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: Thomas Kruse, Senior Vice President & Chief Strategy Officer  **Email Address:** thomas.kruse@vmfh.org>	**Date:** October 27, 2022 **Telephone Number:** 253.680.4007
Legal Name of Applicant: Franciscan Health System, dba CHI Franciscan Health, St. Francis Hospital **Address of Applicant:** 34515 9th Avenue South Federal Way, WA 98003	☐New hospital ☒Expansion of existing hospital (identify facility name and license number) St. Francis Hospital License #: HAC.FS.00000201 **Provide a brief project description, including the number of beds and the location:** This application proposes to maintain 10 acute care beds set-up under the Governor's Proclamation 20-36. **Estimated capital expenditure:** $ 0

Identify the Hospital Planning Area: Southeast 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

FRANCISCAN HEALTH SYSTEM DBA CHI FRANCISCAN HEALTH/ST. FRANCIS HOSPITAL

CERTIFICATE OF NEED APPLICATION TO PERMANENTLY ADD 10 ACUTE CARE BEDS MADE OPERATIONAL UNDER PROCLAMATION 20-36

October 2022

INTRODUCTION

Franciscan Health System, doing business as CHI Franciscan Health, a Washington not-for-profit corporation ("FHS"), owns and operates St. Francis Hospital, located in Federal Way. St. Francis Hospital is currently a 124-bed hospital of which 118 of the beds are acute care (96 med/surg beds and 22 OB beds) beds and six are Level II nursery basinets. In March 2022, St. Francis submitted a certificate of need (CN) application to add 24 acute care beds. This application, assigned CN# 22-40, is pending, and a decision is expected by November 17, 2022.

As allowed under the Governor's Proclamation 20-36, St. Francis Hospital has been operating 10 beds in excess of its current licensed 124 beds since early 2020. These 10 beds are separate and distinct from the 24-bed addition under current CN review. In order to retain these beds, and consistent with the Department's August 9, 2022, COVID-19 Waiver Offboarding guidance/process powerpoint, FHS is submitting the attached CN application.

Assuming both CN applications are approved, St. Francis will ultimately have 34 additional beds, and will be licensed for 158 beds. There is no capital expenditure for the 10 beds associated with this project since the rooms are currently operational. There is also no additional staffing required for the 10 beds. The 10 beds are currently located in an observation unit that was designed to meet all applicable inpatient codes. FHS timely submitted our change of approved use application to Construction Review Services in August consistent with the COVID Glidepath requirements (CRS# 61374848).

Please note that this CN application assumes the exact same admissions and patient day projections as included in the current 24 bed CN request. The purpose of this CN application is not to capture additional volume, rather it is to provide additional relief in the day-to-day operations of the Hospital. The 10 beds achieve this by slightly reducing midnight occupancy levels: with the 24 additional beds, midnight occupancy on medical/surgical beds was expected to be 73% in 2026, with the 10 additional beds, it is expected to be 68%. This relief helps optimize current staffing and processes; and provides flexibility during surge periods.

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 Franciscan Health System, doing business as CHI Franciscan Health, a Washington not-for-profit corporation ("FHS"). St. Francis Hospital is an operating unit of FHS and is owned and managed by FHS. For the ease of this application, the hospital will be referred to as St. Francis. The sole voting member of FHS is Catholic Health Initiatives ("CHI"). On February 22, 2019, CHI underwent a name change to CommonSpirit Health. CommonSpirit Health is the sole voting member of FHS but does not have direct management of any facilities in the State of Washington.

On January 1, 2021, CHI Franciscan Health and Virginia Mason became Virginia Mason Franciscan Health ("VMFH"). The only two members of VMFH are CommonSpirit Health and Virginia Mason Health System. As stated above, CommonSpirit Health is the sole voting member of FHS. The legal name with the Washington State Department of Revenue remains Franciscan Health System.

The address of St. Francis Hospital is:

34515 9th Ave South
Federal Way, WA 98003

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

The legal name with the Washington State Department of Revenue remains Franciscan Health System. St. Francis is a Washington nonprofit corporation. St. Francis' UBI number is 278 002 934.

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

Questions regarding this application should be sent to:

Thomas A. Kruse
Senior Vice President and Chief Strategy Officer
VM Franciscan Health
1145 Broadway Plaza | Suite 1200 | Tacoma, WA 98402
(253) 680-4007
thomaskruse@chifranciscan.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).**

The consultant authorized to speak on behalf of the screening related to this application is:

Jody Carona
Health Facilities Planning & Development
120 1st Avenue West, Suite 100
Seattle, WA 98119
(206) 441-0971
Email: healthfac@healthfacilitiesplanning.com

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

The requested organizational chart is included in Exhibit 1.

Section 2
Facility Description

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

The name and address of the applicant is:

St. Francis Hospital
34515 9th Ave South
Federal Way, WA 98003

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.**

No new facility is proposed. 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.**

St. Francis's existing identification numbers are as follows:

License #: HAC.FS.00000201

Medicare #:50-0141

Medicaid #:100215500

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

St. Francis is currently accredited by the Joint Commission. St. Francis' current accreditation expires in January 2023.

5. **Is the facility operated under a management agreement?**
   Yes ___ No __X__

   If yes, provide a copy of the management agreement.

This question is not applicable.

6. Provide the following scope of service information:

St. Francis' scope of services is detailed in Table 1.

Table 1
St. Francis Hospital Scope of Services

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 (list types)	☐	☐
Organ Transplant - Pediatric (list types	☐	☐
Outpatient Services	☒	☒
Pediatrics	☐	☐
Pharmaceutical	☒	☒
Psychiatric	☐	☐
Skilled Nursing/Long Term Care	☐	☐
Rehabilitation (indicate level, if applicable)	☐	☐
Respiratory Care	☒	☒
Social Services	☒	☒
Surgical Services	☒	☒

Source: Applicant

Section 3
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.**

As noted in the introduction, this CN application requests approval to permanently add the ten (10) beds made operational in early 2020 under the Public Health Emergency Proclamation 20-36. As noted in the letter of intent in Exhibit 2, these beds are consistently occupied with 8-10 patients on average. There is no capital expenditure to add these beds and there is no incremental staffing required.

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 propose the 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.**

Table 2 details St. Francis' current and proposed bed configuration.

Table 2
St. Francis Hospital
Current and Proposed Bed Configuration

	Current (Licensed Beds)	Proposed Bed Addition (CN Application #22-40)	Proposed Beds with Approval of 10 Beds Operated Under PHE #20-36 and CN#22-40
General Acute Care	118	142	152
PPS Exempt Psych	0	0	0
PPS Exempt Rehab	0	0	0
NICU Level II	6	6	6
NICU Level III	0	0	0
NICU Level IV	0	0	0
Specialized Pediatric	0	0	0
Skilled Nursing	0	0	0
Swing Beds	0	0	0
Total	**124**	**148**	**158**

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 of the 118 licensed acute care beds listed in Table 2 are currently set-up as are the 10 beds requested in this application. However, and due to patient care needs (unable to cohort because of isolation, behavior, hospice, privacy or family issues) the number of available beds can and does vary slightly.

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

Table 3 provides the anticipated timeline for this project.

Table 3
St. Francis Hospital
Proposed Timeline for 10-Bed Addition

Event	Anticipated Month/Year
Anticipated CN Approval	June 2023
Design Complete	NA
Construction Commenced	NA
Construction Completed	NA
Facility Prepared for Survey	June 2023
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 med/surg beds and provide care primarily to adults. The most common conditions treated at St. Francis include general medical, pulmonary conditions, septicemia, OB, orthopedics, medical cardiology, interventional cardiology (including emergency and elective PCI), general surgery, neurology, gastroenterology, and oncology.

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 and transition plan submitted consistent with the Governor's COVID Glide Path 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.**

The requested drawings for the areas affected by the project are included in Exhibit 3.

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

The project does not include any new space, just a reconfiguration of existing. The gross square footage of St. Francis with and without the project is 241,340 square feet.

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

This project does not involve any construction; therefore, this question is not applicable.

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

While this project does not involve construction, we have submitted a change in use application to CRS (CRS# 61374848).

Section 4
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.

St. Francis is located in the Southeast King Hospital Planning Area (Southeast King). Southeast King is a large geography spanning from the Puget Sound to the west, the King/Pierce County line to the South, the Cascade foothills to the East and south Bellevue and the eastern shore of Lake Washington in the north. There are four other hospitals located in this Planning Area. Each is listed in Table 4. Table 4 also includes the number of licensed and available/set up beds. Per the DOH Bed Survey, it should be noted that available/set-up beds in the planning area decreased between 2019 and 2020.

Table 4
Southeast King Hospital Planning Area Hospitals,
Licensed and Set Up Bed Capacity, 2019 and 2020

Hospital	Acute Care Licensed Beds	Acute Care Available/ Set Up Beds (2019)	Acute Care Available/ Set Up Beds (2020)	Acute Care Available/ Set Up Beds (2021)	Total Licensed Beds	Total Available/ Set Up Beds (2019)	Total Available/ Set Up Beds (2020)	Total Available/ Set Up Beds (2021)
MultiCare Auburn Medical Center	131	108	108	108	195	172	172	172
MultiCare Covington Hospital	58	58	43	43	58	58	43	43
Virginia Mason Franciscan – St. Elizabeth Hospital[1]	25	25	25	25	25	25	25	25
Virginia Mason Franciscan – St. Francis Hospital	118	118	118	118	124	124	124	124
UW Medicine – Valley Medical Center	321	311	308	308	341	328	328	328
Total	**653**	**620**	**602**	**602**	**743**	**707**	**692**	**692**

Source: DOH Bed Survey 2020 (for 2019) and 2021 (for 2020). Total licensed beds include psych, rehab and neonatal in addition to acute care.

[1] Virginia-Mason Franciscan – St. Elizabeth hospital is licensed for 38 beds; however, as a critical access hospital, bed capacity is limited to 25 beds and therefore only 25 beds are counted in the bed need methodology.

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).**

In preparing the current 24 bed CN application, St. Francis consulted with the Certificate of Need Program (the Program), and it was agreed that despite the availability of full year 2020 CHARS data, and most likely full year 2021 CHARS data by the time that application moved into ex-parte, 2019 was reasonable to use as the baseline due to COVID's anticipated short-term impact on hospital inpatient days. As such, our projections for that application rely on 2019 as the baseline, and we continue to use 2019 in this application.

There are a total of 653 acute care licensed beds and 620 set-up beds in the Planning Area. The numeric bed need methodology is included in Exhibit 4. Step 10 of the methodology based on set-up beds identifies a need of 9 beds in 2023 growing to a need of 29 beds when the project opens and 72 beds by the 3rd year of the project's operation. While bed need was calculated based on set-up beds, when licensed beds are used there is a need for beds by 2026 or within 3 years of the project being made operational.

While we used 2019 data, we did review 2020 CHARS data. It shows only a 0.6% decrease in Southeast King resident days between 2019 and 2020, and a bed need methodology using 2020 as the baseline year continues to support a need for additional beds in the planning area. For reference, the 2020 bed need methodology is also presented in Exhibit 4.

It should be noted, during the public comment on the 24 bed CN application, MultiCare reiterated the need for additional beds, both in the Planning Area and at St, Francis. Per MultiCare:

> *we agree that additional acute care bed capacity is needed in the Southeast King community. MultiCare Auburn receives a substantial number of transfers from St. Francis, and additional capacity at St. Francis could improve access to healthcare services.*

A summary of Step 10 from the numeric need methodology using 2019 as the baseline and set-up acute care beds is found in Table 5.

Table 5
Acute Care Bed Need Methodology Output Summary: Step 10 (Set-up Beds)

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Licensed Beds	653	653	653	653	653	653	653	653	653
Set-Up Beds	620	620	620	620	620	620	620	620	620
Gross Bed Need (Set-up Beds)	553	572	590	609	629	649	671	692	714
Net Bed Need/Surplus (Set-up Beds)	**(67)**	**(48)**	**(30)**	**(11)**	**9**	**29**	**51**	**72**	**94**

Source: Bed need methodology internal analysis

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

The 10 beds St. Francis proposes to retain will be used for general med/surg patients.

As noted in response to earlier sections, St. Francis will increase its med/surg bed capacity from 96 to 148; assuming both projects (CN application #22-40 and this application) are approved.

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 6 details patient days for the past three full calendar years for the type of beds that will increase with the project. Table 7 details the same information for the entire hospital.

Table 6
St. Francis Acute Care Patient Days and Discharges, 2019-2021
Excludes all Newborns[2]

Bed Type[3]	Project-Specific Only	CY2019	CY2020	CY2021
Med/Surg	Available beds	96	96	96
Med/Surg	Discharges	6,003	5,553	5,767
Med/Surg	Patient days	28,447	27,785	30,128
Med/Surg	% Occupancy	81.2%	79.1%	86.0%
OB	Available beds	22	22	22
OB	Discharges	1,254	1,253	1,207
OB	Patient days	2,234	2,153	2,134
OB	% Occupancy	27.8%	26.7%	26.7%
Acute Care	Licensed beds	118	118	118
Acute Care	Available beds	118	118	118
Acute Care	Discharges	7,257	6,806	6,974
Acute Care	Patient days	30,681	29,938	32,262
Acute Care	% Occupancy	71.2%	69.3%	74.9%

Source: Applicant, discharges and days from CHARS, excludes all newborns and 6 level II bassinets

Table 7
St. Francis Patient Days and Discharges, 2019-2021
Excludes Normal Newborns

Entire Hospital	CY2019	CY2020	CY2021
Licensed beds	124	124	124
Available beds	124	124	124
Discharges	7,583	7,181	7,411
Patient days	31,421	30,706	33,214
% Occupancy	69.4%	67.7%	73.4%

Source: Applicant, discharges and days from CHARS, excludes normal newborns (normal newborns do not occupy licensed beds so they are excluded in both Tables 6 and 7.

[2] All newborns are excluded, including Level II, because there is no change to Level II basinets with this project.
[3] Acute care beds are licensed only as such, however operationally St. Francis designates 96 beds as Med/Surg beds and 22 beds as OB/Postpartum beds

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

Table 8 includes the intervening years of FY22-FY23 in addition to the first seven full years of the project. This data assumes approval of the 24 beds requested in application #22-40. Table 9 provides the same information for all acute care beds and the Level II Neonatal unit. In an effort to be conservative, SFH has assumed no growth in patient days beyond the 3rd full year of the project. As noted in the introduction, St. Francis also did not assume any change in patient days from the 24-bed addition application with this application. If the 10 beds requested in this application are not approved, SFH would operate at a higher occupancy level.

Table 8
St. Francis Hospital
Acute Care Patient Days and Discharges, FY2019-FY2030
Excludes all Newborns

Project-Specific Only	Historical			Intervening		Project						
	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30
Licensed beds	118	118	118	118	118	152	152	152	152	152	152	152
Available beds	118	118	118	118	118	152	152	152	152	152	152	152
Discharges	7,465	6,794	7,042	7,137	7,232	7,617	7,936	8,185	8,185	8,185	8,185	8,185
Patient days	31,694	29,129	32,498	32,966	33,441	35,202	36,656	37,791	37,791	37,791	37,791	37,791
Occupancy	73.6%	67.4%	75.5%	76.5%	77.6%	63.4%	66.1%	68.1%	68.1%	68.1%	68.1%	68.1%

Source: Applicant internal data, excludes all newborns

The assumptions used to project discharges and patient days include:

- 24 bed addition opens on July 1, 2023. The 10 beds requested in this application are made permanent in July 2023. Growth in census was anticipated with the opening of the 24 additional Med/Surg beds only.
- Acute care days include Med/Surg services and Obstetrics services. ALOS for OB was held constant through the projection period based on FY2021 actual (ALOS of 1.76). Med/Surg ALOS was held at 4.62, SFH's FY2021 actual ALOS for Med/Surg patients.

- In the intervening years (FY2022 and FY2023), Med/Surg patient days were assumed to grow at approximately 50% of the Southeast King planning area days growth or 1.5% annually due to capacity constraints at St. Francis. The planning area is projected to grow at 3.25% annually (estimated annual growth rate of inpatient days for the Southeast King bed need methodology with 2019 as a baseline).
- In the intervening years, OB patient day growth was held to 0.5% annually (this is the same rate of growth as the female age 15-44 age cohort). LOS held constant based on FY21 actual LOS (ALOS of 1.76).
- Growth in Med/Surg days in FY24, FY25, and FY26 is based on growth in patient days in the Southeast King Planning Area (3.25% annually). In addition, it is assumed St. Francis will be able to retain patients who have had to be transferred from the ED because of lack of capacity, resulting in an ADC growth of 2.0 in FY24; 1.0 ADC in FY25. For the last several years St. Francis has had to transfer between 56 and 93 patients per month. With the additional bed capacity, it has been assumed that a portion of these patients can be 'recaptured' and returned to St. Francis.

Table 9
St. Francis Hospital
Total Patient Days and Discharges, FY 2019-FY2030
Excludes Normal Newborns

Entire	Historical			Intervening		Project						
Hospital	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30
Licensed beds	124	124	124	124	124	158	158	158	158	158	158	158
Available beds	124	124	124	124	124	158	158	158	158	158	158	158
Discharges	7,805	7,150	7,422	7,519	7,616	8,004	8,342	8,576	8,576	8,576	8,576	8,576
Patient days	32,492	29,920	33,334	33,806	34,286	36,052	37,510	38,649	38,649	38,649	38,649	38,649
Occupancy	71.8%	65.9%	73.7%	74.7%	75.8%	62.5%	65.0%	67.0%	67.0%	67.0%	67.0%	67.0%

Source: Applicant internal data, excludes normal newborns

Assumptions:

- In addition to the assumptions listed above for Table 8, Table 9 also includes Level II discharges and patient days. It has been assumed that the Level II discharges remain at a constant percentage of OB discharges (33.2%). ALOS remains constant based on FY21 actual LOS (ALOS of 2.20).

Financial statements based upon the above utilization assumptions are included in Exhibit 5.

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

The requested information is included in Exhibit 6.

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

As detailed in Table 10, in 2019, St. Francis had the 3rd highest midnight occupancy of all acute care hospitals in Washington State (75.5%); by 2021, St. Francis was experiencing the 7th highest occupancy of any hospital statewide (74.9%). Between 2015 and 2021, occupancy at St. Francis has had a range of 69.5% to 78.3%. St. Francis has very little ability to increase its occupancy because of the limited Med/Surg capacity. It is worth noting that four of Franciscan Health's hospitals were consistently in the Top 10.

Table 8
Top 10 Hospitals with Highest Percentage Occupancy 2015 – 2021

Hospital Name	2015	2016	2017	2018	2019	2020	2021
Harborview Medical Center	88.8%	82.9%	87.0%	88.3%	88.4%	85.5%	103.0 %
MultiCare Good Samaritan Hospital	57.6%	60.1%	68.0%	70.5%	78.6%	74.3%	89.9%
PeaceHealth Saint Joseph Hospital	72.8%	76.3%	78.7%	81.0%	80.3%	77.9%	85.7%
Providence Saint Peter Hospital	61.5%	67.9%	72.3%	77.0%	82.3%	76.6%	84.2%
Providence Regional Medical Center Everett	63.5%	69.0%	70.8%	73.9%	75.0%	75.8%	82.8%
Saint Clare Hospital	75.1%	77.9%	75.7%	77.9%	76.8%	69.1%	78.2%
Saint Francis Hospital	75.5%	78.1%	78.3%	75.0%	71.2%	69.5%	74.9%
Saint Anthony Hospital	56.3%	56.2%	61.0%	62.1%	61.8%	63.7%	73.0%
Saint Joseph Medical Center	78.2%	77.9%	81.4%	80.3%	81.0%	74.2%	77.2%

Source: CHARS. Inpatient discharges excluding newborns (Hospital Unit is defined is acute), MDC19 is excluded from Harborview's occupancy data.

Since 2015, and even with the opening of the new MultiCare Covington Hospital (which added 58 beds to the planning area), occupancy of hospitals in Southeast King has increased (this is demonstrated in Table 11). As can be seen in Table 11, St. Francis has consistently had the highest occupancy, and has consistently operated above the *State Health Plan* target occupancy level.

Table 9
Acute Care Occupancy (% of Licensed Beds) of Southeast King Hospitals 2015 – 2021

	Target Midnight Occupancy per State Health Plan	2015	2016	2017	2018	2019	2020	2021
MultiCare Auburn	**65%**	52.7%	52.8%	52.9%	59.1%	58.2%	57.7%	68.7%
MultiCare Covington	**60%**	N/A	N/A	N/A	8.5%	21.3%	26.0%	43.3%
St. Elizabeth	**50%**	51.3%	52.1%	60.1%	58.1%	49.3%	48.7%	48.7%
St. Francis	**65%**	75.5%	78.1%	78.3%	75.0%	71.2%	69.5%	74.9%
UW/Valley Medical Center	**75%**	51.5%	56.7%	56.6%	58.6%	61.3%	63.0%	63.9%
Total	**N/A**	**56.5%**	**59.8%**	**60.2%**	**57.2%**	**58.5%**	**59.2%**	**64.1%**

Source: CHARS. Inpatient discharges excluding newborns (Hospital Unit is defined is acute).

St. Francis is the only Southeast King hospital located west of I-5. Approximately 45% of St. Francis' discharges come from the zip codes west of I-5. Additionally, of those who live west of I-5, more than one-third of patients who have an inpatient encounter are hospitalized at St. Francis; a rate nearly 40 percentage points higher than any other hospital in the Southeast King planning area. In addition, as was noted in the 24-bed application, St. Francis and MultiCare Covington serve different and distinct geographic areas of the SE King Planning Area. On the inpatient side, excluding normal newborns, in 2021, there were 419 unique DRGs for patients hospitalized at SFH. At MHS Covington, excluding normal newborns, there were a total of 262 DRGS; only 60% of what is seen at SFH. SFH also provides two tertiary services: an elective PCI program and a Level II nursery. SFH holds a Level IV trauma designation. Covington does not operate any tertiary service and does not have a trauma designation from the State. All of these factors are likely reflected in the nearly 40% higher case mix index differential of the two hospitals: 1.52 for SFH and 1.10 for Covington[4]. Case mix reflects the diversity, clinical complexity, and resource needs of all the patients in the hospital. A higher CMI indicates a more complex and resource-intensive case load.

[4] Source: Washington State Hospital Association, Discharge Summary Report, 2021.

As stated earlier, the *State Health Plan's* adjusted target occupancy for a hospital the size of St. Francis is 65%. St. Francis has, over the past three years, consistently exceeded the State Health Plan target of 65% with occupancy levels between 69-75% as depicted in Table 11. More relevant to this project, the percent midnight occupancy of the 96 med/surg beds grew to nearly 86% during the most recent fiscal year (Table 12). This is 32% higher than the standard. In FY2019, the med/surg beds were at 95% occupancy or greater at midnight approximately 5% of the time; by FY2021, this percentage had doubled. Forty-four percent of the time in FY19, midnight occupancy was 85% or greater; by FY2021, this had increased to 55%. Clearly, these high occupancy levels impact access. Note, occupancy data in Table 12 will not match occupancy data presented in other tables throughout the document as this table presents the number of inpatients in a bed at midnight each day by unit and type of bed on the unit.

Table 10
St. Francis Hospital
FY2019, FY2020 and FY2021 ADC and Occupancy

	FY 2019		FY 2020		FY 2021	
	Med/ Surg	Acute Care[5]	Med/ Surg	Acute Care	Med/ Surg	Acute Care
Current Licensed/ Set-Up Beds	96	118	96	118	96	118
Avg. Daily Census (ADC) at Midnight	80.0	89.8	73.6	82.3	82.4	90.7
Target Avg. Occupancy	65%	65%	65%	65%	65%	65%
Actual Avg. Occupancy	83.3%	76.1%	76.6%	72.1%	85.8%	76.9%
Occupancy						
100%	7	0	0	0	17	0
95% - 99%	10	2	1	0	23	2
90% - 94%	54	11	11	1	60	10
85% - 89%	89	25	42	11	100	37
80% - 84%	90	74	78	42	83	79
75% - 79%	66	85	102	78	56	94
70% - 74%	33	84	54	102	17	68
Target Occupancy per SHP: 65%	13	64	48	66	8	66
60% - 64%	2	16	20	42	0	4
Less than 60%	1	4	10	24	1	5

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

[5] Acute care is med/surg and OB beds.

As was discussed earlier, St. Francis and the Program agreed to use 2019 data as the baseline in its previous application. However, it is helpful to look at St. Francis' 2020 experience, as well as 2021 and Q1 2022. This data confirms that more beds are needed to ensure the health care needs of the communities it primarily serves are being adequately met.

In FY2021, St. Francis had an average daily med/surg census (all acute care beds less OB beds) of 82.4 and was at a med/surg occupancy level of nearly 86%, well above the 65% target midnight occupancy standard. With the inclusion of all acute care beds, St. Francis's ADC was 90.7 and 77% occupancy. While St. Francis averaged 77% average midnight occupancy for acute care beds in the most recent fiscal year (FY 2021), internal data shows that mid-day/mid-week (between 10AM and 1 PM), census is typically 30% higher, meaning that there were significant days and times of day when no beds were available, and patients were held in the ED or transferred to other hospitals. This trend has continued into Q1 2022. In fact, the Joint Commission noted in a recent survey the excessive levels of ED boarding at SFH; which is directly attributable to a lack of beds.

St. Francis' continued high levels of occupancy is reducing its ability to serve its community. Table 13 illustrates the average number of patients that had to be transferred from the St. Francis Emergency Department each month as a result of lack of capacity or in limited cases, lack of clinical capability. Assuming an ALOS of only 4 days, the ADC in 2021 of these patient transfers, assuming all could have been accommodated at St. Francis, was 7.25.

Table 11
Average Monthly and Yearly Emergency Department Transfers from St. Francis

	CY 2018	CY 2019	CY 2020	CY 2021
Monthly	93	91	67	55
Yearly	1,112	1,100	805	662

Source: Applicant

In addition to the lack of capacity at St. Francis, there are a number of factors in the geography and socioeconomics of the communities served by St. Francis that make access more challenging than in many other King County communities. These challenges are compounded by the Public Health Emergency demonstrating that these communities are no longer assured accessible health care.

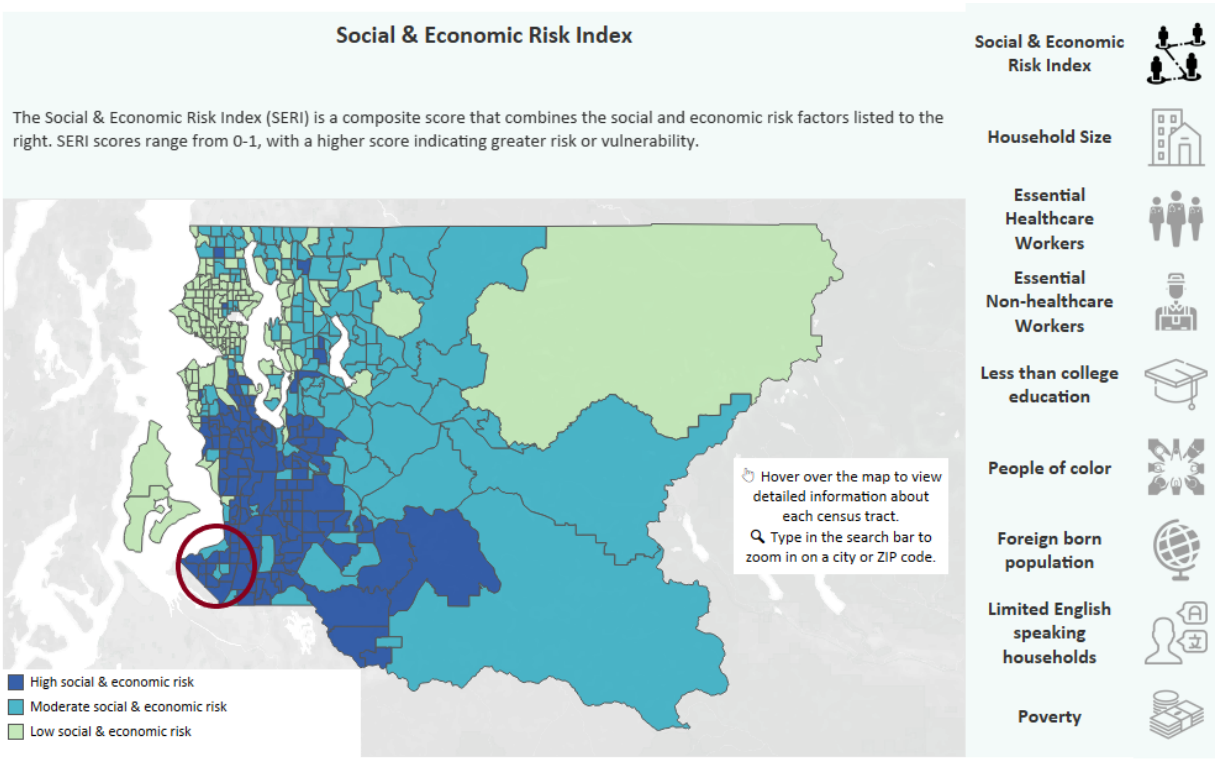
Access to care for patients within the community who must use public transportation is particularly compromised: The King County Metro trip planner indicates when buses are running on schedule it takes approximately one hour to get from Federal Way to MultiCare Auburn Medical Center, requiring two transfers and then walking 0.4 miles from the bus station to the medical center. Travelling to Valley Medical Center is an even greater burden. Travel time to Valley Medical Center is nearly 2 hours, requiring three to four bus transfers.

The communities served by St. Francis are among the most diverse and underserved in the state, and the socioeconomics of South King County have been extensively vetted by King County Public Health and other organizations, including Washington's Department of Health. For example, Public Health-Seattle & King County, Evergreen Health, VM Franciscan Health (St. Elizabeth Hospital, St. Francis Hospital, and St. Anne Hospital), Kaiser Permanente, MultiCare Health System (Auburn Medical Center and Covington Medical Center), Navos, Overlake Medical Center, Seattle Cancer Care Alliance, Seattle Children's, Swedish Medical Center (Ballard Campus, Cherry Hill Campus, First Hill Campus, Issaquah Campus), UW Medicine (Harborview Medical Center, Northwest Hospital & Medical Center, UW Medical Center and Valley Medical Center), Virginia Mason and the Washington State Hospital Association collectively produced *the King County Community Health Needs Assessment 2018/2019*. That Report found:

> *"People of color and low-income residents are at disproportionate risk of being uninsured and having poor health and social outcomes. Many health and social indicators—such as housing quality, alcohol related deaths, obesity, lack of health insurance, and smoking—show regional patterns of inequity.* ***South King County is home to some of the most racially and ethnically diverse communities in our county, and experiences disparities in multiple health and social indicators.***

King County Public Health developed a tool to assess social and economic risk related to COVID-19 outcomes. Although the tool was designed to assess disparities in COVID-19 outcomes, many of the factors that cause disparities in these also related to general health care disparities. As illustrated in Figure 1, residents of Southeast King including the areas surrounding St. Francis have both high social and economic risk placing residents at risk of disparities and vulnerability.

Figure 1: King County Social and Economic Risk Index



Source: King County Public Health Social and Economic Disparities

In the 2021/2022 King County Community Health Needs Assessment (CHNA), residents of South King County, had a significantly shorter life expectancy compared to the King County Average (79.3 years compared to 81.7 years in King County), and of particular concern is that life expectancy in this region of the county has been declining for 10 years. This is likely due to the high level of chronic disease burdens in these communities, including statistically higher prevalence of chronic illnesses (hypertension and diabetes) compared to King County overall.

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

Admission to each of the FHS facilities and programs is based on clinical need. Services are made available to all persons regardless of age, race, color, creed, sex, national origin, ethnicity, religion, marital status, sexual orientation, gender identity or expression, physical, mental or other disability, citizenship, medical condition, or income. A copy of Franciscan Health's policies is included as Exhibit 7.

For hospital charity care reporting purposes, the Department divides Washington State into five regions. St. Francis 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 1.32% of gross revenue and 2.98% of adjusted revenue. During the same time frame, St. Francis's charity care was 1.61% and 4.31%, respectively. The percentage of charity care included in the pro forma is 1.37% of total revenue, which is based on St. Francis's actual FY2021; and is still beyond the King County average.[6]

In addition to providing charity care at a higher rate than King County hospitals, excluding Harborview, St. Francis cares for a large percentage of Medicaid patients. St. Francis's percentage of Medicaid patients is 230% higher than the average of the other hospitals located in the Southeast King Planning area as shown in Table 14.

Given the net need demonstrated by application of the acute care bed need projection methodology, FHS is confident that the case has been made for the beds to be made permanent at St. Francis. In the unlikely event that the CN Program does not identify numeric need for this project, Table 14 demonstrates the ability to approve the project under Criterion 2, which reads:

> ***CRITERION 2: Need for Multiple Criteria***
>
> *Hospital bed need forecasts are only one aspect of planning hospital services for specific groups of people. Bed need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional beds, services or facilities. Even where the total bed supply serving a group of people or planning area is adequate, it may be appropriate to allow an individual institution to expand.*

[6] St. Francis notes that due to data extraction issues in the CHARS inpatient data base, there are no self-pay patients included in the 2019 data forward. This was an extraction issue only, not an upload issue. St. Francis has and will continue to serve self-pay patients.

Standards:

b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:

- *The proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or*

- *The proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or*

- *The proposed development would allow expansion of a crowded institution which has good cost, efficiency or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.*

In such cases, the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.

Table 12
Payor Mix by Percent of Total Patients, 2021

Payer	St. Francis % of Patients	All Other SE King Hospitals % of Patients	King County Range Excluding St. Francis % of Patients
Commercial & HMO	46.9%	50.1%	22.1 – 66.8%
Medicaid	30.0%	16.4%	5.2% – 34.4%
Medicare	20.7%	29.5%	20.7 – 59.5%
Self-Pay & Charity	2.5%	4.0%	1.5% – 8.2%
Total	**100.0%**	**100.0%**	

Source: CHARS 2021 acute care inpatient discharges (acute care units), excludes Seattle Children's, Kindred Hospital, normal newborns, dedicated psychiatric hospitals.

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**

The requested policies are included in Exhibit 7.

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.**

Each requested data item is included in Exhibit 5. Utilization projections and assumptions were previously provided in Section 4, Question 5.

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

St. Francis's fiscal year ends on June 30.

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

St. Francis does not have any of the above agreements or contracts. This question is not applicable.

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.**

Included in Exhibit 8 is documentation from the King County Assessor's office demonstrating that CommonSpirit Health owns the site on which the hospital is located.

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.**

Included in Exhibit 8 is documentation from the King County Assessor's office documenting that CommonSpirit Health owns the site on which the hospital is located, and its present use is a hospital.

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.**

There are no capital expenditures for this project. Therefore, this question is not applicable.

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.**

There are no capital expenditures for this project. Therefore, this question is not applicable.

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.**

St. Francis is an existing operation. No start-up period is anticipated.

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.**

As discussed in response to the previous question, there is no start up period. This question is not applicable.

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

There are no capital expenditures for this project. Therefore, this question is not applicable.

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

There are no capital expenditures for this project. Therefore, this question is not applicable.

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."

St. Francis's projected payer mix is detailed in Table 15. Total hospital payer mix was assumed to change slightly because payer mix for med/surg patients is different from OB patients. The majority of the increase in patient days is assumed to be for med/surg patients.

Table 15
St. Francis Hospital Projected Payer Mix

Payer Mix	Percentage by Gross Revenue	Percentage by Patient
Medicare	41.1%	43.0%
Medicaid	22.0%	27.1%
Commercial/Managed Care	30.7%	24.8%
Other Government (L&I, VA, Workers Comp, etc.)	3.7%	3.0%
Self-Pay	2.6%	2.1%
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.

St. Francis's historical payer mix based on Fiscal Year 2021 is detailed in Table 16.

Table 1613
St. Francis Hospital Historical Payer Mix (FY 2021)

Payer Mix	Percentage by Gross Revenue	Percentage by Patient
Medicare	40.8%	40.7%
Medicaid	22.1%	24.2%
Commercial/Managed Care	30.8%	28.4%
Other Government (L&I, VA, Workers Comp, etc.)	3.7%	3.4%
Self-Pay	2.6%	3.4%
Total	**100.0%**	**100.0%**

Source: Applicant

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.

There is no equipment proposed for this project. This question is not applicable.

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.**

The requested information on other facilities owned/operated and or affiliated with Franciscan Health is included in Exhibit 9. In addition, facilities that are part of VM Franciscan Health are also included in Exhibit 9.

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 information is included in Exhibit 10. Note that the projections are the same as that included in the current CN for the 24 beds.

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

Salary expense corresponds to the FTEs needed to provide the service. FTEs increase in accordance with the increase in patient days. As required by CN Program guidelines, the projected FTEs do not assume any compensation increases.

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

The key clinical staff are as follows:

Table 14
St. Francis Hospital Key Staff

Name	Title	Professional License Number
Aparna Ananth, MD	Division VP, Associate Chief Medical Officer King Region	MD00045928
Holly Cook, RN	Director, Nursing Operations	RN00112119

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.**

While St. Francis is an operating unit of FHS, it is also a related organization to VM Franciscan Health. As such staff recruitment and retention falls under VM Franciscan Health. Therefore, VM Franciscan Health fully acknowledges the current workforce issues experienced by all health care providers, due in part to COVID burnout and challenged by the desire to support and embrace diversity, inclusion, and equity. To ensure the workforce needs are a top priority, VM Franciscan Health employs a Director of Workforce Development. All levels of CommonSpirit Health and VM Franciscan Health are focused on workforce development, retention and efficiencies, including signing bonuses and referral bonuses for front line clinical staff, mid-year market increases, broad based appreciation bonuses, and staffing incentives for extra shifts.

For an organization the size of VM Franciscan Health, and because this project proposes an expansion of an existing facility, and importantly, the rightsizing of it to support current and projected volumes, the staffing needs noted in Exhibit 10 are relatively small. In an effort to assure that we always have the staff needed to support our existing and proposed new programs, VM Franciscan Health offers a competitive wage and benefit package as well as numerous other recruitment and retention strategies. It also recognizes that this is an extraordinary time with regard to staffing. Updated patient care areas and a less crowded environment will help to provide a more attractive experience for staff.

Specific strategies for clinical, ancillary and support staff include:

- VM Franciscan Health offers, and will continue to offer, a generous benefit package for both full and part time employees that includes Medical, Dental, Paid Time Off/Extended Illness/Injury Time, Employee Assistance Plans, and a Tuition Reimbursement Program, among other benefits.

- VM Franciscan Health posts all of its openings on our website via our online applicant tracking system. In addition to our own website, VM Franciscan Health has agreements with several job boards including Indeed.com, Health-e-Careers, and Washington HealthCare News to name a few.

- VM Franciscan Health currently has contracts with more than 40 technical colleges, community colleges, and four-year universities throughout the United States that enable us to offer either training and/or job opportunities. In addition, VM Franciscan Health Education Services staff serves on healthcare program advisory boards and as clinical or affiliate faculty at a number of local institutions. VM Franciscan Health constantly monitors the "wage" market, adjusting as necessary to ensure that our hospitals' wage structures remains competitive.

- VM Franciscan Health provides a career counselor who is available to all staff to encourage development and growth within the healthcare industry. This is further supported through a tuition reimbursement program and referrals to state and federal funds for continuing education. In addition, the Franciscan Foundation has annual scholarships available for current employees to advance their education.

- VM Franciscan Health's various facilities serve as clinical training sites for healthcare specialties such as nursing, diagnostic imaging, physical/occupational therapy, and pharmacy, (to name a few).

- VM Franciscan Health also offers various other recruitment strategies (i.e., new nursing grad events, nursing school class visits, job fairs, career days, direct-e- mail campaigns, etc.) as other ways to bring new healthcare workers to the VM Franciscan Health organization.

- VM Franciscan Health works closely with agency personnel, not only to negotiate rates but to also ensure that agency staff is able to provide the same high-quality skill level that VM Franciscan Health requires of our own employees.

- VM Franciscan Health holds residency program RN career fairs twice a year to help recruit and train new RNs. They go through a formal residency program at the site and in the department, they are hired into. VM Franciscan Health also attends campus career fairs and speaks with graduating RN classes about our opportunities and training for new nurses. We advertise on popular job boards as well as specialty niche sites.

Based on the above, St. Francis has demonstrated that it has the necessary infrastructure in place to recruit the additional staff needed for this project.

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

St. Francis is not a new facility. This question is not applicable.

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

The existing ancillary and support services, and an indication as to whether they are provided in house or under agreement, are provided in Table 18.

Table 15
Ancillary and Support Services

Services Provided	Vendor
Linen service	In-house
Pathology	Cellnetix
Janitorial services	In-house
Biomedical	In-house
Biomedical waste	Stericycle
PT	In-house
Dietary	In-house
Respiratory Therapy	In-house

Source: Applicant

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

No existing ancillary or support agreements are expected to change as a result of this project.

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

St. Francis works closely with most healthcare providers in Southeast King County, as well as the larger South King County region, Tacoma, the greater Pierce County area, and Seattle. This includes EMS, primary care and specialty clinics, other hospitals, nursing homes, assisted living communities, home health and hospice.

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

No existing working relationships are expected to change as a result of this project.

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 additional med/surg beds will promote continuity of care particularly considering the access issues outlined in the *Need* section. St. Francis' already high occupancy is compounded by the community's health disparities, and socioeconomic challenges. An adequate number of med/surg beds, located close to where patients reside, provides the best opportunity to assure patients get timely care, and that continuity from the hospital to the other levels of care in their local communities is maintained. Approval of the project will promote timely access to inpatient service by enhancing St. Francis's bed capacity.

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).**

As noted above, St. Francis has a long track record of working closely with EMS, other existing hospitals, and other health care systems throughout the Puget Sound Region. St. Francis collaborates with area nursing homes, assisted living, adult family homes, home health, and hospice agencies as well as outpatient providers. St. Francis also supports area primary care and specialists, as well as insurers to assure care coordination, smooth transitions of care, and reduced rehospitalization and ED visits.

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 facility or practitioner associated with the application has any history with respect to the above.

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 only alternative to this certificate of need was to have a transition plan to remove the beds from operation by October 27.

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.**

Table 19 details the requested information.

