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

September 5, 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 Relocate Existing, CN-Approved 6-Bed Level II Intermediate Care Nursery from the Auburn Medical Center Campus and License to the Covington Medical Center Hospital Campus and License

Dear Mr. Hernandez:

On behalf of MultiCare Health System, please accept this certificate of need application to relocate the existing, CN-approved 6-bed Level II Intermediate Care Nursery (the "ICN") from the Auburn Medical Center campus and license to the Covington Medical Center campus and license. Both hospitals are located in the Southeast King Planning Area. With the relocation of the 6 beds and tertiary service, CMC would increase its number of licensed beds to 64 licensed beds (58 existing beds + 6 Level II ICN beds) and AMC would decrease its number of licensed beds from 195 to 189 licensed beds (131 general medical surgical beds + 58 psychiatric beds).

Thank you in advance for your review of our application. Check number 138809 in the amount of $40,470 was mailed to the Department of Health office on August 27, 2025. The USPS tracking number is: 9505 5138 2872 5239 0169 62. Based on the tracking number the check was picked up on August 28th.

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

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

Hunter Plumer, MHA
Health Trends Consulting
425-469-5687
hplumer@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 **Email Address** ekobberstad@multicare.org	**Date:** September 5, 2025 **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). + Covington Medical Center. License #212 + Auburn Medical Center. License #183 **Provide a brief description, including the number of beds and the location:** Relocation of 6 Level II Intermediate Care Nursery bassinets from Auburn Medical Center to Covington Medical Center. **Estimated capital expenditure:** $ 2,854,386
Identify the Hospital Planning Area The service area is Southeast King Secondary Hospital Planning Area.	

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 (indicate level)	☐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 Covington Medical Center

Certificate of Need Application for Relocation of Level II Intermediate Care Nursery Bassinets

September 2025

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Introduction and Rationale

MultiCare Health System ("MultiCare") dba MultiCare Auburn Medical Center ("AMC") and MultiCare Covington Medical Center ("CMC") submits this certificate of need ("CN") application to relocate the existing, CN-approved 6-bed Level II Intermediate Care Nursery (the "ICN") from the AMC hospital campus and license to the CMC hospital campus and license. Both hospitals are located in the Southeast King Planning Area. With the relocation of the 6 beds and tertiary service, CMC would increase its number of licensed beds to 64 licensed beds (58 existing beds + 6 Level II ICN beds) and AMC would decrease its number of licensed beds from 195 to 189 licensed beds (131 general medical surgical beds + 58 psychiatric beds).

MultiCare is a locally-governed, not-for-profit, integrated health system that also owns and/or operates Good Samaritan Hospital, Tacoma General / Allenmore Hospital (joint license), Capital Medical Center, Mary Bridge Children's Hospital, AMC, CMC, 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.

CMC had a birth center when it first opened, but did not have a Level II ICN. At that time, considering the total patient volumes between the Auburn and Covington campuses, MultiCare decided to consolidate its neonate program at a single site to ensure the highest quality of care, a consistent patient experience, and long-term financial sustainability. The program was consolidated at AMC because that facility housed the existing Level II ICN.

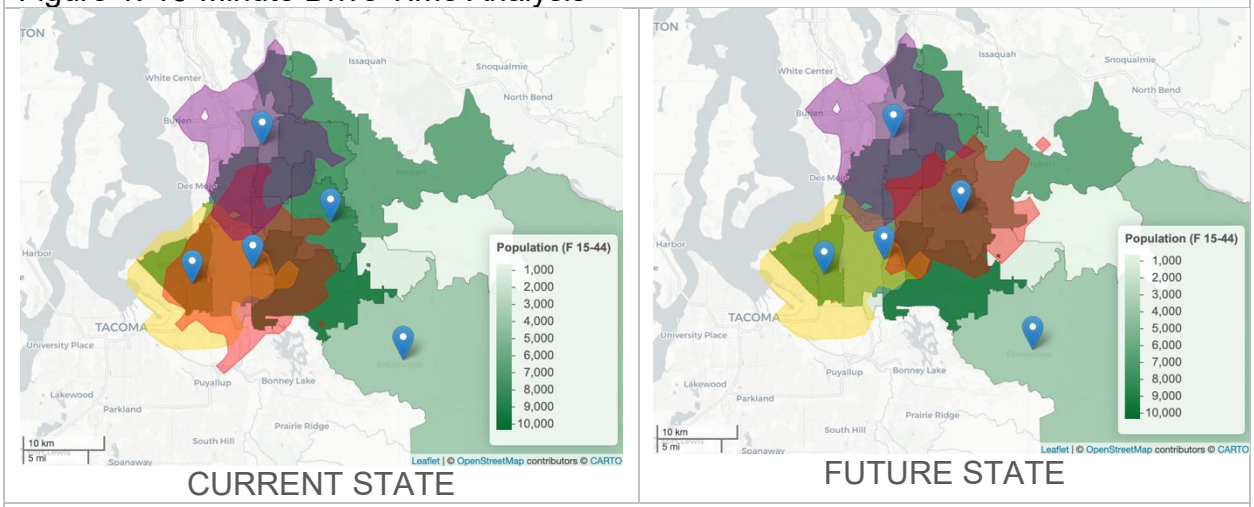
Our long-term strategic assessment has since determined that the community is best served by maintaining a single, integrated program in the market but relocating the program to the Covington campus. This move aligns with the demographic trends in the planning area and allows for the development of a more comprehensive and modern program given the updated facilities available at CMC.

This application is requesting CN approval to relocate the Level II ICN. Relocating the Level II ICN from AMC to CMC will provide significant benefits to patients and the health system.

- **Modern and Efficient Facility Design:** As a newer hospital, CMC offers more modern facilities designed to support contemporary models of patient- and family-centered care. The physical infrastructure can better accommodate a modern birth center, enhancing patient safety, privacy, and comfort. This environment allows for a relatively more supportive healing environment for mothers and infants compared to what is possible in an older facility.

- **Improved Geographic Access**: Moving the Level II ICN to CMC improves geographic access to specialized neonatal care for communities within the eastern part of the Southeast King planning area. See Figure 1 depicting a comparative 15-minute drive time analysis between the current state at AMC and proposed future state at CMC. These figures also display a heat map of the female 15-44 population zip code, which reveals that populous areas are not within a 15-minute drive under the current state.[1] This analysis demonstrates that the proposed relocation represents a more balanced distribution of supply and access to neonate services in the planning area.

Figure 1. 15-Minute Drive Time Analysis



CURRENT STATE FUTURE STATE

Notes: Purple indicates 15-minute drive zone around Valley Medical Center. Yellow indicates 15-minute drive zone around St. Francis Hospital. Red indicates 15-minute drive zone around Auburn Medical Center (current state) or Covington Medical Center (future state). Pins represent locations of planning area hospitals.

Population Source: Claritas 2025; 2025 Female Population (Ages 15-44 Years Old)

- **Maintains Clinical and Operational Efficiency**: It makes clinical and operational sense to continue to operate a single, comprehensive neonate program within the Southeast King Planning Area. Maintaining a consolidated program at one site eliminates inefficiencies and potential care gaps associated with managing a split program. A unified team at CMC can maintain consistent and high-quality clinical care and best practices for all newborns, including those that require intermediate care. This ensures a seamless continuum of care and optimizes the use of specialized resources.

[1] While not shown in the heat map, an analysis of Level II neonate patient days by zip code reveals that areas that have significant utilization of neonate services are not within a 15-minute drive under the current state; similar to the findings from the population analysis observed in Figure 1.

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 ("MultiCare")
   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. Its UBI Number 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).**

   Hunter Plumer, MHA
   Consultant
   16531 62nd Ave W
   Lynnwood, WA, 98037
   386-795-1731
   hplumer@healthtrends.consulting

   Please also include the following associated consultants in communications and access to materials related to this application:
   - Jonathan Fox, PhD | jfox@healthtrends.consulting
   - Frank G. Fox, PhD | frankgfox@comcast.net

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

Please see Exhibit 1 for an organization chart of MultiCare. “MultiCare Covington Medical Center” and “MultiCare Auburn Medical Center” are each trade names (i.e., “Doing Business As” (dba)) of MultiCare.

II. Facility Description

1. Provide the name and address of the existing facility

The 6-bed Level II Intermediate Care Nursery ("ICN") is currently located at MultiCare Auburn Medical Center ("AMC"):

MultiCare Auburn Medical Center
202 N Division St
Auburn, WA 98001

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.

Upon completion of the proposed relocation, the 6-bed Level II ICN will be located at MultiCare Covington Medical Center ("CMC"):

MultiCare Covington Medical Center
17700 SE 272nd St
Covington, WA 98042

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, the ICN will continue to be licensed and certified by Medicare and Medicaid upon project completion.

<u>MultiCare Covington Medical Center</u>

- License #: HAC.FS.60803817
- Medicare #: 500154
- Medicaid #: 2102039

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

CMC is and will continue to be accredited by the Joint Commission.

5. Is the facility operated under a management agreement?

Yes ☐ No ☒

If yes, provide a copy of the management agreement.

6. Provide the following scope of service information:

Service (CMC)	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 (indicate level, if applicable)	☐	☐
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.**

   Please see the *Introduction and Rationale* section at the beginning of this application for a detailed description of the proposed project. MultiCare requests CN approval to relocate the existing, CN-approved 6-bed Level II ICN from the AMC hospital campus and license to the CMC hospital campus and license.

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).**

   Confirmed. Please see the addendum at the end of this application for responses regarding the NICU Level II tertiary service.

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

	Current	Proposed*
General Acute Care	58	58
PPS Exempt Psych		
PPS Exempt Rehab		
NICU Level II		6
NICU Level III		
NICU Level IV (Includes Level III NICU)		
Specialized Pediatric		
Skilled Nursing		
Swing Beds (included in General Acute Care)		
Total	**58**	**64**

*Upon project completion, AMC's licensed bed supply will decrease by six (6) NICU Level II beds.

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.**

   Ten (10) of CMC's 58 CN-approved general acute care beds are not currently set-up. These are beds associated with the birth center that CMC had

previously set-up and is planning to set-up again at the same time as relocating and operating the 6-bed ICN.

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

Table 1. Project Timeline

Event	Anticipated Month/Year
Anticipated CN Approval	March 2026
Design Complete	May 2026
Construction Commenced	October 2026
Construction Completed	February 2027
Facility Prepared for Survey	April 2027
Facility Licensed - Project Complete WAC 246-310-010(47)	May 2027

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

   This CN request seeks to continue serving neonatal patients requiring Level II ICN care in the Southeast King Planning Area. There is no anticipated change in the types of patients expected to be served because of the transfer of the ICN from AMC to CMC.

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 a copy of the single line drawings of the proposed ICN at CMC.

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

   The gross square footage for the proposed ICN at CMC is 3,800 square feet.

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

    The proposed project involves construction less than 12,000 square feet. Therefore, this question is not applicable.

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

    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.

    A technical assistance meeting with CRS was held earlier this year. An official CRS number has not yet been established for this project. CRS will be contacted when design is near completion.

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.**

   Please see Table 2 below for a list of acute care hospitals in the Southeast King Hospital Planning Area.

Table 2. List of Southeast King Acute Care Hospitals

Hospital	Hospital License #	Neonate Tertiary Service Provider
UW Valley Medical Center	155	Level II-III
MultiCare Auburn Medical Center	183	Level II
VMFH St. Francis Hospital	201	Level II
MultiCare Covington Medical Center	212	N/A
VMFH St. Elizabeth Hospital	035	N/A

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

   This CN request does not propose adding any beds beyond those for which CMC and AMC are currently approved. Thus, this question is not applicable.

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

   This CN request does not propose adding any beds beyond those for which AMC is currently approved. It does propose transferring the existing 6 ICN and beds from AMC to CMC, as discussed above.

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 3. Historical Utilization

Auburn Medical Center Level II ICN	**CY2022**	**CY2023**	**CY2024**
Licensed beds	6	6	6
Available beds	6	6	6
Cases	168	152	133
Patient Days[1]	810	830	659
Average Daily Census	2.22	2.27	1.81
Covington Medical Center Entire Hospital	**CY2022**	**CY2023**	**CY2024**
Licensed beds	58	58	58
Available beds	48/58[2]	48	48
Cases	2,666	2,260	2,591
Patient Days	12,056	8,644	9,868
Average Daily Census	33.0	23.7	27.0

[1] AMC Level II ICN patient days are based on the number of units reported for revenue code 0172 which is the primary revenue code for Level II neonates.
[2] Partial year with newborn beds set up.
Source: CHARS 2022-2024 and Applicant.

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

Table 4. Utilization Projections

Covington ICN	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031+**
Licensed Beds	0	0	6	6	6	6	6
Available Beds	0	0	6	6	6	6	6
Cases	0	0	115	223	248	274	274
Patient Days	0	0	569	1,105	1,231	1,356	1,356
Covington Non-ICN	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031+**
Licensed Beds	58	58	58	58	58	58	58
Available Beds	48	48	58	58	58	58	58
Cases	2,591	2,591	3,406	3,814	3,814	3,814	3,814
Patient Days	9,868	9,868	11,133	11,765	11,765	11,765	11,765

Methodology – Covington ICN

a. Total patient days for Southeast King Level II neonates are defined as neonate patients where the highest revenue code reported was 0172 ("Newborn Level II"[2]). These Level II patient days have remained relatively stable over the past three years — 6,601 days in 2022, 6,437 days in 2023, and 6,484 days in 2024. It is assumed that in the forecast the Southeast King Level II market will continue to be stable, with approximately 6,484 Level II patient days per year assumed over the forecast period.
b. Consistent with the timeline presented in Table 1, the Level II ICN is anticipated to be operational at CMC by May 2027.
c. Over the past 3 years, AMC's Level II ICN's average market share of Southeast King Level II neonate patient days was 24%. With the enhanced facilities and geographic access that CMC offers relative to AMC for neonates, as well as MultiCare's ongoing increase in patients served in the community, it is anticipated that CMC will increase its market share to 45% of Southeast King Level II neonate patient days by the third full year of operation (2030). The CMC Level II patient days will then remain constant thereafter.
d. In-migration of out-of-area residents for Level II care to CMC is assumed to be 225 patient days each year over the forecast period, adjusted by effective number of months, which is consistent with experience observed at AMC's ICN in recent years.
e. Cases are calculated by dividing the patient day forecast by AMC's 2024 average length of stay (4.95 days per stay).

Table 5. ICN Historical and Projected Utilization

Historical Market Share and Occupancy of Auburn Medical Center Level II ICN

	2022	2023	2024
Southeast King Planning Area Residents (Max Level II[1])	2,201	2,547	2,514
Auburn Medical Center (SE King Residents)	567	610	563
Auburn Medical Center (SE King Market Share)	25.8%	23.9%	22.4%
Auburn Medical Center (Out-of-Area Residents)	243	220	96
Auburn Medical Center (Total Patient Days)	810	830	659
Auburn Medical Center (Average Daily Census)	2.22	2.27	1.81

[2] *See* https://med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes.

Projected Utilization at Proposed Covington Medical Center Level II ICN Post-Relocation

	May - Dec 2027	2028	2029	2030
# of Months	8	12	12	12
Southeast King Planning Area Residents	1,676	2,514	2,514	2,514
Covington Medical Center (Market Share)	25.0%	35.0%	40.0%	45.0%
CMC (SE King Residents)	419	880	1006	1131
CMC (Out-of-Area Residents)	150	225	225	225
CMC (Total Patient Days)	569	1,105	1,231	1,356
CMC (Average Daily Census)	2.34	3.03	3.37	3.72

[1] Max Level II neonates are defined as neonate patients where the highest revenue code reported was 0172. Therefore, this excludes Southeast King resident Level II patient days where a patient received Level III or IV care (0173 and 0174 revenue code units) during the same hospital stay.
Source: CHARS 2022-2024

Methodology – Covington (Non-ICN)

a. 2025-2026 held constant at 2024 actual CMC volumes.
b. 2027-2030 and later assumed to be 2024 actual CMC volumes plus AMC's Family Birth Center ("FBC") 2024 actual volumes (1,897 patient days and 1,223 cases in 2024), adjusted by the effective number of months.

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

See Exhibits 4A and 4B for CY2024 patient origin statistics for CMC (hospital-wide) and AMC's Level II ICN.

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

This CN request proposes a relocation of beds within a planning area, not a net change in supply of beds. Please see the discussion in the *Introduction and Rationale* section that discusses the enhanced access to care that the proposed project offers for planning area residents.

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.

CMC is committed to meeting community and regional health needs and provides charity care consistent with the MultiCare Charity Care Policy, included under Exhibit 5A.

Our financial pro forma forecast for the ICN provided in Exhibit 6 explicitly allocates 2.73% of gross revenues to be provided for charity care based on CMC's 2024 actual charity care percentage. This figure, which equals the CMC 2024 charity care figure, is above the Southeast King Planning Area Hospital and King County (Less Harborview) Regional charity care average, between 2021 to 2023. Please see Table 6 below.

Table 6. Charity Care Statistics

		% of Total Revenues			
Lic. No	**Region/Hospital**	**2021**	**2022**	**2023**	**3 Year Average**
155	UW Medicine/Valley Medical Center	0.65%	0.67%	0.80%	0.71%
183	MultiCare/Auburn Regional Medical Center	2.03%	1.92%	2.00%	1.99%
201	CHI/Saint Francis Community Hospital	1.37%	1.48%	1.75%	1.53%
212	MultiCare/Covington Medical Center	2.58%	2.36%	2.42%	2.46%
35	CHI/Saint Elizabeth Hospital	0.81%	1.04%	1.13%	0.99%
	SOUTHEAST KING PLANNING AREA HOSPITALS	1.49%	1.50%	1.62%	1.54%
	KING COUNTY (LESS HARBORVIEW)	0.88%	0.99%	0.97%	0.94%

*Southeast King and 3-Year averages are calculated based on unweighted average.
Source: DOH Charity Care Reports, 2021-2023

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 current location of the Level II ICN at AMC presents certain limitations that the proposed relocation is designed to address.

- **Aging Facility Infrastructure:** As an older facility, AMC's physical plant poses constraints on modernizing the birth center. The existing infrastructure makes it challenging and costly to renovate rooms to the specifications required for a state-of-the-art maternal unit.

- **Geography and Patient Demographics:** While AMC has served the community well, regional growth patterns have shifted. There is now a patient population for maternal and newborn services (i.e. young, growing families) concentrated in the service area surrounding CMC. Relocating the neonate services helps improve the geographic access for planning area residents. Please see Figure 1 and *Introduction and Rationale* section, above, and the discussion below explaining the improvement in patient access resulting from the project.

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.

Relocating the Level II ICN from AMC to CMC will provide significant benefits to patients and the health system.

- **Modern and Efficient Facility Design:** As a newer hospital, CMC offers more modern facilities designed to support contemporary models of patient- and family-centered care. The physical infrastructure can better accommodate a modern birth center, enhancing patient safety, privacy, and comfort. This environment allows for a relatively more supportive healing environment for mothers and infants compared to what is possible in an older facility.

- **Improved Geographic Access**: Moving the Level II ICN to CMC improves geographic access to specialized neonatal care for communities within the eastern part of the Southeast King planning area. See Figure 1 depicting a comparative 15-minute drive time analysis between the current state at AMC and proposed future state at CMC. These figures also display a heat map of the female 15-44 population zip code, which reveals that populous areas are not within a 15-minute drive under the current state.[3] This analysis demonstrates that the proposed relocation represents a more balanced distribution of supply and access to neonate services in the planning area.

- **Maintains Clinical and Operational Efficiency**: It makes clinical and operational sense to continue to operate a single, comprehensive neonate program within the Southeast King Planning Area. Maintaining a consolidated program at one site eliminates inefficiencies and potential care gaps associated with managing a split program. A unified team at CMC can maintain consistent and high-quality clinical care and best practices for all newborns, including those that require intermediate care. This ensures a seamless continuum of care and optimizes the use of specialized resources.

The relocation also frees physical capacity at AMC which will give it an opportunity to repurpose that space to expand services focused on meeting the needs of the surrounding community.

[3] While not shown in the heat map, an analysis of Level II neonate patient days by zip code reveals that areas that have significant utilization of neonate services are not within a 15-minute drive under the current state; similar to the findings from the population analysis observed in Figure 1.

11. Provide a copy of the following policies:

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

All requested policies are provided in Exhibits 5A – 5F.

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 6 for the financial exhibit including the following information:

    - Historical revenue and expense statements
    - Pro forma projections
    - FTE staffing
    - Balance Sheet
    - Assumptions to explain/support key financial models

    Please see Table 4, above, for utilization projections.

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

    The hospital's fiscal year is consistent with the calendar year (January to December).

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.

    The agreements listed above are not applicable to the CN request.

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

   The proposed location upon project completion will be CMC's campus. See Exhibit 7A for a copy of the deed of the property where CMC's campus is located.

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

   See Exhibit 7B for summary property information from the King County Assessor's Information Portal demonstrating that the parcels are under the hospital use code.

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 7. Total Estimated Capital Expenditures

Item	Cost
a. Land Purchase	---
b. Utilities to Lot Line	---
c. Land Improvements	---
d. Building Purchase	---
e. Residual Value of Replaced Facility	---
f. Building Construction	$1,769,933
g. Fixed Equipment (not already included in the construction contract)	$69,000
h. Movable Equipment	$298,520
i. Architect and Engineering Fees	$518,750
j. Consulting Fees	---
k. Site Preparation	---
l. Supervision and Inspection of Site	---
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	---

Item	Cost
1. Land	---
2. Building	---
3. Equipment	---
4. Other	---
n. Washington Sales Tax	$198,184
Total Estimated Capital Expenditure	**$2,854,386**

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 is the sole entity responsible for the estimated capital costs.

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.**

   Please see the pro forma projections presented in Exhibit 6, which includes start-up cost estimates and assumptions for the proposed project.

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.**

   MultiCare is the sole entity responsible for the estimated start-up costs.

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

    Please see Exhibit 8 for a non-binding contractor's estimate for the construction costs for the 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.**

    CMC's reimbursement is not tied to its capital expenditures. Furthermore, given the space already exists and requires only remodeling, the proposed project requires only modest capital expenditures. Therefore, the proposed capital expenditures associated with this CN request will not have an unreasonable effect on costs and charges for health services in the planning area.

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

Table 8. Payer Mix Projections

	Payer	% of Cases	% of Revenues
Covington ICN	Medicaid	72%	72%
	Health Care Service Contractor	15%	17%
	Commercial	10%	9%
	Self-Pay	*	*
	Other Government	*	*
	HMO	*	*
Covington Non-ICN (Family Birth Center + Other Existing Acute Services)	Medicare	36%	49%
	Medicaid	35%	23%
	Health Care Service Contractor	15%	15%
	Other Government	2%	3%
	Commercial	9%	7%
	Self-Pay	2%	2%
	HMO	+	+
	L&I	*	*

"*" Suppressed cell if 10 cases or less.
"+" Suppressed cell if other remaining cell is "*".
Source: CHARS 2024

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.

The payer mix projections included in Table 8 above are based on the historical 2024 payer mix for AMC's existing Level II ICN and family birth center services, as well as CMC's general acute care services.

Table 9. Historical Payer Mix

	Payer	% of Cases	% of Revenues
Auburn ICN	Medicaid	72%	72%
	Health Care Service Contractor	15%	17%
	Commercial	10%	9%
	Self-Pay	*	*
	Other Government	*	*
	HMO	*	*
Auburn Family Birth Center	Medicaid	68%	70%
	Health Care Service Contractor	16%	16%
	Commercial	12%	10%
	Self-Pay	2%	2%
	Other Government	1%	1%
	HMO	*	*
	Medicare	*	*
Covington	Medicare	53%	54%
	Medicaid	19%	18%
	Health Care Service Contractor	14%	14%
	Commercial	7%	7%
	Other Government	3%	3%
	Self-Pay	2%	3%
	HMO	+	+
	L&I	*	*

"*" Suppressed cell if 10 cases or less.
"+" Suppressed cell if other remaining cell is "*".
Source: CHARS 2024

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.

See Exhibit 9 for the equipment list for the proposed project.[4]

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.

MultiCare will finance the project-related capital expenditures from its corporate reserves.

See Exhibit 10 for a letter of financial commitment from MultiCare's Executive Vice President of Population Based Care & Chief Financial Officer, James Lee.

16. Provide the most recent audited financial statements for:

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

See Exhibit 11 for the most recent audited financial statements for MultiCare.

[4] CMC will primarily use relocated equipment from the existing Level II ICN at AMC. Exhibit 9 includes the list of new equipment to be purchased.

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.

Please see Table 10 for a list of MultiCare facilities.

Table 10. MultiCare 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[5]	3402 S. 19th Street Tacoma, WA 98405	504016	150453

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

Name	Address	Medicare Provider Number	Medicaid Provider Number
MultiCare Capital Medical Center	3900 Capital Mall Dr SW Olympia, WA 98502	500139	330365
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.**

   See Table 11 below for an FTE schedule of historical and projected FTEs. A FTE schedule by type for the Level II ICN is included in Exhibit 6.

Table 11. Historical and Projected FTEs

	2022	2023	2024	2025	2026	2027	2028	2029	2030
Covington (ICN)	-	-	-	-	-	10.43	10.56	10.63	10.69
Covington (Non-ICN)	325.13	286.62	307.88	307.88	307.88	335.15	348.78	348.78	348.78
Total FTEs	**325.13**	**286.62**	**307.88**	**307.88**	**307.88**	**345.58**	**359.35**	**359.41**	**359.48**

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

   See the assumptions worksheet included in Exhibit 6, which provides a list of assumptions used to project the number and types of FTEs.

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

Table 12. Key Clinical Staff

NAME	Position	License Number
Arun Mathews, MD	Chief Medical Officer	MD60804086
Staci Hartmann, MBA, BSN, RN	Chief Nursing Officer	RN00128461
Alyssa Hamlin, MD	Physician Leader	MD61045315
Michele Denney, RN	Clinical Director of Women's Services	RN00102971

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.

   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."[6]

   Furthermore, while workers have different preferences when it comes to qualitative factors, higher compensation is universally preferred to lower compensation. MultiCare understands this fact, and the projected salary structure for CMC accounts for competitive salaries to attract employees. In addition, since competitive salaries reduce turnover,[7] 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 and retain the new staff that will be required.

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

   CMC is not a new facility. Therefore, this question is not applicable.

[6] https://www.forbes.com/best-employers-by-state/#3c516a7a487a, Last Accessed July 1, 2025.
[7] 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.

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

CMC's existing "Ancillary, Support, and Other" Services are provided in Table 13 below.

Table 13. List of Ancillary, Support, and Other Services

Description	Internal / External	Vendor
Food & Nutrition	Internal	MultiCare
Imaging	Internal	MultiCare
Diagnostic Imaging services (CT, MRI, X-ray, PET)	Internal	MultiCare
Lab & Pathology	Internal	MultiCare
Environmental Services	Internal	MultiCare
Respiratory Therapy	Internal	MultiCare
Health Information Management	Internal	MultiCare
Supply Chain	Internal	MultiCare
IS&T	Internal	MultiCare
Safety/Emergency Mgmt	Internal	MultiCare
Biomedical/Clinical Engineering	Internal	MultiCare
Infection Prevention	Internal	MultiCare
Registration	Internal	MultiCare
Quality Management	Internal	MultiCare
Case Mgmt/Social Work	Internal	MultiCare
Customer Support	Internal	MultiCare
Security	Internal	MultiCare
Medical Staff Services	Internal	MultiCare
NICU specific physicians	External	Pediatrix
Facilities/Environment of Care	Internal	MultiCare
Utilization Review	Internal	MultiCare
Supply Chain	Internal	MultiCare
Perioperative Services	Internal	MultiCare
Pathology Services	External	CellNetix
Pharmacy – Ventilation/Hood Cleaning Services	External	Pentagon Technologies Group, Inc. d/b/a Pentagon Technologies
Interpretation Services Agreement: spoken and sign language interpreters	External	Cross Cultural Communications Inc.
Blood Products and Services	External	Cascade Regional Blood Services
Organ Procurement	External	LifeCenter Northwest

*External not all inclusive; high-level

The existing Level II ICN at AMC has ancillary and support services in place such as dietary, pharmacy, respiratory therapy, and imaging (x-ray). As described in the tertiary service addendum to this application, MultiCare's existing Level II ICN at AMC adheres to the Washington State Perinatal Level of Care Guidelines. MultiCare confirms that it will continue to adhere to the Washington State Perinatal Level of Care Guidelines for the proposed relocation of the Level II ICN to CMC.[8]

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

There are no changes anticipated to the ancillary and support agreements as result of the proposed project. Ancillary and support services specific to the AMC ICN will be extended to the CMC ICN when it becomes operational.

Further, as described in the tertiary service addendum to this application, MultiCare's existing Level II ICN at AMC adheres to the Washington State Perinatal Level of Care Guidelines. MultiCare confirms that it will continue to adhere to the Washington State Perinatal Level of Care Guidelines for the proposed relocation of the Level II ICN to CMC.

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

CMC is an integrated member of the community health system and has developed relationships with many community and regional partners. This includes EMS, primary care and specialty clinics, other hospitals, nursing homes, assisted living communities, home health and hospice.

See Exhibit 14 for a MultiCare system-wide policy for patient transfers.

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

There is no anticipated change to the working relationships as a result of this CN request.

[8] See Exhibit 15 for a copy of the Washington State Perinatal Level of Care Guidelines and corresponding guiding documents from the American Academy of Pediatrics and American College of Obstetricians and Gynecologists referenced in the Washington State guidelines.

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

CMC is not a new facility. Therefore, 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.

This CN request does not propose adding any beds beyond those for which CMC and AMC are currently approved. The proposed relocation of the specialized neonatal services to CMC will continue existing services. 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).

This CN request does not propose adding any beds beyond those for which CMC and AMC are currently approved. Thus, the proposed project will sustain and build upon the relationships with the service area's existing health care system.

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.

MultiCare has no history with the actions described above. Therefore, this question is not applicable.

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 following three options were evaluated in the alternatives analysis:

   - Option One: Continue to Operate the ICN at Auburn Medical Center — Do Nothing
   - Option Two: Close the ICN at Auburn Medical Center and not operate Level II ICN services in the Southeast King planning area.
   - Option Three: Relocate ICN from Auburn Medical Center to Covington Medical Center — The Project

   A fourth option of developing a new ICN at CMC while continuing to operate the existing ICN at AMC was deemed an unfeasible option and not a valid alternative, as projected volumes in the planning area necessary to support a new, incremental Level II program are forecast to be insufficient. Additionally, this fourth option would require additional capital and operational expenditures at CMC.

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 14 to Table 18, which compare the three 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 14: Alternatives Analysis: Promoting Access to Healthcare Services	
Option:	**Advantages/Disadvantages:**
Option One: Continue to Operate the ICN at AMC--Do Nothing	• Continues planning area residents' access to currently supplied specialized neonatal services available in planning area. (Advantage, "A"). • Drive time analysis shows that certain communities in surrounding Covington area do not have as timely access as with the Project. (Disadvantage, "D")
Option Two: Close the ICN at AMC and not operate Level II ICN services in the Southeast King planning area.	• Closing the ICN would drastically reduce access to a medically necessary, specialized neonatal service, forcing families to increasingly travel significantly farther, often outside their community, to receive essential care. (D) • Although other planning area supply is available, this would create a critical gap in access for newborns in the communities that AMC and CMC serve. (D)
Option Three: Relocate ICN from AMC to CMC — **The Project**	• Continues planning area residents' access to currently supplied specialized neonatal services available in planning area. (A) • Improves geographic access for the population of young families who are concentrated in the Covington service area while maintaining overall balance of geographic access for the whole planning area. (A)

Table 15: Alternatives Analysis: Promoting Quality of Care	
Option:	**Advantages/Disadvantages:**
Option One: Continue to Operate the ICN at AMC --Do Nothing	• Leverages the existing, experienced clinical staff who currently provide high-quality care at AMC. (A) • Constrained by operating within an aging facility. (D)
Option Two: Close the ICN at AMC and not operate Level II ICN services in the Southeast King planning area.	• Fundamentally degrades the quality of care in the planning area by creating a significant gap for newborns requiring specialized neonatal services. (D) • Disrupts access to established care pathways that could lead to lower quality health outcomes. (D)

Option Three: Relocate ICN from AMC to CMC — **The Project**	• Leverages the existing, experienced clinical staff who currently provide high-quality care at AMC. (A) • Utilizes a modern facility at CMC designed to support contemporary, family-centered care models. (A)

Table 16: Alternatives Analysis: Capital Cost	
Option:	**Advantages/Disadvantages:**
Option One: Continue to Operate the ICN at AMC --Do Nothing	• No capital costs. (A) • Although no upfront costs, operating in an aging facility typically requires greater devotion of operational expenditures and more costly renovations, which increases capital cost over the longer term. (D)
Option Two: Close the ICN at AMC and not operate Level II ICN services in the Southeast King planning area.	• No direct disadvantages related to capital cost in closing ICN, but there is a significant cost of this option in losing a vital community service. (D)
Option Three: Relocate ICN from AMC to CMC — **The Project**	• Although a modest capital investment is required, this option directs funds toward creating a modern, efficient, and sustainable service in a growing market, which represents a prudent long-term use of capital resources. (A)

Table 17: Alternatives Analysis: Promoting Cost and Operating Efficiency	
Option:	**Advantages/Disadvantages:**
Option One: Continue to Operate the ICN at AMC --Do Nothing	• Avoids the one-time operational costs that would be incurred in the planning and execution of a complex service relocation. (A) • Operating in an older and aging facility leads to higher ongoing maintenance costs compared to a modern, energy-efficient building, resulting in long-term operating inefficiencies. (D)

	• Strategic inefficiency by occupying physical space at the Auburn campus that could be repurposed to meet the needs of the surrounding population near Auburn. (D)
Option Two: Close the ICN at AMC and not operate Level II ICN services in the Southeast King planning area.	• Undermines the operational efficiency of the regional health system by disrupting existing care pathways and creating gaps in access to care. (D)
Option Three: Relocate ICN from AMC to CMC — **The Project**	• One-time operational costs in the planning and execution of a complex service relocation. (D) • Utilizes a modern facility at CMC designed to support contemporary, family-centered care models. (A)

Table 18: Alternatives Analysis: Legal Restrictions	
Option:	**Advantages/Disadvantages:**
Option One: Continue to Operate the ICN at AMC --Do Nothing	• Does not require certificate of need approval. (Neutral, “N”)
Option Two: Close the ICN at AMC and not operate Level II ICN services in the Southeast King planning area.	• Does not require certificate of need approval. (N)
Option Three: Relocate ICN from AMC to CMC — **The Project**	• Requires certificate of need approval. (N)

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

   Per the requirements in WAC 246-310-240(2), MultiCare's primary objective is to affordably meet the Washington State Building Code and the Washington State Energy Code. The proposed relocation utilizes existing space at CMC existing 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 quality of care and enhanced geographic access for patients.

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

   Please see Table 14 to Table 18 above for discussion of the benefits of the CN request relative to other alternatives. These tables demonstrate how the proposed project improves the delivery of health services in the planning area while fostering cost containment and promoting quality assurance and cost effectiveness.

Addendum

Hospital Projects Certificate of Need Application
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.

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 (identify)**
☐ **NICU Level III**	☐ **Open Heart Surgery**
☐ **NICU Level IV**	☐ **Elective PCI***
☐ **Specialized Pediatric (PICU)**	☐ **PPS-Exempt Rehab (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.**

This CN request does not propose adding any beds beyond those for which CMC and AMC are currently approved. Thus, this question is not applicable.

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

Please see Exhibit 5 for a copy of the hospital policies regarding admissions, charity care, non-discrimination, end-of-life, and reproductive health. There

are over 50 policies regarding neonatal care. If there is a particular policy or guideline that the Department would like to review, then MultiCare requests it be allowed to provide it in screening.

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.**

   See Table 8 above for the ICN's current payer mix based on historical 2024 data.

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.**

   See Exhibit 6 for the financial exhibit with the pro forma for the ICN, as well as MultiCare Covington Medical Center with and without the project.

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

   There are capital expenditures required for this CN request. Therefore, this question is not applicable.

Structure and Process of Care

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.**

   Delores Gries, MD (MD60456680) is the current medical director for the ICN at AMC. Dr. Gries is a contracted medical director with Pediatrix Medical Group of Washington.

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

   The medical director is contracted. Therefore, this question is not applicable.

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

There is a Professional Service Agreement ("PSA") in place between MultiCare and Pediatrix Medical Group of Washington, Inc. P.S. ("Pediatrix") that covers the Medical Director position for the Level II ICN at AMC and multiple other facilities. This PSA covers multiple MultiCare facilities, and is broader than a standalone Medical Director contract. Consequently, the PSA includes significant proprietary information as well as a confidentiality clause.

MultiCare is developing a new medical director agreement with Pediatrix specific to the proposed ICN at CMC. A copy for the new medical director agreement will be provided in screening.

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

See Exhibit 13 for the current ICN medical staff roster at AMC inclusive of physicians, RNs, and advanced practice providers which is representative of the proposed credentialed staff when relocating to CMC. If the Department would like to see an expanded list of other credential types, then MultiCare requests that it be allowed to provide any additional requested information during screening.

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

See Exhibit 14 for a MultiCare system-wide policy for patient transfers. Exhibit E of the system-wide policy includes additional detail and requirements related to the transfer of neonate patients.

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.

On June 24, 2024, the Washington State Department of Health Perinatal Levels of Care committee unanimously voted to align the state guidelines with national guidelines.[9] Therefore, the levels of neonatal care outlined in the

[9] WASHINGTON STATE DEPARTMENT OF HEALTH. Washington State Maternal and Neonatal Levels of Care Guidelines. January 2025. Available at https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//950154.pdf

American Academy of Pediatrics and the levels of maternal care specified by the American College of Obstetricians and Gynecologists are now the adopted guidelines for Washington State.

See Exhibit 15 for a copy of the Washington State Perinatal Level of Care Guidelines and corresponding guiding documents from the American Academy of Pediatrics and American College of Obstetricians and Gynecologists referenced in the Washington State guidelines.

As an existing Level II ICN at AMC, MultiCare adheres to the Washington State Perinatal Level of Care Guidelines. MultiCare confirms that it will continue to adhere to the Washington State Perinatal Level of Care Guidelines for the proposed relocation of the Level II ICN to CMC.

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

Patients are assigned case managers who coordinate care and follow up appointments. Appointments are made prior to discharge and discharge summaries are faxed to the new provider upon discharge. Post discharge phone calls are made by the leadership team to ensure the appointment has occurred.

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.

This CN request does not propose adding any ICN services beyond those which are currently performed. This CN request proposes a relocation of these ICN beds from AMC to CMC. Thus, this question is not applicable.

<u>Psychiatric Unit Projects ONLY</u>

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

Not applicable.

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.

Not applicable.

Rehabilitation Unit Projects ONLY

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

   Not applicable.

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

   Not applicable.

NICU Projects ONLY

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

   As described above, on June 24, 2024, the Washington State Department of Health Perinatal Levels of Care committee unanimously voted to align the state guidelines with national guidelines.[10] Therefore, the levels of neonatal care outlined in the American Academy of Pediatrics and the levels of maternal care specified by the American College of Obstetricians and Gynecologists are now the adopted guidelines for Washington State.

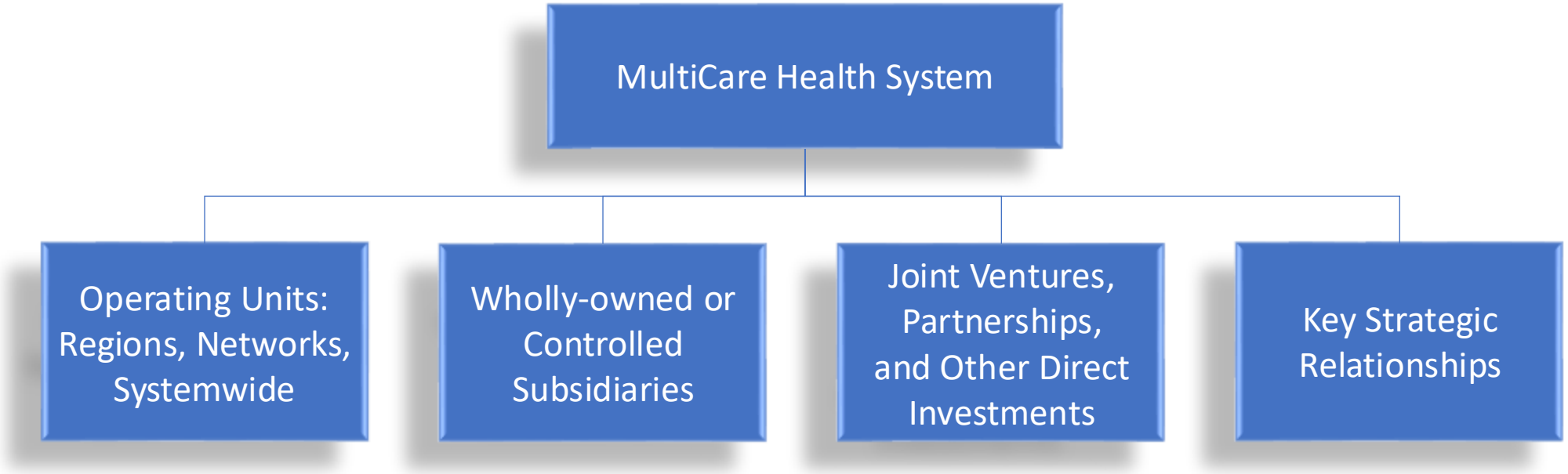
   See Exhibit 15 for a copy of the Washington State Perinatal Level of Care Guidelines and corresponding guiding documents from the American Academy of Pediatrics and American College of Obstetricians and Gynecologists referenced in the Washington State guidelines.

   As an existing Level II ICN at AMC, MultiCare adheres to the Washington State Perinatal Level of Care Guidelines. MultiCare confirms that it will continue to adhere to the Washington State Perinatal Level of Care Guidelines for the proposed relocation of the Level II ICN to CMC.

