Health

Certificate of Need Application
Hospital Projects

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

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

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

Signature and Title of Responsible Officer Thomas A. Kruse, Senior Vice President & Chief Strategy Officer Email Address thomas.kruse@vmfh.org	Date February 29, 2024 Telephone Number 253.680.4007
Legal Name of Applicant Virginia Mason Franciscan Health St. Francis Hospital Address of Applicant 34515 9th Ave South Federal Way, WA 98003	☐ New hospital ☐ Expansion of existing hospital (identify facility name and license number) Provide a brief project description, including the number of beds and the location. Continuation of an existing CN-approved Elective PCI Program in PCI Planning Area 9 - King East. Estimated capital expenditure: $ 0

Identify the Hospital Planning Area

PCI Planning Area 9 – King East

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

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

Certificate of Need Application
to
Assure Continued Operation of an Existing Elective PCI Program in the King East PCI Planning Area

February 2024

Applicant Description

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

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

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

VMFH includes 10 hospitals with more than 18,000 employees and almost 5,000 employed physicians and affiliated providers at nearly 300 care sites throughout the Puget Sound region. VMFH's 1,500-bed health system cares for more than 325,000 emergency department patients and provides more than 300,000 inpatient days each year.

The address of St. Francis Hospital is:

34515 9th Ave South
Federal Way, WA 98003

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

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

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

Questions regarding this application should be sent to:

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

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

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

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

An organizational chart is included in Exhibit 1.

Section 2
Facility Description

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

The name and address of the applicant is:

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

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

No new facility is proposed. This question is not applicable.

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

St. Francis's existing numbers are as follows:

License: HAC.FS.00000201
Medicare #:50-0141
Medicaid #:100215500

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

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

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

Yes ☐ No X

6. Provide the following scope of service information:

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

Table 1
St. Francis Hospital Scope of Services

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

Section 3
Project Description

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

The purpose of this CN application is to protect access to St. Francis' existing elective PCI Program that has served as a safety net for high needs community for nearly 15 years. Without this CN, the community runs the risk of losing access to this service.

In Washington State any hospital can operate an emergency Percutaneous Coronary Intervention (PCI) Program, but only hospitals with prior CN approval can perform elective PCIs. St. Francis secured CN approval in late 2009 to commence an elective PCI Program and had operated a robust emergency PCI program prior to that approval.

WACs 246-310-715 through WAC 246-310-740 guide the review and ongoing compliance of elective PCI Programs. In 2018, the CN Program modified a provision that reduced the minimum operating volume of CN approved programs from 300 to 200. The PCI rules require that numeric need for at least 200 additional PCIs exist in a planning area and that all existing providers perform at least 200 annual PCIs before a new Program can be approved. Per rule, hospitals have three years from CN approval to reach the volume of 200 total annual PCIs. St. Francis has met the 200 annual volume requirement since at least 2014. In fact, St. Francis has performed thousands of PCIs since adding elective PCI in 2009.

St. Francis' PCI primary service area, based on actual patient origin data includes communities within South King and North Pierce Counties. This area incorporates portions of the King West, King East, and Pierce West PCI Planning Areas; including Federal Way, Auburn, Kent, Buckley, DesMoines, SeaTac, Burien, Tukwila, Fife, Milton, Pacific, and Enumclaw. Among other roles, King County Public Health collects and tracks data on health status and disparities. St. Francis' service area is contained in a number of regions tracked by Public Health including Federal Way-North Corridor, Federal Way-Center, Federal Way-Dash Point and South Rim and South King County.

The St. Francis CN award is unique in that it was applied for, and approved, as a joint certificate with the hospital then known as Auburn Regional Medical Center. The rationale for a shared program was predicated on the fact that, at the time, the two hospitals were located in South King County, within the boundaries of the King East PCI Planning Area, about six miles from each other and shared a single cardiology group.

For St. Francis, the CN issuance contained two terms and two conditions, restated below:

TERM

1. *Prior to commencement of the project, ARMC/FHS must provide a letter from the cardiology group committing to continue to provide cardiology services.*

2. *Prior to commencement of the project, FHS must provide the Certificate of Need program a finalized Charity Care Policy approved by the Department's Hospital and Patient Data Systems program.*

Condition Franciscan Health Systems-St- Francis

1. *FHS-St. Francis Hospital must make all reasonable efforts to refer patients as likely Percutaneous Coronary Intervention candidates to the University of Washington Medical Center for the procedure if:*

    1. *The University of Washington Medical Center, at the end of any calendar quarter, demonstrates that its interventional program volumes are not on track for the calendar year to maintain the annual minimum volume that is required by a certification organization to maintain the University of Washington Medical Center's training program.*

    2. *The maximum number of patient referrals that may be expected of FHS-St. Francis Hospital in any one calendar period is 12.*

    3. *The University of Washington Medical Center makes a written request to FHS-St. Francis Hospital for patient referrals. The request must:*

        - *include the number of patients residing in FHS-St. Francis Hospital's PCI planning area that already have had the procedure done at the University during that calendar year; and*
        - *The University's request for referrals may not exceed the difference between the maximum patient referral number (12) and the number of patients from the planning area that has already received a PCI procedure at the University of Washington.*

2. *In the event this PCI program ceases to operate as a joint venture as described in the application and approved by the department, neither Auburn Regional Medical Center or FHS-St. Francis Hospital may continue to operate a PCI program without first obtaining a new Certificate of Need.*

In 2023 after the 2023 PCI cycle commenced, the two hospitals were notified by the Department of Health (DOH) of its intent to revoke the shared CN. The three parties have entered settlement discussions.

Given all of the 'moving' pieces and uncertainty related to PCI in the State, including the potential revocation of St. Francis' fully compliant CN and the highly diverse and high health disparity communities served by St. Francis that would be affected by the loss of a Program, VMFH has opted to file for a new CN in this 2024 cycle. Our rationale is simple: the ability to continue offering accessible, quality elective PCI is imperative for serving our vulnerable residents. St. Francis' Community Health Needs Assessment contains several priorities that would be compromised by the loss of the program, including:

> ***Access to Care****: Support programs that help those who are unhoused, uninsured, or under-insured obtain quality, affordable care.*
>
> ***Chronic Disease:*** *Support programs that prevent and manage chronic disease, with a focus on heart disease and diabetes.*

The PCI uncertainty we reference above includes:

1) The status of a PCI related appeal filed by Trios Health, currently in the State Supreme Court. Trios argues that it is incumbent on the DOH to count all PCIs performed. Trios documented that the State's CHARS database identified verifiable PCIs (per ICD-10 procedure codes) that were performed but not coded to the list of DRGs that the program assigned as PCIs. The outcome of this case could affect how PCI cases are counted going forward.
2) The recent appeal of Swedish Issaquah arguing that the Program's failure to revoke a CN should not be an impediment to another applicant being approved to address a documented need.
3) The 2022 settlement in Thurston County between the DOH and MultiCare, in which DOH determined that it had latitude to approve a CN even when other existing WAC requirements are not met. The relevant language of that settlement, reads:

> *To avoid the burden, expense, and uncertainty of litigation and to help assure that the need for PCI services is met in PCI Planning Area #6, the Parties agree to fully resolve this matter by taking other appropriate certification action as follows:*
>
> ***Additional PCI Program In Planning Area.*** *The Department may grant a CN to a new elective PCI program in Planning Area #6 during the pendency of this other appropriate certification action to address CMC's noncompliance with minimum volume standards, so long as the CN application for that new program is filed within the term of this Agreement identified in Paragraph 5 or within three years following execution of this Agreement, whichever is later. Accordingly, MultiCare waives any right to market protection afforded to it by WAC 246-310-720(2)(b)'s limitation on granting a CN to a new PCI program in Planning Area #6. During*

the application process, MultiCare shall not offer public comment or rebuttal based on WAC 246-310-720(2)(b). If the Department issues a CN, MultiCare shall not challenge the decision on the basis of WAC 246-310-720(2)(b). This provision survives expiration or termination of this Agreement if the Agreement expires or terminates without CMC having met the minimum volume standard in WAC 246-310-720(1).

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

The applicable addendum is included as Section 8 of this application.

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.**

There is no change in beds, by type, associated with this project. Table 2 details St. Francis's current and proposed bed configuration. St. Francis is CN approved for 148 beds; and construction is expected to be completed in Q2 2024 related to the approved addition of 24 of those beds in 2022.

Table 2
St. Francis Hospital
Current and Proposed Bed Configuration

	Current	Proposed
General Acute Care	142	142
PPS Exempt Psych	0	0
PPS Exempt Rehab	0	0
NICU Level II	6	6
NICU Level III	0	0
NICU Level IV	0	0
Specialized Pediatric	0	0
Skilled Nursing	0	0
Swing Beds (included in General Acute Care)	0	0
Total	**148**	**148**

Source: Applicant

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

By Q2 2024 all 148 licensed acute care beds listed in Table 2 will be set-up.

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

Table 3
St. Francis PCI CN Estimated Timeline

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

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

St. Francis' current elective PCI program does and will continue to provide elective and emergent percutaneous coronary interventions or (PCIs). These procedures are minimally invasive but nonsurgical procedures performed to open blocked arteries. Patients in need of PCI have a diagnosed buildup of plaque in their arteries.

Per WAC 246-310-705, "Elective" means a PCI performed on a patient with cardiac function that has been stable in the days or weeks prior to the operation. Elective cases are usually scheduled at least one day prior to the surgical procedure.

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

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

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

There are no changes to the existing hospital or cardiac catheterization laboratory. This question is not applicable.

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

The gross square footage of the hospital is 241,340. This project does not add any new square footage.

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

This project involves no construction.

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

This project involves no construction.

Section 4
Need (WAC 246-310-210)

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

This application seeks assurance that St. Francis will be able to continue the elective PCI Program it secured CN approval to operate in 2009. Currently, the Program is operated under a joint CN with MultiCare Auburn. Given the Department's notice of its intent to revoke the joint CN, this application is being submitted to assure that St. Francis' high volume, high quality, safety net Program continues.

In addition to the joint CN providers, there are currently three other hospitals performing elective PCI in the Planning Area, including Evergreen Health in Kirkland, Overlake Medical Center in Bellevue, and UW Medicine Valley Medical Center in Renton.

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 application does not propose any increase in acute care beds.

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

This application does not propose any increase in acute care beds.

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

The first table is not appliable as there is no increase or change in any bed units as a result of this project. The requested information for the entire hospital is included in Table 4.

Table 4
St. Francis Hospital Historical Utilization

Entire Hospital	2021	2022	2023 (annualized)
Licensed beds	124	124	148
Available beds	124	124	124
Discharges	6,974	7,490	8,210
Patient days	32,262	35,350	38,960

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

This question is not applicable, as this project proposes no expansion of an existing hospital, and no increase in any bed type.

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

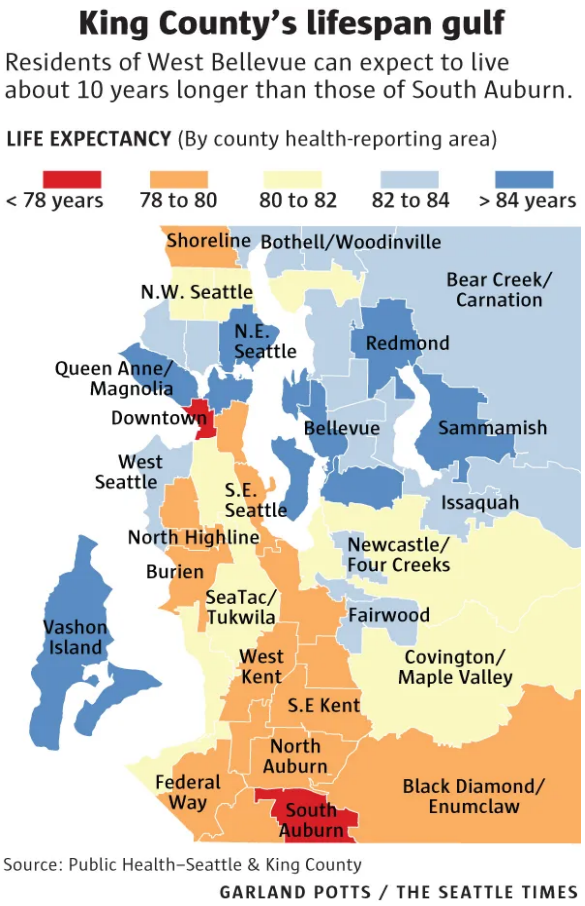
The requested patient origin data for the PCI Program is included as Exhibit 3.

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

St. Francis' current emergent and elective PCI program ensures access and equity in PCI provision within the King East PCI Planning Area and specifically within South King County. Access will be restricted with the loss or restriction of the current St. Francis PCI Program.

The King East PCI Planning Area includes nearly 60% of King County's total population. It includes the areas of the County that lie east of Lake Washington. It spans from the Snohomish/King County line, east to the Snoqualmie summit and the Cascade range, and sweeps along the south end of Lake Washington and continues south to the Pierce/King border and west to the Puget Sound. The area is not homogenous, and the

needs of some communities are staggeringly different than others. For example, a 2016 study found a significant difference in length of life based on geography.



As shown in the Map, there is a 10-year gap in life expectancy between some south King communities compared to the more traditional "Eastside"; all of these areas are part of the King East PCI Planning Area. This data is further supported by recent analyses by Seattle King County Public Health, which found persistent (and increasing) disparities by geographic location, or place. According to the report:

We focus primarily on King County's South Region, which also has the highest concentration of poverty, plus disproportionate representations of people of color and immigrants (half of whom settle in South Region), and significant linguistic diversity. One in four South Region adults has a bachelor's degree, compared to more than half of adults in each of the county's other regions. Not surprisingly, a close look at the South Region reveals some of the same disparities that emerged when we focused on poverty.

Compared to King County in total, St. Francis' primary service area of South King experiences higher cardiac mortality and morbidity, higher rates of acute MIs, high blood pressure and obesity and overall, less access. A summary of the death rates for King County residents per 100,000 for heart disease is reported in Table 5. The rate in South King County is 22% higher and the rate in Federal Way Central is more than 50% higher than King County

The same data shows higher rates of diabetes and obesity; which increase a person's risk of heart disease.

Table 5
King County Heart Disease Death Rates by Region

Region	Heart Disease Deaths/100,000
Federal Way: North Corridor	**172.5**
Federal Way: Central	**182.2**
Federal Way: Dash Point and Southern Rim	**152.8**
King County	120.5
East King County	103.5
South King County	**147.8**
Seattle King County	106.7
North King County	117.6

Source: WA State DOH, Center for Health Statistics (2021)

This is an issue of equity. It would be irresponsible of VMFH to fail to take action to ensure continued access.

St. Francis acknowledges that the CN methodology as forecast in late 2023 identifies no numeric need for a new Program in King East. The lack of numeric need appears to relate to several factors, including the increasing percent of persons admitted to a hospital that had a PCI that was not coded to one of the DRGs that the CN Program uses. Because the Program does not count these cases, the methodology understates use rates.

Most relevant is the fact that the Department has expressed its intent to revoke the joint CN. The CN methodology includes the volumes of non-CN approved providers in its calculation of a use rate but excludes them from its count of capacity. If St. Francis' CN is revoked, our volumes will be excluded from capacity and, holding all else constant in the methodology, there will be need for one additional Program in the King East PCI Planning Area. If the volume of both St. Francis and Auburn are excluded, there is need for two additional programs.

Since the Department has elected to move to revoke the 2009 CN, there is no alternative for the Program other than to exclude the volume of St. Francis in its calculation of numeric need, determine that numeric need exists and approve this CN. To do otherwise would place a great and unjust burden on an already disadvantaged community.

The Department's vision is that *all Washingtonians have the opportunity to attain their full potential of physical, mental, and social health and well-being*. Data that the Department collected and reported demonstrates its knowledge of the disparities and inequities in cardiac mortality and morbidity in our Service Area. Its website states, in part, that its *actions will recognize that social, structural, and economic determinants of health must be addressed to achieve true health equity and optimal health for all.* Protecting the viability of a quality, functioning and fully compliant safety net program such as St. Francis' program is part and parcel, and paramount to the Department's vision. It is the only way to assure continued access for our residents.

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

This project seeks to assure continued availability and accessibility to the underserved in the Primary Service Area. WAC 246-310-210 (2) requires the Program to determine that:

> *All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:*
>
> > *(a) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area, which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;*
> > *(b) The past performance of the applicant in meeting obligations, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any unresolved civil rights access complaints against the applicant);*
> > *(c) The extent to which Medicare, Medicaid, and medically indigent patients are served by the applicant; and*
> > *(d) The extent to which the applicant offers a range of means by which a person will have access to its services (e.g., outpatient services, admission by house staff, admission by personal physician).*

Currently, more than 73% of our PCI patients have Medicare and Medicaid as a payer. In addition, and per CHARS, approximately 60% of the primary service area's PCI patients are Medicare and Medicaid, demonstrating that St. Francis serves a higher percentage of these patients.