Table 16
Advantages and Disadvantages

	Make the 10 beds Permanent	Beds Removed from Service
Patient Access to Health Care Services	Reduces barriers to access for our community.	Continue to face occupancy pressures and patient access is compromised.
Capital Costs	Most efficient use of capital as no capital investment required.	Not applicable
Staffing Impact	More efficient use of staffing with additional bed capacity.	Not applicable
Quality of Care	Positive impact on inpatient capacity as likely to reduce ED boarding and transfers.	Not applicable
Cost or Operational Efficiency	Lower costs and enhanced operational efficiency through less boarding in the ED, reduced transfers, optimizing staffing and improving workflow.	No opportunity to improve operational efficiency. Space will continue to be used inefficiently.
Legal	None	Not applicable

Source: Applicant

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.**

There is no construction proposed for this project. This question is not applicable.

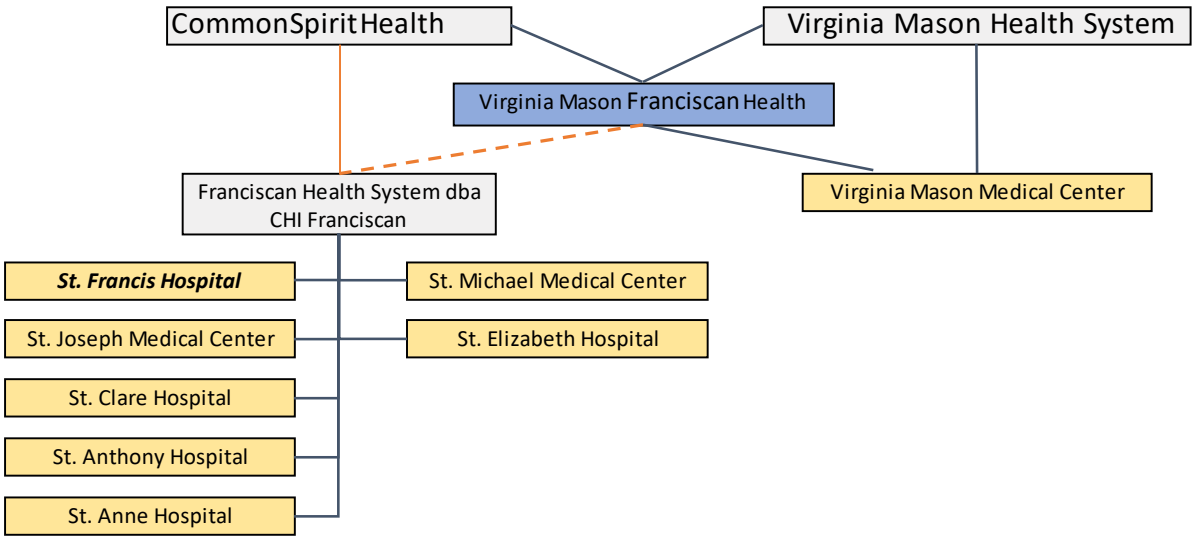
4. **Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.**

As a result of more efficient operations, the cost per patient day is reduced with this project. Also, as noted throughout this application, St. Francis currently operates at extremely high census. As a result, clinical staff often find themselves spending considerable time and energy engaged in non-clinical activity (i.e., monitoring/managing patients in hallways, moving patients from one area to another, calling other units to arrange logistics, etc.). Alleviating this problem through the addition of acute beds will result in a much more efficient use of staff time and skill. In addition, while not specific to staff and system efficiencies, the ability for St. Francis to care for patients needing care in a timely manner is expected to improve overall patient satisfaction and ultimately, outcomes.

The purpose of this CN application is not to capture additional volume, rather it is to provide additional relief in the day- to-day operations of the Hospital. The 10 beds achieve this by slightly reducing midnight occupancy levels: with the 24 additional beds, midnight occupancy on medical/surgical beds was expected to be 73% in 2026, with the 10 additional beds, it is expected to be 68%. This relief helps optimize current staffing and processes; and provides flexibility during surge periods.

Exhibit 1
Organizational Chart

Figure 1
Organizational Chart



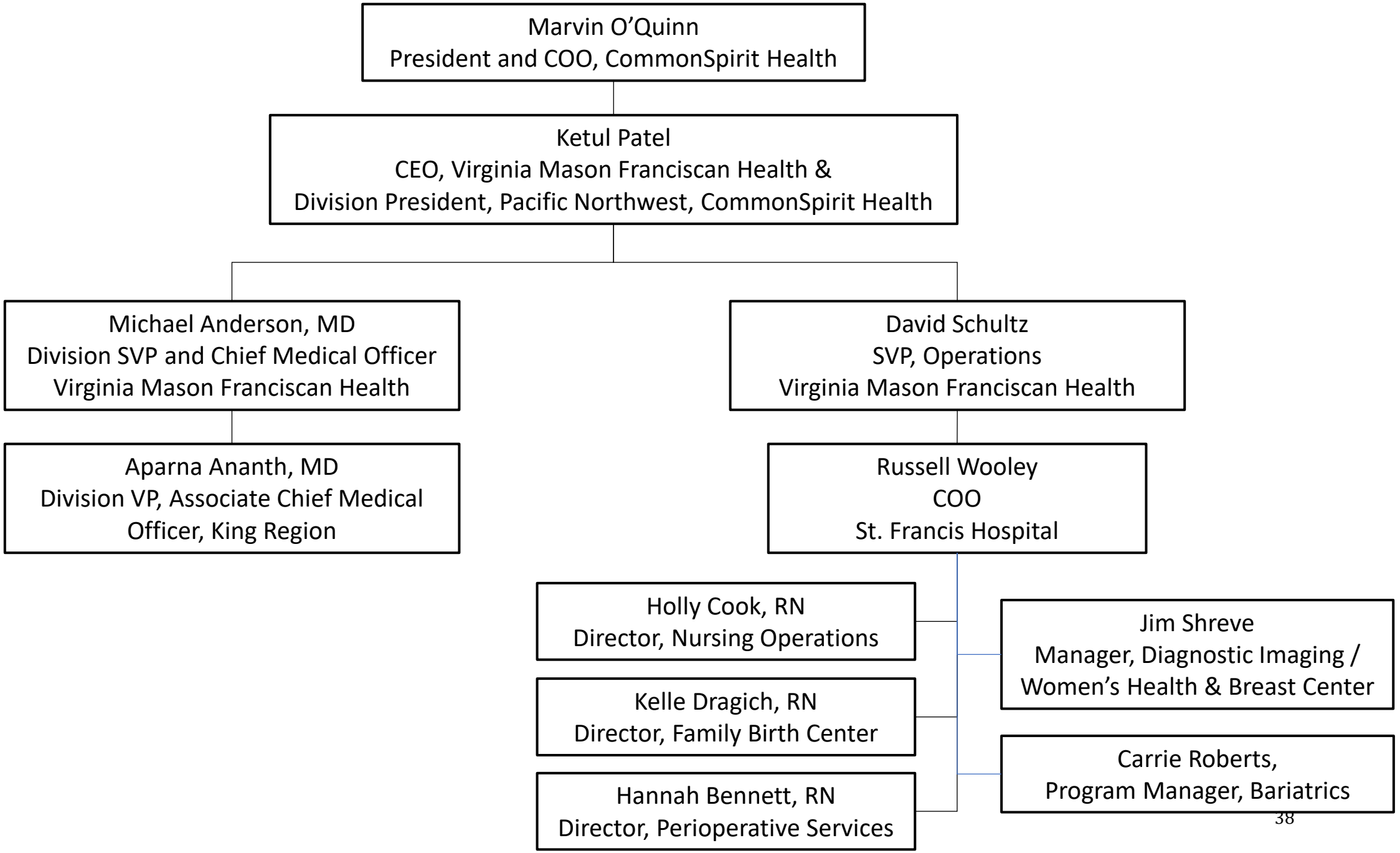

Marvin O'Quinn
President and COO, CommonSpirit Health
Ketul Patel
CEO, Virginia Mason Franciscan Health &
Division President, Pacific Northwest, CommonSpirit Health
Michael Anderson, MD
Division SVP and Chief Medical Officer
Virginia Mason Franciscan Health
Aparna Ananth, MD
Division VP, Associate Chief Medical
Officer, King Region
David Schultz
SVP, Operations
Virginia Mason Franciscan Health
Russell Wooley
COO
St. Francis Hospital
Holly Cook, RN
Director, Nursing Operations
Kelle Dragich, RN
Director, Family Birth Center
Hannah Bennett, RN
Director, Perioperative Services
Jim Shreve
Manager, Diagnostic Imaging /
Women's Health & Breast Center
Carrie Roberts,
Program Manager, Bariatrics

Exhibit 2
Letter of Intent

CATHOLIC HEALTH INITIATIVES

Franciscan Health System

August 26, 2022

COVID Waiver Letter of Intent Notification
Department of Health
Via email: COVIDwaiver@doh.wa.gov

RE: COVID Waiver, St. Francis Hospital

Dear COVID Waiver Letter of Intent Notification Program:

Consistent with the Department's August 9, 2022, COVID-19 Waiver Offboarding guidance/process powerpoint, please accept this Letter of Intent (LOI) as the Franciscan Health System, dba CHI Franciscan Health's ("FHS") LOI to retain 10 beds currently operational at St. Francis Hospital (SFH) post the end of Proclamation 20-36.

1. **A Description of the Extent of Services Proposed:**

SFH hospital has operated 10 beds in excess of its licensed capacity since early 2020. We intend to continue to operate these beds post the rescission of the Governor's Proclamation 20-36 on October 27, 2022. Please note that SFH currently has a CN pending for 24 new beds; these 10 beds are in addition to the 24; so, a new CN will need to be submitted.

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

At this time, we do not believe that there will be any capital expenditure to make the beds permanent.

3. **Description of the Service Area:**

Consistent with the Department's Acute Care Bed Need methodology, the planning area is the Southeast King Hospital Planning Area.

As requested in the August 9, 2022, off-boarding guidance, the following patient transition plan information is being provided.

4. **The average number of patients:**

We expect to have 8-10 patients in these beds on most days.

5. Identification of similar facilities that could provide care to patients:

There are other hospitals to the north, south and east of us; of which about 4-5 are within a 30-minute drive time of SFH. Our experience is that all are currently plagued with high occupancy or workforce constraints.

6. Steps to be taken for patients to be transition, if needed:

Should the CN be denied, SFH will close the unit. If inpatient demand continues to exceed our licensed capacity, and we experience patient boarding in ED because of the inability to transfer, we will first submit a written request for an exemption through the pre-pandemic surge rules that allow hospitals to exceed licensed bed capacity under certain circumstances. In addition, and if required, we will delay the scheduling of non-emergency inpatient surgeries. Finally, and despite the *No Divert Agreement* that King County hospitals have in place, we will go on divert, which will further strain other healthcare providers in the region.

7. Timeline for transitioning clients to CN approved facilities/services if an application is denied:

The 10 beds represent 10% of our capacity. We estimate 30-45 days to be fully in compliance.

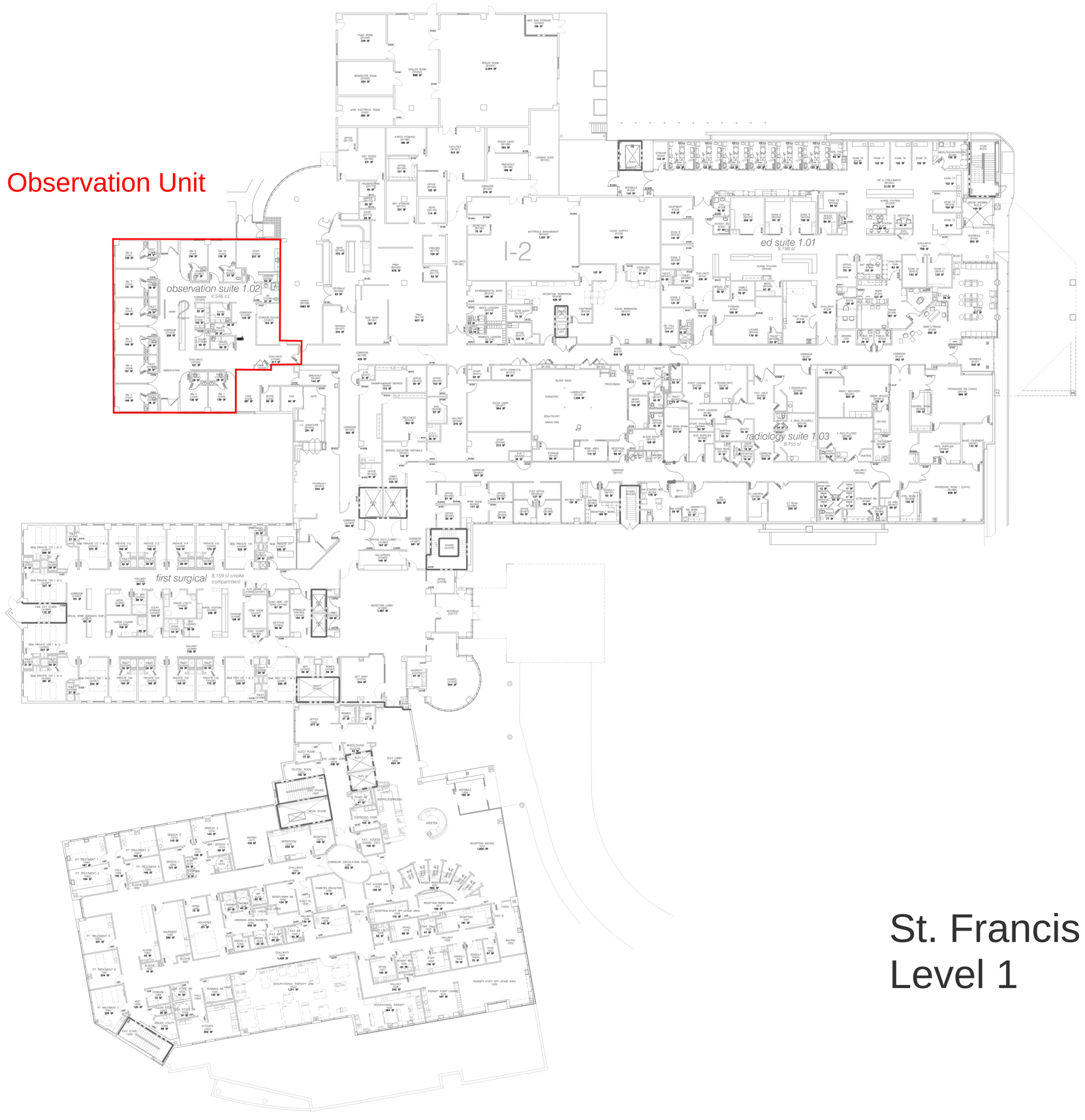
Thank you for your support in this matter. Please feel free to contact me with any questions.

Sincerely,

Thomas A. Kruse
Senior Vice President and Chief Strategy Officer

Exhibit 3
Single Line Drawings

Observation Unit



St. Francis Hospital
Level 1

2019 Baseline Bed Need Methodology

Step 1

1. 2010-2019 Total Resident Days

Excludes MDC 19 and MDC 15, Rehab Service Line

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	164,468	171,422	167,939	170,814	177,030	184,522	193,173	195,842	204,887	201,685
HSA# 1	1,268,003	1,295,661	1,278,057	1,298,805	1,339,856	1,406,560	1,432,552	1,475,082	1,505,669	1,510,484
Statewide Total	2,044,196	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159	2,390,230

STEP 2: Total Resident Days Adjusted to Exclude All Psychiatric Patient Days

2-A. 2010-2019 Total Resident Days (from Step 1)

Excludes MDC 19, MDC 15, Rehab

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	164,468	171,422	167,939	170,814	177,030	184,522	193,173	195,842	204,887	201,685
HSA# 1	1,268,003	1,295,661	1,278,057	1,298,805	1,339,856	1,406,560	1,432,552	1,475,082	1,505,669	1,510,484
Statewide Total	2,044,196	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159	2,390,230

2-B. 2010-2019 Total Psychiatric Hospital Non-MDC 19 Patient Days

Excludes MDC 19, MDC 15, Rehab

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	192	207	595	398	1,715	2,931	2,274	2,511	2,312	2,613
HSA# 1	1,384	1,639	2,907	3,101	9,823	16,266	15,482	16,250	16,704	17,945
Statewide Total	1,563	1,916	3,185	3,410	11,148	18,411	18,309	19,713	20,467	23,321

NOTE: Relevant to this Step, there are 4 psychiatric hospitals statewide:

Fairfax Hospital, Kirkland: Located in HSA 1 and Southeast King Planning Area

Navos, Seattle: Located in HSA 1 and Southeast King Planning Area

Lourdes Counseling Center, Richland: *Located in HSA 3 and Benton-Franklin Planning Area*

2C. 2010-2019 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days

Excludes MDC 19, MDC 15, Rehab

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	164,276	171,215	167,344	170,416	175,315	181,591	190,899	193,331	202,575	199,072
HSA# 1	1,266,619	1,294,022	1,275,150	1,295,704	1,330,033	1,390,294	1,417,070	1,458,832	1,488,965	1,492,539
Statewide Total	2,042,633	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,237,866	2,303,485	2,342,692	2,366,909

STEP 3: Historical Average Use Rates

3-A. 2010-2019 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days (from Step 2-C.)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	164,276	171,215	167,344	170,416	175,315	181,591	190,899	193,331	202,575	199,072
HSA# 1	1,266,619	1,294,022	1,275,150	1,295,704	1,330,033	1,390,294	1,417,070	1,458,832	1,488,965	1,492,539
Statewide Total	2,042,633	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,237,866	2,303,485	2,342,692	2,366,909

3-B. 2010-2019 Total Populations

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	551,969	560,594	569,419	578,452	587,701	597,173	606,877	616,821	627,015	637,468
HSA # 1	4,204,534	4,231,500	4,261,500	4,303,625	4,361,850	4,429,440	4,523,580	4,612,100	4,688,920	4,767,780
Statewide Total	6,724,540	6,767,900	6,817,770	6,882,400	6,968,170	7,061,410	7,183,700	7,310,300	7,427,570	7,546,410

3-C. 2010-2019 Total Use Rates Per 1,000

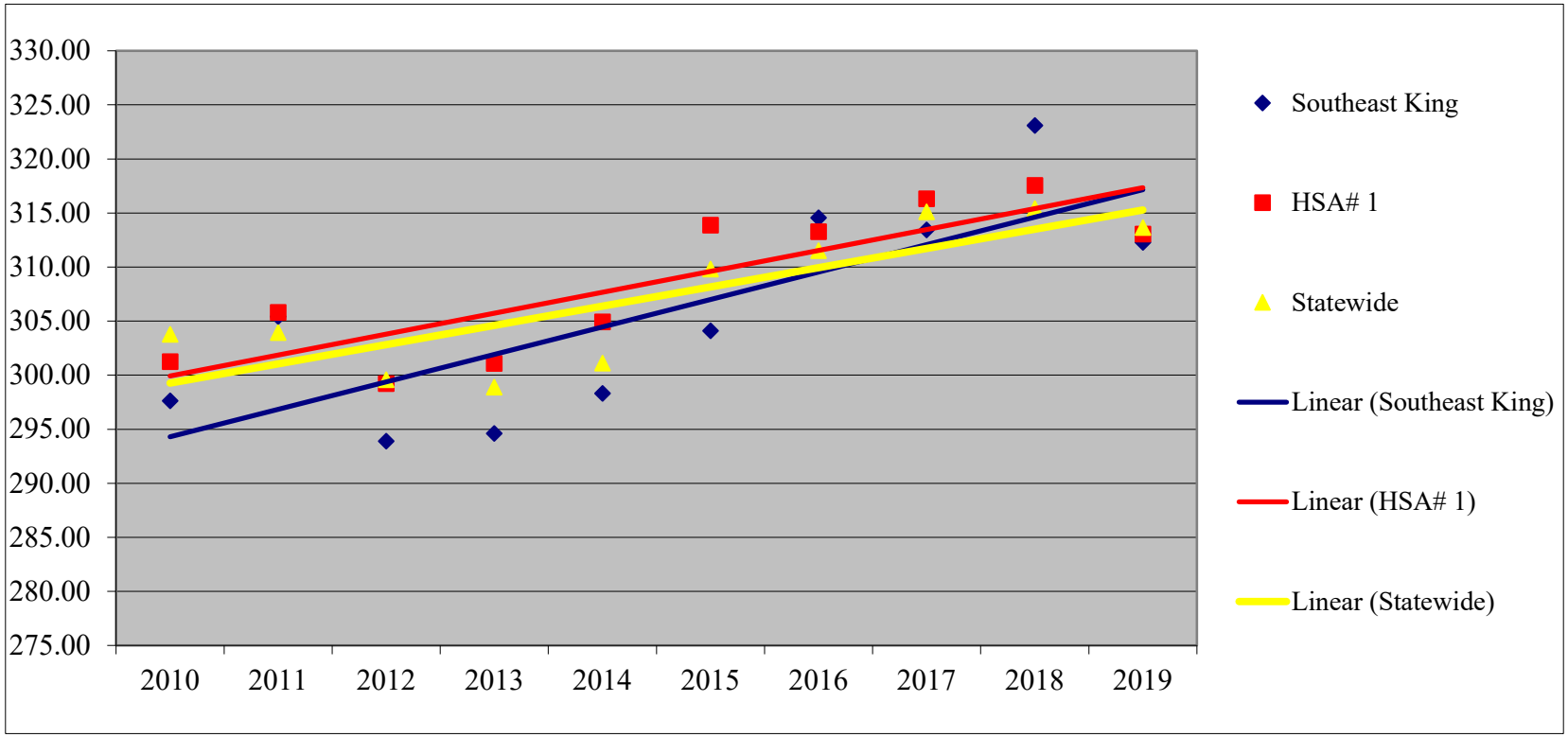
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	297.62	305.42	293.89	294.61	298.31	304.08	314.56	313.43	323.08	312.29
HSA # 1	301.25	305.81	299.23	301.07	304.92	313.88	313.26	316.31	317.55	313.05
Statewide Total	303.76	303.93	299.58	298.89	301.10	309.80	311.52	315.10	315.40	313.65

STEP 4: Historical Use Rate Trend Lines and Slopes

4-A. 2010-2019 Total Use Rates Per 1,000 (from Step 3-C.)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Southeast King	297.62	305.42	293.89	294.61	298.31	304.08	314.56	313.43	323.08	312.29
HSA# 1	301.25	305.81	299.23	301.07	304.92	313.88	313.26	316.31	317.55	313.05
Statewide Total	303.76	303.93	299.58	298.89	301.10	309.80	311.52	315.10	315.40	313.65

4-B. 2010-2019 Total Use Rate Trend Lines



4-C. 2010-2019 Total Use Rate Slopes

HSA#1	1.94
Statewide Total	1.78

STEP 5: Allocation of Patient (Provider) Days Back to Planning Areas Where the Patients Live

5-A. 2019 (Provider) Days by Age and Residence

Excludes MDC 19 ,MDC 15, Rehab

Southeast King

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State
Age 0-64	70,644	1,036	69,608	1.47%
Age 65+	66,729	875	65,854	1.31%
Total	137,373	1,911	135,462	1.39%

Other Washington (WA-Southeast King)

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State
Age 0-64	1,223,944	62,104	1,161,840	5.07%
Age 65+	1,114,623	45,043	1,069,580	4.04%
Total	2,338,567	107,147	2,231,420	4.58%

5-B. **2019 Patient Days by Age and Residence, to Providers by Area**

Excludes MDC 19 , MDC 15, Rehab

Residents of Southeast King

	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)	2019 Add (Patient) Days Provided in OR *	2019 Total Resident Days
Age 0-64	49,560	63,813	113,373	282	113,655
Age 65+	49,423	36,269	85,692	61	85,753
Total	**98,983**	**100,082**	**199,065**	**343**	**199,408**

Other WA Residents

	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)	Add (Patient) Days Provided in OR *	Total Resident Days
Age 0-64	21,084	1,160,131	1,181,215	39,687	1,220,902
Age 65+	17,306	1,078,354	1,095,660	28,888	1,124,548
Total	**38,390**	**2,238,485**	**2,276,875**	**68,575**	**2,345,450**

5-C. **2019 Market Shares - Percentage of Total Resident Patient Days**

Excludes MDC 19, MDC 15, Rehab

Residents of

	To Planning Area Providers	To Other WA Providers	To OR Providers	
Age 0-64	43.61%	56.15%	0.25%	100.00%
Age 65+	57.63%	42.29%	0.07%	100.00%
Total	**49.64%**	**50.19%**	**0.17%**	100.00%

Other WA Residents

Age 0-64	1.73%	95.02%	3.25%	100.00%
Age 65+	1.54%	95.89%	2.57%	100.00%
Total	**1.64%**	**95.44%**	**2.92%**	100.00%

STEP 6: Planning Area Use Rates by Age

Excludes MDC 19, MDC 15, Rehab

6-A. 2019 Population* by Age

	Southeast King	Other WA
Age 0-64	556,085	5,763,562
Age 65+	81,383	1,145,380
Total	**637,468**	**6,908,942**

* Planning area population from Claritas 2019

Other WA population = Statewide population from OFM (2019), minus Planning Area population.

6-B. 2019 Use Rates by Age

Excludes MDC 19, MDC 15, Rehab

	Southeast King	Other WA
Age 0-64	204.38	211.83
Age 65+	1,053.70	981.81
Total	**312.81**	**339.48**

STEP 7A: Planning Area Use Rates by Age

7A-A. 2019 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab

	Southeast King
Age 0-64	204.38
Age 65+	1,053.70
Total	**312.81**

7A-B. Projected Use Rates by Age for

Excludes MDC 19 , MDC 15, Rehab

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	204.38	206.32	208.25	210.19	212.12	214.06	215.99	217.93	219.86
Age 0-64 using State Trend	204.38	206.16	207.94	209.72	211.50	213.28	215.06	216.84	218.62
Age 65+ using HSA Trend	1,053.70	1,055.63	1,057.57	1,059.50	1,061.44	1,063.37	1,065.31	1,067.24	1,069.18
Age 65+ using State Trend	1,053.70	1,055.48	1,057.25	1,059.03	1,060.81	1,062.59	1,064.37	1,066.15	1,067.93

Trended Use Rates (from above) that are Closest to
Current Value - i.e., Requires the Smallest Adjustment

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using State Trend	204.38	206.16	207.94	209.72	211.50	213.28	215.06	216.84	218.62
Age 65+ using State Trend	1,053.70	1,055.48	1,057.25	1,059.03	1,060.81	1,062.59	1,064.37	1,066.15	1,067.93

7A-A. 2019 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab

	Other WA
Age 0-64	211.83
Age 65+	981.81
Total	**339.48**

7A-B. Projected Use Rates by Age for

Excludes MDC 19, MDC 15, Rehab

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	211.83	213.77	215.70	217.64	219.57	221.51	223.44	225.38	227.31
Age 0-64 using State Trend	211.83	213.61	215.39	217.17	218.95	220.73	222.51	224.28	226.06
Age 65+ using HSA Trend	981.81	983.75	985.68	987.62	989.55	991.49	993.42	995.36	997.29
Age 65+ using State Trend	981.81	983.59	985.37	987.15	988.93	990.71	992.49	994.27	996.04

STEP 8: Forecast Patient Days Using Trended Use Rates

8A. Projected Use Rates by Age (from Step 7A-B.) for

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using State Trend	204.38	206.16	207.94	209.72	211.50	213.28	215.06	216.84	218.62
Age 65+ using State Trend	1,053.70	1,055.48	1,057.25	1,059.03	1,060.81	1,062.59	1,064.37	1,066.15	1,067.93

8B. Projected Population* for

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	556,085	560,854	565,663	570,514	575,406	580,340	585,317	590,336	595,398
65+	81,383	85,458	89,736	94,229	98,947	103,901	109,103	114,566	120,302
Total	**637,468**	**646,311**	**655,399**	**664,743**	**674,353**	**684,241**	**694,420**	**704,901**	**715,699**

8C. Projected Resident Patient Days* for

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	113,655	115,627	117,625	119,649	121,699	123,775	125,877	128,007	130,164
65+	85,753	90,198	94,874	99,792	104,964	110,404	116,126	122,144	128,474
Total	**199,408**	**205,826**	**212,499**	**219,441**	**226,663**	**234,179**	**242,003**	**250,151**	**258,637**

Excludes MDC 19, MDC 15, Rehab

8A. Projected Use Rates by Age (from Step 7A-B.) for

Other WA

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using State Trend	211.83	213.61	215.39	217.17	218.95	220.73	222.51	224.28	226.06
Age 65+ using State Trend	981.81	983.59	985.37	987.15	988.93	990.71	992.49	994.27	996.04

8B. Projected Population* for

Other WA

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	5,735,514	5,798,374	5,830,303	5,862,909	5,896,201	5,930,191	5,964,886	5,998,787	6,033,363
65+	1,142,244	1,193,737	1,235,953	1,280,145	1,326,425	1,374,912	1,425,731	1,459,555	1,494,982
Total	**6,877,758**	**6,992,112**	**7,066,256**	**7,143,053**	**7,222,627**	**7,305,103**	**7,390,617**	**7,458,342**	**7,528,345**

8c. Projected Resident Patient Days* for

Other WA

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,214,961	1,238,592	1,255,785	1,273,238	1,290,958	1,308,949	1,327,220	1,345,435	1,363,923
65+	1,121,469	1,174,150	1,217,871	1,263,694	1,311,740	1,362,136	1,415,019	1,451,186	1,489,069
Total	**2,336,430**	**2,412,742**	**2,473,656**	**2,536,932**	**2,602,697**	**2,671,085**	**2,742,238**	**2,796,620**	**2,852,992**

STEP 9: Allocate Forecasted Patient Days to the Planning Areas Where Services are Expected to Be Provided

9A. (From Steps 8-C and D).

Projected Resident Patient Days* for

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	113,655	115,627	117,625	119,649	121,699	123,775	125,877	128,007	130,164
65+	85,753	90,198	94,874	99,792	104,964	110,404	116,126	122,144	128,474
Total	**199,408**	**205,826**	**212,499**	**219,441**	**226,663**	**234,179**	**242,003**	**250,151**	**258,637**

Excludes MDC 19 , MDC 15, Rehab

Projected Resident Patient Days* for

Other Washington

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,214,961	1,238,592	1,255,785	1,273,238	1,290,958	1,308,949	1,327,220	1,345,435	1,363,923
65+	1,121,469	1,174,150	1,217,871	1,263,694	1,311,740	1,362,136	1,415,019	1,451,186	1,489,069
Total	**2,336,430**	**2,412,742**	**2,473,656**	**2,536,932**	**2,602,697**	**2,671,085**	**2,742,238**	**2,796,620**	**2,852,992**

Excludes MDC 19, MDC 15, Rehab

9-B. 2018 Market Shares - Percentage of Total Resident Patient Days (From Step 5-C)

Excludes MDC 19, MDC 15, Rehab

Residents of Southeast King	**To Planning Area Providers**	**To Other WA Providers**	**To OR Providers**
Age 0-64	43.61%	56.15%	0.25%
Age 65+	57.63%	42.29%	0.07%
Total	**49.64%**	**50.19%**	**0.17%**

Other WA Residents

Age 0-64	1.73%	95.02%	3.25%
Age 65+	1.54%	95.89%	2.57%
Total	**1.64%**	**95.44%**	**2.92%**

9C. **Southeast King**

Resident Patient Days* to Providers **Southeast King**

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	49,560	50,420	51,291	52,174	53,067	53,973	54,890	55,818	56,759
65+	49,423	51,985	54,680	57,514	60,495	63,631	66,928	70,397	74,045
Total	**98,983**	**102,405**	**105,971**	**109,688**	**113,563**	**117,603**	**121,818**	**126,215**	**130,803**

Southeast King
Resident Patient Days to Other Washington Providers

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	63,813	64,920	66,042	67,178	68,329	69,495	70,675	71,871	73,082
65+	36,269	38,149	40,127	42,207	44,394	46,695	49,115	51,661	54,338
Total	**100,082**	**103,070**	**106,169**	**109,385**	**112,723**	**116,190**	**119,791**	**123,532**	**127,420**

Southeast King
Resident Patient Days to Oregon Providers

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	282	287	292	297	302	307	312	318	323
65+	61	64	67	71	75	79	83	87	91
Total	**343**	**351**	**359**	**368**	**377**	**386**	**395**	**404**	**414**

9D. **Other Washington Resident Patient Days* to Southeast King Providers**

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	20,981	21,389	21,686	21,988	22,294	22,605	22,920	23,235	23,554
65+	17,259	18,069	18,742	19,447	20,187	20,962	21,776	22,333	22,916
Total	**38,240**	**39,459**	**40,429**	**41,435**	**42,481**	**43,567**	**44,696**	**45,567**	**46,470**

Other Washington Resident Patient Days to Other Washington Providers

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,154,485	1,176,940	1,193,277	1,209,862	1,226,699	1,243,796	1,261,157	1,278,465	1,296,033
65+	1,075,401	1,125,918	1,167,844	1,211,784	1,257,856	1,306,182	1,356,893	1,391,574	1,427,901
Total	**2,229,887**	**2,302,859**	**2,361,121**	**2,421,646**	**2,484,556**	**2,549,978**	**2,618,049**	**2,670,039**	**2,723,935**

Other Washington Resident Patient Days to Oregon Providers

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	39,494	40,262	40,821	41,388	41,964	42,549	43,143	43,735	44,336
65+	28,809	30,162	31,285	32,462	33,697	34,991	36,350	37,279	38,252
Total	**68,303**	**70,424**	**72,106**	**73,851**	**75,661**	**77,540**	**79,493**	**81,014**	**82,588**

9E. **Total Washington Resident Patient Days* to Southeast King Providers**

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	70,541	71,810	72,978	74,161	75,361	76,577	77,810	79,053	80,313
65+	66,682	70,054	73,422	76,962	80,682	84,593	88,704	92,729	96,960
Total	**137,223**	**141,864**	**146,400**	**151,123**	**156,043**	**161,170**	**166,514**	**171,782**	**177,273**

Total Washington Resident Patient Days* to Other Washington Providers

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,218,298	1,241,861	1,259,319	1,277,040	1,295,029	1,313,291	1,331,832	1,350,336	1,369,115
65+	1,111,670	1,164,067	1,207,970	1,253,991	1,302,251	1,352,877	1,406,008	1,443,235	1,482,239
Total	**2,329,969**	**2,405,928**	**2,467,290**	**2,531,031**	**2,597,279**	**2,666,168**	**2,737,840**	**2,793,571**	**2,851,354**

Total Washington Resident Patient Days* to Oregon Providers

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	39,776	40,549	41,113	41,685	42,266	42,856	43,455	44,053	44,659
65+	28,870	30,226	31,353	32,533	33,771	35,070	36,432	37,366	38,343
Total	**68,646**	**70,775**	**72,466**	**74,219**	**76,038**	**77,926**	**79,888**	**81,418**	**83,002**

9-F. **Percent Out-of-State Resident Patient Days * (From Step 5-A)**

Southeast King

	% Out-of-State
Age 0-64	1.47%
Age 65+	1.31%
Total	**1.39%**

Other Washington

Age 0-64	5.07%
Age 65+	4.04%
Total	**4.58%**

9-F. Total Patient Days*, Including Out-of-State Residents

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	71,576	72,863	74,048	75,249	76,466	77,700	78,951	80,212	81,490
65+	67,556	70,973	74,385	77,971	81,740	85,702	89,868	93,945	98,232
Total	**139,132**	**143,836**	**148,433**	**153,220**	**158,206**	**163,402**	**168,818**	**174,158**	**179,722**

Southeast King

Provider Market Share of All Planning Area Resident Days

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Total	49.64%	49.75%	49.87%	49.99%	50.10%	50.22%	50.34%	50.46%	50.57%

Southeast King

Inmigration Days

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Total	40,149	41,431	42,462	43,532	44,644	45,799	47,000	47,943	48,919

Excludes MDC 19, MDC 15, Rehab

STEP 10: Apply Weighted Occupancy Standard to Determine Bed Need

2019 BASELINE

Final Bed Need Calculations

Excludes MDC 19, MDC 15, Rehab

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Population 0-64	556,085	560,854	565,663	570,514	575,406	580,340	585,317	590,336	595,398
0-64 Use Rate	204.38	206.16	207.94	209.72	211.50	213.28	215.06	216.84	218.62
Population 65+	81,383	85,458	89,736	94,229	98,947	103,901	109,103	114,566	120,302
65+ Use Rate	1,053.70	1,055.48	1,057.25	1,059.03	1,060.81	1,062.59	1,064.37	1,066.15	1,067.93
Total Population	637,468	646,311	655,399	664,743	674,353	684,241	694,420	704,901	715,699
Total Area Resident Days	199,408	205,826	212,499	219,441	226,663	234,179	242,003	250,151	258,637
Total Days in Area Hospitals	139,132	143,836	148,433	153,220	158,206	163,402	168,818	174,158	179,722

Planning Area Available Beds - LICENSED BEDS

Multicare Auburn Medical Center	131	131	131	131	131	131	131	131	131
Multicare Covington Medical Center	58	58	58	58	58	58	58	58	58
Saint Elizabeth Hospital	25	25	25	25	25	25	25	25	25
Saint Francis Hospital	118	118	118	118	118	118	118	118	118
UW/Valley Medical Center	321	321	321	321	321	321	321	321	321
TOTAL	653	653	653	653	653	653	653	653	653
Weighted Occupancy Standard	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%
Gross Bed Need	553	572	590	609	629	650	671	693	715
Net Bed Need / Surplus	-100	-81	-63	-44	-24	-3	18	40	62

STEP 10: Apply Weighted Occupancy Standard to Determine Bed Need

2019 BASELINE

Final Bed Need Calculations

Excludes MDC 19, MDC 15, Rehab

Southeast King

	2019	2020	2021	2022	2023	2024	2025	2026	2027
Population 0-64	556,085	560,854	565,663	570,514	575,406	580,340	585,317	590,336	595,398
0-64 Use Rate	204.38	206.16	207.94	209.72	211.50	213.28	215.06	216.84	218.62
Population 65+	81,383	85,458	89,736	94,229	98,947	103,901	109,103	114,566	120,302
65+ Use Rate	1,053.70	1,055.48	1,057.25	1,059.03	1,060.81	1,062.59	1,064.37	1,066.15	1,067.93
Total Population	637,468	646,311	655,399	664,743	674,353	684,241	694,420	704,901	715,699
Total Area Resident Days	199,408	205,826	212,499	219,441	226,663	234,179	242,003	250,151	258,637
Total Days in Area Hospitals	139,132	143,836	148,433	153,220	158,206	163,402	168,818	174,158	179,722

Planning Area Available Beds - SET UP BEDS

Multicare Auburn Medical Center	108	108	108	108	108	108	108	108	108
Multicare Covington Medical Center	58	58	58	58	58	58	58	58	58
Saint Elizabeth Hospital	25	25	25	25	25	25	25	25	25
Saint Francis Hospital	118	118	118	118	118	118	118	118	118
UW/Valley Medical Center	311	311	311	311	311	311	311	311	311
TOTAL	620	620	620	620	620	620	620	620	620
Weighted Occupancy Standard	68.94%	68.94%	68.94%	68.94%	68.94%	68.94%	68.94%	68.94%	68.94%
Gross Bed Need	553	572	590	609	629	649	671	692	714
Net Bed Need / Surplus	-67	-48	-30	-11	9	29	51	72	94

2020 Baseline Bed Need Methodology

Step 1

1. 2011-2020 Total Resident Days

Excludes MDC 19 and MDC 15, Rehab Service Line

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	171,422	167,939	170,814	177,030	184,522	193,173	195,842	204,887	201,685	200,465
HSA# 1	1,295,661	1,278,057	1,298,805	1,339,856	1,406,560	1,432,552	1,475,082	1,505,669	1,510,484	1,457,730
Statewide Total	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159	2,390,230	2,300,642

STEP 2: Total Resident Days Adjusted to Exclude All Psychiatric Patient Days

2-A. 2011-2020 Total Resident Days (from Step 1)
Excludes MDC 19, MDC 15, Rehab

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	171,422	167,939	170,814	177,030	184,522	193,173	195,842	204,887	201,685	200,465
HSA# 1	1,295,661	1,278,057	1,298,805	1,339,856	1,406,560	1,432,552	1,475,082	1,505,669	1,510,484	1,457,730
Statewide Total	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159	2,390,230	2,300,642

2-B. 2011-2020 Total Psychiatric Hospital Non-MDC 19 Patient Days
Excludes MDC 19, MDC 15, Rehab

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	207	595	398	1,715	2,931	2,274	2,511	2,312	2,613	1,074
HSA# 1	1,639	2,907	3,101	9,823	16,266	15,482	16,250	16,704	17,945	10,954
Statewide Total	1,916	3,185	3,410	11,148	18,411	18,309	19,713	20,467	23,321	17,717

NOTE: Relevant to this Step, there are 4 psychiatric hospitals statewide:

Fairfax Hospital, Kirkland: Located in HSA 1 and Southeast King Planning Area
Navos, Seattle: Located in HSA 1 and Southeast King Planning Area
Lourdes Counseling Center, Richland: *Located in HSA 3 and Benton-Franklin Planning Area*

2C. 2011-2020 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days
Excludes MDC 19, MDC 15, Rehab

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	171,215	167,344	170,416	175,315	181,591	190,899	193,331	202,575	199,072	199,391
HSA# 1	1,294,022	1,275,150	1,295,704	1,330,033	1,390,294	1,417,070	1,458,832	1,488,965	1,492,539	1,446,776
Statewide Total	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,237,866	2,303,485	2,342,692	2,366,909	2,282,925

STEP 3: Historical Average Use Rates

3-A. 2011-2020 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days (from Step 2-C.)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	171,215	167,344	170,416	175,315	181,591	190,899	193,331	202,575	199,072	199,391
HSA# 1	1,294,022	1,275,150	1,295,704	1,330,033	1,390,294	1,417,070	1,458,832	1,488,965	1,492,539	1,446,776
Statewide Total	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,237,866	2,303,485	2,342,692	2,366,909	2,282,925

3-B. 2011-2020 Total Populations

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	560,560	569,425	578,497	587,783	597,292	607,031	617,009	627,233	637,713	648,458
HSA # 1	4,231,500	4,261,500	4,303,625	4,361,850	4,429,440	4,523,580	4,612,100	4,688,920	4,767,780	4,834,480
Statewide Total	6,767,900	6,817,770	6,882,400	6,968,170	7,061,410	7,183,700	7,310,300	7,427,570	7,546,410	7,656,200

