum lease payments are as follows:

		Amount (In thousands)
Year(s) ending December 31:		
2022	$	2,029
2023		2,070
2024		2,112
2025		2,156
2026		117
2027–2031		—
Total minimum lease payments		8,484
Less amount representing interest		(696)
Total capital lease payments	$	7,788

EHM acquired certain equipment under capital lease obligations. The leases are collateralized by the related equipment. Future minimum lease payments are as follows:

		Amount (In thousands)
Year(s) ending December 31:		
2022	$	29
2023		—
Total minimum lease payments		29
Less amount representing interest		—
Total capital lease payments	$	29

(8) Tenant Lease Receipts

The District owns and operates the Evergreen Professional Center (EPC), the Evergreen Surgical and Physicians Center (ES&PC), and the DeYoung Pavilion, which contain approximately 52,000 total square feet of space for physician offices and other healthcare services available for lease. As of December 31, 2021 and 2020, the District had space under operating lease terms from 5 to 15 years.

Future minimum rent receipts and sublease receipts on noncancelable operating leases are as follows:

		Owned property receipts	Leased property receipts	Total amount
			(In thousands)	
Year ending December 31:				
2022	$	2,023	4,296	6,319
2023		1,662	3,821	5,483
2024		1,353	2,679	4,032
2025		243	2,283	2,526
2026		153	2,055	2,208
Thereafter		610	8,151	8,761
	$	6,044	23,285	29,329

Rental income related to the EPC, ES&PC, and the DeYoung Pavilion leases was approximately $1.8 million for both years ended 2021 and 2020 and is included in other operating revenue. Rental income related to subleases was approximately $4.9 million and $5.0 million in 2021 and 2020, respectively.

(Continued)

(9) Commitment and Contingencies

(a) Leases

The District leases various equipment and facilities under operating leases. Total rental expense in 2021 and 2020 for all operating leases and various rental agreements was approximately $15.7 million and $14.6 million, respectively.

The future minimum lease payments under noncancelable operating leases that have initial lease terms in excess of one year are as follows:

		Payments (In thousands)
Year ending December 31:		
2022	$	10,188
2023		10,418
2024		10,656
2025		10,651
2026		9,044
Thereafter		33,447
	$	84,404

(b) Insurance Coverage

The District holds professional liability insurance coverage through an independent insurance company. The insurance coverage is based on a claims-made policy. The District is self-insured for the professional liability tail and expected claims payouts on this coverage. The policy's self-insured retention limit is $1.0 million per claim and $4.0 million per aggregate.

The District records its actuarial estimate for professional claims liability at its best estimate of the ultimate losses and costs associated with settling claims. The professional liability expense was $1.4 million for both years ended December 31, 2021 and 2020. At December 31, 2021 and 2020, the estimated long-term and short-term professional claims liability was $5.0 million and $1.4 million and $5.5 million and $1.2 million, respectively.

The District is self-insured for various programs, including employee medical benefits and workers' compensation. The estimated ultimate costs of claims under these programs are accrued when the incidents occur that give rise to the claims. Accrued amounts for these programs of approximately $7.3 million and $5.8 million at December 31, 2021 and 2020, respectively, are reported as part of accrued compensation and related liabilities in the accompanying statements of net position. The accrued amounts include known liabilities of the programs and estimated incurred but not reported claims.

(Continued)

(c) Litigation

The District is involved in litigation arising in the ordinary course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the District's future financial position or results from operations.

(d) Compliance with Laws and Regulations

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participation 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 expulsion by healthcare providers, together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the District is in compliance with the fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions known or unasserted at this time.

(e) Risk Management

The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; and natural disasters. The District maintains commercial insurance coverage designed to provide for claims arising from such matters.

(10) Retirement Plans

The District has a defined-contribution retirement plan covering substantially all eligible employees. The District makes a matching contribution of up to a maximum of 8% of the employee's eligible compensation. All contributions vest over a five-year schedule.