[10] WASHINGTON STATE DEPARTMENT OF HEALTH. Washington State Maternal and Neonatal Levels of Care Guidelines. January 2025. Available at https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//950154.pdf

Exhibit 1.
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

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

July 3, 2025

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

Re: Letter of Intent for relocation of Level II Neonate Intermediate Care Nursery from MultiCare Auburn Medical Center to MultiCare Covington Medical Center

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, MultiCare Health System ("MultiCare") dba MultiCare Auburn Medical Center ("AMC") and MultiCare Covington Medical Center ("CMC") submits this Letter of Intent ("LOI") to relocate the existing, certificate of need ("CN") approved 6-bed Level II Intermediate Care Nursery (the "ICN") from the AMC hospital campus and license to the CMC hospital campus and license. Both hospitals are located in the Southeast King Planning Area.

1. Description of proposed service
   Relocate the existing, CN-approved 6-bed Level II Intermediate Care Nursery from AMC to CMC. Upon project completion, the 6-bed Level II ICN would operate at the CMC's hospital campus and under CMC's hospital license.
2. Estimated cost of the project
   The estimated capital cost of the project is $2,854,386.
3. Identification of the service area
   The service area is the Southeast King Secondary Hospital Planning Area.

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

Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
PO Box 5299, Mailstop: 820-4-SBD
Tacoma, WA 98415
ekobberstad@multicare.org

Hunter Plumer, MHA
HealthTrends
hplumer@healthtrends.consulting

Thank you for your support. Please contact me if you have any questions.

Sincerely,

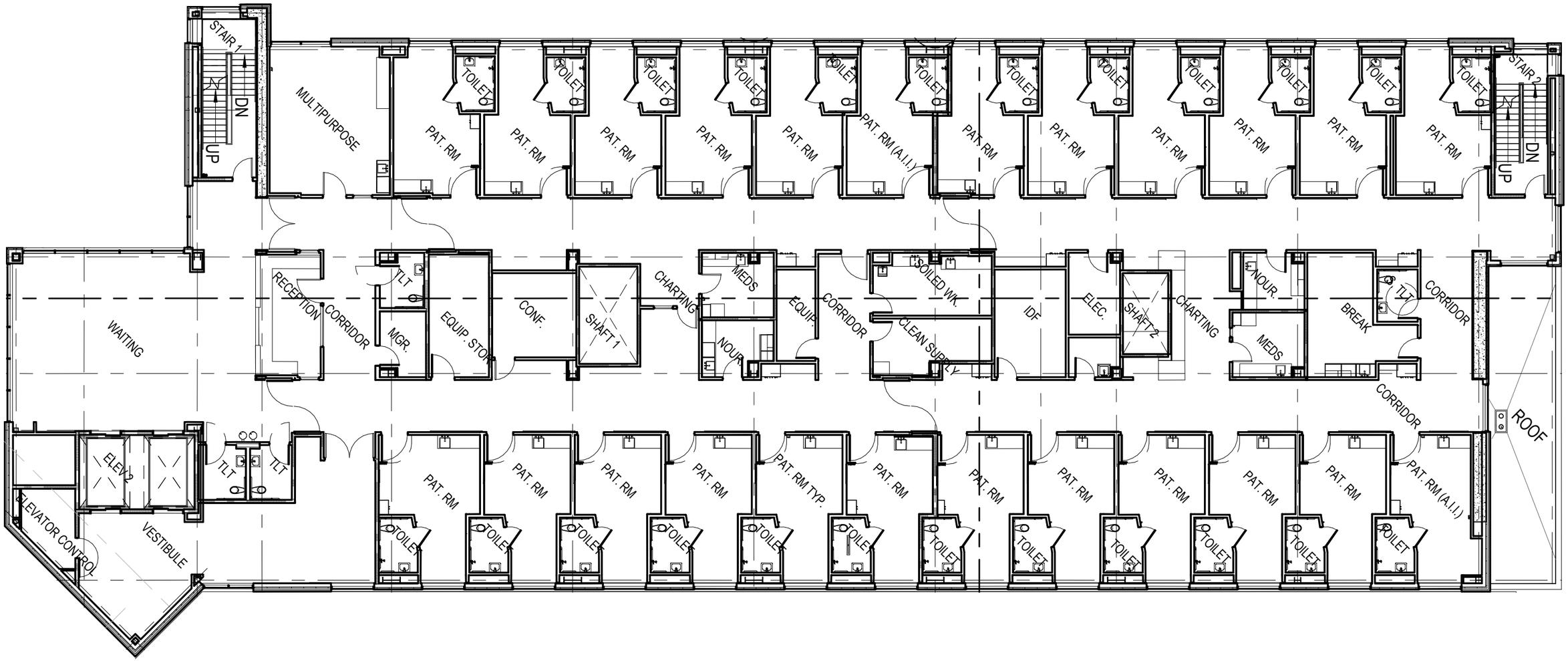
K. Erin Kobberstad, Vice President, Strategic Planning
MultiCare Health System

Exhibit 3.
Single Line Drawings

Floor Plan | Current Bed Floor

Floor 3

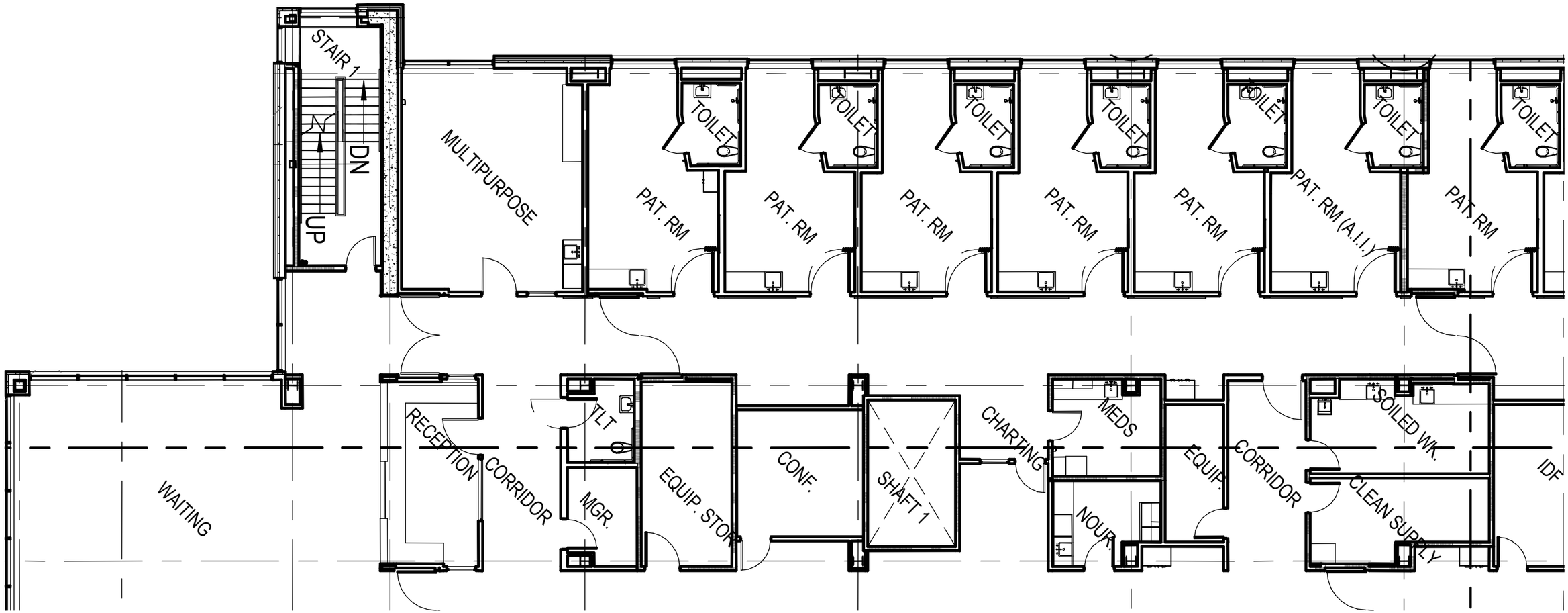
MultiCare Covington



Floor Plan | Current Bed Floor - Area to be Renovated

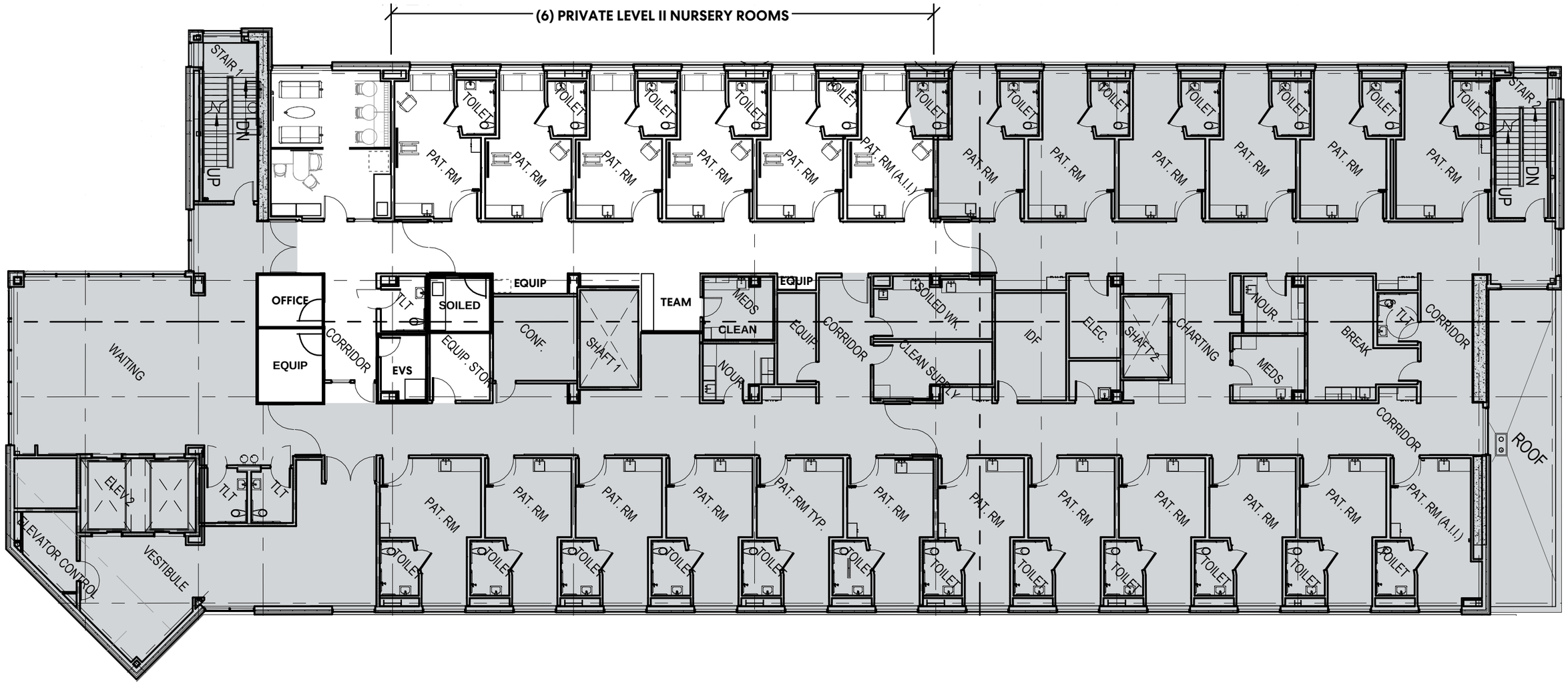
Floor 3

MultiCare Covington



Floor Plan | Level II Nursery Renovation

MultiCare Covington



Floor Plan | Level II Nursery - Area to be Renovated

MultiCare Covington

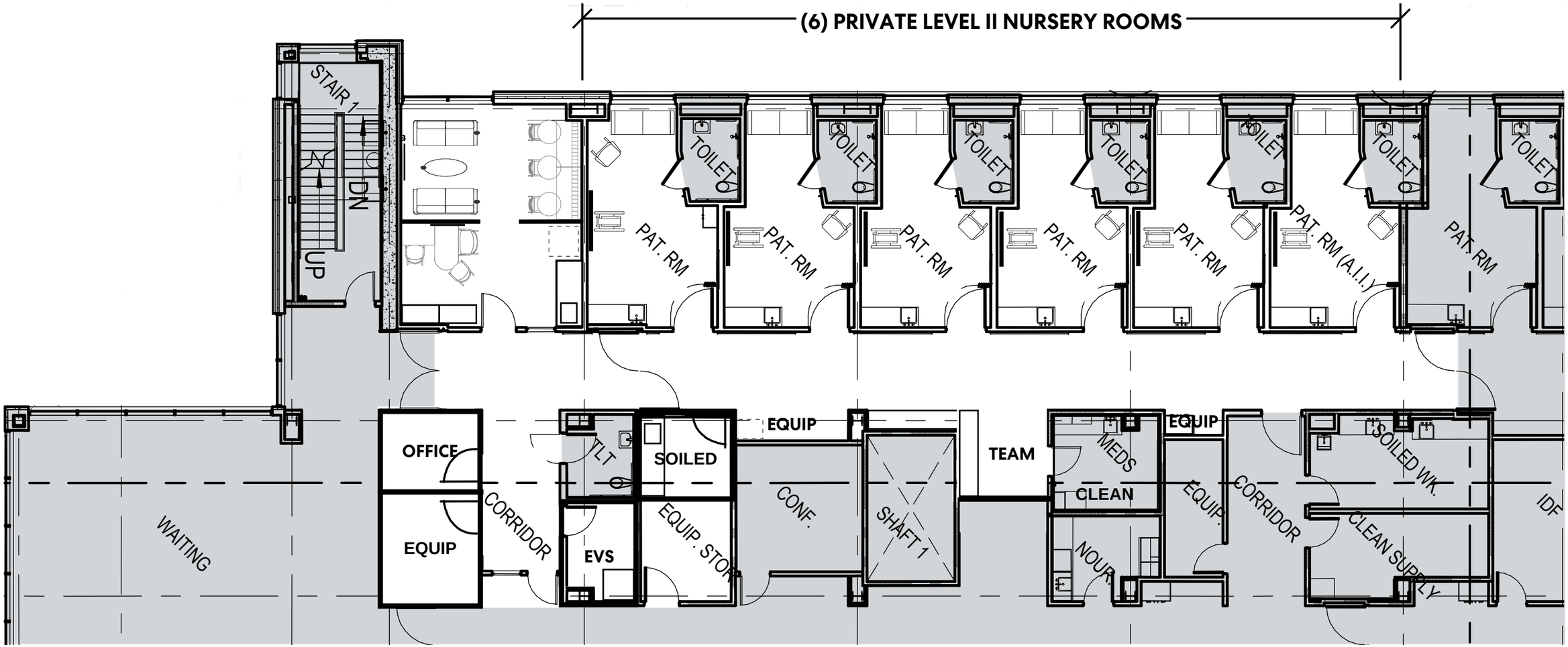


Exhibit 4A.
Patient Origin – MultiCare Covington Medical Center

MultiCare Covington Medical Center (All Inpatient)
2024 Unique Inpatient Hospital-Based Inpatient Volumes by Zip Code

Zip Code	Cases
98042	453
99999	378
98092	186
98038	177
98030	158
98002	151
98031	97
98391	70
98387	62
98010	61
98003	56
98374	51
98032	45
98001	39
98445	34
98375	33
98058	32
98444	29
98023	29
98338	28
98051	26
98198	23
98022	23
98373	20
98321	19
98371	18
98372	16
98360	16
98390	15
98328	15
98168	12
98047	11
All other zip codes with <= 10 cases	213

Source: CHARS 2024

Exhibit 4B.
Patient Origin – MultiCare Auburn Medical Center (Level II ICN)

MultiCare Auburn Medical Center (Level II ICN)
2024 Unique Inpatient Hospital-Based Inpatient Volumes by Zip Code

Zip Code	Cases
98092	21
98002	20
98030	19
98042	13
98032	12
All other zip codes with <= 10 cases	48

Source: CHARS 2024

Exhibit 5A.
Charity Care 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 5B.
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 5C.
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 5D.
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 5E.
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 5F.
Reproductive 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 6A.

Financial Exhibit – Historical

MultiCare Covington Medical Center
Historical Income Statement

	2022	2023	2024
Inpatient Days	12,056	8,644	9,868
PATIENT SERVICE REVENUES:			
HB Inpatient	$ 86,739,659	$ 66,167,519	$ 82,690,859
HB Outpatient	$ 297,513,767	$ 313,791,501	$ 355,461,416
PB Outpatient	$ 118,761	$ 98,552	$ 204,152
Other	$ -	$ -	$ -
TOTAL	$ 384,372,186	$ 380,057,572	$ 438,356,426
DEDUCTIONS FROM REVENUES:			
Contractual Adjustments	$ 275,450,683	$ 271,453,953	$ 305,551,914
Charity Care	$ 9,218,101	$ 9,199,995	$ 11,968,698
Provision for Bad Debts	$ 5,361,590	$ 6,048,216	$ 5,932,341
Allocated Deductions	$ 704	$ 0	$ 0
TOTAL	$ 290,031,078	$ 286,702,165	$ 323,452,954
NET PATIENT SERVICE REVENUE	$ 94,341,109	$ 93,355,407	$ 114,903,473
Other Operating Revenue	$ 267,866	$ 309,235	$ 231,261
Net Assets Released From Restrictions	$ 80,602	$ -	$ -
TOTAL OPERATING REVENUE	$ 94,689,576	$ 93,664,642	$ 115,134,734
Expenses			
Salaries and Wages	$ 42,671,783	$ 32,725,468	$ 37,974,718
Employee Benefits	$ 7,029,886	$ 6,861,990	$ 8,196,609
Supplies & Pharmaceuticals	$ 8,424,949	$ 6,740,476	$ 7,883,131
Professional Fees	$ 4,828,543	$ 4,246,654	$ 3,439,886
Purchased Services	$ 3,139,362	$ 8,047,061	$ 8,532,577
Other Operating Costs	$ 3,706,489	$ 3,678,897	$ 7,818,149
Lease & Rental Fees	$ 166,339	$ 62,543	$ 229,456
Interest	$ 3,261,423	$ 4,909,019	$ 5,494,173
Depreciation & Amort.	$ 3,932,483	$ 3,789,959	$ 4,454,604
System Allocation	$ 22,951,619	$ 20,440,292	$ 20,519,413
TOTAL	$ 100,112,876	$ 91,502,359	$ 104,542,716
NET INCOME	$ (5,423,299)	$ 2,162,282	$ 10,592,018

MultiCare Covington Medical Center
Balance Sheet for Year End 2024

	Period Ending 12/31/2024
Assets	
Cash & Cash Equivalents	$ -
Accounts Receivable	$ 15,115,792
Other Current Assets	$ 1,688,370
Total Current Assets	$ 16,804,162
Land, buildings, and equipment, net of accumulated depreciation	$124,342,570
Other assets	$ -
Total Other Assets	$124,342,570
Total Assets	$141,146,732
Liabilities	
Accounts Payable and Other Accrued Expenses	$ 32,841,204
Other Current Liabilities	$ 2,738,356
Total Current Liabilities	$ 35,579,559
Long-term debt, net of current portion	$ -
Other Liabilities	$ -
Total Other Liabilities	$ -
Total Liabilities	$ 35,579,559
Equity	
Net Assets	$105,567,173
Total Net Assets	$105,567,173
Total Liabilities and Equity	$141,146,732

Exhibit 6B.

Financial Exhibit – Assumptions

MultiCare Covington Medical Center – Level II Intermediate Care Nursery

Financial Model Key Assumptions

Certificate of Need Application

ASSUMPTIONS | Without the Project

In addition to relocating the existing MultiCare Auburn Medical Center ("AMC") Level II intermediate care nursery ("ICN") to MultiCare Covington Medical Center ("CMC"), CMC will also begin performing normal newborn services again with its Family Birth Center ("FBC"). Normal newborn services at the CMC FBC will begin at the same time as the ICN relocation is complete (i.e. May 2027). For the purposes of this financial exhibit, the "Without the Project" scenario forecasts CMC hospital-wide services, including FBC services beginning in May 2027, but it *excludes* the CN-reviewable activity of relocating the Level II ICN.

Revenue and Expense Statement

Volume Assumptions

1. 2025-2026 held constant at 2024 actual CMC volumes.
2. 2027-2030 assumed to be 2024 actual CMC volumes plus AMC's FBC 2024 actual volumes (1,897 patient days in 2024) adjusted by the effective number of months in 2027.

Capital Expenditures

3. Additional capital expenditures not applicable under 'Without the Project' scenario.

Revenues

4. Models do not include any charge inflation.
5. Gross revenues are based on CMC and AMC FBC's 2024 actuals adjusted by the effective number of months.
6. The initials "HB" and "PB" stand for "hospital-based" and "physician-based," respectively.
7. Deductions from revenues are based on CMC's 2024 actuals. The share of deductions allocated to charity care is based on average charity care as a percent of gross revenue in 2024 (2.73%). The share of deductions allocated to bad debt is based on average bed debt as a percent of gross revenue in 2024 (1.35%).
8. Other Operating Revenue and Net Assets Released From Restrictions are held constant at CMC and AMC FBC's 2024 actuals adjusted by the effective number of months.

Expenses

9. Models do not include any expense inflation.
10. All expenses except for System Allocation in the "Without a Project" scenario are held constant at CMC and AMC FBC's 2024 actuals adjusted by the effective number of months operational in 2027.

11. System Allocation is calculated at 17.86% of net patient service revenue based on CMC's 2024 actuals.

Staffing

12. FTEs are provided at the cost center level and held constant at CMC's 2024 actuals.
13. Family Birth Center FTEs are added as of May 2027 and are based on AMC FBC 2024 actuals, adjusted for the effective number of months in 2027.

Cash Flow Statement

14. Net income from CMC revenue and expense statement.
15. Depreciation from CMC revenue and expense statement.
16. Accounts receivable estimated to be equivalent of approximately 48.02 days of net revenue based on 2024 CMC actuals.
17. Accounts payable estimated to be equivalent of approximately 119.76 days of total expenses less depreciation based on 2024 CMC actuals.
18. Additional purchase of PP&E not applicable under "Without the Project" scenario.
19. Additional capital contributed from reserves not applicable under "Without the Project" scenario.
20. Beginning cash balance from 2024 historical CMC balance sheet.

Balance Sheet

21. Cash and cash equivalents based on ending balance for period calculated in cash flow statement.
22. Accounts receivable based on estimates calculated in cash flow statement.
23. Other current assets held constant at 2024 CMC actuals.
24. 'Land, buildings, and equipment, net of accumulated depreciation' calculated by the previous period's value plus additional PP&E (not applicable under "Without the Project" scenario) minus depreciation. Net PPE of relocated FBC equipment incorporated beginning in 2027, adjusted for effective number of months at CMC.
25. Other assets held constant at 2024 CMC actuals, which equaled zero.
26. Accounts payable and Other Accrued Expenses based on estimates calculated in cash flow statement.
27. Other current liabilities held constant at 2024 CMC actuals.
28. Long-term debt, net of current portion held constant at 2024 CMC actuals, which equaled zero.
29. Other liabilities held constant at 2024 CMC actuals, which equaled zero.
30. Net assets calculated by the previous period's value plus net income plus capital contributed from reserves.
31. Net assets – Transfer from affiliate based on net asset value of PPE of FBC relocated in 2027.

ASSUMPTIONS | The Project (ICN Only)

Revenue and Expense Statement

Volume Assumptions

32. See application for volumes projections.

Capital Expenditures

33. See application for capital expenditure estimates for the project-related capital investments.

Revenues

34. Models do not include any charge inflation.
35. Incremental gross revenues for the ICN are calculated at $7,618 per patient day based on AMC ICN's 2024 actuals.
36. Contractual Adjustments are calculated at 67.06% of gross revenues based on estimates of AMC ICN's 2024 actuals.
37. The share of deductions allocated to charity care is based on CMC's average charity care as a percent of gross revenue in 2024 (2.73%).
38. The share of deductions allocated to bad debt is based on CMC's average bed debt as a percent of gross revenue in 2024 (1.35%).
39. Other Operating Revenue and Net Assets Released From Restrictions are held constant at AMC ICN's 2024 actuals, adjusted by effective number of months.

Expenses

40. Models do not include any expense inflation.
41. See the 'Staffing' section below for assumptions underlying salaries & wages.
42. Employee Benefits are calculated at 20.34% of salaries & wages based on AMC ICN's 2024 actuals.
43. Supplies & Pharmaceuticals are calculated at $94.92 per patient day based on AMC ICN's 2024 actuals.
44. Professional Fees are calculated at $594,491.69 per year, adjusted by effective number of months, based on AMC ICN's 2024 actuals plus $2,241.67 in medical director fees based on proposed medical director agreement to be provided in screening.
45. Purchased Services had a negative expense reported in AMC ICN's 2024 actuals. Therefore, for the purposes of the forecast, Purchased Services is held constant at AMC ICN's 2022-2024 three year average of $1,909 (negative $8,297 in 2024, $10,596 in 2023, and $3,428 in 2022).
46. Other Operating Costs are calculated at $74.10 per patient day based on AMC ICN's 2024 actuals.
47. There are no Lease & Rental Fees reported in AMC ICN's 2024 actuals or earlier years (e.g. 2022 and 2023).
48. There are no Interest Expenses reported in AMC ICN's 2024 actuals or earlier years (e.g. 2022 and 2023).
49. See Depreciation Worksheet for calculations underlying Depreciation & Amort line-item. Project related depreciation (Project-Related) is calculated using the straight-line method assuming a

20-year useful life for $2,449,747 in construction-related expenditures and a 7-year useful life for $404,640 in equipment-related expenditures. Existing depreciation for existing equipment is calculated at $14,742 per year based on AMC ICN's 2024 actuals.

50. System Allocation is calculated at 17.86% of net patient service revenue based on CMC's 2024 actuals.
51. See the provided startup cost worksheet for startup cost estimates and assumptions.

Staffing

FTE calculations below assume 1 FTE is 2,080 hours per year.

52. RN FTEs are calculated at 2 RNs with 24-hour coverage 365 days per year.
53. Supervision FTEs are calculated at 0.28 FTEs per 1,000 Level II patient days based on AMC ICN's average during the 2022-2024 period.
54. CNA/MA FTEs are calculated at 0.16 FTEs per 1,000 Level II patient days based on AMC ICN's average during the 2022-2024 period.
55. Non-Productive FTEs are calculated at 18.56% of RN/Supervision/CNA/MA FTEs based on AMC ICN 2024 actuals. Non-Productive FTEs include PTO, Extended Illness, Bereavement, Education, etc.
56. Salares & wages for RN, Supervision, and CNA/MA are calculated assuming 2,080 hours per year based on AMC ICN 2024 actuals. Salaries & wages for Non-Productive FTEs are calculated at 24.49% of RN/Supervision/CNA/MA salaries & wages based on AMC ICN 2024 actuals.

ASSUMPTIONS | With the Project

Revenue and Expense Statement

57. Calculated as the sum of values between "Without the Project" and "The Project".

Staffing

58. FTEs, excluding FBC and the ICN FTES, are provided at the cost center level and held constant at CMC's 2024 actuals.
59. Family Birth Center FTEs are added as of May 2027 and are based on AMC FBC 2024 actuals.
60. Level II ICN FTEs are added as of May 2027 and consistent with total FTEs identified in the FTE schedule provided in "The Project".

Cash Flow Statement

61. Net income from CMC revenue and expense statement.
62. Depreciation from CMC revenue and expense statement.
63. Accounts receivable estimated to be equivalent to approximately 48.02 days of net revenue based on 2024 CMC actuals.
64. Accounts payable estimated to be equivalent to approximately 119.76 days of total expenses less depreciation based on 2024 CMC actuals.
65. Additional purchase of PP&E based on capital expenditures as described in application.
66. Additional capital contributed from reserves based on MultiCare funding of capital expenditures as described in application.
67. Beginning cash balance from 2024 historical CMC balance sheet.

Balance Sheet

68. Cash and cash equivalents based on ending balance for period calculated in cash flow statement.
69. Accounts receivable based on estimates calculated in cash flow statement.
70. Other current assets held constant at 2024 CMC actuals.
71. 'Land, buildings, and equipment, net of accumulated depreciation' calculated by the previous period's value plus additional PP&E minus depreciation. Net PPE of relocated FBC and ICN equipment incorporated beginning in 2027.
72. Other assets held constant at 2024 CMC actuals.
73. Accounts payable and Other Accrued Expenses based on estimates calculated in cash flow statement.
74. Other current liabilities held constant at 2024 CMC actuals.
75. Long-term debt, net of current portion held constant at 2024 CMC actuals.
76. Other liabilities held constant at 2024 CMC actuals.
77. Net assets calculated by the previous period's value plus net income plus capital contributed from reserves.
78. Net assets – Transfer from affiliate based on net asset value of PPE of FBC and ICN relocated in 2027.

Exhibit 6C.

Financial Exhibit – Without the Project

MultiCare Covington Medical Center
Income Statement (Without The Project)

	2025	2026	2027	2028	2029	2030
# of Months	12	12	12	12	12	12
# of Months with Family Birthing Center	0	0	8	12	12	12
Inpatient Days	9,868	9,868	11,133	11,765	11,765	11,765
PATIENT SERVICE REVENUES:						
HB Inpatient	$ 82,690,859	$ 82,690,859	$ 100,634,749	$ 109,606,694	$ 109,606,694	$ 109,606,694
HB Outpatient	$ 355,461,416	$ 355,461,416	$ 356,349,024	$ 356,792,828	$ 356,792,828	$ 356,792,828
PB Outpatient	$ 204,152	$ 204,152	$ 204,152	$ 204,152	$ 204,152	$ 204,152
Other	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 438,356,426	$ 438,356,426	$ 457,187,924	$ 466,603,673	$ 466,603,673	$ 466,603,673
DEDUCTIONS FROM REVENUES:						
Contractual Adjustments	$ 305,551,914	$ 305,551,914	$ 317,918,004	$ 324,101,049	$ 324,101,049	$ 324,101,049
Charity Care	$ 11,968,698	$ 11,968,698	$ 12,482,866	$ 12,739,949	$ 12,739,949	$ 12,739,949
Provision for Bad Debts	$ 5,932,341	$ 5,932,341	$ 6,187,191	$ 6,314,615	$ 6,314,615	$ 6,314,615
Allocated Deductions	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
TOTAL	$ 323,452,954	$ 323,452,954	$ 336,588,061	$ 343,155,614	$ 343,155,614	$ 343,155,614
NET PATIENT SERVICE REVENUE	$ 114,903,473	$ 114,903,473	$ 120,599,864	$ 123,448,060	$ 123,448,060	$ 123,448,060
Other Operating Revenue	$ 231,261	$ 231,261	$ 245,268	$ 252,271	$ 252,271	$ 252,271
Net Assets Released From Restrictions	$ -	$ -	$ 10,218	$ 15,328	$ 15,328	$ 15,328
TOTAL OPERATING REVENUE	$ 115,134,734	$ 115,134,734	$ 120,855,350	$ 123,715,658	$ 123,715,658	$ 123,715,658
Expenses						
Salaries and Wages	$ 37,974,718	$ 37,974,718	$ 41,901,638	$ 43,865,097	$ 43,865,097	$ 43,865,097
Employee Benefits	$ 8,196,609	$ 8,196,609	$ 8,929,616	$ 9,296,119	$ 9,296,119	$ 9,296,119
Supplies & Pharmaceuticals	$ 7,883,131	$ 7,883,131	$ 8,536,599	$ 8,863,333	$ 8,863,333	$ 8,863,333
Professional Fees	$ 3,439,886	$ 3,439,886	$ 3,456,380	$ 3,464,628	$ 3,464,628	$ 3,464,628
Purchased Services	$ 8,532,577	$ 8,532,577	$ 8,698,062	$ 8,780,805	$ 8,780,805	$ 8,780,805
Other Operating Costs	$ 7,818,149	$ 7,818,149	$ 7,962,883	$ 8,035,249	$ 8,035,249	$ 8,035,249
Lease & Rental Fees	$ 229,456	$ 229,456	$ 242,270	$ 248,677	$ 248,677	$ 248,677
Interest	$ 5,494,173	$ 5,494,173	$ 5,494,173	$ 5,494,173	$ 5,494,173	$ 5,494,173
Depreciation & Amort.	$ 4,454,604	$ 4,454,604	$ 4,571,741	$ 4,630,310	$ 4,630,310	$ 4,630,310
System Allocation	$ 20,519,413	$ 20,519,413	$ 21,536,672	$ 22,045,301	$ 22,045,301	$ 22,045,301
TOTAL	$ 104,542,716	$ 104,542,716	$ 111,330,034	$ 114,723,693	$ 114,723,693	$ 114,723,693
NET INCOME	$ 10,592,018	$ 10,592,018	$ 9,525,316	$ 8,991,966	$ 8,991,966	$ 8,991,966

MultiCare Covington Medical Center
FTE Schedule (Without The Project)

	2025	2026	2027	2028	2029	2030
# of Months	12	12	12	12	12	12
# of Months with Family Birthing Center	0	0	8	12	12	12
Access Svcs	3.92	3.92	3.92	3.92	3.92	3.92
Access Svcs ED	8.97	8.97	8.97	8.97	8.97	8.97
Acute OT_PT_ST	2.79	2.79	2.79	2.79	2.79	2.79
Hospital Admin	3.03	3.03	3.03	3.03	3.03	3.03
Covington Infusion Svc	0.01	0.01	0.01	0.01	0.01	0.01
Bone Density	0.84	0.84	0.84	0.84	0.84	0.84
CT Scan	7.09	7.09	7.09	7.09	7.09	7.09
Diabetes Svcs	0.99	0.99	0.99	0.99	0.99	0.99
Emergency Dept	56.89	56.89	56.89	56.89	56.89	56.89
Environmental Svcs	13.20	13.20	13.20	13.20	13.20	13.20
Facilities Mgmt	7.14	7.14	7.14	7.14	7.14	7.14
Hospital Care Mgmt	2.71	2.71	2.71	2.71	2.71	2.71
Hospital Social Work	3.32	3.32	3.32	3.32	3.32	3.32
Hospitalists Surgical	1.32	1.32	1.32	1.32	1.32	1.32
Linen Svcs	1.04	1.04	1.04	1.04	1.04	1.04
Mammography	4.68	4.68	4.68	4.68	4.68	4.68
MedSurg Intermed Care	47.21	47.21	47.21	47.21	47.21	47.21
MRI Imaging	3.14	3.14	3.14	3.14	3.14	3.14
Nursing Admin	0.87	0.87	0.87	0.87	0.87	0.87
Nursing Residents	11.62	11.62	11.62	11.62	11.62	11.62
Nutrition Svcs	9.35	9.35	9.35	9.35	9.35	9.35
OP_SS Surgeries	5.11	5.11	5.11	5.11	5.11	5.11
Operating Room	13.83	13.83	13.83	13.83	13.83	13.83
Palliative Care	0.05	0.05	0.05	0.05	0.05	0.05
Pharmacy Hospital	11.32	11.32	11.32	11.32	11.32	11.32
Post Anesthesia Care	5.15	5.15	5.15	5.15	5.15	5.15
Pre Anesthesia Clinic	0.80	0.80	0.80	0.80	0.80	0.80
Pulse Echo	0.23	0.23	0.23	0.23	0.23	0.23
Radiology	7.78	7.78	7.78	7.78	7.78	7.78
Respiratory Therapy	4.86	4.86	4.86	4.86	4.86	4.86
Security Svcs	10.94	10.94	10.94	10.94	10.94	10.94
Staffing Office	9.81	9.81	9.81	9.81	9.81	9.81
Sterile Processing	6.23	6.23	6.23	6.23	6.23	6.23
Supply Chain Operations	3.58	3.58	3.58	3.58	3.58	3.58
MedSurg Care	26.23	26.23	26.23	26.23	26.23	26.23
Surgical Svcs Admin	1.00	1.00	1.00	1.00	1.00	1.00
Ultrasound	6.24	6.24	6.24	6.24	6.24	6.24
Wound Care	0.17	0.17	0.17	0.17	0.17	0.17
Access Svcs MOB	2.41	2.41	2.41	2.41	2.41	2.41
Imaging Admin	2.00	2.00	2.00	2.00	2.00	2.00
Family Birth Center	0.00	0.00	27.27	40.91	40.91	40.91
Total FTEs	307.88	307.88	335.15	348.78	348.78	348.78

MultiCare Covington Medical Center
Cash Flow Statement (Without the Project)

	2025	2026	2027	2028	2029	2030
Months	12	12	12	12	12	12
OPERATING ACTIVITIES						
Net Income	$ 10,592,018	$ 10,592,018	$ 9,525,316	$ 8,991,966	$ 8,991,966	$ 8,991,966
Depreciation	$ 4,454,604	$ 4,454,604	$ 4,571,741	$ 4,630,310	$ 4,630,310	$ 4,630,310
Accounts Receivable	$ (15,115,792)	$ (15,115,792)	$ (15,865,164)	$ (16,239,850)	$ (16,239,850)	$ (16,239,850)
A/R From Prior Year	$ 15,115,792	$ 15,115,792	$ 15,115,792	$ 15,865,164	$ 16,239,850	$ 16,239,850
Accounts Payable	$ 32,841,204	$ 32,841,204	$ 35,029,843	$ 36,124,162	$ 36,124,162	$ 36,124,162
A/P From Prior Year	$ (32,841,204)	$ (32,841,204)	$ (32,841,204)	$ (35,029,843)	$ (36,124,162)	$ (36,124,162)
Cash Flow from Operating Activities	**$ 15,046,622**	**$ 15,046,622**	**$ 15,536,325**	**$ 14,341,909**	**$ 13,622,276**	**$ 13,622,276**
INVESTING ACTIVITIES						
Purchase of PP&E						
Cash Flow from Investing Activities	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
FINANCING ACTIVITIES						
Capital Contributed From Reserves		$ -				
Cash Flow from Financing Activities	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Beginning Balance	$ -	$ 15,046,622	$ 30,093,243	$ 45,629,568	$ 59,971,477	$ 73,593,753
Annual Increase (Decrease)	$ 15,046,622	$ 15,046,622	$ 15,536,325	$ 14,341,909	$ 13,622,276	$ 13,622,276
Ending Balance	$ 15,046,622	$ 30,093,243	$ 45,629,568	$ 59,971,477	$ 73,593,753	$ 87,216,029

MultiCare Covington Medical Center
Balance Sheet Projections (Without The Project)

	2025	2026	2027	2028	2029	2030
Assets						
Cash & Cash Equivalents	$ 15,046,622	$ 30,093,243	$ 45,629,568	$ 59,971,477	$ 73,593,753	$ 87,216,029
Accounts Receivable	$ 15,115,792	$ 15,115,792	$ 15,865,164	$ 16,239,850	$ 16,239,850	$ 16,239,850
Other Current Assets	$ 1,688,370	$ 1,688,370	$ 1,688,370	$ 1,688,370	$ 1,688,370	$ 1,688,370
Total Current Assets	$ 31,850,784	$ 46,897,406	$ 63,183,102	$ 77,899,698	$ 91,521,973	$105,144,249
Land, buildings, and equipment, net of accumulated depreciation	$119,887,966	$ 115,433,362	$111,814,468	$107,184,158	$102,553,848	$ 97,923,538
Other assets	$ -	$ -	$ -	$ -	$ -	$ -
Total Other Assets	$119,887,966	$ 115,433,362	$111,814,468	$107,184,158	$102,553,848	$ 97,923,538
Total Assets	$151,738,750	$ 162,330,768	$174,997,570	$185,083,856	$194,075,821	$203,067,787
Liabilities						
Accounts Payable and Other Accrued Expenses	$ 32,841,204	$ 32,841,204	$ 35,029,843	$ 36,124,162	$ 36,124,162	$ 36,124,162
Other Current Liabilities	$ 2,738,356	$ 2,738,356	$ 2,738,356	$ 2,738,356	$ 2,738,356	$ 2,738,356
Total Current Liabilities	$ 35,579,559	$ 35,579,559	$ 37,768,199	$ 38,862,518	$ 38,862,518	$ 38,862,518
Long-term debt, net of current portion	$ -	$ -	$ -	$ -	$ -	$ -
Other Liabilities	$ -	$ -	$ -	$ -	$ -	$ -
Total Other Liabilities	$ -	$ -	$ -	$ -	$ -	$ -
Total Liabilities	$ 35,579,559	$ 35,579,559	$ 37,768,199	$ 38,862,518	$ 38,862,518	$ 38,862,518
Equity						
Net Assets	$116,159,190	$ 126,751,208	$136,276,525	$145,268,491	$154,260,456	$163,252,422
Net assets – Transfer from affiliate	$ -	$ -	$ 952,847	$ 952,847	$ 952,847	$ 952,847
Total Net Assets	$116,159,190	$ 126,751,208	$137,229,372	$146,221,338	$155,213,303	$164,205,269
Total Liabilities and Equity	$151,738,750	$ 162,330,768	$174,997,570	$185,083,856	$194,075,821	$203,067,787

Exhibit 6D.