In addition, in 2021 St. Francis' charity care as a percent of adjusted patient service revenue was significantly higher than the rate of the King County region: 3.7%, compared to an average of 2.5%.

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

This project does not propose a partial or full relocation of the facility.

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

This question is not applicable.

11. **Provide a copy of the following policies:**
    - **Admissions policy**
    - **Charity care or financial assistance policy**
    - **Patient rights and responsibilities policy**
    - **Non-discrimination policy**
    - **End of life policy**
    - **Reproductive health policy**
    - **Any other policies directly associated with patient access.**

All requested policies are included in Exhibit 4.

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

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
    i. **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
    ii. **A current balance sheet at the facility level.**
    iii. **Pro forma balance sheets at the facility level throughout the projection period.**
    iv. **Pro forma revenue and expense projections for at least the first three full calendar years following completion of the project. Include all assumptions.**
    v. **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.**

To be conservative, St. Francis has assumed no increase in current PCI volumes. As per CN guidelines, project pro formas are not to include inflation, the actual 2023 revenue and expense cost center serves as the pro forma for years FYE 2025-2027.

All requested information is included in Exhibit 5.

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

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

3. **Provide the following agreements/contracts:**
    i. **Management agreement**
    ii. **Operating agreement**
    iii. **Development agreement**
    iv. **Joint Venture agreement**

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

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

Included in Exhibit 6 is documentation from the King County Assessor's office demonstrating site control.

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

This question is not applicable. There is no construction or remodeling proposed in this project.

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

There is no capital expenditure. St. Francis has been operating an elective PCI program since 2009.

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

There is no capital expenditure. This question is not applicable.

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

There is no start-up period or costs. St. Francis has been operating an elective PCI program since 2009.

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

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

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

There is no construction. This question is not applicable.

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

There are no capital costs. This question is not applicable.

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

The requested information for the hospital at large is included in Table 6 below.

Table 6
St. Francis Hospital Payer Mix

St. Francis Payer Mix	Revenue	Cases
Medicare	42.5%	36.3%
Medicaid	23.0%	24.2%
Commercial	28.7%	32.9%
Self-Pay	2.2%	3.0%
Other	3.6%	3.7%
Total	100.0%	100.0%

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

This project does not propose the addition of beds to an existing facility.

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

No new equipment is proposed.

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.

There is no financing associated with this project.

16. Provide the most recent audited financial statements for:

i. The applicant, and

ii. Any parent entity.

Audited financials are included in Appendix 1.

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

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

The requested information is included in Exhibit 7.

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.**

Table 7
Current Cath Lab Staffing

Staff Position	FTE
Registered Nurse	7.0
Nurse Manager	1.0
Cardiovascular Invasive Specialist	6.0

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

St. Francis is currently operating the elective PCI program that is the subject of this CN. The number and types of FTE's are based on current volumes and operations.

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

The pertinent information for the cath lab staff is included in Section 8 of this application.

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.**

No additional staff is required, as St. Francis currently operates the Program and we have conservatively assumed no incremental PCI volume.

While no new staffing is required, VMFH fully acknowledges the current workforce issues experienced by all health care providers, due in part to COVID burnout and the desire to support and embrace diversity, inclusion, and equity. To ensure the workforce needs remain a top priority, VMFH employs a Director of Workforce Development. All levels of VMFH are focused on workforce development, retention, and efficiencies, including signing bonuses and referral bonuses for front line clinical staff, mid-year market increases, broad based appreciation bonuses, and staffing incentives for extra shifts.

VMFH offers a competitive wage and benefit package as well as numerous other recruitment and retention strategies. It also recognizes that this is an extraordinary time with regard to staffing. Below we have summarized some our strategies for clinical, ancillary and support staff recruitment and retention:

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

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

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

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

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

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

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

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

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

There are no new facilities. This question is not applicable.

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

All ancillary and support services including lab, pharmacy and pre and post procedure areas are currently in place.

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

No existing agreements for the hospital are expected to change as a result of this project. Please note, we have provided new St. Francis-only PCI specific agreements complying with the WAC in response to questions in Section 8 below.

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

Please refer to Section 8 of this application for working relationships specific to PCI.

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

There are no changes to any working relationships with the exception of the development of St. Francis-only PCI specific agreements in Section 8.

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

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

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

The specific purpose of this CN application is specifically to assure continued access and continuity in the provision of a life-saving service for planning area residents. Approval of this project will protect access to the St. Francis existing elective PCI Program that has served as a safety net in the community for nearly 15 years. Without this CN, the community runs the risk of losing this valued service.

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).**

WAC 246-310-230 (4) reads:

> *The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.*

This question was addressed in earlier questions in this section. Additional information is included in Section 8 of the application.

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

No facility or practitioner associated with the application has any history with respect to the above.

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

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

The Department's notice of intent to revoke the 2009 CN is the impetus for this project. For each of the reasons cited in early sections of this application, the community would be disadvantaged were St. Francis forced to cease the elective program. The alternatives considered include:

1) Wait until the outcome of the appeal and settlement discussions to determine if St. Francis may continue the joint CN with MultiCare, or;
2) If revocation proceeds and a CN becomes necessary, apply for the CN in 2025; or
3) Given the uncertainty of outcome to the appeal or settlement, and the extreme negative impact of a disruption in service, submit a CN now as a protective measure to avoid any potential access issues.

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.**

Preserving access to our high-quality, high-volume safety net PCI program is the only viable option. St. Francis' analysis of the criteria is below:

- **Patient Access**: Without an elective PCI Program, service area residents will be referred to Tacoma, Seattle, or Renton. A significant percentage of patients do not have transportation and experience other socioeconomic and health challenges relating to travelling to care (time off from work, funds, childcare, etc.). Importantly, St. Francis is a trusted provider in the community. Pre the elective PCI Program, a relatively high percentage of patients referred did not show at the referred site, and later were admitted through the ED at St. Francis with an active MI. A repeat of this reality needs to be avoided.
- **Capital Cost**: There is no capital cost as the cath lab has been in place since 2019.
- **Legal and Regulatory Restrictions**: The outcome of the Program's current notice to revoke the CN and subsequent settlement conversations are unknown and uncertain. It is not in the best interests of our community to wait idly until the decision is rendered without taking steps to ensure access to care.

- **Staffing Impacts**: As documented elsewhere in the application, there is no incremental staffing required.
- **Quality of Care**: St. Francis submits data to the Washington State COAP Program and also to the National Cardiovascular Data Registry (NCDR). Both of these organizations support hospitals and clinicians in measuring and improving the quality of cardiac care provided. St. Francis' data demonstrates high-quality care and outcomes being achieved. Further, being able to intervene when the patient is more stable and not emergent is better care. Given that so many of our residents lack the means to travel. The loss of the Program could increase acute MI rates and rates of cardiac morbidity and mortality in a region that already has the highest rates in the County.
- **Cost/Operational Efficiency**: PCI volume at St. Francis would be reduced if elective PCIs were not able to be performed. This would increase costs and reduce operational efficiencies.

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

This project does not involve construction.

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

The current emergency and elective PCI program at St. Francis already and will continue to foster cost containment, quality, and cost efficiencies.

Section 8
Addendum for Hospital Projects
Percutaneous Coronary Intervention (PCI)
WAC 246-310-700 through 246-310-755

Project Description

1. **Is the applicant currently providing emergent PCI?**

Yes, St. Francis is currently providing emergency PCI. St. Francis has also been providing elective PCI for 14 years.

2. **If not, what facilities are these patients being sent to in the most recent calendar year?**

This question is not applicable.

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

Table 8 below identifies the PCIs performed at St. Franics during the period of 2021-YTD 2024.

Table 8
Historical PCI Volumes

Year	Volumes
2020	203
2021	373
2022	383

Project Description

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

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

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

St. Francis has been providing elective PCIs since 2009 and is fully equipped with all appropriate devices, including digital imaging and IABP.

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

The catheterization laboratory is staffed and available to perform emergent PCI 24/7. The loss of the CN could, over time, require a reduction in hours.

<u>Certificate of Need Review Criteria</u>

A. Need

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

Please refer to the introduction and need section of this application. St. Francis understands that the methodology will be used. Assuming that the elective program at St. Francis no longer exists (not counted in capacity) results in the need for one additional Program.

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

St. Francis provides emergency and elective PCIs and has operated above 200 cases annually since at least 2014. As noted earlier in the CN, to be conservative, we have assumed that the current volume of 383 cases is flat throughout the three-year planning horizon.

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

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

This standard is met assuming that the St. Francis Program no longer has CN approval, and its capacity is removed from the calculation of need. The requirement that all existing PCI Programs meet or exceed the minimum standard was waived by the Program in the past. See the 2022 settlement in Thurston County between the DOH and MultiCare, in which DOH determined that it had latitude to approve a CN even when other existing WAC requirements are not met.

B. Financial Feasibility

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

Revenue and expense statements for the cost center are included as Exhibit 5.

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

The elective PCI Program has been operational since late 2009. This question is not applicable.

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

The elective PCI Program has been operational since 2009. This question is not applicable.

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

There is no change to the payer mix proposed. The payer mix for the cardiac catheterization laboratory is included in Table 9.

Table 9
St. Francis PCI Program Payer Mix

Revenue Source	Current Emergent and Elective PCI Program Payer Mix - Revenue	Current Emergent and Elective PCI Program Payer Mix - Cases
Medicare	59.4%	55.0%
Medicaid	14.0%	16.1%
Commercial	24.5%	26.2%
Self-Pay	0.9%	1.3%
Other	1.1%	1.3%
Total	100.0%	100.0%

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

There is no capital expenditure because St. Francis has been providing elective PCI for 14 years This CN is submitted to assure status quo.

C. Structure and Process of Care

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

The Medical Director is Keval Shah, MD, license # MD60714513.

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

Dr. Shah is employed. The job description is included as Exhibit 8.

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

This question is not applicable.

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

This is an existing facility, and the proposed staff is the same as the current staff. The information is provided in response to Q18, below.

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

The requested information is included in Table 10.

Table 10
Current Credentialed Staff

Name	License/Certification	License #
Josh Peyton	RN	RN60089637
Brooke Shipley	RN	RN60849437
Carly Mairose	RN	RN60746404
Taila Fisher	RN	RN60096328
Jim Johnson	RN	RN00117870
Larysa Redkozubov	RN	RN60810553
Jed Gosnell	RN	RN60681589
Ian Lahti	Cardiovascular Invasive Specialist Certification	IS61142143
Viktor Sushko	Cardiovascular Invasive Specialist Certification	IS60584314
Megan Paul	Cardiovascular Invasive Specialist Certification	IS60680181
Simone Kassogue	Cardiovascular Invasive Specialist Certification	IS60890070

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

Catheterization laboratory specific policies are included in Exhibit 9.

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

St. Francis has been operating an elective PCI program since 2009. This is not a new program and is not expected to have any impact on the University of Washington Medical Center (UWMC) training programs. As can be identified in the Table 11 below, even with the existence of St. Francis' program, UWMC's program has grown far beyond the hospital standard, increasing by 109% since 2014. St. Francis and VMFH appropriately refer cases to UWMC that it is uniquely qualified and staffed to perform.

Table 11
University of Washington Medical Center
PCI Volumes

	2014	**2022**	**% change**
UWMC	414	866	109%

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

Please see response to Question 20 above.

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

A response has not been requested from the University of Washington Medical Center since this is not the establishment of a new PCI program, but simply a request to ensure the continuance of St. Francis' current program.

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

Table 12 includes the names and historical PCI volumes of the physicians currently performing adult elective PCI procedures at St. Francis.

Table 12
St. Francis Historical Physician Volumes

Physician	License #	2021	2022	2023
Keval Shah	MD60714513	93	92	108
Chat Piyaskulkaew	MD60733496	127	98	151
Total		**237**	**228**	**295**

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

In order to be conservative, St. Francis is assuming current volumes will remain constant for the first three years of operation.

The emergent PCI program is currently supported by and will continue to be supported by the additional cardiologists included in Table 13 below.

Table 13
St. Francis Emergent PCI Program Cardiologists

Physician	License #
Freij Global	MD60590251
Daniel Gottlieb	MD00021018
Eben Tucker	MD00042816
Ming Zhang	MD60218278
Richard Olstein	MD61116878

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

As evidenced in Table 12 above. St. Francis has documented its ability to assure all physicians providing elective PCIs meet the minimum volume standard.

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

The St. Francis PCI program is currently operational and fully staffed. Ongoing recruitment strategies employed by St. Francis are provided in detail in Section 6.

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

The existing PCI program is already fully staffed with nursing and technical staff that comply with all the requirements. These staff are included in Table 10 above. Specific job descriptions for these positions are also included in Exhibit 10.

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

The partnering agreement with is included in Exhibit 11.

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

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

This requirement is addressed under #4 in Exhibit 11:

The Transferring Hospital and the Tertiary Hospital shall coordinate, to the extent possible, the availability of surgical teams and operating rooms at the Tertiary Hospital so that for all hours that elective PCIs are being performed at the Transferring Hospital, there is a reasonable likelihood that the Tertiary Hospital has the capacity to immediately accept a referral. The Parties acknowledge and agree that nothing in this Agreement imposes an obligation on the Tertiary Hospital to maintain an available cardiac surgical suite twenty-four hours a day, seven days a week.

(2) ***Assurance the backup surgical hospital can provide cardiac surgery during all hours that elective PCIs are being performed at the applicant hospital.***

This requirement is addressed under #4 and #5 in Exhibit 11:

The Transferring Hospital and the Tertiary Hospital shall coordinate, to the extent possible, the availability of surgical teams and operating rooms at the Tertiary Hospital so that for all hours that elective PCIs are being performed at the Transferring Hospital, there is a reasonable likelihood that the Tertiary Hospital has the capacity to immediately accept a referral. The Parties acknowledge and agree that nothing in this Agreement imposes an obligation on the Tertiary Hospital to maintain an available cardiac surgical suite twenty-four hours a day, seven days a week.

During times of high census wherein the Tertiary Hospital's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), the Tertiary Hospital will notify the Transferring Hospital and elective procedures will be rescheduled as long as in the attending physician's assessment such delay does not compromise the patient's care and condition.

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

This requirement is addressed under #7 in Exhibit 11:

The Transferring Hospital shall send with each patient transferred from the Transferring Hospital to the Tertiary Hospital, at the time of transfer, the medical information necessary to continue the patient's treatment without interruption. Said information shall include, but is not limited to, all medical 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, and any other essential identifying and administrative information. All patient information transferred by the Transferring Hospital to the Tertiary Hospital shall be in accordance with federal and state privacy mandates.

(4) ***Communication between Physicians. The Transferring Hospital will coordinate communication by the physician(s) performing the elective PCI to the Receiving Hospital cardiac surgeon(s) about the clinical reasons for urgent transfer and the patient's clinical condition.***

This requirement is addressed in #8 in Exhibit 11:

The Transferring Hospital will ensure that the physician performing the elective PCI communicates immediately and directly with the Tertiary Hospital's cardiac surgeon(s) about the clinical reasons for the urgent transfer and patient's clinical condition.

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

This requirement is addressed in #2 in Exhibit 11:

If a determination is made by the attending physician that a patient requires transfer from the Transferring Hospital to the Tertiary Hospital, the Tertiary Hospital shall accept the referred patient promptly subject to available capacity and personnel at the Tertiary Hospital, as more fully described below.

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

The emergency transport agreement and PCI addendum to the agreement is included in Exhibit 12.

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

This requirement is addressed in #4 of the PCI addendum included in Exhibit 12:

Olympic Ambulance will dispatch emergency transportation immediately upon notification of a need for transport by St. Francis. Olympic Ambulance will use its best efforts to respond within twenty (20) minutes. Emergent transports for St. Francis will have priority over other non-emergency patients, such as scheduled transports, in the local area.

This requirement is also addressed in #6b in Exhibit 11:

Document and confirm that emergency transportation begins for each patient within twenty minutes of the initial identification of a complication by the attending physician.

(8) ***Evidence that the emergency transport staff are certified. These staff must be advanced cardiac life support (ACLS) certified and have the skills, experience, and equipment to monitor and treat the patient en route and to manage an intra-aortic balloon pump (IABP).***

This requirement is addressed in #6a in Exhibit 11:

Maintain a signed transportation agreement with a qualified vendor that provides expeditious transport for any patient experiencing complications during an elective PC! that requires a transfer to the Tertiary Hospital. A qualified vendor is one whose transport staff is ACLS certified. The Transferring Hospital 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).

