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

July 23, 2025

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

Re: MultiCare Health System Certificate of Need Application to add 36 Acute Care Beds to MultiCare Tacoma General Hospital in Pierce County

Dear Mr. Hernandez:

On behalf of MultiCare Health System ("MultiCare") and MultiCare Tacoma General Hospital ("Tacoma General"), I submit this certificate of need application request to add 36 acute care beds at MultiCare Tacoma General Hospital.

Tacoma General is one of the largest hospitals in the South Puget Sound Region and is a premier provider of acute care services, recognized for its exceptional clinical outcomes across various specialties. Additional inpatient bed capacity is needed to maintain the quality of care and service levels expected by the communities that we serve, as well as meet the demand of recent and expected population growth in the planning area and surrounding communities.

Thank you in advance for your review of our application. Check number 135869 in the amount of $40,470 was mailed to the Department of Health offices on June 24, 2025. The USPS tracking number is: 9505 5147 1484 5175 4701 87.

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

Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
253-403-8771
ekobberstad@multicare.org

Jonathan Fox, PhD
Health Trends Consulting
425-469-5687
jfox@healthtrends.consulting

Sincerely,

K. Erin Kobberstad
Vice President, Strategic Planning
MultiCare Health System

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 K. Erin Kobberstad Vice President, Strategic Planning	**Date**: 7/23/2025
Email Address: ekobberstad@multicare.org	**Phone Number**: 253-403-8771
Legal Name of Applicant: MultiCare Health System **Address of Applicant** MultiCare Health System 820 A Street Tacoma, WA 98402	☐ New Hospital ☒ Expansion of existing hospital (identify facility name and license number) MultiCare Tacoma General Hospital License #: HAC.FS.00000176 **Provide a brief description, including the number of beds and the location:** MultiCare Tacoma General requests approval to add 36 acute care beds to its current licensed 367-bed facility, located in Tacoma, WA. **Estimated capital expenditure**: $3.1 million

Identify the Hospital Planning Area:

Pierce Central, Washington

Identify if this project proposes the addition of expansion of one of the following services:

☐NICU Level II	☐NICU Level III	☐NICU Level IV	☐Specialized Pediatric (PICU)	☐Psychiatric (within acute care hospital)
☐Organ Transplant (identify)	☐Open Heart Surgery	☐Elective PCI	☐PPS-Exempt Rehab (Level I)	☐Specialty Burn Services

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.

MultiCare Tacoma General Hospital

Certificate of Need Application Proposal to Expand Acute Care Bed Capacity

July 2025

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Introductory Statement and Summary

MultiCare Health System (“MultiCare”) owns and operates MultiCare Tacoma General Hospital (“Tacoma General”). MultiCare is a locally-governed, not-for-profit, integrated health system that also owns and/or operates Good Samaritan Hospital, Allenmore Hospital, Capital Medical Center, Mary Bridge Children's Hospital (“Mary Bridge”), Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, Yakima Memorial Hospital, and Overlake Medical Center. MultiCare also operates the area's largest network of primary care, specialty clinics, and behavioral health services.

Tacoma General is a 367-bed acute care hospital located in Tacoma, Washington, within the Central Pierce County planning region. The 367 beds at Tacoma General are allocated across the areas of acute care (337 beds) and Inpatient Psychiatric (30 beds).

Central Pierce County, the designated planning area for Tacoma General, is a large and growing healthcare market and estimates of resident need indicate the planning area will require an additional 183 acute care beds by 2030, and 353 beds by 2038. Since 2022, Tacoma General’s acute care occupancy has operated at such high levels that it has been unable to provide Medical/Surgical beds for many patients, who must then receive care in the Emergency Department (“ED”) or other areas of the hospital. Presently Tacoma General and Mary Bridge occupy the same (Tacoma General) building, which has constrained the ability of Tacoma General to expand its bed capacity. However, with the approval of Mary Bridge to relocate to its own building (approved through CN21-63), Tacoma General may convert space currently used by Mary Bridge as pediatric inpatient beds to general acute care beds to help fill the gap in need at both the hospital and in the planning area. This request is for approval to convert this to-be-vacated space to increase the licensed bed capacity at Tacoma General by 36 acute care beds. Following project completion, Tacoma General will contain a total of 403 licensed beds (337 + 30 + 36 = 403).

Tacoma General, one of the largest hospitals in the South Puget Sound Region, is a premier provider of acute care services in Central Pierce County and is recognized for its exceptional clinical outcomes across various specialties. Additional inpatient bed capacity is needed to maintain the quality of care and service levels expected by the communities that we serve, and to meet the demand of recent and expected population growth in the planning area and surrounding communities. Tacoma General continues to operate at a very high inpatient occupancy percentage, which impacts access to the quality services offered by our facility. Without approval of the proposed project, many patients at Tacoma General would continue to receive care in the ED and other areas of the hospital rather than an acute care bed and access to acute care services will be constrained for Central Pierce residents, who would be forced to seek care at out-of-area providers. This creates a downstream impact on other hospitals in adjacent planning areas, likely negatively impacting patient access.

MultiCare is the premier health care system in the South Puget Sound region, anchored by its network of hospitals and supported by its comprehensive ambulatory network. With the move of Mary Bridge to its own facility, space within the Tacoma General building will be vacated and available for additional inpatient beds. This space requires no significant construction and offers an extremely cost-effective path to creating needed capacity at Tacoma General. Mary Bridge will vacate its current space within Tacoma General on or about March 2026, making timing a critical component to ensure that the requested beds are available as soon as possible following Mary Bridge's move. With the proposed project, MultiCare can continue to meet the needs of the Central Pierce community by providing appropriate access to high-quality acute care services.

I. Applicant Description

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

   MultiCare Health System
   820 A Street
   Tacoma, WA 98402

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

   MultiCare is a nonprofit corporation. The UBI Number of MultiCare is 601-100-682.

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

   K. Erin Kobberstad
   Vice President, Strategic Planning
   253-403-8771
   MultiCare Health System
   820 A Street
   Tacoma, WA 98402
   ekobberstad@multicare.org

   Please also include the following associated consultants in communications and access to materials related to this application:
   - Shontae Ramsey | Shontae.ramsey@multicare.org
   - Liz Attwood | liz.attwood@multicare.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).**

   Jonathan Fox, PhD
   Consultant
   16531 62nd Ave W
   Lynnwood, WA, 98037
   425-469-5687
   jfox@healthtrends.consulting

   Please also include the following associated consultants in communications and access to materials related to this application:
   - Hunter Plumer, MHA | hplumer@healthtrends.consulting

- Frank G. Fox, PhD | frankgfox@comcast.net

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

See Exhibit 1 for an organization chart of MultiCare Health System. Tacoma General Hospital is a “Doing Business As” (d/b/a) of MultiCare.

II. Facility Description

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

The address of Tacoma General Hospital is:
315 Martin Luther King Jr Way
Tacoma, WA 98405

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

This question is not applicable.

3. 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.

Confirmed. Tacoma General Hospital will continue to be licensed and certified by Medicare and Medicaid upon project completion.

MultiCare Tacoma General Hospital

- License #: HAC.FS.00000176
- Medicare: 3300332
- Medicaid: 3308707

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

Tacoma General Hospital is accredited by the Joint Commission and will continue to have such accreditation after the proposed project.

5. Is the facility operated under a management agreement?

Yes ☐ No ☒

If yes, provide a copy of the management agreement.

This facility is not operated under a management agreement.

6. Provide the following scope of service information:

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

III. 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.**

   The proposed project requests CN approval to add 36 licensed acute care beds within existing space in Tacoma General Hospital. This inpatient space is currently occupied by Mary Bridge. When Mary Bridge relocates to its own building on or about March 2026, this inpatient space will be converted into 36 licensed acute care beds.

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

   This question is not applicable.

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.**

	Current Licensed	Proposed Licensed
General Acute Care	337	373
PPS Exempt Psych	30	30
PPS Exempt Level I Rehab		
NICU Level II		
NICU Level III		
NICU Level IV		
Specialized Pediatric		
Skilled Nursing		
Swing Beds (included in General Acute Care)		
Total	367	403

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.**

   Currently, of the 337 general acute care beds licensed at Tacoma General, 47 are not set up. These beds were not set up because historically there was not sufficient physical space for them. With the migration of Mary Bridge to its own building, additional space will become available within Tacoma General. Thus, independent of

and separate from the proposed project to increase the number of licensed acute care beds by 36, Tacoma General will also be standing up these 47 licensed acute care beds which are not currently set up.

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.**

Event	Anticipated Month/Year
Anticipated CN Approval	March 2026
Design Complete	N/A
Construction Commenced	April 2026
Construction Completed	September 2026
Facility Prepared for Survey	N/A
Facility Licensed - Project Complete WAC 246-310-010(47)	October 2026

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

   All persons in need of general, inpatient acute care services will be served through this project. This includes patients in need of intensive care, semi-intensive care, and medical-surgical services. The patient mix of Tacoma General, in terms of types of cases and acuity, is not expected to change from the current acute care inpatient mix following approval of the proposed project.

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

   Please see Exhibit 2 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 3 for single-line drawings of the existing hospital. We are not planning on moving walls or changing structural components so the existing floor plan and new floor plan will be the same.

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

   The gross square footage of Tacoma General is 1,302,756 square feet. The proposed project will add 17,184 square feet to Tacoma General, which will be 1,319,940 following completion of 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)]**

    The space being used for the proposed project is located inside the Tacoma General hospital building and is currently occupied by Mary Bridge Children's Hospital. There is no new building construction necessary for the proposed project, only the remodeling and renovation of existing interior space. Thus, this question is not applicable.

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

    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 presubmission conference for any construction projects in excess of $250,000.

    MultiCare is currently in communication with CRS regarding the proposed project, as well as the conversion of licensed non-set-up beds to licensed set-up beds. The CRS number from the Technical Assistance Meeting to discuss both of those projects is CRS# 70003689.

IV. Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services. Documentation provided in this section must demonstrate that the proposed project will be needed, available, and accessible to the community it proposes to serve. Do not skip any questions. If you believe a question is not applicable to your project, explain why it is not applicable.

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.**

   Hospitals within the planning area include:
   - MultiCare Tacoma General Hospital (Applicant)
   - MultiCare Allenmore Hospital
   - MultiCare Mary Bridge Children's Hospital
   - Saint Anthony Hospital
   - Saint Joseph Medical Center

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).**

   We summarize the Department's Numeric Need Methodology below in Table 1 and more fully discuss that methodology in Exhibit 4.

   STEP 1: Compile state historical utilization data for at least ten years preceding the base year.

Table 1: Historical Patient Days by Planning Area, 2014 to 2024

Year	HSA1	Central Pierce	Statewide Total
2014	1,102,637	101,769	1,758,589
2015	1,140,701	108,119	1,810,055
2016	1,145,520	101,145	1,820,235
2017	1,174,883	105,821	1,869,402
2018	1,191,953	106,529	1,897,657
2019	1,197,278	107,344	1,921,204
2020	1,149,069	101,215	1,835,399
2021	1,249,023	114,887	2,004,195
2022	1,346,575	123,257	2,155,582
2023	1,339,359	122,234	2,097,358
Annual Growth Rate	2.16%	2.04%	1.96%

Source: CHARS 2014 to 2023.

Notes: Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab) and All WA State Rehab Providers

STEP 2: Subtract psychiatric patient days from each year's historical data

Table 2: Historical Psychiatric Patient Days by Planning Area, 2014 to 2023

Year	HSA1	Central Pierce	Statewide Total
2014	1,840	200	2,184
2015	2,207	175	3,028
2016	3,003	76	3,823
2017	4,539	474	5,347
2018	3,666	278	4,453
2019	3,934	481	4,527
2020	446	0	654
2021	140	0	221
2022	163	8	182
2023	59	18	62

Source: CHARS 2014 to 2023

Notes: Reflects patient days in Psychiatric Hospitals. Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab).

Table 3: Historical Patient Days Less Psychiatric Patient Days by Planning Area, 2014 to 2023

Year	HSA1	Central Pierce	Statewide Total
2014	1,100,797	101,569	1,756,405
2015	1,138,494	107,944	1,807,027
2016	1,142,517	101,069	1,816,412
2017	1,170,344	105,347	1,864,055
2018	1,188,287	106,251	1,893,204
2019	1,193,344	106,863	1,916,677
2020	1,148,623	101,215	1,834,745
2021	1,248,883	114,887	2,003,974
2022	1,346,412	123,249	2,155,400
2023	1,339,300	122,216	2,097,296

Source: CHARS 2014 to 2023

Notes: Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and days in Psychiatric Hospitals and All WA State Rehab Providers

STEP 3: For each year, compute the planning area, statewide, and HSA average use rates

Table 4: Historical Use Rates by Planning Area, 2014 to 2023

Year	HSA1	Central Pierce	Statewide Total
2014	252.4	311.8	250.7
2015	257.0	327.9	254.3
2016	252.6	303.8	251.0
2017	253.8	313.3	253.8
2018	253.4	312.6	253.7
2019	250.3	311.0	252.8
2020	236.1	291.2	238.1
2021	254.7	330.6	258.0
2022	271.3	354.6	274.1
2023	266.6	351.6	263.8

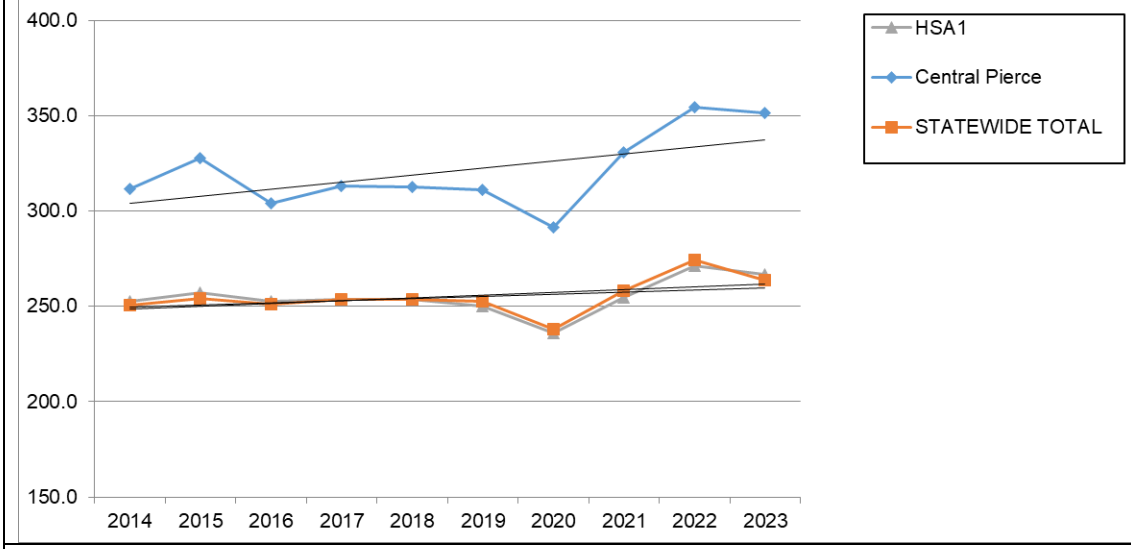
Source: CHARS 2014 to 2023

STEP 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and the state as a whole

Slope coefficients:

HSA 1: 1.109
Central Pierce County: 3.705
Washington State: 1.473

Figure 1: Use Rate by Planning Area, 2014 to 2023



Source: Table 4

STEP 5: Using the latest statewide patient origin study, allocate patient days reported in hospitals back to the hospital planning areas where patients live

For purposes of the bed need model—to estimate migration into and out of the Planning Area—the analysis divides acute care patient days into two planning areas: the Pierce Central County Planning Area and all other Washington State areas. The analysis indicates there was 26.54% out-migration of patient days of Pierce Central residents aged 0-64 years old, and 17.92% out-migration of patient days of Pierce Central residents aged 65 years and older to acute care facilities in other planning areas. The analysis also indicates there was 8.02% in-migration of patient days of Washington state residents from other counties for persons aged 0-64 years old, and 5.48% in-migration of patient days of Washington state residents aged 65 years and over.

STEP 6: Compute each hospital planning area's use rate for each of the age groups considered (age 15 to 64 and 65+)

Table 5: Planning Area Use Rates by Age Group

	Central Pierce	**Other WA Areas**
USE RATES		
0-64	179.26	135.24
65+	1,140.82	847.63

Source: CHARS 2023

STEP 7a: Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the Health Service Area's ten-year use rate trend, whichever trend would result in the smaller adjustment.

The slope of the HSA 1 ten-year use rate trend was applied to the forecasted use rates, as this number was the smallest in overall magnitude.

Step 7B: Possible Adjustment for HMO populations.

Not applicable

Step 8: Forecast patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Table 6: Forecasted Planning Area Patient Days, 2023 to 2038

	2023	2030	2038
Planning Area USE RATES			
0-64	179.26	187.02	195.89
65+	1,140.82	1,148.58	1,157.45
PROJECTED POPULATION			
0-64	285,270	280,412	276,096
65+	62,305	72,574	87,464
TOTALS	**347,575**	**352,986**	**363,560**
PROJECTED # OF PATIENT DAYS for Central Pierce Planning Area Residents			
0-64	51,137	52,443	54,085
65+	71,079	83,357	101,236
TOTALS	**122,216**	**135,800**	**155,320**

Source: Table 5 for use rates; Figure 1 HSA 1 Slope Coefficient; Claritas 2025 Population Estimates

Step 9: Allocate the forecasted patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

This step uses the 2023 in- and out-migration percentages from Step 5 and applies them to forecast patient days to estimate patient days for residents who remain in the Planning Area, plus residents who in-migrate to Planning Area providers. The in-migration ratio, which is used in Step 10, is calculated based on all resident patient days to the Planning Area hospital divided by all Planning Area resident days, by age cohort.

Step 10: Applying weighted average occupancy standards, determine each planning area's bed need.

In determining bed need for hospital expansion requests, the Department uses a "target year," which it currently defines for new facilities as fifteen (15) years after the last full year of actual patient day statistics. In the case of a bed expansion at an existing hospital, the Department considers a seven-year forecast period as its "target year." Since the proposed project is an expansion, we use a 7-year forecast period, where 2030 is the "target" year. Table 7 presents the Department forecast methodology for 2023 ("base year") and forecast periods of 7 years (2030), the "target" year, and 15 years (2038).

We note that in response to 2023 revisions to 42 CFR Part 2, similar to the 2022 CHARS file, the 2023 CHARS file redacted the county and zip code of residence for discharges where a procedure or diagnosis code was associated with substance use or abortion-related services. For discharges where abortion-related services were identified, the hospital and state of residence were also redacted. In 2023, this affected about 99,000 of the approximately 614,000 discharges in CHARS (about 16%). Over 99% of these censored discharges were associated with substance use only. This has a significant impact on the standard bed need methodology where use rate trends are calculated for the state and health service area, and baseline use rates are calculated for zip code areas that define county-based hospital planning areas. As such, we have revised the need methodology to address the issues due to redaction. The modified need methodology calculates patient day utilization and use rate trends for non-redacted data; discharges from earlier years (CHARS 2014-2021) are excluded based on a list of diagnosis and procedure codes of substance use and abortion-related services provided by the Department of Health.[1] In the final step of the modified need methodology, we apply a demand adjustment including both redacted/flagged and non-redacted/flagged utilization for discharges redacted due to substance use diagnoses. Using this demand adjustment, we estimate total projected patient day utilization at planning area hospitals (Table 7).

Table 7: Planning Area Acute Care Bed Need Forecast, 2023 to 2038

	2023	2030	2038	Average Annual Growth
Central Pierce Planning Area	**Year 0**	**Year 7**	**Year 15**	
Population 0-64 (1)	285,270	280,412	276,096	**-0.2%**
0-64 Use Rate (2)	179.26	187.02	195.89	**0.6%**
Population 65+ (1)	62,305	72,574	87,464	**2.3%**
65+ Use Rate (2)	1140.82	1148.58	1157.45	**0.1%**
Total Population	347,575	352,986	363,560	**0.3%**
Total Central Pierce Planning Area Resident Days	122,216	135,800	155,320	**1.6%**
Total Days in Planning Area Hospitals **(Excluding SUD/Abortion Flagged Utilization)**	227,525	259,643	295,300	**1.7%**
Planning Area Hospital(s) flagged utilization as % of non-flagged patient days (3)	24%	24%	24%	
Total Days in Planning Area Hospitals **(Including estimate of SUD/Abortion Flagged Utilization) (3)**	283,113	323,078	367,446	

[1] The Department of Health has a list of ICD-10 diagnosis and procedure codes for substance use, as well as ICD-9 and ICD-10 diagnosis and procedure codes for abortions. We have further developed a list of ICD-9 substance use codes to be consistent with the available ICD-10 codes.

Table 7: Planning Area Acute Care Bed Need Forecast, 2023 to 2038

	2023	2030	2038	Average Annual Growth
Available Licensed Beds (4)				
Saint Anthony Hospital	112	112	112	
Saint Joseph Medical Center	393	393	393	
MultiCare Tacoma General Hospital	337	337	337	
MultiCare Allenmore Hospital	130	130	130	
MultiCare Mary Bridge Children's Hospital	82	82	82	
TOTAL	**1,054**	**1,054**	**1,054**	
Wtd Occ Std (5)	71.54%	71.54%	71.54%	
Gross Bed Need (TPD/365/Occupancy)--Demand	1,084.27	1,237.33	1,407.25	**1.7%**
Bed Supply	1,054	1,054	1,054	
Net Bed Need/Surplus (Demand - Supply)	**30**	**183**	**353**	

Sources: (1) Population Sources: Claritas 2025; OFM Medium Series Projections (2022 Release); OFM Forecast of the State Population by Age and Sex; (2) Resident Use Rate Data Source: CHARS. See Steps 5 & 6. Future use rates adjusted per slope trends from Step 4; (3) Flagged utilization as % of non-flagged patient days based on most recent 5-year average. Note that the difference between the Year 0 Total Days and the unadjusted days in PA hospitals is caused by using the 5-year average rather than the base year only. (4) Bed supply sources: [SJMC] November 2018 Evaluation approving CN App 18-21; [Saint Anthony Hospital] CN1589; [TG/Allenmore] 2021 DOH Acute Care Bed Survey; [Mary Bridge] CN Eval 21-63; [Wellfound] Excluded as dedicated psychiatric beds. CN#1563A; [CHI Franciscan Rehab] Excluded as dedicated rehabilitation beds. See July 2016 evaluation approving CN App 16-18.; (5) Weighted Occupancy: Calculated per 1987 Washington State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area.

Table 7 indicates a current shortage of 30 acute care beds, given the licensed bed supplies at planning area hospitals; that shortage is forecast to grow to a shortage of 183 beds in 2030.

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

   The proposed project will expand the number of acute care inpatient beds.

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

Table 8: MultiCare Tacoma General Bed Use and Occupancy, Acute Care Inpatients, 2022 to May 2025 YTD

Acute Care Only	2022	2023	2024	May 2025 YTD
Admits	16,954	17,872	19,262	8,319
Patient Days	102,169	99,307	97,537	40,485
ALOS	6.03	5.56	5.06	4.87
ADC	279.9	272.1	266.5	268.1
Beds - Licensed	337	337	337	337
Beds - Set Up	290	290	290	290
Occupancy, Licensed	83.1%	80.7%	79.1%	79.6%
Occupancy, Set-up	96.5%	93.8%	91.9%	92.5%

Source: Applicant

Please see Table 9 for historical utilization for all inpatient care provided at Tacoma General.

Table 9: MultiCare Tacoma General Use and Occupancy, All Inpatients, 2022 to May 2025 YTD

Entire Hospital	2022	2023	2024	May 2025 YTD
Admits	18,766	19,590	20,313	8,820
Patient Days	127,325	120,573	104,602	43,683
ALOS	6.78	6.15	5.15	4.95
ADC	348.8	330.3	285.8	289.3
Beds - Licensed	367	367	367	367
Beds - Set Up	317	317	317	317
Occupancy, Licensed	95.1%	90.0%	77.9%	78.8%
Occupancy, Set-up	110.0%	104.2%	90.2%	91.3%

Source: Applicant

Table 8 shows that over the last three years Tacoma General's acute care bed units have operated above the Department's target capacity of 75% for 300+ bed hospitals for its licensed beds. Tacoma General is therefore, presently above its capacity.

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.

Given an anticipated project completion date of September 2026, the year 2027 represents the first full year following project completion. We provide a utilization forecast for the period 2025 to 2036 in Table 10.

Utilization forecast assumptions:

- 2025 utilization assumed to equal May 2025 YTD utilization from Table 8, annualized for a full year.

- 2026 incremental utilization estimated based on occupancy of 50% for new beds, weighted by expected months of operation for new beds. 50% is based on movement of 18 patients from ED (2024 number) to acute care beds.

- Utilization for 2027 and onward is based on expected occupancy of incremental beds to meet historical occupancy with a modest ramp between 2026 and 2028. The occupancy rates for 2027 and 2028 are assumed to equal 69.44% and 75%, respectively.

- Average Length of Stay ("ALOS") for acute care beds is assumed constant over the forecast and set equal to the 2024 Acute Care ALOS of 4.87.

- Unmet need served by additional 36 beds equals about 21.5% in 2027 and with this percentage declining from there due to population-driven increases driving up demand for inpatient beds.

- Cases and patient days are rounded to 0 digits. ALOS is rounded to two digits.

Table 10: MultiCare Tacoma General Acute Care Bed Utilization Forecast, 2025 to 2036

	2025	2026	2027	2028	2029	2030
Patient Days	97,861	99,504	106,986	107,716	107,716	107,716
ADC	268	273	293	295	295	295
ALOS	4.87	4.87	4.87	4.87	4.87	4.87
Admissions	20,109	20,432	21,968	22,118	22,118	22,118
Beds	337	373	373	373	373	373
Occupancy	79.6%	73.1%	78.6%	79.1%	79.1%	79.1%

Table 10: MultiCare Tacoma General Acute Care Bed Utilization Forecast, 2025 to 2036

	2031	2032	2033	2034	2035	2036
Patient Days	107,716	107,716	107,716	107,716	107,716	107,716
ADC	295	295	295	295	295	295
ALOS	5	4.87	4.87	4.87	4.87	4.87
Admissions	22,118	22,118	22,118	22,118	22,118	22,118
Beds	373	373	373	373	373	373
Occupancy	79.1%	79.1%	79.1%	79.1%	79.1%	79.1%

Sources: Applicant based on historical utilization and occupancy.

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

Please see Exhibit 5 for patient origin data for Tacoma General.

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

Central Pierce hospitals, including MultiCare Tacoma General Hospital, MultiCare Allenmore Hospital, Mary Bridge, Saint Joseph Medical Center, and Saint Anthony Hospital, care for both a high proportion of planning area residents, as well as many persons residing in neighboring planning areas. With other planning area hospitals experiencing similarly high occupancy rates, out-migration will increase if the proposed project is not approved. Travel is inconvenient and time-consuming for planning area residents; providing adequate capacity within the planning area and greater service area allows more residents to receive care close to home without unnecessarily traveling long distances and spending extra resources.

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

As a locally based, not-for-profit health care system, MultiCare is committed to serving everyone in the community, without regard to income, race, ethnicity, gender, religion or any other protected class. MultiCare accomplishes its mission through a variety of means, including charity care, health education and outreach programs for underserved populations, free prevention and screening programs, support groups and services for patients and families experiencing chronic and terminal diseases.

MultiCare Tacoma General Hospital is committed to meeting community and regional health needs and provides charity care consistent with the MultiCare Charity Care Policy, included under Exhibit 6.

Our financial pro forma forecast provided in Exhibit 7 allocates 1.56% of total patient service revenue to be provided for charity care, a figure consistent with the amounts provided by MultiCare Tacoma General Hospital and MultiCare Allenmore Hospital, and greater than the Puget Sound Regional charity care average, less King County, over the 2021 to 2023 period. Historical Charity Care amounts provided by MultiCare Tacoma General Hospital and MultiCare Allenmore Hospital and other Puget Sound hospitals are presented in Table 11.

Table 11: Puget Sound Region (Less King County) Charity Care Statistics, 2021 to 2023

Charity Care as % of Total Patient Service Revenue	2021	2022	2023	3 Year Average
MultiCare/Tacoma General – Allenmore Hospital	1.64%	1.66%	1.40%	1.56%
Other Puget Sound Region Hospitals	1.16%	1.18%	1.15%	1.16%

Sources: 2021 to 2023 Department of Health Charity Care Reports; Applicant.

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.

The proposed project does not entail either a partial or full relocation, thus this question is not applicable.

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

The proposed project does not entail either a partial or full relocation, thus this question is not applicable.

11. Provide a copy of the following policies:

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

Please see Exhibit 6 for copies of the MultiCare policies for Admissions (6a), Financial Assistance (6b), Patient Rights & Responsibilities (6c), Non-discrimination (6d), End of Life (6e), and Reproductive Health (6f).

B. Financial Feasibility (WAC 246-310-220)
Financial feasibility is based on the criteria in 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.**

See Exhibit 7 for the financial exhibit including the following information:

- Historical revenue and expense statements
- Pro forma projections
- FTE staffing
- Depreciation table
- Tables of key assumptions for these forecasts

For the “Without Project” scenario, it is assumed that Tacoma General financials are held constant at May 2025 YTD actuals. For Project-Only, financials are driven off revenue and costs per admit associated with 2024 inpatient acute care admissions for all forecast revenues and expenses. In the “With Project” scenario, the Project-Only and Without Project are combined to reflect the hospitals combined operations.

Please see Table 10 above, for patient day utilization projections.

2. Identify the hospital’s fiscal year.

Tacoma General’s fiscal year is the calendar year.

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.

Tacoma General does not hold any of the above agreements, thus this question is not applicable.

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

   Please see Exhibit 8a for a copy of the Pierce County Assessor Property Summary, indicating the site is owned by Tacoma General Hospital.

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

   Tacoma General is located within the HMX Hospital Medical Mixed-Use District ("HMX") defined under the City of Tacoma's land use code. The district is intended for areas that contain hospitals or similar large-scale medical facilities and a dense mix of related and supportive uses. Please see Exhibit 8b for a copy of the City of Tacoma's land use map designating the hospital as being within the HMX land use designation. The Pierce County Assessor Property Summary is also provided in Exhibit 8.

   The proposed project includes remodeling and conversion of a floor within the building already occupied by Tacoma General. The project does not include construction of new facilities nor a change in land use, and therefore the site does not need to undergo rezoning or other land use review prior to project commencement.

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.**

Table 12: Capital Expenditure Table

Item	Capital Expenditure ($)
a. Land Purchase	
b. Utilities to Site	
c. Land Improvement	
d. Building Purchase	
e. Residual Value of Replaced Facility	
f. Building Construction	1,285,345
g. Fixed Equipment (not already included in the construction contract)	
h. Movable Equipment	1,226,810
i. Architect and Engineering Fees	190,000
j. Consulting Fees	
k. Site Preparation	
l. Supervision and Inspection of Site	144,000
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	
2. Building	
3. Equipment	
4. Other	
n. Washington Sales Tax	258,752
Total Estimated Capital Expenditure	**3,104,907**

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.

