Providence SWEDISH

February 28, 2023

Eric Hernandez
Program Manager
Certificate of Need Program
Department of Health
111 Israel Road SE
Tumwater, WA 98501

Re: Application of Swedish Health Services – d/b/a Swedish Issaquah to Operate an Adult Elective PCI Program

Dear Mr. Hernandez:

Attached is the certificate of need application of Swedish Health Services – d/b/a Swedish Issaquah to operate an adult elective PCI program in Planning Area # 9 (King East).

The review and processing fee of $40,470 has been sent in a separate correspondence to the Certificate of Need Program.

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

Andrew Taylor	Chief Strategy Officer Providence Health & Services – WA/MT & Swedish	Andrew.Taylor5@providence.org
Lisa Crockett	VP, System Strategy & Planning Providence	Lisa.Crockett@providence.org
Matt Moe	Director, System Strategy & Planning Providence	Matthew.Moe@providence.org

Sincerely,

Andrew Taylor
Chief Strategy Officer
Providence Health & Services – Washington/Montana & Swedish

Certificate of Need
Hospital Application Packet

Contents:

1. 260-034 Contents List/Mailing Information………………… 1 Page
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Application submission must include:

- One electronic copy of your application, including any applicable addendum – no paper copy is required.
- A check or money order for the review fee of **$40,470** payable to **Department of Health.**[1]

  Include copy of the signed face sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee.

Mail or deliver the application and review fee to:

Mailing Address:	**Other Than By Mail:**
Department of Health Certificate of Need Program P O Box 47852 Olympia, Washington 98504-7852	Department of Health Certificate of Need Program 111 Israel Road SE Tumwater, Washington 98501

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov

[1] Please see Exhibit 1 for a copy of the check (application fee) and letter to the Department of Health.

Application Instructions

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

General Instructions:

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

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

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

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 [signature] **Email Address** Andrew.Taylor5@providence.org	**Date** 2/28/2023 **Telephone Number** 509-474-7253
Legal Name of Applicant Swedish Health Services – d/b/a Swedish Issaquah. **Address of Applicant and Operator** Swedish Issaquah 751 NE Blakely Drive Issaquah, WA 98209	☐ **New hospital** ☐ **Expansion of existing hospital (identify facility name and license number)** **Provide a brief project description, including the number of beds and the location.** Adult Elective PCI Program **Estimated capital expenditure:** $ 0

Identify the Hospital Planning Area: #9 (King East)

Identify if this project proposes the addition or expansion 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

Swedish Health Services –
d/b/a Swedish Issaquah

Certificate of Need Application

Proposing to Operate an Adult Elective PCI Program in Planning Area #9 (King East)

February 2023

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Introduction and Summary

Swedish Health Services d/b/a Swedish Issaquah ("Swedish Issaquah") requests approval to establish and operate an adult elective percutaneous coronary intervention ("PCI") program at the Swedish Issaquah campus, where it currently provides adult emergent PCIs. Swedish Health Services ("Swedish") has a long history of providing cardiac and vascular services to residents of Washington State and is recognized as a clinical leader in cardiac care. All cardiac and vascular services at Swedish are under the oversight and governance of the Swedish Heart and Vascular Institute ("SHVI"), one of the top heart and vascular programs in the State of Washington, which includes a well-established open heart surgery program at Swedish Cherry Hill in Seattle. As a quaternary care center for heart and vascular care, SHVI has significant experience performing both elective and emergent PCIs.

The existing emergent PCI program at Swedish Issaquah is part of the SHVI and draws on the experience and expertise of the Seattle program. Swedish Issaquah has performed emergent PCIs since the hospital opened more than 11 years ago. Approving the provision of elective PCI procedures at Swedish Issaquah complements the existing emergent PCI program, improving access, quality of care and patient safety while keeping East King County residents close to home.

Outside of the provision of elective PCIs, there are no planned changes in services at Swedish Issaquah and, consequently, the proposed project will not impact existing services at the Swedish Issaquah campus. Finally, the proposed project is not a phased project. We expect to provide elective PCI services beginning January 2024, subject to CN approval.

Need is Shown in the King East Planning Area

The Department's 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology was updated in January 2023 and shows need for 1.11 additional elective PCI programs in Planning Area 9 (King East).[1] As a result, WAC 246-310-720(2)(a) is met. The proposed CN approved elective PCI program at Swedish Issaquah will help address the unmet need in the King East planning area.

King East Residents Are Leaving the Planning Area to Receive Elective PCIs

Currently, a significant portion of planning area residents (32.6%) who live in proximity to Swedish Issaquah leave the planning area and travel to facilities outside the planning area to receive an elective PCI procedure.[2] High outmigration rates are an indicator that there is insufficient access within a planning area. Accordingly, the high King East outmigration rate for PCI services indicates there is need for an additional elective PCI program within King East. The approval of the proposed adult elective PCI program at Swedish Issaquah would be responsive to increasing access to needed services that are closer to home for planning area residents.

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[1] See Exhibit 23 for a copy of Department of Health 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology

[2] See Table 8, page 18, for the King East PCI outmigration analysis.

A Swedish Issaquah PCI Program Helps Prevent Fragmentation of Services
Fragmentation of care may occur when a resident receives care from different facilities or different health care organizations outside the planning area. An elective PCI program at Swedish Issaquah will allow residents to receive care close to home, thus reducing the adverse impacts from delaying care or staging treatment due to lack of access to elective PCI services in the planning area.

The Proposed PCI Program Will Not Adversely Impact Other PCI Programs
The Department's 2022-2023 PCI Need Methodology shows projected unmet need of 221 cases by 2026, which is sufficient to support the growth of an emergent and elective PCI program at Swedish Issaquah, as well as the growth of other existing PCI programs in the planning area. In addition, a PCI origin zip code analysis demonstrates that establishing and operating an adult elective PCI program at Swedish Issaquah will not impact the University of Washington Medical Center Cardiovascular Disease and Interventional Cardiology Fellowship Training programs.[3]

A New Elective PCI Program Promotes Judicious Use of Health Care Resources
Swedish Issaquah has two existing cardiac catheterization laboratories ("cath labs") that are fully equipped and fully staffed. There are no capital costs associated with the proposed project. Swedish Issaquah will gain cost and operating efficiencies from Moreover, the Swedish Issaquah emergent program already has in place all operational guidelines, required policies and procedures. The program also has an established PCI quality performance improvement plan and draws from the extensive expertise of the SHVI to provide high quality care to planning area residents.

Swedish Is Committed To, And Has Deep Roots In, The Local Community
Swedish Issaquah is committed to providing health care services to all persons, without regard to income, race, ethnicity, gender, handicap, or any other factor. Swedish also is committed to caring for each person needing care, regardless of his or her ability to pay. As a long-established provider serving the region since 1910, Swedish Health Services has deep roots in and is fully committed to the local community. Swedish has resolved to improve the health of the region beyond normal patient care. This translates to our commitment to charity care, research, community health and education. In 2021, Swedish provided a combined $251.8 million in community benefit.[4] We see this service as our responsibility to our community and we take it seriously.

The proposed adult elective PCI program at Swedish Issaquah meets all four CN criteria. Need (WAC 246-410-210) for a new program is shown in the King East planning area as demonstrated by the Department's 2022-2023 PCI Need Methodology. The project is financially feasible and will not result in an adverse impact on costs or charges of health care services in the planning area, meeting WAC 246-310-220. In addition, the proposed project will promote continuity of care, foster appropriate relationships with the planning

[3] See Exhibit 31 for an analysis of King East planning area PCIs by zip code on the UWMC.
[4] See Table 9.

area's existing health care services, and since the existing cath labs are fully staffed will not impact other programs operating in the planning area, meeting WAC 246-310-230. Finally, the project meets Cost Containment (WAC 246-310-240) as it is the best alternative to meet unmet need and promotes quality assurance and cost effectiveness. Swedish Issaquah looks forward to establishing a new CN approved elective PCI program that will address the unmet need in the King East planning area.

Applicant Description

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

The applicant's legal name is Swedish Health Services d/b/a Swedish Issaquah ("Swedish Issaquah").

Swedish Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

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

Swedish Health Services d/b/a Swedish Issaquah is a private, non-profit organization – 501(c)(3) with a Unified Business Identifier ("UBI") of 178 049 719

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

The contact person for this application is provided below:

Andrew Taylor, Chief Strategy Officer
Providence Health & Services – WA/MT & Swedish
20 West 9th Avenue
Spokane, WA 99204
Phone: 509-474-7253
Andrew.Taylor5@Providence.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).**

This question is not applicable. There is no consultant authorized to speak on our behalf related to the screening of this application.

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

On July 1, 2016, Providence Health & Services and St. Joseph Health System, a California non-profit corporation, became affiliated. The affiliation creates a "super-parent," Providence St. Joseph Health ("PSJH"), a Washington non-profit corporation.

PSJH has facilities located in Alaska, Washington, Montana, Oregon, California, New Mexico, and Texas.

It is important to note that Providence Health & Services remains a viable corporation as do any and all subsidiaries and d/b/as that fall under that corporate umbrella. This new affiliation does not change the name or corporate structure of Providence Health & Services or Swedish Health Services d/b/a Swedish Issaquah. For the purposes of this CN application, the Providence Health & Services legal structure has been provided in Exhibit 2. In addition, an organizational chart for Swedish Health Services d/b/a Swedish Issaquah is provided in Exhibit 3.

Finally, a copy of the Washington State Department of Health Hospital Acute Care License for Swedish Issaquah is provided in Exhibit 4.

Facility Description

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

The existing facility is the following:

Swedish Health Services d/b/a Swedish Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

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

The proposed adult elective percutaneous coronary intervention ("PCI") program will be operated from the existing Swedish Issaquah facility.

Swedish Health Services d/b/a Swedish Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

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.

- HAC.FS. 60256001
- Medicare #: 50-0152
- Medicaid #: 2015502

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

Please see below for a list of the accreditations for Swedish Issaquah. There are no expected changes in accreditation related to implementing the elective PCI program.

- College of American Pathologists (CAP) lab certification, exp. 3/1/2025
- Commission on Cancer Certificate with commendation by the American College of Surgeons, (American College of Surgeons Commission on Cancer Certified), expires 2024
- American College of Radiology in Mammography, College of Radiology Accredited Facility, expires 10/31/2023
- American College of Radiology, Breast MR Imaging Services, expires 10/31/2023
- Det Norske Veritas Accreditation, expires 11/1/2024
- DOH Licensure Survey, September 2021
- DOH Level 1 Cardiac Center, 2021 (WA DOH Categorization)

5. Is the facility operated under a management agreement?

No, the facility is not operated under a management agreement.

6. Provide the following scope of service information:

Please see Table 1 for the current and proposed services offered at Swedish Issaquah. The proposed project will be limited to the addition of adult elective PCI services. No other services will change as a result of the proposed project.

Table 1. Swedish Issaquah Services Offered (Pre and Post Project)

Service	Currently Offered?	Offered Following Project Completion?
Alcohol and Chemical Dependency	NO	NO
Anesthesia and Recovery	YES	YES
Cardiac Care	YES	YES
Cardiac Care – Adult Open Heart Surgery	NO	NO
Cardiac Care – Pediatric Open Heart Surgery	NO	NO
Cardiac Care – Adult Elective PCI	NO	YES
Cardiac Care – Pediatric Elective PCI	NO	NO
Diagnostic Services	YES	YES
Dialysis – Inpatient	NO	NO
Emergency Services	YES	YES
Food and Nutrition	YES	YES
Imaging/Radiology	YES	YES
Infant Care/Nursery	YES	YES
Intensive/Critical Care	YES	YES
Laboratory	YES	YES
Medical Unit(s)	YES	YES
Neonatal – Level II	YES	YES
Neonatal – Level III	NO	NO
Neonatal – Level IV	NO	NO
Obstetrics	YES	YES
Oncology	YES	YES
Organ Transplant - Adult (list types, if applicable)	NO	NO
Organ Transplant - Pediatric (list types, if applicable)	NO	NO
Outpatient Services	YES	YES
Pediatrics	NO	NO
Pharmaceutical	YES	YES
Psychiatric	NO	NO
Skilled Nursing/Long Term Care	NO	NO
Rehabilitation (indicate level, if applicable)	NO	NO
Respiratory Care	YES	YES
Social Services	YES	YES
Surgical Services	YES	YES

Source: Swedish Issaquah

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.**

In this CN application, Swedish Health Services requests approval to provide adult elective PCIs at the Swedish Issaquah campus, where it currently provides adult emergent PCIs. Swedish Health Services has a long history of providing cardiac and vascular services to residents of Washington State and is recognized as a clinical leader in cardiac care. All cardiac and vascular services at Swedish are under the oversight and governance of the Swedish Heart and Vascular Institute, one of the top heart and vascular programs in the State of Washington, which includes a well-established open heart surgery program at Swedish Cherry Hill in Seattle. As a quaternary care center for heart and vascular care, Swedish Heart and Vascular Institute has significant experience in performing both elective and emergent PCIs.

The existing PCI program at Swedish Issaquah is part of the Swedish Heart and Vascular Institute and draws on the experience and expertise of the Seattle program. Swedish Issaquah has performed emergent PCIs since the hospital opened more than 11 years ago. Care received at either the Seattle or Issaquah facilities is of the same high quality since both are part of the Swedish Heart and Vascular Institute, and staff and physicians are exposed to very high volumes with very complex cases and advanced circulatory support devices. Allowing elective PCI procedures at Swedish Issaquah complements the provision of emergent PCIs, improving access, quality of care and patient safety while keeping East King County residents close to home.

The Swedish Issaquah emergent PCI program consistently achieves top scores in quality metrics. In addition to having excellent outcomes with its existing PCI program, Swedish Issaquah operates an 18-bed Intensive Care Unit that works seamlessly with the Swedish Heart and Vascular Institute to deliver outstanding outcomes for higher acuity patients who require additional care. Thus, patients receiving cardiac care, including those who need PCI services at Issaquah, are able to receive all of their care at the Swedish Issaquah facility.

Outside of the provision of elective PCIs, there are no planned changes in services at Swedish Issaquah and, consequently, the proposed project will not impact existing services at the Swedish Issaquah campus. Finally, the proposed project is not a phased project. We expect to provide elective PCI services beginning January 2024, subject to CN approval.

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).**

The proposed adult elective PCI project is an expansion of a tertiary service. We have included the required PCI addendum for the proposed adult elective PCI 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.

The proposed adult elective PCI project will not impact the current and proposed bed types at Swedish Issaquah. There is no change in bed types or bed totals as a result of the proposed project. For clarity, we have provided the count by bed types at Swedish Issaquah as reported in the Department of Health acute care bed survey (see Table 2).

Table 2. Swedish Issaquah Current and Proposed Bed Type

Bed Type	Current	Proposed
General Inpatient Acute Care	153	153
Dedicated or PPS Exempt Psychiatric	0	0
Dedicated or PPS Exempt Rehabilitation	0	0
Long Term Care/Nursing Home Beds	0	0
NICU Level II	15	15
NICU Level III	0	0
NICU Level IV	0	0
Total	**168**	**168**

Source: Swedish Issaquah

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.

Swedish is licensed for 175 beds and currently has 168 beds set-up, including 153 general inpatient acute beds and 15 NICU Level II beds. The remaining 7 beds are not set up, as the 168 set-up beds are meeting the current demand for the hospital. If demand increases, Swedish Issaquah is positioned to set-up additional beds, as needed, up to its licensed capacity of 175 beds.

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

Please see Table 3 for the estimated project timeline.

Table 3. Estimated Project Timeline

Event	Anticipated Month/Year
Anticipated CN Approval	November 2023
Design Complete	N/A
Construction Commenced	N/A
Construction Completed	N/A
Facility Prepared for Survey	December 2023
Facility Licensed - Project Complete WAC 246-310-010(47)	January 2024

Source: Swedish Issaquah

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

The proposed project will serve adult patients diagnosed with coronary artery disease in which appropriate use criteria outlined by the American College of Cardiology ("ACC") demonstrate such patients would benefit from a PCI in comparison to another care modality, including medical management.

Patients will be cared for regardless of their ability to pay, and without regard to income, race, ethnicity, gender, sex, handicap, religion, or any other factor at Swedish Issaquah.

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

Please see Exhibit 5 for a copy of the letter of intent.

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

Please see Exhibit 6 for single line drawings for Swedish Issaquah. Since there is no construction or change in floor plans, the single line drawings both before and after project completion are the same.

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

The gross square footage ("GSF") of the hospital is 362,033. Since there is no construction or alteration of floor plans involved in the proposed project, there is no change in GSF with and without the project.

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

This question is not applicable, as there is no construction involved in the proposed project.

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

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

This question is not applicable, as there is no construction involved in the proposed project.

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

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

The planning area is King East, with the zip-code definition listed in Table 4.

Table 4. King East Planning Area

King East Planning Area Definition			
98001	98019	98034	98057
98002	98022	98038	98058
98003	98023	98039	98059
98004	98024	98042	98065
98005	98027	98045	98072
98006	98028	98047	98074
98007	98029	98051	98075
98008	98030	98052	98077
98010	98031	98053	98092
98011	98032	98055	98224
98014	98033	98056	98288

Source: DOH

Other hospitals in the PCI planning that provide either emergent or elective PCI services are listed in Table 5.

Table 5. Affected Hospitals in Planning Area

Facility	DOH License #	Zip Code	Provides Emergent PCI?	Provides Elective PCI?
EvergreenHealth Medical Center	HAC.FS.00000164	98034	Yes	Yes
Overlake Hospital Medical Center	HAC.FS.00000131	98004	Yes	Yes
MultiCare Auburn Regional Medical Center*	HAC.FS.60311052	98001	Yes	Yes
Saint Francis Hospital*	HAC.FS.00000201	98003	Yes	Yes
UW Medicine/Valley Medical Center	HAC.FS.00000155	98055	Yes	Yes

Sources: 1) https://fortress.wa.gov/doh/facilitysearch/; 2) DOH Annual PCI Surveys

*Joint elective PCI program between MultiCare Auburn Regional Medical Center and Saint Francis Hospital

2. For projects proposing to add acute care beds, provide a numeric need methodology that demonstrates need in this planning area. The numeric need

methodology steps can be found in the Washington State Health Plan (sunset in 1989).

This question is not applicable, as the proposed adult elective PCI project does not seek to expand any bed types. The total number and type of beds will not be impacted by the proposed project (see Table 2).

For the proposed project to operate a CN approved, adult elective PCI program at Swedish Issaquah, please see our response to question 6 in the PCI addendum about the Department's 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology.

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

This question is not applicable, as the proposed PCI project does not seek to expand any bed types. The total number and type of beds will not be impacted by the proposed project (see Table 2).

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.**

Please see Table 6, which includes historical utilization for the Swedish Issaquah facility. There are no project-specific beds, discharges, or patient days, as the proposed project seeks to provide adult elective PCI services only.

Table 6. Swedish Issaquah Historical Utilization, 2020-2022

Project Specific Only	2020	2021	2022
Licensed beds	N/A	N/A	N/A
Available beds	N/A	N/A	N/A
Discharges	N/A	N/A	N/A
Patient days	N/A	N/A	N/A
Entire Hospital	**2020**	**2021**	**2022**
Licensed beds	175	175	175
Available beds	175	168	168
Discharges	5,653	6,102	6,619
Patient days	21,968	25,056	28,514

Source: Swedish Issaquah

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.

This question is not applicable, as the proposed adult elective PCI project does not seek to expand any bed types. The total number and type of beds will not be impacted by the proposed project (see Table 2).

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

The proposed project intends to provide an adult elective PCI program at Swedish Issaquah. Please see Table 7 for a patient origin analysis for PCI procedures performed at Swedish Issaquah for the full year of 2022.

Table 7. Swedish Issaquah Patient Origin by Zip Code, 2022

Zip Code	Count	Zip Code	Count	Zip Code	Count
98075	14	98204	2	98077	1
98027	13	98022	2	98040	1
98029	13	98037	2	98284	1
98074	11	98203	2	98258	1
98053	6	98012	2	32803	1
98065	5	98178	2	77381	1
98059	5	98087	2	98338	1
98045	4	98024	1	98239	1
98922	3	98038	1	98107	1
98052	3	98056	1	98294	1
98006	3	98019	1	98115	1
98014	3	98055	1	98117	1
98008	3	98058	1	98133	1
98208	3	98005	1	98377	1
98296	3	98010	1	98837	1
98033	2	98023	1	98943	1
Total					**133**

Source: Swedish Issaquah

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

Currently, a significant portion of planning area residents (32.6%) who live in proximity to Swedish Issaquah leave the planning area and travel to facilities outside of the planning

area to receive an elective PCI procedure. As noted in Table 8, the King East planning area residents received a combined 1,498 inpatient and outpatient PCIs in 2021 from facilities located within and outside the King East planning area. To be clear, Table 8 represents only PCI procedures received by planning area residents. It does not represent all PCIs performed by King East facilities, which could include any residents outside of the planning area who received a PCI procedure in King East.

As noted in Table 8, out of the 1,498 PCIs received by planning area residents, 489 cases were conducted at hospitals outside of the King East planning area. This represents a 32.6% outmigration rate for these services. Stated differently, almost one-third of King East residents sought PCIs outside of the planning area.

High outmigration rates are an indicator that there is insufficient access within a planning area. Accordingly, the high King East outmigration rate for PCI services indicates there is need for an additional PCI program within King East, which aligns with the 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology. The approval of the proposed adult elective PCI project at Swedish Issaquah would be responsive to increasing access to needed services that are closer to home.

Table 8. King East PCI Outmigration Analysis, 2021[5]

Facility	PCI Outpatient	PCI Inpatient	Hospital Total	Market Share
Overlake Medical Center	148	141	289	19.3%
EvergreenHealth Kirkland	110	119	229	15.3%
UW Medicine/Valley Medical Center	38	137	175	11.7%
St. Francis Hospital	64	90	154	10.3%
MultiCare Auburn Medical Center	8	78	86	5.7%
Swedish Issaquah	0	76	76	5.1%
King East Hospital Subtotal	368	641	1,009	67.4%
Non-King East Hospital Subtotal	307	182	489	32.6%
Total (King East and Non-King East)	**675**	**823**	**1,498**	**100%**

Sources: 1) PNWPop data, 2021 data for patients with King East Zip for IP PCI Procedures (246-251 MSDRGs) and OP PCI procedures (Procedure Codes 92920, 92924, 92928, 92933, 92937, 92943, C9600, C9602, C9604, C9607); 2) Utilized 2021 PCI OP Volumes reported by Evergreen in PCI Survey

Notes on data:
1) Swedish Issaquah inpatient PCI volume of 76 cases represents PCIs only from King East residents. Swedish Issaquah's total PCI cases in 2021 is 100, reflecting patients residing adjacent to the planning area receiving emergent PCIs at Swedish Issaquah.
2) Swedish Health Services' analysis noted that PNWPop data listed 22 PCI cases at Swedish Issaquah as inpatient. This is incorrect. An internal review of those cases found that all 22 patients entered Swedish Issaquah through the emergency department, were stabilized in the ICU, and subsequently administered a

[5] Compared to Table 7 which uses 2022 internal Swedish Health Services data, Table 8 uses 2021 data as market data for 2022 is not available at the time of filing this application.

PCI procedure. These were not scheduled/outpatient cases. Therefore, Table 8 correctly shows 76 inpatient (emergent) PCI procedures at Swedish Issaquah for King East residents.

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

Swedish Issaquah in King East is committed to providing health care services to all persons, without regard to income, race, ethnicity, gender, handicap, or any other factor. Swedish also is committed to caring for each person needing care, regardless of his or her ability to pay. As a long-established provider serving the region since 1910, Swedish Health Services has deep roots in and is fully committed to the local community. Swedish has resolved to improve the health of the region beyond normal patient care. This translates to our commitment to charity care, research, community health and education. We see this service as our responsibility to our community and we take it seriously.

Swedish devotes substantial resources to health-related research, community health activities, and medical education. As a charitable, nonprofit 501(c)(3) organization, Swedish invests its resources in programs and services that improve the health of the community and region, from building partnerships with community clinics that serve the underprivileged to providing free and low-cost health education classes to the public.

In 2021, Swedish Health Services provided a combined $251.8 million in community benefit. Of the $251.8 million, Swedish Issaquah provided $19 million in community benefit.

Table 9. Swedish Health Services – Community Benefit, 2021[6]

Service	Amount
Unfunded portion of Government-sponsored medical care	$174.0 Million
Free and Discounted Medical Care	$25.1 Million
Community health, grants and donations	$10.4 Million
Education and research programs	$34.2 Million
Subsidized services	$8.1 Million
Total	**$251.8 Million**

Source: See Exhibit 7 for Swedish Health Services 2021 Community Benefit Report.

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[6] The categories of community benefit are defined as follows:
(a) Unfunded Portion of Government-sponsored Medical Care. This is the difference between the actual costs of care and what is paid by the state and federal governments. It does not include Medicare.
(b) Free and Discounted Medical Care. This includes financial assistance for those who are uninsured, underinsured, or otherwise unable to pay for their health care.
(c) Community Health, Grants and Donations. This includes free services such as patient education, health screenings, immunizations and support groups, as well as grants and donations to support community partners.
(d) Education and Research Programs. This includes subsidies for medical residency programs, education for nursing and other health professions, and medical research.
(e) Subsidized Services. This includes clinical and social services provided despite a financial loss because they meet identified needs not met elsewhere in the community.

From newly arrived immigrants and at-risk teenagers to low-income seniors and families, Swedish compassionately reaches out to those who might not otherwise receive the health care services they need. Swedish supports the community and underserved populations in a multitude of ways. Below we provide a synopsis of many of Swedish's community programs and services. In addition, please see Exhibit 8 for the Swedish King County Community Health Improvement Program, 2022-2024 that details the priorities Swedish is focusing on in the communities they serve.

- **Supporting And Empowering Black Birthing Women and People**
  The Black Birth Empowerment Initiative (BBEI) at Swedish is a curated program designed for those who identify as Black or African American. Its purpose is to center and uplift the Black birth experience by providing clients the option to work with culturally competent, trained doulas. BBEI caregivers work to reduce health disparities in the Black community including prenatal and postpartum complications and higher rates of stillbirths and pregnancy mortality. The Birth Equity and Women's Health for the Swedish doula program, BBEI was created in direct response to concerns heard from the community. The program's Doula Diversity Scholarship is a key resource for aspiring doulas of color, and it helps advance the initiative's goals. The scholarship covers the cost of doula training and certification, a lending library, and shadowing opportunities. In 2021, the program received community benefit support from Swedish to provide scholarships to four new doulas who will work in the community.

- **Swedish Mobile Vaccine Clinics.**
  In 2021, we answered the call to vaccinate those who needed it most. We launched a mobile vaccination clinic, using COVID-19 data to target our outreach and vaccine education efforts to underserved populations most affected by the pandemic. Our caregiver volunteers made these clinics a reality, and we administered more than 10,000 vaccinations with more than 20 community partners. Caregiver/staff and community volunteers even provided clothing and supply donations at some of these events. The Washington State Hospital Association awarded its 2021 Community Health Leadership Award to Swedish for our mobile vaccine clinic team.

- **Meharry Residency Program.**
  Swedish Health Services (SHS) and Meharry Medical College (MMC) have formed a partnership aimed at addressing health disparities among people of color and promoting diversity in healthcare. The program, which officially launched in September 2021, offers residency opportunities to third-year medical students with financial assistance for transportation, housing, and living expenses. The Diversity Sub-Internship Scholarship is open to all fourth-year medical students from U.S. medical schools and minority groups underrepresented in surgery. The goal of the Swedish/Meharry partnership is to produce a new generation of culturally competent physicians and reduce health disparities by providing culturally competent care to people of color that focuses on health, well-being, and patient experience.

- **Swedish's LGBTQIA+ Program.**
  Swedish's LGBTQIA+ Program is an initiative established in 2020 aimed at improving access to comprehensive healthcare for LGBTQIA+ patients. The program operates under the Office of Health Equity, Diversity and Inclusion and provides specialized support to care teams to ensure optimal care for LGBTQIA+ patients. Swedish offers Health Care Navigation Services for transgender and gender diverse patients seeking gender-affirming care and treatments, connecting patients to relevant primary care clinicians, surgeons, mental health professionals, and resources. Navigation support is available at no additional charge and patients can expect timely follow-up and check-ins. Swedish provides gender-affirming care services with more than 60 clinicians having completed non-clinical transgender health training and listed as gender-affirming clinicians on the Swedish Transgender Health website.

- **Refugee Artisan Initiative.**
  A solution to Swedish's scrub supply problem was just around the corner with Refugee Artisan Initiative (RAI), a nonprofit founded by Ming-Ming Tung-Edelman. RAI helps refugee and immigrant women improve skills developed in their home countries and connects them with artisan U.S. job opportunities. Tung-Edelman applied to Swedish's Community Investment Funding Grant, and not long after, Swedish and RAI partnered to supply our caregivers with measured-to-fit scrubs.

- **Support for Patients and Families.**
  The Swedish Patient Assistance Fund provides patients and their families with financial support for a range of items and services, including utility bills, wheelchairs and walkers, rent and mortgage assistance, skilled nursing and home care, and more.

- **Family Violence Program.**
  Many of Swedish's staff members are specially trained to identify patients who may be victims of family violence and connect them with community agencies that can provide the help they need. In addition, Swedish provides financial support and donates space to organizations, such as New Beginnings and the YWCA, that support battered women and their families.

- **Community Health Education.**
  The Patient/Family Education and Community Health Program is committed to helping patients, families, and the community make informed choices about their health. The program offers classes on topics such as cancer, childbirth, diabetes, orthopedics, nutrition, safety and injury prevention, stress management, and more. In addition to hosting hundreds of health education classes each year, Swedish offers the community many support groups on a range of topics from cancer to bereavement to childbirth.

- **Swedish Community Specialty Clinic.**
  In September 2010, the Swedish Community Specialty Clinic ("SCSC") opened on Swedish First Hill. The former Mother Joseph and Glaser specialty clinics combined and expanded specialty care services to the uninsured in our community. The clinic is partnered with King County Project Access ("KCPA") and

is a testament to Swedish's commitment to serve the uninsured and underinsured patients in our community.

SCSC provides a workable solution to one of the most pressing health care problems facing low-income and uninsured people in our community - access to specialty care services. This program builds on the safety net of primary care provided by the community health and public health clinics in King County. Through KCPA and a volunteer staff of more than 180 Swedish specialty physicians, low-income uninsured patients have access to needed specialty health care and donated ancillary, in- and out-patient hospital services.

Our goal is to set a new standard in community health and to highlight that charity care is a core part of our nonprofit mission, which we continue even in a down economy.

- **Residency programs for the economically disadvantaged**
  Swedish Family Medicine Residency clinics select residents from the nation's top medical schools to provide the best care to people of all ethnic backgrounds and financial situations. Physician residents treat patients regardless of their ability to pay, logging more than 41,000 patient visits each year. In addition to seeing patients at our First Hill and Cherry Hill campuses, the Family Medicine Residency also provides care through partnerships with the SeaMar, Indian Health Board and Downtown Family Medicine Clinics.

- **Health-care services at Ballard High School**
  The Ballard Teen Health Center is a partnership between Swedish and Ballard High School to provide students at the school with physical and mental-health services. Teens visit the center for treatments ranging from illnesses and injuries to confidential family-planning services, STD testing and mental-health counseling. The center, which was started by Swedish in 2002, also provides smoking-cessation programs, nutrition and exercise counseling, general health information and school-wide health promotion and classroom presentations. The center targets adolescents who are uninsured or underinsured and those who have no other options for medical care and counseling.

  Along with the above-mentioned programs, Swedish will provide PCI services to all patients, regardless of his or her ability to pay, and without regard to income, race, ethnicity, gender, handicap, or any other factor, at the facility in Issaquah.

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. The project does not propose either a partial or full relocation of an existing facility.

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. The project does not propose either a partial or full relocation of an existing facility.

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

- Please see Exhibit 9 for the Swedish Notification of Patient Admission policy and the Delivery of the Conditions of Admission Consent Form policy.
- Please see Exhibit 10 for the Swedish Financial Assistance – Charity Care policy.
- Please see Exhibit 11 for the Swedish Patient Rights policy.
- Please see Exhibit 12 for the Providence Non-discrimination policy. This is a systemwide policy with applicability to Swedish.
- Please see Exhibit 13 for the Providence Policy on Care Through the End of Life: Responding to Requests for Provider-hastened Death. This is a systemwide policy with applicability to Swedish.
- Please see Exhibit 14 for the Swedish Advance Directive and CPR Preference policy This is a Swedish policy and is applicable to Swedish Issaquah.
- Please see Exhibit 15 for the Swedish Issaquah Hospital Reproductive Health Services statement.

B. 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.**

Utilization Projections
Swedish Issaquah currently provides emergent PCIs and, in 2022, provided 133 PCI procedures. The proposed project intends to provide an adult elective PCI program at the Swedish Issaquah facility.

- Utilization projections assume emergent cases will grow incrementally by approximately 1.5% combined average growth rate over the four-year period, adding two cases per year from 2023 to 2026. This growth rate is consistent with the planning area growth rates.[7]
- Utilization projections assume elective cases will grow by 52 cases in 2024, which is the first year of operations. This represents an additional one case per week for scheduled PCIs in the first full year of operations. In 2025-2026, volumes will grow modestly, adding 12 cases in 2025 and 12 cases in 2026, representing an incremental one additional case per month in the second and third full year of operations.
- Swedish forecasts that by the end of the third year of operations Swedish Issaquah will grow to a combined 217 emergent and elective cases in 2026.

Please see Table 10 for the Swedish Issaquah 2022 actuals, 2023 projected, and 2024-2026 forecast PCIs.

[7] King East planning area population forecast is expected to grow from 1,023,824 residents in 2021 to 1,102,840 residents by 2026, representing a 1.5% average growth rate. Source: ESRI.

Table 10. Swedish Issaquah Actual, Projected, and Forecasted PCIs, 2022-2026

	2022	2023		2024		2025		2026	
	Actual	Projected		Forecast					
	Total	Incremental	Total	Incremental	Total	Incremental	Total	Incremental	Total
PCI Emergent	133	2	135	2	137	2	139	2	141
PCI Elective	0	0	0	52	52	12	64	12	76
PCI Total	133	2	135	54	189	14	203	14	217

Source: Swedish Issaquah

Since the proposed project is only seeking to add a CN approved adult elective PCI program at Swedish Issaquah and is not adding any additional services in the hospital as a whole, we have kept hospital utilization at a consistent rate holding utilization steady at 2022 levels. This representation makes it easier to compare and understand the impact of the project on the hospital as a whole. Please see Table 11 for the Swedish Issaquah hospital utilization forecast from 2024-2026.

Table 11. Swedish Issaquah Forecasted Hospital Utilization, 2024-2026

Project Specific Only	**2024**	**2025**	**2026**
Licensed beds	N/A	N/A	N/A
Available beds	N/A	N/A	N/A
Discharges	N/A	N/A	N/A
Patient days	N/A	N/A	N/A
Entire Hospital	**2024**	**2025**	**2026**
Licensed beds	175	175	175
Available beds	168	168	168
Discharges	6,619	6,619	6,619
Patient days	28,514	28,514	28,514

Source: Swedish Issaquah

Balance Sheet

Please note that Swedish Health Services does not maintain balance sheets at the facility level and does not routinely use balance sheets as part of its financial analysis when evaluating new business ventures. Instead, a business pro forma is generally relied upon for evaluation of new ventures. With that said, for purposes of this CN application and to satisfy the Department's questions relating to balance sheets, Swedish Issaquah has extrapolated information from the pro forma statements to construct a pro forma balance sheet. This balance sheet was created solely for the Department's review of this Application and will not be generally used in the financial operations of Swedish Issaquah. Please see Exhibit 16 for a balance sheet for the current year and the first three years of operation.[8]

[8] Exhibit 16 includes the balance sheet assumptions.

Proforma Revenue and Expense Statements
Please see Exhibit 17 for proforma revenue and expense statements.[9] Exhibit 17 includes proforma revenue and expense statements for the proposed project, the hospital as a whole (excluding the project), and a combined view that includes both the proposed project and the hospital as a whole.

Historical Revenue and Expense Statements
Please see Exhibit 18 for historical revenue and expense statements for Swedish Issaquah. Exhibit 18 includes historical revenue and expense statements for the cath lab, the hospital as a whole (excluding the cath lab), and a combined view that includes both the cath lab and the hospital as a whole.

2. Identify the hospital's fiscal year.

The Swedish Issaquah fiscal year begins January 1 and ends December 31.

3. Provide the following agreements/contracts:

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

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

Management and Operating Agreements. There are no management or operating agreements for the proposed project.

Development Agreement. There is no development agreement for the proposed project.

Joint Venture Agreement. There is no joint venture agreement for the proposed project.

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

The properties where the Swedish Issaquah campus is located are owned by Swedish Health Services. Please see Exhibit 19 for the deeds related to the Swedish Issaquah campus.

5. Provide county assessor information and zoning information for the site. If

[9] Exhibit 17 includes the pro forma financial assumptions.

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.

The properties where the Swedish Issaquah campus is located are zoned for hospital use. Please see Exhibit 20 for the details of the parcels where the hospital is located.

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.**

This question is not applicable. There proposed project has no capital expenditures.

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.**

This question is not applicable. The proposed project has no capital expenditures.

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.**

This question is not applicable. The proposed project has no start-up costs.

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

This question is not applicable. The proposed project has no start-up costs.

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

This question is not applicable. The proposed project has no construction costs.

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.**

This question is not applicable. The proposed project has no construction costs, no start-up costs, and no capital costs. The project will require standard operational costs that will not adversely impact costs and charges for health care services in the planning area.

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

Please see Table 12 for the projected Swedish Issaquah payor mix for the entire hospital. The projected payor mix is expected to remain consistent with the 2022 payer mix.

Table 12. Swedish Issaquah Payor Mix, 2022 and Forecast

Revenue Source	2022	Forecast
Medicare	37.8%	37.8%
Medicaid	11.4%	11.4%
Commercial	47.3%	47.3%
Other Government (L&I, VA, etc.)	2.1%	2.1%
Self-Pay	1.4%	1.4%
Total	**100.0%**	**100.0%**

Source: Swedish Issaquah

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.

This question is not applicable. The project does not propose the addition of beds to the existing facility.

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.

This question is not applicable. The proposed project has no new equipment costs, as the equipment in place in the existing cath lab is sufficient to provide elective PCI services.

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

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

This question is not applicable. The proposed project has no financing or start-up costs.

16. Provide the most recent audited financial statements for:
- **The applicant, and**
- **Any parent entity.**

Please see Exhibit 21 for the most recent audited financial statements for Providence St. Joseph Health (2021), the parent entity. Separate audited financial statements are not available at the entity level for the applicant, thus neither Swedish Health Services nor Swedish Issaquah have audited financial statements.

C. 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.

Please see Table 13 for a list of facilities owned or managed by Swedish Health Services.

Table 13: Swedish Health Services – Owned and Managed Facilities

Name	Address	Medicare Provider Number	Medicaid Provider Number	Owned or Managed
Swedish First Hill	747 Broadway Seattle, WA 98122-4307	50-0027	3309200	Owned
Swedish Ballard	5300 Tallman Ave. N.W. Seattle, WA 98107-3985	50-0027	3309200	Owned
Swedish Cherry Hill	500 17th Avenue Seattle, WA 98124	50-0025	3309507	Owned
Swedish Edmonds	21601 76th Ave W Edmonds, WA 98026	50-0026	3341807	Managed
Swedish Issaquah	751 NE Blakely Drive Issaquah, WA 98029	50-0152	2015502	Owned
Swedish Mill Creek	13020 Meridian Ave South Everett WA 98208	50-0027	3309200	Owned
Swedish Redmond	18100 NE Union Hill Road Redmond WA 98052	50-0027	3309200	Owned
Redmond Ambulatory Surgery Center	18100 NE Union Hill Rd, Ste 340 Redmond, WA 98052	PTAN G8981745	2175104	Owned

Source: Swedish Health Services

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 proposed project is limited to only the addition of adult elective PCI services that will be provided in the two existing cath labs at Swedish Issaquah. No other services will change as a result of the proposed project.

The current cath lab core staff (including technologists, nurses, management, and other) are sufficient to provide for the additional elective PCI services. As elective PCI volumes

increase, the cardiologist FTEs are expected to increase by 1.0 FTE during the three-year period, adding 0.6 FTE in 2024. 0.2 FTE in 2025, and 0.2 FTE in 2026. This aligns with the additional scheduling of cardiologists to meet the growing demand for elective PCIs.

Please see Table 14 for current, projected, and forecast cath lab FTE.

Table 14: Swedish Issaquah Cath Lab Staff FTE, Current - 2026[10]

Staff Position	2022	2023		2024		2025		2026	
	Current	Projected		Forecast					
	Total	Incremental	Total	Incremental	Total	Incremental	Total	Incremental	Total
Cardiologists	3.0	0.0	3 0	0.6	3.6	0.2	3.8	0 2	4.0
Technologists	6.5	0.0	6 5	0.0	6.5	0.0	6.5	0 0	6.5
Nurses	4.0	0.0	4 0	0.0	4.0	0.0	4.0	0 0	4.0
Management	1.0	0.0	1 0	0.0	1.0	0.0	1.0	0 0	1.0
Other	1.0	0.0	1 0	0.0	1.0	0.0	1.0	0 0	1.0
Total	**15.5**	**0.0**	**15.5**	**0.6**	**16.1**	**0.2**	**16.3**	**0.2**	**16.5**

Source: Swedish Health Services

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

Swedish Issaquah is currently staffed to perform emergency PCIs twenty-four hours per day, seven days per week. Swedish Issaquah has cardiac teams that provide staffing of the Cath Lab from 7:00 a.m. to 5:30 p.m., Monday through Friday. Weekdays after 5:30 p.m. and weekends, the call team is already available for on-call emergent/emergency cases. The on-call team is available to meet the needs of emergency cardiovascular incidents during non-clinical hours. The current lab staff are sufficient to provide elective PCI services. <u>No additional staff are needed</u>, so the current staff and projected staff are one and the same.

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

Please see Table 15 that identifies key staff at the Swedish Issaquah cath lab.

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[10] Definitions
Cardiologist: Interventional cardiology is the subspecialty of cardiology that uses specialized catheter-based techniques to diagnose and treat coronary artery disease, vascular disease, structural heart disease, and congenital heart defects.
Technologist: Radiologic technologists are health care professionals who perform diagnostic imaging procedures, such as X-ray examinations, magnetic resonance imaging (MRI) scans and computed tomography (CT) scans. Some of them specialize in specific techniques such as cardiovascular-interventional radiography, mammography or sonography. Invasive specialists provide invasive procedures and work with physicians to examine and treat patients with cardiac disease.
Nurse: An individual who has graduated from a state-approved school of nursing, passed the NCLEX-RN Examination, and is licensed by a state board of nursing to provide patient care.
Manager: An individual who oversees operations.
Other: Includes scheduling and any support staff.

Table 15: Swedish Issaquah Cath Lab Staff

Caregiver Name	Credential	License #
Nurses		
Peggy Juriga	RN	RN60847047
Patrick Logan	RN	RN00143274
Sally Malaney	RN	RN60248701
Linda Nguyen	RN	RN61280411
Technologists		
Sheri Denchel (Supervisor)	Radiologic Technologist Certification	RT00004196
Darwin James	Cardiovascular Invasive Specialist Certification	IS60454574
Zachary Chiles	Cardiovascular Invasive Specialist Certification	IS60551072
Ruth Knight	Cardiovascular Invasive Specialist Certification	IS60497012
Christine Pagulayan	Radiologic Technologist Certification	RT60068870
Blake Smith	Cardiovascular Invasive Specialist Certification	IS60681665
Steven Swenson	Cardiovascular Invasive Specialist Certification	IS60294833
Ian Thurman	Radiologic Technologist Certification	RT60416192
Interventional Cardiologists		
Huang, Paul P., MD (Medical Director)	MD	MD00037376
Brown, Christopher L., MD	MD	MD61262198
Demopulos, Peter A., MD	MD	MD00026532
Lewis, Howard S., MD	MD	MD00028676
Petersen, John L. II, MD	MD	MD60063791

Source: Swedish Health Services

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.

The cath labs at Swedish Issaquah are currently fully staffed for emergent PCI, both during business hours and on-call. Table 15 provides the current and proposed staffing for the combined emergent and elective PCI program. As shown in Table 14, one of existing Interventional Cardiologists from SHVI will transition to Swedish Issaquah as elective PCI volumes increase at this campus. The new elective PCI program will not require additional staff recruitment.

Swedish recognizes that the healthcare industry is facing unprecedented times. The impact of the pandemic has been devastating to front line healthcare workers as they face increasingly long hours and a constant crisis mode resulting in stress, burnout, and physical and mental challenges. Among other pressures, this has manifested itself in the form of workforce shortages in many health care settings. However, Swedish also recognizes and embraces a unique opportunity during these times to attract diverse healthcare workers from non-traditional schools and community organizations, with lived experiences similar to the families we serve.

Swedish has well-established human resource capabilities. Swedish has an excellent reputation and history recruiting and retaining appropriate personnel. Swedish offers a competitive wage scale, a generous benefit package, and a professionally rewarding work

setting. Being a large and established provider of health care services, Swedish has multiple resources available to assist with the identification and recruitment of appropriate and qualified personnel:

- Experienced system and local talent acquisition teams in King County to recruit qualified staff.
- Strong success in recruiting for critical-to-fill positions with recruiters that offer support on a national as well as local level.
- The ability to leverage our external recruiting solutions entity, Provider Solutions & Development[11], where a team of recruiters work nationwide to support and serve providers with their recruiting efforts.
- Career listings on the Swedish web site and job listings on multiple search engines and listing sites (e.g. Indeed, Career Builders, Monster, NW Jobs).
- Educational programs with local colleges and universities.

Each of these factors has contributed to the ability to maintain a highly qualified employee and management base. Swedish employs a large number of general and specialty care providers. Swedish offers an attractive work environment and hours, thus attracting local residents who are qualified to work in the hospital setting. We do not expect staffing challenges that would disrupt Swedish's ability to achieve its goals and objectives relative to adding an elective PCI program for Swedish Issaquah.

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

This question is not applicable. Swedish Issaquah is an existing community hospital that has been in operation since 2011.

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

Swedish Issaquah is a full-service community hospital that currently provides emergent PCI services. Thus, all services needed to successfully operate an elective PCI program are already in place. They include but are limited to the following:

- Environmental services
- Food and nutrition services
- Facility services
- Volunteer services
- Patient registration, scheduling, and admitting services
- Laboratory services
- Pharmacy services

[11] Providence Solutions & Development is focused on clinical staffing only.

- Respiratory services
- Pre- and post-anesthesia care services
- Inpatient nursing services, including intensive care unit
- Emergency department
- Case management
- Social work
- Ambulatory infusion
- EKG
- Echo cardio
- Imaging services (MRI, CT, radiology, ultrasound, PET CT)

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.

Swedish Issaquah is an existing hospital that has been in operation since 2011. It has long established relationships with existing health care facilities in the planning area and broader community. Swedish Issaquah coordinates patient access to other Providence entities, as well as community providers, to ensure continuity of care during hospital discharge to other levels of care as well as when other facilities need to transfer patients to Swedish Issaquah for more advanced care. Those providers include hospitals, hospice, home care, long-term care facilities, psychiatric care, assisted living, and other providers. These collaborations and referral patterns will continue.

Current relationships include but are not limited to the following:

- Providence Marianwood in Issaquah, which is a part of Providence has a close working relationship with Swedish Issaquah. Providence Marianwood provides comprehensive professional skilled nursing care, including home and community care, rehab, skilled nursing, speech therapy, spiritual care, and Alzheimer's disease and dementia care.
- Issaquah Nursing and Rehab Center operates a 140-bed facility, offering short- and long-term post-acute care and has a long-standing working relationship with Swedish Issaquah.
- Swedish Issaquah is the primary transfer site for both the Swedish Mill Creek and Redmond care sites.
- Transfer agreements are in place with a wide array of hospitals and medical groups in the King County area.
- LifeCenter Northwest and Swedish Issaquah collaborate to provide the community with organ donations.

- Swedish Issaquah collaborates with many community partners who offer psychiatric services to provide the community with medical psychiatric services for more complex patients.

10. Identify whether any of the existing working relationships with healthcare facilities listed above would change as a result of this project. For a new facility, provide a listing of healthcare facilities with which the facility would establish working relationships.

No existing working relationships with healthcare facilities are expected to change as a result of the project.

11. 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.

Swedish Issaquah has developed long-term collaborative relationships with other providers to expand program offerings and ensure access and continuity of appropriate care for residents of King County and the other surrounding communities served by Swedish. Swedish coordinates patient access to other Swedish entities as well as community providers to ensure continuity of care during hospital discharge to other levels of care as well as when other facilities need to transfer patients to Swedish for more advanced care. Those providers include hospitals, hospice, home care, long-term care facilities, psychiatric care, assisted living, and other providers. Swedish completes an annual review to maintain strong, inclusive relationships and processes for the care continuum.

The proposed elective PCI program will promote continuity of the provision of health care services in a number of ways. An elective PCI program at Swedish Issaquah will allow residents to receive care close to home and thus reduce adverse impacts from delaying care or staging treatment due to lack of access to elective PCI service in the planning area. The proposed program also allows planning area residents to receive the majority of their care within a single health care facility, further preventing potential fragmentation of care that may occur when a resident is forced to receive care from different facilities or different health care organizations.

12. 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).

Swedish Issaquah has well-established and collaborative relationships with other providers to ensure access and continuity of appropriate care for residents of King County and the other surrounding communities served by Swedish. Swedish coordinates patient access to other Swedish entities as well as community providers to ensure continuity of care during hospital discharge to other levels of care as well as when other

facilities need to transfer patients to Swedish for more advanced care. Those providers include hospitals, hospice, home care, long-term care facilities, psychiatric care, assisted living, and other providers.

In addition, Swedish has an active discharge planning process, which is initiated either prior to admission (for scheduled admissions) or upon admission. To assist patients and families in obtaining appropriate post-hospital care that will ensure continuity of care, the discharge planning teams work with each patient care unit to facilitate timely and appropriate discharge of patients. In collaboration with other disciplines and community agencies, the discharge planning staff assesses patient need and develops a comprehensive plan for appropriate post-hospital care.

13. **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 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**
    - **A revocation of a license to operate a healthcare facility; or**
    - **A revocation of a license to practice as a health profession; or**
    - **Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.**

Swedish Issaquah has no history of criminal convictions related to ownership / operation of a health care facility, licensure revocations or other sanctions, or decertification as a provider of services in Medicare or Medicaid programs.

D. 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.

Swedish Issaquah is requesting certificate of need approval to operate an adult elective PCI program in planning area #9 (King East). The program will be based out of Swedish Issaquah's existing hospital facility located in Issaquah, WA. Establishing an elective PCI program will help address the unmet need for adult elective PCI services in the planning area.

As part of its due diligence, and in deciding to submit this application, Swedish Issaquah considered the following alternatives:

- Alternative 1: Status quo: Do nothing or postpone action. Do not operate an adult elective PCI program at Swedish Issaquah.
- Alternative 2: The requested project: Seek CN approval to operate an adult elective PCI program in addition to the existing emergent PCI program at Swedish Issaquah.
- Alternative 3: Create a joint venture and seek CN approval to operate an adult elective PCI program.

Please see Tables 16-

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 16. Alternative 1: Do Nothing or Postpone Action

Decision Making Criteria	Analysis
Access to Health Care Services	Maintaining the status quo does not address the need for an additional elective PCI program in planning area 2. It does not address the access to care issues that currently exist. There is no advantage to maintaining the status quo in terms of improving access. (D)

Quality of Care	There is no advantage from a quality of care perspective. (N) Maintaining the status quo will continue to drive shortages in access to elective PCI services within the planning area. Over time, as access is constrained, there will be adverse impacts on quality of care and health outcomes if planning area physicians and their patients cannot find adequate access to elective PCI services. (D)
Cost and Operating Efficiency	With this option, there would be no impacts on costs. (N) The principal disadvantage is that by maintaining the status quo, there would be no improvements to cost or operating efficiencies. (D)
Staffing Impacts	The current staff employed at the Swedish Issaquah cath lab are sufficient to staff the adult elective program. (N) The status quo will not provide opportunities for local job growth and economic development as volumes grow in the future. (D)
Legal Restrictions	There are no legal restrictions to continuing operations as-is. (A)
Capital Costs	There are no capital costs to continuing operations as-is (A)
Final Assessment	**This alternative was not selected.** It does not improve access to health care services, drive cost and operating efficiencies, or provide opportunities for local job growth and economic development. It also may have a detrimental impact on quality of care.

Table 17. Alternative 2: Requested Project (CN Approval to Operate an Adult Elective PCI Program)

Decision Making Criteria	Analysis
Access to Health Care Services	The requested project meets current and future access issues identified in planning area #9. It increases access to care. (A) There are no disadvantages to improving access. (A)

Quality of Care	The requested project meets and promotes quality and continuity of care in planning area #9. (A) From a quality of care perspective, there are no disadvantages. (N)
Cost and Operating Efficiency	This option allows Swedish Issaquah to gain cost and operating efficiencies, as the fixed costs of operating its existing cath labs can be spread across operating both an emergent and elective adult PCI program. (A)
Staffing Impacts	The current staff employed at the Swedish Issaquah cath lab are sufficient to staff the adult elective program, meaning that other PCI programs in the planning area will not be impacted by the proposed project. (A)
Legal Restrictions	Because Swedish Issaquah already operates an emergent adult PCI program and has the ability to add an elective program without completing construction or hiring additional staff, Swedish has the ability to immediately begin providing elective PCI services to planning area residents. This will improve access, quality, and continuity of care. (A) The principal disadvantage is that operating an adult elective PCI program requires CN approval, which requires time and expense. (D)
Capital Costs	There are no capital costs to for the proposed project (A)
Final Assessment	**This alternative (the proposed project) was selected.** It improves access to health care services, promotes quality and continuity of care, leverages existing fixed costs, and requires no capital investment. It can be executed immediately and does not face any adverse or onerous legal or regulatory requirements.

Table 18. Alternative 3: Create a Joint Venture and Seek CN Approval for an Elective PCI Program

Decision Making Criteria	Analysis
Access to Health Care Services	Depending on the partnership, this alternative would have the potential to meet current and future access issues identified in planning area 2. (A)
Quality of Care	Partnering with another entity may adversely impact quality of care when compared to the proposed project, as it adds additional layers of operational complexity. (D)
Cost and Operating Efficiency	A partnership would increase operating complexity and may add other partnership-related costs. In this scenario, costs may increase due to additional efforts required to establish the governance and ownership structure, establish a new staffing structure, and accommodate partner preferences about how to deliver care. (D)
Staffing Impacts	Partnering with another entity would create less staffing flexibility from the perspective of Swedish Issaquah. In this scenario, Swedish Issaquah would have to build and establish additional management processes and structures, and may have to negotiate new compensation benefit packages for clinical staff. (D)
Legal Restrictions	Partnering with another entity introduces a high degree of operational complexity. Under this scenario, a new governance structure would have to be established in addition to obtaining agreement on operational processes. (D) The principal disadvantage is that it requires CN approval, which requires time and expense. (D)
Capital Costs	It is unclear if there would be capital costs associated with a JV, as a JV may include new construction or purchasing of new equipment. (N)
Final Assessment	**This alternative was <u>not</u> selected.** It adds increased operating costs, decreased staffing flexibility, is unclear as

	far as capital costs requirements, and will likely contribute to increased operating complexity.

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

This question is not applicable. as the proposed project does not involve construction.

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

Swedish Issaquah continually works to innovate and improve quality, cost containment, and cost effectiveness in the provision of tertiary services. A number of key aspects related to the proposed elective PCI project include:

Quality Assurance, Cost Effectiveness, and Cost Containment

- The proposed adult elective PCI project supports standard of care and best practices to appropriately treat coronary artery disease at the time of diagnosis. This reduces any detrimental impacts from delaying care or staging treatment due to lack of access to elective PCI service.
- Further, operating an adult elective PCI program at Swedish Issaquah enhances the judicious use of health care resources, allowing the existence of both and emergent and elective program at the same facility.
- There are no capital costs, no start up costs, or financing required so the proposed project will not adversely impact costs of health care services.
- Being part of Swedish Heart & Vascular Institute allows Swedish Issaquah to leverage the well-established Clinical Quality and Operations Governance structure.

Improvements in Financing and Delivery of Health Services

- The proposed PCI project improves access to elective PCI services, which may contribute to the reduced risk of morbidity and mortality associated with delaying or staging procedural treatment for PCI services.
- The proposed program reduces barriers to patient access, including geographic barriers and the potential for patients to travel longer distances from home to access elective PCI services, either within or outside the planning area.

Addendum for Hospital Projects
Certificate of Need Application
Percutaneous Coronary Intervention (PCI)
WAC 246-310-700 through 246-310-755

Facility Description

1. Is the applicant currently providing emergent PCI?

Yes, Swedish Issaquah is currently providing emergent PCIs.

2. If no, what facilities are these patients being sent to in the most recent calendar year?

This question is not applicable, as Swedish Issaquah is currently providing emergent PCI.

3. If yes, provide the number of PCI's performed at the applicant hospital for the most recent three calendar years?

Please see Table 19 for Swedish Issaquah's most recent emergent PCI volume from 2020-2022.

Table 19. Swedish Issaquah Emergent PCIs, 2020-2022

	2020	2021	2022
Emergent PCI	108	100	133

Source: Swedish Issaquah

Project Description

4. WAC 246-310-715(4) states:

Maintain one catheterization lab used primarily for cardiology. The lab must be a fully equipped cardiac catheterization laboratory with all appropriate devices, optimal digital imaging systems, life sustaining apparati, intra-aortic balloon pump assist device (IABP).

Provide documentation and a discussion demonstrating that this proposal meets this requirement.

Swedish Issaquah currently provides emergent PCI services and has been providing emergent PCI services since 2011 in its cath labs. The two cath labs are fully equipped and currently capable of providing emergent and elective PCI services. We do not expect any need for additional equipment in order to provide elective PCIs. Please see Exhibit

22 for a list of key equipment in the existing cath lab that demonstrates that the proposed project meets the requirements of WAC 246-310-715(4).

5. Describe how this project will comply with WAC 246-310-715(5), which requires that the facility be available to perform emergent PCIs twenty-four hours a day, seven days a week in addition to scheduled PCIs?

Swedish Issaquah is currently staffed to perform emergent PCIs twenty-four hours per day, seven days per week. Swedish Issaquah has cardiac teams that provide staffing of the Cath Lab from 7:00 a.m. to 5:30 p.m., Monday through Friday. Weekdays after 5:30 p.m. and weekends, the call team is already available for on-call emergent/emergency cases. The on-call team is available to meet the needs of emergency cardiovascular incidents during non-clinical hours. The call team will maintain a minimum of one nurse and two technicians.

Certificate of Review Criteria

A. Need (WAC 246-310-210, WAC 246-310-715, WAC 246-310-720, and WAC 246-310-745)

6. The department will use the posted need forecasting methodology available as of the application submission date. Confirm that you understand this methodology will be used in reviewing your project.

We confirm the understanding that the Department will use the posted need forecasting methodology available as of the application submission date. For this elective PCI Certificate of Need application submitted by Swedish Issaquah, the *application submission date* is February 28, 2023. As of February 28, 2023, the Department's posted need methodology was updated in January 2023 and shows need for 1.11 program in Planning Area 9.[12] Please see Exhibit 23 for a copy of the Department of Health 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology.

7. Provide the projected number of adult elective PCIs starting in the implementation calendar year and following the initiation of the service, including at least three full calendar years. All new elective PCI programs must comply with the state of Washington annual PCI volume standard of 200 (two hundred) by the end of year three. WAC 246-310-715(2)

Please see Table 20 for the projected PCIs for Swedish Issaquah. The table includes both elective and emergent PCIs. Swedish Issaquah currently provides emergent PCIs and, in 2022, provided 133 emergent PCI procedures. The proposed project intends to expand services to provide an adult elective PCI program at Swedish Issaquah.

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[12] The DOH website lists the file *2022-2023 Final percutaneous coronary interventions (PCI) need forecast (PDF)* as the most recent PCI need methodology. The file pages are footnoted as 'DOH 260-030 January 2023'.

- Utilization projections assume emergent PCI volumes will grow incrementally by an approximately 1.5% combined average growth rate over the four-year period, adding two emergent PCI cases per year from 2023 to 2026. This growth rate is consistent with the planning area growth rates.[13]
- Utilization projections assume elective PCI volumes will total 52 cases in 2024, the first full year of operations. This represents an additional one case per week for scheduled PCIs during the first full year of operations. In 2025-2026, volumes will grow modestly, adding 12 cases in 2025 and 12 cases in 2026, representing an incremental one additional case per month in the second and third full year of operations.
- Swedish forecasts that by the end of the third year of operations Swedish Issaquah will grow to a combined 217 emergent and elective cases in 2026.

Table 20. Swedish Issaquah Current, Projected, and Forecast PCIs, 2022-2026

	2022	2023		2024		2025		2026	
	Actual	Projected		Forecast					
	Total	Incremental	Total	Incremental	Total	Incremental	Total	Incremental	Total
PCI Emergent	133	2	135	2	137	2	139	2	141
PCI Elective	0	0	0	52	52	12	64	12	76
PCI Total	**133**	**2**	**135**	**54**	**189**	**14**	**203**	**14**	**217**

Source: Swedish Issaquah

8. **WAC 246-310-720(2) states:**
   The department shall only grant a certificate of need to new programs within the identified planning area if:
   (a) The state need forecasting methodology projects unmet volumes sufficient to establish one or more programs within a planning area; and
   (b) All existing PCI programs in that planning area are meeting or exceeding the minimum volume standard.

   Provided documentation that this standard is met for the planning area.

The Department's 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology was updated in January 2023 and shows need for 1.11 additional elective PCI programs in Planning Area 9 (King East).[14] As a result, WAC 246-310-720(2)(a) is met. Please see Exhibit 23 for a copy of the Department of Health 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology.

Providence is continuing to seek assistance from the Department of Health and the Office

[13] King East planning area population forecast for residents aged 15 and over is expected to grow from 1,023,824 residents in 2021 to 1,102,840 residents by 2026 representing at 1.5% average growth rate. Source: ESRI.
[14] The DOH website lists the file *2022-2023 Final percutaneous coronary interventions (PCI) need forecast (PDF)* as the most recent PCI need methodology. The file pages are footnoted as 'DOH 260-030 January 2023'. Swedish Issaquah has relied upon this file as the basis for its elective PCI CN application, as it is the most recent available at the time of the application deadline of February 28, 2023.

of the Attorney General so that the standard in WAC 246-310-720(2)(b) is met for Planning Area 9 (King East) during the pendency of this year's concurrent review cycle for elective PCI applications. Currently, an underperforming program at MultiCare Auburn Regional Medical Center and failed enforcement of the WACs related to the minimum volume standards[15] have prevented the approval of a new program to address the unmet need in Planning Area 9 (King East). This issue has been brought to the attention of the Department on numerous occasions.

On October 23, 2019, Swedish Issaquah was notified that its CN application (CN #19-66) proposing to establish an elective PCI program in Planning Area 9 (King East) had been denied by the Department.[16] The denial highlighted an ongoing, significant concern about the failed enforcement of the minimum volume standards for previously approved hospital PCI programs. The lack of enforcement has a corresponding impact on the approval of new elective PCI programs in planning areas like King East.

These concerns were raised to the Department in a letter dated October 31, 2019, and subsequently discussed at an in-person meeting held on November 20, 2019, with representatives from the CN Program and the Office of the Attorney General. Assurances were offered during the meeting that the Department would look into the matter and seek to resolve the identified problems as soon as possible. Three years passed without resolution of the issue, and Providence again sent a letter on October 21, 2022, reiterating concerns that failed enforcement has prevented CN applicants from addressing the unmet needs within the planning area. See Exhibit 24 for the October 21, 2022, letter regarding the enforcement of minimum volume standard for percutaneous coronary intervention programs.

If the Department is unable or unwilling to enforce the minimum volume standards for CN-approved PCI programs, then failure to satisfy WAC 246-310-720(2)(b) should not be grounds for denial of Swedish Issaquah's CN application. As stated in our October 21, 2022, letter: "We cannot let another year pass without addressing the unmet needs within the PCI planning areas, as failing to move quickly on this matter is withholding care and taking away opportunities for interested applicants to gain CN approval to establish new programs."[17]

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[15] Under the volume standard, a hospital PCI program must perform a minimum of 200 adult PCI procedures per year "by the end of the third year of operation and each year thereafter." All existing PCI programs in a planning area must meet or exceed the annual minimum volume standard before a new elective PCI program can be approved. Therefore, the monitoring and enforcement of the PCI minimum volume standard for existing programs is critical, as an underperforming program precludes the approval of a new elective PCI program, even in situations in which the need methodology establishes need for an additional program.
[16] DOH evaluation (CN#19-66), October 23, 2019.
[17] Letter to Department of Health and the Office of the Attorney General, October 21, 2022

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

9. Provide revenue and expense statements for the PCI cost center that show the implementation calendar year and three calendar years following initiation of the service.

Please see Exhibit 17 that includes the revenue and expense pro forma statements for the cath lab cost center (with the project) for years 2023-2026. This includes 2023 (projected) and 2024-2026 (forecast). This statement includes the revenue and expense for the total emergent and elective PCI program in the cath lab cost center.[18]

10. Provide pro forma revenue and expense statements for the hospital with the PCI project that show the implementation year and three calendar years following initiation of the service.

Please see Exhibit 17 that includes the revenue and expense pro forma statements for both the hospital and the cath lab cost center (with the project) for years 2023-2026. This includes 2023 (projected) and 2024-2026 (forecast). This statement includes the revenue and expense for the hospital and the total emergent and elective PCI program in the cath lab cost center.

11. Provide pro forma revenue and expense statements for the hospital without the proposed PCI project that show the same calendar years as provided in response to the two questions above.

Please see Exhibit 17 that includes the revenue and expense pro forma statements for the hospital (without the project) for years 2023-2026. This includes 2023 (projected) and 2024-2026 (forecast). This statement includes the revenue and expense for the hospital and the existing emergent PCI program, but it omits the proposed elective PCI program.

12. Provide the proposed payer mix specific to the proposed unit. If the hospital is already providing emergent PCIs, also provide the current unit's payer mix for reference.

Please see Table 21 for both the current payer mix and forecast payer mix for the project, based on gross service revenue. The assumption is that the payer mix for the proposed project will remain the same as the current payer mix for PCIs in the two cath labs at Swedish Issaquah.

[18] Exhibit 17 includes the proforma assumptions.

Table 21. Swedish Issaquah PCI Payor Mix, Current and Forecast

Revenue Source	2022	Forecast
Medicare	43.7%	43.7%
Medicaid	8.6%	8.6%
Commercial	42.9%	42.9%
Other Government (L&I, VA, etc.)	2.5%	2.5%
Self-Pay	2.2%	2.2%
Total	**100.0%**	**100.0%**

Source: Swedish Issaquah

13. If there is no estimated capital expenditure for this project, explain why.

There are no capital costs required for this project. The current cath labs are fully equipped, no additional equipment is required, and no construction is required to provide elective PCIs at Swedish Issaquah.

C. Structure and Process of Care (WAC 246-310-230 and WAC 246-310-715)

14. Provide the name and professional license number of the current or proposed medical director. If not already disclosed, clarify whether the medical director is an employee or under contract.

Dr. Paul P. Huang, MD, an Interventional Cardiologist, is the Medical Director who oversees the cath labs at Swedish Issaquah. Upon CN approval to provide elective PCIs at Swedish Issaquah, Dr. Paul P. Huang will continue to serve as the Medical Director. His license number is MD00035376, and he is an employee of Swedish Health Services.

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

Dr. Paul P. Huang is an employee of Swedish Health Services. Please see Exhibit 25 for the Medical Director's job description.

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

This question is not applicable. Dr. Paul P. Huang is an employee of Swedish Health Services. Please see Exhibit 25 for the Medical Director's job description.

17. Provide a list of all credentialed staff proposed for this service (including the catheterization lab staff) including their names, license numbers, and specialties. WAC 246-310-715(4)

See Table 22 for a list of both the current and proposed cath lab staff, including names, license numbers, and their specialties.

Table 22. Swedish Issaquah Cath Lab Credentialed Staff (Current and Proposed)

Caregiver Name	Credential	License #
Nurses		
Peggy Juriga	RN	RN60847047
Patrick Logan	RN	RN00143274
Sally Malaney	RN	RN60248701
Linda Nguyen	RN	RN61280411
Technologists		
Sheri Denchel (Supervisor)	Radiologic Technologist Certification	RT00004196
Darwin James	Cardiovascular Invasive Specialist Certification	IS60454574
Zachary Chiles	Cardiovascular Invasive Specialist Certification	IS60551072
Ruth Knight	Cardiovascular Invasive Specialist Certification	IS60497012
Christine Pagulayan	Radiologic Technologist Certification	RT60068870
Blake Smith	Cardiovascular Invasive Specialist Certification	IS60681665
Steven Swenson	Cardiovascular Invasive Specialist Certification	IS60294833
Ian Thurman	Radiologic Technologist Certification	RT60416192
Interventional Cardiologists		
Huang, Paul P., MD (Medical Director)	MD	MD00037376
Brown, Christopher L., MD	MD	MD61262198
Demopulos, Peter A., MD	MD	MD00026532
Lewis, Howard S., MD	MD	MD00028676
Petersen, John L. II, MD	MD	MD60063791

Source: Swedish Issaquah

18. For existing facilities, provide names and professional license numbers for current credentialed staff (including the catheterization lab staff) including their names, license numbers, and specialties. WAC 246-310-715(4)

Swedish Issaquah has two existing cath labs that are fully equipped and fully staffed. Please see Table 22 that includes the credentialed staff who currently provide services at the two cath labs.