3-C. 2011-2020 Total Use Rates Per 1,000

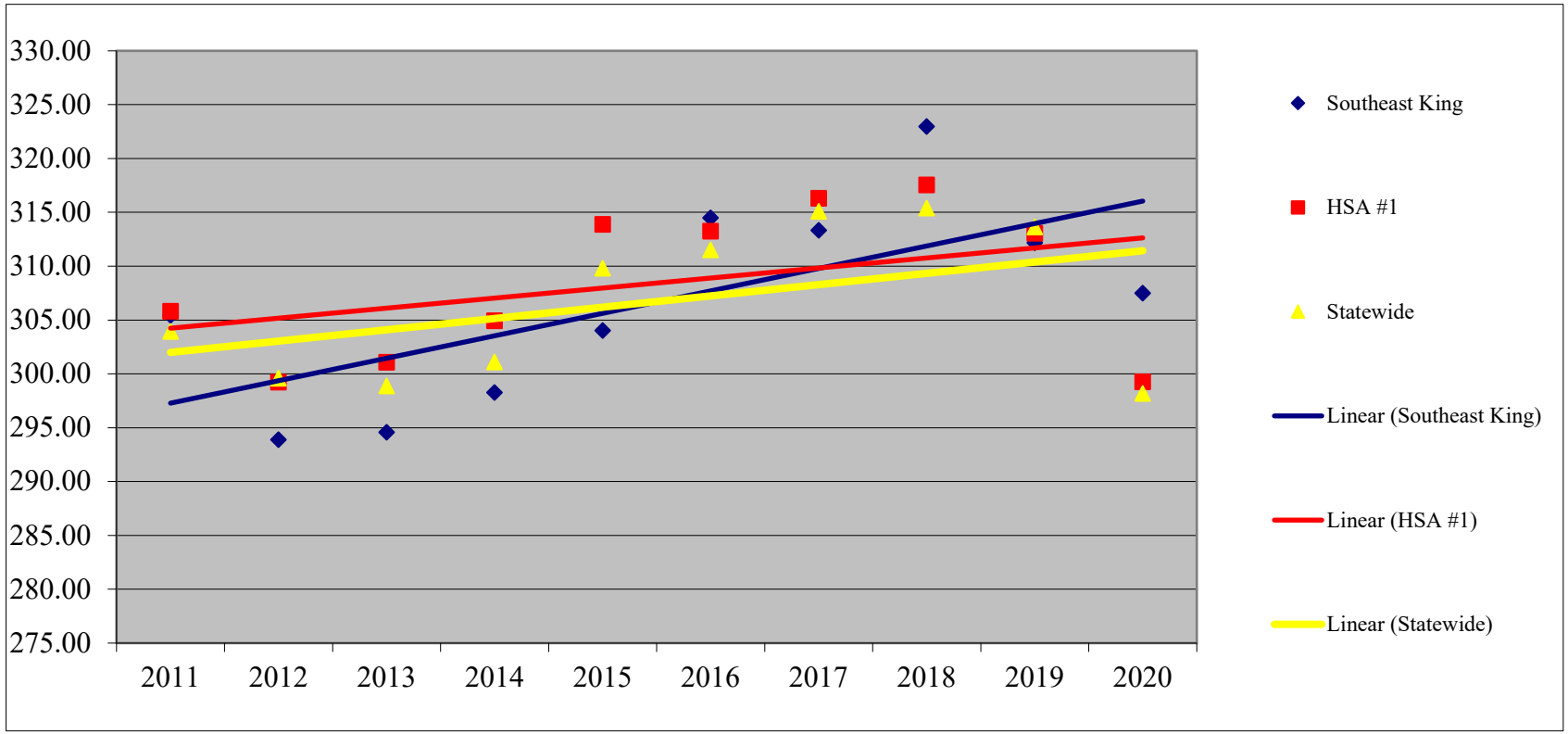
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	305.44	293.88	294.58	298.26	304.02	314.48	313.34	322.97	312.17	307.48
HSA # 1	305.81	299.23	301.07	304.92	313.88	313.26	316.31	317.55	313.05	299.26
Statewide Total	303.93	299.58	298.89	301.10	309.80	311.52	315.10	315.40	313.65	298.18

STEP 4: Historical Use Rate Trend Lines and Slopes

4-A. 2011-2020 Total Use Rates Per 1,000 (from Step 3-C.)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southeast King	305.44	293.88	294.58	298.26	304.02	314.48	313.34	322.97	312.17	307.48
HSA# 1	305.81	299.23	301.07	304.92	313.88	313.26	316.31	317.55	313.05	299.26
Statewide Total	303.93	299.58	298.89	301.10	309.80	311.52	315.10	315.40	313.65	298.18

4-B. 2011-2020 Total Use Rate Trend Lines



4-C. 2011-2020 Total Use Rate Slopes

HSA#1	0.93
Statewide Total	1.05

STEP 5: Allocation of Patient (Provider) Days Back to Planning Areas Where the Patients Live

5-A. 2020 (Provider) Days by Age and Residence

Excludes MDC 19 ,MDC 15, Rehab

Southeast King

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State
Age 0-64	72,195	457	71,738	0.63%
Age 65+	70,407	674	69,733	0.96%
Total	142,602	1,131	141,471	0.79%

Other Washington (WA-Southeast King)

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State
Age 0-64	1,163,218	51,072	1,112,146	4.39%
Age 65+	1,066,838	37,587	1,029,251	3.52%
Total	2,230,056	88,659	2,141,397	3.98%

5-B. 2020 Patient Days by Age and Residence, to Providers by Area

Excludes MDC 19 , MDC 15, Rehab

Residents of Southeast King

	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)	2020 Add (Patient) Days Provided in OR *	2020 Total Resident Days
Age 0-64	51,680	61,840	113,520	364	113,884
Age 65+	51,636	34,235	85,871	81	85,952
Total	**103,316**	**96,075**	**199,391**	**445**	**199,836**

Other WA Residents

	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)	Add (Patient) Days Provided in OR *	Total Resident Days
Age 0-64	20,515	1,101,378	1,121,893	37,152	1,159,045
Age 65+	18,771	1,032,603	1,051,374	24,957	1,076,331
Total	**39,286**	**2,133,981**	**2,173,267**	**62,109**	**2,235,376**

5-C. 2020 Market Shares - Percentage of Total Resident Patient Days

Excludes MDC 19, MDC 15, Rehab

Residents of Southeast King

	To Planning Area Providers	To Other WA Providers	To OR Providers	
Age 0-64	45.38%	54.30%	0.32%	100.00%
Age 65+	60.08%	39.83%	0.09%	100.00%
Total	**51.70%**	**48.08%**	**0.22%**	100.00%

Other WA Residents

Age 0-64	1.77%	95.02%	3.21%	100.00%
Age 65+	1.74%	95.94%	2.32%	100.00%
Total	**1.76%**	**95.46%**	**2.78%**	100.00%

STEP 6: Planning Area Use Rates by Age

Excludes MDC 19, MDC 15, Rehab

6-A. 2020 Population* by Age

	Southeast King	Other WA
Age 0-64	564,014	5,810,748
Age 65+	84,444	1,196,994
Total	**648,458**	**7,007,742**

* Planning area population from Claritas 2020

Other WA population = Statewide population from OFM (2020), minus Planning Area population.

6-B. 2020 Use Rates by Age

Excludes MDC 19, MDC 15, Rehab

	Southeast King	Other WA
Age 0-64	201.92	199.47
Age 65+	1,017.86	899.20
Total	**308.17**	**318.99**

STEP 7A: Planning Area Use Rates by Age

7A-A. 2020 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	Southeast King
Age 0-64	201.92
Age 65+	1,017.86
Total	**308.17**

7A-B. Projected Use Rates by Age for
Excludes MDC 19 , MDC 15, Rehab

	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	201.92	202.85	203.78	204.71	205.64	206.58	207.51	208.44
Age 0-64 using State Trend	201.92	202.97	204.01	205.06	206.11	207.16	208.21	209.26
Age 65+ using HSA Trend	1,017.86	1,018.79	1,019.72	1,020.65	1,021.59	1,022.52	1,023.45	1,024.38
Age 65+ using State Trend	1,017.86	1,018.91	1,019.96	1,021.00	1,022.05	1,023.10	1,024.15	1,025.20

Trended Use Rates (from above) that are Closest to
Current Value - i.e., Requires the Smallest Adjustment

	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	201.92	202.85	203.78	204.71	205.64	206.58	207.51	208.44
Age 65+ using HSA Trend	1,017.86	1,018.79	1,019.72	1,020.65	1,021.59	1,022.52	1,023.45	1,024.38

7A-A. 2020 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab

	Other WA
Age 0-64	199.47
Age 65+	899.20
Total	**318.99**

7A-B. Projected Use Rates by Age for
Excludes MDC 19, MDC 15, Rehab

	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSA Trend	199.47	200.40	201.33	202.26	203.19	204.13	205.06	205.99
Age 0-64 using State Trend	199.47	200.51	201.56	202.61	203.66	204.71	205.76	206.81
Age 65+ using HSA Trend	899.20	900.13	901.06	901.99	902.92	903.85	904.79	905.72
Age 65+ using State Trend	899.20	900.24	901.29	902.34	903.39	904.44	905.49	906.54

STEP 8: Forecast Patient Days Using Trended Use Rates

8A. Projected Use Rates by Age (from Step 7A-B.) for
Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	201.92	202.85	203.78	204.71	205.64	206.58	207.51	208.44
Age 65+ using HSA Trend	1,017.86	1,018.79	1,019.72	1,020.65	1,021.59	1,022.52	1,023.45	1,024.38

8B. Projected Population* for
Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	564,014	568,769	573,565	578,401	583,277	588,195	593,154	598,155
65+	84,444	88,558	92,873	97,398	102,143	107,120	112,339	117,812
Total	**648,458**	**657,328**	**666,438**	**675,799**	**685,421**	**695,315**	**705,493**	**715,968**

8C. Projected Resident Patient Days* for
Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	113,884	115,374	116,881	118,406	119,948	121,507	123,084	124,680
65+	85,952	90,222	94,705	99,410	104,348	109,532	114,973	120,685
Total	**199,836**	**205,596**	**211,586**	**217,815**	**224,296**	**231,039**	**238,058**	**245,364**

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

8A. Projected Use Rates by Age (from Step 7A-B.) for
Other WA

	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSA Trend	199.47	200.40	201.33	202.26	203.19	204.13	205.06	205.99
Age 65+ using HSA Trend	899.20	900.13	901.06	901.99	902.92	903.85	904.79	905.72

8B. Projected Population* for
Other WA

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	5,795,214	5,827,196	5,859,857	5,893,206	5,927,253	5,962,008	5,995,968	6,030,605
65+	1,194,751	1,237,131	1,281,501	1,327,974	1,376,670	1,427,714	1,461,782	1,497,472
Total	**6,989,965**	**7,064,327**	**7,141,358**	**7,221,181**	**7,303,923**	**7,389,722**	**7,457,750**	**7,528,077**

8c. Projected Resident Patient Days* for
Other Washington

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,155,946	1,167,756	1,179,762	1,191,968	1,204,378	1,216,996	1,229,515	1,242,238
65+	1,074,314	1,113,575	1,154,708	1,197,820	1,243,026	1,290,446	1,322,600	1,356,287
Total	**2,230,261**	**2,281,331**	**2,334,470**	**2,389,788**	**2,447,404**	**2,507,441**	**2,552,116**	**2,598,525**

STEP 9: Allocate Forecasted Patient Days to the Planning Areas Where Services are Expected to Be Provided

9A. (From Steps 8-C and D).

Projected Resident Patient Days* for Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	113,884	115,374	116,881	118,406	119,948	121,507	123,084	124,680
65+	85,952	90,222	94,705	99,410	104,348	109,532	114,973	120,685
Total	**199,836**	**205,596**	**211,586**	**217,815**	**224,296**	**231,039**	**238,058**	**245,364**

Excludes MDC 19 , MDC 15, Rehab

Projected Resident Patient Days* for Other Washington

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,155,946	1,167,756	1,179,762	1,191,968	1,204,378	1,216,996	1,229,515	1,242,238
65+	1,074,314	1,113,575	1,154,708	1,197,820	1,243,026	1,290,446	1,322,600	1,356,287
Total	**2,230,261**	**2,281,331**	**2,334,470**	**2,389,788**	**2,447,404**	**2,507,441**	**2,552,116**	**2,598,525**

Excludes MDC 19, MDC 15, Rehab

9-B. 2018 Market Shares - Percentage of Total Resident Patient Days (From Step 5-C)

Excludes MDC 19, MDC 15, Rehab

Residents of Southeast King	**To Planning Area Providers**	**To Other WA Providers**	**To OR Providers**
Age 0-64	45.38%	54.30%	0.32%
Age 65+	60.08%	39.83%	0.09%
Total	**51.70%**	**48.08%**	**0.22%**

Other WA Residents

Age 0-64	1.77%	95.02%	3.21%
Age 65+	1.74%	95.94%	2.32%
Total	**1.76%**	**95.46%**	**2.78%**

9C. **Southeast King Resident Patient Days* to Providers** **Southeast King**

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	51,680	52,356	53,040	53,732	54,432	55,139	55,855	56,579
65+	51,636	54,201	56,894	59,721	62,688	65,802	69,071	72,502
Total	**103,316**	**106,558**	**109,934**	**113,453**	**117,119**	**120,941**	**124,926**	**129,081**

Southeast King Resident Patient Days to Other Washington Providers

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	61,840	62,649	63,468	64,295	65,133	65,979	66,836	67,702
65+	34,235	35,936	37,721	39,595	41,562	43,627	45,794	48,069
Total	**96,075**	**98,585**	**101,189**	**103,891**	**106,695**	**109,606**	**112,630**	**115,771**

Southeast King Resident Patient Days to Oregon Providers

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	364	369	374	378	383	388	393	399
65+	81	85	89	94	98	103	108	114
Total	**445**	**454**	**463**	**472**	**482**	**492**	**502**	**512**

9D. **Other Washington Resident Patient Days* to Southeast King Providers**

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	20,460	20,669	20,882	21,098	21,317	21,541	21,762	21,988
65+	18,736	19,421	20,138	20,890	21,678	22,505	23,066	23,653
Total	**39,196**	**40,090**	**41,020**	**41,987**	**42,996**	**44,046**	**44,828**	**45,641**

Other Washington Resident Patient Days to Other Washington Providers

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,098,434	1,109,656	1,121,064	1,132,663	1,144,455	1,156,445	1,168,342	1,180,432
65+	1,030,668	1,068,334	1,107,796	1,149,157	1,192,526	1,238,019	1,268,867	1,301,185
Total	**2,129,102**	**2,177,989**	**2,228,860**	**2,281,820**	**2,336,981**	**2,394,464**	**2,437,209**	**2,481,617**

Other Washington Resident Patient Days to Oregon Providers

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,053	37,431	37,816	38,207	38,605	39,010	39,411	39,819
65+	24,910	25,821	26,774	27,774	28,822	29,922	30,667	31,448
Total	**61,963**	**63,252**	**64,590**	**65,981**	**67,427**	**68,931**	**70,078**	**71,267**

9E. **Total Washington Resident Patient Days* to Southeast King Providers**

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	72,140	73,025	73,922	74,830	75,749	76,680	77,617	78,566
65+	70,372	73,622	77,032	80,610	84,366	88,307	92,137	96,155
Total	**142,512**	**146,647**	**150,954**	**155,440**	**160,115**	**164,987**	**169,754**	**174,722**

Total Washington Resident Patient Days* to
Other Washington Providers

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,160,274	1,172,305	1,184,532	1,196,958	1,209,588	1,222,425	1,235,178	1,248,134
65+	1,064,903	1,104,269	1,145,517	1,188,752	1,234,088	1,281,646	1,314,661	1,349,255
Total	**2,225,177**	**2,276,574**	**2,330,049**	**2,385,710**	**2,443,676**	**2,504,071**	**2,549,839**	**2,597,388**

Total Washington Resident Patient Days* to
Oregon Providers

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,417	37,800	38,190	38,586	38,988	39,398	39,804	40,217
65+	24,991	25,906	26,864	27,868	28,921	30,025	30,776	31,562
Total	**62,408**	**63,706**	**65,053**	**66,453**	**67,909**	**69,423**	**70,580**	**71,779**

9-F. Percent Out-of-State Resident Patient Days * (From Step 5-A)

Southeast King

	% Out-of-State	
Age 0-64	0.63%	
Age 65+	0.96%	
Total	**0.79%**	

Other Washington

Age 0-64	4.39%	
Age 65+	3.52%	
Total	**3.98%**	

9-F. Total Patient Days*, Including Out-of-State Residents

Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
0-64	72,597	73,488	74,390	75,303	76,229	77,165	78,109	79,064
65+	71,045	74,327	77,769	81,382	85,173	89,152	93,019	97,076
Total	**143,642**	**147,814**	**152,159**	**156,686**	**161,402**	**166,318**	**171,127**	**176,140**

Southeast King

Provider Market Share of All Planning Area Resident Days

	2020	2021	2022	2023	2024	2025	2026	2027
Total	51.70%	51.83%	51.96%	52.09%	52.22%	52.35%	52.48%	52.61%

Southeast King

Inmigration Days

	2020	2021	2022	2023	2024	2025	2026	2027
Total	40,326	41,257	42,225	43,233	44,283	45,377	46,202	47,059

Excludes MDC 19, MDC 15, Rehab

STEP 10: Apply Weighted Occupancy Standard to Determine Bed Need

2020 BASELINE

Final Bed Need Calculations

Excludes MDC 19, MDC 15, Rehab

Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
Population 0-64	564,014	568,769	573,565	578,401	583,277	588,195	593,154	598,155
0-64 Use Rate	201.92	202.85	203.78	204.71	205.64	206.58	207.51	208.44
Population 65+	84,444	88,558	92,873	97,398	102,143	107,120	112,339	117,812
65+ Use Rate	1,017.86	1,018.79	1,019.72	1,020.65	1,021.59	1,022.52	1,023.45	1,024.38
Total Population	648,458	657,328	666,438	675,799	685,421	695,315	705,493	715,968
Total Area Resident Days	199,836	205,596	211,586	217,815	224,296	231,039	238,058	245,364
Total Days in Area Hospitals	143,642	147,814	152,159	156,686	161,402	166,318	171,127	176,140

Planning Area Available Beds - LICENSED BEDS

Multicare Auburn Medical Center	131	131	131	131	131	131	131	131
Multicare Covington Medical Center	58	58	58	58	58	58	58	58
Saint Elizabeth Hospital	25	25	25	25	25	25	25	25
Saint Francis Hospital	118	118	118	118	118	118	118	118
UW/Valley Medical Center	321	321	321	321	321	321	321	321
TOTAL	653	653	653	653	653	653	653	653
Weighted Occupancy Standard	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%	68.90%
Gross Bed Need	571	588	605	623	642	661	680	700
Net Bed Need / Surplus	-82	-65	-48	-30	-11	8	27	47

STEP 10: Apply Weighted Occupancy Standard to Determine Bed Need

2020 BASELINE

Final Bed Need Calculations

Excludes MDC 19, MDC 15, Rehab

Southeast King

	2020	2021	2022	2023	2024	2025	2026	2027
Population 0-64	564,014	568,769	573,565	578,401	583,277	588,195	593,154	598,155
0-64 Use Rate	201.92	202.85	203.78	204.71	205.64	206.58	207.51	208.44
Population 65+	84,444	88,558	92,873	97,398	102,143	107,120	112,339	117,812
65+ Use Rate	1,017.86	1,018.79	1,019.72	1,020.65	1,021.59	1,022.52	1,023.45	1,024.38
Total Population	648,458	657,328	666,438	675,799	685,421	695,315	705,493	715,968
Total Area Resident Days	199,836	205,596	211,586	217,815	224,296	231,039	238,058	245,364
Total Days in Area Hospitals	143,642	147,814	152,159	156,686	161,402	166,318	171,127	176,140

Planning Area Available Beds - SETUP BEDS

Multicare Auburn Medical Center	108	108	108	108	108	108	108	108
Multicare Covington Medical Center	43	43	43	43	43	43	43	43
Saint Elizabeth Hospital	25	25	25	25	25	25	25	25
Saint Francis Hospital	118	118	118	118	118	118	118	118
UW/Valley Medical Center	308	308	308	308	308	308	308	308
TOTAL	602	602	602	602	602	602	602	602
Weighted Occupancy Standard	68.42%	68.42%	68.42%	68.42%	68.42%	68.42%	68.42%	68.42%
Gross Bed Need	575	592	609	627	646	666	685	705
Net Bed Need / Surplus	-27	-10	7	25	44	64	83	103

Exhibit 5
Financials and Assumptions

St. Francis Hospital

Financial Assumptions

The underlying assumptions are detailed below:

Overall (hospital wide) Assumptions:

- Charity care: assumed to be 1.37% (based on FY2021) of gross revenue.
- Bad Debt: assumed to be 0.93% of gross revenue (based on FY2021).
- All information provided in current dollars. No inflation is assumed.
- Project start date 7/1/2023
- The per patient day assumption is based on adjusted patient day. The estimated adjusted patient days are as follows:

Adjusted Patient Days by Fiscal Year

	Intervening		Project						
	FY22	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**	**FY29**	**FY30**
Patient Days	33,806	34,286	36,052	37,509	38,650	38,650	38,650	38,650	38,650
Adjusted Patient Days	83,864	85,420	88,197	90,689	92,888	92,888	92,888	92,888	92,888

Source: Applicant

Adjusted patient days were used for the following financial assumptions: Other Operating Revenue, Supplies, Purchased Services-Other, Rentals and Leases and Other Direct Expenses[1].

- Other operating revenue: The assumption was $37 per adjusted patient day for the variable portion of the revenue. The fixed portion of the revenue was assumed to remain constant based on FY2021 actuals (less CARES Act Revenue).
- Outpatient utilization was assumed to increase by 2% per year
- Deductions from Revenue are provided for the hospital with and without the project.
- Gross patient revenue for the 'without' scenario was calculated using the same rates and utilization of services as in the baseline period of FY2021. Payer mix for the 'with' scenario changes slightly because of the increase in patient days associated with med/surg volumes. No reimbursement changes were used in the pro forma. Thus, the net patient revenue per case changes slightly from the baseline period of FY2021. No increase in charges was assumed.
- Other operating revenue which includes the cafeteria and gift shop sales, was assumed to be $37 per patient day.

[1] In addition to the variable component based on adjusted patient days, there is also a fixed component for Purchased Services-Other ($128,000) and Other Direct Expenses ($52,000).

- Salary expense corresponds to the FTEs needed to provide the service. FTEs increase in accordance with the increase in patient days. This level of productivity is based upon the productivity that occurred in FY2021. The statement does not include any compensation increases.
- Employee benefits are kept at the same percentage of salary as FY2021 or 23.1% throughout the projection period.
- Purchased Services-Utilities: Without the project, Purchased Services-Utilities are assumed to be the same as FY2021. With THE PROJECT, an increase of $29,000 has been assumed annually associated with an increase of 2% of the utility expense in FY2021.
- Insurance: Without the project, Insurance is assumed to be the same as FY2021. With THE PROJECT, an increase of $57,000 which is an increase of 2% of the insurance expense in FY2021.
- Licenses and Taxes: 0.9515% of net patient revenue for B&O taxes for the without project and 1% of net patient service revenue for the project.
- Depreciation expense that is independent of the project is provided from our internal fixed asset system and assumes there is zero capital spending in the projected years (years beyond FY21). Accordingly, the depreciation expense is decreasing each year as historical assets become fully depreciated.
- Depreciation expense associated with THE PROJECT has $16,098,000 of Building Costs being depreciated over 30 years and $4,388,000 of Equipment costs being depreciated over 10 years.
- Administrative adjustments are discounts provided to patients on a case by case basis.
  Administrative adjustments for THE PROJECT are calculated at $7.00 per admission.
  Administrative adjustments for THE WITHOUT are from our system and are about 1.15% of gross revenues.
- Purchased services-other: This line item contains fees paid to CHI Franciscan's parent company, CHI, for services provided to CHI Franciscan such as Legal, Compliance, Information Technology, and Revenue Cycle. This line item also includes payments to vendors for such things as, laundry service, security services, etc. Several of St. Francis's support departments, such as Dietary, are managed by outside companies that have expertise in managing these types of services. Payments for these type of management services are included in this expense category. The vast majority of these costs are fixed and do not fluctuate with changes in volumes. Those services that do fluctuate to volume have a cost assumed to be $53 per adjusted patient day.
- Supplies expense increases proportionate to the increase in patient days. Supplies were assumed to be $480 per adjusted patient day.
- With the exception of the capital associated with the Project, there is no other capital spending. Depreciation expense is the natural wind down of past capital spending combined with the depreciation associated with the Project.
- Medical professional fees are assumed to remain unchanged with the project.

- Rentals and leases are assumed to increase by $10 per adjusted patient day (for specialized medical equipment.)
- Licenses and taxes are assumed to be fixed with the exception of B&O tax which is assumed to be approximately 1% of the net patient service revenue.
- Other direct expenses are assumed to be fixed with the exception of an annual increase of $52,000 that is associated with the general assessment that CHI's parent company charges and is recorded in this expense category. Also, a small amount of costs are assumed to be variable at $16 per adjusted patient day. These variable costs include but are not limited to: bank fees, dues/subscriptions, education, travel postage.

Contractual Allowances:

- *Other* under Contractual Adjustments refers to contractual adjustments which do not fall into the categories which are listed above (Medicare, Medicaid, Workers Compensation, Other Government Programs, or Negotiated Rates). This is a standard template VMFH uses for all CN proformas, and in the case of St. Francis' historical financials, there have been zero *Other* contractual adjustments.

- *Other Adjustments and Allowances/Administrative Adjustments* under *Deductions from Revenue* refer to administrative adjustments that St. Francis makes to its gross revenue. Types of adjustments that may be included are reductions in gross revenue for procedures which are part of a package of services, or other reductions to gross revenue (not including contractual adjustment, bad debt or charity care) which St. Francis uses for business/administrative needs.

Attachment 1
St. Francis Hospital
Revised Financials

Without the Project

HOSPITA□ INFORMATION

COMPARISON STATEMENT OF REVEN□E □ E□PENSE-□NRESTRICTED - **WITHOUT THE PRO□ECT**

F□NDS-HOSPITA□ AGGREGATE *(amounts in 000's)*

		ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	OPERATING REVEN□E:												
2	Inpatient Revenue	□578,086	□551,005	□643,33□	□651,707	□660,1□3	□660,□04	□661,615	□662,331	□662,331	□662,331	□662,331	□662,331
3	Outpatient Revenue	835,174	860,68□	□45,817	□64,□□5	□84,626	1,004,725	1,025,302	1,046,373	1,046,373	1,046,373	1,046,373	1,046,373
4	**TOTAL PATIENT SERVICES REVENUE**	1,413,260	1,411,6□4	1,58□,156	1,616,702	1,644,81□	1,665,62□	1,686,□17	1,708,704	1,708,704	1,708,704	1,708,704	1,708,704
5													
6	DED□CTIONS FROM REVEN□E:												
7	Provision for □ad Debt	13,143	(5,866)	14,737	14,□88	15,244	15,425	15,611	15,801	15,801	15,801	15,801	15,801
8	Contractual Ad□ustments	1,063,338	1,086,138	1,215,38□	1,236,478	1,258,004	1,273,□7□	1,2□0,321	1,307,046	1,307,046	1,307,046	1,307,046	1,307,046
□	Charity and □ncompensated Care	1□,14□	44,074	21,712	22,10□	22,515	22,856	23,205	23,563	23,563	23,563	23,563	23,563
10	Other Ad□ustments and Allowances	1□,041	0	17,□27	18,2□0	18,662	1□,043	1□,433	1□,832	1□,832	1□,832	1□,832	1□,832
11	**TOTAL DEDUCTIONS FRO□ REVENUE**	1,114,671	1,124,346	1,26□,765	1,2□1,865	1,314,425	1,331,303	1,348,570	1,366,242	1,366,242	1,366,242	1,366,242	1,366,242
12	**NET PATIENT SERVICE REVENUE**	2□8,58□	287,348	31□,3□1	324,837	330,3□4	334,326	338,347	342,462	342,462	342,462	342,462	342,462
13													
14	OTHER OPERATING REVEN□E												
15	Other Operating Revenue	5,786	12,107	13,257	6,□13	6,□71	7,00□	7,047	7,087	7,087	7,087	7,087	7,087
16	Tax Revenues	0	0	0	0	0	0	0	0	0	0	0	0
17	**TOTAL OTHER OPERATIN□ REVENUE**	5,786	12,107	13,257	6,□13	6,□71	7,00□	7,047	7,087	7,087	7,087	7,087	7,087
18	**TOTAL OPERATIN□ REVENUE**	304,375	2□□,455	332,648	331,750	337,365	341,335	345,3□4	34□,54□	34□,54□	34□,54□	34□,54□	34□,54□
1□													
20	OPERATING E□PENSES												
21	Salaries and Wages	110,178	118,552	128,353	130,376	132,43□	133,801	135,1□4	136,618	136,618	136,618	136,618	136,618
22	Employee □enefits	25,266	26,□72	2□,618	30,085	30,561	30,875	31,1□6	31,525	31,525	31,525	31,525	31,525
23	Professional Fees	10,888	13,4□3	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8
24	Supplies	37,18□	34,586	3□,524	40,255	41,002	41,4□4	41,□□8	42,514	42,514	42,514	42,514	42,514
25	Purchased Services - □tilities	1,3□2	1,434	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
26	Purchased Services - Other	58,586	65,160	73,435	73,516	73,5□□	73,653	73,70□	73,766	73,766	73,766	73,766	73,766
27	Depreciation	13,771	13,606	15,□1□	12,677	11,670	□,542	8,453	7,000	6,173	5,423	4,473	3,323
28	Rentals and □eases	6,441	7,426	8,216	8,231	8,246	8,257	8,267	8,278	8,278	8,278	8,278	8,278
2□	Insurance	3,080	2,7□6	2,867	2,867	2,867	2,867	2,867	2,867	2,867	2,867	2,867	2,867
30	□icense and Taxes	8,66□	□,128	6,7□8	6,850	6,□03	6,□40	6,□78	7,018	7,018	7,018	7,018	7,018
31	Interest	78	6□	4□	52	30	14	4	0	0	0	0	0
32	Other Direct Expenses	4,673	3,0□6	2,617	2,641	2,666	2,683	2,700	2,717	2,717	2,717	2,717	2,717
33	**TOTAL OPERATIN□ E□PENSES**	280,211	2□6,318	321,□□4	322,148	324,581	324,724	325,□64	326,□01	326,074	325,324	324,374	323,224
34	**NET OPERATIN□ REVENUE**	24,164	3,137	10,654	□,602	12,784	16,611	1□,430	22,648	23,475	24,225	25,175	26,325
35													
36	**NON□OPERATIN□ REVENUE□NET OF E□PENSES**	733	□31	6,□33	0	0	0	0	0	0	0	0	0
37													
38	**NET REVENUE BEFORE ITE□S LISTED BELOW**	24,8□7	4,068	17,587	□,602	12,784	16,611	1□,430	22,648	23,475	24,225	25,175	26,325
3□													
40	E□TRAORDINARY ITEM	0	0	0	0	0	0	0	0	0	0	0	0
41	FEDERA□ INCOME TA□	0	0	0	0	0	0	0	0	0	0	0	0
42													
43	**NET REVENUE OR □E□PENSE□**	□24,8□7	□4,068	□17,587	□□,602	□12,784	□16,611	□1□,430	□22,648	□23,475	□24,225	□25,175	□26,325
44	E□P□ANATION:												
45													
	Ad□usted Patient Days	7□,434	76,656	82,341	83,864	85,420	86,446	87,4□6	88,570	88,570	88,570	88,570	88,570

HOSPITA□ INFORMATION

DED□CTIONS FROM REVEN□E □HOSPITA□ AGGREGATE - **WITHOUT THE PRO□ECT** *(amounts in 000's)*

	ACCT:	ITEM:	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	5800	PROVISION FOR □AD DE□TS	□13,143	(□5,866)	□14,737	□14,□88	□15,244	□15,425	□15,611	□15,801	□15,801	□15,801	□15,801	□15,801
2														
3		CONTRACT□A□ ADJ□STMENTS												
4	5810	Medicare	478,822	473,370	548,207	557,71□	567,428	574,634	582,005	58□,54□	58□,54□	58□,54□	58□,54□	58□,54□
5	5820	Medicaid	275,003	286,648	305,006	310,2□8	315,700	31□,70□	323,810	328,007	328,007	328,007	328,007	328,007
6	5830	Workers Compensation	0	0	0	0	0	0	0	0	0	0	0	0
7	5840	Other Government Programs	37,404	35,235	52,438	53,34□	54,278	54,□67	55,673	56,3□6	56,3□6	56,3□6	56,3□6	56,3□6
8	5850	Negotiated Rates	272,10□	2□0,885	30□,738	315,112	320,5□8	324,66□	328,833	333,0□4	333,0□4	333,0□4	333,0□4	333,0□4
□	5860	Other	0	0	0	0	0	0	0	0	0	0	0	0
10		**Total Contractual Ad□ustments**	1,063,338	1,086,138	1,215,38□	1,236,478	1,258,004	1,273,□7□	1,2□0,321	1,307,046	1,307,046	1,307,046	1,307,046	1,307,046
11														
12		CHARITY CARE												
13	5□00	Inpatient	3,8□6	13,16□	5,□78	6,056	6,135	6,142	6,14□	6,156	6,156	6,156	6,156	6,156
14	5□10	Outpatient	15,253	30,□05	15,734	16,053	16,380	16,714	17,056	17,407	17,407	17,407	17,407	17,407
15														
16														
17		**Total Charity Care**	1□,14□	44,074	21,712	22,10□	22,515	22,856	23,205	23,563	23,563	23,563	23,563	23,563
18														
1□	5□70	ADMINISTRATIVE ADJ□STMENTS	1□,041	0	17,□27	18,2□0	18,662	1□,043	1□,433	1□,832	1□,832	1□,832	1□,832	1□,832
20														
21	5□80	OTHER DED□CTIONS (Specify)												
22		**TOTAL DEDUCTIONS FRO□ REVENUE**	□1,114,671	□1,124,346	□1,26□,765	□1,2□1,865	□1,314,425	□1,331,303	□1,348,570	□1,366,242	□1,366,242	□1,366,242	□1,366,242	□1,366,242

23 E□P□ANATIONS:

HOSPITA□ INFORMATION

□A□ANCE SHEET - □NRESTRICTED F□ND-HOSPITA□ AGGREGATE - **WITHOUT THE PRO□ECT** *(amounts in 000's)*

	ASSETS	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	C□RRENT ASSETS:												
2	Cash	□1,678	□1,240	□212	□4,453	□5,035	□5,511	□5,870	□6,081	□6,081	□6,081	□6,081	□6,081
3	Marketable Securities	0	0	0	0	0	0	0	0	0	0	0	0
4	Accounts Receivable	173,513	182,066	1□3,168	1□6,516	1□□,□34	202,464	205,052	207,700	207,700	207,700	207,700	207,700
5	□ess-Estimated □ncollectable □ Allowances	(136,271)	(144,45□)	(154,781)	(157,464)	(160,202)	(162,230)	(164,303)	(166,425)	(166,425)	(166,425)	(166,425)	(166,425)
6	Receivables From Third Party Payors	0	0	0	0	0	0	0	0	0	0	0	0
7	Pledges And Other Receivables	1,833	2,817	2,536	2,536	2,536	2,536	2,536	2,536	2,536	2,536	2,536	2,536
8	Due From Restricted Funds	0	0	0	0	0	0	0	0	0	0	0	0
□	Inventory	5,874	6,863	□,556	□,733	□,□14	10,033	10,155	10,280	10,280	10,280	10,280	10,280
10	Prepaid Expenses	485	555	682	682	682	682	682	682	682	682	682	682
11	Current Portion Of Funds Held In Trust	0	0	0	0	0	0	0	0	0	0	0	0
12	**TOTAL CURRENT ASSETS**	47,112	4□,082	51,373	56,456	57,8□□	58,□□6	5□,□□2	60,854	60,854	60,854	60,854	60,854
13													
14	□OARD DESIGNATED ASSETS:												
15	Cash	0	0	0	0	0	0	0	0	0	0	0	0
16	Marketable Securities	0	0	0	0	0	0	0	0	0	0	0	0
17	Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
18	**TOTAL BOARD DESI□NATED ASSETS**	0	0	0	0	0	0	0	0	0	0	0	0
1□													
20	PROPERTY, P□ANT AND E□□IPMENT:												
21	□and	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206
22	□and Improvements	2,□33	2,□33	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□
23	□uildings	62,428	64,482	55,435	57,150	57,150	57,150	57,150	57,150	57,150	57,150	57,150	57,150
24	Fixed E□uipment - □uilding Service	2,□□1	22,651	□,131	□,131	□,131	□,131	□,131	□,131	□,131	□,131	□,131	□,131
25	Fixed E□uipment - Other	18,6□1	0	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78
26	E□uipment	114,088	116,7□1	118,268	118,268	118,268	118,268	118,268	118,268	118,268	118,268	118,268	118,268
27	□easehold Improvements	14,806	16,1□5	17,538	17,538	17,538	17,538	17,538	17,538	17,538	17,538	17,538	17,538
28	Construction In Progress	2,231	1,166	1,715	0	0	0	0	0	0	0	0	0
2□	TOTA□	225,374	231,424	235,210	235,210	235,210	235,210	235,210	235,210	235,210	235,210	235,210	235,210
30	□ess Accumulated Depreciation	(132,6□6)	(146,111)	(154,774)	(167,451)	(17□,121)	(188,663)	(1□7,116)	(204,116)	(210,28□)	(215,712)	(220,185)	(223,508)
31	**NET PROPERTY, PLANT □ EQUIP□ ENT**	□2,678	85,313	80,436	67,75□	56,08□	46,547	38,0□4	31,0□4	24,□21	1□,4□8	15,025	11,702
32													
33	INVESTMENTS AND OTHER ASSETS:												
34	Investments In Property, Plant □ E□uipment	0	0	0	0	0	0	0	0	0	0	0	0
35	□ess - Accumulated Depreciation	0	0	0	0	0	0	0	0	0	0	0	0
36	Other Investments	41,31□	33,163	20,085	46,885	5□,475	84,077	110,877	13□,□32	16□,600	1□□,267	228,□34	258,601
37	Other Assets	3,8□□	24,852	30,245	30,245	30,245	30,245	30,245	30,245	30,245	30,245	30,245	30,245
38	**TOTAL INVEST□ ENTS □ OTHER ASSETS**	45,218	58,015	50,330	77,130	8□,720	114,322	141,122	170,177	1□□,845	22□,512	25□,17□	288,846
3□													
40	INTANGI□□ES ASSETS:												
41	Goodwill	10,553	10,727	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□
42	□namortized □oan Costs	0	0	0	0	0	0	0	0	0	0	0	0
43	Preopening And Other Organization Costs	0	0	0	0	0	0	0	0	0	0	0	0
44	Other Intangible Assets	4,140	4,087	4,004	3,□85	3,□66	3,□47	3,□28	3,□0□	3,8□0	3,871	3,852	3,833
45	**TOTAL INTAN□IBLE ASSETS**	14,6□3	14,814	14,6□3	14,674	14,655	14,636	14,617	14,5□8	14,57□	14,560	14,541	14,522
46	**TOTAL ASSETS**	□1□□,701	□207,224	□1□6,832	□216,01□	□218,363	□234,501	□253,825	□276,723	□300,1□□	□324,424	□34□,5□□	□375,□24

HOSPITA□ INFORMATION

□A□ANCE SHEET - □NRESTRICTED F□ND-HOSPITA□ AGGREGATE - **WITHOUT THE PRO□ECT** *(amounts in 000's)*

	LIABILITIES AND FUND BALANCES□UNRESTRICTED	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	C□RRENT □IA□I□TIES:												
2	Notes and □oans Payable	□0	□0	□208	□0	□0	□0	□0	□0	□0	□0	□0	□0
3	Accounts Payable	1,7□1	2,646	2,53□	2,873	2,8□0	2,□02	2,□14	2,□27	2,□27	2,□27	2,□27	2,□27
4	Accrued Compensation and Related □iabilities	10,350	12,□24	14,88□	15,124	15,363	15,521	15,683	15,848	15,848	15,848	15,848	15,848
5	Other Accrued Expenses	13,5□5	15,365	(3,2□1)	16,683	16,784	16,853	16,□24	16,□□6	16,□□7	16,□□7	16,□□7	16,□□7
6	Advances from Third Party Payors	0	22,203	21,075	□,□03	0	0	0	0	0	0	0	0
7	Payables to Third Party Payors	1,71□	0	0	1,774	1,774	1,774	1,774	1,774	1,774	1,774	1,774	1,774
8	Due to Restricted Funds	0	0	0	0	0	0	0	0	0	0	0	0
□	Income Taxes Payable	0	0	0	0	0	0	0	0	0	0	0	0
10	Other Current □iabilities	0	0	0	0	0	0	0	0	0	0	0	0
11	Current Maturities of □ong Term Debt	1,30□	1,383	1,352	8□4	712	351	0	0	0	0	0	0
12	**TOTAL CURRENT LIABILITIES**	28,764	54,521	36,772	47,251	37,523	37,401	37,2□5	37,545	37,546	37,546	37,546	37,546
13													
14	DEFERRED CREDITS:												
15	Deferred Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0
16	Deferred Third Party Revenue	0	0	0	0	0	0	0	0	0	0	0	0
17	Other Deferred Credits	3,522	25,22□	30,434	30,434	30,434	30,434	30,434	30,434	30,434	30,434	30,434	30,434
18	**TOTAL DEFERRED CREDITS**	3,522	25,22□	30,434	30,434	30,434	30,434	30,434	30,434	30,434	30,434	30,434	30,434
1□													
20	□ONG TERM DE□T:												
21	Mortgage Payable	0	0	0	0	0	0	0	0	0	0	0	0
22	Construction □oans - Interim Financing	0	0	0	0	0	0	0	0	0	0	0	0
23	Notes Payable	527	424	0	0	0	0	0	0	0	0	0	0
24	Capitalized □ease Obligations	3,275	1,171	3,30□	1,□57	1,063	351	0	0	0	0	0	0
25	□onds Payable	0	0	0	0	0	0	0	0	0	0	0	0
26	Notes and □oans Payable to Parent	0	0	0	0	0	0	0	0	0	0	0	0
27	Noncurrent □iabilities	0	1,5□5	0	0	0	0	0	0	0	0	0	0
28	TOTA□	3,802	3,1□0	3,30□	1,□57	1,063	351	0	0	0	0	0	0
2□	□ess Current Maturities of □ong Term Debt	(1,30□)	(1,383)	(1,352)	(8□4)	(712)	(351)	0	0	0	0	0	0
30	**TOTAL LON□ TER□ DEBT**	2,4□3	1,807	1,□57	1,063	351	0	0	0	0	0	0	0
31													
32	**UNRESTRICTED FUND BALANCE**	164,□22	125,667	127,66□	137,271	150,055	166,666	186,0□6	208,744	232,21□	256,444	281,61□	307,□44
33													
34	E□□ITY (INVESTOR OWNED)												
35	Preferred Stock												
36													
37	Common Stock												
38													
3□	Additional Paid In Capital												
40													
41	Retained Earnings (Capital Account for Partnership												
42	or Sole Proprietorship)												
43													
44	□ess Treasury Stock												
45	**TOTAL EQUITY**												
46	**TOTAL LIABILITIES AND FUND BALANCE OR EQUITY**	□1□□,701	□207,224	□1□6,832	□216,01□	□218,363	□234,501	□253,825	□276,723	□300,1□□	□324,424	□34□,5□□	□375,□24