MultiCare plans to fund the proposed project through reserves. A letter of financial commitment from MultiCare Health System is included in Exhibit 9.

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.

Tacoma General is currently operating and will continue to operate through the construction of the proposed project. Thus, this question is not applicable.

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.

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

Please see Exhibit 10 for a non-binding contractor's estimate for the proposed project.

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.

Tacoma General's reimbursement is not tied to its capital expenditures. Therefore, the proposed project will not affect costs and charges for health services in the planning area.

Furthermore, given the space already exists and requires only remodeling and not new construction, the proposed project is an extremely cost-effective bed expansion. Typical bed expansion projects require the construction of new space, and on a cost per bed basis, are orders of magnitude more expensive.[2]

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."

Payer	Payer Mix (Admits)	Payer Mix (Gross Revenue)
Commercial	26.0%	28.9%
Medicare	44.0%	44.8%
Medicaid	24.7%	21.0%
Self Pay	1.4%	1.8%
Other Government	3.9%	3.5%
Total	100.0%	100.0%

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.

Payer Mix for MultiCare Tacoma General Hospital, May 2025 YTD:

[2] Given the proposed project will add 36 beds at a cost of about $3.1M, the cost per bed is about $86,000. In comparison, Harborview CN22-41 proposed expanding by 127 beds at a cost of $93M ($725,000/Bed), Seattle Children's CN22-02 proposed expanding by 18 beds at a cost of $7.9M ($500,000/Bed), and VMFH CN22-40 proposed expanding by 24 beds at a cost of $20,486,000 ($850,000/Bed).

Payer	Payer Mix (Admits)	Payer Mix (Gross Revenue)
Commercial	26.0%	28.9%
Medicare	44.0%	44.8%
Medicaid	24.7%	21.0%
Self Pay	1.4%	1.8%
Other Government	3.9%	3.5%
Total	100.0%	100.0%

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.

Please see Exhibit 11 for an equipment list for the proposed project.

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.

A letter of financial commitment from MultiCare is included in Exhibit 9.

16. Provide the most recent audited financial statements for:

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

We include MultiCare's 2022 to 2023 Audited Financials in Exhibit 12.

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

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

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.

A list of MultiCare facilities is included in Table 13.

Table 13: MultiCare Health System Facility List

Name	Address	Medicare Provider Number	Medicaid Provider Number
MultiCare Mary Bridge Children's Hospital	317 Martin Luther King Jr. Way, Tacoma WA 98403	503301	3300340
MultiCare Auburn Medical Center	202 North Division St. Auburn WA 98001	500015	2022467
MultiCare Behavioral Health Inpatient Services - Auburn	202 North Division St. Auburn WA 98001	50-S015	3149101
MultiCare Deaconess Hospital	800 W 5th Ave Spokane, WA 99204-2803	500044	2083493
MultiCare Valley Hospital	12606 East Mission Ave. Spokane Valley 99216-3421	500119	2083493
MultiCare Tacoma General Hospital	315 Martin Luther King Jr. Way, Tacoma WA 98405	500129	3300332
MultiCare Tacoma General Behavioral Health Adolescent Inpatient Services	315 Martin Luther King Jr. Way, Tacoma, WA 98405	50-0129	2071315
MultiCare Allenmore Hospital	1901 South Union Avenue Tacoma WA 98405	500129	3300332
MultiCare Good Samaritan Hospital	407 14th Ave. SE Puyallup, WA 98372	500079	3308707
MultiCare Good Samaritan Hospital, Inpatient Rehabilitation	401 15th Ave. SE, Puyallup, WA 98372	50T079	3200094
Navos	2600 Southwest Holden, Seattle, WA 98126	504009	3500311
MultiCare Covington Hospital	17700 SE 272nd Street Covington, WA 98042	500154	2102039
Wellfound Behavioral Health Hospital[3]	3402 S. 19th Street Tacoma, WA 98405	504016	150453
MultiCare Capital Medical Center	3900 Capital Mall Dr SW Olympia, WA 98502	500139	330365

[3] A joint venture between MultiCare Health System and CHI Franciscan, now Virginia Mason Franciscan Health System.

Table 13: MultiCare Health System Facility List			
Name	**Address**	**Medicare Provider Number**	**Medicaid Provider Number**
MultiCare Yakima Memorial Hospital	2811 Tieton Dr. Yakima, WA 98902	500036	3307501
Overlake Medical Center & Clinics	1035 116th Ave NE Bellevue, WA 98004	500051	1020765
Source: Applicant			

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.**

   Please see the FTE schedule presented in Exhibit 7 for historical and forecast FTEs by occupation.

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

   Based on the number and type of beds included in this requested expansion, it was determined the proposed project required additional FTEs related to Management, Technical, RNs, Assistant Nurse Managers (ANMs), and Certified Nursing Assistants (CNAs). Given the beds will all be located on the 6th floor of Tacoma General's Olympic Tower, it is expected the proposed project will require, in productive FTEs, 1 FTE for Management, 2.1 FTEs for Health Unit Coordinators within Technical operations, and 3.52 FTEs for ANMs. These FTEs depend on the size of the 36-bed unit, but do not vary with the relevant patient census within this unit.

   FTEs needed for the proposed project which vary with the expected patient census include Nurses and CNA/MAs. These numbers are based on the staffing plan for Tacoma General. From this, the new unit is expected to require:

   - 1 Charge RN, 4 Staff RNs, 0.5 RN FTEs for Break Relief, all available 24 hours a day and 365 days a year for an ADC of 18. For ADCs between 21 and 25, the number of Staff and Break Relief RN increase to 5 and 0.75 FTEs, respectively. For ADCs between 26 and 30, the number of Staff RN further increases to 6 FTEs. The number of working hours for 1 FTE is assumed to equal 2,085.7 per year.

   - 3 CNAs available 24 hours a day and 365 days a week for ADCs between 13 and 24. For an ADC between 25 and 30, 4 CNAs available 24 hours a day

and 365 days a year are needed. The number of working hours for 1 FTE is assumed to equal 2,085.7 per year.

Non-productive time is assumed to equal about 14.8% of Productive time, and is allocated across the non-productive categories consistent with the distribution in 2025.

Allocated salaries calculated as a percentage of Total Productive Staffing Costs consistent with the corresponding percentage for 2025 (about 0.41%).

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

   Raylene Alred - Clinical Director, RN00123540
   Angelique Banton - Nurse Manager RN60033638
   Kevin Pieper – CMO, MD00044374

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 present healthcare workforce shortages across Washington and consequent staffing challenges are well known to the Department and exigent healthcare community. As part of the proposed project, MultiCare anticipates hiring about an additional 64 Productive FTEs over the 2026 to 2029 period, including 33 nursing FTEs.

   MultiCare recognizes that job seekers have different preferences and balance many factors when deciding to take a specific job. These often include opportunities for advancement, workplace environment and culture, the support of management, workload and work-related stress, required travel, and other factors. The importance of, or preferences related to these different factors will vary by individual, but MultiCare has created a healthy organizational environment consistent with its mission and valued by its employees. This results in MultiCare consistently being included within Forbes “America’s Best Employers by State.”[4]

   Furthermore, while workers have different preferences when it comes to qualitative factors, competitive compensation is universally preferred. MultiCare understands this fact, and the projected salary structure for Tacoma General accounts for competitive salaries to attract employees. In addition, since competitive salaries

[4] https://www.forbes.com/best-employers-by-state/#3c516a7a487a, Last Accessed July 1, 2025.

reduce turnover,[5] MultiCare is likely to be successful at retaining those staff. This is important for continuity and quality of care.

With an established presence and respected reputation, MultiCare is well-positioned to respond proactively to the staffing shortages in the area and to recruit and retain sufficient qualified staff. It plans to leverage its strong local recruitment program and existing network of local and national recruiting resources to promptly and successfully recruit the new staff that will be required.

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

   This question is not applicable.

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

Table 14: MultiCare Tacoma General Ancillary and Support Services

Description	Internal / External	Vendor
Food & Nutrition	Internal	MHS
Imaging	Internal	MHS
Diagnostic services (CT, Radiation Oncology, MRI, PET)	Internal	MHS
Lab & Pathology	Internal	MHS
Respiratory Therapy	Internal	MHS
Health Information Management	Internal	MHS
Biomedical/Clinical Engineering	Internal	MHS
Quality Management	Internal	MHS
Customer Support	Internal	MHS
Security	Internal	MHS
Medical Staff Services	Internal	MHS
Facilities/Environment of Care	Internal	MHS
Utilization Review	Internal	MHS
Supply Chain	Internal	MHS
Perioperative Services	Internal	MHS
Cath Lab	Internal	MHS
Pharmacy - Ventilation/Hood Cleaning Services	External	Pentagon Technologies Group, Inc. d/b/a Pentagon Technologies

[5] See, for example, Krueger and Summers, "Efficiency Wages and the Inter-Industry Wage Structure," Econometrica, Vol. 56, No. 2 (Mar., 1988), pp. 259-293 and Raff and Summers, "Did Henry Ford Pay Efficiency Wages?," Journal of Labor Economics, Volume 5, Number 4, Part 2 | Oct., 1987.

Table 14: MultiCare Tacoma General Ancillary and Support Services

Description	Internal / External	Vendor
Interpretation Services Agreement: spoken and sign language interpreters	External	Cross Cultural Communications Inc.
Pathology Services	External	CellNetix Pathology
Remote Dosimetry	External	Remote Dosimetrist, LLC
Intraoperative neuromonitoring technical and professional services	External	SpecialtyCare IOM Services, LLC
Neonatal Transport teams in providing critical care transports via air	External	Airlift Northwest (UW Medicine Strategic Outreach)
Perfusion & VAD Program; Pediatric ECMO	External	ECMO Advantage Corp
Organ Procurement	External	Lifecenter Northwest
Blood Products and Services	External	Bloodworks

Source: Applicant

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

   None of the existing ancillary or support agreements are expected to change due to the proposed project.

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

   Tacoma General works closely with the healthcare providers in Central Pierce County, as well as those in Seattle, South King County, and neighboring areas in Pierce County. This includes EMS, primary care and specialty clinics, other hospitals, nursing homes, assisted living communities, home health and hospice.

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

    None of the existing working relationships with healthcare facilities listed above would change as a result of this project.

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

    This question is not applicable.

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

Tacoma General is an integrated member of the community health system and has developed relationships with many community and regional partners. Further, Tacoma General, as part of MultiCare, has established formal relationships with other planning area providers.

The proposed project expands existing services. This expansion is necessary to improve resident access to healthcare services and prevent increases in planning area out-migration. Therefore, the proposed project promotes continuity of services and will not result in an unwarranted fragmentation of services.

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

Tacoma General is an existing planning area hospital with 337 licensed acute care beds, is an integrated member of the community health system and has developed relationships with many community and regional partners—it is part of the service area's existing health care system, which will not change. Therefore, Tacoma General has developed and will continue to develop appropriate relationships with the service area's existing care system to ensure Planning Area and Washington residents have access to high quality care.

14. **Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements.**
    a. **A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or**
    b. **A revocation of a license to operate a healthcare facility; or**
    c. **A revocation of a license to practice as a health profession; or**
    d. **Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.**

No facility or practitioner associated with this application has a history of the listed actions.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

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

   The Central Pierce Numeric Need model documents what Tacoma General has known from its recent experience: There is significant need for additional inpatient bed capacity in the Central Pierce Planning Area. The numeric need model quantifies this need to equal about 183 beds by 2030. Furthermore, with Mary Bridge moving into its own building, space within the Tacoma General building will be vacated. Mary Bridge's move offers an economical and unique opportunity for Tacoma General to help meet this planning area need through the conversion of existing space within its building. Given that MultiCare is committed to help address this planning area need, two different alternatives were considered prior to submitting the proposed project:

   1. Construction of additional inpatient space, which we assume would be a new building on the Tacoma General campus, to add 36 acute care beds.

   2. Renovation and conversion of existing space for the addition of 36 acute care beds (The Project).

   We also acknowledge the option of forgoing the proposed project and "doing nothing." However, while this option does not require the project capital outlays and time and expense of a Certificate of Need, it will lead to barriers to access for Central Pierce residents and fragmentation of care within the planning area. Furthermore, since Tacoma General cares for many Washington residents who live outside Central Pierce, these barriers to access would spill over to neighboring planning areas, potentially straining MultiCare hospitals elsewhere, including MultiCare Good Samaritan Hospital in Puyallup.

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.**

   Please see Table 15 to Table 19, which compare the two options identified above on the basis of patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost/operational efficiency.

Table 15: Alternatives Analysis: Promoting Access to Healthcare Services	
Option:	**Advantages/Disadvantages:**
Construction of an additional inpatient facility to add 36 acute care beds.	• Adds needed acute care inpatient capacity within the planning area. (Advantage, "A") • Addresses the current high occupancy rates at Tacoma General. (A)
Renovation & conversion of existing space for the addition of 36 acute care beds (The Project).	• Same as Option 1 – adds capacity within the planning area. (A) • Same as Option 1 – helps alleviate capacity constraints at Tacoma General. (A)

Table 16: Alternatives Analysis: Promoting Quality of Care	
Option:	**Advantages/Disadvantages:**
Construction of an additional inpatient facility to add 36 acute care beds.	• Accommodates patients and providers in a new, state-of-the-art space. Additional capacity will promote quality of care as patients can be effectively cared for in new inpatient space, avoiding the potential need to out-migrate for care. (A) • It may also assist in the recruitment of providers. (A) • Would be separate from other acute care patient areas of Tacoma General, which is less convenient for patients and providers who may need to navigate multiple buildings. (Disadvantage, "D")
Renovation & conversion of existing space for the addition of 36 acute care beds (The Project).	• Accommodates patients and providers in a renovated space and integrated within the larger building of Tacoma General. This promotes quality of care. (A) • It may also assist in the recruitment of providers. (A)

Table 17: Alternatives Analysis: Capital Cost	
Option:	**Advantages/Disadvantages:**
Construction of an additional inpatient facility to add 36 acute care beds.	• Would be significantly more expensive as compared to the Project, as demonstrated by other Certificate of Need approvals for hospital bed expansions.[6] (D)
Renovation & conversion of existing space for the addition of 36 acute care beds (The Project).	• Requires significantly less capital cost than other similarly sized bed-expansions. (A) • Most efficient use of capital cost to create inpatient capacity. (A)

Table 18: Alternatives Analysis: Promoting Cost and Operating Efficiency	
Option:	**Advantages/Disadvantages:**
Construction of additional patient care building to add 36 acute care beds.	• Adds acute care bed capacity. Tacoma General currently operates at a high occupancy level, which is inefficient. This will reduce the time spent on patient placement and allow patients to be rapidly assigned to an appropriate site of care. (A) • Colocation of clinical and surgical services, providing increased efficiency, flexibility, and quality of care for patient services. (A) • Does not promote cost containment through scope and cost efficiency metrics, given there is a much less costly alternative, Option 2—the Project. (D)
Renovation & conversion of existing space for the addition of 36 acute care beds (The Project).	• Same as Option 1, but is much more timely and significantly less costly to operationalize. (A) • Colocation of clinical and surgical services, providing increased efficiency, flexibility, and quality of care for patient services. Same as Option 1. (A) • Promotes cost containment through scope and cost efficiency metrics to limit excess building cost per bed. (A)

[6] This CN request for 36 Acute Care beds equates to $86,000 per bed. By comparison, the MultiCare Good Samaritan Acute Care bed approval (CN23-07) for a 160-bed expansion cost $2.51 million per bed. The much lower cost is due to the fact there is existing hospital space for this expansion at Tacoma general.

Table 19: Alternatives Analysis: Legal Restrictions	
Option:	**Advantages/Disadvantages:**
Construction of an additional inpatient facility to add 36 acute care beds.	• This option requires certificate-of-need approval, which requires time and expense. (D)
Renovation & conversion of existing space for the addition of 36 acute care beds (The Project).	• Same as Option 1. (D)

1. **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.**

   Per WAC 246-310-240(2) requirements, MultiCare's primary objective is to affordably meet the Washington State Building Code and the Washington State Energy Code. The placement of the expansion project utilizes the existing hospital facilities to reduce disruption of existing hospital and plant facilities. The project promotes cost containment through scope and cost efficiency metrics to focus on existing space within the hospital building and minimize construction cost per bed, while promoting flexibility for clinical services, expanding patient access and quality care for patient services.

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

   As discussed above, this project is necessary to alleviate current acute care inpatient bed capacity constraints at Tacoma General. Without the project, residents of Central Pierce Planning Area as well as others who in-migrate to Tacoma General will be forced to receive inpatient care elsewhere. This would be neither efficient nor promote quality of care.

V. Addendum for Hospital Projects

All Tertiary Services EXCEPT Percutaneous Coronary Intervention (PCI)

The following questions are applicable to ALL tertiary service projects except for elective PCI. There are service-specific sections that follow.

A. General Questions – Applicable to ALL Tertiary Service Projects except for PCI

Project Description

1. Check the box corresponding with the tertiary service proposed by your project:

☐NICU Level II	☐Organ Transplant
☐NICU Level III	☐Open Heart Surgery
☐NICU Level IV	☐Elective PCI*
☐Specialized Pediatric (PICU)	☐PPS-Exempt Rehab Level I (indicate level)
☐Psychiatric (within acute care hospital)	☐Specialty Burn Services

***If you selected "Elective PCI" above, skip this section and move on to the PCI-specific Addendum**

Need

2. If there is a numeric need methodology specific to your service in WAC, provide the WAC-based methodology. If there is no numeric need methodology in WAC, provide and discuss a service-specific numeric need methodology supporting the approval of your project. Include all assumptions and data sources.

3. Are there any service/unit-specific policies or guidelines? If yes, provide copies of the policies/guidelines.

Financial Feasibility

4. Provide the proposed payer mix specific to the proposed unit or service. If this project represents the expansion of an existing unit, provide the current unit's payer mix for reference.

5. **Provide pro forma revenue and expense statements for the proposed unit or service. If this project proposes the expansion of an existing unit, provide both with and without the project.**

6. **If there is no capital expenditure for this project, explain why.**

<u>Structure and Process of Care</u>

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

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

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

10. **Provide the names and professional license numbers of current and proposed credentialed staff for this service/unit.**

11. **If applicable for the service proposed, provide the existing or proposed transfer agreement with a local hospital.**

12. **Will the service/unit proposed comply with any state or national standards? If yes, provide the applicable standard, the rationale for selecting the standard selected, and a detailed discussion outlining how this project will comply with the standard.**

13. **After discharge, what steps are taken to ensure continuity of care for each patient?**

14. **If the proposed service type is already offered in the same planning area, provide a detailed description of the steps that will be taken to avoid unwarranted fragmentation of care within the existing healthcare system.**

B. <u>Psychiatric Unit Projects Only</u>

1. **Confirm that the existing or proposed facility will accept ITA patients.**

2. **Identify if the existing or proposed facility will provide pediatric or geriatric psychiatric services. If yes, identify the number of beds dedicated to each service.**

C. <u>Rehabilitation Unit Projects Only</u>

1. What trauma designation is being proposed for this rehabilitation unit?

2. Will there be separate units for separate diagnoses requiring rehabilitation?

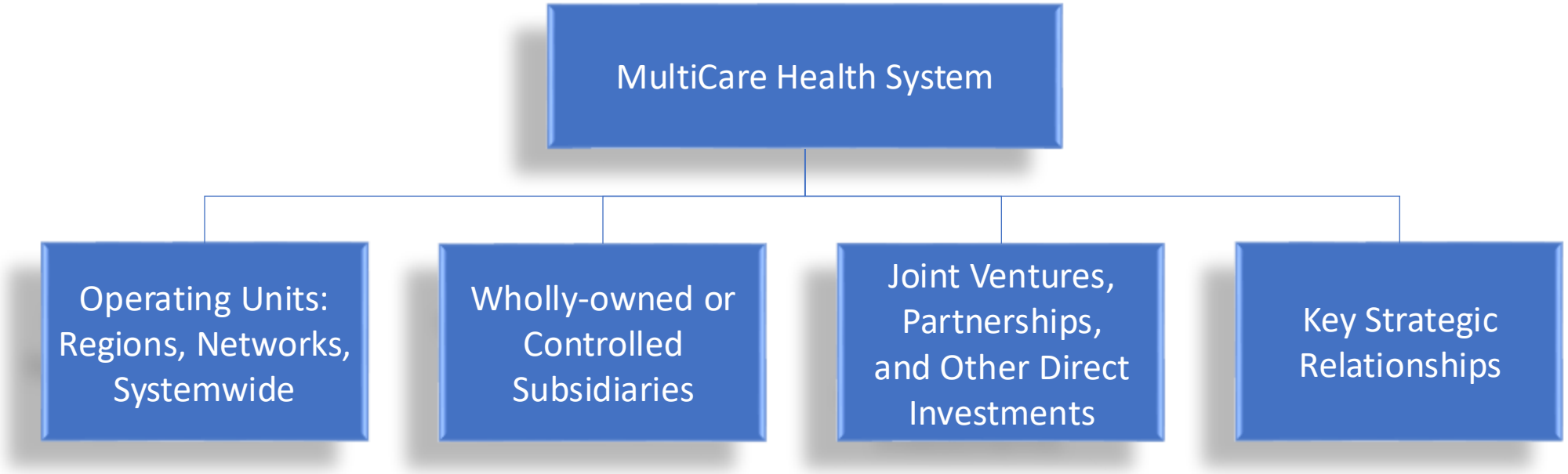
D. NICU Projects ONLY

1. Describe how this project will adhere to the most recent Washington State Perinatal Level of Care Guidelines.

Exhibit 1

MultiCare Health System Organizational Chart

Bird's eye view



Operating Units | Regions

Capital Pacific Region

- Capital Medical Center / OCED
- Capital Physicians

South Puget Sound

- Auburn Medical Center
- Covington Medical Center
- Good Samaritan Hospital / OCEDs[2]
- Tacoma General & Allenmore Hospitals / OCEDs
- Gig Harbor Multi-Specialty Medical Center
- MultiCare Medical Associates
- Puyallup Ambulatory Surgery Center
- VP Surgery Center of Auburn
- Surgery Center of Silverdale[1]
- Neospine[1]

Inland Northwest Region

- Deaconess Hospital / OCED
- Valley Hospital
- Rockwood Clinic

North Sound Region

- Overlake Medical Center
- Overlake Clinics
- Overlake Surgery Center[1]

Yakima Valley

- Yakima Memorial Hospital
- Primary & Specialty Care Clinics
- MultiCare Orthopedics NW
- MultiCare Endoscopy Center Yakima
- MultiCare Surgery Center at Ridgeview

Mary Bridge

- Mary Bridge Children's Hospital and Health Network
- Mary Bridge Children's Pediatrics
- Woodcreek Pediatrics by Mary Bridge
- Treehouse
- Pediatrics NW

Behavioral Health

- Good Samaritan Behavioral Health
- Navos[1]
- Greater Lakes Mental Healthcare[1]
- Wellfound[1]

[1] Operates through separate legal entity
[2] Off-Campus Emergency Department

Operating Units | Systemwide

Systemwide & Institutes

- MultiCare Capital Partners
- Pulse Heart Institute[1]
- MultiCare Cancer Institute
- MultiCare Neuroscience Institute
- MultiCare Institute for Research & Innovation

Population Health

- MultiCare Connected Care[1]
- Physicians of Southwest Washington dba PSW[1]
- PNW CIN dba Embright[1]
- NW Momentum Health Partners ACO[1]
- Eastside Health Network
- Groups Without Walls (GWOW)
- Signal Health (Yakima)

Community-Based

- Indigo Urgent Care
- Occupational Health
- Home Health & Hospice
- Adult Day Health
- Labs Northwest
- Carol Milgard Breast Center[1]
- Olympic Sports & Spine[1]
- Diagnostic Imaging NW
- Tellica Imaging - Washington[1]

Charitable Foundations

- MultiCare Foundations
- Mary Bridge Children's Foundation
- The Memorial Foundation
- Overlake Hospital Foundation

[1] Operates through separate legal entity

Exhibit 2

Letter of Intent

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

June 3, 2025

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

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, MultiCare Health System hereby submits this letter of intent to apply for a certificate of need to add 36 acute care beds to MultiCare Tacoma General Hospital, in Pierce County. In conformance with WAC 246-310-080(1), the following information is provided:

1. A Description of the Extent of Services Proposed:
   MultiCare Health System proposes adding 36 acute care beds to MultiCare Tacoma General Hospital.
2. Estimated Cost of the Proposed Project:
   The estimated capital cost of the project is $3,100,000.
3. Description of the Service Area:
   The primary service area is the Central Pierce Planning Area.

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

Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
P.O. Box 5299, Mailstop: 820-4-SBD
Tacoma, WA 98414
ekobberstad@multicare.org

Jonathan Fox, PhD
HealthTrends
425-469-5687
jfox@healthtrends.consulting

Thank you,

Erin Kobberstad, Vice President, Strategic Planning
MultiCare Health System

Washington State Department of HEALTH
PO Box 47890 Olympia, WA 98504
www.doh.wa.gov • TDD Relay: 711

June 3, 2025

Erin Kobberstad
Vice President, Strategic Planning
MultiCare Health System

Sent via email: ekobberstad@multicare.org

Ms. Kobberstad:

Thank you for your letter of intent submitted on behalf of MultiCare Health System. The letter of intent proposes to add 36 acute care beds to MultiCare Tacoma General Hospital. The capital expenditure associated with this project is $3,100,000.

Your letter of intent was received in the Certificate of Need Program office on June 3, 2025, and is valid for six months from that date, or until **December 3, 2025.**

You also need to be aware that in the event the application proposes a project that is significantly different from that proposed in the letter of intent, the application may be returned. Any one of the following would be considered significant changes in a letter of intent. This is not an exhaustive list, but these are certainly the most common:

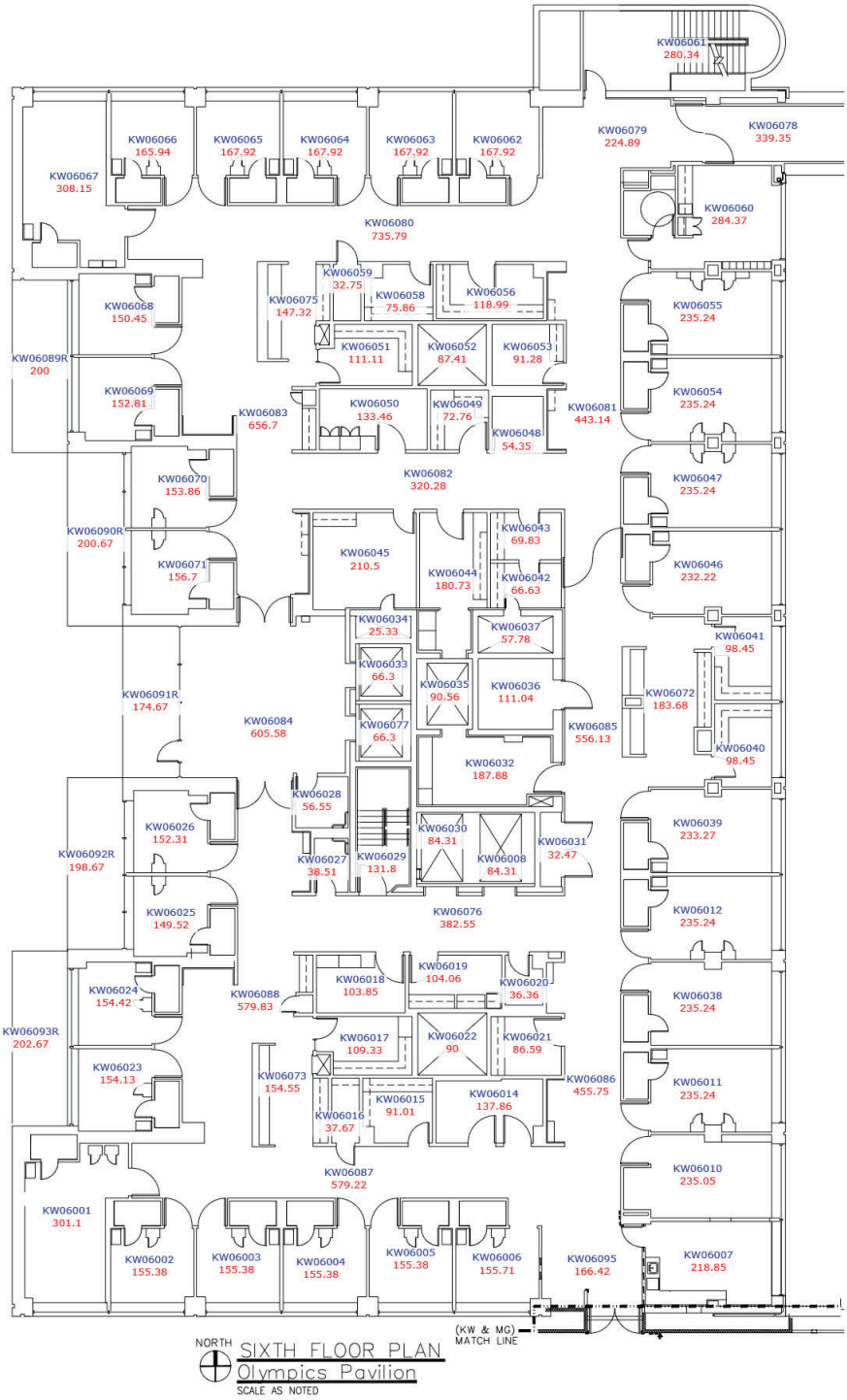
- An increase or decrease in the estimated capital expenditure of 12% or $50,000 whichever is greater (the percent is a dollar amount not a rate)
- An increase in the number of beds or stations
- A change in the applicant
- The addition of a health service subject to review
- A change in the service area
- A significant reduction in the scope of a project without a proportionate reduction in the estimated capital expenditure

If you have any questions as you are preparing the application, you may call us at (360) 236-2955 or e-mail us at CN@doh.wa.gov.