Financial Exhibit – The Project

MultiCare Covington Medical Center - Level II ICN
Income Statement (The Project)

	Pre-Opening	May - Dec 2027	2028	2029	2030
# of Months		8	12	12	12
Patient Days		569	1,105	1,231	1,356
PATIENT SERVICE REVENUES:					
HB Inpatient		$ 4,334,531	$ 8,416,914	$ 9,374,472	$ 10,332,030
HB Outpatient					
PB Outpatient					
Other					
TOTAL		$ 4,334,531	$ 8,416,914	$ 9,374,472	$ 10,332,030
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments		$ 2,906,609	$ 5,644,134	$ 6,286,245	$ 6,928,355
Charity Care		$ 118,348	$ 229,812	$ 255,957	$ 282,101
Provision for Bad Debts		$ 58,660	$ 113,907	$ 126,866	$ 139,825
Allocated Deductions		$ -	$ -	$ -	$ -
TOTAL		$ 3,083,617	$ 5,987,853	$ 6,669,067	$ 7,350,281
NET PATIENT SERVICE REVENUE		$ 1,250,914	$ 2,429,060	$ 2,705,404	$ 2,981,749
Other Operating Revenue		$ -	$ -	$ -	$ -
Net Assets Released From Restrictions		$ 7,904	$ 11,855	$ 11,855	$ 11,855
TOTAL OPERATING REVENUE		$ 1,258,818	$ 2,440,915	$ 2,717,260	$ 2,993,604
Expenses					
Project Related Start-up Costs	$ 338,657				
Salaries and Wages		$ 1,029,600	$ 1,560,438	$ 1,568,456	$ 1,576,475
Employee Benefits		$ 209,467	$ 317,463	$ 319,094	$ 320,725
Supplies & Pharmaceuticals		$ 54,008	$ 104,875	$ 116,806	$ 128,737
Professional Fees		$ 414,261	$ 621,392	$ 621,392	$ 621,392
Purchased Services		$ 1,273	$ 1,909	$ 1,909	$ 1,909
Other Operating Costs		$ 42,163	$ 81,874	$ 91,189	$ 100,503
Lease & Rental Fees		$ -	$ -	$ -	$ -
Interest		$ -	$ -	$ -	$ -
Depreciation & Amort.		$ 130,023	$ 195,035	$ 195,035	$ 195,035
System Allocation		$ 223,388	$ 433,781	$ 483,130	$ 532,479
TOTAL	$ 338,657	$ 2,104,183	$ 3,316,765	$ 3,397,010	$ 3,477,255
NET INCOME	$ (338,657)	$ (845,366)	$ (875,850)	$ (679,750)	$ (483,651)

MultiCare Covington Medical Center - Level II ICN
Staffing Schedule (The Project)

	May - Dec 2027	2028	2029	2030
# of Months	8	12	12	12
Patient Days	569	1,105	1,231	1,356
FTEs				
RN	8.42	8.42	8.42	8.42
Supervision	0.24	0.31	0.34	0.38
CNA/MA	0.14	0.18	0.20	0.22
Non-Productive FTEs	1.63	1.65	1.66	1.67
TOTAL	10.43	10.56	10.63	10.69
Salaries & Wages				
RN	$797,887	$1,196,830	$1,196,830	$1,196,830
Supervision	$23,462	$45,559	$50,743	$55,926
CNA/MA	$5,694	$11,057	$12,315	$13,573
Non-Productive FTEs	$202,557	$306,991	$308,568	$310,146
TOTAL	$1,029,600	$1,560,438	$1,568,456	$1,576,475

MultiCare Covington Medical Center - Level II ICN
Depreciation Schedule (The Project)

	Initial Investment	Useful Life Assumption	----------Forecast----------			
			May - Dec 2027 Year 0	2028 Year 1	2029 Year 2	2030 Year 3
# of Months			8	12	12	12
Tenant Improvements	$ 2,449,747	20	$ 81,658	$ 122,487	$ 122,487	$ 122,487
Equipment	$ 404,640	7	$ 38,537	$ 57,806	$ 57,806	$ 57,806
New Project Related Depreciation	$ 2,854,386		$ 120,195	$ 180,293	$ 180,293	$ 180,293
Existing Depreciation (Existing Equipment)			$ 9,828	$ 14,742	$ 14,742	$ 14,742
Total Depreciation			**$ 130,023**	**$ 195,035**	**$ 195,035**	**$ 195,035**

MultiCare Covington Medical Center - Level II ICN
Startup (The Project)

	Startup Amount
Salaries and Wages (1)	$128,700
Employee Benefits (1)	$26,183
Supplies & Pharmaceuticals (2)	$13,502
Professional Fees (2)	$103,565
Purchased Services (2)	$318
Other Operating Costs (2)	$10,541
System Allocation (2)	$55,847
Total (3)	**$338,657**

(1) Calculated to be equal to one month equivalent of Year 0 projections for the respective line-items.
(2) Calculated to be equal to two months equivalent of Year 0 projections for the respective line-items.
(3) Startup costs can include but are not limited to regulatory/accreditation activities, staff onboarding and training, relocation coordination/project management, IT, etc.

Exhibit 6E.

Financial Exhibit – With the Project

MultiCare Covington Medical Center
Income Statement (With The Project)

	2025	2026	2027	2028	2029	2030
# of Months	12	12	12	12	12	12
# of Months with FBC and ICN	0	0	8	12	12	12
Inpatient Days	9,868	9,868	11,702	12,870	12,996	13,121
PATIENT SERVICE REVENUES:						
HB Inpatient	$ 82,690,859	$ 82,690,859	$ 104,969,280	$ 118,023,607	$ 118,981,165	$ 119,938,723
HB Outpatient	$ 355,461,416	$ 355,461,416	$ 356,349,024	$ 356,792,828	$ 356,792,828	$ 356,792,828
PB Outpatient	$ 204,152	$ 204,152	$ 204,152	$ 204,152	$ 204,152	$ 204,152
Other	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 438,356,426	$ 438,356,426	$ 461,522,456	$ 475,020,587	$ 475,978,145	$ 476,935,703
DEDUCTIONS FROM REVENUES:						
Contractual Adjustments	$ 305,551,914	$ 305,551,914	$ 320,824,613	$ 329,745,183	$ 330,387,294	$ 331,029,404
Charity Care	$ 11,968,698	$ 11,968,698	$ 12,601,214	$ 12,969,761	$ 12,995,906	$ 13,022,051
Provision for Bad Debts	$ 5,932,341	$ 5,932,341	$ 6,245,850	$ 6,428,523	$ 6,441,481	$ 6,454,440
Allocated Deductions	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
TOTAL	$ 323,452,954	$ 323,452,954	$ 339,671,678	$ 349,143,467	$ 349,824,681	$ 350,505,895
NET PATIENT SERVICE REVENUE	$ 114,903,473	$ 114,903,473	$ 121,850,778	$ 125,877,120	$ 126,153,464	$ 126,429,808
Other Operating Revenue	$ 231,261	$ 231,261	$ 245,268	$ 252,271	$ 252,271	$ 252,271
Net Assets Released From Restrictions	$ -	$ -	$ 18,122	$ 27,183	$ 27,183	$ 27,183
TOTAL OPERATING REVENUE	$ 115,134,734	$ 115,134,734	$ 122,114,168	$ 126,156,574	$ 126,432,918	$ 126,709,263
Expenses						
Project related Start-up Costs	$ -	$ -	$ 338,657	$ -	$ -	$ -
Salaries and Wages	$ 37,974,718	$ 37,974,718	$ 42,931,238	$ 45,425,535	$ 45,433,553	$ 45,441,572
Employee Benefits	$ 8,196,609	$ 8,196,609	$ 9,139,082	$ 9,613,582	$ 9,615,213	$ 9,616,844
Supplies & Pharmaceuticals	$ 7,883,131	$ 7,883,131	$ 8,590,607	$ 8,968,208	$ 8,980,139	$ 8,992,070
Professional Fees	$ 3,439,886	$ 3,439,886	$ 3,870,642	$ 4,086,019	$ 4,086,019	$ 4,086,019
Purchased Services	$ 8,532,577	$ 8,532,577	$ 8,699,335	$ 8,782,714	$ 8,782,714	$ 8,782,714
Other Operating Costs	$ 7,818,149	$ 7,818,149	$ 8,005,046	$ 8,117,124	$ 8,126,438	$ 8,135,753
Lease & Rental Fees	$ 229,456	$ 229,456	$ 242,270	$ 248,677	$ 248,677	$ 248,677
Interest	$ 5,494,173	$ 5,494,173	$ 5,494,173	$ 5,494,173	$ 5,494,173	$ 5,494,173
Depreciation & Amort.	$ 4,454,604	$ 4,454,604	$ 4,701,764	$ 4,825,345	$ 4,825,345	$ 4,825,345
System Allocation	$ 20,519,413	$ 20,519,413	$ 21,760,059	$ 22,479,082	$ 22,528,431	$ 22,577,781
TOTAL	$ 104,542,716	$ 104,542,716	$ 113,772,874	$ 118,040,458	$ 118,120,703	$ 118,200,948
NET INCOME	$ 10,592,018	$ 10,592,018	$ 8,341,294	$ 8,116,116	$ 8,312,215	$ 8,508,315

MultiCare Covington Medical Center
FTE Schedule (With The Project)

	2025	2026	2027	2028	2029	2030
# of Months	12	12	12	12	12	12
# of Months with FBC and Level II ICN	0	0	8	12	12	12
Access Svcs	3.92	3.92	3.92	3.92	3.92	3.92
Access Svcs ED	8.97	8.97	8.97	8.97	8.97	8.97
Acute OT_PT_ST	2.79	2.79	2.79	2.79	2.79	2.79
Hospital Admin	3.03	3.03	3.03	3.03	3.03	3.03
Covington Infusion Svc	0.01	0.01	0.01	0.01	0.01	0.01
Bone Density	0.84	0.84	0.84	0.84	0.84	0.84
CT Scan	7.09	7.09	7.09	7.09	7.09	7.09
Diabetes Svcs	0.99	0.99	0.99	0.99	0.99	0.99
Emergency Dept	56.89	56.89	56.89	56.89	56.89	56.89
Environmental Svcs	13.20	13.20	13.20	13.20	13.20	13.20
Facilities Mgmt	7.14	7.14	7.14	7.14	7.14	7.14
Hospital Care Mgmt	2.71	2.71	2.71	2.71	2.71	2.71
Hospital Social Work	3.32	3.32	3.32	3.32	3.32	3.32
Hospitalists Surgical	1.32	1.32	1.32	1.32	1.32	1.32
Linen Svcs	1.04	1.04	1.04	1.04	1.04	1.04
Mammography	4.68	4.68	4.68	4.68	4.68	4.68
MedSurg Intermed Care	47.21	47.21	47.21	47.21	47.21	47.21
MRI Imaging	3.14	3.14	3.14	3.14	3.14	3.14
Nursing Admin	0.87	0.87	0.87	0.87	0.87	0.87
Nursing Residents	11.62	11.62	11.62	11.62	11.62	11.62
Nutrition Svcs	9.35	9.35	9.35	9.35	9.35	9.35
OP_SS Surgeries	5.11	5.11	5.11	5.11	5.11	5.11
Operating Room	13.83	13.83	13.83	13.83	13.83	13.83
Palliative Care	0.05	0.05	0.05	0.05	0.05	0.05
Pharmacy Hospital	11.32	11.32	11.32	11.32	11.32	11.32
Post Anesthesia Care	5.15	5.15	5.15	5.15	5.15	5.15
Pre Anesthesia Clinic	0.80	0.80	0.80	0.80	0.80	0.80
Pulse Echo	0.23	0.23	0.23	0.23	0.23	0.23
Radiology	7.78	7.78	7.78	7.78	7.78	7.78
Respiratory Therapy	4.86	4.86	4.86	4.86	4.86	4.86
Security Svcs	10.94	10.94	10.94	10.94	10.94	10.94
Staffing Office	9.81	9.81	9.81	9.81	9.81	9.81
Sterile Processing	6.23	6.23	6.23	6.23	6.23	6.23
Supply Chain Operations	3.58	3.58	3.58	3.58	3.58	3.58
MedSurg Care	26.23	26.23	26.23	26.23	26.23	26.23
Surgical Svcs Admin	1.00	1.00	1.00	1.00	1.00	1.00
Ultrasound	6.24	6.24	6.24	6.24	6.24	6.24
Wound Care	0.17	0.17	0.17	0.17	0.17	0.17
Access Svcs MOB	2.41	2.41	2.41	2.41	2.41	2.41
Imaging Admin	2.00	2.00	2.00	2.00	2.00	2.00
Family Birth Center	0.00	0.00	27.27	40.91	40.91	40.91
Level II ICN	0.00	0.00	6.95	10.56	10.63	10.69
Total FTEs	307.88	307.88	342.10	359.35	359.41	359.48

MultiCare Covington Medical Center
Cash Flow Statement (With the Project)

	2025	2026	2027	2028	2029	2030
Months	12	12	12	12	12	12
OPERATING ACTIVITIES						
Net Income	$ 10,592,018	$ 10,592,018	$ 8,341,294	$ 8,116,116	$ 8,312,215	$ 8,508,315
Depreciation	$ 4,454,604	$ 4,454,604	$ 4,701,764	$ 4,825,345	$ 4,825,345	$ 4,825,345
Accounts Receivable	$ (15,115,792)	$ (15,115,792)	$ (16,029,725)	$ (16,559,398)	$ (16,595,752)	$ (16,632,106)
A/R From Prior Year	$ 15,115,792	$ 15,115,792	$ 15,115,792	$ 16,029,725	$ 16,559,398	$ 16,595,752
Accounts Payable	$ 32,841,204	$ 32,841,204	$ 35,788,731	$ 37,148,474	$ 37,174,804	$ 37,201,134
A/P From Prior Year	$ (32,841,204)	$ (32,841,204)	$ (32,841,204)	$ (35,788,731)	$ (37,148,474)	$ (37,174,804)
Cash Flow from Operating Activities	**$ 15,046,622**	**$ 15,046,622**	**$ 15,076,653**	**$ 13,771,530**	**$ 13,127,537**	**$ 13,323,636**
INVESTING ACTIVITIES						
Purchase of PP&E		$ (2,854,386)				
Cash Flow from Investing Activities	**$ -**	**$ (2,854,386)**	**$ -**	**$ -**	**$ -**	**$ -**
FINANCING ACTIVITIES						
Capital Contributed From Reserves		$ 2,854,386				
Cash Flow from Financing Activities	**$ -**	**$ 2,854,386**	**$ -**	**$ -**	**$ -**	**$ -**
Beginning Balance	$ -	$ 15,046,622	$ 30,093,243	$ 45,169,897	$ 58,941,427	$ 72,068,964
Annual Increase (Decrease)	$ 15,046,622	$ 15,046,622	$ 15,076,653	$ 13,771,530	$ 13,127,537	$ 13,323,636
Ending Balance	$ 15,046,622	$ 30,093,243	$ 45,169,897	$ 58,941,427	$ 72,068,964	$ 85,392,600

MultiCare Covington Medical Center
Balance Sheet Projections (With The Project)

	2025	2026	2027	2028	2029	2030
Assets						
Cash & Cash Equivalents	$ 15,046,622	$ 30,093,243	$ 45,169,897	$ 58,941,427	$ 72,068,964	$ 85,392,600
Accounts Receivable	$ 15,115,792	$ 15,115,792	$ 16,029,725	$ 16,559,398	$ 16,595,752	$ 16,632,106
Other Current Assets	$ 1,688,370	$ 1,688,370	$ 1,688,370	$ 1,688,370	$ 1,688,370	$ 1,688,370
Total Current Assets	$ 31,850,784	$ 46,897,406	$ 62,887,992	$ 77,189,195	$ 90,353,085	$103,713,075
Land, buildings, and equipment, net of accumulated depreciation	$119,887,966	$ 118,287,749	$114,599,798	$109,774,454	$104,949,109	$100,123,764
Other assets	$ -	$ -	$ -	$ -	$ -	$ -
Total Other Assets	$119,887,966	$ 118,287,749	$114,599,798	$109,774,454	$104,949,109	$100,123,764
Total Assets	$151,738,750	$ 165,185,154	$177,487,790	$186,963,649	$195,302,194	$203,836,839
Liabilities						
Accounts Payable and Other Accrued Expenses	$ 32,841,204	$ 32,841,204	$ 35,788,731	$ 37,148,474	$ 37,174,804	$ 37,201,134
Other Current Liabilities	$ 2,738,356	$ 2,738,356	$ 2,738,356	$ 2,738,356	$ 2,738,356	$ 2,738,356
Total Current Liabilities	$ 35,579,559	$ 35,579,559	$ 38,527,087	$ 39,886,829	$ 39,913,160	$ 39,939,490
Long-term debt, net of current portion	$ -	$ -	$ -	$ -	$ -	$ -
Other Liabilities	$ -	$ -	$ -	$ -	$ -	$ -
Total Other Liabilities	$ -	$ -	$ -	$ -	$ -	$ -
Total Liabilities	$ 35,579,559	$ 35,579,559	$ 38,527,087	$ 39,886,829	$ 39,913,160	$ 39,939,490
Equity						
Net Assets	$116,159,190	$ 129,605,595	$137,946,889	$146,063,005	$154,375,221	$162,883,535
Net assets – Transfer from affiliate	$ -	$ -	$ 1,013,814	$ 1,013,814	$ 1,013,814	$ 1,013,814
Total Net Assets	$116,159,190	$ 129,605,595	$138,960,703	$147,076,819	$155,389,035	$163,897,349
Total Liabilities and Equity	$151,738,750	$ 165,185,154	$177,487,790	$186,963,649	$195,302,194	$203,836,839

Exhibit 7A.
Property Deed

RECORDING REQUESTED BY AND
UPON RECORDATION RETURN TO:

Multicare Health System
c/o Anne R. Redman, Esq.
Bennett, Bigelow & Leedom, P.S.
999 Third Avenue, Suite 2150
Seattle, Washington 98104-4036

Covington Medical Center
Covington, Washington

9903102209

Document Title
STATUTORY WARRANTY DEED

Reference numbers of related documents:
Memorandum of Lease - King County's Registered File No. 9210191729

Grantor: Covington Medical Center Partners, Ltd.,
a Washington limited partnership
Grantee: Multicare Health System, a
Washington not-for-profit corporation

Legal Description:

Lot 2 of King County Lot Line Adjustment
Recorded under Recording Number 9208060760

Assessor's Property Tax Parcel Account Numbers:
252205-9131-03

Date: 3/6/99, 1999

Location of Property: 17700 Southeast 272nd Street
Covington, Washington

CHICAGO TITLE INS. CO
REF# 534725-6

E1671784 03/10/99 366564.2F 20593496.00

STATUTORY WARRANTY DEED

FOR VALUABLE CONSIDERATION, receipt and sufficiency of which are hereby acknowledged, COVINGTON MEDICAL CENTER PARTNERS, LTD., a Washington limited partnership ("Grantor"), as owner and holder of the following property:

(i) the leasehold interest in and to the real property described in Exhibit "A" attached hereto and incorporated herein by reference (the "Land"), pursuant to the terms and conditions of that certain Amended and Restated Covington Ground Lease dated as of September 24, 1992, a memorandum of which lease was recorded on October 19, 1992 under Recording Number 9210191729;

(ii) together with all appurtenances thereto and all improvements thereon, including but not limited to an approximately one hundred seven thousand two hundred fourteen (107,214) gross square foot, four (4) story medical office building whose commonly known address is 17700 Southeast 272nd Street, Covington, Washington, and all rights, privileges, easements and appurtenances of benefit thereto (such real property, improvements and appurtenances being referred to herein as the "**Real Property**");

(iii) together with all of Grantor's right, title and interest in and to all personal property of whatever type, wherever located, used by Grantor in connection with the ownership, use, maintenance or operation thereof (the "**Personal Property**"), including, without limitation, all plans, maps, specifications, all engineering, inspection and similar reports, all tolls, rents, revenues, issues, income, products, proceeds and profits thereof, and all tools, equipment, supplies, inventory, air conditioners, fixtures, equipment, furniture and furnishings; and all of Grantor's interest in any intangible property used or useful in connection with the foregoing, including, without limitation, all contract rights, warranties, guaranties, licenses, permits, entitlements, governmental approvals and certificates of occupancy which benefit the Real Property and/or the Personal Property (the "**Intangible Personal Property**").

the Real Property, the Personal Property and the Intangible Personal Property being referred to herein collectively as the "**Property**"); hereby deeds, grants and conveys to MULTICARE HEALTH SYSTEM, a Washington not-for-profit corporation ("Grantee") said Property

IN WITNESS WHEREOF, Grantor has executed this Deed as of March 5, 1999.

COVINGTON MEDICAL CENTER PARTNERS, LTD., a Washington limited Partnership

BY: Lankford & Associates, Inc.
a Colorado corporation,
Sole General Partner

By: _____
Robert A. Henry
Chief Financial Officer
and Secretary

9903102203

EXHIBIT A
LEGAL DESCRIPTION OF THE LAND

PARCEL A:

LOT 2, KING COUNTY BOUNDARY LINE ADJUSTMENT NO. S92L0022, RECORDED UNDER RECORDING NUMBER 9208060760, IN KING COUNTY, WASHINGTON, SAID LOT BEING DESCRIBED AS FOLLOWS:

THAT PORTION OF THE SOUTHEAST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 25, TOWNSHIP 22 NORTH, RANGE 5 EAST, WILLAMETTE MERIDIAN, IN KING COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHEAST CORNER OF SAID SUBDIVISION, A 4" X 4" CONCRETE MONUMENT WITH A 2" BRASS DISK AND CHISEL "X" IN CASE FOUND IN PLACE;
THENCE NORTH 01°44'54" EAST ALONG THE EAST LINE OF SAID SUBDIVISION A DISTANCE OF 50.00 FEET TO THE NORTHERLY RIGHT OF WAY MARGIN OF S.S.H. NUMBER 5-A (S.E. 272ND STREET) AND THE TRUE POINT OF BEGINNING;
THENCE CONTINUING NORTH 01°44'54" EAST ALONG SAID EAST LINE A DISTANCE OF 581.41 FEET;
THENCE NORTH 87°39'50" WEST PARALLEL WITH THE SOUTH LINE OF SAID SUBDIVISION A DISTANCE OF 151.42 FEET;
THENCE SOUTH 02°20'10" WEST NORMAL TO SAID SOUTH LINE A DISTANCE OF 205.17 FEET;
THENCE NORTH 87°39'50" WEST PARALLEL WITH SAID SOUTH LINE A DISTANCE OF 352.00 FEET TO THE FACE OF A BUILDING TO BE CONSTRUCTED (ACCORDING TO SAID BOUNDARY LINE ADJUSTMENT);
THENCE SOUTH 02°20'10" WEST ALONG THE FACE OF SAID BUILDING AND NORMAL TO SAID SOUTH LINE A DISTANCE OF 14.00 FEET;
THENCE NORTH 87°39'50" WEST ALONG THE FACE OF SAID BUILDING AND PARALLEL WITH SAID SOUTH LINE A DISTANCE OF 50.00 FEET;
THENCE SOUTH 02°20'10" WEST ALONG THE FACE OF SAID BUILDING AND NORMAL TO SAID SOUTH LINE A DISTANCE OF 6.00 FEET;
THENCE NORTH 87°39'50" WEST ALONG THE FACE OF SAID BUILDING AND PARALLEL WITH THE SAID SOUTH LINE A DISTANCE OF 87.00 FEET TO THE NORTHWEST CORNER OF SAID BUILDING;
THENCE NORTH 43°16'17" WEST NORMAL TO THE SOUTHEASTERLY RIGHT OF WAY MARGIN OF S.E. WAX ROAD A DISTANCE OF 163.39 FEET TO SAID SOUTHEASTERLY MARGIN;
THENCE SOUTH 46°43'43" WEST ALONG SAID SOUTHEASTERLY MARGIN A DISTANCE OF 434.54 FEET TO THE NORTH LINE OF THE SOUTH 210.00 FEET OF SAID SUBDIVISION;
THENCE SOUTH 87°39'50" EAST ALONG SAID NORTH LINE A DISTANCE OF 80.00 FEET;
THENCE SOUTH 02°20'10" WEST NORMAL TO SAID NORTH LINE A DISTANCE OF 160.00 FEET TO SAID NORTHERLY MARGIN;
THENCE SOUTH 87°39'50" EAST ALONG SAID MARGIN AND PARALLEL WITH SAID SOUTH LINE A DISTANCE OF 987.13 FEET TO THE POINT OF BEGINNING.

PARCEL B:

AN EASEMENT APPURTENANT TO SAID LOT 2, AS ESTABLISHED BY INSTRUMENT RECORDED UNDER RECORDING NUMBER 9210191728, FOR CONSTRUCTION, PLACEMENT AND MAINTENANCE OF A BUILDING ON, OVER AND UNDER THAT PORTION OF LOT 3 OF SAID BOUNDARY LINE ADJUSTMENT NO. S92L0022, DESCRIBED AS FOLLOWS:

THAT PORTION OF THE SOUTHEAST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 25, TOWNSHIP 22 NORTH, RANGE 5 EAST, WILLAMETTE MERIDIAN, IN KING COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHEAST CORNER OF SAID SUBDIVISION, A 4" X 4" CONCRETE MONUMENT WITH A 2" BRASS DISK AND CHISEL "X" IN CASE FOUND IN PLACE;
THENCE NORTH 01°44'54" EAST ALONG THE EAST LINE OF SAID SUBDIVISION A DISTANCE OF 631.41 FEET;
THENCE NORTH 87°39'50" WEST PARALLEL WITH THE SOUTH LINE OF SAID SUBDIVISION A DISTANCE OF 151.42 FEET;
THENCE SOUTH 02°20'10" WEST NORMAL TO SAID SOUTH LINE A DISTANCE OF 203.17 FEET TO THE POINT OF BEGINNING;
THENCE CONTINUING SOUTH 02°20'10" WEST A DISTANCE OF 2.00 FEET;
THENCE NORTH 87°39'50" WEST PARALLEL WITH SAID SOUTH LINE A DISTANCE OF 352.00 FEET TO THE FACE OF A BUILDING TO BE CONSTRUCTED (ACCORDING TO SAID BOUNDARY LINE ADJUSTMENT);
THENCE NORTH 02°20'10" EAST ALONG THE FACE OF SAID BUILDING AND NORMAL TO SAID SOUTH LINE A DISTANCE OF 2.00 FEET;
THENCE SOUTH 87°39'50" EAST ALONG THE FACE OF SAID BUILDING AND ITS EASTERLY PROLONGATION AND PARALLEL WITH SAID SOUTH LINE A DISTANCE OF 352.00 FEET TO THE POINT OF BEGINNING.

PARCEL C:

AN EASEMENT APPURTENANT TO SAID LOT 2, AS ESTABLISHED BY INSTRUMENT RECORDED UNDER RECORDING NUMBER 9210191728, FOR DRAINAGE, WATER, AND UTILITY LINES, INGRESS AND EGRESS, PARKING, LANDSCAPING AND OPEN SPACE ON, OVER AND UNDER PORTIONS OF LOT 3 OF SAID BOUNDARY LINE ADJUSTMENT NO. S92L0022 AS APPLICABLE ACCORDING TO THE TERMS OF SAID INSTRUMENT.

NOTARY ACKNOWLEDGMENTS

State of California

County of San Diego

On 3/6/99 (Date) before me, Mary Dawn Pampuch, Notary Public, (Name and Title of Officer (e.g., "Jane Doe, Notary Public"))

personally appeared Robert A. Henry, (Name(s) of Signer(s))

☒ personally known to me – **OR** – ☐ proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

MARY DAWN PAMPUCH
COMM. #1069063
NOTARY PUBLIC - CALIFORNIA
SAN DIEGO COUNTY
My Comm. Exp. Sept. 15, 1999

WITNESS my hand and official seal.

Mary Dawn Pampuch
Signature of Notary Public

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

9903102209

Description of Attached Document

Title or Type of Document: Statutory Warranty Deed

Document Date: 3/5/99 Number of Pages: 3

Signer(s) Other Than Named Above: N/A

Capacity(ies) Claimed by Signer(s)

Signer's Name: Robert A. Henry	Signer's Name:
☐ Individual	☐ Individual
☒ Corporate Officer Title(s): Chief Fin. Officer; Sec	☐ Corporate Officer Title(s):
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☐ General
☐ Attorney-in-Fact	☐ Attorney-in-Fact
☐ Trustee	☐ Trustee
☐ Guardian or Conservator	☐ Guardian or Conservator
☐ Other:	☐ Other:
Signer Is Representing: Lankford; Assoc.	Signer Is Representing:
Top of thumb here	Top of thumb here

Exhibit 7B.
Tax Parcel Summary Report

PARCEL DATA

Parcel	252205-9131
Name	PROPERTY VALUATION SERVICES
Site Address	17700 SE 272ND ST 98042
Geo Area	65-50
Spec Area	
Property Name	MULTICARE MEDICAL CENTER

Jurisdiction	COVINGTON
Levy Code	1064
Property Type	C
Plat Block / Building Number	
Plat Lot / Unit Number	
Quarter-Section-Township-Range	SE-25-22-5

Legal Description

LOTS "2" & "3" OF KC BLA #S92L0022 REC #9208060760 (BEING POR OF SE 1/4 SE 1/4 STR 25-22- 05); EXC POR CONVD TO CITY OF COVINGTON BY DEEDS REC #20050209001292, 20050209001293 & 20080520001597 (TAXABLE PORTION) LESS ST PER REC# 20200302001483
PLat Block:
Plat Lot:

LAND DATA

Highest & Best Use As If Vacant	COMMERCIAL SERVICE
Highest & Best Use As Improved	PRESENT USE
Present Use	Medical/Dental Office
Land SqFt	568,581
Acres	13.05

Percentage Unusable	
Unbuildable	NO
Restrictive Size Shape	YES
Zoning	MC
Water	WATER DISTRICT
Sewer/Septic	PUBLIC
Road Access	PUBLIC
Parking	ADEQUATE
Street Surface	PAVED

Views

Rainier	
Territorial	
Olympics	
Cascades	
Seattle Skyline	
Puget Sound	
Lake Washington	
Lake Sammamish	
Lake/River/Creek	
Other View	

Waterfront

Waterfront Location	
Waterfront Footage	0
Lot Depth Factor	0
Waterfront Bank	
Tide/Shore	
Waterfront Restricted Access	
Waterfront Access Rights	NO
Poor Quality	NO
Proximity Influence	NO

Designations

Historic Site	
Current Use	(none)
Nbr Bldg Sites	
Adjacent to Golf Fairway	NO
Adjacent to Greenbelt	NO
Other Designation	NO
Deed Restrictions	NO
Development Rights Purchased	NO
Easements	NO
Native Growth Protection Easement	NO
DNR Lease	NO

Nuisances

Topography	
Traffic Noise	
Airport Noise	
Power Lines	NO
Other Nuisances	NO

Problems

Water Problems	NO
Transportation Concurrency	NO
Other Problems	NO

Environmental

Environmental	NO

BUILDING

Building Number	1
Building Description	MEDICAL CENTER
Number Of Buildings Aggregated	1
Predominant Use	HOSPITAL (331)
Shape	Rect or Slight Irreg
Construction Class	REINFORCED CONCRETE
Building Quality	AVERAGE
Stories	4
Building Gross Sq Ft	111,419
Building Net Sq Ft	86,588

Click the camera to see more pictures.

Reference Link

- Residential Phys Inspection Areas
- King County Tax Districts Codes & Levies (.PDF)
- King County Tax Links
- Property Tax Adv
- Washington Stat Department of Revenue (Externa link)
- Washington Stat Board of Tax Appeals (Externa link)
- Board of Appeals/Equaliz
- Districts Report
- iMap
- Recorder's Offic

Scanned images surveys and oth map documents

- Housing Availab Dashboard

Year Built	1993
Eff. Year	2019
Percentage Complete	100
Heating System	COMPLETE HVAC
Sprinklers	Yes
Elevators	Yes
1 2 3 4	

Picture of Building 1

Section(s) Of Building Number: 1

Section Number	Section Use	Description	Stories	Height	Floor Number	Gross Sq Ft	Net Sq Ft
1	HOSPITAL (331)		4	12		111,419	86,588

TAX ROLL HISTORY

Account	Valued Year	Tax Year	Omit Year	Levy Code	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total Value ($)	New Dollars ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total Value ($)	Tax Value Reason
252205913103	2024	2025		1064	302,500	2,883,300	3,185,800	3,610,000	302,500	2,883,300	3,185,800	
252205913194	2024	2025		1064	10,500,500	100,089,100	110,589,600	0	0	0	0	NP
252205913103	2023	2024		1064	302,500	2,782,200	3,084,700	0	302,500	2,782,200	3,084,700	
252205913194	2023	2024		1064	10,500,500	96,580,200	107,080,700	0	0	0	0	NP
252205913103	2022	2023		1064	290,100	2,458,800	2,748,900	0	290,100	2,458,800	2,748,900	
252205913194	2022	2023		1064	10,068,400	85,353,900	95,422,300	0	0	0	0	NP
252205913103	2021	2022		1064	290,000	2,136,300	2,426,300	0	290,000	2,136,300	2,426,300	
252205913194	2021	2022		1064	10,068,500	74,159,700	84,228,200	0	0	0	0	NP
252205913103	2020	2021		1064	274,000	2,078,900	2,352,900	0	274,000	2,078,900	2,352,900	
252205913194	2020	2021		1064	9,509,100	72,166,600	81,675,700	0	0	0	0	NP
252205913103	2019	2020		1064	274,000	2,064,000	2,338,000	0	274,000	2,064,000	2,338,000	
252205913194	2019	2020		1064	9,509,100	71,649,300	81,158,400	0	0	0	0	NP
252205913103	2018	2019		1064	434,000	3,857,600	4,291,600	0	434,000	3,857,600	4,291,600	
252205913194	2018	2019		1064	7,910,400	70,325,500	78,235,900	0	0	0	0	NP
252205913103	2017	2018		1064	433,900	3,006,000	3,439,900	25,321,000	433,900	3,006,000	3,439,900	
252205913194	2017	2018		1064	7,910,500	54,800,900	62,711,400	0	0	0	0	NP
252205913103	2016	2017		1064	418,900	1,699,700	2,118,600	0	418,900	1,699,700	2,118,600	
252205913194	2016	2017		1064	7,637,700	30,985,900	38,623,600	0	0	0	0	EX
252205913103	2015	2016		1064	359,100	1,747,800	2,106,900	0	359,100	1,747,800	2,106,900	
252205913194	2015	2016		1064	6,546,600	31,863,600	38,410,200	0	0	0	0	EX
252205913103	2014	2015		1064	359,100	1,400,100	1,759,200	0	359,100	1,400,100	1,759,200	
252205913194	2014	2015		1064	6,546,600	25,525,300	32,071,900	0	0	0	0	EX
252205913103	2013	2014		1064	359,100	1,358,500	1,717,600	0	359,100	1,358,500	1,717,600	
252205913194	2013	2014		1064	6,546,600	24,765,700	31,312,300	0	0	0	0	NP
252205913103	2012	2013		1064	359,100	1,292,400	1,651,500	0	359,100	1,292,400	1,651,500	
252205913194	2012	2013		1064	6,546,600	23,560,700	30,107,300	0	0	0	0	NP
252205913103	2011	2012		1064	350,000	908,900	1,258,900	0	6,381,000	16,570,000	22,951,000	
252205913194	2011	2012		1064	6,381,000	16,570,000	22,951,000	0	0	0	0	NP
252205913103	2010	2011		1064	243,300	891,400	1,134,700	0	243,300	891,400	1,134,700	
252205913194	2010	2011		1064	0	0	0	0	0	0	0	
252205913103	2009	2010		1064	229,600	937,400	1,167,000	0	229,600	937,400	1,167,000	
252205913194	2009	2010		1064	0	0	0	0	0	0	0	
252205913103	2008	2009		1064	208,800	1,033,100	1,241,900	0	4,014,700	19,866,800	23,881,500	
252205913103	2007	2008		1064	208,800	1,033,100	1,241,900	0	4,014,700	19,866,800	23,881,500	
252205913103	2006	2007		1064	4,014,700	18,419,500	22,434,200	0	4,014,700	18,419,500	22,434,200	
252205913103	2005	2006		1064	4,014,700	16,888,700	20,903,400	0	4,014,700	16,888,700	20,903,400	
252205913103	2004	2005		1064	4,032,900	14,886,600	18,919,500	0	4,032,900	14,886,600	18,919,500	
252205913103	2003	2004		1064	3,226,300	14,697,400	17,923,700	0	3,226,300	14,697,400	17,923,700	

252205913103	2002	2003		1064	3,226,300	14,697,400	17,923,700	0	3,226,300	14,697,400	17,923,700	
252205913103	2001	2002		1064	2,825,000	14,492,600	17,317,600	0	2,825,000	14,492,600	17,317,600	
252205913103	2000	2001		1064	2,825,000	14,492,600	17,317,600	0	2,825,000	14,492,600	17,317,600	
252205913103	1999	2000		1064	2,825,000	13,744,800	16,569,800	0	2,825,000	13,744,800	16,569,800	
252205913103	1998	1999		1064	2,825,000	13,744,800	16,569,800	0	2,825,000	13,744,800	16,569,800	
252205913103	1997	1998		1064	0	0	0	0	2,825,000	13,744,800	16,569,800	
252205913103	1996	1997		5146	0	0	0	0	2,825,000	12,059,900	14,884,900	
252205913103	1995	1996		5146	0	0	0	0	2,825,000	12,059,900	14,884,900	

SALES HISTORY

Excise Number	Recording Number	Document Date	Sale Price	Seller Name	Buyer Name	Instrument	Sale Reason
3214121	**20221017000546**	10/12/2022	$0.00	MULTICARE HEALTH SYSTEM	COVINGTON CITY OF	Other - See Affidavit	Other
3036484		1/24/2020	$0.00	MULTICARE HEALTH SYSTEM	COVINGTON CITY OF	Other - See Affidavit	Other
3036483		1/24/2020	$0.00	MULTICARE HEALTH SYSTEM	COVINGTON CITY OF	Other - See Affidavit	Other
3036482	**20200302001485**	1/24/2020	$1,380.00	MULTICARE HEALTH SYSTEM	COVINGTON CITY OF	Warranty Deed	Other
2346708	**20080520001597**	1/20/2008	$0.00	MULTICARE HEALTH SYSTEM	COVINGTON CITY OF	Statutory Warranty Deed	Other
2100730	**20050209001292**	1/27/2005	$0.00	MULTICARE HEALTH SYSTEM	COVINGTON CITY OF	Statutory Warranty Deed	Other
1671784	**199903102208**	3/5/1999	$20,593,496.00	COVINGTON MEDICAL CTR PARTNERS LTD	MULTICARE HEALTH SYSTEM	Statutory Warranty Deed	None

REVIEW HISTORY

Tax Year	Review Number	Review Type	Appealed Value	Hearing Date	Settlement Value	Decision	Status
2010	0905068	Local Appeal	$22,443,610	1/1/1900	$0		Completed
1991	9005958	Local Appeal	$1,281,800	11/8/1990	$910,800	REVISE, ASSESSOR RECOMMENDED	Completed
1989	8802220	Local Appeal	$1,203,700	2/2/1989	$947,800	REVISE	Completed

PERMIT HISTORY

Permit Number	Permit Description	Type	Issue Date	Permit Value	Issuing Jurisdiction	Reviewed Date
B25-0028	Replacement of (2) existing operating room booms with (2) new power and med gas booms,	Other	3/18/2025	$236,642	COVINGTON	
M24-0206	DEMO EXISTING EXHAUST FAN. INSTALL EXHAUST FAN AND DUCTWORK.,	Other	12/4/2024	$0	COVINGTON	4/23/2025
B24-0111	MRI MACHINE REPLACEMENT IN EXISTING MRI SUITE AND ASSOCIATED RELEVANT MINOR CONSTRUCTION WORK.,	Remodel	8/19/2024	$0	COVINGTON	4/23/2025
M24-0045	Replace existing Chiller and ductless split heat pump systems, associated with MRI upgrade. The heat pump is like for like tonnage. The new chiller weighs less than the existing chiller, and we are connecting to existing hydronic piping.,	Other	6/25/2024	$0	COVINGTON	4/23/2025
F23-0035	Install new Fire Alarm Control Panel to serve remodeled Orthopedic Suite 105. New FA system shall operate congruent to existing FA system. Install new FA initiating & notification devices to current codes/standards within Orthopedic Suite 105, co	Other	1/26/2024	$0	COVINGTON	6/13/2024
F23-0028	1. Add and relocate fire sprinklers for new walls and ceilings. 2. New fire sprinkler at finished ceilings to be Semi-Recessed with Chrome finish to match existing. Total # of sprinklers (58),	Other	9/26/2023	$0	COVINGTON	6/13/2024
P23-0032	New piping and fixtures as indicated on permit drawings.,	Other	9/13/2023	$0	COVINGTON	6/13/2024

M23-0181	New ductwork and diffusers, as indicated on attached plans.,	Other	9/13/2023	$0	COVINGTON	6/13/2024
B23-0038	A 5,323 SF tenant improvement to Suite 105, including exam rooms and patient and staff support areas.