The Project

HOSPITA□ INFORMATION

COMPARISON STATEMENT OF REVEN□E □ E□PENSE-□NRESTRICTED - **THE PRO□ECT**

F□NDS-HOSPITA□ AGGREGATE *(amounts in 000's)*

		ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	OPERATING REVEN□E:												
2	Inpatient Revenue	□0	□0	□0	□0	□0	□34,8□0	□63,640	□86,0□1	□86,0□1	□86,0□1	□86,0□1	□86,0□1
3	Outpatient Revenue	0	0	0	0	0	0	0	0	0	0	0	0
4	**TOTAL PATIENT SERVICES REVENUE**	0	0	0	0	0	34,8□0	63,640	86,0□1	86,0□1	86,0□1	86,0□1	86,0□1
5													
6	DED□CTIONS FROM REVEN□E:												
7	Provision for □ad Debt	0	0	0	0	0	324	5□2	800	800	800	800	800
8	Contractual Ad□ustments	0	0	0	0	0	27,600	50,343	68,104	68,104	68,104	68,104	68,104
□	Charity and □ncompensated Care	0	0	0	0	0	478	872	1,17□	1,17□	1,17□	1,17□	1,17□
10	Other Ad□ustments and Allowances	0	0	0	0	0	3	5	7	7	7	7	7
11	**TOTAL DEDUCTIONS FRO□ REVENUE**	0	0	0	0	0	28,405	51,812	70,0□0	70,0□0	70,0□0	70,0□0	70,0□0
12	**NET PATIENT SERVICE REVENUE**	0	0	0	0	0	6,485	11,828	16,001	16,001	16,001	16,001	16,001
13													
14	OTHER OPERATING REVEN□E												
15	Other Operating Revenue	0	0	0	0	0	65	118	160	160	160	160	160
16	Tax Revenues	0	0	0	0	0	0	0	0	0	0	0	0
17	**TOTAL OTHER OPERATIN□ REVENUE**	0	0	0	0	0	65	118	160	160	160	160	160
18	**TOTAL OPERATIN□ REVENUE**	0	0	0	0	0	6,550	11,□46	16,161	16,161	16,161	16,161	16,161
1□													
20	OPERATING E□PENSES												
21	Salaries and Wages	0	0	0	0	0	2,528	4,437	5,□33	5,□33	5,□33	5,□33	5,□33
22	Employee □enefits	0	0	0	0	0	583	1,023	1,368	1,368	1,368	1,368	1,368
23	Professional Fees	0	0	0	0	0	0	0	0	0	0	0	0
24	Supplies	0	0	0	0	0	840	1,532	2,072	2,072	2,072	2,072	2,072
25	Purchased Services - □tilities	0	0	0	0	0	2□	2□	2□	2□	2□	2□	2□
26	Purchased Services - Other	0	0	0	0	0	221	2□8	357	357	357	357	357
27	Depreciation	0	0	0	0	0	□76	□76	□76	□76	□76	□76	□76
28	Rentals and □eases	0	0	0	0	0	17	32	43	43	43	43	43
2□	Insurance	0	0	0	0	0	57	57	57	57	57	57	57
30	□icense and Taxes	0	0	0	0	0	65	118	160	160	160	160	160
31	Interest	0	0	0	0	0	0	0	0	0	0	0	0
32	Other Direct Expenses	0	0	0	0	0	80	103	121	121	121	121	121
33	**TOTAL OPERATIN□ E□PENSES**	0	0	0	0	0	5,3□6	8,605	11,116	11,116	11,116	11,116	11,116
34	**NET OPERATIN□ REVENUE**	0	0	0	0	0	1,154	3,341	5,045	5,045	5,045	5,045	5,045
35													
36	**NON□OPERATIN□ REVENUE□NET OF E□PENSES**	0	0	0	0	0	0	0	0	0	0	0	0
37													
38	**NET REVENUE BEFORE ITE□S LISTED BELOW**	0	0	0	0	0	1,154	3,341	5,045	5,045	5,045	5,045	5,045
3□													
40	E□TRAORDINARY ITEM	0	0	0	0	0	0	0	0	0	0	0	0
41	FEDERA□ INCOME TA□	0	0	0	0	0	0	0	0	0	0	0	0
42													
43	**NET REVENUE OR □E□PENSE□**	□0	□0	□0	□0	□0	□1,154	□3,341	□5,045	□5,045	□5,045	□5,045	□5,045
44	E□P□ANATION:												
45													
	Ad□usted Patient Days	0	0	0	0	0	1,751	3,1□3	4,318	4,318	4,318	4,318	4,318

HOSPITA□ INFORMATION

DED□CTIONS FROM REVEN□E □HOSPITA□ AGGREGATE - **THE PRO□ECT** *(amounts in 000's)*

	ACCT:	ITEM:	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	5800	PROVISION FOR □AD DE□TS	□0	□0	□0	□0	□0	□324	□5□2	□800	□800	□800	□800	□800
2														
3		CONTRACT□A□ ADJ□STMENTS												
4	5810	Medicare	0	0	0	0	0	15,473	28,223	38,181	38,181	38,181	38,181	38,181
5	5820	Medicaid	0	0	0	0	0	5,178	□,446	12,778	12,778	12,778	12,778	12,778
6	5830	Workers Compensation	0	0	0	0	0	0	0	0	0	0	0	0
7	5840	Other Government Programs	0	0	0	0	0	□73	1,774	2,400	2,400	2,400	2,400	2,400
8	5850	Negotiated Rates	0	0	0	0	0	5,□76	10,□00	14,745	14,745	14,745	14,745	14,745
□	5860	Other	0	0	0	0	0	0	0	0	0	0	0	0
10		**Total Contractual Ad□ustments**	0	0	0	0	0	27,600	50,343	68,104	68,104	68,104	68,104	68,104
11														
12		CHARITY CARE												
13	5□00	Inpatient	0	0	0	0	0	478	872	1,17□	1,17□	1,17□	1,17□	1,17□
14	5□10	Outpatient	0	0	0	0	0	0	0	0	0	0	0	0
15														
16														
17		**Total Charity Care**	0	0	0	0	0	478	872	1,17□	1,17□	1,17□	1,17□	1,17□
18														
1□	5□70	ADMINISTRATIVE ADJ□STMENTS	0	0	0	0	0	3	5	7	7	7	7	7
20														
21	5□80	OTHER DED□CTIONS (Specify)												
22		**TOTAL DEDUCTIONS FRO□ REVENUE**	□0	□0	□0	□0	□0	□28,405	□51,812	□70,0□0	□70,0□0	□70,0□0	□70,0□0	□70,0□0

23 E□P□ANATIONS:

With the Project

HOSPITA□ INFORMATION

COMPARISON STATEMENT OF REVEN□E □ E□PENSE-□NRESTRICTED - **WITH THE PRO□ECT**

F□NDS-HOSPITA□ AGGREGATE *(amounts in 000's)*

		ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	OPERATING REVEN□E:												
2	Inpatient Revenue	□578,086	□551,005	□643,33□	□651,707	□660,1□3	□6□5,7□4	□725,255	□748,422	□748,422	□748,422	□748,422	□748,422
3	Outpatient Revenue	835,174	860,68□	□45,817	□64,□□5	□84,626	1,004,725	1,025,302	1,046,373	1,046,373	1,046,373	1,046,373	1,046,373
4	**TOTAL PATIENT SERVICES REVENUE**	1,413,260	1,411,6□4	1,58□,156	1,616,702	1,644,81□	1,700,51□	1,750,557	1,7□4,7□5	1,7□4,7□5	1,7□4,7□5	1,7□4,7□5	1,7□4,7□5
5													
6	DED□CTIONS FROM REVEN□E:												
7	Provision for □ad Debt	13,143	(5,866)	14,737	14,□88	15,244	15,74□	16,203	16,601	16,601	16,601	16,601	16,601
8	Contractual Ad□ustments	1,063,338	1,086,138	1,215,38□	1,236,478	1,258,004	1,301,57□	1,340,664	1,375,150	1,375,150	1,375,150	1,375,150	1,375,150
□	Charity and □ncompensated Care	1□,14□	44,074	21,712	22,10□	22,515	23,334	24,077	24,742	24,742	24,742	24,742	24,742
10	Other Ad□ustments and Allowances	1□,041	0	17,□27	18,2□0	18,662	1□,046	1□,438	1□,83□	1□,83□	1□,83□	1□,83□	1□,83□
11	**TOTAL DEDUCTIONS FRO□ REVENUE**	1,114,671	1,124,346	1,26□,765	1,2□1,865	1,314,425	1,35□,708	1,400,382	1,436,332	1,436,332	1,436,332	1,436,332	1,436,332
12	**NET PATIENT SERVICE REVENUE**	2□8,58□	287,348	31□,3□1	324,837	330,3□4	340,811	350,175	358,463	358,463	358,463	358,463	358,463
13													
14	OTHER OPERATING REVEN□E												
15	Other Operating Revenue	5,786	12,107	13,257	6,□13	6,□71	7,074	7,165	7,247	7,247	7,247	7,247	7,247
16	Tax Revenues	0	0	0	0	0	0	0	0	0	0	0	0
17	**TOTAL OTHER OPERATIN□ REVENUE**	5,786	12,107	13,257	6,□13	6,□71	7,074	7,165	7,247	7,247	7,247	7,247	7,247
18	**TOTAL OPERATIN□ REVENUE**	304,375	2□□,455	332,648	331,750	337,365	347,885	357,340	365,710	365,710	365,710	365,710	365,710
1□													
20	OPERATING E□PENSES												
21	Salaries and Wages	110,178	118,552	128,353	130,376	132,43□	136,32□	13□,631	142,551	142,551	142,551	142,551	142,551
22	Employee □enefits	25,266	26,□72	2□,618	30,085	30,561	31,458	32,21□	32,8□3	32,8□3	32,8□3	32,8□3	32,8□3
23	Professional Fees	10,888	13,4□3	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8	13,0□8
24	Supplies	37,18□	34,586	3□,524	40,255	41,002	42,334	43,530	44,586	44,586	44,586	44,586	44,586
25	Purchased Services - □tilities	1,3□2	1,434	1,500	1,500	1,500	1,52□	1,52□	1,52□	1,52□	1,52□	1,52□	1,52□
26	Purchased Services - Other	58,586	65,160	73,435	73,516	73,5□□	73,874	74,007	74,123	74,123	74,123	74,123	74,123
27	Depreciation	13,771	13,606	15,□1□	12,677	11,670	10,518	□,42□	7,□76	7,14□	6,3□□	5,44□	4,2□□
28	Rentals and □eases	6,441	7,426	8,216	8,231	8,246	8,274	8,2□□	8,321	8,321	8,321	8,321	8,321
2□	Insurance	3,080	2,7□6	2,867	2,867	2,867	2,□24	2,□24	2,□24	2,□24	2,□24	2,□24	2,□24
30	□icense and Taxes	8,66□	□,128	6,7□8	6,850	6,□03	7,005	7,0□6	7,178	7,178	7,178	7,178	7,178
31	Interest	78	6□	4□	52	30	14	4	0	0	0	0	0
32	Other Direct Expenses	4,673	3,0□6	2,617	2,641	2,666	2,763	2,803	2,838	2,838	2,838	2,838	2,838
33	**TOTAL OPERATIN□ E□PENSES**	280,211	2□6,318	321,□□4	322,148	324,581	330,120	334,56□	338,017	337,1□0	336,440	335,4□0	334,340
34	**NET OPERATIN□ REVENUE**	24,164	3,137	10,654	□,602	12,784	17,765	22,771	27,6□3	28,520	2□,270	30,220	31,370
35													
36	**NON□OPERATIN□ REVENUE□NET OF E□PENSES**	733	□31	6,□33	0	0	0	0	0	0	0	0	0
37													
38	**NET REVENUE BEFORE ITE□S LISTED BELOW**	24,8□7	4,068	17,587	□,602	12,784	17,765	22,771	27,6□3	28,520	2□,270	30,220	31,370
3□													
40	E□TRAORDINARY ITEM	0	0	0	0	0	0	0	0	0	0	0	0
41	FEDERA□ INCOME TA□	0	0	0	0	0	0	0	0	0	0	0	0
42													
43	**NET REVENUE OR □E□PENSE□**	□24,8□7	□4,068	□17,587	□□,602	□12,784	□17,765	□22,771	□27,6□3	□28,520	□2□,270	□30,220	□31,370
44	E□P□ANATION:												
45													
	Ad□usted Patient Days	7□,434	76,656	82,341	83,864	85,420	88,1□7	□0,68□	□2,888	□2,888	□2,888	□2,888	□2,888

HOSPITA□ INFORMATION

DED□CTIONS FROM REVEN□E □HOSPITA□ AGGREGATE - **WITH THE PRO□ECT** *(amounts in 000's)*

	ACCT:	ITEM:	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	5800	PROVISION FOR □AD DE□TS	□13,143	(□5,866)	□14,737	□14,□88	□15,244	□15,74□	□16,203	□16,601	□16,601	□16,601	□16,601	□16,601
2														
3		CONTRACT□A□ ADJ□STMENTS												
4	5810	Medicare	478,822	473,370	548,207	557,71□	567,428	5□0,107	610,228	627,730	627,730	627,730	627,730	627,730
5	5820	Medicaid	275,003	286,648	305,006	310,2□8	315,700	324,887	333,256	340,785	340,785	340,785	340,785	340,785
6	5830	Workers Compensation	0	0	0	0	0	0	0	0	0	0	0	0
7	5840	Other Government Programs	37,404	35,235	52,438	53,34□	54,278	55,□40	57,447	58,7□6	58,7□6	58,7□6	58,7□6	58,7□6
8	5850	Negotiated Rates	272,10□	2□0,885	30□,738	315,112	320,5□8	330,645	33□,733	347,83□	347,83□	347,83□	347,83□	347,83□
□	5860	Other	0	0	0	0	0	0	0	0	0	0	0	0
10		**Total Contractual Ad□ustments**	1,063,338	1,086,138	1,215,38□	1,236,478	1,258,004	1,301,57□	1,340,664	1,375,150	1,375,150	1,375,150	1,375,150	1,375,150
11														
12		CHARITY CARE												
13	5□00	Inpatient	3,8□6	13,16□	5,□78	6,056	6,135	6,620	7,021	7,335	7,335	7,335	7,335	7,335
14	5□10	Outpatient	15,253	30,□05	15,734	16,053	16,380	16,714	17,056	17,407	17,407	17,407	17,407	17,407
15														
16														
17		**Total Charity Care**	1□,14□	44,074	21,712	22,10□	22,515	23,334	24,077	24,742	24,742	24,742	24,742	24,742
18														
1□	5□70	ADMINISTRATIVE ADJ□STMENTS	1□,041	0	17,□27	18,2□0	18,662	1□,046	1□,438	1□,83□	1□,83□	1□,83□	1□,83□	1□,83□
20														
21	5□80	OTHER DED□CTIONS (Specify)												
22		**TOTAL DEDUCTIONS FRO□ REVENUE**	□1,114,671	□1,124,346	□1,26□,765	□1,2□1,865	□1,314,425	□1,35□,708	□1,400,382	□1,436,332	□1,436,332	□1,436,332	□1,436,332	□1,436,332

23 E□P□ANATIONS:

HOSPITA□ INFORMATION

□A□ANCE SHEET - □NRESTRICTED F□ND-HOSPITA□ AGGREGATE - **WITH THE PRO□ECT** *(amounts in 000's)*

	ASSETS	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	C□RRENT ASSETS:												
2	Cash	□1,678	□1,240	□212	□4,453	□5,035	□7,242	□11,376	□17,187	□23,208	□2□,22□	□35,250	□41,271
3	Marketable Securities	0	0	0	0	0	0	0	0	0	0	0	0
4	Accounts Receivable	173,513	182,066	1□3,168	1□6,516	1□□,□34	206,765	212,8□7	218,308	218,308	218,308	218,308	218,308
5	□ess-Estimated □ncollectable □ Allowances	(136,271)	(144,45□)	(154,781)	(157,464)	(160,202)	(165,676)	(170,588)	(174,□24)	(174,□24)	(174,□24)	(174,□24)	(174,□24)
6	Receivables From Third Party Payors	0	0	0	0	0	0	0	0	0	0	0	0
7	Pledges And Other Receivables	1,833	2,817	2,536	2,536	2,536	2,536	2,536	2,536	2,536	2,536	2,536	2,536
8	Due From Restricted Funds	0	0	0	0	0	0	0	0	0	0	0	0
□	Inventory	5,874	6,863	□,556	□,733	□,□14	10,236	10,525	10,780	10,780	10,780	10,780	10,780
10	Prepaid Expenses	485	555	682	682	682	688	6□2	6□5	6□5	6□5	6□5	6□5
11	Current Portion Of Funds Held In Trust	0	0	0	0	0	0	0	0	0	0	0	0
12	**TOTAL CURRENT ASSETS**	47,112	4□,082	51,373	56,456	57,8□□	61,7□1	67,438	74,582	80,603	86,624	□2,645	□8,666
13													
14	□OARD DESIGNATED ASSETS:												
15	Cash	0	0	0	0	0	0	0	0	0	0	0	0
16	Marketable Securities	0	0	0	0	0	0	0	0	0	0	0	0
17	Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
18	**TOTAL BOARD DESI□NATED ASSETS**	0	0	0	0	0	0	0	0	0	0	0	0
1□													
20	PROPERTY, P□ANT AND E□□IPMENT:												
21	□and	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206	7,206
22	□and Improvements	2,□33	2,□33	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□	2,□3□
23	□uildings	62,428	64,482	55,435	57,150	57,150	73,248	73,248	73,248	73,248	73,248	73,248	73,248
24	Fixed E□uipment - □uilding Service	2,□□1	22,651	□,131	□,131	□,131	□,131	□,131	□,131	□,131	□,131	□,131	□,131
25	Fixed E□uipment - Other	18,6□1	0	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78	22,□78
26	E□uipment	114,088	116,7□1	118,268	118,268	118,268	122,656	122,656	122,656	122,656	122,656	122,656	122,656
27	□easehold Improvements	14,806	16,1□5	17,538	17,538	17,538	17,538	17,538	17,538	17,538	17,538	17,538	17,538
28	Construction In Progress	2,231	1,166	1,715	0	0	0	0	0	0	0	0	0
2□	TOTA□	225,374	231,424	235,210	235,210	235,210	255,6□6	255,6□6	255,6□6	255,6□6	255,6□6	255,6□6	255,6□6
30	□ess Accumulated Depreciation	(132,6□6)	(146,111)	(154,774)	(167,451)	(17□,121)	(18□,63□)	(1□□,068)	(207,044)	(214,1□3)	(220,5□2)	(226,041)	(230,340)
31	**NET PROPERTY, PLANT □ EQUIP□ ENT**	□2,678	85,313	80,436	67,75□	56,08□	66,057	56,628	48,652	41,503	35,104	2□,655	25,356
32													
33	INVESTMENTS AND OTHER ASSETS:												
34	Investments In Property, Plant □ E□uipment	0	0	0	0	0	0	0	0	0	0	0	0
35	□ess - Accumulated Depreciation	0	0	0	0	0	0	0	0	0	0	0	0
36	Other Investments	41,31□	33,163	20,085	46,885	5□,475	63,5□1	□0,3□1	11□,446	14□,114	178,781	208,448	238,115
37	Other Assets	3,8□□	24,852	30,245	30,245	30,245	30,245	30,245	30,245	30,245	30,245	30,245	30,245
38	**TOTAL INVEST□ ENTS □ OTHER ASSETS**	45,218	58,015	50,330	77,130	8□,720	□3,836	120,636	14□,6□1	17□,35□	20□,026	238,6□3	268,360
3□													
40	INTANGI□□ES ASSETS:												
41	Goodwill	10,553	10,727	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□	10,68□
42	□namortized □oan Costs	0	0	0	0	0	0	0	0	0	0	0	0
43	Preopening And Other Organization Costs	0	0	0	0	0	0	0	0	0	0	0	0
44	Other Intangible Assets	4,140	4,087	4,004	3,□85	3,□66	3,□47	3,□28	3,□0□	3,8□0	3,871	3,852	3,833
45	**TOTAL INTAN□IBLE ASSETS**	14,6□3	14,814	14,6□3	14,674	14,655	14,636	14,617	14,5□8	14,57□	14,560	14,541	14,522
46	**TOTAL ASSETS**	□1□□,701	□207,224	□1□6,832	□216,01□	□218,363	□236,320	□25□,31□	□287,523	□316,044	□345,314	□375,534	□406,□04

HOSPITA□ INFORMATION

□A□ANCE SHEET - □NRESTRICTED F□ND-HOSPITA□ AGGREGATE - **WITH THE PRO□ECT** *(amounts in 000's)*

	LIABILITIES AND FUND BALANCES□UNRESTRICTED	ACT□A□ 201□	ACT□A□ 2020	ACT□A□ 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	PROJECTED 2025	PROJECTED 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 202□	PROJECTED 2030
1	C□RRENT □IA□I□TIES:												
2	Notes and □oans Payable	□0	□0	□208	□0	□0	□0	□0	□0	□0	□0	□0	□0
3	Accounts Payable	1,7□1	2,646	2,53□	2,873	2,8□0	2,□27	2,□55	2,□81	2,□81	2,□81	2,□81	2,□81
4	Accrued Compensation and Related □iabilities	10,350	12,□24	14,88□	15,124	15,363	15,814	16,1□7	16,535	16,535	16,535	16,535	16,535
5	Other Accrued Expenses	13,5□5	15,365	(3,2□1)	16,683	16,784	17,000	17,168	17,315	17,316	17,316	17,316	17,316
6	Advances from Third Party Payors	0	22,203	21,075	□,□03	0	0	0	0	0	0	0	0
7	Payables to Third Party Payors	1,71□	0	0	1,774	1,774	1,774	1,774	1,774	1,774	1,774	1,774	1,774
8	Due to Restricted Funds	0	0	0	0	0	0	0	0	0	0	0	0
□	Income Taxes Payable	0	0	0	0	0	0	0	0	0	0	0	0
10	Other Current □iabilities	0	0	0	0	0	0	0	0	0	0	0	0
11	Current Maturities of □ong Term Debt	1,30□	1,383	1,352	8□4	712	351	0	0	0	0	0	0
12	**TOTAL CURRENT LIABILITIES**	28,764	54,521	36,772	47,251	37,523	37,866	38,0□4	38,605	38,606	38,606	38,606	38,606
13													
14	DEFERRED CREDITS:												
15	Deferred Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0
16	Deferred Third Party Revenue	0	0	0	0	0	0	0	0	0	0	0	0
17	Other Deferred Credits	3,522	25,22□	30,434	30,434	30,434	30,634	30,634	30,634	30,634	30,634	30,634	30,634
18	**TOTAL DEFERRED CREDITS**	3,522	25,22□	30,434	30,434	30,434	30,634	30,634	30,634	30,634	30,634	30,634	30,634
1□													
20	□ONG TERM DE□T:												
21	Mortgage Payable	0	0	0	0	0	0	0	0	0	0	0	0
22	Construction □oans - Interim Financing	0	0	0	0	0	0	0	0	0	0	0	0
23	Notes Payable	527	424	0	0	0	0	0	0	0	0	0	0
24	Capitalized □ease Obligations	3,275	1,171	3,30□	1,□57	1,063	351	0	0	0	0	0	0
25	□onds Payable	0	0	0	0	0	0	0	0	0	0	0	0
26	Notes and □oans Payable to Parent	0	0	0	0	0	0	0	0	0	0	0	0
27	Noncurrent □iabilities	0	1,5□5	0	0	0	0	0	0	0	0	0	0
28	TOTA□	3,802	3,1□0	3,30□	1,□57	1,063	351	0	0	0	0	0	0
2□	□ess Current Maturities of □ong Term Debt	(1,30□)	(1,383)	(1,352)	(8□4)	(712)	(351)	0	0	0	0	0	0
30	**TOTAL LON□ TER□ DEBT**	2,4□3	1,807	1,□57	1,063	351	0	0	0	0	0	0	0
31													
32	**UNRESTRICTED FUND BALANCE**	164,□22	125,667	127,66□	137,271	150,055	167,820	1□0,5□1	218,284	246,804	276,074	306,2□4	337,664
33													
34	E□□ITY (INVESTOR OWNED)												
35	Preferred Stock												
36													
37	Common Stock												
38													
3□	Additional Paid In Capital												
40													
41	Retained Earnings (Capital Account for Partnership												
42	or Sole Proprietorship)												
43													
44	□ess Treasury Stock												
45	**TOTAL EQUITY**												
46	**TOTAL LIABILITIES AND FUND BALANCE OR EQUITY**	□1□□,701	□207,224	□1□6,832	□216,01□	□218,363	□236,320	□25□,31□	□287,523	□316,044	□345,314	□375,534	□406,□04

Revised Staffing Table

						After Project Completion						
	Actual 2019	Actual 2020	Actual 2021	Estimated 2022	Estimated 2023	Projected 2024	Projected 2025	Projected 2026	Projected 2027	Projected 2028	Projected 2029	Projected 2030
Nursing												
□ anagement	8.9	□5	□6	□6	□6	8.6	8.6	8.6	8.6	8.6	8.6	8.6
R□	235.0	22□3	238.9	2□2.3	2□5.8	255.3	263.□	2□0.3	2□0.3	2□0.3	2□0.3	2□0.3
□P□	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Patient Care Asst	69.0	□□3	82.3	83.5	8□□	8□9	90.8	93.1	93.1	93.1	93.1	93.1
□ech/Professional	□3	□0	□9	5.0	5.1	5.2	5.□	5.6	5.6	5.6	5.6	5.6
Svc/Support	10.8	8.6	5.9	6.0	6.1	6.3	6.6	6.□	6.□	6.□	6.□	6.□
Ancillary/Support												
□ anagement	□1.6	□1.6	□2.0	□2.0	□2.0	□3.0	□3.0	□3.0	□3.0	□3.0	□3.0	□3.0
R□	169.1	1□9.□	220.2	22□0	22□8	233.6	238.□	2□3.6	2□3.6	2□3.6	2□3.6	2□3.6
□P□	28.5	26.□	2□1	2□6	28.0	28.□	29.□	30.0	30.0	30.0	30.0	30.0
Patient Care Asst	180.□	1□□2	190.8	19□1	19□5	202.5	206.9	211.2	211.2	211.2	211.2	211.2
□ech/Professional	225.5	232.□	25□8	259.2	263.6	2□0.3	2□6.3	281.9	281.9	281.9	281.9	281.9
Svc/Support	216.0	212.□	169.5	1□2.□	1□5.□	1□9.8	183.8	18□6	18□6	18□6	18□6	18□6
Total FTE's	**1,189.0**	**1,192.0**	**1,244.0**	**1,263.6**	**1,283.6**	**1,321.3**	**1,353.3**	**1,381.6**	**1,381.6**	**1,381.6**	**1,381.6**	**1,381.6**
Salaries □ □ ages □000s□	**$110,178**	**$118,552**	**$128,353**	**$130,376**	**$132,439**	**$136,329**	**$139,631**	**$142,551**	**$142,551**	**$142,551**	**$142,551**	**$142,551**
□mployee □enefits □000s□	**$25,266**	**$26,972**	**$29,618**	**$30,085**	**$30,561**	**$31,458**	**$32,219**	**$32,893**	**$32,893**	**$32,893**	**$32,893**	**$32,893**
Salaries □ □ ages / F□□	**$92,664**	**$99,456**	**$103,177**	**$103,178**	**$103,179**	**$103,178**	**$103,178**	**$103,178**	**$103,178**	**$103,178**	**$103,178**	**$103,178**
□mployee □enefits / F□□	**$21,250**	**$22,628**	**$23,808**	**$23,809**	**$23,809**	**$23,808**	**$23,808**	**$23,808**	**$23,808**	**$23,808**	**$23,808**	**$23,808**
S□□ □ □enefits / F□□	**$113,914**	**$122,084**	**$126,985**	**$126,987**	**$126,988**	**$126,986**	**$126,986**	**$126,986**	**$126,986**	**$126,986**	**$126,986**	**$126,986**

Exhibit 6
Patient Origin

St. Francis Hospital Patient Discharges and Days by Zip Code, CY 2021

Zipcode	Planning Area	Discharges	% of Discharges	Days
98003	Southeast King	1,710	23.2%	8,821
98023	Southeast King	1,310	17.7%	6,169
98001	Southeast King	550	7.5%	2,829
98422	Central Pierce	359	4.9%	1,751
98198	Southwest King	279	3.8%	1,188
98032	Southeast King	220	3.0%	1,018
98354	East Pierce	211	2.9%	1,082
98002	Southeast King	210	2.8%	828
98092	Southeast King	176	2.4%	913
98424	Central Pierce	125	1.7%	465
98372	East Pierce	106	1.4%	502
98391	East Pierce	91	1.2%	483
98022	Southeast King	85	1.2%	536
98042	Southeast King	65	0.9%	348
98030	Southeast King	62	0.8%	214
98371	East Pierce	58	0.8%	230
98031	Southeast King	55	0.7%	338
98387	West Pierce	54	0.7%	162
98374	East Pierce	49	0.7%	207
98404	Central Pierce	49	0.7%	124
98405	Central Pierce	47	0.6%	255
98499	West Pierce	46	0.6%	228
98093	Southeast King	44	0.6%	238
98321	East Pierce	42	0.6%	187
98445	West Pierce	41	0.6%	237
98498	West Pierce	39	0.5%	364
98444	West Pierce	37	0.5%	157
98168	Southwest King	35	0.5%	199
98047	Southeast King	32	0.4%	132
98063	Southeast King	32	0.4%	240
98188	Southwest King	30	0.4%	118
98366	Kitsap	30	0.4%	97
98373	East Pierce	30	0.4%	117
98375	East Pierce	30	0.4%	66
98466	Central Pierce	29	0.4%	93
98409	Central Pierce	26	0.4%	131
98038	Southeast King	24	0.3%	139
98338	East Pierce	24	0.3%	72
98058	Southeast King	23	0.3%	87
98106	Southwest King	22	0.3%	119
98360	East Pierce	22	0.3%	60
98146	Southwest King	21	0.3%	116
98312	Kitsap	20	0.3%	50

St. Francis Hospital Patient Discharges and Days by Zip Code, CY 2021

Zipcode	Planning Area	Discharges	% of Discharges	Days
98057	Southeast King	19	0.3%	93
98390	East Pierce	19	0.3%	67
98335	Central Pierce	17	0.2%	37
98584	Mason	16	0.2%	56
98104	Central King	15	0.2%	89
98118	Central King	15	0.2%	151
98408	Central Pierce	15	0.2%	28
98166	Southwest King	14	0.2%	35
98310	Kitsap	13	0.2%	30
98367	Kitsap	13	0.2%	17
98148	Southwest King	12	0.2%	43
98520	West Grays Harbor	12	0.2%	14
98597	Thurston	12	0.2%	18
98513	Thurston	11	0.2%	64
98071	Southeast King	10	0.1%	33
98407	Central Pierce	10	0.1%	16
98418	Central Pierce	10	0.1%	27
All Others	N/A	601	8.1%	2,098
	Total	**7,384**	**100.0%**	**34,626**

Source: Applicant internal data. Excludes newborn discharges (MDC 15).

Exhibit 7
St. Francis Hospital Policies

Current Status: *Active*		**PolicyStat ID:** *10140777*
All Policies Site - CHI Franciscan Health System	**Origination:**	*06/1996*
	Effective:	*07/2021*
	Last Approved:	*07/2021*
	Last Revised:	*07/2021*
	Next Review:	*07/2024*
	Owner:	*Kathryn McKee: Division Director Accreditation/Safety*
	Policy Area:	*Patient Rights/Ethics*
	References:	*Administrative*
	Applicability:	*CHI Franciscan Systemwide*

Notice of Patients Rights and Responsibilities on Admission, 390.00

PURPOSE

To assure all patients and their legal representative have been informed of their patient rights and responsibilities on admission.

POLICY

It is the policy of Franciscan Health System to recognize and respect the rights of all patients. Discrimination in any form is prohibited. Patients receiving any health care services at Franciscan Health System shall be informed of these patient rights as well as their responsibilities.

SUPPORTIVE DATA

- Addendum A: Patient Rights/Responsibilities/Standards/Acknowledgement
- Notice of Interpreter Services, Addendum
- ***Grievance Policy***
- ***Nondiscrimination Policy***
- ***Patient Visitation Policy***
- ***Consent for Treatment Policy***
- 42 CFR 482.13 Conditions of Participation: Patient's Rights
- Joint Commission Standards, Current Edition
- Americans with Disabilities (ADA)
- Ethical/Religious Directives for Catholic Health Care

PROCEDURE

Each patient/legal representative is asked to sign the **Notice and Ac□nowledgment of Patient Rights□ Responsibilities** at registration or admission. Each patient/legal representative is offered a written copy of the hospital's Patient's Rights and Responsibilities. Every effort possible is made to provide this information in advance of providing or discontinuing care. The patient rights/responsibilities information may also be made available to patients throughout their stay upon re□uest.

Series Patients

Outpatients in certain therapeutic programs involving ongoing courses of treatments or therapies may sign an

acknowledgement for an entire course of therapy or treatment prior to the first treatment, and a single form may be signed for the entire course of treatment or therapy if:

1. The department has a written policy describing a process for a special population that has ongoing therapy or treatment. The policy describes the time frame for obtaining signatures for ongoing therapies or treatments . The time frame must be at least annually.
2. The patient (or legal representative) is informed of this provision for the acknowledgement re□uirement. A copy of the acknowledgement is provided to the patient. A note in the medical record is written at the time of the patient's signature denoting the acknowledgement.
3. The acknowledgement is re-obtained,re-documented, and scanned into the EHR as determined by policy but at least annually. A note is written in the medical record at the time of the patient's signature denoting the acknowledgment.

SI□NA□E

Notice of Patient Rights/Responsibilities signs may be posted conspicuously in the main entrance to the hospital, the emergency department entrance and at all the registration areas of the hospital or off campus service locations. The organization at their discretion may determine other locations the signs may be posted. The posted signs must meet the CHI FH approved design standards and have the most current date/version published from marketing. The manager of the service is responsible for assuring the most current sign is posted during construction, renovation, painting or relocation pro□ects. .

The hospital **grievance information sign** is conspicuously posted in the emergency department and other designated locations as determined by the organizations.

Access to Interpreter signs are also posted conspicuously in the main entrance to the hospital, the emergency department entrance and all registration areas of the organization.

RESPONSIBILITY

Patient Access□Registration staff is responsible for providing the patient/legal representative with the site specific □Patient Rights/Responsibilities □Notice and Acknowledgment□form. The patient/legal representative is asked to read, acknowledge and sign that he/she has received the information.

The Director of Patient Access or designee is responsible for keeping current procedures in the department relating to the Patient Rights/Responsibilities notices and educating staff in the implementation of the procedures**. The Patient Rights□Responsibility Notice and Ac□nowledgement form includes detailed information about the hospital□s grievance process, contact information and time lines for resolution.** Staff must document on the acknowledgement form if the information is not provided due to the patient's condition or if the legal representative is not immediately available. Patient Access is at point to assure the most current acknowledgement is available in the EHR and at the registration locations.

Complaints relating to discrimination or violations of patient rights are managed through coordination between **Patient Advocates □Ris□ □anagement □Compliance.** Risk is at point to assure signs and updated grievance information are posted at each site in Emergency Department, the hospital website, registration areas or other designated locations determined by the organization.

Hospital Staff are responsible for being knowledgeable of the standards and processes supporting patient rights and incorporating them into their day-to-day patient interactions.

Facilities Construction Pro ect Coordinator are responsible for assuring signs advising patients of their rights are posted in the main entrances of the hospital, emergency departments, registration areas and other appropriate public locations as determined by the organization. The signage is applicable to the main entrance, emergency services entrance and services/programs throughout the organization where patients are registered.

ar eting is responsible for assuring current patient rights/responsibility information posters are accurate and available and posted on the CHI FH INTERNET.

Safety Regulatory Ris Departments are responsible for assuring current and accurate content is disclosed on written hospital disclosures, pamphlets, and notices of patient rights and responsibilities provided at registration.

PATIENT RI HTS

AS A PATIENT AT FRANCISCAN HEALTH SYSTEM, YOU HAVE THE RIGHT TO:

- e fully informed of all your patient rights and receive a written copy, in advance of furnishing or discontinuing care whenever possible.
- Not be discriminated against because of your race, beliefs, age, ethnicity, religion, culture, language, social, physical or mental disability, socio-economic status, sex, sexual orientation, gender identity or expression.
- To be accompanied by a trained service animal or dog guide.
- e treated with dignity and respect including cultural and personal beliefs, values and preferences.
- Confidentiality, reasonable personal privacy, security, safety, spiritual or religious care accommodations, and communication. If communication restrictions are necessary for patient care and safety, the hospital must document and explain the restrictions to the patient and family.
- e protected from neglect exploitation verbal, mental, physical or sexual abuse Access to protective and advocacy services.
- Receive information about your condition including unanticipated outcomes, agree and be involved in all aspects and decisions of their care including: refusing care, treatment and services to the extent permitted by law and to be informed of the conse uences of your actions and resolving problems with care decisions the hospital will involve the surrogate decision-maker when the patient is unable to make decisions about his or her care.
- Receive information in a manner tailored to the patient's age, language needs and ability to understand. An interpreter, translator or other auxiliary aids, tools or services will be provided to you for vital and necessary information free of charge.
- Make informed decisions regarding care including options, alternatives, risk and benefits. The hospital honors your right to give, rescind and withhold consent.
- Receive an appropriate medical screening examination or treatment for an emergency medical condition within the capabilities of the hospital, regardless of your ability to pay for such services.
- Have a family member or representative of your choice and your physician notified.
- now the individual(s) responsible for, as well as those providing, your care, treatment and services.
- Family or representatives notification of your admission and input in care decisions designate any individual to be present for emotional support during course of stay.
- An appropriate assessment and management of your pain.
- e free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Have advance directives and for hospitals to respect and follow those directives The hospital honors

advance directives, in accordance with law and regulation and the hospital's capabilities, religious directives and policies.

- End of life care□Re□uest no resuscitation or life-sustaining treatment.
- Donate organs and other tissues including medical staff input and direction by family or surrogate decision makers.
- Review, re□uest amendment to and obtain information on disclosures of your health information in accordance with law and regulation.
- File a grievance (complaint) and to be informed of the process to review and resolve the grievance without fear of retribution or denial of care. The grievance process and relevant contact information is spelled out in the notice provided to each patient and/or leg representative.

PATIENT RESPONSIBILITIES

AS A PATIENT AT OUR HOSPITAL, YOU HAVE THE RESPONSIBILITY TO:

- Tell your care providers everything you know about your health, and to let someone know if there are changes in your condition. Provide accurate and current health information to your healthcare team.
- Make known when you have advance directives and provide documents describing your preferences and wishes to the admitting staff or clinical healthcare team.
- Ask for explanation and information if you do not understand what you are told.
- Participate in your health care by helping make decisions, following the treatment plan prescribed by your physician, and accepting responsibility for your choices.
- Demonstrate respect and consideration for other patients and hospital personnel.
- Follow hospital rules and regulations about safety and patient care during your stay such as those about visitors, smoking, noise, etc.
- Meet your financial commitments. Deal with your bill promptly, and contact the billing department if you need to make special arrangements.
- Support mutual consideration and respect by maintaining civil language and conduct in interaction with staff and medical staff.
- Tell your care providers if you have special needs your healthcare team should know about.

□RIEVANCE PROCESS

The notice provided to the patient/legal representative must contain information on the grievance process and how to file a grievance if a person believes their rights have been violated. In addition to filing a grievance with the organization, the notice must include contact information for The Joint Commission and Department of Health agencies. In addition, discrimination grievances may be forwarded to the WA State Human Rights Commission at toll free number 1-800 233-3247 or on-line at www.hum.wa.gov.

SERVICE ANI□ ALS

Individuals with disabilities have a right to be accompanied by a trained service animal or dog guide and receive reasonable accommodations. Refer to hospital policy #104.50 Service Animal Policy.

PATIENT VISITATION RI□HTS

Patients of Franciscan Health System en□oy visitation privileges consistent with the patient preference and sub□ect to the hospital's Justified Clinical Restrictions. Each patient has the right to receive the visitors whom he/ she designates and may designate a support person to exercise the patient's visitation rights on his/ her

behalf. All visitors designated by the patient (or support person where appropriate) shall en□oy visitation privileges that are no more restrictive than those that immediate family member would en□oy. The designation of a support person does not extend to the medical decision making.

The hospital may impose clinically necessary or reasonable restrictions or limitations on patient visitation when necessary to respect all other patient rights and to provide safe care to patients. A □ustified Clinical Restriction may include, but need not be limited to one or more of the following: (i) a court order limiting or restraining contact□(ii) behavior presenting a direct risk or threat to the patient, hospital staff, or others in the immediate environment□(iii) behavior disruptive of the functioning of the patient care unit□(iv) reasonable limitations on the number of visitors at any one time□(v) patient's risk of infection by the visitor□(vi) visitor's risk of infection by the patient□(vii) extraordinary protections because of a pandemic or infectious disease outbreak□(viii) substance abuse treatment protocols re□uiring restricted visitation□(ix) patient's need for privacy or rest□(x) need for privacy or rest by another individual in the patient's shared room□or (xi) when the patient is undergoing clinical intervention or procedure and the treating health care professional believes it is in the patient's best interest to limit visitation during the clinical intervention or procedure.