19. Provide any unit-specific policies or guidelines for the proposed PCI service.

Swedish Issaquah has two existing cath labs that are fully equipped, fully staffed, and has been providing emergent PCIs since the opening of the hospital in 2011. In response to other questions in the PCI addendum, we provide the following policies:

- Exhibit 26. Nurses, Technologists, and Supervisor Job Descriptions
- Exhibit 27. Cath Lab Competency Checklists
- Exhibit 28. Patient Transfer Agreement
- Exhibit 29. Medical Transportation Services Agreement

- Exhibit 30. Swedish Issaquah Elective PCI Quality Performance Improvement Plan, 2023

20. Submit a detailed analysis of the impact the proposed adult elective PCI services will have on the Cardiovascular Disease and Interventional Cardiology Fellowship Training programs at the University of Washington Medical Center. WAC 246-310- 715(1)

Please see Exhibit 31 for an analysis of the emergent and elective PCIs for King East planning area residents by zip code that are currently performed by the University of Washington Medical Center ("UWMC"). In addition, please see our response to question 21 that provides a detailed analysis and our response to question 22 that provides the response from UWMC related to any potential impact of the proposed project on the UWMC Cardiovascular Disease and Interventional Cardiology Fellowship Training programs.

21. Provide discussion and any documentation that the new PCI program would not reduce current volumes below the hospital standard at the University of Washington fellowship training program. WAC 246-310-715(1)

In 2021, UWMC provided a total of 1,054 PCIs, including 695 outpatient (elective) PCIs and 359 inpatient (emergent) PCIs. UWMC performs a very large number of PCI cases for education and training purposes, which supports its Cardiovascular Disease and Interventional Cardiology Fellowship Training programs.

King East planning area residents received a total of 1,498 PCIs in 2021. UWMC performed 134 of these cases, which represents 8.9% of the total PCI volumes for the King East planning area. Of the 44 King East zip codes, there are only five zip codes from which UWMC drew more than five outpatient (elective) PCI cases in 2021. These include 98092 (9 cases), 98077 (8 cases), 98034 (7 cases), 98028 (6 cases), and 98059 (6 cases). Therefore, it is very unlikely that an elective PCI program at Swedish Issaquah will have a material impact on the UWMC's volumes.

In addition, there are five zip codes (98006, 98027, 98029, 98059, and 98075) within a five-mile radius of Swedish Issaquah. These zip codes are closer to Swedish Issaquah than any other hospital facility. Although together the five zip codes represented 172 total inpatient and outpatient PCIs in 2021, UWMC performed only 10 outpatient and 2 inpatient PCIs from these zip codes.

Please see Exhibit 31 an analysis for an analysis of King East planning area PCIs by zip code on the UWMC.

22. Provide a copy of any response from the University of Washington Medical Center.

Please see Exhibit 32 for communication between Dr. Howard Lewis of the Swedish Heart and Vascular Institute and Dr. Larry Dean of the UW Medicine Regional Heart Center. In Dr. Dean's response, he acknowledges that the proposed project by Swedish Issaquah to operate a CN approved elective PCI program at Swedish Issaquah will not impact the Interventional Cardiology Fellowship Training Program at the University of Washington.

23. Provide documentation that the physicians who would perform adult elective PCI procedures at this hospital have performed a minimum of fifty PCI procedures per year for the previous three years prior to submission of this application. WAC 246-310-725.

Please see Table 23 that includes the total PCI volumes for the current interventional cardiologists. As demonstrated, all five cardiologists have performed more than the minimum of fifty PCI procedures for the previous three years. These total volumes include both emergent and elective PCIs, as the cardiologists also perform PCI procedures at Swedish Cherry Hill, which operates both an emergent and CN approved elective PCI program.

Table 23. Interventional Cardiologist Historic PCI Volume, 2020-2022

Interventional Cardiologist	2020	2021	2022
Huang, Paul P., MD	63	87	82
Brown, Christopher L., MD	193	192	99
Demopulos, Peter A., MD	117	147	119
Lewis, Howard S., MD	105	117	114
Petersen, John L. II, MD	72	81	61

Source: Swedish Issaquah

24. Provide projected procedure volumes by physician for each of the physicians listed in the previous question.

Please see Table 24 for the projected procedure volume by interventional cardiologist. Please note that the projected PCI volumes are not limited to those that will be provided at Swedish Issaquah, as the cardiologists also provide PCI procedures at Swedish Cherry Hill. Thus, the projected procedure volumes by physician in Table 24 are inclusive of volume outside of Swedish Issaquah.

Table 24. Interventionalist Cardiologist Projected PCI Volume, 2023-2026

Interventional Cardiologist	2023	2024	2025	2026
Huang, Paul P., MD	84	88	92	97
Brown, Christopher L., MD	101	106	111	117
Demopulos, Peter A., MD	121	127	134	141
Lewis, Howard S., MD	116	122	128	135
Petersen, John L. II, MD	62	65	69	72

Source: Swedish Issaquah

In addition, please see Exhibit 33 for letters from the five interventional cardiologists listed in Table 24, committing to provide elective PCIs at Swedish Issaquah upon CN approval.

25. Provide a discussion on how the projected PCI volumes will be sufficient to assure that all physicians staffing the program will be able to meet volume standards of fifty PCIs per year. WAC 246-310-715(2)

Swedish Health Services has a long history of providing cardiac and vascular services to residents of Washington State and is recognized as a clinical leader in cardiac care. All cardiac and vascular services at Swedish are under the oversight and governance of the Swedish Heart and Vascular Institute, one of the top heart and vascular programs in the State of Washington, which includes a well-established open heart surgery program at Swedish Cherry Hill in Seattle.

The existing PCI program at Swedish Issaquah is part of the Swedish Heart and Vascular Institute and draws on the experience and expertise of the Seattle program. Swedish Issaquah has performed emergent PCIs since the hospital opened in 2011. Based on the projected volumes of elective PCI procedures at Swedish Issaquah and the expected emergent and elective PCI volumes at the Swedish Cherry Hill, sufficient volume exists to ensure the interventional cardiologists who will be staffing the proposed elective PCI program at Swedish Issaquah meet the volume standards set out in WAC 246-310-715(2). Also, as noted in Table 23, all interventional cardiologists who will be staffing the proposed elective PCI program at Swedish Issaquah already are exceeding the minimum volume standards of 50 PCIs per year.

26. Submit a plan detailing how the applicant will effectively recruit and staff the new program with qualified nurses, catheterization laboratory technicians, and interventional cardiologists without negatively affecting existing staffing at PCI programs in the same planning area. WAC 246-310-715(3).

The cath labs at Swedish Issaquah are currently fully staffed for emergent PCI, both during business hours and on-call. Table 22 provides the current and proposed staffing for the combined emergent and elective PCI program. As shown in Table 14, one of existing Interventional Cardiologists from SHVI will transition to Swedish Issaquah as

elective PCI volumes increase at this campus. The new elective PCI program will not require additional staff recruitment.

Swedish recognizes that the healthcare industry is facing unprecedented times. The impact of the pandemic has been devastating to front line healthcare workers as they face increasingly long hours and a constant crisis mode resulting in stress, burnout, and physical and mental challenges. Among other pressures, this has manifested itself in the form of workforce shortages in many health care settings. However, Swedish also recognizes and embraces a unique opportunity during these times to attract diverse healthcare workers from non-traditional schools and community organizations, with lived experiences similar to the families we serve.

Swedish has well-established human resource capabilities. Swedish has an excellent reputation and history recruiting and retaining appropriate personnel. Swedish offers a competitive wage scale, a generous benefit package, and a professionally rewarding work setting. Being a large and established provider of health care services, Swedish has multiple resources available to assist with the identification and recruitment of appropriate and qualified personnel:

- Experienced system and local talent acquisition teams in King County to recruit qualified staff.
- Strong success in recruiting for critical-to-fill positions with recruiters that offer support on a national as well as local level.
- The ability to leverage our external recruiting solutions entity, Provider Solutions & Development where a team of recruiters work nationwide to support and serve providers with their recruiting efforts.
- Career listings on the Swedish web site and job listings on multiple search engines and listing sites (e.g. Indeed, Career Builders, Monster, NW Jobs).
- Educational programs with local colleges and universities.

Each of these factors has contributed to the ability to maintain a highly qualified employee and management base. Swedish employs a large number of general and specialty care providers. Swedish offers an attractive work environment and hours, thus attracting local residents who are qualified to work in the hospital setting. We do not expect staffing challenges that would disrupt Swedish's ability to achieve its goals and objectives relative to adding an elective PCI program for Swedish Issaquah.

27. Provide documentation that the catheterization lab will be staffed by qualified, experienced nursing and technical staff with documented competencies in the treatment of acutely ill patients. The answer to this question should demonstrate compliance with WAC 246-310-730.

All Registered Nurses ("RNs") are ACLS19 certified through the American Heart Association. All RNs have extensive experience (at least 2 years) in a critical care environment. They also have at least one year of experience in a cath/interventional radiology lab that performs interventional and diagnostic cardiovascular/vascular imaging procedures. They also have the capability for managing critically ill patients requiring advanced life support measures—ventilators; transcutaneous/transvenous pacing; intra-aortic balloon pump; vasoactive medications; and invasive monitoring (arterial, pulmonary, Central Venous Pressure).

All technologists are required to have either a Surgical Technologist Registration (RST) with the Department or a Washington State Certified Radiologic Technologist Diagnostic License (AART). All technologists also are required to have BLS-CPR certification. Technologists must have the ability to participate in the on-call schedule with a response time of 30 minutes. Staff members are trained and evaluated annually on many life-saving and sustaining therapies, such as IABP ("intra-aortic balloon pump) counter pulsations. In addition, the technologist staff rotate to Swedish Cherry Hill where they are able to maintain their skills by working in a high volume cath lab with complex cases and advanced circulatory support devices.

Please see Exhibit 26 for job descriptions of registered nurses, technologists, and the supervisor. Please see Exhibit 27 that includes orientation checklists for the cath lab staff.

28. WAC 246-310-735 requires a partnering agreement to include specific information. Provide a copy of the agreement.

Please see Exhibit 28 for the patient transfer agreement between Swedish Cherry Hill and Swedish Issaquah.

29. Identify where, within this agreement or any other agreement provided in this application, numbers (1) through (13) below are addressed.

(1) Coordination between the nonsurgical hospital and surgical hospital's availability of surgical teams and operating rooms. The hospital with on-site surgical services is not required to maintain an available surgical suite twenty- four hours, seven days a week.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 3.1

(2) Assurance the backup surgical hospital can provide cardiac surgery

[19] Advanced cardiac life support (ACLS) refers to a set of clinical interventions for the urgent treatment of cardiac arrest and other life threatening medical emergencies. Only specially trained providers can provide ACLS, as it requires the ability to manage the patient's airway, initiate IV access, read and interpret electrocardiograms and understand emergency pharmacology. Specialized pediatric life support is termed "PALS" (pediatric advanced life support).

during all hours that elective PCIs are being performed at the applicant hospital.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 2.2

(3) Transfer of all clinical data, including images and videos, with the patient to the backup surgical hospital.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 1, Item 1.3. Both the Transferring Hospital and the Receiving Hospital share the same electronic medical record system, providing the same access for clinical data, including images and videos.

(4) Communication by the physician(s) performing the elective PCI to the backup hospital cardiac surgeon(s) about the clinical reasons for urgent transfer and the patient's clinical condition.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 1.5.

(5) Acceptance of all referred patients by the backup surgical hospital.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 2.1.

(6) The applicant hospital's mode of emergency transport for patients requiring urgent transfer. The hospital must have a signed transportation agreement with a vendor who will expeditiously transport by air or land all patients who experience complications during elective PCIs that require transfer to a backup hospital with on-site cardiac surgery.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 1.2.

In addition, please seen Exhibit 29 for a signed Hospital Medical Transportation Agreement.

(7) Emergency transportation beginning within twenty minutes of the initial identification of a complication.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 1, Item 1.2.

(8) Evidence that the emergency transport staff are certified. These staff

must be advanced cardiac life support (ACLS) certified and have the skills, experience, and equipment to monitor and treat the patient en route and to manage an intra-aortic balloon pump (IABP).

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 1, Item 1.2.

(9) The hospital documenting the transportation time from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of the backup hospital. Transportation time must be less than one hundred twenty minutes.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 1.4.

(10) At least two annual timed emergency transportation drills with outcomes reported to the hospital's quality assurance program.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 2, Item 1.7.

(11) Patient signed informed consent for adult elective (and emergent) PCIs. Consent forms must explicitly communicate to the patients that the intervention is being performed without on-site surgery backup and address risks related to transfer, the risk of urgent surgery, and the established emergency transfer agreements.

This requirement is addressed in Exhibit 28Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 1, Item 1.1.

(l2) Conferences between representatives from the heart surgery program(s) and the elective coronary intervention program. These conferences must be held at least quarterly, in which a significant number of preoperative and post- operative cases are reviewed, including all transport cases.

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 3, Item 3.2.

(13) Addressing peak volume periods (such as joint agreements with other programs, the capacity to temporarily increase staffing, etc.).

This requirement is addressed in Exhibit 28: Swedish Issaquah and Swedish/Cherry Hill Patient Transfer Agreement, page 3, Item 3.3.

30. WAC 246-310-740 requires this document to include specific information. Provide a copy of the agreement

Please see Exhibit 30 for the Swedish Issaquah Elective PCI Performance Improvement Plan, 2023.

31. Identify where, within the agreement, numbers (1) through (4) below are addressed.

(1) A process for ongoing review of the outcomes of adult elective PCIs. Outcomes must be benchmarked against state or national quality of care indicators for elective PCIs.

This requirement is addressed in Exhibit 28: Swedish Issaquah Elective PCI Performance Improvement Plan, Sections I-VII, pages 1-4; Attachment A, page 5.

(2) A system for patient selection that results in outcomes that are equal to or better than the benchmark standards in the applicant's plan.

Patient selection is performed through the use of Appropriate Use Criteria (AUC), which is the national standard. This requirement is addressed in Exhibit 28: Swedish Issaquah Elective PCI Performance Improvement Plan, Section VI, page 3; Attachment A, page 5; Attachment C, page 7.

(3) A process for formalized case reviews with partnering surgical backup hospital(s) of preoperative and post-operative elective PCI cases, including all transferred cases.

Swedish uses a multidisciplinary Heart Team approach in attending to elective PCI cases. This includes partnership with the surgical team at Swedish Health Services d/b/a Swedish Cherry Hill. This requirement is addressed in Exhibit 28: Swedish Issaquah Elective PCI Performance Improvement Plan, Section VI, page 3; Attachment A, page 5; Attachment C, page 6; Attachment D, page 8.

(4) A description of the hospital's cardiac catheterization laboratory and elective PCI quality assurance reporting processes for information requested by the department or the department's designee. The department of health does not intend to require duplicative reporting of information.

Swedish has already been reporting PCI data to the department through COAP, including those volumes from the Issaquah campus. This requirement is addressed in Exhibit 28: Swedish Issaquah Elective PCI Performance Improvement Plan, Section VI, page 3; Attachment D, page 8.

Exhibit 1
Check (Application Fee) and Letter to the Department of Health

Providence SWEDISH

February 17, 2023

Eric Hernandez
Program Manager
Certificate of Need Program
Department of Health
111 Israel Road SE
Tumwater, WA 98501

Re: Application of Swedish Health Services – d/b/a Swedish Issaquah to Operate an Adult Elective PCI Program

Dear Mr. Hernandez:

Attached is the review and processing fee of $40,470 for the certificate of need application of Swedish Health Services – d/b/a Swedish Issaquah to operate an adult elective PCI program in Planning Area # 9 (King East). A letter of intent for this project was sent to the Department on January 30, 2023.

The certificate of need application will be sent in a separate correspondence to the Certificate of Need Program on or before February 28, 2023.

Sincerely,

Andrew Taylor
Chief Strategy Officer – North Division
Providence Health & Services

WARNING: FRONT OF ORIGINAL DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER AND AN ARTIFICIAL WATERMARK ON THE REVERSE SIDE

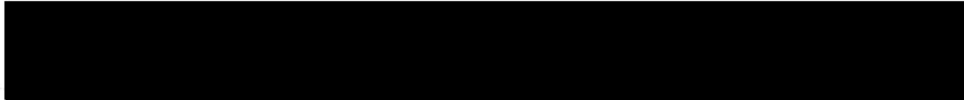
JPMORGAN CHASE BANK, N.A. Columbus OH

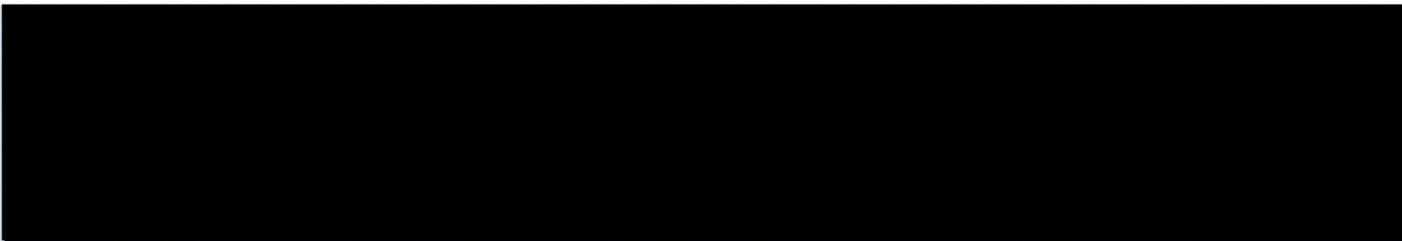
Providence Health & Services - Washington
Swedish Health Services
PO BOX 389673
SEATTLE WA 98138-9673
(425)687-3663

CHECK NUMBER	DATE	AMOUNT
		**$40,470.00

Forty Thousand Four Hundred Seventy Dollars And Zero Cents*****

PAY TO THE ORDER OF
DEPT OF HEALTH
111 ISRAEL RD SE
TUMWATER WA 98501 US





5924889

U.S. Pat.# 6,095,407

Pam Gallagher Felt
Real Estate - Finance
SWEDISH
747 Broadway
Seattle, WA 98122-4307

POSTAL SERVICE CERTIFIED MAIL

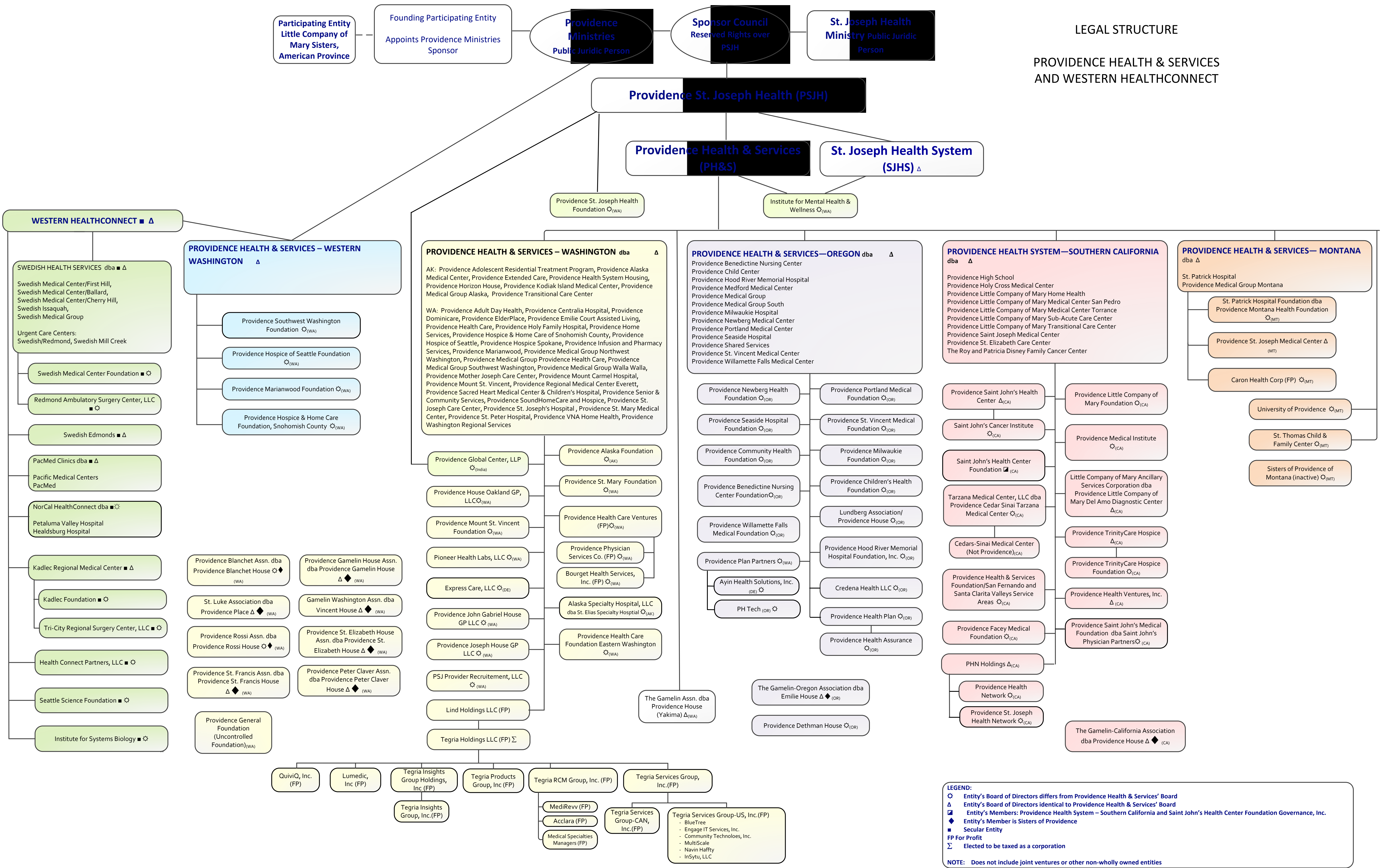
9489 0090 0027 6013 0314 64

Label 890-PB, Oct. 2015
Pitney Bowes

US POSTAGE PITNEY BOWES
ZIP 98104 $ 007.99⁰
02 4W
0000382028 FEB. 17. 2023

Eric Hernandez, Program Manager
Certificate of Need Program
Dept of Health
111 Israel Rd SE
Tumwater, WA 98501

Exhibit 2
Providence Health & Services Legal Structure



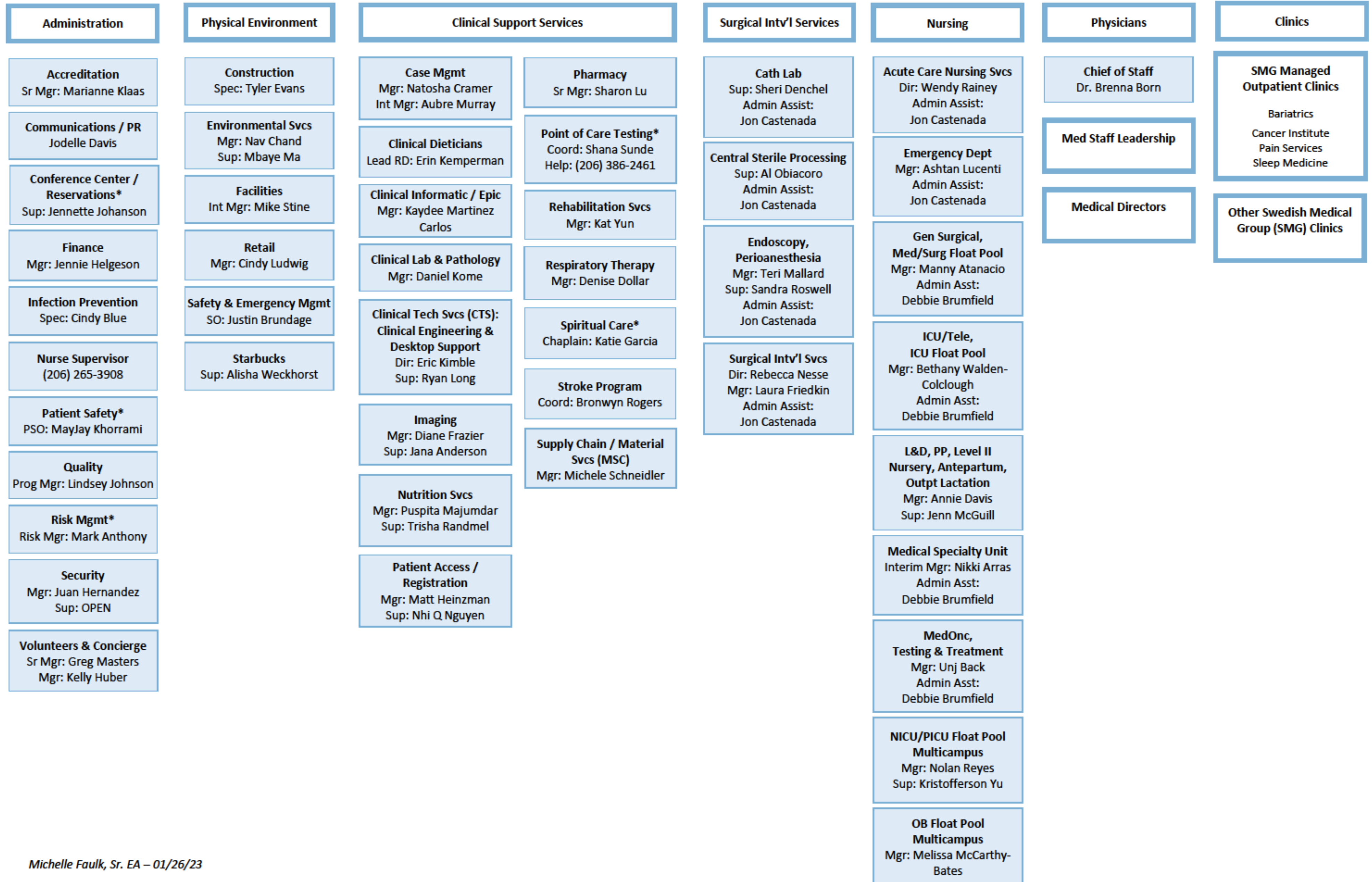
LEGAL STRUCTURE
PROVIDENCE HEALTH & SERVICES AND WESTERN HEALTHCONNECT
Participating Entity Little Company of Mary Sisters, American Province
Founding Participating Entity
Appoints Providence Ministries Sponsor
Providence Ministries Public Juridic Person
Sponsor Council Reserved Rights over PSJH
St. Joseph Health Ministry Public Juridic Person
Providence St. Joseph Health (PSJH)
Providence Health & Services (PH&S)
St. Joseph Health System (SJHS)
Providence St. Joseph Health Foundation
Institute for Mental Health & Wellness
WESTERN HEALTHCONNECT
PROVIDENCE HEALTH & SERVICES – WESTERN WASHINGTON
PROVIDENCE HEALTH & SERVICES – WASHINGTON dba
PROVIDENCE HEALTH & SERVICES—OREGON dba
PROVIDENCE HEALTH SYSTEM—SOUTHERN CALIFORNIA dba
PROVIDENCE HEALTH & SERVICES— MONTANA dba
SWEDISH HEALTH SERVICES dba
Swedish Medical Center/First Hill, Swedish Medical Center/Ballard, Swedish Medical Center/Cherry Hill, Swedish Issaquah, Swedish Medical Group
Urgent Care Centers: Swedish/Redmond, Swedish Mill Creek
Swedish Medical Center Foundation
Redmond Ambulatory Surgery Center, LLC
Swedish Edmonds
PacMed Clinics dba Pacific Medical Centers PacMed
NorCal HealthConnect dba Petaluma Valley Hospital Healdsburg Hospital
Kadlec Regional Medical Center
Kadlec Foundation
Tri-City Regional Surgery Center, LLC
Health Connect Partners, LLC
Seattle Science Foundation
Institute for Systems Biology
Providence Southwest Washington Foundation
Providence Hospice of Seattle Foundation
Providence Marianwood Foundation
Providence Hospice & Home Care Foundation, Snohomish County
AK: Providence Adolescent Residential Treatment Program, Providence Alaska Medical Center, Providence Extended Care, Providence Health System Housing, Providence Horizon House, Providence Kodiak Island Medical Center, Providence Medical Group Alaska, Providence Transitional Care Center
WA: Providence Adult Day Health, Providence Centralia Hospital, Providence Dominicare, Providence ElderPlace, Providence Emilie Court Assisted Living, Providence Health Care, Providence Holy Family Hospital, Providence Home Services, Providence Hospice & Home Care of Snohomish County, Providence Hospice of Seattle, Providence Hospice Spokane, Providence Infusion and Pharmacy Services, Providence Marianwood, Providence Medical Group Northwest Washington, Providence Medical Group Providence Health Care, Providence Medical Group Southwest Washington, Providence Medical Group Walla Walla, Providence Mother Joseph Care Center, Providence Mount Carmel Hospital, Providence Mount St. Vincent, Providence Regional Medical Center Everett, Providence Sacred Heart Medical Center & Children's Hospital, Providence Senior & Community Services, Providence SoundHomeCare and Hospice, Providence St. Joseph Care Center, Providence St. Joseph's Hospital, Providence St. Mary Medical Center, Providence St. Peter Hospital, Providence VNA Home Health, Providence Washington Regional Services
Providence Global Center, LLP (India)
Providence House Oakland GP, LLC
Providence Mount St. Vincent Foundation
Pioneer Health Labs, LLC
Express Care, LLC (DE)
Providence John Gabriel House GP LLC
Providence Joseph House GP LLC
PSJ Provider Recruitement, LLC
Lind Holdings LLC (FP)
Tegria Holdings LLC (FP) Σ
Providence Alaska Foundation
Providence St. Mary Foundation
Providence Health Care Ventures (FP)
Providence Physician Services Co. (FP)
Bourget Health Services, Inc. (FP)
Alaska Specialty Hospital, LLC dba St. Elias Specialty Hospital
Providence Health Care Foundation Eastern Washington
Providence Blanchet Assn. dba Providence Blanchet House
Providence Gamelin House Assn. dba Providence Gamelin House
St. Luke Association dba Providence Place
Gamelin Washington Assn. dba Vincent House
Providence Rossi Assn. dba Providence Rossi House
Providence St. Elizabeth House Assn. dba Providence St. Elizabeth House
Providence St. Francis Assn. dba Providence St. Francis House
Providence Peter Claver Assn. dba Providence Peter Claver House
Providence General Foundation (Uncontrolled Foundation)
The Gamelin Assn. dba Providence House (Yakima)
QuiviQ, Inc. (FP)
Lumedic, Inc (FP)
Tegria Insights Group Holdings, Inc (FP)
Tegria Insights Group, Inc.(FP)
Tegria Products Group, Inc (FP)
Tegria RCM Group, Inc. (FP)
MediRevv (FP)
Acclara (FP)
Medical Specialties Managers (FP)
Tegria Services Group, Inc.(FP)
Tegria Services Group-CAN, Inc.(FP)
Tegria Services Group-US, Inc.(FP)
- BlueTree
- Engage IT Services, Inc.
- Community Technoloes, Inc.
- MultiScale
- Navin Haffty
- InSytu, LLC
Providence Benedictine Nursing Center, Providence Child Center, Providence Hood River Memorial Hospital, Providence Medford Medical Center, Providence Medical Group, Providence Medical Group South, Providence Milwaukie Hospital, Providence Newberg Medical Center, Providence Portland Medical Center, Providence Seaside Hospital, Providence Shared Services, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center
Providence Newberg Health Foundation
Providence Seaside Hospital Foundation
Providence Community Health Foundation
Providence Benedictine Nursing Center Foundation
Providence Willamette Falls Medical Foundation
Providence Plan Partners
Ayin Health Solutions, Inc. (DE)
PH Tech
Providence Portland Medical Foundation
Providence St. Vincent Medical Foundation
Providence Milwaukie Foundation
Providence Children's Health Foundation
Lundberg Association/ Providence House
Providence Hood River Memorial Hospital Foundation, Inc.
Credena Health LLC
Providence Health Plan
Providence Health Assurance
The Gamelin-Oregon Association dba Emilie House
Providence Dethman House
Providence High School, Providence Holy Cross Medical Center, Providence Little Company of Mary Home Health, Providence Little Company of Mary Medical Center San Pedro, Providence Little Company of Mary Medical Center Torrance, Providence Little Company of Mary Sub-Acute Care Center, Providence Little Company of Mary Transitional Care Center, Providence Saint Joseph Medical Center, Providence St. Elizabeth Care Center, The Roy and Patricia Disney Family Cancer Center
Providence Saint John's Health Center
Saint John's Cancer Institute
Saint John's Health Center Foundation
Tarzana Medical Center, LLC dba Providence Cedar Sinai Tarzana Medical Center
Cedars-Sinai Medical Center (Not Providence)
Providence Health & Services Foundation/San Fernando and Santa Clarita Valleys Service Areas
Providence Facey Medical Foundation
PHN Holdings
Providence Health Network
Providence St. Joseph Health Network
Providence Little Company of Mary Foundation
Providence Medical Institute
Little Company of Mary Ancillary Services Corporation dba Providence Little Company of Mary Del Amo Diagnostic Center
Providence TrinityCare Hospice
Providence TrinityCare Hospice Foundation
Providence Health Ventures, Inc.
Providence Saint John's Medical Foundation dba Saint John's Physician Partners
The Gamelin-California Association dba Providence House
St. Patrick Hospital, Providence Medical Group Montana
St. Patrick Hospital Foundation dba Providence Montana Health Foundation
Providence St. Joseph Medical Center
Caron Health Corp (FP)
University of Providence
St. Thomas Child & Family Center
Sisters of Providence of Montana (inactive)
LEGEND:
✪ Entity's Board of Directors differs from Providence Health & Services' Board
Δ Entity's Board of Directors identical to Providence Health & Services' Board
◪ Entity's Members: Providence Health System – Southern California and Saint John's Health Center Foundation Governance, Inc.
◆ Entity's Member is Sisters of Providence
■ Secular Entity
FP For Profit
Σ Elected to be taxed as a corporation
NOTE: Does not include joint ventures or other non-wholly owned entities

Exhibit 3
Swedish Health Services – d/b/a
Swedish Issaquah
Organizational Chart

Providence SWEDISH

Swedish Medical Center Issaquah

Functional Organizational Chart

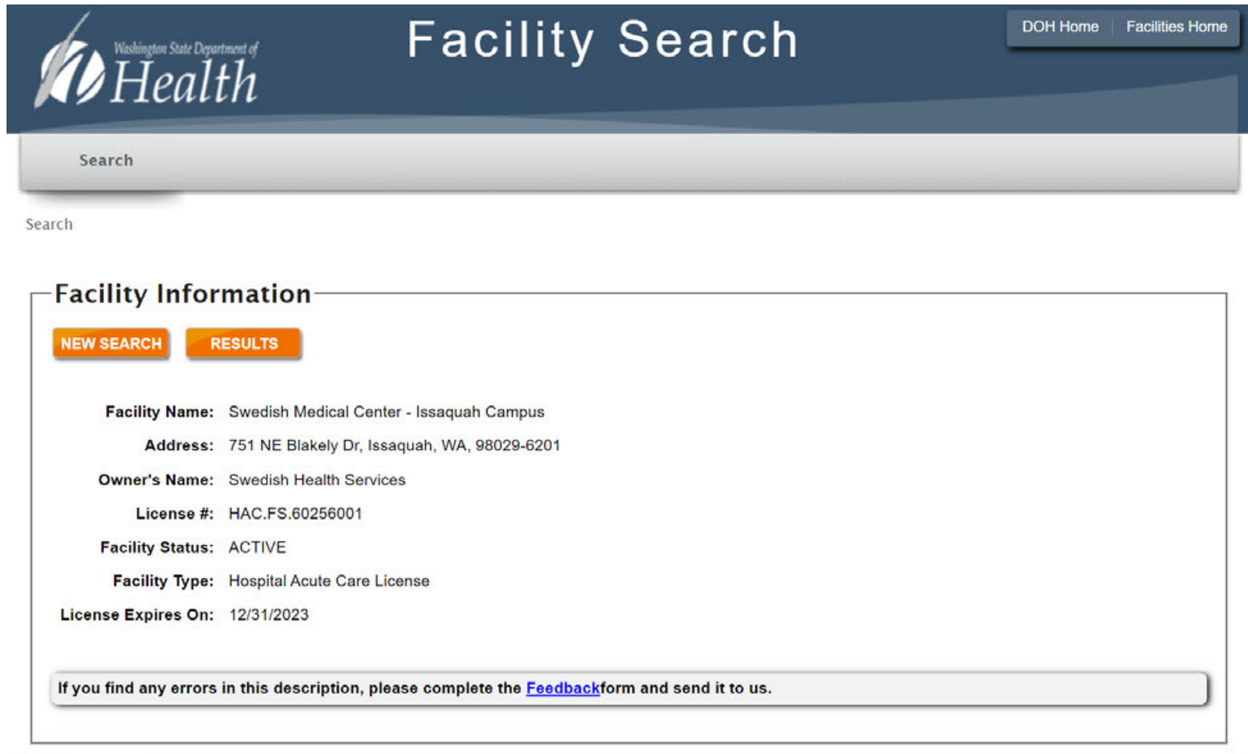


Michelle Faulk, Sr. EA – 01/26/23

Exhibit 4
Swedish Issaquah Acute Care License

Swedish Issaquah

Washington State DOH Acute Care License


Washington State Department of Health

Facility Search

DOH Home | Facilities Home

Search

Search

Facility Information

NEW SEARCH | RESULTS

Facility Name:	Swedish Medical Center - Issaquah Campus
Address:	751 NE Blakely Dr, Issaquah, WA, 98029-6201
Owner's Name:	Swedish Health Services
License #:	HAC.FS.60256001
Facility Status:	ACTIVE
Facility Type:	Hospital Acute Care License
License Expires On:	12/31/2023

If you find any errors in this description, please complete the Feedbackform and send it to us.

Source: https://fortress.wa.gov/doh/facilitysearch/

Exhibit 5
Letter of Intent

Providence SWEDISH

January 30, 2023

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

RE: Letter of Intent: Swedish Health Services – d/b/a Swedish Issaquah, Adult Elective PCI Program

Dear Mr. Hernandez:

Consistent with WAC 246-310-080 and WAC 246-310-710, Swedish Health Services d/b/a Swedish Issaquah ("Swedish Issaquah") hereby submits a letter of intent proposing to establish an adult elective percutaneous coronary intervention (PCI) program.

1. Description of proposed service
   Swedish Issaquah requests certificate of need approval to operate an adult elective PCI program.

2. Estimated cost of the project
   There is no capital expenditure associated with this project.

3. Identification of the service area
   As defined in WAC 246-310-705(5), the planning area for this project is planning area #9 (King East).

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

Andrew Taylor	Chief Strategy Officer Providence Health & Services – WA/MT & Swedish	Andrew.Taylor5@providence.org
Lisa Crockett	VP, System Strategy & Planning Providence	Lisa.Crockett@providence.org
Matt Moe	Director, System Strategy & Planning Providence	Matthew.Moe@providence.org

Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,

Andrew Taylor
Chief Strategy Officer
Providence Health & Services – Washington/Montana & Swedish

Exhibit 6
Single Line Drawings

Swedish Issaquah Campus – Floor 1

LEGEND

- 3 HR FIRE BARRIER
- 2 HR FIRE BARRIER
- 2 HR FIRE W/ SMOKE
- 1 HR FIRE BARRIER
- 1 HR FIRE W/ SMOKE
- SMOKE BARRIER
- 1 HR SMOKE BARRIER
- NON- RATED SMOKE PARTITION
- DR RATING | NUMBER
- HAZARDOUS STORAGE
- SUITE NUMBER
- Smoke Compartment 0,000 ID
- EXIT
- SUITE EXIT ACCESS DOOR
- SHAFTS / ELEV
- CHUTES

Corridors, Suite Separations and Hazardous rooms in Healthcare occupancies are smoke partitions Unless otherwise indicated

All construction is from 2010 unless otherwise noted

- EXIT PASSAGEWAYS
- EXIT ACCESS CORRIDOR
- TRAVEL DISTANCE TO EXIT

SUITE 1074- BUILD OUT 2016

1 HR SPRINKLER SUBSTITUTION PER IBC 404.5 EXCEPT. 1

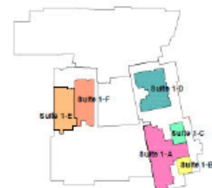
GLASS IN THIS AREA IS PROTECTED BY SPRINKLER WASH PER SPECIFIED SYSTEM. REFER TO IBC TABLE 704.8 FOR 45% OPENINGS BASED ON DISTANCE TO PROPERTY LINE. DOORS NOT RATED.

Smoke Compartment	
14,975	SC1d
3,479	SC1b
17,516	SC1c
17,391	SC1d
16,937	SC1f
17,096	SC1e

1

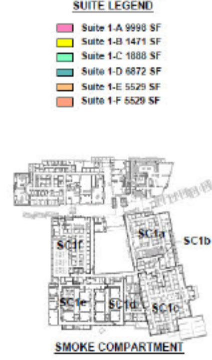
2

Cath Lab 1 and 2



SUITE LEGEND

- Suite 1-A 9998 SF
- Suite 1-B 1471 SF
- Suite 1-C 1888 SF
- Suite 1-D 6872 SF
- Suite 1-E 5529 SF
- Suite 1-F 5529 SF



SMOKE COMPARTMENT

OCCUPANCY LEGEND

- Healthcare
- Business
- Ambulatory
- Assembly
- Parking
- Retail

SPRINKLER LEGEND

- Sprinklered
- No Sprinklers
- Partial Sprinklers

SWEDISH
Health Care

Issaquah Campus
751 NE Blakely Drive
Issaquah, WA 98029

Life Safety Drawings Per NFPA 2012 Life Safety Code

REV DATE

DESIGNED BY: CHECKED BY:

PROG. NO.

DATE AUG 2017

DWG.

Life Safety Plan Issaquah Campus

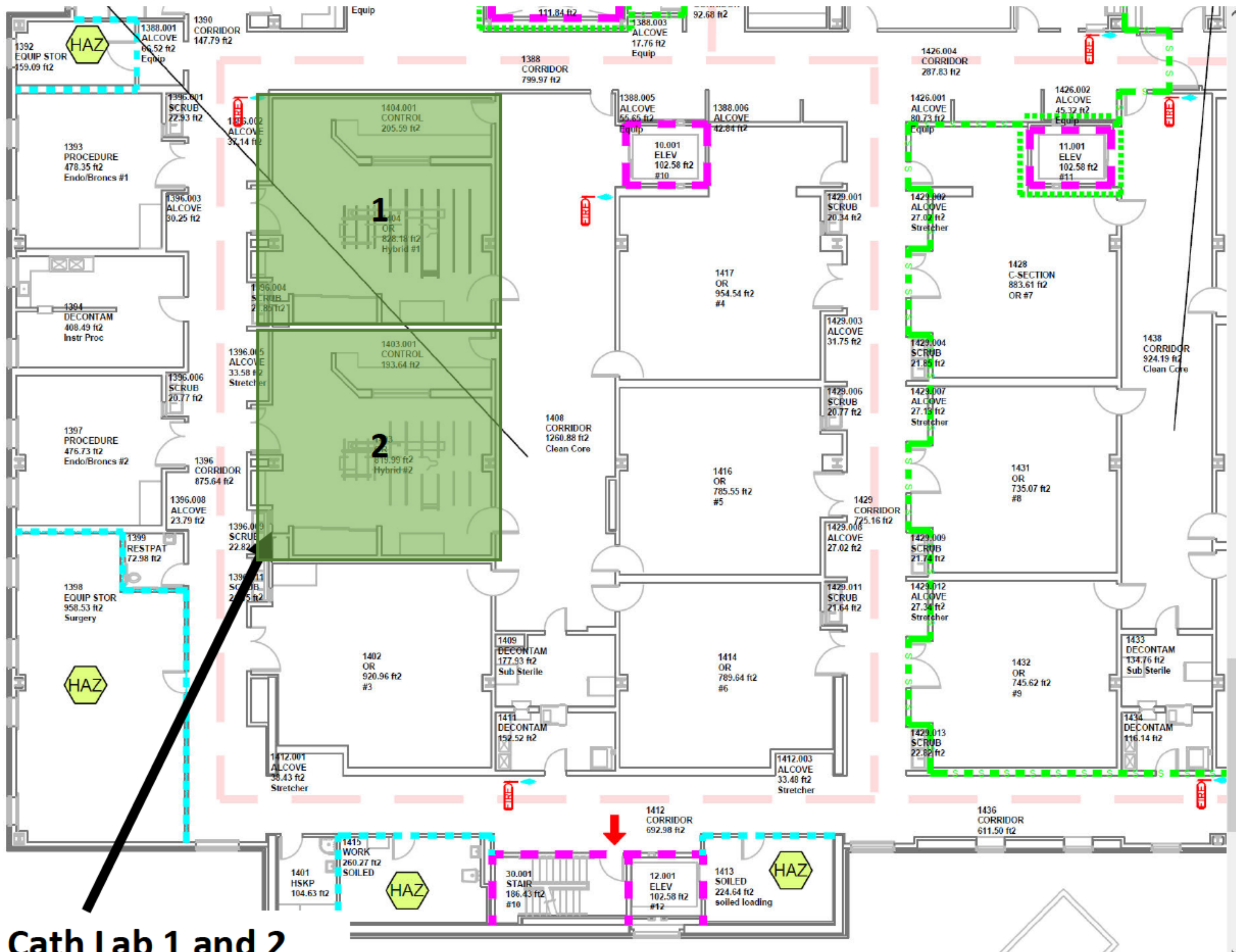
Floor 1

Not to Scale

DWG.

LS01

Swedish Issaquah Campus – Floor 1



Cath Lab 1 and 2

Exhibit 7
Swedish Health Services
Community Benefit Report, 2021

2021 COMMUNITY BENEFIT PROGRAM

Health for **Good**

COMMUNITY HEALTH NEEDS ASSESSMENT

Housing/ homelessness

Mental health

Diabetes/obesity

Racism and discrimination

Drug use/ substance abuse

OUR MISSION

Improve the health and well-being of each person we serve

OUR VISION

Health for a better world

OUR VALUES

Compassion
Justice
Excellence
Dignity
Integrity
Safety

OUR PROMISE

Extraordinary care.
Extraordinary caring.℠

REINVESTING IN THE COMMUNITY

In the last eight years, Swedish spent more than $1.3 billion in community benefit. We are making investments that go beyond the need for free and discounted care by improving access to care and developing new ways to help people stay healthy.

In 2021, we spent more than $252 million on community benefit programs, including $30 million in free and discounted care.

ACCESS TO CARE

In 2021 Swedish provided access to more than 115,881 Medicaid patients.

PROVIDING FINANCIAL ASSISTANCE

Our charity care program provides a 100 percent financial discount to individuals and families between 0-300 percent of the federal poverty level.

Full charity for family of four (up to 300%):

2020	$78,600 or less
2021	$79,500 or less
2022	$83,250 or less

Partial (301 – 400%)

2020	$78,601 - $104,800
2021	$79,501 - $106,000
2022	$83,251 - $111,000

$252 million on community benefit programs

Access to 100,397 Medicaid patients

100 percent financial discount to individuals and families between 0-300 percent of the federal poverty level

SWEDISH

By the **numbers**

2021 COMMUNITY BENEFIT ACROSS SWEDISH

$174 million

Unpaid cost of Medicaid and other means-tested government programs:
This is the difference between the actual cost of care and what is paid by the state and federal government. It does not include Medicare.

$25.1 million

Free and discounted medical care for patients in need:
This is financial assistance for those who are uninsured, underinsured or otherwise unable to pay for their health care.

$34.2 million

Health professions, educations and research:
These are subsidies for medical residency programs, nursing and other education, and medical research.

$8.1 million

Subsidized health services:
This includes clinical and social services provided despite a financial loss because they meet identified needs not met elsewhere in the community.

$10.4 million

Community health improvement and strategic partnerships:
This reflects free services, such as patient education, health screenings, immunizations and support groups as well as donations to community partners.

COMMUNITY BENEFIT BY CAMPUS:

Campus	Amount
Ballard	$ 18 million
Cherry Hill	$ 31 million
Edmonds	$ 29 million
First Hill	$ 117 million
Issaquah	$ 19 million
Mill Creek	$ 8 million
Redmond	$ 2 million
Swedish Medical Group	$ 28 million
JV - PET/CT	$ 107 thousand
SHS Shared Services	$ 8 thousand

Community health needs **assessment**

These leading health concerns were identified to guide us in gathering accurate information to determine current health trends and identify issues for action.

- **Mental and behavioral health** — The number of people with symptoms of depression and suicide ideation have remained similar since April 2020 with 34.1-40.2% of those 18-24 years old feeling depressed and anxious compared to all other age groups. Mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression and outcome of chronic diseases.
- **Homelessness** — Homelessness is an ongoing crisis in Seattle and King County, affecting families, children, older adults and veterans. It disproportionately impacts LGBTQI+ individuals and certain communities of color. We continue to treat homeless patients in our hospitals and witness the human toll of living on the streets.
- **Substance abuse and drug addiction** — The effects of substance abuse contribute to costly social, physical, mental and public health problems, and has a devastating impact on individuals, families and communities.
- **Obesity and diabetes** —Diabetes is a common but serious and costly disease in Washington state. About one in eight adults in Washington state have diabetes. In addition, an estimated one in three have prediabetes. Diabetes is more prevalent among certain groups including racial and ethnic minorities and those with lower income and education levels. We are committed to improving access to resources and screenings for diabetes and to providing education about obesity, appropriate nutrition and physical activity.
- **Joint and back pain** — According to national studies, musculoskeletal pain is the most common type of chronic pain. Chronic joint and back pain seriously affects a person's daily activities and quality of life. Nationwide, low back pain affects 80 percent of individuals at some point in their life that necessitates access to health care services.

Community **partnerships**

Swedish supports the vital work of local agencies and organizations whose efforts further impact the work that we do to find innovative, equitable and measurable ways to reduce health care costs and improve the health and quality of life in our communities.

ASIAN COUNSELING and REFERRAL SERVICE

Lifelong.

Plymouth Housing

friendsofyouth

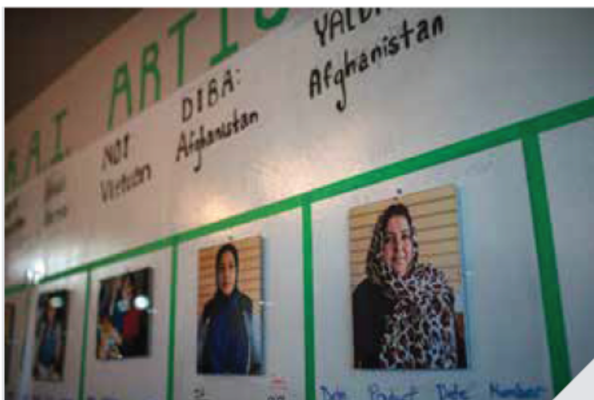
How we **care**

SUPPORTING AND EMPOWERING BLACK BIRTHING WOMEN AND PEOPLE

The Black Birth Empowerment Initiative (BBEI) at Swedish is a curated program designed for those who identify as Black or African American. Its purpose is to center and uplift the Black birth experience by providing clients the option to work with culturally competent, trained doulas. BBEI caregivers work to reduce health disparities in the Black community including prenatal and postpartum complications and higher rates of stillbirths and pregnancy mortality.

According to Sauleiha Akangbe, certified birth doula and manager, Birth Equity and Women's Health for the Swedish doula program, BBEI was created in direct response to concerns heard from the community. "There was a call from our community that Swedish needed to do better for the community. The doula program, with support from leadership, prioritizes the Black doula experience and respects the importance of empowering and honoring the Black birthing experience," says Akangbe.

The program's Doula Diversity Scholarship is a key resource for aspiring doulas of color and it helps advance the initiative's goals. The scholarship covers the cost of doula training and certification, a lending library, and shadowing opportunities. In 2021, the program received community benefit support from Swedish to provide scholarships to four new doulas who will work in the community. Jeleine Osario Smith, a 2021 scholarship recipient says, "I'm hoping with training and education, I will be able to bring the support a laboring family needs when it matters the most.



REFUGEE ARTISAN INITIATIVE

A solution to Swedish's scrub supply problem was just around the corner with Refugee Artisan Initiative (RAI), a nonprofit founded by Ming-Ming Tung-Edelman. RAI helps refugee and immigrant women improve skills developed in their home countries and connects them with artisan U.S. job opportunities.

Tung-Edelman applied to Swedish's Community Investment Funding Grant, and not long after, Swedish and RAI partnered to supply our caregivers with measured-to-fit scrubs.

"Our refugees' sewing skills have never been so valuable. These women will be able to provide an income for their families and achieve their own American dream," Tung-Edelman says of the partnership.

SWEDISH MOBILE VACCINE CLINICS

In 2021, we answered the call to vaccinate those who needed it most. We launched a mobile vaccination clinic, using COVID-19 data to target our outreach and vaccine education efforts to underserved populations most affected by the pandemic. Our caregiver volunteers made these clinics a reality, and we administered over 10,000 vaccinations with over 20 community partners. Caregiver/staff and community volunteers even provided clothing and supply donations at some of these events. The Washington State Hospital Association awarded its 2021 Community Health Leadership Award to Swedish for our mobile vaccine clinic team.

For more information, go to https://blog.swedish.org/swedish-news/wsha-presents-swedish-with-2021-community-health-leadership-award and https://blog.swedish.org/community/tackling-covid-19-hot-spots-more-than-9-000-vaccines-administered.

About **Swedish**

FIRST HILL

SERVING THE REGION SINCE 1910

With a commitment to take care of everyone who comes through our doors, regardless of their ability to pay, Swedish has been woven into the fabric of the Pacific Northwest since 1910.

CHERRY HILL

SWEDISH IS GOVERNED BY THE COMMUNITIES IT SERVES

As a not-for-profit health care system, we are governed by a dedicated group of community members who serve on our Board of Trustees. We value the time and effort of our board members who serve as unpaid volunteers.

OUR ECONOMIC CONTRIBUTION TO THE COMMUNITY

Swedish has grown to become the largest not-for-profit health provider in the greater Seattle area.

- 12,588 caregivers (all employees and providers)
- 1,319 providers
- 3,455 Medical Staff providers
- Volunteering in 2021 posed a challenge for our caregivers due to COVID. Rather than donate their time to our community partners, or to their non-profits of choice, they continued to spend countless hours — as health care heroes — caring for those in our communities affected by COVID-19.

BALLARD

WE HAVE:

- Five hospital campuses (First Hill, Cherry Hill, Ballard, Edmonds and Issaquah)
- An emergency room and specialty center in Redmond (East King County) and the Mill Creek area in Everett
- Swedish Medical Group, a network of 123 primary and specialty care locations throughout the greater Puget Sound area
- Affiliations with suburban hospitals and physician groups

EDMONDS

SWEDISH COMMUNITY BENEFIT PROGRAM
747 Broadway
Seattle, WA 98122
206-386-6000

swedish.org

ISSAQUAH

We do not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity or expression, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY:711)
注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (TTY:711)

COMM-22-0153 4/22

Exhibit 8
Swedish Community Health Improvement Plan, 2022-2024

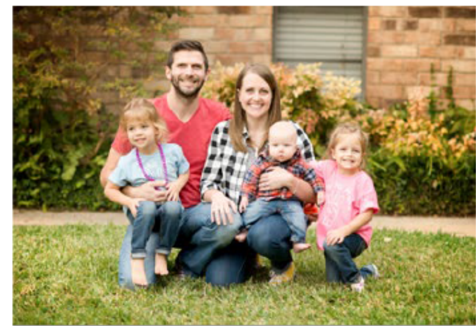
2022 - 2024

COMMUNITY HEALTH IMPROVEMENT PLAN

Swedish

First Hill, Cherry Hill, Issaquah, Ballard

King County, WA



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Kelly R. Guy at Kelly.Guy@Providence.org.

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EXECUTIVE SUMMARY

Providence continues its Mission of service in King County through Swedish Ballard, Cherry Hill, First Hill and Issaquah campuses. These Swedish campuses share a common service area in King County, Washington. King County has a population of approximately 2.2 million people.

Swedish King County hospitals dedicate resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, Swedish provided $222.4 million in community benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for Swedish Edmonds to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: county and state public health data, qualitative data from interviews with community stakeholders and listening sessions with community members, primary data from a community survey, and hospital utilization data.

Swedish Community Health Improvement Plan Priorities

As a result of the findings of our 2021 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Swedish King County hospitals will focus on the following areas for its 2022-2024 Community Benefit efforts:

BEHAVIORAL HEALTH

Behavioral health includes mental health and substance use. Mental health is an important part of overall health and well-being and includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Substance abuse/use, occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home.

ACCESS TO HEALTH CARE

Access to care is a key determinant of health that provides preventive measures and disease management, reducing the likelihood of hospitalizations and emergency room admissions. Access to affordable, quality care is important to physical, social, and mental health. Health insurance, local care options, and a usual source of care help to ensure access to health care. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met.

RACISM AND DISCRIMINATION

We acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. Discrimination is treating a person unfairly because of who they are or because they possess certain characteristics or identities.

HOUSING INSTABILITY AND HOMELESSNESS

Housing instability and homelessness are prevalent issues in area communities. Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Those experiencing homelessness face higher rates of disease and death than the population has stable housing.

INTRODUCTION

Who We Are

Our Mission Improve the health and well-being of each person we serve.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Swedish Ballard Campus
Swedish Ballard first opened on March 12, 1928 as Ballard Accident and General Hospital. Over the years, the hospital grew to meet the needs of the community. In 1992, the hospital merged with Swedish Medical Center. Swedish Ballard is a community hospital and the center of Swedish's Behavioral Health programs. Swedish Ballard is licensed for 133 beds, employs over 600 individuals, and has more than 200 providers who identify Ballard as their primary campus.

Swedish Cherry Hill
Swedish Medical Center Cherry Hill is 205-bed CMS 5-star acute care hospital located in the Central District of Seattle. Cherry Hill is home to the Swedish Neuroscience and Swedish Heart and Vascular Institutes, and provides specialty care for the community and the region in the disciplines of Neurology, Neurosurgery, Cardiology, Cardiac Surgery, and Vascular Surgery.

Swedish First Hill
In 2020, Swedish First Hill had 24,222 hospital admissions, 35,520 ER visits and 19,962 surgeries. Swedish First Hill delivers more babies than any other hospital in Washington State and in 2020 we welcomed 7,552 babies. Our surgical specialists specialize in general, laparoscopic, robotic, hepatobiliary, hernia, oncologic, and breast surgery.

Swedish Issaquah
Located in Issaquah, Washington, the hospital Swedish Issaquah had 5,635 hospital admissions, 23.974 Emergency Department visits and 1,551 newborns in 2020.

Our Commitment to Community

Swedish King County hospitals dedicate resources to improve the health and quality of life for the communities we serve. During 2021, Swedish provided $222.4 million in community benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in King County, WA.

[1] Per federal reporting and guidelines from the Catholic Health Association.

Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

Figure 1. Best Practices for Centering Equity in the CHIP

Address root causes of inequities by utilizing evidence-based and leading practices

Explicitly state goal of reducing health disparities and social inequities

Reflect our values of justice and dignity

Leverage community strengths

Community Benefit Governance

Swedish further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Chief Strategy Officer at Swedish is responsible for coordinating implementation Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan (CHIP).

Planning for the Uninsured and Underinsured

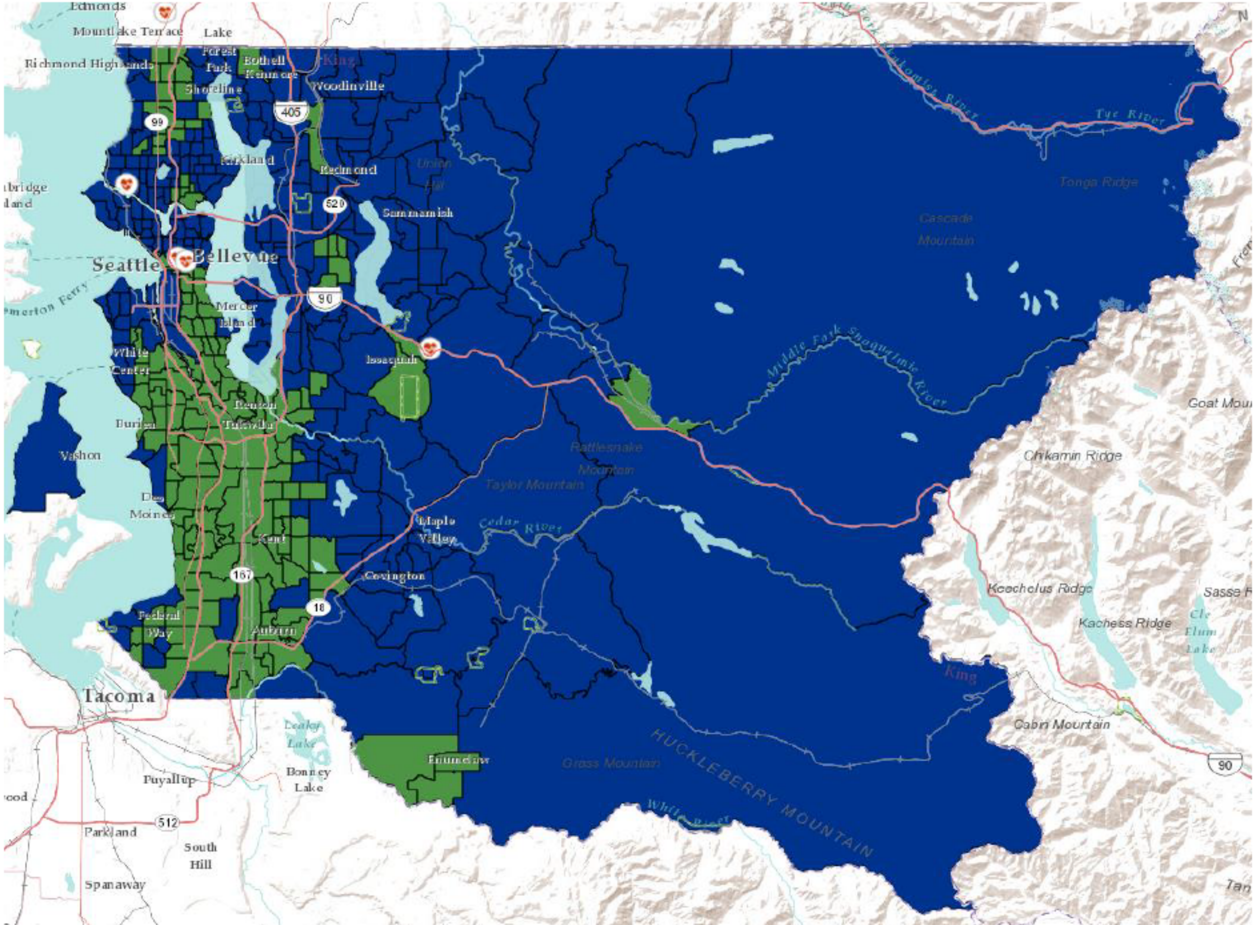
Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Swedish has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Swedish informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click https://www.swedish.org/patient-visitor-info/billing/financial-assistance.

OUR COMMUNITY

Description of Community Served

The Swedish King County service area is King County, WA and includes a population of approximately 2.2 million people.



Of the over 2.2 million residents of King County, roughly 40% live in the "high need" area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of $52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

In King County, the high need service area has a higher rate of children, ages 17 and younger (26.9%) than the population of King County (25.7%). There are fewer young adults, ages 18-34) in the high need area (27.2%) when compared to King County (24.5%).

POPULATION BY RACE AND ETHNICITY

In King County, 10% of the population is Hispanic and 14.9% of the high need service area is Hispanic. The majority population in King County identify as White (62.6%), 18.9% of the population are Asian, 6.7 % are Black/African Americans, 5.7% are two or more races, and 4.4% are other races. The high need service area has a lower percentage of White residents and higher rates of Hispanic, Asians, Blacks, other races, and persons of two or more races.

SOCIOECONOMIC INDICATORS

Income Indicators for King County Service Area

Indicator	Broader Service Area	High Need Service Area	King County
Median Income Data Source: American Community Survey Year: 2019	$121,295	$69,498	$95,063
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	17.1%	24.9%	20.4%

The average median household income for census tracts in the high need service area is approximately $25,000 lower than the median household income for King County. Severe housing cost burden is defined as households spending 50% of more of their income on housing costs. The average severe housing cost burden by population in high need service area census tracts is 4.5% higher than the County value and 7.8% higher than the average in the broader service area census tracts.

Full demographic and socioeconomic information for the service area can be found in the 2021 CHNA for Swedish King County.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Secondary Data

Secondary data were collected from a variety of county and state sources. For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need".

Primary Data

Swedish conducted stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is important, as these individuals have firsthand knowledge of the needs and strengths of the community. Swedish conducted 18 stakeholder interviews including 27 participants, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. Interviews were conducted with representatives from Public Health – Seattle & King County and Snohomish County Public Health. They also completed 9 listening sessions: 7 from King County and 2 from Snohomish County. The goal of the interviews and listening sessions was to identify the needs not currently being met in the community and what assets could be leveraged to address these needs. Swedish also conducted a community survey in English from July 3 to August 31, 2021. In Snohomish County, 232 community members participated in the survey.

Prioritization of Health Needs

The following findings represent the high-priority health-related needs, based on community stakeholder interview and listening session participant input:

- Behavioral health (includes mental and substance use)
- Homelessness and housing instability
- Racism and discrimination

The following findings represent the medium-priority health-related needs, based on community input:

- Access to health care
- Dental care
- Affordable childcare and preschools
- Economic insecurity
- Food insecurity

The survey respondents selected good paying jobs, assistance getting healthy food, and a caring community as the top three priorities needed to improve the health and well-being of themselves and their families.

Significant Community Health Needs Prioritized

The results of the primary data ranking and the subsequent qualitative input determined the 2022-2024 CHIP priorities, which were reviewed, confirmed, and/or refined based on committee member input. The list below ranked in order summarizes the significant health needs for the 2022-2024 CHIP identified through the 2021 CHNA process:

- **Behavioral health challenges (including mental health and substance use)**
- **Access to health care**
- **Racism and discrimination**
- **Housing instability and homelessness**

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. The following community health needs identified in the ministry CHNA will not be addressed: dental care, affordable day care and preschools, economic insecurity and food insecurity. Swedish has chosen to concentrate on those needs that can most effectively be addressed given the organization's areas of focus and expertise. In addition, Swedish will collaborate with local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Swedish Acute Care Counsel (ACC) and the Swedish Health Equity Social Justice Responsibility Committee (HESJR) served as the two oversight committees in conjunction with Dr. Nwando Anyakou, Chief Equity Officer and Kevin Brooks, Chief Operating Officer (Executive Sponsors) to identify and prioritize the top health-related needs in the community for the 2022-2024 CHIP. On September 14, 2021, representatives from ACC, HSJER, Swedish Medical Group (SMG), Swedish Cancer Institute (SCI) and the five Swedish campuses participated in the 2021 Swedish CHNA Prioritization of Need meeting process to review and analyze the aggregated quantitative and qualitative CHNA data, including the needs prioritized by community stakeholders and members.

The Providence Data and Evaluation team presented an in-depth review of publicly available data, internal utilization data, and findings from the stakeholder interviews, listening sessions, and survey. On September 28, 2021, the group reconvened to review the community-identified needs and vote on Swedish priorities for the 2022-2024 CHIP.

The 2022-2024 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has affected all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2021 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Swedish anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Swedish in the enclosed CHIP.

Addressing the Needs of the Community: 2022- 2024 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: ACCESS TO HEALTH CARE

Long-Term Goal(s)

To improve access to health care and preventive resources for the uninsured and underinsured.

Strategies and Strategy Measures for Addressing Access to Health Care

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Offer health education, health fairs, community outreach, and support groups that address to care and preventive practices.	Community at large.	Number and type of activities and persons served.	150,000 persons served.	10% annual increase in persons served.
Provide sponsorships, grant funding and in-kind support to increase access to health care.	Underserved, low-income and minority populations.	List of funded organizations, persons served and program accomplishments.	100,000 persons served.	10% annual increase in persons served.
Collaborate with community agencies to health care access.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in three collaborative partnerships.	Participate in five collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies and equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Swedish Medical Group, Alzheimer's Association, National MS Society, Physicians for Social Responsibility, American Cancer Society, International Community Health Services, Medical Teams International, Ballard Teen Health Clinic, Encompass, March of Dimes, Seattle Indian Health Board, The Max Clinic at Harborview.

COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH

Long-Term Goals

To ensure equitable access to high-quality, culturally responsive and linguistically appropriate mental health and substance use services, especially for vulnerable populations.

An improved workforce of mental health professionals to respond to the community's mental health and substance use needs.