This requirement is also addressed in #4a-c in Exhibit 12:

Olympic Ambulance will dispatch emergency transportation immediately upon notification of a need for transport by St. Francis. Olympic Ambulance will use its best efforts to respond within twenty (20) minutes. Emergent transports for St. Francis will have priority over other non-emergency patients, such as scheduled transports, in the local area. The transport will be done by:

a. *The first preference will be to send a CCT ambulance staffed with Olympic Ambulance CCT level personnel to transport patients.*
b. *In the event that a CCT ambulance is not available within a reasonable timeframe, a Basic Life Support ambulance and Olympic Ambulance BLS staffed crew will be dispatched with the care being maintained by St. Francis CCT level staff during transport to the backup hospital.*

c. *In either case (CCT ambulance or BLS ambulance), St. Francis will send ACLS certified and experienced staff to monitor the patients and equipment in order to specifically manage patients with an intra-aortic balloon pump.*

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

This requirement is addressed in #5 in Exhibit 12:

Olympic Ambulance and St. Francis will agree to total patient transportation time – from notification of the need to transport to arrival in the operating room at a backup hospital with on-site cardiac surgery – of 90 minutes or less.

This requirement is also addressed in #6c in Exhibit 11:

Document transportation times from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of the Tertiary Hospital and confirm transportation time is less than one hundred twenty minutes.

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

This requirement is addressed in #6d in Exhibit 11:

Participate annually in two timed emergency transportation drills with outcomes communicated to the parties' quality assurance programs. The staff and cost of internal resources used for such drills will be the responsibility of the Transferring Hospital. The cost of any external resources required for such drills will be the responsibility of the Transferring Hospital.

This requirement is also addressed in #6 in Exhibit 12:

Olympic Ambulance will participate in at least two annual timed emergency transportation drills with St. Francis and two (2) annual time emergency drills with St. Francis to ensure the timelines referenced within this agreement continue to be met.

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

This requirement is addressed in #1 in Exhibit 11:

The Transferring Hospital shall secure signed, informed consents for adult elective PCIs from all program patients. The consent forms will explicitly communicate to the patients that the intervention is being performed without on-site surgery back-up and address risks related to transfer, the risk of urgent surgery, and refer to this established Partnering Agreement.

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

This requirement is addressed in #10 in Exhibit 11:

The Transferring Hospital and the Tertiary Hospital shall schedule cardiac patient care quality assurance conferences at least quarterly that involve case reviews of a significant number of pre-operative and post-operative PCI cases at the Transferring Hospital including a 100% review of all transport cases.

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

This requirement is addressed in #5 in Exhibit 11:

During times of high census wherein the Tertiary Hospital's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), the Tertiary Hospital will notify the Transferring Hospital and elective procedures will be rescheduled as long as in the attending physician's assessment such delay does not compromise the patient's care and condition.

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

The required Quality document is included in Exhibit 13.

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

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

This requirement is addressed on page 1 and 2 of Exhibit 13:

- *St. Francis Hospital holds formalized case reviews with St. Joseph Medical Center that include preoperative and post-operative elective PCI cases, including all transferred cases. Specifically:*
    - *The PCI Improvement Committee meets quarterly and is comprised of the following participants:*
        - *Quality Assurance/Clinical Effectiveness Leader*
        - *Cardiology Medical Director*
        - *Cath Lab Manager/Supervisor*
        - *Cardiology Quality Manager*
        - *Interventional Cardiologist*
        - *Plus designated staff as committee deems appropriate.*
    - *The Elective PCI Improvement Committee is a part of the hospitals' Quality Assurance Program and abides by all relevant committee standards and reports to:*
        - *Performance Quality Leadership Group*
        - *Hospital Quality Council*
    - *The Elective PCI Improvement Committee is required to prepare a report at least quarterly that includes the results of all performance monitoring activities. The Committee makes recommendations to the Cardiac Leadership Team and Cath Lab Manager to resolve any identified problems. The data, including COAP data and analysis, are evaluated to determine if performance meets the standard of care, and/or the initiation of performance improvement activities may be beneficial.*
    - *Results of the performance review, including action plans and outcomes, are forwarded to the Performance Quality Leadership Group and the Hospital Quality Council for inclusion in the hospital's Quality Programs. Additional*

actions will adhere to the hospital Quality, Peer Review and Medical Executive processes.

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

This requirement is addressed on page 2 of Exhibit 13:

- *Cardiologists use the Society for Cardiac Angiography guidelines for patient, lesion, and case selection to determine which patients are suitable candidates for elective PCI.*

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

This requirement is addressed on page 1 of Exhibit 13:

- *St. Francis Hospital holds formalized case reviews with St. Joseph Medical Center that include preoperative and post-operative elective PCI cases, including all transferred cases.*

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

This requirement is addressed on page 2 of Exhibit 13:

- *Elective PCI outcomes will be included in the WA State Clinical Outcomes Assessment Program (COAP). Outcomes will be benchmarked against the statewide outcome data and included in case review meetings and presented quarterly to the PCI Improvement Committee including recommendations on how to resolve any identified problems.*
    - *Specific benchmarks include at least the following:*
        - *Risk Adjusted Mortality*
        - *Incidence of Vascular Complications*
        - *Thienopyridine on Discharge (Patients with Stents)*
    - *COAP works with member hospitals in perfecting performance improvement initiatives of PCI Programs within the State of Washington.*

Exhibit 1

Organizational Chart

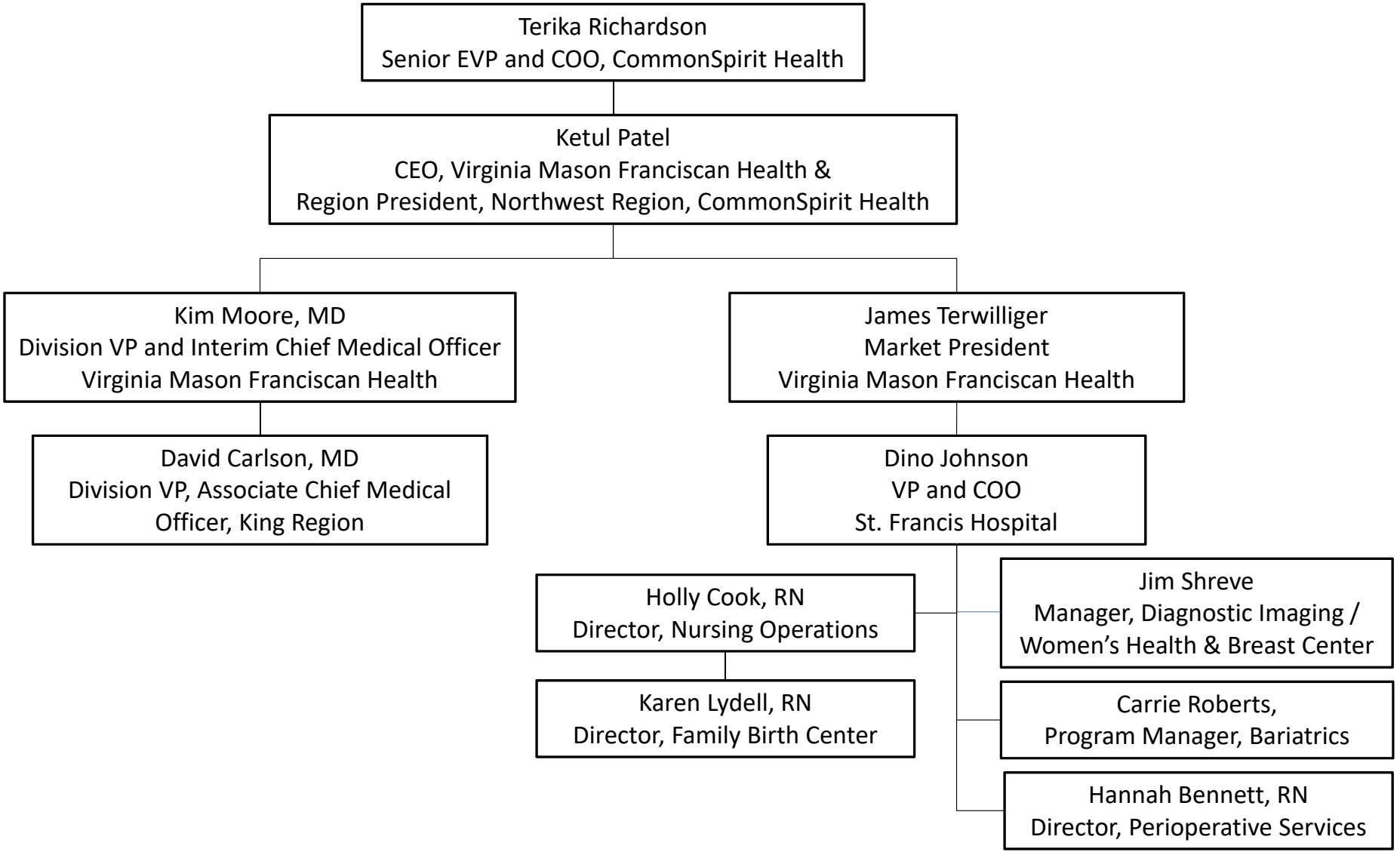

Terika Richardson
Senior EVP and COO, CommonSpirit Health
Ketul Patel
CEO, Virginia Mason Franciscan Health &
Region President, Northwest Region, CommonSpirit Health
Kim Moore, MD
Division VP and Interim Chief Medical Officer
Virginia Mason Franciscan Health
James Terwilliger
Market President
Virginia Mason Franciscan Health
David Carlson, MD
Division VP, Associate Chief Medical
Officer, King Region
Dino Johnson
VP and COO
St. Francis Hospital
Holly Cook, RN
Director, Nursing Operations
Jim Shreve
Manager, Diagnostic Imaging /
Women's Health & Breast Center
Karen Lydell, RN
Director, Family Birth Center
Carrie Roberts,
Program Manager, Bariatrics
Hannah Bennett, RN
Director, Perioperative Services

Exhibit 2

Letter of Intent

Virginia Mason Franciscan Health

RECEIVED
By Jennifer Kido at 7:49 am, Jan 31, 2024

January 29, 2024

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
Via email: FSLCON@DOH.WA.GOV; eric.hernandez@doh.wa.gov

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, Virginia Mason Franciscan Health here within submits a letter of intent for an elective PCI program at St. Francis Hospital. In conformance with WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:
In 2009, St. Francis Hospital (SFH), along with Auburn Regional Medical Center, now MultiCare Auburn (Auburn) received a joint certificate of need (CN#1407) to operate an elective PCI Program. The SFH Program has consistently operated above the required 200 volume threshold and in compliance with all CN requirements. In 2023, the Department of Health (DOH) sent a notice to both parties indicating its intent to revoke the joint CN. Our understanding is that notice was issued because DOH believed Auburn was not meeting the required volume threshold. This decision is currently being appealed, and Auburn is in the process of verifying with DOH that its 2023 volumes were above the required threshold. Given the ongoing nature of Auburn's verifications with DOH, SFH submits this letter of intent to secure a new non-joint program to ensure community access. SFH's program is a safety net for South King County. Its loss would have a significant impact on the community. Accordingly, SFH submits this letter of intent to seek CN review for a non-joint program.

2. Estimated Cost of the Proposed Project:
The estimated capital expenditure for the project is $0.

3. Description of the Service Area:
St. Francis is located in the King East PCI Planning Area.

Please contact me directly with any questions.

Sincerely,

Thomas A. Kruse,
Senior Vice President & Chief Strategy Officer

Exhibit 3

St. Francis PCI Program

Patient Origin

St. Francis Hospital
Patient Origin

Facility	Zip	Patient City	2022
St Francis Hospital	98023	Federal Way	55
St Francis Hospital	98003	Federal Way	48
St Francis Hospital	98001	Auburn	26
St Francis Hospital	98022	Enumclaw	24
St Francis Hospital	98198	Seattle	21
St Francis Hospital	98146	Seattle	16
St Francis Hospital	98148	Seattle	14
St Francis Hospital	98168	Seattle	13
St Francis Hospital	98422	Tacoma	13
St Francis Hospital	98032	Kent	11
St Francis Hospital	98321	Buckley	11
St Francis Hospital	98002	Auburn	10
St Francis Hospital	98166	Seattle	10
St Francis Hospital	98354	Milton	10
St Francis Hospital	98092	Auburn	9
St Francis Hospital	98188	Seattle	8
St Francis Hospital	98047	Pacific	5
St Francis Hospital	98093	Federal Way	3
St Francis Hospital	98108	Seattle	4
St Francis Hospital	98126	Seattle	4
St Francis Hospital	98391	Bonney Lake	4
St Francis Hospital	98008	Bellevue	3
St Francis Hospital	98116	Seattle	3
St Francis Hospital	98372	Puyallup	3
St Francis Hospital	98499	Lakewood	3
St Francis Hospital	98580	Roy	3
St Francis Hospital	47542	#N/A	2
St. Francis Hospital	98031	Kent	2
St Francis Hospital	98042	Kent	2
St Francis Hospital	98062	Seahurst	2
St Francis Hospital	98106	Seattle	2
St Francis Hospital	98118	Seattle	2
St Francis Hospital	98311	Bremerton	2
St. Francis Hospital	98360	Orting	2
St Francis Hospital	98371	Puyallup	2
St Francis Hospital	98373	Puyallup	2
St Francis Hospital	98512	Olympia	2
St Francis Hospital	98541	Elma	2

St Francis Hospital	00261	#N/A	1
St. Francis Hospital	31030	#N/A	1
St. Francis Hospital	33417	#N/A	1
St Francis Hospital	55121	Saint Paul	1
St. Francis Hospital	98010	Black Diamond	1
St Francis Hospital	98037	Lynnwood	1
St. Francis Hospital	98038	Maple Valley	1
St. Francis Hospital	98104	Seattle	1
St. Francis Hospital	98125	Seattle	1
St. Francis Hospital	98144	Seattle	1
St. Francis Hospital	98199	Seattle	1
St. Francis Hospital	98295	Sumas	1
St Francis Hospital	98352	Sumner	1
St. Francis Hospital	98375	Puyallup	1
St. Francis Hospital	98390	Sumner	1
St. Francis Hospital	98396	Wilkeson	1
St. Francis Hospital	98405	Tacoma	1
St. Francis Hospital	98421	Tacoma	1
St. Francis Hospital	98424	Tacoma	1
St. Francis Hospital	98443	Tacoma	1
St. Francis Hospital	98445	Tacoma	1
St Francis Hospital	98498	Lakewood	1
St. Francis Hospital	98520	Aberdeen	1
St. Francis Hospital	98584	Shelton	1
St. Francis Hospital	99026	Nine Mile Falls	1
Total		Total	383

Exhibit 4

Hospital Policies

Status **Active** PolicyStat ID **10140777**

Logo for All Policies Site - CHI Franciscan Health System

Origination	06/1996
Last Approved	07/2021
Effective	07/2021
Last Revised	07/2021
Next Review	07/2024
Owner	Kathryn McKee: Division Director Accreditation/ Safety
Policy Area	Patient Rights/ Ethics
Applicability	CHI Franciscan Systemwide
References	Administrative, RegCompliance

Notice of Patients Rights and Responsibilities on Admission, 390.00

PURPOSE

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

POLICY

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

SUPPORTIVE DATA

- Addendum A: Patient Rights/Responsibilities/Standards/Acknowledgement
- Addendum B Notice of Interpreter Services,
- Complaint Management (Patient Grievance) Policy #320.00
- Nondiscrimination Policy #350.00
- Patient Visitation Rights Policy #393.00
- Consent for Treatment Policy #400.00
- 42 CFR 482.13 Conditions of Participation: Patient's Rights

- Joint Commission Standards, Current Edition
- Americans with Disabilities (ADA)
- Ethical/Religious Directives for Catholic Health Care

PROCEDURE

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

Series Patients

Outpatients in certain therapeutic programs involving ongoing courses of treatments or therapies may sign an acknowledgement for an entire course of therapy or treatment prior to the first treatment, and a single form may be signed for the entire course of treatment or therapy if:

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

SIGNAGE

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

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

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

RESPONSIBILITY

Patient Access/Registration staff is responsible for providing the patient/legal representative with the site specific "Patient Rights/Responsibilities – Notice and Acknowledgment" form. The patient/legal

representative is asked to read, acknowledge and sign that he/she has received the information.