 All spaces area Type B occupancy, medical office building, and are not DOH CRS reviewable., | Remodel | 7/17/2023 | $1,100,000 | COVINGTON | 6/13/2024 |
F23-0021	Upgrade existing fire alarm system Multicare Covington MOB. Provide new notification to code throughout. Provide like-for-like initiating devices throughout. (2) New Fire Alarm Controls Panels, (1) new radio transmitter, (1159) new devices. Joint v	Other	7/13/2023	$0	COVINGTON	6/13/2024
F22-0053	Update fire alarm system in small TI,	Other	7/19/2022	$0	COVINGTON	4/28/2023
F22-0051	SMITH FIRE SYSTEMS (SFS) WILL MODIFY THE EXISTING SPRINKLER SYSTEM TO ACCOMMODATE THE NEW WALLS AND CEILINGS.,	Other	5/23/2022	$0	COVINGTON	7/6/2022
P21-0038	RECONFIGURE SUB-STERILE PROCESSING BETWEEN THE EXISTING OPERATING ROOM 1 AND 3 INCLUDING ADDITION OF A DOOR, CASEWORK REVISIONS, ELECTRICAL REVISIONS AND MECHANICAL REVISIONS.,	Other	4/13/2022	$0	COVINGTON	7/6/2022
B22-0009	571 Sq Roof Overlay; perform moisture scan, replace wet material, remove gravel surfacing, install 1/2' dens deck primed overlayment board, install Garland 2-ply SBS system, new coping metals, counter flashings, walk pad, retro-fit drain inserts, tes	Other	2/2/2022	$718,808	COVINGTON	5/24/2023
P22-0001	Rerough in 4 water closets and rerough in 4 urinals,	Other	1/27/2022	$0	COVINGTON	7/6/2022
B21-0199	REMODEL EXISTING STERILE PROCESSING DEPARTMENT, TWO OPERATING ROOMS, AND ANCILLARY ROOMS IN THE COVINGTON MOB.,	Remodel	1/19/2022	$5,537,836	COVINGTON	8/8/2024
B21-0194	RECONFIGURE SUB-STERILE PROCESSING BETWEEN THE EXISTING OPERATING ROOM 1 AND 3 INCLUDING ADDITION OF A DOOR, CASEWORK REVISIONS, ELECTRICAL REVISIONS AND MECHANICAL REVISIONS.,	Remodel	1/19/2022	$330,000	COVINGTON	5/24/2023
M21-0255	RECONFIGURE SUB-STERILE PROCESSING BETWEEN THE EXISTING OPERATING ROOM 1 AND 3 INCLUDING ADDITION OF A DOOR, CASEWORK REVISIONS, ELECTRICAL REVISIONS AND MECHANICAL REVISIONS.,	Other	1/11/2022	$0	COVINGTON	7/6/2022
P21-0041	Remodel existing sterile processing department, two operating rooms, and ancillary rooms in the Covington MOB.,	Remodel	12/15/2021	$0	COVINGTON	7/6/2022
M21-0302	Remodel existing sterile processing department, two operating rooms, and ancillary rooms in the Covington MOB.,	Remodel	12/15/2021	$0	COVINGTON	7/6/2022
F21-0039	Install fire alarm system in TI Space at Covington CWLW. Wiring by others.,	Other	11/1/2021	$0	COVINGTON	7/6/2022
M21-0217	Tenant Improvement involving the installation of a VAV and ductwork redistribution. 1346-001,	Other	8/30/2021	$0	COVINGTON	7/6/2022
F21-0034	SMITH FIRE WILL MODIFY THE EXISTING SPRINKLER SYSTEM BY ADDING AND RELOCATING 20 SPRINKLERS TO ACCOMMODATE THE REVISED WALLS AND CEILINGS OF THE TENANT IMPROVEMENT.,	Other	8/16/2021	$0	COVINGTON	7/6/2022
P21-0028	Plumbing - This project is on the first floor, and it goes with the building permit # B21-0049,	Other	8/11/2021	$0	COVINGTON	7/6/2022
B21-0049	MINOR ALTERATION OF EXISTING WEIGHT-LOSS CLINIC WITH CHANGES TO PARTITIONS, CASEWORK, FINISHES AND DOORS.,	Remodel	7/29/2021	$850,434	COVINGTON	5/24/2023
F21-0024	Install 4 notification appliances on existing circuit,	Other	7/19/2021	$0	COVINGTON	7/6/2022

B21-0110	THE REMODEL CONSIST OF 187 SQ FT OF REMOVING EXISTING RECEPTION DESK AND INSTALLING NEW RECEPTION DESK, INSTALLING TWO NEW CASEWORK DESKS, RELOCATING EXISTING EQUIPMENT, INSTALLING NEW WALL AND A DOOR TO THE RECEPTION DESK AREA.,	Remodel	7/12/2021	$125,000	COVINGTON	5/24/2023
P21-0025	INSTALLING ONE 3/4' RPBA (BACKFLOW PREVENTER).,		7/8/2021	$0	COVINGTON	7/6/2022
P21-0022	Alteration of 7 sinks,	Other	6/29/2021	$0	COVINGTON	7/6/2022
M21-0128	Tenant Improvement involving Defuser relocation. 578-001,	Other	6/9/2021	$0	COVINGTON	7/6/2022
F21-0015	SMITH FIRE WILL MODIFY THE EXISTING SPRINKLER SYSTEM TO ACCOMODATE THE NEW TENANT WALLS AND CEILINGS. 7 SPRINKLERS WILL BE RELOCATED.,	Other	6/9/2021	$0	COVINGTON	7/6/2022
M21-0074	PHARMACY IS TO RECEIVE SEVERAL MODIFICATIONS TO ENSURE COMPLIANCE WITH USP <795> AND <800>.,	Other	5/12/2021	$0	COVINGTON	7/6/2022
M21-0059	Relocation of six supply diffusers and six return grilles to accommodate new wall layouts. This scope includes rebalancing of airflows to meet ventilation, cooling and heating load requirements. There is no new equipment or modifications to existing	Other	4/6/2021	$0	COVINGTON	7/2/2021
P21-0011	Plumbing waste and vents for 5 sinks,	Other	3/31/2021	$0	COVINGTON	7/2/2021
F21-0007	SMITH FIRE SYSTEMS (SFS) WILL MODIFY EXISTING SPRINKLER SYSTEM TO ACCOMODATE THE NEW WALLS AND CEILINGS.,	Other	3/29/2021	$0	COVINGTON	7/2/2021
B21-0041	MINOR ALTERATION OF EXISTING WOMEN'S CLINIC OF ABOUT 2900 SF. MOVING A FEW WALLS, NEW FINISHES AND CASEWORK IN A PORTION OF THE SUITE.,	Remodel	3/23/2021	$165,000	COVINGTON	8/17/2022
B21-0010	MINOR ALTERATION OF 2900 SF EXISTING WOMENS CLINIC. MOVING WALLS, NEW FINISHES AND CASEWORK IN A PORTION OF THE SUITE.,	Remodel	3/22/2021	$90,000	COVINGTON	7/28/2021
M21-0025	Tenant Improvement Involving the Installation of one Rooftop Heat Pump and three Grilles for service to one Room.,	Other	3/15/2021	$0	COVINGTON	7/2/2021
P21-0007	Adding one sink,	Other	2/4/2021	$0	COVINGTON	5/19/2021
B20-0184	XRAY ROOM TI,	Other	10/22/2020	$100,000	COVINGTON	6/15/2021
M20-0135	Tenant Improvement involving the installation of one terminal unit, three inline ducted heaters, one rooftop exhaust fan with factory curbing, two smoke dampers and ducted return air transfers. 9522-001,	Other	8/5/2020	$0	COVINGTON	5/19/2021
F20-0038	PARTS & SMARTS FIRE ALARM SYSTEM FOR DOCTOR/NURSE SLEEPING ROOMS,	Other	7/21/2020	$0	COVINGTON	5/19/2021
P20-0006	Add one toilet, one lav, one shower and one break room sink to new tenant space.,	Other	7/9/2020	$0	COVINGTON	5/19/2021
F20-0017	SMITH FIRE WILL MODIFY THE EXISTING SPRINKLER SYSTEM TO ACCOMMODATE THE NEW WALLS AND CEILINGS OF THE REMODELED RESPITE ROOM SPACE.,	Other	6/30/2020	$0	COVINGTON	10/1/2020
B20-0047	THE REMODEL SHALL CONSISTS OF 1, 005 SQ FT OF CONSTRUCTION. THE EXISTING SHELL SPACE WILL BE RECONFIGURED INTO 3 RESPITE ROOMS, A BATHROOM, A LOUNGE & KITCHENETTE, AND MIS WORKSPACE. THE EXTENT OF WORK INCLUDES REDESIGN OF NON-STRUCTURAL WALLS,	Remodel	6/3/2020	$275,000	COVINGTON	6/15/2021
P16-0009	MULTICARE LAB REMODEL,		4/13/2020	$0	COVINGTON	7/24/2020
M16-0065	MULTICARE LAB REMODEL,	Other	4/13/2020	$0	COVINGTON	7/24/2020
B16-0029	DEMOLITION AND REMODEL OF EXISTING LAB ON FIRST FLOOR OF EXISTING MEDICAL OFFICE BUILDING. APPROX 1500 SQ FT. Modifications to the existing fire sprinkler system effecting 4 or more heads or any fire alarm system modification to accommodate the tena	Remodel	4/13/2020	$150,000	COVINGTON	6/15/2021

B19-0204	THE REMODEL CONSISTS OF 206 SQ FT OF LIGHT REMODEL. THE EXISTING VENDING BUSINESS ROOM WILL BE RECONFIGURED INTO AN EMPLOYEE LACTATION ROOM AND THE EXISTING ALCOVE SPACE INTO AN OFFICE. THE EXTENT OF WORK INCLUDES REDESIGN OF NON-STRUCTURAL WALLS, DO	Other	3/4/2020	$7,000	COVINGTON	7/24/2020
M20-0002	Installing (2) Fire Dampers common to existing ducting that is going through a wall that will become a 1-hour rated wall during this project.,	Other	2/10/2020	$0	COVINGTON	7/24/2020
F19-0055	SMITH FIRE WILL MODIFY THE EXISTING FIRE SPRINKLER SYSTEM TO PROTECT THE REMODELED LAB SPACE. WORK ON 12 SPRINKLERS IS INCLUDED.,	Other	12/17/2019	$0	COVINGTON	7/24/2020
M19-0162	Piping for CT Scanner and Chiller,	Other	11/7/2019	$0	COVINGTON	7/24/2020
B19-0095	Tenant improvement on Level 2 in the existing MultiCare Covington Medical Center Hospital. Addition of horizontal operable partition to Level 2 waiting and reception area.,	Remodel	7/2/2019	$120,000	COVINGTON	10/1/2020
B19-0086	EXTERIOR 20' X 30' CANOPY (NO WALLS) AND OVERALL LAYOUT FOR STAFF LUNCHTIME EVENT ON FRIDAY, JULY 11, 2019 FROM 11:00 AM TO 1:30PM. SANITARY FACILITIES ARE AVAILABLE IN THE EMERGENCY DEPT. Noted was the installation of a 20'x30' tent. There are to	Other	7/2/2019	$0	COVINGTON	7/24/2020
P16-0009	MULTICARE LAB REMODEL,		6/27/2019	$0	COVINGTON	7/24/2020
M16-0065	MULTICARE LAB REMODEL,	Other	6/27/2019	$0	COVINGTON	7/24/2020
B16-0029	DEMOLITION AND REMODEL OF EXISTING LAB ON FIRST FLOOR OF EXISTING MEDICAL OFFICE BUILDING. APPROX 1500 SQ FT. Modifications to the existing fire sprinkler system effecting 4 or more heads or any fire alarm system modification to accommodate the tena	Remodel	6/27/2019	$150,000	COVINGTON	10/1/2020
P19-0005	Heating water piping as indicated to new terminal unit in room N2033-Clean Storage.,	Other	3/20/2019	$0	COVINGTON	8/30/2019
M19-0028	Demo and replace duct and diffuser in room N1066 Sterile Storage. Demo duct and diffuser then install (1) new terminal unit with hot water piping and additional duct in room N2033 Clean Storage.,	Other	3/20/2019	$0	COVINGTON	8/30/2019
F19-0001	REALIGN 1 NOZZLE, ADD 1 NOZZLE, + RE-HOOK PULL STATION.,	Other	1/10/2019	$0	COVINGTON	8/30/2019
M18-0218	REVISION OF EXISTING HVAC SYSTEM IN N2033 ANESTHESIA WORK ROOM TO ACCOMMODATE STORAGE OF STERILE ITEMS.,	Remodel	11/20/2018	$0	COVINGTON	8/30/2019
M18-0217	REVISE THE HVAC SYSTEM IN N1056 EQUIPMENT STORAGE TO ACCOMMODATE STERILE ITEMS.,	Remodel	11/20/2018	$0	COVINGTON	8/30/2019
P18-0007	Remodel of deli area, revised plumbing to support new, replacement and deleted kitchen equipment.,	Remodel	7/12/2018	$800,000	COVINGTON	8/30/2019
M18-0025	REPLACING 5 VAV BOX TERMINAL UNITS WITH ELECTRIC REHEAT COILS WITH FOUR NEW ONES. REPLACING EXHAUST FAN FOR PRESSURIZATION PURPOSES. PROVIDING NATURAL GAS AND PLUMBING FOR KITCHEN EQUIPMENT. RECONFIGURATION OF THE ANSUL FIRE PROTECTION SYSTEM FOR N	Other	7/12/2018	$0	COVINGTON	8/30/2019
F18-0053	REMODEL OF SERVERY AREA - 2 PHASES FIRE ALARM SYSTEM 28 DEVICES,	Remodel	7/10/2018	$0	COVINGTON	8/30/2019
B18-0016	Scopes of work includes the expansion and remodel of the existing food service area located in the non-essential facility. The extent of work includes removal and redesign of non-structural walls,ceilings, doors, casework equipment and finishes. 3938	Remodel	7/10/2018	$800,000	COVINGTON	8/30/2019
F18-0060	MODIFY EXISTING SYSTEM TO ACCOMMODATE THE NEW WALLS AND CEILINGS. MULTICARE SERVERY,	Other	7/9/2018	$0	COVINGTON	8/30/2019
M18-0013	ADD 2 VAV BOXES REZONE EXISTING FOR THE MRI UNIT,		2/12/2018	$40,000	COVINGTON	5/10/2018

B17-0181	INSTALLATION OF A CONCRETE PAD FOR A MOBILE MRI TRAILER AT MULTICARE HOSPITAL.,	Accessory, New	2/12/2018	$50,000	COVINGTON	5/10/2018
P18-0003	7 MED GAS OUTLETS FOR THE MRI UNIT Modifications to the existing fire sprinkler system effecting 4 or more heads or any fire alarm system modification to accommodate the tenant improvements are to be by separate permit. The following conditions and		2/8/2018	$40,000	COVINGTON	5/10/2018
F18-0011	MODIFY EXISTING FIRE ALARM SYSTEM IN H3 OCCUPANCY AREA - CYLINDER STORAGE S1109, MED GAS MAINIFILD S11110.,	Other	2/6/2018	$0	COVINGTON	5/10/2018
F18-0002	1ST FLOOR MOB MRI TI - FIRE ALARM SYSTEM. 20 DEVICES,	Other	1/25/2018	$0	COVINGTON	5/10/2018
B17-0184	REVISE DOOR SWING AS SHOWN IN CCD-067 AND PROVIDE MANUAL SHUT OFF AND ALARM AS SHOWN IN CCD-066. A SEPARATE PERMIT WILL BE REQUIRED FOR THE MOVING OR ADDING OF FIRE ALARM DEVICES.,	Other	1/8/2018	$20,000	COVINGTON	5/10/2018
F17-0056	RELOCATE PENDANT SPRINKLERS IN EXISTING MOB MRI, T.I. SPACE TO NEW CEILING LAYOUT. 23 SPRINKLER HEADS.,	Other	1/4/2018	$0	COVINGTON	5/10/2018
B17-0181	INSTALLATION OF A CONCRETE PAD FOR A MOBILE MRI TRAILER AT MULTICARE HOSPITAL.,	Accessory, New	11/27/2017	$50,000	COVINGTON	5/10/2018
B17-0111	APPROXIMATELY 2,272 SQ. FT. OF 1ST FLOOR INTERIOR REMODEL OF THE MRI AND THE CONNECT SPACES TO THE EMERGENCY DEPARTMENT AND TO THE NEW HOSPITAL. THE HOSPITAL IS UNDER SEPARATE PERMIT.,	Remodel	10/9/2017	$800,000	COVINGTON	5/10/2018
F17-0038	INSTALL FIRE DOOR INTERFACE FOR MULTICARE MEDICAL OFFICE BUILDING (MOB) - 2 DEVICES.,	Other	9/13/2017	$0	COVINGTON	2/28/2018
F17-0034	TENANT IMPROVEMENT - FIRE ALARM INSTALLATION. Permit scope includes the relocation and addition of duct detectors for a tenant improvement. The following conditions and information are provided to increase the success of the project and by no means	Other	8/22/2017	$0	COVINGTON	2/28/2018
F17-0031	MODIFY THE EXISTING SYSTEM TO ACCOMODATE THE NEW WALLS AND CEILINGS - 6 HEADS,	Other	8/15/2017	$0	COVINGTON	2/28/2018
F17-0010	HOOK UP CHEMICAL-BASED HOOD AND DUCT SUPPRESSION SYSTEM TO PRE-PIPED HOOD. 10 NOZZLES.,	Other	7/18/2017	$0	COVINGTON	2/28/2018
B17-0065	EXTERIOR 20' X 30' CANOPY (NO WALLS) AND OVERALL LAYOUT FOR STAFF LUNCHTIME EVENT ON JULY 26, 2017. SANITARY FACILITIES ARE AVAILABLE IN THE EMERGENCY DEPT. Noted was the installation of a 20'x30' tent. There are to be no changes or deviations to	Other	6/29/2017	$0	COVINGTON	2/28/2018
M17-0078	MODIFY EXISTING VENTILATION DUCTWORK TO ACCOMODATE A NEW ELECTRICAL ROOM. MODIFY EXISTING VENTILATION DUCTWORK TO ACCOMODATE A MODIFICATION TO THE EXISTING ELECTRICAL ROOMS.,	Other	6/12/2017	$0	COVINGTON	2/28/2018
B17-0061	CONSTRUCT NEW ELECTRICAL ROOM ON FIRST FLOOR OF EXISTING MEDICAL OFFICE BUILDING.,	Other	6/12/2017	$400,000	COVINGTON	2/28/2018
B17-0057	DEMOLITION OF DUCTWORK AND HVAC, AND DEMOLITION OF PLUMBING SYSTEMS IN EXISTING MOB BUILDING. FINAL SPACE CONDITION WILL BE AN EMPTY SHELL SPACE.,	Demolition	5/18/2017	$12,700	COVINGTON	2/28/2018
M17-0054	INSTALL PRE-FAB WALK-IN BOX AND REMOTE REFRIGERATION SYSTEM. ROOF RACK SCOPE BY GENERAL CONTRACTOR UNDER SEPARATE PERMIT.,	Other	5/11/2017	$0	COVINGTON	2/28/2018
F17-0021	REMOVE EXISTING PENDENT SPRINKLERS, INSTALL UPRIGHT SPRINKLERS AT STRUCTURE IN THE EXISTING MOB.,	Other	5/10/2017	$0	COVINGTON	2/28/2018
F16-0075	SET 4 LPG TEMPORARY TANKS ON JOBSITE.,	Other	12/27/2016	$0	COVINGTON	6/1/2017
M16-0231	TEMPORARY HEAT FOR NEW MULTICARE COVINGTON HOSPITAL,	Other	12/22/2016	$0	COVINGTON	6/1/2017

F16-0065	FIRE ALARM SYSTEM FOR MULTICARE FACILITY.,	Other	12/20/2016	$0	COVINGTON	6/1/2017
P16-0028	TENANT IMPROVEMENT FOR LEVEL 2 AND LEVEL 4 OF NEW MULTICARE HOSPITAL,		11/17/2016	$0	COVINGTON	6/1/2017
M16-0200	NEW TENANT IMPROVEMENT FOR LEVEL 2 AND LEVEL 4 OF NEW MULTICARE HOSPITAL,	Other	11/14/2016	$0	COVINGTON	6/1/2017
M15-0160	MECHANICAL WORK FOR NEW HOSPITAL ADDITION.,	Building, New	10/27/2016	$0	COVINGTON	6/1/2017
B16-0100	REMODEL EASTERN PORTION OF LEVEL ONE OF THE EXISTING MULTICARE MEDICAL OFFICE BUILDING. REMODEL INCLUDES RELOCATED MRI MACHINE, RELOCATED SERVERY AND REMODELED DINING AREA.,	Remodel	8/23/2016	$1,250,000	COVINGTON	7/25/2017
F16-0059	PROVIDE AUTOMATIC FIRE SPRINKLER SYSTEM AND STANDPIPE SYSTEM FOR HOSPITAL
tandpipe will need to be flow tested at the roof.,	Building, New	8/9/2016	$0	COVINGTON	6/1/2017
B16-0081	TENANT IMPROVEMENT FOR LEVEL 2 AND LEVEL 4 OF NEW MULTICARE HOSPITAL.,	Building, New	7/26/2016	$9,398,400	COVINGTON	7/25/2017
F16-0055	REMOVE ONE 6000 GALLON DIESEL UNDERGROUND STORAGE TANK.,	Other	7/7/2016	$0	COVINGTON	6/1/2017
F16-0051	INSTALL 6000 GALLON ABOVE GROUND FUEL TANK TO SUPPLY GENERATOR (APPROX 16 MONTHS).,	Other	6/30/2016	$0	COVINGTON	6/1/2017
F16-0052	INSTALL 31,000 GALLON DIESEL UNDERGROUND STORAGE TANK FOR EMERGENCY GENERATOR FUEL SYSTEM.,	Other	6/22/2016	$0	COVINGTON	6/1/2017
F16-0030	UNDERGROUND CONNECTION, FDC AND PIV FOR HOSPITAL ADDITION.,	Other	5/4/2016	$0	COVINGTON	6/1/2017
M16-0036	TEMPORARY RELOCATION OF GENERATOR,	Other	4/13/2016	$0	COVINGTON	6/1/2017
F16-0018	RELOCATION OF FUEL TANK AND GENERATOR,	Other	4/13/2016	$0	COVINGTON	6/1/2017
B16-0039	CONVERT ONE STOREFRONT WINDOW INTO A TEMPORARY LOADING DOCK DURING CONSTRUCTION OF HOSPITAL EXPANSION PROJECT. POUR CONCRETE PAD TO ACCOMMODATE STAGING CONEX, RECYCLING CONTAINER, AND TRASH COMPACTOR. A FENCE WILL BE ERECTED AROUND THE RECYCLING AND	Remodel	4/12/2016	$65,354	COVINGTON	5/24/2017
P15-0036	PLUMBING WORK FOR NEW HOSPITAL BUILDING ADDITION.,	Building, New	3/2/2016	$0	COVINGTON	5/24/2017
B15-0157	ADDITION OF HOSPITAL TO EXISTING EMERGENCY DEPARTMENT.

 INSTALLATION OF UNDERGROUND FIRE LINE, INSTALLATION OF 2013 NFPA 13 COMPLIANT FIRE SPRINKLER SYSTEM AND INSTALLATION OF 2013 NFPA 72 COMPLIANT FIRE ALARM SYSTEM ARE TO BE BY SEPARATE | Building, New | 3/2/2016 | $32,164,460 | COVINGTON | 5/10/2018 |
| B16-0024 | ERECT TOWER CRANE AND INSTALL FOOTING., | Other | 2/29/2016 | $10,000 | COVINGTON | 5/24/2017 |
| B15-0113 | BUILD-OUT AND RELOCATION OF HEART CENTER CLINIC FROM LEVEL 1 TO LEVEL 3, SUITE 300

 Modifications to the existing fire sprinkler system effecting 4 or more heads or any fire alarm system modification to accommodate the tenant improvements | Remodel | 9/23/2015 | $200,000 | COVINGTON | 6/6/2016 |
| B15-0115 | DEMO AND REMODEL OF EXISTING SLEEP CLINIC AND REPLACEMENT WITH NEW MEDICAL CLINIC ON 3RD FLOOR OF EXISTING MEDICAL OFFICE BUILDING, APPROX 2100 SQUARE FEET.

Modifications to the existing fire sprinkler system effecting 4 or more heads or | Remodel | 8/5/2015 | $386,000 | COVINGTON | 6/6/2016 |
| F14-0048 | FIRE ALARM MODIFICATIONS TO MULTICARE PEDIATRIC DEPARTMENT, 23 DEVICES.
 Permit scope includes the addition of a Gamewell HPF24S6 Power Supply and notification appliances for a tenant improvement. Complete audible coverage will be required for | Remodel | 12/17/2014 | $0 | COVINGTON | |

B14-0091	REMODEL OF SUITE 460 FOR PEDIATRICS CLINIC.

 Noted is the remodel of suite 460 for a new pediatrics clinic. Modification to the existing fire sprinkler or fire alarm systems to accommodate the tenant improvement is to be by separate per | Remodel | 12/11/2014 | $673,758 | COVINGTON | 7/27/2015 |
| B14-0102 | TEMPORARY EXTERIOR 30' X 40' TENT FOR GROUND BREAKING CELEBRATION ON 10/28/14. SETUP ON 10/27 AT 4PM. TAKE DOWN 10/28 AT 1PM.

 Noted was the installation of a 30ÔÇÖX40ÔÇÖ tent to be used as part of a grand opening celebration. Dates of o | Other | 10/21/2014 | $1,400 | COVINGTON | 7/23/2015 |
P14-0010	1 LAVATORY SINK.,		8/6/2014	$0	COVINGTON	
M11-0024	Mechanical Permit - Multicare	Other	8/24/2011	$2,000,631	COVINGTON	5/17/2012
B11-0014	Construction of 24,000 sq ft emergency department and associated site development.	Building, New	7/11/2011	$4,000,000	COVINGTON	5/17/2012
B08-0010	Interior tenant improvement of approx 440 sqft on 1st floor pharmacy/physical therapy areas.	Remodel	3/24/2008	$275,142	COVINGTON	11/18/2009
B07-0011	Tenant improvement of existing shell for 3rd floor conference room.	Remodel	2/20/2007	$172,000	COVINGTON	11/18/2009
B07-0010	Remodel of existing new MRI equipment & conference room.	Remodel	2/20/2007	$548,000	COVINGTON	11/18/2009
B06-0021	INTERIOR REMODEL OF EXISTING OFFICE SPACE FOR NEW MED SPA	Remodel	4/26/2006	$211,000	COVINGTON	6/9/2006
B05-0204		Building, New	2/14/2006	$275,000	COVINGTON	6/9/2006
B05-0178		Remodel	11/3/2005	$200,000	COVINGTON	6/9/2006
B05-0044		Remodel	4/19/2005	$210,000	COVINGTON	5/20/2005
B04-0199		Remodel	9/13/2004	$150,000	COVINGTON	3/11/2005
B02-0139		Remodel	5/13/2002	$35,000	COVINGTON	8/22/2002
0621		Other	10/2/2000	$136,038	COVINGTON	3/23/2001
0225	None	Remodel	10/21/1998	$32,620	COVINGTON	

HOME IMPROVEMENT EXEMPTION

Property Taxes

Pay your real property or personal property tax bills

Enter tax account or parcel number

Note: Please do not include dashes

Account or Parcel Search
2522059131

SEARCH

252205913194 ×

252205913103 ×

Clear all ×

Tax payer name: MULTICARE HEALTH SYSTEM

Tax account # 252205913194

NOTE: There is a secondary tax account associated with this property.

Account Summary

Parcel Number
2522059131

Tax Account Status
This account is active.

Mailing Address

PO BOX 5299
TACOMA WA 98415
Pay by mail

Billing Details

THERE IS A SECONDARY TAX ACCOUNT ASSOCIATED WITH THIS PROPERTY. THE ONLINE PAYMENT OPTION IS NOT AVAILABLE FOR THIS TYPE OF ACCOUNT. FOR ASSISTANCE, PLEASE CALL (206) 263-2890.

Breakdown by Tax Year

Payment History

2025 Tax / Fee Distribution

2025 Tax / Fee Distribution Chart

Request a Tax Statement

Tax payer name: PROPERTY VALUATION SERVICES

Tax account # 252205913103

NOTE: There is a secondary tax account associated with this property.

Account Summary

Parcel Number
2522059131

Tax Account Status
This account is active.

Mailing Address

14400 METCALF AVE
OVERLAND PARK KS 66223
Pay by mail

Billing Details

THERE IS A SECONDARY TAX ACCOUNT ASSOCIATED WITH THIS PROPERTY. THE ONLINE PAYMENT OPTION IS NOT AVAILABLE FOR THIS TYPE OF ACCOUNT. FOR ASSISTANCE, PLEASE CALL (206) 263-2890.

Breakdown by Tax Year

Payment History

2025 Tax / Fee Distribution

2025 Tax / Fee Distribution Chart

Request a Tax Statement

Cart

Total $0.00

PROCEED TO CHECKOUT

Treasury Operations

Location

King Street Center
201 South Jackson Street #710 Seattle, WA 98104

Hours

Monday through Friday
8:30 AM to 4:30 PM

Phone

206-123-4567
TTY Relay: 711

Customer Service

Property Tax Information and Customer Service

206-263-2890
PropertyTax.CustomerService@kingcounty.gov

Mobile Homes/Commercial Personal Property

206-263-2844
Treasury.PersonalProperty@kingcounty.gov

Maintenance Assessment Management Systems Local Improvement Districts

206-263-1893
mams.lid@kingcounty.gov

Tax Foreclosures

206-263-2649
TaxForeclosures@kingcounty.gov

Exhibit 8.
Contractor's Estimate Letter

ABBOTT CONSTRUCTION

Thursday, September 4, 2025

Eric Hernandez, Acting Executive Director
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Tumwater, WA 98501

Re: Certificate of Need Application
MultiCare Health Systems – Level 2 Neonatal Care Project in Covington, WA

Dear Mr. Hernandez,

On behalf of MultiCare Covington Medical Center, I am writing regarding the Certificate of Need Application for the proposed 6 room Level 2 Neonatal Care Project, planned to be constructed in Covington, WA. Based on our experience with similar construction projects, we have developed the following capital costs estimate:

Construction Costs	**$1,769,933.00**
Washington State Sales Tax	**$161,064.00**
Total	**$1,930,997.00**

Based on our experience, we believe the costs are a reasonable estimate of the expected cost for construction. Please contact us if you have any questions or require any additional information.

Sincerely,
ABBOTT CONSTRUCTION, LLC

Matt McKeeby
Project Executive

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

ABBOTTCONSTRUCTION.COM

Exhibit 9.
Equipment List

MultiCare Covington Medical Center

Level II ICN List of New Equipment

Item Description	Fixed or Moveable Equipment	Quantity	Cost
Headwall: Modular, Neonatal	F	6	$ 57,000.00
Ice Machine: Dispenser, Nugget, Freestanding	F	1	$ 12,000.00
Warmer, Infant: Care System	M	2	$ 73,969.00
Monitor, O.B.: Antepartum, Maternal/Fetal	M	6	$ 78,721.00
Sofa: Sleeper/Convertible	M	6	$ 91,371.00
Chair, Clinical: Recliner, Treatment	M	6	$ 39,159.00
Cart, Computer: Workstation	M	6	$ 15,300.00
		Total Cost (Before Tax)	$ 367,520.00
		Tax	$ 37,119.52
		TOTAL FFE BUDGET EST.	**$ 404,639.52**

Exhibit 10.
Letter of Financial Commitment

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

July 22, 2025,

Eric Hernandez, Acting Executive Director
Certificate of Need Program
Washington Department of Health
111 Israel Road SE
Tumwater WA 98501

Re: Certificate of Need Application for Relocation of Level II ICN beds in the Southeast King Planning Area

Dear Mr. Hernandez:

Please accept this letter as evidence of financial support for MultiCare Health System's certificate of need application request to relocate the existing, certificate of need approved 6-bed Level II Intermediate Care Nursery from the MultiCare Auburn Medical Center hospital campus and license to the MultiCare Covington Medical Center hospital campus and license.

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

Please contact me if there are any questions regarding this letter of financial commitment. I can be reached at 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 11A.
Audited Financial Statements,
2021-2022

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2022 and 2021

(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:

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, 2022 and 2021, 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, 2022 and 2021, 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 21, 2023

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2022 and 2021

(In thousands)

Assets		2022	2021
Current assets:			
Cash and cash equivalents	$	542,067	308,732
Accounts receivable		511,727	460,569
Supplies inventory		60,070	60,056
Other current assets, net		165,586	96,361
Total current assets		1,279,450	925,718
Donor restricted assets held for long-term purposes		119,526	96,775
Investments		1,968,205	2,610,531
Property, plant, and equipment, net		2,109,253	2,010,134
Right-of-use operating lease asset, net		169,823	140,718
Right-of-use financing lease asset, net		16,798	20,458
Goodwill and intangible assets, net		253,274	172,063
Other assets, net		329,808	382,562
Total assets	$	6,246,137	6,358,959
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	326,664	283,004
Accrued compensation and related liabilities		329,672	340,029
Accrued interest payable		23,643	18,059
Current portion of right-of-use operating lease liability		29,908	26,376
Current portion of right-of-use financing lease liability		4,965	4,283
Current portion of long-term debt		18,496	43,609
Total current liabilities		733,348	715,360
Interest rate swap liabilities		9,470	119,100
Right-of-use operating lease liability, net of current portion		147,116	120,273
Right-of-use financing lease liability, net of current portion		12,491	16,933
Long-term debt, net of current portion		1,972,137	1,572,235
Other liabilities, net		231,045	208,307
Total liabilities		3,105,607	2,752,208
Commitments and contingencies (note 15)			
Net assets:			
Controlling interest		2,930,546	3,430,009
Noncontrolling interest		34,471	—
Without donor restrictions		2,965,017	3,430,009
With donor restrictions		175,513	176,742
Total net assets		3,140,530	3,606,751
Total liabilities and net assets	$	6,246,137	6,358,959

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations

Years ended December 31, 2022 and 2021

(In thousands)

	2022	2021
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 3,765,888	3,504,691
Other operating revenue	231,429	314,323
Net assets released from restrictions for operations	6,382	5,170
Total revenues, gains, and other support without donor restrictions	4,003,699	3,824,184
Expenses:		
Salaries and wages	2,199,265	1,870,645
Employee benefits	297,613	278,185
Supplies	658,470	600,757
Purchased services	396,747	349,159
Depreciation and amortization	140,892	126,307
Interest	56,842	47,670
Other	541,246	486,005
Total expenses	4,291,075	3,758,728
(Deficit) Excess of revenues over expenses from operations	(287,376)	65,456
Other income (loss):		
Investment (loss) income	(344,301)	213,993
Gain on interest rate swaps, net	127,688	25,873
Other loss, net	(11,047)	(13,729)
Total other (loss) income, net	(227,660)	226,137
(Deficit) Excess of revenues over expenses	$ (515,036)	291,593

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2022 and 2021

(In thousands)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2020	$ 3,111,401	—	142,761	3,254,162
Excess of revenues over expenses	291,593	—	—	291,593
Changes in pension assets	24,810	—	—	24,810
Contributions and other	490	—	35,697	36,187
Net assets released from restriction for capital acquisitions	1,715	—	(1,715)	—
Net assets released from restriction for operations and other	—	—	(5,170)	(5,170)
Income on investments	—	—	1,816	1,816
Increase in assets held in trust by others	—	—	3,353	3,353
Change in net assets	318,608	—	33,981	352,589
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

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2022 and 2021

(In thousands)

	2022	2021
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (466,221)	352,589
Adjustments to reconcile (decrease) increase in net assets to net cash (used in) provided by operating activities:		
Depreciation and amortization	140,892	126,307
Amortization of bond premiums, discounts, and issuance costs	(2,163)	(2,433)
Net realized and unrealized losses (gains) on investments	378,740	(188,615)
Change in fair value of interest rate swap	(133,126)	(35,247)
(Loss) gain on disposal of assets, net	(3,009)	2,373
Loss (gain) on joint ventures, net	7,032	(513)
Restricted contributions for long-term purposes	(4,968)	(16,952)
Changes in operating assets and liabilities:		
Accounts receivable	(51,158)	(73,590)
Supplies inventory and other current assets	(43,673)	(17,586)
Right-of-use lease asset	35,690	40,614
Other assets, net	80,665	(38,219)
Accounts payable and accrued expenses and accrued interest payable	27,421	67,751
Accrued compensation and related liabilities	(14,765)	38,053
Right-of-use lease liability	(30,021)	(30,721)
Other liabilities, net	21,842	(8,287)
Net cash (used in) provided by operating activities	(56,822)	215,524
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(237,295)	(216,973)
Proceeds from disposal of property, plant, and equipment	6,360	7,629
Purchase of additional ownership in PSW and OSS, net of cash received	(86,915)	—
Purchase of Capital Medical Center and related real estate, net of cash received	—	(179,662)
Investments in joint ventures, net	(11,445)	(10,373)
Purchases of investments	(8,827,993)	(5,634,748)
Sales of investments	9,072,857	5,175,627
Change in donor trusts	(2,833)	5,700
Net cash used in investing activities	(87,264)	(852,800)
Cash flows from financing activities:		
Repayment of long-term debt	(415,646)	(8,522)
Proceeds from bond issuance	798,300	—
Payment of debt issue expenses	(5,702)	—
Principal payments on finance lease obligations	(4,499)	(8,645)
Restricted contributions for long-term purposes	4,968	16,952
Net cash provided by (used in) financing activities	377,421	(215)
Net change in cash and cash equivalents	233,335	(637,491)
Cash and cash equivalents, beginning of year	308,732	946,223
Cash and cash equivalents, end of year	$ 542,067	308,732
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 52,258	48,260
Noncash activities:		
(Decrease) increase in deferred compensation plans	(11,750)	13,471
Increase in accounts payable for purchases of property, plant, and equipment	9,301	1,266

See accompanying notes to consolidated financial statements.

(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 and Thurston Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2022, MHS was licensed to operate 2099 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 and Capital Medical Center) and one behavioral health hospital (Navos). MHS also operates eight outpatient surgical sites, five 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 accountable care organization (MultiCare Connected Care), a leading population health company (Physicians of Southwest Washington), a physical therapy provider (Olympic Sports & Spine) and two fundraising foundations (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 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.

(Dollars in thousands)

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
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:

		2022
Total operating revenues	$	36,305
Excess of revenue over expenses		1,394

The following unaudited information presents MultiCare's results for the years ended December 31, 2022 and 2021, had the acquisition date been January 1, 2021 for the PSW acquisition:

	2022 (Unaudited)	2021 (Unaudited)
Total operating revenues	4,010,866	3,896,190
(Deficit) Excess of revenues over expenses	(513,848)	300,750

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

(Continued)

(Dollars in thousands)

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 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:

		2022
Total operating revenues	$	15,176
Excess of revenue over expenses		1,146

(Continued)

(Dollars in thousands)

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

	2022 (Unaudited)	2021 (Unaudited)
Total operating revenues	$ 3,994,219	3,862,945
(Deficit) Excess of revenues over expenses	(512,468)	294,959

On April 1, 2021, MHS completed the purchase of Capital Medical Center in Olympia, Washington from an affiliate of LifePoint Health and physician owners to acquire a 100% ownership interest. Capital Medical Center is licensed to operate 107 inpatient hospital beds as well as operates multiple primary care and multispecialty clinics within Thurston County. The acquisition of Capital Medical Center was valued at $44,662. Assets and liabilities purchased included land, buildings, equipment, accounts receivable, intangibles and other assets offset by accounts payable, accrued compensation, other current liabilities and other liabilities and were recorded at their estimated fair values as determined based on standard asset appraisal techniques. MHS hired substantially all of the employees previously employed by Capital Medical Center. The following table summarizes the estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Patient accounts receivable	$	13,500
Other current assets		3,628
Land, buildings and equipment		30,551
Intangibles and other assets		8,915
Accounts payable, accrued compensation and other current liabilities		(8,695)
Other liabilities		(3,295)
Total identifiable net assets assumed		44,604
Recognized amount of goodwill assumed:		
Goodwill		58
Total	$	44,662
Total cash consideration transferred	$	39,173

(Continued)

(Dollars in thousands)

On December 20, 2021, MHS completed a separate purchase of land and buildings associated with the Capital Medical Center hospital campus and several surrounding clinic offices from an affiliate of Medical Properties Trust (MPT). The acquisition was valued at $135,000 of land, buildings and other related assets acquired.

Recognized amounts of identifiable assets acquired:		
Land	$	20,053
Buildings		114,069
Leasehold improvements		163
Intangible assets		715
Total		135,000
Transaction expenses		3,148
Total cash consideration transferred	$	138,148

(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 $1,749 and $2,308 at December 31, 2022 and 2021, respectively. MHS has recorded a corresponding payable of $1,301 and $775 at December 31, 2022 and 2021, 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 2022 and 2021, 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.

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, 2022 or 2021.

(Dollars in thousands)

The following table summarizes the balances of goodwill and intangible assets at December 31, 2022 and 2021:

		2022	2021
Goodwill	$	232,085	152,927
Intangible assets, net of accumulated amortization of $7,035 and $10,343, respectively		21,189	19,136
Total	$	253,274	172,063

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 $1,474 and $3,544 for the years ended December 31, 2022 and 2021, 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, 2022 and 2021, MHS held ownership interests in 26 and 21 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 year ended December 31, 2022 was $7,032 associated with several joint ventures. Gain on joint ventures for the year ended December 31, 2021 was $513. Gains and losses are included in other operating revenue on the consolidated statements of operations and changes in net assets.

(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 $4,781 and $4,634 as of December 31, 2022 and 2021, 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 decreased by $148 and $1,178 in 2022 and 2021, respectively 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, 2022 and 2021, 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 and changes in net assets. These swaps have notional amounts totaling approximately $709,000 and expire starting in August 2027 through August 2049. The majority of the swaps have the economic effect of fixing the LIBOR-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, 2022 and 2021, MHS has recorded $21,265 and $20,305, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2022, $12,683 of pledges are due in one year or less and $8,582 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 $89,946 and $89,738 for 2022 and 2021, respectively, and incurred assessments of $63,961 and $64,570 for 2022 and 2021, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations and changes in net assets. MHS has outstanding receivables of $17,287 and $16,737 associated with this program as of December 31, 2022 and 2021, 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 $52,000 and $48,000 in 2022 and 2021, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $424,000 and $300,406 in 2022 and 2021, 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 and changes in net assets 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 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. MHS does not expect the adoption of this ASU to have a material effect on its consolidated 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

(Dollars in thousands)

applicable to MHS. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In March 2020, FASB issued ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the effects of Reference Rate Reform on Financial Reporting.* The amendments in this update provide practical expedients to contract modifications when it is being modified due to the replacement of a reference rate within the contract. The provisions of this ASU are effective immediately and will be available through December 31, 2022. Modifications completed after December 31, 2022 must use current guidance instead of the provisions in this ASU. MHS made all necessary contract modifications in 2022 and the adoption of this ASU did not have a material effect on its consolidated financial statements.

(2) Coronavirus (COVID-19) Impact

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law and on March 11, 2021, the American Rescue Plan Act (ARPA) was signed into law. Both the CARES Act and ARPA were aimed to direct economic assistance for American workers, families, and small businesses, and preserve jobs for American industries. The COVID-19 pandemic impacted all hospitals and physician offices throughout the health system.

The CARES Act and ARPA require the amount of funding received to be validated, which requires management to quantify lost revenues and increased expenses associated with the pandemic. The CARES Act authorized funding to be distributed under the Provider Relief Fund (PRF) and the Coronavirus Relief Fund (CRF). MHS has recognized revenue associated with the PRF, CRF and ARPA funding according to the terms and conditions of the CARES Act and ARPA, and as contribution revenue under FASB ASC 958-605. Refunding of amounts received may be required by the CARES Act if a receiving entity is unable to quantify the financial losses intended to be covered by funding. MHS has determined that it is able to justify retaining all funding received and has not recorded any liabilities as of December 31, 2022 and 2021 for potential repayment of funds received.

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 and will apply for additional funding until the national disaster declaration is no longer in effect.

The following table shows the funding that has been received to prepare and respond to COVID-19 and recognized as other operating revenue for the years ended December 31, 2022 and 2021:

Sources of external relief funding		2022	2021	Total
CARES Act Provider Relief Fund	$	—	176,448	176,448
American Rescue Plan Rural Funds		—	5,284	5,284
FEMA		14,578	1,405	15,983
Total	$	14,578	183,137	197,715

(Continued)

(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 Classification System (APCs), or fee schedules.
- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare; however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services 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 2022 or 2021.