Strategies and Strategy Measures for Addressing Behavioral Health

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Conduct depression screening and suicide risk assessment screenings for patients in primary care clinics and the ED.	All patients in primary care and ED will be screened for depression. If persons are experiencing depression, they will be further screened for suicide risk.	Number of patients screened for depression and suicide risk. Results of screening assessments.	54% of patients are annually screened for depression.	75% of patients are annually screened for depression.
Support the psychology postdoctoral program for primary care.	Serves anyone in the Swedish community with mental health concerns, irrespective of their ability to pay.	Number of Fellows. Number of patients seen by Psychology Fellows on an annual basis.	Support two postdoctoral fellows in psychology. Each Fellow will provide 800-1,000 visits per year.	Support two postdoctoral fellows in psychology. Each Fellow will provide 800-1,000 visits per year.
Provide community education, outreach and support groups related to mental health and substance use topics.	Community at large.	Education and outreach topics, support groups and events. Number of participant encounters.	10,000 persons served.	10% annual increase in persons served.
Offer Virtual Addiction Bridge Clinic.	A no barrier clinic, open to the community.	Number of persons served and services provided.	Number of virtual visits in 2022 will determine baseline.	5% annual increase in number of virtual Bridge Clinic visits.

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Provide Medication Assisted Treatment (Suboxone) in the ED to assist in the treatment of opioid use disorder.	Emergency Department patients who present with opioid use disorder, opioid withdrawal, and/or opioid overdose.	Number of patients provided with MAT in the ED.	Ballard Campus administered Suboxone to 23 persons. Cherry Hill Campus administered Suboxone to 27 persons. First Hill Campus administered Suboxone to 32 persons. Issaquah Campus ED administered Suboxone to 17 persons.	Annual increase of 10% in number of persons provided with MAT in the ED.
Participate in community focused initiatives and collaborative partnerships focused on mental health and substance use topics.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in three collaborative partnerships.	Participate in three collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies, equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

NAMI-Seattle chapter, March of Dimes, The Friendship Circle of WA, ParentWise, Ballard Alliance, Denise Louise Education Center, Valley Cities Behavioral Health Care, Swedish School-Based Mental Health Services.

COMMUNITY NEED ADDRESSED #3: HOUSING INSTABILITY AND HOMELESSNESS

Long-Term Goal

Provide a sufficient supply of safe, affordable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs.

Strategies and Strategy Measures for Addressing Housing Instability and Homelessness

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Provide sponsorships, grant funding and in-kind support to address housing and homelessness.	Underserved, low-income and minority populations.	List of funded organizations, persons served and program accomplishments.	75,000 persons served.	10% annual increase in persons served.
Provide medical outreach efforts to support individuals experiencing homelessness.	Persons experiencing homelessness.	Number of persons treated.	934 persons experiencing homelessness treated.	Annually increase in persons treated by 10%.
Collaborate with community agencies to address housing and homelessness.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in two collaborative partnerships.	Participate in four collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies and equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Operation Night Watch/Point in Time Program, Neighborcare Health, Eastside Baby Corner, Friends of Youth, Solid Ground, Downtown Emergency Service, Wellspring Family Services, Community Roots Housing, Neighborhood House, Mary's Place, Plymouth Housing Group, Ballard Alliance, Action Hub, Interim CDA, Healthcare for the Homeless Network.

COMMUNITY NEED ADDRESSED #4: RACISM AND DISCRIMINATION

Long-Term Goal

To actively work to eliminate social inequities and forms of oppression our communities, ensuring all people have the opportunities and access to live their fullest, healthiest lives.

Strategies and Strategy Measures for Addressing Racism and Discrimination

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Provide sponsorships, grant funding and	Underserved, low-income and	List of funded organizations, persons served	50,000 persons served.	10% annual increase in persons served.

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
in-kind support to focus on increased equity.	minority populations.	and program accomplishments.		
Partner with community stakeholders to design/create culturally effective care to address inequities.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in two collaborative partnerships.	Participate in four collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies and equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Alliance for Education, Seattle Central College Foundation, Doula Birth Training, Entre Hermanos, Gay City, KinOn Healthy Living PROgram, API Chaya, El Centro de la Raza, African American Health Board, Chinese Information and Service Center, Hopelink, Women's Health Equity Project

2022- 2024 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the authorized body of the hospital on April 19, 2022. The final report was made widely available by May 15, 2022.

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R. Guy Hudson, MD, MBA
Chief Executive Officer
Swedish Health Services

____

Kristen Swanson, RN, PhD, FAAN
Chair Board of Trustees
Swedish Health System

____

Justin M. Crowe, PhD
Senior Vice President, Community Partnerships
Providence Health & Services

CHNA/CHIP Contact:

Kelly R. Guy
Regional Director
Swedish Community Health Investment & Partnerships
Kelly.Guy@Providence.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.

Exhibit 9
Swedish Notification of Patient Admission Policy
and
Delivery of the Conditions of Admission Consent Form Policy

Status Active PolicySat ID 12362963

Origination	03/2016	Owner	Marianne Klaas: Senior Director Accreditation
Last Approved	09/2022	Area	Clinical
Effective	09/2022	Applicability	WA - Swedish Medical Center
Next Review	09/2025	Document Types	Administrative and Clinical Procedure

Notification of Inpatient Admission

COPY

Clinical Area: All inpatient units
Population Covered: All inpatients
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah

Related Policies and Procedures:

Nursing Minimum Documentation Reference
Patient Access: Standard Entry for Primary Care Provider (PCP)
Patient Rights

Purpose

To define the process for inpatient admission notification to family member / representative and primary care provider (PCP), and associated documentation in the medical record.

Policy Statement

The patient has the right to have a *family member or representative* of their choice notified promptly of their inpatient hospital admission. Nursing staff members are responsible for performing and documenting notification to the family/representative, or documenting the patient's declination.

The patient also has the right to have their own *primary care provider* (PCP) notified promptly of an inpatient hospital admission. Notification to primary care physicians occurs via an automated process in electronic medical record (EMR) and/or via fax if provider does not utilize Epic. Health Information Management (HIM) staff provides faxed notification when applicable, and scans record of such

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notification into Epic.

LIP Order Requirement

This protocol is contingent upon a licensed independent practitioner's (LIP) order for inpatient admission.

Responsible Persons

Inpatient unit registered nurses (RN), Health Information Management (HIM).

Prerequisite Information

Notification to family / patient representative: As part of every inpatient admission, nursing staff must ask the patient whether the hospital should notify a family member or representative about the admission. If the patient requests notification and identifies the family member or representative to be notified, the hospital promptly notifies the designated individual. The explicit designation of a family member or representative by the patient takes precedence over any non-designated relationship.

The inpatient unit RN documents that the patient, unless incapacitated, was asked *no later than the time of inpatient admission* whether he or she wanted a family member/representative notified, the date, time and method of notification when the patient requested such, or whether the patient declined to have notice provided. If the patient is incapacitated at the time of admission, the medical record must indicate what steps were taken to identify and provide notice to a family member/representative.

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Telephone notification: If voicemail notification is necessary, per 45 CFR 164.510(b)(3), Swedish Medical Center staff can indicate:

- The hospital name
- Admission unit
- The fact that patient has been admitted as an inpatient to our facility
- The patient's general condition, and unit contact phone number

Procedure

Responsible Person	Steps
Inpatient Unit RN	**FAMILY MEMBER / PATIENT REPRESENTATIVE NOTIFICATION** Upon admission to an inpatient unit, ask the patient if they would like to have a family member or representative notified of their admission to Swedish Medical Center. 1. Complete the Notification of Inpatient Admission fields in the RN Admission Navigator in Epic.

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	2. The medical record must reflect the question and the patient's reply. Document the patient's response/indication: "Yes," "Unable to Obtain," or "Patient Declined." 3. If patient is incapacitated at inpatient admission and representative is not known or not available, document the reason for inability to obtain information and follow up when able to obtain information. • Incomplete documentation will display in the RN Documentation Reminder Report. • Document every attempt to obtain notification information. See Attachments for Documentation for Notification of Inpatient Admission to Family Member / Patient Representative
Patient Access, HIM	**PRIMARY CARE PROVIDER (PCP) NOTIFICATION:** The PCP is recorded in Epic via Patient Access (scheduling, registration) representatives. ***PCP Record in Epic:*** In cases when the Primary Care Provider record (SER) is in Epic, then notification occurs automatically via InBasket functionality or via automatic fax notification (eFax). ***PCP Record not in Epic:*** In the event the inpatient's PCP record is not in Epic, then designated staff members in HIM will create a new provider record (SER) in Epic, send prompt fax notification of Inpatient Admission to the provider, and scan such notification into Epic.

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Definitions

Prompt notification. "Promptly" means as soon as possible after the physician's or other qualified practitioner's order to admit the patient has been given. Notice may be given orally in person, by telephone, or by other methods that achieve prompt notification. [Interpretive Guidelines §482.13(b)(4)]

Forms

None.

Addenda

See Attachments

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Regulatory Requirement

Centers for Medicare & Medicaid Services (CMS). §482.13(b)(4)

References

None.

Stakeholders

Author/Contact

Marianne Klaas, Administrative Director of Accreditation, Safety, Injury Management & Clinical Quality Investigations

Expert Consultants

Epic Analysts
Clinical Nursing Education and Practice
SMC Revenue Cycle Education
Patient Access
Health Information Management

Sponsor

Marianne Klaas, Administrative Director of Accreditation, Safety, Injury Management & Clinical Quality Investigations

Stellent: SWED_020452

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Attachments

Documentation for Notification of Inpatient Admission to Family Member or Patient Representative

Approval Signatures

Step Description	Approver	Date
	Mary Alice Duthie: Nurse Educator	09/2022

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Marianne Klaas: Senior Director Accreditation	09/2022

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Status **Active** PolicyStat ID **12798360**

Origination	09/2007
Last Approved	01/2023
Effective	01/2023
Next Review	01/2026
Owner	Carol Boland: Program Manager
Area	Patient Access
Applicability	WA - Swedish Medical Center
Document Types	Administrative Policy and Procedure

Delivery of the Conditions of Admission Consent Form

COPY

Population Covered: All Patients
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond

Related Policies and Procedures:

Advance Directive and CPR Preference
Patient Rights
Managing Disruptive Patient Behavior: Healthcare Agreement
Consents: Who Can Authorize

Purpose

To ensure the standard *Conditions of Admission* (COA) form is appropriately communicated and signed by the patient or their authorized representative at time of admission to Swedish Medical Center (SMC). The COA form serves as the initial consent for treatment at Swedish Medical Center and other consents may be obtained depending on the context of care.

Policy Statement

Consent is necessary prior to any treatment or procedure, except in emergency situations. All facility admissions require the COA form signed by the patient or his/her authorized representative at the time of each hospital outpatient visit or bedded admission encounter. For recurring hospital outpatient accounts, this form is required to be obtained at the initial visit of a treatment plan and/or after periods of more than 90 days between services for ongoing treatment.

When **Preferred language** for medical discussions is other than English, provide patient with a translated document in their preferred language and certified in-person, telephonic or Video Remote Interpreting (VRI) to ensure patient understanding.

The contents of the COA form are reviewed by patient access staff with the patient and/or the patient's authorized representative during the admission process. The patient's or authorized representative's signature is obtained confirming consent for care, receiving a *Financial Assistance at Swedish* brochure, *Patient Rights and Responsibilities* (see Patient Rights policy), knowledge of billing information, and receipt of the *Notice of Privacy Practices* brochure. The patient or their representative may be referred to appropriate administrative or clinical staff with questions about the COA form. **Changes to the COA form are not permitted.**

Patient Access staff are responsible for explaining the contents of *Conditions of Admission* form, affixing patient label to the form, obtaining appropriate signatures, and scanning the form into the electronic medical record (EMR) once signed.

In the event a signature cannot be obtained at admission, a SMC staff member will mark the check box "Unable to obtain signature at admission" and follow-up will occur to ensure that each patient's medical record contains a signed *Conditions of Admission* form.

Responsible Persons

COPY

Patient Access and Clinical Units

Procedure

Responsible Person	Steps
Patient Access Staff	**OBTAINING CONSENT FOR COA FORM** *The following steps are performed at the time of registration. These steps may also be performed on the unit if the patient is admitted directly to a room.* 1. During admission, a Patient Access staff member reviews the *Conditions of Admission* form with the patient or the patient's authorized representative. **Points to emphasize during COA review:** • Consent to receive medical care from the providers at Swedish Medical Center. • If a staff member is accidently exposed to your blood or body fluids, you give consent to be tested for certain viruses so caregivers can be quickly treated. • CPR will be performed in the event of an emergency unless there is a Living Will (Health-Care Directive) on file. • SMC is not responsible for personal items.

- Weapons, drugs, tobacco, and prohibited behaviors are not permitted on SMC property.
- Medical information may be disclosed to your insurance plan(s) for payment.
- The patient is offered a *Financial Assistance at Swedish* brochure and informed that financial assistance is available to those who qualify.
- The patient may receive bills from other providers associated with his or her care at a Swedish Medical Center facility.
- The *Notice of Privacy Practices* brochure is offered to the patient and/or their representative to keep.
- *Patient Rights and Responsibilities* information (see Patient Rights policy) is offered to the patient and/or their representative.
- Changes to the COA form are not permitted.

2. The patient or his/her authorized representative signs the COA form.
3. The Patient Access staff member affixes a label to the COA form and scans into EMR.

IF NO SIGNATURE CAN BE OBTAINED AT ADMISSION

1. If patient is unable to sign COA form and no authorized representative can be reached at admission, then SMC staff members mark the check box "Unable to obtain signature at admission."
2. Patient Access staff will make multiple attempts to communicate the content of the COA form and have the patient sign and/or reach their authorized representative for signature. Such attempts are documented using **HAR Account Note** in the EMR.
    - During the attempts to gain a signature, Patient Access will withhold the COA from scanning into EMR and continue to seek a signature until such time the patient is discharged. If patient is discharged without COA signed, clinical information in the chart should reflect the urgency of the admission and the patient's inability to receive COA communication throughout his/her encounter.
    - Access staff may also seek assistance of the clinical unit staff to help obtain the COA signature.
3. Scan COA at discharge even if patient refused or no signature was obtained.

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Definitions

None.

Forms

See Attachments

Conditions of Admission Consent - Form #396584, rev. 10/22 - ENGLISH

Supplemental Information

Patient's Authorized Representative

In the event that a patient is not competent to sign upon admission or is a minor, the following persons may sign the consent on behalf of the patient (listed in priority order):

1. Appointed guardian of the patient, if any
2. Individual, if any, to whom the patient has given a Durable Power of Attorney that encompasses the authority to make health care decisions
3. Patient's spouse or state registered domestic partner
4. Patient's children who are at least eighteen (18) years of age
5. Patient's parents
6. Patient's adult brothers and sisters

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If verbal consent is received from the patient or their authorized representative it must be documented on the **COA** form including the date, time, and relationship to patient

Regulatory Requirements

WAC 246-320-166 (4c)

RCW 7.70.065 – Informed consent – Persons authorized to provide for patients who are not competent.

References

Providing Health Care to Minors under Washington Law

Addenda

See Attachments

Conditions of Admission Form
Notice of Privacy Practices
Financial Assistance at Swedish Information
Who Should Sign the Conditions of Admission Form

Stakeholders

Author/Contact

Carol Boland, Process Owner, Operational Excellence
Patient Access leadership

Expert Consultants

Cory Wiley-Godoi, Senior Accreditation Program Manager
Alanna Kroeker, Senior Manager Corporate Compliance
Edith Rutledge, Senior Manager Health Information Management (HIM)
Rebeca Derkitt, Manager, Patient Safety and Risk Management
Sandy Banzer, Providence Executive Director Market Operations

Sponsor

Larisa Cummings, Director of Patient Access, Swedish Health Services

PolicyStat: 12753157

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Attachments

Conditions of Admission Form, 396584, rev 10/22

Financial Assistance at Swedish Information

Notice of Privacy Practices - Your Rights Our Responsibilities, ADMN-02-03189

Who Should - Could Sign the Conditions of Admission Form 04-27-2020

Approval Signatures

Step Description	Approver	Date
Standards Committee Program Manager	Mary Alice Duthie: Nurse Educator	01/2023
Swedish Access Registration Group	Larisa Cummings: Director Patient Access	12/2022
Owner	Carol Boland: Program Manager	12/2022

Older Version Approval Signatures

Standards Committee Program Manager	Mary Alice Duthie: Nurse Educator	12/2022
Swedish Access Registration Group	Larisa Cummings: Director Patient Access	11/2022
Owner	Carol Boland: Program Manager	11/2022

Applicability

WA - Swedish Medical Center

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Exhibit 10
Swedish Financial Assistance – Charity Care Policy

FINANCIAL ASSISTANCE – CHARITY CARE

Administrative Policy
Approved: 06/01/2022
Department: All Swedish Hospital Facilities, Departments and Clinics
Population Covered: All patients who are provided with emergent or medically necessary healthcare services
Implementation Date: 07/01/2022

Swedish Health Services and Swedish Edmonds ("SHS" or "Swedish") is a not-for-profit healthcare organization guided by a commitment to its Mission of improving the health and well-being of each person we serve, by its Core Values of safety, patient-centered care, respect, caring and compassion, teamwork and partnership, continuous learning and improvement and leadership, and by the belief that healthcare is a human right. It is the philosophy and practice of each SHS hospital that emergent and medically necessary healthcare services are readily available to those in the communities we serve, regardless of their ability to pay.

Scope

This policy applies to all SHS hospitals and to all emergency, urgent and other medically necessary services provided by SHS hospitals (with exception of experimental, investigative, or elective care). A list of SHS hospitals covered by this policy can be found in Exhibit A Covered Facilities List.

This policy shall be interpreted in a manner consistent with Section 501(r) of the Internal Revenue Code of 1986, as amended. In the event of a conflict between the provisions of such laws and this policy, such laws shall control.

Purpose

The purpose of this policy is to ensure a fair, non-discriminatory, effective, and uniform method for the provision of Financial Assistance (charity care) to eligible individuals who are unable to pay in full or part for medically necessary emergency and other hospital services provided by SHS hospitals.

It is the intent of this policy to comply with all federal, state, and local laws. This policy and the financial assistance programs herein constitute the official Financial Assistance Policy ('FAP') and Emergency Medical Care Policy for each hospital owned, leased or operated by SHS.

Responsible Persons

Revenue Cycle departments

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Policy

SHS will provide free or discounted hospital services to qualified low income, uninsured and underinsured patients when the ability to pay for services is a barrier to accessing medically necessary emergency and other hospital care and no alternative source of coverage has been identified. Patients must meet the eligibility requirements described in this policy to qualify.

SHS hospitals with dedicated emergency departments will provide, without discrimination, care for emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act) consistent with available capabilities, regardless of whether an individual is eligible for financial assistance. SHS will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making financial assistance determinations.

SHS hospitals will provide emergency medical screening examinations and stabilizing treatment or refer and transfer an individual if such transfer is appropriate in accordance with 42 C.F.R 482.55. SHS prohibits any actions, admission practices, or policies that would discourage individuals from seeking emergency medical care, such as permitting debt collection activities that interfere with the provision of emergency medical care.

List of Professionals Subject to SHS FAP:

Each SHS hospital will specifically identify a list of those physicians, medical groups, or other professionals providing services who are and who are not covered by this policy. Each SHS hospital will provide this list to any patient who requests a copy. The provider list can also be found online at the SHS website: www.swedish.org.

Financial Assistance Eligibility Requirements:

Financial assistance is available to both uninsured and insured patients and guarantors where such assistance is consistent with this policy and federal and state laws governing permissible benefits to patients. SHS hospitals will make a reasonable effort to determine the existence or nonexistence of third-party coverage which may be available, in whole or part, for the care provided by SHS hospitals, prior to directing any collection efforts at the patient.

When a patient or their guarantor is determined to be qualified for retroactive, health care coverage through the medical assistance programs under chapter 74.09 RCW, SHS hospital will provide assistance to the patient or guarantor with applying for such coverage. Financial Assistance may be denied if the patient or their guarantor fails to make reasonable efforts to cooperate with and assist SHS hospitals in applying for such coverage. SHS hospitals will not place unreasonable burdens on the patient or guarantor during the application process for Financial Assistance and retro active coverage, taking into account any physical, mental, intellectual, or sensory deficiencies, or language barriers which may hinder the reasonable party's capability of complying with application procedures. Patients who are obviously or categorically ineligible or have been deemed ineligible in the prior 12 months for a state or federal program will not be required to apply for such programs in order to receive Financial Assistance.

Uninsured patients may receive an uninsured discount. Eligible Financial Assistance balances include but are not limited to the following: Self pay, charges for insured patients with coverage from a plan in which SHS does not participate, coinsurance, deductible, and copayment amounts related to insured patients. Deductible and coinsurance amounts claimed as a Medicare bad debt will be excluded from the reporting of charity care.

Patients seeking financial assistance must complete the standard SHS Financial Assistance Application and eligibility will be based upon financial need as of the date of service or as of the date of application, whichever indicates the lower amount of income and greatest financial need. Patients may re-apply for assistance if their financial circumstances change, even if a previous application was denied or approved in part. Reasonable efforts will be made to notify and inform patients of the availability of Financial Assistance by providing information during admission and discharge, on written communications

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concerning billing or collections, in patient accessible billing or financial services areas, on SHS hospital's website, by oral notification during payment discussions, as well as on signage in high volume inpatient and outpatient areas, such as admitting and the emergency department. Translations will be made available in any language spoken by more than ten percent of the population in the hospital's service area.

Applying for Financial Assistance:

Patients or guarantors may request and submit a Financial Assistance Application, which is free of charge and available at the SHS ministry or by the following means: advising patient financial services staff at or prior to the time of discharge that assistance is requested and submitted with completed documentation; by mail, or by visiting www.swedish.org, downloading and submitting the completed application with documentation. A person applying for financial assistance will be given a preliminary screening, which will include a review of whether the patient has exhausted or is not eligible for any third-party payment sources.

Each SHS hospital shall make designated personnel available to assist patients in completing the Financial Assistance Application and determining eligibility for SHS financial assistance or financial assistance from government-funded insurance programs, if applicable. Interpretation services are available to address any questions or concerns and to assist in the completion of the Financial Assistance Application.

A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to SHS to support eligibility determination at any time upon learning that a party's income falls below minimum FPL per the relevant Federal and State regulations.

SHS acknowledges that a determination of eligibility can be made at any time upon learning that a party's income is below 200% of the federal poverty standard. In addition, SHS may choose to grant financial assistance solely based on an initial determination of a patient's status as an indigent person. In these cases, documentation may not be required.

Individual Financial Situation:

Individual Financial Situation: Income, certain monetary assets, and expenses of the patient will be used in assessing the patient's individual financial situation. SHS will seek only such information regarding assets as is reasonably necessary and readily available to determine the existence, availability, and value of a person's assets. SHS will consider and collect information related to such assets as required by the Centers for Medicare and Medicaid (CMS) for Medicare cost reporting. This information may include the reporting of assets convertible to cash and unnecessary for the patient's daily living. Monetary assets shall not include any equity in a primary residence, retirement plans other than 401(k) plans, any prepaid burial contract or burial plot, any life insurance policy with a value of $10,000 or less, and one motor vehicle, as well as a second motor vehicle if it is needed for employment or medical purposes as well as the first $10,000 of monetary assets for a family of two, and either 50% of the remaining monetary asset value, or $1,500 per additional family member, whichever is greater. Duplicate forms of verification will not be requested. Only one current account statement is required to verify monetary assets. If no documentation is available a written and signed statement from the patient or guarantor is sufficient. Asset information collected will not be used for collection activities. Monetary assets will not be used for determination of eligibility if a patient's or guarantor's income is at or below 300% of the federal poverty standard.

Income Qualifications:

Income criteria, based on Federal Poverty Level (FPL), shall be used to determine eligibility for free or discounted care. Please see Exhibit B for details.

Determinations and Approvals:

Patients will receive notification of FAP eligibility determination within 14 days of submission of the completed Financial Assistance application and necessary documentation. Once an application is

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received, extraordinary collections efforts will be pended until a written determination of eligibility is sent to the patient. The hospital will not make a determination of eligibility for assistance based upon information which the hospital believes is incorrect or unreliable.

Dispute Resolution:

The patient may appeal a determination of ineligibility for financial assistance by providing relevant additional documentation to the hospital within 30 days of receipt of the notice of denial. All appeals will be reviewed and if the review affirms the denial, written notification will be sent to the guarantor and State Department of Health, where required, and in accordance with the law. The final appeal process will conclude within 10 days of receipt of the denial by the hospital. An appeal may be sent to Swedish Medical Center, Attn: Corporate Business Office, 747 Broadway, Seattle, WA 98122.

Presumptive Charity:

SHS may approve a patient for a charity adjustment to their account balance by means other than a full Financial Assistance application. Such determinations will be made on a presumptive basis using an industry-recognized financial assessment tool that evaluates ability to pay based on publically available financial or other records, including but not limited to household income, household size, and credit and payment history.

Other Special Circumstances:

Patients who are eligible for FPL-qualified programs such as Medicaid and other government-sponsored low-income assistance programs, are deemed to be indigent. Therefore, such patients are eligible for Financial Assistance when the programs deny payment and then deem the charges billable to the patient. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off. Including but not limited to medically necessary services related to the following:

- Denied inpatient stays
- Denied inpatient days of care
- Non-covered services
- Prior Treatment Authorization Denials
- Denials due to restricted coverage

Catastrophic Medical Expenses:

SHS, at its' discretion, may grant charity in the event of a catastrophic medical expense. These patients will be handled on an individual basis.

Times of Emergency:

Financial assistance may be available at SHS's discretion in times of a national or state emergency, independent of assistance for catastrophic expenses.

Limitation on Charges for all Patients Eligible for Financial Assistance:

No patient who qualifies for any of the above-noted categories of assistance will be personally responsible for more than the "Amounts Generally Billed" (AGB) percentage of gross charges, as defined below.

Reasonable Payment Plan:

Once a patient is approved for partial financial assistance, but still has a balance due, SHS will negotiate a payment plan arrangement. The reasonable payment plan shall consist of monthly payments that are not more than 10 percent of a patient's or family's monthly income, excluding deductions for Essential Living Expenses that the patient listed on their financial assistance application.

Billing and Collections:

Any unpaid balances owed by patients or guarantors after application of available discounts, if any, may be referred to collections. Collection efforts on unpaid balances will cease pending final determination of FAP eligibility. SHS does not perform, allow, or allow collection agencies to perform any extraordinary collection actions. For information on SHS billing and collections practices for amounts owed by

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patients, please see SHS Hospital's policy, which is available free of charge at each SHS hospital's registration desk, or at: www.swedish.org.

Patient Refunds:

In the event that a patient or guarantor has made a payment for services and subsequently is determined to be eligible for free or discounted care, any payments made related to those services during the FAP-eligible time period which exceed the payment obligation will be refunded, in accordance with state regulations.

Annual Review:

This SHS Financial Assistance (Charity Care) Policy will be reviewed on an annual basis by designated Revenue Cycle leadership.

Definitions

For the purposes of this policy the following definitions and requirements apply:

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

2. Amounts Generally Billed (AGB): The amounts generally billed for emergency and other medically necessary care to patients who have health insurance is referred to in this policy as AGB. SHS determines the applicable AGB percentage by multiplying the hospital's gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare and commercial payors. Information sheets detailing the AGB percentages, and how they are calculated, can be obtained by visiting the following website: www.swedish.org or by calling **1-866-747-2455** to request a copy.

3. Extraordinary Collection Action (ECA): ECAs are defined as those actions requiring a legal or judicial process, involve selling a debt to another party or reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process for this purpose include a lien; foreclosure on real property; attachment or seizure of a bank account or other personal property; commencement of a civil action against an individual; actions that cause an individual's arrest; actions that cause an individual to be subject to body attachment; and wage garnishment.

Exceptions

See Scope above.

Regulatory Requirements

Internal Revenue Code Section 501(r); 26 C.F.R. 1.501(r)(1) – 1.501(r)(7)
Washington Administrative Code (WAC) Chapter 246-453
Revised Code of Washington (RCW) Chapter 70.170.060
Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd
42 C.F.R. 482.55 and 413.89

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References

American Hospital Associations Charity Guidelines
Providence St. Joseph Health Commitment to the Uninsured Guidelines
Provider Reimbursement Manual, Part I, Chapter 3, Section 312

Stakeholders

Author/Contact

Executive Director Financial Counseling and Financial Assistance

Expert Consultants

Swedish/Providence Legal Services

Sponsor

Kimberly Sullivan, SVP Chief Revenue Cycle Officer

Financial Assistance (Charity Care).doc(rev.4/1/2019)

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Exhibit A
Covered Facilities List

SHS Hospitals in Washington	
Swedish Medical Center First Hill/Ballard	Swedish Medical Center Cherry Hill
Swedish Issaquah	Swedish Edmonds

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Exhibit B

Income Qualifications for SHS Hospitals

If...	Then ...
Annual family income, adjusted for family size, is at or below 300% of the current FPL guidelines,	The patient is determined to be financially indigent and qualifies for financial assistance 100% write-off on patient responsibility amounts.[1]
Annual family income, adjusted for family size, is between 301% and 400% of the current FPL guidelines,	The patient is eligible for a discount of 75% from original charges on patient responsibility amounts.
If annual family income, adjusted for family size, is at or below 400% the FPL AND the patient has incurred total medical expenses at SHS hospitals in the prior 12 months in excess of 20% of their annual family income, adjusted for family size, for services subject to this policy,	The patient is eligible for 100% charity benefit on patient responsibility amounts.

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Exhibit 11
Swedish Patient Rights Policy

Status Active PolicyStat ID 12519319

Origination	05/2013	Owner	Larisa Cummings: Director Patient Access
Last Approved	12/2022	Area	Corporate Compliance
Effective	12/2022	Applicability	WA - SMC + SMG
Next Review	12/2025	Document Types	Administrative Policy and Procedure

Patient Rights

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Population Covered: All patients
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond

Related Policies and Procedures:

Advance Directive and CPR Preference
Complaints and Grievances: Patient/Family
Conditions of Admission Form and Consent
Non-Discrimination Policy, PSJH-CLIN-1203
Notification of Inpatient Admission
Visitation Guidelines
Potentially Inappropriate Care and Management of Disputed Treatment Requests (Futile Care)
System-wide Patient Rights and Responsibilities Policy PSJH-CLIN-1206

Purpose

To provide resources and direction for general communication of patient rights.

Policy Statement

Hospitals must inform each patient (or representative) of their rights. Whenever possible, this notice must be provided before providing or stopping care. All patients, inpatient or outpatient, must be informed of their rights as hospital patients. The patient's rights should be provided and explained in a language or manner that the patient (or the patient's representative) can understand in accordance with

federal and state law. See System-wide Patient Rights and Responsibilities Policy PSJH-CLIN-1206.

Responsible Persons

Patient Registration representatives, Environmental Services staff members.

Procedure

Responsible Person	Steps
Patient Registration Representatives, Department Managers	Offer *Patient Rights and Responsibilities* flyer to patients in all Patient Registration areas, including all hospital outpatient departments and emergency departments. For specific Swedish region versions of the flyer, go to the Providence Patient Rights Sharepoint site and refer to PRR Print on Demand to print flyer or Web2Print to order printed flyers. Provide translated versions of flyer when prompted or otherwise appropriate, or arrange interpreter if needed and these will be located on the Providence Patient Rights Sharepoint site. See System-wide Patient Rights and Responsibilities Policy PSJH-CLIN-1206.
Patient Registration Representatives	Review the *Conditions of Admission (COA)* information with patient/representative at admission per policy guidelines. Offer *Notice of Privacy Practices*, see Attachments to *Conditions of Admission (COA)*. *Notice of Privacy Practices* is mentioned as the last clause of the Conditions of Admission form. *Notice of Privacy Practices* needs to be available at admission, clearly in view of patients and available upon request, per state law (RCW 70.02.120).
Environmental Services Nursing (Edmonds only)	**Inpatients**: Ensure that a copy of the *Welcome to Swedish* brochure is placed in every inpatient unit bed according to the EVS policy/procedure *Cleaning a Discharge Room*. At Edmonds campus, the inpatient nursing staff members ensure delivery of the *Welcome to Swedish* brochure during the unit admission process.

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Definitions

None.

Forms

For specific Swedish region versions of the flyer, go to the Providence Patient Rights Sharepoint site and refer to PRR Print on Demand to print flyer or Web2Print to order printed flyers. English and translated versions are available on this sharepoint site.

See System-wide Patient Rights and Responsibilities Policy PSJH-CLIN-1206.

Required signage in all Patient Registration areas (Patient Rights notification):

- *Patient Rights and Responsibilities* poster - see Providence Patient Rights Sharepoint site
- *Notice of Compliant* poster (ADMN-16-0139 R-12/19) - See Attachments

Addenda

See Attachments

Notice of Patient Concerns poster
Welcome to Swedish brochure
Pediatric Bill of Rights
Patient Rights & Responsibilities – Related Hospital Regulations

Regulatory Requirement

CMS. §482.13 – Condition of Participation: Patient's Rights.

WAC 246-320-141 – Patient Rights and Organizational Ethics.

DNV. PR.1 - PR.9

RCW 70.02.120

References

CMS State Operations Manual

Stakeholders

Author/Contact

Alanna Kroeker, Manager Compliance

Expert Consultants

Director of Patient Access

Co-Sponsors

Marianne Klaas, Regional Director of Accreditation, Safety, Injury Management & Clinical Quality Investigations

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Stellent: SWED_017876

Attachments

Notice of Complaint Poster ADMN-16-0139 rev.12/19

Patient Rights and Related Hospital Regulations.pdf

Pediatrics Bill of Rights PEDS-06-06842 rev.1/12

Welcome to Swedish Booklet ADMN-17-0268 rev.6/19

Approval Signatures

Step Description	Approver	Date
Standards Committee Program Manager	Mary Alice Duthie: Nurse Educator	12/2022
Owner	Alanna Kroeker: Senior Manager Compliance	12/2022

Exhibit 12
Providence Non-discrimination Policy

Status **Active** PolicyStat ID **8535567**

Implementation	09/2020
Last Reviewed	09/2020
Effective	09/2020
Last Revised	09/2020
Next Review	09/2025

Owner	Jill Cooper: VP Reliability Patient Safety
Policy Area	Clinical
Applicability	Providence St. Joseph Health Systemwide
Departments	Posted on Internet

PSJH-CLIN-1203 Nondiscrimination Policy

Executive Sponsor:	Amy Compton-Phillips, EVP, Chief Clinical Officer
Policy Owner:	Jill Cooper, VP Reliability & Patient Safety
Contact Person:	Shannon Alexander, Clinical Patient Safety & Risk Director

Scope:
This policy applies to Providence St. Joseph Health and its Affiliates[i] (collectively known as "PSJH") and their caregivers (employees); employees of affiliated organizations; members of System, community ministry and foundation boards; volunteers; trainees; independent contractors; and others under the direct control of PSJH (collectively referred to as workforce members), with respect to their involvement in the provision of health program and/or activities offered by PSJH. This policy does not apply to nondiscrimination in employment or in the provision of employee benefits by PSJH, or in the provision of coverage through Providence Health Plan (PHP), which are covered by other policies (see end of Reference section below). This is a management level policy, reviewed and recommended by the Policy Advisory Committee (PAC) to consider for approval by senior leadership which includes vetting by Executive Council (EC) with final approval by the President, Chief Executive Officer or appropriate delegate.

Purpose:
To establish PSJH's System-level policy and procedures prohibiting discrimination against individuals accessing any Health Program and/or Activity (defined below) provided by PSJH, designating caregivers responsible for implementation and monitoring of this policy, and establishing the internal grievance procedure for complaints alleging discrimination related to a PSJH Program or Activity.
In addition to this policy, PSJH is committed to nondiscrimination in employment and in the provision of benefits to caregivers of PSJH, and in the provision of coverage through PHP. These commitments are more fully outlined in PSJH's applicable Human Resources policies and benefit plan documents, or in the applicable PHP policies. This policy is not intended to replace, substitute or modify: (1) PSJH's and Affiliates' policies that prohibit discrimination in employment and provide for an internal grievance procedure for employment-related disputes; (2) any grievance procedure set forth in the applicable summary plan description for individuals participating in a PSJH benefit plan; or (3) PHP's policies governing nondiscrimination and associated grievance procedures in its health-related insurance activities. For information on the latter policies and grievance procedures, please see the links provided at

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the end of the Reference section below.

Definitions: For purposes of applying this policy, the following definitions apply:

1. *Auxiliary aids and services* include:(1) Qualified interpreters on-site or through video remote interpreting (VRI) services, as defined in 28 CFR 35.104 and 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;(2) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;(3) Acquisition or modification of equipment and devices; and(4) Other similar services and actions.[ii]
2. *Caregiver*: Refers to all workforce members of PSJH.
3. *Disability:* The term "disability" is defined by the federal government in various ways, depending on the context. For the purposes of federal disability nondiscrimination laws (such as the Americans with Disabilities Act (ADA), Section 503 of the Rehabilitation Act of 1973 and Section 188 of the Workforce Innovation and Opportunity Act), the definition of a person with a disability is typically defined as someone who (1) has a physical or mental impairment that substantially limits one or more "major life activities," (2) has a record of such an impairment, or (3) is regarded as having such an impairment. More information on federal disability non-discrimination laws, visit DOL's Disability Nondiscrimination Law Advisor.
    - **In States Other than Washington**: Means with respect to an individual, a physical or mental impairment that, in Alaska, Montana, New Mexico, Oregon and Texas *substantially limits*, or in California *limits*, one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment, as defined in 42 U.S.C. 12102, as amended;
    - **In Washington:** RCW Ch.49.60.040 (7)
        a. "Disability" means the presence of a sensory, mental, or physical impairment that:
            i. Is medically cognizable or diagnosable; or
            ii. Exists as a record or history; or
            iii. Is perceived to exist whether or not it exists in fact.
        b. A disability exists whether it is temporary or permanent, common or uncommon, mitigated or unmitigated, or whether or not it limits the ability to work generally or work at a particular job or whether or not it limits any other activity within the scope of this chapter.
        c. For purposes of this definition, "impairment" includes, but is not limited to:
            i. Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs,

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respiratory, including speech organs, cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine; or

ii. Any mental, developmental, traumatic, or psychological disorder, including but not limited to cognitive limitation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

4. *Discrimination on the Basis of Sex:* Discrimination on the basis of sex includes but is not limited to discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, gender or sex stereotyping, and gender identity.
5. *Gender Identity Gender identity* for some refers to a person's innate, deeply felt psychological sense of gender, which may or may not correspond to the person's body or sex assigned at birth.
   - *Gender identity* is frequently confused with sexual orientation, but the two concepts are different. Sexual orientation refers to how we interact with and are attracted to others, while gender identity refers to how we see ourselves. Just like gender-conforming people, transgender people can be of any sexual orientation.
   - *Transgender* As indicated above, society has traditionally expected persons who were assigned as a particular sex at birth to behave a certain way in relation to their gender: males are expected to behave in a "masculine" way, females in a "feminine" way. *Transgender* is an umbrella term covering anyone whose gender identity or expression does not conform to society's expectations for, or stereotypes about, people assigned a particular sex.
     As an umbrella term, the word "transgender" is an adjective that covers a wide spectrum of people whose gender identity differs from their sex assigned at birth. Transgender also includes persons who are *gender non-conforming*. Gender non-conforming people may not consider themselves transgender, but have an appearance or gender expression that does not conform to gender stereotypes.
6. *Gender Expression Gender expression* refers to how a person represents, or expresses, their gender identity to others -- through appearance, dress, mannerisms, speech patterns, social interactions, and other characteristics and behaviors.
7. *Health Program or Activity*: Means the provision or administration of health-related services, and provision of assistance to individuals in obtaining health-related services or insurance coverage.[iii]
8. *Limited English Proficiency:* Means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English.
9. *National Origin*: Includes, but is not limited to, an individual's, or their ancestor's, place of origin (such as country or world region) or an individual's manifestation of the physical, cultural, or linguistic characteristics of a national original group.
10. *Qualified Bilingual/Multilingual Staff*: Qualified bilingual/multilingual staff must demonstrate to the covered entity that they are proficient in English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology, and are able to effectively, accurately and impartially communicate directly with individuals with limited English proficiency in their primary language. An individual who meets the definition of "qualified bilingual/multilingual staff: does not necessarily qualify to interpret or translate for individuals

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with limited English proficiency within the meaning of this rule.[iv]

11. *Qualified Interpreter for an Individual with a Disability:*
    1. Means an interpreter who via a remote interpreting service or an on-site appearance:
        a. Adheres to generally accepted interpreter ethics principles, including client confidentiality; and
        b. Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology (e.g., sign language interpreters).
    2. For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral trans iterators (individuals who represent or spell in the characters of another alphabet), and cued language trans iterators (individuals who represent or spell by using a small number of hand shapes).
12. *Qualified Interpreter or Translator for an Individual with Limited English Proficiency or non-English speaking*: Means an interpreter or translator, who interprets or translates effectively, accurately, and impartially; who via a remote interpreting service or an on-site appearance: Means an interpreter who via a remote interpreting service or an on-site appearance:
    - Adheres to generally accepted interpreter or translator ethics principles, as applicable, including client confidentiality;
    - In the case of an interpreter has demonstrated proficiency in speaking, and in the case of a translator has demonstrated proficiency in writing, and in both cases, demonstrates proficiency in understanding both spoken English and at least one other spoken language; and
    - In the case of an interpreter is able to interpret, and in the case of a translator is able to translate: effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.
13. *Section 1557 Civil Rights Coordinator*: or *Civil Rights Coordinator:* Means the responsible PSJH caregiver(s) designated to coordinate PSJH's efforts to comply with this policy in any PSJH Program or Activity, including the investigation of any grievances filed under this policy, and who are listed by Region/Ministry in the Procedure section below.
14. *Sex stereotypes:* Means stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics.

Policy:

Consistent with PSJH's Mission and Core Values, it is the policy of PSJH to not discriminate against, exclude, or treat differently any individuals accessing any PSJH Program or Activity on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), marital status, age, sex (including pregnancy, childbirth, breastfeeding and related medical conditions, gender, gender identity, gender expression and sexual orientation, genetic information (including family medical history), or military/veteran status as those terms are defined under federal and state laws and rules. Discrimination will not be tolerated.

PSJH applies all appropriate federal and/or state protections for religious freedom and conscience. It is

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also PSJH's policy to provide free auxiliary aids and language assistance services to individuals with Disabilities, or Limited English Proficiency, or non-English speaking who are accessing PSJH Programs or Activities. Such services may include providing Qualified Bilingual/Multilingual Staff, Qualified Interpreters, and Qualified Translation free of charge as needed or appropriate.

PSJH has established applicable grievance procedures for individuals accessing any PSJH Program or Activity, which provides for prompt and equitable resolution of complaints alleging violations of applicable federal or state laws that prohibit discrimination, including but not limited to Sections 504 and 508 of the Rehabilitation Act of 1973, the Americans With Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (42 U.S.C. 18116), and its implementing regulations at 45 CFR part 92 (collectively referred to below as "Section 1557"). Any person who believes that someone accessing a PSJH Program or Activity has been subjected to discrimination on the basis of race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), marital status, age, sex (including pregnancy, childbirth, breastfeeding and related medical conditions, gender, gender identity, gender expression and sexual orientation, genetic information (including family medical history), or military/veteran status may file a grievance under this procedure. It is against the law for PSJH to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Human Resources also maintains a policy on this topic.

References:

- PSJH-EIS-903 Web Accessibility Policy
- Section 1557 of the Affordable Care Act (42 U.S.C. 18116)
- Section 1557 implementing regulations at 45 CFR part 92
- Title VI of the Civil Rights Act of 1964
- Title IX of the Education Amendments of 1972
- The Age Discrimination Act of 1975, subject to the exclusions described in 45 CFR 91.3(b)(1)
- Section 504 and 508 of the Rehabilitation Act of 1973
- Title 42, Chapter 126 Americans with Disabilities Act of 1990, as Amended
- Cal. Health & Safety Code § 1259
- RCW Ch. 49.60 Discrimination—Human Rights Commission
- **28 CFR § 35.104 – Definitions; Nondiscrimination On The Basis Of Disability in State and Local Government Services**
- Washington State Disability https://app.leg.wa.gov/RCW/default.aspx?cite=49.60.040
- United States Department of Labor, Office of Disability Employment Policy https://www.dol.gov/odep/faqs/general.htm#3
- Department of Labor Policies on Gender Identity: Rights and Responsibilities https://www.dol.gov/agencies/oasam/civil-rights-center/internal/policies/gender-identity

For Human Resources policies applicable to caregivers, or questions about caregiver benefits, and applicable grievance procedures, please contact your local Human Resources department or see: HRforCaregivers.org.

For PHP's policies applicable to nondiscrimination in the provision of health-related coverage and grievance procedures, see: https://healthplans.providence.org/nondiscrimination-statement.

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Applicability:
[i] For purposes of this policy, "Affiliates" is defined as any entity that is wholly owned or controlled by PSJH, Providence Health & Services, St. Joseph Health or Western HealthConnect (for example, Hoag Memorial Hospital Presbyterian, Swedish Health Services, Swedish Edmonds, Covenant Health, Kadlec Regional Medical Center, PacMed Clinics, St. Joseph Heritage Healthcare and Inland Northwest Health Services).
[ii] https://www.govinfo.gov/content/pkg/CFR-2017-title45-vol1/xml/CFR-2017-title45-vol1-part92.xml
[iii] For nondiscrimination and grievance policies related to PSJH's provision of health-related insurance or other benefits, to PSJH caregivers or through Providence Health Plan, please see the applicable links at the end of the References section below.
[iv] Nondiscrimination in Health Programs and Activities, page 31390 Retrieved 7/31/2019 from https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov

Attachments

Nondiscrimination Investigation and Review PROCEDURE.12.2021.pdf

Approval Signatures

Step Description	Approver	Date
PSJH President/CEO	Cynthia Johnston: Compliance Spec PSJH	09/2020
PSJH Executive Council	Cynthia Johnston: Compliance Spec PSJH	09/2020
PSJH Policy Advisory Committee	Cynthia Johnston: Compliance Spec PSJH	09/2020

Applicability

AK - Credena Health, AK - Providence Alaska MC, AK - Providence Kodiak Island MC, AK - Providence Medical Group, AK - Providence PEC/PTCC - NOT IN USE, AK - Providence Seward MC, AK - Providence St. Elias Specialty Hospital, AK - Providence Valdez MC, CA - Credena Health, CA - Healdsburg Hospital, CA - PSJH Physician Enterprise Northern, CA - PSJH Physician Enterprise Southern, CA - Petaluma Valley Hospital, CA - Providence Cedars-Sinai Tarzana MC, CA - Providence Holy Cross MC, CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance, CA - Providence Mission Hospitals, CA - Providence Queen of the Valley Medical Center, CA - Providence Redwood Memorial Hospital, CA - Providence Saint John's Health Center, CA - Providence Saint Joseph MC, Burbank, CA - Providence Santa Rosa Memorial Hospital, CA - Providence St. Joseph Hospital - Eureka, CA - Providence St. Joseph Hospital Orange, CA - Providence St. Jude Medical Center, CA - Providence St. Mary Medical Ctr Apple Valley, CA - SoCal Region, MT - Credena Health, MT - Providence St.

Joseph MC, Polson, MT - St. Patrick Hospital, NM - Covenant Hobbs Hospital, OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health, OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO), OR - Providence Ctr for Medically Fragile Children, OR - Providence Health Oregon Labs, OR - Providence Hood River Memorial Hospital, OR - Providence Medford MC, OR - Providence Medical Group, OR - Providence Medical Group, OR - Providence Milwaukie Hospital, OR - Providence Newberg MC, OR - Providence Portland MC, OR - Providence Seaside Hospital, OR - Providence St. Vincent MC, OR - Providence Willamette Falls MC, PHCC - Home & Community Care, PHCC - Home Health, PHCC - Home Medical Equipment, PHCC - Hospice/Palliative Care, PHCC - Infusion/Pharmacy, PHCC - PACE (Programs of All-Inclusive Care), PHCC - Providence Home and Community Care (Legacy), PHCC - Skilled Nursing/Assisted Living, Providence Express Care, Providence Physician Enterprise, Providence St. Joseph Health, TX - Covenant Children's Hospital, TX - Covenant Hospital Levelland, TX - Covenant Hospital Plainview, TX - Covenant Medical Center, TX - Covenant Medical Group, TX - Covenant Specialty Hospital, TX - Grace Clinic, TX - Grace Surgical Hospital, WA - Credena Health, WA - EWA Providence Medical Group, WA - Kadlec Regional Medical Center, WA - NWR Providence Medical Group, WA - PacMed, WA - Providence Centralia Hospital, WA - Providence DominiCare, WA - Providence Holy Family Hospital, WA - Providence Mt. Carmel Hospital, WA - Providence Regional MC Everett, WA - Providence Sacred Heart Med Ctr & Children's, WA - Providence St. Joseph's Hospital, WA - Providence St. Luke's Rehabilitation Medical, WA - Providence St. Mary MC, WA - Providence St. Peter Hospital, WA - Providence Surgery Center, Pacific Campus, WA - SWR Providence Medical Group, WA - Swedish Medical Center, WA - Swedish Medical Group, WA - USFHP

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Exhibit 13
Providence Policy on Care Through End of Life: Responding to Requests for Provider Hastened Death

Status **Active** PolicyStat ID **11299043**

Implementation	03/2022	Owner	Ira Byock: SVP Founder IHC
Last Reviewed	03/2022	Policy Area	Clinical
Effective	03/2022	Applicability	Providence St. Joseph Health Systemwide
Last Revised	03/2022		
Next Review	02/2027		

PSJH-CLIN-1207 Policy on Care Through The End of Life: Responding to Requests for Provider-Hastened Death

Executive Sponsor:	Amy Compton Phillips, MD, EVP, Chief Clinical Officer
Policy Owner:	Ira Byock, MD, CMO Institute for Human Caring
Contact Person:	Ira Byock, MD, CMO Institute for Human Caring

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Scope:

This policy applies to all Providers and Caregivers, as defined in the Definitions below, of Providence St. Joseph Health and its Affiliates[i] (collectively known as "PSJH" or "PSJH Affiliates").

This is a management level policy reviewed and recommended by the Policy Advisory Committee for approval by senior leadership which includes vetting by Executive Council with final approval by the President, Chief Executive Officer or appropriate delegate.

Values Context:

Providence St. Joseph Health (PSJH) holds the well-being of every patient as a whole person at the center of its Mission and Values. We strive to accompany patients and families in a welcoming and compassionate manner. PSJH provides care through the end of life grounded in the values of respecting the sacredness of life, providing compassionate care to incurably ill and vulnerable persons, and respecting the integrity of health-care providers.

PSJH is committed to providing the best care possible through the end of life to every person we serve. We honor each individual's inherent dignity and worth. We strive to preserve each patient's opportunity to live as fully and well as possible in the context of their family and community.

It is our privilege to care for and support people who are seriously ill and facing death with respect and love. The values set forth in the *Ethical and Religious Directives for Catholic Health Care Services* ("ERDs")

help guide the PSJH approach to care.

Purpose:

This policy applies the Mission and Values of PSJH and the ERDs to the care for people with serious medical conditions that threaten life or are expected to result in death. The policy expresses our commitment to provide patients with the highest quality care and support for patients and their loved ones through the end of life and into bereavement. This policy affirms PSJH's stance of providing appropriate care while allowing patients to die naturally of underlying conditions. The policy also affirms that PSJH and its Providers and Caregivers will not participate in Provider-Hastened Death as defined below.

This policy will guide a competent, compassionate, and communicative approach to the care of patients who inquire about Provider-Hastened Death and delineates the specific actions that are proscribed by PSJH as falling outside the bounds of legitimate clinical care.

Definitions:

Provider

Provider is defined to include any physician, physician assistant or nurse practitioner who:

(A) (1) is an employee of a PSJH Affiliate; and/or (2) provides services to a PSJH Affiliate pursuant to a contract with any PSJH Affiliate, and/or (3) is a member of the medical and/or allied health staff of any PSJH Affiliate; and

(B) while acting within the scope of employment, contract, and/or medical or allied health staff membership for any PSJH Affiliate; and

(C) whether (1) at a PSJH Affiliate site, or (2) at any other location where a PSJH Affiliate provides care or services to patients.

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Caregiver

Caregiver is defined to include any non-Provider who:

(A) (1) is an employee of a PSJH Affiliate; and/or (2) provides services to a PSJH Affiliate pursuant to a contract with any PSJH Affiliate; and/or (3) is a volunteer of any PSJH Affiliate; and

(B) while acting within the scope of employment, contract, and/or volunteer duties for any PSJH Affiliate; and

(C) whether (1) at a PSJH Affiliate site, or (2) at any other location where a PSJH Affiliate provides care or services to patients.

Provider-Hastened Death

For the purposes of this policy, Provider-Hastened Death refers to actions by a physician, physician assistant, nurse practitioner or any person that are intended to cause the death of a patient as a means to end suffering. These actions include, but are not limited to, prescribing a lethal dose of a

drug in which the lethal agent is self-administered for the specific purpose of enabling a patient to end their life. States which have enacted laws or otherwise legalized such actions under specified procedures for people with life-limiting conditions use terms such as Death with Dignity, Medical Aid-in-Dying and End-of-Life Options. Provider-Hastened Death is morally distinct from the withholding and withdrawing of life-support that may result in the foreseen but unintended death of the patient. The term Provider-Hastened Death also encompasses Euthanasia.

Euthanasia

Euthanasia is a form of Provider-Hastened Death in which a physician, physician assistant, nurse practitioner or any person physically administers a lethal drug to another person, usually by injection. Euthanasia is legal for specified conditions and circumstances in Canada and several European countries, but is not currently legal in any U.S. jurisdiction.

Palliative Care

Specialized medical care focused on providing relief from the symptoms, pain, and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. Preferably, palliative care is provided by an interdisciplinary team of physicians, nurses, chaplains, and other specialists who work together with a patient's care team to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Withholding and/or Withdrawal of Life Sustaining Treatment

This is the process of not beginning or of discontinuing ongoing life-sustaining medical treatments with the purpose of forgoing excessively burdensome or insufficiently beneficial treatment. Under appropriate circumstances, withholding or withdrawal of life-sustaining treatment is a part of a plan of care that focuses on care that is proportionate to the condition of the patient and allows death to occur naturally due to an underlying pathology.

Policy:

1. Essential components of care for people with life-limiting medical conditions and those facing the end of life include clear communication with the individual and (as appropriate) the individual's loved ones, which includes discussion of expected physical and functional outcomes and which allows for shared decision-making to articulate an individual's personal values, preferences, and priorities within an advance care planning document.
2. PSJH respects the right of each individual or, at times of incapacity, their health care agent, legal representative, or surrogate decision maker, to make choices without undue influence, including the weighing of benefits and burdens of any treatment, not to begin or to discontinue life-sustaining treatments if the patient/proxy determines that there is no reasonable hope for sufficient benefit or there is excessive burden to themselves or their family or community (cf. ERD 57; Patient Self-Determination Act).
3. PSJH strives to treat each individual's pain and other distressing symptoms effectively in a manner consistent with the standard of care with the goal of achieving comfort and enhancing a person's quality of life. Treatment plans will often require multiple modalities, including

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medications and physical treatments.

4. In light of the wholeness of the human person, a person's suffering often entails elements of one's psychosocial, spiritual, and personal world. As such, comprehensive and compassionate care for seriously ill and dying people deserves access to skillful psychosocial therapies and spiritual support for the person who is ill and their family.
5. Palliative Care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. Specialty palliative care is an important means of providing excellent symptom management, skillful communication to enable shared decision-making and psychosocial counseling and spiritual support. However, these services should be available to patients in need regardless of enrollment in actual palliative care programs.
6. PSJH also supports timely referral to hospice as an indispensable service in assuring comprehensive and coordinated interdisciplinary support to patients and families in the final months, weeks, and days of life, through the dying process, and for family grief support.
7. Whatever the source of suffering, PSJH seeks to preserve consciousness and responsiveness unless the alleviation of suffering requires treatments that are sedating. When suffering persists at an intolerable level despite all reasonable treatments, consideration of palliative sedation as a reasonable option may be offered even if such therapy may indirectly or unintentionally shorten a person's life. Any party directly involved in the care of a patient may request an ethics consultation if there are moral questions about the appropriateness of this plan of care.
8. In several states within our contemporary practice environments, people with limited life-expectancy have legal avenues for intentionally hastening their deaths (terms include Medical Aid-in-Dying, Death with Dignity, End-of-Life Options). PSJH considers intentionally hastening death to fall outside the scope of legitimate medical practice. This determination derives from the PSJH Mission and Values and from the Catholic moral tradition. This stance is consistent with leading medical associations, such as the American Medical Association, the American College of Physicians, and the National Hospice and Palliative Care Organization.
9. PSJH prohibits Providers and Caregivers from encouraging or facilitating Provider-Hastened Death of PSJH patients. The specific limits about which Providers and Caregivers must be aware and clearly communicate to their patients are that they are not permitted to: a) complete legally-mandated forms attesting to eligibility for aid in dying, b) prescribe or administer substances intended to hasten a patient's death, c) prescribe or administer medications for the specific purpose of easing the anticipated effects of such lethal substances (e.g., providing a prophylactic anti-emetic to be used as an adjunct with the lethal agent), and/or d) be present when a patient is in the process of being given or actively taking substances intended to cause death. However, Providers and Caregivers must not actively obstruct eligible patients from discussing, exploring, or pursuing legal avenues to hastening death. Within the context of a therapeutic relationship, Providers and Caregivers should discuss with the patient why they may be inquiring about hastened death and what unmet needs there may be. Although Providers and Caregivers are prohibited from participating in Provider-Hastened Death, this restriction must not inadvertently diminish attention to patient's concerns or needs, or result in real or perceived patient abandonment. Instead, in patients' most vulnerable times, Providers and Caregivers should seek to strengthen therapeutic relationships with patients and, better understand the concerns that led to the inquiry.[ii]
10. This policy does not replace local or regional policies of PSJH Affiliates on the same subject

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that might include more specific direction for Providers and Caregivers based on the legislation in their respective states. All Providers and Caregivers are expected to be familiar with and comply with any relevant policies regarding Provider-Hastened Death within or applicable to the PSJH Affiliate(s) in which they serve. Any such policies should be consistent with this policy. If significant discrepancies exist, a review by the regional ethicist should be initiated. PSJH shall provider Providers and Caregivers a copy of the applicable policy.

11. PSJH recognizes an important distinction between administration of medications intended to cause death and the Withholding and/or Withdrawing of Life-Sustaining Treatments (e.g. mechanical ventilation, ECMO, intravenous vasopressors, renal dialysis, etc.). Whenever in the patient's (or the surrogate decision maker's) judgment the potential benefit of a treatment is outweighed by the perceived burden, such choices will typically be honored in accordance with applicable PSJH and regional policies and the patient's advance directive (if available).
12. Providers and Caregivers are provided with the document, "Responding to Questions about Provider-Hastened Death: A Toolkit." (Link) This Toolkit contains important information about engaging in conversations with patients and residents who inquire about Provider-Hastened Death. Managers and Directors are also encouraged to make use of the document, "Provider-Hastened Death: Operational Guidelines for Caregivers." (Link) The Operational Guidelines provide practical guidance to front-line caregivers who encounter questions about Provider Hastened Death from patients or loved ones.

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References:

[1] United States Conference of Catholic Bishops (2018). "Ethical and Religious Directives for Catholic Health Care Services." *6TH ed. Washington, D.C.: USCCB*. [Link]

[2] Callahan D. (1996). The Goals of Medicine: Setting New Priorities. Hastings Center Report; 26(6): S1-S27. [Link]

[3] Providence Institute for Human Caring (2021). "Responding to Questions about Provider-Hastened Death: A Toolkit." *Providence*. [Link]

[4] Providence Institute for Human Caring (2021). "Provider Hastened Death: Operational Guidelines for Caregivers." Providence. [Link]

[5] Berlinger N, Jennings B, Wolf SM. (2013) "The Hastings Center Guidelines for Decisions on Life-sustaining Treatment Near the End of Life: Revised and Expanded 2ND ed. Oxford:" *Oxford University Press*. [Link]

[6] American Medical Association (2018). "*Physician-Assisted Suicide, Code of Medical Ethics Opinion 5.7 and 1.1.7.*" [Link]

[7] American College of Physicians (2017). *"American College of Physicians Reaffirms Opposition to Legalization of Physician-Assisted Suicide*." [Link]

[8] National Hospice and Palliative Care Organization (2021). "*Statement on Legally Accelerated Death.*" [Link]

[9] Providence Mission Statement. [Link]

[10] Providence FY 20 Annual Report to Our Communities; Community Health Needs Assessments and Improvement Plans. [Link]

[11] Byock, I. (2017). "We Must Earn Confidence in End-of-Life Comfort Care." *Health Progress*. 2017; November-December: 19-25. [Link]

[12] American Academy of Hospice and Palliative Medicine. "*Advisory Brief: Guidance on Responding to Requests for Physician-Assisted Dying.*" [Link]

State by State Laws for Providence Ministries:

California (2016): AB-15 End of Life Law:[Link]

New Mexico (2021): End of Life Options Act: [Link]

Oregon (1997): Oregon's Death with Dignity Act: [Link]

Washington (2009): The Washing Death with Dignity Act: [Link]

Montana (2009): SB-202 [Link]

Applicability:

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[i] For purposes of this policy*, "Affiliates" is defined as any not-for-profit or non-profit entity that is wholly owned or controlled by Providence St. Joseph Health (PSJH), Providence Health & Services, St. Joseph Health System, Western HealthConnect, Kadlec, Covenant Health Network, Grace Health System, NorCal HealthConnect, or is a not-for-profit or non-profit entity majority owned or controlled by PSJH or its Affiliates and bears the Providence, Swedish Health Services, St. Joseph Health, Covenant Health, Grace Health System, Kadlec, or Pacific Medical Centers names (includes Medical Groups, Home and Community Care, etc.). *Policies and/or procedures may vary for secular Affiliates. Further, where an organization is not wholly owned or majority owned, exceptions may apply.

[ii] When there is a question regarding the provision of information on Provider-Hastened Death or about providing a specific referral, an ethics consultation with a PSJH ethicist is encouraged.

Approval Signatures

Step Description	Approver	Date
PSJH President/CEO	Cynthia Johnston: Sr Compliance Spec PSJH	03/2022
PSJH Executive Council	Cynthia Johnston: Sr Compliance Spec PSJH	03/2022
PSJH Policy Advisory Committee	Cynthia Johnston: Sr Compliance Spec PSJH	03/2022

Exhibit 14
Swedish Advance Directive and CPR Preference Policy

Status **Active** PolicyStat ID **10063280**

Origination	02/2002
Last Approved	02/2020
Effective	02/2020
Next Review	02/2023
Owner	Rebeca Derkitt: Manager Patient Safety
Area	Risk Management
Applicability	WA - Swedish Medical Center
Document Types	Administrative and Clinical Policy and Procedure

Advance Directive and CPR Preference

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Clinical Area: All clinical areas
Population Covered: All patients
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond

Related Policies and Procedures:

Advance Directive Status: Documentation
Bloodless Program: Refusal of Blood Products (Adult)
Code Blue: Cardiac/Respiratory Arrest in the Operating Room
Delivery of the Conditions of Admission Consent Form
Management of Resuscitation Preferences (Code Status)
Patient Rights

Purpose

To define the process for facilitating communication between patients and licensed independent practitioners (LIP) in order to obtain appropriate individualized care orders concerning Advance Directives and resuscitation.

Policy Statement

All patients who have a cardiac or respiratory arrest are resuscitated unless LIP orders to *not* resuscitate are obtained. If a patient is classified as "Do Not Resuscitate" (DNR), the attending LIP enters the resuscitation status order. Verbal resuscitation orders must be dated and signed or electronically authenticated by signature of the LIP within 24 hours. Until the resuscitation status order is obtained, all patients are considered full code. The Resuscitation Order Sheet is completed by the LIP, including identifying with whom (patient or legal next-of-kin) they have discussed the orders. (See also *Medical Rules and Regulations*.)

If the patient arrives to a Swedish Medical Center (SMC) facility and provides a completed Physician Order for Life-Sustaining Treatment (POLST) form, these orders will be honored for up to 24 hours or until the content can be reviewed and converted into a resuscitation status order by the attending LIP or his/her designee.

Upon emergency department (ED), ambulatory surgery, observation admission and/or inpatient admission, patients or their surrogates are also asked by registration caregivers (in ED) or nurse caregivers (all other clinical areas noted) whether they have Advance Directives and/or have expressed wishes concerning cardiopulmonary resuscitation (CPR) or other care issues in order to support an individualized plan of care that accurately reflects the patient's wishes.
No employee, hospital volunteer, attending physician, or physician's employee will act as a witness for any patient executing Advance Directives.

Every attempt is made to honor Advance Directives. If the clinical team has concerns related to the directives, resources such as the Ethics Consultation Committee are used to reach resolution. If the provider believes the care directed by the patient or surrogate is futile, the process within the *Potentially Inappropriate Care and Management of Disputed Treatment Requests*
policy is followed.

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LIP Order Requirement

Elements of this procedure require a licensed independent practitioner's (LIP) order.

Responsible Persons

Patient Registration, Registered nurses (RN), LIPs, licensed practical nurses (LPN), and nursing technicians (NT).

Prerequisite Information

CFR §489.102 requires the hospital to provide written notice of its policies regarding the implementation of patients' rights to make decisions concerning medical care, such as the right to formulate Advance Directives. If an individual is incapacitated or otherwise unable to communicate, the hospital may provide the Advance Directive information required to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with state law.

Although both inpatients and outpatients have the same rights, §489.102(b)(1) requires that notice of the hospital's Advance Directive policy be provided at the time an individual is admitted as an **inpatient**. However, in view of the broader notice requirements, the hospital should also provide the Advance Directive notice to outpatients (or their representatives) who are in the **emergency department**, who are in an **observation status**, or who are **undergoing surgery**. The notice should be presented at the time of registration. **NOTE:** Notice is not required for other outpatients, given that they are unlikely to become incapacitated. (*CMS State Operations Manual*).

Procedure

► ***Requires LIP order***	
Responsible Person	**Steps**
LIP, Nursing Staff	**GENERAL CONSIDERATIONS** 1. SMC provides all patients or their surrogates with information about their rights under Washington State law, as well as policies regarding a patient's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and to formulate Advance Directives. 2. SMC assigns responsibilities to Nursing to inquire of all patients or a designated surrogate whether written directions exist for medical treatment near the end of life. It is the responsibility of a patient or surrogate to inform staff and attending LIP of any directives. 3. It is documented in the **emergency department**, **ambulatory surgery**, **observation admission** and/or **inpatient**'s medical record whether the individual has or has not executed Advance Directives. If the patient does not have advance directives, information regarding Advance Directives is offered to adult patients. If the patient cannot respond or refuses information, staff documents this in their respective clinical admission workflow. 4. SMC does not place any conditions concerning the provision of care or otherwise limit, withdraw, or refuse care to any individual based solely on whether or not the individual has Advance Directives. 5. The Advance Directives are used in concert with further assessment to assure that the patient's intent and interests are accurately addressed. 6. Specific procedures are outlined below to ensure that patients have the right to determine their course of treatment.
Patient Registration, Nursing Staff,	**PREADMISSION**

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► ***Requires LIP order***	
Health Information Management	1. All pre-admitted surgical adult patients are advised in the preadmission packet to bring a copy of any signed Advance Directives, living will, or durable power-of-attorney for health care to the hospital with them. 2. Patient Registration or delegated unit staff faxes the documents to Health Information Management (HIM) for scanning into the electronic medical record (EMR) (see Forms - Attachments for *Cover Sheet for Scanning Advance Directives* or *Cover Sheet for Scanning Advance Directives: Swedish Edmonds*). 3. Each patient receives and signs the *Condition of Admission* form in *Conditions of Admission* policy which describes the SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless SMC has an LIP order stating otherwise. During this process, patients are given an opportunity to express their wishes surrounding emergent resuscitation.
LIP, Clinical Staff	**EMERGENCY DEPARTMENTS (ED)** 1. Each ED patient receives and signs the *Condition of Admission* form in the *Conditions of Admission* policy which describes SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless SMC has an LIP order stating otherwise. 2. Upon admit or when the patient is stabilized, a Patient Registration staff member asks the patient or their surrogate decision maker whether they have an Advance Directive(s). 3. If the patient/surrogate indicates they have an Advance Directive(s), the Patient Registration staff member verifies or records the location of the Advance Directive(s) in the EMR. If not found in the EMR, the patient/surrogate is asked that a copy be provided, which will be faxed to Health Information Management (HIM) for scanning into the patient's EMR - See Foms - Attachments (for Swedish Edmonds, *fax to ER Patient Registration*). a. If the patient has an Advance Directive but failed to bring a copy into the hospital, ED registration staff documents that the patient indicated they have an Advance Directive but it is not available. b. If the patient is incapacitated and no representative is available, and is subsequently admitted to the hospital, clinical staff documents their effort to obtain the patient's Advance Directive status and location.

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► ***Requires LIP order***	
	4. If the patient has not completed these documents, they are offered an Advance Directive pamphlet *Advance Care Planning, (see Attachments)* to provide information regarding the patient's rights and choices. 5. If the patient refuses this information, the refusal is documented in the EMR. **NOTE:** Advance Directive status(es) entered at ED admission are confirmed again by clinical staff upon observation or inpatient admission in clinical workflows.