REQUIRED REVIEW:

Regulatory, Risk, Patient Access

Attachments

Addendum □: Notice of Interpreter Services
5□64□1 Patient Rights Responsibilities Notice 2017.pdf
Addendum A: Patient Rights/Responsibilities/Standards/Acknowledgement

Approval Signatures

Approver	Date
Gillian Payne: Document Control Coordinator	07/2021
□athryn Mc□ee: Division Director Accreditation/Safety	07/2021

Applicability

CHI Franciscan Health, Franciscan System Services, St. Anne Hospital, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center, St. Michael Medical Center

CO□ □ONSPIRIT HEALTH
□OVERNANCE POLICY ADDENDU□

ADDENDU□ Finance □ □003A□3 **EFFECTIVE DATE:** July 1, 2022

SUB□ECT: Financial Assistance - Washington

ASSOCIATED POLICIES

CommonSpirit Governance Policy	Finance G-003, *Financia□Assistance Po□icy*
CommonSpirit Governance Policy	Finance G-004, *□i□ing and Co□ections*

This Washington addendum (Addendum) supplements CommonSpirit Governance Policy G-003, *Financia□Assistance* (the Financial Assistance Policy), as necessary, in light of and to comply with Washington statutes and regulations regarding provision of Hospital Charity Care, in accordance with the □Coordination with Other □aws□section of the Financial Assistance Policy.

This Addendum applies to all CommonSpirit Health Direct Affiliates and Tax-Exempt Subsidiaries in the state of Washington, as defined in the Financial Assistance Policy. If any provision of this Addendum is in conflict with, or inconsistent with, any provision of the Financial Assistance Policy, this Addendum shall control.

References in the Financial Assistance Policy to Medically Necessary Care and Emergent Medical Care are to be interpreted consistently with the definitions of □Appropriate Hospital □ased Medical Services□and □Emergency Care or Emergency Services□contained in WAC 246-453-010(7) and (11), respectively. However, this addendum shall use the terms □Appropriate Hospital □ased Medical Services□and □Emergency Care or Emergency Services□.

DEFINITIONS

A. □Family Income□means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual, in accordance with WAC 246-453-010 (17).

B. □Appropriate Hospital-□ased Medical Services□means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other e□ually effective more conservative or substantially less costly course of treatment available or suitable for the person re□uesting the service. For purpose of this section, □course of treatment□may include mere observation or, where appropriate, no treatment at all□WAC 246-453-010 (7).

C. □Emergency Care or Emergency Services□means services provided for care related emergency medical or mental condition□WAC 246-453-010 (11).

D. □Eligibility □ualification Period□means that Patients approved to be eligible shall be granted Financial Assistance for all eligible accounts incurred for services received twenty-

four (24) months prior to the determination date (plus the fourteen (14) day determination period), and prospectively for a period of six (6) months following the determination date. If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services received twenty-four (24) months prior to the determination date.

ELI□IBILITY FOR FINANCIAL ASSISTANCE

A. No minimum account balance shall be re□uired for a patient to □ualify for Financial Assistance.

B. Pursuant to the terms of the Financial Assistance Policy, unless eligible for Presumptive Financial Assistance, certain eligibility criteria must be met in order for a patient to □ualify for Financial Assistance. This Addendum updates such eligibility criteria with the following:

- Any patient whose Family Income is at or below 300□ percent of the FP□ shall receive a full discount from his or her account balance for Appropriate Hospital □ased Medical Services and Emergency Care or Emergency Services provided to the patient after payment, if any, by third-party payers or sponsors.
- Any patient whose Family Income is between 301□ to 350□ of the FP□ shall receive discounted care up to 75□, which may be reduced from his or her account balance for Appropriate Hospital □ased Medical Services and Emergency Care or Emergency Services provided to the patient after payment, if any, by third-party payers or sponsors, and any amounts reasonably related to assets considered as set forth in the Hospital Facility□s Policy on Asset Testing.
- Any patient whose Family Income is between 351□ to 400□ of the FP□ shall receive discounted care up to 50□ from his or her account balance for Appropriate Hospital □ased Medical Services and Emergency Care or Emergency Services provided to the patient after payment, if any, by any third-party payers or sponsors, and any amounts reasonably related to assets considered as set forth in the Hospital Facility□s Policy on Asset Testing.
- In the event a Hospital Facility provides discounted care greater than what is re□uired above (either through amounts generally billed (□AG□□), self-pay, or other discounts) the patient shall receive that greater discounted care amount.

C. With respect to those assets that may be taken into consideration, Hospital Facility will seek only such information regarding assets as is reasonably necessary and readily available to determine the existence, availability, and value of such assets.

- Hospital Facility will consider assets and collect information related to such assets as re□uired by the Centers for Medicare and Medicaid (□CMS□) for Medicare cost reporting. Such information may include reporting of assets convertible to cash and unnecessary for the patient□s daily living.
- Duplicate forms of verification will not be re□uested and only one current account statement is re□uired to verify monetary assets.
- If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient.

- Asset information will not be used for collection activities.
- The following types of assets shall be excluded from consideration:
    - The first □5,000 of monetary assets for an individual or □8,000 of monetary assets for a family of two, plus an additional □1,500 of monetary assets for each additional family member. The value of any asset that has a penalty for early withdrawal shall be the value of the asset after the penalty has been paid□
    - Any e□uity in a primary residence□
    - Retirement plans other than 401(k) plans□
    - One motor vehicle and a second motor vehicle if it is necessary for employment or medical purposes□
    - Any prepaid burial contract or burial plot□and
    - Any life insurance policy with a face value of □10,000 or less.

D. □Patient Cooperation Standards,□as defined in the Financial Assistance Policy, shall only apply to the extent they:

- allow the Hospital Facility to pursue reimbursement from any third-party coverage that may be identified to the Hospital Facility, in accordance with WAC 246-453-020(1)□
- allow the Hospital Facility to make every reasonable effort to determine the existence or nonexistence of third-party sponsorship that might cover in full or in part the charges for services provided to each patient, in accordance with WAC 246-453-020(4)□and
- do not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party□s capability of complying with the application procedures, in accordance with WAC 246-453-020(5).

E. Eligibility for Financial Assistance re□uires that a person be a Washington State resident and that the medical services sought are Appropriate Hospital-□ased Medical Services, as opposed to services which are investigational, elective or experimental in nature. If a person is not a Washington State resident, that person is not eligible for Financial Assistance when that person enters Washington State solely for the purpose of seeking medical care. Refugees, asylees, and those seeking asylum are exempt from the Washington State residency re□uirement for Financial Assistance eligibility. Also exempt from the Washington State residency re□uirement are those patients in need of Emergency Care or Emergency Services. Financial Assistance will not be denied based on immigration status. Exceptions to residence and scope of services re□uirements outlined in this paragraph may be made with the approval of the Hospital Facility Chief Financial Officer or their designee.

THE □ETHOD FOR APPLYIN□ FOR FINANCIAL ASSISTANCE

A. For the purposes of reaching an initial determination of sponsorship status, Hospital Facilities shall rely upon information provided orally by the responsible party. The Hospital Facility may re□uire the responsible party to sign a statement attesting to the accuracy of the information provided to the Hospital Facility for purposes of the initial determination of

sponsorship status, in accordance with WAC 246-453-030(1). In accordance with WAC 246-453-020(1), if the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person, collection efforts directed at the responsible party will be precluded pending a final determination of that classification, provided that the responsible party is cooperative with the Hospital Facility's reasonable efforts to reach a final determination of sponsorship status.

B. In accordance with WAC 246-453-030(2), in addition to the documents listed in the Financial Assistance Policy, any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate:

- Forms approving or denying eligibility for Medicaid or state-funded medical assistance
- Forms approving or denying unemployment compensation or
- Written statements from employers or welfare agencies.

C. If there is indication that due to the patient's mental, physical or intellectual capacity, or due to a language barrier, completing the application procedure would place an unreasonable burden on the patients, the Hospital Facility will take reasonable measures to facilitate the application process, including engaging an interpreter to assist the patient through the application process if necessary.

D. Hospital Facilities shall make every reasonable effort to reach initial and final determinations of eligibility for financial assistance in a timely manner. Nevertheless, Hospital Facilities shall make those determinations at any time, even after the Application Period, upon learning of facts or receiving the documentation described herein, indicating that the responsible party's income is equal to or below three hundred percent (300%) of the federal poverty guidelines as adjusted for family size. The timing of reaching a final determination of eligibility for financial assistance shall have no bearing on the Hospital Facility's identification of charity care deductions from revenue as distinct from bad debts. WAC 246-453-020(10).

E. Any responsible party who has been initially determined to meet the criteria for receiving financial assistance shall be provided with at least fourteen (14) calendar days or such time as the person's medical condition may require, or such time as may be reasonably necessary to secure and to present documentation described within WAC 246-453-030 prior to receiving a final determination of sponsorship status.

F. In accordance with WAC 246-453-030(4), in the event that the responsible party is not able to provide any of the documentation described above, the Hospital Facility shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

. In accordance with WAC 245-453-030(5), information requests from the Hospital Facility to the responsible party for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the responsible party's qualification for charity sponsorship, and may not be used to discourage applications for such sponsorship. Only those facts relevant to eligibility may

be verified, and duplicate forms of verification shall not be demanded.

H. The Hospital Facility shall notify persons applying for financial assistance of their final determination of sponsorship status within fourteen (14) calendar days of receiving information in accordance with WAC 246-453-020(7) such notification shall include a determination of the amount for which the responsible party will be held financially accountable.

I. In the event that the Hospital Facility denies the responsible party s application for financial assistance, the Hospital Facility shall notify the responsible party of the denial within fourteen (14) days and provide the basis for the denial.

. In the event that a responsible party pays a portion or all of the charges related to Appropriate Hospital ased Medical Services and Emergency Care or Emergency Services, and is subse uently found to have met the financial assistance criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate shall be refunded to the patient within thirty (30) days of achieving the charity care designation. WAC 246-453-020(11).

. In accordance with WAC 246-453-020(6), Hospital Facilities shall not re uire deposits from those responsible parties whose income is e ual to or below three hundred percent (300) of the federal poverty guidelines as ad usted for family size, as indicated through an initial determination of sponsorship status.

L. For services provided to patients on or after July 1, 2022, the following procedures will apply for identifying patients and/or their guarantors who may be eligible for health care coverage through Washington medical assistance programs or the Washington Health enefit Exchange:

- As a part of the application process for determining eligibility for Financial Assistance and charity care, Hospital Facility will uery as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under chapter 74.0 RCW or the Washington Health enefit Exchange.
- As part of the Financial Assistance process, Hospital Facility staff will also work with patients/families who do not have applicable third-party coverage to assess whether such patients/families may be eligible for Medicaid and/or health care coverage through Washington s Health enefit Exchange (RCW 43.71). Staff will provide assistance with Medicaid and ualified Health Plan applications and including but not limited to providing the patient/family with information about the application process, assisting patients through the application process, providing necessary forms that must be completed, and/or connecting the patient/family with other agencies or resources who can assist the patient/family in completing such applications.
- In providing assistance to the application process, Hospital Facility will take into account any physical, mental, intellectual, sensory deficiencies or language barriers which may hinder either the patient or their guarantor from complying with the application procedures and will not impose procedures on the patient or guarantor that would constitute an unreasonable burden.
- If the patient or guarantor fails to make reasonable efforts to cooperate with

Hospital Facility in applying for coverage under chapter 74.0□ RCW or the Washington Health □enefit Exchange, Hospital Facility is not obligated to provide charity care to such patient.

- The Hospital Facility shall not re□uire a patient to apply for any public or private programs where the patient is categorically ineligible or has been deemed ineligible in the prior 12 months.

PRESU□PTIVE ELI□IBILITY

In the event the responsible party□s identification as an indigent person is obvious to Hospital Facility personnel, and the Hospital Facility personnel are able to establish the position of the income level within the broad criteria described in RCW 70.170.060, based on the individual life circumstances contained within the Financial Assistance Policy or otherwise, the Hospital Facility is not obligated to establish the exact income level or to re□uest documentation from the responsible party, unless the responsible party re□uests further review.

APPEALS

A. All responsible parties denied financial assistance shall be provided with, and notified of, an appeals procedure that enables them to correct any deficiencies in documentation or re□uest review of the denial and results in review of the determination by the Hospital Facility□s chief financial officer.

B. Responsible parties shall be notified that they have thirty (30) calendar days within which to re□uest an appeal of the final determination of their eligibility for financial assistance. Within the first fourteen (14) days of this period, the Hospital Facility shall not refer the account at issue to an external collection agency. If the Hospital Facility has initiated collection activities and discovers an appeal has been filed, it shall cease collection efforts until the appeal is finalized. After the fourteen (14) day period, if no appeal has been filed, the hospital may initiate collection activities.

C. If the final determination of the appeal affirms the previous denial of financial assistance, the Hospital Facility shall send written notification to the responsible party and the Department of Health in accordance with state law.

All other terms set forth in CommonSpirit Governance Policy Finance G-003, *Financia□ Assistance*, remain unaltered.

CO□ □ONSPIRIT HEALTH
□OVERNANCE POLICY

SUB□ECT: Financial Assistance	**EFFECTIVE DATE:** July 1, 2022
POLICY NU□BER: Finance G-003	**ORI□INAL EFFECTIVE DATE:** July 1, 2021

POLICY

Pursuant to Internal Revenue Code (IRC) Section 501(r), in order to remain tax-exempt, each CommonSpirit Health Hospital Organization is re□uired to establish a written Financial Assistance Policy (FAP) and an Emergency Medical Care Policy which apply to all Emergency Medical Care and Medically Necessary Care (herein referred to as EMCare) provided in a Hospital Facility. The purpose of this Policy is to describe the conditions under which a Hospital Facility provides Financial Assistance to its patients. In addition, this Policy describes the actions a Hospital Facility may take in the event of nonpayment of a patient account.

SCOPE

This Policy applies to CommonSpirit and each of its tax-exempt Direct Affiliates[1] and tax-exempt Subsidiaries[2] that operate a Hospital Facility (referred to individually as a CommonSpirit Hospital Organization and collectively as CommonSpirit Hospital Organizations). It is the policy of CommonSpirit to provide, without discrimination, EMCare in CommonSpirit Hospital Facilities to all patients, without regard to a patient's financial ability to pay.

PRINCIPLES

As Catholic health care providers and tax-exempt organizations, CommonSpirit Hospital Organizations are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for services provided.

The following principles are consistent with CommonSpirit's mission to deliver compassionate, high-□uality, affordable healthcare services and to advocate for those who are poor and vulnerable. It is the desire of CommonSpirit Hospital Organizations that the financial ability of people who need health care services does not prevent them from seeking or receiving care.

1 A Direct Affiliate is any corporation of which CommonSpirit Health is the sole corporate member or sole shareholder, as well as Dignity Community Care, a Colorado nonprofit corporation.

2 A Subsidiary refers to either an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint fifty percent (50□) or more of the voting members of the governing body of such organization or holds fifty percent (50□) or more of the voting rights in such organization (as evidenced by membership powers or securities conferring certain decision-making authority on the Direct Affiliate) or any organization in which a Subsidiary holds such power or voting rights.

CommonSpirit Hospital Organizations will provide, without discrimination, Emergency Medical Care to individuals regardless of their eligibility for Financial Assistance or for government assistance in CommonSpirit Hospital Facilities.

CommonSpirit Hospital Organizations are dedicated to providing Financial Assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for non-emergent Medically Necessary Care provided in CommonSpirit Hospital Facilities.

APPLICATION

A. This Policy applies to:

- All charges for EMCare provided in a Hospital Facility by a CommonSpirit Hospital Organization.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a CommonSpirit Hospital Organization if such care is provided within a Hospital Facility.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a Substantially-Related Entity that occurs within a Hospital Facility.
- Non-covered Medically Necessary Care provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit or in circumstances where the patient's benefits have been exhausted.
- Collection and recovery activities shall be conducted in accordance with the CommonSpirit Governance Policy Finance G-004, *Billing and Collections*.

B. Coordination with Other Laws

The provision of Financial Assistance may be subject to additional laws or regulations pursuant to federal, state or local laws. Such law governs to the extent it imposes more stringent requirements than this Policy. In the event that a subsequently adopted state or local law directly conflicts with this Policy, the CommonSpirit Hospital Organization shall, after consultation with its local CommonSpirit Legal Team representative, CommonSpirit Revenue Cycle leadership, and CommonSpirit Tax leadership, be permitted to adopt an addendum to this Policy before the next policy review cycle, with such minimal changes to this Policy as are necessary to achieve compliance with any applicable laws.

DEFINITIONS

Amounts Generally Billed (AGB) means the maximum charge a patient who is eligible for Financial Assistance under this Financial Assistance Policy is personally responsible for paying, after all deductions and discounts (including discounts available under this Policy) have been applied and less any amounts reimbursed by insurers. No patient eligible for Financial Assistance will be charged more than the AGB for EMCare provided to the patient. CommonSpirit calculates the AGB on a Facility-by-Facility basis using the "lookback" method by multiplying the "Gross Charges" for any EMCare that it provides by AGB percentages, which are based upon past claims allowed under Medicare and private insurance as set forth in

federal law. “Gross Charges” for these purposes means the amount listed on each Hospital Facility’s chargemaster for each EMCare service.

Application Period means the time provided to patients by the CommonSpirit Hospital Organization to complete the Financial Assistance application. It expires on the later of (i) 365 days from the patient’s discharge from the Hospital Facility or the date of the patient’s EMCare, or (ii) 240 days from the date of the initial post-discharge bill for the EMCare received at a Hospital Facility.

CommonSpirit Entity Service Area means, for purposes of this Policy, the community served by a Hospital Facility as described in its most recent Community Health Needs Assessment, as described in IRC Section 501(r)(3).

Community Health Needs Assessment (CHNA) is conducted by a Hospital Facility at least once every three (3) years pursuant to IRC Section 501(r)(1)(A) each CommonSpirit Hospital Organization then adopts strategies to meet the community health needs identified through the CHNA.

Eligibility Determination Period For purposes of determining Financial Assistance eligibility, a Hospital Facility will review annual Family Income from the prior six-month (6) period, or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date Family Income, taking into consideration the current earnings rate.

Eligibility Qualification Period After submitting the Financial Assistance application and supporting documents, patients approved to be eligible shall be granted Financial Assistance for all eligible accounts incurred for services received twelve (12) months prior to the determination date, and prospectively for a period of six (6) months from the determination date. If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services received twelve (12) months prior to the determination date.

Emergency edical Care, E TALA Any patient seeking care for an emergency medical condition within the meaning of Section 1867 of the Social Security Act (42 .S.C. 13 5dd) at a Hospital Facility shall be treated without discrimination and without regard to a patient’s ability to pay for care. Furthermore, any action that discourages patients from seeking EMCare, including, but not limited to, demanding payment before treatment or permitting debt collection and recovery activities that interfere with the provision of EMCare, is prohibited. Hospital Facilities shall also operate in accordance with all federal and state re uirements for the provision of care relating to emergency medical conditions, including screening, treatment and transfer re uirements under the federal Emergency Medical Treatment and abor Act (EMTA A) and in accordance with 42 CFR 482.55 (or any successor regulation). Hospital Facilities should consult and be guided by any CommonSpirit EMTA A Policy, EMTA A regulations, and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an emergency medical condition and the processes to be followed with respect to each.

Extraordinary Collection Actions (ECAs) The Hospital Facility will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under this

Policy. An ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

- Selling an individual's debt to another party except as expressly provided by federal law and
- Reporting adverse information about the individual to consumer credit bureaus.

ECAs do not include any lien that a Hospital Facility is entitled to assert under state law on the proceeds of a judgment or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Facility provided care.

Family means (using the Census Bureau definition) a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service (IRS) rules, if the patient claims someone as a dependent on his or her income tax return, that person may be considered a dependent for purposes of the provision of Financial Assistance. If IRS tax documentation is not available, family size will be determined by the number of dependents documented on the Financial Assistance application and verified by the Hospital Facility.

Family Income is determined consistent with the IRS definition of Modified Adjusted Gross Income for the applicant and all members of the applicant's Family. In determining eligibility, CommonSpirit Hospital Organization may consider the 'monetary assets' of the patient's Family. However, for purposes of this determination, monetary assets will not include retirement or deferred compensation plans.

Federal Poverty Level Guidelines (FPL) are updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines.

Financial Assistance means assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare provided in a Hospital Facility and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Guarantor means an individual who is legally responsible for payment of the patient's bill.

Hospital Facility (or Facility) means a healthcare facility that is required by a state to be licensed, registered or similarly recognized as a hospital and that is operated by a CommonSpirit Hospital Organization.

Medically Necessary Care means any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers life, cause suffering or pain, results in illness or infirmity, threatens to cause or aggravate a handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no other equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures only to improve aesthetic appeal of a normal, or normally functioning, body part.

Operates a Hospital Facility - A Hospital Facility is considered to be operated either by use of its own employees or by contracting out the operation of the Facility to another organization. A Hospital Facility may also be operated by a CommonSpirit Hospital Organization if the CommonSpirit Hospital Organization has a capital or profits interest in an entity taxed as a partnership which directly operates a state licensed Hospital Facility or which indirectly operates a state licensed Hospital Facility through another entity taxed as a partnership.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publicly available information. A determination that a patient is presumptively eligible for Financial Assistance will result in free or discounted EMCare for the period during which the individual is presumptively eligible.

Substantially Related Entity means, with respect to a CommonSpirit Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides EMCare in a state licensed Hospital Facility, unless the provision of such care is an unrelated trade or business described in IRC Section 513 with respect to the Hospital Organization.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare covered by this Policy.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

A. Financial Assistance Available for EMCare

A patient who qualifies for Financial Assistance will receive free or discounted EMCare, and as such will never be responsible for more than AGB for EMCare. Financial Assistance shall be provided to patients who meet the eligibility requirements as described herein and have established residency within the CommonSpirit Entity Service Area as defined by the most recent Hospital Facility CHNA, unless the visit is urgent or emergent or occurs within a California Hospital Facility. Residents of countries outside the United States of America are not eligible for financial assistance without prior approval from the Hospital Facility Chief Financial Officer (or his or her designee), unless the visit is urgent or emergent. All scheduled services for patients who reside outside the CommonSpirit Entity Service Area require prior approval from the Hospital Facility Chief Financial Officer (or his or her designee). If an ordering provider has requested services at a Hospital Facility and the same service is also provided at another facility closer to the patient's residence and outside the CommonSpirit Entity Service Area, the Hospital Facility may request the ordering provider to re-evaluate the services and request the services be performed closer to the patient's residence.

B. Financial Assistance Not Available for Other than EMCare

Financial Assistance is not available for care other than EMCare. In the case of care other than EMCare, no patient will be responsible for more than the net charges for such care (gross charges for such care after all deductions and insurance reimbursements have been applied).

C. Amount of Financial Assistance Available

Eligibility for Financial Assistance will be considered for those individuals who are □ninsured, □nderinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of Financial Assistance shall be based on an individualized determination of financial need, and shall not take into account any potential discriminatory factors such as age, ancestry, gender, gender identity, gender expression, race, color, national origin, sexual orientation, marital status, social or immigrant status, religious affiliation, or any other basis prohibited by federal, state, or local law.

□nless eligible for Presumptive Financial Assistance, the following eligibility criteria must be met in order for a patient to □ualify for Financial Assistance:

- The patient must have a minimum account balance of ten dollars (□10.00) with the CommonSpirit Hospital Organization. Multiple account balances may be combined to reach this amount. Patients/Guarantors with balances below ten dollars (□10.00) may contact a financial counselor to make monthly installment payment arrangements.
- The patient must comply with Patient Cooperation Standards as described herein.
- The patient must submit a completed Financial Assistance Application (FAA).

D. Charity Care

- □p to 200□ of the FP□ – Any patient whose Family Income is at or below 200□ of the FP□, including, without limitation, any □ninsured or □nderinsured patient, is eligible to receive Financial Assistance up to a 100□ discount from his or her account balance for eligible services provided to the patient after payment, if any, by any third-party(ies).

- 201□ - 400□ of the FP□ – Any patient whose Family Income is at or above 201□ but lower than 400□ of the FP□, including, without limitation, any □ninsured or □nderinsured patient, is eligible to receive Financial Assistance reducing his or her account balance for eligible services provided to the patient after payment, if any, by any third-party(ies), to an amount no more than the Hospital Facility's AGB.

E. Patient Cooperation Standards

A patient must cooperate with the Hospital Facility in providing the information and documentation necessary to determine eligibility. Such cooperation includes completing any re□uired applications or forms. The patient is responsible for notifying the Hospital Facility of any change in financial situation that would impact the assessment of eligibility.

A patient must exhaust all other payment options, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties prior to being approved. An applicant for Financial Assistance is responsible for applying to public programs for available coverage. He or she is also expected to pursue public or private health insurance payment options for care provided by a CommonSpirit Hospital Organization within a Hospital Facility.

A patient's and, if applicable, any Guarantor's cooperation in applying for applicable programs and identifiable funding sources, shall be re□uired. A Hospital Facility shall make affirmative efforts to help a patient or patient's Guarantor apply for public and private programs, which may include coverage under a health insurance exchange, commercial health insurance, or health plan coverage purchased through CO□RA. If a Hospital Facility determines that coverage under a health insurance exchange, commercial health insurance, or a CO□RA plan is potentially available, and that a patient is not a Medicare or Medicaid beneficiary, the Hospital Facility may re□uire that the patient or Guarantor (i) provide the Hospital Facility and applicable foundation with information necessary to determine the monthly premium for such patient, and (ii) cooperate with Hospital Facility and foundation staff to determine whether he or she □ualifies for premium assistance, which may be offered (through designated foundation funds) for a limited time to assist in securing the insurance coverage mentioned above.

F. Uninsured Patient Discount

Non-covered services under an insurance policy and patients/Guarantors that provide evidence that no health insurance coverage exists either through an employer-provided program or a governmental program such as Medicare, Medicaid or other state and local program to pay for the medically necessary health care services rendered to the patient, shall be eligible for an □ninsured Patient Discount. This Discount shall not apply to cosmetic or non-medically necessary procedures and will only be available for eligible services.

Each Hospital Facility shall calculate and determine the discount from gross charges available to eligible patients. The Financial Assistance described above supersedes this □ninsured Patient Discount. If it is determined that the application of Financial Assistance will further reduce the patient's bill, Hospital Facility will reverse the Uninsured Patient Discount and apply the applicable ad□ustments under the Financial Assistance Policy.

□. Self□Pay Discount

For those □ninsured patients who do not □ualify for any of the financial assistance discounts described in this Policy, Hospital Facilities may apply an automatic (self-pay) discount to a patient's bill in accordance with CommonSpirit Revenue Cycle guidelines and procedures. This self-pay discount is not means-tested.

THE □ETHOD FOR APPLYIN□ FOR FINANCIAL ASSISTANCE

All patients must complete the CommonSpirit FAA to be considered for Financial Assistance, unless they are eligible for Presumptive Financial Assistance. The FAA is used by the Hospital Facility to make an individual assessment of financial need.

To □ualify for assistance, patient must provide bank or checking account statements evidencing the patient's available resources (those convertible to cash and unnecessary for the patient's daily living) and at least one (1) piece of supporting documentation that verifies Family Income is re□uired to be submitted along with the FAA. Supporting documentation may include, but is not limited to:

- Copy of the individual's most recently filed federal income tax return;
- Current Form W-2□

- Current paystubs or
- Signed letter of support.

The Hospital Facility may, at its discretion, rely on evidence of eligibility other than described in the FAA or herein. Other evidentiary sources may include:

- External publicly available data sources that provide information on a patient/Guarantor's ability to pay;
- A review of patient's outstanding accounts for prior services rendered and the patient/Guarantor's payment history;
- Prior determinations of the patient's or Guarantor's eligibility for assistance under this Policy, if any or
- Evidence obtained as a result of exploring appropriate alternative sources of payment and coverage from public and private payment programs.

In the event no income is evidenced on a completed FAA, a written document is required which describes why income information is not available and how the patient or Guarantor supports basic living expenses (such as housing, food, and utilities). Financial Assistance applicants who participate in the National Health Services Corps (NHSC) oan Repayment Program are exempt from submitting expense information.

PRESU PTIVE ELI IBILITY

CommonSpirit Hospital Organizations recognize that not all patients and Guarantors are able to complete the FAA or provide requisite documentation. Financial counselors are available at each Hospital Facility location to assist any individual seeking application assistance. For patients and Guarantors who are unable to provide required documentation, a Hospital Facility may grant Presumptive Financial Assistance based on information obtained from other resources. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Recipient of state-funded prescription programs
- Homeless or one who received care from a homeless or free care clinic
- Participation in Women, Infants and Children programs (WIC)
- Food stamp eligibility
- Eligibility or referrals for other state or local assistance programs (e.g., Medicaid)
- ow income/subsidized housing is provided as a valid address or
- Patient is deceased with no known spouse or known estate.

This information will enable Hospital Facilities to make informed decisions on the financial needs of patients, utilizing the best estimates available in the absence of information provided directly by the patient. A patient determined eligible for Presumptive Financial Assistance will receive free or discounted EMCare for the period during which the individual is presumptively eligible.

Medicaid patients who receive non-covered medically necessary services will be considered for Presumptive Financial Assistance. Financial assistance may be approved in instances prior to the Medicaid effective date.

If an individual is determined to be presumptively eligible, a patient will be granted Financial Assistance for a period of twelve (12) months ending on the date of presumptive eligibility

determination. As a result, Financial Assistance will be applied to all eligible accounts incurred for services received twelve (12) months prior to the determination date. The presumptively eligible individual will not receive financial assistance for EMCare rendered after the date of determination without completion of a FAA or a new determination of presumptive eligibility.

For patients, or their Guarantors, who are non-responsive to a Hospital Facility's application process, other sources of information may be used to make an individual assessment of financial need. This information will enable the Hospital Facility to make an informed decision on the financial need of non-responsive patients, utilizing the best estimates available in the absence of information provided directly by the patient.

For the purpose of helping financially needy patients, a Hospital Facility may use a third-party to review a patient's, or the patient's Guarantor's, information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capability score. The model's rule set is designed to assess each patient based upon the same standards and is calibrated against historical Financial Assistance approvals by the Hospital Facility. This enables the Hospital Facility to assess whether a patient is characteristic of other patients who have historically □ualified for Financial Assistance under the traditional application process.

When the model is utilized, it will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows a Hospital Facility to screen all patients for Financial Assistance prior to pursuing any ECAs. The data returned from this review will constitute ade□uate documentation of financial need under this Policy.

In the event a patient does not □ualify for presumptive eligibility, the patient may still provide re□uisite information and be considered under the traditional FAA process.

Patient accounts granted presumptive eligibility status will be provided free or discounted care for eligible services for retrospective dates of service only. This decision will not constitute a state of free or discounted care as available through the traditional application process. These accounts will be treated as eligible for Financial Assistance under this Policy. They will not be sent to collection, will not be sub□ect to further collection action, and will not be included in Hospital Facility bad debt expense. Patients will not be notified to inform them of this decision. Additionally, any deductible and coinsurance amount claimed as a Medicare bad debt shall be excluded from the reporting of charity care.

Presumptive screening provides a community benefit by enabling a CommonSpirit Hospital Organization to systematically identify financially needy patients, reduce administrative burdens, and provide Financial Assistance to patients and their Guarantors, some of whom may have not been responsive to the FAA process.

NOTIFICATION ABOUT FINANCIAL ASSISTANCE

Notification about the availability of Financial Assistance from CommonSpirit Hospital Organizations shall be disseminated by various means, which may include, but not be limited to:

- Conspicuous publication of notices in patient bills□

- Notices posted in emergency rooms, urgent care centers, admitting/registration departments, business offices, and at other public places as a Hospital Facility may elect and
- Publication of a summary of this Policy on the Hospital Facility's website, as provided in Addendum A, and at other places within the communities served by the Hospital Facility as it may elect.

Patients may obtain additional information regarding the Hospital Facility's AGB percentage and how the AGB percentages were calculated from a Hospital Facility's financial counselor as provided in Addendum A.

Such notices and summary information shall include a contact number and shall be provided in English, Spanish, and other primary languages spoken by the population served by an individual Hospital Facility, as applicable.

Referral of patients for Financial Assistance may be made by any member of the CommonSpirit Hospital Organization non-medical or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

CommonSpirit Hospital Organizations will provide financial counseling to patients about their bills related to EMCare and will make the availability of such counseling known. It is the responsibility of the patient or the patient's Guarantor to schedule consultations regarding the availability of Financial Assistance with a financial counselor.

A provider listing will be published by each CommonSpirit Hospital Facility on its website, on or before July 1, 2021, and will be updated by management periodically (but no less than quarterly) thereafter.

ACTIONS IN THE EVENT OF NONPAYMENT

The actions a CommonSpirit Hospital Organization may take in the event of nonpayment with respect to each Hospital Facility are described in a separate policy, CommonSpirit Governance Policy Finance G-004, *Billing and Collections*. Members of the public may obtain a free copy of this Policy by contacting the Hospital Facility Patient Access/Admitting department, as provided in Addendum A.

APPLICATION OF PROCEDURES

CommonSpirit Revenue Cycle leadership is responsible for the implementation of this Policy.

ATTACHMENTS

Financial Assistance Application (FAA)

REFERENCES

CommonSpirit Governance Policy	Finance G-004, *Billing and Collections*

ASSOCIATED DOCU□ENTS

CommonSpirit Governance Addendum	Finance G-003A-1, *Financial Assistance - California*
CommonSpirit Governance Addendum	Finance G-003A-2, *Financial Assistance - Oregon*
CommonSpirit Governance Addendum	Finance G-003A-3, *Financial Assistance - Washington*
CommonSpirit Governance Addendum	Finance G-003A-A, *Hospital Facility Financial Assistance Contact Information Addendum Template*

ANNUAL APPROVAL

APPROVED □Y COMMONSPIRIT HEA□TH □OARD: March 17, 2021

CO□ □ONSPIRIT HEALTH
□OVERNANCE POLICY

SUB□ECT: □illing and Collections	**EFFECTIVE DATE:** July 1, 2022
POLICY NU□BER: Finance G-004	**ORI□INAL EFFECTIVE DATE:** July 1, 2021

POLICY

The purpose of this Policy is to provide clear and consistent guidelines for conducting billing, collections, and recovery functions in a manner that promotes compliance with Internal Revenue Code (IRC) Section 501(r) and applicable collection laws and regulations, patient satisfaction, and efficiency. This Policy outlines the circumstances under which Hospital Facilities will undertake collections actions on delin□uent patient accounts related to the provision of Emergency Medical Care and Medically Necessary Care (herein referred to as EMCare) and identifies Permissible Collections Activities. This Policy describes the actions that a Hospital Facility may take to obtain payment of a bill for EMCare in the event of non-payment, including, but not limited to, any permissible collection actions.

SCOPE

This Policy applies to CommonSpirit Health and each of its tax-exempt Direct Affiliates[1] and tax-exempt Subsidiaries[2] that operate a Hospital Facility (referred to individually as a CommonSpirit Hospital Organization and collectively as CommonSpirit Hospital Organizations). It is the policy of CommonSpirit to follow the highest standards of ethics and integrity in their conduct of collections and recovery activities and to follow collections protocols for the fair treatment to all CommonSpirit Hospital Organizations patients at each Hospital Facility.

PRINCIPLES

After CommonSpirit Hospital Organization patients have received services, Hospital Facilities will bill patients/Guarantors and applicable payers accurately and in a timely manner. During this billing and collections process, staff will provide □uality customer service and timely follow-up, and all outstanding accounts will be handled in accordance with all applicable laws and regulations. In addition, CommonSpirit values re□uire that all individuals be treated with

1 A Direct Affiliate is any corporation of which CommonSpirit Health is the sole corporate member or sole shareholder, as well as Dignity Community Care, a Colorado nonprofit corporation.

2 A Subsidiary refers to either an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint fifty percent (50□) or more of the voting members of the governing body of such organization or holds fifty percent (50□) or more of the voting rights in such organization (as evidenced by membership powers or securities conferring certain decision-making authority on the Direct Affiliate) or any organization in which a Subsidiary holds such power or voting rights.

reverence and compassion. CommonSpirit has defined certain collections actions to be in conflict with CommonSpirit's organizational values and have prohibited their use at any time.

APPLICATION

A. This Policy applies to:

- All charges for EMCare provided in a Hospital Facility by a CommonSpirit Hospital Organization.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a CommonSpirit Hospital Organization, to the extent such care is provided within a Hospital Facility.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a Substantially-Related Entity that occurs within a Hospital Facility.
- Non-covered Medically Necessary Care provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit or in circumstances where the patient's benefits have been exhausted.
- Any collection and recovery activities conducted by the Hospital Facility or a designated supplier of billing and collections services (Designated Supplier), or its third-party collection agents of a Hospital Organization to collect amounts owed for EMCare described above. All third-party agreements governing such collection and recovery activities must include a provision re□uiring compliance with this Policy and indemnification for failures as a result of its noncompliance. This includes, but is not limited to, agreements between third-parties who subse□uently sell or refer debt of the Hospital Facility.

□. **Coordination with other laws**

The provision of Financial Assistance and billing and collection of patient accounts may now or in the future be sub□ect to additional regulation pursuant to federal, state, or local laws. Such law governs to the extent it imposes more stringent re□uirements than this Policy. In the event that a subse□uently adopted state or local law directly conflicts with this Policy, the CommonSpirit Hospital Organization shall, after consultation with its local CommonSpirit □egal Team representative, CommonSpirit Revenue Cycle leadership and CommonSpirit Tax leadership, be permitted to adopt an addendum to this Policy before the next policy review cycle, with such minimal changes to this Policy as are necessary to achieve compliance with any applicable laws.

PRINCIPLES

Through the use of billing statements, written correspondence, and phone calls, CommonSpirit Hospital Organizations will make diligent efforts to inform patients/Guarantors of their financial responsibilities and available Financial Assistance options, as well as follow up with patients/Guarantors regarding outstanding accounts. As Catholic health care providers, CommonSpirit Hospital Organizations are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for the services provided.

Finally, CommonSpirit Hospital Organizations are designated as charitable (i.e., tax-exempt) organizations under IRC Section 501(c)(3). Pursuant to IRC Section 501(r), among other

things, in order to remain tax-exempt, each CommonSpirit Hospital Organization must do the following with respect to patients receiving EMCare at any Hospital Facility:

- □imit the amounts individuals eligible for Financial Assistance are charged for EMCare to not more than the Amounts Generally □illed (AG□) to individuals who have insurance covering such Care□
- □ill less than gross charges to individuals eligible for Financial Assistance for all other medical care□and
- Not engage in Extraordinary Collections Actions before the Hospital Facility has made reasonable efforts to determine whether the individual is eligible for assistance under CommonSpirit Governance Policy Finance G-003, *Financial Assistance.*

DEFINITIONS

Amounts □enerally Billed □A□B□means the maximum charge a patient who is eligible for Financial Assistance under this Financial Assistance Policy is personally responsible for paying, after all deductions and discounts (including discounts available under this Policy) have been applied and less any amounts reimbursed by insurers. No patient eligible for Financial Assistance will be charged more than the AG□ for EMCare provided to the patient. CommonSpirit calculates the AG□ on a Facility-by-Facility basis using the "lookback" method by multiplying the "Gross Charges" for any EMCare that it provides by AG□ percentages, which are based upon past claims allowed under Medicare and private insurance as set forth in federal law. "Gross Charges" for these purposes means the amount listed on each Hospital Facility's chargemaster for each EMCare service.

Application Period means the time provided to patients by the CommonSpirit Hospital Organization to complete the Financial Assistance application. It expires on the later of (i) 365 days from the patient's discharge from the Hospital Facility or the date of the patient's EMCare, or (ii) 240 days from the date of the initial post-discharge bill for the EMCare received at a Hospital Facility.

Emergency □edical Care, E□TALA □Any patient seeking care for an emergency medical condition within the meaning of Section 1867 of the Social Security Act (42 □.S.C. 13□5dd) at a Hospital Facility shall be treated without discrimination and without regard to a patient's ability to pay for care. Furthermore, any action that discourages patients from seeking EMCare, including, but not limited to, demanding payment before treatment or permitting debt collection and recovery activities that interfere with the provision of EMCare, is prohibited. Hospital Facilities shall also operate in accordance with all federal and state re□uirements for the provision of care relating to emergency medical conditions, including screening, treatment and transfer re□uirements under the federal Emergency Medical Treatment and □abor Act (EMTA□A) and in accordance with 42 CFR 482.55 (or any successor regulation). Hospital Facilities should consult and be guided by any CommonSpirit EMTA□A Policy, EMTA□A regulations, and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an emergency medical condition and the processes to be followed with respect to each.

Extraordinary Collection Actions □ECAs□□The Hospital Facility will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under the Hospital Facility's FAP. An ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

- Selling an individual's debt to another party except as expressly provided by federal law□and
- Reporting adverse information about the individual to consumer credit bureaus.

ECAs do not include any lien that a Hospital Facility is entitled to assert under state law on the proceeds of a □udgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal in□uries for which the Facility provided care.

Financial Assistance means assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare provided in a Hospital Facility and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Financial Assistance Policy □FAP□ means CommonSpirit Governance Policy Finance G-003, *Financial Assistance*, which describes CommonSpirit's Financial Assistance program, including the criteria patients/Guarantors must meet in order to be eligible for Financial Assistance as well as the process by which individuals may apply for Financial Assistance.

□**uarantor** means an individual who is legally responsible for payment of the patient's bill.

Hospital Facility □or Facility□ means a healthcare facility that is re□uired by a state to be licensed, registered, or similarly recognized as a hospital and that is operated by a CommonSpirit Hospital Organization. In reference to the performance of billing and collection activities, the term "Hospital Facility" may also include a Designated Supplier.

□**edically Necessary Care** means any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, in□ury or disease that endangers life, cause suffering or pain, results in illness or infirmity, threatens to cause or aggravate a handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no other e□ually effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures only to improve aesthetic appeal of a normal, or normally functioning, body part.

Notification Period means the 120-day period beginning on the date the Hospital Facility provides the first post-discharge billing statement for the EMCare. A Facility will refrain from engaging in an ECA during the Notification Period, unless reasonable efforts have been made to determine a patient is eligible for Financial Assistance.

Operates a Hospital Facility - A Hospital Facility is considered to be operated either by use of its own employees or by contracting out the operation of the Facility to another organization. A Hospital Facility may also be operated by a CommonSpirit Hospital Organization if the CommonSpirit Hospital Organization has a capital or profits interest in an entity taxed as a partnership which directly operates a state licensed Hospital Facility or which indirectly operates a state licensed Hospital Facility through another entity taxed as a partnership.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publicly available information. A determination that a patient is presumptively eligible for Financial Assistance will result in free or discounted EMCare for the period during which the individual

is presumptively eligible. See also Presumptive Eligibility in CommonSpirit Governance Policy Finance G-003, *Financial Assistance.*

Substantially Related Entity means, with respect to a CommonSpirit Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides EMCare in a state licensed Hospital Facility, unless the provision of such care is an unrelated trade or business described in IRC Section 513 with respect to the Hospital Organization.