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 2022 or 2021. 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, 2022 and 2021 are as follows:

	2022	2021
Payors:		
Medicare	$ 1,068,131	947,979
Medicaid	623,026	554,039
Premera	521,521	501,370
Regence	392,750	334,844
Aetna	192,352	202,379
Kaiser Permanente	134,237	128,538
United Healthcare	133,716	132,535
First Choice	117,366	119,596
Self-pay	23,149	25,450
Other	559,640	557,961
	$ 3,765,888	3,504,691

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, 2022 and 2021 was as follows:

	2022	2021
Medicare	35 %	33 %
Medicaid	25	21
Premera	7	10
Regence	6	7
Self-pay	5	7
First Choice	1	1
Health Care Exchange	1	1
Other commercial insurance	20	20
	100 %	100 %

(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, 2022 and 2021:

		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)

		Fair value measurements at reporting date using		
	December 31, 2021	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	$ 825,254	825,254	—	—
Equity securities	304,915	304,915	—	—
Fixed income bond funds	403,280	403,280	—	—
Fixed income governmental obligations	210,812	141,941	68,871	—
Fixed income other	376,108	—	376,108	—
Commingled trust fund – international equity	172,069	—	172,069	—
Donor trusts	22,455	—	—	22,455
Total assets at fair value	2,314,893	$ 1,675,390	617,048	22,455
Investment assets valued at NAV	343,651			
Total assets at fair value or NAV	$ 2,658,544			
Liabilities:				
Interest rate swaps	$ 119,100	—	119,100	—

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2022 and 2021:

	NAV December 31, 2022	NAV December 31, 2021	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 125,067	132,637	N/A	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	269,628	199,212	N/A	Daily	1 or more business days prior to valuation date
Limited partnerships	8,556	11,802	1,800	N/A	N/A
Total investments valued at NAV	$ 403,251	343,651	1,800		

(Continued)

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.

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, 2022 and 2021 were $133,126 and $35,246, respectively, and are included in gain on interest rate swaps in other (loss) income, net in the consolidated statements of operations and changes in net assets. Also included in the gain (loss) on interest rate swaps is the loss on net cash settlement amounts associated with the swaps of $5,439 and $9,373 for the years ended December 31, 2022 and 2021, respectively.

(Dollars in thousands)

The following table represents both the fair value and settlement value for the interest rate swap assets and liabilities as of December 31, 2022 and 2021:

	Asset derivatives					
	2022			2021		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Other assets, net	$ 23,496	26,079	Other assets, net	$ —	—

	Liability derivatives					
	2022			2021		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	$ 9,470	11,317	Interest rates swap liabilities	$ 119,100	124,921

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2022 and 2021 is as follows:

	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

(Dollars in thousands)

	December 31, 2021		
	Donor restricted assets	Investments	Total
Mutual funds	$ 8,002	817,252	825,254
Equity securities	2,956	301,959	304,915
Fixed income securities	9,600	980,600	990,200
Commingled trust fund – international equity	1,668	170,401	172,069
Hedge funds	1,286	131,351	132,637
Common trust funds	1,931	197,281	199,212
Limited partnerships	115	11,687	11,802
Donor trusts	22,455	—	22,455
Pledge receivables, net and other	48,762	—	48,762
Total	$ 96,775	2,610,531	2,707,306

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, 2022 and 2021, MHS' financial resources are as follows:

	2022	2021
Cash and cash equivalents	$ 542,067	308,732
Accounts receivable	511,727	460,569
Other current assets, net	165,586	96,361
Donor restricted assets	119,526	96,775
Investments	1,968,205	2,610,531
	3,307,111	3,572,968
Less prepaid assets included in other current assets, net	(58,353)	(37,444)
Less donor restricted assets	(119,526)	(96,775)
Less investments with redemption limitations of greater than one year	(8,556)	(11,802)
Total financial assets available for general expenditures	$ 3,120,676	3,426,947

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, 2022 and 2021 is as follows:

	2022	2021
Land and land improvements	$ 164,041	138,910
Buildings	2,360,383	2,313,543
Equipment	1,051,005	940,116
	3,575,429	3,392,569
Less accumulated depreciation	(1,640,005)	(1,500,929)
	1,935,424	1,891,640
Construction in progress	173,829	118,494
Property, plant, and equipment, net	$ 2,109,253	2,010,134

Total depreciation and amortization expense for the years ended December 31, 2022 and 2021 was $140,892 and $126,307, respectively. Depreciation expense charged to operations for the years ended

(Continued)

(Dollars in thousands)

December 31, 2022 and 2021 amounted to $139,145 and $122,293, respectively. Depreciation expense charged to operations for the year ended December 31, 2021 is net of a $48,094 reduction in expense as part of the change in estimated useful lives.

(9) Other Assets, Net

Other assets are as follows at December 31, 2022 and 2021:

		2022	2021
Investment in joint ventures	$	58,977	77,951
Deferred compensation plan assets held in trust (note 12)		87,039	98,789
Accrued pension asset (note 12)		36,428	60,951
Self-insured retention receivables, net of current portion (notes 13 and 14)		17,462	22,558
Net investment in lease (note 17(b))		22,655	23,172
Notes receivable (note 10)		75,284	75,546
Interest rate swaps (note 5(b))		23,496	—
Other		8,467	23,595
Other assets, net	$	329,808	382,562

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, 2022 and 2021:

		2022	2021
Professional liability, net of current portion (note 13)	$	103,813	89,628
Deferred compensation liability (note 12)		87,039	98,789
Workers' compensation liability, net of current portion (note 14)		15,444	15,454
Other		24,749	4,436
Other liabilities, net	$	231,045	208,307

(Continued)

(Dollars in thousands)

(12) Retirement Plans

(a) Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the Plan) covering eligible employees. The Plan was closed to new employees effective after July 31, 2002. The benefits are based on years of service and the employee's highest five consecutive years of compensation. MHS contributions to the Plan vary from year to year, but the minimum contribution required by law has been provided in each year. 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 Plan, which has measurement dates of December 31, 2022 and 2021:

		2022	2021
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	663,039	715,286
Service cost		650	650
Interest cost		19,329	18,786
Actuarial gain		(142,861)	(23,106)
Expected administrative expenses		(650)	(650)
Benefits paid		(85,170)	(47,927)
Projected benefit obligations at end of year	$	454,337	663,039
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	723,990	760,876
Actual (loss) gain on plan assets		(147,327)	11,700
Actual administrative expenses		(728)	(659)
Benefits paid		(85,170)	(47,927)
Fair value of plan assets at end of year	$	490,765	723,990
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	36,428	60,951
Amount recognized in net assets without donor restrictions:			
Net loss		106,367	90,859

	2022	2021
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	5.50 %	3.00 %

(Continued)

(Dollars in thousands)

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

The components of net periodic benefit cost are as follows during the years ended December 31, 2022 and 2021:

		2022	2021
Components of net periodic benefit cost:			
Service cost	$	650	650
Interest cost		19,329	18,786
Expected return on plan assets		(30,858)	(29,726)
Amortization of net actuarial loss		5,335	16,205
Settlement cost		14,559	3,534
	$	9,015	9,449

	2022	2021
Weighted average assumptions used to determine benefit obligation as of December 31:		
Discount rate	3.00 %	2.70 %
Expected return on plan assets	4.50	4.50

During the years ended December 31, 2022 and 2021, the Plan made lump-sum cash payments (settlements) to plan participants and in exchange the 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 years ended December 31, 2022 and 2021 and the pro-rata portion of the remaining balance in net assets without donor restrictions was recognized as part of net periodic benefit costs.

The accumulated benefit obligation for the Plan was $454,337 and $663,039 at December 31, 2022 and 2021, respectively.

(Continued)

(Dollars in thousands)

(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
2023	$ 33,692
2024	33,463
2025	34,284
2026	33,643
2027	34,680
2028–2032	165,364

(ii) Plan Assets

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

		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			

		Fair value measurements at reporting date using		
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 11,324	11,324	—	—
Trading securities:				
Mutual funds	124,670	124,670	—	—
Fixed income bond funds	97,505	97,505	—	—
Fixed income governmental obligations	209,474	177,503	31,971	—
Fixed income other	202,017	—	202,017	—
Commingled trust fund – international equity	16,625	—	16,625	—
	661,615	$ 411,002	250,613	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$ 5,983			
Broker payables	(34,584)			
Total assets at fair value	633,014			
Investments valued at NAV	90,976			
Total assets at fair value or NAV	$ 723,990			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2022 and 2021.

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2022 and 2021:

	NAV December 31, 2022	NAV December 31, 2021	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Absolute return funds	$ 63,783	84,911	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	4,402	6,065	850	N/A	N/A
Total investments valued at NAV	$ 68,185	90,976	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.

Limited partnerships include investments in private equity and venture capital in both developed and emerging markets with approximately 35% invested in private equity in developed markets,

(Continued)

(Dollars in thousands)

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.

The defined benefit plan weighted average asset allocations at December 31, 2022 and 2021 by asset category are as follows:

	2022	2021
Asset category:		
Domestic equities	13 %	12 %
International equities	9	7
Fixed income securities	77	80
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:

	2022	2021
Asset category:		
Domestic equities	12 %	12 %
International equities	8	8
Fixed income securities	80	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 Plans' overall equity exposure by investing in non-U.S. stocks that are less than fully correlated to domestic equities with similar return expectations; to maintain a diversified exposure within the international stock

market through the use of multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies.

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

Fixed Income

The strategic role of fixed income securities is to diversify the 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) 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.

MHS' funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2022 and 2021 were approximately $58,000 and $54,545, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to the defined benefit and defined contribution plans as described above, MHS also maintains 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, 2022 and 2021, 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 from MHS.

At December 31, 2022 and 2021, the estimated gross professional liability (including current and long-term portions) was $128,101 and $119,073, 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 $22,754 and $33,191 as of December 31, 2022 and 2021, 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, 2022 and 2021, the estimated net liability based on future claims cost totaled $21,470 and $21,133, respectively. The gross liabilities (including both current and long-term portions) total $24,836 and $24,341 as of December 31, 2022 and 2021, 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 $3,366 and $3,207 as of December 31, 2022 and 2021, 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. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2022 and 2021 was $12,984 and $9,632, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(Continued)

(Dollars in thousands)

(15) Long-Term Debt

Long-term debt consists of the following at December 31, 2022 and 2021:

	2022	2021
WHCFA Revenue bonds, 2022A	$ 49,985	—
WHCFA Revenue bonds, 2022B	108,145	—
WHCFA Revenue bonds, 2022C	80,000	—
WHCFA Revenue bonds, 2022D	130,170	—
WHCFA Revenue bonds, 2022 Taxable Private Placement	430,000	—
2020 Taxable bonds	300,000	300,000
2020 OCED financing	57,249	59,289
2019 Term loan	—	35,255
WHCFA Revenue bonds, 2017 Series A and B	314,550	318,220
WHCFA Revenue bonds, 2017 Series C, D, and E	111,010	191,010

	2022	2021
2017 Term loans	$ —	130,170
WHCFA Revenue bonds, 2015 Series A and B	343,675	348,085
WHCFA Revenue bonds, 2012 Series A	—	60,000
WHCFA Revenue bonds, 2009 Series A and B	—	98,130
Other	19,085	23,106
	1,943,869	1,563,265
Adjusted for:		
Current portion	(18,496)	(43,609)
Bond premiums, discounts, and debt issuance costs	46,764	52,579
Long-term debt, net of current portion	$ 1,972,137	1,572,235

(a) 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, which were between 2.43% and 4.45% at December 31, 2022, 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.

(Continued)

(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 starting in January 2023, 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 tax exempt private placement debt with Bank of America, NA. The principal is due in full in 2047 with monthly interest payments starting in January 2023, 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.

(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) 2020 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. Due to the specific terms of the agreement, the lease qualified as a financing type lease. The agreement did not meet the criteria for sale-leaseback accounting treatment and instead is considered a financing liability. The agreement bears an implicit interest rate of 4.64%. Annual principal payments range from $2,136 in 2023 to $4,482 in 2039 with a final principal payment of $390 in 2041.

(h) 2019 Term Loan

In August 2019, MHS entered into a fixed rate term loan agreement with JPMorgan Chase Bank, N.A., with an interest rate of 1.89%. The principal balance of $35,255 was paid in full in 2022.

(i) Washington Health Care Facility Authority (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 $4,135 in 2023 to $62,410 in 2047.

(j) 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, which were between 0.44% and 3.58% at December 31, 2022, reset monthly and are based on 70% of SOFR.

In November 2017, MHS entered into an $80,000 variable rate private placement agreement (Series E) with Wells Fargo Municipal Capital Strategies, LLC. In December 2022, MHS refunded the 2017 Series E bonds and replaced them with 2022 Series C.

(k) 2017 Term Loans

In November 2017, MHS entered into two $65,085 variable rate term loan agreements with Wells Fargo Bank, N.A. In December 2022, MHS refunded the 2017 Term Loans and replaced them with 2022 Series D.

(l) 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.

(m) WHCFA Revenue Bonds 2012 Series A

In November 2012, MHS issued $60,000 of 2012 Series A bonds. In August 2022, MHS refunded the 2012 Series A bonds and replaced them with 2022 Series B.

(n) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued the 2009 Series A and B bonds as variable rate demand bonds for $50,000 each. The bonds were backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds. In August 2022, MHS refunded the 2009 Series A and B bonds and replaced them with 2022 Series A and 2022 Series B.

(o) Other

The other debt listed is primarily made up of debt held by Navos. Of the outstanding debt at December 31, 2022, $16,531 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.

(p) 2022 Line of Credit

In October 2022, MHS entered into a $200,000 revolving credit agreement with JPMorgan Chase Bank, NA. The term of the line of credit is for 12 months and bears interest at a variable rate based upon SOFR. The line on credit has no draws as of December 31, 2022.

(Dollars in thousands)

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, 2022 and 2021.

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:		
2023	$	18,496
2024		21,627
2025		22,704
2026		23,825
2027		46,202
Thereafter		1,811,015
	$	1,943,869

A summary of interest costs is as follows during the years ended December 31, 2022 and 2021:

		2022	2021
Interest cost:			
Charged to operations	$	59,006	50,103
Amortization of bond premiums, discounts, and issuance costs		(2,163)	(2,433)
Capitalized		555	382
	$	57,398	48,052

(16) Commitments and Contingencies

Approximately 43% of MHS employees were covered under collective bargaining agreements as of December 31, 2022. 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 December 2025.

(Dollars in thousands)

(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 18 years, and existing leases have expiration dates through 2037. 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, 2022 and 2021 were as follows:

		2022	2021
Operating lease cost	$	36,768	37,283
Finance lease cost:			
Amortization of right-of-use assets		4,745	9,031
Interest on lease liabilities		802	3,402
Total finance lease cost		5,547	12,433
Short term lease cost		1,503	1,578
Variable lease cost		9,138	9,233
Sublease income		(1,727)	(1,662)
Total lease cost	$	51,229	58,865

Other information related to leases as of December 31, 2022 and 2021 was as follows:

		2022	2021
Weighted average remaining lease term (years):			
Operating leases		7.2	6.5
Finance leases		6.0	6.6
Weighted average discount rate:			
Operating leases		4.0 %	4.0 %
Finance leases		4.4	4.4
Operating cash flows from operating leases	$	(35,805)	(36,688)
Operating cash flows from finance leases		(802)	(3,402)
Financing cash flows from finance leases		(4,499)	(8,645)
Right-of-use assets obtained in exchange for new operating lease liabilities		56,322	36,385
Right-of-use assets obtained in exchange for new finance lease liabilities		3,528	11,948

(Continued)

(Dollars in thousands)

Maturities of lease liabilities under noncancelable leases as of December 31, 2022 are as follows:

		Operating leases	Finance leases	Total
For year ended December 31:				
2023	$	35,782	5,623	41,405
2024		31,596	5,400	36,996
2025		28,447	3,351	31,798
2026		26,272	873	27,145
2027		20,794	597	21,391
Thereafter		61,729	4,031	65,760
Total undiscounted lease payments		204,620	19,875	224,495
Less present value discount		(27,596)	(2,419)	(30,015)
Total lease liabilities	$	177,024	17,456	194,480

(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. At December 31, 2022, MHS' other assets, net include a net investment in lease of $22,655.

Revenue from leases for the years ended December 31, 2022 and 2021 is as follows:

		2022	2021
Interest income on net investment in finance leases	$	1,032	1,048
Variable lease income		28	28
Total lease income	$	1,060	1,076

(Continued)

(Dollars in thousands)

Future lease payments receivable as of December 31, 2022 are as follows:

Year ended December 31:		
2023	$	1,227
2024		1,227
2025		1,227
2026		1,227
2027		1,227
Thereafter		40,565
Total lease payments to be received		46,700
Less unearned interest income		(24,045)
Net investment in lease	$	22,655

(18) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2022 and 2021:

		2022	2021
Healthcare services	$	51,816	57,511
Endowment funds, perpetual trusts and related receivables		78,231	76,079
Purchase of property, plant and equipment		42,001	39,721
Indigent care		2,459	2,167
Health education		1,006	1,264
Total net assets with donor restrictions	$	175,513	176,742

(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.

(Dollars in thousands)

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, 2020	$ 2,825	42,424	45,249
Investment return:			
Investment income	18	527	545
Net appreciation – realized and unrealized	65	1,289	1,354
Total investment return	83	1,816	1,899
Contributions	—	2,271	2,271
Appropriation of endowment assets for expenditure	(47)	(2,499)	(2,546)
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

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 $27,650 and $31,008, respectively, as of December 31, 2022 and 2021. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $4,262 and $1,059, respectively, as of December 31, 2022 and 2021.

(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 2022 or 2021.

(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, 2022 and 2021:

	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

	2021				
	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	$ 1,130,560	432,037	65,231	242,817	1,870,645
Employee benefits	128,295	72,692	15,595	61,603	278,185
Supplies	482,058	43,267	66,679	8,753	600,757
Purchased services	132,808	44,695	25,750	145,906	349,159
Depreciation and amortization	70,583	18,057	3,626	34,041	126,307
Interest	40,788	3,936	—	2,946	47,670
Other	293,968	57,179	20,779	114,079	486,005
	$ 2,279,060	671,863	197,660	610,145	3,758,728

(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

On January 17, 2023, Yakima Valley Memorial Hospital (Yakima) in Yakima, Washington affiliated with MHS. Yakima is a 238 bed hospital as well as operates primary and specialty care clinics in the Yakima Valley region. No consideration was exchanged and MHS became the sole corporate member of Yakima. The unaudited results of operations for the year ended December 31, 2022 is total operating revenue of $521,288 and total deficit of revenue over expenses from operations of $33,211. These unaudited results are not included within the results of operations of MHS for the year ended December 31, 2022 nor are these results indicative of future financial results. MHS is still completing the accounting for the affiliation pending the determination of the fair value of the inherent contribution made.

MHS has evaluated the subsequent events through March 21, 2023, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 11B.
Audited Financial Statements,
2022-2023

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.

Exhibit 12.
Medical Director Agreement

To be provided in screening

Exhibit 13.
ICN Medical Staff Roster

Level II ICN Medical Staff Roster

NPI	WA Lic #	LastName	FirstName	Degree	Specialty
1528352481	MD61215655	Anderson	Danielle	MD	Obstetrics_Gynecology
1346426350	MD60667080	Arora	Prem	MD	Neonatal_Perinatal Med
1164445276	MD00048250	Azari	Ahmad	MD	Obstetrics_Gynecology
1316103658	AP60114508	Bailey	Michele	ARNP	Neonatal_Perinatal Med
1992995591	MD60184340	Behnam	Mark	MD	Obstetrics_Gynecology
1609361294	MD61231186	Berger	Michael	MD	Obstetrics_Gynecology
1477648459	MD61034441	Bhoplay	Vinay	MD	Obstetrics_Gynecology
1285833939	MD60057935	Boswell	Elizabeth	MD	Obstetrics_Gynecology
1275809311	MD61633580	Butler	Emmary	MD	Obstetrics_Gynecology
1265630701	MD61566595	Cabell	Cortney	MD	Obstetrics_Gynecology
1700855517	MD60918856	Carisio-Farber	Renee	MD	Obstetrics_Gynecology
1225121890	AP30005099	Carter	Becky	ARNP	Neonatal_Perinatal Med
1013515824	AP61124296	Cervantes	Yazmin	ARNP	Neonatal_Perinatal Med
1649609579	MD61114174	Chan	Jeanne	MD	Obstetrics_Gynecology
1609852300	MD61259693	Cheng	Jacky	MD	Obstetrics_Gynecology
1770675092	MD60844955	Clark	Michael	MD	Obstetrics_Gynecology
1487164463	AP61273691	Crane	Nadia	CNM	Certified Nurse Midwife
1093013773	AP60157743	Cummings	Ashley	CNM	Certified Nurse Midwife
1205855038	MD00037197	Czuk	Mary	MD	Obstetrics_Gynecology
1003892480	MD61404475	Davis	Wesley	MD	Obstetrics_Gynecology
1508260605	MD61643331	Deleon	Emily	MD	Obstetrics_Gynecology
1881607208	MD61227590	Dolskaya	Elena	MD	Obstetrics_Gynecology
1851347967	MD00039294	Draper	Wendy	MD	Obstetrics_Gynecology
1467593533	MD60407479	Erkins	Johnny	MD	Obstetrics_Gynecology
1205443637	AP61092013	Etherington	Katie	CNM	Certified Nurse Midwife
1104295211	AP61073659	Falk	Jaimee	ARNP	Obstetrics_Gynecology
1891750568	MD60596415	Fenton	Bradford	MD	Obstetrics_Gynecology
1457986150	AP61075184	Fielding	Deannita	ARNP	Neonatal_Perinatal Med
1336658368	AP60799116	Fino-Fugate	Rebecca	CNM	Certified Nurse Midwife
1962935593	MD61224393	Fluckiger	Andrew	MD	Obstetrics_Gynecology
1710031125	AP60870200	Fox	Stephanie	ARNP	Neonatal_Perinatal Med
1528214020	OP60084282	Galbraith	Lisa	DO	Obstetrics_Gynecology
1164187167	AP61424040	Gilmore	Cecilia	CNM	Certified Nurse Midwife
1568575470	MD00044192	Glover	Agnes	MD	Obstetrics_Gynecology
1417918160	MD60456680	Gries	Delores	MD	Neonatal_Perinatal Med
1801347828	AP612000686	Grisinger	Ellen	CNM	Certified Nurse Midwife
1356705438	MD61045315	Hamlin	Alyssa	MD	Obstetrics_Gynecology
1437126067	MD00037276	Hannon	Elena	MD	Obstetrics_Gynecology
1275102618	AP61323420	Haymond	Jessica	CNM	Certified Nurse Midwife
1942814553	AP61455485	Heffel	Cydnee	CNM	Obstetrics_Gynecology
1265524847	ND00039878	Hitchcock	Christina	MD	Obstetrics_Gynecology
1750389425	MD61621543	Howser III	Donald	MD	Obstetrics_Gynecology
1619067782	OP00001094	Hunter	Catherine	DO	Gynecology
1972504488	MD61508925	Jacob	Clyde	MD	Obstetrics_Gynecology
1659517159	MD60454304	Jayaram	Archana	MD	Neonatal_Perinatal Med
1154956720	AP61163082	Johnson	Arlene	CNM	Certified Nurse Midwife

Level II ICN Medical Staff Roster

NPI	WA Lic #	LastName	FirstName	Degree	Specialty
1295785236	MD60616236	Kuluz	Michael	MD	Neonatal_Perinatal Med
1174170724	AP61016241	Kurtz	Jennifer	ARNP	Neonatal_Perinatal Med
1053924951	AP61466682	Lesko	Leona	CNM	Certified Nurse Midwife
1952501975	MD00048417	Linares	Silvia	MD	Obstetrics_Gynecology
1750458873	MD61485190	Lofquist	Frederica	MD	Obstetrics_Gynecology
1386989804	AP60315861	Macpherson	Laura Marie	CNM	Certified Nurse Midwife
1730489634	MD60366132	Malmberg	Annika	MD	Obstetrics_Gynecology
1225021934	AP30004331	Marbut	Kristie	ARNP	Neonatal_Perinatal Med
1770520728	MD60474298	Maynard	Steven	MD	Obstetrics_Gynecology
1881370385	AP61499407	McClurg	Julie	ARNP	Neonatal_Perinatal Med
1821746504	AP61521783	McEwen	Koy	ARNP	Neonatal_Perinatal Med
1104361252	AP60833763	McGehee	Amy	ARNP	Obstetrics_Gynecology
1457360794	MD00037434	Metcalf	Sharon	MD	Obstetrics_Gynecology
1689196057	AP60699315	Meyer	Monica	CNM	Certified Nurse Midwife
1053056747	PA61294185	Miller	Katherine	PA-C	Obstetrics_Gynecology
1689198111	AP60809280	Miller	Corinne	ARNP	Neonatal_Perinatal Med
1821004748	MD00024643	Minehan	David	MD	Obstetrics_Gynecology
1497779136	MD00042107	Nevil	Keven	MD	Obstetrics_Gynecology
1659638021	MD60974806	Newell	Elizabeth	MD	Obstetrics_Gynecology
1417152075	MD60459498	Nunthirapakorn	Thida	MD	Obstetrics_Gynecology
1609161330	MD61579915	Park	Mary	MD	Obstetrics_Gynecology
1184638439	MD00036137	Park-Hwang	Esther	MD	Obstetrics_Gynecology
1710274493	MD61008954	Pavey	Ashleigh	MD	Neonatal_Perinatal Med
1235486713	AP60292018	Peppers	Ann	ARNP	Neonatal_Perinatal Med
1598102808	OP61427552	Poteet	Jessica	DO	Obstetrics_Gynecology
1730232489	MD00026732	Richardson	Yolanda	MD	Obstetrics_Gynecology
1790963338	MD61332659	Ricks-Cord	Anila	MD	Obstetrics_Gynecology
1851520324	AP60215562	Riffel	Jennifer	CNM	Obstetrics_Gynecology
1154525897	MD61451687	Rodriguez	Maria	MD	Obstetrics_Gynecology
1043408503	PA60413047	Rosenblum	Peter	PA-C	Obstetrics_Gynecology
1477797330	AP61479487	Russ	Rosemarie	ARNP	Neonatal_Perinatal Med
1700861861	MD00022365	Sanford	Elizabeth	MD	Obstetrics_Gynecology
1174136907	AP61432695	Sansone	Jamie	CNM	Certified Nurse Midwife
1760612550	MD61468562	Santoyo-Perez	Michelle	MD	Obstetrics_Gynecology
1760444897	MD00033781	Sato	Ray	MD	Neonatal_Perinatal Med
1801024336	MD60809525	Schendel-Dittmann	Megan	MD	Obstetrics_Gynecology
1538122239	MD60455485	Scott	Serena	MD	Neonatal_Perinatal Med
1073593166	MD61509701	Segall	Kristen	MD	Obstetrics_Gynecology
1447335963	MD00036379	Smith	Melissa	MD	Obstetrics_Gynecology
1447454194	AP61324822	Solis	Ellen	CNM	Certified Nurse Midwife

Level II ICN Medical Staff Roster

NPI	WA Lic #	LastName	FirstName	Degree	Specialty
1881957686	MD61628386	Stinson	Katrina	MD	Obstetrics_Gynecology
1780972638	MD60236067	Tan-Dy	Cherrie	MD	Neonatal_Perinatal Med
1497382634	OP61548428	Terhune	Elizabeth	DO	Obstetrics_Gynecology
1659465185	MD60926804	Thai	Renee	MD	Obstetrics_Gynecology
1396206413	MD61628394	Thompson	Jennifer	MD	Obstetrics_Gynecology
1851360655	MD61613928	Todd	Darwana	MD	Obstetrics_Gynecology
1437544822	MD60948258	Tran	Mai	MD	Obstetrics_Gynecology
1699302810	MD61563653	Volkova	Zoya	MD	Obstetrics_Gynecology
1831359645	MD61050030	Vongsy	Katrina	MD	Obstetrics_Gynecology
1922026236	MD00024602	Wallace	Calvin	MD	Obstetrics_Gynecology
1407381650	MD61151043	Weyenberg	Lydia	MD	Obstetrics_Gynecology
1750915989	AP61339464	White	Jennifer	ARNP	Neonatal_Perinatal Med
1194105320	OP61235398	Williams	Bryan	DO	Neonatal_Perinatal Med
1790920510	MD60015282	Williams	Richard	MD	Obstetrics_Gynecology
1922486885	OP61637830	Winston	Emelia	DO	Obstetrics_Gynecology
1225185671	MD60506634	Yao	Yvonne	MD	Obstetrics_Gynecology
1841604857	OP60850351	Yuan	Holly	DO	Obstetrics_Gynecology
1427001494	MD60003294	Zwiesler	Daniel	MD	Obstetrics_Gynecology

Exhibit 14.
Transfer Agreement

MULTICARE HEALTH SYSTEM
INTER-FACILITY PATIENT TRANSFER AGREEMENT
AMONG MHS-AFFILIATED HOSPITALS & FACILITIES

This Inter-Facility Patient Transfer Agreement ("Agreement") is made by and between each MHS Affiliated Hospital or Facility listed in Exhibit A ("Facility"). Exhibit A may be modified, from time-to-time, to fully reflect all MHS-Affiliated Facilities and entities covered by this Agreement.

All Facilities wish to establish a coordinated program for the use of the respective skills, resources and physical plant of each other MHS-Affiliated Facility to provide improved and continuous patient care.

NOW, THEREFORE, each MHS-Affiliated Facility agrees as follows:

1. **Term of Agreement.** This Agreement shall be effective April 23, 2018 and shall continue for a term of ten (10) years, or until terminated or replaced by a subsequent agreement among the MHS-Affiliated Health Care Facilities described on Exhibit A below.

2. **Purpose of Agreement.** To provide continuous patient care to meet the needs of patients, each MHS Facility agrees to accept appropriate transfers from any other MHS-Affiliated Health Care Facility for MHS patients in need of the specialized services of the type provided by the receiving Facility, whenever the receiving Facility has the capability to accept such a transfer.

3. **Patient Transfer & Transport Policy.** Each Facility shall follow the guidelines and provisions of the MultiCare Health System Patient Care Policy, entitled: Patient Transfer & Transport to Another Facility, as amended, whenever transferring or transporting an MHS patient between Facilities. In addition:

- Patients transferred for cardiac surgery back-up must meet the requirements on Exhibit B.
- Patients transferred to neuro interventional radiology must meet the requirements set forth on Exhibit C.
- Patients transferred for obstetrics must meet the requirements set forth on Exhibit D.
- Neonate patient transfers must meet the requirements set forth on Exhibit E.

4. **Coordination of Transfer of Patient.** The need to transfer a patient from one MHS-Affiliated Facility to another shall be determined by the patient's attending physician. When such a determination has been made, the transferring Facility shall immediately notify the appropriate physician in the receiving Facility's unit of the proposed transfer. The transferring physician and the receiving physician shall confer and jointly determine the patient's appropriateness for transfer. A patient in an emergency medical condition within the meaning of the Act (defined below) may be transferred only if the receiving Facility has agreed to accept the transfer and to provide appropriate medical treatment and has available space and qualified personnel to treat the patient. Prior to moving the patient, the transferring Facility must receive confirmation from the receiving Facility that it can accept the patient.

To the extent applicable, the Emergency Medical Treatment and Active Labor Act of 1985 (42 USC §1395dd) (the "Act") shall apply its implementing regulations and supersede any contrary provision of this Agreement.

5. Patient Medical Records Not Available In EPIC. The transferring Facility shall send along with each transferred patient an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption including a discharge summary together with essential identifying and administrative information, if that information is not otherwise contained within MHS' electronic patient record system (EPIC). The information shall include, when appropriate, the following:

a) Initial diagnostic impression.
b) Patient's name, address, hospital number and age, and name, address and phone number of next of kin.
c) History of injury or illness. d) Condition at admission.
e) Vital signs (including Glasgow coma score).
f) Pre-hospital condition and treatment.
g) Condition and treatment during stay in emergency department and at time of transfer.
h) Treatment rendered to patient including medications given and route of administration.
i) Laboratory and x-ray findings, appropriate laboratory specimens (when appropriate or indicated) and all x-ray films.
j) Fluids given by type and volume.
k) Name, address and phone number of physician referring the patient.
l) Name of physician at receiving party who has been contacted about the patient.
m) Name, address and phone number of patient's designee who is patient's attorney-in-fact under patient's healthcare power of attorney.
n) The original or a copy of patient's healthcare power of attorney, living will and/or healthcare directives. Additional

information may be required as set forth on the applicable Exhibit.

6. Transportation of Patient. The transferring Facility shall arrange for transportation of the patient to the receiving Facility including selection of the mode of transportation and providing qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transfer unless otherwise agreed between the Facilities. The receiving Facility's responsibility for the patient's care shall begin when the patient is admitted either as an inpatient or an outpatient at the receiving Facility.

7. Transfer of Patient's Personal Property. The transferring Facility is responsible for the transfer or the appropriate disposition of the patient's personal effects including money and valuables and information related to these items. The receiving Facility's responsibility for the Patient's personal effects and belongings shall begin when the receiving Facility has inventoried and documented receipt of such items.

8. Patient's Consent to Transfer. The transferring Facility is responsible for obtaining the patient's consent (or proper substituted or implied consent) to the extent necessary under the Act.

9. Patient Transfer Coordinators. Each Facility shall provide the other Facility with the name and title of persons authorized to initiate, confirm and accept the transfer of a patient on behalf of such Facility. Each receiving Facility shall inform the transferring Facility of the location to which to bring patients in the Facility. The MHS-Affiliated Facilities agree to provide each other information about the patient care services offered by each Facility. The Facilities agree to cooperate and jointly review cases in which either party has questions about appropriateness of transfer.

10. Transfers Arising from Mass Casualties or Natural Disasters: Mutual Aid Pact. In the event of any cause or circumstance arising from a natural disaster or mass casualty, each MHS-Affiliated Facility shall communicate with other MHS-Affiliated Facilities as soon thereafter as is practicable, to ascertain the relative impacts of such disaster or casualty upon one another and their respective capabilities for sending and/or receiving patients under the Agreement. In such situations:

a) Whenever circumstances allow, each Facility, as the receiving Facility, further agrees to accept "block transfers" of as many patients sent from the sending Facility as may be practicable, to free up beds in the Facility most directly impacted by the event, including patients with lower acuity levels or non-emergent needs.

b) Each facility will, in addition to their obligations under the Agreement, establish communications protocols to be triggered in the event of a natural disaster or mass casualty, including the appointment of designated patient transfer coordinators at each facility who shall act as the primary point(s) of contact during any such event or circumstance.

c) At such time as the long-term needs of the sending Facility are better understood in the context of the event, the sending Facility will advise the receiving Facility of its capacity to retrieve patients sent in contemplation of the need for bed space, at which time the parties will evaluate the plan of care for each such patient and determine whether the patient's needs will best be met by returning to the original Facility or remaining at the receiving Facility.

11. Nondiscrimination. No MHS-Affiliated Facility may refuse to receive a patient because of such patient's race, religion, gender, age, national origin, sexual orientation, marital status, handicap, disability or medical diagnosis in providing services under this Agreement.

12. Patient HIV Status. No MHS-Affiliated Facility may refuse to receive a patient because the patient is HIV positive or has AIDS. To the extent that such information is not specially protected within EPIC, the portion of the medical records reflecting the patient's HIV or AIDS status will be transmitted in a secure and sealed envelope with the patient's medical records. The patient's HIV status may be disseminated only to those healthcare providers who have a medical need to know or as provided by law.

13. Confidentiality. Each MHS-Affiliated Facility agrees that the confidentiality of each patient's medical records must be maintained. To achieve that goal, each MHS-Affiliated Facility agrees to transport medical records in a manner designed to maintain the confidentiality of the medical record as required by applicable law, including applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

14. Financial Arrangements- Non-MHS-Owned Facilities. Charges for services performed by each Facility for patient's transfer pursuant to this Agreement shall be collected by the party rendering such services and shall be collected directly from patient, from third party payors or other sources of payment. To the extent that this agreement applies to any Facility which is not wholly owned by MHS, no MHS- Affiliated Facility shall have any liability to any other MHS-Affiliated Facility for the billing, collection or payment of charges for services performed by such other Facility except as otherwise provided in this Agreement or to the extent that such liability would exist separate and apart from this Agreement.

15. Independent Contractor Status – Non-MHS-Owned Facilities. To the extent that any MHS-Affiliated Health Care Facility is not wholly owned by MHS, such Facility may constitute an independent contractor with respect to the other party. In such circumstances, neither party is authorized or permitted to act or to claim to be acting as an agent or employee of the other party. Nothing in this Agreement alters in any way control of the management, assets or affairs of either party. In such circumstances, neither party by this Agreement assumes any liability for any debts or obligations of any kind incurred by the other party to this Agreement. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other Facility on a limited or general basis.

16. Compliance with Laws and Regulations. Each Facility is deemed an instrumentality of the Federal Government [Medicare/Medicaid Providers] and terms of this agreement will be construed in accordance with applicable Federal and State statutes.

17. Termination Without Cause. Any MHS-Affiliated Facility may terminate its participation in this Agreement without cause, upon 30 days' advance written notice to all other participating MHS-Affiliated Facilities identified in Exhibit A, in which event the terminating Facility must complete its duties under the Agreement with respect to any patient who is being transferred at the time of termination.

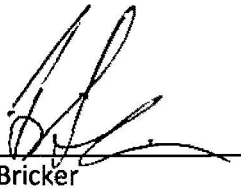
18. Agreement Remains Valid Between Other MHS-Affiliated Facilities. The termination of this Agreement by any Facility shall not affect the duties and obligations of other MHS-Affiliated Facilities participating in this Agreement.

19. Authorization for Agreement. The execution and performance of this Agreement by each MHS-Affiliated Facility has been duly authorized by MultiCare Health System and this Agreement constitutes the valid and enforceable obligation of each MHS-Affiliated Facility in accordance with its terms.

SIGNATURE PAGE TO FOLLOW

IN WITNESS, WHEREOF, MultiCare Health System hereby affirms the obligation of each MHS-Affiliated Facility identified herein to abide by the terms of this Agreement until terminated.

MultiCare Health System:

By: 

Print Name: Tim Bricker

Title: SVP – Chief Exec. – South Sound Region

Date: 4/17/18

MultiCare Health System:

By: 

Print Name: Bill Robertson

Title: CEO – MHS

Date: 4/17/18

Exhibit A

MHS Affiliated Hospitals & Facilities

The following Facilities are each wholly-owned MHS Facilities subject to this Agreement as MHS Affiliated Hospitals & Facilities ("Facility" and/or "Facilities"):

Tacoma General Hospital

Allenmore Hospital

Good Samaritan Hospital

Auburn Medical Center

Mary Bridge Children's Hospital

Covington Medical Center

Deaconess Hospital

Valley Hospital

Good Samaritan Rehabilitation (Division of Good Samaritan Hospital) Day

Surgery of Tacoma

Gig Harbor Ambulatory Surgery Center

Exhibit B

Requirements for Elective PCI Patients

Purpose: This Exhibit B to the MHS Inter-Facility Patient Transfer Agreement applies to patients transferred to MHS Tacoma General Hospital for cardiac surgery back-up and support following elective percutaneous coronary interventions ("PCI Patients") at a facility without the availability of on-site cardiac surgeons.

1. Consent. In addition to the requirements set forth in the Agreement, the Party performing the intervention or PCI, shall obtain consent from PCI Patients which explicitly communicates to such patients that the percutaneous coronary intervention ("PCI") is being performed without on-site surgery back-up and addresses risks related to transfer, the risk of urgent surgery which would require a transfer to MHS Tacoma General Hospital for on-site surgery back-up, and refer to this Agreement.

2. Coordination. Facilities lacking on-site surgery backup shall coordinate, to the extent possible, the availability of surgical teams and operating rooms at MHS so that for all hours that elective PCIs are being performed at Facility, there is a reasonable likelihood that MHS has the capacity to immediately accept a referral. The Parties acknowledge and agree that nothing in this Agreement imposes an obligation on MHS to maintain an available cardiac surgical suite twenty-four hours a day, seven days a week and that the only MHS Hospital with on-site surgery back-up is MHS Tacoma General Hospital.

3. Periods of High Occupancy. During times of high census where a Facility's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), that Facility will notify those MHS Facilities performing PCI procedures, which lack on-site surgical backup, that elective procedures will be rescheduled subject to the attending physician's assessment that such delay does not compromise the patient's care and condition.

4. Transportation of PCI Patients. In addition to the requirements set forth in Section 5 of the Agreement, Facility shall:

a. Maintain a signed transportation agreement with a qualified vendor that provides for expeditious transport for any patient experiencing complications during an elective PCI that requires transfer to another Facility. A qualified vendor is one whose transport staff is ACLS certified. The transferring Facility will provide the experienced and skilled personnel and equipment to monitor and treat the patient en route, including management of an intra-aortic balloon pump (IABP);
b. Document and confirm that emergency transportation begins for each patient within twenty minutes of the initial identification of a complication by the attending physician;
c. Document transportation times from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of receiving Facility and confirm transportation time is less than one hundred twenty minutes; and
d. Participate annually in two timed emergency transportation drills with outcomes communicated to each participating Facility's quality assurance programs. The staff and cost of internal resources used for such drills will be the responsibility of each Facility employing such staff or owning that resource. The cost of any external resources required for such drills will be the responsibility of each Facility.

5. PCI Patient Medical Records. In addition to the information required in Section 6 of the Agreement, transferring Facility shall send to receiving Facility all records (or copies thereof) related to the emergency condition which the patient has presented available at the time of the transfer, along with all diagnostic imaging and videos, if such records, diagnostic imaging and videos are not otherwise directly accessible via EPIC or other electronic systems maintained by MHS at each applicable Facility associated with such transfers.

6. Physician Communication. Transferring Facility will monitor all transfers to assure that the physician performing the elective PCI communicates immediately and directly with receiving Facility's cardiac surgeon(s) about the clinical reasons for the urgent transfer and the PCI Patient's clinical condition.