In addition to the retirement plan, the District maintains a voluntary employee deferred compensation program under the provision of Section 457 of the Internal Revenue Service Code. Under this program, the District employees can defer a portion of their income until withdrawn in future years. All assets are required to be held in trust for the exclusive benefit of participants and their beneficiaries. The District also contributes up to 4% of compensation as base pension depending on years of service.

Retirement plan expense, incurred and reflected in employee benefits, was approximately $21.2 million and $19.6 million in 2021 and 2020, respectively. Employee contributions to the benefit plans totaled approximately $35.0 million and $31.1 million in 2021 and 2020, respectively. Both plans are administered by the District under recordkeeping and trust agreements with third parties.

The District has a postemployment benefit plan covering the executive management team. The District makes annual contributions to the SERP. The SERP is recorded under assets limited as to use and under noncurrent liabilities on the statements of net position. At December 31, 2021 and 2020, the SERP balance was $2.8 million and $3.0 million, respectively.

(Continued)

(11) Concentration of Credit Risk

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

	Receivables	
	2021	2020
Non-Government third-party payors	43.4%	42.6%
Medicare	35.9	32.5
Patient self-pay	9.2	11.3
Medicaid	11.5	13.6
	100.0%	100.0%

(12) Property Taxes

The King County treasurer acts as an agent to collect property taxes levied in the county for all taxing authorities. Taxes are levied annually on January 1, on property values listed as of the prior May 31. Assessed values are established by the King County assessor at 100% of fair market value. A revaluation of all property is required every four years.

Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly by the county treasurer.

The District is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general district purposes. The Washington State Constitution and Washington State Law, RCW 84.55.100, limit the rate. The District may also levy taxes at a lower rate. Additional amounts of tax need to be authorized by a vote of the residents of the District.

For 2021 and 2020, the District's regular levy request was $0.20 per $1,000 and $0.19 per $1,000 on a total assessed valuation of the property within the District of $101.4 billion and $99.6 billion for a total regular levy of $19.8 million and $19.3 million, respectively. Excess levies totaled $8.3 million in both 2021 and 2020, and related to debt service, mainly due to the hospital-based emergency department and patient facility, which opened in 2007.

Property taxes are recorded as receivables when levied. Since state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

(Continued)

(13) Blended Component Unit

Condensed combining statements for the District and its blended component unit, the Foundation, are shown below:

	Statement of net position – December 31, 2021			
	Combined entities	Eliminations/ reclassifications	District	Foundation
	(In thousands)			
Assets:				
Current assets:				
Total current assets	$ 224,126	(1,501)	216,100	9,527
Noncurrent assets:				
Total other assets	337,693	—	332,861	4,832
Capital assets, net	326,320	—	326,320	—
Total assets	888,139	(1,501)	875,281	14,359
Deferred outflows of resources	8,184	—	8,184	—
Total assets and deferred outflows of resources	$ 896,323	(1,501)	883,465	14,359
Liabilities:				
Total current liabilities	$ 146,517	(1,501)	146,464	1,554
Total noncurrent liabilities	294,087	—	294,087	—
Total liabilities	440,604	(1,501)	440,551	1,554
Net position:				
Invested in capital assets, net of related debt	114,924	—	114,924	—
Restricted:				
Expendable	2,377	—	403	1,974
Nonexpendable	10,474	—	1,055	9,419
Unrestricted	327,944	—	326,532	1,412
Total net position	455,719	—	442,914	12,805
Total liabilities and net position	$ 896,323	(1,501)	883,465	14,359

(Continued)

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	Statement of net position – December 31, 2020			
	Combined entities	Eliminations/ reclassifications	District	Foundation
	(In thousands)			
Assets:				
Current assets:				
Total current assets	$ 206,620	(1,227)	198,593	9,254
Noncurrent assets:				—
Total other assets	343,966	—	339,922	4,044
Capital assets, net	310,158	—	310,158	—
Total assets	860,744	(1,227)	848,673	13,298
Deferred outflows of resources	2,830	—	2,830	—
Total assets and deferred outflows of resources	$ 863,574	(1,227)	851,503	13,298
Liabilities:				
Total current liabilities	$ 113,871	(1,227)	113,800	1,298
Total noncurrent liabilities	309,015	—	309,015	—
Total liabilities	422,886	(1,227)	422,815	1,298
Net position:				
Invested in capital assets, net of related debt	86,507	—	86,507	—
Restricted:				
Expendable	10,339	—	1,556	8,783
Nonexpendable	5,421	—	3,454	1,967
Unrestricted	338,421	—	337,171	1,250
Total net position	440,688	—	428,688	12,000
Total liabilities and net position	$ 863,574	(1,227)	851,503	13,298