Nursing Staff, Health Information Management	**AMBULATORY SURGERIES, OBSERVATION ADMISSIONS, INPATIENTS**
	
	1. Each patient receives and signs the *Condition of Admission* form in the *Conditions of Admission* policy which describes the SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless SMC has an LIP order stating otherwise. During this process, patients are given an opportunity to express their wishes surrounding emergent resuscitation.
	2. Upon admitting or preadmitting the patient, the clinical caregiver also asks the patient or their surrogate decision maker whether they have completed Advance Directives [a living will or a Durable Power of Attorney for Health Care (DPOA)].
	3. If they have completed these documents, the caregiver asks that a copy be provided for scanning into the patient's medical record. (The original stays with the patient.) If copies are not readily available, documentation of key information (designates, DPOA, etc.) is written on the admit database. The patient or family is encouraged to bring a copy into the hospital for scanning and reference.
	    a. A new patient list column is available to track the status of the advance directive. The column displays the status of the document and the time the initial screening question was asked.
	    b. Fax Advance Directive to HIM for scanning into the EMR (see Forms - Attachments for *Fax Cover Sheet for Swedish* or *Fax Cover Sheet for Swedish Edmonds*).
	4. If the patient has not completed these documents, information (*Advance Directive Booklet* - See Attachments) is offered.
	5. If the patient refuses this information, the refusal is documented.

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► ***Requires LIP order***	
LIP, Clinical Staff	**POLST** 1. If the patient or surrogate brings a completed POLST form (or a copy) into the facility, this is honored until the LIP incorporates these decisions/directions into the patient's orders, which must occur within 24 hours.
Patient Registration	**HOSPITAL OUTPATIENT DEPARTMENTS** 1. Each patient is given and signs the *Conditions of Admission* form in *Conditions of Admission* policy which describes the SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless we have a LIP order stating otherwise. 2. Per CMS, documentation of Advance Directive status is not required in all hospital outpatient clinic settings, given that the patient is not likely to become incapacitated. Some hospital outpatient settings with recurring patients (oncology, psychiatry) record this information.
LIP, Clinical Staff	**HONORING PATIENT WISHES FOR NO EMERGENT CARE** 1. If a patient expresses a wish for no emergent care, the clinical staff of the unit alerts the LIP. 2. The LIP then has a conversation with the patient and documents the outcomes of the discussion in the progress notes. 3. If an order for Do Not Resuscitate is warranted, the LIP provides the order for staff. DNR must be signed/dated or e-authenticated within 24 hours by the LIP. (See *Medical Staff Rules & Regulations*.)
LIP, Clinical Staff	**REVOCATION** 1. If a patient wishes to revoke an Advance Directive, he or she may do so by indicating this verbally. The appropriate staff member: a. Documents in the medical record what the patient stated. ► b. Notifies the attending LIP (calls directly to obtain an order) and documents the conversation in a Progress Note in the EMR. c. Returns any related document(s) in the medical record to the patient. d. If original documents were scanned into the EMR, alert Health Information Management to change the description in the EMR under scanned documents to "Void as of xxx date".
LIP, Clinical Staff	**TRANSFER OF PATIENTS TO OTHER FACILITIES** 1. Nursing staff makes copies of any Advance Directives in the patient's chart when the patient is transferred to a nursing home, other hospital,

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► ***Requires LIP order***	
	skilled nursing facility, or hospice organization. 2. A copy of any Advance Directive is sent with other transfer documentation. ► 3. The LIP carries over any *Do Not Resuscitate* orders as part of the transfer orders.

Definitions

Advance Directives. A document in which an individual either states choices for medical treatment or designates who should make treatment choices if the person loses decision-making capacity. Examples of Advance Directives include a living will and durable power-of-attorney for health care.

Living Will. A document in which an individual can stipulate the kind of life-prolonging medical care he or she would want if terminally ill and unable to make medical decisions.

Durable Power-of-Attorney for Health Care (DPOA). A document in which an individual names someone else (the "agent" or "proxy") to make health care decisions in the event the individual becomes unable to make them him/herself.

Resuscitation. Full application of CPR, including intubation, electrical therapy, and appropriate medications.

POLST. Physician Orders for Life Sustaining Treatment. This is a document, signed by the patient and the physician that outlines the patient's wishes for life-sustaining medical treatment.

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Forms

See Attachments

- POLST - Physician Orders for Life-Sustaining Treatment form 4/2021
- Cover Sheet for Scanning Advance Directives (Fax cover sheet)
- Cover Sheet for Scanning Advance Directives: Swedish Edmonds (Fax cover sheet)

Addenda

See Attachments

Advance Care Planning (ADMN-13-12500)
Advance Directive Booklet (NU-18-0223)
Welcome To Swedish brochure. Specific pages educate the patient about CPR and general policy statements.
Patient Rights (poster, flyers or online). Describes the many rights patients have during their healthcare stay, including "To make advance treatment directives, such as Durable Power of Attorney for Health Care and Living Wills, or Physician Order for Life Sustaining Treatment (POLST), and to have caregivers follow your wishes."

Supplemental Information

The Code Blue Committee reviews all resuscitation codes and establishes appropriate performance improvement actions and feedback.

Regulatory Requirements

Det Norske Veritas (DNV) (NIAHO) standard PR.3.

Centers for Medicare & Medicaid Services. CFR §482.13(b)(3), §489.100 (Advance Directive Definition), §489.102(b)(1) (Advance Directive Notification Requirements for Providers).

WAC 246-320-141 (1)(k).

The Patient Self-Determination Act. Sections 4206 and 4761 of the Omnibus Budget Reconciliation Act of 1990.

Washington State's Natural Death Act (1992). RCW 70.122.

Washington State Hospital Association (WSHA) POLST - POLST Form - POLST Brochure (wsma.org)

Stakeholders

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Author/Contact

Margo Bykonen, RN, MN, Chief Nursing Officer, Swedish Health Services
Marianne Klaas, RN, MN, Regional Administrative Director for Accreditation, Safety, Injury Management, & Clinical Quality Investigations

Expert Consultants

Accreditation Program Manager
Patient Access Leadership

Sponsor

Margo Bykonen, RN, MN, Chief Nursing Officer, Swedish Health Services

Stellent: SWED_006678

Attachments

Advance Care Plan Brochure, ADMN-13-12500, rev. 6/21 - ENGLISH

Advance Directive Booklet, NU-18-0223, rev.9/19 - ENGLISH

Edmonds Campus Cover Sheet for Scanning Advance Directives.pdf

Fax Cover Sheet for Scanning Advance Directives

Patient Rights and Responsibilities, RWS15-55532, rev. 2/21 - ENGLISH

POLST - Physician Orders for Life-Sustaining Treatment form 4/2021

Welcome to Swedish Booklet, ADMN-17-0268, rev. 6/19 - ENGLISH

Approval Signatures

Step Description	Approver	Date

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Exhibit 15
Swedish Issaquah Hospital Reproductive Health Services Statement

Washington State Department of Health

Hospital Reproductive Health Services

In accordance with 2SSB 5602 (Laws of 2019), the purpose of this form is to provide the public with specific information about which reproductive health services are and are not generally available at each hospital.
Please contact the hospital directly if you have questions about services that are available.

Hospital name: Swedish Issaquah		
Physical address: 751 NE Blakely Dr.		
City: Issaquah	State: WA	ZIP Code: 98029
Hospital contact: 425-313-4000	Contact phone #: 425-313-4454	

An acute care hospital may not be the appropriate setting for all reproductive health services listed below.
Some reproductive services are most appropriately available in outpatient settings such as a physician office or clinic, depending on the specific patient circumstances.

The following reproductive health services are generally available at the above listed hospital:

Abortion services
- ☑ Medication abortion *
- ☑ Referrals for abortion
- ☑ Surgical abortion *

Contraception services
- ☑ Birth control: provision of the full range of Food and Drug Administration-approved methods including intrauterine devices, pills, rings, patches, implants, etc.
- ☑ Contraceptive counseling
- ☑ Hospital pharmacy dispenses contraception
- ☑ Removal of contraceptive devices
- ☑ Tubal ligations
- ☑ Vasectomies

Emergency contraception services
- ☑ Emergency contraception - sexual assault
- ☑ Emergency contraception - no sexual assault

Infertility services
- ☑ Counseling
- ☑ Infertility testing and diagnosis
- ☐ Infertility treatments including but not limited to in vitro fertilization

Other related services
- ☑ Human immunodeficiency virus (HIV) testing
- ☑ Human immunodeficiency virus (HIV) treatment
- ☑ Pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prescriptions, and related counseling
- ☑ Sexually transmitted disease testing and treatment
- ☑ Treatment of miscarriages and ectopic pregnancies

Pregnancy-related services
- ☑ Counseling
- ☑ Genetic testing
- ☑ Labor and delivery
- ☑ Neonatal intensive care unit
- ☑ Prenatal care
- ☑ Postnatal care
- ☑ Ultrasound

Comments; limitations on services; other services

When necessary, on an emergency basis, termination of pregnancy procedures may be performed at our facilities. Elective pregnancy terminations are not performed in our facilities; however, we provide patients with access to such reproductive health services by providing referrals to independent providers in the community.

☑ **Additional comments on next page**

Brian Trickel [signature]
Signed by:

09/30/2019
Date (mm/dd/yyyy)

Hospital Reproductive Health Services

Hospital name: Swedish Issaquah

Additional comments; limitations on services; other services (*continued*)

The services listed here occur within the privacy of the patient-provider relationship and may be affected by the independent agency of the provider.

Some services listed on this form may be provided when medically indicated.

Brian Trickel [signature]

Signed by:

09/30/2019

Date (mm/dd/yyyy)

Exhibit 16
Swedish Issaquah Balance Sheet, 2022-2026
and Assumptions

Swedish Issaquah Balance Sheet, 2022-2026*

	2022 *Actual*	2023 *Projected*	2024 *Forecast*	2025 *Forecast*	2026 *Forecast*
Assets					
Current Assets:					
Cash and Cash Equivalents	87,688,424	87,688,424	87,688,424	87,688,424	87,688,424
Patient Accounts Receivable, Net	42,872,608	43,090,241	43,805,502	43,990,940	44,176,378
Other Receivables	7,530,696	7,530,696	7,530,696	7,530,696	7,530,696
Supplies Inventory	5,793,187	5,745,366	5,840,734	5,865,459	5,890,184
Other Current Assets	469,587	469,587	469,587	469,587	469,587
Total Current Assets	**144,354,502**	**144,524,314**	**145,334,943**	**145,545,106**	**145,755,269**
Property, Plant & Equipment:					
Property Plant Equipment Gross	540,271,849	552,353,700	566,294,361	581,483,850	597,321,791
Accumulated Depreciation	(216,145,920)	(234,226,006)	(252,306,092)	(270,386,178)	(288,466,264)
Property, Plant & Equipment Net	**324,125,929**	**318,127,694**	**313,988,269**	**311,097,672**	**308,855,527**
Other Long Term Assets:					
Other LT Assets	1,558,984	1,558,984	1,558,984	1,558,984	1,558,984
Total Other Long-Term Assets	**1,558,984**	**1,558,984**	**1,558,984**	**1,558,984**	**1,558,984**
Total Assets	**470,039,415**	**464,210,992**	**460,882,196**	**458,201,762**	**456,169,780**
Liabilities					
Current Liabilities:					
Accounts Payable	11,707,169	11,707,169	11,707,169	11,707,169	11,707,169
Accrued Compensation	8,163,065	8,163,065	8,163,065	8,163,065	8,163,065
Payable to Contractual Agencies	448,220	448,220	448,220	448,220	448,220
Other Current Liabilities	1,129,829	1,129,829	1,129,829	1,129,829	1,129,829
Current Portion of Debt	6,208,215	6,208,215	6,208,215	6,208,215	6,208,215
Total Current Liabilities	**27,656,498**	**27,656,498**	**27,656,498**	**27,656,498**	**27,656,498**
Total Long-Term Debt & Other Liabilities	339,277,784	339,277,784	339,277,784	339,277,784	339,277,784
Total Liabilities	**366,934,282**	**366,934,282**	**366,934,282**	**366,934,282**	**366,934,282**
Total Net Assets	**103,105,133**	**97,276,710**	**93,947,914**	**91,267,480**	**89,235,498**
Total Liabilities and Net Assets	**470,039,415**	**464,210,992**	**460,882,196**	**458,201,762**	**456,169,780**

Source: Swedish Issaquah

*Assumptions for the balance sheet are included in Exhibit 16 below.

Assumptions for Balance Sheet

A	B	C
Category/Item	**General Assumptions for Hospital Excluding Existing Cath Labs (Forecast Years 2024-2026)**	**Assumptions for the Existing Cath Lab and the PCI Project (If Different from Hospital)**
Cash	Cash is held constant based on 2022 actuals.	Balance sheet presented at consolidated hospital level.
Accounts Receivable ("AR"), Net	Assumed to equal 4.5% (rounded to 1 decimal place) of Total Gross Service Revenue based on 2022 actual level and in-line with historical levels, net of Allowance for Doubtful Accounts and Allowance for Contractual Adjustments, rounded to the nearest whole dollar.	Balance sheet presented at consolidated hospital level.
Other Receivables	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Supplies Inventory	Assumed to equal 0.6% (rounded to 1 decimal place) of Total Gross Service Revenue based on 2022 actual level and in-line with historical levels, rounded to the nearest whole dollar.	Balance sheet presented at consolidated hospital level.
Other Current Assets	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Fixed Assets	Fixed assets decline by annual depreciation of $18,080,086 and increase by an capital expenditures in the following amounts: *2023:* $12,081,851, *2024:* $13,940,661, *2025:* $15,189,489, *2026*: $15,837,941	Balance sheet presented at consolidated hospital level.
Other Long-Term (LT) Assets	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Accounts Payable	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Accrued Compensation	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Payable to Contractual Agencies	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Other Current Liabilities	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Current Portion of Debt	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Total Long-Term Debt and Other Liabilities	Assumed to remain flat with 2022 throughout forecast period.	Balance sheet presented at consolidated hospital level.
Net Assets	Net assets are equal to prior year net assets plus net operating income.	Balance sheet presented at consolidated hospital level.

Exhibit 17
Swedish Issaquah Proforma Financial Statements, 2023-2026 and Assumptions

Swedish Issaquah, Projected, 2023; Pro Forma Forecast, 2024 – 2026
The Project (Cath Lab Cost Center Includes Emergent and Elective PCI)
Revenue and Expense Statement*

	2023	2024	2025	2026
	Projected	*Forecast*	*Forecast*	*Forecast*
Gross Service Revenue (GSR)				
Medicare	17,364,942	24,310,920	26,111,728	27,912,536
Medicaid	3,457,094	4,839,931	5,198,445	5,556,958
Commercial	17,047,049	23,865,868	25,633,710	27,401,552
Other (Tricare, Workers Comp, and VA)	993,418	1,390,785	1,493,806	1,596,827
Self Pay	874,208	1,223,891	1,314,549	1,405,208
Other	-	-	-	-
Total Gross Service Revenue	**39,736,711**	**55,631,395**	**59,752,238**	**63,873,081**
Revenue Deductions before Bad Debt				
Contractual Adjustments	27,299,120	38,218,768	41,049,788	43,880,807
Charity Care	504,656	706,519	758,853	811,188
Revenue Deductions *before* Bad Debt	**27,803,776**	**38,925,287**	**41,808,641**	**44,691,995**
Provision for Bad Debts	158,947	222,526	239,009	255,492
Total Revenue Deductions	**27,962,723**	**39,147,813**	**42,047,650**	**44,947,487**
Net Service Revenue				
Other Operating Revenue	-	-	-	-
Total Operating Revenue	**11,773,988**	**16,483,582**	**17,704,588**	**18,925,594**
Operating Expenses				
Salaries and Wages	2,121,569	2,121,569	2,121,569	2,121,569
Benefits	129,416	129,415	129,416	129,415
Professional Fees	-	-	-	-
Supplies	1,641,870	2,298,618	2,468,886	2,639,154
Purchased Services	168,210	235,494	252,938	270,382
Depreciation	44,625	44,625	44,625	44,625
Interest and Amortization	-	-	-	-
Other Expenses	8,750	11,200	11,550	11,813
Total Operating Expenses	**4,114,440**	**4,840,921**	**5,028,984**	**5,216,958**
Net Operating Income	**7,659,548**	**11,642,661**	**12,675,604**	**13,708,636**
System Allocation	3,706,359	5,189,845	5,574,426	5,959,006
Non-Operating Gains (Losses)	-	-	-	-
Net Income	**3,953,189**	**6,452,816**	**7,101,178**	**7,749,630**
NOI Margin	***33.6%***	***39.1%***	***40.1%***	***40.9%***

Source: Swedish Issaquah

*All proforma assumptions are included in Exhibit 17 below.

Swedish Issaquah, Projected, 2023; Pro Forma Forecast, 2024 – 2026

Status Quo: Hospital Without Project (Hospital – The Project)

Revenue and Expense Statement*

	2023	2024	2025	2026
	Projected	*Forecast*	*Forecast*	*Forecast*
Gross Service Revenue (GSR)				
Medicare	344,967,286	344,967,286	344,967,286	344,967,286
Medicaid	105,751,080	105,751,080	105,751,080	105,751,080
Commercial	435,776,990	435,776,990	435,776,990	435,776,990
Other (Tricare, Workers Comp, and VA)	18,925,076	18,925,076	18,925,076	18,925,076
Self Pay	12,255,583	12,255,583	12,255,583	12,255,583
Other	148,193	148,193	148,193	148,193
Total Gross Service Revenue	**917,824,208**	**917,824,208**	**917,824,208**	**917,824,208**
Revenue Deductions before Bad Debt				
Contractual Adjustments	630,545,231	630,545,231	630,545,231	630,545,231
Charity Care	11,656,367	11,656,367	11,656,367	11,656,367
Revenue Deductions *before* Bad Debt	**642,201,598**	**642,201,598**	**642,201,598**	**642,201,598**
Provision for Bad Debts	3,671,297	3,671,297	3,671,297	3,671,297
Total Revenue Deductions	**645,872,895**	**645,872,895**	**645,872,895**	**645,872,895**
Net Service Revenue				
Other Operating Revenue	11,179,427	11,179,427	11,179,427	11,179,427
Total Operating Revenue	**283,130,740**	**283,130,740**	**283,130,740**	**283,130,740**
Operating Expenses				
Salaries and Wages	87,938,770	87,938,770	87,938,770	87,938,770
Benefits	10,345,908	10,345,908	10,345,908	10,345,908
Professional Fees	6,407,106	6,407,106	6,407,106	6,407,106
Supplies	36,955,716	36,955,716	36,955,716	36,955,716
Purchased Services	22,098,254	22,098,254	22,098,254	22,098,254
Depreciation	18,035,461	18,035,461	18,035,461	18,035,461
Interest and Amortization	10,066,183	10,066,183	10,066,183	10,066,183
Other Expenses	11,930,520	11,930,520	11,930,520	11,930,520
Total Operating Expenses	**203,777,918**	**203,777,918**	**203,777,918**	**203,777,918**
Net Operating Income	**79,352,822**	**79,352,822**	**79,352,822**	**79,352,822**
System Allocation	89,134,434	89,134,434	89,134,434	89,134,434
Non-Operating Gains (Losses)	-	-	-	-
Net Income	**(9,781,612)**	**(9,781,612)**	**(9,781,612)**	**(9,781,612)**
Net Operating Margin	***-3.5%***	***-3.5%***	***-3.5%***	***-3.5%***

Source: Swedish Issaquah

*All proforma assumptions are included in Exhibit 17 below.

Swedish Issaquah, Projected, 2023; Pro Forma Forecast, 2024 – 2026
Hospital With Project (Hospital + The Project)
Revenue and Expense Statement*

	2023 *Projected*	2024 *Forecast*	2025 *Forecast*	2026 *Forecast*
Gross Service Revenue (GSR)				
Medicare	362,332,228	369,278,206	371,079,014	372,879,822
Medicaid	109,208,174	110,591,011	110,949,525	111,308,038
Commercial	452,824,039	459,642,858	461,410,700	463,178,542
Other (Tricare, Workers Comp, and VA)	19,918,494	20,315,861	20,418,882	20,521,903
Self Pay	13,129,791	13,479,474	13,570,132	13,660,791
Other	148,193	148,193	148,193	148,193
Total Gross Service Revenue	**957,560,919**	**973,455,603**	**977,576,446**	**981,697,289**
Revenue Deductions before Bad Debt				
Contractual Adjustments	657,844,351	668,763,999	671,595,019	674,426,038
Charity Care	12,161,023	12,362,886	12,415,220	12,467,555
Revenue Deductions *before* Bad Debt	**670,005,374**	**681,126,885**	**684,010,239**	**686,893,593**
Provision for Bad Debts	3,830,244	3,893,823	3,910,306	3,926,789
Total Revenue Deductions	**673,835,618**	**685,020,708**	**687,920,545**	**690,820,382**
Net Service Revenue				
Other Operating Revenue	11,179,427	11,179,427	11,179,427	11,179,427
Total Operating Revenue	**294,904,728**	**299,614,322**	**300,835,328**	**302,056,334**
Operating Expenses				
Salaries and Wages	90,060,339	90,060,339	90,060,339	90,060,339
Benefits	10,475,324	10,475,323	10,475,324	10,475,323
Professional Fees	6,407,106	6,407,106	6,407,106	6,407,106
Supplies	38,597,586	39,254,334	39,424,602	39,594,870
Purchased Services	22,266,464	22,333,748	22,351,192	22,368,636
Depreciation	18,080,086	18,080,086	18,080,086	18,080,086
Interest and Amortization	10,066,183	10,066,183	10,066,183	10,066,183
Other Expenses	11,939,270	11,941,720	11,942,070	11,942,333
Total Operating Expenses	**207,892,358**	**208,618,839**	**208,806,902**	**208,994,876**
Net Operating Income	**87,012,370**	**90,995,483**	**92,028,426**	**93,061,458**
System Allocation	92,840,793	94,324,279	94,708,860	95,093,440
Non-Operating Gains (Losses)	-	-	-	-
Net Income	**(5,828,423)**	**(3,328,796)**	**(2,680,434)**	**(2,031,982)**
NOI Margin	***-2.0%***	***-1.1%***	***-0.9%***	***-0.7%***

Source: Swedish Issaquah

*All proforma assumptions are included in Exhibit 17 below.

Assumptions for Pro Forma Forecast

A	B	C	D
Category/Item	**General Assumptions for Hospital Excluding Existing Cath Labs (Forecast Years 2024-2026)**	**Assumptions for the Existing Cath Lab and the PCI Project (If Different from Hospital)**	**Additional Notes**
Procedure Volume	Not applicable - applicable only to the proposed PCI project.	Emergent PCI cases will grow incrementally by approximately 1.5% combined average growth rate over the four-year period, adding two cases per year from 2023 to 2026. This growth rate is consistent with the planning area growth rates. Elective PCI projections assume elective cases will grow by 52 cases in 2024, which is the first year of operations. This represents an additional one case per week for scheduled PCIs in the first full year of operations. In 2025-2026, volumes will grow modestly, adding 12 cases in 2025 and 12 cases in 2026, representing an incremental one additional case per month in the second and third full year of operations.	
Patient Days	Held constant using 2022 actuals	Not applicable.	
GROSS SERVICE REVENUE (GSR)			
Medicare	Total Gross Service Revenue ("GSR") held constant in forecast using 2022 actuals as the base assumption. Payor mix ratios used to project future GSR are as follows: Medicare - 37.8%, Medicaid - 9.4%, Commercial - 47.3%, Other Government - 2.1%, and Self Pay - 1.4%.	Total Gross Service Revenue ("GSR") is calculated as GSR per procedure multiplied by number of procedures. GSR per procedure ($294,346) is calculated as the average of 2020-2022 for the cath lab, rounded to the closest whole dollar. GSR by payor is calculated by multiplying total GSR by each payor's relative percentage (payor mix). Payor mix is held constant in the forecast using 2022 actuals for the existing cath lab as the base assumption. Payor mix ratios used to project future GSR are as follows: Medicare - 43.7%, Medicaid - 8.7%, Commercial - 42.9%, Other Government - 2.5%, and Self Pay - 2.2%.	
Medicaid			
Commercial			
Other Government			Other GSR includes Tricare, VA and other government.
Self Pay			
TOTAL CONTRACTUAL ALLOWANCES	Total Contractual Allowances are calculated by applying the discount rate based on most recent experience (full year 2022). The discount is calculated by dividing each year's revenue deduction by the corresponding year's GSR for each category (rounded to the nearest whole %). Total contractuals allowances are 69 0%.	Total contractuals allowances for the project are 69.0%.	
Bad Debt	0.4.% of total GSR based 2023 projected rates.	0.4.% of total GSR based 2023 projected rates.	
Charity Care	1.27% of total GSR based on the King East planning average, 2018-2020.	1 27% of total GSR based on the King East planning average, 2018-2020.	Planning area 3 year average (2018-2020) for charity care is 1 27%, while Swedish Issaquah recent 3 year average (2020-2022) is 1.23%. We project that charity care rates will slightly increase post COV D pandemic with the elimination of the Medicaid continuous coverage provision beginning in March 2023. Please see Exhibit 34 for a copy of the most recently available King East planning area and King County charity care rates from 2018-2020.
Other Operating Revenue	Based on 2022 actuals and held constant from 2023-2026	There is no Other Operating Revenue for the proposed PCI project.	"Other Operating Revenue" includes but is not limited to the following: Gift shop revenue and Lease revenue for space rented by 3rd parties.

Assumptions for Pro Forma Forecast

A	B	C	D
Category/Item	**General Assumptions for Hospital Excluding Existing Cath Labs (Forecast Years 2024-2026)**	**Assumptions for the Existing Cath Lab and the PCI Project (If Different from Hospital)**	**Additional Notes**
Salaries and Wages	Total FTE count was calculated as the number of FTEs needed to support patient days volume based on 2022 actual staffing mix; Salaries are calculated as FTEs by discipline (based on 2022 actual staffing mix) x average hourly wage rate by discipline experienced in 2022 x 2,080 hours (full-time equivalent annual hours). Forecast for 2024-2026 are held constant at 2022 rates	Forecast for 2023-2026 are held constant at 2022 rates. No additional cath lab staff are required for the project. One additional Interventional Cardiologists is added during the 2024-2026. Interventional Cardiologists are included in the System Allocation expense of 31 5% of Net Operating Revenue.	Interventional Cardiologists salaries and benefits are included in System Allocation expense.
Benefits	Based on 2022 actuals and held constant from 2023-2026	6.1% based on 2022 actual percentage rounded to 1 decimal place for both the emergent and project. In 2022, Swedish changed accounting practice and shifted benefits from System Allocation to	
Professional Fees	Based on 2022 actuals and held constant from 2023-2026	Not applicable. Any Professional Fees are included in the System Allocation.	
Supplies	Based on 2022 actuals and held constant from 2023-2026	Based on 2022 actuals of $12,162 per procedure, rounded to the nearest whole dollar, and forecast through 2023-2026.	
Purchased Services	Based on 2022 actuals and held constant from 2023-2026	Based on 2022 actuals of $1,246, rounded to the nearest whole dollar, per procedure and forecast through 2023-2026.	
Depreciation	Based on 2022 actuals and held constant from 2023-2026	Based on 2022 actuals and held constant through 2023-2026	
Interest and Amortization	Based on 2022 actuals and held constant from 2023-2026	Not applicable at the cost center level	
Other Expenses	Based on 2022 actuals and held constant from 2023-2026	Based on 2022 actuals and held constant through 2023-2026	Other expenses includes but is not limited to the following: Licenses, Rentals/Leases, State Medicaid provider tax, travel, and training.
NON-OPERATING EXPENSES			
System Allocation	Based on 2022 actuals of 31.5% of Net Operating Revenue and forecast out through 2023-2026	Based on 2022 actuals of 31.5% of Net Operating Revenue and forecast out through 2023-2026	System Allocation includes but is not limited to the following: Information Services (including EPIC), Revenue Cycle, Human Resources, Finance, Real Estate, System Office, Marketing & Communication, Physician Services, Payor Contracting, Regional Shared Services, and additional employer benefits.

Exhibit 18
Swedish Issaquah Historical Financials, 2020-2022

Swedish Issaquah, Historical Revenue and Expense Statement, 2020-2022

Cath Lab Cost Center

	2020	2021	2022
	Actual	*Actual*	*Actual*
Gross Service Revenue (GSR)			
Medicare	14,913,203	15,402,815	15,793,722
Medicaid	2,991,177	2,253,872	3,120,466
Commercial	12,808,535	14,053,500	15,500,318
Other (Tricare, Workers Comp, and VA)	220,647	597,600	893,708
Self Pay	296,625	570,028	806,252
Other	-	-	-
Total Gross Service Revenue	**31,230,187**	**32,877,815**	**36,114,466**
Revenue Deductions before Bad Debt			
Contractual Adjustments	21,673,750	22,751,448	24,900,924
Charity Care	374,762	361,656	505,603
Revenue Deductions *before* Bad Debt	**22,048,512**	**23,113,104**	**25,406,527**
Provision for Bad Debts	343,532	(98,633)	-
Total Revenue Deductions	**22,392,044**	**23,014,471**	**25,406,527**
Net Service Revenue			
Other Operating Revenue	-	-	-
Total Operating Revenue	**8,838,143**	**9,863,344**	**10,707,939**
Operating Expenses			
Salaries and Wages	1,514,142	1,722,273	1,806,216
Benefits	-	-	109,764
Professional Fees	-	-	-
Supplies	1,076,077	1,143,021	1,617,560
Purchased Services	206,979	182,848	165,731
Depreciation	33,622	43,714	44,625
Interest and Amortization	-	-	-
Other Expenses	152	9,155	8,750
Total Operating Expenses	**2,830,972**	**3,101,011**	**3,752,646**
Net Operating Income	**6,007,171**	**6,762,333**	**6,955,293**
System Allocation	2,739,971	2,931,041	3,370,775
Non-Operating Gains (Losses)	-	-	-
Net Income	**3,267,200**	**3,831,292**	**3,584,518**
NOI Margin	***37.0%***	***38.8%***	***33.5%***

Source: Swedish Issaquah

Swedish Issaquah, Historical Revenue and Expense Statement, 2020-2022

Hospital With Cath Lab Cost Center

	2020	2021	2022
	Actual	*Actual*	*Actual*
Gross Service Revenue (GSR)			
Medicare	276,687,905	327,508,749	360,761,008
Medicaid	71,544,869	94,250,060	108,871,546
Commercial	348,851,222	416,960,756	451,277,308
Other (Tricare, Workers Comp, and VA)	13,220,577	20,036,037	19,818,784
Self Pay	9,455,026	10,330,196	13,061,835
Other	548,244	60,981	148,193
Total Gross Service Revenue	**720,307,843**	**869,146,779**	**953,938,674**
Revenue Deductions before Bad Debt			
Contractual Adjustments	499,858,036	601,786,149	657,773,279
Charity Care	8,572,963	9,178,878	13,018,450
Revenue Deductions *before* Bad Debt	**508,430,999**	**610,965,027**	**670,791,729**
Provision for Bad Debts	7,595,564	(2,760,795)	465,136
Total Revenue Deductions	**516,026,563**	**608,204,232**	**671,256,865**
Net Service Revenue			
Other Operating Revenue	12,978,770	8,188,768	11,179,427
Total Operating Revenue	**217,260,050**	**269,131,315**	**293,861,236**
Operating Expenses			
Salaries and Wages	71,476,619	78,532,420	89,744,986
Benefits	9,381,319	10,752,339	10,455,672
Professional Fees	4,839,787	6,751,978	6,407,106
Supplies	32,235,510	36,507,026	38,573,276
Purchased Services	22,620,519	24,744,679	22,263,985
Depreciation	14,950,655	15,744,624	18,080,086
Interest and Amortization	11,568,255	12,156,669	10,066,183
Other Expenses	11,140,704	12,738,783	11,939,270
Total Operating Expenses	**178,213,368**	**197,928,518**	**207,530,564**
Net Operating Income	**39,046,682**	**71,202,797**	**86,330,672**
System Allocation	67,354,209	79,976,431	92,505,209
Non-Operating Gains (Losses)	-	-	-
Net Income	**(28,307,527)**	**(8,773,634)**	**(6,174,537)**
NOI Margin	***-13.0%***	***-3.3%***	***-2.1%***

Source: Swedish Issaquah

Swedish Issaquah, Historical Revenue and Expense Statement, 2020-2022

Hospital Without Cath Lab Cost Center

	2020	2021	2022
	Actual	*Actual*	*Actual*
Gross Service Revenue (GSR)			
Medicare	261,774,702	312,105,934	344,967,286
Medicaid	68,553,692	91,996,188	105,751,080
Commercial	336,042,687	402,907,256	435,776,990
Other (Tricare, Workers Comp, and VA)	12,999,930	19,438,437	18,925,076
Self Pay	9,158,401	9,760,168	12,255,583
Other	548,244	60,981	148,193
Total Gross Service Revenue	**689,077,656**	**836,268,964**	**917,824,208**
Revenue Deductions before Bad Debt			
Contractual Adjustments	478,184,286	579,034,701	632,872,355
Charity Care	8,198,201	8,817,222	12,512,847
Revenue Deductions *before* Bad Debt	**486,382,487**	**587,851,923**	**645,385,202**
Provision for Bad Debts	7,252,032	(2,662,162)	465,136
Total Revenue Deductions	**493,634,519**	**585,189,761**	**645,850,338**
Net Service Revenue			
Other Operating Revenue	12,978,770	8,188,768	11,179,427
Total Operating Revenue	**208,421,907**	**259,267,971**	**283,153,297**
Operating Expenses			
Salaries and Wages	69,962,477	76,810,147	87,938,770
Benefits	9,381,319	10,752,339	10,345,908
Professional Fees	4,839,787	6,751,978	6,407,106
Supplies	31,159,433	35,364,005	36,955,716
Purchased Services	22,413,540	24,561,831	22,098,254
Depreciation	14,917,033	15,700,910	18,035,461
Interest and Amortization	11,568,255	12,156,669	10,066,183
Other Expenses	11,140,552	12,729,628	11,930,520
Total Operating Expenses	**175,382,396**	**194,827,507**	**203,777,918**
Net Operating Income	**33,039,511**	**64,440,464**	**79,375,379**
System Allocation	64,614,238	77,045,390	89,134,434
Non-Operating Gains (Losses)	-	-	-
Net Income	**(31,574,727)**	**(12,604,926)**	**(9,759,055)**
Net Operating Margin	***-15.1%***	***-4.9%***	***-3.4%***

Source: Swedish Issaquah

Exhibit 19
Swedish Issaquah Deeds

20090618000716
FIRST AMERICAN WD 50.00
PAGE001 OF 009
06/18/2009 13:28
KING COUNTY, WA

E2395425
06/18/2009 13:26
KING COUNTY, WA
TAX $396,907.57
SALE $22,297,897.00 PAGE001 OF 001

AFTER RECORDED RETURN TO:

FOSTER PEPPER PLLC
1111 Third Avenue Suite 3400
Seattle, WA 98101
Attention: Kelly Angell

SPECIAL WARRANTY DEED

1ST AM 393150

Unofficial Copy

Grantor(s):	GRAND-GLACIER LLC, a Washington limited liability company
Grantee(s):	SWEDISH HEALTH SERVICES, a Washington nonprofit corporation
Abbreviated Legal Description:	Blocks 29, 30, 33-35 Final Plat of Issaquah Highlands West 45, Vol. 235 of Plats, P. 15 through 22; and Block 31, BLA No. LLA 08-003IH, Vol. 241 of Surveys, P. 182-183, Rec No. 20080304900004
Additional legal description	See Exhibit A
Assessor's Tax Parcel Account Number(s):	363025-0050-02; 363025-0060-00; 363025-0070-08; 363025-0090-04; 363025-0100-02; 363025-0110-00
Related Documents	N/A

The Grantor, GRAND-GLACIER LLC, a Washington limited liability company, as successor through merger of Grand Ridge Partnership (Limited Partnership) and Glacier Ridge Partnership (Limited Partnership) dated July 1, 2003, for and in consideration of Ten Dollars ($10) and other good and valuable consideration in hand paid, grants, bargains, sells, conveys and confirms to SWEDISH HEALTH SERVICES, a Washington nonprofit corporation, the Grantee, the real estate described on Exhibit A attached hereto and incorporated herein by reference, situated in the County of King, State of Washington, (the "Property"), together with the related development rights to construct on the Property up to a total of 510,000 square feet of Allowable Development on the Property as defined and described in that certain Grand Ridge Annexation and Development Agreement dated June 19, 1996, a memorandum of which is recorded under King County Recording No. 9606251228, as amended and the related Amended and Restated Declaration of Retained and Assigned Rights dated May 10, 2005, and recorded under King County Recording No. 20050511000708 and any other related documents, all of which foregoing development on the Property shall be consistent with the

AFTER RECORDED RETURN TO:

FOSTER PEPPER PLLC
1111 Third Avenue Suite 3400
Seattle, WA 98101
Attention: Kelly Angell

20080310001688
FIRST AMERICAN WD 48.00
PAGE001 OF 007
03/10/2008 14:18
KING COUNTY, WA

E2336277
03/10/2008 14:16
KING COUNTY, WA
TAX $133,505.00
SALE $7,500,000.00 PAGE001 OF 001

SPECIAL WARRANTY DEED

1ST AM
327297

Grantor(s):	GRAND-GLACIER LLC, a Washington limited liability company
Grantee(s):	SWEDISH HEALTH SERVICES, a Washington nonprofit corporation
Abbreviated Legal Description:	Block 32 of City of Issaquah Boundary Line Adjustment No. LLA 08-003 IH, recorded in Vol. 241 of Surveys, Pages 182 through 183, records of King County, Washington under Auditor's File No. 20080304900004.
Additional legal description	See Exhibit A
Assessor's Tax Parcel Account Number(s):	363025-0080-06 and portion of 363025-0070-08
Related Documents	N/A

Unofficial Copy

The Grantor, GRAND-GLACIER LLC, a Washington limited liability company, for and in consideration of Ten Dollars ($10) and other good and valuable consideration in hand paid, grants, bargains, sells, conveys and confirms to SWEDISH HEALTH SERVICES, a Washington nonprofit corporation, the Grantee, the real estate described on Exhibit A attached hereto and incorporated herein by reference, situated in the County of King, State of Washington.

Grantor, for itself and for its successors in interest, does by these presents expressly limit the covenants of the deed to those herein expressed, and exclude all covenants arising or to arise by statutory or other implication, and do hereby covenant that against all persons whomsoever lawfully claiming or to claim by, through or under Grantor and not otherwise, will forever warrant and defend the said described real estate, subject to the exceptions set forth on Exhibit B attached hereto and incorporated herein by reference.

King County

NE Blakely Dr

3630250090

3205700000

751

510

3630250040

3630250080

3630250050

3630250070

3630250200

3630250190

3630250210

Highlands Dr NE

King County Assessor's Office, King County GIS Center, King County, King county Assessor's Office, King County GIS Center

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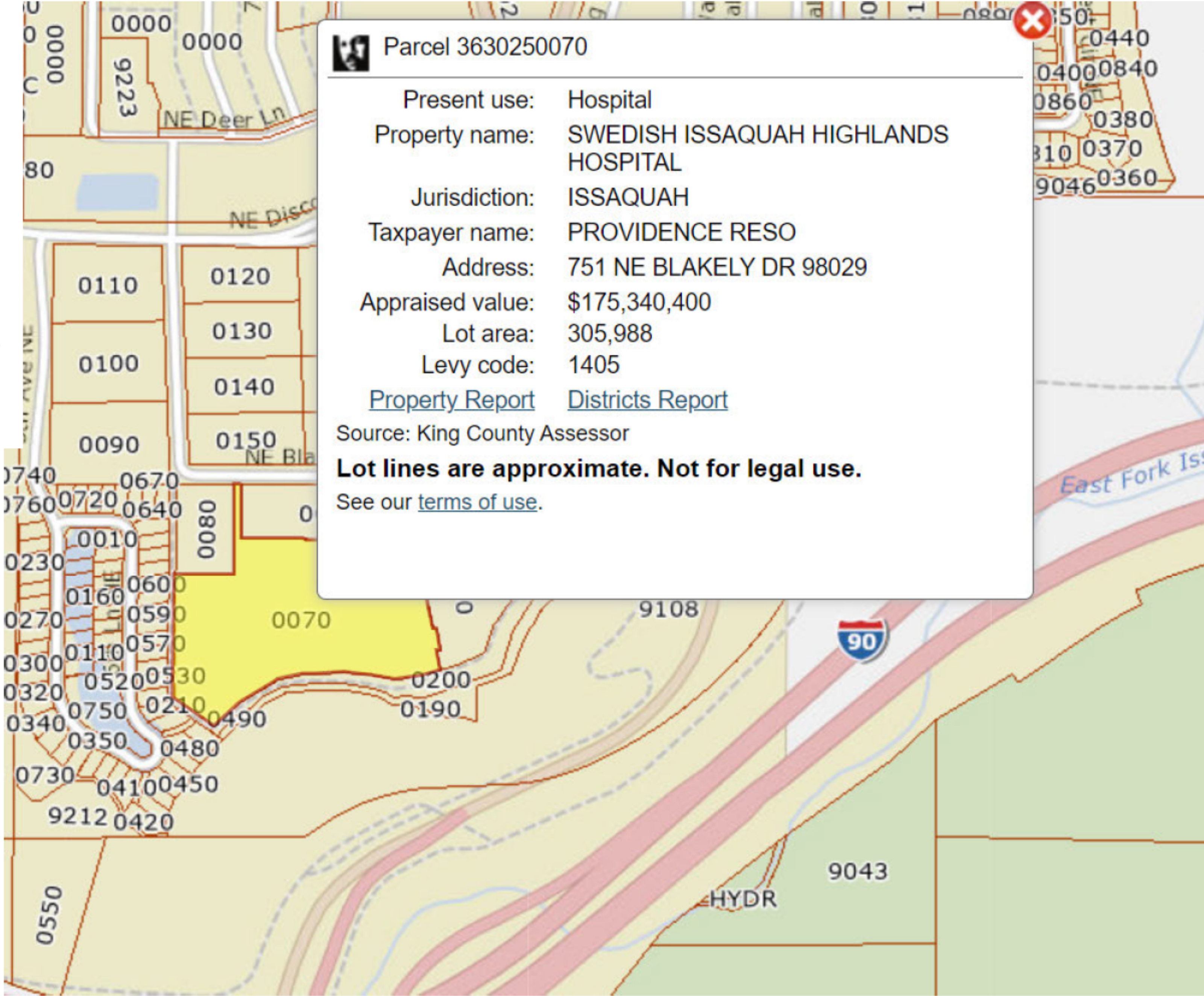
Date: 2/2/2023

Exhibit 20
Swedish Issaquah Hospital Zoning

Swedish Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

Swedish Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

Source (2/7/23):
https://kingcounty.gov/services/gis/Maps/parcel-viewer.aspx



Swedish Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

Source (2/7/23):
https://kingcounty.gov/services/gis/Maps/parcel-viewer.aspx

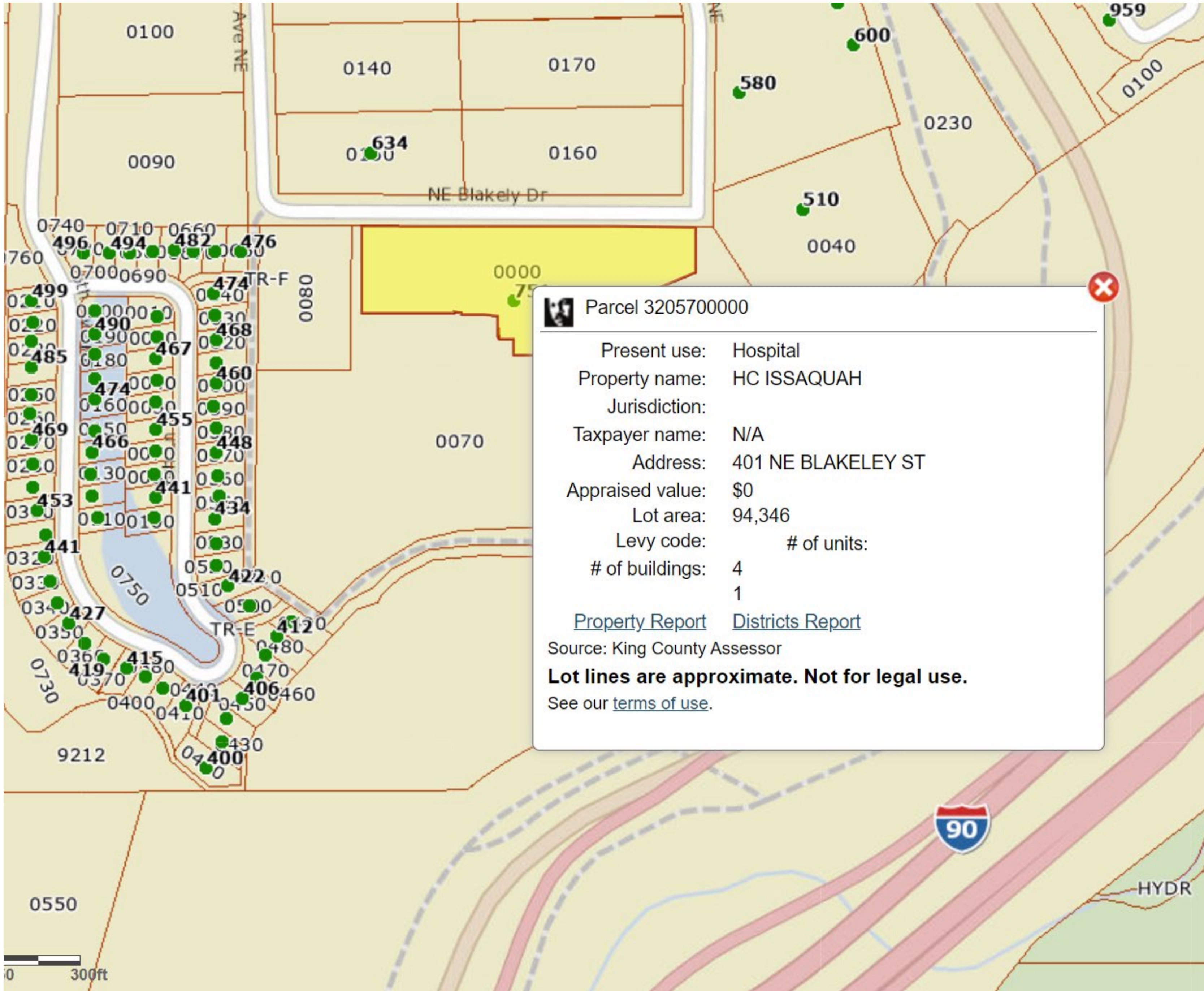


Exhibit 21
PSJH Audited Financials, 2021

CONTINUING DISCLOSURE ANNUAL REPORT

Information Concerning

PROVIDENCE ST. JOSEPH HEALTH AND THE OBLIGATED GROUP

The Continuing Disclosure Annual Report ("the Annual Report") is intended solely to provide certain limited financial and operating data in accordance with undertakings of Providence and the Members of the Obligated Group under Rule 15c2-12 ("the Undertaking") and does not constitute a reissuance of any Official Statement relating to the bonds referenced above or a supplement or amendment to such Official Statement.

The Annual Report contains certain financial and operating data for the fiscal year ended December 31, 2021. Providence has undertaken no responsibility to update such data since December 31, 2021, except as set forth herein. This Annual Report may be affected by actions taken or omitted or events occurring after the date hereof. Providence has not undertaken to determine, or to inform any person, whether any such actions are taken or omitted, or events do occur. Providence disclaims any obligation to update this Annual Report, or to file any reports or other information with repositories, or any other person except as specifically required by the Undertaking.

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About Providence

Our Organization

Providence St. Joseph Health ("Providence") is a national, not-for-profit Catholic health system comprising a diverse family of organizations driven by a belief that health is a human right. With 52 hospitals, over 900 clinics, and many other health and educational services, our health system employs nearly 120,000 caregivers serving patients in communities across seven Western states – Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. Our caregivers provide quality, compassionate care to all those we serve, regardless of coverage or ability to pay.

Continuing an enduring commitment to world-class care and serving all, especially those who are poor and vulnerable, Providence uses scale to create Health for a Better World, one community at a time. We have been pioneering health care for more than 160 years and have a history of responding with compassion and innovation during challenging health care environments, including the current pandemic. We are reimagining the future of health care delivery in our communities for all ages and populations. Our strategies to diversify and modernize are enabling high-quality care at affordable prices, including through networks of same-day clinics and online care and services.

We are privileged to serve in dynamic markets with growing populations, which has led to consistent increases in service utilization. We offer a comprehensive range of industry-leading services, including an integrated delivery system of acute and ambulatory care for inpatient and outpatient services, 29 long-term care facilities, 17 supportive housing facilities, over 8,000 directly employed providers and approximately 25,000 affiliated providers, a health plan, senior care, financial assistance programs, community health investments, and educational ministries that include a high school and university.

Providence maintains headquarters in Renton, Washington, and Irvine, California, and is governed by a sponsorship council comprised of members of its two sponsoring ministries, Providence Ministries and St. Joseph Health Ministry. We are dedicated to ensuring the continued vibrancy of not-for-profit, Catholic health care in the United States. As one of the largest health systems in the United States, our Mission and values call us to serve each person with love, dignity, and compassion, reflecting the legacy of the Sisters of Providence and the Sisters of St. Joseph.

The Mission

As expressions of God's healing love, witnessed
through the ministry of Jesus, we are steadfast in serving all,
especially those who are poor and vulnerable ®

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Our Vision

Health for a Better World

Our Promise

"*Know me, care for me, ease my way.*"

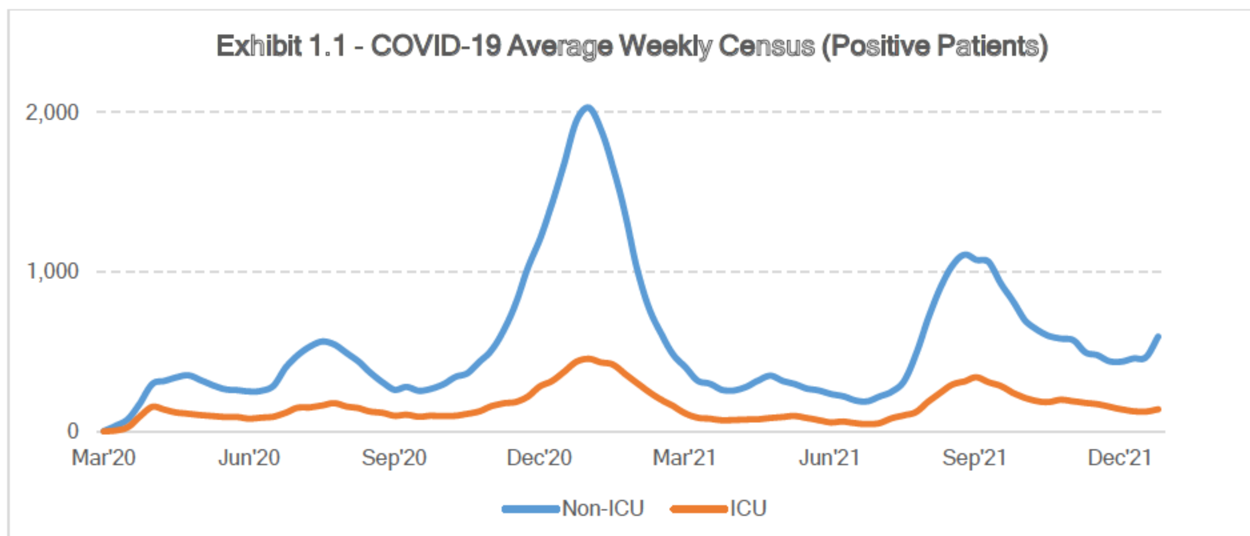
COVID-19: Providence Continues to Respond to Meet Community Needs

Providence continued to meet the health care needs of its communities in 2021. The second year of the pandemic brought additional surges with several Providence service areas hitting their highest COVID census to date. Providence was able to continue serving those in need across the family of organizations despite health care labor shortages. Providence has responded with investments in programs to retain caregivers, rapidly fill open positions, and support the mental health and well-being of caregivers.

Since Providence admitted the first known U.S. patient with COVID-19 in January 2020, the System has taken a number of key steps in response to COVID-19, which include:

- Investing $220 million into the workforce over several months to reward, retain and recruit top talent. Key components include recognition bonuses for caregivers; sign-on and referral bonuses to accelerate hiring; and increases in base pay for lower paid positions.
- Prioritizing caregiver mental health and well-being. In 2021, Providence launched new programs and resources to check in with every caregiver, quickly and confidentially to identify those in crisis and connect them to appropriate resources.
- Ensuring compliance with vaccination mandates to keep caregivers and patients safe. In its five states with COVID-19 vaccine mandates, Providence reported a compliance rate of 99 percent, meaning 99 percent of caregivers in those states received either the vaccine or a medical or religious exemption.
- Facilitating volunteer hours from both our clinical and administrative caregivers to support hospitals and vaccination sites in our communities. By summer 2021, Providence had administered over 900,000 doses of the vaccine to caregivers, patients, and members of the communities we serve.
- Promoting health equity in the prevention, testing and treatment of COVID-19 by proactively partnering with underserved communities. Results include 738 community-based or mobile testing and vaccine events; more than 41,000 tests, over 61,000 COVID-19 vaccines and approximately 164,000 kits with PPE and other resources provided to those at high risk and in disproportionately impacted communities.
- Accelerating telehealth services, which increased from an average of 50 visits a day to a peak of more than 12,000 per day. From April 2020 to December 2021, Providence provided 3.2 million telehealth visits.
- Expanding our electronic intensive care unit capabilities to remotely monitor patients on home quarantine.
- Leveraging technology to deliver a COVID-19 consumer awareness hub, a triage chatbot, urgent virtual visit platform, live testing locations, and remote patient monitoring for COVID-19 patients.

We continue to manage ongoing trends in COVID-19 cases while providing access to other comprehensive care in a safe manner for both caregivers and patients. The chart below shows Providence's average weekly COVID-19 positive patients through December 2021.



Providence has received relief in the form of grants and advance payments from the Coronavirus Aid Relief and Economic Security ("CARES") Act. We received $1.3 billion in total grants from the CARES Act,

including $228 million received during the fiscal year ended December 31, 2021. We have recognized substantially all of that amount as revenue, with $313 million being recorded during fiscal year 2021. In the second quarter of 2020, CMS distributed $1.6 billion of COVID-19 Accelerated and Advance Payments ("CAAPs") to Providence in response to the COVID-19 Public Health Emergency which would be repaid to CMS through the offsetting of future payments. A total of $621 million in CAAPs payments has been repaid in fiscal year 2021. The advance payments from CMS will continue to be offset from claim payments in future quarters.

The CARES Act delayed the timing of required federal employment tax deposits for certain employer social security taxes incurred from March 27, 2020, through December 31, 2020. The CARES Act treats these amounts as timely paid if 50 percent of the deferred amount is paid by December 31, 2021, and the remainder by December 31, 2022. Providence deferred $365 million in social security taxes incurred during the pandemic and $183 million of the balance was paid in December 2021. The remaining balance will be paid by December 2022.

We continue to take steps to preserve our operating performance and liquidity, including reassessing current and new capital projects outside of those focused on patient and caregiver safety and COVID-19. We have also reduced discretionary spending including travel, use of third-party contractors, purchased services, and professional services. As demand returns to pre-pandemic levels, we are flexing our labor and supply resources to allow us to efficiently and safely provide the services required by our patients.

Our Integrated Strategic & Financial Plan

Guided by our Mission, values, vision, and promise, Providence has developed and adopted an Integrated Strategic & Financial Plan that serves as our roadmap for accelerating progress toward our vision of Health for a Better World. Supported by three areas of strategic focus, our plan ensures integration between our strategic aspirations and financial capacity.

Strengthen the core. We are focused on delivering outstanding, affordable health care, housing, education and other essential services to our patients and communities by:

- Creating a diverse workforce reflecting the communities we serve and a caregiver experience where all caregivers are included, developed, and inspired to carry on the Mission
- Delivering safe, compassionate, high-value quality health care
- Being the provider partner of choice in all our communities
- Stewarding our resources to improve operational earnings
- Fostering community commitment to our Mission via philanthropy

Be our communities' health partner. We are focused on being our communities' health partner, working to achieve the physical, spiritual, and emotional well-being of all. We seek to ease the way of our communities by:

- Transforming care, improving population health outcomes, and reducing health disparities, especially for poor and vulnerable populations
- Leading the way in improving our nation's mental and emotional well-being
- Extending our commitment to whole person care for people at every age and stage of life
- Engaging with partners in ensuring health equity for all by addressing systemic racism and the social determinants of health, with a focus on education, housing, and the environment
- Being the preferred health partner for those we serve

Transform our future. We are focused on responding to the evolving needs of the communities we serve, pursuing new opportunities that transform our services. We seek to expand and sustain our Mission by:

- Diversifying sources of earnings to ensure sustainability of the ministry
- Digitally enabling, simplifying, and personalizing the health experience
- Creating an integrated scientific wellness, clinical research and genomics program that is nationally recognized for breakthrough advances
- Utilizing insights and value from data to drive strategic transformation
- Activating the voice and presence of Providence locally and nationally to improve health for all

Strategic affiliations. As part of our overall strategic planning and development process, Providence regularly evaluates and, if deemed beneficial, selectively pursues opportunities to affiliate with other service providers and invest in new facilities, programs, or other health care related entities. Providence also routinely assesses existing partnerships and arrangements with third parties and adjusts as appropriate to best meet community needs. Likewise, we are frequently presented with opportunities from, and conduct discussions with, third parties regarding potential affiliations, partnerships, mergers, acquisitions, joint operating arrangements, or other forms of collaboration, including some that could affect the Obligated Group Members. It is common for several such discussions to be in process concurrently. Providence's management pursues arrangements when there is a perceived strategic or operational benefit that is expected to enhance our ability to achieve the Mission and/or deliver on our strategic objectives. As a result, it is possible that the current organization and assets of the Obligated Group may change.

Providence will continue to evaluate opportunities for strategic growth. Providence does not typically disclose such discussions unless and until it appears likely that an agreement will be reached, and any required regulatory approvals will be forthcoming.

Region Information

Aligning our Puget Sound strategies and operations. In the fourth quarter of 2021, Providence realigned its service areas into the Puget Sound region to fully coordinate our operations in the western part of Washington State. With this contiguous market growth and operational alignment strategy, our ministries and facilities will be better positioned to meet the health needs of this region and connect our communities through seamless access to care.

Providence is organized into the geographic regions spanning seven states across the western United States shown in the graphic below.

Exhibit 1.2 - Areas We Serve

Providence's operating revenue share by geographic region is presented for the fiscal years ended December 31:

	Fiscal Year Ended	
EXHIBIT 1.3 - REGIONAL OPERATING REVENUE SHARE	12-31-2020	12-31-2021
Alaska	3.5%	3.7%
Puget Sound Region (1)	17.1%	17.2%
Washington and Montana (1)	12.8%	12.8%
Oregon	19.1%	18.1%
Northern California (2)	5.9%	5.8%
Southern California (2)	31.7%	31.2%
West Texas and Eastern New Mexico	4.6%	4.7%
Other (including Home & Community Care) (1), (3)	5.3%	6.5%

(1) Includes 2020 restatement to align the new Puget Sound Region created in the fourth quarter of 2021.
(2) Includes recognition of revenue from California provider fee program of $517 million in 2021 and $754 million in 2020.
(3) Increase driven primarily by diversified revenue growth of 71 percent among Tegria entities compared to the prior year.

Alaska

The Alaska region includes five hospitals and 23 clinics with a 30 percent inpatient market share statewide in 2020, as reported by the Alaska Health Facilities Data Reporting Program. The Alaska facilities are located in the greater Anchorage area, with 50 percent inpatient market share, as reported by the Alaska Health Facilities Data Reporting Program. The Alaska region also has facilities located in the remote communities of Kodiak, Seward, and Valdez. Providence Alaska Medical Center is an acute care facility located in Anchorage and the only comprehensive tertiary referral center in the state. St. Elias Specialty Hospital, a long-term acute care hospital (the only one in the state) is also located in the Anchorage area. Three critical access hospitals are in Kodiak, Seward, and Valdez, all co-located with skilled nursing facilities.

Puget Sound Region

The Puget Sound region includes Northwest Washington, Southwest Washington, and Swedish with a total inpatient market share of 28 percent in their service areas in 2020, as reported by the Comprehensive Hospital Abstract Reporting System. In the greater Puget Sound area of Washington, Swedish Health Services operates five hospital campuses: First Hill, Cherry Hill, Ballard, Edmonds, and Issaquah, which are in King and Snohomish counties. Swedish also has ambulatory care centers in Redmond and Mill Creek, and a network of more than 100 primary care and specialty clinics throughout the Seattle area. The Puget Sound region's realignment noted above includes Providence Regional Medical Center in Everett, Providence St. Peter Hospital in Olympia, and Providence Centralia Hospital, all previously included under the Washington and Montana region.

Washington and Montana

The Washington-Montana region includes 9 hospitals, with a 42 percent inpatient market share in their service areas in 2020, as reported by the Comprehensive Hospital Abstract Reporting System. The region is composed of two geographic markets: Eastern Washington and Western Montana. The region provides a variety of services, including home health and hospice care, primary and immediate care services, inpatient rehabilitation, skilled nursing and transitional care, and general acute care services.

Oregon

The Oregon region includes eight hospitals in Portland, Hood River, Medford, Milwaukie, Newberg, Seaside and Oregon City, with a total inpatient market share of 29 percent in their service areas in 2020, as reported by Apprise Health Insights. Providence St. Vincent Medical Center and Providence Portland Medical Center provide tertiary care to the Portland metropolitan market. The region also provides nearly 200 primary care, specialty and immediate care clinics, home health care, and housing. The Health Plans are based in Oregon, and the majority of its nearly 670,000 members live in the region.

Northern California

The Northern California region includes six hospitals in the North Coast, Humboldt, Napa, and Sonoma communities with a total inpatient market share of 38 percent in their service areas in 2020, as reported by the Office of Statewide Health Planning and Development. The acute care hospitals in Northern California include Queen of the Valley Medical Center in Napa, Santa Rosa Memorial Hospital, Petaluma Valley Hospital, Providence St. Joseph Hospital in Eureka, Providence Redwood Memorial Hospital in Fortuna, and Healdsburg Hospital. Providence Medical Foundation operates clinics in the region with its contracted physician partners. In January 2021, Providence acquired Healdsburg District Hospital, an acute care facility serving Healdsburg and surrounding areas in Sonoma County.

Southern California

The Southern California region includes 13 acute care hospitals in Los Angeles, Orange, and San Bernardino counties, with a total inpatient market share of 24 percent in their service areas in 2020, as reported by the Office of Statewide Health Planning and Development. In Los Angeles County, Providence includes six acute care facilities. Our largest hospital, Providence St. Joseph Medical Center, is in Burbank, with additional hospitals in Mission Hills, San Pedro, Torrance, and Santa Monica. Providence Medical Foundation operates over 50 practice locations in the market, including the Facey, PMI, and Providence St. John's medical

foundations. In addition, Providence has seven acute care facilities within Orange and San Bernardino counties: Apple Valley, Fullerton, Mission Viejo, Laguna Beach, Newport Beach, Irvine, and Orange. Mission Hospital is located on two campuses in Mission Viejo and Laguna Beach, and maintains the region's level II trauma center, as well as a women's center. Hoag Hospital, which also is composed of two campuses, in Newport Beach and Irvine, also includes Hoag Orthopedic Institute.

In June 2021, Providence announced that Providence St. Mary Medical Center and Kaiser Permanente plan to open a new hospital facility with 260 beds in Victorville to replace the existing Providence St. Mary Medical Center facility, with an anticipated opening date of 2027 for the new facility. Providence St. Mary Medical Center and Kaiser Permanente will enter into a Joint Venture for the ownership and operation of the new hospital facility once opened. The existing Providence St. Mary Medical Center facility will permanently close once the new facility is operational. This project is currently pending regulatory approvals in the state of California.

In January 2022, officials from Providence and Hoag announced an agreement to end the affiliation established in 2012 by January 31, 2022. The two organizations have agreed to disaffiliate, with Hoag becoming independent from Providence and Covenant Health Network, the structure that governs the affiliation. Excluding Hoag, the Southern California region had a total inpatient market share of 19 percent in their service areas in 2020. Refer to the Litigation section below for additional details.

West Texas and Eastern New Mexico

The West Texas-Eastern New Mexico region includes Covenant Health System and Covenant Medical Group. Covenant Health System and its related Texas affiliates are the market's largest health system with seven licensed hospitals. The inpatient market share was 40 percent in their service areas in 2020, as reported by Texas Health Care Information Collection. Covenant Health System operates Covenant Medical Center, Covenant Children's Hospital, Covenant Health Plainview, and Covenant Health Levelland, and Covenant Specialty Hospital, a long-term acute care facility, in addition to Grace Health System, which includes Grace Clinic and Grace Surgical Hospital. CHS also operates Covenant Medical Group, a medical foundation physician network of employed and aligned physicians, a joint venture acute rehabilitation facility, and Hospice of Lubbock. In January 2021, Covenant Health System acquired Lea Regional Medical Center an acute care facility located in eastern New Mexico serving Hobbs and the surrounding area. Subsequent to the acquisition, the hospital was renamed Hobbs Hospital.

Financial Information

The summary audited combined financial information as of and for the fiscal years ended December 31, 2021, and 2020, respectively, are presented below. The financial information should be read in conjunction with the audited combined financial statements of the System, including the notes thereto, and the report of KPMG LLP, independent auditors.

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make assumptions, estimates and judgments that affect the amounts reported in the combined financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any. System management considers critical accounting policies to be those that require the more significant judgments and estimates in the preparation of its combined financial statements, including the following: recognition of net patient service revenues, which includes contractual allowances; impairment of long-lived assets; valuation of investments; and reserves for losses and expenses related to health care professional and general liability risks. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Actual results could differ materially from those estimates.

Summary Audited Combined Statements of Operations

	Fiscal Year Ended	
EXHIBIT 2.1 - COMBINED STATEMENTS OF OPERATIONS $ PRESENTED IN MILLIONS	12-31-2020	12-31-2021
Net Patient Service Revenues	$18,964	$20,908
Premium Revenues	2,424	2,320
Capitation Revenues	1,732	1,870
Other Revenues	2,555	2,230
Total Operating Revenues	**25,675**	**27,328**
Salaries and Benefits	12,646	13,966
Supplies	3,821	4,168
Purchased Healthcare Services	1,989	2,129
Interest, Depreciation, and Amortization	1,375	1,406
Purchased Services, Professional Fees, and Other	6,150	6,373
Total Operating Expenses	**25,981**	**28,042**
Deficit of Revenues Over Expenses from Operations	**(306)**	**(714)**
Total Net Non-Operating Gains	1,046	1,232
Excess of Revenues Over Expenses	**$740**	**$518**
Operating EBIDA [1]	**$1,121**	**$812**

[1] Excludes $120 million in 2021 and $53 million in 2020 in amortization of software as a service asset.

Summary Audited Combined Balance Sheets

EXHIBIT 2.2 - COMBINED BALANCE SHEET $ PRESENTED IN MILLIONS	As of 12-31-2020	12-31-2021
Current Assets:		
Cash and Cash Equivalents [1]	$3,230	$1,143
Short-Term Investments [1], [2]	1,082	1,322
Accounts Receivable, Net	2,365	3,158
Supplies Inventory	361	402
Other Current Assets	1,480	1,649
Current Portion of Assets Whose Use is Limited	146	169
Total Current Assets	**8,664**	**7,843**
Management Designated Cash and Investments [1], [2]	10,950	11,629
Assets Whose Use is Limited	556	661
Property, Plant & Equipment, Net	11,033	11,329
Other Assets	3,451	3,413
Total Assets	**$34,654**	**$34,875**
Current Liabilities:		
Current Portion of Long-Term Debt	127	81
Master Trust Debt Classified as Short-Term	934	189
Accounts Payable	1,155	1,432
Accrued Compensation	1,453	1,627
Other Current Liabilities [2]	3,020	3,253
Total Current Liabilities	**6,689**	**6,582**
Long-Term Debt, Net of Current Portion	6,061	6,834
Pension Benefit Obligation	1,203	977
Other Liabilities [2]	3,985	2,810
Total Liabilities	**$17,938**	**$17,203**
Net Assets:		
Controlling Interests	14,857	15,507
Noncontrolling Interests	309	404
Net Assets without Donor Restrictions	15,166	15,911
Net Assets with Donor Restrictions	1,550	1,761
Total Net Assets	**16,716**	**17,672**
Total Liabilities and Net Assets	**$34,654**	**$34,875**

(1) Unrestricted Cash and Investments were $14.1 billion in 2021 and $15.3 billion in 2020.

(2) Includes $1.6 billion from the Centers for Medicare & Medicaid Services ("CMS") Advanced Payment Program in 2020 of which $621 million was repaid as of December 31, 2021.