Suspending ECAs when a Financial Assistance Application (FAA) is Submitted means a Facility (or other authorized party) does not initiate an ECA, or take further action on any previously initiated ECAs, to obtain payment for the EMCare until either:

- The Facility has determined whether the individual is FAP-eligible based on a complete FAP application and met the reasonable efforts requirement, as defined herein, with respect to a completed FAA; or
- In the case of an incomplete FAA, the individual has failed to respond to requests for additional information or documentation within a reasonable period of time (thirty (30) days) given to respond to such requests.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and TRICARE), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare covered by this Policy.

BILLING PRACTICES

CommonSpirit Hospital Organizations will follow standard procedures in collecting on accounts related to EMCare provided at a CommonSpirit Hospital Facility as follows:

A. Insurance Billing

- For all insured patients, Hospital Facilities will bill applicable third-party payers (based on information provided or verified by the patient/Guarantor, or appropriately verified from other sources) in a timely manner.
- If an otherwise valid claim is denied (or not processed) by the payer due to an error by a Hospital Facility, the Hospital Facility will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
- If an otherwise valid claim is denied (or not processed) by a payer due to factors outside of the Hospital Facility's control, staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable follow-up efforts, Hospital Facilities may bill the patient or take other actions consistent with payer contracts.

B. Patient Billing

- All patients/Guarantors will be billed directly and timely and receive a statement as part of the Hospital Facility's normal billing process.
- For insured patients, after claims have been processed by all available third-party payers, Hospital Facilities will bill patients/Guarantors in a timely manner for their respective liability amounts as determined by their insurance benefits.
- All patients/Guarantors may at any time re□uest, and the Hospital Facility will provide, an itemized statement for their accounts.
- If a patient disputes his or her account and re□uests documentation regarding the bill, staff will provide the re□uested documentation in writing within ten (10) days (if possible) and will hold the account for at least thirty (30) days before referring the account for collection.
- Hospital Facilities shall approve payment plan arrangements for patients/Guarantors who indicate they may have difficulty paying their balance in a single installment.
- Revenue Cycle leadership has the authority to make exceptions to this provision on a case-by-case basis for special circumstances (in accordance with operating procedures).
- Hospital Facilities are not re□uired to accept patient-initiated payment arrangements and may refer accounts to a third-party collection agency as outlined below if the patient defaults on an established payment plan.

C. Collection Practices

- Any collection activities conducted by the Facility, a Designated Supplier, or its third-party collection agents will be in conformance with all federal and state laws governing debt collection practices.

- All patients/Guarantors will have the opportunity to contact the Hospital Facility regarding Financial Assistance, payment plan options, and other applicable programs that may be available with respect to their accounts, as provided in Addendum A.
  - A Hospital Facility's FAP is available free of charge.
  - Individuals with questions regarding a Hospital Facility's FAP may contact the financial counseling office by phone or in person.
- In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Policy, Hospital Facilities may engage in collection activities, including Permissible ECAs, to collect outstanding patient balances.
  - General collection activities may include phone calls, statements, and other reasonable efforts in accordance with standard industry practices.
  - Patient balances may be referred to a third-party for collection at the discretion of the Facility and in compliance with all applicable federal, state, and local non-discrimination practices. The Facility will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:
    - There is a reasonable basis to believe the patient owes the debt.
    - All third-party payers identified by the patient/Guarantor in a prompt and timely manner that have been properly billed, and the remaining debt is the financial responsibility of the patient. Hospital Facilities shall not bill a patient for any amount the insurance company or a third-party is obligated to pay.
    - Hospital Facilities will not refer accounts for collection while a claim on the account is pending payment from a third-party payer. However, claims which remain in "pending" status with a third-party payer for an unreasonable length of time despite efforts to facilitate resolution may be re-classified as "denied."

- Hospital Facilities will not refer accounts for collection when the insurance claim was denied due to a Hospital Facility error. However, a Hospital Facility may still refer the patient liability portion of such claims for collection if unpaid.
- Hospital Facilities will not refer accounts for collection where the patient has initially applied for Financial Assistance, and the Hospital Facility has not yet made reasonable efforts (as defined below) with respect to the account.
- □pon receipt of a notice of □ankruptcy Discharge, CommonSpirit Hospital Organizations will cease all collection attempts, including assignment to a collection agency. The patient/debtor will not be contacted by any method, including phone calls, letters, or statements after receipt of the notification. All communication, if necessary, must occur with the trustee or the attorney assigned to the case.
  - No Facility shall send any unpaid self-pay account to a third-party collection agent as long as the patient or Guarantor is engaged in Patient Cooperation Standards, as defined in CommonSpirit Governance Policy Finance G-003, *Financial Assistance*.

REASONABLE EFFORTS AND E□TRAORDINARY COLLECTION ACTIONS

□efore engaging in ECAs to obtain payment for EMCare, Hospital Facilities must make reasonable efforts to determine whether an individual is eligible for Financial Assistance. In no event will an ECA be initiated prior to 120 days (or longer, if re□uired by applicable law) from the date the Facility provides the first post-discharge billing statement (i.e., during the Notification Period) unless all reasonable efforts have been made. The following scenarios describe the reasonable efforts that a Facility must take before engaging in ECAs.

A. Engaging in ECAs – Notification Re□uirement

- With respect to any EMCare provided in the Facility, a patient must be notified about the FAP as described herein, prior to initiating an ECA. The notification re□uirement is as follows:
  - **Notification Letter** □ The Hospital Facility will notify a patient about the FAP by providing the individual with a written notice (Notification □etter) at least thirty (30) days prior to initiating an ECA. The Notification □etter must:
    - Include a plain language summary of the FAP□
    - Indicate Financial Assistance is available for eligible individuals□and
    - Identify the ECA(s) that the Hospital Facility (or other authorized party) intends to initiate to obtain payment for the EMCare if the amount due is not paid or an FAA is not submitted before a specified deadline, which is no earlier than the last day of the Application Period.
  - **Oral Notification** □ In con□unction with the provision of the Notification □etter, the Hospital Facility will attempt to orally notify the patient about how to obtain assistance under the FAP during the registration process, using the most current telephone number provided by the patient. This attempt will be documented contemporaneously.
  - **Notification in the Event of □ultiple Episodes of Care** - The Hospital Facility may satisfy this notification re□uirement simultaneously for multiple episodes of EMCare and notify the individual about the ECAs the Facility intends to initiate to obtain payment for multiple outstanding bills for EMCare. However, if a Facility aggregates an individual's outstanding bills for multiple episodes of EMCare before initiating one or more ECAs to obtain payment for those bills, it will have not have made reasonable efforts to determine whether the individual is FAP-eligible unless it refrains from initiating the ECA(s) until 120 days after the first post-discharge billing statement for the most recent episode of EMCare included in the aggregation.

B. Reasonable Efforts when a Patient Submits an Incomplete FAA

- The Hospital Facility will suspend any ECAs already initiated against the patient/Guarantor until Financial Assistance eligibility has been determined.
- The Hospital Facility will provide a written notification to the patient with a list of re□uired documentation the patient or Guarantor must provide to consider the FAA complete and give the patient thirty (30) days to provide the necessary information. The notification will include the contact information, including telephone number and physical location of the Facility or department within the Facility that can provide information about and assist with the preparation of the FAP.

C. Reasonable Efforts when a Completed FAA Is Submitted

- If a patient submits a completed FAA during the Application Period, the Hospital Facility must:
  - Suspend any ECAs to obtain payment for the EMCare.
  - Make a determination as to whether the individual is FAP-eligible for the EMCare and notify the individual in writing of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.
  - If the Hospital Facility determines the individual is FAP-eligible for the EMCare, the Hospital Facility must do the following:
    - Refund the individual any amount he or she has paid for the EMCare (whether to the Hospital Facility or any other party to whom the Hospital Facility has referred or sold the individual's debt for the EMCare) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual.
    - Take all reasonably available measures to reverse any ECA, including the removal of any adverse information that was reported to a consumer reporting agency or credit bureau from the individual's credit report.
  - If the Hospital Facility determines the individual is not FAP-eligible for the EMCare, the Facility will have made reasonable efforts and may engage in the Permissible ECAs.

D. Reasonable Efforts when No FAA Is Submitted within ninety □90□days after the First Post□Discharge Billing Statement for the □ost Recent Episode of E□ Care

- The Facility will issue the Notification □etter as described under Reasonable Efforts – Engaging in ECAs – Notification Re□uirement. If no FAA is received within thirty (30) days after the Notification □etter has been sent, the re□uirement to engage in reasonable efforts to determine FAP-eligibility will have been satisfied. Thus, the Hospital Facility may engage in ECAs that are permitted under this Policy beginning 120 days after the first post-discharge billing statement.
- **Waiver** - □nder no circumstances will a Hospital Facility accept from any individual a waiver, whether oral or written, that an individual does not wish to apply for Financial Assistance, for the purpose of satisfying the re□uirements to engage in reasonable efforts described in this Policy.

E. Permissible Extraordinary Collections Actions

● After making reasonable efforts, which includes the notification re□uirement, to determine Financial Assistance eligibility as outlined above, a Hospital Facility (or other authorized party) may engage in the following ECAs to obtain payment for EMCare:
○ Selling an individual's debt to another party except as expressly provided by federal law□and
○ Reporting adverse information about the individual to consumer credit bureaus.

A Hospital Facility will refrain from ECAs against a patient if he or she provides documentation that he or she has applied for health care coverage under Medicaid, or other publicly-sponsored healthcare programs, unless or until the individual's eligibility for such programs has been determined and any available coverage from third parties for the EMCare has been billed and processed.

F. Reasonable Efforts □Third□Party Agreements

● With respect to any sale or referral of an individual's debt related to EMCare to another party (except for those debt sales not considered an ECA as described in the Internal Revenue Service Treasury Regulations) the Hospital Facility will enter into and, to the extent applicable, enforce a legally binding written agreement with the party. To meet the re□uirement to engage in reasonable efforts to determine an individual's FAP-eligibility, these agreements must, at a minimum, include the following provisions:
○ If the individual submits an FAA (whether complete or incomplete) after the referral or sale of the debt but before the end of the Application Period, the party will Suspend ECAs to obtain payment for the EMCare.
○ If the individual submits an FAA (whether complete or incomplete) after the referral or sale of the debt but before the end of the Application Period and is determined to be FAP-eligible for the EMCare, the party will do the following in a timely manner:
▪ Adhere to procedures specified in the agreement and this Policy so that the individual does not pay, and has no obligation to pay, the party and the Hospital Facility together more than he or she is re□uired to pay for the EMCare as a FAP-eligible individual.
▪ If applicable, and if the party (rather than the Hospital Facility) has the authority to do so, take all reasonably available measures to reverse any ECA (other than the sale of a debt) taken against the individual.
○ If the third-party contractor refers or sells the debt to a subse□uent party (the fourth party) during the Application Period, the third-party will obtain a written agreement from that subse□uent party including all the elements described under this section.
○ The third-party contractor must make reasonable attempts to work with a patient with unpaid bills to resolve his/her account. Aggressive or unethical collection practices are not tolerated.

□. Reasonable Efforts – Providing Documents Electronically

● A Hospital Facility may provide any written notice or communication described herein electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.

FINANCIAL ASSISTANCE DOCU□ENTATION

A. Processing Re□uests

- CommonSpirit's values of human dignity and stewardship shall be reflected in the application process, financial need determination, and granting of assistance.
- Re□uests for Financial Assistance shall be processed promptly, and Hospital Facilities shall notify the patient or applicant in writing within thirty (30) to sixty (60) days of receipt of a completed application.
- A Hospital Facility will not make a determination of eligibility on information it has reason to believe is false or unreliable or obtained through the use of coercive practices.
- If eligibility is approved based on the completion of an FAA, the patient will be granted Financial Assistance for all eligible accounts incurred for services received twelve (12) months prior to the determination date and prospectively for a period of six (6) months from the determination date.
- If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services received twelve (12) months prior to the determination date. The Presumptively Eligible individual will not receive Financial Assistance for EMCare rendered after the date of determination without completion of an FAA or a new determination of Presumptive Eligibility.
- If denied eligibility for Financial Assistance offered by a Hospital Facility, a patient or Guarantor, may re-apply whenever there has been a material change of income or status.
- Patients/Guarantors may seek a review from a Hospital Facility in the event of a dispute over the application of this Policy or the FAP. Patients/Guarantors denied Financial Assistance may also appeal their eligibility determination, as provided in Addendum A.
- The basis for the dispute or appeal should be in writing and submitted within three (3) months of the decision on Financial Assistance eligibility.
- The Hospital Facility will postpone any determination of FAP eligibility because the Hospital Facility is awaiting the results of a Medicaid application.

B. Presumptive Financial Assistance

- Reasonable efforts to determine FAP-eligibility are not re□uired when an individual is determined eligible for Presumptive Financial Assistance.
- □**edicaid** - Medicaid patients who receive non-covered medically necessary services will be considered for Presumptive Financial Assistance. Financial assistance may be approved in instances prior to the Medicaid effective date.

RESPONSIBILITY

CommonSpirit Revenue Cycle leadership is ultimately responsible for determining whether a Hospital Facility has made reasonable efforts to determine whether an individual is eligible for Financial Assistance. This body also has final authority in deciding whether the Hospital Organization may proceed with any of the ECAs outlined in this Policy.

REFERENCES

CommonSpirit Governance Policy Finance G-003, *Financial Assistance*

ANNUAL APPROVAL

APPROVED □Y THE COMMONSPIRIT HEA□TH □OARD: March 17, 2021

Current Status: *Active*		**PolicyStat ID:** *10140760*
All Policies Site - CHI Franciscan Health System	**Origination:**	*06/1996*
	Effective:	*07/2021*
	Last Approved:	*07/2021*
	Last Revised:	*06/2018*
	Next Review:	*07/2024*
	Owner:	*Kathryn McKee: Division Director Accreditation/Safety*
	Policy Area:	*General Governance*
	References:	*Administrative*
	Applicability:	*CHI Franciscan Systemwide*

Nondiscrimination Policy, 3□0.00

POLICY

As a recipient of Federal financial assistance, CHI Franciscan Health (CHI Franciscan) is dedicated to providing services to patients and welcoming visitors in a manner that respects, protects, and promotes patient rights. CHI Franciscan does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of age, race, color, creed, national origin, ethnicity, religion, marital status, sex, sexual orientation, gender identity or expression, physical , mental or other disability, citizenship, medical condition, or any other basis prohibited by federal, state, or local law in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CHI Franciscan directly or through a contractor or any other entity with which CHI Franciscan arranges to carry out its programs and activities.

SUPPORTIVE DATA:

- Service Animals #104.50
- Patient Rights/Responsibilities Policy #390.00
- Grievance Policy #320.00
- Interpreter Services/Communication Aid Policy #721.50
- Interpreter services https://chifh.catholichealth.net/Comm/is/Pages/default.aspx

PROCEDURE

State and federal laws and CHI Franciscan policy prohibit retaliation in any form against any person who has filed a discrimination complaint or assisted in the investigation of a discrimination complaint.

A. **Notice of Program Accessibility**
In compliance with Section 504 of regulation 45 C.F.R. 84.22(f) and Section 1557 of regulation 45 C.F.R.92., CHI Franciscan has implemented procedures to ensure that interested persons, including those with impaired vision or hearing can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons.
CHI Franciscan facilities and all its programs and activities are accessible to and useable by individuals with limited English proficiency (LEP) and by individuals with disabilities, including those who are deaf, hard of hearing, or blind, or who have other sensory impairments. Access features include, but are not limited to:

- Convenient off-street parking designated for disabled persons

- Curb cuts and ramps between parking areas and buildings
- Level access into first floor level with elevator access to all other floors; automatic doors
- Fully accessible offices , meeting rooms, bathrooms, public waiting rooms, cafeteria, patient treatment areas including examination and patient rooms.
- A range of assistive devices and communication aids available to persons who are deaf, hard of hearing, or blind, or have other sensory impairments. There is no additional charge for such aids.
- Qualified sign language interpreters for persons who are deaf or hard of hearing
- A 24 hour telecommunication device (TTY/TDD), which can connect the caller to all extensions within the facility and/or portable (TTY/TTD) units, for use by individuals who are deaf, hard of hearing or speech impaired.
- Communication boards/note pads
- Assistive devices for person with impaired manual skills
- Qualified language interpreters for persons with LEP
  Each facility/program is required to identify the aids available within their internal procedures. Any patient requiring an available aid should inform the admitting staff of his/her special need(s). CHI Franciscan will provide notice during registration of services available at no charge.

B. **Auxiliary Aids and Services for Individuals with Disabilities**
CHI Franciscan will take appropriate steps to ensure that individuals with LEP and individuals with disabilities, including those who are deaf, hard of hearing, or blind or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures are intended to ensure effective communication with patients involving their medical conditions, treatments, services and benefits. The procedures also apply to, at minimum, communication of information contained in important documents, including consent to treatment forms, conditions of admission forms, and financial and insurance benefits forms. All necessary auxiliary aids and services shall be provided without cost to the individual(s) being served.
CHI Franciscan will provide written notice of these patient rights during registration. Refer to Patient Rights/Responsibilities Policy. Staff that may have direct contact with individuals with LEP and individuals with disabilities will be trained in effective communication techniques, including the effective use and access to interpreters, aids, and services.
Procedures:

1. **Identification and Assessment of Needs**
   CHI Franciscan will provide notice of the availability of, contact information, and the procedure for requesting auxiliary aids and services, through notices posted, at minimum in main facility entrances, emergency entrances, and patient care registration entrances. When individuals self-identify as a person with LEP or with a disability that affects the ability to communicate or to access or manipulate written materials, or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in specific situations. Inpatients are screened on admission for barriers to communication.
2. **Provision of Auxiliary Aids and Services**
   CHI Franciscan shall provide the following services or aids to achieve effective communication with individuals with disabilities:
   a. **For Persons Who Are Deaf or Hard of Hearing (Hearing Impaired)**

- For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the facility/program staff handling intake/registration or the clinician as appropriate, is responsible for arranging for a qualified interpreter when needed. Refer to Policy #721.50 Interpreter Services/Communication Aid Policy
- Communicating by Telephone with Persons Who Are Deaf or Hard of Hearing. CHI Franciscan utilizes a 24 hour telecommunication device for deaf persons (TDDs) and relay services for external telephone with TTY users. We accept and make calls through a relay service.
- Other possible methods of communication may include, but are not limited to: Note-takers; computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunications devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.
- Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. Family members or friends of the person will not be used as interpreters unless specifically requested by that individual, and after an offer of an interpreter at no charge to the person has been made by the facility. **Such an offer and the response will be documented in the person□s medical record**. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.
- NOTE: Children will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

b. **For Persons Who are Blind or Who Have Low Vision**

- Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
- Other possible methods of communication may include, but are not limited to: qualified readers; reformatting into large print; taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

c. **For Persons With Speech Impairments**

- To ensure effective communication with persons with speech impairments, staff may utilize written materials; TDDs; computers; flashcards; alphabet boards; and other communication aids.

d. **For Persons With □anual Impairments**

- Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following:

- Note-takers; computer-aided transcription services; speaker phones; or other effective methods that help to ensure effective communication by individuals with manual impairments.

e. **Communication with Persons with LEP**

- CHI Franciscan will take reasonable steps to ensure that persons with LEP have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of CHI Franciscan is to ensure that each of its facilities, services and programs provides meaningful communication with LEP patients/ clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. Interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served. Patients/clients and their families will be informed of the availability of free of charge assistance at point of facility or program access.
- Language assistance will be provided at each of the CHI Franciscan facilities/programs, and may include use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations and state agencies providing interpretation or translation services, or technology and telephonic interpretation services. Each facility and program is responsible for defining the language assistance methods available to patients and clients and are responsible for ensuring staff is provided notice of its internal policies and procedures. Staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.
- CHI Franciscan will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of and adherence to this policy within the organization.
- Maintain an accurate and current listing of outside interpreter services who have agreed to provide qualified interpreter services for facility/program patients. See Language Interpreter Services Form. These listings may be obtained on the CHI Franciscan intranet/ departments/interpretive services, or Interpreter Services/Comminication Aid Policy #721.50. Some LEP persons may prefer or request to use a family member or friend as an interpreter. Family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter, at no charge to the person, has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.
  Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.
- **Providing Notice to LEP Persons**
  Each facility or program will post notices and signs in languages LEP persons understand informing them of the availability of language assistance, free of charge. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry,

including but not limited to main admitting, the emergency room and outpatient areas. **Refer to Addendum A: Notice of Interpreter Services**

- **□onitoring Language Needs and Implementation**
  CHI Franciscan will periodically assess changes in demographics, types of services or other needs that may require reevaluation of the LEP policy and its supporting procedures. The efficacy of the procedures will be regularly assessed. The assessment is inclusive of, but not limited to, mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients, staff, and community organizations. Each facility or program within CHI Franciscan will set benchmarks for translation of vital documents into additional languages over time.

◦ Refer to Interpreter Services/Commincation Aid Policy #721.50

C. **Regional and Hospital Section □0□ and Section □□□□ Coordination**
CHI Franciscan facility administration designates a Section 504 and Section 1557 Coordinator for each hospital who is responsible for assuring compliance oversight for non-discrimination requirements. This includes maintenance of an accurate and current list of the contacts, compliance with current policies/ standards, relevant staff training, and signage/communication compliance. The Emergency Department Patient Access representative is designated for each CHI Franciscan facility to serve as the local point of contact for language services and aids. The Patient Advocate is responsible for an effective grievance process relating to nondiscrimination issues and can be contacted at 1-877-426-4701 or via mail to the hospital's administration office.

D. **Section □0□Section □□□□ □rievance Procedure**
All CHI Franciscan facilities/programs have an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any discrimination. Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure.
Procedure:

◦ Grievances must be submitted to the patient advocate or designee within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

◦ Grievances may be confidentially submitted to the patient advocate or designee in writing or by calling the CHI Franciscan Concern Line and must include the name and address of the person filing the grievance. The grievance must state the problem or action alleged to be discriminatory and the remedy or relief sought.

◦ The patient advocate or designee will coordinate an investigation of the grievance. This investigation must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The patient advocate or designee will retain grievance investigation findings, files, and records for CHI Franciscan facilities/programs.

◦ The patient advocate or designee will issue a written decision on the grievance no later than 30 days after its filing.

◦ The person filing the grievance may appeal the grievance decision with the patient advocate supervisor by writing to the hospital administration office within 15 days of receiving the grievance letter of response.

◦ The patient advocate supervisor will issue a written decision in response to the appeal no later than 30 days after its filing.

◦ The availability of each a facility or program grievance procedure does not prevent a person from

filing a complaint of discrimination on the basis of disability with the US Department of Health and Human Services, Office for Civil Rights.

The patient advocate will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The patient advocate or designee will be responsible for such arrangements.

Any patient who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under the hospital grievance policy and has the right to file a civil rights complaint with the U.S. Department of health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, and at:

U.S. Department of health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

E. **Accessibility Signage**

The hospital will maintain in operable working condition those features of facilities and equipment that are required to be readily accessible to and usable by individuals with disabilities. Problems with such equipment should be reported immediately to the site Patient Access Services.

REFERENCES

- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- Age Discrimination Act of 1975
- Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 code of Federal Regulations Parts 80, 84, and 91
- Ethical and Religious Directives for Catholic Health Services
- Section 1557 of the Affordable Care Act

REQUIRED REVIEW:

RISK, PATIENT ACCESS, LEGAL, REGULATORY

Attachments

b64_6b5cf7b9-0bb7-4d6f-8dea-03292c31532a

Approval Signatures

Approver	Date
Gillian Payne: Document Control Coordinator	07/2021
Kathryn McKee: Division Director Accreditation/Safety	07/2021

Applicability

CHI Franciscan Health, Franciscan System Services, St. Anne Hospital, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center, St. Michael Medical Center

Current Status: *Active*			**PolicyStat ID:** *8186343*
	Origination:		*03/2014*
	Effective:		*06/2020*
	Last Approved:		*06/2020*
	Last Revised:		*06/2020*
	Next Review:		*06/2023*
All Policies Site - CHI Franciscan Health System	**Owner:**	*Rose Shandrow: Div Director Mission*	
	Policy Area:	*Corporate Ethics/Privacy*	
	References:	*Administrative*	
	Applicability:	*CHI Franciscan Systemwide*	

End of Life, 044.00

PURPOSE

Provide guidance and support for our system policy on respect of life.

POLICY STATEMENTS

It is the policy of all CHI Franciscan Health System hospitals that all services rendered in our facilities shall be supportive of life. The hospital's goal is to help patients make informed decisions about end of life care without the hospital actively participating in the provisions associated with the Death with Dignity Act.
It is the policy of each hospital to provide tools and support to a patient and their family that improves their quality of life when facing the problems associated with life threatening illness.

At no time may direct actions to terminate life be performed or permitted within CHI Franciscan Health System hospitals and clinics.

Extraordinary means to sustain life need not be utilized when death appears to be imminent and inevitable.

PATIENT AND FAMILY SUPPORT

Access to Spiritual Care Services, Hospice Care and Palliative Medical Services are available within CHI Franciscan facilities to support the quality of end of life.
Upon request, the hospital will provide each adult patient with information about their rights under Washington (WA) state law to make decision concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. The hospital policy of accepting the patient's or his/her surrogate decision-maker's decision concerning life-sustaining treatment **does not** include assisted suicide or euthanasia.
Initiating Ethics Committee Consults, may be requested to advise on policy statements and guidelines for decision-making where ethical considerations are involved. Medical Staff, staff and family/surrogate decision makers may request a consult.

REQUIRED REVIEW

Senior Vice President of Mission

Attachments

No Attachments

Approval Signatures

Approver	Date
Joan VanSickle: Document Control Coordinator	06/2020
Rose Shandrow: Div Director Mission	06/2020

Applicability

CHI Franciscan Health, Harrison Medical Center, Highline Medical Center, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center

Current Status: *Active*		**PolicyStat ID:** *10586953*
All Policies Site - CHI Franciscan Health System	**Origination:**	*03/2014*
	Effective:	*10/2021*
	Last Approved:	*10/2021*
	Last Revised:	*07/2018*
	Next Review:	*10/2024*
	Owner:	*Rose Shandrow: Chief Mission Officer*
	Policy Area:	*Corporate Ethics/Privacy*
	References:	
	Applicability:	*CHI Franciscan Systemwide*

Reproductive Healthcare, 392.00

PURPOSE

Provide general guidance in the area of reproductive health care.

POLICY

Formulation of policy and practice are consistent with the Franciscan Health System mission to protect human life and respect human dignity.

It is the policy of Franciscan Health System that all services rendered in our hospitals shall be supportive of life. At no time may direct actions to terminate life be performed or permitted.

Medical Staff, staff, and family/surrogate decision-makers may consult with the CHI FH Ethics Committee to advise on policy for decision-making where ethical considerations involving reproductive health care might need additional guidance. See: Initiating Ethics Consult Policy, #370.00.

For hospitals with Emergency Departments: Franciscan Health System supports the hospital's obligations under WAC 246-320-370 for emergency contraception provisions for sexual assault victims. The Emergency Department (ED) must provide emergency contraception as a treatment option to any woman who seeks treatment as a result of a sexual assault. The Emergency Department provider must provide each patient with medically and factually accurate and unbiased written and oral information about emergency contraception. Refer to: Sexual Assault Victims Emergency Contraception Options Policy, #826.75

REQUIRED REVIEW:

Senior Vice President of Mission

DISTRIBUTION:

Regional Administrative Manual

CROSS REFERENCE:

Attachments

No Attachments

Approval Signatures

Approver	Date
Gillian Payne: Document Control Coordinator	10/2021
Rose Shandrow: Div Director Mission	10/2021

Applicability

CHI Franciscan Health, Franciscan System Services, St. Anne Hospital, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center, St. Michael Medical Center

Exhibit 8
King Count Assessor Information

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

- New Search
- Property Tax Bill
- Map This Property
- Glossary of Terms
- Area Report
- Property Detail

PARCEL

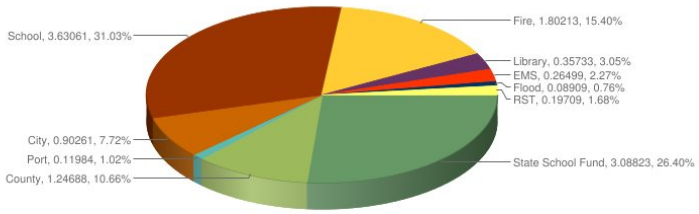
Parcel Number	750451-0020
Name	COMMON SPIRIT HEALTH
Site Address	34515 9TH AVE S 98003
Legal	ST FRANCIS HOSPITAL - BSP AS PER 2ND AMENDMENT UNDER REC # 20010726001843

BUILDING 1

Year Built	1987
Building Net Square Footage	220608
Construction Class	REINFORCED CONCRETE
Building Quality	AVERAGE
Lot Size	235790
Present Use	Hospital
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2021 **Levy Code:** 1205 **Total Levy Rate:** $11.69880 **Total Senior Rate:** $6.34960



50.22% 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 ($)
2021	2022	2,122,100	67,933,700	70,055,800	0	0	0	0
2020	2021	2,122,100	67,486,900	69,609,000	0	0	0	0
2019	2020	2,122,100	67,651,600	69,773,700	0	0	0	0
2018	2019	1,886,300	66,743,700	68,630,000	0	0	0	0
2017	2018	1,886,300	64,303,300	66,189,600	0	0	0	0
2016	2017	1,886,300	65,199,600	67,085,900	0	0	0	0
2015	2016	1,886,300	66,614,600	68,500,900	0	0	0	0
2014	2015	1,886,300	66,432,400	68,318,700	0	0	0	0
2013	2014	1,886,300	64,809,000	66,695,300	0	0	0	0
2012	2013	1,886,300	64,736,100	66,622,400	0	0	0	0
2011	2012	1,886,300	64,545,800	66,432,100	0	0	0	0
2010	2011	1,886,300	60,449,400	62,335,700	23,036,800	0	0	0
2009	2010	1,871,100	37,427,800	39,298,900	0	0	0	0
2008	2009	1,871,100	34,780,800	36,651,900	0	0	0	0
2007	2008	1,871,100	33,768,600	35,639,700	0	0	0	0
2006	2007	935,500	30,938,900	31,874,400	0	0	0	0
2005	2006	877,100	30,403,000	31,280,100	0	0	0	0
2004	2005	877,100	27,466,000	28,343,100	0	0	0	0
2003	2004	877,100	27,329,200	28,206,300	6,951,700	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
- Scanned images of plats

Notice mailing date: 06/24/2021

2002	2003	877,100	17,794,500	18,671,600	3,219,200	0	0	0
2001	2002	814,800	15,029,100	15,843,900	0	0	0	0
2000	2001	841,500	14,595,000	15,436,500	0	0	0	0
1999	2000	841,500	14,059,525	14,901,025	0	0	0	0
1997	1998	0	0	0	0	841,500	13,550,300	14,391,800
1996	1997	0	0	0	0	841,500	13,550,300	14,391,800
1994	1995	0	0	0	0	841,500	13,550,300	14,391,800
1993	1994	0	0	0	0	841,500	13,550,300	14,391,800
1992	1993	0	0	0	0	841,500	12,798,000	13,639,500

Updated: June 24, 2021

Exhibit 9
Facility Listing

Facility Listing

Facility/Agency	Facility Type	Address	Medicare Provider No.	Medicaid Provider No.	Owned/ Managed
St. Joseph Medical Center	Hospital	1717 S. "J" Street Tacoma, WA 98405	50-0108	3309309	Owned
St. Clare Hospital	Hospital	11315 Bridgeport Way SW Lakewood, WA 98499	50-0021	3300258	Owned
St. Francis Hospital	Hospital	34515 9th Avenue S. Federal Way, WA 98003	50-0141	3300118	Owned
Enumclaw Regional Hospital Association dba. St. Elizabeth Hospital	Hospital	1450 Battersby Avenue Enumclaw, WA 98022	50-1335	3310406	Owned
St. Anthony Hospital	Hospital	11567 Canterwood Blvd NW Gig Harbor, WA 98332	50-0151	3300597	Owned
Franciscan Hospice Care Center	Hospital	2901 Bridgeport Way University Place, WA 98467	50-0108	3309309	Owned
Gig Harbor Same Day Surgery	HOPD	6401 Kimball Drive Gig Harbor, WA 98335	50-0108	3309309	Owned
Franciscan Hospice	Hospice	2901 Bridgeport Way University Place, WA 98467	50-1526	3990264	Owned
Highline Medical Center, a non profit Corporation dba. St. Anne Hospital	Hospital	16251 Sylvester Road SW Burien, WA 98166	50-0011 (hospital) 50-1527 (hospice)	1013171 (hospital) 1015012 (home health) 1006162 (hospice)	Owned
Harrison Medical Center, a non profit Corporation dba St. Michael Medical Center	Hospital	1800 NW Myhre Road Silverdale, WA, 98383	50-0039 (hospital) 50-7076 (home health agency)	3303500 (hospital) 9008533 (home health)	Owned
Virginia Mason Franciscan Health Hospital	Hospital	1100 9th Ave Seattle, WA 98101	50-0005	3315009	Owned
Virginia Mason Franciscan Health Bellevue	ASC	11695 NE 4th St Bellevue, WA 98004	8861182	7139595	Owned
Virginia Mason Franciscan Health Issaquah Medical Center (state licensed ASC only)	ASC	100 NE Gilman Blvd Issaquah, WA 98027	120887	7070220	Owned
Virginia Mason Franciscan Health Lynnwood Regional Medical Center (state licensed ASC only)	ASC	19116 33rd Ave W Lynnwood, WA 98036	AB26267	7111172	Owned
Bailey Boushay House Skilled Nursing Facility	Skilled Nursing	2720 E Madison St Seattle, WA 98112	50-5476	4111068	Owned

Source: Applicant

Hospitals that are a joint venture are not included in the above list (Rehabilitation Hospital and Wellfound Behavioral Health Hospital)

Exhibit 10
FTE Table

						After Project Completion						
	Actual 2019	Actual 2020	Actual 2021	Estimated 2022	Estimated 2023	Projected 2024	Projected 2025	Projected 2026	Projected 2027	Projected 2028	Projected 2029	Projected 2030
Nursing												
□ anagement	8.9	□5	□6	□6	□6	8.6	8.6	8.6	8.6	8.6	8.6	8.6
R□	235.0	22□3	238.9	2□2.3	2□5.8	255.3	263.□	2□0.3	2□0.3	2□0.3	2□0.3	2□0.3
□P□	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Patient Care Asst	69.0	□□3	82.3	83.5	8□□	8□9	90.8	93.1	93.1	93.1	93.1	93.1
□ech/Professional	□3	□0	□9	5.0	5.1	5.2	5.□	5.6	5.6	5.6	5.6	5.6
Svc/Support	10.8	8.6	5.9	6.0	6.1	6.3	6.6	6.□	6.□	6.□	6.□	6.□
Ancillary/Support												
□ anagement	□1.6	□1.6	□2.0	□2.0	□2.0	□3.0	□3.0	□3.0	□3.0	□3.0	□3.0	□3.0
R□	169.1	1□9.□	220.2	22□0	22□8	233.6	238.□	2□3.6	2□3.6	2□3.6	2□3.6	2□3.6
□P□	28.5	26.□	2□1	2□6	28.0	28.□	29.□	30.0	30.0	30.0	30.0	30.0
Patient Care Asst	180.□	1□□2	190.8	19□1	19□5	202.5	206.9	211.2	211.2	211.2	211.2	211.2
□ech/Professional	225.5	232.□	25□8	259.2	263.6	2□0.3	2□6.3	281.9	281.9	281.9	281.9	281.9
Svc/Support	216.0	212.□	169.5	1□2.□	1□5.□	1□9.8	183.8	18□6	18□6	18□6	18□6	18□6
Total FTE's	**1,189.0**	**1,192.0**	**1,244.0**	**1,263.6**	**1,283.6**	**1,321.3**	**1,353.3**	**1,381.6**	**1,381.6**	**1,381.6**	**1,381.6**	**1,381.6**
Salaries □ □ ages □000s□	**$110,178**	**$118,552**	**$128,353**	**$130,376**	**$132,439**	**$136,329**	**$139,631**	**$142,551**	**$142,551**	**$142,551**	**$142,551**	**$142,551**
□mployee □enefits □000s□	**$25,266**	**$26,972**	**$29,618**	**$30,085**	**$30,561**	**$31,458**	**$32,219**	**$32,893**	**$32,893**	**$32,893**	**$32,893**	**$32,893**
Salaries □ □ ages / F□□	**$92,664**	**$99,456**	**$103,177**	**$103,178**	**$103,179**	**$103,178**	**$103,178**	**$103,178**	**$103,178**	**$103,178**	**$103,178**	**$103,178**
□mployee □enefits / F□□	**$21,250**	**$22,628**	**$23,808**	**$23,809**	**$23,809**	**$23,808**	**$23,808**	**$23,808**	**$23,808**	**$23,808**	**$23,808**	**$23,808**
S□□ □ □enefits / F□□	**$113,914**	**$122,084**	**$126,985**	**$126,987**	**$126,988**	**$126,986**	**$126,986**	**$126,986**	**$126,986**	**$126,986**	**$126,986**	**$126,986**

Appendix 1
Audited Financials

COMMONSPIRIT HEALTH

Consolidated Financial Statements as of
and for the Years Ended June 30, 2022 and 2021
With Report of Independent Auditors

COMMONSPIRIT HEALTH

TABLE OF CONTENTS

Ernst & Young LLP
Suite 1700
18101 Von Karman Avenue
Irvine, CA 92612

Tel: +1 949 794 2300
Fax: +1 949 437 0590
ey.com

Building a better working world

Report of Independent Auditors

The Board of Stewardship Trustees
CommonSpirit Health

Opinion

We have audited the consolidated financial statements of CommonSpirit Health (CommonSpirit), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes (collectively referred to as the financial statements).

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of CommonSpirit at June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of 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 CommonSpirit's ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's 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 of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. 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

Building a better working world

the override of internal control. □ isstatements are considered material if there is a su□stantial li□elihood that, individually or in the aggregate, they □ould influence the □udgment made □y a reasona□le user □ased on the financial statements.

In performing an audit in accordance □ith □AAS, □e:

- □□ercise professional □udgment and maintain professional s□epticism throughout the audit.
- Identify and assess the ris□s of material misstatement of the financial statements, □hether due to fraud or error, and design and perform audit procedures responsive to those ris□s. Such procedures include e□amining, on a test □asis, evidence regarding the amounts and disclosures in the financial statements.
- O□tain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, □ut not for the purpose of e□pressing an opinion on the effectiveness of CommonSpirit's internal control. Accordingly, no such opinion is e□pressed.
- □valuate the appropriateness of accounting policies used and the reasona□leness of significant accounting estimates made □y management, as □ell as evaluate the overall presentation of the financial statements.
- Conclude □hether, in our □udgment, there are conditions or events, considered in the aggregate, that raise su□stantial dou□t a□out CommonSpirit's a□ility to continue as a going concern for a reasona□le period of time.

□ e are re□uired to communicate □ith those charged □ith governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that □e identified during the audit.

Other Information

□ anagement is responsi□le for the other information. □he other information comprises the □ anagement □iscussion and Analysis of Financial Condition and Results of Operations □ut does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and □e do not e□press an opinion or any form of assurance thereon.

In connection □ith our audit of the financial statements, our responsi□ility is to read the other information and consider □hether a material inconsistency e□ists □et□een the other information and the financial statements, or the other information other□ise appears to □e materially misstated. If, □ased on the □or□ performed, □e conclude that an uncorrected material misstatement of the other information e□ists, □e are re□uired to descri□e it in our report.

Ernst & Young LLP

Septem□er 22, 2022

COMMONSPIRIT HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2022 AND 2021 (in millions)

Assets	2022	2021
Current assets:		
Cash and cash equivalents	$ 2,592	$ 3,329
Short-term investments	596	1,124
Patient accounts receivable, net	4,472	4,323
Provider fee receivable	693	1,151
Other current assets	3,296	2,354
Total current assets	11,649	12,281
Long-term investments	16,087	19,497
Property and equipment, net	15,876	16,274
Right-of-use operating lease assets	1,715	1,892
Ownership interests in health-related activities	3,038	3,141
Other long-term assets, net	1,949	1,791
Total assets	$ 50,314	$ 54,876

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2022 AND 2021 (in millions)

Liabilities and Net Assets	2022	2021
Current liabilities:		
Current portion of long-term debt	$ 1,619	$ 754
Demand bonds subject to short-term liquidity arrangements	247	247
Accounts payable	1,481	1,705
Accrued salaries and benefits	1,831	1,994
Provider fee payable	225	405
Medicare advances	793	1,422
Other accrued liabilities - current	3,435	2,931
Total current liabilities	9,631	9,458
Other liabilities - long-term:		
Self-insured reserves and claims - long-term	1,066	1,024
Pension and other postretirement benefit liabilities	2,501	3,761
Derivative instruments	150	287
Operating lease liabilities	1,626	1,801
Medicare advances - long-term	-	1,088
Other accrued liabilities - long-term	750	1,018
Total other liabilities - long-term	6,093	8,979
Long-term debt, net of current portion	13,561	14,541
Total liabilities	29,285	32,978
Net assets:		
Without donor restrictions - attributable to CommonSpirit Health	18,808	19,646
Without donor restrictions - noncontrolling interests	1,079	1,187
With donor restrictions	1,142	1,065
Total net assets	21,029	21,898
Total liabilities and net assets	$ 50,314	$ 54,876

See notes to consolidated financial statements.