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

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

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

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

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

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

PATIENT RIGHTS

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

- Be fully informed of all your patient rights and receive a written copy, in advance of furnishing or discontinuing care whenever possible.
- Not be discriminated against because of your race, beliefs, age, ethnicity, religion, culture, language, social, physical or mental disability, socio-economic status, sex, sexual orientation, gender identity or expression.
- To be accompanied by a trained service animal or dog guide.
- Be treated with dignity and respect including cultural and personal beliefs, values and preferences.
- Confidentiality, reasonable personal privacy, security, safety, spiritual or religious care accommodations, and communication. If communication restrictions are necessary for patient care and safety, the hospital must document and explain the restrictions to the patient

and family.

- Be protected from neglect; exploitation; verbal, mental, physical or sexual abuse; Access to protective and advocacy services.
- Receive information about your condition including unanticipated outcomes, agree and be involved in all aspects and decisions of their care including: refusing care, treatment and services to the extent permitted by law and to be informed of the consequences of your actions; and resolving problems with care decisions; the hospital will involve the surrogate decision-maker when the patient is unable to make decisions about his or her care.
- Receive information in a manner tailored to the patient's age, language needs and ability to understand. An interpreter, translator or other auxiliary aids, tools or services will be provided to you for vital and necessary information free of charge.
- Make informed decisions regarding care including options, alternatives, risk and benefits. The hospital honors your right to give, rescind and withhold consent.
- Receive an appropriate medical screening examination or treatment for an emergency medical condition within the capabilities of the hospital, regardless of your ability to pay for such services.
- Have a family member or representative of your choice and your physician notified.
- Know the individual(s) responsible for, as well as those providing, your care, treatment and services.
- Family or representatives notification of your admission and input in care decisions; designate any individual to be present for emotional support during course of stay.
- An appropriate assessment and management of your pain.
- Be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Have advance directives and for hospitals to respect and follow those directives; The hospital honors advance directives, in accordance with law and regulation and the hospital's capabilities, religious directives and policies.
- End of life care; Request no resuscitation or life-sustaining treatment.
- Donate organs and other tissues including medical staff input and direction by family or surrogate decision makers.
- Review, request amendment to and obtain information on disclosures of your health information in accordance with law and regulation.
- File a grievance (complaint) and to be informed of the process to review and resolve the grievance without fear of retribution or denial of care. The grievance process and relevant contact information is spelled out in the notice provided to each patient and/or leg representative.

PATIENT RESPONSIBILITIES

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

- Tell your care providers everything you know about your health, and to let someone know if there are changes in your condition. Provide accurate and current health information to your

healthcare team.

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

GRIEVANCE PROCESS

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

SERVICE ANIMALS

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

PATIENT VISITATION RIGHTS

Patients of Franciscan Health System enjoy visitation privileges consistent with the patient preference and subject to the hospital's Justified Clinical Restrictions. Each patient has the right to receive the visitors whom he/ she designates and may designate a support person to exercise the patient's visitation rights on his/ her behalf. All visitors designated by the patient (or support person where appropriate) shall enjoy visitation privileges that are no more restrictive than those that immediate family member would enjoy. The designation of a support person does not extend to the medical decision making.

The hospital may impose clinically necessary or reasonable restrictions or limitations on patient visitation when necessary to respect all other patient rights and to provide safe care to patients. A justified Clinical Restriction may include, but need not be limited to one or more of the following: (i) a court order limiting or restraining contact; (ii) behavior presenting a direct risk or threat to the patient, hospital staff, or others in the immediate environment; (iii) behavior disruptive of the functioning of the

patient care unit; (iv) reasonable limitations on the number of visitors at any one time; (v) patient's risk of infection by the visitor; (vi) visitor's risk of infection by the patient; (vii) extraordinary protections because of a pandemic or infectious disease outbreak; (viii) substance abuse treatment protocols requiring restricted visitation; (ix) patient's need for privacy or rest; (x) need for privacy or rest by another individual in the patient's shared room; or (xi) when the patient is undergoing clinical intervention or procedure and the treating health care professional believes it is in the patient's best interest to limit visitation during the clinical intervention or procedure.

REQUIRED REVIEW:

Regulatory, Risk, Patient Access

Attachments

596491 Patient Rights Responsibilities Notice.pdf

Addendum B: Notice of Interpreter Services

Patient Rights Notice 2017 596491.pdf

Approval Signatures

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

COMMONSPIRIT HEALTH
GOVERNANCE POLICY ADDENDUM

ADDENDUM Finance G-003A-3 **EFFECTIVE DATE:** February 15 , 2024

SUBJECT: Financial Assistance - Washington

ASSOCIATED POLICIES

CommonSpirit Governance Policy	Finance G-003, *Financial Assistance Policy*
CommonSpirit Governance Policy	Finance G-004, *Billing and Collections*

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

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

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

DEFINITIONS

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

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

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

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

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

ELIGIBILITY FOR FINANCIAL ASSISTANCE

A. No minimum account balance shall be required for a patient to qualify for Financial Assistance.

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

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

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

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

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

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

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

E. Eligibility for Financial Assistance shall not be based on a person's residency.

THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

A. For the purposes of reaching an initial determination of sponsorship status, Hospital Facilities shall rely upon information provided orally by the responsible party. The Hospital Facility may require the responsible party to sign a statement attesting to the accuracy of the information provided to the Hospital Facility for purposes of the initial determination of sponsorship status, in accordance with WAC 246-453-030(1). In accordance with WAC 246-453-020(1), if the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person, collection efforts directed at the responsible party will be precluded pending a final determination of that classification, provided that the responsible party is cooperative with the Hospital Facility's reasonable efforts to reach a final determination of sponsorship status.

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

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

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

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

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

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

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

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

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

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

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

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

- As a part of the application process for determining eligibility for Financial Assistance and charity care, Hospital Facility will query as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange.
- As part of the Financial Assistance process, Hospital Facility staff will also work with patients/families who do not have applicable third-party coverage to assess whether such patients/families may be eligible for Medicaid or health care coverage through Washington's Health Benefit Exchange (RCW 43.71). Staff will provide assistance with Medicaid and Qualified Health Plan applications and including but not limited to providing the patient/family with information about the application process, assisting patients through the application process, providing necessary forms that must be completed, or connecting the patient/family with other agencies or resources who can assist the patient/family in completing such applications.
- In providing assistance to the application process, Hospital Facility will take into account any physical, mental, intellectual, sensory deficiencies or language barriers which may hinder either the patient or their guarantor from complying with the application procedures and will not impose procedures on the patient or guarantor that would constitute an unreasonable burden.
- If the patient or guarantor fails to make reasonable efforts to cooperate with Hospital Facility in applying for coverage under chapter 74.09 RCW or the Washington Health Benefit Exchange, Hospital Facility is not obligated to provide charity care to such patient.
- The Hospital Facility shall not require a patient to apply for any public or private programs where the patient is categorically ineligible or has been deemed ineligible in the prior 12 months.

PRESUMPTIVE ELIGIBILITY

In the event the responsible party's identification as an indigent person is obvious to Hospital Facility personnel, and the Hospital Facility personnel are able to establish the position of the

income level within the broad criteria described in RCW 70.170.060, based on the individual life circumstances contained within the Financial Assistance Policy or otherwise, the Hospital Facility is not obligated to establish the exact income level or to request documentation from the responsible party, unless the responsible party requests further review.

APPEALS

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

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

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

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

Status **Active** PolicyStat ID **14430561**

Logo for All Policies Site - CHI Franciscan Health System

Origination	03/2014
Last Approved	09/2023
Effective	09/2023
Last Revised	09/2023
Next Review	09/2026
Owner	Michael Cox: SVP Mission Integration
Policy Area	Corporate Ethics/ Privacy
Applicability	VMFH and its affiliated entities, as applicable
References	Administrative, RegCompliance

End of Life, 044.00

PURPOSE

Provide general guidance and support for our Virginia Mason Franciscan Health (VMFH) and it's affiliated entities, as applicable, on end of life care.

POLICY STATEMENTS

Virginia Mason Franciscan Health provides high quality health care to everyone in our care, recognizing each person's inherent dignity as a unique expression of life. We value informed consent and all clinicians are supported in disclosing all options with their patients, including interventions not available at our facilities in a non-directive manner with a safe transfer of care when requested. VMFH does not participate in the Washington State Death with Dignity Act at any of our facilities.

Virginia Mason Franciscan Health provides care to all patients across the lifespan. End of life care is provided to all patients, regardless of their participation under the act, and our clinicians seek to ensure patients are kept as free of pain as possible so that they may die comfortably and with dignity. Virginia Mason Franciscan Health honors patient's advance directives, including those that outline a preference to forgo life-sustaining treatments.

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

PATIENT AND FAMILY SUPPORT

A. Access to Spiritual Care Services, Hospice Care and Palliative Medical Services are available within Virginia Mason Franciscan Health facilities to support the quality of end of life.

B. Virginia Mason Franciscan Health will provide each adult patient with information about their rights under Washington (WA) state law to make the decision concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

C. Initiating Ethics Committee Consults, may be requested to advise on policy statements and guidelines for decision-making where ethical considerations are involved. Medical Staff, staff and family/surrogate decision makers may request a consultation. See: Initiating Ethics Consult Policy #370.00

REFERENCES

The Ethical and Religious Directives for Catholic Health Care Services, Sixth edition (See: Issues in Care for the Seriously Ill and Dying Introduction and ERDs 57, 61; The Professional-Patient Relationship Introduction and ERDs 24, 26-28)

REQUIRED REVIEW

Senior Vice President of Mission, Division Vice President of Ethics and Theology

Approval Signatures

Step Description	Approver	Date
Final Step	Joan VanSickle: Document Control Coordinator	09/2023
Reviewer	Laura Webster: Div VP Ethics	09/2023
	Michael Cox: SVP Mission Integration	09/2023

COMMONSPIRIT HEALTH
ADMINISTRATIVE POLICY

SUBJECT: Non-discrimination under the Americans with Disabilities Act (ADA)	**POLICY NUMBER:** Clinical A-021
EFFECTIVE DATE: October 9, 2023	**ORIGINAL EFFECTIVE DATE:** April 2, 2023

X National/System Offices X Acute Care Facilities X Non-Acute Care Facilities

PURPOSE

The purpose of this Policy is to confirm that no individual, including patients and visitors, shall be excluded or subjected to discrimination on the grounds of disability, race, color, national origin, age, sex, sexual orientation, gender identity, gender expression, or any other class protected by law when accessing, or obtaining the benefits of, any program or service offered by CommonSpirit Health.

POLICY

A. It is the policy of CommonSpirit to treat each individual as a unique person of incomparable worth, with the same right to adequate health care as all other persons (USCCB, 2018), and to provide to all persons full and equal access to CommonSpirit services and facilities.

B. CommonSpirit shall:
   1. Provide services and programs in the most integrated setting appropriate to the needs of the qualified individual with a disability;
   2. Make programs, services, activities, and facilities are accessible to all persons;
   3. Make reasonable modifications in its policies, practices, and procedures to avoid discrimination on the basis of disability, unless doing so would result in a fundamental alteration of the program, service, activity, or facility;
   4. Provide auxiliary aids to persons with disabilities, at no additional cost, where necessary to afford an equal opportunity to participate in or benefit from a program or activity;
   5. Designate a responsible employee to coordinate its efforts to comply with Section 504 and the Americans with Disabilities Act (ADA);
   6. Adopt grievance procedures to handle complaints of disability discrimination;
   7. Provide and post written notices that indicate:
      a. That the covered entity does not discriminate on the basis of disability;
      b. How to contact the individual who coordinates the covered entity's efforts to comply with the law; and

c. Information about the grievance procedures.

8. Local administrative policies may expand on CommonSpirit System Administrative Policies on the same topic, but may not be less stringent than the System Administrative Policy.

AFFECTED AREAS OR DEPARTMENTS

This Policy applies to CommonSpirit and its Direct Affiliates[1] and Subsidiaries[2], as well as any other related entity whose governing documents expressly require or provide for such entity(ies) to comply with CommonSpirit's policies and procedures (Conforming Entity).

DEFINITIONS

Individual with a Disability as defined by the Americans with Disabilities Act (ADA) is a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment (U.S. Department of Justice [USDoJ], 2020; U.S. Department of Health and Human Services [USHHS], 2015).

REFERENCES

Rosenbaum, S. (2007). The Americans with Disabilities Act in a health care context. In MJ Field & AM Jett, (Eds.). The Future of Disability in America. Washington, DC: National Academies Press.

United States Conference of Catholic Bishops. (2018). Ethical and religious directives for Catholic health care services (6th ed.). Retrieved from https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

United States Department of Justice. (2020, February 24). A guide to disability rights laws. Civil Rights Division. Retrieved from https://www.ada.gov/cguide.htm.

United States Department of Justice. (2012, October 10). Revised ADA regulations: Implementing Title II and Title III. Civil Rights Division. Retrieved from https://www.ada.gov/regs2010/ADAregs2010.htm.

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

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

.

Status **Active** PolicyStat ID **13907945**

Logo for All Policies Site - CHI Franciscan Health System	Origination	03/2014	Owner: Michael Cox: SVP Mission Integration
	Last Approved	10/2023	
	Effective	10/2023	Policy Area: Corporate Ethics/ Privacy
	Last Revised	10/2023	
	Next Review	10/2026	Applicability: VMFH and its affiliated entities, as applicable

Reproductive Healthcare, 392.00

PURPOSE

Provide general guidance in the area of reproductive health care.

POLICY

Virginia Mason Franciscan Health System-Wide

Virginia Mason Franciscan Health provides high quality health care to everyone in our care, recognizing each person's inherent dignity as a unique expression of life. We value informed consent and all clinicians are supported in disclosing all medically appropriate options with their patients, including interventions not available at our facilities. We do not provide direct abortions or in-vitro fertilization in any of our facilities. When a pregnant patient arrives with a serious pathological condition that puts the their life at risk, our clinicians are supported to pursue operations, treatments, and medications within the standard of care that have as their direct purpose the cure of a proportionately serious pathological condition even if this indirectly results in the termination of the pregnancy.

Clinicians, staff, patients, and their health care representatives should request an ethics consultation when a pregnant patient arrives with a serious pathological condition that puts the life of a pregnant person at risk of an irreversible complication, impairment of a bodily function, organ, part, or life is at risk. If the threat of harm is immediate, interventions should be provided and not be delayed while either waiting for a response from a request for an ethics consult and while the ethics consult process continues. See: Initiating Ethics Consult Policy, #370.00

VMFH Catholic Facilities:

The Ethical and Religious Directives for Catholic Health Care Services (ERDs) provides moral

guidance in Catholic health settings. Catholic entities do not provide elective sterilization. Procedures within the standards of care that induce sterility (whether temporary or permanent) are permitted when the direct intention is to cure or alleviate a serious pathological condition. Clinicians, staff, patients, and surrogate decision-makers consult with the Ethics Consult Service when ethical guidance is needed involving reproductive health care. See: Initiating Ethics Consult Policy #370.00

Catholic Sponsored Entities:

- VMFH St. Anthony Hospital in Gig Harbor, WA
- VMFH St. Clare Hospital in Lakewood, WA
- VMFH St. Elizabeth Hospital in Enumclaw, WA
- VMFH St. Francis Hospital in Federal Way, WA
- VMFH St. Joseph Medical Center in Tacoma, WA

VMFH Non-Catholic Facilities:

Clinicians and their patients in non-Catholic facilities do not use the Ethical and Religious Directives (ERDs) for moral guidance, unless they themselves are Catholic. Non-Catholic facilities can provide a range of elective reproductive services.

Non-Catholic Facilities:

- VMFH St. Anne Hospital in Burien, WA
- VMFH St. Michael Medical Center in Silverdale, WA
- VMFH Virginia Mason Medical Center in Seattle, WA

Emergency Contraception for Sexual Assault Victims:

For all of our hospitals with Emergency Departments: Virginia Mason Franciscan Health System supports the hospital's obligations under WAC 246-320-370 for emergency contraception provisions for sexual assault victims. The Emergency Department (ED) must provide emergency contraception as a treatment option to any person with ovaries who seeks treatment as a result of a sexual assault. The Emergency Department provider must provide each patient with medically and factually accurate and unbiased written and oral information about emergency contraception in a language the patient understands, the option to be provided emergency contraception, and must immediately provide emergency contraception, as defined in WAC 246-320-010, to each victim of sexual assault if the victim requests it and if it is not medically contraindicated**.** Refer to: Sexual Assault Victims Emergency Contraception Options Policy, #826.75

REFERENCES

The Ethical and Religious Directives for Catholic Health Care Services, Sixth edition (See: Issues in Care for the Beginning of Life Introduction and ERDs 45, 47, 48, & 49; The Professional-Patient Relationship

Introduction and ERDs 26-28; and Collaborative Arrangements with Other Health Care Organizations and Providers Introduction and ERDs 70 & 75)

WAC 246-320-370: Emergency Contraception for Sexual Assault Victims.