Management's Discussion and Analysis: Fiscal Year Ended December 31, 2021

Management's discussion and analysis provides additional narrative explanation of Providence's financial condition, operational results, and cash flow to assist in increasing understanding of the combined financial statements. The summary audited combined financial information as of and for the fiscal years ended December 31, 2021, and 2020, respectively, are presented below.

Results of Operations

Operations Summary

Operating earnings before interest, depreciation, and amortization ("EBIDA") were $812 million for the fiscal year ended December 31, 2021, or 3.0 percent of operating revenues, compared with $1.1 billion and 4.4 percent in the same period in 2020. The deficit of revenues over expenses from operations was $714 million for the fiscal year ended December 31, 2021, compared with deficit of revenues over expenses from operations of $306 million in the same period in 2020. The increase in the current year deficit was primarily driven by lower CARES Act funding recognized of $313 million in 2021, compared with $957 million in the prior year, amid ongoing COVID-19 surges across our markets.

Operating results for the fiscal year ended December 31, 2021 continued to be impacted by COVID-19 surges throughout the year, due to the Alpha, Delta, and Omicron variants, which peaked in the first and third quarters for Alpha and Delta, and began to rapidly increase in the fourth quarter for Omicron. Despite the continued impact from COVID-19, the System saw an overall increase in volumes as compared to the prior year which included several periods of volume disruptions including the deferral of non-emergent procedures in the first and second quarters of 2020. As a result, net patient service revenues increased 10 percent in the fiscal year ended December 31, 2021, compared with the same period in 2020. The increase came primarily from higher outpatient volumes and emergency room visits. Along with the increase in volumes, the System saw an overall increase in the acuity of the patients as demonstrated in the 7 percent increase in case mix adjusted admissions ("CMAA") over the prior year. Payor mix remained relatively flat versus the prior year. The increased volumes and acuity, coupled with the labor shortages experienced system-wide, resulted in higher labor costs and increased usage of agency staffing and overtime. In response to the labor shortages, Providence initiated payroll incentives to improve retention, particularly among our frontline caregivers.

The results include the net recognition of reimbursements from state provider fee programs of $239 million (revenue of $863 million and expense of $624 million) for the fiscal year ended December 31, 2021, compared with $329 million (revenue of $1.1 billion and expense of $753 million) in comparable period of the prior year. The current year amount is based on ratable recognition of provider fee programs versus the prior year amount which included $93 million related to prior reporting periods.

As noted above, the disaffiliation with Hoag will include the following impacts to Providence's system consolidated results. Hoag represented 7 percent of Providence's audited total operating revenues for fiscal year ended December 31, 2021. Hoag's operating EBIDA was $303 million for the fiscal year ended December 31, 2021. Hoag accounted for 17 percent of Providence's unrestricted cash and investment, net of debt financing relating to Hoag assets, as of December 31, 2021. The underlying Hoag debt and finance lease obligations also accounted for 8 percent, or $573 million of total system debt. Hoag's net assets were 22 percent of system net assets as of December 31, 2021. Refer to the Litigation section below for additional details.

Providence's key financial indicators are presented for the fiscal years ended December 31:

EXHIBIT 3.1 - OPERATIONS SUMMARY $ PRESENTED IN MILLIONS	Fiscal Year Ended 12-31-2020	 12-31-2021
Operating Revenues	$25,675	$27,328
Operating Expenses	25,981	28,042
Deficit of Revenues Over Expenses from Operations	(306)	(714)
Operating Margin %	(1.2)	(2.6)
Operating EBIDA	1,121	812
Operating EBIDA Margin %	4.4	3.0
Premium and Capitation Revenues	4,156	4,190
CARES Act Grants Recognized	957	313
Net Service Revenue/Case Mix Adjusted Admits	12,922	13,069
Net Expense/Case Mix Adjusted Admits	13,110	13,476
Total Community Benefit	$1,750	$1,881
Full-Time Equivalents ("FTEs") (thousands)	103	105

For the three months ended December 31, 2021, operating EBIDA was $88 million, or 1.2 percent of operating revenues, compared with $304 million and 4.5 percent in the same period in 2020. Deficit of revenues over expenses from operations was $309 million for the three months ended December 31, 2021, compared with deficit of revenues over expenses from operations of $93 million in the same period in 2020, and includes $142 million from the CARES Act recognized, compared with $275 million in the prior year. During the three months ended December 31, 2021, we continued to see staffing shortages leading to increased usage of agency staffing and overtime, and in some ministries, the staffing shortages required us to defer surgeries and other procedures.

Volumes increased 6 percent for the three months ended December 31, 2021, compared with the same period in 2020. The System experienced significant increases across our key volume indicators as emergency room visits increased 15 percent, acute admissions increased 5 percent, and outpatient visits increased 4 percent compared with the same period in 2020. Operating revenues were $7.1 billion, an increase of 4 percent for the three months ended December 31, 2021, compared with the same period in 2020, driven by net patient service revenues growth of 8 percent. The increase in volumes led to an 11 percent increase in salaries and benefits due to continued wage pressures and retention efforts, greater usage of agency staffing and increased overtime. Supplies expense increased by 3 percent, both compared with the prior year, driven by a 7 percent increase in pharmaceutical spend and a 2 percent increase in medical supply expense.

Providence's key financial indicators are presented for the periods indicated:

EXHIBIT 3.2 - OPERATIONS SUMMARY $ PRESENTED IN MILLIONS	Three Months Ended 12-31-2020	 12-31-2021
Operating Revenues	$6,825	$7,128
Operating Expenses	6,918	7,437
Deficit of Revenues Over Expenses from Operations	(93)	(309)
Operating Margin %	(1.4)	(4.3)
Operating EBIDA	304	88
Operating EBIDA Margin %	4.5	1.2
Premium and Capitation Revenues	1,086	1,063
CARES Act Grants Recognized	275	142

Volumes

The System experienced an increase in both volumes and the acuity of the patients served, which yielded a 7 percent increase in CMAA for the fiscal year ended December 31, 2021, compared with the same period in 2020. Volumes increases were driven by higher outpatient and admission volumes and increases in emergency room visits compared with the prior year.

Providence's key volume indicators are presented for the fiscal years ended December 31:

EXHIBIT 3.3 - SYSTEM UTILIZATION DATA PRESENTED IN THOUSANDS UNLESS NOTED	Fiscal Year Ended 12-31-2020	 12-31-2021
Inpatient Admissions	447	458
Acute Adjusted Admissions	913	967
Acute Patient Days	2,340	2,532
Long-Term Care Patient Days	340	317
Outpatient Visits (incl. Physicians)	23,472	26,040
Virtual Visits (incl. Telehealth)	1,654	1,578
Emergency Room Visits	1,720	1,874
Surgeries and Procedures	589	674
Acute Average Daily Census (Actual)	6,393	6,936
Providence Health Plan Members	699	668

Operating Revenues

Operating revenues increased 6 percent to $27.3 billion, for the fiscal year ended December 31, 2021, compared with $25.7 billion in the prior year. The increases were driven by net patient service revenues growth of 10 percent, and growth in our diversified revenues of 45 percent. Net patient service revenues were $20.9 billion for the fiscal year ended December 31, 2021, compared to $19.0 billion in 2020, driven by higher patient volumes.

Providence's operating revenues by state are presented for the fiscal years ended December 31 (footnotes appear beneath last table):

EXHIBIT 3.4 - OPERATING REVENUES BY STATE $ PRESENTED IN MILLIONS	Fiscal Year Ended 12-31-2020	 12-31-2021
Alaska	$830	$912
Washington	6,543	7,358
Montana	427	475
Oregon	5,137	5,344
California	9,151	9,855
Texas	1,032	1,154
Total Revenues from Contracts with Customers	23,120	25,098
Other Revenues	2,555	2,230
Total Operating Revenues	$25,675	$27,328

Providence's operating revenues by line of business are presented for the fiscal years ended December 31:

EXHIBIT 3.5 - OPERATING REVENUES BY LINE OF BUSINESS $ PRESENTED IN MILLIONS	Fiscal Year Ended 12-31-2020	 12-31-2021
Hospitals	$16,145	$17,614
Health Plans and Accountable Care	2,739	2,580
Physician and Outpatient Activities	2,728	3,234
Long-term Care, Home Care, and Hospice	1,268	1,315
Other Services	240	355
Total Revenues from Contracts with Customers	23,120	25,098
Other Revenues	2,555	2,230
Total Operating Revenues	$25,675	$27,328

Providence's operating revenues by payor are presented for the fiscal years ended December 31:

EXHIBIT 3.6 - OPERATING REVENUES BY PAYOR (1) $ PRESENTED IN MILLIONS	Fiscal Year Ended 12-31-2020	 12-31-2021
Commercial	$11,331	$12,350
Medicare	8,021	8,722
Medicaid	3,517	3,645
Self-pay and Other	251	381
Total Revenues from Contracts with Customers	23,120	25,098
Other Revenues	2,555	2,230
Total Operating Revenues	$25,675	$27,328

(1) Refer to Exhibit 7.3 for supplementary information on net patient service revenue payor mix driven by patient utilization.

Operating Expenses

Operating expenses were $28.0 billion, an increase of 8 percent for the fiscal year ended December 31, 2021, compared with the same period in 2020. The increase was driven by costs to serve increased volumes of patients, including labor costs and increased PPE, and pharmaceutical spend. Overall, salaries and benefits expenses increased 10 percent for the fiscal year ended December 31, 2021, compared with the same period in 2020, due to increased agency spend, overtime, and wages, including actions taken by the System to improve retention. Despite these increases, labor productivity increased by 9 percent on an adjusted occupied bed volumes basis compared to the same period in 2020, due to the higher volumes and the continued labor shortages experienced across the System. Medical supply costs per CMAA were higher by 2 percent, compared with the prior year. Supplies expense increased by 9 percent compared to the prior year, driven by an 11 percent increase in pharmaceutical spend and a 10 percent increase in medical supply expense.

Non-Operating Activity

Non-operating gains, driven by investment portfolio performance, totaled $1.2 billion for the fiscal year ended December 31, 2021, compared with non-operating gains of $1.0 billion for the same period in 2020.

Liquidity and Capital Resources; Outstanding Indebtedness

Unrestricted Cash and Investments

Unrestricted cash and investments totaled approximately $14.1 billion as of December 31, 2021, compared to $15.3 billion as of December 31, 2020, driven by the overall impacts of the pandemic, offset by investment performance. The System also experienced an increase in accounts receivable of $793 million due primarily to protracted payment cycles from payers, in addition to delayed claims billing from electronic health record implementations in our California markets. The System repaid $250 million on a one-year bridge loan that matured in March 2021. Further impacting cash was $621 million of prepayments from 2020 that were recouped by CMS, through lower payments on current services being provided in the fiscal year ended December 31, 2021. The above were offset by $228 million in grants received from the CARES Act in the fiscal year ended December 31, 2021.

In July 2021, Providence placed a $1.25 billion syndicated revolving credit facility (eight participating banks) with a 2026 maturity, replacing the $550 million credit facility that was scheduled to mature September 2021. At December 31, 2021, $205 million was drawn on the new facility.

In the fourth quarter of 2021, Providence completed the Series 2021 Plan of Finance that included the issuance of $1.1 billion of Series 2021A, 2021B, and 2021C revenue bonds and direct obligation notes, $742 million of which was used to refinance prior debt obligations. The intended uses of funds included refinancing master trust debt and repayment of outstanding lines of credit.

Providence's liquidity is presented for the fiscal years ended December 31:

EXHIBIT 4.1 - INVESTMENTS BY DURATION $ PRESENTED IN MILLIONS	As of 12-31-2020	12-31-2021
Cash and Cash Equivalents [(1)]	$3,230	$1,143
Short-Term Investments	1,082	1,322
Long-Term Investments	10,950	11,629
Total Unrestricted Cash and Investments	$15,262	$14,094

(1) Includes $1.6 billion from the CMS Advanced Payment Program in 2020, of which $1.0 billion remains outstanding as of December 31, 2021.

Providence maintains a long-term investment portfolio comprised of operating and foundation investment assets. Providence's target asset allocation for the long-term portfolio, by general asset class, is presented for the fiscal years ended December 31:

EXHIBIT 4.2 - INVESTMENTS BY TYPE	As of 12-31-2020	12-31-2021
Cash and Cash Equivalents	2%	0%
Domestic and International Equities	45%	45%
Debt Securities	38%	40%
Other Securities	15%	15%

Financial Ratios

Providence's financial ratios presented for the fiscal years ended December 31:

EXHIBIT 4.3 - SUMMARY OF KEY RATIOS	As of 12-31-2020	12-31-2021
Total Debt to Capitalization %	31.6	30.6
Cash to Debt Ratio %	218.2	200.7
Days Cash on Hand [(1)]	226	191
Maximum Annual Debt Service	395	414
Cash to Net Assets Ratio	1.01	0.89

(1) Days Cash on Hand, a measure of cash in relation to monthly operating expenses, is calculated as follows: (unrestricted cash & investments) / (total operating expenses - depreciation and amortization expenses)/days outstanding during the periods)

System Capitalization

Providence's capitalization is presented for the fiscal years ended December 31:

EXHIBIT 4.4 - SYSTEM CAPITALIZATION $ PRESENTED IN MILLIONS UNLESS NOTED	As of 12-31-2020	12-31-2021
Long-Term Indebtedness	$6,188	$6,915
Less: Current Portion of Long-Term Debt	127	81
Net Long-Term Debt	6,061	6,834
Net Assets - Without Donor Restrictions	15,166	15,911
Total Capitalization	$21,227	$22,745
Long-Term Debt to Capitalization %	28.6	30.0

System Debt Service Coverage

Providence's coverage of Maximum Annual Debt Service ("MADS") on indebtedness is presented for the fiscal years ended December 31:

EXHIBIT 4.5 - SYSTEM DEBT SERVICE COVERAGE $ PRESENTED IN MILLIONS UNLESS NOTED	As of 12-31-2020	12-31-2021
Income Available for Debt Service:		
Excess of Revenues Over Expenses	$740	$518
Less: Unrealized (Gains) on Trading Securities	(692)	(601)
Plus: Loss on Extinguishment of Debt	-	3
Plus: Loss on Pension Settlement Costs and Other	19	19
Plus: Depreciation	1,097	1,094
Plus: Interest and Amortization	278	312
Total	$1,442	$1,345
Debt Service Requirements: (1)		
MADS	$395	$414
Coverage of Debt Service Requirements (1)	3.7x	3.2x

(1) Debt Service Requirements has the meaning assigned to such term in the Master Indenture.

System Governance and Management

Corporate Governance

Providence serves as the parent and corporate member of PH&S and SJHS. Providence was created in connection with the combination of the multi-state health care systems of PH&S and the SJHS, which was effective on July 1, 2016 (the "Combination"). Providence has been determined to be an organization that is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. Prior to the Combination, the sole corporate member of PH&S was Providence Ministries, which acted through its sponsors, who are five individuals appointed by the Provincial Superior of the Sisters of Providence, Mother Joseph Province. Similarly, the sole corporate member of SJHS was St. Joseph Health Ministry, a California non-profit public benefit corporation. Providence Ministries and St. Joseph Health Ministry are each a public juridic person under Canon law, responsible for assuring the Catholic identity and fidelity to the Mission of their respective systems. Pursuant to the Combination, Providence Ministries and St. Joseph Health Ministry have entered into an agreement that establishes a sponsorship model through contractual obligations exercised by the parties' sponsors collectively (the "Sponsors Council"). The Sponsors Council retains certain reserved rights with respect to Providence. Among the powers reserved to the Sponsors Council are the following powers over the affairs of Providence (excluding certain affiliates, such as: Providence - Western Washington, Western HealthConnect, Swedish, Swedish Edmonds, PacMed, Kadlec, and Hoag Hospital): to amend or repeal the articles of incorporation or bylaws of Providence; the appointment and removal, with or without cause, of the directors of Providence; the appointment and removal, with or without cause, of the President and Chief Executive Officer of Providence; the approval of the acquisition of assets, incurrence of debt, encumbering of assets and sale of certain property; the approval of operating and capital budgets, upon recommendation of the Providence Board of Directors; and the approval of dissolution, consolidation or merger. Providence has reserved rights over PH&S and SJHS, which powers may be exercised by the Board of Providence. Given the complexity of Providence's governance structure, Providence routinely evaluates and considers alternative governance models to best meet Providence's governance needs.

The following table lists the current members of the Board of Directors of Providence and the Sponsors Council.

Board of Directors	Term Expires (December 31)	Sponsors Council	Term Expires (December 31)
Mary Lyons, PhD., Chair ‡	2022	Ned Dolejsi	2022
Richard Blair †	2022	Jeff Flocken	2025
Isiaah Crawford, PhD. ‡	2022	Barbara Savage	2022
Sr. Diane Hejna, CSJ, RN. ‡	2022	Bill Cox	2022
Sr. Phyllis Hughes, RSM, PhD. ‡	2022	Russell Danielson	2027
Charles W. Sorenson, M.D. ‡	2024	Sr. Sharon Becker, CSJ	2027
Michael Murphy Δ	2022	Mark Koenig	2027
Sr. Carol Pacini, LCM Δ	2023	Sr. Margaret Pastro, SP	2028
Christina Fisher Δ	2025	Sr. Mary Therese Sweeney, CSJ	2028
Eric Sprunk Δ	2025	Sr. Cecilia Magladry, CSJ	2025
Rod Hochman, M.D.	Ex-officio		

† Not eligible for an additional term.
‡ Eligible for one additional three-year term.
Δ Eligible for up to two additional terms.

Executive Leadership Team

The following are key members of Providence's executive leadership team.

Name	Title
Rod Hochman, M.D.	President and CEO
Greg Hoffman	Executive Vice President and CFO
John Whipple	Senior Vice President and Interim Chief Legal Officer

Support Services

The leadership structure operates under six councils that work collaboratively to achieve a streamlined set of strategic priorities across Providence and its family of organizations. Chartered by the Executive Leadership Committee, the councils are inclusive of the regions, lines of business, and other key functional areas. Corporate officers and supporting staff oversee the management activities performed on a day-to-day basis by the management staff of each region. The Chief Financial Officer of Providence and Finance staff oversee the annual budget and multi-year planning activities of the organization, including capital allocation. Other areas in which the corporate staff provides centralized services or coordinates the activities of the service areas include legal affairs, insurance and risk management, treasury services, real estate strategy and operations, marketing, supplies management, technical support, fund-raising, quality of care, medical ethics, pastoral services, mission effectiveness, human resources, planning and policy development, and public affairs.

Obligated Group

Providence and the other entities so designated in the Glossary are currently Obligated Group Members under the Master Indenture.

For the fiscal year ended December 31, 2021, the audited combined operating revenues, and total assets attributable to the Obligated Group Members were approximately 81 percent and 82 percent, respectively, of Providence's totals. For the fiscal year ended December 31, 2020, the audited combined operating revenues, and total assets attributable to the Obligated Group Members were approximately 81 percent and 83 percent, respectively, of Providence's totals. Refer to Exhibit 7 for supplementary information on the Obligated Group Members.

Providence is the Obligated Group Agent under the Master Indenture. Under the Master Indenture, debt incurred or secured through the issuance of Obligations under the Master Indenture are the responsibility, jointly and severally, of the Obligated Group Members. Pursuant to the Master Indenture, Obligated Group Members may be added to and withdrawn from the Obligated Group under certain conditions described in the Master Indenture. Indebtedness evidenced or secured by obligations issued under the Master Indenture is solely the obligation of the Obligated Group, and such obligations are not guaranteed by, or the liabilities of, Sisters of

Providence, Mother Joseph Province, any other Province of the Sisters of Providence, Sisters of St. Joseph of Orange, the Roman Catholic Church, or any affiliate of Providence that is not an Obligated Group Member.

Obligated Group Utilization

The Obligated Group's key volume indicators are presented for the fiscal years ended December 31:

EXHIBIT 5.1 - OBLIGATED GROUP UTILIZATION DATA PRESENTED IN THOUSANDS UNLESS NOTED	Fiscal Year Ended 12-31-2020	12-31-2021
Obligated Group		
Inpatient Admissions	429	438
Acute Adjusted Admissions	843	884
Acute Patient Days	2,254	2,433
Long-Term Care Patient Days	330	303
Outpatient Visits (incl. Physicians)	19,410	21,669
Emergency Room Visits	1,664	1,792
Surgeries and Procedures	469	506
Acute Average Daily Census (Actual)	6,158	6,665

Obligated Group Capitalization

The Obligated Group's capitalization is presented for the fiscal years ended December 31:

EXHIBIT 5.2 - OBLIGATED GROUP CAPITALIZATION $ PRESENTED IN MILLIONS UNLESS NOTED	As of 12-31-2020	12-31-2021
Obligated Group		
Long-Term Indebtedness	$5,809	$6,603
Less: Current Portion of Long-Term Debt	110	70
Net Long-Term Debt	5,699	6,533
Net Assets - Without Donor Restrictions	12,741	13,133
Total Capitalization	$18,440	$19,666
Long-Term Debt to Capitalization %	30.9	33.2

Obligated Group Debt Service Coverage

The Obligated Group's coverage of MADS on indebtedness is presented for the fiscal years ended December 31:

EXHIBIT 5.3 - OBLIGATED GROUP DEBT SERVICE COVERAGE $ PRESENTED IN MILLIONS UNLESS NOTED	As of 12-31-2020	12-31-2021
Obligated Group		
Income Available for Debt Service:		
Excess of Revenues Over Expenses	$1,140	$995
Less: Unrealized (Gains) on Trading Securities	(561)	(542)
Plus: Loss on Extinguishment of Debt	-	3
Plus: Loss on Pension Settlement Costs and Other	19	19
Plus: Depreciation	1,001	984
Plus: Interest and Amortization	257	259
Total	$1,856	$1,718
Debt Service Requirements: (1)		
MADS	$395	$414
Coverage of Debt Service Requirements (1)	4.7x	4.1x

(1) Debt Service Requirements has the meaning assigned to such term in the Master Indenture.

Outstanding Master Trust Indenture Obligations

As of December 31, 2021, Providence had Obligations outstanding under the Master Indenture totaling $6 billion. This excludes Obligations that secure interest rate or other swap transactions, or credit facilities. The Obligations outstanding under the Master Indenture relating to tax-exempt and taxable bond/note indebtedness are described further in the Note 8 to the Combined Audited Financial Statements for the fiscal year ended December 31, 2021.

Certain of the outstanding Obligations secure tax-exempt bonds previously issued for the benefit of one or more Obligated Group Members (collectively, the “Direct Placement Bonds”) that were purchased directly by commercial banks. Certain other of the outstanding Obligations secure taxable loans and lines of credit previously incurred on behalf of the Obligated Group (the “Taxable Loans”) from one or more commercial banks or a syndicate of banks. Certain other of the outstanding Obligations secure payment obligations relating to a letter of credit facility (the “Credit Facility”) issued by a credit bank for the benefit of, or by, certain Obligated Group Members. The financial covenants relating to the Direct Placement Bonds, the Taxable Loans, and the Credit Facility are substantially consistent with the covenants in the Master Indenture. In addition to financial covenants, the Direct Placement Bonds, the Taxable Loans, and the Credit Facility include events of default that may cause an acceleration of the Obligations secured thereby, and, in turn, all Obligations secured by the Master Indenture. Certain documents relating to the Direct Placement Bonds, the Taxable Loans, and the Credit Facility containing these financial covenants and events of default are available for review on EMMA (http://emma.msrb.org).

Control of Certain Obligated Group Members

General

Providence is the sole corporate member of PH&S and SJHS. PH&S is the sole corporate member of Providence – Washington, Providence – Southern California, LCMASC, Providence – St. John’s, Providence – SJMC Montana, Providence – Montana, and Providence – Oregon. Providence Ministries is the co-corporate member, alongside Western Health Connect of Providence – Western Washington. Western HealthConnect is the sole corporate member of Swedish, Swedish Edmonds, Pac Med, and Kadlec.

SJHS is the sole corporate member of SJHNC and, as more fully described hereinafter, a corporate member of St. Joseph Orange, St. Jude, Mission Hospital, St. Mary and CHS.

Northern California Region

SJHS is the sole member of St. Joseph Health Northern California, LLC, which operates the hospital facilities known as Providence Santa Rosa Memorial Hospital, Providence Queen of the Valley Medical Center, Providence St. Joseph Hospital, and Providence Redwood Memorial Hospital. The corporate entities of Providence Santa Rosa Memorial Hospital, Providence Queen of the Valley Medical Center, Providence St. Joseph Hospital, and Providence Redwood Memorial Hospital, each a California nonprofit public benefit corporation (collectively, the “Hospitals”) transferred their assets to SJHNC effective as of April 1, 2018. Effective December 31, 2019, those four remaining corporate entities in connection with this reorganization were dissolved.

Southern California Region

In connection with the March 2013 affiliation of SJHS and Hoag Hospital, a new entity known as Covenant Health Network, Inc. (“CHN”), a California nonprofit public benefit corporation, was created. CHN is a corporate member of Hoag Hospital and St. Joseph Orange, St. Jude, Mission Hospital and St. Mary (the “SJHS Southern California Hospitals”). CHN, The George Hoag Family Foundation (“Hoag Family Foundation”) and the constituent churches of the Los Ranchos Presbytery of the Presbyterian Church (USA), as represented by the Association of Presbyterian Ministers (“APM”), are the corporate members of Hoag Hospital. None of CHN, Hoag Family Foundation or APM is an Obligated Group Member or is obligated for payment with respect to the Bonds.

SJHS, CHN, Hoag Hospital, and the SJHS Southern California Hospitals entered into an affiliation pursuant to the terms of an Affiliation Agreement dated as of October 15, 2012 (the “CHN Affiliation

Agreement"). The CHN Affiliation Agreement, which became effective as of March 1, 2013, is designed to allow SJHS and each of the SJHS Southern California Hospitals on the one hand, and Hoag Hospital on the other hand, to preserve their respective Catholic and Presbyterian heritages and identities while creating an integrated community health care delivery system. The Affiliation Agreement was amended as of June 1, 2017, and Providence became a party to the arrangement. In addition, a Supplemental Agreement and two amendments were also entered into between the parties in 2017.

CHN does not have any corporate members, and neither Providence, SJHS, its affiliates, nor Hoag Hospital have any ownership interest in CHN. CHN's governing board consists of seven members, four of whom are designated by Providence in its sole discretion from persons who are members of the governing boards of SJHS, SJHS Southern California Hospitals, St. Joseph Health Ministry and/or Sisters of St Joseph of Orange, and/or members of Providence or SJHS management. The remaining three members are designated by Hoag Family Foundation and APM, acting jointly, in their sole discretion from members of the governing board of Hoag Hospital. The CHN board provides strategic planning leadership and oversight for the Southern California region.

CHN and SJHS have certain reserved powers with respect to the governance, management, and operation of each of the SJHS Southern California Hospitals and Hoag Hospital. Some of these powers may be exercised only by a supermajority vote of the CHN Board of Directors, meaning the affirmative vote of at least three of the four members designated by Providence, and of at least two of the three members designated by Hoag Family Foundation and APM. Such reserved powers and powers that require a supermajority vote may be reviewed and revised from time to time. These reserved powers include, among others, certain actions relating to: (i) changes in articles and bylaws, (ii) certain board member and management appointments and removals; and (iii) certain hospital mergers, acquisitions, joint ventures, asset sales, cash transfers and financings. Hoag Family Foundation and APM also have reserved powers with respect to certain management and operating matters and transactions involving Hoag Hospital. See "Litigation" below.

Effective January 19, 2022, Hoag Hospital withdrew as an Obligated Group Member under the Master Trust Indenture dated as of May 1, 2003. Providence's disaffiliation with Hoag also includes the dissolution of CHN, a third-party member. Refer to the Litigation section below for additional details.

West Texas/Eastern New Mexico Region

SJHS and Lubbock Methodist Hospital System ("LMHS") are the corporate members of CHS. CHS is the sole corporate member of CMC, Covenant Levelland and Covenant Plainview. LMHS is not an Obligated Group Member and is not obligated for payment with respect to the Bonds.

CHS was formed in 1998 pursuant to an affiliation between SJHS and LMHS and its affiliates, pursuant to which CHS became the sole corporate member of certain entities previously affiliated with LMHS and, together with certain of such entities, joined the obligated group to which SJHS and its affiliates were party.

CHS is governed by a 19-member board of directors. LMHS and SJHS each appoint eight directors. SJHS also appoints the Chief Executive Officer of CHS, who is an ex-officio voting director. The CMC Chief of Staff and Covenant Children's Hospital Chief of Staff also serve as ex-officio voting directors. SJHS has extensive authority with respect to the financial affairs of CHS and its subsidiaries, including, but not limited to, the approval of budgets of CHS and its subsidiaries and selection and retention of auditors.

As part of the affiliation, SJHS, CHS and LMHS entered into an agreement that significantly restricts the ability of SJHS to sever its relationship with CHS and the entities formerly affiliated with LMHS. Under certain circumstances, it also restricts CHS and SJHS from a wide variety of transactions (the "Covered Transactions"), including: (i) certain management agreements, leases, joint ventures and other transactions that might have the effect of transferring control of Covenant Medical Center or all assets of CHS and its subsidiaries to an unrelated third party, or in a manner that voids or reduces LMHS's right, as a member, to appoint directors; (ii) a sale, transfer or conveyance of all or substantially all of CHS' assets (including all of CHS' affiliates, taken in the aggregate); (iii) an affiliation, management agreement, lease or joint venture under which a third party acquires the right to control CHS, as a whole; or (iv) any other transaction in which the ability to appoint and remove more than 50 percent of the directors of CHS is transferred to a third party.

In the event SJHS or CHS undertakes a Covered Transaction, they are obligated to provide notice and information to LMHS and to make a "reciprocal offer" to LMHS, including an offer to purchase LMHS's

membership rights in CHS and a simultaneous obligation to offer CHS' membership rights to LMHS at the same purchase price, adjusted upward by a formula that reflects the dissolution percentages Pursuant to the terms of the affiliation, the dissolution percentages are SJHS – 57 percent; LMHS – 43 percent.

Other Information

Non-Obligated Group System Affiliates

In addition to the Obligated Group Members, Providence includes: health plans; a provider network; numerous fundraising foundations; Providence Ventures, Inc., a Washington corporation that invests in health care activities; Tegria, a company that provides technologies and services to the health care sector; various not-for-profit corporations that own and operate assisted living facilities and low-income housing projects, including housing facilities for the elderly; and the University of Providence formerly known as University of Great Falls, located in Great Falls, Montana. Providence also includes multiple operations involving or supporting home health, outpatient surgery, imaging services and other professional services provided through for-profit and non-profit entities that are not part of the Obligated Group. These entities are organized as subsidiaries of Providence, partnerships, or joint ventures with other entities. Obligated Group Members also may engage in informal alliances and/or contract-based physician relationships. Affiliates that are not Obligated Group Members are referred to in this Annual Report as the Non-Obligated Group System Affiliates. Certain Non-Obligated Group System Affiliates that are of significant operational or strategic importance and other Non-Obligated Group System Affiliates are discussed elsewhere in this Annual Report only to the extent they are viewed by management to be of operational or strategic importance.

Ambulatory Care Network

The Providence Ambulatory Care Network (“ACN") partners in the well-being of all people by creating personalized, convenient, affordable health solutions. In 2021, the ACN provided over 3.1 million visits in 375 access points across seven states. The ACN consists of ambulatory surgery centers, imaging centers, urgent care centers, retail clinics and active wellness sites. By expanding our ambulatory care network through strategic partnerships and multiple growth projects at scale, the ACN improves patient access and reduces costs for consumers and employers. The ACN offers advantages to consumers and physicians, including greater affordability, predictability, flexibility, and convenience, while offering a seamless connection to Providence full continuum of care.

Population Health Management

Population Health models and initiatives form a vital pillar in achieving our strategic plan of transforming care, delivering value-based care, and creating healthier communities together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery and coordination of affordable quality health care and services. We integrate solutions to improve social determinants of health, identify health disparities, and provide care management for complex patients. We are building community partnerships to increase access to health services, transportation, housing, education, food banks, mental health services, and support needed by vulnerable communities to achieve health equity.

Our Population Health Management division is composed of a family of services, including Population Health Informatics, Value-Based Care, Payer Contracting, Risk Sharing & Payments Models, Care Management, Mental Health Improvement, and Health Equity that support our Providence regional care delivery systems; and three businesses: Providence Health Plans, Ayin Health Solutions, and Home & Community Care.

Providence Health Plan (“PHP”), a 501(c)(4) Oregon non-profit health care service contractor, and Providence Health Assurance (“PHA”), a wholly owned subsidiary of PHP, are collectively referred to as the Health Plans. Providence Plan Partners (“PPP”) is a 501(c)(4) Washington non-profit corporation.

The Health Plans provide services to a wide range of clients, including self-funded employers, and insurance coverage for large group employers, small group employers, individual and family coverage under the Affordable Care Act, Medicare Commercial, Medicare Advantage, Managed Medicaid risk administration,

pharmacy benefits management, workers compensation services, and network access services under preferred plans. Providence Health Plan members reside in 49 states nationwide.

Ayin Health Solutions is our population health management company that provides a comprehensive suite of services to employer, payer, provider, and government clients. Ayin is a for-profit, non-risk bearing entity providing administrative and clinical services in multiple states and incorporated in Delaware.

Home & Community Care is a trusted partner for individuals and families. Our community-based care and services are geared to help in times of need, aging and illness, and at the end of life. We provide a full range of post-acute services, including assisted living, skilled nursing and rehabilitation, home health, home infusion and pharmacy services, home medical equipment, hospice and palliative care, Program of All-Inclusive Care for the Elderly locations, supportive housing, and personal home care services. As our Mission calls us to serve the most vulnerable and poor members of our community, we provide a full range of services and support to more than 30,000 patients, participants, and residents each day. The demand for these services continues to increase in the markets we serve, creating opportunities for continued growth, innovation, and investment.

Physician Enterprise

Providence's Physician Enterprise creates health for a better world by serving patients across the Western United States with quality, compassionate, coordinated care. Collectively, our medical groups and affiliate practices are the third largest group in the country with over 11,000 providers. This includes: Providence Medical Group, serving Alaska, Washington, Montana, and Oregon; Swedish Medical Group, with staffed clinics throughout Washington's greater Puget Sound area; Pacific Medical Centers in western Washington; Kadlec, serving southeast Washington; Providence St. John's Medical Foundation in Southern California; Providence Medical Institute ("PMI") in Southern California; Providence Facey Medical Foundation ("Facey") in Southern California; Providence Medical Foundation in Northern and Southern California; and Covenant Medical Group, and Covenant Health Partners in west Texas and eastern New Mexico.

Tegria

Tegria is a Providence-owned technology and solutions company that combines select Providence investments and acquisitions into a comprehensive portfolio of solutions to accelerate technological, clinical, and operational advances in health care. Tegria focuses on three key initiatives: healthcare consulting and technology services, revenue cycle management solutions, and software technology and platforms. Tegria is comprised of more than 3,500 strategists, technologists, service providers and scientists who currently serve more than 500 organizations across North America.

Interest Rate Swap Arrangements

Providence and/or certain of its affiliates may enter into interest rate swap contracts from time to time to increase or decrease variable rate debt exposure, to achieve a targeted mix of fixed and floating rate indebtedness and for other purposes.

At December 31, 2021, SJHS was party to five interest rate swap agreements with a current notional amount totaling approximately $401 million and with varying expiration dates. The swap agreements require SJHS to make fixed rate payments in exchange for variable rate payments made by the counterparties. SJHS's payment obligations under such swap agreements are secured by Obligations issued under the Master Indenture.

Below is a summary of those swap agreements, including the fair value of the swaps as of December 31, 2021. Fair values are based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, also taking into account any nonperformance risk. Changes in the fair value of the interest rate swaps are included within non-operating gains and losses. See also the discussion under "Other Information - Interest Rate Swap Arrangements" and Note 8 to the Combined Audited Financial Statements for the fiscal year ended December 31, 2021.

INTEREST RATE SWAPS $ PRESENTED IN MILLIONS	NOTIONAL	TERM	COUNTERPARTY	RECEIVE	PAY	FAIR VALUE
Fixed Payor	167.9	Jul-47	MUFG Union	68% of 3 Month LIBOR	3.529%	(59.5)
Fixed Payor	44.6	Jul-47	Wells Fargo	68% of 3 Month LIBOR	3.520%	(15.5)
Fixed Payor	60.8	Dec-40	Wells Fargo	55.70% of 1 Month LIBOR + 0.23%	3.229%	(12.9)
Fixed Payor	60.8	Dec-40	Wells Fargo	55.70% of 1 Month LIBOR + 0.23%	3.229%	(12.9)
Fixed Payor	67.2	Dec-40	Wells Fargo	55.70% of 1 Month LIBOR + 0.23%	3.229%	(14.3)

Entering into derivative agreements, including those described above, creates a variety of risks to Providence. Pursuant to certain of these agreements, both SJHS and the counterparty are required to deliver collateral in certain circumstances in order to secure their respective obligations under the agreements. As of December 31, 2021, SJHS posted collateral in the amount of $17 million. The amount of collateral delivered by SJHS over the term of the agreements could increase or decrease based upon SJHS' credit ratings and movements of United States dollar swap rates and could be substantial. Under certain circumstances, the derivative agreements are subject to termination prior to their scheduled termination date and prior to the maturity of the related revenue bonds. Payments due upon early termination may be substantial. In the event of an early termination of an agreement, there can be no assurance that (i) SJHS or any other Obligated Group Member will receive any termination payment payable to it by the provider, (ii) SJHS or any other Obligated Group Member will have sufficient amounts to pay a termination payment payable by it to the provider, or (iii) SJHS or the other Obligated Group Members will be able to obtain a replacement agreement with comparable terms. For financial reporting purposes, Providence has generally not treated its swap agreements as effective hedges against the interest cost of underlying debt. To the extent that swaps are not treated as effective hedges, Providence must recognize any changes in the fair market value of the swap agreements and the related debt as non-operating gains or losses. See Note 8 to the Combined Audited Financial Statements for the fiscal year ended December 31, 2021.

Litigation

Certain material litigation may result in adverse outcomes to the Obligated Group. Obligated Group Members are involved in litigation and regulatory investigations arising in the course of doing business. After consultation with legal counsel, except as described below, management estimates that these matters will be resolved without material adverse effect on the Obligated Group's future consolidated financial position or results of operations.

In 2019, the U.S. Department of Justice served Swedish Health Services with a Civil Investigative Demand requesting documents pertaining to certain arrangements and joint ventures and physician organizations. Swedish is cooperating with the Department and compiling the responsive documents.

On February 3, 2022, the Washington State Attorney General's Office filed a complaint against Providence Health & Services - Washington, Swedish Health Services, Swedish Edmonds, and Kadlec Regional Medical Center, seeking injunctive relief and damages for alleged violations of the Washington State Consumer Protection Act. The litigation is in the early stages. At this time, no determination can be made as to whether such litigation will have a material adverse effect on Providence, financial or otherwise.

Several civil actions are pending or threatened against certain affiliates, including Obligated Group Members, alleging medical malpractice. In the opinion of management of Providence, based upon the advice of legal counsel and risk management personnel, the currently estimated costs and related expenses of defense will be within applicable insurance limits or will not materially adversely affect the financial condition or operations of Providence.

In early May 2020, Hoag Family Foundation and APM, two of the three corporate members of Hoag Hospital, filed a complaint under a California Corporations Code statute seeking to involuntarily dissolve CHN, the third corporate member. The complaint sought to remove Hoag Hospital as an Obligated Group Member through this involuntary dissolution claim. A trial date was set for April 2022. In January 2022, Hoag and Providence reached agreement to amicably end the affiliation, and Hoag exited from the Obligated Group on January 19, 2022. In accordance with this agreement, the complaint was dismissed with prejudice as to all claims, and the dismissal was entered by the Court on January 10, 2022. Hoag accounted for 7 percent of the

Obligated Group's audited total operating revenues for the fiscal year ended December 31, 2021, and 7 percent of Providence's audited total operating revenues for the fiscal year ended December 31, 2021. Hoag accounted for 17 percent of Providence's unrestricted cash and investments, net of debt financing relating to Hoag assets, as of December 31, 2021.

Employees

As of December 31, 2021, Providence employed approximately 120,000 caregivers (excluding Hoag), representing 105,117 FTEs. Of Providence's total employees, approximately 32 percent are represented by 19 different labor unions.

Providence management strives to provide market-competitive salaries and benefits to all employees. Management of Providence believes the salary levels and benefits packages for its employees are competitive in all the respective markets. At the same time, management understands that the health care industry is rapidly evolving. Leadership of each of the separate employers within Providence is working to ensure the compensation and benefits are modern and reflect competitive market practices. This will require continued negotiations at the various employers within Providence throughout 2022. In the past two years, Providence has experienced strikes at different facilities as a result of contract negotiations. In each situation, the facility operated with qualified replacement employees and experienced limited disruption to hospital operations or patient service. Management is also aware of ongoing organizing efforts by labor unions within the health care industry, including in markets where the separate employers within Providence operate.

The separate employers across the System are committed to ensuring they have enough employees to continue providing high-quality services throughout the pandemic. Leadership at the different facilities have implemented vaccination policies consistent with local, state, and federal mandates to protect employees and patients. To retain existing employees and ease workload pressures, the different facilities contract with staffing agencies for supplemental staffing, offer incentives to work extra shifts, and provide paid leave for those who experience adverse vaccine side effects or require isolation for a work related COVID-19 exposure.

Community Benefit

Our community benefit program is a vital part of our vision. It includes free or low-cost care (charity care) and the costs of uncompensated care for Medicaid and other government-funded programs, along with proactive investments such as subsidized health services, education, and community health improvement. Each year, we take a holistic approach to community building by identifying unmet needs and responding with tailored community benefit investments designed to improve health and well-being.

Building on our commitment to care for those who are poor and vulnerable, we invested $1.9 billion in community benefit in the fiscal year ended December 31, 2021, compared with $1.8 billion in the same period in 2020. Because more of our patients covered by Medicaid needed higher acuity and more complex care in 2021, our unpaid costs of Medicaid totaled $1.2 billion for the fiscal year ended December 31, 2021, compared with $1.1 billion for the same period in 2020.

Environmental, Social, and Governance Standards

Over the last two years, Providence advanced a social responsibility framework that includes a stronger commitment to diversity, equity, inclusion, and environmental stewardship. We updated our Integrated Strategic & Financial Plan to more clearly express our commitment and acceleration of this important work to address social, racial, and economic disparities in the communities we serve. Providence's social responsibility framework aims to deploy the assets of our system to support community health improvement, strengthen local economies and reduce our carbon footprint. In 2021, our sustainable and inclusive purchasing program committed to increase our spend with women and minority owned business enterprises by over $300 million across the next five years. We also deploy an investing portfolio which includes shareholder advocacy, impact investing, and socially conscious portfolio screens. In 2021, Providence made progress towards its climate commitment to become carbon negative by 2030. We are implementing an environmental stewardship system strategy that encourages waste reductions, efficient energy and water use, local agriculture partnerships, less toxic and fewer chemical use, and a reduction in carbon from travel.

Providence Information Security Program

Providence's information security program consists of over 200 full-time employees. The information security team's global reach enables 24/7 coverage of information technology ("IT") risks and real-time defense of Providence's information ecosystem. Providence's cybersecurity program has adopted the National Institute of Standards and Technology ("NIST") Cyber Security Framework ("CSF") as the foundational model for organizing the team's strategy, with policies and standards aligned to a controls-based framework based on NIST 800-53. Standardizing the program on this framework and rooting the program in controls-based policies allows the system to measure cybersecurity maturity and update controls as the IT risk landscape evolves. IT risk is quantified and tracked in the Cyber Balance Sheet ("CBS") operational tool, which combines real-time telemetry from enterprise IT and cybersecurity tools with risk-weighted measurements. This approach allows for risk-informed decision-making within the IT organization and the Providence Board of Directors.

Insurance

Providence has developed insurance programs that provide coverage for various insurable risks utilizing commercial products and self-insurance using two captive insurance companies domiciled in Arizona and Bermuda with reinsurance. The program uses benchmarking and insurance, actuarial and finance analytics to guide decisions regarding the types of coverage purchased, the limits or amounts of insurance, and quality of coverage terms. The quality of insurance products is maintained in part by requiring commercial insurers to have an A rating or better from A.M. Best to be on Providence's program. Management reviews strategy at least annually with input from brokers, actuaries, and consultants. Funding of captive insurers conforms to regulatory requirements of the domicile. The major lines of insurance maintained include property, professional and general liability, directors and officers liability, employment practices liability, auto liability, fiduciary liability, cyber liability, technology errors and omissions, workers' compensation and employers' liability, and crime.

Retirement Plans

As described more completely under the caption "Retirement Plans" in Note 9 to the combined audited financial statements included in Exhibit 7, the System currently sponsors defined benefit and contribution plans. Although the System had certain defined benefit plans in place prior to January 1, 2010, in April 2009, the PH&S Board of Directors approved a freeze of the existing defined benefit plans, a cap on the ongoing cash balance interest credit formula, and the implementation of new defined contribution plans referenced within Note 9, all effective December 31, 2009.

The System's remaining unfunded liability with respect to the defined benefit plans increased from approximately 60 percent at December 31, 2020 to 66 percent at December 31, 2021. The increase in the unfunded liability occurred primarily due to a change in the valuation discount rate. The System's contribution to the defined benefit plans was approximately $111 million and $113 million at December 31, 2021 and 2020, respectively.

The System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $557 million and $545 million for the fiscal years ended December 31, 2021, and 2020, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

Accreditation and Memberships

Providence's acute care hospital facilities are appropriately licensed by applicable state licensing agencies, certified for Medicare and Medicaid/Medi-Cal reimbursement, and (except Covenant Levelland, Providence Seward Medical Center, and Providence Valdez Medical Center) accredited by The Joint Commission. Providence's five hospitals operated by Swedish Health Services are accredited by DNV. Each long-term care facility or unit is licensed by applicable state licensing agencies and is appropriately certified for Medicare and Medicaid/Medi-Cal reimbursement.

Glossary of Certain Terms

Credit Group:	Obligated Group Members, Designated Affiliates, Limited Credit Group Participants, and Unlimited Credit Group Participants, collectively.
Obligated Group or Obligated Group Members:	Obligated Group Members under the Master Indenture and currently: Providence PH&S Providence – Washington Providence – Southern California LCMASC Providence – Saint John's Providence – SJMC Montana Providence – Montana Providence – Oregon Providence – Western Washington Swedish Swedish Edmonds PacMed Western HealthConnect Kadlec SJHS St. Joseph Orange St. Jude Mission Hospital St. Mary Hoag Hospital SJHNC CHS CMC Covenant Children's Covenant Levelland Covenant Plainview
Designated Affiliates:	Designated Affiliates under the Master Indenture. There are currently no Designated Affiliates.
Limited Credit Group Participants:	Limited Credit Group Participants under the Master Indenture. There are currently no Limited Credit Group Participants.
Unlimited Credit Group Participants:	Unlimited Credit Group Participants under the Master Indenture. There are currently no Unlimited Credit Group Participants.

CHS:	Covenant Health System, a Texas nonprofit corporation and currently an Obligated Group Member.
CMC:	Covenant Medical Center, a Texas nonprofit corporation and currently an Obligated Group Member.
Covenant Children's:	Methodist Children's Hospital, a Texas nonprofit corporation and currently an Obligated Group Member, doing business as Covenant Children's Hospital.
Covenant Levelland:	Methodist Hospital Levelland, a Texas nonprofit corporation and currently an Obligated Group Member, doing business as Covenant Levelland Hospital.
Covenant Plainview:	Methodist Hospital Plainview, a Texas nonprofit corporation and currently an Obligated Group Member, doing business as Covenant Plainview Hospital.
Hoag Hospital:	Hoag Memorial Hospital Presbyterian, a California nonprofit public benefit corporation and currently an Obligated Group Member.
Kadlec:	Kadlec Regional Medical Center, a Washington nonprofit corporation and currently an Obligated Group Member.
LCMASC:	Little Company of Mary Ancillary Services Corporation, a California nonprofit public benefit corporation and currently an Obligated Group Member.
Mission Hospital:	Mission Hospital Regional Medical Center, a California nonprofit public benefit corporation and currently an Obligated Group Member.
PacMed:	PacMed Clinics, a Washington nonprofit corporation and currently an Obligated Group Member.
PH&S:	Providence Health & Services, a Washington nonprofit corporation and currently an Obligated Group Member.
Providence – Montana:	Providence Health & Services – Montana, a Montana nonprofit corporation and currently an Obligated Group Member.

Providence – Oregon:	Providence Health & Services – Oregon, an Oregon nonprofit corporation and currently an Obligated Group Member.
Providence – Saint John's:	Providence Saint John's Health Center, a California nonprofit religious corporation and currently an Obligated Group Member.
Providence – SJMC Montana:	Providence St. Joseph Medical Center, a Montana nonprofit corporation and currently an Obligated Group Member.
Providence – Southern California:	Providence Health System – Southern California, a California nonprofit religious corporation and currently an Obligated Group Member.
Providence – Washington:	Providence Health & Services – Washington, a Washington nonprofit corporation and currently an Obligated Group Member.
Providence – Western Washington:	Providence Health & Services – Western Washington, a Washington nonprofit corporation and currently an Obligated Group Member.
Providence St. Joseph Health, Providence, we, us, our:	Providence St. Joseph Health, a Washington nonprofit corporation and currently an Obligated Group Member and the Obligated Group Agent.
SJHNC:	St. Joseph Health Northern California, LLC, a California limited liability company and currently an Obligated Group Member.
SJHS:	St. Joseph Health System, a California nonprofit public benefit corporation and currently an Obligated Group Member.
St. Joseph Orange:	St. Joseph Hospital of Orange, a California nonprofit public benefit corporation and currently an Obligated Group Member.
St. Jude:	St. Jude Hospital, a California nonprofit public benefit corporation and currently an Obligated Group Member, doing business as St. Jude Medical Center.
St. Mary:	St. Mary Medical Center, a California nonprofit public benefit corporation and currently an Obligated Group Member.
Swedish:	Swedish Health Services, a Washington nonprofit corporation and currently an Obligated Group Member.
Swedish Edmonds:	Swedish Edmonds, a Washington nonprofit corporation and currently an Obligated Group Member.
System:	Providence and all entities that are included within the combined financial statements of Providence.
Western HealthConnect:	Western HealthConnect, a Washington nonprofit corporation and currently an Obligated Group Member.

Exhibit 6 – Obligated Group Facilities

Exhibit 6.1
Acute Care Facilities by Region

A list of Providence's acute care facilities in each region as of December 31, 2021, each of which is owned, operated, or managed by an Obligated Group Member:

Region	Obligated Group Member	Facility	Location(s)	Licensed Acute Care Beds*
Alaska				
	Providence Health & Services-Washington	Providence Alaska Medical Center	Anchorage	401
		Providence Kodiak Island Medical Center (1)	Kodiak	25
		Providence Seward Medical and Care Center (2)	Seward	6
		Providence Valdez Medical Center (2)	Valdez	11
Puget Sound Region				
	Swedish Edmonds	Swedish Edmonds (1)	Edmonds	217
		Swedish Medical Center Campuses (3):		
	Swedish Health Services	Swedish Ballard	Ballard	133
		Swedish Issaquah	Issaquah	175
		Swedish Cherry Hill	Seattle	349
		Swedish First Hill	Seattle	697
	Providence Health & Services-Washington	Providence Centralia Hospital	Centralia	128
		Providence Regional Medical Center Everett	Everett	595
		Providence St. Peter Hospital (4)	Olympia	372
Washington and Montana				
	Providence Health & Services-Washington	Providence St. Joseph's Hospital	Chewelah	25
		Providence Mount Carmel Hospital	Colville	55
		Providence Sacred Heart Medical Center and Children's Hospital	Spokane	691
		Providence Holy Family Hospital	Spokane	197
		Providence St. Mary Medical Center	Walla Walla	142
	Kadlec Regional Medical Center	Kadlec Regional Medical Center	Richland	337
	Providence Health & Services-Montana	St. Patrick Hospital	Missoula (MT)	253
	Providence St. Joseph Medical Center	Providence St. Joseph Medical Center	Polson (MT)	22
Oregon				
	Providence Health & Services-Oregon	Providence Hood River Memorial Hospital	Hood River	25
		Providence Medford Medical Center	Medford	168
		Providence Milwaukie Hospital	Milwaukie	77
		Providence Newberg Medical Center	Newberg	40
		Providence Willamette Falls Medical Center	Oregon City	143
		Providence St. Vincent Medical Center	Portland	539
		Providence Portland Medical Center	Portland	483
		Providence Seaside Hospital (1)	Seaside	25

Region	Obligated Group Member	Facility	Location(s)	Licensed Acute Care Beds*
Northern California				
	St. Joseph Health Northern California, LLC.	Providence St. Joseph Hospital	Eureka	153
		Providence Redwood Memorial Hospital	Fortuna	35
		Providence Queen of the Valley Medical Center	Napa	200
		Providence Santa Rosa Memorial Hospital	Santa Rosa	298
Southern California				
	Providence Health System-Southern California	Providence St. Joseph Medical Center	Burbank	392
		Providence Holy Cross Medical Center	Mission Hills	329
		Providence Little Company of Mary Medical Center San Pedro	San Pedro	183
		Providence Tarzana Medical Center (2)	Tarzana	249
		Providence Little Company of Mary Medical Center Torrance	Torrance	327
	Providence Saint John's Health Center	Providence Saint John's Health Center	Santa Monica	266
	St. Mary Medical Center	St. Mary Medical Center	Apple Valley	213
	St. Jude Medical Hospital	St. Jude Medical Center	Fullerton	320
		Mission Hospital Regional Medical Center Campuses (5):		504
	Mission Hospital Regional Medical Center	Mission Hospital Regional Medical Center	Mission Viejo	
		Mission Hospital Laguna Beach	Laguna Beach	
		Hoag Memorial Hospital Presbyterian Campuses (6):		530
	Hoag Memorial Hospital Presbyterian	Hoag Memorial Hospital Presbyterian	Newport Beach	
		Hoag Hospital Irvine	Irvine	
	St. Joseph Hospital of Orange	St. Joseph Hospital of Orange (7)	Orange	463
West Texas and Eastern New Mexico				
	Methodist Hospital Levelland	Covenant Hospital Levelland (8)	Levelland	48
		CHS Campuses:		381
	Covenant Health System	Covenant Medical Center	Lubbock	
		Covenant Medical Center - Lakeside	Lubbock	
	Methodist Children's Hospital	Covenant Children's Hospital	Lubbock	227
	Methodist Hospital Plainview	Covenant Hospital Plainview (8)	Plainview	68
TOTAL				11,517

* Includes all acute care licensure categories except for normal newborn bassinettes and partial hospitalization psychiatric beds
(1) Leased by an Obligated Group Member
(2) Managed by an Obligated Group Member, but not a member of the Obligated Group
(3) Four campuses with three licenses
(4) Includes a 50-bed chemical dependency center
(5) Two campuses on one license, including 36 acute care psychiatric beds in Laguna Beach
(6) Two campuses on one license
(7) Includes 37 acute care psychiatric beds
(8) Leased facility and Obligated Group Member

Exhibit 6.2
Long-Term Care Facilities by Region

Providence's principal owned or leased long-term care facilities as of December 31, 2021, each of which is owned, operated, or managed by an Obligated Group Member:

Region	Obligated Group Member	Facility	Location(s)	Licensed Long-Term Care Beds
Alaska				
	Providence Health & Services-Washington	Providence Kodiak Island Medical Center [1]	Kodiak	22
		Providence Seward Medical and Care Center [1]	Seward	40
		Providence Valdez Medical Center [2]	Valdez	10
		Providence Extended Care	Anchorage	96
		Providence Transitional Care Center	Anchorage	50
Puget Sound Region				
	Providence Health & Services-Washington	Providence Marionwood	Issaquah	117
		Providence Mother Joseph Care Center	Olympia	152
		Providence Mount St. Vincent	Seattle	215
Washington and Montana				
	Providence Health & Services-Washington	Providence St. Joseph Care Center	Spokane	113
Oregon				
	Providence Health & Services-Oregon	Providence Benedictine Nursing Center	Mt. Angel	98
		Providence Child Center	Portland	58
Northern California				
	St. Joseph Health Northern California, LLC.	Providence Santa Rosa Memorial Hospital	Santa Rosa	31
Southern California				
	Providence Health System-Southern California	Providence Holy Cross Medical Center	Mission Hills	48
		Providence Little Company of Mary Subacute Care Center San Pedro	San Pedro	125
		Providence Little Company of Mary Transitional Care Center	Torrance	115
		Providence St. Elizabeth Care Center	North Hollywood	52
West Texas and Eastern New Mexico				
	Covenant Health System	Covenant Long-term Acute Care [2]	Lubbock	56
TOTAL				1,398

[1] Leased by an Obligated Group Member
[2] Managed or owned by an Obligated Group Member, but not a member of the Obligated Group

Exhibit 7 - Supplementary Information

[ATTACHED]

EXHIBIT 7.1 - SUMMARY AUDITED COMBINED STATEMENTS OF OPERATIONS

	Ended December 31, 2021 (in 000's of dollars)		Ended December 31, 2020 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Operating Revenues:				
Net Patient Service Revenues	$ 20,908,081	19,404,119	18,964,084	17,761,749
Premium Revenues	2,319,654	306,794	2,423,924	280,738
Capitation Revenues	1,870,284	815,937	1,732,072	767,954
Other Revenues	2,230,060	1,603,604	2,554,510	2,078,110
Total Operating Revenues	27,328,079	22,130,454	25,674,590	20,888,551
Operating Expenses:				
Salaries and Benefits	13,965,710	11,979,653	12,646,320	11,001,078
Supplies	4,168,341	3,812,102	3,821,427	3,515,553
Purchased Healthcare Services	2,128,660	463,856	1,988,983	408,792
Interest, Depreciation, and Amortization	1,406,121	1,242,720	1,374,618	1,257,945
Purchased Services, Professional Fees, and Other	6,373,235	4,693,800	6,149,563	4,442,402
Total Operating Expenses	28,042,067	22,192,131	25,980,911	20,625,770
Excess (Deficit) of Revenues Over Expenses From Operations	(713,988)	(61,677)	(306,321)	262,781
Total Net Non-Operating Gains	1,231,826	1,057,033	1,045,857	877,050
Excess of Revenues Over Expenses	$ 517,838	995,356	739,536	1,139,831

EXHIBIT 7.2 - SUMMARY AUDITED COMBINED STATEMENTS OF CASH FLOWS

	Ended December 31, 2021 (in 000's of dollars)		Ended December 31, 2020 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Net Cash Provided by (Used in) Operating Activities	$ (940,586)	(578,177)	3,148,727	3,525,593
Net Cash Used in Investing Activities	(1,513,393)	(757,713)	(1,741,794)	(1,129,877)
Net Cash Provided by (Used in) Financing Activities	366,984	(701,151)	507,062	(748,447)
Increase (Decrease) in Cash and Cash Equivalents	(2,086,995)	(2,037,041)	1,913,995	1,647,269
Cash and Cash Equivalents, Beginning of Period	3,230,204	2,280,747	1,316,209	633,478
Cash and Cash Equivalents, End of Period	$ 1,143,209	243,706	3,230,204	2,280,747

EXHIBIT 7.3 - SUMMARY AUDITED NET PATIENT SERVICE REVENUE PAYOR MIX

	Ended December 31, 2021		Ended December 31, 2020	
	Consolidated	Obligated	Consolidated	Obligated
Commercial	50%	48%	49%	48%
Medicare	33%	33%	32%	32%
Medicaid	15%	16%	16%	17%
Self-pay and Other	2%	3%	3%	3%

EXHIBIT 7.4 - SUMMARY AUDITED COMBINED BALANCE SHEETS

	As of December 31, 2021 (in 000's of dollars)		As of December 31, 2020 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Current Assets:				
Cash and Cash Equivalents	$ 1,143,209	243,706	3,230,204	2,280,747
Short-Term Investments	1,322,076	1,154,049	1,082,438	885,093
Accounts Receivable, Net	3,157,401	2,823,304	2,365,360	2,183,641
Supplies Inventory	402,474	379,191	361,272	343,909
Other Current Assets	1,648,443	1,560,936	1,479,535	1,283,925
Current Portion of Assets Whose Use is Limited	169,368	30,092	145,093	191
Total Current Assets	7,842,971	6,191,278	8,663,902	6,977,506
Management Designated Cash and Investments	11,629,401	8,509,298	10,950,114	8,115,473
Assets Whose Use is Limited	660,204	295,207	555,734	192,594
Property, Plant, and Equipment, Net	11,329,182	10,020,003	11,033,440	9,866,197
Other Assets	3,413,203	3,669,521	3,451,231	3,687,795
Total Assets	$ 34,874,961	28,685,307	34,654,421	28,839,565
Current Liabilities:				
Current Portion of Long-Term Debt	81,163	70,238	127,107	110,353
Master Trust Debt Classified as Short-Term	188,715	188,715	933,860	933,860
Accounts Payable	1,431,703	1,222,449	1,155,330	978,443
Accrued Compensation	1,627,464	1,468,365	1,452,606	1,321,568
Other Current Liabilities	3,252,489	2,440,493	3,020,050	2,106,505
Total Current Liabilities	6,581,534	5,390,260	6,688,953	5,450,729
Long-Term Debt, Net of Current Portion	6,833,712	6,532,720	6,061,327	5,698,916
Pension Benefit Obligation	976,899	976,899	1,202,762	1,202,862
Other Liabilities	2,810,500	1,554,958	3,985,353	2,739,486
Total Liabilities	$ 17,202,645	14,454,837	17,938,395	15,091,993
Net Assets:				
Controlling Interests	15,506,686	13,133,773	14,857,133	12,741,287
Noncontrolling Interests	405,073	(533)	308,509	(533)
Net Assets Without Donor Restrictions	15,911,759	13,133,240	15,165,642	12,740,754
Net Assets With Donor Restrictions	1,760,557	1,097,230	1,550,384	1,006,818
Total Net Assets	17,672,316	14,230,470	16,716,026	13,747,572
Total Liabilities and Net Assets	$ 34,874,961	28,685,307	34,654,421	28,839,565

EXHIBIT 7.5 - KEY PERFORMANCE METRICS

	Ended December 31, 2021		Ended December 31, 2020	
	Consolidated	Obligated	Consolidated	Obligated
Inpatient Admissions	457,839	437,547	446,966	429,199
Acute Patient Days	2,531,775	2,432,772	2,339,728	2,254,003
Acute Outpatient Visits	13,157,877	12,343,202	11,671,846	10,938,450
Primary Care Visits	13,371,271	8,568,033	12,303,694	7,740,634
Inpatient Surgeries and Procedures	187,959	180,274	186,823	179,387
Outpatient Surgeries and Procedures	486,303	325,656	402,611	290,006
Long-Term Care Admissions	4,444	4,123	5,742	5,324
Long-Term Care Patient Days	317,096	303,083	340,396	329,871
Long-Term Care Average Daily Census	226	188	224	195
Home Health Visits	1,088,713	758,040	1,150,386	730,649
Hospice Days	1,115,010	659,695	1,074,947	616,459
Housing and Assisted Living Days	442,140	190,185	600,757	221,764
Health Plan Members	668,189	n/a	699,076	n/a
Acute Average Daily Census	6,936	6,665	6,393	6,158
Acute Licensed Beds	12,001	11,251	11,817	11,287
FTEs	105,117	91,269	103,036	89,643
Historical Debt Service Coverage Ratio	4.25	5.42	3.92	5.04

EXHIBIT 7.6 - SUMMARY AUDITED COMBINING STATEMENTS OF OPERATIONS BY REGION

	Ended December 31, 2021 (in 000's of dollars)								
	Alaska	Puget Sound Region	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Other/ Eliminations	Consolidated
Operating Revenues:									
Net Patient Service Revenues	$ 909,352	4,388,098	3,018,269	2,488,560	1,436,764	6,527,274	1,171,335	968,429	20,908,081
Premium Revenues	-	-	-	2,038,002	-	-	-	281,652	2,319,654
Capitation Revenues	-	-	174,521	35,311	90,839	1,563,981	-	5,632	1,870,284
Other Revenues	91,697	309,072	307,177	397,931	65,889	443,882	116,617	497,795	2,230,060
Total Operating Revenues	1,001,049	4,697,170	3,499,967	4,959,804	1,593,492	8,535,137	1,287,952	1,753,508	27,328,079
Operating Expenses:									
Salaries and Benefits	388,346	2,287,609	1,542,842	1,743,076	656,652	3,110,084	521,568	3,715,533	13,965,710
Supplies	133,370	741,684	563,608	488,430	226,443	1,217,650	245,136	552,020	4,168,341
Purchased Healthcare Services	1	1,293	101,929	1,156,683	54,400	678,396	-	135,958	2,128,660
Interest, Depreciation, and Amortization	56,115	200,686	108,533	116,009	70,512	379,887	77,459	396,920	1,406,121
Purchased Services, Professional Fees, and Other	348,624	1,685,624	1,187,281	1,386,475	674,058	3,495,163	453,181	(2,857,171)	6,373,235
Total Operating Expenses	926,456	4,916,896	3,504,193	4,890,673	1,682,065	8,881,180	1,297,344	1,943,260	28,042,067
Excess (Deficit) of Revenues Over Expenses From Operations	74,593	(219,726)	(4,226)	69,131	(88,573)	(346,043)	(9,392)	(189,752)	(713,988)
Total Net Non-Operating Gains	110,522	84,781	93,384	169,074	77,987	448,725	50,165	197,188	1,231,826
Excess (Deficit) of Revenues Over Expenses	$ 185,115	(134,945)	89,158	238,205	(10,586)	102,682	40,773	7,436	517,838

EXHIBIT 7.7 - SUMMARY AUDITED COMBINING BALANCE SHEETS BY REGION

As of December 31, 2021
(in 000's of dollars)

	Alaska	Puget Sound Region	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Other/ Eliminations	Consolidated
Current Assets:									
Cash and Cash Equivalents	$ 730,221	(168,848)	253,196	1,580,808	31,200	(1,141,288)	227,905	(369,985)	1,143,209
Short-Term Investments	-	-	-	-	167	743,130	29,108	549,671	1,322,076
Accounts Receivable, Net	153,660	588,666	335,524	260,840	221,812	1,195,225	181,875	219,799	3,157,401
Supplies Inventory	13,454	65,240	39,577	49,107	23,561	98,593	19,020	93,922	402,474
Other Current Assets	39,839	148,797	133,981	246,072	178,639	732,659	(35,002)	203,458	1,648,443
Current Portion of Assets Whose Use is Limited	-	-	-	-	-	-	-	169,368	169,368
Total Current Assets	937,174	633,855	762,278	2,136,827	455,379	1,628,319	422,906	866,233	7,842,971
Management Designated Cash and Investments	1,197,960	859,760	1,011,869	2,567,034	526,265	3,378,708	308,873	1,778,932	11,629,401
Assets Whose Use is Limited	(346,674)	19,962	4,095	49,620	9,249	46,356	4,815	872,781	660,204
Property, Plant, and Equipment, Net	421,519	1,774,490	970,997	974,800	736,473	4,233,366	754,650	1,462,887	11,329,182
Other Assets	412,826	460,419	266,500	153,697	25,902	1,254,238	111,436	728,185	3,413,203
Total Assets	$ 2,622,805	3,748,486	3,015,739	5,881,978	1,753,268	10,540,987	1,602,680	5,709,018	34,874,961
Current Liabilities:									
Current Portion of Long-Term Debt	2,249	17,222	(422)	(2,720)	74,495	147,636	41,308	(198,605)	81,163
Master Trust Debt Classified as Short-Term	-	-	-	-	-	1,535	-	187,180	188,715
Accounts Payable	38,057	150,104	81,702	92,362	51,929	456,819	39,231	521,499	1,431,703
Accrued Compensation	41,623	194,166	162,383	186,216	48,695	353,273	61,617	579,491	1,627,464
Other Current Liabilities	97,236	501,803	311,552	708,127	189,796	1,022,956	120,792	300,227	3,252,489
Total Current Liabilities	179,165	863,295	555,215	983,985	364,915	1,982,219	262,948	1,389,792	6,581,534
Long-Term Debt, Net of Current Portion	256,861	1,302,653	636,204	122,474	273,357	1,928,926	433,748	1,879,489	6,833,712
Pension Benefit Obligation	-	291,697	-	3,160	-	-	-	682,042	976,899
Other Liabilities	43,531	326,222	92,008	114,095	31,165	600,738	75,244	1,527,497	2,810,500
Total Liabilities	$ 479,557	2,783,867	1,283,427	1,223,714	669,437	4,511,883	771,940	5,478,820	17,202,645
Net Assets:									
Controlling Interests	2,096,785	802,599	1,687,733	4,361,983	988,605	4,695,858	770,059	103,064	15,506,686
Noncontrolling Interests	16,787	6,859	-	2,270	-	334,351	16,700	28,106	405,073
Net Assets Without Donor Restrictions	2,113,572	809,458	1,687,733	4,364,253	988,605	5,030,209	786,759	131,170	15,911,759
Net Assets With Donor Restrictions	29,676	155,161	44,579	294,011	95,226	998,895	43,981	99,028	1,760,557
Total Net Assets	2,143,248	964,619	1,732,312	4,658,264	1,083,831	6,029,104	830,740	230,198	17,672,316
Total Liabilities and Net Assets	$ 2,622,805	3,748,486	3,015,739	5,881,978	1,753,268	10,540,987	1,602,680	5,709,018	34,874,961

EXHIBIT 7.8 - KEY PERFORMANCE METRICS BY REGION

	Ended December 31, 2021							
	Alaska	Puget Sound Region	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Consolidated
Inpatient Admissions	15,789	98,729	66,405	56,417	26,729	171,817	21,953	457,839
Acute Patient Days	125,561	592,756	396,948	335,803	149,883	801,906	128,918	2,531,775
Acute Outpatient Visits	478,726	2,221,071	1,988,418	3,592,030	749,391	3,354,130	761,581	13,157,877
Primary Care Visits	119,072	2,698,294	2,719,281	2,239,543	737,085	3,401,506	616,737	13,371,271
Inpatient Surgeries and Procedures	8,490	42,818	32,405	24,879	7,430	65,715	6,222	187,959
Outpatient Surgeries and Procedures	11,658	91,357	69,405	130,758	17,251	133,062	20,281	486,303
Long-Term Care Admissions	200	n/a	n/a	66	14	1,691	307	4,444
Long-Term Care Patient Days	52,815	n/a	n/a	9,350	5,694	70,563	8,319	317,096
Long-Term Care Average Daily Census	113	n/a	n/a	26	16	n/a	23	226
Home Health Visits	14,084	n/a	4,916	n/a	n/a	n/a	n/a	1,088,713
Hospice Days	24,364	n/a	n/a	n/a	n/a	5,294	68,885	1,115,010
Housing and Assisted Living Days	28,461	n/a	966	42,176	n/a	n/a	n/a	442,140
Health Plan Members	n/a	n/a	n/a	668,189	n/a	n/a	n/a	668,189
Average Daily Census	344	1,624	1,088	920	411	2,197	353	6,936
Acute Licensed Beds	482	2,666	1,824	1,500	809	3,846	874	12,001
FTEs	3,702	18,059	13,641	15,240	4,724	26,297	5,521	105,117

PROVIDENCE ST. JOSEPH HEALTH

Combined Financial Statements

December 31, 2021 and 2020

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

Opinion

We have audited the combined financial statements of Providence St. Joseph Health (the Health System), which comprise the combined balance sheets as of December 31, 2021 and 2020, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

In our opinion, the accompanying combined financial statements present fairly, in all material respects, the financial position of the Health System as of December 31, 2021 and 2020, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

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 Auditors' Responsibilities for the Audit of the Combined Financial Statements section of our report. We are required to be independent of the Health System 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 Combined Financial Statements

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

In preparing the combined financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for one year after the date that the combined financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Combined Financial Statements

Our objectives are to obtain reasonable assurance about whether the combined financial statements, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our 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 the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the combined financial statements.