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2022 AND 2021 (in millions)

	2022	2021
Operating revenues:		
Net patient revenue	$ 30,490	$ 28,996
Premium revenue	1,156	1,189
Revenue from health-related activities, net	139	314
Other operating revenue	2,038	2,690
Contributions	84	64
Total operating revenues	33,907	33,253
Operating expenses:		
Salaries and benefits	18,170	16,006
Supplies	5,588	5,086
Purchased services and other	9,523	9,225
Depreciation and amortization	1,463	1,487
Interest expense, net	459	451
Total operating expenses	35,203	32,255
Operating income (loss)	(1,296)	998
Nonoperating income (loss):		
Investment income (loss), net	(971)	3,399
Loss on early extinguishment of debt	-	(12)
Income tax expense	(72)	(139)
Change in fair value and cash payments of interest rate swaps	179	86
Contribution from business combinations	-	1,018
Other components of net periodic postretirement costs	324	86
Other	(11)	14
Total nonoperating income (loss), net	(551)	4,452
Excess (deficit) of revenues over expenses	$ (1,847)	$ 5,450
Less excess (deficit) of revenues over expenses attributable to noncontrolling interests	(1)	261
Excess (deficit) of revenues over expenses attributable to CommonSpirit Health	$ (1,846)	$ 5,189

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2022 AND 2021 (in millions)

	CommonSpirit Health	Noncontrolling Interests	Donor Restrictions	Total Net Assets
Balance, June 30, 2020	$ 12,317	$ 419	$ 859	$ 13,595
Excess of revenue over expenses	5,189	261	-	5,450
Contributions	-	-	106	106
Contribution from business combinations	-	573	78	651
Net assets released from restrictions for capital	37	-	(37)	-
Net assets released from restrictions for operations and other	-	-	(50)	(50)
Change in funded status of pension and other postretirement benefit plans	2,019	-	-	2,019
Other	84	(66)	109	127
Increase in net assets	7,329	768	206	8,303
Balance, June 30, 2021	$ 19,646	$ 1,187	$ 1,065	$ 21,898
Deficit of revenue over expenses	(1,846)	(1)	-	(1,847)
Contributions	-	-	122	122
Net assets released from restrictions for capital	46	-	(46)	-
Net assets released from restrictions for operations and other	-	-	(75)	(75)
Change in funded status of pension and other postretirement benefit plans	995	-	-	995
Other	(33)	(107)	76	(64)
Increase (decrease) in net assets	(838)	(108)	77	(869)
Balance, June 30, 2022	$ 18,808	$ 1,079	$ 1,142	$ 21,029

See notes to consolidated financial statements.

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2022 AND 2021 (in millions)

	2022	2021
Cash flows from operating activities:		
Change in net assets	$ (869)	$ 8,303
Adjustments to reconcile change in net assets to cash provided by (used in) operating activities:		
Loss on early extinguishment of debt	-	12
Depreciation and amortization	1,463	1,487
Changes in equity of health-related entities	(189)	(345)
Deconsolidation of joint venture	51	-
Contribution from business combinations	-	(1,018)
Net assets related to business combinations	-	(78)
Noncash special charges and other	52	49
Net (gain) loss on sales of facilities and investments in unconsolidated organizations	(1)	(69)
Change in fair value of swaps	(238)	(158)
Change in funded status of pension and other postretirement benefit plans	(995)	(2,019)
Pension cash contributions	(19)	(139)
Changes in certain assets and liabilities:		
Accounts receivable, net	(345)	(540)
Accounts payable	(170)	178
Self-insured reserves and claims	44	(73)
Accrued salaries and benefits	(110)	430
Changes in broker receivables/payables for unsettled investment trades	206	63
Provider fee assets and liabilities	277	(24)
Other accrued liabilities	(26)	(144)
Medicare advances	(1,719)	(137)
Prepaid and other current assets	5	(162)
Other, net	(703)	(279)
Cash provided by (used in) operating activities before net change in investments	(3,286)	5,337
Net (increase) decrease in investments	4,010	(7,474)
Cash provided by (used in) operating activities	724	(2,137)

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2022 AND 2021 (in millions)

	2022	2021
Cash flows from investing activities:		
Purchases of property and equipment	$ (1,486)	$ (1,497)
Investments in health-related activities	(105)	(174)
Business acquisitions, net of cash acquired	(138)	382
Proceeds from asset sales	276	918
Cash distributions from health-related activities	86	271
Other, net	(35)	(167)
Cash used in investing activities	(1,402)	(267)
Cash flows from financing activities:		
Borrowings	118	2,347
Repayments	(211)	(2,585)
Loss on early extinguishment of debt	-	(12)
Swaps cash collateral received	101	104
Distributions to noncontrolling interests	(110)	(76)
Contribution by noncontrolling interests	43	28
Cash used in financing activities	(59)	(194)
Net decrease in cash and cash equivalents	(737)	(2,598)
Cash and cash equivalents at beginning of year	3,329	5,927
Cash and cash equivalents at end of year	$ 2,592	$ 3,329
Supplemental disclosures of cash flow information:		
Cash paid for interest, net of capitalized interest	$ 473	$ 445
Supplemental schedule of noncash investing and financing activities:		
Property and equipment acquired through capital lease or note payable	$ 33	$ 181
Investments in health-related activities	$ 21	$ 146
Accrued purchases of property and equipment	$ 73	$ 151

See notes to consolidated financial statements.

1. ORGANIZATION

CommonSpirit Health is a Colorado nonprofit public benefit corporation exempt from federal and state income taxes. CommonSpirit Health was created by the alignment of Catholic Health Initiatives ("CHI") and Dignity Health in February 2019. CommonSpirit Health is a Catholic health care system sponsored by the public juridic person, Catholic Health Care Federation ("CHCF").

CommonSpirit Health owns and operates health care facilities in 21 states and is the sole corporate member (parent corporation) of other primarily nonprofit corporations that are exempt from federal and state income taxes. As of June 30, 2022, CommonSpirit Health is comprised of approximately 2,200 care sites, consisting of 142 hospitals, including academic health centers, major teaching hospitals, and critical access facilities, community health services organizations, accredited nursing colleges, home health agencies, living communities, a medical foundation and other affiliated medical groups, and other facilities and services that span the inpatient and outpatient continuum of care. CommonSpirit Health also has offshore and onshore captive insurance companies. The accompanying consolidated financial statements include CommonSpirit Health and its direct affiliates and subsidiaries (together, "CommonSpirit").

CommonSpirit Health and substantially all of its direct affiliates and subsidiaries have been granted exemptions from federal income tax as charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation – The accompanying consolidated financial statements of CommonSpirit were prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP") and include the accounts of all wholly-owned affiliates and affiliates over which CommonSpirit exercises control or has a controlling financial interest, after elimination of intercompany transactions and balances.

Reclassification – In the year ended June 30, 2022, CommonSpirit reclassified assets and liabilities previously held for sale, as ministries in North Dakota and Minnesota no longer met the requirements as held for sale. The assets and liabilities were classified as held for sale, within other current assets and other accrued liabilities - current, respectively, in the audited consolidated balance sheet as of June 30, 2021, but have been reclassified for all periods presented to the respective financial statement line items in the accompanying consolidated financial statements. Additional depreciation expense related to the reclassification was recorded in the year ended June 30, 2022, and is immaterial to the consolidated financial statements.

The adjusted balances as of June 30, 2021, in the consolidated financial statement presentation for applicable lines, are included below as a result of the held for sale reclassification above (in millions):

	As Originally Presented	Reclassifications	As Adjusted
Other current assets	$ 2,712	$ (358)	$ 2,354
Long-term investments	19,480	17	19,497
Property and equipment, net	16,002	272	16,274
Right-of-use operating lease assets	1,863	29	1,892
Ownership interests in health-related activitites	3,107	34	3,141
Other long-term assets, net	1,785	6	1,791
Total assets subject to reclassification	$ 44,949	$ -	$ 44,949
Other accrued liabilities - current	$ 2,984	$ (53)	$ 2,931
Operating lease liabilitites	1,750	51	1,801
Other accrued liabilities - long-term	1,017	1	1,018
Long-term debt, net of current portion	14,540	1	14,541
Total liabilities subject to reclassification	$ 20,291	$ -	$ 20,291

Use of Estimates – The preparation of financial statements in conformity with U.S. 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 revenues and expenses during the reporting period. CommonSpirit considers critical accounting policies to be those that require more significant judgments and estimates in the preparation of its consolidated financial statements, including the following: recognition of net patient revenue, which includes contractual discounts and adjustments; price concessions and charity care; fair value of acquired assets and assumed liabilities in business combinations; recorded values of depreciable and amortizable assets, investments and goodwill; reserves for self-insured workers' compensation and professional and general liabilities; contingent liabilities; and assumptions for measurement of pension and other postretirement benefit liabilities. Management bases its estimates on historical experience and various other assumptions that it believes are reasonable under the particular circumstances. Actual results could differ from those estimates.

Cash and Cash Equivalents – Cash and cash equivalents consist primarily of cash and liquid marketable securities with an original maturity of three months or less.

Inventories – Inventories, primarily consisting of pharmacy drugs and medical and surgical supplies, are stated at the lower of cost or net realizable value, determined using the first-in, first-out method. Inventories are recorded in other current assets in the accompanying consolidated balance sheets.

Broker Receivables and Payables for Unsettled Investment Trades – CommonSpirit accounts for its investments on a trade date basis. Amounts due to/from brokers for investment activity represent transactions that have been initiated prior to the consolidated balance sheet date, but are formally settled subsequent to the consolidated balance sheet date. These balances are recorded within other current assets and other accrued liabilities - current, respectively. See Notes 6 and 12.

Assets and Liabilities Held for Sale – Assets and liabilities held for sale represent assets and liabilities that are expected to be sold within one year. A group of assets and liabilities expected to be sold within one year is classified as held for sale if it meets certain criteria. The assets and liabilities held for sale are measured at the lower of carrying value or fair value less cost to sell. Such valuations include estimates of fair values generally based upon firm offers, discounted cash flows and incremental direct costs to transact a sale (Level 2 and Level

3 inputs). These balances are recorded within other current assets and other accrued liabilities - current, respectively. See Notes 3, 6 and 12.

Investments and Investment Income – Short-term investments consist of investments with an original maturity of more than three months up to one year. Long-term investments consist of investments with original maturities greater than one year.

The CommonSpirit Board of Stewardship Trustees Investment Committee establishes guidelines for investment decisions. Within those guidelines, CommonSpirit invests in equity and debt securities which are measured at fair value and are classified as trading securities. Accordingly, unrealized gains and losses on marketable securities are recorded within excess (deficit) of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets, and cash flows from the purchases and sales of marketable securities are reported as a component of operating activities in the accompanying consolidated statements of cash flows.

CommonSpirit also invests in alternative investments through limited partnerships. Alternative investments are comprised of private equity, real estate, hedge fund and other investment vehicles. CommonSpirit receives a proportionate share of the investment gains and losses of the partnerships. The limited partnerships generally contract with managers who have full discretionary authority over the investment decisions, within CommonSpirit's guidelines. These alternative investment vehicles invest in equity securities, fixed income securities, currencies, real estate, commodities, and derivatives.

CommonSpirit accounts for its ownership interests in these alternative investments under the equity method, the value of which is based on the net asset value ("NAV") practical expedient and is determined using investment valuations provided by the external investment managers, fund managers or general partners.

Alternative investments generally are not marketable, and many alternative investments have underlying investments that may not have quoted market values. The estimated value of such investments is subject to uncertainty and could differ had a ready market existed. Such differences could be material. CommonSpirit's risk is limited to its capital investment in each investment and capital call commitments, as discussed in Note 8.

Investment income or loss is included in excess (deficit) of revenues over expenses unless the income or loss is restricted by donor or law. Income earned on tax-exempt borrowings for specific construction projects is offset against interest expense capitalized for such projects during construction.

Also recorded in investments are assets limited as to use set aside by CommonSpirit for future long-term purposes, including amounts held by trustees under bond indenture agreements, funds set aside for self-insurance programs, amounts contributed by donors with stipulated restrictions, and amounts held for mission and ministry purposes.

Liquidity – Cash and cash equivalents, short-term investments, patient and other accounts receivable, broker receivables, and provider fee receivables are the financial assets available to meet expected expenditure needs within the next year. Additionally, although intended to satisfy long-term obligations, management estimates that approximately 80.7% of the CommonSpirit Health Operating Investment Pool, LLC ("CSH OIP"), as stated at June 30, 2022, could be utilized within the next year, if needed. CommonSpirit also has credit facility programs, as described in Note 13, available to meet unanticipated liquidity needs.

Deferred Financing Costs and Original Issue Discounts/Premiums on Bond Indebtedness – CommonSpirit amortizes deferred financing costs and original issue discounts/premiums on bond indebtedness over the estimated average period the related bonds will be outstanding, which approximates the effective interest method. Both deferred financing costs and original issue discounts/premiums are recorded with the related debt.

Property and Equipment – Property and equipment are stated at cost if purchased and at fair market value upon receipt if acquired through a business combination or donated, or upon the date of impairment, if impaired. Depreciation of property and equipment is recorded using the straight-line method. Amortization of finance lease assets is included in depreciation expense. Estimated useful lives by major classification are as follows:

Land improvements	2 to 40 years
Buildings and improvements	5 to 65 years
Equipment	3 to 40 years
Software	3 to 10 years

Asset Impairment – CommonSpirit routinely evaluates the carrying value of its long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows generated by the underlying tangible assets. When the carrying value of an asset exceeds the estimated recoverability, an asset impairment charge is recognized. The impairment tests are based on financial projections prepared by management that incorporate anticipated results from programs and initiatives being implemented and market value assessments of the assets. If these projections are not met, or if negative trends occur that impact the future outlook, the value of the long-lived assets may be impaired.

Goodwill and indefinite-lived intangible assets are tested for impairment annually on various dates and when an event or circumstance indicates the value of the reporting unit or intangible asset may be impaired. CommonSpirit uses the income and market approaches to estimate the fair value of its reporting units and uses the income approach to estimate the fair value of its indefinite-lived intangible assets. If the carrying value exceeds the fair value, an impairment charge is recognized. See Note 11.

Fair Value of Financial Instruments – The carrying amounts reported in the accompanying consolidated balance sheets for assets and liabilities, such as cash and cash equivalents, patient accounts receivable, interests in unconsolidated foundations, excess insurance receivables, community investment loans, broker receivables and payables on unsettled investment trades, accounts payable, and accrued expenses approximate fair value due to the nature of these items. The fair value of investments is disclosed in Note 8.

Derivative Instruments – CommonSpirit utilizes derivative arrangements to manage interest costs and the risk associated with changing interest rates. CommonSpirit records derivative instruments on the accompanying consolidated balance sheets as either an asset or liability measured at its fair value. See Notes 8 and 14.

CommonSpirit does not have derivative instruments that are designated as hedges. Interest cost and changes in fair value of derivative instruments are included in change in fair value and cash payments of interest rate swaps in nonoperating income, net, in the accompanying consolidated statements of operations and changes in net assets.

Ownership Interests in Health-Related Activities – Generally, when the ownership interest in a health-related activity is more than 50% and CommonSpirit has a controlling interest, the ownership interest is consolidated, and a noncontrolling interest is recorded in net assets without donor restrictions. When the ownership interest is at least 20%, but not more than 50%, or CommonSpirit has the ability to exercise significant influence over operating and financial policies of the investee, it is accounted for under the equity method, and the income or loss is reflected in revenue from health-related activities, net. Ownership interests for which CommonSpirit's ownership is less than 20% or for which CommonSpirit does not have the ability to exercise significant influence are measured at cost. See Note 10.

Self-Insurance Plans – The liability for self-insured reserves and claims represents the estimated ultimate net cost of all reported and unreported losses incurred through June 30. Actuarial estimates of uninsured losses at June 30, 2022 and 2021, have been accrued as liabilities and include an actuarial estimate for claims incurred but not reported ("IBNR"). CommonSpirit has insurance coverage in place for amounts in excess of the self-insured retention for workers' compensation and professional and general liabilities. The current and long-term portions of these liabilities are reflected accordingly in other accrued liabilities - current and other accrued liabilities - long-term in the accompanying consolidated balance sheets.

CommonSpirit is also self-insured for certain employee medical benefits. The liability for IBNR claims for these benefits is included in other accrued liabilities - current in the accompanying consolidated balance sheets.

Patient Accounts Receivable and Net Patient Revenue – Patient service revenue is reported at the amounts that reflect the consideration CommonSpirit expects to be paid in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others, and include consideration for retroactive revenue adjustments due to settlement of audits and reviews. Generally, performance obligations for patients receiving inpatient acute care services and outpatient services are recognized over time as services are provided. Net patient revenue is primarily comprised of hospital and physician services.

Performance obligations are generally satisfied over a period of less than one year. As such, CommonSpirit has elected to apply the optional exemption provided in Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") No. 2015-14, *Revenue From Contracts with Customers (Topic 606)*, and

is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period.

CommonSpirit determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with CommonSpirit's financial assistance policy, and implicit price concessions provided to uninsured and underinsured patients. CommonSpirit determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy, and historical experience. CommonSpirit determines its estimate of implicit price concessions based on its historical collection experience with these classes of patients using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. CommonSpirit relies on the results of detailed reviews of historical write-offs and collections in estimating the collectability of accounts receivable. Updates to the hindsight analysis are performed at least quarterly using primarily a rolling eighteen-month collection history and write-off data. Subsequent changes to estimates of the transaction price are generally recorded as adjustments to net patient revenue in the period of the change.

Subsequent changes that are determined to be the result of an adverse change in a third-party payor's ability to pay are recorded as bad debt expense in purchased services and other in the accompanying consolidated statements of operations and changes in net assets. Bad debt expense for 2022 and 2021 was not significant.

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements included in net patient revenue follows:

Medicare: Payments for inpatient services are generally made on a prospectively determined rate based on clinical diagnosis. Certain facilities receive cost-based reimbursement. Hospital outpatient services are generally paid based on prospectively determined rates. Physician services are paid based upon established fee schedules.

Medicaid: Payments for inpatient services are generally made on a prospectively determined rate based on clinical diagnosis or on a per case or per diem basis. Hospital outpatient services and physician services are paid based upon established fee schedules, a cost basis reimbursement methodology, or discounts from established charges.

Commercial: Payments for inpatient and outpatient services provided to patients covered under commercial insurance policies are paid using a variety of payment methodologies, including per diem and case rates.

Self-Pay and Other: Payment agreements with uninsured or underinsured patients, along with other responsible entities, including institutions, other hospitals and other government payors, are based on a variety of payment methodologies.

Net patient revenue includes estimated settlements under payment agreements with third-party payors. Settlements with third-party payors are accrued on an estimated basis in the period in which the related services are rendered and adjusted in future periods as final settlements are determined. These settlements are estimated and evaluated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity.

Premium Revenue – CommonSpirit has at-risk agreements with various payors to provide medical services to enrollees. Under these agreements, CommonSpirit receives monthly payments based on the number of enrollees, regardless of services actually performed by CommonSpirit. CommonSpirit accrues costs when services are rendered under these contracts, including estimates of IBNR claims and amounts receivable/payable under risk-sharing arrangements. The IBNR accrual includes an estimate of the costs of services for which CommonSpirit is responsible, including out-of-network services, and is recorded in other accrued liabilities - current.

Financial Assistance (Charity Care) – Charity care is free or discounted health services provided to persons who cannot afford to pay and who meet CommonSpirit's criteria for financial assistance. The amount of services written off as charity quantified at customary charges was $2.0 billion for 2022 and 2021. CommonSpirit estimates the cost of charity care by calculating a ratio of cost to usual and customary charges and applying that ratio to the usual and customary uncompensated charges associated with providing care to patients who qualify for charity care. This amount is not included in net patient revenue in the accompanying consolidated statements of operations and changes in net assets. The estimated cost of charity care associated with write-offs in 2022 and 2021 was $473 million and $507 million, respectively. See Note 20.

Other Operating Revenue – Other operating revenue includes grant revenues, including funds received from the Coronavirus Aid, Relief, and Economic Security Act ("CARES PRF"), American Rescue Plan Act of 2021 ("ARP Rural"), retail pharmacy revenues, management services revenues, rental revenues, cafeteria revenues, certain contributions released from restrictions, gains on sales of assets and joint venture interests, and other nonpatient care revenues. See Note 4.

Contributions and Net Assets With Donor Restrictions – Gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is met, net assets with donor restrictions related to capital purchases are reclassified as net assets without donor restrictions and reflected as net assets released from restrictions used for the purchase of property and equipment in the accompanying consolidated statements of operations and changes in net assets, whereas net assets with donor restrictions related to other gifts are reclassified as net assets without restrictions and recorded as other operating revenue. Gifts received with no restrictions are recorded as contributions in operating revenues. Gifts of long-lived operating assets, such as property and equipment, are reported as additions to net assets without donor restrictions, unless otherwise specified by the donor.

Unconditional promises to give cash and other assets to CommonSpirit are recorded at fair value at the date the promise is received using a discount rate based on the U.S. Treasury yield rates and are generally due within five years. Conditional promises to give are recorded when the conditions have been substantially met. Donor indications of intentions to give are not recorded; such gifts are recorded at fair value only upon actual receipt of the gift or pledge. Investment income on net assets with donor restrictions is classified pursuant to the intent or requirement of the donor.

Total net assets with donor restrictions are $1.1 billion as of June 30, 2022 and 2021. Of these net assets with donor restrictions, endowment net assets totaled $295 million and $272 million in 2022 and 2021, respectively. Endowment assets, which are primarily to be used for equipment and expansion, research and education, or charity purposes, include donor-restricted funds that CommonSpirit must hold in perpetuity or for a donor-specified period. Changes in endowment net assets primarily relate to investment returns, contributions, and appropriations for expenditures. CommonSpirit preserves the fair value of these gifts as of the date of donation unless otherwise stipulated by the donor. Donor-restricted endowment funds are classified as net assets with donor restrictions until those amounts are appropriated for expenditure. CommonSpirit considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund, (2) the purposes of the organization and the donor-restricted endowment fund, (3) general economic conditions, (4) the possible effects of inflation and deflation, (5) the expected total return from income and the appreciation of investments, (6) other resources of CommonSpirit, and (7) the investment policies of CommonSpirit.

CommonSpirit has investment and spending policies for endowment assets designed to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets.

Endowment assets are invested in a manner that is intended to produce results that achieve the respective benchmark while assuming a moderate level of investment risk. Actual returns in any given year may vary from this amount. To satisfy its long-term rate-of-return objectives, CommonSpirit relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). CommonSpirit targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints.

Community Benefits – As part of its mission, CommonSpirit provides services to the poor and benefits for the broader community. The costs incurred to provide such services are included in excess (deficit) of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets. CommonSpirit prepares a summary of unsponsored community benefit expense in accordance with Internal Revenue Service Form 990, Schedule H, and the Catholic Health Association of the United States ("CHA") publication, *A Guide for Planning and Reporting Community Benefit*. See Note 20.

Interest Expense – Interest expense on debt issued for construction projects is capitalized until the projects are placed in service. Interest expense, net, includes interest and fees on debt, net of these capitalized amounts. See Note 16.

Income Taxes – CommonSpirit has established its status as an organization exempt from income taxes under Internal Revenue Code Section 501(c)(3) and the laws of the states in which it operates, and as such, is generally not subject to federal or state income taxes. However, CommonSpirit's exempt organizations are subject to income taxes on net income derived from a trade or business, regularly carried on, which does not further CommonSpirit's exempt purposes. No significant income tax provision has been recorded in the accompanying consolidated financial statements for net income derived from an unrelated trade or business.

CommonSpirit's for-profit subsidiaries account for income taxes related to its operations. The for-profit subsidiaries recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of their assets and liabilities, along with net operating loss and tax credit carryovers, for tax positions that meet the more-likely-than-not recognition criteria. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Income tax interest and penalties are recorded as income tax expense. For the years ended June 30, 2022 and 2021, CommonSpirit's taxable entities recorded an immaterial amount of interest and penalties as part of the provision for income taxes. CommonSpirit's taxable entities did not have any material unrecognized income tax expense as of June 30, 2022 and 2021. CommonSpirit reviews its tax positions quarterly and has determined that there are no material uncertain tax positions that require recognition in the accompanying consolidated financial statements.

Performance Indicator – Management considers excess (deficit) of revenues over expenses to be CommonSpirit's performance indicator. Excess (deficit) of revenues over expenses includes all changes in net assets without donor restrictions except for the effect of contributions with donor restrictions, contribution from business combinations, changes in accounting principles, net assets released from restrictions used for purchase of capital and operations, change in funded status of pension and other postretirement benefit plans, gains and losses from discontinued operations, and other changes, including change in ownership interests held by controlled subsidiaries and change in accumulated unrealized derivative gains and losses.

Operating and Nonoperating Activities – CommonSpirit's primary purpose is to provide a variety of health care-related activities, education and other benefits to the communities in which it operates. Activities directly related to the furtherance of this purpose are recorded as operating activities. Other activities outside of this mission are reported as nonoperating activities. Such activities include net investment income (loss), loss on early extinguishment of debt, income tax expense, interest cost and changes in fair value of interest rate swaps, contributions from business combinations, other components of net periodic postretirement costs, and the nonoperating component of Joint Operating Agreement ("JOA") income share adjustments.

Recent Accounting Pronouncements – In August 2018, the FASB issued ASU No. 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General (Subtopic 715-20) Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans*, which applies to employer sponsored defined benefit pension and other postretirement plans. The amendments modify, remove and add certain disclosure requirements. CommonSpirit adopted this updated disclosure requirements for the annual period ended June 30, 2022. See Note 17.

Subsequent Events – CommonSpirit has evaluated subsequent events occurring between the end of the most recent fiscal year and September 22, 2022, the date the consolidated financial statements were issued. See Notes 3, 4 and 14.

3. ACQUISITIONS, AFFILIATIONS AND DIVESTITURES

Yavapai Regional Medical Center – In November 2020, a consolidated affiliate of CommonSpirit, Dignity Community Care ("DCC"), and Yavapai Community Hospital Association, dba Yavapai Regional Medical Center ("YRMC"), an Arizona nonprofit corporation, effected a business combination which transferred the sole membership of YRMC and its applicable subsidiaries to DCC for no cash consideration. YRMC owns and operates two acute care hospitals, a regional wellness center, an imaging center, a network of primary and specialty physician clinics, and a fundraising foundation in the Prescott, Arizona area. The transaction resulted in the recognition of a $507 million gain in the year ended June 30, 2021, recorded in contribution from business combinations in nonoperating income (loss) in the accompanying consolidated statements of operations and changes in net assets, and $5 million recorded in contribution from business combinations for net assets with

donor restrictions, calculated as the fair value of the excess of identifiable assets acquired over liabilities assumed, determined based on Level 3 inputs, including estimated future cash flows and probability-weighted performance assumptions.

Virginia Mason Health System – In January 2021, CommonSpirit formed a new integrated health system through the creation of a Joint Operating Company ("JOC"), Virginia Mason Franciscan Health ("VMFH"), a Washington nonprofit corporation, bringing together CommonSpirit Franciscan Health System and Virginia Mason Health System ("VMHS"). With the addition of an acute hospital and other care sites from VMHS, VMFH now operates eleven hospitals and nearly 300 sites of care within the Pacific Northwest. The JOC is a controlled subsidiary of CommonSpirit. Based on the terms of the JOC agreement, CommonSpirit will consolidate the operations of VMHS and accounted for the business combination using the acquisition method of accounting. The agreement did not include consideration and resulted in the recognition of a $511 million gain in the year ended June 30, 2021, recorded in contribution from business combinations in nonoperating income (loss) in the accompanying consolidated statements of operations and changes in net assets, and $73 million recorded in contribution from business combinations for net assets with donor restrictions, calculated as the fair value of the excess of identifiable assets acquired over liabilities assumed, determined based on Level 3 inputs, including estimated future cash flows and probability-weighted performance assumptions.

The following summarizes the fair value estimate of YRMC's and VMHS's assets acquired and liabilities assumed as of November 1, 2020, and January 1, 2021, respectively (in millions):

	YRMC	VMHS
Current assets	$ 226	$ 390
Long-term investments	124	429
Property and equipment, net	272	576
Other long-term assets, net	61	161
Current liabilities	(33)	(319)
Other liabilities - long-term	(7)	(180)
Long-term debt, net of current portion	(131)	(473)
Total contribution of net assets	$ 512	$ 584

Other – In February 2022, CommonSpirit entered into a definitive agreement to acquire two hospital facilities, one in western Kansas and one in northern Colorado, and the transaction was finalized in May 2022. The acquired facilities support the mission and strategy to expand the scope and quality of care in those rural and surrounding communities, and will be managed by Centura Health pursuant to the existing JOA. The purchase price is immaterial to the consolidated financial statements.

In March 2021, CommonSpirit sold a portion of its investment in a joint venture resulting in a pretax gain of $523 million, which is included in other operating revenue in the consolidated statements of operations and changes in net assets. Income tax expense of $93 million is recorded in nonoperating income (loss) related to the transaction. CommonSpirit will continue to account for its remaining interest in the joint venture under the equity method.

Held for Sale – In April 2022, CommonSpirit and Trinity Health signed an agreement for Trinity Health to acquire all facilities and assets of MercyOne, a regional health system in Iowa. MercyOne has operated under a JOA between Trinity Health and CommonSpirit. The transaction closed in September 2022, for a purchase price of $613 million. As such, certain assets and liabilities of the Iowa ministries are classified as held for sale, within other current assets and other accrued liabilities - current, respectively, in the accompanying consolidated balance sheet as of June 30, 2022.

A summary of major classes of assets and liabilities held for sale is presented below as of June 30, 2022 (in millions):

Cash and cash equivalents	$	35
Patient accounts receivable, net		148
Other current assets		50
Long-term investments		70
Property and equipment, net		362
Right-of-use operating lease assets		121
Ownership interests in health-related activities		117
Other long-term assets, net		5
Total assets held for sale	$	908
Current portion of long-term debt	$	1
Accounts payable		16
Accrued salaries and benefits		49
Medicare advances		32
Other accrued liabilities - current		45
Operating lease liabilities		104
Other accrued liabilities - long-term		2
Long-term debt, net of current portion		1
Total liabilities held for sale	$	250

4. COVID-19 PANDEMIC

In December 2019, a novel strain of coronavirus, known as COVID-19, was first detected. The virus spread worldwide and in March 2020 was declared a pandemic by the World Health Organization. The Centers for Disease Control and Prevention confirmed the first case in the United States in February 2020, and with the rapid spread across all 50 states, the United States government passed new laws designed to help the nation respond to this pandemic.

The CARES PRF funds provide stimulus in the form of financial aid to cover extensive emergency funding to hospitals and providers through existing mechanisms to prevent, prepare for, and respond to COVID-19. For the years ended June 30, 2022 and 2021, CommonSpirit has received approximately $21 million and $478 million, respectively, under CARES PRF in the form of grants as reimbursement through the Public Health and Social Services Emergency Fund for lost revenues attributable to COVID-19. These funds are not required to be repaid upon attestation and compliance with certain terms and conditions. For the years ended June 30, 2022 and 2021, $27 million and $690 million, respectively, has been recognized within other operating revenue as earned. As of June 30, 2022 and 2021, $9 million and $15 million, respectively, of deferred revenue is included within other accrued liabilities - current, in the consolidated balance sheets. CommonSpirit will continue to monitor the terms and conditions of CARES PRF funding and the impact of the pandemic on revenues and expenses. Additional CARES PRF funds totaling $259 million were received in July and August 2022 that will be recognized in 2023.

Additional relief to address the continued impact of COVID-19 was provided through the American Rescue Plan Act of 2021 (“ARP Rural”), in addition to the CARES PRF funds. For the year ended June 30, 2022, CommonSpirit has received approximately $149 million ARP Rural funds in the form of grants recorded as other operating revenues.

To date, CommonSpirit also received $2.8 billion in funds under the Medicare Accelerated and Advance Payment Program, which was received in the entirety prior to fiscal year 2022. These payments are advances that will be recouped by withholding future Medicare fee-for-service payments for claims until such time as the full accelerated payment has been recouped. As of June 30, 2022 and 2021, the terms and conditions in effect at that

time prescribed that any outstanding balance remaining after 29 months from date of receipt are subject to interest of 4%. As such, as of June 30, 2022, $793 million is recorded as a current liability in Medicare advances and $32 million is recorded in current liabilities as held for sale. As of June 30, 2021, $1.4 billion was recorded as a current liability in Medicare advances, and $1.1 billion was recorded in Medicare advances – long-term.

CommonSpirit had deferred approximately $416 million of employer payroll taxes through June 30, 2022, pursuant to the Paycheck Protection Program and Health Care Enhancement Act, of which $208 million was paid in December 2021, and $208 million is recorded as a current liability in accrued salaries and benefits.

CommonSpirit recorded $67 million of Employee Retention Credits under CARES PRF during the year ended June 30, 2022. These funds relate to qualified wages paid between April 1, 2020, and June 30, 2020, and are recorded in other operating revenue.

While the aid received from the programs above provides much needed assistance during this crisis, CommonSpirit is unable to assess the extent to which the amounts and benefits received, or to be received, will offset the negative impacts on its results of consolidated operations and financial position arising from the COVID-19 pandemic.

5. NET PATIENT REVENUE

The percentage of inpatient and outpatient services, calculated on the basis of usual and customary charges, is as follows for the years ended June 30:

	2022	2021
Inpatient services	50%	51%
Outpatient services	50%	49%

Patient revenue, net of contractual discounts and adjustments and implicit price concessions, is comprised of the following for the years ended June 30 (in millions):

	2022	2021
Government	$ 15,480	$ 14,780
Contracted	12,787	11,937
Self-pay and other	2,223	2,279
Net patient revenue	$ 30,490	$ 28,996

Government payor type includes Medicare fee for service, Medicare capitated, Medicare managed care fee for service, Medicaid fee for service, Medicaid capitated and Medicaid managed care fee for service patient accounts. Contracted payor type includes contracted rate payors and commercial capitated patient accounts.

Total operating revenues by service line are as follows for the years ended June 30 (in millions):

	2022	2021
Hospitals	$ 27,712	$ 26,391
Physician organizations	3,171	2,962
Long-term care and home care	295	302
Other	468	530
Net patient and premium revenue	31,646	30,185
Health plans, accountable care, and other	2,261	3,068
Total operating revenues	$ 33,907	$ 33,253

6. OTHER CURRENT ASSETS

Other current assets consist of the following at June 30 (in millions):

	2022	2021
Inventories	$ 795	$ 822
Receivables, other than patient accounts receivable	583	653
Broker receivables for unsettled investment trades	576	493
Assets held for sale	908	-
Prepaid expenses	372	344
Other	62	42
Total other current assets	$ 3,296	$ 2,354

7. CASH AND INVESTMENTS

CommonSpirit's cash and investments include consolidated membership interests in the CommonSpirit Health Operating Investment Pool, LLC ("CSH OIP") as of June 30, 2022 and 2021. Short-term and long-term investments also include assets limited as to use set aside by CommonSpirit for future long-term purposes as outlined below (in millions):

	2022	2021
Cash and cash equivalents	$ 2,592	$ 3,329
Short-term investments	596	1,124
Long-term investments	16,087	19,497
Total cash and investments	19,275	23,950
Less:		
Held for self-insured claims	1,758	1,888
Under bond indenture agreements for debt service	78	85
Donor-restricted	579	607
Other	613	707
Total assets limited as to use	3,028	3,287
Unrestricted cash and investments	$ 16,247	$ 20,663

8. FAIR VALUE MEASUREMENTS

CommonSpirit accounts for certain assets and liabilities at fair value or on a basis that approximates fair value. A fair value hierarchy for valuation inputs categorizes the inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels and is determined by the lowest level of input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices are available in active markets for identical assets or liabilities as of the measurement date. Financial assets in this category include money market funds, U.S. Treasury securities and listed equities.

Level 2: Pricing inputs are based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Financial assets and liabilities in this category generally include asset-backed securities, corporate bonds and loans, municipal bonds, and derivative instruments.

Level 3: Pricing inputs are generally unobservable for the assets or liabilities and include situations where there is little, if any, market activity for the investment. The inputs into the determination of fair value require management's judgment or estimation of assumptions that market participants would use in pricing the assets or liabilities. The fair values are therefore determined using model-based techniques that include option pricing models, discounted cash flow models, and similar techniques.

The following represents assets and liabilities measured at fair value or at the NAV practical expedient on a recurring basis as of June 30 (in millions):

	2022			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and short-term investments	$ 2,963	$ 420	$ -	$ 3,383
U.S. government securities	944	476	-	1,420
U.S. corporate bonds	73	588	-	661
U.S. equity securities	1,553	3	-	1,556
Foreign government securities	-	79	-	79
Foreign corporate bonds	1	192	-	193
Foreign equity securities	1,558	1	-	1,559
Asset-backed securities	-	143	-	143
Private equity	-	-	64	64
Multi-strategy hedge funds	10	-	-	10
Real estate	28	1		29
Community Investment Program	-	-	127	127
Other investments	172	177	-	349
Assets measured at fair value	$ 7,302	$ 2,080	$ 191	9,573
Assets at NAV				9,772
Less: Assets classified as held for sale included above				(70)
Total assets				$ 19,275
Liabilities				
Derivative instruments	$ -	$ 234	$ -	$ 234
Other	1	-	100	101
Total liabilities	$ 1	$ 234	$ 100	$ 335

	2021			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and short-term investments	$ 3,543	$ 289	$ -	$ 3,832
U.S. government securities	1,350	489	-	1,839
U.S. corporate bonds	120	1,314	-	1,434
U.S. equity securities	2,969	5	-	2,974
Foreign government securities	-	256	-	256
Foreign corporate bonds	1	825	-	826
Foreign equity securities	3,008	1	-	3,009
Asset-backed securities	-	146	-	146
Private equity	-	-	65	65
Real estate	49	1	-	50
Community Investment Program	-	-	132	132
Other investments	234	182	-	416
Assets measured at fair value	$ 11,274	$ 3,508	$ 197	14,979
Assets at NAV				8,971
Total assets				$ 23,950
Liabilities				
Derivative instruments	$ -	$ 472	$ -	$ 472
Other	4	-	90	94
Total liabilities	$ 4	$ 472	$ 90	$ 566

Assets and liabilities measured at fair value on a recurring basis reflected in the table above are reported in short-term investments, long-term investments, current liabilities and other liabilities – long term in the accompanying consolidated balance sheets.

The Level 2 and 3 instruments listed in the fair value hierarchy tables above use the following valuation techniques and inputs:

For marketable securities, such as U.S. and foreign government securities, U.S. and foreign corporate bonds, U.S. and foreign equity securities, mortgage and asset-backed securities, and structured debt, in the instances where identical quoted market prices are not readily available, fair value is determined using quoted market prices and/or other market data for comparable instruments and transactions in establishing prices, discounted cash flow models and other pricing models. These inputs to fair value are included in industry-standard valuation techniques, such as the income or market approach. CommonSpirit classifies all such investments as Level 2.

For private equity investments where no fair value is readily available, the fair value is determined using models that take into account relevant information considered material. Due to the significant unobservable inputs present in these valuations, CommonSpirit classifies all such investments as Level 3.

The fair value of collateral held under securities lending program is classified as Level 2. The collateral held under this program is placed in commingled funds whose underlying investments are valued using techniques similar to those used for the marketable securities noted above. Amounts reported do not include noncash collateral of $56 million and $209 million as of June 30, 2022 and 2021, respectively.

The fair value of assets and liabilities for derivative instruments, such as interest rate swaps classified as Level 2, is determined using an industry standard valuation model, which is based on a market approach. A credit risk spread (in basis points) is added as a flat spread to the discount curve used in the valuation model. Each leg is discounted and the difference between the present value of each leg's cash flows equals the fair value of the swap.

Investments that are measured using the NAV per share practical expedient have not been classified in the fair value hierarchy. The NAV amounts presented in the table above are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

Related to investments valued using the NAV per share practical expedient, management also performs, on a regular basis when information is available, various validations and testing of NAV provided and determines that the investment managers' valuation techniques are compliant with fair value measurement accounting standards.

Level 3 financial assets totaling $51 million were recorded through contributions from business combinations in 2021 related to the formation of CSH OIP.

The following table and explanations identify attributes relating to the nature and risk of investments for which fair value is determined using a calculated NAV as of June 30, 2022 (in millions):

		NAV Practical Expedient	Unfunded Commitments	Redemption Frequency (If Currently Eligible)	Redemption Notice Period
Private equity	(1)	$ 1,394	$ 636	-	-
Multi-strategy hedge funds	(2)	2,997	-	Weekly, Monthly, Quarterly, Semi-annually, Annually	3 - 100 days
Real estate	(3)	1,335	53	Quarterly	45 - 90 days
Commingled funds - debt securities	(4)	1,061	54	Daily, Monthly, Quarterly	1 - 90 days
Commingled funds - equity securities	(5)	2,985	-	Daily, Weekly, Bi-Weekly, Monthly, Bi-Monthly, Quarterly	2 - 90 days
Total		$ 9,772	$ 743		

(1) This category includes private equity funds that specialize in providing capital to a variety of investment groups, including, but not limited to, venture capital, leveraged buyout, mezzanine debt, distressed debt, and other situations. There are no provisions for redemptions during the life of these funds. Distributions from each fund will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2022, to be over the next 12 years.

(2) This category includes investments in hedge funds that pursue diversification of both domestic and foreign fixed income and equity securities through multiple investment strategies. The primary objective for these funds is to seek attractive long-term, risk-adjusted absolute returns. Under certain circumstances, an otherwise redeemable investment or portion thereof could become restricted. The following table reflects the various redemption frequencies, notice periods, and any applicable lock-up periods or gates to redemption as of June 30, 2022:

Percentage of the Value of Category (2)		Redemption	Redemption Notice	Redemption Locked Up Until	Redemption Gate % of Account
Total	Subtotal	Frequency	Period	(if applicable)	(if applicable)
13.9%	13.9%	Annually	60 days	up to 3 years	up to 50.0%
0.3%	0.3%	Semi-annually	75 -90 days	up to 2 years	-
33.5%	2.3%	Quarterly	30 - 45 days	up to 2 years	up to 20.0%
	21.5%	Quarterly	55 - 65 days	up to 1 year	up to 10.0% - 50.0%
	9.7%	Quarterly	90 days	-	up to 12.5% - 25.0%
44.4%	36.3%	Monthly	30 - 50 days	-	up to 16.7% - 25.0%
	8.1%	Monthly	60 - 90 days	-	up to 20.0%
7.9%	7.9%	Weekly	3 days	-	-

(3) This category includes investments in real estate funds that invest primarily in institutional-quality commercial and residential real estate assets within the U.S. and investments in publicly traded real estate investment trusts. Investments representing 15% of the value of investments in this category do not have provisions for redemptions during the life of these funds. Distributions will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2022, to be over the next 11 years.

(4) This category includes investments in commingled funds that invest primarily in domestic and foreign debt and fixed income securities, the majority of which are traded in over-the-counter markets. Also included in this category are commingled fixed income funds that provide capital in a variety of mezzanine debt, distressed debt and other special debt securities situations. Investments representing approximately 12% of the value of investments in this category do not have provisions for redemptions during the life of these funds. Distributions will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2022, to be over the next seven years.