7. Quality Assurance. The Parties shall schedule cardiac patient care quality assurance conferences at least twice per year that involve case reviews of a significant number of pre-operatives and post-operative PCI cases at Facility including a one-hundred percent (100%) review of all transport cases.

Exhibit C

Requirements for Stroke Patients

Purpose: This Exhibit C to the MHS Inter-Facility Patient Transfer Agreement applies to stroke patients transferred to a MHS neuro-interventional radiology program ("Stroke Program").

1. **Coordination**. Facilities shall coordinate, to the extent possible, transfer process and communication through the MultiCare Health System Transfer and Triage Center. There is a reasonable likelihood that another MHS Facility has the capacity to immediately accept a transfer.

2. **Periods of High Occupancy**. During times of high census where Facility's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), that Facility will notify those MHS Facilities and Facility's elective procedures will be rescheduled subject to the attending physician's assessment that such delay does not compromise the patient's care and condition.

3. **Transportation of Stroke Patients**. In addition to the requirements set forth in Section 5 of the Agreement, Facility shall:

   a. Maintain a signed transportation agreement with a qualified vendor that provides for expeditious transport for any stroke patient that requires transfer to another Facility. A qualified vendor is one whose transport staff is ACLS certified; critical care transport is preferred.

   b. The patient's medical condition and the ability of the transferring hospital to provide necessary stabilizing treatment and the clinical judgment of the transferring and receiving physicians is the determining factor as to when the patient should be transferred.

   c. Provide the following patient care including:
   -IV access (Preference is RAC and Left arm 18 gauge if possible)
   -Use Normal saline for all fluids
   -NPO unless patient passed a documented RN swallow screen (consider gastric tube for medications)

4. **Stroke Patient Medical Records**. In addition to the information required in Section 5 of the Agreement, Facility shall send to MHS all records (or copies thereof) related to the emergency condition which the patient has presented available at the time of the transfer, along with all diagnostic imaging and videos.

5. Physician Communication. Transferring Facility will monitor all transfers to assure that the receiving physician immediately is available to address the clinical reasons for the urgent transfer and patient's clinical condition.

7. Quality Assurance. The receiving Facility shall provide hospital summary after discharge. This is handled by the MHS Transfer and Triage Center. The receiving Facility reviews 100% of transfers, coordinated by the Director of Stroke Quality Management. Summary reports are provided on a quarterly basis to the transferring Facilities.

Exhibit D
Requirements for Obstetric Patients

Purpose: This Exhibit C to the MHS Inter-Facility Patient Transfer Agreement applies to obstetric patients transferred to a MH facility.

1. **Contact Numbers:**
   a. Transfers to TG: (253-403-1034)
   b. Transfers to GSH: (253-697-5900)
   c. Transfers to AMC: (232-333-2522)

2. **Tacoma General Hospital**. Each Facility shall use the following checklist when transferring obstetric patients to Tacoma General Hospital.
   a. Contact the Birth Center Charge Nurse (253-403-1034) to coordinate transfer, to include confirmation of available obstetric bed space, confirmation of available NICU bed space (if applicable), and identification of an accepting provider.
   b. If transferring to Maternal Fetal Medicine service, the Birth Center Charge Nurse will contact the MFM Provider on call and arrange a return call to the transferring provider.
   c. If transferring a low risk patient due to unavailable obstetric services and the patient has no Obstetric provider at Tacoma General Hospital, the Birth Center Charge Nurse will facilitate contact with the MultiCare OB/GYN Associate on call to receive the patient as an obstetric "NO DOC" patient.
   d. If transferring a low risk patient requiring the level of services available at Tacoma General Hospital, but transferring provider is retaining status as attending provider, coordinate transfer with the Birth Center Charge Nurse.
   e. Proceed to Section 4 below, All MHS Obstetrics Transfers.

3. **Good Samaritan Hospital and Auburn Medical Center**. Each Facility shall use the following checklist when transferring obstetric patients to Good Samaritan Hospital or Auburn Medical Center.
   a. Patients must be 34 weeks or greater and deemed low risk prior to transfer. All patients less than 34 weeks or deemed high risk will be transferred to TG.
   b. Contact the Labor and Delivery Charge Nurse at Good Samaritan (253-697-4383) or Auburn Medical Center (232-333-2522) to coordinate transfer, to include confirmation of available obstetric bed space, confirmation of available SCN bed space (if applicable), and identification of an accepting provider.
   c. OBHG will be contacted to assess and accept appropriate transfers. This will be a provider to provider call.
   d. Proceed to Section 4 below, All MHS Obstetrics Transfers.

4. **All MHS Obstetrics Transfers.** After consultation, if the patient is accepted for transfer, follow sending Party's policies for transferring a patient to another facility. For patients whose prenatal course is not documented in EPIC, include copy of the prenatal chart with transport documents.
   a. For patients with diagnosis of preterm labor or active term labor, reassess cervical dilatation prior to transporting the patient, if last exam has been greater than 1 hour (documentation of which shall be provided under Section 4(d) below), to assure that advanced labor has not increased the risk of in transit delivery.

b. For patients with preterm labor or active labor with fetal concerns, where risk for delivery in transit is high, contact the NICU to coordinate attendance of the Neonatal Transport Team to stabilize and transport the neonate.
c. Prior to the patient's departure from the transferring Party, a hand off report to the Birth Center Charge Nurse will occur.
d. In addition to the requirement s of this Agreement, provide the following, if such records are not directly available at the receiving Party through EPIC or other systems maintained by MHS at the receiving Party:
    i. Copy of the patient's hospital chart including:
        1. Prenatal record
        2. Allergies
        3. Past medical history, home medications
        4. Medications and treatment at the transferring Party
        5. Summary of current complaint to include onset, signs and symptoms
        6. Demographic face sheet
        7. Documentation of the (1) labor assessment, (2) last exam, (3) fetal heart rate and (4) vital signs.

Exhibit E

Requirements for Neonates

Purpose: This Exhibit D to the MHS Inter-Facility Patient Transfer Agreement applies to neonate patients transferred to a MHS Facility. MHS and Facility are sometimes referred to in this Exhibit E individually as "Party" or, collectively, as the "Parties."

1. **Contact Numbers:**
    a. Transfers to TG: (253-403-1024)
    b. Transfers to GSH: (253-697-5900)
    c. Transfers to AMC: (253-545-2522 and request the NICU department)

2. **Tacoma General**. Facility shall adhere to the following when requesting a transfer to the Tacoma General NICU:
    a. Consult with the Neonatologist on call in the MHS NICU (253-403-1024).
    b. After consultation, if the patient is accepted for transfer by the neonatologist, the TG NICU Transport Team will be dispatched to transport the infant.
    c. The Transport Team will provide the following documents and request they be completed (the transport team may assist in completing the forms or the physician at the referring hospital may do so):
        i. Signed, dated and timed "Neonatal Transport Consent"
        ii. Signed, dated and timed "Notice of Privacy Practices Acknowledgement Form"
        iii. Signed, dated and timed "Authorization for MultiCare to use or disclose My Health Care Information"
        iv. Provide copies of the patient/maternal chart:
            1. All maternal documentation (i.e. Maternal History/physical; lab values; delivery notes; nurses/physician notes; etc.)
            2. All infant documentation: (i.e. Admission physical, lab values, radiology studies, nursing notes, physician notes, etc.)

3. **Good Samaritan Hospital and Auburn Medical Center.** Facility shall use the following checklist when transferring neonatal patients to Good Samaritan Hospital or Auburn Medical Center.
    a. Patients must be 34 weeks or greater and deemed low risk prior to transfer. Any patient less than 34 weeks or deemed high risk must be transferred to the TG NICU.
    b. Contact the Labor and Delivery Charge Nurse at Good Samaritan (253-697-4383) or Auburn Medical Center (232-333-2522) to coordinate transfer, to include confirmation of available SCN bed space and identification of an accepting provider.
    c. IPS (253-597-4626) will be contacted to assess and accept appropriate transfers. This will be a provider to provider call.
    d. After consultation, if the patient is accepted for transfer, follow sending Party's policies for transferring a patient to another facility.
    e. Prior to the patient's departure from the transferring Party, a hand off report to the Special Care Nursery Nurse must occur.
    f. In addition to the requirements of this Agreement, provide the following, if such records are not directly available at the receiving Party through EPIC or other systems maintained by MHS at the receiving location:
        i. Copy of the patient's hospital chart including:
            1. Birth record
            2. Medications and treatment at the transferring Party
            3. Nursing notes

4. Summary of current complaint to include onset, signs and symptoms (H&P and progress notes)
5. Physician orders
6. Demographic face sheet

Exhibit F

Requirements for Pediatric Patients

Purpose: This Exhibit F to the MHS Inter-Facility Patient Transfer Agreement applies to pediatric patients transferred to Mary Bridge Children's Hospital.

1. **Contact Numbers:**

Transfer to Mary Bridge Children's Hospital:

Contact the Transfer Center (855-647-1010)

2. **Transfers to Mary Bridge:** Facility shall adhere to the following when requesting a transfer to Mary Bridge Children's Hospital:
    a. Contact the transfer center to get in touch with any of the following Inpatient Physician Services (IPS), Emergency Department physician or Pediatric Intensivist. (855-647-1010)
    b. The transfer center will connect the referring physician to the correct MB physician to consult and accept transfer.
    c. If the patient is accepted for transfer by the MB designated physician, the MB physician will offer the pediatric transport team (TT) to come and retrieve the patient.
    d. If the TT is not available, the referral physician and the MB physician will discuss the safest alternative mode of transportation for the patient.
    e. The Transport Team will provide the following documents and request they be completed (the transport team may assist in completing the forms or the physician at the referring hospital may do so):
        1. Signed, dated and timed "Transport Consent"
        2. Signed, dated and timed "Notice of Privacy Practices Acknowledgement Form"
        3. Signed, dated and timed "Authorization for MultiCare to use or disclose My Health Care Information"
        4. Provide copies of the patient's chart:
            1. All pediatric documentation: (i.e. Admission physical, lab values, radiology studies, nursing notes, physician notes, transfer summary, etc.)
        5. Signed, dated and timed "Passenger Release of Liability"
            1. It will be at the TT discretion to allow 1 family member to accompany the patient in the ambulance. So long as the patient's status is stable and the family member will not be a hindrance to the safe transport of the patient.

FIRST AMENDMENT TO
MHS INTER-FACILITY PATIENT TRANSFER AGREEMENT
AMONG MHS-AFFILIATED HOSPITALS & FACILITIES

THIS FIRST AMENDMENT ("Amendment") to the MHS Inter-Facility Patient Transfer Agreement ("Agreement") is made and entered into by and between each MHS Affiliated Hospital or Facility listed in Exhibit A ("Facility").

WHEREAS the Parties have previously entered into a MHS Inter-Facility Patient Transfer Agreement dated April 23, 2018;

WHEREAS the Parties wish to further revise the Agreement to amend Exhibit A of the Agreement.

Now, therefore, in consideration of the mutual benefits, promises, payments and undertakings of the Parties, it is hereby agreed that:

FA-1. Exhibit A "MHS Affiliated Hospitals & Facilities" of the Agreement is hereby amended to include Capital Medical Center, Olympia Washington.

FA-2. Except as set forth in this First Amendment, all terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties hereto have executed this First Amendment effective as of the last date shown below.

MultiCare Health System:

By: Tamara Uson
Print Name: Tamara Uson
Title: AVP – Nursing Operations
Date: 10/04/2022 09:57 AM EDT

MultiCare Health System:

By: William Callicoat
Print Name: Will Callicoat
Title: President - CapMC & Market Leader Thurston County
Date: 10/04/2022 12:13 PM EDT

SECOND AMENDMENT TO
MHS INTER-FACILITY PATITIENT TRANSFER AGREEMENT
AMOUNG MHS-AFFLIATED HOSPITALS & FACILITIES

THIS SECOND AMENDMENT ("Amendment") to the MHS Inter-Facility Patient Transfer Agreement Among MHS Affiliated Hospitals and Facilities ("Agreement") is made and entered into by and between MultiCare Health System ("MHS") Affiliated Hospitals which are sometimes referred to in this Amendment individually as "Party" or, collectively, as the "Parties."

WHEREAS the Parties have previously entered into a Master Services Agreement dated April 23, 2018;

WHEREAS the Agreement was amended through mutually agreed upon Amendment dated October 4, 2022;

WHEREAS the Parties wish to further revise the Agreement to amend Exhibit A of the Agreement;

NOW, THEREFORE, in consideration of the mutual benefits, promises, payments and undertakings of the parties, it is hereby acknowledged that:

FA-1. Exhibit A "MHS Affiliated Hospitals & Facilities" of the Agreement is hereby amended to include Yakima Valley Memorial Hospital Association d/b/a MultiCare Yakima Memorial ("MYM").

FA-2. Except as set forth in this Amendment, all terms and conditions of the Agreement, as previously amended, shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties hereto have executed this Second Amendment effective as of the last date shown below.

MultiCare Health System

Tamara Uson

Tamara Uson
Assistant Vice President Nursing Operations
March 08, 2024 10:29 PT
IP: 76.121.166.53

MultiCare Health System

Tammy K. Buyok

Tammy K. Buyok
Yakima President & Market Leader. Yakima Valley Region
March 07, 2024 7:22 PT
IP: 199.79.112.6

THIRD AMENDMENT TO
MHS INTER-FACILITY PATIENT TRANSFER AGREEMENT
AMONG MHS-AFFILIATED HOSPITALS & FACILITIES

THIS THIRD AMENDMENT ("Amendment") to the MHS Inter-Facility Patient Transfer Agreement Among MHS Affiliated Hospitals and Facilities ("Agreement") is made and entered into by and between MultiCare Health System ("MHS") Affiliated Hospitals which are sometimes referred to in this Amendment individually as "Party" or, collectively, as the "Parties".

WHEREAS the Parties have previously entered into a MHS Inter-Facility Patient Transfer Agreement dated April 23, 2018;

WHEREAS the Agreement was amended through mutually agreed upon Amendments dated October 4, 2022 and March 8. 2024;

WHEREAS the Parties wish to further revise the Agreement to Amend Exhibit A of the Agreement.

NOW, THEREFORE, in consideration of the mutual benefits, promises, payments and undertakings of the parties, it is hereby acknowledged that:

TA-1. Exhibit A "MHS Affiliated Hospitals & Facilities" of the Agreement is hereby amended to include the following:

a. Yakima Orthopedics ASC (MYASC, LLC) and;
b. Yakima Endoscopy Center (MEC Yakima, LLC)

TA-2. Except as set forth in this Amendment, all terms and conditions of the Agreement, as previously amended, shall remain in full force and effect

IN WITNESS WHEREOF, the Parties hereto have executed this Third Amendment effective as of the last date shown below.

MultiCare Health System:

By: Eddie Bratko

Print Name: Eddie Bratko

Title: President Tacoma General AH

Date: October 04, 2024 8:26 PT

MultiCare Health System:

By: Tammy K. Buyok

Print Name: Tammy Buyok

Title: Yakima Mkt Leader Pres Yakima Mem Hospital

Date: October 28, 2024 9:29 PT

Exhibit 15.
Washington State Perinatal Level of Care Guidelines

WASHINGTON STATE DEPARTMENT OF HEALTH

Washington State Maternal and Neonatal Levels of Care Guidelines

Washington State Department of HEALTH

DOH 950-154 January 2025

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Maternal and Neonatal Levels of Care Guidelines

On June 24, 2024, the Washington State Department of Health Levels of Care committee unanimously voted to align the state guidelines with national guidelines. The committee adopted the levels of neonatal care outlined in the American Academy of Pediatrics and the levels of maternal care specified by the American College of Obstetricians and Gynecologists.

The documents below should serve as a guide for hospitals applying for Level II, Level III, or Level IV designations. Detailed criteria for each guideline can be found in these.

Documents

1. Stark AR, Pursley DM, Papile LA, Eichenwald EC, Hankins CT, Buck RK, Wallace TJ, Bondurant PG, Faster NE. Standards for Levels of Neonatal Care: II, III, and IV. Pediatrics. 2023 Jun 1;151(6): Online at: Standards for Levels of Neonatal Care: II, III, and IV | Pediatrics | American Academy of Pediatrics
2. The American College of Obstetrics and Gynecologist (2019). Obstetric Care Consensus: Levels of Maternal Care (LoMC) (9). Online at: Levels of Maternal Care | ACOG

Subcommittee for Maternal and Neonatal Levels of Care (LOC) 2024 Document

Trish Anderson, MBA, BSN
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Maureen Shogan, MN, RNC
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Susan Stauffer, BSN, RNC-NIC
Neonatal Intensive Care Clinical Nurse Specialist, Clinical Program Coordinator
Providence Sacred Heart Medical Center & Children's Hospital, Spokane, WA

Bat-Sheva Stein, DNP, MSN, RN
LOC Subcommittee Coordinator
Washington State Department of Health, Olympia, WA Bat-Sheva.Stein@doh.wa.gov

Annie Nguyen-Vermillion, MD
EvergreenHealth NICU Medical Director
Kirkland, WA

DOH 950-154 January 2025
To request this document in another format, call 1-800-525-0127.
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please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Standards for Levels of Neonatal Care: II, III, and IV

Ann R. Stark, MD, FAAP, DeWayne M. Pursley, MD, MPH, FAAP, Lu-Ann Papile, MD, FAAP, Eric C. Eichenwald, MD, FAAP, Charles T. Hankins, MD, MBA, FAAP, Rosanne K. Buck, RN, MS, NNP-BC, C-ONQS, Tamara J. Wallace, DNP, APRN, NNP-BC, Patricia G. Bondurant, DNP, RN, Nicole E. Faster, MSN, RN, RNC-NIC

OVERVIEW

Establishment of risk-appropriate care was first proposed in 1976 when leaders in perinatal health proposed a model system of regionalized care for obstetrical and neonatal patients, including definitions of graded levels of hospital care.[1] Risk-appropriate care, in which infants with mild to complex critical illness or physiologic immaturity are cared for in a facility with the personnel and resources appropriate for their needs and condition, results in improved outcomes. This concept is supported by the American Academy of Pediatrics (AAP) policy statement "Levels of Neonatal Care," which provides a review of data supporting a tiered provision of neonatal care and reaffirms the need for nationally consistent standards of care to improve neonatal outcomes.[2]

The work of the AAP NICU Verification Program began in 2013 when the state of Texas mandated that all Texas facilities caring for newborns required a neonatal level of care designation to receive Medicaid payment for neonatal services and announced a plan to engage survey agencies to verify levels of neonatal care. The AAP was identified as 1 of 2 Texas-approved survey agencies to pilot the verification survey process in 2016, and the NICU Verification Program was officially launched. Since 2016, the NICU Verification Program has provided third-party surveys by experienced and credentialed neonatologists, neonatal nurses, and pediatric surgeons to assess compliance with state-specific risk-appropriate neonatal care standards.

Since then, discussions were initiated with the Georgia Department of Public Health in 2019 to provide NICU verification surveys in Georgia. Additionally, the AAP NICU Verification Program is named as the approved neonatal survey agency for neonatal care services in Missouri's code of state regulations for neonatal care designation. The AAP continues to be approached by additional states and

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

To cite: Stark AR, Pursley DWM, Papile LA, et al. Standards for Levels of Neonatal Care: II, III, and IV. *Pediatrics*. 2023;151(6):e2023061957

independent facilities for verification services outside Texas, Georgia, and Missouri.

Although all states regulate health care facilities, specifications for levels of neonatal care and adherence to requirements vary widely.[3,4] Data indicate that facilities often assess themselves at a higher level than an independent observer, yet only a few states require verification by a third-party surveying agency or health department official. Recognizing that a national neonatal verification program is vital to high-quality and equitable care, the AAP NICU Verification Program has developed the "Standards for Levels of Neonatal Care: II, III, and IV," which have the potential to improve the quality and consistency of risk-appropriate neonatal care and is critical to the future growth of the AAP NICU Verification Program.

The AAP Standards for Levels of Neonatal Care are considered a complementary implementation tool as they are based on existing AAP policy; evidence-based literature; standards of professional practice from national neonatal, perinatal, and surgical organizations; published data; and, when no data existed, expert opinion. Developed by the AAP NICU Verification Program Leadership Team with the support of AAP staff, the Standards codify the minimum components of care expected for each level of neonatal care from Special Care Nursery (Level II), to complex subspecialty care including surgery (Level IV NICU). The NICU Verification Program also convened a virtual stakeholder meeting in September 2020, which included national leaders in neonatal intensive care, neurodevelopmental follow-up care, pediatric surgery, and quality and patient safety. The Section on Neonatal-Perinatal Medicine (SONPM) Clinical Leaders Group (CLG) and Follow-up Group provided additional input to the Standards, and published standards from nursing, pediatric surgery, and therapist organizations have been integrated as well.

The lack of standardized or state-specific risk-appropriate neonatal care policies is a barrier to the delivery of regulated and high-quality neonatal care. By establishing and implementing risk-appropriate neonatal care standards, the NICU Verification Program believes that the AAP will improve neonatal outcomes by ensuring that every infant receives care in a facility with the personnel and resources appropriate for the newborn's needs and condition. Although the Standards are identified as minimum requirements for each level of neonatal care, the AAP NICU Verification Program encourages facilities to go beyond the minimum. The AAP NICU Verification Program upholds the AAP Equity Agenda and is committed to supporting efforts to improve health outcomes by encouraging facilities to further assess the health disparities of their patients, families, and community. The AAP values equity, diversity, and inclusivity and recognizes that family-centered care is essential for best outcomes and encourages facilities to amplify their focus on family members and staff to elevate the quality of neonatal care and improve the health outcomes of the nation's most vulnerable population.[3,4]

The AAP "Standards for Levels of Neonatal Care II, III, and IV" (the "Standards") were developed through the cooperative efforts of the AAP NICU Verification Program Leadership Team and the Committee on Fetus and Newborn (COFN), the SONPM, and the SONPM CLG. The Standards delineate the components of care expected for each level of neonatal care from Special Care Nursery (Level II), to complex subspecialty care including surgery (Level IV NICU) by setting forth standards for institutional commitment, neonatal programing, personnel, ancillary services, patient and family care resources, and equipment required for each level of neonatal care. Compliance with the Standards will not guarantee that a particular neonatal program is in compliance with applicable state law or other requirements. In addition, the Standards are not designed to be an educational resource for clinicians related to treatment decisions or standards of patient care. Rather, the Standards set forth the minimum components to be included in any neonatal program desiring to be recognized as providing a particular level of neonatal care.

STANDARD I: INSTITUTIONAL COMMITMENT

(a) The facility's organized medical staff and institutional governing body must demonstrate an institutional commitment to the neonatal program and will:
1. include a commitment of the facility's governing body supporting the level-specific provisions of neonatal services as described in the neonatal program description;
2. include allocation of sufficient personnel and resources to attain optimal neonatal care;
3. reaffirm the neonatal program at least every 3 years; and
4. verify the neonatal program description is current at the time of neonatal verification.

STANDARD II: NEONATAL PROGRAM DESCRIPTION

(a) The facility will provide a detailed description of the neonatal services provided that includes a comprehensive explanation of the scope of services available to all neonatal and obstetrical patients that is consistent with accepted professional standards of practice and clinical care; defines the neonatal population served; and supports the health, safety, and optimal care of all patients.
1. The comprehensive description of neonatal services will include, at a minimum:
   i. identification of the resources used to develop the facility's neonatal policies and procedures for the neonatal services it provides;
   ii. description of the review and revision schedule for all neonatal medical practice guidelines, neonatal nursing policies, and ancillary care team policies that does not exceed 3 years;
   iii. written guidelines for consultation, triage, stabilization, and transfer of newborns and/or pregnant or antepartum persons who receive care at the facility;
   iv. provisions to facilitate continuity of care for high-risk neonatal patients from delivery to discharge;
   v. delineation of roles, responsibilities, and authority of the medical, nursing, and ancillary patient care directors;
   vi. physician, advanced practice nurse, and/or other medical care provider staffing plan for neonatal coverage;
   vii. plan for nurse staffing including provisions for flexibility and change in census and acuity;
   viii. completion of an annual educational needs assessment to evaluate the ongoing educational needs of all staff participating in the care of newborns;
   ix. annual educational plan for all staff participating in the care of newborns that includes didactic education, simulation, competency, and skills validation;
   x. appropriate allocations for family-centered care including providing parents with reasonable access to their infants and encouraging advocacy, shared decision-making, and participation in their child's care;
   xi. assurance of equitable care for all neonatal patients and families and provisions for promoting an environment of cultural humility;
   xii. capability of neonatal care team members to have the knowledge and skills to provide lactation support;
   xiii. a process to assess and establish appropriate on-going care for all newborns after discharge;
   xiv. a description of the Neonatal Patient Safety and Quality Improvement Program (NPSQIP); and
   xv. established evacuation policies and procedures to guarantee that obstetrical and neonatal patients receive, or are transferred to, the appropriate level(s) of care.

STANDARD III: NEONATAL PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM (NPSQIP)

NPSQIP Core Components:

(a) The facility will have a system for identification and review of significant events that could indicate threats to patient safety, with a goal of learning from identified events and mitigating future risk of recurrence, including:
   1. a list of specific triggers or safety indicators that warrant a record review, with the goal of identifying significant safety events such as errors, adverse events, near misses, complications, and mortalities;
   2. a process for systematic multidisciplinary review of selected cases or safety events, using acceptable failure mode and effect analysis tools with a goal of identifying interventions to improve systems and reduce future safety risks; and
   3. a process for monitoring the implementation of identified interventions.

(b) The facility will have a dashboard or equivalent that is used to summarize and track quality indicators relevant to newborn care, including:
   1. a list of selected quality measures relevant to the facility with a process for obtaining data needed for each selected neonatal quality measure;
   2. a platform to display performance on the selected quality measures, including a process for updating data with a frequency that allows for appropriate identification of performance concerns;
   3. benchmarking of performance, when possible, with internal or external benchmarks; and
   4. a multidisciplinary forum for review of the dashboard or equivalent.

(c) The facility will have a structured approach to quality improvement (QI) that seeks to improve care quality and outcomes.[5] Quality outcomes include care that is safe, efficient, effective, timely, equitable, and patient centered.[6] Approaches will include:
   1. a clear process for determining current QI initiatives, with a goal that the unit is engaged in at least 1 to 2 such initiatives at any given time;
   2. identification of a multidisciplinary QI team for each initiative, with a designated team lead;
   3. use of structured improvement methods or framework to guide improvement efforts; and
   4. a multidisciplinary quality committee that meets regularly to identify and review QI initiatives.

(d) The facility will maximize efforts to standardize and improve care through the use of guidelines and policies that align with research-driven and evidence-based best practices, including:
   1. a process for identifying topics for guideline or policy development;
   2. a process for developing guidelines and policies that incorporate evidence-based recommendations;
   3. a platform for making guidelines and policies readily available to clinical providers; and
   4. a process for periodic review of guidelines and policies to guarantee they remain updated, and evidence based.

(e) The facility will have multidisciplinary involvement in quality and safety activities, including:
   1. involvement of all disciplines represented in the neonatal quality and safety activities as appropriate and as described above; and
   2. for level IV facilities, involvement of subspecialty services with significant presence in the neonatal unit.

(f) The neonatal-specific unit will coordinate with hospital quality and safety activities, including:
   1. structured collaboration with the obstetrics and pediatric surgery departments, if applicable, to identify and implement opportunities for shared quality and safety efforts;
   2. participation in hospital-level quality and safety activities to confirm alignment of neonatal quality goals with hospital priorities;
   3. alignment with hospital activities and reporting of quality measures to national organizations; and
   4. participation in efforts to guarantee everyday readiness for external assessments by regulatory organizations.

(g) The facility will participate in larger communities of perinatal safety and quality, including:
   1. collaboration between transferring and receiving hospitals to examine and improve population-level quality and safety through structured activities such as transport review and sharing of clinical protocols; and
   2. for level III and IV facilities, participation in regional, state, or national databases that allows benchmarking of performance.

NPSQIP Additional Best Practices:

(h) Encourage and support the integration of family into quality improvement and patient safety initiatives.

(i) Explicit efforts to identify inequities and target equity in quality measures.

(j) A process for random chart audits and peer review.

(k) Neonatal team training for safety and Just Culture.

STANDARD IV: GENERAL PROGRAM REQUIREMENTS

Family-Centered Care Core Components:

(a) The facility will:
   1. allow all parents to have reasonable access to their infants at all times;
   2. have access to the services, personnel, and equipment needed to provide the appropriate level of care for all infants;
   3. support the physiologic, developmental, and psychosocial needs of infants and their families;
   4. have a process to screen every family for social determinants, depression, and cultural needs; and
   5. refer patients and families to appropriate resources as needed.

Family-Centered Care Additional Best Practices:

(b) Implement the utilization of primary nursing.

(c) Involve family in daily and multidisciplinary patient care rounds.

(d) Implement and support a family advisory council.
(e) Establish a process to evaluate potential health disparities of the patient population served.
(f) Implement a coordinated process to assess and address the emotional needs of families.
(g) Engage in shared decision-making by involving family in discharge planning, including transport discussions.
(h) Provider and staff training on shared decision-making and how to engage in difficult and inclusive conversations.
(i) Explicit efforts to support lactation and the needs of breastfeeding[a] individuals.

Lactation and Neonatal Nutrition

(j) The facility will:
1. have personnel with the knowledge and skills to support lactation available at all times;
2. have pumping equipment and secure human milk storage facilities available;
3. have policies and procedures in place to support:
   i. the initiation and maintenance of lactation;
   ii. early initiation of milk expression;
   iii. safety, preparation, storage, and use of human milk and formula;
   iv. long-term pumping and transition to breastfeeding; and
   v. the utilization of donor human milk, if available.
4. provide annual education to all direct care providers on the importance of, and support of lactation (ie, pumping, mixing, safe storage, misappropriation, and proper identification); and
   i. all direct care providers have didactic education, skills verification, and competency on the proper mixing of human milk and formula;
5. establish a program for breastfeeding and lactation support, including data collection.

Neonatal Resuscitation

(i) The facility must have written policies and procedures specific to the resuscitation and stabilization of newborns based on current standards of professional practice.[7]
1. At least 1 person with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7.[7]
2. A full range of neonatal resuscitative equipment, supplies, and medications must be immediately available at all times.[7]
3. If the facility provides obstetrical delivery services:
   i. Each birth will be attended by at least 1 AAP Neonatal Resuscitation Program (NRP) trained provider whose only responsibility is the management of the newborn and initiating resuscitation.[7]
   ii. In the event of identified antepartum and intrapartum risk factors, at least 2 NRP trained providers should be present at birth and be responsible solely for the management and resuscitation of the newborn.[7] Additional qualified providers should be available depending on the anticipated risk, number of newborns, and the obstetrical setting.[7]
   iii. If advanced resuscitation measures are anticipated, a fully qualified neonatal resuscitation team should be present at the time of birth.[7]

Radiology

(j) When obtaining imaging in neonatal and obstetrical patients, radiology services will incorporate the "as low as reasonably achievable" principle.[8]

Policies and Procedures

(k) The facility will have written:
1. neonatal, medical, and ancillary care guidelines, policies, and procedures that are established on evidence-based literature, and best-practice standards, that are monitored and tracked for adherence, reviewed at least every 3 years, and revised as needed;
2. a policy that mandates the escalation of concern and the urgent presence of a privileged care provider at the bedside, including a method to track adherence;
3. policies and procedures that define the criteria for neonatal team presence at a delivery and identify a method to track adherence, if applicable;
4. policies and procedures for the triage, stabilization, and transfer of obstetrical patients to the appropriate level of care, if applicable;
5. policies and procedures for consultation by telehealth and telephone, if applicable;
6. policies and procedures for intrafacility and interfacility neonatal transport;
7. policies and procedures for transfer to a higher level of neonatal care or for services not available at the facility, if applicable;
8. policies and procedures for car seat safety observation before discharge; and
9. policies and procedures for disaster response, including evacuation of obstetrical and neonatal patients to the appropriate level(s) of care.

Staff Privileges

(l) The facility will have:
1. specified requirements for all privileged care providers participating in the care of neonatal patients, and have a credentialing process for delineation of privileges;
2. a process to verify that all ancillary care services, clinical staff, and support staff have relevant neonatal training and expertise; and
3. a mechanism in place for medical, nursing, and ancillary care leadership to review and approve these credentials and track adherence.

[a] The word chestfeeding may be used by nonbinary, transgender, and other parents to identify how they feed their infants. It may refer to human milk or human milk substitute feeding, from a person who lactates or not. Because of this broad and variable definition, chestfeeding and breastfeeding are not always synonymous, and the words are not interchangeable. Published literature findings on breastfeeding may not hold the same outcomes for chestfeeding. Throughout this document, the words breastfeeding and human milk will be used.

STANDARD V: LEVEL II SPECIAL CARE NURSERY (SCN) REQUIREMENTS

Level II SCN Requirements

(a) The Level II SCN will provide comprehensive care of infants born ≥32 wk or with birth wt ≥1500 g who[2]:
1. are mild to moderately ill with physiologic immaturity or who have conditions that are expected to resolve quickly[2];
2. are not anticipated to require subspecialty services on an urgent basis[2];
3. require continuous positive airway pressure (CPAP) or short-term (less than 24 h) conventional mechanical ventilation for a condition expected to resolve rapidly or until transfer to a higher-level facility is achieved[2]; or
4. are back transferred from a higher-level facility for convalescent care.[2]

Neonatal Medical Director

(b) The neonatal medical director (NMD) will:
1. be a board eligible or certified neonatologist or a board-certified pediatrician with sufficient training and expertise to assume responsibility of care for infants who require level II care, including endotracheal intubation, assisted ventilation, and CPAP management, or equivalent[5];
   i. if the neonatologist or pediatrician is certified by The American Board of Pediatrics, they will meet maintenance of certification (MOC) requirements;
2. complete annual continuing medical education (CME) specific to neonatology; and
3. demonstrate a current status of NRP completion.

Neonatologists

(c) If the NMD and/or on-site provider is not a neonatologist, the privileged care provider must maintain a consultative relationship with a board certified or eligible neonatologist at a higher-level neonatal facility; and
1. the facility must have a written policy or guideline that defines the criteria for neonatologist consultation at a higher-level neonatal facility.

Privileged Care Providers

(d) Privileged care providers with pediatric- or neonatal-specific training qualified to manage the care of infants with mild to moderate critical conditions, including emergencies, will[5]:
1. be continuously available on-site, or on-call and available to arrive on-site within an appropriate time frame as defined by the facility's policies and procedures;
   i. if the on-site or on-call provider is not a physician, a written policy will be in place that defines the criteria for notification and time frame for on-site physician presence, and a tracking mechanism for compliance is required;
   ii. if an infant is maintained on a ventilator, a pediatric- or neonatal-specific privileged care provider who can manage respiratory emergencies will be immediately available on-site;
2. demonstrate a current status of NRP completion;
3. complete annual continuing education requirements specific to neonatology; and
4. have credentials reviewed at least every 2 years by the NMD.

(e) At least 1 person with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7[7]; and
1. demonstrate a current status of NRP completion.

(f) The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9]

Nursing Leadership

(g) The level II SCN nurse leader will:
1. be a registered nurse (RN) with experience and training in perinatal nursing and neonatal conditions, with nursing certification preferred[5];
2. have at least a Bachelor of Science in Nursing, Master's preferred;
3. demonstrate a current status of NRP completion;
4. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level II SCN care;
5. be responsible for inpatient activities in the level II SCN and, as appropriate, obstetrical, well newborn, and/or pediatric units;
6. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate;
7. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level II SCN; and
8. foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment focused on the quality of care and patient care outcomes.[5]

Clinical Nurse Staffing

(h) A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9,10]

Clinical Nurse Staff

(i) Each clinical nurse will:
1. be an RN, with nursing certification specific to the care environment preferred;
2. demonstrate a current status of NRP completion;
3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level II SCN; and

4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

(j) If the facility utilizes licensed practical nurses (LPNs) or nonlicensed direct care providers to support the clinical nursing staff, the facility must:
1. have written criteria that define the LPNs' or nonlicensed direct care providers' scope of neonatal care;
2. provide annual education specific to the care of the neonatal population served; and
3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

Nursing Orientation and Education

(k) Level II SCN nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.[9]

(l) The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.

(m) Annual nursing education will address the annual needs assessment and incorporate simulation and skills verification of low-volume, high-risk procedures consistent with the types of care provided in the level II SCN and include education related to serious safety events.

Clinical Nurse Educator

(n) The level II SCN clinical nurse educator or perinatal nurse educator will:
1. be an RN, with nursing certification specific to the care environment preferred;
2. have at least a Bachelor of Science in Nursing, Master's preferred;
3. demonstrate a current status of NRP completion;
4. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes[5]; and
5. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level II neonatal care.[9]

(o) The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the clinical nurse educator.

Neonatal Transport

(p) The facility will have policies and procedures in place to identify a local neonatal transport program to facilitate neonatal transport to a higher-level neonatal facility.

Pediatric Medical Subspecialists and Pediatric Surgical Specialists

(q) Policies and procedures will be in place for referral to a higher level of neonatal care when pediatric medical subspecialty or pediatric surgical specialty consultation and/or intervention is needed.

Laboratory Services

(r) Laboratory services will have:
1. laboratory personnel on-site 24/7;
2. the ability to determine blood type, crossmatch, and perform antibody testing;
3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or cytomegalovirus (CMV)-negative blood;
4. the ability to perform neonatal blood gas monitoring; and
5. the ability to perform analysis on small volume samples.

(s) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to verify timely and direct communication of all critical value results.

Pharmacy

(t) The facility will have at least 1 registered pharmacist with experience in neonatal and/or pediatric pharmacology who will:
1. be available for consultation on-site, or by telehealth or telephone, 24/7;
2. complete continuing education requirements specific to pediatric and neonatal pharmacology; and
3. participate in multidisciplinary care, as needed.

(u) The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level II SCN; and
1. have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.

Diagnostic Imaging

(v) Radiology services will have:
1. appropriately trained radiology personnel continuously available on-site to meet routine diagnostic imaging needs and to address emergencies;
2. personnel appropriately trained in ultrasonography, including cranial ultrasonography, on-call and/or available on-site to perform advanced imaging as requested; and
3. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested.

Respiratory Therapy

(w) The respiratory care leader will:
1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
2. have sufficient time allocated to oversee the respiratory therapists (RTs) who provide care in the level II SCN;
3. provide oversight of annual simulation and skills verification, which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs[9]; and

5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

(x) Respiratory care practitioners assigned to the SCN will:
1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal or pediatric respiratory care certification preferred;
2. be on-site 24/7 and immediately available when an infant is supported by assisted ventilation or CPAP;
3. be able to attend deliveries and assist with resuscitation as requested;
4. demonstrate a current status of NRP completion;
5. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the SCN; and
6. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.

Dietitian

(y) The facility must have, or have the ability to consult with, at least 1 registered dietitian or nutritionist who has specialized training in neonatal nutrition, who will[5]:
1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
2. establish policies and procedures to verify proper preparation and storage of human milk and formula; and
3. have policies and procedures for dietary consultation for patients in the SCN.

Neonatal Nutrition

(z) The facility will:
1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk[5];
2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and
3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

Lactation and Breastfeeding Support

(aa) The facility will:
1. have personnel with the knowledge and skills to support lactation available at all times;
2. have a certified lactation counselor (CLC), international board-certified lactation consultant (IBCLC) preferred, available for on-site consultation on weekdays and accessible by telehealth or telephone 24/7; and
3. operationally review CLC and/or IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.[11]

Neonatal Therapists

(bb) If the facility does not have in-house access to neonatal therapy expertise, the facility will have a formal process in place for providing on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served. The facility will have on-site access to the following as needed[12]:
1. an occupational or physical therapist with neonatal expertise, and neonatal therapy certification preferred[5]; and
2. at least 1 individual skilled in the evaluation and management of neonatal feeding and swallowing concerns, with neonatal therapy certification preferred.[5]

(cc) The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.[12]

Social Worker

(dd) The SCN social worker will:
1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.[5]

(ee) The facility will:
1. provide 1 social worker for every 30 beds providing level II neonatal care and/or specialty and subspecialty perinatal care[5];
2. have a written description that clearly identifies the responsibilities and functions of the SCN social worker; and
3. have social services available for each family with an infant in the SCN as needed.

Pastoral Care

(ff) Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.[5]

Retinopathy of Prematurity

(gg) If the facility back transfers infants for convalescent care, the facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having[13]:
1. documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity[5,13]; and
2. the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity, if needed.[5,13]

Discharge and Follow-up

(hh) Systems will be in place to establish preparation for SCN discharge, including postdischarge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.
   1. The facility will:
      i. have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; and
      ii. have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

STANDARD VI: LEVEL III NICU REQUIREMENTS

Level III NICU Requirements

(a) The Level III neonatal facility will:
   1. provide comprehensive care for infants born at all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, and/or conventional mechanical ventilation[2];
   2. have the ability to provide high-frequency ventilation, inhaled nitric oxide (iNO) delivery, and/or therapeutic hypothermia or have policies and procedures in place to facilitate neonatal transfer to a higher level of care[2];
   3. provide care for infants who are back transferred for convalescent care[2]; and
   4. have sufficient experience based on patient volume and a systematic process to assess the quality of care provided to each very low birth weight infant, including a method to track specific quality indicators including obstetrical and neonatal transfers, review aggregate data using accepted methodology, and develop action plans as needed to improve patient outcomes.[2,14]

Neonatal Medical Director

(b) The NMD will:
   1. be a board eligible or certified neonatologist or equivalent;
      i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine;
   2. complete annual continuing CME specific to neonatology; and
   3. demonstrate a current status of NRP completion.

Neonatologists

(c) The NICU neonatologists will:
   1. be a board eligible or certified neonatologist or equivalent;
      i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine;
   2. complete annual CME specific to neonatology;
   3. demonstrate a current status of NRP completion;
   4. have credentials that are reviewed by the NMD at least every 2 years; and
   5. preferably be on-site and immediately available 24/7 or on-call and available to arrive on-site within an appropriate time frame, as defined by the facility's policies and procedures.
      i. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and time frame for on-site presence, and a tracking mechanism for compliance is required.