Sincerely,

Randy Huyck, Certificate of Need Analyst
Office of Community Health Systems

Exhibit 3
Single-Line Drawings



Total Area	**17,184.13**
Property	Tacoma
Building	Tacoma General and Mary Bridge Hospitals
Floor	06 - Sixth Floor (Olympic)

Exhibit 4

Central Pierce Numeric Need Methodology

Central Pierce Planning Area Bed Need Methodology, CHARS 2023

Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 1

TOTAL NUMBER OF RESIDENT PATIENT DAYS

Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and All WA State Rehab Providers

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Annual Growth Rate
HSA1	1,102,637	1,140,701	1,145,520	1,174,883	1,191,953	1,197,278	1,149,069	1,249,023	1,346,575	1,339,359	2.16%
Central Pierce	101,769	108,119	101,145	105,821	106,529	107,344	101,215	114,887	123,257	122,234	2.04%
STATEWIDE TOTAL	1,758,589	1,810,055	1,820,235	1,869,402	1,897,657	1,921,204	1,835,399	2,004,195	2,155,582	2,097,358	1.96%

Source: CHARS 2014-2023
*Note: Does not include out-migration to other states

Central Pierce Planning Area Bed Need Methodology, CHARS 2023

Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 2

TOTAL NUMBER OF PATIENT DAYS
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and All WA State Rehab Providers

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
HSA1	1,102,637	1,140,701	1,145,520	1,174,883	1,191,953	1,197,278	1,149,069	1,249,023	1,346,575	1,339,359
Central Pierce	101,769	108,119	101,145	105,821	106,529	107,344	101,215	114,887	123,257	122,234
STATEWIDE TOTAL	1,758,589	1,810,055	1,820,235	1,869,402	1,897,657	1,921,204	1,835,399	2,004,195	2,155,582	2,097,358

TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS
In Psychiatric Hospitals. 'Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
HSA1	1,840	2,207	3,003	4,539	3,666	3,934	446	140	163	59
Central Pierce	200	175	76	474	278	481	0	0	8	18
STATEWIDE TOTAL	2,184	3,028	3,823	5,347	4,453	4,527	654	221	182	62

TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
HSA1	1,100,797	1,138,494	1,142,517	1,170,344	1,188,287	1,193,344	1,148,623	1,248,883	1,346,412	1,339,300
Central Pierce	101,569	107,944	101,069	105,347	106,251	106,863	101,215	114,887	123,249	122,216
STATEWIDE TOTAL	1,756,405	1,807,027	1,816,412	1,864,055	1,893,204	1,916,677	1,834,745	2,003,974	2,155,400	2,097,296

Source: CHARS 2014-2023
*Note: Does not include out-migration to other states

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 3

TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS

Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Annual Growth Rate
HSA1	1,100,797	1,138,494	1,142,517	1,170,344	1,188,287	1,193,344	1,148,623	1,248,883	1,346,412	1,339,300	2.18%
Central Pierce	101,569	107,944	101,069	105,347	106,251	106,863	101,215	114,887	123,249	122,216	2.06%
STATEWIDE TOTAL	1,756,405	1,807,027	1,816,412	1,864,055	1,893,204	1,916,677	1,834,745	2,003,974	2,155,400	2,097,296	1.97%

TOTAL POPULATIONS

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Annual Growth Rate
HSA1	4,361,850	4,429,440	4,523,580	4,612,100	4,688,920	4,767,780	4,864,783	4,902,850	4,963,025	5,022,900	1.57%
Central Pierce	325,762	329,159	332,643	336,219	339,888	343,656	347,526	347,519	347,535	347,575	0.72%
STATEWIDE TOTAL	7,005,209	7,106,620	7,237,219	7,344,073	7,463,479	7,581,818	7,706,310	7,766,975	7,864,400	7,951,150	1.41%

USE RATE PER 1,000

Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Annual Growth Rate
HSA1	252.4	257.0	252.6	253.8	253.4	250.3	236.1	254.7	271.3	266.6	0.61%
Central Pierce	311.8	327.9	303.8	313.3	312.6	311.0	291.2	330.6	354.6	351.6	1.34%
STATEWIDE TOTAL	250.7	254.3	251.0	253.8	253.7	252.8	238.1	258.0	274.1	263.8	0.56%

Sources:
CHARS 2014-2022
Source: OFM SADE 2014-2023
Source: OFM Forecast of the State Population by Age and Sex (November 2024)
Claritas 2023
*Note: Does not include out-migration to other states

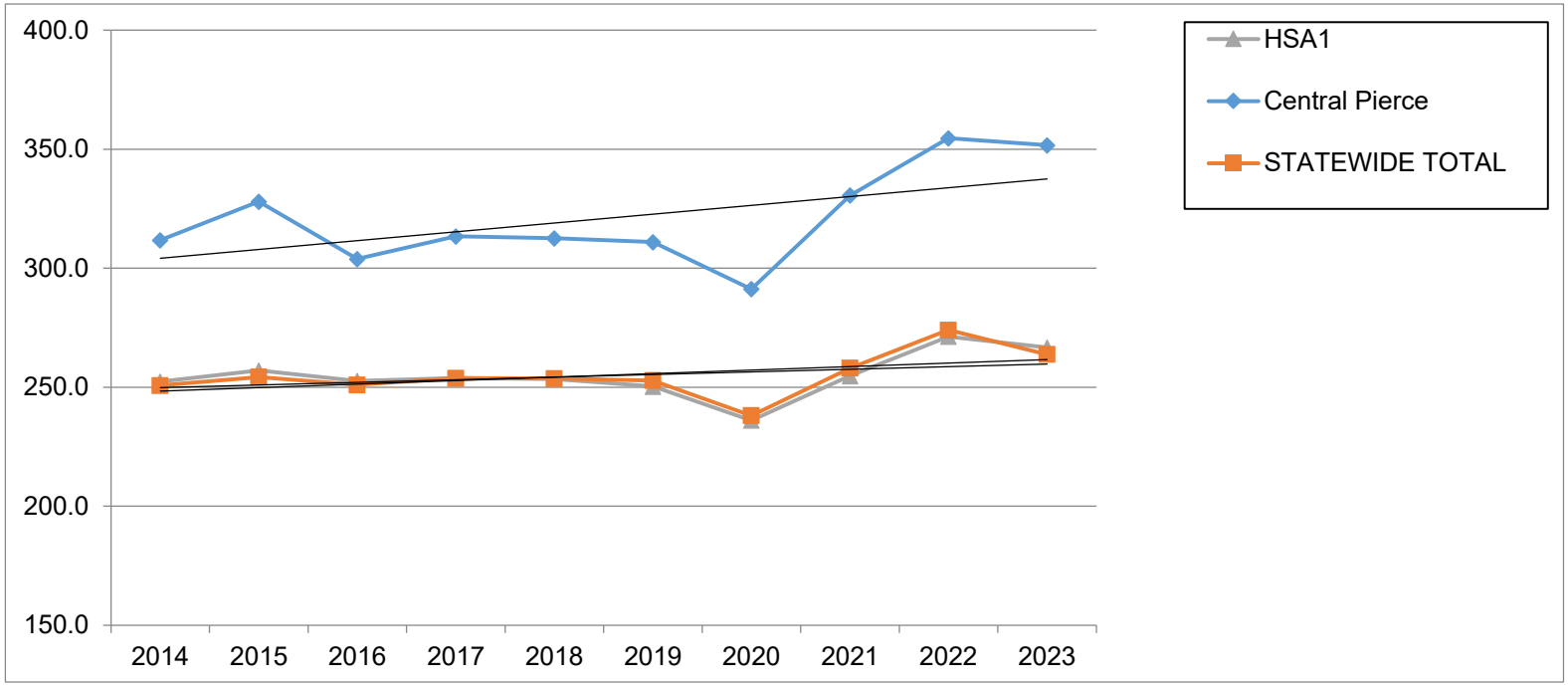
Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 4

USE RATE PER 1,000

Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Slope
HSA1	252.4	257.0	252.6	253.8	253.4	250.3	236.1	254.7	271.3	266.6	1.109
Central Pierce	311.8	327.9	303.8	313.3	312.6	311.0	291.2	330.6	354.6	351.6	3.705
STATEWIDE TOTAL	250.7	254.3	251.0	253.8	253.7	252.8	238.1	258.0	274.1	263.8	1.473

Trend Adjustment Selection	Slope
HSA1	1.109



*Note: Does not include out-migration to other states

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 5

STEP #5
2023 DATA

	Total Patient Days	Out of State Residents	WA Residents	Out of State as % of WA Residents
TO Planning Area Hospitals				
0-64	106,475	868	105,607	0.82%
65+	121,050	971	120,079	0.81%
TOTAL	**227,525**	**1,839**	**225,686**	**0.81%**
TO Other WA Hospitals				
0-64	844,040	49,951	794,089	6.29%
65+	1,118,123	40,602	1,077,521	3.77%
TOTAL	**1,962,163**	**90,553**	**1,871,610**	**4.84%**
Total patient days to WA Hospitals	**2,189,688**	**92,392**	**2,097,296**	**4.41%**

MARKET SHARE
PERCENTAGE OF PATIENT DAYS

	TO Planning Area Hospitals	TO Other WA Hospitals	To Oregon Hospitals
% OF Planning Area Residents			
0-64	73.46%	26.54%	0.00%
65+	82.08%	17.92%	0.00%
TOTAL	**78.47%**	**21.53%**	**0.00%**
% OF Other WA Residents			
0-64	8.02%	91.98%	0.00%
65+	5.48%	94.52%	0.00%
TOTAL	**6.57%**	**93.43%**	**0.00%**

	TO Planning Area Hospitals	TO Other WA Hospitals	Days in Oregon hospitals	Total Days for Residents
Planning Area Residents				
0-64	37,564	13,573		51,137
65+	58,343	12,736		71,079
TOTAL	**95,907**	**26,309**	**0**	**122,216**
Other WA Residents				
0-64	68,043	780,516		848,559
65+	61,736	1,064,785		1,126,521
TOTAL	**129,779**	**1,845,301**	**0**	**1,975,080**
Totals:	**225,686**	**1,871,610**	**0**	**2,097,296**

2023 POPULATIONS BY Planning Area

	Planning Area	Other WA Areas	Total Pop WA
0-64	285,270	6,273,786	6,559,056
65+	62,305	1,329,789	1,392,094
TOTAL	**347,575**	**7,603,575**	**7,951,150**

NOTE: Utilization from Psychiatric Hospitals Excluded

WA Source: CHARS 2023 Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and All WA State Rehab Providers; Claritas 202
Oregon Source: Oregon data excluded

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 6

2021 Data
USE RATE BY PLANNING AREA (defined as age specific inpatient days per 1,000 population)

	Central Pierce	Other WA Areas
USE RATES		
0-64	179.26	135.25
65+	1,140.82	847.14

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharge
Step 7

USE RATE BY Planning Area FROM STEP 6

Step 4 Trend Adjustment	Slope
HSA1	1.109

*State Health Plan specifies projected by applying either the HSA trend or Statewide trend, whichever trend would result in the smaller adjustme

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Planning Area																
PROJECTED USE RATES*																
0-64 using HSA Trend	179.26	180.37	181.48	182.58	183.69	184.80	185.91	187.02	188.13	189.24	190.35	191.46	192.56	193.67	194.78	195.89
0-64 using Statewide Trend	1,140.82	1,141.93	1,143.04	1,144.15	1,145.25	1,146.36	1,147.47	1,148.58	1,149.69	1,150.80	1,151.91	1,153.02	1,154.12	1,155.23	1,156.34	1,157.45
Other WA Areas																
PROJECTED USE RATES*																
65+ using HSA Trend	135.25	136.36	137.47	138.58	139.69	140.80	141.91	143.02	144.13	145.23	146.34	147.45	148.56	149.67	150.78	151.89
65+ using Statewide Trend	847.14	848.25	849.36	850.47	851.58	852.69	853.80	854.90	856.01	857.12	858.23	859.34	860.45	861.56	862.67	863.78

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 8

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Planning Area																
(using Trend slope from Step 4 for future year adjustments)																
USE RATES																
0-64	179.26	180.37	181.48	182.58	183.69	184.80	185.91	187.02	188.13	189.24	190.35	191.46	192.56	193.67	194.78	195.89
65+	1,140.82	1,141.93	1,143.04	1,144.15	1,145.25	1,146.36	1,147.47	1,148.58	1,149.69	1,150.80	1,151.91	1,153.02	1,154.12	1,155.23	1,156.34	1,157.45
PROJECTED POPULATION																
0-64	285,270	284,205	283,144	282,595	282,048	281,502	280,956	280,412	279,869	279,327	278,785	278,245	277,706	277,168	276,631	276,096
65+	62,305	63,434	64,584	66,108	67,669	69,266	70,901	72,574	74,287	76,040	77,835	79,672	81,552	83,477	85,448	87,464
TOTALS	**347,575**	**347,639**	**347,728**	**348,704**	**349,717**	**350,767**	**351,857**	**352,986**	**354,156**	**355,367**	**356,620**	**357,917**	**359,259**	**360,646**	**362,079**	**363,560**
PROJECTED # OF PATIENT DAYS for Central Pierce Planning Area Residents																
0-64	51,137	51,261	51,384	51,598	51,810	52,022	52,233	52,443	52,651	52,859	53,066	53,272	53,476	53,680	53,883	54,085
65+	71,079	72,437	73,822	75,638	77,498	79,404	81,356	83,357	85,407	87,507	89,659	91,863	94,122	96,436	98,807	101,236
TOTALS	**122,216**	**123,699**	**125,206**	**127,235**	**129,308**	**131,426**	**133,589**	**135,800**	**138,058**	**140,366**	**142,725**	**145,135**	**147,598**	**150,116**	**152,690**	**155,320**

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 9

9 A--Resident Day Calculations

Planning Area Days	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
0-64	51,137	51,261	51,384	51,598	51,810	52,022	52,233	52,443	52,651	52,859	53,066	53,272	53,476	53,680	53,883	54,085
65+	71,079	72,437	73,822	75,638	77,498	79,404	81,356	83,357	85,407	87,507	89,659	91,863	94,122	96,436	98,807	101,236
TOTALS	**122,216**	**123,699**	**125,206**	**127,235**	**129,308**	**131,426**	**133,589**	**135,800**	**138,058**	**140,366**	**142,725**	**145,135**	**147,598**	**150,116**	**152,690**	**155,320**
Planning Area Population																
0-64	285,270	284,205	283,144	282,595	282,048	281,502	280,956	280,412	279,869	279,327	278,785	278,245	277,706	277,168	276,631	276,096
65+	62,305	63,434	64,584	66,108	67,669	69,266	70,901	72,574	74,287	76,040	77,835	79,672	81,552	83,477	85,448	87,464
TOTALS	**347,575**	**347,639**	**347,728**	**348,704**	**349,717**	**350,767**	**351,857**	**352,986**	**354,156**	**355,367**	**356,620**	**357,917**	**359,259**	**360,646**	**362,079**	**363,560**
WA Population (OFM Forecast)																
0-64	6,559,056	6,594,833	6,629,034	6,661,979	6,693,979	6,724,922	6,755,880	6,789,063	6,829,810	6,873,121	6,916,598	6,957,244	6,990,566	7,028,397	7,072,101	7,120,336
65+	1,392,094	1,440,867	1,486,948	1,531,422	1,574,296	1,615,602	1,655,406	1,693,889	1,724,379	1,751,902	1,778,817	1,808,051	1,844,121	1,875,161	1,899,868	1,919,673
TOTALS	**7,951,150**	**8,035,700**	**8,115,982**	**8,193,401**	**8,268,275**	**8,340,524**	**8,411,286**	**8,482,952**	**8,554,189**	**8,625,023**	**8,695,415**	**8,765,295**	**8,834,687**	**8,903,558**	**8,971,969**	**9,040,009**
Other WA Areas Population																
0-64	6,273,786	6,310,628	6,345,890	6,379,384	6,411,931	6,443,420	6,474,924	6,508,651	6,549,941	6,593,794	6,637,813	6,678,999	6,712,860	6,751,229	6,795,470	6,844,240
65+	1,329,789	1,377,433	1,422,364	1,465,314	1,506,627	1,546,336	1,584,505	1,621,315	1,650,092	1,675,862	1,700,982	1,728,379	1,762,569	1,791,684	1,814,420	1,832,209
TOTALS	**7,603,575**	**7,688,061**	**7,768,254**	**7,844,697**	**7,918,558**	**7,989,757**	**8,059,429**	**8,129,966**	**8,200,033**	**8,269,656**	**8,338,795**	**8,407,378**	**8,475,428**	**8,542,912**	**8,609,890**	**8,676,449**
WA-Planning Area Use Rate, based on the same trend adjustment used for the Planning Area (Step 4)																
0-64	135.3	136.4	137.5	138.6	139.7	140.8	141.9	143.0	144.1	145.2	146.3	147.5	148.6	149.7	150.8	151.9
65+	847.1	848.3	849.4	850.5	851.6	852.7	853.8	854.9	856.0	857.1	858.2	859.3	860.4	861.6	862.7	863.8
Other WA Areas Patient Days																
0-64	848,559	860,540	872,385	884,063	895,683	907,227	918,842	930,845	944,013	957,645	971,399	984,832	997,268	1,010,455	1,024,611	1,039,554
65+	1,126,521	1,168,410	1,208,100	1,246,204	1,283,011	1,318,541	1,352,844	1,386,070	1,412,501	1,436,419	1,459,836	1,485,265	1,516,600	1,543,639	1,565,240	1,582,617
TOTALS	**1,975,080**	**2,028,949**	**2,080,485**	**2,130,267**	**2,178,694**	**2,225,768**	**2,271,686**	**2,316,915**	**2,356,515**	**2,394,064**	**2,431,235**	**2,470,097**	**2,513,869**	**2,554,094**	**2,589,851**	**2,622,171**

9B Market Shares--% Of Patient Days (From Step 5 C)

% OF Planning Area Residents	**TO Planning Area Hospitals**	**TO Other WA Hospitals**	**TO Oregon Hospitals**
0-64	73.46%	26.54%	0.00%
65+	82.08%	17.92%	0.00%
% OF Other WA Residents	**TO Planning Area Hospitals**	**TO Other WA Hospitals**	**TO Oregon Hospitals**
0-64	8.02%	91.98%	0.00%
65+	5.48%	94.52%	0.00%

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 9

9C Planning Area Resident Patient Days to Planning Area Providers

Planning Area Residents To Planning Area Providers	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
0-64	37,564	37,655	37,745	37,902	38,059	38,214	38,369	38,523	38,676	38,829	38,981	39,132	39,282	39,432	39,581	39,729
65+	58,343	59,458	60,594	62,085	63,612	65,176	66,779	68,421	70,104	71,827	73,594	75,403	77,257	79,156	81,102	83,096
TOTALS	**95,907**	**97,113**	**98,340**	**99,987**	**101,670**	**103,390**	**105,148**	**106,944**	**108,780**	**110,656**	**112,574**	**114,535**	**116,539**	**118,588**	**120,683**	**122,825**
Planning Area Residents To Other WA Providers																
0-64	13,573	13,606	13,639	13,695	13,752	13,808	13,864	13,920	13,975	14,030	14,085	14,140	14,194	14,248	14,302	14,355
65+	12,736	12,979	13,227	13,553	13,886	14,228	14,578	14,936	15,303	15,680	16,065	16,460	16,865	17,279	17,704	18,140
TOTALS	**26,309**	**26,585**	**26,866**	**27,248**	**27,638**	**28,036**	**28,441**	**28,856**	**29,278**	**29,710**	**30,150**	**30,600**	**31,059**	**31,527**	**32,006**	**32,495**
Planning Area Residents To Oregon Providers																
0-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

9D Other WA Resident Patient Days to Planning Area Providers

Other WA Residents To Planning Area Providers	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
0-64	68,043	69,004	69,953	70,890	71,822	72,747	73,679	74,641	75,697	76,790	77,893	78,970	79,967	81,025	82,160	83,358
65+	61,736	64,032	66,207	68,295	70,312	72,259	74,139	75,960	77,408	78,719	80,002	81,396	83,113	84,595	85,779	86,731
TOTALS	**129,779**	**133,035**	**136,160**	**139,185**	**142,134**	**145,007**	**147,818**	**150,601**	**153,106**	**155,509**	**157,896**	**160,366**	**163,081**	**165,620**	**167,939**	**170,089**
Other WA Residents To Other WA Providers																
0-64	780,516	791,536	802,431	813,173	823,861	834,479	845,163	856,204	868,316	880,855	893,506	905,862	917,301	929,430	942,451	956,196
65+	1,064,785	1,104,378	1,141,893	1,177,909	1,212,699	1,246,282	1,278,705	1,310,110	1,335,093	1,357,700	1,379,834	1,403,869	1,433,487	1,459,044	1,479,461	1,495,886
TOTALS	**1,845,301**	**1,895,914**	**1,944,324**	**1,991,082**	**2,036,561**	**2,080,761**	**2,123,869**	**2,166,314**	**2,203,409**	**2,238,555**	**2,273,339**	**2,309,731**	**2,350,788**	**2,388,474**	**2,421,912**	**2,452,082**
Other WA Residents To Oregon Providers																
0-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 9

9E Total WA Resident Patient Days to Planning Area Providers

Total Wa Resident Days to Planning Area Providers	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
0-64	105,607	106,659	107,699	108,792	109,880	110,962	112,048	113,164	114,374	115,619	116,874	118,102	119,250	120,457	121,741	123,087
65+	120,079	123,490	126,801	130,380	133,924	137,435	140,918	144,381	147,512	150,547	153,596	156,799	160,370	163,751	166,881	169,827
TOTALS	**225,686**	**230,149**	**234,500**	**239,172**	**243,804**	**248,397**	**252,966**	**257,545**	**261,886**	**266,166**	**270,470**	**274,901**	**279,620**	**284,208**	**288,622**	**292,915**
Total Wa Resident Days to Other WA Providers																
0-64	794,089	805,142	816,070	826,868	837,613	848,287	859,027	870,124	882,291	894,885	907,590	920,001	931,495	943,678	956,753	970,551
65+	1,077,521	1,117,357	1,155,121	1,191,462	1,226,585	1,260,509	1,293,283	1,325,046	1,350,396	1,373,379	1,395,899	1,420,330	1,450,352	1,476,324	1,497,166	1,514,025
TOTALS	**1,871,610**	**1,922,499**	**1,971,190**	**2,018,330**	**2,064,198**	**2,108,797**	**2,152,310**	**2,195,170**	**2,232,687**	**2,268,264**	**2,303,489**	**2,340,331**	**2,381,847**	**2,420,001**	**2,453,919**	**2,484,577**
Total Wa Resident Days to OR Providers																
0-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

9F Total Patient Days Including out of State Residents

% Out of State Resident Patient Days, 2018 (From Step 5A)	
Planning Area	
0-64	0.82%
65+	0.81%
TOTALS	**0.81%**
Other Washington	
0-64	6.29%
65+	3.77%
TOTALS	**4.84%**

Planning Area Provider Total Patient Days, Including Out of State Residents

	2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
0-64	*106,475*	*107,536*	*108,584*	*109,686*	*110,784*	*111,874*	*112,969*	*114,095*	*115,314*	*116,570*	*117,835*	*119,073*	*120,230*	*121,447*	*122,742*	*124,099*
65+	*121,050*	*124,488*	*127,826*	*131,434*	*135,007*	*138,547*	*142,057*	*145,548*	*148,705*	*151,764*	*154,838*	*158,067*	*161,667*	*165,076*	*168,231*	*171,201*
TOTALS	***227,525***	***232,024***	***236,410***	***241,120***	***245,790***	***250,420***	***255,026***	***259,643***	***264,019***	***268,334***	***272,673***	***277,140***	***281,897***	***286,523***	***290,972***	***295,300***

Central Pierce Planning Area Bed Need Methodology, CHARS 2023
Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRGs 945 and 946 (Rehab), All WA State Rehab Providers, and all SUD and abortion flagged discharges
Step 10 - Licensed

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	Average Annual Growth
Central Pierce Planning Area	**Year 0**							**Year 7**								**Year 15**	
Population 0-64 (1)	285,270	284,205	283,144	282,595	282,048	281,502	280,956	280,412	279,869	279,327	278,785	278,245	277,706	277,168	276,631	276,096	**-0.2%**
0-64 Use Rate (2)	179.26	180.37	181.48	182.58	183.69	184.80	185.91	187.02	188.13	189.24	190.35	191.46	192.56	193.67	194.78	195.89	**0.6%**
Population 65+ (1)	62,305	63,434	64,584	66,108	67,669	69,266	70,901	72,574	74,287	76,040	77,835	79,672	81,552	83,477	85,448	87,464	**2.3%**
65+ Use Rate (2)	1140.82	1141.93	1143.04	1144.15	1145.25	1146.36	1147.47	1148.58	1149.69	1150.80	1151.91	1153.02	1154.12	1155.23	1156.34	1157.45	**0.1%**
Total Population	347,575	347,639	347,728	348,704	349,717	350,767	351,857	352,986	354,156	355,367	356,620	357,917	359,259	360,646	362,079	363,560	**0.3%**
Total Central Pierce Planning Area Resident Days	122,216	123,699	125,206	127,235	129,308	131,426	133,589	135,800	138,058	140,366	142,725	145,135	147,598	150,116	152,690	155,320	**1.6%**
Total Days in Planning Area Hospitals **(Excluding SUD/Abortion Flagged Utilization)**	227,525	232,024	236,410	241,120	245,790	250,420	255,026	259,643	264,019	268,334	272,673	277,140	281,897	286,523	290,972	295,300	**1.7%**
Planning Area Hospital(s) flagged utilization as % of non-flagged patient days (3)	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	24%	
Total Days in Planning Area Hospitals **(Including estimate of SUD/Abortion Flagged Utilization) (3)**	283,113	288,711	294,170	300,030	305,841	311,602	317,333	323,078	328,523	333,892	339,291	344,850	350,769	356,525	362,062	367,446	
Available Beds (4)																	
Saint Anthony Hospital	112	112	112	112	112	112	112	112	112	112	112	112	112	112	112	112	
Saint Joseph Medical Center	393	393	393	393	393	393	393	393	393	393	393	393	393	393	393	393	
MultiCare Tacoma General	337	337	337	337	337	337	337	337	337	337	337	337	337	337	337	337	
MultiCare Allenmore	130	130	130	130	130	130	130	130	130	130	130	130	130	130	130	130	
MultiCare Mary Bridge Children's Hospital	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	
TOTAL	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	**1,054**	
Wtd Occ Std (5)	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	71.54%	
Gross Bed Need (TPD/365/Occupancy)--Demand	1,084.27	1,105.71	1,126.61	1,149.06	1,171.31	1,193.37	1,215.32	1,237.33	1,258.18	1,278.74	1,299.42	1,320.71	1,343.38	1,365.42	1,386.63	1,407.25	**1.7%**
Bed Supply	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	
Net Bed Need/Surplus (Demand - Supply)	**30**	**52**	**73**	**95**	**117**	**139**	**161**	**183**	**204**	**225**	**245**	**267**	**289**	**311**	**333**	**353**	

(1) Washington State projections - Source: OFM Forecast of the State Population by Age and Sex (November 2024)
(2) Use Rate Data Source: 2023 CHARS. See Steps 5 & 6. Future use rates adjusted per slope trends from Step 4.
(3) Flagged utilization as % of non-flagged patient days based on most recent 5-year average. Note that the difference between the Year 0 Total Days and the unadjusted days in PA hospitals is caused by using the 5-year average rather than the base year only.
(4) Bed supply sources:
[SJMC] November 2018 Evaluation approving CN App 18-21;
[Saint Anthony Hospital] CN1589;
[TG/Allenmore] 2021 DOH Acute Care Bed Survey;
[Mary Bridge] CN Eval 21-63;
[Wellfound] Excluded as dedicated psychiatric beds. CN#1563A;
[CHI Franciscan Rehab] Excluded as dedicated rehabilitation beds. See July 2016 evaluation approving CN App 16-18.
(5) Weighted Occupancy: Calculated per 1987 Washington State Health Plan Vol. 2, p. 84 as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area.