KPMG LLP, a Delaware limited liability partnership and a member firm of
the KPMG global organization of independent member firms affiliated with
KPMG International Limited, a private English company limited by guarantee.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the combined financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the combined financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the combined financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for a reasonable period of time.

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

Other Information

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The Obligated Group Combining Balance Sheets and Statements of Operations Information included on pages 35 and 36 is presented for purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 8, 2022

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2021 and 2020

(In millions of dollars)

Assets		2021	2020
Current assets:			
Cash and cash equivalents	$	1,143	3,230
Accounts receivable		3,158	2,365
Supplies inventory		402	361
Other current assets		1,649	1,480
Current portion of assets whose use is limited		1,491	1,228
Total current assets		7,843	8,664
Assets whose use is limited		12,290	11,506
Property, plant, and equipment, net		11,329	11,033
Operating lease right-of-use assets		1,012	1,219
Other assets		2,401	2,232
Total assets	$	34,875	34,654
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	81	127
Master trust debt classified as short-term		189	934
Accounts payable		1,432	1,155
Accrued compensation		1,627	1,453
Current portion of operating lease right-of-use liabilities		197	262
Other current liabilities		3,056	2,758
Total current liabilities		6,582	6,689
Long-term debt, net of current portion		6,834	6,061
Pension benefit obligation		977	1,203
Long-term operating lease right-of-use liabilities, net of current portion		992	1,145
Other liabilities		1,818	2,840
Total liabilities		17,203	17,938
Net assets:			
Controlling interests		15,507	14,857
Noncontrolling interests		404	309
Net assets without donor restrictions		15,911	15,166
Net assets with donor restrictions		1,761	1,550
Total net assets		17,672	16,716
Total liabilities and net assets	$	34,875	34,654

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Operations

Years ended December 31, 2021 and 2020

(In millions of dollars)

		2021	2020
Operating revenues:			
Net patient service revenues	$	20,908	18,964
Premium revenues		2,320	2,424
Capitation revenues		1,870	1,732
Other revenues		2,230	2,555
Total operating revenues		27,328	25,675
Operating expenses:			
Salaries and benefits		13,966	12,646
Supplies		4,168	3,821
Purchased healthcare services		2,129	1,989
Interest, depreciation, and amortization		1,406	1,375
Purchased services, professional fees, and other		6,373	6,150
Total operating expenses		28,042	25,981
Deficit of revenue over expenses from operations		(714)	(306)
Net nonoperating gains (losses):			
Loss on extinguishment of debt		(3)	—
Investment income, net		1,245	1,106
Other		(10)	(60)
Total net nonoperating gains		1,232	1,046
Excess of revenues over expenses	$	518	740

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Changes in Net Assets

Years ended December 31, 2021 and 2020

(In millions of dollars)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2019	$ 14,344	150	1,381	15,875
Excess of revenues over expenses	688	52	—	740
Contributions, grants, and other	(80)	107	287	314
Net assets released from restriction	53	—	(118)	(65)
Pension related changes	(148)	—	—	(148)
Increase in net assets	513	159	169	841
Balance, December 31, 2020	14,857	309	1,550	16,716
Excess of revenues over expenses	443	75	—	518
Contributions, grants, and other	(53)	20	385	352
Net assets released from restriction	74	—	(174)	(100)
Pension related changes	186	—	—	186
Increase in net assets	650	95	211	956
Balance, December 31, 2021	$ 15,507	404	1,761	17,672

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2021 and 2020

(In millions of dollars)

		2021	2020
Cash flows from operating activities:			
Increase in net assets	$	956	841
Adjustments to reconcile increase in net assets to net cash (used in) provided by operating activities:			
Depreciation and amortization		1,154	1,110
Loss on extinguishment of debt		3	—
Gain on affiliation activities		(52)	—
Restricted contributions and investment income received		(385)	(287)
Net realized and unrealized gains on investments		(1,107)	(973)
Changes in certain current assets and liabilities		(286)	1,038
Change in certain long-term assets and liabilities		(1,224)	1,420
Net cash (used in) provided by operating activities		(941)	3,149
Cash flows from investing activities:			
Property, plant, and equipment additions, net of disposals		(1,295)	(978)
Purchases of alternative investments, commingled funds, and trading securities		(13,545)	(9,389)
Proceeds from sales of alternative investments, commingled funds, and trading securities		13,570	8,925
Cash paid through affiliation and divestiture activities, net of cash received		(152)	(189)
Other investing activities		(91)	(111)
Net cash used in investing activities		(1,513)	(1,742)
Cash flows from financing activities:			
Proceeds from restricted contributions and restricted income		385	287
Debt borrowings		1,337	1,106
Debt payments		(1,335)	(850)
Other financing activities		(20)	(36)
Net cash provided by financing activities		367	507
(Decrease) increase in cash and cash equivalents		(2,087)	1,914
Cash and cash equivalents, beginning of year		3,230	1,316
Cash and cash equivalents, end of year	$	1,143	3,230
Supplemental disclosure of cash flow information:			
Cash paid for interest, net of amounts capitalized	$	247	267

See accompanying notes to combined financial statements.

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence St. Joseph Health (the Health System), a Washington nonprofit corporation, is the sole corporate member of Providence Health & Services (PHS) and the St. Joseph Health System (SJHS). PHS, a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries. SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations include 52 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) and further described as a public charitable organization under Section 509(a)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax under Section 501(a) of the Internal Revenue Code as charitable organizations described in Section 501(c)(3). During 2021 and 2020, the Health System did not record any liability for unrecognized tax benefits.

(b) Basis of Presentation

The accompanying combined financial statements of the Health System were prepared in accordance with U.S. generally accepted accounting principles and include the assets, liabilities, revenues, and expenses of all wholly owned affiliates, majority-owned affiliates over which the Health System exercises control, and, when applicable, entities in which the Health System has a controlling financial interest. Intercompany balances and transactions have been eliminated in combination.

(c) Performance Indicator

The performance indicator is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from the performance indicator include net assets released from restriction for the purchase of property, plant, and equipment, certain changes in funded status of pension and other postretirement benefit plans, restricted contributions from affiliations, net changes in noncontrolling interests in combined joint ventures, and certain other activities.

(d) Operating and Nonoperating Activities

The Health System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, long-term care, population health management, and other healthcare and health insurance services. Activities directly associated with the furtherance of this mission are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health System's primary mission are considered to be nonoperating. Nonoperating activities include

investment earnings, gains or losses from debt extinguishment, certain pension related costs, gains or losses on interest rate swaps, and certain other activities.

(e) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) fair value of acquired assets and assumed liabilities in business combinations; (3) fair value of investments; (4) reserves for self-insured healthcare plans; and (5) reserves for professional, workers' compensation, and general insurance liability risks.

The accounting estimates used in the preparation of the combined financial statements will change as new events occur, additional information is obtained, or the operating environment changes. Assumptions and the related estimates are updated on an ongoing basis, and external experts may be employed to assist in the evaluation, as considered necessary. Actual results could materially differ from those estimates.

(f) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original or remaining maturity of three months or less when acquired.

(g) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(h) Investments Including Assets Whose Use Is Limited

The Health System has classified all of its investments as trading securities. These investments are reported on the combined balance sheets at fair value on a trade-date basis.

Assets whose use is limited primarily include assets held by trustees under indenture agreements and designated assets set aside by management of the Health System for future capital improvements and other purposes, over which management retains control. Assets whose use is limited also include funds held for self-insurance purposes, health plan medical claims payments and other statutory reserve requirements, as well as, assets held by related foundations.

(i) Liquidity

Cash and cash equivalents and accounts receivable are the primary liquid resources used by the Health System to meet expected expenditure needs within the next year. The Health System has credit facility programs, as described in Note 8, available to meet unanticipated liquidity needs. Although intended to satisfy long-term obligations, management estimates that approximately 64% and 67% of noncurrent investments, as stated at December 31, 2021 and 2020, respectively, could be utilized within the next year if needed.

(j) Derivative Instruments

The Health System allows certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage market risk related to the Health System's equity, fixed-income, and commodities holdings. Also, the Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating gains (losses) in the accompanying combined statements of operations.

(k) Net Assets

Net assets without donor restrictions are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in net assets without donor restrictions.

Net assets with donor restrictions are those whose use by the Health System has been limited by donors to a specific time period, in perpetuity, and/or purpose.

Net assets with donor restrictions are available for the following purposes as of December 31:

		2021	2020
Program support	$	1,421	1,242
Capital acquisition		235	208
Low-income housing and other		105	100
Total net assets with donor restrictions	$	1,761	1,550

(l) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise to give is no longer conditional. The gifts are reported as contributions with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported as other operating revenues in the combined statements of operations or as net assets released from restriction in the combined statements of changes in net assets.

(m) Charity Care and Community Benefit

The Health System provides community benefit activities that address significant health priorities within its geographic service areas. These activities include Medicaid and Medicare shortfalls, community health services, education and research, and free and low-cost care (charity care).

Charity care is reported at cost and is determined by multiplying the charges incurred at established rates for services rendered by the Health System's cost-to-charge ratio. The cost of charity care

(Continued)

provided by the Health System for the years ended December 31, 2021 and 2020 was $271 and $276, respectively.

(n) Subsequent Events

The Health System has performed an evaluation of subsequent events through March 8, 2022, the date the accompanying combined financial statements were issued.

In May 2020 two of the three corporate members of Hoag Hospital, Hoag Family Foundation and the Association of Presbyterian Members of Hoag, filed a complaint under a California Corporations Code statute seeking to involuntarily dissolve Covenant Health Network, the third corporate member. The complaint included removing Hoag Hospital as an Obligated Group Member through this involuntary dissolution claim. In January 2022, Hoag and the Health System reached an agreement to amicably end the affiliation, and Hoag exited from the Obligated Group on January 19, 2022. In accordance with this agreement, the complaint was dismissed with prejudice as to all claims, and the dismissal was entered by the Court on January 10, 2022. Hoag accounts for 7 percent of the Obligated Group's audited total operating revenues for the year ended December 31, 2021, and 7 percent of the Health System's audited total operating revenues for the year ended December 31, 2021. Hoag accounts for 17 percent of the Health System's unrestricted cash and investments, net of debt financing relating to Hoag assets, as of December 31, 2021. The Health System will record the disaffiliation transaction during the first quarter of 2022 and expects a nonoperating charge of approximately $3,300 pending further adjustments.

(o) New Accounting Pronouncements

In August 2018, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2018-13*, Fair Value Measurement (Topic 820) Changes to the Disclosure Requirements for Fair Value Measurement*, which modifies the disclosure requirements on fair value measurements in Topic 820, *Fair Value Measurement*. The Health System adopted ASU 2018-13 effective January 1, 2020, and the provisions of the standard did not have a material impact on the combined financial statements.

In May 2019, the FASB issued ASU 2019-06, *Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit entities*, which provides optional alternatives to goodwill and certain intangible assets acquired in a business combination. The alternatives are intended to (1) reduce the frequency of impairment tests; (2) simplify the impairment test when it is required; and (3) result in recognition of fewer intangible assets in future business combinations. The ASU also provides an alternative to amortize goodwill over ten years, or less than ten years if a shorter useful life is more appropriate. The Health System adopted the alternatives under the ASU as of January 1, 2021. Goodwill is amortized over a ten-year period, and the provisions of the standard did not have a material impact on the combined financial statements.

(p) Reclassifications

Certain reclassifications, which have no impact on net assets or changes in net assets, have been made to prior year amounts to conform to the current year presentation.

(2) COVID-19 Pandemic and CARES Act Funding

Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was enacted on March 27, 2020, authorized $100,000 in funding to hospitals and other healthcare providers that was distributed through the Public Health and Social Services Emergency Fund (the Fund). Payments from the Fund were intended to compensate healthcare providers for lost revenues and incremental expenses incurred in response to the COVID-19 pandemic and were not required to be repaid, provided the recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using this funding to reimburse expenses or losses that other sources are obligated to reimburse. The U.S. Department of Health and Human Services (HHS) initially distributed $30,000 of this funding based on each provider's share of total Medicare fee-for-service reimbursement in 2019 but announced that $50,000 in CARES Act funding (including the $30,000 already distributed) would be allocated proportional to providers' share of 2018 patient service revenue. HHS indicated that distributions of the remaining $50,000 were targeted primarily to hospitals in COVID-19 high impact areas, to rural providers, and to reimburse providers for COVID-19 related treatment of uninsured patients. The Health System received payments of approximately $1,072 from the Fund in 2020, and $957 was recognized as other operating revenue during the year ended December 31, 2020. The Health System received payments of approximately $228 from the Fund in 2021, and $313 was recognized as other operating revenue during the year ended December 31, 2021.

As a way to increase cash flow to Medicare providers impacted by the COVID-19 pandemic, the CARES Act expanded the Medicare Accelerated and Advance Payment Program. Inpatient acute care hospitals may request accelerated payments of up to 100% of the Medicare payment amount for a six-month period (not including Medicare Advantage payments), although CMS is now reevaluating pending and new applications in light of direct payments made available through the Fund. Under this program, CMS based payment amounts for inpatient acute care hospitals on the provider's Medicare fee-for-service reimbursements in the last six months of 2019. Such accelerated payments were interest free for inpatient acute care hospitals and the Health System's ambulatory providers for up to 29 months. The program required CMS to start recouping the payments beginning 12 months after receipt by the provider by withholding future Medicare fee-for-service payments for claims until the full accelerated payment has been recouped. The recoupment started at 25% for the first 11 months, and then increased to 50% for the succeeding six months. The program required any outstanding balance remaining after 29 months to be repaid by the provider or be subject to an interest rate currently set at 4%. The payments were made for services a healthcare entity provided to its Medicare patients who are the healthcare entity's customers. These payments have no impact on recognition of revenue, which is recognized at the time services are provided to the patients. In April 2020, the Health System received approximately $1,630 of accelerated payments, which were accrued on the combined balance sheets as of December 31, 2020 in other current and other long-term liabilities. These liabilities were reduced as claims submitted for services provided were recognized beginning after the one-year period. As of December 31, 2020, $996 was recorded in other long-term liabilities on the combined balance sheets. As of December 31, 2021, $1,009 was recorded in other current liabilities on the combined balance sheets.

The CARES Act also provided for deferred payment of the employer portion of social security taxes between March 27, 2020 and December 31, 2020, with 50% of the deferred amount due December 31, 2021 and the remaining 50% due December 31, 2022. The Health System began deferring the employer portion of social security taxes in mid-April 2020. As of December 31, 2020, the Health System deferred

(Continued)

$365 in social security taxes, which are included in accrued compensation and other long-term liabilities in the accompanying combined balance sheets. As of December 31, 2021, $183 in social security taxes are included in accrued compensation in the accompanying combined balance sheets.

Under accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect reported amounts. Accordingly, the impact of COVID-19 has increased the uncertainty associated with several of the assumptions underlying management's estimates. COVID-19's overall impact on the Health System will be driven primarily by the severity and duration of the pandemic; the pandemic's impact on the United States economy and the timing, scope, and effectiveness of federal, state, and local governmental responses to the pandemic. Those primary drivers are uncertain and beyond management's control and may adversely impact the Health System's revenue growth, supply chain, investments, and workforce, among other aspects of the Health System's business. The actual impact of COVID-19 on the Health System's combined financial statements may differ significantly from the judgments and estimates made as of the year ended December 31, 2021.

(3) Revenue Recognition

(a) Net Patient Service Revenues

The Health System has agreements with governmental and other third-party payors that provide for payments to the Health System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods.

Net patient service revenues are recognized at the time services are provided to patients. Revenue is recorded in the amount which the Health System expects to collect, which may include variable components. Variable consideration is included in the transaction price to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of $48 and $20 for the years ended December 31, 2021 and 2020, respectively.

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers of Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were $624 and $753 for the years ended December 31, 2021 and 2020, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were $863 and $1,082 for the years ended December 31, 2021 and 2020, respectively.

(b) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of

the Health System's performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The balance of contract liabilities was $23 and $30 as of December 31, 2021 and 2020, respectively, and is included in other current liabilities in the combined balance sheets. The Health System has no material contract assets.

(c) Disaggregation of Revenue

The Health System earns the majority of its revenues from contracts with customers. Revenues and adjustments not related to contracts with customers are included in other revenue.

Operating revenues from contracts with customers by state are as follows for the years ended December 31:

		2021	2020
Alaska	$	912	830
Washington		7,358	6,543
Montana		475	427
Oregon		5,344	5,137
California		9,855	9,151
Texas		1,154	1,032
Total revenues from contracts with customers		25,098	23,120
Other revenues		2,230	2,555
Total operating revenues	$	27,328	25,675

Operating revenues from contracts with customers by line of business are as follows for the years ended December 31:

		2021	2020
Hospitals	$	17,614	16,145
Health plans and accountable care		2,580	2,739
Physician and outpatient activities		3,234	2,728
Long-term care, home care, and hospice		1,315	1,268
Other		355	240
Total revenues from contracts with customers		25,098	23,120
Other revenues		2,230	2,555
Total operating revenues	$	27,328	25,675

Operating revenues from contracts with customers by payor are as follows for the years ended December 31:

		2021	2020
Commercial	$	12,350	11,331
Medicare		8,722	8,021
Medicaid		3,645	3,517
Self-pay and other		381	251
Total revenues from contracts with customers		25,098	23,120
Other revenues		2,230	2,555
Total operating revenues	$	27,328	25,675

(4) Fair Value Measurements

ASC Topic 820, *Fair Value Measurements,* requires a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs include quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs include inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

(a) Assets Whose Use Is Limited

The fair value of assets whose use is limited, other than those investments measured using net asset value per share (NAV) as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable.

The composition of assets whose use is limited is set forth in the following tables:

	December 31,	Fair value measurements at reporting date using		
	2021	Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 697	697	—	—
Equity securities:				
Domestic	1,256	1,256	—	—
Foreign	467	467	—	—
Mutual funds	2,218	2,218	—	—
Domestic debt securities:				
State and federal government	2,048	1,672	376	—
Corporate	980	—	980	—
Other	554	—	554	—
Foreign debt securities	315	—	315	—
Commingled funds	110	110	—	—
Other	24	12	12	—
Investments measured using NAV	4,282			
Total management-designated cash and investments	12,951			
Gift annuities, trusts, and other	370	80	14	276
Funds held by trustee:				
Cash and cash equivalents	96	96	—	—
Domestic debt securities	332	204	128	—
Foreign debt securities	32	—	32	—
Total funds held by trustee	460			
Total assets whose use is limited	$ 13,781			

(Continued)

	December 31, 2020	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 940	940	—	—
Equity securities:				
Domestic	1,274	1,274	—	—
Foreign	491	491	—	—
Mutual funds	1,645	1,645	—	—
Domestic debt securities:				
State and federal government	1,613	1,104	509	—
Corporate	1,159	—	1,159	—
Other	851	—	851	—
Foreign debt securities	466	—	466	—
Commingled funds	132	132	—	—
Other	7	4	3	—
Investments measured using NAV	3,455			
Total management-designated cash and investments	12,033			
Gift annuities, trusts, and other	264	53	12	199
Funds held by trustee:				
Cash and cash equivalents	178	178	—	—
Domestic debt securities	232	86	146	—
Foreign debt securities	27	—	27	—
Total funds held by trustee	437			
Total assets whose use is limited	$ 12,734			

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds, the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

The following table presents information, including unfunded commitments for investments where the NAV was used to estimate the value of the investments as of December 31:

	Fair value		Unfunded	Redemption	Redemption
	2021	2020	commitments	frequency	notice period
Hedge funds:					
Long/short equity	$ 866	598	—	Monthly, quarterly, semi-annually, or annually	30–120 days
Credit	290	272	9	Quarterly or annually	45–150 days
Relative value	172	178	—	Quarterly	60–90 days
Global macro	173	112	30	Monthly or quarterly	2–90 days
Fund of hedge funds	19	18	—	Quarterly	90 days
Private equity	1,210	797	591	Not applicable	Not applicable
Private real estate	294	250	185	Not applicable	Not applicable
Real assets	159	113	75	Monthly or quarterly	10–60 days
Commingled	1,099	1,117	—	Monthly, quarterly, semi-annually, or annually	6–90 days
Total	$ 4,282	3,455	890		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies, such as long/short equity, credit, relative value, global macro, and fund of hedge funds positions in both domestic and international markets, with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include certain funds with provisions that limit the Health System's ability to access assets invested. These provisions include lockup terms that range up to three years from the subscription date or are continuous and determined as a percent of total assets invested. The Health System is in various stages of the lockup periods dependent on hedge fund and period of initial investments.

Private equity and private real estate funds make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

Real asset strategies invest in securities backed by tangible real assets, with the objective of achieving attractive diversified total returns over the long term, while maximizing the potential for real returns in periods of rising inflation. Real asset investments should provide a return in excess of inflation, and their performance should be sensitive to changes in inflation or expectations for future levels of inflation. The real asset category is made up of many different underlying sectors inclusive of agriculture, commodities, gold, infrastructure, private energy, MLPs (Master Limited Partnerships), real estate, REITs (Real Estate Investment Trusts), timberland, and TIPS (Treasury Inflation Protected Securities). Each of these sectors tends to have a high degree of sensitivity to inflation and be less correlated with traditional equities and fixed income.

Commingled describes a type of fund structure. Commingled funds consist of assets from several accounts that are blended together. Investors in commingled fund investments benefit from economies of scale, which allow for lower trading costs per dollar of investment.

(b) Unsettled Transactions

Investment sales and purchases initiated prior to and settled subsequent to the combined balance sheet date result in amounts due from and to brokers. As of December 31, 2021, the Health System recorded a receivable of $28 for investments sold but not settled and a payable of $43 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets. As of December 31, 2020, the Health System recorded a receivable of $35 for investments sold but not settled and a payable of $68 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets.

(c) Derivative Instruments

The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in assets whose use is limited in the combined balance sheets as of December 31:

		2021	2020
Derivative assets:			
Futures contracts	$	922	762
Foreign currency forwards and other contracts		94	180
Total derivative assets	$	1,016	942
Derivative liabilities:			
Futures contracts	$	(922)	(762)
Foreign currency forwards and other contracts		(95)	(179)
Total derivative liabilities	$	(1,017)	(941)

The Health System also uses short-term forward purchase and sale commitments of mortgage-backed assets. The total notional derivative amount of mortgage contracts purchased and sold was $893 and $437, respectively, as of December 31, 2021. The total notional derivative amount of mortgage contracts purchased and sold was $843 and $386, respectively, as of December 31, 2020. These meet the definition of a derivative instrument in cases where physical delivery of the assets is not taken at the earliest available delivery date.

(d) Investment Income, Net

		2021	2020
Interest and dividend income	$	138	133
Net realized gains on sale of trading securities		506	281
Change in net unrealized gains on trading securities		601	692
Investment income, net	$	1,245	1,106

(e) Assets Measured Using Significant Unobservable Inputs

Level 3 assets include charitable remainder trusts, real property, and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

The Health System had Level 3 purchases of $45 and $56 in 2021 and 2020, respectively. The Health System had Level 3 sales of $41 and $56 in 2021 and 2020, respectively. There were $4 transfers out of Level 3 in 2021. There were no transfers in or out of Level 3 in 2020.

(5) Property, Plant, and Equipment, Net

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, and maintenance and repairs are expensed. The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term. Impairment of property, plant, and equipment is assessed when there is evidence that events or changes in circumstances have made recovery of the net carrying value of assets unlikely.

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use.

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Property, plant, and equipment and the total accumulated depreciation are as follows as of December 31:

	Approximate useful life (years)	2021	2020
Land	—	$ 1,530	1,515
Buildings and improvements	5–60	11,406	10,914
Equipment:			
Fixed	5–25	1,373	1,364
Major movable and minor	3–20	7,003	6,673
Construction in progress	—	1,820	1,380
		23,132	21,846
Less accumulated depreciation		(11,803)	(10,813)
Property, plant, and equipment, net		$ 11,329	11,033

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized for software development.

(6) Other Assets

Other assets are summarized as follows as of December 31:

	2021	2020
Investment in nonconsolidated joint ventures	$ 399	341
Goodwill, net of accumulated amortization	441	417
Intangible assets, net of accumulated amortization	242	289
Beneficial interest in noncontrolled foundations	320	277
Other	999	908
Total other assets	$ 2,401	2,232

Goodwill is recorded as the excess of cost over fair value of the acquired net assets. Beginning in 2021 with the adoption of ASU 2019-06, goodwill is amortized over a ten-year period. Goodwill is tested for impairment when a triggering event occurs that indicates that it is more likely than not that the fair value of the reporting unit is below its carrying value. The Health System recorded no goodwill impairment for the years ended December 31, 2021 and 2020.

Indefinite-lived intangible assets are recorded at fair value using various methods depending on the nature of the intangible asset and are tested annually for impairment. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

(7) Leases

The Health System enters into operating and finance leases primarily for buildings and equipment. For leases with terms greater than 12 months, the Health System records the related right-of-use (ROU) asset and liability at the present value of the lease payments over the contract term using the Health System's incremental borrowing rate. Building lease agreements generally require the Health System to pay maintenance, repairs, and property taxes, which are variable based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU asset or lease liability. Variable lease costs also include escalating rent payments that are not fixed at lease commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation. Most leases include one or more options to renew the lease at 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 the Health System's discretion and are evaluated at the lease commencement, with only those that are reasonably certain of exercise included in determining the appropriate lease term.

The components of lease cost are as follows for the year ended December 31:

		2021	2020
Operating lease cost:			
Fixed lease expense	$	257	282
Short-term lease expense		32	11
Variable lease expense		159	147
Total operating lease cost	$	448	440
Finance lease cost:			
Amortization of ROU assets	$	35	30
Interest on finance lease liabilities		26	22
Total finance lease cost	$	61	52

Supplemental cash flow and other information related to leases as of and for the year ended December 31 are as follows:

		2021	2020
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows from operating leases	$	254	282
Operating cash flows from finance leases		27	23
Financing cash flows from finance leases		26	23
Additions to ROU assets obtained from operating leases		34	189
Additions to ROU assets obtained from finance leases		5	222
Weighted-average remaining lease term (in years):			
Operating leases		9	10
Finance leases		17	18
Weighted-average discount rate:			
Operating leases		3.6 %	3.6 %
Finance leases		6.0 %	6.0 %

Commitments related to noncancellable operating and finance leases for each of the next five years and thereafter as of December 31, 2021 are as follows:

		Operating	Finance
2022	$	233	53
2023		215	49
2024		163	47
2025		146	44
2026		130	43
Thereafter		506	493
		1,393	729
Less imputed interest		204	286
Total lease liabilities		1,189	443
Less current portion		197	34
Long-term portion	$	992	409

Lease assets and lease liabilities as of December 31 were as follows:

	Classification		2021	2020
Assets:				
Operating	Operating leases ROU assets	$	1,012	1,219
Finance	Property, plant, and equipment, net		412	436
Liabilities:				
Current:				
Operating	Current portion of operating lease ROU liabilities		197	262
Finance	Current portion of long-term debt		34	38
Long-term:				
Operating	Long-term operating lease ROU liabilities, net of current portion		992	1,145
Finance	Long-term debt, net of current portion		409	432

(8) Debt

(a) Short-Term and Long-Term Debt

The Health System has borrowed master trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)
- Wisconsin Public Finance Authority (WPFA)

Short-term and long-term unpaid principal consists of the following at December 31:

	Maturing through	Coupon rates	Unpaid principal 2021	Unpaid principal 2020
Master trust debt:				
Fixed rate:				
Series 2005, Direct Obligation Notes	2030	5.30–5.39%	$ 31	33
Series 2008B, LHFDC Revenue Bonds	2023	4.00–5.00	4	5
Series 2009C, CHFFA Revenue Bonds	2034	5.00	91	91
Series 2009D, CHFFA Revenue Bonds	2034	1.70	40	40
Series 2011A, AIDEA Revenue Bonds	2041	5.00–5.50	—	123
Series 2011B, WHCFA Revenue Bonds	2021	3.50–5.00	—	11
Series 2011C, OFA Revenue Bonds	2026	3.50–5.00	6	8
Series 2012A, WHCFA Revenue Bonds	2042	3.00–5.00	441	452
Series 2012B, WHCFA Revenue Bonds	2042	4.00–5.00	—	100
Series 2013A, OFA Revenue Bonds	2024	5.00	25	33
Series 2013A, CHFFA Revenue Bonds	2037	4.00–5.00	324	325
Series 2013D, Direct Obligation Notes	2023	4.38	252	252
Series 2014A, CHFFA Revenue Bonds	2038	4.00–5.00	170	180
Series 2014B, CHFFA Revenue Bonds	2044	4.25–5.00	119	119
Series 2014C, WHCFA Revenue Bonds	2044	4.00–5.00	80	92
Series 2014D, WHCFA Revenue Bonds	2041	5.00	177	177
Series 2015A, WHCFA Revenue Bonds	2045	4.00	78	78
Series 2015C, OFA Revenue Bonds	2045	4.00–5.00	71	71
Series 2016A, CHFFA Revenue Bonds	2047	2.50–5.00	448	448
Series 2016B, CHFFA Revenue Bonds	2036	1.25–4.00	190	190
Series 2016H, Direct Obligation Bonds	2036	2.75	300	300
Series 2016I, Direct Obligation Bonds	2047	3.74	400	400
Series 2018A, Direct Obligation Bonds	2048	4.00	350	350
Series 2018B, WHCFA Revenue Bonds	2033	5.00	142	142
Series 2019A, Direct Obligation Bonds	2029	2.53	650	650
Series 2019B, CHFFA Revenue Bonds	2039	5.00	118	118
Series 2019C, CHFFA Revenue Bonds	2039	5.00	323	323
Series 2021A, Direct Obligation Bonds	2051	2.70	775	—
Series 2021B, WHCFA Revenue Bonds	2042	4.00	178	—
Series 2021C, PFA Revenue Bonds	2041	4.00	102	—
Total fixed rate			5,885	5,111

	Maturing through	Effective interest rate (1) 2021	Effective interest rate (1) 2020	Unpaid principal 2021	Unpaid principal 2020
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	0.03 %	0.58 %	$ —	80
Series 2012D, WHCFA Revenue Bonds	2042	0.03	0.58	—	80
Series 2012E, Direct Obligation Notes	2042	0.07	0.85	—	221
Series 2016C, LHFDC Revenue Bonds	2030	0.57	0.92	29	31
Series 2016D, WHCFA Revenue Bonds	2036	0.67	1.01	75	86
Series 2016E, WHCFA Revenue Bonds	2036	0.59	0.94	55	86
Series 2016F, MFFA Revenue Bonds	2026	0.57	0.92	27	32
Series 2016G, Direct Obligation Notes	2047	0.08	0.73	—	100
Total variable rate				186	716
Wells Fargo Credit Facility	2021	Not applicable	2.92	—	205
Wells Fargo Credit Facility	2021	Not applicable	1.52	—	250
Wells Fargo Credit Facility	2026	0.65 %	Not applicable	205	—
Unpaid principal, master trust debt				6,276	6,282
Premiums, discounts, and unamortized financing costs, net				225	202
Master trust debt, including premiums and discounts, net				6,501	6,484
Other long-term debt				603	638
Total debt				$ 7,104	7,122

(1) Variable rate debt and credit facilities carry floating interest rates attached to indexes, which are subject to change based on market conditions.

Short-term master trust debt includes debt issued with final maturity or mandatory redemption within one year of December 31, 2021 and 2020. In March 2020, the Health System placed a $250 short-term bridge loan from Wells Fargo Bank, NA with a final maturity of March 2021. In October 2020, the Health System drew $205 from its syndicated revolver, administered by Wells Fargo Bank, with an agreement maturity of September 2021. At December 31, 2020, the Health System also had $377 of debt with remarketing provisions supported by syndicated credit facilities, administered by US Bank, NA, which matured in July 2021 and a mandatory redemption of $100 that occurred in October 2021.

During 2021, the Health System issued $1,112 of Series 2021A, 2021B, and 2021C revenue bonds and direct obligation bonds. The intended uses of funds included refinancing legacy SJHS and PHS master trust debt and repayment of outstanding lines of credit. The Health System recorded nonoperating losses of $3 due to extinguishment of debt during the year ended December 31, 2021.

The following table reflects classification of long-term debt obligations in the accompanying combined balance sheets as of December 31:

		2021	2020
Current portion of long-term debt	$	81	127
Master trust debt classified as short-term		189	934
Long-term debt, classified as a long-term liability		6,834	6,061
Total debt	$	7,104	7,122

(b) Other Long-Term Debt

Other long-term debt consists of the following as of December 31:

		2021	2020
Finance leases	$	443	470
Notes payable		157	164
Bonds not under master trust indenture and other		3	4
Total other long-term debt	$	603	638

(c) Debt Service

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

		Master trust	Other	Total
2022	$	231	39	270
2023		327	33	360
2024		176	29	205
2025		492	30	522
2026		580	60	640
Thereafter		4,470	412	4,882
Scheduled principal payments of long-term debt	$	6,276	603	6,879

(d) Derivative Instruments

The Health System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. As of December 31, 2021 and 2020, the Health System had interest rate swap contracts with a total current notional amount totaling $401 and $418, respectively, with varying expiration dates. The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating gains (losses) in the accompanying combined statements of operations. Settlements related to these agreements are classified as a component of interest, depreciation, and amortization expense in the accompanying combined statements of operations. For the years ended December 31, 2021 and 2020, the change in valuation was a gain of $27 and a loss of $25, respectively, and settlements recognized as a component of interest expense were $13 and $12, respectively.

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. The fair value of the interest rate swaps is based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, taking also into account any nonperformance risk. Collateral posted for the interest rate swaps consist of cash and U.S. government securities, which are both categorized as Level 1 financial instruments.

As of December 31, 2021 and 2020, the fair value of outstanding interest rate swaps was in a net liability position of $115 and $142, respectively, and is included in other liabilities in the accompanying combined balance sheets. Collateral posted in connection with the outstanding swap agreements as of December 31, 2021 and 2020 was $17 and $40, respectively. These amounts were included in other assets in the accompanying combined balance sheets.

The following tables present the fair value of swaps:

	December 31, 2021	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Liabilities under interest rate swaps	$ 115	—	115	—

	December 31, 2020	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Liabilities under interest rate swaps	$ 142	—	142	—

(9) Retirement Plans

(a) Defined Benefit Plans

The Health System sponsors various frozen defined benefit retirement plans. The measurement dates for the defined benefit plans are December 31. A rollforward of the change in projected benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

		2021	2020
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	3,037	2,794
Service cost		17	16
Interest cost		79	95
Plan amendments		2	—
Actuarial (gain) loss		(56)	311
Benefits paid and other		(183)	(179)
Projected benefit obligation at end of year		2,896	3,037
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year		1,833	1,699
Actual return on plan assets		158	200
Employer contributions		111	113
Benefits paid and other		(183)	(179)
Fair value of plan assets at end of year		1,919	1,833
Funded status		(977)	(1,204)
Unrecognized net actuarial loss		534	720
Unrecognized prior service cost		2	—
Net amount recognized	$	(441)	(484)
Amounts recognized in the combined balance sheets consist of:			
Current liabilities	$	(1)	(1)
Noncurrent liabilities		(974)	(1,203)
Unrestricted net assets		534	720
Net amount recognized	$	(441)	(484)
Weighted average assumptions:			
Discount rate		3.00 %	2.70 %
Rate of increase in compensation levels		4.00	3.00
Long-term rate of return on assets		6.25	6.25

(Continued)

Net periodic pension cost for the defined benefit plans includes the following components:

		2021	2020
Components of net periodic pension cost:			
Service cost	$	17	16
Interest cost		79	95
Expected return on plan assets		(101)	(98)
Recognized net actuarial loss		57	38
Net periodic pension cost	$	52	51
Special recognition – settlement expense	$	18	22

Certain plans sponsored by the Health System allow participants to receive their benefit through a lump-sum distribution upon election. When lump-sum distributions exceed the combined total of service cost and interest cost during a reporting period, settlement expense is recognized. Settlement expense represents the proportional recognition of unrecognized actuarial loss and prior service cost. Settlement expense for the years ended December 31, 2021 and 2020 is included in net nonoperating gains (losses) in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,845 and $2,983 at December 31, 2021 and 2020, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2022	$	190
2023		187
2024		185
2025		182
2026–2031		1,021
	$	1,765

The Health System expects to contribute approximately $110 to the defined benefit plans in 2021.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.25% in calculating the 2021 and 2020 expense amounts. This assumption is based on capital market assumptions and the plan's target asset allocation.

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.25% to be outside of a reasonable range of expected returns, or if actual plan

returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

The target asset allocation and expected long-term rate of return on assets (ELTRA) were as follows at December 31:

	2021 Target	2021 ELTRA	2020 Target	2020 ELTRA
Cash and cash equivalents	2 %	2.0 %	2 %	2.0 %
Equity securities	45	8%–9%	45	8%–9%
Debt securities	33	3%–4%	33	2%–3%
Other securities	20	5%–8%	20	5%–9%
Total	100 %	6.25 %	100 %	6.25 %

The following table presents the Health System's defined benefit plan assets measured at fair value:

	December 31, 2021	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 161	161	—	—
Equity securities:				
Domestic	308	308	—	—
Foreign	119	119	—	—
Mutual funds	276	276	—	—
Domestic debt securities:				
State and government	271	239	32	—
Corporate	151	—	151	—
Other	26	—	26	—
Foreign debt securities	56	—	56	—
Commingled funds	138	138	—	—
Investments measured using NAV	502			
Transactions pending settlement, net	(89)			
Total	$ 1,919			

The following table presents the Health System's defined benefit plan assets measured at fair value:

	December 31, 2020	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 76	76	—	—
Equity securities:				
Domestic	348	348	—	—
Foreign	134	134	—	—
Mutual funds	215	215	—	—
Domestic debt securities:				
State and government	409	362	47	—
Corporate	158	—	158	—
Other	18	—	18	—
Foreign debt securities	48	—	48	—
Commingled funds	143	143	—	—
Investments measured using NAV	492			
Transactions pending settlement, net	(208)			
Total	$ 1,833			

The Health System's defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments provided by the fund managers are reasonable estimates of fair value.

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value 2021	Fair value 2020	Redemption frequency	Redemption notice period
Hedge funds:				
Long/short equity	$ 45	55	Monthly or quarterly	30–65 days
Credit and other	165	61	Monthly or quarterly	90 days
Real assets	—	1	NA	NA
Risk parity	—	140	NA	NA
Commingled	292	235	Monthly	6–30 days
Total	$ 502	492		

The Health System's defined benefit plans also allow certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the plans' fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in the plans' assets as of December 31:

		2021	2020
Derivative assets:			
Futures contracts	$	233	160
Foreign currency forwards and other contracts		2	3
Total derivative assets	$	235	163
Derivative liabilities:			
Futures contracts	$	(233)	(160)
Foreign currency forwards and other contracts		(1)	(2)
Total derivative liabilities	$	(234)	(162)

(b) Defined Contribution Plans

The Health System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the Health System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $557 and $545 in 2021 and 2020, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(c) Other Plans

The Health System recorded amounts totaling $613 and $523 as of December 31, 2021 and 2020, respectively, based on the fair value of various 457 (b) plans' assets. These other plan assets are investments in mutual funds valued using Level 1 fair value measurements and are included in other assets in the accompanying combined balance sheets.

(10) Self-Insurance Liabilities

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates insurance captives, Providence Assurance, Inc. and American Unity Group, Ltd., to self-insure or reinsure certain layers of professional and general liability risk.

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported

claims and actuarially determined estimates of claims incurred but not reported. Insurance coverage in excess of the per occurrence self-insured retention has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2021 and 2020, the estimated liability for future costs of professional and general liability claims was $635 and $507, respectively. At December 31, 2021 and 2020, the estimated workers' compensation obligation was $387 and $399, respectively. Both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

(11) Commitments and Contingencies

(a) Commitments

Firm purchase commitments at December 31, 2021, primarily related to construction and equipment and software acquisition, are approximately $445.

(b) Litigation

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

(12) Functional Expenses

Operating expenses classified by their natural classification on the combined statements of operations are presented by their functional classifications as follows for the years ended December 31:

2021

	Program activities					Supporting activities			
	Hospitals	Health plans and accountable care	Physician and outpatient	Long-term care, home care, and hospice	Total programs	General and administrative	Other	Total supporting	Total operating expenses
Salaries and benefits	$ 7,668	146	2,694	721	11,229	2,267	470	2,737	13,966
Supplies	3,312	2	316	199	3,829	—	339	339	4,168
Purchased healthcare services	229	1,442	302	156	2,129	—	—	—	2,129
Interest, depreciation, and amortization	798	8	89	20	915	442	49	491	1,406
Purchased services, professional fees and other	2,988	211	1,245	128	4,572	1,576	225	1,801	6,373
Total operating expenses	$ 14,995	1,809	4,646	1,224	22,674	4,285	1,083	5,368	28,042

2020

	Program activities					Supporting activities			
	Hospitals	Health plans and accountable care	Physician and outpatient	Long-term care, home care, and hospice	Total programs	General and administrative	Other	Total supporting	Total operating expenses
Salaries and benefits	$ 7,049	141	2,458	687	10,335	2,042	269	2,311	12,646
Supplies	3,055	2	282	172	3,511	—	310	310	3,821
Purchased healthcare services	204	1,490	163	132	1,989	—	—	—	1,989
Interest, depreciation, and amortization	788	8	76	20	892	464	19	483	1,375
Purchased services, professional fees and other	3,122	261	1,212	134	4,729	1,268	153	1,421	6,150
Total operating expenses	$ 14,218	1,902	4,191	1,145	21,456	3,774	751	4,525	25,981

Supporting activities include costs that are not controllable by operational leadership. Health System leadership drives these costs, which benefit the entire Health System. Costs that are controllable by operational leadership are allocated to the respective program activities.

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Balance Sheets Information

December 31, 2021 and 2020

(In millions of dollars)

	2021			2020		
Assets	**Obligated Group**	**Nonobligated, Eliminations, and Other**	**Total combined**	**Obligated Group**	**Nonobligated, Eliminations, and Other**	**Total combined**
Current assets:						
Cash and cash equivalents	$ 244	899	1,143	2,281	949	3,230
Accounts receivable, net	2,823	335	3,158	2,184	181	2,365
Supplies inventory	379	23	402	344	17	361
Other current assets	1,561	88	1,649	1,284	196	1,480
Current por ion of assets whose use is limited	1,184	307	1,491	885	343	1,228
Total current assets	6,191	1,652	7,843	6,978	1,686	8,664
Assets whose use is limited	8,805	3,485	12,290	8,308	3,198	11,506
Property, plant, and equipment, net	10,020	1,309	11,329	9,866	1,167	11,033
Operating lease right-of-use assets	743	269	1,012	928	291	1,219
Other assets	2,926	(525)	2,401	2,760	(528)	2,232
Total assets	$ 28,685	6,190	34,875	28,840	5,814	34,654
Liabilities and Net Assets						
Current liabilities:						
Current por ion of long-term debt	$ 70	11	81	110	17	127
Master trust debt classified as short-term	189	—	189	934	—	934
Accounts payable	1,222	210	1,432	978	177	1,155
Accrued compensation	1,468	159	1,627	1,322	131	1,453
Current por ion of operating lease right-of-use liabilities	156	41	197	211	51	262
Other current liabilities	2,285	771	3,056	1,896	862	2,758
Total current liabili ies	5,390	1,192	6,582	5,451	1,238	6,689
Long-term debt, net of current portion	6,533	301	6,834	5,699	362	6,061
Pension benefit obligation	977	—	977	1,203	—	1,203
Long-term operating lease right-of-use liabilities, net of current portion	720	272	992	858	287	1,145
Other liabili ies	835	983	1,818	1,881	959	2,840
Total liabilities	14,455	2,748	17,203	15,092	2,846	17,938
Net assets:						
Net assets without donor restrictions	13,133	2,778	15,911	12,741	2,425	15,166
Net assets with donor restrictions	1,097	664	1,761	1,007	543	1,550
Total net assets	14,230	3,442	17,672	13,748	2,968	16,716
Total liabilities and net assets	$ 28,685	6,190	34,875	28,840	5,814	34,654

See accompanying independent auditors' report

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Statements of Operations Information

Years ended December 31, 2021 and 2020

(In millions of dollars)

	2021			2020		
	Obligated Group	Nonobligated, Eliminations, and Other	Total combined	Obligated Group	Nonobligated, Eliminations, and Other	Total combined
Operating revenues:						
Net patient service revenues	$ 19,404	1,504	20,908	17,762	1,202	18,964
Other revenues	2,726	3,694	6,420	3,127	3,584	6,711
Total operating revenues	22,130	5,198	27,328	20,889	4,786	25,675
Operating expenses:						
Salaries and benefits	11,980	1,986	13,966	11,001	1,645	12,646
Supplies	3,812	356	4,168	3,516	305	3,821
Interest, depreciation, and amortization	1,243	163	1,406	1,258	117	1,375
Purchased services, professional fees, and other	5,157	3,345	8,502	4,851	3,288	8,139
Total operating expenses	22,192	5,850	28,042	20,626	5,355	25,981
(Deficit) excess of revenues over expenses from operations	(62)	(652)	(714)	263	(569)	(306)
Net nonoperating gains (losses):						
Loss on extinguishment of debt	(3)	—	(3)	—	—	—
Investment income, net	1,078	167	1,245	871	235	1,106
Other	(18)	8	(10)	6	(66)	(60)
Total net nonoperating gains	1,057	175	1,232	877	169	1,046
Excess (deficit) of revenues over expenses	$ 995	(477)	518	1,140	(400)	740

See accompanying independent auditors' report.

Exhibit 22
Cath Lab Equipment List

Swedish Issaquah Cath Lab Equipment Inventory		
Capital Equipment	**Model Number**	**Manufacture SN**
X-Ray System Hybrid Lab		
Siemens Artis Zee		
Siemens Artis Zee		
Hemodynamic Monitoring System		
McKesson Software 13.21	13.21	
McKesson Software 13.21	13.21	
Contrast Power Injector		
Medrad Mark V	ProVis	109473
Medrad Mark V	ProVis	109570
Portable Ultrasound Units		
Sonosite X-Porte		04DCJO
Sonosite M-Turbo		Q5C16L
IVUS Units		
Boston Scientific IVUS/FFR	Polaris	202127
Phillips Vocano	5s	052-07129-001
FFR		
Boston Scientific FFR Link		SPM02779
Boston Scientific FFR Link		SPM05278
Defibrillator		
Life Pak	15	
Life Pak	15	
IABP Units		
Maquet	CS300	s1189250C1
Maquet (ICU)	CS300	s11890331
Maquet	Cardiosave	CH35179402
Temporary Pacemakers		
Medtronic-single	5348	PEP104637R
Medtronic-single	5348	PEP104850R
Medtronic-single (ICU)	5348	PEP104889R
Medtronic-dual (ICU)	5388	PFG153329R
O2 Sat Machine		
GEM5000		22010983
POCT		
iStat	300-C	344315
iStat	300-C	343060
Interventional Equipment		
Rotopro		RP005286
Angiojet	Ultra	64072
JetStream		1106-1631
EKOS		PT3B-5032
EKOS		PTB-5670
Shockwave-expected 3/2023		

Exhibit 23
DOH 2022-2023 PCI Numeric Need Methodology

Department of Health
2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology
Using COAP Data

Planning Area	County	2021 15+ Pop	2021 PCI Pop./1000 (1a)	2021 Inpatient PCIs CHARS	2021 Outpatient PCIs SURVEY	Total PSA PCIs	2021 Use Rate (1b)	2026 15+ Pop	2026 PCI Pop./ 1000 (1a)	2026 Use Rate	2026 Projected Demand (2a)	Current PCI Capacity (3d)	2026 Projected Net Need (4)	Projected Need/200 (5a)	# of New Programs (5b)
PSA 1	Adams	14,520		15	20			15,358							
	Asotin	18,972		<10	<10			19,589							
	Ferry	6,681		<10	<10			6,742							
	Grant	78,923		91	34			86,114							
	Lincoln	9,070		<10	16			9,056							
	Pend Oreille	11,912		17	12			12,250							
	Spokane	423,095		471	438			444,334							
	Stevens	38,795		73	56			40,226							
	Whitman	42,159		20	16			42,940							
	Total:	**644,125**	**644.12**			**1306**	**2.03**	**676,610**	**676.6**	**2.03**	**1,372**	**1,401**	**-29**	**-0.15**	**0**
PSA 2	Benton	160,587		186	156			172,316							
	Columbia	3,395		<10	<10			3,295							
	Franklin	74,119		52	29			85,599							
	Garfield	1,909		<10	<10			1,875							
	Walla Walla	50,952		89	59			52,167							
	Total:	**290,962**	**290.96**			**584**	**2.01**	**315,253**	**315.3**	**2.01**	**633**	**477**	**156**	**0.78**	**0**
PSA 3	Chelan	63,890		93	63			66,772							
	Douglas	35,385		48	25			37,845							
	Okanogan	34,962		46	36			35,816							
	Total:	**134,237**	**134.24**			**311**	**2.32**	**140,432**	**140.4**	**2.32**	**325**	**370**	**-45**	**-0.22**	**0**
PSA 4	Kittitas	39,844		60	47			42,027							
	Klickitat East	7,031		<10	<10			7,438							
	Yakima	197,706		287	176			208,220							
	Total:	**244,581**	**244.58**			**575**	**2.35**	**257,684**	**257.7**	**2.35**	**606**	**385**	**221**	**1.10**	**1**
PSA 5	Clark	409,608		333	291			445,459							
	Cowlitz	89,787		154	238			92,710							
	Klickitat Wes	12,805		<10	<10			13,691							
	Skamania	10,377		<10	<10			10,811							
	Wahkiakum	3,518		<10	13			3,453							
	Total:	**526,096**	**526.10**			**1047**	**1.99**	**566,124**	**566.1**	**1.99**	**1,127**	**1,226**	**-99**	**-0.50**	**0**

Source: County_Age Pop. Projections OFM August 2017
Sub county Pop Claritas 2021-2026
2021 COAP Data (Inpatient and Outpatient)

Department of Health
2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology
Using COAP Data

Planning Area	County	2021 15+ Pop	2021 PCI Pop./1000 (1a)	2021 Inpatient PCIs CHARS	2021 Outpatient PCIs SURVEY	Total PSA PCIs	2021 Use Rate (1b)	2026 15+ Pop	2026 PCI Pop./ 1000 (1a)	2026 Use Rate	2026 Projected Demand (2a)	Current PCI Capacity (3d)	2026 Projected Net Need (4)	Projected Need/200 (5a)	# of New Programs (5b)
PSA 6	Grays Harbo	61,593		121	119			62,813							
	Lewis	66,323		123	99			68,755							
	Mason	58,067		86	119			62,120							
	Pacific	18,250		28	34			18,374							
	Thurston	244,954		388	242			264,713							
	Total:	**449,187**	**449.19**			**1359**	**3.03**	**476,776**	**476.8**	**3.03**	**1,442**	**1,001**	**441**	**2.21**	**2**
PSA 7	Pierce East	333,741		456	413			358,464							
	Total:	**333,741**	**333.74**			**869**	**2.60**	**358,464**	**358.5**	**2.60**	**933**	**383**	**550**	**2.75**	**2**
PSA 8	Pierce West	400,286		403	639			418,904							
	Total:	**400,286**	**400.29**			**1042**	**2.60**	**418,904**	**418.9**	**2.60**	**1,090**	**1,687**	**-597**	**-2.98**	**0**
PSA 9	King East	1,032,518		816	1051			1,085,850							
	Total:	**1,032,518**	**1,032.52**			**1867**	**1.81**	**1,085,850**	**1085.8**	**1.81**	**1,963**	**1,764**	**199**	**1.00**	**0**
PSA 10	King West	875,827		630	652			923,504							
	Total:	**875,827**	**875.83**			**1282**	**1.46**	**923,504**	**923.5**	**1.46**	**1,352**	**2,521**	**-1,169**	**-5.85**	**0**
PSA 11	Snohomish	689,882		792	772			740,976							
	Total:	**689,882**	**689.88**			**1564**	**2.27**	**740,976**	**741.0**	**2.27**	**1,680**	**1,168**	**512**	**2.56**	**2**
PSA 12	Island	70,507		126	156			73,106							
	San Juan	15,227		23	28			15,925							
	Skagit	108,188		192	253			115,076							
	Total:	**193,922**	**193.92**			**778**	**4.01**	**204,106**	**204.1**	**4.01**	**819**	**427**	**392**	**1.96**	**1**
PSA 13	Clallam	64,450		142	269			66,312							
	Jefferson	29,449		57	119			30,873							
	Kitsap	228,935		309	684			240,361							
	Total:	**322,833**	**322.83**			**1580**	**4.89**	**337,546**	**337.5**	**4.89**	**1,652**	**1,336**	**316**	**1.58**	**1**
PSA 14	Whatcom	193,399		251	556			206,630							
	Total:	**193,399**	**193.40**			**807**	**4.17**	**206,630**	**206.6**	**4.17**	**862**	**1,020**	**-158**	**-0.79**	**0**

Source: County_Age Pop. Projections OFM August 2017
Sub county Pop Claritas 2021-2026
2021 COAP Data (Inpatient and Outpatient)

Department of Health

2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology

Using COAP Data

Planning Area	County	2021 15+ Pop	2021 PCI Pop./1000 (1a)	2021 PCIs (COAP ONLY)	2021 Use Rate (1b)	2026 15+ Pop	2026 PCI Pop./1000 (1a)	2026 Use Rate	2026 Projected Demand (2a)	Current PCI Capacity (3d)	2026 Projected Net Need (4)	Projected Need/200 (5a)	# of New Programs (5b)
PSA 1	Adams	14,520		33		15,358							
	Asotin	18,972		<10		19,589							
	Ferry	6,681		10		6,742							
	Grant	78,923		123		86,114							
	Lincoln	9,070		20		9,056							
	Pend Oreille	11,912		23		12,250							
	Spokane	423,095		704		444,334							
	Stevens	38,795		111		40,226							
	Whitman	42,159		30		42,940							
	Total:	**644,125**	**644.12**		**1.65**	**676,610**	**676.6**	**1.65**	**1,117**	**1,571**	**-454**	**-2.27**	**0**
PSA 2	Benton	160,587		313		172,316							
	Columbia	3,395		11		3,295							
	Franklin	74,119		93		85,599							
	Garfield	1,909		<10		1,875							
	Walla Walla	50,952		148		52,167							
	Total:	**290,962**	**290.96**		**1.94**	**315,253**	**315.3**	**1.94**	**612**	**525**	**87**	**0.44**	**0**
PSA 3	Chelan	63,890		172		66,772							
	Douglas	35,385		70		37,845							
	Okanogan	34,962		77		35,816							
	Total:	**134,237**	**134.24**		**2.38**	**140,432**	**140.4**	**2.38**	**334**	**384**	**-50**	**-0.25**	**0**
PSA 4	Kittitas	39,844		103		42,027							
	Klickitat East	7,031		<10		7,438							
	Yakima	197,706		491		208,220							
	Total:	**244,581**	**244.58**		**2.44**	**257,684**	**257.7**	**2.44**	**630**	**390**	**240**	**1.20**	**1**
PSA 5	Clark	409,608		554		445,459							
	Cowlitz	89,787		270		92,710							
	Klickitat Wes	12,805		<10		13,691							
	Skamania	10,377		<10		10,811							
	Wahkiakum	3,518		11		3,453							
	Total:	**526,096**	**526.10**		**1.61**	**566,124**	**566.1**	**1.61**	**910**	**917**	**-7**	**-0.03**	**0**

Source: County_Age Pop. Projections OFM August 2017
Sub county Pop Claritas 2021-2026
2021 COAP Data (Inpatient and Outpatient)

Department of Health
2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology
Using COAP Data

Planning Area	County	2021 15+ Pop	2021 PCI Pop./1000 (1a)	2021 PCIs (COAP ONLY)	2021 Use Rate (1b)	2026 15+ Pop	2026 PCI Pop./1000 (1a)	2026 Use Rate	2026 Projected Demand (2a)	Current PCI Capacity (3d)	2026 Projected Net Need (4)	Projected Need/200 (5a)	# of New Programs (5b)
PSA 6	Grays Harbo	61,593		225		62,813							
	Lewis	66,323		240		68,755							
	Mason	58,067		186		62,120							
	Pacific	18,250		57		18,374							
	Thurston	244,954		726		264,713							
	Total:	**449,187**	**449.19**		**3.19**	**476,776**	**476.8**	**3.19**	**1,522**	**1,176**	**346**	**1.73**	**1**
PSA 7	Pierce East	333,741		762		358,464							
	Total:	**333,741**	**333.74**		**2.28**	**358,464**	**358.5**	**2.28**	**818**	**417**	**401**	**2.01**	**2**
PSA 8	Pierce West	400,286		794		418,904							
	Total:	**400,286**	**400.29**		**1.98**	**418,904**	**418.9**	**1.98**	**831**	**1,407**	**-576**	**-2.88**	**0**
PSA 9	King East	1,032,518		1688		1,085,850							
	Total:	**1,032,518**	**1,032.52**		**1.63**	**1,085,850**	**1085.8**	**1.63**	**1,775**	**1,554**	**221**	**1.11**	**1**
PSA 10	King West	875,827		1229		923,504							
	Total:	**875,827**	**875.83**		**1.40**	**923,504**	**923.5**	**1.40**	**1,296**	**2,459**	**-1,163**	**-5.82**	**0**
PSA 11	Snohomish	689,882		1635		740,976							
	Total:	**689,882**	**689.88**		**2.37**	**740,976**	**741.0**	**2.37**	**1,756**	**1,276**	**480**	**2.40**	**2**
PSA 12	Island	70,507		209		73,106							
	San Juan	15,227		44		15,925							
	Skagit	108,188		324		115,076							
	Total:	**193,922**	**193.92**		**2.98**	**204,106**	**204.1**	**2.98**	**607**	**286**	**321**	**1.61**	**1**
PSA 13	Clallam	64,450		318		66,312							
	Jefferson	29,449		122		30,873							
	Kitsap	228,935		704		240,361							
	Total:	**322,833**	**322.83**		**3.54**	**337,546**	**337.5**	**3.54**	**1,196**	**920**	**276**	**1.38**	**1**
PSA 14	Whatcom	193,399		566		206,630							
	Total:	**193,399**	**193.40**		**2.93**	**206,630**	**206.6**	**2.93**	**605**	**697**	**-92**	**-4.61**	**0**

Source: County_Age Pop. Projections OFM August 2017
Sub county Pop Claritas 2021-2026
2021 COAP Data (Inpatient and Outpatient)

Exhibit 24
Letter to Department of Health and the Office of the Attorney General

October 21, 2022

VIA EMAIL

Mr. Eric Hernandez
Manager, Certificate of Need
Office of Community Health Systems
Department of Health
111 Israel Road SE
Tumwater, Washington 98501

Ms. Janis Snoey
Managing Assistant Attorney General
Office of the Attorney General
Agriculture and Health Division
7141 Cleanwater Drive SW
Olympia, Washington 98504

Re: Enforcement of Minimum Volume Standard for Percutaneous Coronary Intervention Programs

Dear Mr. Hernandez and Ms. Snoey:

On October 23, 2019, Swedish Health Services d/b/a Swedish Issaquah ("Swedish") was notified that its Certificate of Need ("CN") application (CN #19-66) proposing to establish an elective percutaneous coronary intervention ("PCI") program in Planning Area #9 (King East) had been denied by the Department of Health ("the Department") Certificate of Need Program ("CN Program"). The denial highlights an ongoing, significant issue within the State of Washington regarding the failure of some previously approved hospital PCI programs to meet the required minimum volume standard.

An in-person meeting was held on November 20, 2019, with representatives from the CN Program and the Office of the Attorney General to discuss our concerns and seek to understand how the Department planned to enforce the minimum volume standard for underperforming PCI programs or implement other rulemaking solutions. While assurances were offered during the meeting that the Department would look into the matter and seek to resolve the identified problems as soon as possible, three years has passed with no resolution. ***We are writing to request a meeting with you to discuss our ongoing concerns and to request that steps be taken to resolve this urgent matter <u>prior to</u> the start of the 2023 PCI concurrent review cycle.***

A. PCI Minimum Volume Standard and Requirement of Ongoing Compliance

The establishment of a new elective PCI program is subject to CN review as a new tertiary health service.[1] The Department has, by regulation, adopted standards governing both (1) the CN approval of new PCI programs and (2) the ongoing operation of programs after they have been approved.[2] The regulations "establish minimum requirements for obtaining a certificate of need and operating an elective PCI program".[3]

[1] WAC 246-310-020(1)(3)(i)(E).

[2] WAC 246-310-705 through WAC 246-310-755.

[3] WAC 246-310-700.

The volume standard for elective PCI programs is one of the key minimum requirements. Under this standard, a hospital PCI program must perform a minimum of 200 adult PCI procedures per year "by the end of the third year of operation and each year thereafter."[4] All existing PCI programs in a planning area must meet or exceed the annual minimum volume standard before a new elective PCI program can be approved.[5] Therefore, the monitoring and enforcement of the PCI minimum volume standard for existing programs is critical, as an underperforming program precludes the approval of a new elective PCI program, even in situations in which the need methodology establishes need for an additional program.

Per WAC 246-310-755, ongoing compliance with the PCI minimum volume standard is required:

> If the Department issues a certificate of need (CON), it will be conditioned to require ongoing compliance with the CON standards. Failure to meet the standards may be grounds for revocation or suspension of a hospital's CON, or other appropriate licensing or certification actions.
>
> (1) Hospitals granted a certificate of need must meet:
>
> (a) The program procedure volume standards within three years from the date of initiating the program; and
>
> (b) QA standards in WAC 246-310-740.
>
> (2) The Department may reevaluate these standards every three years.

B. Two Hospitals Have a History of Failing to Meet the PCI Minimum Volume Standard

On an annual basis, the Department conducts a survey of all hospitals in Washington State to determine the extent to which outpatient PCI services are used throughout the State and to project future need for outpatient services. The outpatient PCI data gathered from the surveys is combined with inpatient PCI data available in CHARS to determine the total number of PCIs performed by each hospital.

Based on the CHARS database and annual survey data, two hospitals – MultiCare Auburn Regional Medical Center and MultiCare Capital Medical Center – have a history of falling well below the annual PCI minimum volume standard. The standard was adopted to ensure patient safety and quality of care. To our knowledge, the Department has not conducted a review of these underperforming programs or sought to enforce ongoing compliance with the PCI minimum volume standard, despite both hospitals being significantly below the standard.

1. MultiCare Auburn Regional Medical Center

On October 23, 2009, the CN Program approved a CN application by Auburn Regional Medical Center ("Auburn Regional") to establish an elective PCI program, provided the applicant agreed to meet certain conditions.[6] However, the Auburn Regional PCI program has not, in fact, met the conditions associated with the minimum volume standard. At no

[4] WAC 246-310-720(1). On March 20, 2018, the Department adopted amended rules under WSR #18-07-102 that changed WAC 246-310-715, WAC 246-310-720, WAC 246-310-725 and WAC 246-310-745 to provide that hospitals with an elective PCI program must perform a minimum of two hundred adults PCIs per year by the end of the third year of operation and each year thereafter. Prior to the amendment, hospitals with an elective PCI program had to perform three hundred PCIs per year by the end of the third year of operation and each year thereafter.

[5] WAC 246-310-720(2)(b).

[6] CN Program Evaluation of Auburn Regional Medical Center PCI Application (October 23, 2009).

point during the past 12 years that Auburn Regional has sought to establish and operate an elective PCI program has it met or exceeded the minimum volume standard.

Table 1 shows the 2008-2021 PCI volumes at Auburn Regional, as well as the percentage of the required minimum volume for the hospital's PCI program. Based on historical volumes and trend, it is unlikely that Auburn Regional will ever attract enough patients to achieve the current 200 procedure per year minimum volume standard.

Table 1. PCI Volumes for MultiCare Auburn Regional Medical Center, 2008-2021

		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
MultiCare Auburn Regional Medical Center	Inpatient PCI	89	80	114	109	103	125	93	96	86	74	110	96	117	98
	Outpatient PCI			17	24	0	2	8	8	11	10	7	5	3	*
	Total PCI	**89**	**80**	**131**	**133**	**103**	**127**	**101**	**104**	**97**	**84**	**117**	**101**	**120**	*
	Required Volume			300	300	300	300	300	300	300	300	200	200	200	200
	% of Required Volume			43.7%	44.3%	34.3%	42.3%	33.7%	34.7%	32.3%	28.0%	58.5%	50.5%	60.0%	*

Source: CHARS 2008-2021 and DOH Outpatient PCI Surveys.

*As of October 21, 2022, MultiCare Auburn Region Medical Center has not filed its 2022 PCI Survey (Y2021 data).

2. MultiCare Capital Medical Center

On October 23, 2009, the CN Program also approved an application by Capital Medical Center ("Capital") to establish an elective PCI program.[7] Table 2 shows the 2008-2021 PCI volumes for Capital. Like Auburn Regional, Capital has remained well below the minimum volume standard, and its historical volumes indicate that it is unlikely ever to meet the standard.[8]

Table 2. PCI Volumes for MultiCare Capital Medical Center, 2008-2021

		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
MultiCare Capital Medical Center	Inpatient PCI	32	24	73	78	103	80	56	57	63	61	63	51	56	58
	Outpatient PCI		29	55	4	6	23	23	23	25	36	*	38	88	*
	Total PCI	**32**	**53**	**128**	**82**	**109**	**103**	**79**	**80**	**88**	**97**	*	**89**	**144**	*
	Required Volume			300	300	300	300	300	300	300	300	200	200	200	200
	% of Required Volume		17.7%	42.7%	27.3%	36.3%	34.3%	26.3%	26.7%	29.3%	32.3%	*	44.5%	72.0%	*

Source: CHARS 2008-2021 and DOH Outpatient PCI Surveys.

*As of October 21, 2022, MultiCare Capital Medical Center has not filed survey responses for its 2018 or 2021 outpatient PCI data.

---

[7] CN Program Evaluation of Capital Medical Center PCI Application (October 23, 2009).

[8] On September 19, 2014, the CN Program issued a Notice of Suspension of CN #1410 to Capital Medical Center ("Capital"). The Department, Providence St. Peter Hospital and Capital entered into a stipulated Agreed Order as a condition to Capital's CN to establish an elective PCI program. The Agreed Order required Capital to make "reasonable efforts" to meet charity care targets. Data from 2010-2012 demonstrated that Capital failed to make reasonable efforts to meet the charity care requirements, which provided the CN Program with grounds to suspend or revoke CN #1410. On March 15, 2016, Capital entered into a new settlement agreement. As part of this settlement, when Capital fails to provide the regional average of charity care, it is required to make donations to one or more local organizations that provide medical care to indigent persons. To date, Capital has failed to meet the charity care requirements and has had to make donations on an annual basis, per the terms of the settlement agreement. During this same period of time, Capital has failed to meet the minimum volume standard for PCI programs, but the Department has not enforced ongoing compliance with the volume standard.