Privileged Care Providers

(d) Privileged care providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on-site 24/7 and[5]:
   1. demonstrate a current status of NRP completion;
   2. complete annual continuing education requirements specific to neonatology; and
   3. have their credentials reviewed at least every 2 years by the NMD.

(e) At least 1 person with the skills to perform a complete neonatal resuscitation, including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7[7]; and
   1. demonstrate a current status of NRP completion.

(f) The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9]

Nursing Leadership

(g) The level III NICU nurse leader will:
   1. be an RN with experience and training in neonatal nursing and conditions, with nursing certification preferred[5];
   2. have at least a Bachelor of Science in Nursing, Master's preferred;
   3. demonstrate a current status of NRP completion;
   4. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level III NICU care;
   5. be responsible for inpatient activities in the NICU(s) and, as appropriate, obstetrical, well newborn, and/or pediatric units;
   6. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate;

7. provide oversight of annual neonatal-specific education which includes low-volume, high-risk procedures consistent with the care provided in the level III NICU; and
8. foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes.[5]

Clinical Nurse Staffing

(h) A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9,10]

Clinical Nurse Staff

(i) Each clinical nurse will:
1. be an RN, with nursing certification specific to the care environment preferred;
2. demonstrate a current status of NRP completion;
3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level III NICU; and
4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

(j) If the facility utilizes LPNs or nonlicensed direct care providers to support the clinical nursing staff, the facility must:
1. have written criteria that define the LPNs' or nonlicensed direct care providers' scope of neonatal care;
2. provide annual education specific to the care of the neonatal population served; and
3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

Nursing Orientation and Education

(k) Level III NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.[9]

(l) The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.

(m) Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume, high-risk procedures consistent with the types of care provided in the level III NICU and include education related to serious safety events.

Clinical Nurse Specialist

(n) The clinical nurse specialist will:
1. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred[5];
2. have at least a Bachelor of Science in Nursing, Master's or Doctorate preferred[5];
3. demonstrate a current status of NRP completion[5];
4. foster continuous quality improvement in nursing care[5];
5. develop and educate staff to provide evidence-based nursing care[5];
6. be responsible for mentoring new staff and developing team building skills[5];
7. provide leadership to multidisciplinary teams[5];
8. facilitate case management of high-risk neonatal patients[5]; and
9. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes.[5]

(o) The roles and responsibilities of the NICU clinical nurse specialist can be allocated to multiple individuals to perform this role.

Clinical Nurse Educator

(p) The NICU clinical nurse educator will:
1. be an RN, with nursing certification specific to the care environment preferred;
2. have at least a Bachelor of Science in Nursing, Master's preferred;
3. demonstrate a current status of NRP completion;
4. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes[5]; and
5. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level III neonatal care.[9]

(q) The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

Neonatal Transport

(r) If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services.[5] The director of neonatal transport services can be the neonatal medical director or another physician who is a pediatrician, board eligible or certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport.[5]
1. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.[5]

(s) Responsibilities of the director of neonatal transport services include the following:
1. train and supervise staff[5];
2. provide appropriate review of all transport records[5];

3. develop and implement policies and procedures for patient care during transport[5];
4. develop guidelines for determining transport team composition and medical control and establish a mechanism to track adherence[5];
5. establish policies and procedures to provide transport updates and outreach education[5];
6. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention[5]; and
7. report neonatal transport data and neonatal-specific reviews back to the NPSQIP.
8. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.[5]

(t) The facility will:
1. establish minimum education, experience, and training requirements for all transport team members[15];
2. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide a level of care that is similar to that of the admitting unit[15]; and
3. provide annual transport education to all transport team members that incorporates equipment training, didactic education, simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.[15]

Neonatal Outreach

(u) The level III facility will provide multidisciplinary outreach education to referring facilities by assessing educational needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities, if applicable.[5]

Pediatric Medical Subspecialists

(v) The facility must have the ability to obtain pediatric medical subspecialist advice or formal consultation either on-site or by prearranged consultative agreement using telehealth technology and/or telephone consultation from a distant location from a broad range of pediatric medical subspecialists including, but not limited to[2]:
1. cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism.

(w) If the pediatric medical subspecialist is available for on-site consultation, they will:
1. have credentials to consult at the facility including documented training, certification, competencies, and CME specific to their subspecialty; and
2. document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.

Neonatal Surgical Program — Optional for Level III

Pediatric Surgeons

(x) Pediatric surgeons and pediatric surgical specialists will be available on-site or at another closely related NICU facility.[5]
1. If pediatric surgery is not offered on-site at the facility, policies and procedures will be in place with a facility that provides surgical care to facilitate transfer of an infant when needed.
   i. Infants requiring cardiovascular surgery or extracorporeal membrane oxygenation (ECMO) will be transferred to a facility that provides these services.
2. If pediatric surgery is accessible on-site, the surgeons will:
   i. be available at the bedside within 1 hour of request or identified need[16];
   ii. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty[16];
   iii. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention[16]; and
   iv. report neonatal surgical and anesthesia care back to the NPSQIP.

Anesthesiologists

(y) If pediatric surgery is performed on-site, anesthesia providers with pediatric expertise must[16]:
1. be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need[16];
2. serve as the primary responsible anesthesia provider for all infants $<$24 mo of age and should serve as the primary anesthesiologist for children $\leq$5 y of age based on the American Society of Anesthesiologists (ASA) physical status classification[16]; and
3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.[16]

Laboratory Services

(z) Laboratory services will have:
1. laboratory personnel on-site 24/7;
2. the ability to determine blood type, crossmatch, and perform antibody testing;
3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV-negative blood;
   i. policies and procedures will be in place to facilitate emergent access to blood and blood component therapy so that the NICU can provide hematologic interventions, if applicable;
4. the ability to perform neonatal blood gas monitoring;
5. the ability to perform analysis on small volume samples; and
6. access to perinatal pathology services, if applicable.

(aa) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to maintain timely and direct communication of all critical value results.

Pharmacy

(bb) The facility will have at least 1 registered pharmacist with experience in neonatal and/or pediatric pharmacology who will:
1. be available for consultation on-site, or by telehealth or telephone, 24/7;
2. complete continuing education requirements specific to pediatric and neonatal pharmacology; and

3. participate in multidisciplinary care, including participation in patient care rounds.

(cc) The facility will have neonatal appropriate total parenteral nutrition (TPN) available 24/7, and:

1. the facility will have a written policy and procedure for the proper preparation and delivery of TPN.

(dd) The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level III NICU, and:

1. have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.

Diagnostic Imaging

(ee) Radiology services will have:

1. appropriately trained radiology personnel continuously available on-site to meet routine diagnostic imaging needs and to address emergencies;
2. fluoroscopy available on-call 24/7;
   i. if fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care;
3. personnel appropriately trained in the following techniques will be on-call and/or available on-site to perform advanced imaging as requested:
   i. ultrasonography, including cranial ultrasonography;
   ii. computed tomography (CT); and
   iii. magnetic resonance imaging (MRI); and
4. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested.

(ff) The facility will provide pediatric echocardiography and have the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested.

Respiratory Therapy

(gg) The respiratory care leader will:

1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
2. have sufficient time allocated to oversee the RTs who provide care in the level III NICU;
3. provide oversight of annual simulation and skills verification which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs[9]; and
5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

(hh) Respiratory care practitioners assigned to the NICU will:

1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred;
2. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;
3. demonstrate a current status of NRP completion;
4. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and
5. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.

Dietitian

(ii) At least 1 registered dietitian or nutritionist who has specialized training in neonatal nutrition will have dedicated time allotted to serve the NICU and will[5]:

1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
2. establish policies and procedures to verify proper preparation and storage of human milk and formula;
3. participate in multidisciplinary care, including participation in patient care rounds; and
4. have policies and procedures for dietary consultation for infants in the NICU.

Neonatal Nutrition

(jj) The facility will:

1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk[5];
2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and
3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

Lactation and Breastfeeding Support

(kk) The facility will:

1. have personnel with the knowledge and skills to support lactation available at all times;
2. have an IBCLC available for on-site consultation on weekdays and accessible by telehealth or telephone 24/7; and
3. operationally review IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.[11]

Neonatal Therapists

(ll) The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family and psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served.[12]

(mm) The facility will have on-site access to the following neonatal therapists who have dedicated time allocated to serve the NICU:

1. an occupational and/or physical therapist with neonatal expertise, and neonatal therapy certification preferred[5]; and
2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.[5]
   i. If swallow studies are not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transfer to a higher level of care.

(nn) The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.[12]

Social Worker

(oo) The NICU social worker will:

1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.[5]

(pp) The facility will:

1. provide 1 social worker for every 30 beds providing level III neonatal care and/or specialty and subspecialty perinatal care[5];
2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and
3. have social services available for each family with an infant in the NICU as needed.

Pastoral Care

(qq) Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.[5]

Retinopathy of Prematurity

(rr) The facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having[13]:

1. documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity[5,13]; and
2. the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.[5,13]

Discharge and Follow-up

(ss) Systems will be in place to establish preparation for NICU discharge, including postdischarge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.

1. The facility will:
   i. have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; and
   ii. provide developmental follow-up services or have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

STANDARD VII: LEVEL IV NICU REQUIREMENTS

Level IV NICU Requirements

(a) The level IV neonatal facility will:

1. provide comprehensive care for infants born at all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, conventional and high frequency mechanical ventilation, iNO delivery, and/or therapeutic hypothermia[2];
2. have the capability to provide surgical repair of complex congenital or acquired conditions[2];
3. have the ability to provide ECMO or policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides ECMO[2];
4. maintain a broad range of pediatric medical subspecialists, pediatric surgical specialists, and pediatric anesthesiologists[2];
5. facilitate transport and provide outreach education to lower-level facilities[2]; and
6. have sufficient experience based on patient volume and a systematic process to assess the quality of care provided, including a method to track specific quality indicators and clinical diagnoses, review aggregate data using accepted methodology, and develop action plans as needed to improve patient outcomes.[2,14]

Neonatal Medical Director

(b) The NMD will:

1. be a board-certified neonatologist or equivalent;
   i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine;
2. complete annual CME specific to neonatology; and
3. demonstrate a current status of NRP completion.

Neonatologists

(c) The NICU neonatologists will:

1. be a board eligible or certified neonatologist or equivalent;
   i. if the neonatologist is certified The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine;
2. complete annual CME specific to neonatology;
3. demonstrate a current status of NRP completion;
4. have credentials that are reviewed by the NMD at least every 2 years; and
5. preferably be on-site and immediately available 24/7, or on-call and available to arrive on-site within an appropriate time frame, as defined by the facility's policies and procedures.
   i. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and time frame for on-site presence, and a tracking mechanism for compliance is required.

Privileged Care Providers

(d) Privileged care providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on-site 24/7 and[5]:

1. demonstrate a current status of NRP completion;
2. complete annual continuing education requirements specific to neonatology; and
3. have their credentials reviewed at least every 2 years by the NMD.

(e) At least 1 person with the skills to perform a complete neonatal resuscitation, including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7[7]; and

1. demonstrate a current status of NRP completion.

(f) The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9]

Nursing Leadership

(g) The level IV NICU nurse leader will:

1. be an RN with experience and training in neonatal nursing and conditions, with nursing certification preferred[5];
2. have at least a Bachelor of Science in Nursing, Master's preferred;
3. demonstrate a current status of NRP completion;
4. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level IV NICU care;
5. be responsible for inpatient activities in the NICU(s) and, as appropriate, obstetrical, well newborn, and/or pediatric units;
6. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate;
7. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level IV NICU; and
8. foster collaborative relationships with multidisciplinary team members and facility leadership to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes.[5]

Clinical Nurse Staffing

(h) A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9,10]

Clinical Nurse Staff

(i) Each clinical nurse will:
   1. be an RN, with nursing certification specific to the care environment preferred;
   2. demonstrate a current status of NRP completion;
   3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level IV NICU; and
   4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

(j) If the facility utilizes LPNs or nonlicensed direct care providers to support the clinical nursing staff, the facility must:
   1. have written criteria that define the LPNs' or nonlicensed direct care providers' scope of neonatal care;
   2. provide annual education specific to the care of the neonatal population served; and
   3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

Nursing Orientation and Education

(k) Level IV NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.[9]

(l) The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.

(m) Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume, high-risk procedures consistent with the types of care provided in the level IV NICU and include education related to serious safety events.

Clinical Nurse Specialist

(n) The clinical nurse specialist will:
   1. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred[5];
   2. have at least a Master of Science in Nursing, Doctorate preferred[5];
   3. demonstrate a current status of NRP completion[5];
   4. foster continuous quality improvement in nursing care[5];
   5. develop and educate staff to provide evidence-based nursing care[5];
   6. be responsible for mentoring new staff and developing team building skills[5];
   7. provide leadership to multidisciplinary teams[5];
   8. facilitate case management of high-risk neonatal patients[5]; and
   9. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes.[5]

(o) The facility will have a dedicated full-time equivalent (FTE) allocated to perform the roles and responsibilities of the NICU clinical nurse specialist.

Clinical Nurse Educator

(p) The NICU clinical nurse educator will:
   1. be an RN, with nursing certification specific to the care environment preferred;
   2. have at least a Bachelor of Science in Nursing, Master's preferred;
   3. demonstrate a current status of NRP completion;
   4. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes[5]; and
   5. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level IV neonatal care.[9]

(q) The facility will have at least 1 dedicated FTE allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

Additional Neonatal Support Personnel

(r) The facility will foster collaborative and consultative relationships with additional neonatal support personnel to facilitate comprehensive multidisciplinary care consistent with the types of care provided in the level IV NICU.

Neonatal Transport

(s) If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services.[5] The director of neonatal transport services can be the neonatal medical director or another physician who is a pediatrician, board eligible or certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport.[5]
   1. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.[5]

(t) Responsibilities of the director of neonatal transport services include the following:
   1. train and supervise staff[5];
   2. provide appropriate review of all transport records[5];
   3. develop and implement policies and procedures for patient care during transport[5];
   4. develop guidelines for determining transport team composition and medical control and establish a mechanism to track adherence[5];
   5. establish policies and procedures to provide transport updates and outreach education[5];
   6. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention[5]; and
   7. report neonatal transport data and neonatal-specific reviews back to the NPSQIP.
   8. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.[5]

(u) The facility will:
1. establish minimum education, experience, and training requirements for all transport team members[15];
2. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide a level of care that is similar to that of the admitting unit[15]; and
3. provide annual transport education to all transport team members that incorporates equipment training, didactic education, simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.[15]

Neonatal Outreach

(v) The level IV facility will provide multidisciplinary outreach education to referring facilities by assessing educational needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities.[5]

Pediatric Medical Subspecialists

(w) The facility must have on-site access to a broad range of pediatric medical subspecialties including, but not limited to[2]:
1. cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism; and
2. the pediatric medical subspecialists must:
   i. be readily accessible for in-person consultation;
   ii. have credentials to consult at the facility, including documented training, certification, competencies, and continuing education specific to their subspeciality; and
   iii. document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.

Neonatal Surgical Program – Required for Level IV

Pediatric Surgeons

(x) Pediatric surgeons and pediatric surgical specialists will:
1. be available at the bedside within 1 hour of request or identified need and be capable of performing major pediatric surgery, including surgery for complex conditions[16];
   i. if transplant or cardiac surgery is not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transport to a facility that provides appropriate surgical care;
2. provide consultation to a broad range of pediatric surgical specialists including, but not limited to[5,16]:
   i. general pediatric surgery, neurosurgery, urology, ophthalmology, otolaryngology, orthopedics, and plastic surgery;
3. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty[16];
4. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention[16]; and
5. report neonatal surgical and anesthesia care back to the NPSQIP.

Anesthesiologists

(y) Pediatric anesthesiologists must:
1. be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need[16];
2. serve as the primary responsible anesthesia provider for all infants $<$24 mo of age and should serve as the primary anesthesiologist for children $\leq$5 y of age or based on the ASA physical status classification[16]; and
3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.[16]

Laboratory Services

(z) Laboratory services will have:
1. laboratory personnel on-site 24/7;
2. the ability to determine blood type, crossmatch, and perform antibody testing;
3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV-negative blood;
   i. policies and procedures will be in place to facilitate emergent access to blood and blood component therapy so that the NICU can provide a full range of hematologic interventions;
4. the ability to perform neonatal blood gas monitoring;
5. the ability to perform analysis on small volume samples;
6. the capability to process biopsies and perform autopsies; and
7. access to perinatal pathology services, if applicable.

(aa) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to maintain timely and direct communication of all critical value results.

Pharmacy

(bb) The facility will have at least 1 registered pharmacist with experience in neonatal and/or pediatric pharmacology who will:
1. be available for consultation on-site, or by telehealth or telephone, 24/7;
2. complete continuing education requirements specific to pediatric and neonatal pharmacology; and
3. participate in multidisciplinary care, including participation in patient care rounds.

(cc) The facility will have neonatal appropriate TPN available 24/7; and
1. the facility will have a written policy and procedure for the proper preparation and delivery of TPN.

(dd) The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level IV NICU; and
1. have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.

Diagnostic Imaging

(ee) Radiology services will have:

1. appropriately trained radiology personnel continuously available on-site to meet routine diagnostic imaging needs and to address emergencies;
2. fluoroscopy available on-call 24/7;
3. personnel appropriately trained in the following techniques will be on-call and/or available on-site to perform advanced imaging as requested:
   i. ultrasonography, including cranial ultrasonography;
   ii. CT;
   iii. MRI; and
4. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested.

(ff) The facility will provide pediatric echocardiography and have the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested.

Respiratory Therapy

(gg) The respiratory care leader will:

1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
2. have sufficient time allocated to oversee the RTs who provide care in the level IV NICU;
3. provide oversight of annual simulation and skills verification, including neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs[9]; and
5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

(hh) Respiratory care practitioners assigned to the NICU will:

1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred;
2. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries, if applicable;
3. demonstrate a current status of NRP completion;
4. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and
5. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.

Dietitian

(ii) The NICU will have at least 1 full-time NICU-dedicated registered dietitian or nutritionist available on-site who has specialized training in neonatal nutrition and will[5]:

1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
2. establish policies and procedures to verify proper preparation and storage of human milk and formula;
3. participate in multidisciplinary care, including participation in patient care rounds; and
4. have policies and procedures for dietary consultation for infants in the NICU.

Neonatal Nutrition

(jj) The facility will:

1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk[5];
2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and
3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

Lactation and Breastfeeding Support

(kk) The facility will:

1. have personnel with the knowledge and skills to support lactation available at all times;
2. have an IBCLC available for on-site consultation on weekdays and accessible by telehealth or telephone 24/7; and
3. operationally review IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.[11]

Neonatal Therapists

(ll) The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served.[12]

(mm) The facility will have on-site access to the following neonatal therapists who have dedicated time allocated to serve the NICU:

1. an occupational and/or physical therapist with sufficient neonatal expertise, and neonatal therapy certification preferred[5]; and
2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.[5]

(nn) The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.[12]

Child Life Services

(oo) Child life services, or the equivalent, will be available for on-site consultation to support patient- and family-centered care by establishing and maintaining therapeutic relationships between patients, family members, multidisciplinary team members, and community resources.

Social Worker

(pp) The NICU social worker will:

1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.[5]

(qq) The facility will:

1. provide at least 1 social worker for every 30 beds providing level IV neonatal care and/or specialty and subspecialty perinatal care, if applicable[5];
2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and
3. have social services available for each family with an infant in the NICU as needed.

Pastoral Care

(rr) Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.[5]

Retinopathy of Prematurity

(ss) The facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having[13]:

1. documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity[5,13]; and
2. the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.[5,13]

Discharge and Follow-up

(tt) Systems will be in place to establish preparation for NICU discharge including postdischarge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.

1. The facility will:
   i. have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; and
   ii. provide developmental follow-up services or have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

APPENDIX: NEONATAL LEVELS OF CARE COMPARISON: LEVEL (II, III, AND IV) REQUIREMENTS

Level II	Level III	Level IV
Level of Neonatal Care Requirements		
(a) The Level II SCN will provide comprehensive care of infants born ≥32 wk or with birth wt ≥1500 g who[2]: 1. are mild to moderately ill with physiologic immaturity or who have conditions that are expected to resolve quickly[2]; 2. are not anticipated to require subspecialty services on an urgent basis[2]; 3. require CPAP or short term (less than 24 h) conventional mechanical ventilation for a condition expected to resolve rapidly or until transfer to a higher-level facility is achieved[2]; or 4. are back transferred from a higher-level facility for convalescent care.[2]	(a) The Level III neonatal facility will: 1. provide comprehensive care for infants born at all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, and/or conventional mechanical ventilation[2]; 2. have the ability to provide high-frequency ventilation, iNO delivery, and/or therapeutic hypothermia or have policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides these services[2]; 3. provide care for infants who are back transferred for convalescent care[2]; and 4. have sufficient experience based on patient volume and a systematic process to assess the quality of care provided to each very low birth weight infant, including a method to track specific quality indicators including obstetrical and neonatal transfers, review aggregate data using accepted methodology, and develop	(a) The Level IV neonatal facility will: 1. provide comprehensive care for infants born at all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, conventional and high frequency mechanical ventilation, iNO delivery, and/or therapeutic hypothermia[2]; 2. have the capability to provide surgical repair of complex congenital or acquired conditions[2]; 3. have the ability to provide ECMO or have policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides ECMO[2]; 4. maintain a broad range of pediatric medical subspecialists, pediatric surgical specialists, and pediatric anesthesiologists[2]; 5. facilitate transport and provide outreach education to lower-level facilities[2]; and 6. have sufficient experience based on patient volume and a systematic process to assess the quality of care provided, including a method

Continued

Level II	Level III	Level IV
	action plans as needed to improve patient outcomes.[2,14]	to track specific quality indicators and clinical diagnoses, review aggregate data using accepted methodology, and develop action plans as needed to improve patient outcomes.[2,14]
Neonatal Medical Director		
(b) The NMD will: 1. be a physician who is a board-eligible or -certified neonatologist or a board-certified pediatrician with sufficient training and expertise to assume responsibility of care for infants who require level II care, including endotracheal intubation, assisted ventilation, and CPAP management, or equivalent[5]; i. if the neonatologist or pediatrician is certified by The American Board of Pediatrics, they will meet MOC requirements; 2. complete annual CME specific to neonatology; and 3. demonstrate a current status of NRP completion.	(b) The NMD will: 1. be a board-eligible or -certified neonatologist or equivalent; i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine; 2. complete annual CME specific to neonatology; and 3. demonstrate a current status of NRP completion.	(b) The NMD will: 1. be a board-certified neonatologist or equivalent; i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine; 2. complete annual CME specific to neonatology; and 3. demonstrate a current status of NRP completion.
Neonatologists		
(c) If the NMD and/or on-site provider is not a neonatologist, the privileged care provider must maintain a consultative relationship with a board-certified or -eligible neonatologist at a higher-level neonatal facility; and 1. the facility must have a written policy or guideline that defines the criteria for neonatologist consultation at a higher-level neonatal facility.	(c) The NICU neonatologists will: 1. be a board-eligible or -certified neonatologist or equivalent; i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine; 2. complete annual CME specific to neonatology; 3. demonstrate a current status of NRP completion; 4. have credentials that are reviewed by the NMD at least every 2 years; and 5. preferably be on-site and immediately available 24/7, or on-call and available to arrive on-site within an appropriate time frame, as defined by the facility's policies and procedures. i. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and time frame for on-site presence, and a tracking mechanism for compliance is required.	(c) The NICU neonatologists will: 1. be a board-eligible or -certified neonatologist or equivalent; i. if the neonatologist is certified by The American Board of Pediatrics, they will meet MOC requirements in neonatal-perinatal medicine; 2. complete annual CME specific to neonatology; 3. demonstrate a current status of NRP completion; 4. have credentials that are reviewed by the NMD at least every 2 years; and 5. preferably be on-site and immediately available 24/7, or on-call and available to arrive on-site within an appropriate time frame as defined by the facility's policies and procedures. i. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and time frame for on-site presence, and a tracking mechanism for compliance is required.
Privileged Care Providers		
(d) Privileged care providers with pediatric- or neonatal-specific training qualified to manage the care of infants with mild to moderate critical conditions, including emergencies will[5]: 1. be continuously available on-site, or on-call and available to arrive on-site within an appropriate time frame, as defined by the facility's policies and procedures; i. if the on-site or on-call provider is not a physician, a written policy will be in	(d) Privileged care providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on-site 24/7 and[5]: 1. demonstrate a current status of NRP completion; 2. complete annual continuing education requirements specific to neonatology; and 3. have their credentials reviewed at least every 2 years by the NMD.	(d) Privileged care providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on-site 24/7 and[5]: 1. demonstrate a current status of NRP completion; 2. complete annual continuing education requirements specific to neonatology; and 3. have their credentials reviewed at least every 2 years by the NMD.

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Level II	Level III	Level IV
place that defines the criteria for notification and time frame for on-site physician presence, and a tracking mechanism for compliance is required; ii. if an infant is maintained on a ventilator, a pediatric- or neonatal-specific privileged care provider who can manage respiratory emergencies will be immediately available on-site; 2. demonstrate a current status of NRP completion; 3. complete annual continuing education requirements specific to neonatology; and 4. have their credentials reviewed at least every 2 years by the NMD. (e) At least 1 person with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7[7]; and 1. demonstrate a current status of NRP completion. (f) The facility will establish a written policy for backup medical care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent privileged care providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9]	(e) At least 1 person with the skills to perform a complete neonatal resuscitation, including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately on-site 24/7[7]; and 1. demonstrate a current status of NRP completion. (f) The facility will establish a written policy for backup medical care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent privileged care providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9]	(e) At least 1 person with the skills to perform a complete neonatal resuscitation, including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7[7]; and 1. demonstrate a current status of NRP completion. (f) The facility will establish a written policy for backup medical care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent privileged care providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9]
Nursing Leadership		
(g) The level II SCN nurse leader will: 1. be an RN with experience and training in perinatal nursing and neonatal conditions, with nursing certification preferred[5]; 2. have at least a Bachelor of Science in Nursing, Master's preferred; 3. demonstrate a current status of NRP completion; 4. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level II SCN care; 5. be responsible for inpatient activities in the level II SCN and, as appropriate, obstetrical, well newborn, and/or pediatric units; 6. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate; 7. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level II SCN; and	(g) The level III NICU nurse leader will: 1. be an RN with experience and training in neonatal nursing and conditions, with nursing certification preferred[5]; 2. have at least a Bachelor of Science in Nursing, Master's preferred; 3. demonstrate a current status of NRP completion; 4. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level III NICU care; 5. be responsible for inpatient activities in the NICU(s) and, as appropriate, obstetrical, well newborn, and/or pediatric units; 6. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate; 7. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level III NICU; and	(g) The level IV NICU nurse leader will: 1. be an RN with experience and training in neonatal nursing and conditions, with nursing certification preferred[5]; 2. have at least a Bachelor of Science in Nursing, Master's preferred; 3. demonstrate a current status of NRP completion; 4. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level IV NICU care; 5. be responsible for inpatient activities in the NICU(s) and, as appropriate, obstetrical, well newborn, and/or pediatric units; 6. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate; 7. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level IV NICU; and

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Level II	Level III	Level IV
8. foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment focused on the quality of care and patient care outcomes.[5]	8. foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes.[5]	8. foster collaborative relationships with multidisciplinary team members and facility leadership to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes.[5]
Clinical Nurse Staffing		
(h) A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9,10]	(h) A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9,10]	(h) A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.[9,10]
Clinical Nurse Staff		
(i) Each clinical nurse will: 1. be an RN, with nursing certification specific to the care environment preferred; 2. demonstrate a current status of NRP completion; 3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level II SCN; and 4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.	(i) Each clinical nurse will: 1. be an RN, with nursing certification specific to the care environment preferred; 2. demonstrate a current status of NRP completion; 3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level III NICU; and 4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.	(i) Each clinical nurse will: 1. be an RN, with nursing certification specific to the care environment preferred; 2. demonstrate a current status of NRP completion; 3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level IV NICU; and 4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.
(j) If the facility utilizes LPNs or nonlicensed direct care providers to support the clinical nursing staff, the facility must: 1. have written criteria that define the LPNs' or nonlicensed direct care providers' scope of neonatal care; 2. provide annual education specific to the care of the neonatal population served; and 3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.	(j) If the facility utilizes LPNs or nonlicensed direct care providers to support the clinical nursing staff, the facility must: 1. have written criteria that define the LPNs' or nonlicensed direct care providers' scope of neonatal care; 2. provide annual education specific to the care of the neonatal population served; and 3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.	(j) If the facility utilizes LPNs or nonlicensed direct care providers to support the clinical nursing staff, the facility must: 1. have written criteria that define the LPNs' or nonlicensed direct care providers' scope of neonatal care; 2. provide annual education specific to the care of the neonatal population served; and 3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.
Nursing Orientation and Education		
(k) Level II SCN nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.[9]	(k) Level III NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.[9]	(k) Level IV NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.[9]
(l) The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.	(l) The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.	(l) The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.
(m) Annual nursing education will address the annual needs assessment and incorporate simulation and skills verification of low-	(m) Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume,	(m) Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume,

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Level II	Level III	Level IV
volume, high-risk procedures consistent with the types of care provided in the level II SCN and include education related to serious safety events.	high-risk procedures consistent with the types of care provided in the level III NICU and include education related to serious safety events.	high-risk procedures consistent with the types of care provided in the level IV NICU and include education related to serious safety events.
Clinical Nurse Specialist		
	(n) The clinical nurse specialist will: 1. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred[5]; 2. have at least a Bachelor of Science in Nursing; Master's or Doctorate preferred[5]; 3. demonstrate a current status of NRP completion[5]; 4. foster continuous quality improvement in nursing care[5]; 5. develop and educate staff to provide evidence-based nursing care[5]; 6. be responsible for mentoring new staff and developing team building skills[5]; 7. provide leadership to multidisciplinary teams[5]; 8. facilitate case management of high-risk neonatal patients[5]; and 9. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes.[5] (o) The roles and responsibilities of the NICU clinical nurse specialist can be allocated to multiple individuals to perform this role.	(n) The clinical nurse specialist will: 1. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred[5]; 2. have at least a Master of Science in Nursing; Doctorate preferred[5]; 3. demonstrate a current status of NRP completion[5]; 4. foster continuous quality improvement in nursing care[5]; 5. develop and educate staff to provide evidence-based nursing care[5]; 6. be responsible for mentoring new staff and developing team building skills[5]; 7. provide leadership to multidisciplinary teams[5]; 8. facilitate case management of high-risk neonatal patients[5]; and 9. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes.[5] (o) The facility will have a dedicated FTE allocated to perform the roles and responsibilities of the NICU clinical nurse specialist.
Clinical Nurse Educator		
(n) The level II SCN clinical nurse educator or perinatal nurse educator will: 1. be an RN, with nursing certification specific to the care environment preferred; 2. have at least a Bachelor of Science in Nursing; Master's preferred; 3. demonstrate a current status of NRP completion; 4. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes[5]; and 5. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level II neonatal care.[9] (o) The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the clinical nurse educator.	(p) The NICU clinical nurse educator will: 1. be an RN, with nursing certification specific to the care environment preferred; 2. have at least a Bachelor of Science in Nursing; Master's preferred; 3. demonstrate a current status of NRP completion; 4. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes[5]; and 5. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level III neonatal care.[9] (q) The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the NICU clinical nurse educator.	(p) The NICU clinical nurse educator will: 1. be an RN, with nursing certification specific to the care environment preferred; 2. have at least a Bachelor of Science in Nursing; Master's preferred; 3. demonstrate a current status of NRP completion; 4. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes[5]; and 5. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level IV neonatal care.[9] (q) The facility will have at least 1 dedicated FTE allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

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Level II	Level III	Level IV
Additional Neonatal Support Personnel		
		(r) The facility will foster collaborative and consultative relationships with additional neonatal support personnel to facilitate comprehensive multidisciplinary care consistent with the types of care provided in the level IV NICU.
Neonatal Transport		
(p) The facility will have policies and procedures in place to identify a local neonatal transport program to facilitate neonatal transport to a higher-level neonatal facility.	(r) If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services.[5] The director of neonatal transport services can be the neonatal medical director or another physician who is a pediatrician, board-eligible or -certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport.[5] 1. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.[5] (s) Responsibilities of the director of neonatal transport services include the following: 1. train and supervise staff[5]; 2. provide appropriate review of all transport records[5]; 3. develop and implement policies and procedures for patient care during transport[5]; 4. develop guidelines for determining transport team composition and medical control, and establish a mechanism to track adherence[5]; 5. establish policies and procedures to provide transport updates and outreach education[5]; 6. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention[5]; and 7. report neonatal transport data and neonatal-specific reviews back to the NPSQIP. 8. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.[5] (t) The facility will: 1. establish minimum education, experience, and training requirements for all transport team members[15]; 2. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide	(s) If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services.[5] The director of neonatal transport services can be the neonatal medical director or another physician who is a pediatrician, board-eligible or -certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport.[5] 1. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.[5] (t) Responsibilities of the director of neonatal transport services include the following: 1. train and supervise staff[5]; 2. provide appropriate review of all transport records[5]; 3. develop and implement policies and procedures for patient care during transport[5]; 4. develop guidelines for determining transport team composition and medical control, and establish a mechanism to track adherence[5]; 5. establish policies and procedures to provide transport updates and outreach education[5]; 6. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention[5]; and 7. report neonatal transport data and neonatal-specific reviews back to the NPSQIP. 8. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.[5] (u) The facility will: 1. establish minimum education, experience, and training requirements for all transport team members[15]; 2. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide a level of care that is similar to that of the admitting unit[15]; and 3. provide annual transport education to all transport team members, which incorporates equipment training, didactic education,

Continued

Level II	Level III	Level IV
	a level of care that is similar to that of the admitting unit[15]; and 3. provide annual transport education to all transport team members, which incorporates equipment training, didactic education, simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.[15]	simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.[15]
Neonatal Outreach		
	(u) The level III facility will provide multidisciplinary outreach education to referring facilities by assessing education needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities, if applicable.[5]	(v) The level IV facility will provide multidisciplinary outreach education to referring facilities by assessing education needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities.[5]
Pediatric Medical Subspecialists		
(q) Policies and procedures will be in place for referral to a higher level of neonatal care when pediatric medical subspecialty or pediatric surgical specialty consultation and/or intervention is needed.	(v) The facility must have the ability to obtain pediatric medical subspecialist advice or formal consultation either on-site or by prearranged consultative agreement using telehealth technology and/or telephone consultation from a distant location, from a broad range of pediatric medical subspecialists including, but not limited to[2]: 1. cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism. (w) If the pediatric medical subspecialist is available for on-site consultation, they will: 1. have credentials to consult at the facility which includes documented training, certification, competencies, and continuing education specific to their subspecialty; and 2. document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.	(w) The facility must have on-site access to a broad range of pediatric medical subspecialties including, but not limited to[2]: 1. cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism; and 2. the pediatric medical subspecialists must: i. be readily accessible for in-person consultation; ii. have credentials to consult at the facility, including documented training, certification, competencies, and continuing education specific to their subspeciality; and iii. document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.
Neonatal Surgical Program		
Pediatric Surgeons		
(Optional for level III, but required for level IV)	(x) Pediatric surgeons and pediatric surgical specialists will be available on-site or at another closely related NICU facility.[5] 1. If pediatric surgery is not offered on-site at the facility, policies and procedures will be in place with a facility that provides surgical care to facilitate transfer of an infant when needed. i. Infants requiring cardiovascular surgery or ECMO will be transferred to a facility that provides these services. 2. If pediatric surgery is accessible on-site, the surgeons will:	(x) Pediatric surgeons and pediatric surgical specialists will: 1. be available at the bedside within 1 hour of request or identified need and be capable of performing major pediatric surgery, including surgery for complex conditions[16]; i. if transplant or cardiac surgery is not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transport to a facility that provides appropriate surgical care; 2. provide consultation to a broad range of pediatric surgical specialists including, but not limited to[5,16]:

Continued

Level II	Level III	Level IV
	i. be available at the bedside within 1 hour of request or identified need[16]; ii. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty[16]; iii. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention[16]; and iv. report neonatal surgical and anesthesia care back to the NPSQIP.	i. general pediatric surgery, neurosurgery, urology, ophthalmology, otolaryngology, orthopedics, and plastic surgery; 3. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty[16]; 4. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention[16]; and 5. report neonatal surgical and anesthesia care back to the NPSQIP.
Anesthesiologists		
	(y) If pediatric surgery is performed on-site, anesthesia providers with pediatric expertise must[16]: 1. be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need[16]; 2. serve as the primary responsible anesthesia provider for all infants <24 mo of age and should serve as the primary anesthesiologist for children ≤5 y of age based on the ASA physical status classification[16]; and 3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.[16]	(y) Pediatric anesthesiologists must: 1. be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need[16]; 2. serve as the primary responsible anesthesia provider for all infants <24 mo of age and should serve as the primary anesthesiologist for children ≤5 y of age or based on the ASA physical status classification[16]; and 3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.[16]
Laboratory Services		
(r) Laboratory services will have: 1. laboratory personnel on-site 24/7; 2. the ability to determine blood type, crossmatch, and perform antibody testing; 3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV-negative blood; 4. the ability to perform neonatal blood gas monitoring; and 5. the ability to perform analysis on small volume samples. (s) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to verify timely and direct communication of all critical value results.	(z) Laboratory services will have: 1. laboratory personnel on-site 24/7; 2. the ability to determine blood type, crossmatch, and perform antibody testing; 3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV-negative blood; i. policies and procedures will be in place to facilitate emergent access to blood and blood component therapy so that the NICU can provide hematologic interventions, if applicable; 4. the ability to perform neonatal blood gas monitoring; 5. the ability to perform analysis on small volume samples; and 6. access to perinatal pathology services, if applicable. (aa) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to maintain timely and direct communication of all critical value results.	(z) Laboratory Services will have: 1. laboratory personnel on-site 24/7; 2. the ability to determine blood type, crossmatch, and perform antibody testing; 3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV negative blood; i. policies and procedures will be in place to facilitate emergent access to blood and blood component therapy so that the NICU can provide a full range of hematologic interventions; 4. the ability to perform neonatal blood gas monitoring; 5. the ability to perform analysis on small volume samples; 6. the capability to process biopsies and perform autopsies; and 7. access to perinatal pathology services, if applicable. (aa) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in

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Level II	Level III	Level IV
		place to maintain timely and direct communication of all critical value results.
Pharmacy		
(t) The facility will have at least 1 registered pharmacist with experience in neonatal and/or pediatric pharmacology who will: 1. be available for consultation on-site, or by telehealth or telephone, 24/7; 2. complete continuing education requirements specific to pediatric and neonatal pharmacology; and 3. participate in multidisciplinary care, as needed. (u) The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level II SCN; and 1. have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.	(bb) The facility will have at least 1 registered pharmacist with experience in neonatal and/or pediatric pharmacology who will: 1. be available for consultation on-site, or by telehealth or telephone, 24/7; 2. complete continuing education requirements specific to pediatric and neonatal pharmacology; and 3. participate in multidisciplinary care, including participation in patient care rounds. (cc) The facility will have neonatal appropriate TPN available 24/7; and 1. the facility will have a written policy and procedure for the proper preparation and delivery of TPN. (dd) The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level III NICU; and 1. have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.	(bb) The facility will have at least 1 registered pharmacist with experience in neonatal and/or pediatric pharmacology who will: 1. be available for consultation on-site, or by telehealth or telephone, 24/7; 2. complete continuing education requirements specific to pediatric and neonatal pharmacology; and 3. participate in multidisciplinary care, including participation in patient care rounds. (cc) The facility will have neonatal appropriate TPN available 24/7; and 1. the facility will have a written policy and procedure for the proper preparation and delivery of TPN. (dd) The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level IV NICU; and 1. have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.
Diagnostic Imaging		
(v) Radiology services will have: 1. appropriately trained radiology personable available on-site to meet routine diagnostic imaging needs and to address emergencies; 2. personnel appropriately trained in ultrasonography, including cranial ultrasonography, will be on-call and/or available on-site to perform advanced imaging as requested; and 3. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested.	(ee) Radiology services will have: 1. appropriately trained radiology personnel available on-site to meet routine diagnostic imaging needs and to address emergencies; 2. fluoroscopy available on-call 24/7; i. if fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care; 3. personnel appropriately trained in the following techniques will be on-call and/or available on-site to perform advanced imaging as requested: i. ultrasonography, including cranial ultrasonography; ii. CT; iii. MRI; and 4. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested. (ff) The facility will provide pediatric echocardiography and have the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested.	(ee) Radiology services will have: 1. appropriately trained radiology personnel available on-site to meet routine diagnostic imaging needs and to address emergencies; 2. fluoroscopy available on-call 24/7; 3. personnel appropriately trained in the following techniques will be on-call and/or available on-site to perform advanced imaging as requested: i. ultrasonography, including cranial ultrasonography; ii. CT; iii. MRI; and 4. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested. (ff) The facility will provide pediatric echocardiography and have the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested.
Respiratory Therapy		
(w) The respiratory care leader will: 1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred; 2. have sufficient time allocated to oversee	(gg) The respiratory care leader will: 1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred; 2. have sufficient time allocated to oversee the	(gg) The respiratory care leader will: 1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred; 2. have sufficient time allocated to oversee the

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Level II	Level III	Level IV
the RTs who provide care in the level II SCN; 3. provide oversight of annual simulation and skills verification, which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures; 4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs[9]; and 5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.	RTs who provide care in the level III NICU; 3. provide oversight of annual simulation and skills verification, which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures; 4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs[9]; and 5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.	RTs who provide care in the level IV NICU; 3. provide oversight of annual simulation and skills verification, which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures; 4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs[9]; and 5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.
(x) Respiratory care practitioners assigned to the SCN will: 1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred; 2. be on-site 24/7 and immediately available when an infant is supported by assisted ventilation or CPAP; 3. be able to attend deliveries and assist with resuscitation as requested; 4. demonstrate a current status of NRP completion; 5. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the SCN; and 6. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.	(hh) Respiratory care practitioners assigned to the NICU will: 1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred; 2. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries; 3. demonstrate a current status of NRP completion; 4. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and 5. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.	(hh) Respiratory care practitioners assigned to the NICU will: 1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred; 2. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries, if applicable; 3. demonstrate a current status of NRP completion; 4. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and 5. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.
Dietitian		
(y) The facility must have, or have the ability to consult with, at least 1 registered dietitian or nutritionist who has specialized training in neonatal nutrition, who will[5]: 1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge; 2. establish policies and procedures to verify proper preparation and storage of human milk and formula; and 3. have policies and procedures for dietary consultation for infants in the SCN.	(ii) At least 1 registered dietitian or nutritionist who has specialized training in neonatal nutrition will have dedicated time allotted to serve the NICU and will[5]: 1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge; 2. establish policies and procedures to verify proper preparation and storage of human milk and formula; 3. participate in multidisciplinary care, including participation in patient care rounds; and	(ii) The NICU will have at least 1 full-time NICU-dedicated registered dietitian or nutritionist available on-site who has specialized training in neonatal nutrition and will[5]: 1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge; 2. establish policies and procedures to verify proper preparation and storage of human milk and formula; 3. participate in multidisciplinary care, including participation in patient care rounds; and 4. have policies and procedures for dietary consultation for infants in the NICU.