Exhibit 5
Patient Origin Data

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98405	Yes	1,163	5,306
98404	Yes	987	4,539
98409	Yes	780	3,618
98444	No	723	3,337
98406	Yes	704	3,093
98408	Yes	627	3,008
98407	Yes	712	3,005
98466	Yes	658	2,826
98387	No	655	2,511
98445	No	557	2,509
98499	No	517	2,402
98498	No	434	2,050
98391	No	389	1,808
98375	No	272	1,806
98002	No	248	1,758
98402	Yes	317	1,706
98374	No	390	1,701
98467	Yes	316	1,548
98335	Yes	363	1,375
98418	Yes	296	1,352
98042	No	218	1,194
98403	Yes	274	1,190
98092	No	198	1,186
98372	No	223	1,160
98373	No	263	1,147
98338	No	292	1,146
98371	No	246	1,104
98003	No	228	1,079
98023	No	241	1,019
98465	Yes	233	984
98422	Yes	256	874
98001	No	151	717
98446	No	171	707
98332	Yes	211	637
98902	No	64	625
98503	No	147	601
98360	No	123	582
98424	Yes	157	571
98580	No	112	536
98513	No	114	528

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98502	No	121	527
98328	No	114	513
98512	No	92	505
98584	No	97	498
98443	Yes	107	490
98390	No	101	484
98070	No	117	479
98321	No	104	477
98366	No	148	469
98501	No	106	460
98597	No	128	458
98038	No	90	453
98032	No	82	426
98329	Yes	104	415
98354	No	82	397
98030	No	76	368
98198	No	86	368
98367	No	133	355
98908	No	50	291
98532	No	55	281
98550	No	54	281
98901	No	42	270
98516	No	79	260
98022	No	55	250
98531	No	45	247
98349	Yes	63	232
98031	No	51	229
98312	No	66	219
98520	No	63	217
98579	No	34	214
98327	No	56	200
98388	No	58	191
98903	No	24	191
98433	No	62	185
98047	No	42	167
98506	No	35	167
98942	No	17	166
98370	No	32	148
98569	No	29	140
98401	Yes	27	134
98010	No	33	133
98577	No	25	129

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98311	No	35	126
98359	No	41	124
98439	No	41	124
98541	No	20	120
98333	Yes	44	111
98528	No	36	111
98051	No	13	110
98383	No	18	91
97045	No	3	89
98948	No	8	87
98385	No	10	84
98563	No	27	84
98496	No	16	80
98188	No	16	79
98411	Yes	26	77
98419	Yes	11	77
98464	Yes	16	77
98558	No	15	77
98951	No	11	75
98168	No	18	73
98058	No	22	71
98310	No	24	71
98936	No	9	71
98568	No	10	69
98592	No	5	69
98576	No	20	67
98448	Yes	14	66
98548	No	8	62
98571	No	6	58
98303	Yes	22	57
98625	No	2	57
98055	No	7	56
98057	No	6	56
98546	No	12	56
98356	No	9	51
98362	No	9	51
98394	Yes	17	50
98632	No	7	50
98304	No	8	49
98395	Yes	12	47
98108	No	6	45
98322	No	4	45

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98377	No	11	43
98589	No	9	43
98056	No	8	41
98043	No	3	40
98178	No	9	40
98045	No	3	39
98052	No	2	38
98104	No	5	38
98509	No	5	38
99515	No	1	38
98035	No	3	37
98596	No	10	36
98585	No	8	35
98588	No	10	35
98560	No	2	33
98925	No	2	33
98059	No	7	32
98087	No	4	32
40110	No	1	31
98417	Yes	11	31
98595	No	7	31
98382	No	11	30
98802	No	2	30
98106	No	8	28
98146	No	9	28
98166	No	11	28
98380	No	7	28
98932	No	3	28
98064	No	5	27
98065	No	2	27
98557	No	6	27
98103	No	3	26
98272	No	1	26
98537	No	6	26
98926	No	4	26
98930	No	3	26
29138	No	1	25
95965	No	1	25
98110	No	7	25
98346	No	8	25
98564	No	11	25
98093	No	6	24

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98421	Yes	9	24
98851	No	1	24
98923	No	4	24
98937	No	6	24
98315	No	12	23
98533	No	3	23
98547	No	7	23
98355	No	5	22
98507	No	10	22
98524	No	15	22
98570	No	5	22
23456	No	1	21
98270	No	2	20
98640	No	5	20
98947	No	3	20
98953	No	4	20
51350	No	1	19
98118	No	5	19
98148	No	3	19
98155	No	2	19
98591	No	6	19
28467	No	3	18
89149	No	1	18
98071	No	6	18
98559	No	2	18
98586	No	4	18
98944	No	1	18
98323	No	5	17
98490	Yes	2	17
74021	No	2	16
97470	No	2	16
98036	No	3	16
98139	No	2	16
98320	No	3	16
98361	No	6	16
98540	No	3	16
V3M 3Z4	No	1	16
98006	No	2	15
98326	No	2	15
98909	No	1	15
98013	No	3	14
98040	No	2	14

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98116	No	2	14
98587	No	5	14
98907	No	1	14
32792	No	1	13
74014	No	1	13
98415	Yes	4	13
99213	No	1	13
30121	No	1	12
49021	No	1	12
83815	No	1	12
98004	No	1	12
98125	No	3	12
98229	No	1	12
98331	No	3	12
98340	No	1	12
98562	No	5	12
98661	No	2	12
99133	No	1	12
23504	No	1	11
98007	No	2	11
98012	No	2	11
98109	No	5	11
98273	No	1	11
98325	No	2	11
98342	No	1	11
98572	No	3	11
98590	No	2	11
41103	No	1	10
77584	No	2	10
78108	No	1	10
78801	No	1	10
85304	No	1	10
98026	No	1	10
98126	No	3	10
98201	No	2	10
99224	No	3	10
CO92LH	No	1	10
83118	No	1	9
84081	No	1	9
85122	No	1	9
96753	No	1	9
97304	No	1	9

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98115	No	3	9
98133	No	3	9
98337	No	6	9
98363	No	5	9
98508	No	3	9
98539	No	2	9
98555	No	3	9
98599	No	1	9
14586	No	1	8
83835	No	1	8
85028	No	1	8
85286	No	2	8
92627	No	1	8
96706	No	1	8
97754	No	1	8
98008	No	1	8
98033	No	4	8
98072	No	4	8
98114	No	1	8
98208	No	2	8
98274	No	2	8
98368	No	4	8
98556	No	1	8
99155	No	1	8
99686	No	2	8
32407	No	1	7
33478	No	1	7
72653	No	1	7
75077	No	1	7
76133	No	1	7
85332	No	1	7
89432	No	1	7
91214	No	1	7
94107	No	4	7
94521	No	1	7
97016	No	1	7
98119	No	3	7
98290	No	2	7
98339	No	2	7
98365	No	3	7
98511	No	3	7
98575	No	1	7

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
98665	No	1	7
98921	No	1	7
99574	No	1	7
99921	No	2	7
11101	No	1	6
11354	No	1	6
33534	No	1	6
40511	No	1	6
57769	No	1	6
78501	No	1	6
83530	No	1	6
89048	No	1	6
90046	No	1	6
97365	No	2	6
97420	No	1	6
97801	No	2	6
98203	No	5	6
98239	No	1	6
98251	No	1	6
98277	No	2	6
98344	No	3	6
98345	No	1	6
98351	Yes	4	6
98538	No	1	6
98649	No	1	6
99001	No	2	6
99117	No	1	6
99218	No	1	6
99336	No	1	6
99576	No	1	6
25234	No	1	5
33023	No	2	5
34695	No	1	5
52601	No	1	5
70506	No	1	5
97003	No	1	5
97058	No	1	5
98075	No	2	5
98117	No	2	5
98136	No	2	5
98204	No	2	5
98593	No	2	5

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
99173	No	2	5
99204	No	3	5
99301	No	1	5
02151	No	1	4
07017	No	1	4
32246	No	1	4
36544	No	1	4
55405	No	1	4
81635	No	1	4
85041	No	1	4
85085	No	1	4
85120	No	1	4
85375	No	1	4
90014	No	1	4
92109	No	1	4
92801	No	1	4
96778	No	2	4
96913	No	1	4
97006	No	1	4
97321	No	1	4
98034	No	2	4
98121	No	1	4
98144	No	1	4
98240	No	1	4
98542	No	1	4
98582	No	2	4
98620	No	2	4
98660	No	2	4
98922	No	1	4
98935	No	1	4
99214	No	1	4
99320	No	1	4
99611	No	1	4
24540	No	1	3
34287	No	1	3
34606	No	1	3
37135	No	1	3
49670	No	1	3
60534	No	1	3
60585	No	1	3
63401	No	1	3
78382	No	1	3

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
80012	No	1	3
83686	No	2	3
85396	No	1	3
92345	No	1	3
94609	No	1	3
95821	No	1	3
96743	No	1	3
96928	No	1	3
97017	No	1	3
97220	No	1	3
97402	No	1	3
98122	No	1	3
98138	No	1	3
98230	No	1	3
98381	No	1	3
98386	No	2	3
98416	Yes	1	3
98583	No	1	3
98952	No	1	3
99161	No	1	3
99201	No	1	3
99349	No	1	3
99352	No	1	3
03869	No	1	2
23502	No	1	2
29860	No	1	2
31027	No	1	2
31909	No	1	2
44012	No	1	2
46236	No	1	2
47630	No	1	2
56501	No	1	2
61847	No	1	2
70435	No	1	2
72758	No	1	2
73119	No	1	2
75161	No	1	2
80910	No	1	2
84078	No	1	2
85205	No	2	2
85296	No	1	2
90604	No	1	2

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
97225	No	1	2
98005	No	1	2
98027	No	1	2
98029	No	2	2
98112	No	1	2
98124	No	1	2
98296	No	1	2
98330	No	1	2
98384	No	1	2
98392	No	1	2
98526	No	1	2
98565	No	1	2
98639	No	1	2
98823	No	1	2
98840	No	1	2
98855	No	1	2
99026	No	1	2
99203	No	1	2
99206	No	1	2
99223	No	1	2
99507	No	1	2
00961	No	1	1
33165	No	1	1
59718	No	1	1
59801	No	1	1
72019	No	1	1
74756	No	1	1
78141	No	1	1
78232	No	1	1
80132	No	1	1
80924	No	1	1
83617	No	1	1
83709	No	1	1
85251	No	1	1
89156	No	1	1
95340	No	1	1
95560	No	1	1
95835	No	1	1
97002	No	1	1
97116	No	1	1
97124	No	1	1
97206	No	1	1

MultiCare Tacoma General Patient Origin Analysis
Acute Care Discharges Only, 2024

Zip Code	Central Piece Planning Area	Discharges	Patient Days
97701	No	1	1
98021	No	1	1
98028	No	1	1
98037	No	1	1
98102	No	1	1
98105	No	2	1
98199	No	1	1
98226	No	1	1
98336	No	1	1
98353	No	2	1
98396	No	1	1
98611	No	1	1
98624	No	1	1
98664	No	1	1
98685	No	1	1
98938	No	1	1
99202	No	1	1
99208	No	1	1
99337	No	1	1
99517	No	1	1
V0M 1G0	No	1	1
P0H 1C0	No	1	1
13066	No	1	0
53222	No	1	0
54115	No	1	0
94010	No	1	0
97138	No	1	0
97233	No	1	0
97703	No	1	0
97756	No	1	0
98074	No	1	0
98607	No	1	0
99037	No	1	0

Exhibit 6

MultiCare Tacoma General Hospital Policies

Exhibit 6a
Admissions Policy

Title: ADMISSION OF A PATIENT

Scope:

This scope applies to all inpatient areas at MultiCare Health System. It includes Tacoma General Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Rockwood Clinic and Capital Medical Center.

Policy Statement:

This policy applies to the admission of a patient. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient with a provider admission order, medical necessity and the expectation that patient will remain at least overnight and occupy a bed. Patients who are being admitted for elective inpatient surgery are considered formally admitted once anaesthesia induction has begun.

The medical record contains information to justify the admission of the patient.

Plans of care and discharge plans are initiated for each admission.

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

Procedure:

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

A. The Provider will:

1. Determine patient admission needs
2. Coordinate care between the patient's primary care provider and Specialists providing care to the patient
3. Identify necessary level of care and monitoring
4. Provide appropriate orders (preferably entered into the EMR, however may be called, faxed or sent to the appropriate unit). These orders should include but are not limited to:

a. Admission Status (inpatient, ambulatory, observation for)

b. Admitting Diagnosis,

c. Attending Physician and

d. Admitting unit

e. Vital sign parameters

f. Allergies/Reactions

g. Diet orders

h. Activity orders

i. Diagnostic, Lab and Imaging orders

j. Medications and IVs to be administered during hospital stay, including Medication Reconciliation of home medications.

k. Procedure/Treatments

l. Resuscitation status as appropriate

5. Assess patient at the bedside within timeframe outlined by Medical Staff Bylaws
6. Identify goals of treatment and treatment plan
7. Inform patient about risks, benefits and alternatives of surgery and/or procedures and obtain informed consent as indicated
8. Complete the patient's History and Physical (H&P) as outlined by Medical Staff Bylaws.
9. Initiate appropriate discharge plan as indicated

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

III. Patient Access Services will:

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

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

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

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

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

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

IV. Procedure for Admission to Clinical Care Area:

A. Obtain a Bed Assignment:

1. A Provider will contact the appropriate department for bed availability and assignment. This may be the MultiCare Transfer Center (MTC), or the House Supervisor.

2. The admitting patient care staff will be notified of pending admission and bed assignment.

B. Responsibilities

1. Clerical support responsibilities:

a. Retrieve past medical records, including recent ED or urgent care services, as needed

2. RN:

a. Obtain handoff/report of patient condition and receive patient into appropriate care area.

b. Place identification bands with appropriate information

c. Identify and prioritize appropriate patient care needs.

d. Obtain/acknowledge necessary physician orders

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

ii. The RN ensures that orders are accurately implemented.

e. Complete the nursing admission documentation and verify that appropriate admission data is collected and documented

f. Ensure that the Advance Directive information has been obtained and document the content of the advanced directive in the patient's record if known.

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

i. A referral may be made to Care Management/ Social Workers who can provide resources to the patient

ii. The Health Care Directive form (87-6030-2e) may be offered to the patient

iii. The care team initiates a patient plan of care

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

A. The type of chart created will be driven by patient location and availability of the EMR

Related Forms:
Notice of Privacy Practices, Conditions for Treatment, Financial Disclosures, Patient's Rights Materials, Financial Assistance Form #87-9158-0A
Important Message from Medicare Form # 87-0568-3e
Important Message from TriCare Form # 88-0061-0
Health Care Directive Form #87-6030-2e

References:

CMS Standards:

45 C.F.R. § 80

45 C.F.R. § 84

45 C.F.R. § 91

	29 U.S.C. § 794 Centers for Medicare and Medicaid. (2020). *State Operations Manual- Regulations and Interpretive Guidelines for Hospitals.* The Joint Commission. (2020). *Comprehensive Accreditation Manual for Hospitals.* PC 01.02.03, RC 02.01.01, RI 01.01.01 EP2, 5, RI 01.02.01, EP 1,2,22, RI 01.05.01 Washington State Department of Health. (2010). *Chapter 246-320 WAC Hospital Licensing Regulations.*
	Point of Contact: Executive Director, Patient Access 253-697-1865

Approval By:	***Date of Approval:***
Patient Access Leadership	8/12; 7/14; 4/17; 8/20
NOC	11/20
CapMC QSSC	7/21
MHS Quality Safety Steering Council	9/14; 5/17; 8/17; 4/18; 12/20
Original Date:	*12/00*
Revision Dates:	*8/04; 7/07; 9/09; 06/12; 8/14; 4/17; 10/20*
Reviewed with no Changes Dates:	XX

Distribution: MHS Intranet
Scope/locations of services updated March, 2017.
Ethnicity and Pre-existing condition added per non exclusion law 7/17
MultiCare Deaconess Hospital, MultiCare Valley Hospital, MultiCare Rockwood Clinic
Added to scope 7/21/17
4/11/18 - Approved at SKRB 3/26/18 and QSSC 4/10/18 to apply to Covington Medical Center
Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 6b

Financial Assistance Policy

Status **Active** PolicyStat ID **15104875**

Origination	05/1997
Last Approved	01/2024
Effective	02/2024
Last Revised	01/2024
Next Review	01/2025

Owner	Cassie Stokes: Dir Revenue Cycle Policy
Area	Revenue Cycle
Applicability	MultiCare Hospitals + Yakima +BHN
Tags	DOH

Financial Assistance – Hospital Based Services

Scope:

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

Locations include Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, Home Health and Hospice, Navos Behavioral Health Center, Capital Medical Center, and Yakima Memorial Hospital.

Policy Statement:

MHS is guided by a mission to provide high quality, patient-centered care. We are committed to serving all patients, including those who lack health insurance coverage or who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that take into account an individual's ability to pay for medically necessary health care services.

Definitions:

1. **Collection Efforts** and **Extraordinary Collections Actions** (ECA) are defined by the MHS Collection Guidelines policy.
2. **Charity Care** and/or **Financial Assistance** means medically necessary hospital health care rendered to Eligible Persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. When

communicating with patients, the phrase “Financial Assistance” will be used in lieu of “Charity Care.” Both terms are synonymous with one another for the purposes of this policy and MHS billing statements.

3. **Eligible Person(s)** is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 400% the federal poverty standards adjusted for family size.
4. **Emergency Medical Conditions** (EMC) are defined by the MHS Emergency Medical Treatment and Active Labor Act (EMTALA), Compliance With policy, which is consistent with WAC 246-453-010.
5. **Family** is defined per WAC 246-453-010 (18) as a group of two or more persons related by birth, marriage or adoption that live together; all such related persons are considered as members of one family.
6. **Income** is defined per WAC 246-453-010(17) as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities.
7. **Medically Necessary** is defined per WAC 246-453-010 (7) as appropriate hospital-based medical services.
8. **Responsible Party** means that individual who is responsible for the payment of any hospital charges not otherwise covered by a funding source as described below.

Policy Guidelines:

This policy provides a guideline for making consistent and objective decisions regarding eligibility for Financial Assistance. Financial Assistance is available for medically necessary hospital-based health care services (to include emergency care) provided by MultiCare Health System.

Emergency care will be provided to patients with Emergent Medical Conditions regardless of their ability to pay. MHS shall allocate resources to identify charity cases and provide uncompensated care per RCW 70.170 and WAC 246- 453. *See* MHS Policy: Emergency Medical Treatment and Active Labor (EMTALA), Compliance With.

MHS supports the state-wide voluntary pledge of hospitals to provide Financial Assistance to Eligible Persons in accordance with the methodology provided and updated annually by the Washington State Hospital Association.

Consideration for Financial Assistance will be given equally to all Eligible Persons, regardless of race, color, sex, religion, age, national origin, veteran’s status, marital status, sexual orientation, immigration status or other legally protected status. *See* MHS Policy: Patient Nondiscrimination

All information relating to the Financial Assistance application is confidential and protected by HIPAA guidelines. *See* HIPAA Privacy Compliance – Administrative policy.

Lists of providers accepting and not accepting Financial Assistance are available at https://www.multicare.org/financial-assistance/ .

This policy describes the processes for evaluating applications and awarding Financial Assistance for free and discounted care at the following levels based on the Federal Poverty Limit (FPL) adjusted for family size:

1. 100% Financial Assistance - Income levels at or below 300% of the (FPL); or
2. Sliding Scale Financial Assistance - Income levels between 300.5% and 400% of the FPL.

Procedure:

I. **Eligibility Criteria**

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

A. *Exhaustion of All Funding Sources*

1. Any of the following sources must first be exhausted before a Responsible Party will be considered for Financial Assistance:
    a. Group or individual medical plans
    b. Workers compensation programs
    c. Medicaid programs
    d. Other state, federal or military programs
    e. Third party liability situations (e.g., auto accidents or personal injuries)
    f. Tribal health benefit programs
    g. Health care sharing ministry programs
    h. Any other persons or entities having a legal responsibility to pay
    i. Health saving account (HSA) funds. MHS may require a Responsible Party to fully utilize any available funds from HSA to satisfy outstanding balances.
    j. MHS will pursue payment from any available Funding Source. The remaining patient liability will be eligible for Financial Assistance based on the criteria in this policy.

B. *Accurate Completion of Financial Assistance application*.

1. Incomplete applications will be denied. Patients may appeal the denial and provide the missing information per the guidelines set forth below.
2. If the application places an unreasonable burden, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the Responsible Party's capability of complying with the application procedures on the Responsible Party, then the application process will not be imposed.

C. *Medicaid Eligibility Within 90 Days of Services in Lieu of Application*

1. A determination of Medicaid eligibility within (90) days of date of services may replace the Financial Assistance application and may be used to qualify the Responsible Party for 100% Financial Assistance except for spend down amounts. Proof of eligibility will be the presence of Medicaid coverage during the applicable timeframe in the patient's coverage record in Epic.

D. *Presumptive determination or Extraordinary Circumstances*

1. The Responsible Party may qualify for Financial Assistance based on a presumptive determination or extraordinary life circumstances, as outlined below

E. *Medically Necessary Health Care Services Rendered*

1. The services provided to the patient must be medically necessary and not elective.
2. Scheduled services that appear to not be medically necessary will be reviewed by Utilization Management prior to the date of service to determine medical necessity

F. *International Patients*

1. Eligibility determinations for International Patients for non-medically necessary services will be considered on a case-by-case basis by a committee representing Physician Leadership, Revenue Cycle and Finance

II. **Proof of Income:** Income will be evaluated based on the following criteria:

A. *Income Verification*

1. Any of the following types of documentation will be acceptable for purposes of verifying income:
    a. W2 withholding statements
    b. Payroll check stubs
    c. Most recent filed IRS tax returns
    d. Determination of Medicaid and/or state-funded medical assistance
    e. Determination of eligibility for unemployment compensation
    f. Written statements from employers or welfare agencies
2. For Social Security and Pension benefits, bank statements may be used to demonstrate the consistent monthly deposit.
3. In the event the Responsible Party is unable to provide the documentation described above, MHS must rely upon the written and signed statements from the Responsible Party for making a final determination of eligibility.
4. MHS may also use third party verification of ability to make a presumptive determination and apply a charity discount without receiving a financial

assistance application.

B. *Calculation of Income*

1. MHS will use the following guidelines to calculate income:
    a. All Family income will be included in the calculation.
    b. Based on the type of documentation provided, the income will be calculated to represent a twelve (12) month period.

C. *Timing of Determination*

1. Income will be determined as of the time the services were provided.
2. Income at the time of application for Financial Assistance will be considered if the application is made within two years of the time the services were provided and the Responsible Party has been making good faith efforts towards payment for the services

III. **Process for Determination of Eligibility**

A. At the time of registration or as soon as possible following the initiation of services, MultiCare will make an initial determination of eligibility following the patient's review of the FPL grid. If a patient is determined to likely fall below 300% of the FPL, they will not be asked for payment and will be referred to a Patient Financial Navigator (PFN), who will provide additional information about Financial Assistance and other programs that may be available to the patient.

B. Collection activity will cease for 30 calendar days for patients believed to be under 300% of the FPL and the Responsible Party will be asked to complete a Financial Assistance application. If no application is received within 30 days, collection activity will resume.

C. When an application is received, a PFN will review the application to determine eligibility.

D. Incomplete applications will be denied. The Responsible Party will be provided a letter specifying missing information and may Appeal the decision per the requirements below.

E. A written notice of determination will be sent to the applicant within fourteen (14) calendar days from receipt of the complete application.

F. If approved, this notice will include the amount for which the Responsible Party is financially responsible, if any.

G. Approvals will be valid for 180 days and a new application will be required after such time. Awards to Eligible Persons on fixed incomes like Social Security shall be approved for one (1) year, at the discretion of the PFN reviewing the application.

IV. **Appeals**

A. The Responsible Party may appeal the determination by providing additional verification of income or family size within thirty (30) calendar days of receipt of the determination.

B. MultiCare will respond to the appeal within fourteen (14) calendar days from receipt

of the appeal.

C. All appeals will be reviewed and approved or denied by the Manager or Director, Patient Financial Navigation.

D. If an appeal is denied, it will be presented to the AVP, Financial Clearance, Vice President of Revenue Cycle or Chief Financial Officer (CFO) for final determination. If this determination affirms the previous denial of Financial Assistance, written notification will be sent to the Responsible Party and the Department of Health in accordance with state law.

E. Collection efforts will be suspended during the thirty (30) calendar day appeal period and the fourteen (14) calendar day appeal review period.

V. **Application of Financial Assistance Discount Levels**

A. Financial Assistance applies to combined balances for all open accounts for the Responsible Party at time of application submission. The amount owed by an Eligible Person qualifying under this Financial Assistance policy will not exceed amounts generally billed to a Responsible Party not receiving assistance. The method used to calculate the discount to an Eligible Person's balance will be based on an annual retrospective analysis. A rate will be determined for each hospital. This will be calculated using a Look-Back Method pulling a year of claims that have paid in full for Medicare and private/commercial health insurance Responsible Party to determine the "Amount Generally Billed". Patients may obtain information about the Amounts Generally Billed calculations free of charge by calling 800-919-1936.

1. Balances will be considered for Financial Assistance based on the FPL guidelines in Appendix A.
2. If an Eligible Person's residence is in Hawaii or Alaska, the associated FPL guidelines for those states will be utilized to make the determination of assistance.

B. Financial Assistance adjustments will be considered on an individual account balance basis. Approvals on adjustments will be authorized as follows:

1. Patient Financial Navigators: $0.01 - $4,999
2. Supervisor: $5,000 - $49,999
3. Manager/Director: $50,000 - $99,999
4. AVP: $100,000 - $499,999
5. Vice President: $500,000 - $999,999
6. SVP, CFO: $1,000,000 - $2,999,99

C. The volume of applications and adherence to this policy will be tracked and audited on a monthly basis. This report will be reviewed and signed by the Vice President of Revenue Cycle or AVP, Financial Clearance.

VI. **Presumptive Eligibility**

A. Eligibility may be determined presumptively.

1. MHS may utilize third party vendor software or software applications to

determine an account's collectability. This is a "soft" credit check and will not impact the Responsible Party's credit standing.

2. If these reviews determine the patient may be at 300% or below of the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance.

VII. **Extraordinary Life Circumstances**

A. Extraordinary Life Circumstances may also warrant Financial Assistance. Examples of such circumstances may include:

1. **Homeless Persons:** A Homeless person is an individual who has no home or place of residence and depends on charity or public assistance. Such individuals will be eligible for Financial Assistance, even if they are unable to provide the documentation required for the Financial Assistance application.

2. **Deceased Patients:** The charges incurred by a patient who expires may still be considered eligible for Financial Assistance. For the Financial Assistance application, the deceased patient will count as a family member. Accounts in an “Estate” status or situations where the estate has not been opened are not eligible for Financial Assistance until the Estate is settled.

3. **Inmates:** Responsible Party who is incarcerated may be considered eligible in the event the State or County has made a determination that the State or County is not responsible for charges and the inmate/patient is responsible for the bill. Charges incurred while in custody are usually paid through the Law Enforcement Agency and would not qualify for Financial Assistance.

4. **Catastrophic Determinations:** Responsible Party may qualify for a Catastrophic Discount. Only medically necessary services are eligible for a Catastrophic Discount. A Catastrophic event will be determined on a case-by- case basis. Catastrophic cases may include extraordinary medical expenses or hardship situations. All income and non-income resources are considered in the determination, to include the Responsible Party’s future income earning potential, especially where his or her ability to work may be limited as a result of illness and/or their ability to make payments over an extended period of time. All of the debt or a portion of the debt may qualify for Financial Assistance. The Director or Manager of Patient Financial Navigation will assist in making a catastrophic event application determination.

B. Requests for Financial Assistance may originate from other sources including a physician, community or religious groups, social services, financial services personnel, and/or the Responsible Party.

VIII. **Individuals that Qualify for Medical Assistance Programs**

A. MHS takes the following steps to identify patients or guarantors that may qualify for medical assistance programs under RCW 74.09:

1. Patient Financial Navigators review completed financial assistance applications and will follow up with patients or guarantors that appear to qualify for medical assistance programs.
2. Navigators are available on site at MHS hospital facilities, including our off-campus emergency departments, to identify and screen patients and their guarantors.
3. All self-pay patients admitted to an MHS hospital facility are screened to determine if they qualify for any medical assistance programs.
4. Patients may be referred for screening for coverage or medical assistance programs by Care Managers, Registration staff, and providers.
5. Certified Navigators are located throughout MHS and are available at no cost to help customers sign up for coverage through Washington Healthplanfinder. This service is available to anyone searching for a health plan—not only MHS patients.

B. Once a patient or guarantor is identified as potentially being eligible for a medical assistance program:
    1. The patient is screened by a Navigator, who helps determine eligibility for public health care coverage based on household size and income.
    2. If the patient's eligibility is confirmed, then a Navigator will partner with the patient and assist the patient in applying for the appropriate health plan.
    3. The patient account is flagged to ensure no billing occurs while the application is pending.

C. MHS is not obligated to provide financial assistance if a patient or their guarantor qualifies for retroactive health care coverage under RCW 74.09 and the patient or their guarantor fails to make reasonable efforts to cooperate with a Navigator's attempts to assist them in applying for such coverage. (RCW 70.170.060(5)).

IX. Collection Efforts for Outstanding Patient Accounts

A. MHS will not initiate collection efforts or requests for deposits, provided that the Responsible Party within a reasonable time is cooperative with the system's efforts to reach a determination of Financial Assistance eligibility status. ECA may only be initiated after the Notification Period, in accordance with the MHS Policy: Collection Guidelines, Patient Accounts.

B. The Responsible Party's financial obligation remaining after application of the sliding fee schedule will follow regular collection procedures to obtain payment, pursuant to Policy.

C. In the event that a Responsible Party pays a portion or all of the charges related to medically necessary health care services, and is subsequently found to have met the Financial Assistance criteria, any payments for services above the qualified amount will be refunded to the Responsible Party within 30 days of the eligibility determination.

X. Staff Training

A. All relevant and appropriate staff supporting Hospital based locations who perform registration, admission, billing, or other related functions shall participate in standardized training based on this Financial Assistance Policy and the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about the availability of Financial Assistance.

B. The training shall help ensure staff can answer Financial Assistance questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.

XI. **Dissemination of MHS Financial Assistance Policy**

A. All patients are provided with information about the availability of Financial Assistance upon registration. Additional copies can be requested from the Hospital Financial Navigators or Patient Access Techs within the hospital facilities.

B. Notices in all languages spoken by more than 10 percent of the population advising patients of the availability of Financial Assistance will be posted in key public areas of the hospital, including Admissions and/or Registration, the Emergency Department, Billing and Financial Services.

C. This policy, the application, and a plain language summary are available to patients free of charge by contacting 800-919-1936.

D. Financial counselors are available to discuss Financial Assistance options in person at all hospital locations or over the phone for other areas of the health system.

E. Billing Statements sent to Responsible Parties will contain information regarding the availability of Financial Assistance in both English and Spanish.

F. Written materials are available in English, Spanish, Russian and Vietnamese. .

G. Wide-reaching community notifications will occur in the following ways:

1. Available at registration areas of all hospital facilities,
2. On MHS website www.multicare.org
3. Communications provided to our community partners for distribution, and
4. Upon request, by calling 800-919-1936

Related Forms:

Appendix A
Proof of Income for Financial Assistance Instruction Sheet
Financial Assistance Application
Financial Assistance Letter to Patients
Patient Brochure Containing Plain Language Summary

References:

RCW 70.170

WAC 246-453

Federal Register Vol 79, December 31, 2014 Final Rule

Notes:
3/1/22 - Added HHH to scope per Cassie Stokes

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is on the organization intranet.

Attachments

Appendix A.pdf

Approval Signatures

Step Description	Approver	Date
Council / Committee Approvals	Michelle Bowers: QM System Project Analyst Sr	03/2024
Policy Coordinator	Michelle Bowers: QM System Project Analyst Sr	03/2024
	Cassie Stokes: Dir Revenue Cycle Policy	01/2024

Applicability

MultiCare Auburn Medical Center, MultiCare Behavioral Health Network, MultiCare Capital Medical Center, MultiCare Covington Medical Center, MultiCare Deaconess Hospital, MultiCare Good Samaritan Hospital, MultiCare Mary Bridge Childrens Hospital, MultiCare Tacoma Gen/Allenmore (System-wide), MultiCare Valley Hospital, MultiCare Yakima Memorial Hospital

Standards

No standards are associated with this document

Exhibit 6c

Patient Non-Discrimination Policy

Origination	06/2012
Last Approved	06/2025
Effective	06/2025
Last Revised	06/2025
Next Review	06/2026

Area	Compliance, Privacy & Civil Rights
Applicability	MultiCare System Wide with Yakima
Accreditations	DOH, DOJ

Patient Nondiscrimination

Scope:

This policy applies to all MultiCare Health System (MHS) workforce members, which includes but is not limited to employees, medical staff, residents, students, volunteers, and contractors.

Location Scope:

This policy applies to all wholly owned and controlled MHS entities, including but not limited to the following: MultiCare Ambulatory, MultiCare Allenmore Hospital, MultiCare Auburn Medical Center, MultiCare Capital Medical Center, MultiCare Covington Medical Center, MultiCare Deaconess Hospital, MultiCare Good Samaritan Hospital, MultiCare Mary Bridge Children's Hospital, MultiCare Navos Hospital, MultiCare Tacoma General Hospital, MultiCare Valley Hospital, MultiCare Yakima Memorial Hospital, Behavioral Health Network facilities and all wholly owned and controlled administrative and ambulatory locations and services.

Policy Statement:

It is the policy of MHS to provide equal access to its facilities and services without discrimination on the basis of age, race, color, creed, national origin, ethnicity, immigration status, religion, marital status, sex, sexual orientation, gender identity or expression, disability, citizenship, medical condition, or any other basis prohibited by federal, state, or local law.

This policy applies to MHS workforce member's interactions with patients, companions, and visitors of MHS. For questions regarding employment discrimination, please see the MHS Policy and Procedure

"*Equal Employment Opportunity and Employment Law*."

For questions you can contact the Integrity Line by phone at (866) 264-6121 or by email at compliance@multicare.org.

Special Instructions:

Any person who believes they or any specific class of individuals have been subjected to prohibited discrimination may file a complaint with the Privacy & Civil Rights Office through the Integrity Line.

All reports will receive a written response within fourteen (14) days.