REQUIRED REVIEW

Senior Vice President of Mission

Division Vice President of Ethics and Theology

Chief Medical Officer

Chief Nursing Officer

Approval Signatures

Step Description	Approver	Date
Final Step	Joan VanSickle: Document Control Coordinator	10/2023
Reviewer	Laura Webster: Div VP Ethics	10/2023
	Michael Cox: SVP Mission Integration	10/2023

Washington State Department of Health

Hospital Reproductive Health Services

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

Hospital name: St. Francis Hospital		
Physical address: 34515 9th Ave South		
City: Federal Way	State: WA	ZIP Code: 98003
Hospital contact: Matt Miller	Contact phone #: 253-680-8881	

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

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

Abortion services
- ☐ Medication abortion
- ☐ Referrals for abortion
- ☐ Surgical abortion

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

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

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

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

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

Comments; limitations on services; other services

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

☐ **Additional comments on next page**

Dino Johnson — Signed by:

8/27/19 — Date (mm/dd/yyyy)

DOH 346-107 August 2019

Washington State Department of Health

Hospital Reproductive Health Services

Hospital name: St. Francis Hospital

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

Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman (patient) are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available

Dino Johnson — Signed by:

8/27/19 — Date (mm/dd/yyyy)

Exhibit 5

Financials

	Actual			Projected			
	2021	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**
Gross Revenue							
Inpatient Revenue	23,953,193	25,668,837	34,211,004	34,211,004	34,211,004	34,211,004	34,211,004
Outpatient Revenue	29,733,026	36,847,875	36,183,079	36,183,079	36,183,079	36,183,079	36,183,079
Total Gross Revenue	53,686,219	62,516,712	70,394,083	70,394,083	70,394,083	70,394,083	70,394,083
Deductions from Revnue							
Provision for Bad Debt	483,176	375,100	703,941	703,941	703,941	703,941	703,941
Contractual Adjustments	42,030,941	49,350,692	56,195,596	56,195,596	56,195,596	56,195,596	56,195,596
Charity and Uncompensated Care	751,607	937,751	1,267,093	1,267,093	1,267,093	1,267,093	1,267,093
Other Adjustments and Allowances	-	-	-	-	-	-	-
Total Deductions from Revenue	43,265,724	50,663,543	58,166,631	58,166,631	58,166,631	58,166,631	58,166,631
Net Patient Service Revenue	10,420,495	11,853,169	12,227,452	12,227,452	12,227,452	12,227,452	12,227,452
Other Operating Revenue	-	797	-	-	-	-	-
Total Operating Revenue	10,420,495	11,853,966	12,227,452	12,227,452	12,227,452	12,227,452	12,227,452
Operating Expenses							
Salaries and Wages	1,274,411	1,438,135	1,617,440	1,617,440	1,617,440	1,617,440	1,617,440
Employee Benefits	351,737	359,534	396,273	396,273	396,273	396,273	396,273
Contract Labor	255,288	758,160	572,675	572,675	572,675	572,675	572,675
Supplies	2,690,274	2,953,090	3,192,034	3,192,034	3,192,034	3,192,034	3,192,034
Purchased Services - Utilities	2,624	2,988	4,096	4,096	4,096	4,096	4,096
Purchased Services - Other	263,090	240,842	248,810	248,810	248,810	248,810	248,810
Depreciation	700,393	680,687	540,712	540,712	540,712	540,712	540,712
Rentals and Leases	1,380	2,672	3,340	3,340	3,340	3,340	3,340
Other Direct Expenses	1,125	2,339	8,719	8,719	8,719	8,719	8,719
Other Ancillary Expenses	2,979,585	4,226,130	4,955,743	4,955,743	4,955,743	4,955,743	4,955,743
Total Operating Expenses	8,519,908	10,664,576	11,539,842	11,539,842	11,539,842	11,539,842	11,539,842
Net Operating Income	1,900,588	1,189,389	687,610	687,610	687,610	687,610	687,610

Exhibit 6

Site Control Documentation

Department of Assessments

201 South Jackson Street, Room 708
Seattle, WA 98104

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

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

Send us mail

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

PARCEL

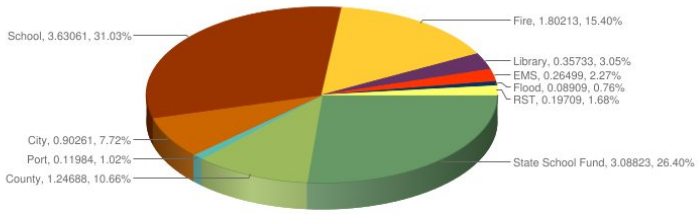
Parcel Number	750451-0020
Name	COMMON SPIRIT HEALTH
Site Address	34515 9TH AVE S 98003
Legal	ST FRANCIS HOSPITAL - BSP AS PER 2ND AMENDMENT UNDER REC # 20010726001843

BUILDING 1

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

TOTAL LEVY RATE DISTRIBUTION

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



50.22% Voter Approved

Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

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

Reference Links:

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

Notice mailing date: 06/24/2021

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

Updated: June 24, 2021

Exhibit 7

Facility List

Facility Listing

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

Source: Applicant

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

Exhibit 8

Medical Director Job Description

Medical Director
Cardiac Catheterization Lab/STEMI Program
Duties

Medical Director for the Cardiac Catheterization Laboratories and STEMI Program must be licensed and board certified in Interventional Cardiology. The Medical Director should have a minimum of 5 years of experience in invasive cardiology with strong leadership qualities. The Medical Director must disclose all conflicts of interest related to the laboratory.

The Medical Director of Cardiac Catheterization Laboratories will work closely and collaboratively with the Manager of Heart and Vascular, Chief Operating Officer, Chief Medical Officer and the Executive dyad for the Center for Cardiovascular Health.

The Medical Director of the Cardiac Catheterization Laboratories must be able to devote up to 10 hours per month on the following duties. Any hours over 10/month will need pre-approval.

A. Develop an efficient, collaborative working environment within cardiovascular and outlying organizations; including: referral hospitals and emergency medical services.
B. Responsible for policy development with the Manager of HVC.
C. Fiscally responsible with medical supplies, equipment and staff resources. Provides guidance to other physicians using the Cardiac Catheterization Laboratories on medical supplies, equipment and staff resources.
D. Assume medical leadership responsibility for clinical issues associated with delivery of care in cardiovascular procedural areas.
E. Provide medical leadership guidance in developing new technologies and procedures in the cardiovascular procedural areas and the Cardiovascular Service Line.
F. Promote high quality standards: Assists in setting quality metrics, monitors monthly data for improvement, implements processes to improve outcomes for patients.
G. Provide oversight of staff education, suggest and insure appropriate CEU opportunities for staff.
H. Responsible for advocating for healthcare resources; including new technology/equipment.
I. Aligns cardiovascular procedural areas and STEMI program to the Cardiovascular Service Line initiatives of Operations, Quality, Growth and Financial goals.
J. Work in collaboration with the institution and qualified medical and health physicist to ensure personnel safety and compliance regarding the use of x-ray generating equipment, including compliance with local regulations and laws.

Advocate for adequate radiation safety training and protective equipment for those working in the cardiac cath lab.

K. Assist with setting and revising criteria for granting privileges to physicians, within the Heart and Vascular Center.
L. Periodically review physician's performance, providing education, review performance of new physicians and orientation of those physicians and making recommendations for renewal of laboratory/interventional privileges.
M. Responsible for organization of Cardiac Cath Conference, Angio Review and M&M meetings to be a non-punitive process for improvement that is focused on practice improvement.
N. Maintain communication and cooperation among physicians, cardiovascular staff, clinicians, and the hospital administration to ensure that the patient is best served.
O. Utilizes American College of Cardiology and Society Cardiovascular Angiography and Interventions standards to promote best practices within the Heart and Vascular Center.
P. Provides oversight and guidance to STEMI Coordinator in operational planning, development and assessment of STEMI Program.

Created: November 18, 2014

Exhibit 9

Cath Lab Policies

Origination:	*10/2017*
Effective:	*02/2024*
Last Approved:	*02/2024*
Last Revised:	*02/2024*
Next Review:	*02/2027*
Owner:	*Patricia Hetrick: CNS*
Policy Area:	*Scopes of Service*
References:	*RegCompliance*
Applicability:	*CHI Franciscan Systemwide*

Cardiovascular Interventional Lab (Cath Lab) Scope of Service

POLICY

A. Exclusion patient population:

1. Pediatric, with exceptions in cardiac surgery capable hospitals based on body habitus and age
2. Bariatric patients that exceed the weight limit of the procedure table

B. For both Washington State Level I and Level II Cardiac Centers, a hospital-wide "no divert" policy exists for patients who meet the "Immediate" or "High Risk" criteria (Appendix A).

1. For Level I Cardiac Centers (Appendix B):
    a. If the Cath Lab is unable to immediately receive a ST-elevation myocardial infarction (STEMI) patient due to procedure(s) already in progress:
        I. If safe to do so, a non-emergent patient for which the key or critical elements have not yet occurred may be moved from the procedure table to a temporary staffed holding area in order for the STEMI patient to receive treatment.
        II. If unsafe to do so, the cardiologist may transfer the STEMI patient or consider fibrinolytic therapy.
    b. If the Cath Lab is unable to receive STEMI patients due to other than procedures already in progress (i.e., essential personnel and/or material resources are unavailable and/or the environment of care is unsafe):
        I. Cath Lab leadership will pro-actively notify the Emergency Department (ED) physician. Rationale: The ED physician is responsible for hospital *Code STEMI* activation and must communicate to EMS if the Cath Lab is temporarily unavailable.
        II. Cath Lab leadership will notify the ED physician once able to immediately receive *Code STEMI* patients again. Rationale: The ED physician must communicate to EMS when the Cath Lab is available to receive patients after any period of unavailability.
        III. If an in-house *Code STEMI*, the cardiologist may consider transfer or fibrinolytic therapy.
2. For Level II Cardiac Centers (Appendix C):
    a. Prehospital personnel transport STEMI patients to Level I Cardiac Centers (Appendix A).

b. If a STEMI patient presents themself to the ED of a Level II Cardiac Center (or in-hospital STEMI), the patient will immediately be transferred to a Level I Cardiac Center.

c. Fibrinolytic therapy may be considered for appropriate patients if immediate transfer is not possible.

C. For Cath Labs with 24/7 emergency capability:

1. A current monthly "call team" schedule is available in the Cath Lab spaces and ED. The ED is responsible for call team activation.
2. In addition to the physician, three Cath Lab staff members are on-call in a combination of at least one registered nurse (RN) and one cardiovascular technician (CVT) or interventional radiology technician (IRT), with the third member a RN, CVT or IRT.
3. Transport of the patient is a coordinated effort between the sending (e.g., ED) and receiving areas (i.e., Cath Lab). A patient will not be transported to the Cath Lab unless the physician is present to manage the patient.
4. On-call staff remain with patient until disposition to assigned unit.
5. Post-case, the procedure room will be cleaned and disinfected and made ready for the next procedure before leaving the facility.
6. On-call staff perform a final check with the physician before leaving facility.

D. This policy is consistent with organizational policy in providing patients and their significant others with:

1. Informed consent for planned procedure(s)
2. Emotional support while under care
3. A pre-procedure physical assessment and relevant diagnostic testing
4. Education regarding the planned procedure, including what to expect during and after the procedure and care once home
5. The most current evidence-based medical and interventional therapies with the assistance of specialized RNs, CVTs, and IRTs
6. Post-procedure assessment, monitoring, and care
7. Procedure-specific discharge education

SUPPORTIVE DATA

Acute Stroke Transfer Procedure

American Society of PeriAnesthesia Nurses, Practice Recommendation 1: Patient Classification/Staffing Recommendations, from the 2021-2022 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements

Cardiovascular/Interventional Labs: Call Team Response Time and Responsibilities

Clinical Engineering Work Request Procedure, 520.00

Code STEMI (ST Elevation Myocardial Infarction) Response Procedure

Concurrent and Overlapping Surgeries

Incident Reporting Information System (IRIS) Guidelines and Management, 418.00

Laser Safety Policy 555.00

Lead Equivalent Protective Devices (LEPD), 515.00

Lost Radiation Badge Report Guidelines

Malfunctioning/Defective Medical Equipment, 512.00

Medical Equipment Management Plan, 514.00

Medical Imaging Equipment Maintenance Failure

Plan for the Provision of Patient Care

Radiation Badge Wear Policy

Radiation Dose Reporting - Fluoroscopy

Regional Fire Response Procedure, 522.00

Structure Standards

Surgical Smoke and Bio-Aerosol Evacuation

Transfer/Discharge of Patient to Another Medical Facility, #846.50

Transporting of Patient (In-House) Policy, 846.60

Washington Administrative Code 246-310-735, Partnering Agreements

Washington State Department of Health, Washington State Emergency Cardiac and Stroke (ECS) System

SERVICES BY FACILITY

A. St. Joseph Medical Center (Tacoma)

1. Level I Cardiac and Level I Stroke Center
    a. Comprehensive cardiovascular care, including 24/7 emergent percutaneous coronary intervention (PCI)
    b. Standalone Interventional Radiology Lab performs regional Neurointerventional Radiology consultation and treatment for acute ischemic stroke (AIS).
2. Provides cardiothoracic surgery and structural heart intervention.
3. Combined Cardiology, Electrophysiology, and Vascular Lab
    a. 24/7 emergency capability
    b. Regular hours (excluding weekends and holidays)
        I. Twelve (12) Day of Procedure (Induction)/Postanesthesia Care (Recovery) bays, 0600 - 1930
        II. Seven (7) Procedure rooms, 0600 - 1630
    c. Provides diagnostic and interventional procedures, including:
        I. Right and left cardiac catheterization
        II. PCI
        III. Electrophysiology mapping studies and cardiac ablation

IV. Permanent pacemaker and cardioverter implantation and generator changes
V. Left atrial appendage occlusion (LAAO)
VI. Transcatheter aortic valve replacement (TAVR)
VII. Transcatheter Edge to Edge Repair for mitral valve (TEER)
VIII. Noncardiac endovascular intervention

B. St. Michael Medical Center (Silverdale)

1. Level I Cardiac and Level II Stroke Center
    a. Comprehensive cardiovascular care, including 24/7 PCI
    b. Fibrinolytic therapy available for AIS; admission to stroke-desginated unit or transport to Level I Stroke Center
2. Provides cardiothoracic surgery and structural heart intervention.
3. Combined Cardiology, Electrophysiology, Vascular, and Interventional Radiology Lab
    a. 24/7 emergency capability
    b. Regular hours (excluding weekends and holidays)
        I. Sixteen (16) Induction/Recovery bays plus seven (7) "radial lounge" recliners, 0500 - 2130
        II. Six (6) Procedure rooms, including a multipurpose room and hybrid operating rooms, 0500 - 1630
    c. Provides diagnostic and interventional procedures, including:
        I. Right and left cardiac catheterization
        II. PCI
        III. Electrophysiology mapping studies and cardiac ablation
        IV. Convergent Procedure for persistent atrial fibrillation
        V. Permanent pacemaker and cardioverter implantation and generator changes
        VI. LAAO
        VII. TAVR
        VIII. Noncardiac endovascular intervention

C. St. Francis Hospital (Federal Way)

1. Level I Cardiac and Level III Stroke Center
    a. Provides 24/7 emergent PCI.
    b. Fibrinolytic therapy available for AIS; transport to a Level I/II Stroke Center
2. No cardiothoracic surgery or structural heart intervention. St. Francis Hospital performs PCI procedures without on-site cardiothoracic surgery capability in accordance with Washington state requirements. If a patient experiences a procedural complication requiring cardiothoracic surgery, (s)he is transported to a cardiothoracic surgery capable hospital with whom there is a working agreement.
3. Combined Cardiology and Interventional Radiology Lab
    a. 24/7 emergency capability

b. Regular hours (excluding weekends and holidays)
    I. Four (4) Induction/Recovery bays, 0530-1800
    II. Two (2) Procedure rooms, 0700 - 1730
c. Provides diagnostic and interventional procedures, including:
    I. Right and left cardiac catheterization
    II. PCI
    III. Permanent pacemaker and cardioverter implantation and generator changes
    IV. Noncardiac endovascular intervention
d. Patients requiring cardiothoracic surgery are transferred to an appropriate hospital for management.