(5) This category includes investments in commingled funds that invest primarily in domestic or foreign equity securities with multiple investment strategies. A majority of the funds attempt to match or exceed the returns of specific equity indices.

The investments included above are not expected to be sold at amounts that are materially different from NAV.

9. PROPERTY AND EQUIPMENT, NET

Property and equipment, net, consists of the following at June 30 (in millions):

	2022	2021
Land and improvements	$ 2,098	$ 2,103
Buildings	13,182	12,735
Equipment	9,783	9,656
Total	25,063	24,494
Add: Construction in progress	2,418	2,795
Less: Accumulated depreciation	(11,605)	(11,015)
Property and equipment, net	$ 15,876	$ 16,274

The current year decline in property and equipment, net, is primarily due to balances classified as Held for Sale of $362 million as of June 30, 2022. See Note 3.

10. OWNERSHIP INTERESTS IN HEALTH-RELATED ACTIVITIES

Joint Operating Agreements – CommonSpirit participates in JOAs with hospital-based organizations in three separate markets. The agreements generally provide for, among other things, joint management of the combined operations of the local facilities included in the JOAs through JOCs. CommonSpirit retains ownership of the assets, liabilities, equity, revenues and expenses of the CommonSpirit facilities that participate in the JOAs. The financial statements of the CommonSpirit facilities managed under all JOAs are included in the accompanying consolidated financial statements. Transfers of assets from facilities owned by the JOA participants generally are restricted under the terms of the agreements.

As of June 30, 2022 and 2021, CommonSpirit has investment interests of 65%, 50% and 50% in JOCs based in Colorado, Iowa, and Ohio, respectively. CommonSpirit's interests in the JOCs are included in ownership interests in health-related activities in the accompanying consolidated balance sheets and totaled $523 million and $549 million at June 30, 2022 and 2021, respectively. CommonSpirit recognizes its investment in all JOCs under the equity method of accounting. The JOCs provide varying levels of services to the related JOA sponsors, and operating expenses of the JOCs are allocated to each sponsoring organization.

Other Ownership Interests in Health-Related Activities – In addition to the JOCs above, CommonSpirit has significant ownership interests that are accounted for under the equity method and reflected in the accompanying consolidated balance sheets in ownership interests in health-related activities. CommonSpirit's significant ownership interests are as follows:

- CommonSpirit's ownership interest in Conifer was 23.8% as of June 30, 2022 and 2021. Conifer provides revenue cycle services and health information management solutions for CHI's acute care operations.

- CommonSpirit's ownership interest in Premier Health was 22% as of June 30, 2022 and 2021. CHI exchanged it's ownership of the Dayton, Ohio market-based organization for the ownership interest in Premier Health in 2018.

The following table summarizes the financial position and results of operations for the significant health-related activities discussed above, unless otherwise specified, which are accounted for under the equity method, as of and for the 12 months ended June 30, or a portion of the periods thereof while held by CommonSpirit (in millions):

	2022			
	Hospitals	**JOCs**	**Other**	**Total**
Total assets	$ 2,731	$ 1,606	$ 2,358	$ 6,695
Total liabilities	1,484	661	215	2,360
Total net assets	1,247	945	2,143	4,335
Total operating revenues, net	1,959	932	1,257	4,148
Excess (deficit) of revenues over expenses	(138)	(183)	295	(26)
Investment at June 30 recorded in ownership interests in health-related activities	257	523	894	1,674
Income (loss) recorded in revenue from health-related activities, net	(27)	(91)	58	(60)

	2021			
	Hospitals	**JOCs**	**Other**	**Total**
Total assets	$ 3,020	$ 1,691	$ 2,075	$ 6,786
Total liabilities	1,691	726	227	2,644
Total net assets	1,329	965	1,848	4,142
Total operating revenues, net	1,881	947	1,263	4,091
Excess (deficit) of revenues over expenses	128	(134)	294	288
Investment at June 30 recorded in ownership interests in health-related activities	274	549	836	1,659
Income (loss) recorded in revenue from health-related activities, net	17	(65)	60	12

Other than the investments described above, ownership interests totaling $1.4 billion and $1.5 billion as of June 30, 2022 and 2021, respectively, are not material individually to the consolidated financial statements.

11. OTHER LONG-TERM ASSETS, NET

Other long-term assets, net, consist of the following at June 30 (in millions):

	2022	2021
Notes receivable, primarily secured	$ 50	$ 55
Goodwill	358	287
Intangible assets - definite-lived, net	120	76
Intangible assets - indefinite-lived	657	706
Donor-restricted assets	521	451
Other	243	216
Total other long-term assets, net	$ 1,949	$ 1,791

Goodwill is measured as of the effective date of a business combination as the excess of the aggregate of the fair value of consideration transferred over the fair value of the tangible and intangible assets acquired and liabilities assumed.

Intangible assets consist primarily of trademarks, trademark agreements, noncompete agreements, certificates of need, and other contracts, and are recorded at fair value using various methods based on the nature of the asset. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

Goodwill and intangible assets whose lives are indefinite are not amortized and are evaluated for impairment at least annually or when circumstances indicate a possible impairment may exist. No impairment on goodwill or intangible assets was recorded for the years ended June 30, 2022 and 2021.

The aggregate amortization expense related to intangible assets is $11 million for the years ended June 30, 2022 and 2021, respectively, and is recorded in depreciation and amortization on the accompanying consolidated statements of operations and changes in net assets.

Estimated amortization expense related to intangible assets is $8 million in 2023 and 2024, $7 million in 2025, $6 million in 2026 and 2027, and $85 million thereafter.

12. OTHER ACCRUED LIABILITIES - CURRENT

Other accrued liabilities – current consists of the following at June 30 (in millions):

	2022	2021
Deferred revenue - CARES PRF	$ 9	$ 15
Construction retention and contracts payable	140	61
Liabilities held for sale	250	-
Liabilities due to medical groups and physicians	76	75
Capitation claims	110	106
Due to government agencies	119	123
Accrued interest expense	144	150
Operating lease liabilities	263	281
Self-insured reserves and claims	467	452
Broker payables for unsettled investments trades	948	659
Due to unconsolidated affiliates	62	93
Other	847	916
Total other accrued liabilities - current	$ 3,435	$ 2,931

13. DEBT

The CommonSpirit Health Master Trust Indenture ("CommonSpirit MTI") has an Obligated Group, which is comprised of the former Dignity Health Obligated Group and CHI entities (collectively, the "CommonSpirit Obligated Group"). The CommonSpirit Obligated Group represents approximately 85% of consolidated revenues of CommonSpirit as of June 30, 2022 and 2021, respectively.

Debt, net of unamortized debt issuance costs, discounts and premiums consists of the following at June 30 (in millions):

	2022	2021
Under the CommonSpirit MTI:		
Fixed rate debt:		
Fixed rate revenue bonds payable in installments through 2050; interest at 2.70% to 7.00%	$ 4,938	$ 5,093
Fixed rate taxable bonds payable in installments through 2065; interest at 1.55% to 5.27%	7,747	7,747
Taxable term loan payable in 2025; interest at 2.95%	250	250
Total fixed rate debt	12,935	13,090
Variable rate debt:		
Direct purchase bonds payable in installments through 2024; interest set at prevailing market rates (2.08% to 2.09% at June 30, 2022)	101	106
Floating rate notes payable with mandatory tender through 2025; interest set at prevailing market rates (2.31% at June 30, 2022)	153	153
Variable rate demand bonds payable in installments through 2047; interest set at prevailing market rates (0.70% to 1.15% at June 30, 2022)	247	247
Auction rate certificates payable in installments through 2042; interest set at prevailing market rates (0.89% to 1.09% at June 30, 2022)	240	240
Bank line of credit maturing in 2023; interest set at prevaling market rates (2.22% to 2.69% at June 30, 2022)	156	54
Commercial paper notes with maturities ranging from 14 to 105 days at June 30, 2022; interest set at prevailing market rates (1.30% to 2.80% at June 30, 2022)	553	553
Total variable rate debt	1,450	1,353
Total debt under CommonSpirit MTI	14,385	14,443
Other:		
Various notes payable and other debt payable in installments	699	729
Finance lease obligations	343	370
Total debt	15,427	15,542
Less amounts classified as current	(1,619)	(754)
Less demand bonds subject to short-term liquidity arrangements	(247)	(247)
Total long-term debt	$ 13,561	$ 14,541

Scheduled principal debt payments, net of discounts and premiums, and considering obligations subject to short-term liquidity arrangements as due according to their long-term amortization schedule, for the next five years and thereafter, are as follows (in millions):

	Long-Term Debt Other Than Demand Bonds	Demand Bonds Subject to Short-Term Liquidity Arrangements	Total Long-Term Debt
2023	$ 1,582	$ 97	$ 1,679
2024	348	-	348
2025	1,811	-	1,811
2026	629	-	629
2027	141	-	141
Thereafter	9,948	150	10,098
Subtotal	14,459	247	14,706
Finance lease obligations	343	-	343
Premium and Issuance cost, net	378	-	378
Total	$ 15,180	$ 247	$ 15,427

Debt Arrangements – **Fixed Rate Revenue Bonds** – CommonSpirit has fixed rate revenue bonds outstanding, substantially all of which may be redeemed, in whole or in part, prior to the stated maturities without a premium.

Fixed Rate Taxable Bonds – CommonSpirit has taxable fixed rate bonds that are due in August 2023, October 2024, 2025, 2029, 2030, 2049, and 2050 and November 2022, 2024, 2040, 2041, 2042 and 2064. Early redemption of the debt, in whole or in part, may require a premium depending on market rates.

Fixed Rate Taxable Term Loan – CommonSpirit has a taxable fixed rate term loan due in April 2025.

Taxable Commercial Paper – CommonSpirit has a commercial paper program that permits the issuance of up to $881 million in aggregate principal amount outstanding, with maturities limited to 270-day periods. The commercial paper program is backed by CommonSpirit's self-liquidity program, which is comprised of CommonSpirit's cash management and operating investment programs and dedicated bank lines of credit to ensure the availability of funds to purchase any commercial paper that the remarketing agent is unable to remarket.

Floating Rate Notes – CommonSpirit has floating rate notes ("FRNs") that bear interest at variable rates determined weekly and monthly. These FRNs are subject to mandatory tender on predetermined dates.

Variable Rate Direct Purchase Bonds – CommonSpirit has variable rate direct purchase bonds placed with holders that bear interest at variable rates determined monthly based upon a percentage of the London Inter-bank Offered Rate ("LIBOR"), plus a spread. These bonds are subject to mandatory tender on predetermined dates.

Variable Rate Demand Bonds – CommonSpirit has variable rate demand bonds ("VRDBs") that are remarketed weekly and may be put at the option of the holders. Two series of VRDBs totaling $150 million are backed by bank letters of credit, while the remaining two series totaling $97 million are supported through CommonSpirit's self-liquidity program discussed above. The bank letters of credit and the self-liquidity program ensure the availability of funds to purchase any bonds tendered that the remarketing agent is unable to remarket. The letters of credit to support the $150 million of VRDBs expire in March 2024.

Auction Rate Certificates – CommonSpirit has $240 million of auction rate certificates ("ARCs") that are remarketed weekly. The certificates are insured by Assured Guaranty. Holders of ARCs are required to hold the certificates until the remarketing agent can find a new buyer for any tendered certificates.

Notes Payable to Banks Under Credit Agreements – CommonSpirit maintains a $900 million syndicated line of credit facility for working capital, letters of credit, capital expenditures and other general corporate purposes. The amount outstanding under the syndicated credit facility was $156 million as of June 30, 2022. This credit facility expires in June 2023.

CommonSpirit maintains $190 million in dedicated lines of credit to support the organization's self-liquidity program, to be used to fund tenders of VRDBs and maturing principal of commercial paper due to a failed remarketing. The lines of credit expiration dates are August 2023 and December 2023. No amounts have been drawn.

CommonSpirit also maintains an $85 million single-bank line of credit facility to be used for the issuance of standby letters of credit. The credit facility expires in June 2023. No amounts have been drawn.

2022 Financing Activity – In November 2021, CommonSpirit drew $102 million on its syndicated line of credit for the redemption in full of the Kentucky Economic Development Finance Authority Fixed Rate Put Bonds, Series 2009B, and the Colorado Health Facilities Authority Fixed Rate Put Bonds, Series 2008D-3.

2021 Financing Activity – In August 2020, CommonSpirit renewed a $125 million line of credit used to support its self-liquidity program scheduled to mature in August 2020, to August 2023.

In September 2020, CommonSpirit repaid $800 million of draws during February through April 2020 on its syndicated line of credit.

In September 2020, CommonSpirit drew $54 million on its syndicated line of credit for the redemption in full of the Colorado Health Facilities Authority Variable Rate Revenue Bonds, Series 2004B-6.

In October 2020, CommonSpirit issued $1.7 billion of taxable fixed rate bonds at par with repayments of $450 million, $550 million and $658 million to be made in October 2025, 2030 and 2050, respectively. A portion of the proceeds were used to refund $537 million of tax-exempt fixed rate bonds, $230 million of tax-exempt variable rate bonds, $196 million of taxable variable rate bonds, $153 million of tax-exempt floating rate notes, $79 million of affiliate debt, and $439 million for general working capital purposes and to pay the cost of issuance expenses.

In October 2020, CommonSpirit issued $577 million of tax-exempt fixed rate bonds at a premium. Proceeds included $300 million of new money to reimburse for prior capital expenditures and $344 million to refinance tax-exempt variable rate bonds. The bonds mature in April 2049.

In November 2020, CommonSpirit repaid a $31 million draw on its syndicated line of credit using proceeds from the CommonSpirit 2020 taxable bonds.

In December 2020, CommonSpirit increased a line of credit used to issue standby letters of credit from $35 million to $85 million. The line of credit is scheduled to expire in June 2023.

In December 2020, CommonSpirit renewed a $65 million line of credit used to support its self-liquidity program scheduled to mature in December 2020, to December 2023.

In March 2021, CommonSpirit renewed and extended two letters of credit issued by Dignity Health scheduled to expire in November 2021 to support VRDBs of $75 million each, to March 2024. This did not change the terms, provisions or classification of the VRDBs.

In June 2021, CommonSpirit redeemed in full the Colorado Health Facilities Authority Revenue Bonds (Catholic Health Initiatives) Series 2009A. The bonds were redeemed at par.

14. DERIVATIVE INSTRUMENTS

CommonSpirit's derivative instruments include 31 floating-to-fixed rate interest rate swaps and one basis swap as of June 30, 2022. CommonSpirit uses interest rate swaps to manage interest rate risk associated with outstanding variable rate debt. Under the floating-to-fixed rate swaps, CommonSpirit receives a percentage of LIBOR, plus a spread, and pays a fixed rate. The basis swap allows CommonSpirit to receive a percentage of LIBOR, plus a spread and pay a percentage of Securities Industry and Financial Markets Association ("SIFMA").

CommonSpirit's derivative instruments also include eight total return swaps as of June 30, 2022. CommonSpirit receives a fixed rate and pays a variable rate percentage of SIFMA, plus a spread. CommonSpirit uses these total return swaps to reduce interest expense associated with the fixed rate debt.

The following table shows the outstanding notional amount of derivative instruments measured at fair value, net of credit value adjustments, as reported in the accompanying consolidated balance sheets as of June 30, 2022 and 2021 (in millions):

	Maturity Date of Derivatives	Interest Rate	Notional Amount Outstanding	Fair Value
			2022	
Derivatives not designated as hedges:				
Interest rate swaps	2024 - 2047	3.2% - 4.0%	$ 2,003	$ (234)
Risk participation agreements	2025 - 2029 with extension options	SIFMA plus spread	497	-
Total return swaps	2024 - 2030	SIFMA plus spread	321	-
Total derivative instruments			2,821	(234)
Cash collateral			-	84
Derivative instruments, net			$ 2,821	$ (150)
			2021	
Derivatives not designated as hedges:				
Interest rate swaps	2024 - 2047	3.2% - 4.0%	$ 2,117	$ (473)
Risk participation agreements	2022 - 2025 with extension options	SIFMA plus spread	510	-
Total return swaps	2024 - 2030	SIFMA plus spread	322	1
Total derivative instruments			2,949	(472)
Cash collateral			-	185
Derivative instruments, net			$ 2,949	$ (287)

CommonSpirit held $2.0 billion notional amount of interest rate swaps and $818 million notional amount of total return swaps at June 30, 2022, which have a negative fair value of $234 million and a fair value deemed immaterial, respectively. CommonSpirit posted $84 million of collateral against the fair value of the interest rate swaps as of June 30, 2022.

CommonSpirit's interest rate swaps mature between 2024 and 2047. CommonSpirit has the right to terminate the swaps prior to maturity for any reason. The termination value would be the fair value or the replacement cost of the swaps, depending on circumstances. The derivative agreements have certain early termination triggers caused by an event of default or a termination event. The events of default include failure to make payment when due, failure to give notice of a termination event, cash on hand dropping below a specified number of days, and defaults under other agreements (cross-default provision). Termination events can include credit ratings dropping below a defined minimum credit rating threshold by either party.

CommonSpirit has $160 million notional of interest rate swaps that are insured and have a negative fair value of $30 million as of June 30, 2022. In the event the insurer is downgraded below a specified minimum credit rating, the counterparties have the right to terminate the swaps if CommonSpirit Health does not provide alternative credit support acceptable to them within 30 days of being notified of the downgrade. If both the insurer and CommonSpirit Health are downgraded below a specified minimum credit rating, the counterparties have the right to terminate the swaps.

CommonSpirit has $1.8 billion notional amount of interest rate swaps that are not insured, of which the counterparties have various rights to terminate $306 million notional. These include the outstanding notional amounts of $100 million and $146 million at each five-year anniversary date commencing in March 2023 and September 2023, respectively. Swaps in the outstanding notional amounts of $60 million have mandatory puts in March 2028. The termination value would be the fair value or the replacement cost of the swaps, depending on the circumstances. These interest rate swaps with the optional and mandatory put options have a negative fair value of $35 million as of June 30, 2022. The remaining uninsured swaps in the notional amount of $1.5 billion have a negative fair value of $162 million as of June 30, 2022.

CommonSpirit has floating rate derivatives in the notional amount of $818 million as of June 30, 2022. These include $497 million of risk participation agreements which have a fair value deemed immaterial and $321 million notional of total return swaps with a fair value deemed immaterial as of June 30, 2022.

In July 2021, CommonSpirit novated swaps in the outstanding amount of $322 million held with one counterparty to another. The swap notional amount of $68 million with the mandatory put in March 2023 was removed as part of this transaction.

In June 2022, CommonSpirit novated risk participation agreements in the notional amount of $71 million to another counterparty.

In July 2022, CommonSpirit novated risk participation agreements in the notional amount of $132 million to another counterparty.

All swap and derivative bank counterparties have consented to the CommonSpirit Health MTI.

15. LEASES

CommonSpirit enters into operating and finance leases primarily for buildings and equipment and determines if an arrangement is a lease at inception of the contract. For leases with terms greater than 12 months, CommonSpirit records the related right-of-use asset ("ROU") and lease liability at the present value of lease payments over the contract term using a risk-free interest rate, subject to certain adjustments. CommonSpirit does not separate contract lease and non-lease components except for a class of underlying assets related to supply agreements, which include associated equipment. Certain building lease agreements require CommonSpirit to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU asset or lease liability. Lease costs also include escalating rent payments that are not fixed at commencement but are based on the Consumer Price Index or other measure of cost inflation. Future changes in the indices are included within variable lease costs. Certain leases include one or more options to renew the lease at the end of the initial term, with renewal terms that generally extend the lease at the then market rate of rental payment. Certain leases also include an option to buy the underlying asset at or a short time prior to the termination of the lease. All such options are at CommonSpirit's discretion and are evaluated at the commencement of the lease, with only those that are reasonably certain of exercise included in determining the appropriate lease term and lease type.

The components of lease cost, net for the year ended June 30 are as follows (in millions):

	2022	2021
Operating lease cost	$ 298	$ 336
Variable lease cost	181	152
Short-term rent expense	81	69
Amortization of right-of-use assets	33	41
Interest on finance lease liabilities	10	11
Sublease income	(10)	(5)
Total lease cost, net	$ 593	$ 604

Following is supplemental consolidated balance sheet information related to leases as of June 30 (in millions):

Lease Type	Balance Sheet Classification	2022	2021
Operating Leases:			
Operating lease ROU assets	Right-of-use operating lease assets	$ 1,715	$ 1,892
Operating lease obligations - current	Other accrued liabilities - current	263	281
Operating lease obligations - long-term	Operating lease liabilities	1,626	1,801
Finance Leases:			
Finance lease ROU assets	Property and equipment, net	299	293
Current finance lease liabilities	Current portion of long-term debt	38	36
Long-term finance lease liabilities	Long-term debt, net of current portion	305	334

Supplemental cash flow and other information related to leases for the years ended June 30 are as follows (in millions):

	2022	2021
ROU assets obtained in exchange for new operating lease liabilities	$ 248	$ 371
ROU assets obtained in exchange for new finance lease liabilities	58	175
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	312	346
Operating cash flows from finance leases	10	11
Financing cash flows from finance leases	34	34
Weighted-average remaining lease term:		
Operating leases	9 years	11 years
Finance leases	18 years	19 years
Weighted-average discount rate:		
Operating leases	2.0%	2.0%
Finance leases	4.0%	4.0%

Commitments related to operating and finance leases for each of the next five years and thereafter as of June 30, 2022, are as follows (in millions):

	Operating	Finance	Total
2023	$ 323	$ 47	$ 370
2024	296	43	339
2025	275	39	314
2026	254	36	290
2027	197	28	225
Thereafter	938	261	1,199
Total minimum future lease payments	2,283	454	2,737
Less: Imputed Interest	(270)	(109)	(379)
Total lease liabilities	2,013	345	2,358
Less: held for sale liabilities	(124)	(2)	(126)
Less: current lease liabilities	(263)	(38)	(301)
Total lease liabilities	$ 1,626	$ 305	$ 1,931

16. INTEREST EXPENSE, NET

The components of interest expense, net, include the following (in millions):

	2022	2021
Interest and fees on debt	$ 485	$ 470
Capitalized interest expense	(26)	(19)
Interest expense, net	$ 459	$ 451

17. RETIREMENT PROGRAMS

CommonSpirit maintains defined benefit pension plans and other postretirement benefit plans that cover most Dignity Health and CHI employees. Benefits for both types of plans are generally based on age, years of service and employee compensation.

Certain of CHI's plans were frozen in previous years, and benefits earned by employees through that time period remain in the retirement plans where employees continue to receive interest credits and vesting credits, if applicable.

Actuarial valuations are performed for all of the plans. These valuations are dependent on various assumptions. These assumptions include the discount rate and the expected rate of return on plan assets (for pension), which are important elements of expense and liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover, and the rate of compensation increases. CommonSpirit evaluates all assumptions in conjunction with the valuation updates and modifies them as appropriate. In the years ended June 30, 2022 and 2021, the actuarial gains and losses were primarily driven by the change in discount rate assumption.

Pension costs and other postretirement benefit costs are allocated over the service period of the employees in the plans. The principle underlying this accounting is that employees render service ratably over the period, and therefore, the effects in the accompanying consolidated statements of operations and changes in net assets follow the same pattern. Net actuarial gains and losses are amortized to expense on a plan-by-plan basis when they exceed the accounting corridor. The accounting corridor is a defined range within which amortization of net gains and losses is not required and is equal to 10% of the greater of the plan assets or benefit obligations. Gains or losses outside of the corridor are subject to amortization over the average employee future service period.

Contributions to the defined benefit pension plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to plan participants. Dignity Health management believes the majority of its plans qualify

under a church plan exemption, and as such, are not subject to Employee Retirement Income Security Act ("ERISA") funding requirements. CommonSpirit's funding policy requires that, at a minimum, contributions equal the unfunded normal cost plus amortization of any unfunded actuarial accrued liability. Contributions to these funded plans are anticipated at $163 million in 2023, which exceeds the funding policy minimum contributions.

The accumulated benefit obligation exceeds plan assets for the defined benefit plans and postretirement benefit plans in the aggregate for the years ended June 30, 2022 and 2021. The following summarizes the benefit obligations and funded status for the defined benefit pension and postretirement benefit plans (in millions):

	2022	2021
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 14,389	$ 14,096
Service cost	406	396
Interest cost	329	305
Actuarial (gain) loss	(2,566)	148
Acquisitions and other	-	138
Settlements	(34)	(140)
Benefits paid	(650)	(554)
Benefit obligation at end of year	$ 11,874	$ 14,389
Accumulated benefit obligation	$ 11,416	$ 13,826
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 11,082	$ 8,887
Actual return on plan assets	(924)	2,565
Settlements	(26)	(133)
Employer contributions	240	226
Benefits paid	(650)	(554)
Acquisitions and other	-	91
Fair value of plan assets at end of year, net	$ 9,722	$ 11,082
Funded status	$ (2,152)	$ (3,307)

The change in net actuarial loss of $995 million is included in the statement of changes in net assets for the year ended June 30, 2022. The actuarial losses for the years ended June 30, 2022 and 2021, are $894 million and $1.9 billion, respectively.

The settlement component of net periodic benefit cost is recognized in the accompanying consolidated statements of operations and changes in net assets within nonoperating income (loss).

The following table summarizes the assumptions used to determine benefit obligations as of June 30:

	2022	2021
To determine benefit obligations:		
Discount rate	3.7% - 4.9%	1.4%-3.1%
Rate of compensation increase	3.8%	3.8%
Weighted-average interest credit rate for cash balance plans and other applicable plans	7.4%	4.4%
To determine net periodic benefit cost:		
Discount rate	0.5% - 3.1%	1.4%-3.0%
Expected return on plan assets	3.8% - 7.1%	4.4%-7.1%
Rate of compensation increase	3.8%	3.8%
Weighted-average interest credit rate for cash balance plans and other applicable plans	4.5% - 5.5%	4.5% - 5.5%

The following table summarizes the components of net periodic benefit cost recognized in the accompanying consolidated statements of operations and changes in net assets (in millions):

	2022	2021
Service cost	$ 406	$ 396
Interest cost	329	305
Expected return on plan assets	(733)	(602)
Settlements	13	44
Net prior service credit amortization	(1)	(1)
Net actuarial loss amortization	68	168
Net periodic benefit cost	$ 82	$ 310

The service cost amount above is recorded in salaries and benefits on the accompanying consolidated statements of operations and changes in net assets. All other costs of net periodic benefit cost above are reflected in nonoperating income (loss) in the consolidated statements of operations and changes in net assets.

The following represents the fair value of plan assets, net, measured on a recurring basis as of June 30 (in millions). See Note 8 for the definition of Levels 1 and 2 in the fair value hierarchy and investments valued using the NAV practical expedient and discussion regarding fair value measurement.

	2022		
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Total**
Assets			
Cash and short-term investments	$ 479	$ 14	$ 493
U.S. government securities	329	24	353
U.S. corporate bonds	234	298	532
U.S. equity securities	795	2	797
Foreign government securities	-	10	10
Foreign corporate bonds	-	53	53
Foreign equity securities	1,024	1	1,025
Real estate	14	-	14
Other	8	-	8
Assets measured at fair value	$ 2,883	$ 402	3,285
Assets at NAV:			
U.S. government securities			120
U.S. corporate bonds			996
U.S. equity securities			563
Foreign corporate bonds			125
Foreign equity securities			1,682
Private equity			1,503
Hedge funds			1,074
Real estate			595
Total assets			$ 9,943
Other plan assets (liabilities)			
Due from brokers for unsettled investment trades			47
Due to brokers for unsettled investment trades			(268)
Fair value of plan assets, net			$ 9,722

	2021		
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Total
Assets			
Cash and short-term investments	$ 232	$ 222	$ 454
U.S. government securities	209	53	262
U.S. corporate bonds	302	397	699
U.S. equity securities	1,731	2	1,733
Foreign government securities	-	35	35
Foreign corporate bonds	-	145	145
Foreign equity securities	2,040	1	2,041
Real estate	25	-	25
Other	-	54	54
Assets measured at fair value	$ 4,539	$ 909	5,448
Assets at NAV:			
U.S. corporate bonds			627
U.S. equity securities			716
Foreign corporate bonds			138
Foreign equity securities			1,529
Private equity			1,133
Hedge funds			1,151
Real estate			430
Total assets			$ 11,172
Liabilities			
Foreign currency exchange contracts	-	51	51
Total liabilities	$ -	$ 51	$ 51
Other plan assets (liabilities)			
Due from brokers for unsettled investment trades			88
Due to brokers for unsettled investment trades			(127)
Fair value of plan assets, net			$ 11,082

The following table summarizes the weighted-average asset allocations by asset category for the pension plans:

	2022	2021
Cash and cash equivalents	5%	4%
U.S. government securities	5%	2%
U.S. corporate bonds	15%	12%
U.S. equity securities	14%	22%
Foreign corporate bonds	2%	3%
Foreign equity securities	27%	32%
Private equity	15%	10%
Other	17%	15%
Total	100%	100%

The asset allocation policy for the pension plans for 2022 is as follows: public equity, 49%; fixed income, 21%; private equity, 14%; hedge funds, 8%; real assets, 6%; and cash and opportunistic, 2%.

The asset allocation policy for the pension plans for 2021 is as follows: domestic fixed income, 12%; international fixed income, 2%; domestic equity, 32%; international equity, 26%; private equity, 10.5%; hedge funds, 9%; real assets, 6%; and cash and opportunistic, 2.5%.

CommonSpirit's investment strategy for the assets of the pension plans is designed to achieve returns to meet obligations and grow the assets of the portfolios longer term, consistent with a prudent level of risk. The strategy balances the liquidity needs of the pension plans with the long-term return goals necessary to satisfy future obligations. The target asset allocation is diversified across traditional and non-traditional asset classes. Diversification is also achieved through participation in U.S. and non-U.S. markets, market capitalization, and investment manager style and philosophy. The complementary investment styles and approaches used by both traditional and alternative investment managers are aimed at reducing volatility while capturing the equity premium from the capital markets over the long term. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. Consistent with CommonSpirit's fiduciary responsibilities, the fixed income allocation generally provides for security of principal to meet near-term expenses and obligations. Periodic reviews of the market values and corresponding asset allocation percentages are performed to determine whether a rebalancing of the portfolio is necessary.

CommonSpirit's pension plan portfolio return assumptions for 2022 and 2021 were based on the long-term weighted-average returns of comparative market indices for the asset classes represented in the portfolio and expectations about future returns.

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2023	$ 836
2024	978
2025	716
2026	740
2027	763
2028-2032	3,968
Total	$ 8,001

CommonSpirit maintains defined contribution retirement plans for most employees. Employer contributions to those plans of $407 million and $362 million for 2022 and 2021, respectively, included in salaries and benefits in the accompanying consolidated statements of operations and changes in net assets, are primarily based on a percentage of a participant's contribution.

18. COMMITMENTS, CONTINGENT LIABILITIES, GUARANTEES AND OTHER

The following summary encompasses matters related to litigation, regulatory and compliance matters, and developments thereto.

General – The health care industry is subject to voluminous and complex laws and regulations of federal, state and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not necessarily limited to, the rules governing licensure, accreditation, controlled substances, privacy, government program participation, government reimbursement, antitrust, anti-kickback, prohibited referrals by physicians, false claims, and in the case of tax-exempt organizations, the requirements of tax exemption. Management believes CommonSpirit is materially in compliance with all applicable laws and regulations of the Medicare and Medicaid programs. Compliance with such laws and regulations is complex and can be subject to future governmental interpretation as well as significant regulatory action, including fines, penalties and exclusion from the Medicare and Medicaid programs. Certain CommonSpirit entities have been contacted by governmental agencies regarding alleged violations of Medicare practices for certain services. Additionally, certain CommonSpirit entities have identified and self-disclosed potential instances of noncompliance with applicable regulations. In the opinion of management after consultation with legal counsel, the ultimate outcome of these matters will not have a material adverse effect on CommonSpirit's consolidated financial statements.

In recent years, government activity has increased with respect to investigations and allegations of wrongdoing. In addition, during the course of business, CommonSpirit becomes involved in civil litigation. Management assesses the probable outcome of unresolved litigation and investigations and records contingent liabilities reflecting estimated liability exposure. Following is a discussion of matters of note.

Pension Plan Litigation – In April 2013, Dignity Health was served with a class action lawsuit filed in the United States District Court for the Northern District of California by a former employee alleging breaches of fiduciary duty and other claims under ERISA in connection with the Dignity Health Pension Plan ("DHPP"). Among other things, the complaint originally alleged that, because Dignity Health is not a church or an association of churches, the DHPP does not qualify as a "church plan". The complaint also challenged the constitutionality of ERISA's church plan exemption. Dignity Health and the sponsoring religious orders established the DHPP and determined the DHPP was a church plan that should be exempt from ERISA, including ERISA's funding requirements, and received private letter rulings from the Internal Revenue Service that confirmed its church plan status. The plaintiff sought to represent a class comprised of participants and beneficiaries of the DHPP as of April 2013, when the complaint was filed.

In July 2014, the District Court ruled that only a church or an association of churches may establish a church plan; the DHPP did not qualify as a church plan since Dignity Health was not a church when the plan was established, and, therefore, DHPP was not exempt from ERISA. Dignity Health appealed the decision. In July 2016, the Ninth Circuit Court of Appeals issued its opinion, which affirmed the District Court's order and held that a church plan must be established by a church or by an association of churches and must be maintained either by a church or by a church-controlled or church-affiliated organization whose principal purpose or function is to provide benefits to church employees. The Ninth Circuit remanded the case to the District Court for further proceedings.

Dignity Health appealed the decision to the United States Supreme Court, which agreed to hear Dignity Health's case together with those of two other faith-based health systems facing similar challenges to church plan status.

In June 2017, the Supreme Court issued its unanimous opinion reversing the decision of the Ninth Circuit. The Court concluded that the 1980 amendment to Section 3(33)(C) of ERISA was intended by Congress to expand the types of pension plans that could qualify as church plans to include plans maintained by faith-based organizations such as Dignity Health and regardless of who first established the plans. The decision did not determine whether Dignity Health satisfied the requirements to maintain a church plan. In fact, the Court specifically noted that it was not deciding (1) whether any hospital was sufficiently associated with a church for its pension plan to qualify for the church plan exemption, or (2) whether an internal retirement committee could qualify as a "principal purpose" organization entitled to maintain a church plan. The Supreme Court remanded the case to the Ninth Circuit for further action based on its decision.

Based on the Supreme Court's decision, the Ninth Circuit returned the case to the District Court to continue the proceedings with regard to the two outstanding questions and other claims that were not decided by the Supreme

Court. The plaintiff amended its original complaint in November 2017, and Dignity Health filed a motion to dismiss the case in December 2017. The motion was heard in March 2018. In September 2018, the District Court issued its ruling denying Dignity Health's motion to dismiss. The decision was primarily based upon the procedural standard that requires the Court to accept the plaintiff's allegations in the amended complaint as true and does not permit Dignity Health to refute those allegations. As a result, the Court found that the amended complaint was sufficient to withstand dismissal at this stage, but encouraged the parties to further develop the factual record as a basis to consider Dignity Health's objections in the future.

The parties subsequently agreed to settle the litigation. In March 2022, the United States District Court for the Northern District of California granted final approval of the settlement agreement. The settlement resolves all claims asserted in the litigation and releases the named defendants and certain other releases in exchange for certain mandatory cash contributions to the DHPP over a five-year period, certain one-time payments, and non-monetary relief with respect to DHPP administration and accrued benefits protection, bringing the litigation to a full and final end. The terms of the settlement do not materially change the commitments Dignity Health has and continues to honor with respect to the DHPP. The settlement will have no impact on the financial position or results of operations of CommonSpirit.

Seismic standards – The State of California issued seismic safety standards in 1994 which have since been amended on several occasions. The regulations called for structural building upgrades to be in place by January 2013. Subsequent legislation extended the date of required improvements to 2030. Buildings improved or built to the new seismic standards may remain in an acute care service beyond 2030.

Each of the acute care service buildings at CommonSpirit's California facilities either: (1) already meets the standards in effect until 2030, (2) is not subject to these standards, (3) will not be used for acute care services beyond the extended deadline, or (4) is scheduled to undergo remediation before applicable deadline dates. The amount of capital required for meeting the 2030 standards, both structural or non-structural, is not yet determined, but is anticipated to be material.

In addition to the foregoing, in late 2014, the State of California created a new seismic performance category allowing buildings that were previously required to be decommissioned in 2030 to remain in use indefinitely if they could be retrofitted to meet certain new standards. CommonSpirit is undertaking the necessary evaluation of its buildings, to be completed by 2024, to test the viability of their continued use beyond 2030.

Long-term Contracts – CommonSpirit has entered into certain Master Services Agreements ("MSAs") with related parties for the purchase of revenue cycle management services that terminate in fiscal years 2031 and 2033. The agreements are amended from time to time and are subject to annual adjustments for inflation and achievement of certain performance levels, which reflect market terms. These amounts are recorded in purchased services and other in the accompanying statements of operations and changes in net assets. The MSAs are subject to significant penalties for cancellation without cause.

Purchase Commitments – CommonSpirit has entered into various agreements that require certain minimum purchases of goods and services, including management services agreements for information and clinical technology and sponsorship agreements, at levels consistent with normal business requirements. Excluding the long-term contracts noted above, outstanding unconditional purchase commitments were approximately $378 million at June 30, 2022.

19. FUNCTIONAL EXPENSES

CommonSpirit provides health care services, including inpatient, outpatient, ambulatory, long-term care and community-based services to individuals within the various geographic areas supported by its facilities. Expenses for these program services represent costs that are controllable by operational leadership. Support services include administration, financial services and purchasing, financial planning and budgeting, information technology, risk management, public relations, human resources, cash, debt and investment management, legal, mission services, and other functions that are supported centrally for all of CommonSpirit and are driven by CommonSpirit leadership.

Following is a summary of the program and support services provided for the years ended June 30, 2022 and 2021 (in millions):

	2022			
	Program Services - Health care	Support Services - Management and Administrative	Support Services - Fundraising	Total Expenses
Salaries and benefits	$ 17,068	$ 1,076	$ 26	$ 18,170
Supplies	5,436	152	-	5,588
Purchased services and other	8,269	1,185	69	9,523
Depreciation and amortization	1,301	162	-	1,463
Interest expense	384	75	-	459
Total operating expenses	$ 32,458	$ 2,650	$ 95	$ 35,203

	2021			
	Program Services - Health care	Support Services - Management and Administrative	Support Services - Fundraising	Total Expenses
Salaries and benefits	$ 15,090	$ 890	$ 26	$ 16,006
Supplies	5,019	67	-	5,086
Purchased services and other	7,958	1,206	61	9,225
Depreciation and amortization	1,341	146	-	1,487
Interest expense	379	72	-	451
Total operating expenses	$ 29,787	$ 2,381	$ 87	$ 32,255

20. UNSPONSORED COMMUNITY BENEFIT EXPENSE (UNAUDITED)

Unsponsored community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. These benefits (a) generate a low or negative margin, (b) respond to the needs of special populations, such as persons living in poverty and other disenfranchised persons, (c) supply services or programs that would likely be discontinued, or would need to be provided by another nonprofit or government provider, if the decision was made on a purely financial basis, (d) respond to public health needs, and/or (e) involve education or research that improves overall community health.

The unpaid costs of Medicaid/Medi-Cal includes $225 million and $493 million in direct benefit expense related to the California provider fee program in 2022 and 2021, respectively, and direct offsetting revenue related to the program of $529 million and $1.0 billion for 2022 and 2021, respectively.

Benefits for the Poor include services provided to persons who are low-income or medically indigent and cannot afford to pay for health care services because they have insufficient resources and/or are uninsured or underinsured. Serving these populations helps to achieve health equity.

Benefits for the Broader Community refer to programs in the general communities that CommonSpirit serves, including but beyond those for low-income and vulnerable persons. Most services for the broader community are aimed at improving the health and welfare of the overall community. CommonSpirit provides services to nonprofit organizations that promote the total health of their local communities, including the development of and connection to health and social services, support for affordable housing and healthy food, increasing opportunities for jobs and job training, and expanding access to health care for uninsured and underinsured persons.

Financial Assistance (Charity Care) is free or discounted health services provided to persons who cannot afford to pay and who meet CommonSpirit's criteria for financial assistance.

Net Community Benefit, excluding the unpaid cost of Medicare, is the total cost incurred after deducting direct offsetting revenue from government programs, patients, and other sources of payment or reimbursement for services provided to program patients. Restricted revenue from grants, fees, and other sources of payment or reimbursement for services provided to patients, program participants and the community also are included in direct offsetting revenue. The comparable amount of net community benefit was $2 billion for 2021 and net community benefit, including the unpaid cost of Medicare, was $5 billion for 2021.

Following is a summary of CommonSpirit's community benefits for 2022, in terms of services to the poor and benefits for the broader community, which has been prepared in accordance with Internal Revenue Service Form 990, Schedule H and the CHA publication, *A Guide for Planning and Reporting Community Benefit* (dollars in millions):

	Unaudited			
	Total Benefit Expense	**Direct Offsetting Revenue**	**Net Community Benefit**	**% of Total Expenses**
Benefits for the poor:				
Traditional charity care	$ 473	$ -	$ 473	1.3%
Unpaid costs of Medicaid / Medi-Cal	4,948	(2,951)	1,997	5.7%
Other means-tested programs	79	(1)	78	0.2%
Community services:				
Community health services	84	(29)	55	0.2%
Subsidized health services	32	(5)	27	0.1%
Cash and in-kind contributions	58	-	58	0.2%
Community building activities	7	(1)	6	0.0%
Community benefit operations	12	-	12	0.0%
Total community services for the poor	193	(35)	158	0.5%
Total benefits for the poor	5,693	(2,987)	2,706	7.7%
Benefits for the broader community:				
Community services:				
Community health services	32	(6)	26	0.1%
Health professions education	321	(29)	292	0.8%
Subsidized health services	163	(56)	107	0.3%
Research	51	(44)	7	0.0%
Cash and in-kind contributions	5	-	5	0.0%
Community building activities	5	(1)	4	0.0%
Community benefit operations	16	-	16	0.1%
Total benefits for the broader community	593	(136)	457	1.3%
Total community benefits	$ 6,286	$ (3,123)	$ 3,163	9.0%
Unpaid costs of Medicare	4,217	(2,486)	1,731	4.9%
Total community benefits, including unpaid costs of Medicare	$ 10,503	$ (5,609)	$ 4,894	13.9%

* * *