A person may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

OCRComplaint@hhs.gov

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

Or with the U.S. Department of Justice Civil Rights Division through the Complaint Portal, available at https://www.ada.gov/file-a-complaint/ or by mail:

U.S. Department of Justice

Civil Rights Division

950 Pennsylvania Avenue, NW

Washington, D.C. 20530

1-800-514-0301 (voice) or 1-833-610-1264 (TTY)

ada.gov

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

Procedure:

MHS Personnel will:

1. Nondiscrimination – MHS will treat all patients and visitors receiving or participating in services with equality and in a welcoming manner that is consistent with Multicare's nondiscrimination policy. Specifically, MultiCare does not discriminate or exclude people or treat them differently because of age, race, color, creed, national origin, ethnicity, immigration status, religion, marital status, sex, sexual orientation, gender identity or expression, disability, citizenship, medical condition, or any other basis prohibited by federal, state, or local law.
2. Notice – MHS will provide notices to patients regarding this policy and its commitment to providing access to and the provision of services in a nondiscriminatory manner pursuant to Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act.
3. Effective Communication: MHS will inform patients, companions, and visitors of the availability of interpreter services free of charge. MultiCare will inform patients of their right to appropriate auxiliary aids and services such as qualified language interpreters for limited English-speaking patients and sign language interpreters for hearing-impaired patients and how to obtain these aids and services. Aids and services will be provided free of charge to the patient and the patients companion in a timely manner when such aids and services are necessary to ensure an equal opportunity to participate. MultiCare will provide meaningful access to individuals with limited English proficiency. A Notice of Language Availability will be advertised in the state's top 15 languages as required.
4. Reasonable Accommodation: MHS will make a reasonable accommodation for a patient consistent with Federal and State requirements.
    - The Section 1557 Coordinator, or appropriate Privacy and Civil Rights Office delegate, will help determine and approve the suitable change or exception.
    - Contact the Section 1557 Coordinator, or appropriate Privacy and Civil Rights Office delegate, to request a reasonable accommodation:
        - Integrity Line 866-264-6121
        - Compliance email at compliance@multicare.org
        - Internal Portal – https://multicare.cqs.symplr.com/portal
5. Visitation Rights – MHS will afford visitation rights to patients free from discrimination and will ensure that visitors receive equal visitation privileges consistent with patient preferences.
6. Accessibility – MHS will ensure compliance with regulations established by the Americans with Disabilities Act of 1990 with respect to accessibility to MHS facilities. MHS will perform continual monitoring of facilities for location identification, and condition of signage, door operation, parking, ramps, and restrooms. Access features will include:
    - Convenient off-street parking designated specifically for disabled persons.
    - Curb cuts and ramps between parking areas and buildings.
    - Level access into first floor level with elevator access to all other floors.
    - Fully accessible offices, meeting rooms, restrooms, public waiting areas, cafeteria,

patient treatment areas, including examining rooms and patient wards.

- A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, blind, deaf-blind, low vision or with other sensory impairments. There is no additional charge for such aids.

7. Provision of Services – MHS workforce will determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment on the basis of age, race, color, creed, national origin, ethnicity, immigration status, religion, marital status, sex, sexual orientation, gender identity or expression, disability, citizenship, medical condition, or any other basis prohibited by federal, state, or local law.

   If any MHS workforce member recognizes or has any reason to believe that a patient or a relative, close friend, or companion of a patient is deaf, deaf-blind, or low vision, the workforce member must advise the person that appropriate auxiliary aids and services will be provided free of charge to the Patient or Companion. Examples of auxiliary aids and services include, but are not limited to, qualified sign language interpreters, notetakers, real-time computer-aided transcription services, written materials, exchange of written notes, assistive listening devices, assistive listening systems, closed caption decoders, voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices, videotext displays; accessible electronic and information technology, Brailled materials and displays; and large print materials. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. If the MHS workforce member is the responsible health care provider, the provider must ensure that such aids and services are provided when appropriate. All other personnel should direct that person to the appropriate ADA Administrator(s) reachable at 1-888-210-3396 for Puget Sound Region, 1-855-593-0325 for Inland Northwest and 1-833-677-5786 for Yakima.

8. A person may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201
   1-800-368-1019, 800-537-7697 (TDD)
   Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

   Or with the U.S. Department of Justice Civil Rights Division through the Complaint Portal, available at https://www.ada.gov/file-a-complaint/ or by mail:

   U.S. Department of Justice
   Civil Rights Division
   950 Pennsylvania Avenue, NW

Washington, D.C. 20530
1-800-514-0301 (voice) or 1-833-610-1264 (TTY)
ada.gov

9. Compliance – MHS's Chief Compliance Officer, Privacy/Civil Rights Director or designee is responsible for coordinating compliance with this Policy. MHS has designated its Director, Privacy/Civil Rights to coordinate efforts under 1557 of the Affordable Care Act and Section 504 of the Americans with Disabilities Act.

Related Policies:

Policy on Compliance with the Americans With Disabilities Act, Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Patient Protection and Affordable Care Act (Public Facing)

Compliance and Ethics Program, Reporting, and Investigating Concerns of Violations Patient Grievances

Patient Grievances

Equal Employment Opportunity and Employment Law

Emergency Medical Treatment and Active Labor (EMTALA), Compliance with Employee Complaint Grievance Procedure

References:

The Americans with Disabilities Act of 1990 (ADA), 42 USC §§ 12101 et seq.

Washington Law Against Discrimination, Ch. RCW 49.60.030

Washington State Human Rights Commission regulations, Ch. 16226 WAC
ADA Title III regulations, 28 CFR §§36.301 et seq.

Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116)

Section 504 of the Rehabilitation Act of 1973

Title VI of the Civil Rights Act of 1964

Age Discrimination Act of 1975

45 C.F.R. § 80 (2012) – Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964.

45 C.F.R. § 84 (2012) – Enforcement of nondiscrimination on the basis of handicap in programs or activities conducted by the Department of Health and Human Services.

45 C.F.R. § 91 (2012) – Nondiscrimination on the basis of age in programs or activities receiving Federal financial assistance from HHS.

RCW 49.60 – Discrimination – Human Rights Commission

Idaho Title 67, Chapter 59 – Idaho Human Rights Act

29 U.S.C. § 794 – Nondiscrimination under Federal grants and programs.

RCW 49.60

I.C. § 67-5909

WAC 246-341-0420(4), WAC 246-341-0420(5), WAC 246-341-0420(6)

Exhibit 6d

Patient Rights and Responsibilities Policy

Current Status: *Active* **PolicyStat ID:** *16426405*

Origination:	*09/1990*
Effective:	*08/2024*
Last Approved:	*08/2024*
Last Revised:	*08/2024*
Next Review:	*08/2027*
Owner:	*Elizabeth Cooley: Dir Revenue Regulations*
Area:	*Patient Care Services*
References:	*DOH, TJC*
Applicability:	*MultiCare Hospitals (w/o Yakima)*

Patient Rights and Responsibilities: Adults and Special Rights of Adolescents

Scope:

This procedure applies to all patients and their families within the MultiCare Health System (MHS).

This scope applies to all ambulatory and inpatient areas at MultiCare Health System. It includes Tacoma General Hospital/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, and Capital Medical Center.

Procedure Statement:

This policy establishes the MHS procedure to define patient rights by law and policy and define the procedure for providing this information to patients and families with MultiCare.

A. Patients will be provided a copy of the Patient Rights and Responsibilities brochure. This occurs on an annual basis, usually at the time of registration (or as soon as feasible), or more frequently as desired by patient and family. Brochures will be available to patients and families in registration areas.

Procedure:

The following steps are to be followed to assure that the patients and families at MHS are aware of their rights and responsibilities:

A. MultiCare staff (employed, volunteer and contracted) will support and abide by the rights of patients who seek services within MultiCare Health System.

B. Personnel responsible for admitting patients to the "inpatient" status will provide a copy of the Patient Rights and Responsibilities brochure at the time of admission (or as soon as feasible) and validate that the patient has received a copy at least yearly.

C. Directors/Managers in patient registration areas will ensure the brochure is available for patients and families.

Related Policies:

Advanced Directives: Living Will and Mental Health
Patient Grievances

Related Forms:

Patient Rights and Responsibilities Booklet # 87-9158-0c

References:

Joint Commission Standards on Patient Rights
CMS Conditions of Participation

Notes:
Scope/locations of services updated March 2017
Approved at SKRB 3/26/2018 and MHS QSSC 4/10/2018 to apply to Covington Medical Center
Approved by MHS QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Council / Committee / Director or AVP level Approvals	Michelle Bowers: QM System Project Analyst Sr	11/2024
	Cassie Stokes: Dir Revenue Cycle Policy	08/2024

Applicability

MultiCare Auburn Medical Center, MultiCare Capital Medical Center, MultiCare Covington Medical Center, MultiCare Deaconess Hospital, MultiCare Good Samaritan Hospital, MultiCare Mary Bridge Childrens Hospital, MultiCare Tacoma General/Allenmore Hospitals, MultiCare Valley Hospital

Exhibit 6e
Patient End of Life Policy

Status **Active** PolicyStat ID **14080940**

Origination	03/2009
Last Approved	07/2023
Effective	07/2023
Last Revised	07/2023
Next Review	07/2026

Owner	Janine Siegel: Bioethicist
Area	Ethics, Rights and Responsibilities
Applicability	All Hospitals + Yakima + Ambulatory
References	DOH

Death with Dignity (AID in Dying) (I-1000)

Scope:

This is a system policy applicable to all MultiCare Health System (MHS) hospitals and facilities. It includes Allenmore Hospital, Auburn Medical Center, Capital Medical Center, Covington Medical Center, Deaconess Medical Center, Good Samaritan Hospital, Mary Bridge Children's Hospital, Tacoma General, Valley Hospital, Yakima Memorial Hospital, all ambulatory areas, and MultiCare Home Health & Hospice.

Note: For Mary Bridge Children's Hospital the patient must be 18 years and older.

Definitions:

Act means Washington's Death with Dignity Act, codified at RCW 70.245.010 et seq.

Attending Qualified Medical Provider means the qualified medial provider who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

Consulting Qualified Medical Provider means a qualified medical provider who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

Life Ending Medications means medications prescribed to a Qualified Patient under the Act for self-administration by the Qualified Patient for the purpose of ending his or her life in accordance with the Act.

Qualified Medical Provider includes physician, physician assistant, and advanced registered nurse practitioner.

Qualified Patient means a patient who meets all of the criteria under the Act and who has performed all of the requisite steps required under the Act in order to obtain a prescription for Life Ending Medications pursuant to the Act.

Social Work/Case Manager means the assigned social worker, care manager, hospice team member or other department providing substantially similar service or support to the patient.

Policy Statement:

MHS acknowledges the rights and responsibilities under the Washington Death with Dignity Act ("Act") also known as Initiative 1000. This policy outlines MHS participation under the Act.

A. MHS Qualified Medical Providers and other Clinical Staff are expected to respond to questions about Death with Dignity with respect and compassion. No Patient will be denied other medical care or treatment because of the Patient's participation under the Act.

B. Qualified Patients, as defined in the Act, may not ingest Life Ending Medications at any MHS hospital, medical center, or facility.

C. MHS pharmacies will not fill prescriptions for Life Ending Medications prescribed under the Act.

D. Members of the Medical Staffs of any MHS hospital and other Qualified Medical Providers employed by MHS may counsel their Patients about the Act.

E. Members of the Medical Staffs of any MHS hospital or hospice, and any other Qualified Medical Provider employed by MHS, may serve in the role of Attending or Consulting Qualified Medical provider as defined by and in accordance with the Act, provided they do not facilitate delivery or ingestion of Life Ending Medications within any MHS hospital or facility.

F. MHS Employees and Qualified Medical Providers are allowed to make their own individual decisions regarding their level of participation in working directly with Qualified Patients who choose to participate in the Act. Those that choose to participate should know and understand the requirements of the Act.

G. All Qualified Medical Providers employed by MHS who choose to participate in activities under the Act should be familiar with the reporting and documentation obligations under the Act. Forms for Patients and Providers are located here: https://doh.wa.gov/data-and-statistical-reports/health-statistics/death-dignity-act/forms-patients-and-providers

Home Health & Hospice Provisions

A. Home Health & Hospice personnel will provide all ordinary care routinely delivered to patients at home regardless of their participation in the Act.

B. Home Health & Hospice personnel may discuss Death with Dignity/Medical Aid in Dying as a treatment option for terminally ill Patients and provide resources about dispensing pharmacies and participating physicians.

C. Home Health & Hospice personnel may, at their option, serve as witnesses for Qualified Patients who elect Death with Dignity/Medical Aid in Dying.

D. Home Health & Hospice personnel **may not**:

1. Facilitate the physical delivery of Life Ending Medications to a Qualified Patient's residence, or
2. Assist Qualified Patients in managing their Initiative 1000 prescriptions, or
3. Assist Qualified Patients in ingesting Life Ending Medications.

Rights and Responsibilities:

A. Patients who have questions about the Act or their rights under the Act should be directed to Social Work or the patient's Qualified Medical Provider.

B. Social Work, in coordination with Care Management and other members of the care team, will provide Patients who request information about the Act with resource materials appropriate to their inquiry.

C. Qualified Patients who desire to ingest Life Ending Medications at any MHS hospital will be informed that they cannot do so while admitted to the hospital and that staff will not aid or assist any Patients in undertaking acts to end their life in the acute care setting.

1. If they wish to proceed prior to their planned discharge from the hospital, they will be advised of the need for discharge and transfer or transport to another suitable location.
2. Reasonable steps will be taken to accommodate the Qualified Patient's desire for early discharge and transfer or transport, subject to approval by their Attending Qualified Medical Provider (unless the Patient insists upon leaving against medical advice) and after the Patient has consented to such transfer or transport.

D. The appropriate House Supervisor or Manager on Duty will be notified in the event of any attempt on the part of a Qualified Medical Provider, Patient, Family Member or Surrogate to allow or enable a Qualified Patient to take Life Ending Medications prescribed under the Act while admitted to the hospital.

References:

Compassion & Choices of WA accessed 7.24.2023 from https://www.compassionandchoices.org/in-your-state/washington/for-patients

The WA Death With Dignity Act, RCW 70.245 accessed 7.24.2023 from https://apps.leg.wa.gov/rcw/default.aspx?cite=70.245&full=true

WA Administrative Code Death with Dignity Act Requirements Title 246 accessed 7.24.2023 from: https://app.leg.wa.gov/wac/default.aspx?cite=246-978

WA State DOH Forms for Patients and Providers Death with Dignity Act accessed 7.24.2023 from https://doh.wa.gov/data-and-statistical-reports/health-statistics/death-dignity-act/forms-patients-and-providers

Notes:
7/17 Added Covington Medical Center to the scope
2/20 Added Home Health and Hospice to the scope
Approved by MHS QSSC March 2022 to apply to Capital Medical Center

Attachments

1: Initiative 1000 – Death with Dignity Summary of I-1000 Documentation Requirements for Providers Who Elect to Participate

Approval Signatures

Step Description	Approver	Date
Council / Committee Approvals	Michelle Bowers: QM System Project Analyst Sr	07/2023
Policy Coordinator	Michelle Bowers: QM System Project Analyst Sr	07/2023
	Janine Siegel: Bioethicist	07/2023

Standards

No standards are associated with this document

Exhibit 6f

Reproductive Health Policy

Status **Active** PolicyStat ID **15270807**

Origination	01/2024	Owner	William Robertson: CEO
Last Approved	01/2024	Area	Administrative
Effective	01/2024	Applicability	MultiCare System-Wide
Last Revised	01/2024		
Next Review	01/2027		

Reproductive Health - Pregnancy Terminations

Scope:

This policy applies to all MultiCare locations and to all MultiCare clinicians. This policy applies to all inpatient areas at MultiCare Health System. It includes Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Capital Medical Center,Deaconess Hospital, Tacoma General Hospital /Allenmore Hospital, Valley Hospital and all ambulatory areas.

Policy Statement:

Washington State has declared that “every individual possesses a fundamental right of privacy with respect to personal reproductive decisions [and] it is the public policy of the state of Washington that: …Every pregnant individual has the fundamental right to choose or refuse to have an abortion …prior to viability of the fetus or to protect the pregnant individual’s life or health.” RCW 9.02.100, 9.02.110.

The federal Department of Health & Human Services has reinforced the applicability of EMTALA to pregnant individuals who present to the emergency department. Through CMS guidance, the agency stated that an “emergency medical condition” for pregnant individuals may include ectopic pregnancy, complications of pregnancy loss, and emergent hypotensive disorders, among other conditions. Abortion may be the necessary stabilizing treatment for such condition and must be provided to the patient regardless of state law. www.cms.gov/files/document/qso-22-22-hospitals.pdf.

Special Instructions:

A. When a medical interruption of pregnancy occurs such that the pregnancy is highly unlikely to result in a viable infant, the pregnancy is considered a risk to the pregnant individual’s life or health.

B. MultiCare supports our community partners who provide pregnant individuals with access to

abortion and other health care. MultiCare will continue to refer patients to these community providers. If, from a patient safety or clinical capabilities perspective, a MultiCare hospital or other clinical facility is the most appropriate setting for a surgical abortion procedure, then MultiCare will provide access to the necessary care.

Procedure:

1. A health care provider acting within the provider's scope of practice shall make a good faith judgment as to the viability of the fetus or as to the risk to life or health of a pregnant individual when caring for a pregnant individual. RCW 9.02.110, 9.02.130. MultiCare may provide elective or medically indicated terminations of pregnancy or may refer patients to community providers.

2. A provider who objects to the performance of an abortion is not required by MultiCare to participate in the procedure and such decision is without consequences to employment or professional privileges. RCW 9.02.150.

3. The patient is required to give informed consent prior to commencement of the procedure. A minor pregnant individual does not require parental consent. Consent is not required from an individual claiming parentage of the fetus.

Definitions:

Abortion: Any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth. RCW 9.02.170.

"Reproductive health care services" means all services, care, or products of a medical, surgical, psychiatric, therapeutic, mental health, behavioral health, diagnostic, preventative, rehabilitative, supportive, counseling, referral, prescribing, or dispensing nature relating to the human reproductive system including, but not limited to, all services, care, and products relating to pregnancy, assisted reproduction, contraception, miscarriage management, or the termination of a pregnancy, including self-managed terminations. Reproductive health care services are a "protected health care service" in Washington state. RCW 7.115.010.

Viability: The point in the pregnancy when, in the judgment of the physician on the particular facts of the case, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measure. RCW 9.02.170.

Medical Management: When a pregnancy is highly likely to result in fetal demise, a pregnancy carries risks to the life or health of the pregnant individual.

Fetal Death: Any product of conception that shows no evidence of life (breathing, heartbeat, pulsation of the umbilical cord, or definite movement of voluntary muscles) after complete expulsion or extraction from its mother.

Related Forms:

Informed Consent (form #88-0134-2)

References:

RCW 9.02, 7.115.
www.cms.gov/files/document/qso-22-22-hospitals.pdf

Approved by CEO Council-1/4/2024

Approval Signatures

Step Description	Approver	Date
Site Administrator	Michelle Bowers: QM System Project Analyst Sr	02/2024

Applicability

MultiCare All Policies Site-View Only, MultiCare Ambulatory, MultiCare Auburn Medical Center, MultiCare Behavioral Health Network, MultiCare Capital Medical Center, MultiCare Covington Medical Center, MultiCare Deaconess Hospital, MultiCare Good Samaritan Hospital, MultiCare Laboratories, MultiCare Mary Bridge Childrens Hospital, MultiCare Tacoma Gen/Allenmore (System-wide), MultiCare Valley Hospital

Standards

No standards are associated with this document

Exhibit 7

Pro Forma Financials

MultiCare Tacoma General Pro Forma
Income Statement (Entire Hospital)

Historical + Without the Project

	2024	May 2025 Annualized	2026	2027	2028	2029
PATIENT SERVICE REVENUES:						
HB Inpatient	$1,647,647,640	$1,716,543,164	$1,716,543,164	$1,716,543,164	$1,716,543,164	$1,716,543,164
HB Outpatient	$2,296,024,833	$2,406,582,862	$2,406,582,862	$2,406,582,862	$2,406,582,862	$2,406,582,862
PB Outpatient	$18,846,381	$19,517,826	$19,517,826	$19,517,826	$19,517,826	$19,517,826
Other	$0	$0	$0	$0	$0	$0
TOTAL	$3,962,518,854	$4,142,643,853	$4,142,643,853	$4,142,643,853	$4,142,643,853	$4,142,643,853
DEDUCTIONS FROM REVENUES:						
Contractual Adjustments	$2,797,398,069	$2,918,353,680	$2,918,353,680	$2,918,353,680	$2,918,353,680	$2,918,353,680
Charity Care	$70,053,758	$64,048,775	$64,048,775	$64,048,775	$64,048,775	$64,048,775
Provision for Bad Debts	$21,498,846	$9,907,535	$9,907,535	$9,907,535	$9,907,535	$9,907,535
TOTAL	$2,888,950,673	$2,992,309,990	$2,992,309,990	$2,992,309,990	$2,992,309,990	$2,992,309,990
NET PATIENT SERVICE REVENUE	$1,073,568,180	$1,150,333,863	$1,150,333,863	$1,150,333,863	$1,150,333,863	$1,150,333,863
OTHER OPERATING REVENUE	$5,150,613	$7,164,720	$7,164,720	$7,164,720	$7,164,720	$7,164,720
TOTAL OPERATING REVENUE	$1,078,718,794	$1,157,498,583	$1,157,498,583	$1,157,498,583	$1,157,498,583	$1,157,498,583
OPERATING EXPENSES						
Salaries and Wages	$297,344,647	$346,703,731	$346,703,731	$346,703,731	$346,703,731	$346,703,731
Employee Benefits	$64,407,744	$78,044,431	$78,044,431	$78,044,431	$78,044,431	$78,044,431
Supplies	$218,893,112	$264,806,077	$264,806,077	$264,806,077	$264,806,077	$264,806,077
Professional Fees	$48,403,977	$53,688,835	$53,688,835	$53,688,835	$53,688,835	$53,688,835
Purchased Services	$71,409,943	$136,173,511	$136,173,511	$136,173,511	$136,173,511	$136,173,511
Other Operating Costs	$74,812,332	$78,791,186	$78,791,186	$78,791,186	$78,791,186	$78,791,186
Lease & Rental Fees	$6,654,385	$8,184,043	$8,184,043	$8,184,043	$8,184,043	$8,184,043
Interest	$16,558,929	$14,286,271	$14,286,271	$14,286,271	$14,286,271	$14,286,271
Depreciation & Amort.	$20,557,985	$22,568,764	$22,568,764	$22,568,764	$22,568,764	$22,568,764
TOTAL	$819,043,055	$1,003,246,847	$1,003,246,847	$1,003,246,847	$1,003,246,847	$1,003,246,847
INCOME/(LOSS) FROM OPERATIONS	$259,675,739	$154,251,736	$154,251,736	$154,251,736	$154,251,736	$154,251,736
Corporate Services	$212,992,659	$58,449,493	$58,449,493	$58,449,493	$58,449,493	$58,449,493
OPERATING MARGIN	$46,683,080	$95,802,242	$95,802,242	$95,802,242	$95,802,242	$95,802,242

Forecast assumptions: 2025 based on May 2025 YTD annualized; 2026 through 2029 based on annualized May 2025 YTD amount, held constant

MultiCare Tacoma General Pro Forma
Income Statement (Project Only Increment)

Project Only

	2026	2027	2028	2029
PATIENT SERVICE REVENUES:				
HB Inpatient	$26,453,700	$152,252,100	$164,537,100	$164,537,100
HB Outpatient	$0	$0	$0	$0
PB Outpatient	$0	$0	$0	$0
Other	$0	$0	$0	$0
TOTAL	$26,453,700	$152,252,100	$164,537,100	$164,537,100
DEDUCTIONS FROM REVENUES:				
Contractual Adjustments	$18,811,533	$108,268,233	$117,004,239	$117,004,239
Charity Care	$412,762	$2,375,618	$2,567,303	$2,567,303
Provision for Bad Debts	$63,650	$366,334	$395,893	$395,893
TOTAL	$19,287,945	$111,010,185	$119,967,435	$119,967,435
NET PATIENT SERVICE REVENUE	$7,165,755	$41,241,915	$44,569,665	$44,569,665
OTHER OPERATING REVENUE	$0	$0	$0	$0
TOTAL OPERATING REVENUE	$7,165,755	$41,241,915	$44,569,665	$44,569,665
OPERATING EXPENSES				
Salaries and Wages	$1,413,025	$6,773,029	$7,419,536	$7,419,536
Employee Benefits	$318,072	$1,524,609	$1,670,138	$1,670,138
Supplies	$713,688	$4,107,574	$4,439,008	$4,439,008
Professional Fees	$157,806	$908,239	$981,523	$981,523
Purchased Services	$232,873	$1,340,283	$1,448,429	$1,448,429
Other Operating Costs	$307,127	$1,403,355	$1,516,590	$1,516,590
Lease & Rental Fees	$21,644	$124,568	$134,619	$134,619
Interest	$0	$0	$0	$0
Depreciation & Amort.	$77,523	$310,093	$310,093	$310,093
TOTAL	$3,241,758	$16,491,749	$17,919,935	$17,919,935
INCOME/(LOSS) FROM OPERATIONS	$3,923,997	$24,750,166	$26,649,730	$26,649,730
Corporate Services	$358,288	$2,062,096	$2,228,483	$2,228,483
OPERATING MARGIN	$3,565,709	$22,688,070	$24,421,247	$24,421,247

MultiCare Tacoma General Pro Forma
Revenue Assumptions (Project Only)

Utilization	Assumption
Admits	See utilization forecast
Patient Days	See utilization forecast
Average Daily Census (ADC)	See utilization forecast

Payer	Payer Mix (Admits)	Payer Mix (Gross Revenue)
Commercial	26.0%	28.9%
Medicare	44.0%	44.8%
Medicaid	24.7%	21.0%
Self Pay	1.4%	1.8%
Other Government	3.9%	3.5%
Total	100.0%	100.0%

Revenue Sources and Adjustments	Assumption
Gross Revenue	$81,900.00/admit based on 2024 average of total charges across adult (less psychiatric) inpatient admissions
Contractual adjustments	Projected at 71.11% of gross revenues, estimated based on 2024 average difference between Gross Revenues and Revenues Net Contractuals.
Charity Care	Projected at 1.56% of gross revenues based on May 2025 YTD ratio of Charity Care to Gross Revenue.
Bad Debt	Projected at 0.24% of gross revenues based on May 2025 YTD ratio of Bad Debt to Gross Revenue.

MultiCare Tacoma General Pro Forma
Expense Assumptions (Project Only)

Category/Item	Assumption (Project Only Forecasted Years)
Staffing Costs	
Salaries and Wages	Based on FTE schedule and historical compensation per FTE.
Employee Benefits	22.51% of Salaries and Wages, consistent with May 2025 YTD ratio of benefits to salaries and wages.
Other Expenses	
Non-Salary, Wage, and Benefits Expenses (Non-SWB)	Non-salary and wage expense includes Supplies, Professional Fees, Purchased Services, Other Operating Costs, and Lease & Rental Fees. Estimated to equal in aggregate $4,241 per admit based on 2024 average of total non-salary and wage direct expenses associated with adult inpatient (less psychiatric) admissions.
Supplies	Estimated to equal 52.10% of Non-SWB expenses based on 2024 distribution.
Professional Fees	Estimated to equal 11.52% of Non-SWB expenses based on 2024 distribution.
Purchased Services	Estimated to equal 17.00% of Non-SWB expenses based on 2024 distribution.
Other Operating Costs	Estimated to equal 17.80% of Non-SWB expenses based on 2024 distribution. For the 2026 partial year, these expenses also include an additional $63,295 in non-capitalized labor costs associated with the proposed project.
Lease & Rental Fees	Estimated to equal 1.58% of Non-SWB expenses based on 2024 distribution.
Interest	Project related interest; See Amortization and Depreciation Table
Depreciation & Amort.	Project related depreciation and amortization; See Amortization and Depreciation Table
Corporate Services	5.00% of Net Revenue based on Tacoma General May 2025 YTD amount rounded to the nearest decimal

MultiCare Tacoma General Pro Forma
Income Statement (Entire Hospital)

With the Project

	2026	2027	2028	2029
PATIENT SERVICE REVENUES:				
HB Inpatient	$1,742,996,864	$1,868,795,264	$1,881,080,264	$1,881,080,264
HB Outpatient	$2,406,582,862	$2,406,582,862	$2,406,582,862	$2,406,582,862
PB Outpatient	$19,517,826	$19,517,826	$19,517,826	$19,517,826
Other	$0	$0	$0	$0
TOTAL	$4,169,097,553	$4,294,895,953	$4,307,180,953	$4,307,180,953
DEDUCTIONS FROM REVENUES:				
Contractual Adjustments	$2,937,165,213	$3,026,621,913	$3,035,357,919	$3,035,357,919
Charity Care	$64,461,537	$66,424,393	$66,616,078	$66,616,078
Provision for Bad Debts	$9,971,185	$10,273,869	$10,303,427	$10,303,427
TOTAL	$3,011,597,935	$3,103,320,175	$3,112,277,425	$3,112,277,425
NET PATIENT SERVICE REVENUE	$1,157,499,618	$1,191,575,778	$1,194,903,528	$1,194,903,528
OTHER OPERATING REVENUE	$7,164,720	$7,164,720	$7,164,720	$7,164,720
TOTAL OPERATING REVENUE	$1,164,664,338	$1,198,740,498	$1,202,068,248	$1,202,068,248
OPERATING EXPENSES				
Salaries and Wages	$348,116,756	$353,476,759	$354,123,267	$354,123,267
Employee Benefits	$78,362,503	$79,569,039	$79,714,568	$79,714,568
Supplies	$265,519,765	$268,913,651	$269,245,085	$269,245,085
Professional Fees	$53,846,641	$54,597,074	$54,670,358	$54,670,358
Purchased Services	$136,406,384	$137,513,794	$137,621,940	$137,621,940
Other Operating Costs	$79,098,313	$80,194,541	$80,307,776	$80,307,776
Lease & Rental Fees	$8,205,686	$8,308,610	$8,318,661	$8,318,661
Interest	$14,286,271	$14,286,271	$14,286,271	$14,286,271
Depreciation & Amort.	$22,646,287	$22,878,857	$22,878,857	$22,878,857
TOTAL	$1,006,488,606	$1,019,738,597	$1,021,166,783	$1,021,166,783
INCOME/(LOSS) FROM OPERATIONS	$158,175,733	$179,001,901	$180,901,466	$180,901,466
Corporate Services	$58,807,781	$60,511,589	$60,677,977	$60,677,977
OPERATING MARGIN	$99,367,951	$118,490,312	$120,223,489	$120,223,489

MultiCare Tacoma General Pro Forma
Balance Sheet (Entire Hospital)