D. St. Anne Hospital (Burien)

1. Level II Cardiac and Level II Stroke Center
    a. Fibrinolytic therapy available for STEMI; resuscitation and stabilization prior to transfer to a Level I Cardiac Center
    b. Fibrinolytic therapy available for AIS; admission to stroke-designated unit or transport to Level I Stroke Center
2. No cardiac surgery, structural heart intervention, or PCI
3. Combined Cardiology and Interventional Radiology Lab
    a. No 24/7 emergency capability
    b. Regular hours (excluding weekends and holidays)
        I. Twelve (12) Induction/Recovery bays, 0700 - 1730
        II. Two (2) Procedure rooms, 0700 - 1730
    c. Provides diagnostic and interventional procedures, including but not limited to:
        I. Diagnostic right and left cardiac catheterization
        II. Permanent pacemaker and cardioverter implantation and generator changes
        III. Noncardiac endovascular intervention
    d. Patients requiring PCI or cardiothoracic surgery are transferred to an appropriate hospital for management.

E. St. Anthony Hospital (Gig Harbor)

1. Level II Cardiac and Level II Stroke Center
    a. Fibrinolytic therapy available for STEMI; resuscitation and stabilization prior to transfer to a Level I Cardiac Center.
    b. Fibrinolytic therapy available for AIS; admission to stroke-designated unit or transport to Level I Stroke Center.
2. No cardiac surgery, structural heart intervention, or PCI
3. Combined Cardiology and Interventional Radiology Lab
    a. No 24/7 emergency capability

b. Regular hours (excluding weekends and holidays)
    I. Twelve (12) Induction/Recovery bays, 0700 - 1600
    II. Two (2) Procedure rooms, 0700 - 1600
c. Provides diagnostic and interventional procedures, including but not limited to:
    I. Diagnostic right and left cardiac catheterization
    II. Permanent pacemaker and cardioverter implantation and generator changes
    III. Noncardiac endovascular intervention
d. Patients requiring PCI or cardiothoracic surgery are transferred to an appropriate hospital for management.

F. St. Elizabeth Hospital (Enumclaw) and St. Clare Hospital (Lakewood)

1. Neither have a Cath Lab.
2. Both are Level II Cardiac and Level III Stroke Centers.
    a. Fibrinolytic therapy available for STEMI; resuscitation and stabilization prior to transfer to a Level I Cardiac Center.
    b. Fibrinolytic therapy available for AIS; transport to a Level I/II Stroke Center.
3. St. Clare has a standalone Interventional Radiology Lab without 24/7 emergency capability.
4. St. Elizabeth does not have a standalone Interventional Radiology Lab.

PATIENT CARE PRIORITIZATION, TRIAGE, AND TRANSFER

A. Elective outpatients are scheduled for a date of procedure and time of arrival.

B. ED outpatients, bedded observation status patients, and admitted inpatients requiring diagnostic or interventional procedures are scheduled ("added on") based on clinical condition and priority determined by a provider.

C. A patient experiencing a *Code STEMI* medical emergency is prioritized over scheduled and "added on" patients.

D. If transporting from one department to another, a RN must accompany any monitored/critical care patient or any patient requiring ongoing nursing evaluation/observation.

E. If transporting to another facility with an intra-aortic balloon pump (IABP) in place, a Cath Lab RN competent to manage the pump must accompany the patient. EMS will manage the patient, but the RN must manage the IABP. After reaching the destination, the patient will be placed on the destination IABP equipment and the RN will return with the origination IABP equipment.

STAFFING

A. The responsible Department Director/Manager develops the staffing plan for each patient care area in accordance with organizational policy.

B. Procedure Room

1. Staffing in the procedure room is based on patient acuity and complexity, the procedure(s) to be performed, and the need for specialized or intensive equipment.
2. In addition to a physician, minimum staffing requirements are one RN, one IRT/CVT and one additional staff member (a RN or IRT/CVT). A trained RN may function as Circulator, Scrub, or Monitor and a trained IRT/CVT may function as Scrub or Monitor.
3. Support personnel includes another physician, additional staff members, Anesthesia, Respiratory Therapy and/or clinical specialists from subscribed hardware/software and material/equipment manufacturers.

C. Minimum staffing requirements for Induction and Recovery considers the American Society of PeriAnesthesia Nurses (ASPAN) patient classification and staffing recommendations.

1. PeriAnesthesia care (Induction and Recovery) may occur within the same physical environment. This may require the blending of patients and staffing patterns.
    a. Staffing considers patient acuity, census, nursing observations, required interventions, patient flow processes, support services, and physical environment.
    b. Clinical judgment is used to determine safe nurse-patient assignments based on patient acuity and nurse knowledge and skills.
    c. Support personnel may include certified nursing assistants (CNAs), combined CNA/health unit coordinators (HUCs), and/or combined HUC/telemetry monitor technicians.
2. Induction
    a. The RN focus is on validation of existing information and preparing the patient and family for the procedure.
    b. Minimum staffing requirements are two RNs, each providing care for up to four patients. Individual Cath Labs determine additional staffing requirements based on:
        I. Patient safety
        II. Patient volume, characteristics, and acuity
        III. Average time in patient preparation
        IV. Additional focus of the Induction area (i.e., blending of phases of care and physical layouts)
3. Phase I Recovery
    a. Patients who are clinically unstable or received anesthesia during their procedure are admitted to Phase I Recovery.
    b. The RN focus is on providing a critical care level of nursing during the immediate postanesthesia period and transitioning the patient to Phase II Recovery or an observation/inpatient unit for continued care.
    c. Minimum staffing requirements are two RNs, with at least one RN competent in Phase I Recovery care within direct line of site and with immediate access to the patient. The second RN should be able to hear a staff call for assistance and be able to immediately respond. Individual Cath Labs determine additional Phase I Recovery staffing requirements based on:
        I. Patient safety
        II. Patient volume, characteristics, acuity, and complexity of care
        III. Additional focus of the Phase I Recovery area (i.e., blending of phases of care and physical

layouts)

d. A 1:1 nurse-to-patient ratio is maintained from the start of Phase I Recovery admission until the critical elements below are met.
    I. Report received from anesthesia provider, questions answered, and care hand off complete
    II. Stable/secure airway
        i. No airway maneuvers or oral airway
        ii. No evidence of obstruction
        iii. No symptoms of respiratory distress
    III. Hemodynamically stable
    IV. No agitation, restlessness, or combative behavior
    V. Initial assessment complete

4. Phase II Recovery
    a. Clinically stable patients who received procedural sedation (without anesthesia) are admitted directly to Phase II Recovery.
    b. The RN focus is on preparing the patient and family for discharge home, and includes providing care instructions and education on prescribed medications.
    c. Minimum staffing requirements are two RNs, with at least one RN competent in Phase II Recovery. The second RN should be able to hear a staff call for assistance and be able to immediately respond. Individual Cath Labs determine additional Phase II staffing requirements based on:
        I. Patient safety
        II. Patient volume, characteristics, acuity, and complexity of care
        III. Family support
        IV. Additional focus of the Phase II Recovery area (i.e., blending of phases of care and physical layouts)
    d. A 1:3-5 nurse-to-patient ratio is generally acceptable for patients until discharged or requiring extended care:
        I. Extended observation or interventions (e.g., potential risk for bleeding, removing lines)
        II. Awaiting discharge transportation
        III. Awaiting non-critical care observation or inpatient bed

ENVIRONMENT OF CARE

A. RADIATION SAFETY

1. The Radiation Safety Officer (RSO) is responsible for the radiation safety program. A RSO or Deputy RSO is on site.
2. Staff members who work in the procedure rooms properly wear their assigned dosimeter ("badge") when on duty (neck level, above or over the lead apron, if wearing apron), exchange it as required, store it only in an approved location, and immediately report to the [Deputy] RSO if lost.

3. A staff member may voluntary declare her pregnancy and request a separate dosimeter to monitor fetal exposure.
4. Lead equivalent protective devices (LEPDs) (e.g., aprons) are required to reduce exposure to radiation and keep radiation exposure as low as reasonably achievable. Prior to each use, the LEPD is visually inspected for defects. In general, cracks or holes larger than a staple punch are grounds for reporting to the manager/designee and removing the device from service. For cleaning, mild soap and water or water-based antibacterial wipes are used before hanging on approved rack to air dry.
5. A Medical Health Physicist performs annual radiation safety surveys and calibration evaluations on all radiation producing devices. Results of these inspections are forwarded to Clinical Engineering for correction.
6. During a procedure, a staff member verbalizes the patient radiation dose to the physician at 3Gy and every 1Gy thereafter and documents each notification.
    a. If the equipment being used tracks fluoroscopy time only, a staff member verbalizes the cumulative time at 30 minutes and every 15 minutes thereafter and documents each notification.
    b. If the radiation dose reaches/exceeds 3Gy (or 60 minutes if equipment tracks fluoroscopy time only), the event is reported via the *Incident Reporting Information System (IRIS) Guidelines and Management, 418.00*.
    c. If the radiation dose reaches/exceeds 5Gy (or 60 minutes if equipment tracks fluoroscopy time only), additional patient radiation safety steps must be taken, including physician-patient discussion, patient skin inspection education, and follow-up phone calls.
7. Annual radiation safety training is required per the new employee dosimeter application. Current Cath Lab radiation safety training:
    a. New Hire (via *Pathways*): *Radiation Safety in Perioperative Practice* and *Radiation Safety and Fluoroscopy_PNW*
    b. Annual (calendar year) (via *Pathways*): *Radiation Safety and Fluoroscopy_PNW*

B. LASER SAFETY

1. The Laser Safety Officer (LSO) is responsible for the laser safety program. A LSO or Deputy LSO is on site.
    a. Laser Equipment will be checked into Biomed or designee prior to use for scheduled cases. The Vendor will have available a copy of the latest preventive maintenance.
    b. The Vendor will complete a safety check prior to use of the laser in the laser treatment procedure room.
2. Laser warning signs marked specific to the type of laser being used are posted at all entrances to the laser treatment procedure room. Room access is controlled to prevent unintentional exposure to laser beam.
3. Eye protection specifically designed for laser usage is used to protect against class 3B and 4 lasers with appropriate optical density and wavelength for the laser in use. Appropriate laser safety goggles are placed at the entrance to laser treatment procedure room.
4. The patient's eyes are protected with laser safety goggles. If unable to wear laser safety goggles, a laser specific eye shield may be used. Alternatively, saline-moistened eye gauze pads may be applied to both eyes.

5. All laser treatment procedure room windows (including door windows) are covered with nontransparent coverings for the following wavelengths: Nd Yag, Holmium Yag, and KTP.
6. The laser operator-trained person assigned to operate the laser is responsible for a laser safe environment and does not have other duties during the laser portion of the case.
7. A mechanical smoke evacuator is used to evacuate plume and noxious fumes. A fit-tested N95 respirator is required during cases that may generate aerosols, require airborne precautions, or in which there is possible disease transmission (e.g., human papillomavirus).
8. Fire safety precautions
    a. A fire extinguisher is present in the laser treatment procedure room.
    b. The laser is not activated in the presence of flammable or combustible agents (e.g., alcohol-based skin antiseptics, tinctures, and petroleum-based lubricants). The lowest patient effective oxygen concentration is used. The anesthesia provider considers additional safety measures regarding anesthetic gases and endotracheal tube use.
    c. Sterile water is available to the Scrub on the sterile field to keep moist the sponges, towels, and drapes near the procedure site.
9. Staff involved in laser procedures will complete New Hire and annual (calendar year) "Laser Safety" training in *Clinical Skills + SSO*. Laser operators will also complete initial and periodic training on laser equipment specifically used in the procedure rooms.

C. EQUIPMENT SAFETY

1. There is a formal process for selecting, acquiring, inspecting, testing, using, and maintaining fixed and portable medical equipment.
2. Each piece of medical equipment is tested for performance and safety prior to initial use. Thereafter, preventive maintenance inspections are scheduled.
    a. Equipment will have a sticker attached (if space allows) that indicates the month and year preventive maintenance is due, or "NO PM REQUIRED" for devices that do not require routine preventive maintenance.
    b. Equipment users are expected to check the date on this sticker prior to each use. If expired, a work request is submitted to Clinical Engineering. Equipment should not be used until serviced except in the event a delay in use would create a patient safety issue.
3. Technologists perform standard warm-up procedures according to equipment specifications.
    a. If equipment appears defective, malfunctions, or fails:
        I. The equipment is removed from service and made unavailable to others. It is marked "DEFECTIVE" or "DO NOT USE" to avoid accidental use.
        II. Substitute equipment is used, if available.
        III. The patient or staff member is treated/stabilized, if necessary.
        IV. The equipment user or manager/designee notifies Clinical Engineering. If the equipment event is urgent or life threatening, the hospital telephone operator can page them after regular hours.
        V. The equipment event and any injury to the patient or staff member, or near miss, is documented via IRIS.

D. FIRE SAFETY

1. Prior to procedure start, an Epic-based *Fire Safety* assessment is completed. Based on the assessment, a *Fire Risk* score is automatically assigned (Low, Medium, or High) and an interactive drop-down safety protocol for that score becomes visible.
    a. Procedure site: Above or Below xiphoid
    b. Open oxygen source: Face Mask, Nasal Cannula, or None
    c. Ignition source: Cautery, Fiberoptic light source, Laser, or None
    d. Prepping Agent: Alcohol-based, Other volatile chemical, Non-volatile chemical, or None
2. During a fire, the charge nurse/designee is responsible for immediately assessing oxygen use in the clinical areas and procedure rooms.
    a. If fire poses an imminent threat to the clinical area (within the same fire compartment), the charge nurse/designee may authorize the shut off of oxygen in that area.
    b. If fire poses an imminent threat to a procedure room (within the same fire compartment), the charge nurse/designee consults with any present anesthesia provider before shutting off oxygen, if time permits.
    c. If fire does not pose an imminent threat, a designated hospital representative will assess and determine the plan for oxygen shut off as time permits.
    d. Coordination of alternate sources of oxygen will be done through the Hospital Command Center.
3. If evacuation of procedure rooms is required:
    a. Notify all operating physicians and anesthesia providers of the need to terminate surgery as safely and quickly as possible.
    b. If unable to terminate the procedure, the patient will be stabilized and transferred to an alternate location to continue the procedure.
    c. Discontinue dispensing oxygen and gases.
    d. Utilize resuscitation ("ambu") bags for patient ventilation until reaching a safe area to connect resuscitation bags to oxygen source.

PRACTICE GUIDELINES, PERFORMANCE IMPROVEMENT, AND QUALITY METRICS

A. PRACTICE GUIDELINES

1. Provider, nursing, and technician specialty organizations and publications (e.g., American College of Cardiology, ASPAN, and Alliance of Cardiovascular Professionals)
2. CommonSpirit Health (CSH) Cardiovascular Service Line (CVSL) Specialty Clinical Councils (e.g., Cardiac Electrophysiology, Vascular, and Cardiology): Physician-led; focus on quality, clinical guideline development, research, knowledge sharing, program development, establishment of centers of excellence, and stewardship initiatives
3. CSH CVSL Sub-councils (e.g., Cath Lab Leaders, LAAO Coordinators, and Registry Managers): Support the Clinical Councils, facilitate communication, discuss new program development, and share best practices
4. CSH national standardized, evidenced-based, multidisciplinary policies/procedures

5. Regional standardized, evidenced-based, multidisciplinary computerized order sets and policies/ procedures

B. PERFORMANCE IMPROVEMENT

1. Twice monthly multi-regional and multi-specialty physician "cath conferences": Review challenging cases; peer-to-peer consultation and shared decision making for complex patients
2. Monthly multi-regional and multi-specialty physician Morbidity & Mortality conferences: Review patients with unanticipated complications and/or quality metric fallouts
3. Quarterly Center for Cardiovascular Health individual regional meetings (Pierce, Peninsula, and King): Joins the cardiovascular specialties and operational leadership in discussion on current provision of patient care topics, surgical/procedural volumes, and service line measures, a composite of:
    a. Year-over-year growth
    b. Patient access and system integrity
    c. Improved clinical care
    d. Patient experience
    e. Research and academics growth
    f. Provider and staff engagement
4. Quarterly regional Emergency Medical Services sponsored meetings with hospital Emergency and Cardiovascular partners; RN data abstractor presents data specific to regional performance and patient outcomes
5. Individual STEMI case multidisciplinary review via email, including ED team/leadership, Cath Lab team/ leadership, and prehospital Physician Advisor (as appropriate)
6. Hospital Incident Reporting Information System (IRIS): Allows for formal reporting and investigation of any event that is not consistent with the routine care of the patient, including near misses, or any event that is not consistent with normal operations that may impact the patient
7. New patient program/procedures: New requests are researched and discussed with the respective Medical Director(s) and appropriate Cardiovascular or Interventional Radiology leadership prior to presenting to Medical Staff leadership for review, approval, and credentialing.