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Level II	Level III	Level IV
	4. have policies and procedures for dietary consultation for infants in the NICU.	
Neonatal Nutrition		
(z) The facility will: 1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk[5]; 2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for, human milk, donor human milk, fortification of human milk, and formula; and 3. have policies and procedures in place for accurate verification and administration of human milk and formula and to avoid misappropriation.	(jj) The facility will: 1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk[5]; 2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for, human milk, donor human milk, fortification of human milk, and formula; and 3. have policies and procedures in place for accurate verification and administration of human milk and formula and to avoid misappropriation.	(jj) The facility will: 1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk[5]; 2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for, human milk, donor human milk, fortification of human milk, and formula; and 3. have policies and procedures in place for accurate verification and administration of human milk and formula and to avoid misappropriation.
Lactation and Breastfeeding Support		
(aa) The facility will: 1. have personnel with the knowledge and skills to support lactation available at all times; 2. have a CLC, IBCLC preferred, available for on-site consultation on weekdays and accessible by telehealth or telephone 24/7; and 3. operationally review CLC and/or IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.[11]	(kk) The facility will: 1. have personnel with the knowledge and skills to support lactation available at all times; 2. have an IBCLC available for on-site consultation on weekdays, and accessible by telehealth or telephone 24/7; and 3. operationally review IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.[11]	(kk) The facility will: 1. have personnel with the knowledge and skills to support lactation available at all times; 2. have an IBCLC available for on-site consultation on weekdays, and accessible by telehealth or telephone 24/7; and 3. operationally review IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.[11]
Neonatal Therapists		
(bb) If the facility does not have in-house access to neonatal therapy expertise, the facility will have a formal process in place for providing on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served. The facility will have on-site access to the following as needed[12]: 1. an occupational or physical therapist with neonatal expertise, and neonatal therapy certification preferred[5]; and 2. at least 1 individual skilled in the evaluation and management of neonatal feeding and swallowing concerns, with neonatal therapy certification preferred.[5] (cc) The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.[12]	(ll) The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served.[12] (mm) The facility will have on-site access to the following neonatal therapists who have dedicated time allocated to serve the NICU: 1. an occupational and/or physical therapist with sufficient neonatal expertise, and neonatal therapy certification preferred[5]; and 2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.[5] i. If swallow studies are not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transfer to a higher level of care. (nn) The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal	(ll) The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served.[12] (mm) The facility will have on-site access to the following neonatal therapists who have dedicated time allocated to serve the NICU: 1. an occupational and/or physical therapist with sufficient neonatal expertise, and neonatal therapy certification preferred[5]; and 2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.[5] (nn) The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.[12]

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Level II	Level III	Level IV
	therapist coverage based on the specific need and volume of the neonatal population served.[12]	
Child Life Services		
		(oo) Child life services, or equivalent, will be available for on-site consultation to support patient- and family-centered care by establishing and maintaining therapeutic relationships between patients, family members, multidisciplinary team members, and community resources.
Social Worker		
(dd) The SCN social worker will: 1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.[5] (ee) The facility will: 1. provide 1 social worker for every 30 beds providing level II neonatal care and/or specialty and subspecialty perinatal care[5]; 2. have a written description that clearly identifies the responsibilities and functions of the SCN social worker; and 3. have social services available for each family with an infant in the SCN as needed.	(oo) The NICU social worker will: 1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.[5] (pp) The facility will: 1. provide 1 social worker for every 30 beds providing level III neonatal care and/or specialty and subspecialty perinatal care[5]; 2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and 3. have social services available for each family with an infant in the NICU as needed.	(pp) The NICU social worker will: 1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.[5] (qq) The facility will: 1. provide at least 1 social worker for every 30 beds providing level IV neonatal care and/or specialty and subspecialty perinatal care, if applicable[5]; 2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and 3. have social services available for each family with an infant in the NICU as needed.
Pastoral Care		
(ff) Personnel skilled in pastoral care will be available as needed and by family request and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.[5]	(qq) Personnel skilled in pastoral care will be available as needed and by family request and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.[5]	(rr) Personnel skilled in pastoral care will be available as needed and by family request and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.[5]
Retinopathy of Prematurity		
(gg) If the facility back transfers infants for convalescent care, the facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having[13]: 1. documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity[5,13]; 2. the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity, if needed.[5,13]	(rr) The facility must have a process in place to appropriately identify infants at risk for retinopathy to guarantee timely examination and treatment by having[13]: 1. documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity[5,13]; and 2. the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.[5,13]	(ss) The facility must have a process in place to appropriately identify infants at risk for retinopathy to guarantee timely examination and treatment by having[13]: 1. documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity[5,13]; and 2. the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.[5,13]
Discharge and Follow-up		
(hh) Systems will be in place to establish preparation for SCN discharge, including postdischarge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed. 1. The facility will: i. have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk	(ss) Systems will be in place to establish preparation for NICU discharge, including postdischarge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed. 1. The facility will: i. have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with	(tt) Systems will be in place to establish preparation for NICU discharge including postdischarge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed. 1. The facility will: i. have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up

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Level II	Level III	Level IV
neonatal follow-up with appropriate developmental follow-up services; and ii. have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.	appropriate developmental follow-up services; and ii. provide developmental follow-up services or have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.	with appropriate developmental follow-up services; and ii. provide developmental follow-up services or have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Levels of Maternal Care

Number 9
(Replaces Obstetric Care Consensus Number 2, February 2015)

ABSTRACT: Maternal mortality and severe maternal morbidity, particularly among women of color, have increased in the United States. The leading medical causes of maternal mortality include cardiovascular disease, infection, and common obstetric complications such as hemorrhage, and vary by timing relative to the end of pregnancy. Although specific modifications in the clinical management of some of these conditions have been instituted, more can be done to improve the system of care for high-risk women at facility and population levels. The goal of levels of maternal care is to reduce maternal morbidity and mortality, including existing disparities, by encouraging the growth and maturation of systems for the provision of risk-appropriate care specific to maternal health needs. To standardize a complete and integrated system of perinatal regionalization and risk-appropriate maternal care, this classification system establishes levels of maternal care that pertain to basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV). The determination of the appropriate level of care to be provided by a given facility should be guided by regional and state health care entities, national accreditation and professional organization guidelines, identified regional perinatal health care service needs, and regional resources. State and regional authorities should work together with the multiple institutions within a region, and with the input from their obstetric care providers, to determine the appropriate coordinated system of care and to implement policies that promote and support a regionalized system of care. These relationships enhance the ability of women to give birth safely in their communities while providing support for circumstances when higher level resources are needed. This document is a revision of the original 2015 Levels of Maternal Care Obstetric Care Consensus, which has been revised primarily to clarify terminology and to include more recent data based on published literature and feedback from levels of maternal care implementation.

The American Association of Birth Centers; the American College of Nurse-Midwives; the Association of Women's Health, Obstetric and Neonatal Nurses; the Commission for the Accreditation of Birth Centers; and the Society for Obstetric Anesthesia and Perinatology endorse this document. The American Academy of Family Physicians and the American Hospital Association support this document. The American Society of Anesthesiologists has reviewed this document. This document was developed jointly by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine in collaboration with Sarah J. Kilpatrick, MD, PhD; M. Kathryn Menard, MD, MPH; Christopher M. Zahn, MD; and the Centers for Disease Control and Prevention's representative William M. Callaghan, MD, MPH. The findings, conclusions, and views in this Obstetric Care Consensus do not necessarily represent the official position of the Centers for Disease Control and Prevention or the U.S. government.

Purpose

1. To reaffirm the need for levels of maternal care, as initially presented in the 2015 Obstetric Care Consensus, which includes uniform definitions, a standardized description of maternity facility capabilities and personnel, and a framework for integrated systems that addresses maternal health needs.
2. To reaffirm that the goal of levels of maternal care is to reduce maternal morbidity and mortality, including existing disparities, by encouraging the growth and maturation of systems for the provision of risk-appropriate care specific to maternal health needs. Central to systems is the development of collaborative relationships between hospitals of differing levels of maternal care in proximate regions, which ensures that every maternity hospital has the personnel and resources to care for unexpected obstetric emergencies, that risk assessment is judiciously applied, and that consultation and referral are readily available when high-risk care is needed. These relationships enhance the ability of women to give birth safely in their communities while providing support for circumstances when higher level resources are needed.

3. To clarify definitions and revise criteria by applying experience from jurisdictions that are actively implementing levels of maternal care.

Background

Maternal mortality and severe maternal morbidity, particularly among women of color, have increased in the United States. The Centers for Disease Control and Prevention (CDC) reported that pregnancy-related deaths increased from 7.2 per 100,000 live births in 1987 to 18.0 in 2014 (1), and non-Hispanic black women had a 3.3 times greater pregnancy-related mortality ratio compared with non-Hispanic white women (1, 2). Furthermore, severe maternal morbidity increased by nearly 200% between 1993 and 2014 (1, 3–6). In addition, data shared by 13 maternal mortality review committees showed that as many as 60% of pregnancy-related deaths during 2013–2017 were potentially preventable (2). These data underscore the need to focus on the quality and safety of maternal care systems. Implementation of levels of maternal care has been identified as a common theme when identifying actionable opportunities to prevent maternal mortality (2, 7). The leading medical causes of maternal mortality include cardiovascular disease, infection, and common obstetric complications such as hemorrhage, and vary by timing relative to the end of the pregnancy (2). Although specific modifications in the clinical management of some of these conditions have been instituted (eg, the use of thromboembolism prophylaxis and development of hemorrhage and hypertension practice management bundles), more can be done to improve the system of care for high-risk women at facility and population levels (8, 9). This document is a revision of the original 2015 Levels of Maternal Care Obstetric Care Consensus, which has been revised primarily to clarify terminology and to include more recent data based on published literature and feedback from levels of maternal care implementation.

Regionalized Perinatal Care

In the 1970s, most states developed coordinated regional systems for perinatal care that were predominantly focused on neonatal outcomes (10). The designated regional or tertiary care centers provided the highest levels of obstetric and neonatal care and served smaller facilities' needs through education and transport services. Numerous studies validated the concept that improved neonatal outcomes were achieved through the application of risk-appropriate maternal transport systems (11, 12). A comprehensive meta-analysis showed an increased risk of neonatal mortality for very-low-birth-weight infants (less than 1,500 g) born outside of a neonatal intensive care unit level III hospital (38% versus 23%; adjusted odds ratio [adjusted OR], 1.62; 95% CI, 1.44–1.83) (13). Similarly, neonatal mortality was higher for very-low-birth-weight infants born in hospitals staffed by neonatologists in the absence of a more complete multidisciplinary team (level II), compared with those born in level III centers (14). However, although regionalized systems that promote maternal transfer to improve neonatal outcomes are well established, similar safety networks focused on maternal medical risk-based needs are not well defined and, thus, not established in many areas of the United States.

Importantly, accredited birth centers and hospitals that offer basic and specialty maternity services provide needed obstetric care for most women who are giving birth in the United States (15). Furthermore, they often provide maternity care in rural and underserved communities, which offers the benefit of keeping women with low- or moderate-risk pregnancies in their local communities. Closing hospitals with low-volume obstetric services could have counterproductive adverse health consequences (16, 17) and potentially increase health care disparities (18, 19) by limiting access to maternity care.

Women with complex high-risk conditions often benefit from giving birth in hospitals that offer a broad array of specialty and subspecialty services. Perhaps the most direct evidence that caring for the sickest women in higher acuity centers is associated with improved outcomes is that women with a high comorbidity index had a significantly higher adjusted relative risk of severe maternal morbidity when they gave birth in hospitals of low acuity (adjusted OR, 9.55; 95% CI, 6.83–13.35) compared with hospitals of high acuity (adjusted OR, 6.50; 95% CI, 5.94–7.09) (20). Additional recent data suggest that hospital delivery volume, health care provider patient volume, and hospital level or rating can all affect maternal outcomes (20–27). Furthermore, data indicate that outcomes are better if women with certain conditions, such as placenta previa or placenta accreta, are managed in hospitals with high delivery volume (28, 29).

This information should not be interpreted to imply that hospitals with low delivery volumes are not safe for care of women with low-risk pregnancies, or as a call to close hospitals with a lower volume or acuity. In remote or rural areas, hospitals with low delivery volumes are often the only local delivery option. Rather, these data, combined with the fact that 59% of hospital births in the United States occur at hospitals where fewer than 1,000 newborns are delivered annually (15), underscore the importance of adequately staffed and equipped level I and II hospitals; regionalized care with defined relationships between different level facilities; continuous risk assessment; and the potential benefit of caring for women with high risk of maternal morbidity in centers with higher level, acuity-focused resources and specialty and subspecialty personnel.

Goals for Regionalized Maternal Care

Regionalized maternal care is intended to maintain and increase access to care by developing, strengthening, and better defining relationships among facilities within a region. In turn, this should facilitate consultation and transfer of care when appropriate so that low- to

moderate-risk women can stay in their communities while pregnant women with high-risk conditions receive care in facilities that are prepared to provide the required level of specialized care. Each facility should have a clear understanding of its capability to handle increasingly complex levels of maternal care and should have a well-defined threshold to transfer women to health care facilities that offer a higher level of care. In emergency situations, the nearest level-appropriate hospital should be used if added travel to a farther level-appropriate hospital increases risk. An important goal of regionalized maternal care is for level III or IV facilities to provide training for quality improvement initiatives, support for education, and severe morbidity and mortality case review for hospitals in their regional system. These recommendations should be considered guidelines, not mandates, and it should be acknowledged that geographic and local issues will affect systems of implementation for regionalized maternal and neonatal care.

Ongoing Levels of Maternal Care Programs

Development of levels of maternal care programs are increasing. Several states, including Georgia, Indiana, Texas, and Iowa, passed legislation or changed their administrative codes to establish a specific maternal level of care designation for all hospitals that provide maternity care. An essential component of all of these programs is the concept of an integrated system in which level III or IV maternal centers provide education and consultation, including training for quality improvement initiatives and severe morbidity and mortality case review, to level I and II facilities and provide for a streamlined system for maternal transport when necessary.

The CDC developed the Levels of Care Assessment Tool (LOCATe) (30) in 2013 to address a need identified by states and national partners for a simple, web-based tool that standardizes the assessment of maternal and neonatal care capabilities of facilities. It is in alignment with the national guidelines published by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine and the national guidelines published by the American Academy of Pediatrics. (31). The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, in collaboration with the CDC, the Arizona Perinatal Trust, and the National Perinatal Information Center, expanded on the work achieved with LOCATe to develop the Levels of Maternal Care verification program. The verification program involves an on-site survey to assess levels of maternal care in an obstetric facility according to the Levels of Maternal Care Obstetric Care Consensus criteria. A multidisciplinary team that represents organizations with expertise in maternal risk-appropriate care piloted this program with 14 facilities across three states (Georgia, Illinois, and Wyoming). The team performed an on-site comprehensive review of the maternal services available in each facility using the hospital's LOCATe results as the initial step in the verification process (32). Experience from LOCATe and the pilot verification program have informed the revisions of this document to better enable implementation.

Definitions of Levels of Maternal Care

To standardize a complete and integrated system of perinatal regionalization and risk-appropriate maternal care, this classification system establishes levels of maternal care that pertain to basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV). Definitions, capabilities, and health care providers for each of the four levels of maternal care and for birth centers are delineated in Table 1. Maternal care refers to all aspects of antepartum, intrapartum, and postpartum care. Table 1 also refers to low-, moderate-, and high-risk care; defining what constitutes these levels of risk should be individualized by facilities and regions, with input from their obstetric care providers. Accredited birth centers (freestanding facilities that are not hospitals) (see Accredited Birth Centers section for more information) are an integral part of many regionalized care systems and are, therefore, included in the table; however, capabilities and health care providers are not delineated in the table because well-established standards governing birth centers in the United States are already available (33).

One of the most common questions that arose subsequent to the publication of the first Levels of Maternal Care Obstetric Care Consensus was related to the availability of personnel, particularly the requirements for personnel to be "available" or "present" on-site. This revised document provides clarification related to the availability of personnel by providing more specific terminology as defined below.

- **Physically present at all times:** the specified person should be on-site in the location where perinatal care is provided, 24 hours a day, 7 days a week.
- **Readily available at all times:** the specified person should be available 24 hours a day, 7 days a week, for consultation and assistance, and able to be physically present on-site within a time frame that incorporates maternal and fetal or neonatal risks and benefits with the provision of care. Further defining this time frame should be individualized by facilities and regions, with input from their obstetric care providers. If referring to the availability of a service, the service should be available 24 hours a day, 7 days a week unless otherwise specified.

General Considerations Relevant for All Levels of Maternal Care

- All facilities need to have the capability to stabilize and provide initial care for any patient while being able to accomplish transfer if needed and, thus, must have resources to manage the most common

Table 1. Levels of Maternal Care: Definitions, Capabilities, and Health Care Providers*

Accredited Birth Center	
Definition	Care for low-risk women with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth
Capabilities and health care providers	• Refer to birthcenters.org for American Association of Birth Centers' Standards for Birth Centers.
Level I (Basic Care)	
Definition	Care of low- to moderate-risk pregnancies with ability to detect, stabilize, and initiate management of unanticipated maternal–fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available
Capabilities	• Capability and equipment to provide low-risk and appropriate moderate-risk maternal care and a readiness at all times to initiate emergency procedures to meet unexpected needs of women and newborns within the center. This includes ○ ability to begin emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits. ○ limited obstetric ultrasonography with interpretation readily available at all times.† ○ support services readily available at all times†, including laboratory testing and blood bank. ○ capability to implement patient safety bundles‡ for common causes of preventable maternal morbidity, such as management of maternal venous thromboembolism, obstetric hemorrhage, and maternal severe hypertension in pregnancy.§ ○ ability at all times† to initiate massive transfusion protocol, with process to obtain more blood and component therapy as needed. • Stabilization and the ability to facilitate transport to a higher-level hospital when necessary. This includes ○ risk identification and determination of conditions necessitating consultation, referral, and transfer. ○ a mechanism and procedure for transfer/transport to a higher-level hospital available at all times.† ○ a reliable, accurate, and comprehensive communication system between participating hospitals, hospital personnel, and transport teams. • Ability, in collaboration with higher-level facility partners, to initiate and sustain education and quality improvement programs to maximize patient safety.
Health care providers	• Every birth attended by at least one qualified birthing professional (midwife‖, family physician, or ob-gyn) and an appropriately trained and qualified RN with level-appropriate competencies as demonstrated by nursing competency documentation. • Physician with privileges to perform emergency cesarean delivery readily available at all times.† • Primary maternal care providers, including midwives‖, family physicians, or ob-gyns readily available at all times.† • Appropriately trained and qualified RNs with level-appropriate competencies as demonstrated by nursing competency documentation readily available at all times.† • Nursing leadership has level-appropriate formal training and experience in maternal care. • Anesthesia providers, such as anesthesiologists, nurse anesthetists, or anesthesiologist assistants working with an anesthesiologist,¶ for labor analgesia and surgical anesthesia readily available at all times.†

(*continued*)

Table 1. Levels of Maternal Care: Definitions, Capabilities, and Health Care Providers* (*continued*)

Level II (Specialty Care)	
Definition	Level I facility plus care of appropriate moderate- to high-risk antepartum, intrapartum, or postpartum conditions
Capabilities	Level I facility capabilities plus • Computed tomography scan, magnetic resonance imaging, nonobstetric ultrasound imaging, and maternal echocardiography with interpretation readily available daily (at all times not required). • Standard obstetric ultrasound imaging with interpretation readily available at all times.[†]
Health care providers	Level I facility health care providers plus • Ob-gyn readily available at all times.[†] ○ Based upon available resources and facility determination of the most appropriate staffing, it may be acceptable for a family physician with obstetric fellowship training or equivalent training and skills in obstetrics, and with surgical skill and privileges to perform cesarean delivery to meet the criteria for being readily available at all times. • Physician obstetric leadership is a board-certified[#] ob-gyn with experience in obstetric care. ○ Based upon available resources and facility determination of the most appropriate staffing, it may be acceptable for such leader to be board certified in another specialty with privileges and expertise in obstetric care including with surgical skill and privileges to perform cesarean delivery. • An MFM readily available at all times[†] for consultation onsite, by phone, or by telemedicine, as needed. • Anesthesiologist readily available at all times.[†] • Internal or family medicine physicians and general surgeons readily available at all times[†] for obstetric patients.

(*continued*)

Table 1. Levels of Maternal Care: Definitions, Capabilities, and Health Care Providers* (*continued*)

Level III (Subspecialty Care)	
Definition	Level II facility plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions
Capabilities	Level II facility capabilities plus • In-house availability of all blood components. • Computed tomography scan, magnetic resonance imaging, maternal echocardiography, and nonobstetric ultrasound imaging services and interpretation readily available at all times.† • Specialized obstetric ultrasound and fetal assessment, including Doppler studies, with interpretation readily available at all times.† • Basic interventional radiology (capable of performing uterine artery embolization) readily available at all times.† • Appropriate equipment and personnel physically present at all times** onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU. • Onsite medical and surgical ICUs that accept pregnant women and women in the postpartum period. The ICUs have adult critical care providers physically present at all times.** An MFM is readily available at all times† to actively communicate or consult for all obstetric patients in the ICU. • Documented mechanism to facilitate and accept maternal transfers/transports. • Provide outreach education and patient transfer feedback to level I and II designated facilities to address maternal care quality issues. • Provide perinatal system leadership if acting as a regional center (for example, in areas where level IV facilities are not available) (see Level IV).
Health care providers	Level II health care providers plus • Nursing leaders and adequate number of RNs who have special training and experience in the management of women with complex and critical maternal illnesses and obstetric complications • Board-certified# ob-gyn physically present** at all times • An MFM with inpatient privileges readily available at all times,† either onsite, by phone, or by telemedicine. Timing of need to be onsite is directed by urgency of clinical situation. However, MFM must be able to be onsite to provide direct care within 24 hours. • Director of maternal–fetal medicine service is a board-certified MFM. • Director of obstetric service is a board-certified ob-gyn or MFM. • Board-certified anesthesiologist# physically present** at all times. • Director of obstetric anesthesia services is board-certified anesthesiologist with obstetric anesthesia fellowship training or experience in obstetric anesthesia. • Full complement of subspecialists, such as subspecialists in critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, and neonatology, readily available for inpatient consultation at all times.†

(*continued*)

Table 1. Levels of Maternal Care: Definitions, Capabilities, and Health Care Providers* (*continued*)

Level IV (Regional Perinatal Health Care Centers)	
Definition	Level III facility plus on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care
Capabilities	Level III facility capabilities plus • On-site medical and surgical care of complex maternal conditions with the availability of critical care unit or ICU beds. • On-site ICU care for obstetric patients with primary or co-management by maternal–fetal medicine team. Co-management includes at least daily rounds by an MFM with interaction with the ICU team and other subspecialists with daily documentation. In some settings, the ICU is in an adjoining or connected building, which is acceptable as long as maternal–fetal medicine care is as noted above. If the woman must be transported by ambulance to the ICU, this is not considered onsite. • Perinatal system leadership, including facilitation of collaboration with facilities in the region, analysis and review of system perinatal outcome and quality data, provision of outreach education and assistance with quality improvement as needed.
Health care providers	Level III health care providers plus • Maternal–fetal medicine care team with expertise to manage highly complex, critically ill, or unstable maternal patients. A board-certified MFM attending with full inpatient privileges is readily available at all times[†] for consultation and management. This includes co-management of ICU-admitted obstetric patients. • Nursing Service Line leadership with advanced degree and national certification. • Continuous availability of adequate numbers of RNs who have experience in the care of women with complex medical illnesses and obstetric complications with close collaboration between critical care nurses and obstetric nurses with expertise in caring for critically ill women. • Board-certified anesthesiologist with obstetric anesthesia fellowship training or experience in obstetric anesthesia physically present at all times.** • At least one of the following adult subspecialties readily available at all times for consultation and treatment as needed onsite: neurosurgery, cardiac surgery, or transplant. If the facility does not have all three subspecialties available, there should be a process in place to transfer women to a facility that can provide the needed service.

Abbreviations: CMs, certified midwives; CNMs, certified nurse–midwives; ICU, intensive care unit; MFM, maternal–fetal medicine subspecialists; ob-gyns, obstetrician–gynecologists; RNs, registered nurses.

*These guidelines are limited to maternal needs. Consideration of fetal or neonatal needs and the appropriate level of care should occur following existing guidelines. In fact, levels of maternal care and levels of neonatal care may not match within facilities. Additionally, these are guidelines, and local issues will affect systems of implementation for regionalized maternal care, perinatal care, or both.

[†]Readily available at all times: the specific person should be available 24 hours a day, 7 days a week for consultation and assistance, and able to be physically present onsite within a time frame that incorporates maternal and fetal or neonatal risks and benefits with the provision of care. Further defining this time frame should be individualized by facilities and regions, with input from their obstetric care providers. If referring to the availability of a service, the service should be available 24 hours a day, 7 days a week unless otherwise specified.

[‡]Available at https://safehealthcareforeverywoman.org/patient-safety-bundles.

[§]See also Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. ACOG Committee Opinion No. 767. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e174–80.

[‖]Midwives who meet International Confederation of Midwives standards, such as certified nurse–midwives (CNMs) and certified midwives (CMs), and who are legally recognized to practice within the jurisdiction of the state.

[¶]Scope of practice for nurse anesthetists and anesthesiologist assistants may vary by state.

[#]Also includes physicians who have completed residency training and are eligible for board certification according to applicable board policies.

[**]Physically present at all times: the specific person should be onsite in the location where the perinatal care is provided, 24 hours a day, 7 days a week.

Table 2. Summary and Recommendations for Levels of Maternal Care

Summary and Recommendations	Grade of Recommendations
To standardize a complete and integrated regionalized system of perinatal care and risk-appropriate maternal care, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine recommend a classification system for levels of maternal care as defined in Table 1. Each higher level of care includes and builds on the capabilities of the lower levels.	1C Strong recommendation, low quality evidence
All facilities need to have the capability to stabilize and provide initial care for any patient while being able to accomplish transfer if needed and, thus, must have resources to manage the most common obstetric emergencies such as hemorrhage and hypertension. To ensure optimal care of all pregnant women, all birth centers, basic (level I), and specialty care (level II) hospitals should collaborate with subspecialty care and regional perinatal health facilities to develop and maintain maternal transport plans and cooperative agreements to meet the health care needs of women who develop complications.	1C Strong recommendation, low quality evidence
Collaborating receiving hospitals should openly accept transfers. Of note, the decision to transfer a patient is not only based on guidelines but also dependent on the health care provider's judgment of the severity of illness, balancing the need for a higher level of care with risks associated with moving the woman out of her community.	1C Strong recommendation, low quality evidence
Pregnant women should receive the same level of trauma care as nonpregnant patients.	1C Strong recommendation, low quality evidence
The appropriate care level for patients should be driven by their medical need and not limited to or governed by financial constraints.	1C Strong recommendation, low quality evidence
Because obesity is extremely common throughout the United States, all facilities should have appropriate equipment for the care and delivery of pregnant women with obesity, including appropriate birth beds, operating tables and rooms, and operating equipment. The degree of obesity may be one of the factors that affect decisions for transfer of a woman to a higher level of care, although there are no well-established body mass index cut-off levels to determine level-specific care for pregnant women or women in the postpartum period with obesity.	1C Strong recommendation, low quality evidence
Because of the importance of accurate data for the assessment of outcomes and quality indicators, all facilities should have infrastructure and guidelines for data collection, storage, and retrieval that allow regular review for trends.	1C Strong recommendation, low quality evidence
Levels of maternal and neonatal care may not match within facilities. However, a pregnant woman should be cared for at the facility that best meets her needs as well as her neonate's needs.	1C Strong recommendation, low quality evidence
All maternity facilities should have the necessary institutional support, including financial, to meet the needs of level-appropriate maternal care, including provision of health care personnel, facility resources, and collaborative relationships with perinatal hospitals within their region.	1C Strong recommendation, low quality evidence

obstetric emergencies such as hemorrhage and hypertension (Table 2). Because all facilities cannot maintain the breadth of resources available at subspecialty centers, interfacility transport of pregnant women or women in the postpartum period is an essential component of a regionalized perinatal health care system. To ensure optimal care of all pregnant women, all birth centers, basic (level I), and specialty care (level II) hospitals should collaborate with subspecialty care and regional perinatal health facilities to develop and maintain maternal transport plans and cooperative agreements to meet the health care needs of women who develop complications.

- Collaborating receiving hospitals should openly accept transfers. Of note, the decision to transfer a patient is not only based on guidelines but also dependent on the health care provider's judgment of the severity of illness, balancing the need for a higher level of care with the risks associated with moving the woman out of her community.
- Trauma is not integrated into the levels of maternal care because trauma center levels are already

established. Pregnant women should receive the same level of trauma care as nonpregnant patients.

- The appropriate care level for patients should be driven by their medical need and not limited to or governed by financial constraints.
- Because obesity is extremely common throughout the United States, all facilities should have appropriate equipment for the care and delivery of pregnant women with obesity, including appropriate birth beds, operating tables and rooms, and operating equipment (34). The degree of obesity may be one of the factors that affects decisions for transfer of a woman to a higher level of care, although there are no well-established body mass index cut-off levels to determine level-specific care for pregnant women or women in the postpartum period with obesity.
- Because of the importance of accurate data for the assessment of outcomes and quality indicators, all facilities should have infrastructure and guidelines for data collection, storage, and retrieval that allow regular review for trends.
- Although this document focuses on maternal care and does not include an in-depth discussion about risk-based neonatal care capability, optimal perinatal care requires synergy in institutional capabilities for the woman and the fetus or neonate. Levels of maternal and neonatal care may not match within facilities. However, a pregnant woman should be cared for at the facility that best meets her needs as well as her neonate's needs.
- Consistent with the levels of neonatal care published by the American Academy of Pediatrics (35), each level of maternal care reflects required minimal capabilities, physical facilities, and medical and support personnel. Each higher level of care includes and builds on the capabilities of the lower levels.
- All maternity facilities should have the necessary institutional support, including financial, to meet the needs of level-appropriate maternal care, including provision of health care personnel, facility resources, and collaborative relationships with perinatal hospitals within their region.

Accredited Birth Centers

The American Association of Birth Centers (AABC) initially published the *Standards for Birth Centers* in 1985; the most recent version was published in 2017 (33). Birth centers are freestanding facilities that are not considered hospitals. Birth centers provide peripartum care for low-risk women with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth. Birth centers are part of the health care system in the United States. Although state regulations vary regarding licensure and accreditation, the AABC's national standards outline that each birth center should have an established consultation, collaboration, or referral system to meet the needs of the woman or infant (33). The Commission for the Accreditation of Birth Centers is the only accrediting agency that chooses to use the national AABC's *Standards for Birth Centers* in its accreditation process. The American College of Obstetricians and Gynecologists recognizes accredited birth centers as an integral part of regionalized care. Further details, including the standards for birth centers, are available from the AABC (www.birthcenters.org).

Implementation and Monitoring

Regional centers, which include all level IV facilities and any level III facility that functions in this capacity, should develop relationships with level I and level II hospitals in their referral network. Likewise, Level I and II hospitals should be open to collaboration and establishing relationships with a level III or IV facility in their region. Birth centers, according to the AABC 2017 Standards, should have relationships with a higher-level facility. The regional center should coordinate access to risk-appropriate health services, provide support for quality and safety monitoring, and provide outreach education. These functions are ideally accomplished in collaboration with, and supported by, public health agencies.

Listed in Table 3 are suggested examples of conditions or complications for which care may be provided at specific levels. It is important to emphasize that these examples are listed as suggested maternal conditions, and the table is not designed to be exhaustive or definitive. Some conditions present across a range of severity and, depending on the severity, geography, and available resources, it may be appropriate to care for some patients at a level different from what is listed in Table 3. Facilities, with input from their obstetric care providers, should individualize the types of conditions or complications that they are capable of caring for based on the actual resources available for their level of care, as well as other considerations such as location, availability of transport, access to readily available resources in the local or regional area, and coordination with other centers. To standardize approaches within and among facilities and regionalized systems, it may be reasonable for individual facilities and regionalized systems, with input from their obstetric care providers, to develop their own specific lists of conditions or complications that warrant consultation or consideration for transfer.

Concentrating care of women who have the most complex pregnancies at designated regional perinatal health care centers will allow these centers to maintain the expertise needed to achieve optimal outcomes. In agreement with this concept, a 2018 collaborative report from nine maternal mortality review committees recommended that adopting levels of maternal care would have a considerable effect nationally on reducing maternal mortality (6).

Table 3. Examples (Not Requirements) of Appropriate Patient by Level*

Level	Example (Not Requirement)
Accredited birth center	Women with an uncomplicated term singleton vertex fetus who are expected to have an uncomplicated birth
Level I	Low-risk women with uncomplicated pregnancies and women with higher-risk conditions such as the following: • uncomplicated twin gestation • labor after cesarean • uncomplicated cesarean delivery • preeclampsia† • well-controlled gestational diabetes
Level II	Any patient appropriate for level I care, plus higher-risk conditions such as the following: • placenta previa with no previous uterine surgery • maternal medical conditions that require additional monitoring such as pregestational diabetes, poorly controlled asthma, or poorly controlled or complicated chronic hypertension • anticipated complicated cesarean delivery
Level III	Any patient appropriate for level II care, plus higher-risk conditions or complications such as the following: • moderate maternal cardiac disease • suspected placenta accreta or placenta previa and previous uterine surgery • suspected placenta percreta • adult respiratory distress syndrome or other conditions that require ventilatory support antepartum or postpartum • acute fatty liver of pregnancy • coagulation disorders • complex hematologic or autoimmune disorders • expectant management of preeclampsia with severe features remote from term
Level IV	Any patient appropriate for level III care, plus higher-risk conditions or complications such as the following: • severe maternal cardiac conditions • severe pulmonary hypertension • pregnant women who require neurosurgery or cardiac surgery • pregnant women in unstable condition and in need of an organ transplant

*This list provides a series of examples and is not intended to serve as a comprehensive or definitive list of conditions appropriate to manage at each level. Some conditions present across a range of severity and, depending on the severity, geography, and available resources, it may be appropriate to care for some patients at a level different from what is listed above. Facilities, with input from their obstetric care providers, should individualize the types of conditions or complications that they are capable of caring for based on the actual resources available for their level of care, as well as other considerations such as location, availability of transport, access to readily available resources in the local or regional area, and coordination with other centers.

†Preeclampsia with severe features may warrant transfer to a higher-level facility. Delivery or expectant management of a woman with preeclampsia with severe features is best accomplished in a setting with resources appropriate for maternal and neonatal care.

Regionalization of maternal health care services requires that there be available and coordinated specialized services, professional continuing education to maintain competency, facilitation of opportunities for transport and back-transport, and collection of data on perinatal outcomes to evaluate the effectiveness of delivery of perinatal health care services and the safety and efficacy of new therapies. Because the health statuses of women and fetuses may differ in acuity, referral should be organized to meet the greatest needs of either or both. In some cases with specific care needs, optimal coordination of care will not be delineated by geographic area, but rather by availability of specific expertise (eg, transplant services or fetal surgery). However, it is

equally important to keep women in the care of the birthing facilities in their communities unless risk factors or comorbidities evolve such that the indicated level of care needed is beyond the capabilities of those birthing facilities. Regionalization and support of perinatal services in level I and II facilities would help to maintain such birthing facilities as opposed to threatening closure.

Measurement and Evaluation of Regionalized Maternal Care

If regionalization improves care, then implementation of levels of maternal care should be associated with a decrease in preventable maternal severe morbidity and mortality. There also should be a shift toward less severe morbidity in level I and II facilities. Therefore, facilities and regional systems should develop methods to track transports, severe maternal morbidity, and mortality and to assess preventability so that they can measure the efficacy of their system using levels of maternal care. Quantitative and qualitative evaluation of equity in outcomes should be an integral part of tracking and assessing the efficacy of the system.

Operational definitions are needed to compare data and outcomes between levels of maternal care. Two concepts to implement with the use of levels of maternal care are proposed: 1) identify women at highest risk of morbidity and 2) identify outcomes that may improve with appropriate assignments of levels of maternal care.

Some women at extreme risk of severe morbidities such as stroke, cardiopulmonary failure, or massive hemorrhage can be identified during the antepartum period and should give birth in the appropriate level-of-care hospital. Examples of such women include those with suspected placenta accreta spectrum disorders or those with severe heart disease, such as complex cardiac malformations and pulmonary hypertension, coronary artery disease, or cardiomyopathy. Other less predictable but high-acuity maternal conditions include preeclampsia with difficult to control hypertension, and hemolysis, elevated liver enzymes, and low platelet count (HELLP) syndrome.

Improved maternal outcomes that may accrue with appropriate use of levels of maternal care assignments include reduction in preventable severe morbidity and mortality such as stroke, returns to the operating room, complications from known or suspected placenta accreta, and unplanned intensive care unit admissions. The incidence of these outcomes could decrease or be shifted from level I and II to level III or IV hospitals. The development of comprehensive lists of conditions that comprise extreme morbidity risks and of which outcomes should be measured is currently an evolving process. Therefore, prospective measurement with continuous monitoring and evaluation of any regionalized maternal care system is critical to improving care processes and outcomes.

Determination and Implementation of Levels of Maternal Care

The determination of the appropriate level of care to be provided by a given facility should be guided by regional and state health care entities, national accreditation and professional organization guidelines, identified regional perinatal health care service needs, and regional resources (36). State and regional authorities should work together with the multiple institutions within a region, and with input from their obstetric care providers, to determine the appropriate coordinated system of care and to implement policies that promote and support a regionalized system of care.

The first step in implementation is development of the classification system for maternal care that is appropriate for the specific state or geographic area. The next step is establishing defined levels in all facilities that provide maternal care within the system. More information is needed to help optimize implementation, including further understanding of perceived barriers to implementation by hospitals and obstetric facilities, identifying or developing tools and resources to address these barriers, and identifying examples and best practice of successful implementation of a levels of care system. Making such information available to other facilities and systems that are in the process of or planning to implement a level of care system can accelerate the uptake. Furthermore, it is critical to implementation to identify how best to provide the financing needed to establish a levels of maternal care system, how to manage different payer programs, and how to identify which financial models are most sustainable. An important consideration related to the financial concerns is to ensure that facilities are not financially "penalized" for appropriately transferring a woman to a higher-level facility.

Interdisciplinary work groups are needed to further explore what is needed to adopt the proposed levels of maternal care classification system in all facilities that provide maternal care. In addition to information needed to optimize implementation, research is needed to assess the effect of implementing a levels of maternal care system on maternal and perinatal outcomes with a particular focus on reducing maternal morbidity and mortality.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/LOMC.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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Society for Maternal–Fetal Medicine Grading System: Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Recommendations

Obstetric Care Consensus documents will use the Society for Maternal-Fetal Medicine's grading approach: http://www.ajog.org/article/S0002-9378%2813%2900744-8/fulltext. Recommendations are classified as either strong (Grade 1) or weak (Grade 2), and quality of evidence is classified as high (Grade A), moderate (Grade B), and low (Grade C)*. Thus, the recommendations can be one of the following six possibilities: 1A, 1B, 1C, 2A, 2B, 2C.

Grade of Recommendation	Clarity of Risk and Benefit	Quality of Supporting Evidence	Implications
1A. Strong recommendation, high quality evidence	Benefits clearly outweigh risk and burdens, or vice versa.	Consistent evidence from well performed randomized controlled trials or overwhelming evidence of some other form. Further research is unlikely to change confidence in the estimate of benefit and risk.	Strong recommendations, can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1B. Strong recommendation, moderate quality evidence	Benefits clearly outweigh risk and burdens, or vice versa.	Evidence from randomized controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an effect on confidence in the estimate of benefit and risk and may change the estimate.	Strong recommendation, and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1C. Strong recommendation, low quality evidence	Benefits appear to outweigh risk and burdens, or vice versa.	Evidence from observational studies, unsystematic clinical experience, or from randomized controlled trials with serious flaws. Any estimate of effect is uncertain.	Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.
2A. Weak recommendation, high quality evidence	Benefits closely balanced with risks and burdens.	Consistent evidence from well-performed randomized controlled trials or overwhelming evidence of some other form. Further research is unlikely to change confidence in the estimate of benefit and risk.	Weak recommendation, best action may differ depending on circumstances or patients or societal values.
2B. Weak recommendation, moderate quality evidence	Benefits closely balanced with risks and burdens; some uncertainty in the estimates of benefits, risks, and burdens.	Evidence from randomized controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an effect on confidence in the estimate of benefit and risk and may change the estimate.	Weak recommendation, alternative approaches likely to be better for some patients under some circumstances.
2C. Weak recommendation, low quality evidence	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens.	Evidence from observational studies, unsystematic clinical experience, or from randomized controlled trials with serious flaws. Any estimate of effect is uncertain.	Very weak recommendation, other alternatives may be equally reasonable.
Best practice	Recommendation in which either (i) there is enormous amount of indirect evidence that clearly justifies strong recommendation (direct evidence would be challenging, and inefficient use of time and resources, to bring together and carefully summarize), or (ii) recommendation to contrary would be unethical.		

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