HISTORICAL + Combined Balance Sheet

Year	2024	2025	2026	2027	2028	2029
ASSETS						
CURRENT ASSETS:						
Cash and equivalents	(1,045,697,198)	(827,071,093)	(659,599,630)	(458,650,652)	(270,049,644)	(79,003,065)
Accounts Receivable	222,581,954	235,052,477	236,553,453	243,691,220	243,720,540	244,388,267
Other receivables	3,708,761	4,377,153	4,377,153	4,377,153	4,365,194	4,377,153
Inventories	18,751,155	45,227,195	45,349,088	45,928,742	45,985,349	45,985,349
Prepaid expenses	3,350,249	18,212,619	18,260,178	18,470,590	18,490,618	18,490,618
Total Current Assets	**(797,305,079)**	**(524,201,649)**	**(355,059,757)**	**(146,182,946)**	**42,512,057**	**234,238,322**
PROPERTY, PLANT AND EQUIPMENT:						
Land	7,581,710	7,581,710	7,581,710	7,581,710	7,581,710	7,581,710
Land Improvements	4,702,752	3,898,871	-	-	-	-
Buildings	651,303,248	517,928,373	519,680,109	519,680,109	519,680,109	519,680,109
Equipment	236,321,414	235,046,287	1,226,810	-	-	-
Capital Clearing Suspense	695,772	327,576	327,576	327,576	327,576	327,576
Total Property, Plant and Equipment	**900,604,895**	**764,782,818**	**528,816,205**	**527,589,395**	**527,589,395**	**527,589,395**
Less: Accumulated Depreciation	(554,354,361)					
Net Property, Plant and Equipment	**346,250,534**	**764,782,818**	**528,816,205**	**527,589,395**	**527,589,395**	**527,589,395**
Construction in progress	14,507,920	23,054,040	-	-	-	-
Total Property, Plant and Equipment, Net	**360,758,454**	**787,836,857**	**528,816,205**	**527,589,395**	**527,589,395**	**527,589,395**
Total Other Assets	**2,584,189,842**	**3,124,045,810**	**3,124,045,810**	**3,124,045,810**	**3,124,045,810**	**3,124,045,810**
TOTAL ASSETS	**2,147,643,218**	**3,387,681,019**	**3,297,802,258**	**3,505,452,259**	**3,694,147,262**	**3,885,873,528**
LIABILITIES						
Accounts payable and accrued expenses	47,401,375	59,165,359	59,319,860	60,003,403	59,904,343	60,068,465
Accrued compensation and related benefits	318,677,106	398,053,030	399,675,329	405,829,167	405,460,573	406,571,424
Patient refunds payable	11,536,658	11,314,648	11,314,648	11,314,648	11,314,648	11,314,648
Estimated third party settlements	1,400,000	1,487,070	1,496,672	1,541,832	1,542,018	1,546,243
Total Current Liabilities	**379,015,139**	**470,020,107**	**471,806,509**	**478,689,051**	**478,221,582**	**479,500,779**
NET ASSETS:						
Net Assets without donor restrictions	1,768,628,079	2,917,660,912	2,825,995,749	3,026,763,208	3,215,925,680	3,406,372,748
Total Net Assets	**1,768,628,079**	**2,917,660,912**	**2,825,995,749**	**3,026,763,208**	**3,215,925,680**	**3,406,372,748**
TOTAL LIABILITIES & NET ASSETS	**2,147,643,218**	**3,387,681,019**	**3,297,802,258**	**3,505,452,259**	**3,694,147,262**	**3,885,873,528**

MultiCare Tacoma General Pro Forma
Staffing (Entire Hospital)

FTE Schedule — **Historical + W/O Project**

	2024	2025*	2026	2027	2028	2029
Productive FTEs						
ARNP/PA	10.42	7.00	7.00	7.00	7.00	7.00
CNA/MA	198.24	211.13	211.13	211.13	211.13	211.13
Other	116.85	146.88	146.88	146.88	146.88	146.88
LPN	37.96	36.63	36.63	36.63	36.63	36.63
Management	44.62	49.02	49.02	49.02	49.02	49.02
Physician	8.23	5.54	5.54	5.54	5.54	5.54
Professional	96.46	94.10	94.10	94.10	94.10	94.10
Resident	27.74	32.36	32.36	32.36	32.36	32.36
RN	768.60	813.45	813.45	813.45	813.45	813.45
Service/Maintenance	229.62	435.02	435.02	435.02	435.02	435.02
Supervision	68.12	84.03	84.03	84.03	84.03	84.03
Technical	347.64	447.77	447.77	447.77	447.77	447.77
Contract Labor	158.83	129.87	129.87	129.87	129.87	129.87
Total Productive FTEs	2,113.33	2,492.80	2,492.80	2,492.80	2,492.80	2,492.80
Non-Productive FTEs						
Bereavement	4.04	5.32	5.32	5.32	5.32	5.32
Education	21.59	26.44	26.44	26.44	26.44	26.44
Orientation	49.75	42.59	42.59	42.59	42.59	42.59
Extended Illness (EIT)	30.40	32.81	32.81	32.81	32.81	32.81
Jury Duty	0.42	0.67	0.67	0.67	0.67	0.67
Other Non-Productive	5.18	6.12	6.12	6.12	6.12	6.12
Paid Time Off (PTO)	200.09	246.07	246.07	246.07	246.07	246.07
Vacation	1.00	0.38	0.38	0.38	0.38	0.38
Sick Leave	5.04	5.08	5.08	5.08	5.08	5.08
Total Non-Productive FTEs	317.50	365.46	365.46	365.46	365.46	365.46
Total FTEs	2,430.83	2,858.26	2,858.26	2,858.26	2,858.26	2,858.26

*Annualized

MultiCare Tacoma General Pro Forma
Staffing (Entire Hospital)

Wage & Salary Schedule — Historical + W/O Project

	2024	2025*	2026	2027	2028	2029
Productive Costs						
ARNP/PA	1,614,971	1,314,884	1,314,884	1,314,884	1,314,884	1,314,884
CNA/MA	12,114,339	12,873,223	12,873,223	12,873,223	12,873,223	12,873,223
Other	7,313,248	11,180,813	11,180,813	11,180,813	11,180,813	11,180,813
LPN	3,347,355	3,295,688	3,295,688	3,295,688	3,295,688	3,295,688
Management	9,211,746	9,708,654	9,708,654	9,708,654	9,708,654	9,708,654
Physician	5,257,147	5,181,197	5,181,197	5,181,197	5,181,197	5,181,197
Professional	13,344,910	13,517,369	13,517,369	13,517,369	13,517,369	13,517,369
Resident	3,064,489	3,597,760	3,597,760	3,597,760	3,597,760	3,597,760
RN	113,653,543	126,351,408	126,351,408	126,351,408	126,351,408	126,351,408
Service/Maintenance	14,976,961	29,830,408	29,830,408	29,830,408	29,830,408	29,830,408
Supervision	9,061,275	10,984,003	10,984,003	10,984,003	10,984,003	10,984,003
Technical	35,080,617	50,088,991	50,088,991	50,088,991	50,088,991	50,088,991
Contract Labor	25,116,825	21,029,371	21,029,371	21,029,371	21,029,371	21,029,371
Total Productive Salaries	253,157,425	298,953,770	298,953,770	298,953,770	298,953,770	298,953,770
Non-Productive Costs						
Bereavement	415,951	540,978	540,978	540,978	540,978	540,978
Education	2,448,309	2,794,850	2,794,850	2,794,850	2,794,850	2,794,850
Orientation	4,657,496	4,312,782	4,312,782	4,312,782	4,312,782	4,312,782
Extended Illness (EIT)	3,152,200	3,743,190	3,743,190	3,743,190	3,743,190	3,743,190
Jury Duty	47,508	71,910	71,910	71,910	71,910	71,910
Other Non-Productive	11,323,571	6,567,460	6,567,460	6,567,460	6,567,460	6,567,460
Paid Time Off (PTO)	22,435,953	27,627,118	27,627,118	27,627,118	27,627,118	27,627,118
Vacation	291,391	339,506	339,506	339,506	339,506	339,506
Sick Leave	478,179	525,932	525,932	525,932	525,932	525,932
Total Non-Productive Costs	45,250,558	46,523,725	46,523,725	46,523,725	46,523,725	46,523,725
Allocated Salaries	-	1,226,235	1,226,235	1,226,235	1,226,235	1,226,235
Total Salaries	298,407,984	346,703,731	346,703,731	346,703,731	346,703,731	346,703,731

*Annualized

MultiCare Tacoma General Pro Forma
Staffing (Project Only Increment)

FTE Schedule — Project Only

	2026	2027	2028	2029
Productive FTEs				
ARNP/PA				
CNA/MA	12.60	16.80	16.80	16.80
Other				
LPN				
Management	1.00	1.00	1.00	1.00
Physician				
Professional				
Resident				
RN	23.10	28.35	32.55	32.55
Service/Maintenance				
Assistant Nurse Manager	3.52	3.52	3.52	3.52
Technical	2.10	2.10	2.10	2.10
Contract Labor				
Total Productive FTEs	42.32	51.77	55.97	55.97
Non-Productive FTEs				
Bereavement	0.09	0.12	0.12	0.12
Education	0.45	0.55	0.60	0.60
Orientation	0.73	0.90	0.97	0.97
Extended Illness (EIT)	0.57	0.69	0.75	0.75
Jury Duty	0.01	0.02	0.02	0.02
Other Non-Productive	0.11	0.13	0.14	0.14
Paid Time Off (PTO)	4.23	5.17	5.59	5.59
Vacation	0.01	0.01	0.01	0.01
Sick Leave	0.09	0.11	0.12	0.12
Total Non-Productive FTEs	6.28	7.68	8.31	8.31
Total FTEs	48.60	59.45	64.28	64.28

*Annualized

MultiCare Tacoma General Pro Forma
Staffing (Project Only Increment)

Wage & Salary Schedule — Project Only

	2026	2027	2028	2029
Productive Costs				
ARNP/PA				
CNA/MA	188,922	998,776	998,776	998,776
Other				
LPN				
Management	41,829	167,315	167,315	167,315
Physician				
Professional				
Resident				
RN	834,287	4,056,447	4,631,888	4,631,888
Service/Maintenance				
Assistant Nurse Manager	138,060	552,240	552,240	552,240
Technical	31,788	127,151	127,151	127,151
Contract Labor				
Total Productive Salaries	1,234,885	5,901,929	6,477,370	6,477,370
Non-Productive Costs				
Bereavement	2,594	12,691	13,720	13,720
Education	12,449	60,916	65,858	65,858
Orientation	20,230	98,989	107,019	107,019
Extended Illness (EIT)	15,561	76,145	82,322	82,322
Jury Duty	346	1,692	1,829	1,829
Other Non-Productive	2,939	14,383	15,550	15,550
Paid Time Off (PTO)	116,365	569,395	615,589	615,589
Vacation	173	846	915	915
Sick Leave	2,421	11,845	12,806	12,806
Total Non-Productive Costs	173,077	846,902	915,609	915,609
Allocated Salaries	5,063	24,198	26,557	26,557
Total Salaries	1,413,025	6,773,029	7,419,536	7,419,536

*Annualized

MultiCare Tacoma General Pro Forma
Staffing (Entire Hospital)

FTE Schedule — With the Project

	2026	2027	2028	2029
Productive FTEs				
ARNP/PA	7.00	7.00	7.00	7.00
CNA/MA	223.73	227.93	227.93	227.93
Other	146.88	146.88	146.88	146.88
LPN	36.63	36.63	36.63	36.63
Management	50.02	50.02	50.02	50.02
Physician	5.54	5.54	5.54	5.54
Professional	94.10	94.10	94.10	94.10
Resident	32.36	32.36	32.36	32.36
RN	836.55	841.80	846.00	846.00
Service/Maintenance	435.02	435.02	435.02	435.02
Supervision	87.55	87.55	87.55	87.55
Technical	449.87	449.87	449.87	449.87
Contract Labor	129.87	129.87	129.87	129.87
Total Productive FTEs	2,535.12	2,544.57	2,548.77	2,548.77
Non-Productive FTEs				
Bereavement	5.41	5.43	5.44	5.44
Education/Orientation	26.89	26.99	27.03	27.03
Extended Illness (EIT)	33.54	33.71	33.78	33.78
Jury Duty	1.23	1.36	1.41	1.41
Other Non-Productive	6.13	6.13	6.13	6.13
Paid Time Off (PTO)	246.18	246.21	246.22	246.22
Vacation	4.61	5.55	5.97	5.97
Sick Leave	5.08	5.08	5.08	5.08
Total Non-Productive FTEs	329.07	330.46	331.07	331.07
Total FTEs	2,864.19	2,875.03	2,879.84	2,879.84

*Annualized

MultiCare Tacoma General Pro Forma
Staffing (Entire Hospital)

Wage & Salary Schedule — With the Project

	2026	2027	2028	2029
Productive Costs				
ARNP/PA	1,314,884	1,314,884	1,314,884	1,314,884
CNA/MA	13,062,144	13,871,999	13,871,999	13,871,999
Other	11,180,813	11,180,813	11,180,813	11,180,813
LPN	3,295,688	3,295,688	3,295,688	3,295,688
Management	9,750,483	9,875,969	9,875,969	9,875,969
Physician	5,181,197	5,181,197	5,181,197	5,181,197
Professional	13,517,369	13,517,369	13,517,369	13,517,369
Resident	3,597,760	3,597,760	3,597,760	3,597,760
RN	127,185,695	130,407,855	130,983,296	130,983,296
Service/Maintenance	29,830,408	29,830,408	29,830,408	29,830,408
Supervision/ANM	11,122,063	11,536,243	11,536,243	11,536,243
Technical	50,120,779	50,216,142	50,216,142	50,216,142
Contract Labor	21,029,371	21,029,371	21,029,371	21,029,371
Total Productive Salaries	300,188,654	304,855,699	305,431,139	305,431,139
Non-Productive Costs				
Bereavement	543,571	553,669	554,698	554,698
Education	2,807,299	2,855,766	2,860,708	2,860,708
Orientation	4,333,012	4,411,771	4,419,801	4,419,801
Extended Illness (EIT)	3,758,751	3,819,335	3,825,512	3,825,512
Jury Duty	72,256	73,602	73,740	73,740
Other Non-Productive	6,570,399	6,581,842	6,583,009	6,583,009
Paid Time Off (PTO)	27,743,483	28,196,513	28,242,707	28,242,707
Vacation	339,679	340,352	340,420	340,420
Sick Leave	528,353	537,777	538,738	538,738
Total Non-Productive Costs	46,696,803	47,370,627	47,439,334	47,439,334
Allocated Salaries	1,231,299	1,250,433	1,252,793	1,252,793
Total Salaries	348,116,756	353,476,759	354,123,267	354,123,267

*Annualized

MultiCare Tacoma General Pro Forma
Depreciation

	Capital Expenditures	Useful Life	Monthly Depreciation
Buildout	$ 1,751,736	15	$ 9,732
Equipment	$ 1,353,171	7	$ 16,109
Capitalized Interest	$ -	15	$ -
Total Capital Costs	**$ 3,104,907**		$ 25,841

	2026	2027	2028	2029
# of Months	**3**	**12**	**12**	**12**
Buildout	$ 29,196	$ 116,782	$ 116,782	$ 116,782
Equipment	$ 48,328	$ 193,310	$ 193,310	$ 193,310
Capitalized Interest	$ -	$ -	$ -	$ -
Subtotal	**$ 77,523**	**$ 310,093**	**$ 310,093**	**$ 310,093**
Depreciation per month	$ 25,841	$ 25,841	$ 25,841	$ 25,841

Exhibit 8

Site Control Documents

Exhibit 8a

Property Summary Detail

Pierce County Assessor-Treasurer
Property Summary

315 MARTIN LUTHER KING JR WAY

TACOMA GENERAL HOSPITAL
2003210010

Tax Description

Section 32 Township 21 Range 03 Quarter 34 NEW TACOMA L 1 THRU 12 B 321 TOG/W VAC S 4TH ST & VAC ALLEY PER ORD #17841, #1704 & #22495 TOG/W S 17 FT VAC S 3RD ST PER ORD #16753 TOG/W 4 IN STRIP "K" ST ABUTT VAC PER ORD #22732 (DCPLEMS5-21-82) DCGRES3-30-83 DC6/3/96JU

Property Details

Parcel Number	2003210010
Site Address	315 MARTIN LUTHER KING JR WAY
Account Type	Real Property
Category	Land and Improvements
Use Code	6510-HOSPITAL

Taxpayer Details

Taxpayer Name	TACOMA GENERAL HOSPITAL
Mailing Address	14400 METCALF AVE OVERLAND PARK, KS 66223-2989

Appraisal Details

Neighborhood	405 / 331
Value Area	PI5
Appr Acct Type	Commercial
Business Name	TACOMA GENERAL HOSPITAL
Last Inspection	07/23/2024-New Construction
Appraisal Area	4

Related Parcels

Group Account Number	975
Located On	n/a
Associated Parcels	2006886717 2099002730 2818070635

Assessed Value

Value Year	2024	**Assessed Total**	178,395,200
Tax Year	2025	**Assessed Land**	2,145,500
		Assessed Improvements	176,249,700
Taxable Value	0		
Tax Code Area	005	**Current Use Land**	0
Tax Code Area Rate	10.862023302706	**Personal Property**	0
Notice of Value Mailing Date	06/26/2024		

Assessment Details

2024 Values for 2025 Tax

Taxable Value 0
Assessed Value 178,395,200

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**$0.00**	**$0.00**

Property Tax Exemptions

Tax Year 2025
Type Non-Profit Caregivers, Libraries
Expiration Date n/a

Land Details

Land Economic Area 2045
RTSQQ 03-21-32-34
Value Area PI5
Neighborhood 405 / 331
Square Footage 50,068
Acres 1.149
Front Foot 740
Electric Power Installed
Sewer Sewer/Septic Installed
Water Water Installed

Building 1 Details

General Characteristics

Property Type Commercial
Condition Average
Quality Good
Neighborhood 405
Occupancy Hospital
Square Feet 361,000
Net Square Feet 361,000
Attached Garage Square Feet 0
Detached Garage Square Feet 0
Carport Square Feet 0
Finished Attic Square Feet 0
Total Basement Square Feet 0
Finished Basement Square Feet 0
Basement Garage Door 0
Fireplaces 0

Built-As

DESCRIPTION	Hospital
YEAR BUILT	1983
ADJUSTED YEAR BUILT	2004
SQUARE FEET	185,000
STORIES	7
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Warm and Cool Air Zone
UNITS	0
SPRINKLER SQUARE FEET	185,000

DESCRIPTION	Hospital
YEAR BUILT	2003
ADJUSTED YEAR BUILT	2008
SQUARE FEET	176,000
STORIES	4
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Reinforced Concrete
ROOF	n/a
HVAC	Complete HVAC
UNITS	0
SPRINKLER SQUARE FEET	176,000

Sales History

Sorry, no sales available for display

Map

0 40 mi

Powered by Esri

Photos

2024_PRI_2-29-2024_20240226JN.jpg

Sketches

Sorry, no sketches available for display

Exhibit 8b
Tacoma General Zoning Map

Tacoma General Zoning Map

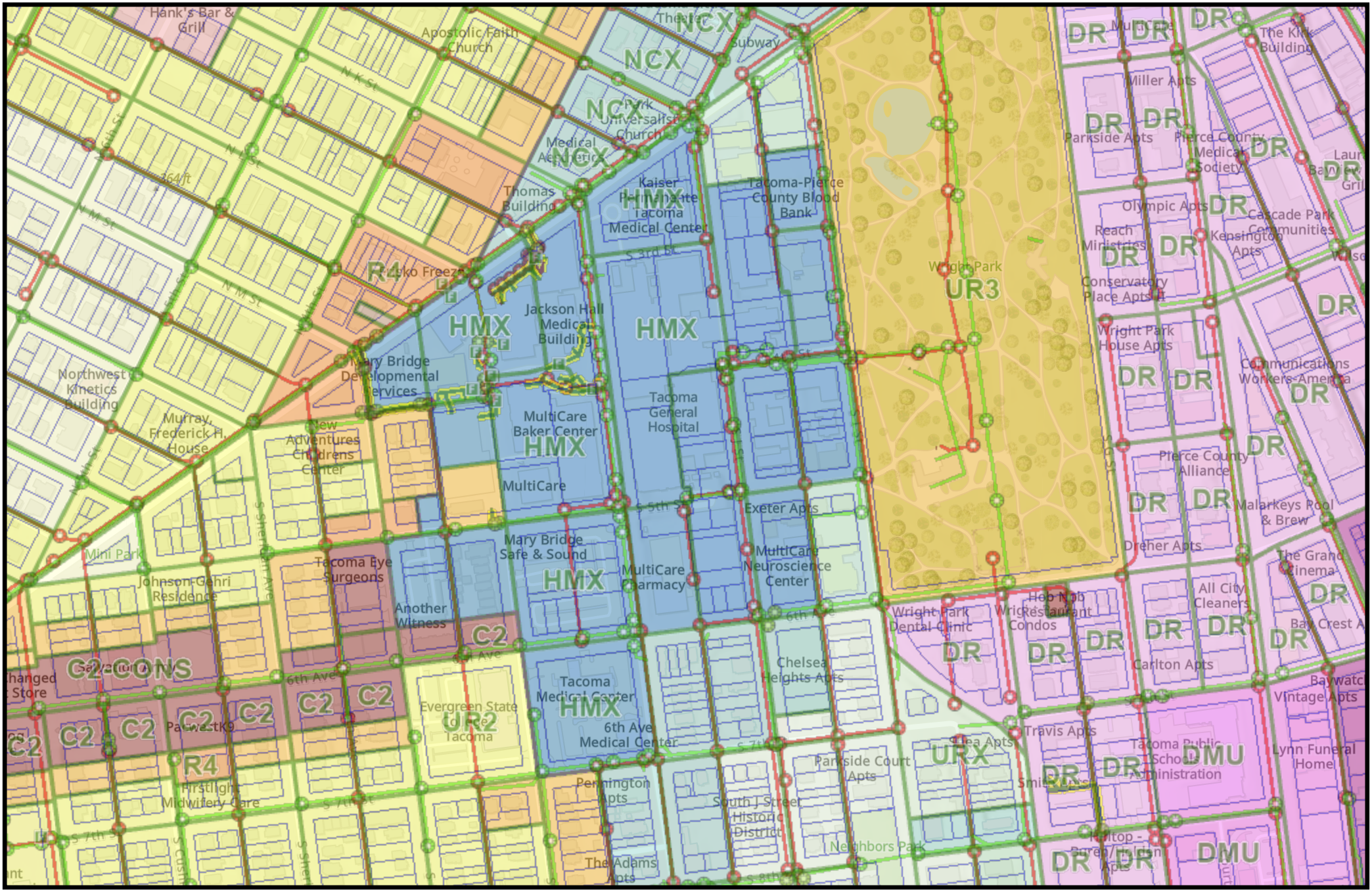


Exhibit 9
Letter of Financial Commitment

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

July 2, 2025

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

RE: MultiCare Health System Certificate of Need Request for Tacoma General 36 Beds

Dear Mr. Hernandez:

Please accept this letter as evidence of financial support for MultiCare Health System's certificate of need application request to add 36 additional acute care beds to Tacoma General Hospital, in Pierce County.

MultiCare is pleased to commit from its corporate reserves full funding for the estimated capital expenditures, working capital requirements, and costs associated with the project. MultiCare has sufficient cash reserves to fully fund the project.

Please contact me if there are any questions regarding this letter of financial commitment. I can be reached at James.g.lee@multicare.org or at 253-459-8081. Thank you for your time and assistance in this important matter.

Sincerely,

James Lee, Executive Vice President
Population Based Care & CFO
MultiCare Health System

Exhibit 10
Contractor Letter

ABBOTT CONSTRUCTION

Friday, July 18, 2025

Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Tumwater, WA 98501

Re: Certificate of Need Application
MultiCare Health Systems – Tacoma General Hospital 6th Floor Olympic Wing

To Whom It May Concern:

On behalf of Tacoma General Hospital, I am writing regarding the Certificate of Need Application for the proposed added beds for the 6th Floor of the Olympic Wing for treatment spaces in Tacoma, Washington. Below is the following cost estimate for this project base on the scope of work and design provided:

Construction Costs	**$1,285,345.00**
Washington State Sales Tax	**$132,391.00**
Total	**$1,417,736.00**

Based on our experience in the industry and working in this facility, we believe the costs are a reasonable estimate of the expected cost for construction.

Sincerely,
ABBOTT CONSTRUCTION, LLC

Matt McKeeby
Project Executive

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

SEATTLE
3408 1st Avenue South
Seattle, WA 98134 WA CL JRABBCI 022 JZ
206.467.8500 / office
206.447.1885 / fax

ABBOTTCONSTRUCTION.COM

Exhibit 11
Equipment List

MultiCare Tacoma General
Equipment List

Category	Description	Quantity	Unit Price	Total
Alarm	Alarm: Bed/Chair, Patient Exit	30	$ 255	$ 7,650
Allowance	Allowance: Monitoring/Cabling	30	$ 20	$ 600
Bed	Bed: Electric	30	$ 13,000	$ 390,000
Board	Board: White, Dry Erase	30	$ 1,200	$ 36,000
Bracket	Bracket: Computer Workstation	10	$ 1,500	$ 15,000
Bracket	Bracket: Monitor, Wall, Flat Panel	10	$ 200	$ 2,000
Cabinet, Patient Room	Cabinet, Patient Room: Bedside	30	$ 800	$ 24,000
Carts	Misc	10	$ 500	$ 5,000
Crash Cart	Includes defibrilator and suction	2	$ 22,300	$ 44,600
Chair, Interiors	Chair, Interiors: Stacking w/o Arms	60	$ 500	$ 30,000
Chair, Task	Without arms sitting height	10	$ 850	$ 8,500
Chair, Task	Standing height	4	$ 900	$ 3,600
Chair	Staff Lounge	6	$ 500	$ 3,000
Clock	Clock: Analog, Synchronized, Wireless	30	$ 200	$ 6,000
Computers	Desktop	15	$ 750	$ 11,250
Computers	Printers	2	$ 950	$ 1,900
Computers	Peripherals	15	$ 500	$ 7,500
Computers	WOWs	4	$ 1,200	$ 4,800
Curtain	Curtain: Allowance	60	$ 600	$ 36,000
Dispenser	Dispenser: Disinfectant Wipes, Wall Mount	10	$ 60	$ 600
Dispenser	Dispenser: Emesis Bag, Wall Mount	10	$ 40	$ 400
Dispenser	Dispenser: Soap, Wall Mount	5	$ 98	$ 490
Dispenser, Glove	Dispenser, Glove: Triple Box	30	$ 60	$ 1,800
Flowmeter	Flowmeter: Air, Integrated	60	$ 40	$ 2,400
Flowmeter	Flowmeter: Oxygen, Low-Flow, Integrated	60	$ 40	$ 2,400
Hamper	Hamper: Linen	30	$ 250	$ 7,500
Hovermat & Jack	Hovermat & Jack	1	$ 5,500	$ 5,500
Microwave	Microwave	1	$ 250	$ 250
Module, Physiologic	Module, Physiologic: Multi-parameter	10	$ 5,000	$ 50,000
Monitor, Physiologic	Monitor, Physiologic: Bedside	10	$ 5,000	$ 50,000
Monitor, Physiologic	Monitor, Physiologic: Transport	10	$ 5,000	$ 50,000
Nurse Call	Nurse Call: Speaker, Pillow	30	$ 350	$ 10,500
POCT	Point of Care Testing	2	$ 10,100	$ 20,200
Phones	Phones	10	$ 500	$ 5,000
Patient Lift - Motor & Sling	Patient Lift - Motor & Sling	4	$ 4,069	$ 16,276
Pyxis	Medstation - 2 drawer	1	$ 20,324	$ 20,324

MultiCare Tacoma General
Equipment List

Category	Description	Quantity	Unit Price	Total
Regulator	Regulator: Suction, Intermittent/Continuous	60	$ 500	$ 30,000
Refrigerator - full size	Refrigerator	1	$ 1,400	$ 1,400
Scale	Stand on type	2	$ 3,500	$ 7,000
Stand, IV	Stand, IV: Stainless Steel	30	$ 250	$ 7,500
Table, Overbed	Table, Overbed: General	30	$ 700	$ 21,000
Table 2'x4'	Staff Lounge	4	$ 425	$ 1,700
Warmer - Large	Blanket Warmer	1	$ 3,800	$ 3,800
Waste Can	Waste Can: 20-31 Gallon	40	$ 60	$ 2,400
Waste Disposal	Waste Disposal: Suction Canister, Wall	60	$ 20	$ 1,200
Wheel Chairs		2	$ 225	$ 450
Shipping and Freight				$ 20,000
IT/IS Services and Equipment				$ 249,320
Subtotal				$ 1,226,810
Sales Tax	10.3%			$ 126,361
Total				$ 1,353,171

Exhibit 12

MultiCare Health System Consolidated Financial Statements, 2022 to 2023

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2023 and 2022

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2800
401 Union Street
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

Report on the Audit of the Consolidated Financial Statements

Opinion

We have audited the consolidated financial statements of MultiCare Health System (the Company)(a Washington nonprofit corporation), which comprise the consolidated balance sheets as of December 31, 2023 and 2022, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2023 and 2022, and the results of its operations and its 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 Consolidated Financial Statements section of our report. We are required to be independent of the Company 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 Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the consolidated financial statements are issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated 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 consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated 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 consolidated 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 Company'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 consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company'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.