C. QUALITY METRICS: A dedicated RN data abstractor team populates the Registries/Databases/Program. Hospital performance is reported out in a group setting (e.g., regional meetings) and individual performance 1:1 with physician.

1. National Cardiovascular Data Registries (NCDR®) - AFib Ablation, CathPCI, EP Device Implant, LAAO, and STS/ACC TVT: Compares hospitals within the Registry that perform atrial fibrillation ablation, PCI, cardioverter/cardiac resynchronization implantation, LAAO, and TAVR/TEER
2. National Society of Thoracic Surgeons Adult Cardiac Surgery and General Thoracic Surgery Databases: Compares hospitals within the Databases that perform adult cardiac and general thoracic surgery
3. National Society for Vascular Surgery Quality Initiative® (VQI®): Compares hospitals within the collaborative to national and regional benchmarks for carotid endarterectomy, carotid artery stent, and endovascular abdominal aortic aneurysm repair procedures; each hospital and physician receives regular performance data to use in support of quality improvement initiatives
4. National Get with the Guidelines® - Heart Failure Registry: Benchmarks participating hospitals by size and

region; evaluates by physician group or individual

5. Regional Foundation for Health Care Quality Cardiac Care Outcomes Assessment Program (COAP): Compares hospitals within the Pacific Northwest region that perform PCI and adult cardiac surgery

REQUIRED REVIEW

Cath Lab Leadership; Center for Cardiovascular Health; System Nursing Leadership Team

All revision dates: 02/2024, 10/2022, 10/2017

Attachments

Appendix A: Prehospital Cardiac Triage Destination Procedure.pdf
Appendix B: Hospital Emergency Response Guideline for Acute Coronary Syndrome (ACS), Level I Cardiac Center.pdf
Appendix C: Hospital Emergency Response Guideline for Acute Coronary Syndrome (ACS), Level II Cardiac Center.pdf

Approval Signatures

Step Description	Approver	Date
	Keith Sprague: Executive Division Director, CVSL	02/2024
Cardiovascular/Interventional Radiology	Patricia Hetrick: CNS	02/2024
	Patricia Hetrick: CNS	02/2024

Applicability

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

Origination:	*10/2017*
Effective:	*02/2022*
Last Approved:	*02/2022*
Last Revised:	*02/2022*
Next Review:	*02/2025*
Owner:	*Patricia Hetrick: CNS*
Policy Area:	*Cardiac Cath Lab/ Interventional Radiology*
References:	
Applicability:	*CHI Franciscan Systemwide*

Cardiovascular/Interventional Labs: Call Team Response Time and Responsibilities

PURPOSE/EXPECTED OUTCOME

To communicate the combined Cardiovascular/Interventional Labs Call Team response time and responsibilities

DEFINITIONS

Call Team: Registered Nurses, Interventional Radiology Technologists, and Cardiovascular Technologists assigned to report for work once activated

BACKGROUND

A. A current monthly Call Team schedule is posted in the Cardiovascular/Interventional Radiology Lab spaces and Emergency Department.

B. The individual staff member is responsible to ensure current, accurate contact information at all times.

C. Changes to the Call Team schedule after posting require the approval of the Director/Manager/Supervisor or designee.

D. Approved changes are made to the Call Team schedule by the Director/Manager/Supervisor or designee.

PROCEDURE

Once activated, the Call Team members will:

1. Acknowledge receipt of notification within 10 minutes.
2. Be on site ready for work within 30 minutes.
3. Remain with the patient until disposition to assigned room.
4. Ensure the procedure room is cleaned and ready for the next procedure.
5. Check in with physician prior to leaving facility.

REQUIRED REVIEW

Combined Cardiovascular/Interventional Radiology Lab Leadership; Center for Cardiovascular Health

Leadership

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Keith Sprague: Executive Division Director, CVSL	02/2022
Cardiovascular/Interventional Radiology	Patricia Hetrick: CNS	02/2022
	Patricia Hetrick: CNS	02/2022

Applicability

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

Current Status: *Active* **PolicyStat ID:** *12960672*

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Last Revised: *11/2020*
Next Review: *02/2026*
Owner: *Patricia Hetrick: CNS*
Policy Area: *Cardiac Cath Lab/ Interventional Radiology*
References:
Applicability: *CHI Franciscan Systemwide*

Cardiovascular/Interventional Radiology (Cath Lab/IR) Procedure Rooms: Cleaning and Disinfection, Staff Responsibilities

PURPOSE

To outline Cath Lab/IR staff responsibilities in cleaning and disinfection of the procedure rooms

BACKGROUND

Although health care infection control guidelines are readily available in the hospital and ambulatory settings, data directly applicable to Cath Lab/IR environmental cleaning are limited.

A. The Society for Cardiovascular Angiography and Interventions (SCAI) revisited their earlier guidelines for infection control in the cardiac catheterization laboratory (Chambers et al., 2006). The updated version focuses mostly on the individual patient and staff preparation and little on environmental cleaning. Recommendations at the time of writing:

1. Per SCAI: 1) Spot-clean between procedures; 2) Wet-mop or wipe floor if gross spillage is evident; 3) Remove trash between each case; 4) Completely clean room once a day; and 5) Air vents should be cleaned at least monthly
2. Per the Centers for Disease Control (as stated by SCAI): After the last procedure, wet-vacuum or mop the floor

B. The Society of Interventional Radiology endorses the cleaning and disinfection practices set forth in the joint practice guidelines developed by interventional radiologists and nursing professionals from the Association of periOperative Room Nurses (AORN) and Association for Radiologic and Imaging Nursing (Chan et al., 2012). The authors state that given the limited scientific foundation, their recommendations are intended to guide clinical practice and are not mandated.

C. In addition to the guidelines set forth by the Association for the Health Care Environment [of the American Hospital Association], CommonSpirit Health National Environmental Services (EVS) Leadership Team (2020) mandated the use of AORN cleaning and disinfection practices in the Cath Lab/IR procedure rooms. Terminal cleaning and disinfection practices are essentially the same as between procedures except during terminal cleaning:

1. Damp high dusting disinfection is performed.

2. All walls are cleaned/disinfected using a flat mop.
3. Enhanced cleaning processes may be required after isolation patient discharge.

DEFINITIONS

CLEAN: Remove visible contaminants; damaged items may not be able to be cleaned

DISINFECT: Destroy microorganisms; clean prior to disinfection; damaged items may not be able to be disinfected

TERMINAL CLEANING: Procedure room cleaning and disinfection performed by EVS after regular business hours or when notified by Cath Lab/IR staff after discharge of an isolation patient; Cath Lab/IR staff may terminally clean a room after discharge of an isolation patient to accommodate the remaining patient schedule

POLICY

A. Environmental controls to decrease transmission of microorganisms into the procedure room during and between procedures include keeping outside doors closed whenever possible and limiting traffic to essential personnel only.

B. Environmental cleaning and disinfection to reduce the number of microorganisms in the procedure room to the lowest level possible is a team effort involving both Cath Lab/IR and EVS personnel.

1. Cleaning and disinfection work flow moves:
    a. Top to bottom
    b. Outside to inside
    c. Clean to dirty
    d. Counterclockwise around the room (walls)
2. Cleaning and disinfection practices that produce mist, aerosols, or dust will not be used.
3. Cleaning cloths and mops will be placed in the cleaning solution only once and changed after each use.

C. EVS maintains an adequate supply of approved cleaning/disinfection solutions and related accessories (e.g., buckets, cleaning cloths, mops) inside the Cath Lab/IR spaces.

D. Appropriate personal protective equipment is worn and EVS-approved cleaning/disinfection practices are used according to manufacturer recommendations.

E. Procedure rooms are terminally cleaned once a day by EVS (nightly) and any time after an isolation patient is discharged (by EVS if notified, otherwise by Cath Lab/IR staff).

1. After weekend, holiday, and after-hours procedural cases, Cath Lab/IR staff is responsible for notifying EVS to perform terminal cleaning of a procedure room.
2. Any time after an isolation patient has been discharged, Cath Lab/IR staff will leave the isolation signage on the procedure room door until the room has been terminally cleaned and is ready for use.
3. Special cleaning and disinfection processes may be required for specific organisms (e.g., C. difficile) and/or infection transmission-based isolation precautions (e.g., airborne).
4. After an airborne isolation patient has been discharged (e.g., COVID-19), the room will be left vacant for a period of time dependent on the number of room air exchanges per hour.

CATH LAB/IR STAFF RESPONSIBILITY

A. Prior to the First Procedure of the Day in Each Room

1. Perform a visual inspection for cleanliness.
2. As needed, damp-dust all horizontal surfaces within reach before bringing supplies into the room.
3. Inspect outside equipment before bringing into the room, cleaning/disinfecting as needed.
4. If first procedure is an isolation patient, remove all non-essential equipment and supplies and ensure appropriate signage is displayed on the door.

B. Between Procedures (Non-Isolation)

1. If visibly contaminated, spot-clean lead aprons using soap and water.
2. Remove all trash and soiled linen.
3. Spot clean/disinfect walls as needed.
4. Clean/Disinfect:
    a. High touch surfaces (e.g., door knobs)
    b. All equipment, mobile (e.g., intravenous poles/pumps) and fixed (e.g., imaging hardware)
    c. All furniture, mobile (e.g., tables and trash/linen receptacles) and fixed (e.g., cabinets and counters)
    d. Air vents
    e. Procedure table and mattress, arm boards, controls, attachments, and base
5. Clean/Disinfect computers and other electronic devices used during a procedure if:
    a. Clinician hands were contaminated (wearing gloves is contaminated)
    b. Touched by patient
    c. Visibly contaminated
6. Replace trash and linen liners.
7. Make procedure bed.
8. Perform a visual inspection for cleanliness.
9. Move all mobile furniture and equipment toward the center of the room. Mop the perimeter, then move toward the center of the room. Next, move the furniture and equipment back in place while the floor is still wet to sanitize wheels. Lastly, mop around the procedure table.

C. Terminal (including Isolation)

1. If visibly contaminated, spot-clean lead aprons using soap and water.
2. Remove all trash and soiled linen.
3. Perform damp high dusting disinfection.
4. Clean/Disinfect walls to ceiling height using flat mop.

5. Clean/Disinfect:
    a. High touch surfaces (e.g., door knobs)
    b. All equipment, mobile (e.g., intravenous poles/pumps) and fixed (e.g., imaging hardware)
    c. All furniture, mobile (e.g., tables and trash/linen receptacles) and fixed (e.g., cabinets and counters)
    d. Air vents
    e. Procedure table and mattress, arm boards, controls, attachments, and base
6. Clean/Disinfect all computers, keyboards, mice, monitors, and other electronic devices.
7. Replace trash and linen liners.
8. Make procedure bed.
9. Perform a visual inspection for cleanliness.
10. Move all mobile furniture and equipment toward the center of the room. Mop the perimeter, then move toward the center of the room. Next, move the furniture and equipment back in place while the floor is still wet to sanitize wheels. Lastly, mop around the procedure table.

D. Before Leaving Room at the End of Day

1. If visibly contaminated, spot-clean lead aprons using soap and water.
2. Remove all trash and soiled linen.
3. Clean/Disinfect visibly contaminated surfaces, equipment, furniture, and walls.
4. Clean/Disinfect *non*-wall mounted computers, keyboards, mice, and monitors. Note: Wall mounted and desktop computers permanently located inside the procedure room are cleaned and disinfected during terminal cleaning.
5. If last procedure was an isolation patient, notify EVS and include the time that it is safe to enter the room. Ensure appropriate signage remains displayed on the door.

REFERENCES

A. Chambers, C., Eisenhauer, M., McNicol, L., Block, P., Phillips, W., Dehmer, G., Heupler, F. and Blankenship, J., 2005. Infection control guidelines for the cardiac catheterization laboratory: Society guidelines revisited. Catheterization and Cardiovascular Interventions, 67(1), pp.78-86. (Approved by Society for Cardiovascular Angiography and Intervention)

B. Chan, D., Downing, D., Keough, C. E., Saad, W. A., Annamalai, G., d'Othee, B. J., ... & Krishnamurthy, V. (2012). Joint practice guideline for sterile technique during vascular and interventional radiology procedures: from the society of interventional radiology, association of perioperative registered nurses, and association for radiologic and imaging nursing, for the society of interventional radiology (Wael Saad, MD, Chair), standards of practice committee, and endorsed by the cardiovascular interventional radiological society of Europe and the Canadian interventional radiology association. Journal of Vascular and Interventional Radiology, 23(12), 1603-1612.

C. Cleaning and Disinfection of Computer Equipment policy #104.80 (Infection Prevention)

D. Cleaning and Disinfection of the Environment and Equipment Policy #104.85 (Infection Prevention)

E. Cleaning of Cath Lab/PostOp/PreOp Department, 8003.00 (Environmental Services)

F. Cleaning of Stretchers: In-Between Patient Use, 8050.00 (Environmental Services)

G. COVID-19 Considerations for Cardiovascular/Interventional Radiology (Cath Lab/IR) (Cath Lab/IR)

H. Decontamination Standard # 115.00 (Infection Prevention)

I. Disinfectant Standard # 120.00 (Infection Prevention)

J. Infection Prevention and Control Standard, 153.00 (Infection Prevention)

K. Invasive Area Standard Work Activity Sheets: In-Between and Terminal Invasive Cleaning for All Invasive Procedure Rooms, including Operating Suites, Invasive Radiology, Cath Lab, and Endoscopy. CommonSpirit Health National EVS Leadership Team, January 2020.

L. Isolation Patient Room and Dismissal Cleaning - Multidrug Resistant Organisms: MDRO – Acinetobacter, MRSA, VRE ESBL, Contact, Droplet and Airborne Precautions, C-Difficile, 8021.00 (Infection Prevention)

M. Lead Equivalent Protective Devices (LEPD), 515.00 (Equipment Management)

N. Perioperative Sanitation and Cleaning Procedure (Perioperative Services)

O. Prion and Creutzfeldt-Jakob Disease Managment Protocol (Perioperative Services)

P. Room Cleaning, Infection Control "Bug Byte", https://chifh.catholichealth.net/Comm/ip/_layouts/15/WopiFrame.aspx?sourcedoc=/Comm/ip/Documents/Bug%20Bytes/Room%20Cleaning%20Frequently%20Asked%20Questions.doc&action=default

Q. Standard Precautions Policy # 939.50 (Infection Prevention)

R. Surgery Area Cleaning (Terminal Cleaning), 8027 (Environmental Services)

S. Terminal Cleaning Cath Labs and Specials Treatment Rooms, 8044.00 (Environmental Services)

REQUIRED REVIEW

Diagnostic Imaging (SJMC); Cardiovascular and Critical Care (SMMC); Infection Control; Environmental Services; Perioperative Service Line; Regional Cardiovascular Service Line

DISTRIBUTION

Cardiovascular/Interventional Radiology

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Keith Sprague: Executive Division Director, CVSL	02/2023
	Patricia Hetrick: CNS	01/2023

Applicability

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

Current Status: *Active* **PolicyStat ID:** *10249926*

Origination: *11/2017*
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Last Approved: *08/2021*
Last Revised: *08/2021*
Next Review: *08/2024*
Owner: *Patricia Hetrick: CNS*
Policy Area: *Cardiac Cath Lab/ Interventional Radiology*
References:
Applicability: *CHI Franciscan Systemwide*

Contrast-Induced Nephropathy Prevention: Cath Lab/IR

PURPOSE

I. Perform routine pre-procedural screening of all patients with the possibility of contrast use by determining the Maximum Allowable Contrast Dose (MACD)

II. Communicate the MACD to intra-procedural staff and the provider to facilitate prudent contrast use throughout the procedure

III. Ensure formal notification process exists for any contrast dose greater than the determined MACD *or greater than 300 mL regardless of MACD*

BACKGROUND

I. The volume of contrast administered during a procedure is crucial. However, no single, universally accepted threshold is known to cause contrast-induced nephropathy (CIN).

II. The provider may utilize the Epic *Hydration Orders for Reducing the Risk of Radiocontrast Induced Nephrotoxicity [30400683]* for patients determined to be at higher risk for CIN.