(Continued)

	Statement of revenue, expenses, and changes in net position – year ended December 31, 2021		
	Combined entities	District	Foundation
		(In thousands)	
Revenue:			
Operating revenue:			
Net patient service revenue	$ 768,533	768,533	—
Other operating revenue	52,195	46,843	5,352
Total operating revenue	820,728	815,376	5,352
Expenses:			
Operating expenses:			
Other operating expenses	795,441	788,742	6,699
Depreciation and amortization	37,830	37,830	—
Total operating expenses	833,271	826,572	6,699
Excess (deficit) of revenue over expenses from operations	(12,543)	(11,196)	(1,347)
Nonoperating income, net of expenses:			
Property taxes	27,968	27,968	—
Interest and amortization expense	(9,081)	(9,081)	—
Other nonoperating revenue	5,307	4,549	758
Net nonoperating income	24,194	23,436	758
Excess of revenue over expenses	11,651	12,240	(589)
Capital grants and contributions	3,380	1,986	1,394
Total change in net position	15,031	14,226	805
Net position, beginning of year	440,688	428,688	12,000
Net position, end of year	$ 455,719	442,914	12,805

(Continued)

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
(d/b/a EvergreenHealth)

Notes to Financial Statements

December 31, 2021 and 2020

	Statement of revenue, expenses, and changes in net position – year ended December 31, 2020		
	Combined entities	District	Foundation
		(In thousands)	
Revenue:			
Operating revenue:			
Net patient service revenue	$ 664,008	664,008	—
Other operating revenue	46,336	41,406	4,930
Total operating revenue	710,344	705,414	4,930
Expenses:			
Operating expenses:			
Other operating expenses	717,360	712,139	5,221
Depreciation and amortization	35,828	35,828	—
Total operating expenses	753,188	747,967	5,221
Excess (deficit) of revenue over expenses from operations	(42,844)	(42,553)	(291)
Nonoperating income, net of expenses:			
Property taxes	27,872	27,872	—
Interest and amortization expense	(9,106)	(9,106)	—
Other nonoperating revenue	47,069	46,879	190
Net nonoperating income	65,835	65,645	190
Excess of revenue over expenses	22,991	23,092	(101)
Capital grants and contributions	2,183	726	1,457
Total change in net position	25,174	23,818	1,356
Net position, beginning of year	415,514	404,870	10,644
Net position, end of year	$ 440,688	428,688	12,000

(Continued)

	Statement of cash flows – year ended December 31, 2021		
	Combined entities	District	Foundation
		(In thousands)	
Net cash provided by (used in):			
Operating activities	$ 116	(290)	406
Noncapital financing activities	13,038	13,031	7
Capital and related financing activities	(30,052)	(30,052)	—
Investing activities	3,200	2,419	781
Net increase in cash and cash equivalents	(13,698)	(14,892)	1,194
Cash and cash equivalents, beginning of year	83,847	78,813	5,034
Cash and cash equivalents, end of year	$ 70,149	63,921	6,228

	Statement of cash flows – year ended December 31, 2020		
	Combined entities	District	Foundation
		(In thousands)	
Net cash provided by (used in):			
Operating activities	$ 38,334	35,741	2,593
Noncapital financing activities	46,923	46,916	7
Capital and related financing activities	86,524	86,524	—
Investing activities	(145,201)	(143,185)	(2,016)
Net increase in cash and cash equivalents	26,580	25,996	584
Cash and cash equivalents, beginning of year	57,267	52,817	4,450
Cash and cash equivalents, end of year	$ 83,847	78,813	5,034