KPMG LLP

Seattle, Washington
March 20, 2024

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2023 and 2022

(In thousands)

Assets		2023	2022
Current assets:			
Cash and cash equivalents	$	512,076	542,067
Accounts receivable		659,925	511,727
Supplies inventory		70,636	60,070
Other current assets, net		244,617	165,586
Total current assets		1,487,254	1,279,450
Donor restricted assets held for long-term purposes		151,563	119,526
Investments		1,996,970	1,968,205
Property, plant, and equipment, net		2,469,467	2,109,253
Right-of-use operating lease asset, net		235,679	169,823
Right-of-use financing lease asset, net		18,003	16,798
Goodwill and intangible assets, net		259,830	253,274
Other assets, net		401,519	329,808
Total assets	$	7,020,285	6,246,137
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	409,309	326,664
Accrued compensation and related liabilities		420,730	329,672
Accrued interest payable		27,333	23,643
Line of credit		62,935	—
Current portion of right-of-use operating lease liability		37,412	29,908
Current portion of right-of-use financing lease liability		6,443	4,965
Current portion of long-term debt		22,411	18,496
Total current liabilities		986,573	733,348
Interest rate swap liabilities		6,425	9,470
Right-of-use operating lease liability, net of current portion		208,545	147,116
Right-of-use financing lease liability, net of current portion		12,504	12,491
Long-term debt, net of current portion		1,961,949	1,972,137
Other liabilities, net		247,573	231,045
Total liabilities		3,423,569	3,105,607
Commitments and contingencies (note 15)			
Net assets:			
Controlling interest		3,301,130	2,930,546
Noncontrolling interest		34,925	34,471
Without donor restrictions		3,336,055	2,965,017
With donor restrictions		260,661	175,513
Total net assets		3,596,716	3,140,530
Total liabilities and net assets	$	7,020,285	6,246,137

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations

Years ended December 31, 2023 and 2022

(In thousands)

	2023	2022
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 4,521,328	3,765,888
Other operating revenue	417,619	231,429
Net assets released from restrictions for operations	10,068	6,382
Total revenues, gains, and other support without donor restrictions	4,949,015	4,003,699
Expenses:		
Salaries and wages	2,518,778	2,199,265
Employee benefits	381,067	297,613
Supplies	807,705	658,470
Purchased services	486,031	396,747
Depreciation and amortization	163,267	140,892
Interest	81,941	56,842
Other	698,697	541,246
Total expenses	5,137,486	4,291,075
Deficit of revenues over expenses from operations	(188,471)	(287,376)
Other income (loss):		
Investment income (loss)	282,866	(344,301)
Gain on interest rate swaps, net	14,410	127,688
Inherent contribution	293,012	—
Other income (loss), net	9,382	(11,047)
Total other income (loss), net	599,670	(227,660)
Excess (deficit) of revenues over expenses	$ 411,199	(515,036)

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2023 and 2022

(In thousands)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2021	$ 3,430,009	—	176,742	3,606,751
Deficit of revenues over expenses	(515,036)	—	—	(515,036)
Changes in pension assets	(15,508)	—	—	(15,508)
Changes from noncontrolling interest	—	34,471	—	34,471
Contributions and other	26,539	—	14,875	41,414
Net assets released from restriction for capital acquisitions	4,542	—	(4,542)	—
Net assets released from restriction for operations	—	—	(6,382)	(6,382)
Loss on investments	—	—	(611)	(611)
Decrease in assets held in trust by others	—	—	(4,569)	(4,569)
Change in net assets	(499,463)	34,471	(1,229)	(466,221)
Balance, December 31, 2022	2,930,546	34,471	175,513	3,140,530
Excess of revenues over expenses	349,718	61,481	—	411,199
Changes in pension assets	(158)	—	—	(158)
Changes from noncontrolling interest	—	(61,027)	—	(61,027)
Contributions and other	20,582	—	65,863	86,445
Net assets assumed in affiliation	—	—	19,657	19,657
Net assets released from restriction for capital acquisitions	442	—	(442)	—
Net assets released from restriction for operations	—	—	(10,068)	(10,068)
Gain on investments	—	—	12,095	12,095
Decrease in assets held in trust by others	—	—	(1,957)	(1,957)
Change in net assets	370,584	454	85,148	456,186
Balance, December 31, 2023	$ 3,301,130	34,925	260,661	3,596,716

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2023 and 2022

(In thousands)

	2023	2022
Cash flows from operating activities:		
Increase (decrease) in net assets	$ 456,186	(466,221)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by (used in) operating activities:		
Depreciation and amortization	163,267	140,892
Amortization of bond premiums, discounts, and issuance costs	(4,120)	(2,163)
Net realized and unrealized gains on investments	(222,484)	378,740
Change in fair value of interest rate swap	(5,970)	(133,126)
Gain on disposal of assets, net	(34,027)	(3,009)
Loss on joint ventures, net	4,371	7,032
Net assets assumed from affiliation	(312,669)	—
Restricted contributions for long-term purposes	(24,336)	(4,968)
Changes in operating assets and liabilities:		
Accounts receivable	(78,278)	(51,158)
Supplies inventory and other current assets	(72,922)	(43,673)
Right-of-use lease asset	57,252	35,690
Other assets, net	40,427	80,665
Accounts payable and accrued expenses and accrued interest payable	41,947	27,421
Accrued compensation and related liabilities	60,582	(14,765)
Right-of-use lease liability	(34,518)	(30,021)
Other liabilities, net	14,918	21,842
Net cash provided by (used in) operating activities	49,626	(56,822)
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(294,860)	(237,295)
Proceeds from disposal of property, plant, and equipment	57,640	6,360
Cash obtained from affiliation	29,814	—
Purchase of additional ownership in PSW and OSS, net of cash received	—	(86,915)
Investments in joint ventures, net	(38,393)	(11,445)
Purchases of investments	(6,831,712)	(8,827,993)
Sales of investments	7,021,038	9,072,857
Change in donor trusts	(22,232)	(2,833)
Net cash used in investing activities	(78,705)	(87,264)
Cash flows from financing activities:		
Repayment of long-term debt	(82,401)	(415,646)
Proceeds from line of credit, net	62,935	—
Proceeds from bond issuance	—	798,300
Payment of debt issue expenses	—	(5,702)
Principal payments on finance lease obligations	(5,782)	(4,499)
Restricted contributions for long-term purposes	24,336	4,968
Net cash (used in) provided by financing activities	(912)	377,421
Net change in cash and cash equivalents	(29,991)	233,335
Cash and cash equivalents, beginning of year	542,067	308,732
Cash and cash equivalents, end of year	$ 512,076	542,067
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 77,251	52,258
Noncash activities:		
Increase (decrease) in deferred compensation plans	17,628	(11,750)
(Decrease) increase in accounts payable for purchases of property, plant, and equipment	(7,492)	9,301

See accompanying notes to consolidated financial statements.

(Dollars in thousands)

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

(a) Organization Description

MultiCare Health System (MHS), a Washington nonprofit corporation, is an integrated healthcare delivery system providing inpatient, outpatient, and other healthcare services primarily to the residents of Pierce, King, Spokane, Thurston and Yakima Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2023, MHS was licensed to operate 2,577 inpatient hospital beds, including 120 beds associated with a joint venture psychiatric hospital in Tacoma, Washington. MHS operates nine acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Covington Hospital, Deaconess Hospital, Valley Hospital, Capital Medical Center and Yakima Memorial Hospital) and one behavioral health hospital (Navos). MHS also operates eight outpatient surgical sites, six free-standing emergency departments, home health, hospice, and multiple urgent care, primary care and multispecialty clinics located throughout the MHS service areas.

The consolidated financial statements include the operations of these facilities and services as well as those of four wholly owned subsidiaries (Greater Lakes Mental Healthcare, Medis, Inc., MultiCare Rehabilitation Specialists, P.C., and PNW PACE Partners, LLC), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned professional services organization that employes providers for Yakima Memorial Hospital (Memorial Physicians, LLC), a wholly owned accountable care organization (MultiCare Connected Care), a wholly owned clinically integrated healthcare network (Central Washington Healthcare Partners, LLC dba SignalHealth), a leading population health company (Physicians of Southwest Washington), a physical therapy provider (Olympic Sports & Spine) and three fundraising foundations (Yakima Valley Memorial Hospital Charitable Foundation, Mary Bridge Children's Foundation and MultiCare Foundations, which is doing business as MultiCare Health Foundation, Good Samaritan Foundation, MultiCare South King Health Foundation, MultiCare Behavioral Health Foundation and MultiCare Inland Northwest Foundation).

On January 17, 2023, MHS completed its affiliation with Yakima Valley Memorial Hospital (Yakima) and became the sole corporate member. No consideration was exchanged as part of this transaction. Yakima operates an acute care facility, clinics and other services to the greater Yakima Valley region. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. The net assets assumed resulted in an inherent contribution of $293,012 in the consolidated statements of operations. The remaining contribution of $19,657 was restricted and is included in net assets assumed in affiliation with donor restrictions in the consolidated statements of changes in net assets. The following table summarizes the estimated fair values of assets acquired and liabilities assumed as of the acquisition date.

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	29,814
Accounts receivable		69,920
Other current assets		16,675
Land, buildings and equipment		252,096

(Continued)

(Dollars in thousands)

Intangible asset and other assets	$	105,830
Accounts payable, accrued compensation and other current liabilities		(112,076)
Long-term debt and other non-current liabilities		(49,590)
Total identifiable net assets assumed	$	312,669

The following are the results of Yakima in 2023 that have been included in the consolidated statements of operations and consolidated statements of changes in net assets from the acquisition date for the year ended December 31, 2023:

Total operating revenues	$	544,287
Change in net assets without restrictions		151,121
Change in net assets with restrictions		4,693

The following unaudited information presents MultiCare's results for the years ended December 31, 2023 and 2022, had the acquisition date been January 1, 2022 for the Yakima affiliation:

		2023	2022
		(Unaudited)	
Total operating revenues	$	4,949,015	4,524,987
Changes in net assets without donor restrictions		463,044	(504,189)
Changes in net assets with donor restrictions		85,148	5,394

On May 1, 2022, MHS completed the purchase of additional units of Physicians of Southwest Washington, LLC (PSW). Total consideration of this transaction was $49,956 and increased MHS' ownership to 75%. As part of the consideration of this business combination, MHS equity interest was valued at its estimated fair value based on the cash consideration transferred using standard valuation techniques of the equity acquired. As a result of the remeasurement of MHS equity interest in PSW, a gain of $9,105 was recognized within other operating revenue on the consolidated statement of operations for the year ended December 31, 2022. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. PSW is a leading population health company that provides management of risk contracts and manages a leading national accountable care organization (ACO) among other population health service offerings. The following table summarizes the total consideration and the estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Consideration:		
Cash consideration transferred	$	17,358
Fair value of MHS's equity interest before business combination		32,598
Total	$	49,956

(Continued)

(Dollars in thousands)

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	24,649
Other current assets		21,640
Land, buildings and equipment		647
Intangibles and other assets		1,799
Accounts payable, accrued compensation and other current liabilities		(24,454)
Total identifiable net assets assumed		24,281
Noncontrolling interest recognized		(23,731)
Goodwill		49,406
Total	$	49,956

The following are the results of PSW in 2022 that have been included in the consolidated statement of operations and statement of changes in net assets from the acquisition date for the year ended December 31, 2022:

Total operating revenues	$	36,305
Excess of revenue over expenses		1,394

The following unaudited information presents MHS's results for the year ended December 31, 2022, had the acquisition date been January 1, 2022 for the PSW acquisition:

		2022 (Unaudited)
Total operating revenues	$	4,010,866
Deficit of revenues over expenses		(513,848)

On September 22, 2022, MultiCare Rehabilitation Specialists, P.C. completed the purchase of additional units of Olympic Sports & Spine, PLLC (OSS). Total consideration of this transaction was $36,959 and increased MHS's ownership to 80.16%. As part of the consideration of this business combination, MHS equity interest was valued at its estimated fair value based on the cash consideration transferred using standard valuation techniques of the equity acquired. As a result of the remeasurement of MHS equity interest in OSS, a loss of $8,191 was recognized within other operating revenue on the consolidated statement of operations for the year ended December 31, 2022. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. OSS provides physical, occupational, and massage therapy services in the south Puget Sound area. The following table summarizes the total consideration and the

(Dollars in thousands)

estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Consideration:		
Cash consideration transferred	$	7,377
Fair value of MHS's equity interest before business combination		29,582
Total	$	36,959
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	5,988
Other current assets		6,167
Land, buildings and equipment		5,156
Intangibles and other assets		1,453
Accounts payable, accrued compensation and other current liabilities		(2,409)
Total identifiable net assets assumed		16,355
Noncontrolling interest recognized		(9,148)
Goodwill		29,752
Total	$	36,959

The following are the results of OSS in 2022 that have been included in the consolidated statement of operations and statement of changes in net assets from the acquisition date for the year ended December 31, 2022:

Total operating revenues	$	15,176
Excess of revenue over expenses		1,146

The following unaudited information presents MHS's results for the year ended December 31, 2022, had the acquisition date been January 1, 2021 for the OSS acquisition:

		2022 (Unaudited)
Total operating revenues	$	3,994,219
Deficit of revenues over expenses		(512,468)

(b) Principles of Consolidation

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

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and assumptions.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid instruments with maturities of three months or less at the date of purchase. Cash equivalents and investments that are held by outside investment managers or restricted per contractual or regulatory requirements are classified as investments on the consolidated balance sheets.

(e) Accounts Receivable

Accounts receivable are primarily comprised of amounts due for healthcare services from patients and third-party payors and are recorded net of amounts for contractual adjustments and implicit price concessions.

(f) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is stated at lower of cost or net realizable value using the average cost method, except for pharmacy, which uses the first-in, first-out (FIFO) method. Obsolete and unusable items are expensed at the time such determination is made.

(g) Donor Restricted Assets

The majority of the donor restricted assets are invested in MHS' investments and are stated at fair value or estimated fair value. Donor restricted assets that are held separately from MHS' investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in mutual funds, fixed income securities, and equity securities. Those with readily determinable fair values are stated at fair value. Those investments for which quoted market prices are not readily determinable are carried at values provided by the respective investment managers or trustees, which management believes approximates fair value.

Charitable gift annuities, which are included in donor restricted assets, totaled $1,947 and $1,749 at December 31, 2023 and 2022, respectively. MHS has recorded a corresponding payable of $1,406 and $1,301 at December 31, 2023 and 2022, respectively, to pay for estimated future obligations to beneficiaries. The current portion of these obligations is included in accounts payable and accrued expenses and the long-term portions are included in other liabilities, net in the accompanying consolidated balance sheets. According to Washington State law, MHS, as a distinct legal entity holding charitable gift annuities, is required to maintain unrestricted net assets of at least $500, which MHS has done for each of the periods presented.

(h) Investments

MHS accounts for its investment portfolio as a trading portfolio, therefore, investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are recorded at fair value, which are determined based on quoted market prices or prices with observable inputs obtained from national securities exchanges or similar sources. Other investments, including limited partnerships, commingled real estate trust funds, limited liability partnerships, and hedge funds are carried at net asset value (NAV) provided by the respective investment managers, which management believes approximates fair value. Valuations provided by investment managers consider variables such as valuation and financial performance of underlying investments, quoted market prices for similar securities, recent sale prices of underlying investments, and other pertinent information. Management reviews the valuations provided by investment managers and believes that the carrying values of these financial instruments are reasonable estimates of fair value.

Realized gains and losses are recorded using the average cost method. Investment income or loss (including realized gains and losses on investments, change in unrealized gains or losses, interest, and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law.

(i) Property, Plant, and Equipment

Property, plant, and equipment are recorded at cost. Depreciation expense is computed using the straight-line method over the following estimated useful lives of the assets:

Buildings	5–80 years
Land improvements	8–20 years
Equipment	3–30 years

MHS capitalizes all software implementation costs that meet the criteria for capitalization, including those that relate to a service contract (e.g., hosting arrangement). The capitalized software implementation costs are reflected within property, plant and equipment in the consolidated balance sheets. These costs are amortized together with the costs of the related software license; however, the implementation costs related to a service arrangement are amortized over the term of the arrangement. The amortization period for all capitalized implementation costs is generally 10 years.

Maintenance and repairs are charged to operations as they occur. Expenditures that materially increase values, change capacities, or extend useful lives are capitalized. Gains upon sale or retirement of property, plant, and equipment are included in other operating revenue whereas losses are included in other expenses. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of constructing those assets.

MHS assesses potential impairments to its long-lived assets as well as its intangible assets, as described below, when there is evidence that events or changes in circumstances indicate that an impairment has been incurred. These changes can include a deterioration in operating performance, a reduction in reimbursement rates from government or third-party payors or a change in business strategy. An impairment charge is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2023 and 2022, there were no impairment charges.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(j) Leases

Management reviews contracts in order to identify leases and properly classify leases as either operating or financing. MHS is a lessee of various equipment and facilities under noncancelable operating and financing leases. Operating and financing right-of-use (ROU) liabilities are recognized based on the net present value of lease payments over the lease term at the commencement date of the lease and are reduced by payments made on each lease on the straight-line basis. Since most of the leases do not provide an implicit rate of return, MHS uses its incremental borrowing rate based on information available at the commencement date of the lease in determining the present value of lease payments. Generally, MHS cannot determine the interest rate implicit in the lease because it does not have access to the lessor's estimated residual value or the amount of the lessor's deferred initial direct costs. Therefore, MHS generally uses its incremental borrowing rate as the discount rate for the lease. MHS' incremental borrowing rate for a lease is the rate of interest it would have to pay on a collateralized basis to borrow an amount equal to the lease payments using similar terms. Leases with an initial term of 12 months or less are not recorded on the balance sheet; rather, rent expense for these leases is recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

If a lease contains a renewal option at the commencement date and it is considered reasonably certain that the renewal option will be exercised by management to renew the lease, the renewal option payments are included in MHS' net minimum lease payments used to determine the right-of-use lease liabilities and related lease assets. All other renewal options are included in right-of-use lease liabilities and related lease assets when they are reasonably certain to be exercised.

All lease agreements generally require MHS to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU lease liability or ROU lease asset. Variable lease cost also includes escalating rent payments that are not fixed at 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.

(Dollars in thousands)

Variable lease payments associated with MHS' leases are recognized when the event, activity, or circumstance in the lease agreement on which those payments are assessed occurs. Variable lease payments are presented in other expenses in the consolidated statement of operations and changes in net assets.

MHS has elected the practical expedient to not separate lease components from non-lease components related to its real estate leases.

(k) Goodwill and Intangible Assets

Goodwill is an asset representing the future economic benefits arising from the difference in the fair value of the business acquired and the fair value of the identifiable and intangible net assets acquired in a business combination. Indefinite-lived intangible assets are assets that are not amortized because there is no foreseeable limit to cash flows generated from them.

If it is more likely than not that goodwill is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment charge. Goodwill is not amortized and along with indefinite-lived intangible assets is evaluated at least annually for impairment. There were no impairment charges recognized during the years ended December 31, 2023 or 2022.

The following table summarizes the balances of goodwill and intangible assets at December 31, 2023 and 2022:

		2023	2022
Goodwill	$	232,085	232,085
Intangible assets, net of accumulated amortization of $7,712 and $7,035, respectively		27,745	21,189
Total	$	259,830	253,274

The balance sheet as of December 31, 2023 includes intangible assets recognized as part of the Yakima affiliation in the amount of $7,696. The balance sheet as of December 31, 2022 includes goodwill recognized as part of the PSW and OSS transactions in the amounts of $49,406 and $29,752, respectively, and intangible assets recognized of $1,719 and $1,421, respectively.

Amortizing intangible assets are comprised of certificates of need, license agreements, trade names and lease arrangements, which all have finite useful lives. Amortization expense is recorded on a straight-line basis over the estimated useful life of the assets, which ranges from three to thirty years, associated with the nature of the intangible asset. Amortization expense was $677 and $1,474 for the years ended December 31, 2023 and 2022, respectively.

(l) Investment in Joint Ventures

MHS maintains ownership in certain joint ventures related to imaging, office buildings, behavioral health and other healthcare focused activities and accounts for these joint ventures under the equity method of accounting. As of December 31, 2023 and 2022, MHS held ownership interests in 27 and 26 joint ventures, respectively. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheets. Loss on joint ventures for the years ended December 31, 2023 and 2022 were $4,371 and $7,032, respectively, associated with several joint ventures. Gains and losses are included in other operating revenue on the consolidated statements of operations.

(m) Estimated Third-Party Payor Settlements

Medicare cost reports are filed annually by MHS with the Medicare intermediary and are subject to audit and adjustment prior to settlement. Estimates of net settlements due to Medicare were $7,646 and $4,781 as of December 31, 2023 and 2022, respectively, and have been recorded within accounts payable and accrued expenses in the accompanying consolidated balance sheets. Third-party settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, based upon the amount of the final settlements. Patient service revenue increased by $2,865 in 2023 and decreased by $148 in 2022 to reflect changes in the estimated Medicare settlements for prior years.

(n) Interest Rate Swaps

MHS maintains several interest rate swap agreements as a means of hedging its exposure to variable-based interest rates and fluctuations in cash flows as part of its overall interest rate risk management strategy. All MHS interest rate swaps are recorded at fair value. The accounting for changes in the fair value of these swaps depends on whether those had been designated as cash flow hedges. As of December 31, 2023 and 2022, none of MHS' interest rate swaps were designated as cash flow hedges and therefore, the changes in fair value are recognized and included in other income (loss) on the consolidated statements of operations. These swaps have notional amounts totaling approximately $559,000 and expire starting in August 2027 through August 2049. During 2023, the interest rate swap agreements were amended to change the variable rate basis from LIBOR to SOFR due to the discontinuation of LIBOR. The majority of the swaps have the economic effect of fixing the SOFR-based variable interest rate on an equivalent amount of MHS' outstanding floating rate principal debt.

Under master netting provisions of the International Swap Dealers Association (ISDA) agreement with each of the counterparties, MHS is permitted to settle with the counterparties on a net basis. However, due to the nature of the specific swap arrangements in MHS' interest rate swap portfolio, the fair value of interest rate swap assets and swap liabilities are presented on a gross basis on the consolidated balance sheets.

(o) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by MHS in perpetuity. When restricted funds to be used for operations are expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains, and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restriction – capital acquisitions.

MHS applies the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, related to using the present value technique to measure fair value of pledges receivable. In accordance with ASC Topic 820, MHS has applied the expected present value technique to pledges received after January 1, 2009 that adjusts for a risk premium to take into account the risks inherent in those expected cash flows. Pledges of financial support are recorded as pledges receivable when unconditional pledges are made and are stated at net realizable value. Pledges are reported net of an allowance for uncollectible pledges and pledges to be collected in future years are reflected at a discounted value using a weighted average discount rate. As of December 31, 2023 and 2022, MHS has recorded $26,678 and $21,265, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2023, $15,886 of pledges are due in one year or less and $10,792 in two to eight years.

(p) Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which MHS expects to receive in exchange for providing patient services. These amounts are due from patients, third-party payors, and others and include the variable consideration for retroactive adjustments to revenue due to final settlement of audits, reviews, and investigations. MHS bills the patient and third-party payors several days after the services are performed or when the patient is discharged from the facility, whichever is later.

(q) Hospital Safety Net Assessment

The State of Washington (the State) has a safety net assessment program involving Washington State hospitals to increase funding from other sources and obtain additional federal funds to support increased payments to providers for Medicaid services. In connection with this program, MHS recorded increases in patient service revenue of $99,048 and $89,946 for 2023 and 2022, respectively, and incurred assessments of $68,134 and $63,961 for 2023 and 2022, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations. MHS has outstanding receivables of $13,666 and $17,287 associated with this program as of December 31, 2023 and 2022, respectively, which are included with accounts receivable on the consolidated balance sheets.

(r) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated and undercompensated healthcare services to the communities it serves within the purview of its mission. Because MHS does not pursue collection of amounts determined to qualify as uncompensated care, MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its historical collections from these patients. Patients who meet the criteria of MHS' uncompensated care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Such amounts determined to qualify as charity care are not reported as revenue. The State provides guidelines for charity care provided by hospitals in the state. Hospitals are recommended to provide full charity care to patients who meet 100% of the federal poverty guidelines and a lesser amount to patients who meet up to 200% of the federal poverty guidelines. MHS provides full charity care to patients who meet 300% of the federal poverty guidelines and also provides uncompensated care on a sliding scale for patients whose income is between 301% and 500% of the federal poverty guidelines for true self-pay patients and patients with deductibles and coinsurance amounts. The estimated cost of charity care provided was approximately $67,000 and $52,000 in 2023 and 2022, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $496,000 and $424,000 in 2023 and 2022, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(s) Other Operating Revenue

Other operating revenue includes revenue from cafeteria sales, retail pharmacy, laboratory revenue from community providers, medical office rental income, contributions without donor restrictions, grant revenue, contracted behavioral healthcare revenue, capitated revenue, and other miscellaneous revenue.

(t) Excess of Revenues over Expenses

The consolidated statements of operations include excess of revenues over expenses. Changes in net assets without donor restrictions, which are excluded from the excess of revenues over expenses, primarily include changes in accrued pension asset, net assets assumed in affiliation, net assets released from restrictions for capital expenditures, and capital assets received.

(u) Federal Income Taxes

ASC Subtopic 740-10, *Income Taxes*, clarifies the accounting for uncertainty in income taxes recognized in MHS' consolidated financial statements. This topic also prescribes a recognition threshold and measurement standard for the financial statement recognition and measurement of an income tax position taken or expected to be taken in a tax return. Only tax positions that meet the "more-likely than-not" recognition threshold at the effective date may be recognized or continue to be recognized upon adoption. In addition, this topic provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition. Other than Medis, Inc., Physicians of Southwest Washington, LLC and Olympic Sports & Spine, PLLC, which are all taxable

entities, all of the other entities have obtained determination letters from the Internal Revenue Service that they are exempt from federal income taxes under Section 501(a) of the Internal Revenue Code as an organization described in 501(c)(3) of the Internal Revenue Code, except for tax on unrelated business income.

(v) Self-Insurance Reserves

MHS is self-insured with respect to professional and general liability, workers' compensation and medical and other health benefits with excess insurance coverage over self-insured retention limits. MHS records insurance liabilities for these specific items by using third party actuarial calculations and certain assumptions and inputs such as MHS historical claims experience and the estimated amount of future claims that will be incurred.

(w) New and Pending Accounting Standards

In June 2016, FASB issued Accounting Standards Update (ASU) 2016-13 and in November 2019, issued ASU 2019-10, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* The amendments in this update require that financial assets are measured at amortized cost basis and presented at the net amount expected to be collected. This eliminates the probable initial recognition threshold in current GAAP and, instead, reflects an entity's current estimate of all expected credit losses and broadens the information that an entity must consider in developing its expected credit loss estimate for assets measured either collectively or individually. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2023. The adoption of this ASU did not have a material impact on our financial statements.

In April 2019, FASB issued ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments – Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments.* The amendments in this update are divided into four separate topics that discuss the details of the improvement areas and the amendments made to the Codification for these improvement areas. Topics 1, 2 and 5 in this ASU relate specifically to ASU 2016-13, which is effective for MHS for the year beginning January 1, 2023. Topics 3 and 4 in this ASU have been evaluated and are not applicable to MHS. The adoption of this ASU did not have a material impact on our financial statements.

(2) Coronavirus (COVID-19) Impact

MHS has filed applications and obtained reimbursement of additional expenses from the Federal Emergency Management Agency (FEMA) based on criteria due to the national emergency declaration made due to COVID-19. MHS has submitted funding applications with FEMA that covers costs incurred in order to respond to the COVID-19 pandemic. MHS recognizes FEMA reimbursements as they are obligated by the agency. MHS recognized $111,226 and $14,578 of FEMA reimbursements for the years ended December 31, 2023 and 2022, respectively, within other operating revenue in the statements of operations.

(3) Revenue from Contracts with Customers

Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by MHS and are recognized either over time or at a point in time. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred through a point in time in relation to total actual charges incurred. MHS believes that this method provides a useful depiction of the provision of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospitals or clinics receiving inpatient or outpatient services. MHS measures an inpatient performance obligation from time of admission to time of discharge and an outpatient performance obligation from the start of the outpatient service to the completion of the outpatient service. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided to patients and customers.

MHS has elected to apply the optional exemption in ASC 606-10-50-14a as all of MHS' performance obligations related to contracts with a duration of less than one year. Under this exemption, MHS was not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Any unsatisfied or partially unsatisfied performance obligations are completed within days or weeks of the end of the year.

MHS determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with MHS policy, and implicit price concessions provided to uninsured patients. MHS determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies and historical experience. MHS determines its estimate of implicit price concessions based on its historical collection experience with each class of patients.

Contractual agreements with third-party payors provide for payments at amounts less than MHS' established charges. A summary of the payment arrangements with major third-party payors is as follows:

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, which provides for reimbursement based on Medicare Severity Diagnosis-Related Groups (MS-DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis, acuity, and expected use of hospital resources. The majority of Medicare outpatient services is reimbursed under a prospective payment methodology, the Ambulatory Payment Classifications (APCs), or fee schedules.
- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare; however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services is reimbursed under a prospective payment methodology, the Enhanced Ambulatory Patient Groups (EAPG), or fee schedules.
- Other – MHS has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to MHS under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates and fee schedules.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from the related programs. There can be no assurance that regulatory or governmental authorities will not challenge MHS' compliance with these laws and regulations, and it is not possible to determine the impact, if any, that such claims or penalties would have upon MHS. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims that can reduce the amount of revenue ultimately received.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled and no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2023 or 2022.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. MHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. MHS estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for prior years were not significant for 2023 or 2022. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

Consistent with MHS' mission, care is provided to patients regardless of their ability to pay. MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its collection experience with those patients. Patients who meet the criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as uncompensated care are not reported as revenue.

(Dollars in thousands)

MHS has determined that the best depiction of its revenue is by its mix of payors as this shows the amount of revenue recognized from each portfolio. Patient service revenue disaggregated by payor for the years ended December 31, 2023 and 2022 are as follows:

		2023	2022
Payors:			
Medicare	$	1,392,360	1,068,131
Medicaid		697,273	623,026
Premera		568,520	521,521
Regence		408,562	392,750
Aetna		191,124	192,352
United Healthcare		150,687	133,716
First Choice		131,606	117,366
Kaiser Permanente		112,527	134,237
Self-pay		20,654	23,149
Other		848,015	559,640
	$	4,521,328	3,765,888

MHS has elected to apply the practical expedient under ASC 340-40-25-4 and therefore, all incremental customer contract acquisition costs are expensed as incurred, as the amortization period of the asset that MHS would have otherwise recognized is one year or less in duration.

(4) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are residents of the communities it serves and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2023 and 2022 was as follows:

	2023	2022
Medicare	35 %	35 %
Medicaid	22	25
Premera	8	7
Regence	7	6
Self-pay	5	5
First Choice	2	1
Health Care Exchange	1	1
Other commercial insurance	20	20
	100 %	100 %

(Continued)

(5) Fair Value Measurements

(a) Fair Value Hierarchy

In accordance with ASC Topic 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for similar assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical or similar assets or liabilities that MHS could access at the measurement date. Level 1 securities generally include investments in equity securities, mutual funds and certain fixed income securities.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are based upon observable market inputs for the asset or liability, either directly or indirectly. Level 2 securities generally include investments in fixed income securities (composed primarily of government, agency and corporate bonds) and interest rate swaps.
- Level 3 inputs are unobservable market inputs for the asset or liability. Level 3 securities include donor trusts where MHS is not the trustee.

The level in the fair value hierarchy within which a fair value measurement, in its entirety, falls is based on the lowest level input that is significant to the fair value measurement.

ASC Subtopic 820-10 allows for the use of a practical expedient for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value. The practical expedient used by MHS is the Net Asset Value (NAV) per share, or its equivalent. In some instances, the NAV may not equal the fair value that would be calculated under fair value accounting standards. Valuations provided by investment managers consider variables such as the financial performance of underlying investments, recent sales prices of underlying investments and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the redemption price. MHS reviews valuations and assumptions provided by investment managers for reasonableness and believes that the carrying amounts of these financial instruments approximate the estimated of fair value of the instrument. Where investments are not presented at fair value, NAV is used as a practical expedient to approximate fair value.

(Dollars in thousands)

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2023 and 2022:

		Fair value measurements at reporting date using		
	December 31, 2023	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 1,069,171	1,069,171	—	—
Fixed income bond funds	363,707	363,707	—	—
Fixed income governmental obligations	160,305	124,321	35,984	—
Fixed income other	163,597	—	163,597	—
Donor trusts	36,427	—	—	36,427
Interest rate swaps	26,421	—	26,421	—
Total assets at fair value	1,819,628	$ 1,557,199	226,002	36,427
Investment assets valued at NAV	289,026			
Total assets at fair value or NAV	$ 2,108,654			
Liabilities:				
Interest rate swaps	$ 6,425	—	6,425	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 927,945	927,945	—	—
Equity securities	8,204	8,204	—	—
Fixed income bond funds	327,965	327,965	—	—
Fixed income governmental obligations	152,312	114,851	37,461	—
Fixed income other	178,595	—	178,595	—
Commingled trust fund – international equity	14,376	—	14,376	—
Donor trusts	29,431	—	—	29,431
Interest rate swaps	23,496	—	23,496	—
Total assets at fair value	1,662,324	$ 1,378,965	253,928	29,431
Investment assets valued at NAV	403,251			
Total assets at fair value or NAV	$ 2,065,575			
Liabilities:				
Interest rate swaps	$ 9,470	—	9,470	—

(Continued)

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2023 and 2022:

	NAV December 31, 2023	NAV December 31, 2022	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 1,472	125,067	60	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	280,800	269,628	N/A	Daily	1 or more business days prior to valuation date
Limited partnerships	6,754	8,556	1,800	N/A	N/A
Total investments valued at NAV	$ 289,026	403,251	1,860		

Hedge funds include investments in hedge fund-of-funds products with certain investment managers. The fair values of the investments in this category have been estimated using the NAV per share of the investment.