C. Request for Immediate Action
The annual minimum volume standard for hospital PCI programs was implemented to protect patient safety and maintain high-quality clinical care. At the time that Auburn Regional and Capital were granted CN approval to establish elective PCI programs, the minimum volume standard was 300 procedures per year, a standard that neither hospital has come close to achieving during the history of its programs. Even with the new minimum volume standard of 200 procedures per year that was adopted in 2018, neither Auburn Regional nor Capital have met or exceeded the volume standard. In the meantime, no new hospital PCI programs can be approved in the PCI planning areas until the existing programs meet or exceed the minimum volume standard. This is of great concern when the PCI need methodology shows a need for an additional PCI program in a planning area such as King East, yet an underperforming program and the current WACs prevent a new program from addressing the unmet need.

We are urgently requesting that the Department either (a) enforce the minimum volume standard in WAC 246-310-755 or (b) complete rulemaking to amend WAC 246-310-720(2):

> (2) The department shall only grant a certificate of need to new programs within the identified planning area if:
>
> > (a) The state need forecasting methodology projects unmet volumes sufficient to establish one or more programs within a planning area; and
> >
> > (b) All existing PCI programs in that planning area are meeting or exceeding the minimum volume standard.

Without the enforcement of WAC 246-310-755, potential applicants – like Swedish Issaquah – have been prevented from addressing the unmet needs within the planning area. If the Department does not enforce the minimum volume standard for the underperforming programs, then eliminating WAC 246-310-720(2)(b) presents a viable solution that would increase access to care without undermining the viability of the underperforming programs at Auburn Regional or Capital.

Thanks for consideration of our request to discuss our concerns and seek to understand how the Department plans to resolve the current issues ***prior to*** the start of the 2023 PCI concurrent review cycle. We cannot let another year pass without addressing the unmet needs within the PCI planning areas, as failing to move quickly on this matter is withholding care and taking away opportunities for interested applicants to gain CN approval to establish new programs.

Please contact either of us to schedule a meeting as soon as possible so that we can discuss these matters further. We appreciate your assistance with this time-sensitive situation.

Sincerely,

Lisa A. Crockett
VP, System Strategy & Planning
Strategic Services
Providence
lisa.crockett@providence.org

Betsy M. Vo
VP, Division Senior Corporate Counsel – Central
Department of Legal Affairs
Providence
betsy.vo@providence.org

Exhibit 25
Medical Director Job Description

Providence SWEDISH

DESCRIPTION OF MEDICAL DIRECTOR DUTIES

Title: Medical Director, Swedish Heart and Vascular, Issaquah Department: Cath Lab

Reports to Job Title: Swedish Heart and Vascular Institute Executive Medical Director

Dyad Partner: Director of Operations, SHV, Clinic Administrator, and Cath Lab Manager

Job Summary:

The Medical Director models behaviors and actions that are in support of the SHS mission, vision, and values, and that fulfills our promise of patients and communities first.

The Medical Director conducts ongoing critical assessments of their department to develop, socialize and achieve goals that lead to Swedish realizing its mission.

The Medical Director works in a dyad partnership with an Administrative partner. The Medical Director is responsible for ensuring that all medical programs under his/her leadership conform to SHS standards of quality of care and that physicians and advanced practice clinicians ("APCs") adhere to all applicable SHS guidelines.

With their dyad partner, the Medical Director develops the strategic plan for the program in coordination with SHS administration and, where applicable, appropriate institute/enterprise/departmental leadership; assists with medical staff recruitment to achieve appropriate staffing levels; and ensures that clinic staff is well informed regarding relevant strategy, direction, current issues, and management response to those issues.

Depending on role and scope of responsibility, the Medical Director shares joint accountability with their dyad partner for attainment off financial performance targets and for compliance with accreditation standards, and organizational requirements, such as medical management strategies, disease management programs, and service improvement initiatives, including customer satisfaction and complaint resolution.

Medical Directors are responsible for providing annual performance reviews for all of the providers in their program/area of oversight in accordance with SHS policy and procedures.

Program and Position-Specific Roles, Responsibilities, and Accountabilities:

Core Competencies:

- Skills and desire to guide the overall development of the program incorporating new technologies, treatments, procedures, and or research
- Demonstrates strong interpersonal and communication skills, including an ability to communicate with a wide variety of individuals -- physicians, APCs, administrators, and support staff-- recognizing different styles and cultures.
- Possesses good listening skills, taking other viewpoints into consideration and encouraging feedback, especially from those who might not otherwise participate.
- Able to gain consensus among multiple constituencies using effective negotiation and persuasive skills. • Maintains flexibility and the ability to change direction on short notice.
- Prioritizes and works effectively under time constraints and pressure.
- Acts as a team player, balancing advocacy for one's own specialty/priorities and support of the greater goals for SHS and the institute/enterprise/department as a whole.
- Works collaboratively with SHS and institute/enterprise/departmental leadership to implement strategic goals

Core Duties and Responsibilities:

1. **Provide guidance and leadership**
    a. Foster an environment of teamwork and collaboration with the providers and staff, both in your department and as appropriate, organization wide.
    b. Provide effective leadership, by motivating staff and providers to produce excellence in their work both individually and as a team. Create a positive work environment for all staff.
    c. Create timely and direct communication channels to deal with service, clinical or performance issues, ensuring prompt and appropriate resolution.
    d. Serve as a role model in setting standard of practice and performance.
    e. Promote and provide opportunities for both clinical and/or administrative staff professional development.
2. **Accountabilities**
    a. Working with accountable leader and dyad partner, develop objectives and associated goals that align with SHS mission and strategic vision.
    b. Objectives and associated goals should be actionable and support the realization of the SHS strategic plan
    c. Achieves said goals
    d. On an annual basis, update objectives and goals with accountable leader and dyad partner based on previous year accomplishments and organizational needs and strategies.
3. **Partnership and engagement with Administrative Dyad**
    a. Medical Director will provide clinical direction and oversight, and Administrative Dyad will provide operational leadership and business expertise
    b. Trust, respect, recognition of the partnership.

c. Mutually accountable to dyad partner for collaborative decision making, planning, and execution of the work to be accomplished together.
d. Dedicated communication with dyad partner to be conducted on a regular basis.

4. **Provider relations and/or representation**
   a. Serve as a professional link between supervised medical staff and other Swedish medical directors, departments, and Administration to resolve conflicts, facilitate communication, and engage in development of interdisciplinary treatment teams and approaches.
5. **Monitor quality and appropriateness of medical care**
   a. Participate in clinic, department, or program-specific and system-wide quality assurance and improvement programs (including, but not limited to, Culture of Safety, HIM Chart Integrity, and Electronic Quality Variance Reporting) through active involvement in identifying indicators, utilization of services, and appropriateness of treatment for clinical services.
   b. Organize and lead multidisciplinary process to develop, maintain, and update clinical pathways, guidelines, and care plans related to specialty.
   c. Direct the development and implementation of methods to monitor and analyze outcomes, track project development and performance improvement for the program.
   d. Manage patient clinical complaints and feedback.
   e. Promote best practices around staff engagement, patient experience, and value.
6. **Clinical peer review**
   a. Monitor clinical adherence to all applicable SHS policies and procedures, initiating prompt corrective action plans to address issues.
   b. Provide direct supervision to all employed providers.
   c. Utilize tools and other resources to analyze provider performance and lead effort to address issues in conjunction with dyad partner.
7. **Organizational participation and communication**
   a. Attend relevant standing meetings with the administrative and provider staff to monitor and evaluate internal operations and progress towards meeting annual goals.
   b. Serve as the key communications link to staff physicians, other providers, and dyad partner by relaying all information garnered from meetings by tying institute/enterprise/departmental and SHS-wide efforts and initiatives to the clinic, program, or department level.
   c. Participate actively in meetings outside of specific clinic, program, or department and act as a liaison for communication and problem-solving both internally and externally.
8. **Strategic development**
   a. Participate in the institute/enterprise/departmental and SHS strategic planning processes, updating organizational design to maximize productivity and operational efficiency while improving quality and controlling costs.
   b. With the dyad partner work collaboratively in the budgeting process, helping to set reasonable financial goals and striving to maintain cost-effective practice guidelines while achieving the highest quality of care.
   c. Actively participate in the process of Care Transformation by supporting and implementing SHS strategic initiatives in Care Transformation.

9. **Monitor development and adherence to policies and procedures**
    a. Provide medical direction and oversight for the development, implementation and compliance with appropriate program policies, procedures, and standards of care.
    b. Consult and participate actively in all compliance efforts, including but not limited to, standards and recommendations of the Joint Commission or DNV, applicable standards of relevant professional societies, and all applicable local, state, and federal laws and regulations.
10. **Provider behavior and impairment issues**
    a. Promptly address provider behavior and impairment issues at the local level and/or seek assistance and guidance from SHS leadership, as appropriate.

Qualifications:

- Licensed Physician or Advanced Practice Clinician in the state of Washington
- Swedish Medical Center medical staff member in good standing
- Active Board Certification in relevant Specialty
- Active DBA Registration
- Participating provider status with Medicare, Medicaid, and applicable government programs

Exhibit 26
Nurses, Technologists, and Supervisor Job Descriptions

SWEDISH

Acute Care RN

Job Description

JOB INFORMATION

Primary JDID:	12122 6064
Job Title:	Acute Care RN
Job Content Title:	Registered Nurse (RN) Acute Care
FLSA:	
Original Creation Date:	1/1/2017 12:00:00 AM

ORGANIZATIONAL INFORMATION

Region:	
Employer:	Ext File JD Process Level.XLSX Not found!
Department:	
Reports To:	Unit Director/Manager and/or Clinical Coordinator

Key Relationships:

Reports to the Nurse Manager of the assigned nursing department or unit.

Accountable to the Chief Nursing Executive.

All members of the unit patient care team, to include providers and outside agencies

Patients and families receiving care.

MISSION, VALUES and VISION

The Mission:	Improve the health and well-being of each person we serve.
Our Values:	Compassion, Justice, Excellence, Dignity, Integrity and Safety
Our Vision:	Health for a Better World

GENERAL SUMMARY

The Registered Nurse (RN) provides professional, comprehensive nursing care for patients in an acute care environment. Accountable for the delivery of coordinated, safe, compassionate, therapeutic, evidence-based quality care to patients and families, based on individual physical, emotional, and spiritual needs, and appropriate care strategies throughout the lifespan. Practices in accordance with the Nurse Practice Act in the state of employment, the American Nurses Association (ANA) Code of Ethics for Nurses, and the ANA scope and standards of practice. Key functions and specific skills for the job are found in the unit specific onboarding checklist and in standards that are applicable to the specialty.

ESSENTIAL FUNCTIONS

The job duties listed are essential functions of the position. However, other duties may be assigned, and may also be considered essential functions of the position.
The caregiver must be sufficiently fluent in the English language to satisfactorily perform the essential functions of the position. The degree of fluency required will vary depending upon the nature of the position.

Caregivers are expected to honor the Mission, Values, Vision and Promise and adhere to the Code of Conduct, policies and standards of their organization.

For direct patient care roles: Performs and maintains currency of essential competencies as required by specific area of hire and populations served.

- Employs Nursing Professional Practice: Assesses, identifies appropriate nursing diagnoses, plans, implements and evaluates patients' care. Develops, updates and coordinates the patient's plan of care to achieve patient goals and to optimize outcomes and transitions across the care continuum. Monitors, records and communicates patient condition as appropriate. Performs and maintains currency of essential competencies as required by specific area of hire and populations served.
- Advocates: Effectively advocates for ethical and holistic care by partnering in care planning to promote the autonomy, dignity, rights, values and beliefs of those we serve.
- Facilitates Learning: Fosters a learning environment for patient/families, nursing, and other members of the healthcare team including students; facilitates formal and informal learning for patient/families, nursing, other members of the healthcare team, and community.

- Aligns Practice with Safety and Quality: Accountable for safety, identifies and corrects problems, and integrates evidence, and best practice into nursing care; uses data and evidence to improve patient outcomes. Aligns patient safety, self-safety and environmental safety as equally important for best outcomes.
- Engages in Professional Development: Engages in ongoing professional development; practices to the top of license within the legal parameters of the Nurse Practice Act, the Nursing Social Policy Statement, the ANA Code of Ethics for Nurses, and specialty standards. Promotes a culture of inquiry that explores, integrates and disseminates research and evidence based practice.
- Leads in the Practice Setting & Community: Leads and coordinates teams, appropriately delegates, coordinates care and collaborates with others as equal members of the inter-professional care team to integrate nursing knowledge. Models professional behaviors as a representative of the nursing profession.

QUALIFICATIONS

EDUCATION

Required/Preferred	*Education Level*	*Major/Area of Study*	*And/Or*
Required	Ext File Education.XLSX Not found!	Nursing degree/diploma required upon hire.	
Required	Bachelor's Degree	Bachelor's degree in Nursing or higher within 6 years of hire.	Or equivalent educ/experience
Preferred	Bachelor's Degree	Bachelor's degree in nursing upon hire.	

Education/Experience Equivalencies

- A RN with 20 years of RN experience will not be required to obtain a BSN.
- Exceptions will be considered on a case-by-case basis at each facility by the most senior administrative nursing leader in consultation with the Human Resources leader.

RNs employed prior to 1/1/13 are encouraged to obtain a Bachelor's degree or higher degree in Nursing, but obtaining the degree will not be a condition of employment.

EXPERIENCE

Required/Preferred	*Minimum Experience*	*Details*
Required	1 year	Acute care experience working with the patient population similar to department of hire or completion of the specialty residency located at that facility.

JOB SPECIFIC KNOWLEDGE, SKILLS and ABILITIES

- Able to read, write, understand and communicate in English to satisfactorily perform the essential functions of the position
- Proficiency with Information Technology; such as electronic health records, communications systems, computers and equipment necessary to perform essential functions of the position.
- Skilled to work with a wide range of staff as part of an interdisciplinary team including physicians, nurses, and ancillary staff.
- Ability to use independent, critical judgment in all aspects of patient care delivery.
- Demonstrated interpersonal skills that convey a positive and supportive attitude.
- Ability to effectively manage multiple responsibilities, urgent responses, and challenging situations.
- When working in the role as a Patient Safety Attendant or Sitter, is responsible for ensuring both patient and environmental safety measures.

SPECIAL EQUIPMENT

- Special patient care equipment, to include Safe Patient Handling equipment, as specified by the assigned nursing unit.
- Telephone, paging, and fax and other communication technologies.
- Clinical and administrative information systems.

LICENSES and CERTIFICATIONS

Required upon hire: Washington Registered Nurse License (Vendor Managed)
Required upon hire: National Provider BLS - American Heart Association (Vendor Managed)
Preferred upon hire: National Certification in area of specialty is preferred, unless otherwise indicated

ADDITIONAL REQUIRED CERTIFICATIONS by DEPARTMENT

Department	*Certification*	*Time Frame*	*Or*
3900 SS EICU - 10000360	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3900 SS FLoat Pool - 10000412	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3900 SS ICU Float - 10000413	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3900 SS OB Float Pool - 10000415	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3900 SS periop FLoat Pool - 10000416	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH INTENSIVE CARE - 10000430	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH INTENSIVE CARE - 10000430	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3901 SFH PED ICU - 10000431	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH NICU - 10000432	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3901 SFH TELEMETRY - 10000434	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH TELEMETRY - 10000434	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3901 PROGRESS CARE FLR 10 - 10000437	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 PROGRESS CARE FLR 10 - 10000437	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3901 SFH PEDIATRIC UNIT - 10000445	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH POSTPARTUM - 10000446	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3901 SFH ANTEPARTUM - 10000447	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3901 SFH EMERGENCY SERVICES - 10000448	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH EMERGENCY SERVICES - 10000448	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH EMERGENCY SERVICES - 10000448	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3901 SFH LABOR AND DELIVERY - 10000462	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3901 RECOVERY SVC S FLR 0C - 10000472	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 RECOVERY SVC S FLR 0C - 10000472	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH FLOAT POOL - 10000563	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3901 SFH OB FLOAT POOL - 10000565	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3901 SFH PEDS FLOAT POOL - 10000566	National Provider PALS - American Heart Association (Vendor Managed)	within 90 days of hire	
3901 SFH PEDS FLOAT POOL - 10000566	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	within 90 days of hire	
3901 SFH IMCU - 10005304	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3902 SBA FAMILY CHILDBIRTH - 10000573	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3902 SBA EMERGENCY SERVICES - 10000575	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	

3902 SBA EMERGENCY SERVICES - 10000575	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3902 SBA EMERGENCY SERVICES - 10000575	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3902 SBA RECOVERY - 10000580	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3902 SBA RECOVERY - 10000580	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3902 SBA FLOAT POOL - 10000615	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH CRITICAL CARE - 10000616	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH NEURO CRITICALCARE - 10000617	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH NEURO CRITICALCARE - 10000617	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH NEURO TELEMETRY - 10000618	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH NEURO TELEMETRY - 10000618	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH INTERVENTIONAL CARDIAC - 10000619	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH INTERVENTIONAL CARDIAC - 10000619	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH SURGICAL TELEMETRY - 10000620	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH SURGICAL TELEMETRY - 10000620	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH IP REHAB UNIT - 10000623	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH IP REHAB UNIT - 10000623	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH EMERGENCY SERVICES - 10000624	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH EMERGENCY SERVICES - 10000624	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH EMERGENCY SERVICES - 10000624	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH NEURO EPILEPSY - 10000630	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH INTERVENTIONAL RADIOLOGY - 10000652	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH INTERVENTIONAL RADIOLOGY - 10000652	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH RECOVERY - 10000636	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH RECOVERY - 10000636	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3903 SCH CARDIAC CATH - 10000643	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3903 SCH FLOAT POOL - 10000692	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS NICU - 10000699	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3904 SIS ICU TELEMETRY - 10000702	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS ICU TELEMETRY - 10000702	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3904 SIS POSTPARTUM - 10000705	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3904 SIS EMERGENCY SERVICES - 10000706	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS EMERGENCY SERVICES - 10000706	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	

3904 SIS EMERGENCY SERVICES - 10000706	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3904 SIS LABOR AND DELIVERY - 10000710	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS LABOR AND DELIVERY - 10000710	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3904 SIS RECOVERY - 10000713	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS CARDIAC CATH - 10000719	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS FLOAT POOL - 10000753	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3904 SIS ICU FLOAT - 10000754	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED ICU - 10000760	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED SHORT STAY UNIT - 10000764	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED PROGRESSIVES CARE UNIT - 10000765	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED FAMILY CHILDBIRTH CTR - 10000767	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3905 SED NICU - 10000768	National Provider NRP - American Academy of Pediatrics (Vendor Managed)	upon hire:	
3905 SED EMERGENCY SERVICES - 10000769	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED EMERGENCY SERVICES - 10000769	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED EMERGENCY SERVICES - 10000769	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3905 SED RECOVERY - 10000777	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED RECOVERY - 10000777	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED CARDIAC CATH - 10000789	National Provider ACLS - American Heart Association (Vendor Managed)	within 90 days of hire	
3905 SED ENDOSCOPY - 10000806	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3905 SED FLOAT - 10000838	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3906 EMERGENCY SERVICES - 10000844	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3906 EMERGENCY SERVICES - 10000844	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3906 EMERGENCY SERVICES - 10000844	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	
3907 EMERGENCY SERVICES - 10000853	National Provider ACLS - American Heart Association (Vendor Managed)	upon hire:	
3907 EMERGENCY SERVICES - 10000853	National Provider PALS - American Heart Association (Vendor Managed)	upon hire:	
3907 EMERGENCY SERVICES - 10000853	National Institutes of Health Stroke Scale Certificate - NIH Stroke Scale Training Course (Vendor Managed)	within 90 days of hire	

SWEDISH

Cardiovascular Technologist
Job Description

JOB INFORMATION

Primary JDID:	10454 7285
Job Title:	Cardiovascular Technologist
Job Content Title:	Cardiac Cath Lab Technologist
FLSA:	
Original Creation Date:	1/20/2015 12:00:00 AM

ORGANIZATIONAL INFORMATION

Region:	
Employer:	Ext File JD Process Level.XLSX Not found!
Department:	
Reports To:	Supervisor Cardiac Cath and Electrophysiology Labs, Cherry Hill

MISSION, VALUES and VISION

The Mission:	Improve the health and well-being of each person we serve.
Our Values:	Compassion, Justice, Excellence, Dignity, Integrity and Safety
Our Vision:	Health for a Better World

GENERAL SUMMARY

Assists with the performance of a variety of technical procedures including but not limited to percutaneous diagnostic and interventional cardiac/vascular procedures and open surgical procedures under the direct supervision of a physician. Participates in all daily duties necessary to perform high-quality patient care and imaging within the Cath/IR Department. Responsible for obtaining optimal radiographs and assisting the physician in an aseptic environment. Must be capable of patient monitoring and demonstrate knowledge of appropriate response to changes in patient condition. Must maintain in-depth knowledge of complex diagnostic and interventional cardiovascular equipment/supplies and be capable of assisting with their use. Must be available for on-call shifts as necessary.

ESSENTIAL FUNCTIONS

The job duties listed are essential functions of the position. However, other duties may be assigned, and may also be considered essential functions of the position.
The caregiver must be sufficiently fluent in the English language to satisfactorily perform the essential functions of the position. The degree of fluency required will vary depending upon the nature of the position.

Caregivers are expected to honor the Mission, Values, Vision and Promise and adhere to the Code of Conduct, policies and standards of their organization.

For direct patient care roles: Performs and maintains currency of essential competencies as required by specific area of hire and populations served.

- Demonstrates functional understanding of various radiology imaging equipment to include digital x-ray and computer assisted applications.
- Maintains ability to calibrate and perform analysis functions for vessel diameter and stenosis.
- Understands the set-up and operation of monitoring equipment and vital sign recording.
- Provides for documentation in procedure flowsheet as necessary.
- Assesses patient vital signs and condition as required, notifying physician of any changes.
- Demonstrates knowledge in reading electrocardiograms.
- Demonstrates knowledge in heart pressures and wave forms.
- Demonstrates knowledge of advanced cardiac life support skills.
- Demonstrates the ability to work as a cohesive team member with all technologists, nurses, and physicians in a variety of roles to include scrub tech, circulating and recording tech.
- Demonstrates proficiency in the use of a power injector and understands contrast utilization, precautions, and reaction treatments.
- Demonstrates ability to complete all billing/charging forms.

- Demonstrates ability to scrub and assist with diagnostic, interventional and open surgical procedures and is knowledgeable and competent with the various cardiac and peripheral (IR) supplies and equipment.
- Anticipates the needs of the physician when scrubbed and has an in-depth understanding of the type of procedure and steps necessary to perform it.
- Consistently demonstrates excellent interpersonal skills, commitment to customer service principles and attitude.
- Exemplifies behaviors described in the SMC's Service Excellence Commitments.
- Participates in restocking and cleaning the rooms.
- Participates in all procedures performed in the cardiac catheterization procedure rooms.

QUALIFICATIONS

EDUCATION

Required/Preferred	*Education Level*	*Major/Area of Study*	*And/Or*
Required	Ext File Education.XLSX Not found!	Graduate of a two-year invasive cardiovascular program or successful completion of a formal Radiologic Technologist program.	

EXPERIENCE

Required/Preferred	*Minimum Experience*	*Details*
Required	1 year	Previous cath lab experience.
Required	1 year	Experience in Interventional Radiology.

JOB SPECIFIC KNOWLEDGE, SKILLS and ABILITIES

- Familiar with and able to operate various types of digital radiographic and fluoroscopic equipment utilizing safe radiation practices.
- Consistently demonstrate ability to acquire, review and print diagnostic images as well as perform analysis functions consistent with the current equipment applications.
- In conjunction with the team, operate patient monitoring equipment and assess patient vital signs and condition. Functions as part of the team in a variety of roles including scrubbing, circulating, and recording.
- Knowledge of aseptic technique and sterile procedures.
- Is familiar with and capable of assisting with the setup and use of complex interventional and diagnostic tools and supplies (percutaneous cardiac interventional (PCI) technologies).
- Competent in the use of computer applications.
- Is proficient in the use of the power injector.
- Demonstrates excellent customer service skills, ability to work as a team, and able to multi-task.

LICENSES and CERTIFICATIONS

Required upon hire: Washington Cardiovascular Invasive Specialist Certification (Vendor Managed) Or
Required upon hire: Washington Radiologic Technologist (Vendor Managed) Or
Required upon hire: National Certification from Cardiovascular Credentialing International (Vendor Managed) Or
Required upon hire: National Certification from American Registry of Radiologic Technologists (Vendor Managed)
Required upon hire: National Provider BLS - American Heart Association (Vendor Managed)
Required upon hire: National Provider ACLS - American Heart Association (Vendor Managed)

SWEDISH

Supervisor Cardiovascular Services

Job Description

JOB INFORMATION

Primary JDID: 10542 9466
Job Title: Supervisor Cardiovascular Services
Job Content Title: Supervisor Cath Lab and Interventional Radiology
FLSA:
Original Creation Date: 8/1/2012 12:00:00 AM

ORGANIZATIONAL INFORMATION

Region:
Employer: Ext File JD Process Level.XLSX Not found!
Department:

Reports To: Manager, Surgery
Supervises: Nursing, Technical, and Support Staff

MISSION, VALUES and VISION

The Mission: Improve the health and well-being of each person we serve.
Our Values: Compassion, Justice, Excellence, Dignity, Integrity and Safety
Our Vision: Health for a Better World

GENERAL SUMMARY

A supervisory position responsible for effective coordination and execution of daily patient care activities in the Cath and Interventional Radiology labs. Accountable for optimization of nursing and technical staff resources as well as supplies. Functions as liaison with the cardiologists, radiologists, staff and leadership. Demonstrates in-depth knowledge and understanding of the processes and procedures relating to Cath and Interventional Radiology services throughout the medical center. Assists in formulating strategies for monitoring and assuring quality and quality improvement.

ESSENTIAL FUNCTIONS

The job duties listed are essential functions of the position. However, other duties may be assigned, and may also be considered essential functions of the position.
The caregiver must be sufficiently fluent in the English language to satisfactorily perform the essential functions of the position. The degree of fluency required will vary depending upon the nature of the position.

Caregivers are expected to honor the Mission, Values, Vision and Promise and adhere to the Code of Conduct, policies and standards of their organization.

For direct patient care roles: Performs and maintains currency of essential competencies as required by specific area of hire and populations served.

- Supervises technical and nursing activities of the Cath and Interventional Radiology staff.
- Effectively coordinates and prioritizes patient flow in the CATH/IR department, optimizing staff and supply resources.
- Facilitates development of standards for service and quality when appropriate; evaluates and maintains standards as required.
- Acts as liaison between the Medical staff of Cardiology and Interventional Radiology and the Medical Imaging Team to facilitate effective communication regarding operational issues.
- Responsible for scheduling nursing, technical and support staff resources in CATH/IR in coordination with the Operations Manager.
- Responsible for training, continuing education, monitoring staff performance and maintaining staff competencies for personnel assigned to CATH/IR.
- Responsible for updating training protocols for all technical staff and departmental procedure protocols.
- Responsible for researching new and emerging technologies/procedures to assure a seamless introduction into the technical competencies of the CATH/IR staff.
- Responsible for quality control and aseptic technique protocol application, identifying those areas in need of inservice.
- Accountable for inventory control: purchasing, PAR level assignments, cost justification, appropriateness screening of new products in coordination with the Cardiologists and Interventional Radiologists, inventory tracking and negotiating purchasing incentives/pricing with vendors.

- Responsible for making sure that CPT vs. hospital charge codes are current for complete coding and reimbursement of the CATH/IR procedures.
- Provides input in the department budgeting process regarding staffing recommendations, capital requests, safety and physical plan requirements.
- Assures completion of criteria-based performance evaluations for CATH/IR staff within the specified time frames.
- Facilitates and assists with the process of posting positions, interviewing, and hiring of qualified staff as necessary.
- Assists in assuring compliance with local, state, federal and JCAHO standards.
- Serves as a role model and holds self and others accountable for high quality service standards.
- Leads the CATH/IR Team to work cooperatively toward common goals.
- Performs at an expert level in all aspects of Cardiology and Interventional Radiology and possess an in-depth knowledge of procedures and products.
- Demonstrates patient care skills appropriate for all age groups, neonate through geriatric, utilizing age specific imaging techniques and protocols.
- Assures budgetary compliance in collaboration with the Surgical and Procedural Leadership.

QUALIFICATIONS

EDUCATION

Required/Preferred	Education Level	Major/Area of Study	And/Or
Required	Coursework/Training	Cardiovascular Technology program.	Or
Required	Coursework/Training	Radiology Technologist program.	

EXPERIENCE

Required/Preferred	Minimum Experience	Details
Required	4 years	Cardiovascular Technologist and/or Interventional Radiologic Technologist.
Required	Ext File Experience.XLSX Not found!	Prior supervisory or lead technologist.
Required	Ext File Experience.XLSX Not found!	Working collaboratively within a team and team building, problem solving, conflict resolution and excellent interpersonal communication.

JOB SPECIFIC KNOWLEDGE, SKILLS and ABILITIES

- Excellent verbal and written communication skills.
- Strong leadership skills.
- Ability to communicate professionally and effectively.
- Is able to develop and maintain excellent working relationships with clinical staff, physicians, managers and directors.
- Able to read, write, understand and communicate in English.
- Excellent customer service skills are essential.
- Ability to implement operational changes to meet budget targets.
- Knowledge of federal, state, and local requirements and regulations regarding hospitals and patient care.
- Demonstrated knowledge and skill working collaboratively within a team and team building, problem solving, conflict resolution and excellent interpersonal communication are required.
- Ability to address issues in tactful ways.
- Ability to communicate in ways that are broadly understood and create a harmonious working environment by building relationships between team members and multiple departments.
- Demonstrates dedication to strong customer service with knowledge that 'customers' exist in multiple arenas.
- Familiar with and able to operate various types of digital radiographic imaging equipment associated with current practices and procedures in Cath lab and Interventional Radiology.
- Demonstrates knowledge of sterile technique and ability to scrub and assist with a wide variety of Cath and IR tools.
- Able to educate others on safe operating practices and image optimization.
- Computer literacy - Ability to use hospital information systems, Word/Excel, and email.
- Meet criteria of their respective professional category.
- Must demonstrate advanced clinical and organizational skills related to the care of patients within this specialty.
- Ability to plan and modify clinical approaches.

JOB SPECIFIC KNOWLEDGE, SKILLS and ABILITIES

- Must maintain CPR certification and attend applicable hospital inservices.
- Ability to provide direct patient care is required.
- Able to discern departmental needs in managing daily workload and staffing within budget and standard of care.

LICENSES and CERTIFICATIONS

Required upon hire: Washington Cardiovascular Invasive Specialist Certification (Vendor Managed) Or
Required upon hire: Washington Radiologic Technologist (Vendor Managed)
Required upon hire: National Provider BLS - American Heart Association (Vendor Managed)
Required upon hire: National Provider ACLS - American Heart Association (Vendor Managed)
Required within 1 year of hire: National Certification from Cardiovascular Credentialing International (Vendor Managed)
Preferred upon hire: Advanced Registry in Interventional Radiology

Exhibit 27
Cath Lab Competency Checklists

NOTE: The electronic version of this document or form is the latest and only acceptable version. You are responsible to ensure any printing of this document is identical to the e-version.

Procedural Areas Competency Documents for Technologists

1. Procedural Areas: Cardiac Catheterization, Electrophysiology and Interventional Radiology: New Hire Tech Competency Checklist

2. Cardiac Catheterization Lab Specific: New Hire Technologist Competency Checklist

3. Cardiac Catheterization Lab Specific: Technologist Tier 2 Competency Checklist

4. Electrophysiology Lab Specific: New Hire Technologist Competency Checklist

5. Fluoroscopic NG Tube Insertion: Technologist Competency Checklist

6. G Tube Removal: RN and Technologist Competency Checklist

7. Interventional Radiology Specific: New Hire Technologist Competency Checklist

8. Philips Monitor Checklist 2018 Orientation Checklist

9. Pigtail Drain Removal: Technologist Competency Checklist

10. Tunneled Jugular Central Venous Catheter (CVC) Removal: Technologist Competency Checklist

SWEDISH

Procedural Areas:
Cardiac Catheterization, Electrophysiology and Interventional Radiology: New Hire Tech Competency Checklist

Name ________________________ Date __________ Unit__________ Manager____________________

Day One Tasks	Date	Staff Initials
Hospital and Department Tour (including scavenger hunt)		
Supply Pyxis Access Forms (including Pyxis Healthstream module)		
Obtain Dosimeter and order lead apron		
Request EPIC access		
Request pager and Emergin access		
Obtain badge access and orient to Kronos		
Orient to eQVR process and Employee injury reports		
Review disaster plan		
Radiation safety / Pregnancy safety and screening		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Patient Safety: Reports Vital Signs to RN or LIP as appropriate, reports patient pain to RN, provides Patient/Family Education as needed		
Cardiovascular Assessment: Evaluates Chest Pain, Arterial Pressure		
Code Blue Procedures: Calls a Code, Performs CPR, Responsibilities		
Verifies complete Procedural Consent Forms		
Correctly verifies patient with two identifiers		
Safety: Standard and Sterile Precautions / Droplet, Contact, Special Enteric, and Reverse Isolation		
Safety: Provides Handoff Communication		

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Safety: Participates in Safety Pause		
Safety: Communicates utilizing ISBAR		
Collects pertinent data; interprets data to identify the patient's needs and potential problems		
Identifies abnormal patient data and reports findings to LIP		
Delivers individualized patient care based on assessment of patient and procedure being performed		
Adjusts priorities based on changing clinical situation		
Heart Monitor: Application of Electrodes and Defibrillator pads		
Medication Administration: Local Anesthetics (Lidocaine, Bupivicaine)		
Assisting with Medication Administration: Antihypertensizes, Vasodilators (Nitroglycerine, Verapamil)		
Medication Administration: Antithrombotics (ReoPro, Heparin, TPA, Integrilin)		
Site Management post removal of Femoral Venous Sheath		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Site Management post removal of Brachial Arterial Sheath		
Site Management of a sheath left in place		
Pulse Assessment (Carotid, Femoral, Pedal, Radial)		
Assessment of patient with a Radial Band (circulation, movement, sensation)		
Assessment of groin post closure device placement (Starclose, AngioSeal, PerClose)		
Documents correctly per the Vascular Management policy		
Documents patient education		
Identifies when it is and is not appropriate to take a verbal order. Utilizes the read back method when taking verbal orders		
Orders and labels lab specimens obtained during the procedure		
Set up and assist with Intravascular Ultrasound (IVUS)		
Set up and assist with Angiojet		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Vascular Management: Percutaneous Arterial/Venous Sheath Management (Adult)		
Vascular Management: Femostop for Removal of Femoral Sheaths (Adult)		
Vascular Management: Safeguard for Track Ooze Post Vascular Closure Device Placement (Adult)		
Vascular Management: Brachial Sheath Removal [Adult]		
Vascular Management: EKOS Lysis Infusion System [Adult]		
Vascular Management: Lidocaine Injection for Sheath Removal After Vascular Access [Adult]		
Radial Band		
Pyxis Supply Stations™: Invasive Procedural Areas		
Safety Pause Checklist and Debriefing for Procedural Areas		
Transfers: Interdepartmental (Adult)		
Sterile Field: Guidelines and Recommendations for Perioperative and Invasive Procedure Areas		
Dispensing and Labeling Medications/Solutions to the Sterile Field in Perioperative, Perinatal, and Procedural Areas		
Verbal and Telephone Orders: Accepting, Receiving, Transcribing and Authenticating		
Review Code BART algorithm applicable to your respective campus Type “BART” in the standards website, then open applicable document		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Required Competencies	Date of Completion	Staff Initials
Femoral Artery Sheath Pull Competency		
Vascular Management: Femostop Application: Competency Checklist		
Vascular Management: Femostop Monitoring, Deflation, and Removal: Competency Checklist		
Post-Vascular Management Assessment and Bleeding Management: Competency Checklist		
Radial Band Monitoring, Deflation and Removal Competency Checklist		
Radial Band Application Competency		
iStat Competency		
Current Basic Life Support (BLS) Certification		
Current Advanced Cardiac Life Support (ACLS) Certification		
For Cath Lab Tech's only: Cath Lab Specific Tech Competency		
For EP Lab Tech's only: EP Lab Specific Tech Competency		
For IR Lab Tech's only: IR Lab Specific Tech Competency		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Cardiac Catheterization Lab Specific: New Hire Technologist Competency Checklist

Name ______________________ Date __________ Unit__________ Manager ______________________

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Scrub: Permanent Pacemaker Insertion		
Scrub: ICD Insertion		
Scrub: Temporary Transvenous Pacemaker Insertion		
Scrub: Cardioversion		
Scrub: Intra-aortic Balloon Pump Insertion		
Scrub: Left Heart Catheterization		
Scrub: Right Heart Catheterization		
Scrub: Right and Left Heart Catheterization		
Scrub: Femoral Percutaneous Coronary Intervention		
Scrub: Radial Percutaneous Coronary Intervention		
Scrub: Use of Laser		
Scrub: Angiojet		
Scrub: Rotoblator		
Scrub: Use of Volcano Ultrasound		
Scrub: Use of (what is name of Boston Sci ultrasound?)		
Scrub: Left Ventricular Assist Device (LVAD)		
Scrub: Peripheral Stent Placement		
Scrub: Watchman procedure		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Recording: Permanent Pacemaker Insertion		
Recording: ICD Insertion		
Recording: Temporary Transvenous Pacemaker Insertion		
Recording: Cardioversion		
Recording: Intra-aortic Balloon Pump Insertion		
Recording: Left Heart Catheterization		
Recording: Right Heart Catheterization		
Recording: Right and Left Heart Catheterization		
Recording: Femoral Percutaneous Coronary Intervention		
Recording: Radial Percutaneous Coronary Intervention		
Recording: Use of Laser		
Recording: Angiojet		
Recording: Rotoblator		
Recording: Use of Volcano Ultrasound		
Recording: Use of (what is name of Boston Sci ultrasound?)		
Recording: Extracorpeal Membrane Oxygenation (ECMO)		
Recording: Left Ventricular Assist Device (LVAD)		
Recording: Peripheral Stent Placement		
Recording: MitraClip		
Recording: Watchman procedure		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

Observer Signature: ______________________________ Date: ______________
Observer Signature: ______________________________ Date: ______________
Observer Signature: ______________________________ Date: ______________

SWEDISH

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Cardiac Cath Lab Department Structure, Cherry Hill		
Implant Infection Control Guidelines: Invasive Cardiology Services		
Impella 2.5 Percutaneous VAD Support (Cardiac Cath Lab and CVOR): Insertion and Management		
Intra-Aortic Balloon Pump Management		
Intra-Aortic Balloon (IAB) Insertion, Percutaneous: Adult		
Cardiac Implanted Electronic Device (CIED) Management in Perioperative and Invasive Procedure Areas for Patients Requiring Anesthesia		

Required Competencies	Date of Completion	Staff Initials
Tier II Technologist Competency Checklist (Cherry Hill only, as applicable)		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Cardiac Catheterization Lab Specific: Technologist Tier 2 Competency Checklist

Name ______________________ Date __________ Unit__________ Manager ______________________

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Prioritizes care appropriately during complicated, high acuity, or salvage patients		
Proficiently sets up for cases in the Hybrid OR		
Proficiently assists in the Hybrid OR		
Scrub: Extracorporeal Membrane Oxygenation (ECMO)		
Scrub: Mitraclip		
Scrub: Rescue PCI with Impella Support		
Scrub: Rescue PCI with Intra-aortic Balloon Pump (IABP) Support		
Scrub: Chronic Total Occlusion (CTO)		
Scrub: Transaortic Valve Replacement (TAVR)		
Scrub: Valvuloplasty		
Recording: Extracorporeal Membrane Oxygenation (ECMO)		
Recording: Mitraclip		
Recording: Rescue PCI with Impella Support		
Recording: Rescue PCI with Intra-aortic Balloon Pump (IABP) Support		
Recording: Chronic Total Occlusion (CTO)		
Recording: Transaortic Valve Replacement (TAVR)		
Recording: Valvuloplasty		
Circulating: Extracorporeal Membrane Oxygenation (ECMO)		
Circulating: Mitraclip		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Circulating: Rescue PCI with Impella Support		
Circulating: Rescue PCI with Intra-aortic Balloon Pump (IABP) Support		
Circulating: Chronic Total Occlusion (CTO)		
Circulating: Transaortic Valve Replacement (TAVR)		
Circulating: Valvuloplasty		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Electrophysiology Lab Specific: New Hire Technologist Competency Checklist

Name ______________________ Date __________ Unit___________ Manager______________________

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Scrub: Manifold Set-up		
Scrub: Permanent Pacemaker Insertion		
Scrub: EP Study		
Scrub: Pulmonary Vein Ablation		
Scrub: Non-Pulmonary Vein Ablation		
Scrub: Sequoia Ablations		
Scrub: Temporary Transvenous Pacemaker		
Scrub: ICD insertion		
Scrub: Cardioversion		
Scrub: Nips procedures Cardioversion		
Scrub: Internal circulate Cardioversion		
Scrub: Stereotaxis		
Scrub: Arterial Line Set-up		
Recording: Permanent Pacemaker Insertion		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Recording: EP Study		
Recording: Pulmonary Vein Ablation		
Recording: Non-Pulmonary Vein Ablation		
Recording: Sequoia Ablations		
Recording: Temporary Transvenous Pacemaker		
Recording: ICD insertion		
Recording: Cardioversion		
Recording: Nips procedures Cardioversion		
Recording: Internal circulate Cardioversion		
Recording: Stereotaxis		
Recording: Arterial Line Set-up		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Implant Infection Control Guidelines: Invasive Cardiology Services		
Electrophysiology Lab Department Structure		
Roles and Responsibilities in the Electrophysiology Lab: Device Implantation/Chronic Lead Extraction		
Roles and Responsibilities in the Electrophysiology Lab: Electrophysiology Testing and Ablation		
Cardiac Implanted Electronic Device (CIED) Management in Perioperative and Invasive Procedure Areas for Patients Requiring Anesthesia		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Fluoroscopic NG Tube Insertion: Technologist Competency Checklist

Name ______________________ Date ____________ Unit____________ Manager______________________

☐ Initial Competency ☐ Annual Competency

Instructions: Two successful (met) observations are required for unsupervised practice. Ongoing yearly competency is waived, provided the Technologist has completed one successful NG Tube Insertion under flouroscopy in the past year without adverse event. Observation is on an actual patient.

Fluoroscopy NG Tube Insertion Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Prepare for procedure: AIDET, verify informed consent, position patient on the table, and pre-procedure time out.		
Obtain supplies: 6f Tegtmeyer catheter, 3 way stopcock, 24” extension tubing, 60cc syringe, paper tape, viscous lidocaine from RN, possibly glide wire with NS syringe		
IR Radiologist is present for immediate imaging guidance and provides direct supervision.		
Apply moderate amount of viscous lidocaine to preferred nare and ask patient to sniff it back.		
With fluoro tube in steep RAO centered on head/neck, advance Tegtmeyer catheter into nare, and advance, visualizing catheter tip into the oropharanx		
Direct the catheter tip posteriorly at the level of the epiglottis to the esophagus, avoiding the trachea. Ask the patient to swallow at this time. If the patient starts to cough, the catheter is most likely in the trachea.		
If the catheter passes easily into the esophagus without patient coughing, rotate fluoroscope to AP and center on the distal esophagus/stomach. Advance catheter while visualizing the catheter enter the gastric fundus.		
Secure catheter position with tape to patient’s nose. Store monitor last image demonstrating catheter tip in gastric fundus.		

Successful Fluoroscopic NG Tube Insertion #1 completed Date: ____________________Observer Signature: ______________________

Successful Fluoroscopic NG Tube Insertion #2 completed Date: ____________________Observer Signature: ______________________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

G Tube Removal: RN and Technologist Competency Checklist

Name ______________________ Date __________ Unit__________ Manager ____________________

☐ Initial Competency ☐ Annual Competency

Instructions: Two successful (met) observations are required for unsupervised practice. Ongoing yearly competency is waived, provided the RN or Technologist has completed one successful G Tube Removal in the past year without adverse event. Observation can be simulated or on an actual patient.

G Tube Removal Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Verify LIP order for G Tube removal		
Consult with IR Radiologist with plan to supervise and advise		
Obtain needed supplies • Chloraprep solution • 4 x 4 gauze • Towels • 20cc syringe • Paper tape		
Bring patient back to IR holding area		
AIDET and perform hand hygiene		
Informed consent is not necessary		
Position patient supine on gurney		
Inspect G tube area for excoriation, signs of infection, skin integrity		
Clean skin area around tube with chlorhexidine		
Remove sterile water from retention balloon via balloon port (roughly 6-10mls)		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

G Tube Removal Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Pull gently, and tube should come out easily. Report any resistance to the LIP before proceeding.		
Inform patient that there might be gastric content discharge for a few hours, depending on when they last ate. This is normal and will subside.		
Dress the skin with a pad of 4 x 4s and paper tape. Enough to contain gastric contents as needed.		
Inform patient to not eat for a few hours while the tract is closing up		
Walk patient out and perform hand hygiene		
Progress report in EPIC stating: date/time, G tube French size, and general disposition of the patient upon discharge		
Report to IR MD		
Complete charge master in EPIC		

Successful G Tube Removal #1 completed Date: ____________________ Observer Signature: ____

Successful G Tube Removal #2 completed Date: ____________________ Observer Signature: ____

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Interventional Radiology Specific: New Hire Technologist Competency Checklist

Name ______________________ Date __________ Unit __________ Manager ______________________

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Scrub: Myelogram		
Scrub: Kyphoplasty		
Scrub: AV Fistula/Shunt De-clotting		
Scrub: Internal Jugular Tunneled Central Venous Catheter Placement		
Scrub: Subclavian Tunneled Central Venous Catheter Placement		
Scrub: Non-tunneled Central Venous Catheter Placement		
Scrub: Uterine Fibroid Embolization		
Scrub: Central Line Placement		
Scrub: Port Placement		
Scrub: PICC Line Placement		
Scrub: Liver Biopsy		
Scrub: Liver Embolization		
Scrub: Upper Extremity Angiogram		
Scrub: Lower Extremity Angiogram		
Scrub: Cerebral Angiogram		
Scrub: Chest Tube Placement		
Scrub: Nephrostomy Tube		
Scrub: IVC Filter Placement		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Scrub: IVC Filter Removal		
Scrub: Thrombolysis / EKOS		
Recording: Myelogram		
Recording: Kyphoplasty		
Recording: AV Fistula/Shunt De-clotting		
Recording: Internal Jugular Tunneled Central Venous Catheter Placement		
Recording: Subclavian Tunneled Central Venous Catheter Placement		
Recording: Non-tunneled Central Venous Catheter Placement		
Recording: Permanent Hemodialysis Shunt Placement		
Recording: Temporary Hemodialysis Shunt Placement		
Recording: Uterine Fibroid Embolization		
Recording: Central Line Placement		
Recording: Port Placement		
Recording: PICC Line Placement		
Recording: Liver Biopsy		
Recording: Liver Embolization		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Recording: Upper Extremity Angiogram		
Recording: Lower Extremity Angiogram		
Recording: Cerebral Angiogram		
Recording: Chest Tube Placement		
Recording: Nephrostomy Tube		
Recording: IVC Filter Placement		
Recording: IVC Filter Removal		
Recording: Thrombolysis / EKOS		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Review all Code Stroke/Code IR Algorithms applicable to your campus		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Competencies	Date of Completion	Staff Initials
G Tube Removal Competency		
Fluoroscopic NG Tube Insertion Competency		
Pigtail Catheter Removal Competency		
Tunneled Jugular Central Venous Catheter (CVC) Removal		
Tier II Technologist Competency Checklist		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Philips Monitor Checklist 2018

Orientation Checklist

Name____ Unit ___________________

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Turn Monitor On	
Stand by Function	
Admit Patient	
Suspend Monitoring	
Resume Monitoring	
Discharge Patient	
View Different Patients from another Patient's Room (Care Group)	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Adjust Limits for HR	
Change Leads	
Adjust Lead Size	
Add ST segment Monitoring • Adjust ST segment Alarms	
Turn on Pacing Alert	
Relearn Patient Rhythm	
Use E- calipers to Measure Intervals	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Print Real time recording **(excludes Neuro East at CH)** • Print from both room and central station	
Change waves to be graphed from the default ECG settings	

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

SKILL	DATE DEMONSTRATED
Start/Stop NIBP (including STAT mode)	
Adjust BP limits	
Add pressure module	
Label Pressure Module with desired Hemodynamic Parameter (etc. PA, ABP, ICP)	
Adjust Pressure Limits on Hemodynamic Parameters	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Select Sector Segment Set up to Perform Telemetry Monitoring	
Pair and Unpair Telemetry unit	
Replace Telemetry Unit Battery	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Silence Alarm	
Review an Alarm /Delete as Needed	
View Alarm History	
Record/Print ECG from Alarm History	

Preceptor Name and Initials ____

Preceptor Name and Initials ____

Preceptor Name and Initials ____

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Pigtail Drain Removal: Technologist Competency Checklist

Name ______________________________ Date ___________ Unit_____________ Manager_________________________

☐ Initial Competency ☐ Annual Competency

Instructions: Two successful (met) observations are required for unsupervised practice. Ongoing yearly competency is waived, provided the Technologist has completed one successful Pigtail Drain Removal without adverse event in the past year. Observation can be simulated or on an actual patient.

Pigtail Drain Removal Procedure	**Met #1 Observer Initials**	**Met #2 Observer Initials**
Verify the LIP order for drain removal		
Obtain supplies including but not limited to: Suture removal kit, 4 x 4 gauze, chlorhexidine, transparent dressing, sterile towel pack		
AIDET, perform hand hygiene		
Position patient appropriately		
Remove drain. Notify the LIP for any resistance before proceeding.		
Dress skin site per standard		
Document removal in Electronic Medical Record in LDA workflow		
Provide verbal report to IR Radiologist		
Perform hand hygiene		

Successful Pigtail Drain Removal #1 completed Date: ________________ Observer Signature: ______________________________

Successful Pigtail Drain Removal #2 completed Date: ________________ Observer Signature: ______________________________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Tunneled Jugular Central Venous Catheter (CVC) Removal: Technologist Competency Checklist

Name ______________________ Date ____________ Unit____________ Manager______________________

☐ Initial Competency ☐ Annual Competency

Instructions: Two successful (met) observations are required for unsupervised practice. Ongoing yearly competency is waived, provided the Technologist has completed one successful tunneled jugular CVC Removal in the past year without adverse event. Observation is on an actual patient.

Tunneled jugular CVC Removal Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Verify LIP order for tunneled jugular CVC removal		
Interventional Radiologist supervises of the procedure		
If performing the tunneled jugular CVC removal outside of the Cath/IR department, notifies the patient's primary RN		
Obtains supplies • 4 x 4 gauze • Sterile disposable towels • Medium transparent dressing • Suture removal kit • Sterile gloves • Quick-clot hemostasis patch • Hemostat • Lidocaine 1% • 18g, 27g needle • Two 20cc syringes, one 10cc syringe		
Performs hand hygiene and AIDET		
Inspect insertion site for any concerns (i.e. hematoma, bleeding, etc)		
Positions patient upright (head of bed at least 45 degrees). Adjust bed height to accommodate the Technologists ergonomics		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Tunneled jugular CVC Removal Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Places medical waste disposal can within reach		
Sterile prep the area and exposed catheter with Chloraprep and sterile disposable towels		
LIP administers lidocaine at skin entrance site and along the catheter tract up to and around the cuff		
Attempt to remove the catheter with gentle pressure. If the catheter does not dislodge, dissect with sterile hemostat around the catheter in a parallel trajectory, palpating the cuff. The catheter cuff will eventually be free from scarring tissue.		
Remove catheter fully and visualize the cuff. Hold pressure at the insertion site until hemostasis is achieved		
Apply an appropriate dressing (i.e. sterile transparent dressing)		
Provide patient education regarding site care		
Performs hand hygiene		
Document line removal in electronic medical record in LDA workflow		

Successful Tunneled Jugular CVC Removal #1 completed Date: ________________ Observer Signature: ____

Successful Tunneled Jugular CVC Removal #2 completed Date: ________________ Observer Signature: ____

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

NOTE: The electronic version of this document or form is the latest and only acceptable version. You are responsible to ensure any printing of this document is identical to the e-version.

Procedural Areas Competency Documents for RN

1. Procedural Areas: Cardiac Catheterization, Electrophysiology and Interventional Radiology: New Hire RN Competency Checklist
2. Cardiac Catheterization Lab Specific: New Hire RN Competency Checklist
3. Electrophysiology Lab Specific: New Hire Competency Checklist
4. G Tube Removal: RN and Technologist Competency Checklist
5. Interventional Radiology Specific: New Hire RN Competency Checklist
6. Philips Monitor Checklist

Procedural Areas:
Cardiac Catheterization, Electrophysiology and Interventional Radiology: New Hire RN Competency Checklist

Name ______________________ **Date** __________ **Unit**__________ **Manager**______________________

Day One Tasks	Date	Staff Initials
Hospital and Department Tour (including scavenger hunt)		
Medication and Supply Pyxis Access Forms (including Pyxis Healthstream module)		
Obtain Dosimeter		
Configure EPIC access		
Request pager and Emergin access		
Obtain badge access and orient to Kronos		
Orient to eQVR process and Employee injury reports		
Review disaster plan		
Radiation safety / Pregnancy safety and screening		
Complete Adult Procedural Sedation module in HealthStream		
Order lead apron (may be done after day one per department standard)		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Patient Assessment (as applicable to department): Neurological, Respiratory, Gastrointestinal, Genitourinary, Integumentary, Vital Signs, Pain Scale, Psychosocial, Patient/Family Education		
Cardiovascular Assessment: Evaluate Chest Pain, ECG Interpretation, Arterial Pressure		
Respiratory Procedures/Equipment: Arterial Blood Gas Interpretation		
Respiratory Procedures/Equipment: Oxygen Administration (cannula, mask, bag-valve-mask)		
Respiratory Procedures/Equipment: C-Pap/Bi-Pap		
Respiratory Procedures/Equipment: Mechanical Ventilators		
Respiratory Procedures/Equipment: Tracheostomy Tube		
Respiratory Procedures/Equipment: Suctioning (Oral , Nasopharangeal, Tracheal)		
Code Blue Procedures: Calls a Code		
Code Blue Procedures: Performs CPR/Defibrillation		
Code Blue Procedures: Administers Code Medications		
Code Blue Procedures: Responsibilities, Documentation of Code		
Verifies complete Procedural Consent Forms		
Correctly verifies patient with two identifiers		
Safety: Performs Standard and Sterile Precautions / Droplet, Contact, Special Enteric, and Reverse Isolation		
Safety: Provides Handoff Communication		
Safety: Performs Safety Pause		
Safety: Communicates utilizing SBAR		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Collects pertinent data; interprets data to identify the patient's needs and potential problems		
Identifies abnormal patient data and reports findings to LIP		
Delivers individualized patient care based on assessment of patient and procedure being performed		
Adjusts priorities based on changing clinical situation		
Heart Monitor: Application of Electrodes and Defibrillator pads		
Medications: Administration (PO, IM, SubQ, IV, Inhalation), Ordering/Obtaining, Documentation		
Medication Administration: Inotropes (Milrinone, Dobutamine)		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Medication Administration: Antiarrhythmics (Amiodarone, Lidocaine, Procainamide, Adenosine, Diltiazem)		
Medication Administration: Reversal Agents (Narcan, Romazicon, Protamine)		
Medication Administration: Antihypertensives, Vasodilators (Nitroglycerine, Metoprolol, Nitroprusside, Verapamil, Esmolol)		
Medication Administration: Vasopressors (Dopamine, Epinephrine, Levophed, Neosynephrine, Atropine, Isuprel)		
Medication Administration: Sedation (Benzodiazepines, Narcotics, Propofol, Precedex)		
Medication Administration: Antithrombotics (ReoPro, Heparin, Alteplase, Integrilin)		
Site Management Post Removal of Femoral Venous Sheath		
Site Management Post Removal of Brachial Arterial Sheath		
Site Management of a Sheath left in place		
Pulse Assessment (Carotid, Femoral, Pedal, Radial)		
Assessment of patient with a Radial Band (circulation, movement, sensation)		
Assessment of groin post closure device placement (Starclose, AngioSeal, PerClose)		
Documents correctly per the Procedural Sedation policy		
Documents correctly per the Vascular Management policy		
Documents correctly for general patient care (pain management, etc)		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Documents patient education		
Identifies when it is and is not appropriate to take a verbal order. Utilizes the read back method when taking verbal orders		
Orders, obtains and labels lab specimens obtained during the procedure		
Set up and assists with Intravascular Ultrasound (IVUS)		
Set up and assists with Angiojet		
Set up and performs Temporary External Pacing		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Vascular Management: Percutaneous Arterial/Venous Sheath Management (Adult)		
Vascular Management: Femostop for Removal of Femoral Sheaths (Adult)		
Vascular Management: Safeguard for Track Ooze Post Vascular Closure Device Placement (Adult)		
Vascular Management: Brachial Sheath Removal [Adult]		
Vascular Management: Lidocaine Injection for Sheath Removal After Vascular Access [Adult]		
Radial Band		
Procedural Sedation: Adult		
Procedural Sedation: Recommended Moderate Sedation Drugs and Doses: Adult		
Pyxis Supply Stations™: Invasive Procedural Areas		
Safety Pause Checklist and Debriefing for Procedural Areas		
Transfers: Interdepartmental (Adult)		
IV Extravasation/Infiltration Management: Non-Chemotherapy		
IV: Peripheral IV Insertion (Adult)		
Sterile Field: Guidelines and Recommendations for Perioperative and Invasive Procedure Areas		
Dispensing and Labeling Medications/Solutions to the Sterile Field in Perioperative, Perinatal, and Procedural Areas		
Verbal and Telephone Orders: Accepting, Receiving, Transcribing and Authenticating		
Ventilator Management: Adult		
Review Code BART algorithm applicable to your respective campus Type “BART” in the standards website, then open applicable document		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Required Competencies	Date of Completion	Staff Initials
Vascular Management: Femostop Application: Competency Checklist		
Vascular Management: Femostop Monitoring, Deflation, and Removal: Competency Checklist		
Post-Vascular Management Assessment and Bleeding Management: Competency Checklist		
Radial Band Monitoring, Deflation and Removal Competency Checklist		
Procedural Sedation Competency Verification		
iStat Competency		
Pass of Emergency Measures Exam		
Peripheral Catheter Initial Competency		
Current Basic Life Support (BLS) Certification		
Current Advanced Cardiac Life Support (ACLS) Certification		
Philips Monitor Checklist		
For Cath Lab RN's only: Cath Lab Specific RN Competency		
For IR RN's only: IR Specific RN Competency		
For EP Lab RN's only: EP Lab Specific RN Competency		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Cardiac Catheterization Lab Specific: New Hire RN Competency Checklist

Name ______________________ Date __________ Unit___________ Manager______________________

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Circulating: Permanent Pacemaker Insertion		
Circulating: ICD Insertion		
Circulating: Temporary Transvenous Pacemaker Insertion		
Circulating: Cardioversion		
Circulating: Intra-aortic Balloon Pump Insertion		
Circulating: Left Heart Catheterization		
Circulating: Right Heart Catheterization		
Circulating: Right and Left Heart Catheterization		
Circulating: Femoral Percutaneous Coronary Intervention		
Circulating: Radial Percutaneous Coronary Intervention		
Circulating: Use of Laser		
Circulating: Angiojet		
Circulating: Rotoblator		
Circulating: Use of Volcano Ultrasound		
Circulating: Use of (what is name of Boston Sci ultrasound?)		
Circulating: Extracorpeal Membrane Oxygenation (ECMO)		
Circulating: Left Ventricular Assist Device (LVAD)		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Circulating: Peripheral Stent Placement		
Circulating: MitraClip		
Circulating: Watchman procedure		
Recording: Permanent Pacemaker Insertion		
Recording: ICD Insertion		
Recording: Temporary Transvenous Pacemaker Insertion		
Recording: Cardioversion		
Recording: Intra-aortic Balloon Pump Insertion		
Recording: Left Heart Catheterization		
Recording: Right Heart Catheterization		
Recording: Right and Left Heart Catheterization		
Recording: Femoral Percutaneous Coronary Intervention		
Recording: Radial Percutaneous Coronary Intervention		
Recording: Use of Laser		
Recording: Angiojet		
Recording: Rotoblator		
Recording: Use of Volcano Ultrasound		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

Knowledge and Skills Assessment	Demonstration Code	Observer Initials
Recording: Use of (what is name of Boston Sci ultrasound?)		
Recording: Extracorpeal Membrane Oxygenation (ECMO)		
Recording: Left Ventricular Assist Device (LVAD)		
Recording: Peripheral Stent Placement		
Recording: MitraClip		
Recording: Watchman procedure		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Cardiac Cath Lab Department Structure, Cherry Hill		
Implant Infection Control Guidelines: Invasive Cardiology Services		
Impella 2.5 Percutaneous VAD Support (Cardiac Cath Lab and CVOR): Insertion and Management		
Intra-Aortic Balloon Pump Management		
Intra-Aortic Balloon (IAB) Insertion, Percutaneous: Adult		
Cardiac Implanted Electronic Device (CIED) Management in Perioperative and Invasive Procedure Areas for Patients Requiring Anesthesia		

Required Competencies	Date of Completion	Staff Initials
Procedural Sedation Competency Verification		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Electrophysiology Lab Specific: New Hire Competency Checklist

Name ______________________ **Date** __________ **Unit**__________ **Manager**______________________

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Circulating: Permanent Pacemaker Insertion		
Circulating: EP Study		
Circulating: Pulmonary Vein Ablation		
Circulating: Non-Pulmonary Vein Ablation		
Circulating: Sequoia Ablations		
Circulating: Temporary Transvenous Pacemaker		
Circulating: ICD insertion		
Circulating: Cardioversion		
Circulating: Nips procedures Cardioversion		
Circulating: Internal circulate Cardioversion		
Circulating: Stereotaxis		
Circulating: Arterial Line Set-up		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Scrub: Manifold Set-up		
Scrub: Permanent Pacemaker Insertion		
Scrub: EP Study		
Scrub: Pulmonary Vein Ablation		
Scrub: Non-Pulmonary Vein Ablation		
Scrub: Sequoia Ablations		
Scrub: Temporary Transvenous Pacemaker		
Scrub: ICD insertion		
Scrub: Cardioversion		
Scrub: Nips procedures Cardioversion		
Scrub: Internal circulate Cardioversion		
Scrub: Stereotaxis		
Scrub: Arterial Line Set-up		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Recording: Permanent Pacemaker Insertion		
Recording: EP Study		
Recording: Pulmonary Vein Ablation		
Recording: Non-Pulmonary Vein Ablation		
Recording: Sequoia Ablations		
Recording: Temporary Transvenous Pacemaker		
Recording: ICD insertion		
Recording: Cardioversion		
Recording: Nips procedures Cardioversion		
Recording: Internal circulate Cardioversion		
Recording: Stereotaxis		
Recording: Arterial Line Set-up		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Review of Policies/Procedures/Job Aids	Date of Review	Staff Initials
Electrophysiology Heparinization and Protamine Reversal for Cardiac Ablations		
Implant Infection Control Guidelines: Invasive Cardiology Services		
Electrophysiology Lab Department Structure		
Roles and Responsibilities in the Electrophysiology Lab: Device Implantation/Chronic Lead Extraction		
Roles and Responsibilities in the Electrophysiology Lab: Electrophysiology Testing and Ablation		
Cardiac Implanted Electronic Device (CIED) Management in Perioperative and Invasive Procedure Areas for Patients Requiring Anesthesia		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

G Tube Removal: RN and Technologist Competency Checklist

Name ______________________ **Date** __________ **Unit**__________ **Manager**______________________

☐ Initial Competency ☐ Annual Competency

Instructions: Two successful (met) observations are required for unsupervised practice. Ongoing yearly competency is waived, provided the RN or Technologist has completed one successful G Tube Removal in the past year without adverse event. Observation can be simulated or on an actual patient.

G Tube Removal Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Verify LIP order for G Tube removal		
Consult with IR Radiologist with plan to supervise and advise		
Obtain needed supplies • Chloraprep solution • 4 x 4 gauze • Towels • 20cc syringe • Paper tape		
Bring patient back to IR holding area		
Acknowledge, Introduce, Duration, Explanation, and Thank You (AIDET) and perform hand hygiene		
Informed consent is not necessary		
Position patient supine on gurney		
Inspect G tube area for excoriation, signs of infection, skin integrity		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

G Tube Removal Procedure	Met #1 Observer Initials	Met #2 Observer Initials
Clean skin area around tube with chlorhexidine		
Remove sterile water from retention balloon via balloon port (roughly 6-10mls)		
Pull gently, and tube should come out easily. Report any resistance to the LIP before proceeding.		
Inform patient that there might be gastric content discharge for a few hours, depending on when they last ate. This is normal and will subside.		
Dress the skin with a pad of 4 x 4s and paper tape. Enough to contain gastric contents as needed.		
Inform patient to not eat for a few hours while the tract is closing up		
Walk patient out and perform hand hygiene		
Progress report in EPIC stating: date/time, G tube French size, and general disposition of the patient upon discharge		
Report to IR MD		
Complete charge master in EPIC		

Successful G Tube Removal #1 completed Date: ____________________ Observer Signature: ______________________________

Successful G Tube Removal #2 completed Date: ____________________ Observer Signature: ______________________________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Interventional Radiology Specific: New Hire RN Competency Checklist

Name ______________________ **Date** __________ **Unit**__________ **Manager**______________________

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Circulating: Myelogram		
Circulating: Kyphoplasty		
Circulating: AV Fistula/Shunt De-clotting		
Circulating: Internal Jugular Tunneled Central Venous Catheter Placement		
Circulating: Subclavian Tunneled Central Venous Catheter Placement		
Circulating: Non-tunneled Central Venous Catheter Placement		
Circulating: Uterine Fibroid Embolization		
Circulating: Central Line Placement		
Circulating: Port Placement		
Circulating: PICC Line Placement		
Circulating: Liver Biopsy		
Circulating: Liver Biopsy and Embolization		
Circulating: Upper Extremity Angiogram		
Circulating: Lower Extremity Angiogram		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Knowledge and Skills Assessment	Date and Demonstration Code	Observer Initials
Circulating: Cerebral Angiogram		
Circulating : Chest Tube Placement		
Circulating: Nephrostomy Tube		
Circulating: IVC Filter Placement		
Circulating: IVC Filter Removal		
Circulating: Code IR / Thrombectomy		
Circulating: Thrombolysis / EKOS		

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Observer Signature: ______________________________ Date: ______________

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Review of IR Specific Policies/Procedures/Job Aids	Date of Review	Staff Initials
Accudrain External Ventricular Drainage Device (EVD) and Intracranial Pressure (ICP) Monitoring		
Limitorr External Ventricular Drainage Device (EVD) and Intracranial Pressure (ICP) Monitoring		
Vascular Management: EKOS Lysis Infusion System [Adult]		
Review all Code Stroke/Code IR Algorithms applicable to your campus		
Medication Administration: Alteplase for Stroke		

Required Competencies	Date of Completion	Staff Initials
G Tube Removal Competency		
Procedural Sedation Competency Verification		

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

Philips Monitor Checklist 2018

Orientation Checklist

Name____ Unit ___________________

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Turn Monitor On	
Stand by Function	
Admit Patient	
Suspend Monitoring	
Resume Monitoring	
Discharge Patient	
View Different Patients from another Patient's Room (Care Group)	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Adjust Limits for HR	
Change Leads	
Adjust Lead Size	
Add ST segment Monitoring • Adjust ST segment Alarms	
Turn on Pacing Alert	
Relearn Patient Rhythm	
Use E- calipers to Measure Intervals	

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Print Real time recording **(excludes Neuro East at CH)** • Print from both room and central station	
Change waves to be graphed from the default ECG settings	

SKILL	DATE DEMONSTRATED
Start/Stop NIBP (including STAT mode)	
Adjust BP limits	
Add pressure module	
Label Pressure Module with desired Hemodynamic Parameter (etc. PA, ABP, ICP)	
Adjust Pressure Limits on Hemodynamic Parameters	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Select Sector Segment Set up to Perform Telemetry Monitoring	
Pair and Unpair Telemetry unit	
Replace Telemetry Unit Battery	

SKILL	DATE DEMONSTRATED/PRECEPTOR INITIALS
Silence Alarm	
Review an Alarm /Delete as Needed	
View Alarm History	
Record/Print ECG from Alarm History	

Preceptor Name and Initials ____

Preceptor Name and Initials ____

Preceptor Name and Initials ____

Demonstration Codes: VO = Verbalizes Understanding; DO = Demonstrates Understanding; SO = Simulates Understanding; N/A = Not Applicable

SWEDISH MEDICAL CENTER

Intra-Aortic Balloon Pump Initial: Competency Checklist

Name ______________________________ **Date** ____________ **Unit**_____________ **Manager**_________________________

Preceptor: By initialing each box and signing the paper you are attesting that the learner is at minimum Competent with caring for the IABP. Competency: can maintain safe practice, follows standards of practice, applies knowledge and develops priorities and decision making skills.