Common trust funds include investments in a collective or common trust account that invests funds in an underlying fund or set of funds. The trust account seeks an investment return that approximates the performance of an index as defined by each common trust fund. The fair value of the investments in this category are estimated using the NAV per share of the fund that is derived from the underlying investments in the trust fund.

Limited partnerships include investments in private equity and venture capital funds in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(b) Interest Rate Swaps

The interest rate swaps are recorded at estimated fair value by using certain observable market inputs that participants would use from closing prices for similar assets. In addition, other valuation techniques and market inputs are used that help determine the fair values of these swaps, which include certain valuation models, current interest rates, forward yield curves, implied volatility and credit default swap pricing.

(Dollars in thousands)

The fair value of the interest rate swaps liability is included in interest rate swap liabilities on the consolidated balance sheets, and the fair value of the interest rate swap asset is included in other assets, net on the consolidated balance sheets. The fair value gains of these interest rate swaps for the years ended December 31, 2023 and 2022 were $5,969 and $133,126, respectively, and are included in gain on interest rate swaps in other income (loss), net in the consolidated statements of operations. Also included in the gain on interest rate swaps is the gain (loss) on net cash settlement amounts associated with the swaps of $8,441 and ($5,439) for the years ended December 31, 2023 and 2022, respectively.

The following table represents both the fair value and settlement value for the interest rate swap assets and liabilities as of December 31, 2023 and 2022:

	Asset derivatives					
	2023			2022		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Other assets, net	$ 26,421	29,351	Other assets, net	$ 23,496	26,079

	Liability derivatives					
	2023			2022		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	$ 6,425	7,143	Interest rates swap liabilities	$ 9,470	11,317

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2023 and 2022 is as follows:

	December 31, 2023		
	Donor restricted assets	Investments	Total
Mutual funds	$ 25,522	1,043,649	1,069,171
Fixed income securities	16,414	671,195	687,609
Hedge funds	35	1,437	1,472

(Continued)

(Dollars in thousands)

	December 31, 2023		
	Donor restricted assets	Investments	Total
Common trust funds	$ 6,703	274,097	280,800
Limited partnerships	162	6,592	6,754
Donor trusts	36,427	—	36,427
Pledge receivables, net and other	66,300	—	66,300
Total	$ 151,563	1,996,970	2,148,533

	December 31, 2022		
	Donor restricted assets	Investments	Total
Mutual funds	$ 20,491	907,454	927,945
Equity securities	181	8,023	8,204
Fixed income securities	14,548	644,324	658,872
Commingled trust fund – international equity	317	14,059	14,376
Hedge funds	2,762	122,305	125,067
Common trust funds	5,954	263,674	269,628
Limited partnerships	190	8,366	8,556
Donor trusts	29,431	—	29,431
Pledge receivables, net and other	45,652	—	45,652
Total	$ 119,526	1,968,205	2,087,731

Fixed income securities include mutual funds, corporate bonds, mortgage-backed securities, asset-backed securities, U.S. government obligations, and state government obligations.

(7) Liquidity and Availability of Financial Assets

MHS actively monitors the availability of resources required to meet its operating obligations and other contractual commitments, while also striving to maximize investment returns of its available funds. To help meet its general obligations, MHS can also access the credit markets as a means of producing liquidity, if needed. MHS draws income, appreciation and distributions from its endowment fund up to 5% of the endowment average account value annually, as applicable donor restrictions are met, as another way of providing liquidity. For purposes of analyzing resources available to meet general expenditures over a 12-month period, MHS considers all expenditures related to its ongoing activities to provide integrated healthcare delivery as well as the conduct of services undertaken to support these activities to be general expenditures.

(Dollars in thousands)

At December 31, 2023 and 2022, MHS' financial resources are as follows:

	2023	2022
Cash and cash equivalents	$ 512,076	542,067
Accounts receivable	659,925	511,727
Other current assets, net	244,617	165,586
Donor restricted assets	151,563	119,526
Investments	1,996,970	1,968,205
	3,565,151	3,307,111
Less prepaid assets included in other current assets, net	(68,927)	(58,353)
Less donor restricted assets	(151,563)	(119,526)
Less investments with redemption limitations of greater than one year	(6,754)	(8,556)
Total financial assets available for general expenditures	$ 3,337,907	3,120,676

In addition to financial assets available to meet general expenditures over the next 12 months, MHS operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures. MHS also has a $200,000 line of credit available for general expenditures, if needed (note 15).

(8) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2023 and 2022 is as follows:

	2023	2022
Land and land improvements	$ 218,551	164,041
Buildings	2,596,458	2,360,383
Equipment	1,236,255	1,051,005
	4,051,264	3,575,429
Less accumulated depreciation	(1,806,178)	(1,640,005)
	2,245,086	1,935,424
Construction in progress	224,381	173,829
Property, plant, and equipment, net	$ 2,469,467	2,109,253

(Continued)

(Dollars in thousands)

Total depreciation and amortization expense for the years ended December 31, 2023 and 2022 was $163,267 and $140,892, respectively. Depreciation expense charged to operations for the years ended December 31, 2023 and 2022 amounted to $162,991 and $139,145, respectively.

(9) Other Assets, Net

Other assets are as follows at December 31, 2023 and 2022:

		2023	2022
Investment in joint ventures	$	92,953	58,977
Deferred compensation plan assets held in trust (note 12)		104,668	87,039
Accrued pension asset (note 12)		49,236	36,428
Self-insured retention receivables, net of current portion (notes 13 and 14)		18,128	17,462
Net investment in lease (note 17(b))		22,459	22,655
Notes receivable (note 10)		75,138	75,284
Interest rate swaps (note 5(b))		26,421	23,496
Other		12,516	8,467
Other assets, net	$	401,519	329,808

Deferred compensation plan assets held in trust are participant-managed investments consisting of equity and fixed income mutual funds with prices quoted in active markets.

(10) Notes Receivable

In December 2020, MHS executed a promissory note with Astria Health for a $75,000 loan. The loan bears a fixed interest rate of 9.5% with payments due June 30 and December 31 of each year. In December 2022, the credit agreement was amended to extend the maturity date. The loan matures in December 2025.

(11) Other Liabilities, Net

Other liabilities are as follows at December 31, 2023 and 2022:

		2023	2022
Professional liability, net of current portion (note 13)	$	121,130	103,813
Deferred compensation liability (note 12)		104,668	87,039
Workers' compensation liability, net of current portion (note 14)		15,651	15,444
Other		6,124	24,749
Other liabilities, net	$	247,573	231,045

(Continued)

(Dollars in thousands)

(12) Retirement Plans

(a) MHS Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the MHS Plan) covering eligible employees. The MHS Plan was closed to new employees effective after July 31, 2002. The benefits are based on years of service and the employee's highest five consecutive years of compensation. MHS contributions to the MHS Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2016, participants no longer accrue pension benefits under the Plan.

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the MHS Plan, which has measurement dates of December 31, 2023 and 2022:

		2023	2022
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	454,337	663,039
Service cost		780	650
Interest cost		24,026	19,329
Actuarial loss (gain)		10,060	(142,861)
Expected administrative expenses		(780)	(650)
Benefits paid		(32,492)	(85,170)
Projected benefit obligations at end of year	$	455,931	454,337
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	490,765	723,990
Actual gain (loss) on plan assets		47,597	(147,327)
Actual administrative expenses		(703)	(728)
Benefits paid		(32,492)	(85,170)
Fair value of plan assets at end of year	$	505,167	490,765
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	49,236	36,428
Amount recognized in net assets without donor restrictions:			
Net loss		106,209	106,367

(Continued)

(Dollars in thousands)

	2023	2022
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	5.30 %	5.50 %

The expected return on plan assets assumption is based upon an analysis of historical long-term returns for various investment categories as measured by appropriate indices. These indices are weighted based upon the extent to which plan assets are invested in the particular categories in arriving at MHS' determination of a composite expected return. An actuary reviews the assumptions annually for reasonableness.

The components of net periodic benefit cost are as follows during the years ended December 31, 2023 and 2022:

	2023	2022
Components of net periodic benefit cost:		
Service cost	$ 780	650
Interest cost	24,026	19,329
Expected return on plan assets	(37,568)	(30,858)
Amortization of net actuarial loss	112	5,335
Settlement cost	—	14,559
	$ (12,650)	9,015

	2023	2022
Weighted average assumptions used to determine benefit obligation as of December 31:		
Discount rate	5.50 %	3.00 %
Expected return on plan assets	6.30	4.50

During the year ended December 31, 2022, the MHS Plan made lump-sum cash payments (settlements) to plan participants and in exchange the MHS Plan was relieved of all remaining liabilities of future payments to those plan participants. These settlements are included in benefits paid within the change in projected benefit obligation. The total amount of these settlements exceeded the total service costs and interest costs for the year ended December 31, 2022 and the pro-rata portion of the remaining balance in net assets without donor restrictions was recognized as part of net periodic benefit costs.

(Continued)

(Dollars in thousands)

The accumulated benefit obligation for the MHS Plan was $455,931 and $454,337 at December 31, 2023 and 2022, respectively.

(i) Estimated Future Benefit Payments

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

	Pension benefits
2024	$ 36,424
2025	35,716
2026	36,681
2027	36,443
2028	36,330
2029–33	170,058

(ii) Plan Assets

The following tables set forth by level, within the fair value hierarchy, the MHS Plan's investments at fair value:

		Fair value measurements at reporting date using		
	December 31, 2023	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 2,586	2,586	—	—
Trading securities:				
Mutual funds	47,061	47,061	—	—
Fixed income bond funds	38,421	38,227	194	—
Fixed income governmental obligations	199,689	159,733	39,956	—
Fixed income other	166,770	6,764	160,006	—
Commingled trust fund – international equity	10,724	—	10,724	—
	465,251	$ 254,371	210,880	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2023	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$ 20,343			
Broker payables	(54,381)			
Total assets at fair value	431,213			
Investments valued at NAV	73,954			
Total assets at fair value or NAV	$ 505,167			

		Fair value measurements at reporting date using		
	December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 8,926	8,926	—	—
Trading securities:				
Mutual funds	91,812	91,812	—	—
Fixed income bond funds	5,100	4,921	179	—
Fixed income governmental obligations	187,978	140,834	47,144	—
Fixed income other	162,979	13,368	149,611	—
Commingled trust fund – international equity	12,729	—	12,729	—
	469,524	$ 259,861	209,663	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$ 38,910			
Broker payables	(85,854)			
Total assets at fair value	422,580			
Investments valued at NAV	68,185			
Total assets at fair value or NAV	$ 490,765			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2023 and 2022.

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2023 and 2022:

	NAV December 31, 2023	NAV December 31, 2022	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Absolute return funds	$ 70,377	63,783	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	3,577	4,402	850	N/A	N/A
Total investments valued at NAV	$ 73,954	68,185	850		

Absolute return fund investments consist primarily of listed equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles. These investments use derivatives or other instruments for both investment and hedging purposes and may take long and/or short positions, and the derivative investments may include but are not restricted to futures, options, swaps, and forward currency contracts.

(Continued)

(Dollars in thousands)

Limited partnerships include investments in private equity and venture capital in both developed and emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

The defined benefit plan weighted average asset allocations at December 31, 2023 and 2022 by asset category are as follows:

	2023	2022
Asset category:		
Domestic equities	6 %	13 %
International equities	5	9
Fixed income securities	88	77
Alternative investments	1	1
	100 %	100 %

(iii) Investment Objectives

The target asset allocations for each asset class are set based on the achieved funding levels for the Plan and are summarized below:

	2023	2022
Asset category:		
Domestic equities	5 %	12 %
International equities	5	8
Fixed income securities	90	80
	100 %	100 %

(iv) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected market returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. stock market using multimanager portfolio strategies; and achieve returns in excess of passive indices using active investment managers and strategies.

The strategic role of international equities is to provide higher expected market return premiums (along with domestic equities) of the major asset classes and diversify the Plan's overall equity exposure by investing in non-U.S. stocks that are less than fully correlated to domestic equities with similar return expectations; to maintain a diversified exposure within the international stock market through the use of multimanager portfolio strategies; and to achieve returns in excess of passive indices through the use of active investment managers and strategies.

The strategic role of emerging markets is to diversify the portfolio relative to domestic equities and fixed income investments and to specifically include equity investment in selected global markets and may also include currency hedging for defensive purposes.

Fixed Income

The strategic role of fixed income securities is to diversify the Plan’s equity exposure by investing in fixed income securities that exhibit a low correlation to equities and lower volatility; maintain a diversified exposure within the U.S. fixed income market using multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies. It also provides effective diversification against equities and a stable level of cash flow.

Alternative Investments

The strategic role of alternative investments is for diversification relative to equities and fixed income investments, to add absolute return using hedging strategies, and to achieve expected return premiums over longer holding periods. Alternative investments include investments in equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles, hedge funds and private equities and are under the supervision and control of investment managers. Hedge funds include investments in a variety of instruments including stocks, bonds, commodities, and a variety of derivative instruments. Private equities consist primarily of equity investments made in companies that are not quoted on a public stock market, which can include U.S. and non-U.S. venture capital, leveraged buyouts, and mezzanine financing.

(b) Yakima Defined Benefit Pension Plan

Yakima operates one qualified defined benefit pension plan (the Yakima Plan) covering eligible employees. The Yakima Plan was closed to new employees effective after May 31, 2008. The benefits are based on years of service and the employee’s highest five consecutive years of compensation. Contributions to the Yakima Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2010 for nonunion participants and December 31, 2011 for union participants, participants no longer accrue pension benefits under the Yakima Plan.

(Dollars in thousands)

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the Yakima Plan, which has measurement dates of December 31, 2023:

Change in projected benefit obligation:		
Projected benefit obligations at beginning of year	$	111,906
Interest cost		5,899
Actuarial loss		2,107
Benefits paid		(8,168)
Projected benefit obligations at end of year	$	111,744
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	$	111,962
Actual gain on plan assets		9,534
Benefits paid		(8,168)
Fair value of plan assets at end of year	$	113,328
Funded status recognized in consolidated balance sheets consist of:		
Asset for pension benefits	$	1,584
Amount recognized in net assets without donor restrictions:		
Net loss		(5,190)
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate		5.25 %

The expected return on plan assets assumption is based upon an analysis of historical long-term returns for various investment categories as measured by appropriate indices. These indices are weighted based upon the extent to which plan assets are invested in the particular categories in arriving at Yakima's determination of a composite expected return. An actuary reviews the assumptions annually for reasonableness.

The components of net periodic benefit cost are as follows during the year ended December 31, 2023:

Components of net periodic benefit cost:		
Interest cost	$	5,899
Expected return on plan assets		(6,191)
	$	(292)

(Continued)

(Dollars in thousands)

Weighted average assumptions used to determine benefit obligation as of December 31:	
Discount rate	5.25 %
Expected return on plan assets	5.75

The accumulated benefit obligation for the Yakima Plan was $111,744 at December 31, 2023.

(i) Estimated Future Benefit Payments

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

	Pension benefits
2024	$ 8,737
2025	8,842
2026	8,840
2027	8,831
2028	8,784
2029–2033	42,065

(ii) Plan Assets

The following tables set forth by level, within the fair value hierarchy, the Yakima Plans' investments at fair value:

		Fair value measurements at reporting date using			
	December 31, 2023	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 16,006	16,006	—	—
Trading securities:				
Equity securities	97,322	97,322	—	—
Total assets at fair value	$ 113,328	113,328	—	—

(Continued)

(iii) Investment Categories

Equity securities

The strategic role of equity securities (domestic and international) is to provide higher expected market returns of the major asset classes within the applicable markets and maintain a diversified exposure within the portfolio.

(c) Defined Contribution Plans

MHS currently maintains three defined contribution plans including the MHS 401(a) Retirement Account Plan (RAP), the MHS 403(b) Employee Savings Plan, and the MHS 401(k) Plan. Most employees assigned to work at Deaconess Hospital, Valley Hospital, Rockwood Clinic and Capital Medical Center are eligible for participation in the MHS 401(k) Plan, which is funded by both MHS and employee contributions. The MHS 403(b) Employee Savings Plan is 100% funded by employee contributions, and the RAP is 100% funded by MHS contributions.

Yakima currently maintains two defined contribution plans including a 403(b) tax-deferred annuity plan and a 401(k) plan, which is a safe harbor plan. The 403(b) plan was frozen to contributions as of January 1, 2020. The 401(k) plan is funded by both Yakima and employee contributions.

MHS' and Yakima's funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2023 and 2022 were approximately $65,000 and $58,000, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(d) Other

In addition to the defined benefit and defined contribution plans as described above, MHS and Yakima also maintain several deferred compensation arrangements for the benefit of eligible employees. Substantially all amounts that are deferred under these arrangements are held in trust until such time as these funds become payable to the participating employees.

(13) Professional Liability

MHS maintains a self-insurance program for professional liability with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability as of December 31, 2023 and 2022, which comprises estimated deductibles and retentions for known claims at year-end and a liability for incurred but not reported claims based on an actuarially determined estimate.

During 2022, MHS began operations of a wholly owned insurance captive, Commencement Re (the Captive). On September 15, 2022, the Captive took on the risk to self-insure and reinsure certain layers of professional and general liability risk from MHS.

(Dollars in thousands)

At December 31, 2023 and 2022, the estimated gross professional liability (including current and long-term portions) was $156,125 and $128,101, respectively. The current portion is included in accounts payable and accrued expenses, and the remainder is included in other liabilities, net in the accompanying consolidated balance sheets. MHS has recorded a receivable for amounts to be received from the excess insurance carriers for their portion of the claims (including current and long-term portions) of $15,100 and $22,754 as of December 31, 2023 and 2022, respectively. The current amount is included in other current assets, net, and the remainder is included in other assets, net in the accompanying consolidated balance sheets.

(14) Workers' Compensation and Employee Health Benefit Programs

MHS maintains a self-insurance program for workers' compensation with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability based on an actuarial estimate of future claims payments. At December 31, 2023 and 2022, the estimated net liability based on future claims cost totaled $21,711 and $21,470, respectively. The gross liabilities (including both current and long-term portions) total $24,738 and $24,836 as of December 31, 2023 and 2022, respectively. The long-term amounts are included in other liabilities, net, and the current portions are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets. These liabilities are secured by a letter of credit with the State of Washington. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,028 and $3,366 as of December 31, 2023 and 2022, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

MHS maintains a self-insurance program for employee medical and dental insurance. Employees can elect to be included in the self-insurance plan as a part of their fringe benefit package. Yakima maintained a separate self-insurance program for employee medical and dental insurance during 2023. Yakima employees were moved into the MHS program as of January 1, 2024. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2023 and 2022 was $25,346 and $12,984, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(15) Long-Term Debt

Long-term debt consists of the following at December 31, 2023 and 2022:

	2023	2022
WHCFA Revenue bonds, 2022A	$ 49,985	49,985
WHCFA Revenue bonds, 2022B	108,145	108,145
WHCFA Revenue bonds, 2022C	80,000	80,000
WHCFA Revenue bonds, 2022D	130,170	130,170
WHCFA Revenue bonds, 2022 Taxable Private Placement	430,000	430,000
2020 Taxable bonds	300,000	300,000

(Continued)

(Dollars in thousands)

	2023	2022
OCED financing	$ 75,642	57,249
WHCFA Revenue bonds, 2017 Series A and B	310,415	314,550
WHCFA Revenue bonds, 2017 Series C and D	111,010	111,010
WHCFA Revenue bonds, 2015 Series A and B	329,345	343,675
Other	17,005	19,085
	1,941,717	1,943,869
Adjusted for:		
Current portion	(22,411)	(18,496)
Bond premiums, discounts, and debt issuance costs	42,643	46,764
Long-term debt, net of current portion	$ 1,961,949	1,972,137

(a) Washington Health Care Facility Authority (WHCFA) Revenue Bonds, 2022A

In August 2022, MHS issued $49,985 of 2022 Series A bonds. These bonds were issued as variable rate tax exempt private placement debt with Royal Bank of Canada, with principal payments ranging from $1,845 in 2040 to final payment of $20,365 in 2044. The interest rates reset monthly and are based on SIFMA plus a spread.

(b) WHCFA Revenue Bonds, 2022B

In August 2022, MHS issued $108,145 of 2022 Series B bonds. These bonds were issued as variable rate tax exempt private placement debt with PNC Bank, NA. Principal payments range from $7,035 in 2040 to $22,085 in 2045, with a final payment of $19,715 in 2046 with interest payable semi-annually in February and August, based on SOFR plus a spread.

(c) WHCFA Revenue Bonds, 2022C

In December 2022, MHS issued $80,000 of 2022 Series C bonds. These bonds were issued as variable rate tax exempt private placement debt with Banc of America Preferred Funding Corp. The principal is due in full in 2047 with monthly interest payments based on SIFMA plus a spread.

(d) WHCFA Revenue Bonds, 2022D

In December 2022, MHS issued $130,170 of 2022 Series D bonds. These bonds were issued as variable rate taxable private placement debt with Bank of America, NA. The principal is due in full in 2047 with monthly interest payments based on SOFR plus a spread.

(e) WHCFA Revenue Bonds, 2022 Taxable Private Placement

In August 2022, MHS issued $430,000 of Series 2022 taxable private placement bonds. The bonds were acquired by various private investors. Included in the issuance are $130,000 in bonds bearing 4.48% fixed rate interest with principal due in full in 2037, and $300,000 in bonds bearing 4.75% fixed rate interest with principal due in full in 2052.

(Continued)

(f) 2020 Taxable Bonds

In July 2020, MHS issued $300,000 of taxable 2020 series bonds. These bonds were issued as fixed rate bonds that bear interest of 2.803%. The principal of $300,000 is due in 2050, with interest only payments made semiannually in February and August of each year.

(g) OCED Financing

In June 2020, MHS finalized a sale-leaseback transaction for four off-campus emergency departments (OCED) with total cash proceeds received of $61,794. In October 2022, MHS finalized a sale-leaseback for three additional OCEDs. Due to the specific terms of the agreements, the leases qualified as financing type leases. The agreements did not meet the criteria for sale-leaseback accounting treatment and instead are considered a financing liability. For the agreement finalized in 2022, cash proceeds are not received until construction commences and repayment of the financing liabilities do not start until construction is completed. Construction of the first OCED was completed in December 2023. The 2020 agreement bears an implicit interest rate of 4.64% while the 2022 agreement bears an implicit interest rate of 5.90%. Total annual principal payments range from $1,856 in 2043 to $6,431 in 2039.

(h) WHCFA Revenue Bonds 2017 Series A and B

In November 2017, MHS issued $333,970 of 2017 Series A and B bonds. These bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.0%. Annual principal payments range from $4,310 in 2024 to $62,410 in 2047.

(i) WHCFA Revenue Bonds 2017 Series C, D, and E

In November 2017, MHS entered into a $111,010 variable rate private placement agreement (Series C and D) with JPMorgan Chase Bank, National Association. The first annual principal payment of $55,505 is due in 2048, with a final principal payment of $55,505 in 2049. The interest rates reset monthly and are based on SOFR plus a spread.

(j) WHCFA Revenue Bonds 2015 Series A and B

In April 2015, MHS issued $373,390 of 2015 Series A and B bonds. Series A and B bonds were issued as fixed rate bonds that bear interest ranging from 2.0% to 5.0%. Annual principal payments range from $4,295 in 2040 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(k) Other

The other debt listed is primarily made up of debt held by Navos. Of the outstanding debt at December 31, 2023, $16,350 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. These provisions state that Navos maintains the assets that were built or purchased with these notes and maintains their usage when the promissory note was signed for the length specified. If these provisions are not met, the note must be repaid based on the terms of the agreement. The forgivable debt is subject to a forgiveness provision in years 2028 through 2068.

(Dollars in thousands)

(I) Line of Credit

In October 2022, MHS entered into a $200,000 revolving credit agreement with JPMorgan Chase Bank, NA. In October 2023, the agreement was amended to $100,000. The line of credit matures October 2024 and bears interest at a variable rate based upon SOFR. The balance outstanding was $62,935 as of December 31, 2023. The line on credit had no draws as of December 31, 2022.

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2023 and 2022.

Each fixed-rate revenue bond requires semiannual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

Principal maturities on long-term debt are as follows:

Year ending December 31:		
2024	$	22,456
2025		23,581
2026		24,753
2027		25,993
2028		27,298
Thereafter		1,817,636
	$	1,941,717

A summary of interest costs is as follows during the years ended December 31, 2023 and 2022:

		2023	2022
Interest cost:			
Charged to operations	$	81,941	59,006
Amortization of bond premiums, discounts, and issuance costs		(2,226)	(2,163)
Capitalized		2,486	555
	$	82,201	57,398

(Continued)

(Dollars in thousands)

(16) Commitments and Contingencies

Approximately 42% of MHS employees were covered under collective bargaining agreements as of December 31, 2023. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through March 2026.

(17) Leases

(a) Lessee

MHS leases various equipment and facilities under noncancelable operating and finance leases. Lease terms for noncancelable operating leases range from 1 to 20 years, and existing leases have expiration dates through 2042. Lease terms for finance leases range from 1 to 21 years, and existing leases have expiration dates through 2040.

The components of lease cost for the years ended December 31, 2023 and 2022 were as follows:

		2023	2022
Operating lease cost	$	42,050	36,768
Finance lease cost:			
Amortization of right-of-use assets		5,922	4,745
Interest on lease liabilities		819	802
Total finance lease cost		6,741	5,547
Short term lease cost		751	1,503
Variable lease cost		—	9,138
Sublease income		(595)	(1,727)
Total lease cost	$	48,947	51,229

Other information related to leases as of December 31, 2023 and 2022 was as follows:

	2023	2022
Weighted average remaining lease term (years):		
Operating leases	8.6	7.2
Finance leases	5.5	6.0
Weighted average discount rate:		
Operating leases	4.0 %	4.0 %
Finance leases	4.4	4.4

(Continued)

(Dollars in thousands)

	2023	2022
Operating cash flows from operating leases	$ (39,882)	(35,805)
Operating cash flows from finance leases	(819)	(802)
Financing cash flows from finance leases	(5,782)	(4,499)
Right-of-use assets obtained in exchange for new operating lease liabilities	62,205	56,322
Right-of-use assets obtained in exchange for new finance lease liabilities	7,676	3,528

Maturities of lease liabilities under noncancelable leases as of December 31, 2023 are as follows:

	Operating leases	Finance leases	Total
For year ended December 31:			
2024	$ 45,337	7,278	52,615
2025	41,668	5,215	46,883
2026	37,006	2,420	39,426
2027	30,844	2,154	32,998
2028	27,300	1,305	28,605
Thereafter	106,550	3,045	109,595
Total undiscounted lease payments	288,705	21,417	310,122
Less present value discount	(42,748)	(2,470)	(45,218)
Total lease liabilities	$ 245,957	18,947	264,904

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS and is the only asset that MHS leases out as a lessor. The lease has a 20-year initial lease term, with four 5-year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40-year lease. There is no purchase option stated in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. The net investment in this lease was $22,459 and $22,655 at December 31, 2023 and 2022, respectively, and is included in other assets, net on the consolidated balance sheets.

(Continued)

(Dollars in thousands)

Revenue from leases for the years ended December 31, 2023 and 2022 is as follows:

		2023	2022
Interest income on net investment in finance leases	$	1,022	1,032
Variable lease income		28	28
Total lease income	$	1,050	1,060

Future lease payments receivable as of December 31, 2023 are as follows:

Year ended December 31:		
2024	$	1,227
2025		1,227
2026		1,227
2027		1,227
2028		1,227
Thereafter		39,346
Total lease payments to be received		45,481
Less unearned interest income		(23,022)
Net investment in lease	$	22,459

(18) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2023 and 2022:

		2023	2022
Healthcare services	$	105,652	51,816
Endowment funds, perpetual trusts and related receivables		71,548	78,231
Purchase of property, plant and equipment		79,602	42,001
Indigent care		2,499	2,459
Health education		1,360	1,006
Total net assets with donor restrictions	$	260,661	175,513

(Continued)

(Dollars in thousands)

(19) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

The following tables present MHS' endowment net asset composition as well as associated changes therein:

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2021	$ 2,861	44,012	46,873
Investment return:			
Investment income	16	376	392
Net depreciation – realized and unrealized	(85)	(987)	(1,072)
Total investment return	(69)	(611)	(680)
Contributions	—	3,499	3,499
Appropriation of endowment assets for expenditure	(28)	(581)	(609)
Endowment net assets, December 31, 2022	2,764	46,319	49,083
Investment return:			
Investment income	72	933	1,005
Net depreciation – realized and unrealized	334	5,850	6,184
Total investment return	406	6,783	7,189
Contributions	—	18,188	18,188
Appropriation of endowment assets for expenditure	(1,198)	(29,455)	(30,653)
Endowment net assets, December 31, 2023	$ 1,972	41,835	43,807

(Continued)

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $18,698 and $27,650, respectively, as of December 31, 2023 and 2022. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $4,020 and $4,262, respectively, as of December 31, 2023 and 2022.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2023 or 2022.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that an annual spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(Continued)

(Dollars in thousands)

(20) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fundraising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2023 and 2022:

	2023				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 1,566,478	510,975	162,278	279,047	2,518,778
Employee benefits	159,185	78,846	40,516	102,520	381,067
Supplies	630,578	47,346	124,610	5,171	807,705
Purchased services	184,355	69,179	51,253	181,244	486,031
Depreciation and amortization	110,864	13,849	12,005	26,549	163,267
Interest	69,347	818	77	11,699	81,941
Other	378,173	54,197	155,055	111,272	698,697
	$ 3,098,980	775,210	545,794	717,502	5,137,486

	2022				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 1,357,838	464,219	93,787	283,421	2,199,265
Employee benefits	133,164	75,536	20,705	68,208	297,613
Supplies	535,376	48,220	70,994	3,880	658,470
Purchased services	135,500	68,800	32,771	159,676	396,747
Depreciation and amortization	87,289	14,878	7,580	31,145	140,892
Interest	40,631	3,715	70	12,426	56,842
Other	281,895	48,356	121,797	89,198	541,246
	$ 2,571,693	723,724	347,704	647,954	4,291,075

(Continued)

(21) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(22) Subsequent Events

MHS has evaluated the subsequent events through March 20, 2024, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.