POLICIES to REVIEW:	Intra- Aortic Balloon Pump Management Intra-Aortic Balloon Removal: Percutaneous Vascular Management: Percutaneous Arterial/Venous Sheath Management (Adult)

Intra-Aortic Balloon Pump (IABP) Competency	**Orientee initial/ Preceptor Initial/Date**
Demonstrates safe care for the patient with an IABP • Inspection of the IABP catheter and transducer line • Fast-flush of the arterial line every hour to insure patency • No lab draws from the IABP arterial line unless no other access available	**O**_____**P**_____**Date**_____
Verbalize the indications for an IABP, the reason for each trigger mode, connecting the IABP to the console, changing the helium tank	**O**_____**P**_____**Date**_____
Verbalize the adverse effects of inappropriate timing	**O**_____**P**_____**Date**_____

Documents accurately and appropriately for a patient with an IABP
• Every 15 minutes x4, 30 minutes x2 then every 60 minutes or as patient status requires
  o Vital signs and Hemodynamic parameters
  o Lower extremity vascular checks
  o Left hand vascular checks
  o Insertion site (bleeding, hematoma, retroperitoneal bleed)
• Hourly urine output
• Sheath/IABP site every 4 hours
	O_____**P**_____**Date**_____

Assesses and documents appropriate timing of the IABP in 1:2 (if patient is stable) • Hourly: Mean, Unassisted Systole, Assisted Systole, Unassisted End Diastolic, Assisted End Diastolic, Augmented Diastolic	**O**_____**P**_____**Date**_____
Demonstrates appropriate labeling and documentation of IABP timing • Print and Label a 1:2 balloon-assisted arterial tracing every shift	**O**_____**P**_____**Date**_____
Verbalizes reportable conditions	**O**_____**P**_____**Date**_____
Verbalizes emergency management and trouble shooting of an IABP • Steps following a balloon rupture • Steps in a Code Blue (Asystole, Ventricular Fibrillation) • Loss of pulse or ischemia in the affected extremity (or Left hand) • Bleeding • Alarms: Rapid gas loss, No Trigger, IABP Catheter Alarms, etc	**O**_____**P**_____**Date**_____
Discuss steps for weaning the IABP	**O**_____**P**_____**Date**_____
Verbalize safe IABP catheter removal (review policy)	**O**_____**P**_____**Date**_____

Date: ____________________Orientee Signature__________________________________Preceptor Signature: ____

Exhibit 28
Patient Transfer Agreement

PATIENT TRANSFER AGREEMENT

This PATIENT TRANSFER AGREEMENT (this "Agreement") is made by and between Swedish Medical Center / Issaquah (the "Transferring Hospital") and Swedish Medical Center / Cherry Hill (the "Receiving Hospital").

RECITALS

A. The Transferring Hospital seeks to provide elective percutaneous coronary interventions ("PCI") for its patients and has applied for a certificate of need pursuant to WAC 246-310-700 et. Seq.

B. The Transferring Hospital recognizes that it may on certain occasions need to transfer a patient receiving PCI to another hospital with on-site open heart surgical services.

C. The Transferring Hospital has identified the Receiving Hospital, located at 500 17th Ave, Seattle, Washington, as a health care facility experienced and qualified to provide the necessary open heart surgical services desired by the Transferring Hospital.

D. The Receiving Hospital desires to accept all referred PCI patients from the Transferring Hospital under the terms set forth herein.

NOW, THEREFORE, in consideration of the mutual benefits to be derived and the terms and conditions contained herein, the parties agree as follows:

1. RESPONSIBILITIES OF THE TRANSFERRING HOSPITAL. The Transferring Hospital shall be responsible for performing or ensuring performance of the following:

1.1. Informed Consent. The Transferring Hospital shall secure the patient's signed informed consent for the PCI. The consent form shall indicate that the Transferring Hospital does not have on-site surgical backup and shall address the risks associated with transfer and urgent surgery under this Agreement and the transfer agreement in place with the Receiving Hospital.

1.2. Emergency Transport. The Transferring Hospital shall arrange for appropriate and safe transportation to the Receiving Hospital. Before the Effective Date, the Transferring Hospital shall have an agreement with a transport vendor. The emergency transport staff shall be advanced cardiac life support certified and have the skills, training, and equipment necessary to monitor and treat the patient during transport and to manage an intra-aortic balloon pump. The Emergency transport shall commence within twenty (20) minutes of the initial identification of a complication.

1.3. Transfer of Clinical Data. The Transferring Hospital shall transfer all clinical data, including images and videos, with the patient to the Receiving Hospital.

1.4. Documentation of Transfer. The Transferring Hospital shall document the reason(s) for recommending the transfer in the patient's medical record, a copy of which shall be sent with the patient to the Receiving Hospital. The Transferring Hospital shall document the transport time from the decision to transfer the patient to arrival in the operating room of the Receiving Hospital, which under no circumstances shall be longer than two (2) hours.

1.5. Communications between Physicians. The Transferring Hospital shall coordinate communications between the physician performing the elective PCI and the cardiac surgeon at the Receiving Hospital regarding the reasons for the patient's transfer and clinical condition.

1.6. Hours of Operation. The Transferring Hospital shall keep the Receiving Hospital informed of its hours of operation of elective PCI services.

1.7. Transportation Drills. The Transferring Hospital shall conduct two (2) timed emergency transport drills per year. The outcomes of these transport drills shall be reported to the Transferring Hospital's quality assurance program for review.

1.8. Confidential Information. The Transferring Hospital shall establish a policy and/or protocol for maintaining the confidentiality of the patient's medical and other confidential records in accordance with applicable state and federal law.

2. RESPONSIBILITIES OF THE RECEIVING HOSPITAL. The Receiving Hospital shall be responsible for performing or ensuring performance of the following:

2.1. Acceptance of Transfers. The Receiving Hospital agrees to accept all patients referred by the Transferring Hospital under this Agreement.

2.2. Hours of Operation. The Receiving Hospital shall ensure that it is available to provide cardiac surgery during the hours that elective PCIs are available at the Transferring Hospital.

2.3. Confidential Information. The Receiving Hospital shall establish a policy and/or protocol to maintain the confidentiality of the patient's medical and other confidential records in accordance with applicable state and federal law.

3. JOINT RESPONSIBILITIES OF TRANSFERRING HOSPITAL AND RECEIVING HOSPITAL. The Transferring Hospital and Receiving Hospital shall be jointly responsible for performing or ensuring performance of the following:

3.1. Coordination. The Transferring Hospital and Receiving Hospital shall coordinate the availability of surgical teams and operating rooms. The Transferring Hospital and the Receiving Hospital shall each designate a person who is responsible to coordinate patient transfers under this Agreement.

3.2. Conferences. Representatives of the Transferring Hospital's PCI program and the Receiving Hospital's surgical program shall hold quarterly conferences during which preoperative and postoperative cases are reviewed, including all transport cases occurring during that quarter. Case reviews shall include review of the quality measures and outcomes more fully described in Exhibit A attached to this Agreement.

3.3. Peak Volume Periods. The parties shall address peak volume periods, as necessary, if capacity issues arise.

4. BILLING. Each party shall be responsible for billing and collecting from the patient, third party payer, or other responsible party for the items and services rendered to the patient by such party. Neither party shall be responsible to the other for such charges.

5. TERM AND TERMINATION.

5.1. Term. The term of this Agreement is for one year (1) year beginning on the first day of operations at the Transferring Hospital (the "Effective Date"), and will automatically renew for successive one (1) year periods unless either party gives the other notice of termination as specified below prior to an expiration date.

5.2. Termination. Either party may terminate this Agreement at any time with or without cause, upon thirty (30) days written notice to the non-terminating party.

6. GENERAL PROVISIONS

6.1. Governing Law and Venue. The terms of this Agreement shall be construed and governed by the laws of the State of Washington and the venue for any dispute arising out of this Agreement shall be brought in the Superior Court for King County.

6.2. Assignment. Neither party may assign this Agreement without the prior written consent of the other.

6.3. Insurance. Each party shall maintain in full force and effect throughout the term of this Agreement, at its own expense, a policy of comprehensive general liability insurance and professional liability insurance, each having a single limit of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate for bodily injury and property damage to insure against any loss, damage or claim arising out of the performance of each party's respective obligations under this Agreement. Each party will provide the other with certificates evidencing said insurance, if and as requested.

6.4. Notification. Whenever written notice is required or permitted to be given by one party to the other (other than notice of transfer or acceptance of a patient), such notice shall be deemed to have been given if delivered in hand or by registered or certified mail, return receipt requested, postage prepaid, to such party at the address identified in the recitals.

6.5. Conflict with Governing Law. If any provisions of this Agreement shall at any time conflict with any applicable state or federal law, this Agreement shall be modified in writing by the parties hereto to conform to such law.

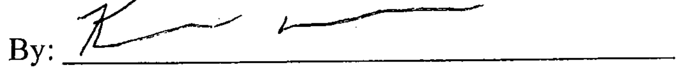
6.6. Entire Agreement. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all negotiations, prior discussions, agreements or understandings, whether written or oral, with respect to the subject matter hereof, as of the Effective Date. This Agreement shall bind and benefit the parties and their respective successors and assigns.

6.7. Cooperation. The parties agree to cooperate with each other in the fulfillment of their respective obligations under the terms of this Agreement and to comply with the requirements of the law and with all applicable ordinances, statutes, regulations, directives, orders, or other lawful enactments or pronouncements of any federal, state, municipal, local or other lawful authority.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered by their respective officers thereunto duly authorized as of February 18, 2011.

TRANSFERRING HOSPITAL:

SWEDISH MEDICAL CENTER / ISSAQUAH



By: ____________________

Name and Title: Kevin Brown,
Chief Administrative Officer

RECEIVING HOSPITAL:

SWEDISH MEDICAL CENTER / CHERRY HILL

By: ____________________

Name and Title: Marcel Loh,
Chief Administrative Officer

EXHIBIT A

PCI Case Reviews

PCI case reviews shall include review of the following quality measures and outcomes:

1. Planned PCI procedure
2. Details of transfer
3. Hemodynamic status at transfer and on admission
4. Any complication of PCI and surgery procedure
5. Review of process
6. Patient outcome

Exhibit 29
Hospital Medical Transportation Services Agreement

DocuSign Envelope ID: D2F0A364-314F-48BB-B72C-EBD8700101AB

HOSPITAL MEDICAL TRANSPORTATION SERVICES AGREEMENT

THIS MEDICAL TRANSPORTATION SERVICES AGREEMENT ("Agreement") is effective as of November 1, 2018 by and between Swedish Health Services d/b/a Swedish Medical Center (Swedish), and American Medical Response Ambulance Services, Inc., whose principal place of business is located at 13075 Gateway Drive #100, Seattle WA 98168 (Provider).

RECITALS

A. Swedish is entering into this agreement for services to be provided at the following acute care hospitals and freestanding Emergency Departments (ED), which are licensed by the State of Washington, and certified to participate in the Medicare and Medicaid programs:

- Swedish First Hill - 747 Broadway, Seattle, WA 98122
- Swedish Cherry Hill - 500 17th Ave, Seattle, WA 98122
- Swedish Ballard – 5300 Tallman Ave. NW, Seattle, WA 98107
- Swedish Issaquah – 751 NE Blakely Drive, Issaquah WA 98029
- Swedish Edmonds—21601 76th Ave W, Edmonds, WA 98026
- Swedish Mill Creek Ambulatory Care Center (freestanding ED)— 13020 Meridian Ave S, Everett, WA 98208
- Swedish Redmond Ambulatory Care Center (freestanding ED) —18100 NE Union Hill Rd, Redmond, WA 98052

B. Swedish anticipates the need for Advanced Life Support (ALS)/Critical Care Transport (CCT), Basic Life Support (BLS) ambulance transport, and for Wheelchair/cabulance transport for and between the above locations. The patient population will include adults and pediatric patients. The purpose of this contract is to define and contract on a non-exclusive basis for Advanced Life Support (ALS)/Critical Care Transport (CCT), Basic Life Support (BLS) ambulance transport, and Wheelchair/cabulance services for Swedish patients.

C. Provider is a provider of medical transportation services licensed by the State of Washington and certified to participate in the Medicare and Medicaid programs. Provider is currently providing ambulance and non-ambulance transportation services to Swedish under that certain Hospital Ambulance Transportation Services Agreement effective December 1, 2013, as amended, which is superseded by this Agreement as provided in Section 18.d of this Agreement.

D. Swedish desires to arrange for medical transportation services for patients for whom it has financial responsibility with respect to such services, and to assure that all of its patients have access to timely, high quality medical transportation services.

E. Swedish desires that Provider furnish medical transportation services to patients, and Provider agrees to provide such services, pursuant to the terms and conditions set forth herein.

DocuSign Envelope ID: D2F0A364-314F-48BB-B72C-EBD8700101AB

AGREEMENT

NOW, THEREFORE, for and in consideration of the mutual promises and covenants contained herein, it is mutually agreed as follows:

1) Services.

(a) Provider will provide on a non-exclusive basis the following medical transport services for patients for which Swedish is the responsible payor on an as-needed basis as more fully described on Exhibit A (the "Services"):
   i. Wheelchair/cabulance transport;
   ii. BLS ambulance; and
   iii. ALS/CCT ambulance.

Note: Provider will not be providing Advanced Life Support services but will provide Critical Care Transportation with an RN for patient care.

(b) Provider shall furnish the medical transportation specified on Exhibit A (Services) for patients upon request by an employee or other agent of Swedish, subject to the availability of its personnel and vehicles. Provider shall make Services available twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year.

(c) Provider shall staff and equip ALS/CCT, BLS and wheelchair/cabulance vehicles according to the requirements listed and described in Exhibit A.

(d) Provider shall meet specific ALS/CCT, BLS and wheelchair/cabulance unit response times, as detailed in Exhibit A. These response time requirements should be met twenty-four (24) hours per day, three hundred sixty-five (365) days per year.

(e) Provider agrees to render Services under this Agreement in compliance with all requirements on Exhibit A, as well as all applicable laws, regulations, and requirements of Medicare and Medicaid, and in accordance with the prevailing standards of quality and care applicable to ALS/CCT, BLS ambulance and wheelchair/cabulance services. Provider shall, during the term of this Agreement, maintain all licenses and other authorizations necessary to provide Services. Provider shall assure that the ALS/CCT, BLS ambulance and wheelchair/cabulance units meet all applicable federal, state and county requirements, including licensing, permit and inspection requirements. Provider shall be responsible for all maintenance, calibration, fuel, equipment, supplies and other services required in connection with the ALS/CCT, BLS ambulance, and wheelchair/cabulance units. Provider shall provide services in compliance with the standards and recommendations of accrediting bodies for the facilities in Recital A, including Det Norske Veritas ("DNV"), Commission on Accreditation of Rehabilitation Facilities ("CARF"), as applicable. Provider shall staff its ambulances with personnel who are licensed or certified as required by law and shall equip its ambulances with all equipment and supplies required by law.

(f) Annually, Provider shall meet with a representative from Swedish to review Provider's performance against the standards in Exhibit A and Exhibit B to ensure performance is satisfactory.

(g) During the term hereof, both parties shall maintain vigorous continuous quality improvement programs and shall cooperate with the other party's reasonable requests for information and assistance as pertains to the Services

(h) Provider shall ensure that each employee or contractor providing services on its behalf is fully licensed and qualified to provide such services. In addition, Provider shall ensure that it has conducted a criminal background check in accordance with state requirements. Provider, its owners, members, directors, employees, and contractors shall not be disqualified from participating in the Medicare or Medicaid programs.

(i) Provider will use its Computer Aided Dispatch (CAD) system and billing systems to gather and provide comprehensive reporting data customized to meet Swedish's requirements. This data and reports, based on input from Swedish, will include information on: transport types, destinations, total number of transports, and response times. Provider will deliver the data or reports to Swedish on a regular weekly or monthly basis at Swedish's request. Provider will review such reports with Swedish on a regular basis to focus on any necessary improvements to meet Swedish patient transport needs. Swedish may request other reports from Provider, with the data and frequency of distribution to be mutually agreed upon.

2) Charges.

(a) Swedish shall be financially responsible and shall reimburse Provider for Services delivered to "Hospital-Responsible Patients" as specified on Exhibit A. For all other patients, Swedish shall not be financially responsible and Provider may bill and seek reimbursement from the patients and/or their third-party payors in accordance with its policies and procedures, as well as the standards in Exhibit C.

(b) Swedish shall compensate Provider for Services rendered to Hospital-Responsible Patients in the manner and amounts set forth on Exhibit C.

(c) The parties will work cooperatively to assure that patients and/or third-party payors are billed appropriately for services provided, in accordance with applicable Medicare and third-party payor guidelines and Swedish policies and procedures.

(d) Provider will be responsible for obtaining their own Advance Beneficiary Notice of Noncoverage (ABN) forms. Swedish will assist Provider as reasonably requested in obtaining such forms from patients.

3) Documentation of Medical Necessity.

(a) Swedish shall be responsible for documenting the medical necessity of all services ordered by authorized persons for any patient. Without limiting the generality of the foregoing, Swedish shall be responsible for obtaining any preauthorization, physicians' orders, Physician Certification Statements ("PCS") or certificates of medical necessity required to document medical necessity or to comply with the requirements of Medicare, Medicaid or other third-party payor for any patient. Provider will supply, at its own expense, PCS forms and patient transfer envelopes and any other items needed for patient transport.

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(b) For patients covered by Medicaid or Medicare Part B, or other third-party payors as required by such payors, Swedish shall assure that a PCS in the form prescribed by Provider is completed prior to any non-emergency transport or as soon thereafter as possible. Such PCS shall be completed by the physician, physician assistant, nurse practitioner, clinical nurse specialist attending the patient, registered nurse or discharge planner.

(c) Swedish shall routinely furnish Provider with all medical and financial information reasonably requested by Provider to assist Provider in, as applicable, preparing and submitting complete claim forms, submitting encounter data, determining whether a patient is a Hospital-Responsible Patient, determining what (if any) other third party coverage exists for a patient, documenting the medical necessity of any service performed for any third party payor billed directly by Provider, and otherwise performing the functions required or contemplated hereunder. This includes giving a copy of the patient's "Face" sheet to the Provider's ambulance crew.

(d) Provider shall document each Service provided to a Hospital-Responsible Patient on Provider's standard patient care form Provider shall take all reasonable steps to assure that all information provided to Swedish is complete and accurate.

4) Term of Agreement; Termination.

(a) The term of this Agreement shall be two (2) years beginning on November 1, 2018 and ending October 31, 2020 unless this Agreement is terminated at an earlier date pursuant to Section 4(b), below. This Agreement may be extended for additional 12-month periods, up to a maximum of three additional years upon written amendment signed by both parties. At least sixty (60) days prior to the expiration date, the parties agree to discuss, in good faith, any extension or modification of this Agreement.

(b) This Agreement may be terminated prior to its normal expiration pursuant to the following provisions:

i. For uncured breach: Either party may terminate this Agreement in the event of the other party's material breach hereof; provided, however, that termination for breach shall not become effective unless and until the non-terminating party has been given written notice of such breach, and such party shall have failed to have cured such breach to the reasonable satisfaction of the other within thirty (30) days following said notice.

ii. Insurance cancellation or nonrenewal: In the event any insurance required to be maintained by either party to this Agreement is cancelled or not renewed, or in the event either party loses any license, permit or other legal entitlement necessary to lawfully perform its obligations hereunder, such party shall immediately notify the other and this Agreement shall be deemed terminated, effective immediately.

iii. Insolvency: In the event a party files a voluntary petition in bankruptcy or makes an assignment for the benefit of creditors or otherwise seeks relief from creditors under any Federal or state bankruptcy, insolvency, reorganization or moratorium statute, or is the subject of an involuntary petition in bankruptcy which is not dismissed with prejudice within sixty (60) days of its filing, the other party may terminate this Agreement immediately.

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iv. Without Cause: By either party without cause, upon ninety (90) days written notice.

5) Effect of Termination.

In the event of termination of this Agreement, in order to assure continuity of Services to Patients, Provider agrees that it will, if requested by Swedish, continue to provide Services to patients for such reasonable time period as may be necessary for Swedish to secure another Services provider; provided, however, that following the effective date of termination, (a) Swedish shall pay Provider its full usual and customary rates, evidenced by Provider's published fee schedule; (b) if this Agreement has been terminated by Provider for nonpayment by Swedish, Provider may, to the extent permitted by law, request payment in advance or other form of security for payment and (c) the provisions requiring continuing performance post-termination shall remain in effect according to their terms.

6) Indemnification.

Each party (the "Indemnitor") shall indemnify, defend and hold the other, and its employees and agents (collectively the "Indemnitee") harmless against any claims, liability, losses or damages (collectively "Claims"), incurred by the Indemnitee which arise from any breach of this Agreement or any negligent, intentional or other tortuous act or failure to act of the Indemnitor related to the performance of this Agreement. This provision shall survive the termination of this Agreement. The Indemnitee agrees to promptly notify the Indemnitor of any Claim against it, which it expects to give rise to a duty of indemnity by the Indemnitor.

7) Insurance.

At all times during the term of this Agreement, each party shall maintain general and professional liability insurance coverage in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the annual aggregate, providing coverage for the negligent acts or omissions of such party and its employees and agents. Appropriate proof of coverage shall be made available to either party upon request.

In addition, Provider agrees to maintain automobile liability insurance coverage throughout the term of this Agreement. This insurance coverage shall apply to each and every Provider vehicle utilized in conjunction with Swedish programs or services. Swedish will be promptly notified if Provider is contemplating substantial changes in this insurance coverage. This insurance coverage will be evidenced by an insurance certificate supplied by Provider. This certificate will be supplied to Swedish at the time of each automobile liability insurance renewal.

8) Medical Records; Access Clause.

Provider will make available upon written request of the Comptroller General of the United States or the Secretary of the United States Department of Health and Human Services (HHS), or any of their duly authorized representatives, this Agreement and all books, documents and records of Provider, until the expiration of four (4) years after the services furnished under this Agreement are completed. The provision of this paragraph will have force and effect only to the extent that the provisions of Section 1861(v)(I)(I) of the Social Security Act, U.S. Code Section 1395x(v)(1)(I), and the regulations related thereto, are applicable to this Agreement.

9) Non-Discrimination.

Provider agrees: (a) not to differentiate or discriminate in its provision of Services to patients on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, national origin, age, disability, handicap, or sex, as those terms are defined under federal law and rules; and (b) to render Services to patients in the same manner, and in accordance with the same standards, as offered to other patients.

10) Confidential Information.

Provider shall maintain all patients' information including, but not limited to, each Patient's name, address, telephone number and all medical information pertaining to Patients, as confidential, and shall use such information only in the performance of this Agreement or as otherwise authorized by applicable law. Provider agrees not to advertise, disclose, or otherwise discuss this Agreement and its business relationship with Swedish and or its affiliates without the prior written consent of Swedish. Swedish shall maintain the confidentiality of this Agreement, Provider's rates charged hereunder, the compensation methodology set forth in the Exhibit(s) hereto and any other information designated by Provider as confidential and shall use such information only in the performance of this Agreement or as otherwise required by law.

11) HIPAA Compliance.

Each party shall comply with the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 as amended or modified by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and the regulations there under and shall be collectively referred to herein as “HIPAA”. Each party acknowledges and agrees that it is considered a covered entity under HIPAA. Accordingly, both parties will use and disclose Protected Health Information in accordance with HIPAA and other Federal and state laws regarding the confidentiality of patient records.

12) Force Majeure.

Provider shall not be responsible for any delay or failure of performance resulting from circumstances beyond its control and without its fault or negligence. In the event of any major disaster, epidemic, labor dispute, interruption in supply or other cause beyond Provider's control, Provider shall render services under this Agreement within the limitation of its available equipment and personnel.

13) No Influence on Referrals.

It is not the intent of either party to this Agreement that any remuneration, benefit or privilege provided for under this Agreement shall influence or in any way be based on the referral or recommended referral by either party of patients to the other party or its affiliated providers, if any, or the purchasing, leasing, or ordering of any services other than specific services described in this Agreement. Any payments specified in this Agreement are consistent with fair market value for the services provided.

14) Jeopardy; Severability.

Notwithstanding anything to the contrary in this Agreement, if any term, covenant, condition or provision of this Agreement should be deemed to violate any future statute, regulation or ordinance, or be otherwise deemed illegal (collectively, "Jeopardy Event"), then the parties shall use their best efforts to meet forthwith and attempt to renegotiate this Agreement to remove or negate the effect of the Jeopardy Event. If the parties are unable to renegotiate this Agreement as specified above, such illegal, unenforceable or invalid provisions or part thereof shall be stricken from this Agreement, and such provision shall not affect the legality, enforceability or validity of the remainder of this Agreement, except as hereafter provided. If any provision or part thereof of this Agreement is stricken in accordance with the provisions of this Section, then this stricken provision shall be replaced, to the extent possible, with a legal, enforceable and valid provision that is as similar in economic effect to the stricken provision as is legally possible. However, if either party reasonably and in good faith determines that the finding of illegality or unenforceability adversely affects the material consideration for its performance under this Agreement, then such party may, at its option, by giving written notice to the other, terminate this Agreement.

15) Compliance.

The parties will comply in all material respects with all applicable Federal and state laws and regulations.

16) Compliance Program and Code of Conduct.

Provider has made available to Swedish a copy of its Code of Conduct, Anti-kickback policies and other compliance policies, as may be changed from time-to-time and Swedish acknowledges receipt of such documents. Provider warrants that its personnel will comply with Provider's compliance policies, including mandatory training related to the Anti-kickback Statute.

17) Non-Exclusion.

Each party represents and certifies that neither it nor any practitioner who orders or provide Services on its behalf hereunder has been convicted of any conduct that constitutes grounds for mandatory exclusion as identified in 42 U.S.C.§ 1320a-7(a). Each party further represents and certifies that it is not ineligible to participate in Federal health care programs or in any other state or federal government payment program. Each party agrees that if DHHS/OIG excludes it, or any of its practitioners or employees who order or provide Services, from participation in Federal health care programs, the party must notify the other party within five (5) days of knowledge of such fact, and the other party may immediately terminate this Agreement, unless the excluded party is a practitioner or employee who immediately discontinues ordering or providing Services hereunder

18) Miscellaneous Provisions

(a) It is mutually agreed that Provider is and at all times shall be acting as an independent contractor. Except to the extent that Swedish is required to exercise professional control over Provider by applicable Medicare requirements, Swedish shall neither have nor exercise any control or direction over the methods by which Provider and its employees or subcontractors shall perform their duties arising hereunder.

(b) All notices, requests, demands or other communications under this Agreement shall be in

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writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the second day after mailing if mailed to the party to whom notice is to be given, by first class mail, certified, postage prepaid, and properly addressed as provided under the signature block of each party. Any party may change their address for purposes of this Section by giving the other party written notice of the new address in the manner set forth above.

(c) This Agreement shall be governed by and construed in accordance with the laws of the State of Washington. Venue for any disputes shall lie in federal or state court in King County, Washington. The substantially prevailing party in any legal proceeding arising from this Agreement shall be awarded its reasonable attorneys' fees and costs.

(d) This Agreement (including the Exhibits and any attachments thereto, which are incorporated herein by this reference) constitutes the entire agreement between the parties with respect to the subject matter hereof, superseding all prior oral and written agreements with respect thereto, and no amendment shall be valid unless it is documented in a written instrument duly executed by the party or parties making such amendment. Specifically, this Agreement supersedes that certain Hospital Medical Transportation Agreement dated December 1, 2013, as amended, between the parties. Nothing in this Agreement shall be construed to confer upon any person, any remedy or claim as third-party beneficiaries or otherwise.

(e) No waiver of any breach of any provision of this Agreement shall be deemed a waiver of any preceding or succeeding breach. No extension of time for performance of any obligations or acts shall be deemed an extension of the time for performance of any other obligations or acts.

(f) Neither party may assign this Agreement nor any rights hereunder, nor may they delegate any of the duties to be performed hereunder without the prior written consent of the other party. This Agreement shall be binding upon, and shall inure to the benefit of, the parties to it and their respective legal representatives, successors and assigns.

(g) Each individual executing this Agreement on behalf of any entity which is a party to this Agreement represents and warrants that he or she is duly authorized to execute and deliver this Agreement on behalf of said entity. This Agreement may be signed in counterparts.

[Signatures are on the next page]

IN WITNESS WHEREOF, each party hereto has caused this Hospital Medical Transportation Services Agreement to be executed in its name as of the date first written above.

Swedish Health Services	Provider:
By: DocuSigned by: David West CB0FABE3F982426...	By: DocuSigned by: Thomas Wagner 24DD9CBD0C42438...
Title: COO CHerry Hill	Title: Chief Executive Officer, West Reg
Date: 1/22/2019	Date: 1/15/2019

Address for Notice provision:

Swedish Medical Center
747 Broadway
Seattle, WA 98122
Attention: Contracts Manager

With a cc to
Chief Legal Officer
Providence St. Joseph Health
1801 Lind Ave SW #9016
Renton WA 98057

American Medical Response
13075 Gateway Drive #100
Seattle WA 98168
Attn: Regional Director

With a cc to
Legal Department
American Medical Response, Inc.
6363 S Fiddler's Green Cir. 14th Floor
Greenwood Village, CO 80111

EXHIBIT A

Definitions, Services, Response Times, Reports, and Transport Request Protocols

Definition:

"Hospital Responsible Patient" shall refer to an individual who either is

(a) an inpatient of First Hill, Cherry Hill, Issaquah, or Ballard inpatients receiving a round trip transportation to and from the same Hospital (e.g., inpatient travels off campus to receive specialized treatment and returns to the same hospital), or

(b) an inpatient transferred one way between First Hill and Ballard (because such Hospitals are covered by the same hospital license).

I. Medical Transportation Definitions &Requirements

Basic Life Support (BLS)

- Staffed by two Washington State certified Emergency Medical Technicians (EMT's).
- Transport the sick and injured, non-life-threatened patient.
- Transport patients requiring oxygen therapy and extrication.
- BLS Units can transport patients with non-medicated IV fluids.
- BLS Units cannot start IV lines or transport medicated lines unless on a locked out pump.

Basic Life Support (BLS) Bariatric

- Staffed by two Washington State certified Emergency Medical Technicians (EMT's).
- Transport the sick and injured, non-life-threatened patient.
- Transport patients requiring oxygen therapy and extrication.
- BLS Units can transport patients with non-medicated IV fluids.
- BLS Units cannot start IV lines or transport medicated lines unless on a locked out pump.
- Able to transport a patient up to 1300 pounds.

Wheelchair/cabulance

- Staffed by one First Aid/CPR or EMT trained driver.
- Transportation for wheelchair dependent patient from bed to bed.
- Able to transport patients requiring oxygen therapy (self-administered).
- Able to transport patients requiring a chair 32 inches wide or less.

Wheelchair/cabulance Bariatric

- Staffed by one First Aid/CPR or EMT trained driver.
- Transportation for wheelchair dependent patient from bed to bed.
- Able to transport patients requiring oxygen therapy (self-administered).

Advanced Life Support (ALS)/Critical Care Transport (CCT)

- Staffed by a Washington State licensed Registered Nurse and Advanced Cardiac Life Support (ACLS) Emergency Medical Technician.
- Three channel IV pumps for multiple IV lines.
- Heart monitor with defibrillator, pacing and invasive monitoring (ICP/CVP/Arterial Lines) capabilities.

- Establishing or maintaining IV accesses to include antiarrhythmics, narcotics, vasopressors, and IV fluids.
- Monitoring/maintaining respiratory status to include intubation and pulse oximetry as needed.
- Portable ventilating systems.
- Other specialized critical patient care equipment or procedures as ordered by the patient's physician (such as cardiac STEMI patients).

II. Response Time Requirements

Response time is defined as the time from which Swedish personnel place a call to Provider's designated phone number to when vehicle arrives at the Swedish facility requesting the service. At the time of each call, Swedish personnel shall alert the Provider to the level of service required for the patient transport. Ambulance transport definitions are delineated below.

<table>
<tr><th colspan="2">AMBULANCE TRANSPORT DEFINITIONS</th></tr>
<tr><td>ALS/CCT Emergency (0 – 30 minutes)
▪ CCT (ALS) unit is needed
▪ Transport must occur as quickly as possible due to the patient's clinical status</td><td>ALS/CCT (0 – 60 minutes)
▪ CCT (ALS) unit is needed
▪ Patient is stable and transfer can occur up to 60 minutes from call without any expectation of patient deterioration</td></tr>
<tr><td colspan="2">BLS (0 – 60 minutes)
▪ BLS unit is needed
▪ Transfer can occur up to 60 minutes with no concern of patient deterioration</td></tr>
<tr><td>BLS or CCT (Scheduled)
▪ BLS unit is needed
▪ Transport is non-emergent, and patient pick up is scheduled in excess of a 60-minute response time.
▪ Swedish personnel to specify response time and unit will be scheduled within 60 minutes of original response time request.</td><td>Wheelchair/cabulance (Scheduled)
▪ Wheelchair or Cabulance unit is needed
▪ Transport is non-emergent, and patient pick up is scheduled in excess of a 60-minute response time.
▪ Swedish personnel to specify response time and unit will be scheduled within 60 minutes of original response time request.</td></tr>
</table>

Response times noted above are expected to be less than the time listed and will be measured each calendar quarter for each campus. Provider shall meet the above response times for at least 95% of all transports.

Patient transports shall be measured and evaluated for each campus within three weeks of the end of each calendar quarter. Provider and Swedish will evaluate the response time performance using the data and reports supplied by Provider to Swedish and compared to Swedish's own data.

<u>Exceptions to Response Time Performance Standards</u>. Provider may apply and Swedish may grant exemptions to response time performance standards in situations beyond that Provider's control. Examples of such situations may include, without limitation, declared disasters, cancelled requests, location changes, and accidents. Swedish shall examine each request for exemption in good faith. If

Swedish determines the circumstances warrant, Swedish shall grant an exemption of the response time from inclusion in the performance standards calculation.

Response Times for Emergent Percutaneous Coronary Interventions.

In conformance with WAC 246-310-735 (7), Provider will ensure transport for emergent percutaneous coronary intervention ("PCI") cases will begin within twenty (20) minutes of the initial identification of a complication as determined by Swedish's treating physician.

In conformance with WAC 246-310-735 (9) and specifically regarding transport of PCI patients, transportation time will be less than one hundred and twenty (120) minutes.

In conformance with WAC 246-310-735 (10), Swedish and Provider will participate in a minimum of two annual timed emergency transportation drills pursuant to the provision of PCI services at Swedish, with outcomes reported to the Swedish's quality assurance program.

Response Times and Special Patient Conditions

Swedish and Provider will collaborate to improve processes and communication to respond to transport needs of patients with specific conditions.

III. Reports

Provider shall furnish Swedish with data and reports regarding its use of medical transportation services on a weekly, monthly, or quarterly basis, or on another time interval as requested by Swedish. Such data and reports may include recommendations regarding ways to improve the cost-effectiveness, quality or scheduling of such services.

Provider recognizes Swedish also has certain reporting requirements to maintain Det Norske Veritas (DNV) accreditation. Provider will continue to meet with Swedish on a regular basis and discuss any data or report modifications that may be necessary to address these requirements, and the evolving needs of the Swedish system.

IV. Protocols to Request Patient Transport.

Swedish personnel will call Provider's designated phone number to order medical transportation services from Provider. Provider shall promptly order such services and, if such services are not available within the contracted response time requirement, Swedish will call another company. Swedish will accept Providers ambulance if estimated response time is within the contracted requirements. Except as expressly provided in this Agreement by Provider, Provider shall not be financially responsible for any services ordered by Provider on behalf of Swedish or any Patient from another medical transportation services provider. Medical transportation services provided by Provider shall be included in all average response time calculations.

If Provider is delayed to any patient pick up, a Provider dispatcher will call the Swedish nurses station associated with the patient and advise Swedish staff of the delay.

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V. Annual Review

On an annual basis, or on a more frequent basis as requested by Swedish, Swedish shall review Provider's performance of the standards in this Exhibit A, as well as Exhibit B.

EXHIBIT B

Annual Performance Review Standards

Annually, Provider's performance shall be reviewed to ensure Provider meets the standards in Exhibit A, as well as the following standards:

1. Appropriate licensing of all drivers.
2. Regular review of driving records of all drivers.
3. Insurance covering vehicles and passengers.
4. Safety feature in vehicles.
5. Safety equipment
6. Accessibility
7. Training of drivers regarding the organization's transportation procedures and the unique needs of the persons served.
8. Written emergency procedures available in the vehicle(s).
9. First aid supplies available in the vehicle(s).
10. Maintenance of vehicles owned or operated by the organization according to manufacturers' recommendations.

EXHIBIT C
Compensation

I. AMBULANCE AND WHEELCHAIR/CABULANCE RATES

a. For services provided to all Hospital-Responsible Patients, Hospital shall pay Provider at the following rates:

BLS Non-Emergent Base rate: $252.66

BLS Emergency Base rate: $404.26

ALS/CCT Base Rate: $821.15 (Staffed by RNs)

Mileage/mile (applies to all levels of service): $ 7.37

Transports billed to Swedish will be billed at the level of service provided.

NON-AMBULANCE RATES

Cabulance / Wheelchair transportation billed to Swedish

Base Rate -	$65.00 (includes first 20 miles)
Mileage -	$ 2.50 per mile after 20 miles

For the Swedish Edmonds facility only, and only for Intra-Campus transports between Swedish Edmonds and Swedish Cancer Institute – Edmonds (SCI) and between Swedish Edmonds and Edmonds Imaging, transports shall be billed at the following rates:

a. Basic Life Support: $135.00 for each leg of the transport
b. Critical Care Transport: $215.00 for each leg of the transport
c. Waiting Time Charges: All waiting time that exceeds 30 minutes shall be billed at $50.00 / hour and shall be charged in half hour increments

Provider will invoice Swedish within sixty (60) days of the transport. Claims will be paid to Provider within forty-five (45) days of receiving a clean claim.

For purposes of this Agreement, a "Clean Claim" shall be defined as a claim on a CMS 1500 form that includes the following information:

(1) Patient name;
(2) Date of birth;
(3) Social Security Number (Medicare or Medicaid number, if applicable);
(4) Date of service;
(5) Pick-up location;
(6) Destination location;
(7) Patient's condition; and
(8) Itemized charges.

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(b) For all other patients (i.e., any patient who is not a Hospital-Responsible Patient), Provider shall bill patient and/or payor directly.

III. RATE INCREASES

Starting January 1, 2020, and then every January 1st thereafter during the term of this Agreement, the above rates shall be adjusted to reflect the annual Medicare rates for ambulance services for King County. The new rates shall take effect for services provided on or after January 1st, except if Medicare delays issuance of a fee schedule until after January 1st, in which case the new rates will take effect on the 1st of the month following publication of the fee schedule.

IV. AMR Compassionate Care Program

American Medical Response (AMR) provides reduced cost health care services to patients who are uninsured or underinsured, and able to provide documentation of hardship. Patients or authorized parties acting on the patient's behalf requesting hardship assistance are considered individually on a case-by-case basis. Compassionate Care Program eligibility is solely based upon the information and required documentation provided for that case. Notwithstanding the foregoing, in the event a hospital partner, social services agency or public agency validates and/or confirms in writing to AMR that an applicant qualifies for Compassionate Care Program services, the documentation process set forth herein shall be waived and AMR shall process such applicant's request based on the validation and/or confirmation.

AMR provides a Compassionate Care Program application if the applicant's income for the previous year (or current income) less medical expenses is equal to or less than 200% of the federal poverty level based off household size. The 200% threshold is adjusted annually in conjunction with the standards established by the federal government. Based off the information provided and household size, the patient may receive a discount of 20%, 40%, 60%, 80%, or 100% of full charges.

Exhibit 30
Swedish Issaquah Elective PCI Quality Performance Improvement Plan

Swedish Issaquah Medical Center
Elective Percutaneous Coronary Intervention (PCI)
Performance Improvement Plan
2023

I. Purpose

Our definition of quality is doing the right thing, in the right way, at the right time, for the right patient, in a cost-effective manner resulting in positive clinical outcomes and satisfaction. Issaquah has an existing emergent PCI program, established in 2011. Swedish/Issaquah uses the same Performance Improvement Plan used in other Swedish facilities under the Swedish Health System.

Performance Improvement is an ongoing, organization-wide effort dedicated to patient safety, continuous improvement of patient outcomes, and of performance of services through appropriate, timely and effective care. Performance Improvement occurs at all levels within the organization from physicians to the staff level. This plan strives to integrate performance activities to focus on improving health outcomes and safety through monitoring, analysis, and communication.

II. Scope

The elective PCI program requires collaboration and coordination of efforts across multiple inpatient and outpatient services and disciplines to promote and support evidence-based practice standards. Accordingly, the PCI Performance Improvement Program exists to ensure the delivery of safe quality care to those patients undergoing percutaneous coronary intervention.

In addition, the Performance Improvement Plan will include provision for compilation and analysis of annual statistics on overall program volumes and annual case volumes for every physician providing PCIs at Swedish/Issaquah. It is the intent of this data collection to allow Swedish/Issaquah the capability to assess program and physician compliance with WAC 246-310-720, WAC 246-310-725, and WAC 246-310-740.

III. Authority, Organization, and Responsibilities

The Medical Director of the cardiac cath lab, in conjunction with the delegated Medical Staff QA committees, are responsible for ensuring that the directives of the PCI Performance Improvement Plan are met and reported through the hospital's quality reporting structure, outlined in Attachment B.

IV. Goals and Objectives

The PCI Performance Improvement Plan is designed to meet the following goals and objectives relating to interventional procedures:

- Optimize patient outcomes
- Improve patient care processes
- Ensure patient safety
- Reduce and/or prevent medical errors
- Improve customer (patient, family, physician) satisfaction
- Ensure appropriate resource utilization.

These goals and objectives are accomplished by utilizing the Plan-Do-Study-Act (PDSA) problem solving cycle as a model for approaching performance improvement activity:

Plan

- Establish priorities for the investigation and resolution of issues by focusing on processes with the greatest potential for impact on patient safety, clinical outcomes, satisfaction, appropriate resource utilization and cost reduction.
- Promote integration and collaboration across the departments, linking strategic planning, performance improvement and evaluation, budgeting, capital equipment expenditures and other key governance processes to improve patient care.

Do

- Design performance measures utilizing recognized professional resources and evidence-based practices.
- Facilitate communication through objective documentation, communication and reporting.
- Include analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement.

Study

- Measure and systematically collect outcome data.
- Identify baseline data and continuing measurement I assessment of processes to determine level of performance.
- Compare data with both internal and external benchmarking sources.

Act

- Identify system improvements that positively impact patient safety, performance/patient outcomes and best practices.
- Assess individual competence and performance, including peer review when appropriate.

V. Patient Selection

Patient selection for elective PCI will be facilitated in multiple levels. Primarily, eligible patients will be identified through the appropriate use criteria developed by the American College of Cardiology (ACC)/American Heart Association (AHA), which will be documented in the patient's chart. Further patient assessment and selection are also determined through an internal multidisciplinary case conference, which is attended by Cardiac Surgeons, Cardiac Interventionalist, General Cardiologists, and if needed, Heart Failure physicians and Cardiac Imaging specialists. Recommendations from this conference will be presented back to the patient to determine next steps of care.

VI. Data Collection and Analysis

Information for the elective PCI Performance Improvement Plan will be collected by the Quality Management & Regulatory Compliance Department in conjunction with the cardiac cath lab. Data is collected both concurrently and retrospectively through various sources including but not limited to:

- PCI data sheet/PCI internal database (all interventions)
- Clinical Outcomes Assessment Program (COAP)
- AMI Core Measures (Joint Commission & CMS)
- National Cardiovascular Data Registry Cath-PCI (NCDR Cath-PCI) Registry

Attachment A identifies data elements that will be collected/utilized as part of the PCI Performance Improvement Plan.

VII. Reporting

The PCI Performance Improvement Committee, which aims to meet at least quarterly, is a multidisciplinary committee comprised of the Medical Director of Cath Lab, cardiologists and interventionalists, including at least one member from the Swedish Heart and Vascular Institute (SHVI), a representative from the Cardiac Surgery program at Swedish/Cherry Hill, Cath Lab RNs, ED physicians, ED Manager, In-patient Nursing, local EMS, and Quality Division.

At least annually, the Chair of the PCI Performance Improvement Committee, or a designated member, will attend the PCI QA committee meeting of the Swedish Heart Institute to report and exchange PI data.

Review by the Performance Improvement Committee consists of:

- Case presentations - focusing on patient selection, appropriateness of care and evidence-based practices
- Process measures - combining internal database reporting/analysis with chart review
- Outcomes measures - mortality, success measures and adverse events
- Utilization measures - focusing on cost and resources
- Preoperative and post-operative cases
- All transferred cases

Trends in performance measures are compiled and analyzed, and opportunities for improvement are identified to improve the safety and quality of care for patients receiving PCI's. Findings, results, conclusions, and recommendations are documented in the meeting minutes. Reports are made to respective medical staff services committees and the Board (please see attachment B). Special focused studies may be undertaken by the PCI Performance Improvement Committee when analyses of data or information indicates variation in performance involving single events, or patterns or trends which fall outside acceptable recognized or expected standards.

The Chair of the PCI Performance Improvement Committee shall report performance trends regarding annual program and physician volumes to the Medical Executive Committee and to the organization's leadership including administrative and management staff. If out of compliance with WAC volume standards (cited above), the PCI Performance Improvement

Committee and organization leadership will evaluate implications and undertake performance improvement, as appropriate.

VIII. Evaluation

The Performance Improvement Plan is reviewed, revised as necessary, and approved on an annual basis by the Quality Council. It is then forwarded to the Medical Executive Committee and the Board Quality Committee of the Board of Commissioners for review and approval.

IX. Confidentiality

The confidential nature of Performance Improvement activities will be respected. All minutes, reports and supporting documents resulting from the organizational committee structure for Performance Improvement are for the sole purpose of improvement of patient care and service and, as such, are subject to the provisions of RCW 70.41.200. Non-specific patient health information (PHI) will be provided to the Department of Health upon request.

X. References

Title 42 Public Health Chapter IV CMS, DHHS Part 482.21 Conditions of Participation

Joint Commission, 2009 Hospital Accreditation Standards, LD.03.01.01 - LD.03.03.01 and PI.01.01.01 - PI.03.01.01.

Washington Administrative Code (WAC) 246-310-740, Quality Assurance

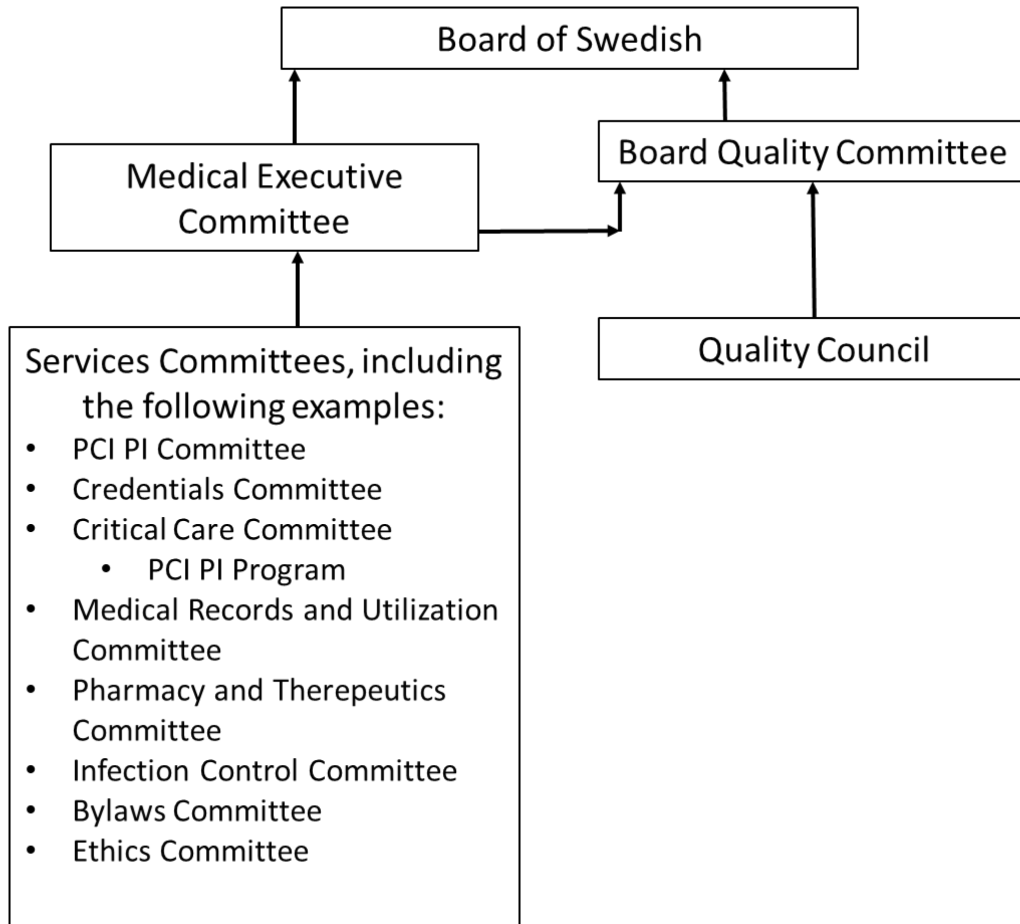
Attachment A

Elective PCI Performance Improvement Indicators

Indicator	Data Elements	Source/Benchmark	Reporting Cadence
Patient Selection	Documentation of AUC	Internal Reporting	Monthly
	Proportion of Procedures evaluated as Rarely Appropriate (stable ischemic heart disease)	NCDR Cath-PCI Registry	Quarterly
Procedure	Case Volume (Facility)	>200 cases/year (by Year 3)	Annually
	Case Volume (Provider)	>50 cases/year (by Year 3)	Annually
Processes	Transfer Volume	Internal Reporting	Monthly
	Proportion of cases requiring in emergent CABG	COAP NCDR Cath-PCI Registry	Quarterly
	Cardiac Rehab Referral Rate	COAP NCDR Cath-PCI Registry	Quarterly
Outcomes	In-Hospital Mortality, Risk Adjusted	COAP NCDR Cath-PCI Registry	Quarterly
	Post-Procedure Cardiogenic Shock	COAP	Quarterly
	Bleeding Rate, Risk Adjusted	COAP	Quarterly
	Intra- or Post-Procedure Stroke	COAP NCDR Cath-PCI Registry	Quarterly
Utilization	Same Day Discharge Rate	COA	Monthly

Attachment B

Communication Flowchart



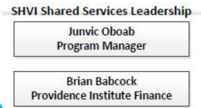
Attachment C

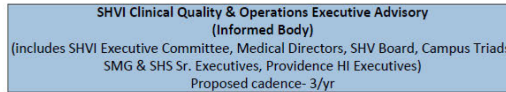
2023 Interventional Cardiology & PCI Quality Initiatives

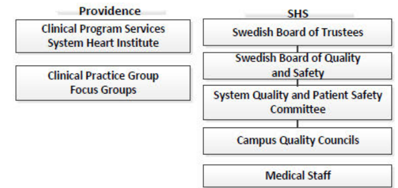
- **PCI Outcomes** - Decrease and Maintain PCI Observed/Expected Mortality of less than 1.0
- **PCI Outcomes** - Decrease Bleeding Rate – Risk Adjusted for PCI patients to less than 1.7% (COAP 2021 Benchmark)
- **Patient Selection & Appropriateness** - Establish Heart Team Model Review Process for High-Risk PCI patients
- **Patient Selection & Appropriateness** - Implement Cardiogenic Shock Protocol for appropriate STEMI patients
- **Utilization** - Increase Same Day Discharge for Elective PCI patients to greater than 50%

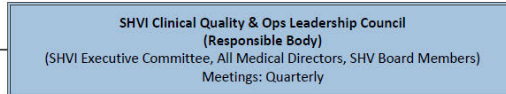
Attachment D

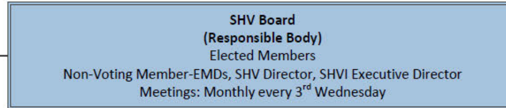
Clinical Quality & Ops Governance
Draft

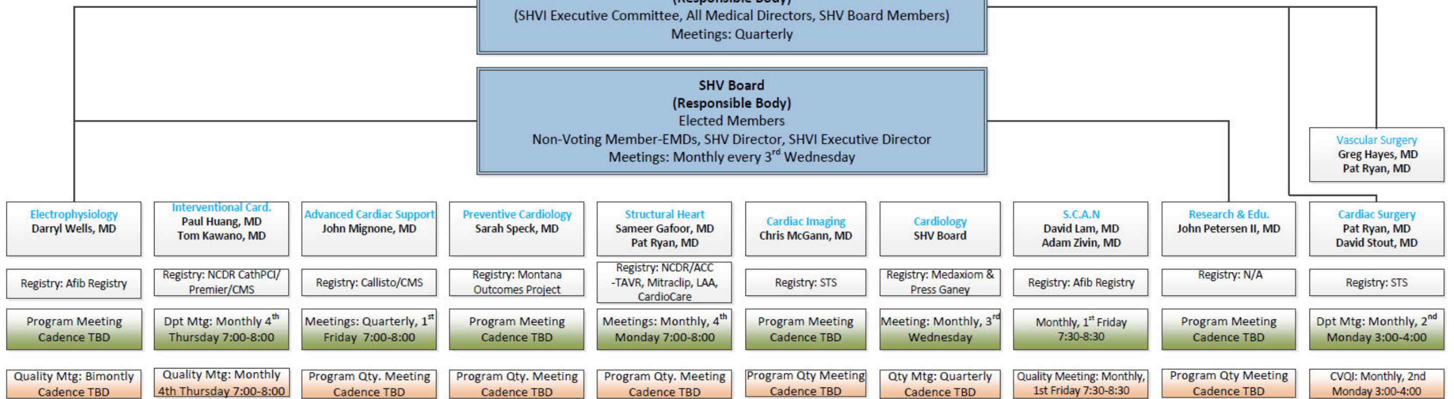












Responsible: This team does the work to complete the task. Every task needs at least one Responsible party, but it's ok to assign more.
Accountable: This team delegates work and is the last one to review the tasks or deliverable before it's deemed complete. On some tasks, the Responsible party may also serve as the Accountable one.
Consulted: Every deliverable is strengthened by review and consultation from more than one team member. Consulted parties are typically the people who provide input based on either how it will impact their future project work or their domain of expertise on the deliverable itself.
Informed: These team members simply need to be kept in the loop on project/program progress rather than roped into the details of every deliverable.

SHVI Clinical Quality& Ops Governance — 02.06.2023 V.1

Exhibit 31
Analysis of King East Planning Area PCIs to UWMC, 2021

Analysis of King East Planning Area PCIs to UWMC, 2021

Zipcode	UWMC Outpatient PCI	UWMC Inpatient PCI	UWMC PCI Total (King East)	UWMC % of Total (King East)	Zip Code Total	UW Market Share
98001	3	3	6	4.5%	59	10.2%
98002	1	1	2	1.5%	48	4.2%
98003	1	0	1	0.7%	80	1.3%
98004	3	0	3	2.2%	47	6.4%
98005	1	0	1	0.7%	18	5.6%
98006	2	1	3	2.2%	42	7.1%
98007	1	1	2	1.5%	36	5.6%
98008	1	0	1	0.7%	31	3.2%
98010	1	0	1	0.7%	9	11.1%
98011	3	0	3	2.2%	46	6.5%
98014	1	0	1	0.7%	11	9.1%
98019	1	1	2	1.5%	14	14.3%
98022	1	1	2	1.5%	32	6.3%
98023	1	0	1	0.7%	80	1.3%
98024	0	0	0	0.0%	5	0.0%
98027	0	0	0	0.0%	42	0.0%
98028	6	2	8	6.0%	40	20.0%
98029	1	1	2	1.5%	26	7.7%
98030	5	3	8	6.0%	43	18.6%
98031	5	2	7	5.2%	38	18.4%
98032	2	1	3	2.2%	39	7.7%
98033	3	0	3	2.2%	35	8.6%
98034	7	0	7	5.2%	73	9.6%
98038	4	3	7	5.2%	47	14.9%
98039	0	0	0	0.0%	3	0.0%
98042	2	2	4	3.0%	67	6.0%
98045	0	0	0	0.0%	21	0.0%
98047	0	0	0	0.0%	8	0.0%
98051	0	0	0	0.0%	4	0.0%
98052	5	2	7	5.2%	68	10.3%
98053	4	0	4	3.0%	30	13.3%
98055	3	1	4	3.0%	25	16.0%
98056	3	1	4	3.0%	37	10.8%
98057	3	0	3	2.2%	22	13.6%
98058	2	1	3	2.2%	42	7.1%
98059	6	0	6	4.5%	35	17.1%
98065	0	0	0	0.0%	8	0.0%
98072	1	2	3	2.2%	41	7.3%
98074	1	0	1	0.7%	26	3.8%
98075	1	0	1	0.7%	27	3.7%
98077	8	1	9	6.7%	27	33.3%
98092	9	1	10	7.5%	65	15.4%
98224	0	0	0	0.0%	0	0.0%
98288	1	0	1	0.7%	1	100.0%
Total	103	31	134	100.0%	1,498	8.9%

Source: PNWPop Data for 2021 IP PCI Cases, East King Patient Zips, Facilities in WA, MSDRG 246-251

Source: PNWPop Data for 2021 OP PCI Cases, East King Patient Zips, Facilities in WA, Procedure codes: 92920, 92924, 92928, 92933, 92937, 92943, C9600, C9602, C9604, C9607 & Evergreen OP PCI survey volumes for 2021

Exhibit 32
University of Washington Correspondence Regarding the Proposed Project's impact on the Cardiovascular Disease and Interventional Cardiology Fellowship Training Program

Correspondence Between Swedish Heart and Vascular Institute and University of Washington Medicine Regional Heart Center

Email from Howard Lewis, MD, Swedish Heart Institute to Larry Dean, MD, University of Washington Medicine Regional Heart Center

From: Lewis, Howard S
Sent: Thursday, February 9, 2023 5:23 PM
To: lsdean@uw.edu
Subject: Subject: Proposed Swedish Issaquah East King County Elective PCI Program

Larry Dean, MD
Director, UW Medicine Regional Heart Center
Seattle, WA

Dear Larry,

As you may be aware, Swedish Health Services plans to establish and operate a CON approved elective PCI program at its Issaquah Campus located in the East King planning area. The Department of Health's 2022-2023 Percutaneous Coronary Intervention Numeric Need Methodology published in January 2023 shows need for an elective PCI program in King East (planning area #9).

As part of our due diligence, our analysis of PCI volumes in and outside of the King East planning area demonstrate that an elective PCI program at Swedish Issaquah will not adversely impact the PCI volumes at the University of Washington. Consequently, an elective PCI program at Swedish Issaquah will not impact the Cardiovascular Disease and Interventional Cardiology Fellowship Training Programs at the University of Washington.

If you have questions or concerns regarding our program, please feel free to contact me.

I need to close the loop on this so I would greatly appreciate if you could acknowledge receipt of this communication.

Regards and thanks,

Howard Lewis, MD
Interventional Cardiology
Swedish Heart and Vascular Institute

Correspondence Between Swedish Heart and Vascular Institute and University of Washington Medicine Regional Heart Center

Email from Larry Dean, MD, University of Washington Medicine Regional Heart Center to Howard Lewis, MD, Swedish Heart Institute

From: Larry S. Dean <lsdean@uw.edu>
Sent: Wednesday, February 15, 2023 11:49:43 AM
To: Lewis, Howard S <Howard.Lewis@swedish.org>
Subject: [EXTERNAL] Re: Subject: Proposed Swedish Issaquah East King County Elective PCI Program

Caution: This email originated from outside of the Providence family of organizations.

Do not click links or open attachments unless you recognize the sender and know the content is safe.
If you suspect this email is phishing or a scam, use the report button in the Outlook toolbar to report it to Providence Cybersecurity.

Hi Howard,

Sorry for my tardy response but I've been busy on the inpatient service.

I've reviewed your letter and agree that your CN application for elective PCI in East King Swedish Issaquah will not impact the Interventional Cardiology fellowship training program at the University of Washington.

Please let me know if you have additional questions.

Hope all is well.

Larry

Larry S. Dean, MD, MSCAI, FACC

Professor of Medicine and Surgery

Associate Division Director, Cardiology

Founding Director, UW Medicine Regional Heart Center

Medical Director of Outreach and Clinical Integration, UW Medicine Heart Institute

Medical Director of Clinical Products and Smart Innovation, UW Medicine

1959 NE Pacific Street | Box 356171 | Seattle, WA 98195
PHONE: 206.598.5762 FAX: 206.598.8269 CELL: 206.910.2048

ASSITANT: 206.598.5762

EMAIL: lsdean@uw.edu WEB: uwmedicine.org

Exhibit 33
Cardiologist Commitment Letters

February 15, 2023

Eric Hernandez, Executive Director
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Swedish Health Services – d/b/a Swedish Issaquah Request to Operate an Adult Elective PCI Program

Dear Mr. Hernandez:

As requested in WAC 246-310-725, and specifically in relation to the Certificate of Need ("CN") application submitted by Swedish Issaquah, this letter provides documentation that I intend to provide elective percutaneous coronary interventions ("PCI") at the Swedish Issaquah campus.

I currently serve on the active Medical Staff at Swedish, and I currently provide PCIs on an emergent basis at the Swedish Issaquah campus. I expect to also provide elective PCIs at the Swedish Issaquah campus upon approval of CN to operate adult elective PCI program,

Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,

Howard S Lewis

Howard S. Lewis, MD
Interventional Cardiologist
MD00028676

Providence SWEDISH

February 15, 2023

Eric Hernandez, Executive Director
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Swedish Health Services – d/b/a Swedish Issaquah Request to Operate an Adult Elective PCI Program

Dear Mr. Hernandez:

As requested in WAC 246-310-725, and specifically in relation to the Certificate of Need ("CN") application submitted by Swedish Issaquah, this letter provides documentation that I intend to provide elective percutaneous coronary interventions ("PCI") at the Swedish Issaquah campus.

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Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,

John L. Petersen, MD
Interventional Cardiologist
MD60063791

Providence SWEDISH

February 15, 2023

Eric Hernandez, Executive Director
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Swedish Health Services – d/b/a Swedish Issaquah Request to Operate an Adult Elective PCI Program

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Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,

Peter A. Demopulos, MD
Interventional Cardiologist
MD00026532

Providence SWEDISH

February 15, 2023

Eric Hernandez, Executive Director
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Swedish Health Services – d/b/a Swedish Issaquah Request to Operate an Adult Elective PCI Program

Dear Mr. Hernandez:

As requested in WAC 246-310-725, and specifically in relation to the Certificate of Need ("CN") application submitted by Swedish Issaquah, this letter provides documentation that I intend to provide elective percutaneous coronary interventions ("PCI") at the Swedish Issaquah campus.

I currently serve on the active Medical Staff at Swedish, and I currently provide PCIs on an emergent basis at the Swedish Issaquah campus. I expect to also provide elective PCIs at the Swedish Issaquah campus upon approval of CN to operate adult elective PCI program,

Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,

Paul P. Huang, MD
Medical Director, Interventional Cardiologist
MD00037376

Providence SWEDISH

February 15, 2023

Eric Hernandez, Executive Director
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Swedish Health Services – d/b/a Swedish Issaquah Request to Operate an Adult Elective PCI Program

Dear Mr. Hernandez:

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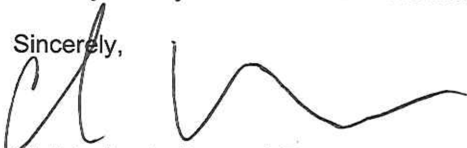
Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,



Christopher L. Brown, MD
Interventional Cardiologist
MD61262198

Exhibit 34
King East and King County
Charity Care, 2018-2020

King East Planning Area Charity Care, 2018-2020

King East Charity Care	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as % of Total PSR	Charity Care as % of Adjusted PSR
2020	8,752,627,281	3,591,025,120	1,383,413,626	3,778,188,535	122,286,716	1.40%	3.24%
2019	8,841,096,485	3,590,414,604	1,351,205,961	3,899,475,920	98,047,158	1.11%	2.51%
2018	8,125,367,557	3,371,329,367	1,257,346,626	3,496,691,564	107,111,674	1.32%	3.06%
2018-2020 (3 year average)	**25,719,091,323**	**10,552,769,091**	**3,991,966,213**	**11,174,356,019**	**327,445,548**	**1.27%**	**2.93%**

2020							
East King Planning Area							
CHI/Saint Francis Community Hospital	1,411,694,051	557,853,317	329,745,451	524,095,283	44,074,316	3.12%	8.41%
EvergreenHealth/Kirkland	1,904,525,415	812,105,367	195,076,839	897,343,209	8,243,072	0.43%	0.92%
MultiCare/Auburn Regional Medical Center	794,179,352	316,723,104	226,361,352	251,094,896	20,389,527	2.57%	8.12%
Overlake Hospital Medical Center	1,687,996,648	746,157,966	119,010,963	822,827,719	19,579,616	1.16%	2.38%
Providence/Swedish - Issaquah	720,307,841	276,687,905	71,544,869	372,075,067	8,572,963	1.19%	2.30%
UW Medicine/Valley Medical Center	2,233,923,974	881,497,461	441,674,152	910,752,361	21,427,222	0.96%	2.35%
TOTALS	**8,752,627,281**	**3,591,025,120**	**1,383,413,626**	**3,778,188,535**	**122,286,716**	**1.40%**	**3.24%**
2019							
East King Planning Area							
CHI/Saint Francis Community Hospital	1,413,260,165	567,288,903	318,361,010	527,610,252	19,148,837	1.35%	3.63%
EvergreenHealth/Kirkland	2,017,928,129	834,672,040	183,630,903	999,625,186	7,849,763	0.39%	0.79%
MultiCare/Auburn Regional Medical Center	852,214,961	352,942,637	232,372,657	266,899,667	25,121,952	2.95%	9.41%
Overlake Hospital Medical Center	1,680,136,121	739,227,675	108,609,779	832,298,667	18,059,448	1.07%	2.17%
Providence/Swedish - Issaquah	721,666,518	264,746,274	71,645,339	385,274,905	6,960,454	0.96%	1.81%
UW Medicine/Valley Medical Center	2,155,890,591	831,537,075	436,586,273	887,767,243	20,906,704	0.97%	2.35%
TOTALS	**8,841,096,485**	**3,590,414,604**	**1,351,205,961**	**3,899,475,920**	**98,047,158**	**1.11%**	**2.51%**
2018							
East King Planning Area							
CHI/Saint Francis Community Hospital	1,193,570,912	467,851,035	279,313,787	446,406,090	22,822,669	1.91%	5.11%
EvergreenHealth/Kirkland	1,865,937,636	791,978,053	179,328,330	894,631,253	6,527,444	0.35%	0.73%
MultiCare/Auburn Regional Medical Center	811,370,174	429,089,053	196,749,374	185,531,747	23,941,239	2.95%	12.90%
Overlake Hospital Medical Center	1,563,834,104	690,349,044	102,153,218	771,331,842	22,142,173	1.42%	2.87%
Providence/Swedish - Issaquah	668,756,533	241,403,179	68,740,261	358,613,093	6,627,502	0.99%	1.85%
UW Medicine/Valley Medical Center	2,021,898,198	750,659,003	431,061,656	840,177,539	25,050,647	1.24%	2.98%
TOTALS	**8,125,367,557**	**3,371,329,367**	**1,257,346,626**	**3,496,691,564**	**107,111,674**	**1.32%**	**3.06%**

Source: https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-patient-information-and-charity-care/charity-care-washington-hospitals

King County Charity Care, 2018-2020

King County Charity Care	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as % of Total PSR	Charity Care as % of Adjusted PSR
2020	28,838,953,255	10,477,054,363	5,628,729,123	12,733,169,769	404,164,913	1.40%	3.17%
2019	30,761,538,207	11,240,178,475	5,877,250,976	13,644,108,756	379,995,236	1.24%	2.79%
2018	28,896,117,517	10,461,088,267	5,780,774,174	12,654,255,076	380,181,394	1.32%	3.00%
2018-2020 (3 year average)	**88,496,608,979**	**32,178,321,105**	**17,286,754,273**	**39,031,533,601**	**1,164,341,543**	**1.32%**	**2.98%**

Source: https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-patient-information-and-charity-care/charity-care-washington-hospitals

King County Charity Care (less Harborview Medical Center), 2018-2020

King County Charity Care (less Harborview Medical Center)	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as % of Total PSR	Charity Care as % of Adjusted PSR
2020	26,357,264,751	9,688,026,304	4,842,948,314	11,826,290,133	317,332,498	1.20%	2 68%
2019	28,231,571,587	10,422,422,011	5,090,018,224	12,719,131,352	283,895,144	1.01%	2 23%
2018	26,448,831,298	9,717,231,651	4,977,207,093	11,754,392,554	297,334,293	1.12%	2 53%
2018-2020 (3 year average)	**81,037,667,636**	**29,827,679,966**	**14,910,173,631**	**36,299,814,039**	**898,561,935**	**1.11%**	**2.48%**

Source: https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-patient-information-and-charity-care/charity-care-washington-hospitals