A. Diabetes mellitus
B. History of kidney disease, kidney transplant, or solitary functioning kidney
C. Calculated creatinine clearance or calculated GFR less than 60 mL/min
D. History of heart failure
E. History of multiple myeloma
F. Exposure to IV radiocontrast media within the past 72 hours
G. Long-term non-steroidal anti-inflammatory agents or COX-II inhibitors, aminoglycosides, cyclosporine, lithium, amphotericin B, cisplatin, and/or carboplatin

SUPPORTIVE DATA

Aoun, J., Nicolas, D., Brown, J. R., & Jaber, B. L. (2018). Maximum allowable contrast dose and prevention of acute kidney injury following cardiovascular procedures. *Current opinion in nephrology and hypertension*, *27*(2), 121–129. https://doi.org/10.1097/MNH.0000000000000389

RESPONSIBLE PERSONS

Physicians, Advanced Practice Clinicians, Radiology Technologists, Cardiovascular Technologists, Registered Nurses, Managers/Directors, and designated Compliance/Performance Improvement roles.

PROCEDURE

1. The MACD calculation tool is available on computer desktops. Document the MACD for the patient and include it in the procedural time out.
2. Procedural staff will notify physician at 100 mL and every 50 mL thereafter. For example, "We have given 100 mL and the maximum dose for this patient is 225 mL."
3. Submit an IRIS for any contrast dose greater than the MACD *or greater than 300 mL regardless of MACD* for tracking and follow-up purposes. Rationale: The MACD may be higher than 300 mL and the case may require more than 300 mL of contrast. The intent of the process is not to hinder the ability to perform an optimal study but to heighten awareness of contrast usage and communicate the need for patient follow-up.
4. Document all contrast use in MacLab or EHR, and communicate during patient hand-off to next phase of care.

REQUIRED REVIEW

Diagnostic Imaging Leadership; Regional Cardiovascular Service Line

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Keith Sprague: Executive Division Director, CVSL	08/2021
Cardiovascular/Interventional Radiology	Patricia Hetrick: CNS	08/2021
	Patricia Hetrick: CNS	08/2021

Applicability

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

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Next Review: *02/2026*
Owner: *Patricia Hetrick: CNS*
Policy Area: *Cardiac Cath Lab/ Interventional Radiology*
References:
Applicability: *CHI Franciscan Systemwide*

COVID-19 Practice Guidelines for Cardiovascular Laboratory/Interventional Radiology (Cath Lab/IR)

PURPOSE

To communicate Cath Lab/IR COVID-19 practice guidelines

POLICY

A. The COVID-19 Prevention Plan (CPP) (PolicyStat) is the definitive organizational response to prevent the transmission of COVID-19.

B. Site-specific Infection Prevention Program Managers are available for consultation as needed.

C. Leadership will evaluate on a weekly basis the community transmission rate and direct infection prevention practices that may supersede existing policy. *Pathogens of Concern Updates* (OneNet) and *Process Change Alerts* provide timely need-to-know information and related practice changes.

D. **Any staff member may choose to elevate their personal protective equipment (PPE) at any time.**

E. CODE BLUE: All Code Blue responses will be treated as COVID-19 positive.

SUPPORTIVE DATA

- COVID-19 Prevention Plan (CPP) (PolicyStat)
- Pathogens of Concern Updates (OneNet)

PRE-/POST-PROCEDURE

A. Asymptomatic patients - not tested, pending test results (e.g., admission), or confirmed negative:

1. Spaced at least six feet apart
2. Privacy curtains between beds pulled closed
3. Masked, unless contraindicated
4. Standard precautions
5. **During HIGH community transmission rate:**
    a. Eye protection during every patient encounter.
    b. For aerosol-generating procedures (AGPs) and uncontrolled respiratory secretions (refer to

signage), treat as COVID-19 positive (refer to section B.):

I. Highest level of PPE: Fit-tested N95 with eye protection or CAPR/PAPR, gown, and gloves

II. Private room or procedure room

B. Symptomatic patients **OR** confirmed positive patients, even if asymptomatic

1. Private room or procedure room

a. No *pre*-procedure private room:

I. If arriving from home, mask for source control and isolate as far as safely possible from the general population.

II. If in-house (e.g., ED or nursing unit), hold at sending location (if possible) until ready to transport directly into the procedure room.

III. If transferred in from another hospital for a procedure, hold at initial receiving location (e.g., ED) (if possible) until ready to transport directly into the procedure room.

b. No *post*-procedure private room and not directly transporting to receiving nursing unit (e.g., Intensive Care):

I. Consult the main Post Anesthesia Care Unit in advance of procedure start for possible private room availability and post-procedure care.

II. Post-procedure care may occur in the procedure room until stable and required criteria met before transport to accepting unit.

III. If no other options *and no AGPs or uncontrolled respiratory secretions:* Mask for source control and isolate in a pre-designated location within the post-procedural area as far as safely possible from the general population until appropriate bed available (or discharge home).

2. Masked when others are present in the room, unless contraindicated

C. **REGARDLESS of community transmission rate:**

a. Highest level of PPE during every patient encounter: Fit-tested N95 with eye protection or CAPR/PAPR, gown, and gloves

b. Private room or procedure room for AGPs or uncontrolled respiratory secretions (refer to signage).

PROCEDURE ROOM

1. Restrict the exposed/symptomatic (pending test results or confirmed positive) patient population to a dedicated Cath Lab/IR room, if possible.
2. Perform the procedure at the end of the working day, if possible. Note: Patients may be undergoing procedures in neighboring rooms. No modification to ventilation for any of the Cath Lab/IR rooms is required.
3. Provide advance notice to Anesthesia and Respiratory Therapy to:

a. Consider intubation prior to transport to the Cath Lab/IR. Rationale: Patients with a borderline respiratory status may be intubated to avoid emergent intubation and AGPs while in the Cath Lab/IR room.

b. Verify that required anesthesia equipment/supplies (e.g., HEPA filter for circuit) are in place inside

the Cath Lab/IR room or readily available outside the room (e.g., GlideScope).

c. Potentially wait outside the procedure room in PPE if not required to remain inside, in case of clinical deterioration.

4. Remove all non-essential equipment and supplies from the Cath Lab/IR room prior to patient arrival.
5. Store additional supplies (e.g., extra common wires) for potential use in a plastic bag inside the room to minimize door opening. If not used, these supplies may be later returned to stock.
6. Place clean patient labels inside room for potential lab sampling.
7. Seal room openings that communicate outside the immediate Cath Lab/IR room, if applicable (e.g., control room).
8. Identify an appropriate location to temporarily isolate the incoming transport bed/stretcher (ideally inside the Cath Lab/IR room). Wipe down the bed frame with hospital grade disinfectant wipes.
9. If available, ensure the fully charged mechanical chest compression device (e.g., Lucas) is inside the Cath Lab/IR Department [but outside the room] in the event of a Code Blue.
10. Identify an additional team member to remain readily available outside the Cath Lab/IR room and function as a runner in order to prevent personnel from leaving and re-entering the Cath Lab/IR room. The door may be opened wide enough to hand off items.
11. Post appropriate room isolation signage on the Cath Lab/IR room door. Wear N95, if fit-tested, with eye protection/face shield; otherwise, CAPR or PAPR with hood (aka shroud); CAPR with disposable lens cover plus surgical mask; or PAPR with face shield and cuff plus surgical mask. Note: Although the CAPR with disposable lens cover or PAPR with face shield provides personal respirator protection, a **surgical mask is required** to prevent exhaled air from reaching the sterile field.
12. The Cath Lab/IR will coordinate patient transport with the sending unit. This patient must move from the point of origin directly into the designated Cath Lab/IR room without delay or holding in another area unless a private room is available.
13. The patient will be transported to the Cath Lab/IR room with a surgical mask in place. The surgical mask will remain in place during the procedure (if possible) and subsequent transport to the accepting unit.
14. No hospital paperwork will enter the Cath Lab/IR room with the patient. Determine the status of the informed consent for the procedure. If still pending and patient is able to consent, consider obtaining informed consent similar to the telephone consent procedure. The interventional cardiologist may verbally consent the patient in the presence of two witnessing licensed health care providers (RN, PA, ARNP, or physician). The consent form may then be completed with the printed name of the patient giving consent, the provider signature, and the dual witness signature with "Verbal Consent" documented in the witness line.
15. Unless transferring to Intensive Care, Anesthesia will extubate and recover the patient with existing Cath Lab/IR staff support prior to transfer to the accepting unit. The patient will not transfer to the post-procedural area or to the main Post Anesthesia Care Unit unless a private room is available.
16. For transport to the accepting unit:
    a. Place a surgical mask on the patient.
    b. Transport staff will don a clean gown and gloves and [continue to] wear the N95 mask with eye protection/face shield (or CAPR/PAPR) to the accepting unit.
    c. Transport staff will doff PPE with assistance on accepting unit, then clean reusable PPE prior to

returning to the Cath Lab/IR.

17. After the patient has been discharged from the procedure room:
    a. If there was no AGP, there is no time requirement for the Cath Lab/IR room to remain empty with the door closed before re-entry for cleaning and disinfection.
    b. If there was an AGP, the individual room air exchange rate determines the minimum time requirement for the Cath Lab/IR room to remain closed before the next patient procedure. AGP precautions signage will be posted on the Cath Lab/IR door to prevent re-entry and will remain in place until the minimum time has passed.
        I. Any procedural staff members remaining in the room during the minimum AGP time requirement (e.g., sharps/waste collection, breakdown of equipment) must remain in full AGP PPE.
        II. No clean items may enter the room during this time.
18. Contact Environmental Services (EVS) to perform the required terminal cleaning and disinfection, unless performed by local staff.
    a. EVS will remove the room isolation and AGP signage upon completion of terminal cleaning and disinfection (or notify staff to remove the signage).
    b. Once terminal cleaning and disinfection have been completed, the room is ready for use.

EDUCATION

All Cath Lab/IR personnel are fit-tested for a N95 mask and instructed in its wear and/or trained in CAPR/PAPR use.

REQUIRED REVIEW

Division Director, Diagnostic Services (SJMC); Director of Ambulatory Surgery and Procedural Services (SMMC); Infection Prevention; Center for Cardiovascular Health

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Keith Sprague: Executive Division Director, CVSL	03/2023
Cardiovascular/Interventional Radiology	Patricia Hetrick: CNS	02/2023
	Patricia Hetrick: CNS	02/2023

Applicability

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

State of Washington
Prehospital Cardiac Triage Destination Procedure

Assess Applicability for Triage

- ❒ Post cardiac arrest with ROSC
  -OR-
- ❒ ≥ 21 years of age with symptoms lasting more than 10 minutes but less than 12 hours suspected to be caused by coronary artery disease:
  - **Chest discomfort** (pressure, crushing pain, tightness, heaviness, cramping, burning, aching sensation), usually in the center of the chest lasting more than a few minutes, or that goes away and comes back.
  - **Pain or discomfort in □or both arms,** neck, jaws, shoulders, or back.
  - **Shortness of breath** with or without chest discomfort.
  - **Epigastric (stomach) discomfort,** such as unexplained indigestion, belching, or pain.
  - **Other symptoms** may include sweating, nausea/vomiting, lightheadedness.

NOTE: Women, diabetics, and geriatric patients might not have chest discomfort or pain. Instead they might have nausea/vomiting, back or jaw pain, fatigue/weakness, or generalized complaints.

NO → Transport per regional patient care procedures

YES — ***If ALS has not been dispatched, upgrade if available.***

Assess Immediate Criteria

- ❒ Post cardiac arrest with return of spontaneous circulation
- ❒ Hypotension or pulmonary edema
- ❒ EKG positive for STEMI (if available)

NO

Assess □igh Ris□ Criteria
In addition to symptoms in Box 1, pt. has 4 or more of the following:

- ❒ Age ≥ 55
- ❒ 3 or more CAD risk factors:
  - ❍ family history
  - ❍ high blood pressure
  - ❍ high cholesterol
  - ❍ diabetes
  - ❍ current smoker
- ❒ Aspirin use in last 7 days
- ❒ ≥2 anginal events in last 24 hours, including current episode
- ❒ Known coronary disease
- ❒ ST deviation ≥ 0.5 (if available)
- ❒ Elevated cardiac markers (if available)

NO → If EMS personnel still suspect an acute coronary event, contact medical control for destination. If not, transport per regional patient care procedures.

YES

Unstable patients (life-threatening arrhythmias, severe respiratory distress, shock) unresponsive to EMS treatment should be taken to the closest hospital.

Assess Transport Time and Determine Destination by Level of Prehospital Care□

BLS□ILS	ALS

BLS□ILS

Level I Cardiac Hospital w/in 30 minutes

- **YES** → Go to Level I Cardiac Hospital and alert destination hospital en route ASAP
- **NO** → Level II Cardiac Hospital 30 minutes closer than Level I□
  - **YES** → Go to closest Level II Cardiac Hospital and alert destination hospital en route ASAP
  - **NO** → Go to Level I Cardiac Hospital and alert destination hospital en route ASAP

ALS

Level I Cardiac Hospital w/in 60 minutes

- **YES** → Go to Level I Cardiac Hospital and alert destination hospital en route ASAP
- **NO** → Level II Cardiac Hospital 60 minutes closer than Level I□
  - **YES** → Go to closest Level II Cardiac Hospital and alert destination hospital en route ASAP

□ Slight modifications to the transport times may be made in county operating procedures□See page □□
Consider ALS and air transport for all transports greater than □□ minutes□
If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination□
This also applies if there are two or more Level II facilities to choose from□

DOH 346-050 April 2011

State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure

A Assess applicability for triage – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. NOTE: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.

B Assess immediate criteria – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.

C Assess high risk criteria – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:

- ❒ 3 or more CAD (coronary artery disease) risk factors:
  - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
  - Family history: father or brother with heart disease before 55, or mother or sister before 65
  - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
  - High cholesterol: patient/family report or patient on cholesterol medication
  - Diabetes: patient/family report
  - Current smoker: patient/family report.
- ❒ Aspirin use in last 7 days: any aspirin use in last 7 days.
- ❒ ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
- ❒ Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
- ❒ ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
- ❒ Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.

D Determine destination – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.

E Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II

You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrinolytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it's greater than 60 minutes or rendezvous with air transport.

What if there are two or more Level I or II facilities to choose from

If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in destination decision.

DOH 346-050 April 2011

Washington State Department of Health

Hospital Emergency Response Guideline
For Acute Coronary Syndrome (ACS)
LEVEL I Cardiac Center

Purpose: To ensure hospital preparedness when receiving ACS patients while limiting unnecessary use of hospital resources.

1. **Cardiac Activation**: To be used for STEMI, CPA-ROSC from presumed ischemic heart disease, and patients with hypotension or pulmonary edema, i.e., patients who meet the Immediate Field Criteria on the Prehospital Cardiac Triage Destination Procedure.

   All necessary components of the hospital-based emergency response to ACS should be initiated as soon as notified by EMS of an impending transport of these major ACS patients.

   These components should include the following, according to the receiving hospital's scope of capability:

   a. Identify primary nurse and physician who will meet the patient upon arrival.

   b. Identify most appropriate available bed in ER/cath lab to receive patient.

   c. Open cath lab. If not immediately available consider redirecting patient transport to another Level I Cardiac Center if capable of a more timely cath lab evaluation.

   d. Recruit cardiologist to respond to ER or cath lab.

   e. Prepare for initiation of therapeutic hypothermia for appropriate CPA-ROSC patients.

   f. Recruit additional team members as resources allow and are required to provide immediate care according to the level of categorization of the hospital. These may include but are not limited to the following:

      - Respiratory Therapist
      - Pharmacist
      - Radiology Technician
      - EKG Technician
      - Intensivist

Hospital Emergency Response Guideline
For Acute Coronary Syndrome (ACS)
LEVEL I Cardiac Center

2. **Cardiac Alert** (UA/NSTEMI) and patients who have a prehospital high risk score of FOUR or greater on the Prehospital Cardiac Triage Destination Procedure.

   These patients should receive an immediate evaluation by the in-house elements of the cardiac team to further evaluate the possibility of a time-critical ACS being responsible for the patient's symptoms.

   The components of this initial response need not include activation of the cath lab or recruitment of a cardiologist. Response should include the following within the scope of capability of the receiving hospital:

   a. Identify primary nurse and physician who will meet the patient upon arrival.

   b. Identify most appropriate available bed in ER to receive patient.

   c. Recruit additional team members such as resources allow and are required to provide for the rapid evaluation and immediate care of the patient. These may include but are not limited to the following:

      - Radiology Technician
      - EKG Technician
      - Lab Technician

   d. Prepare to initiate ACS 'rapid rule out' pathway.

The intent of this guideline is to ensure a comprehensive response to obvious critical ACS patients while avoiding excessive recruitment of resources for patients who need further, but *immediate*, evaluation to determine the likelihood that their symptoms are from ACS. Once that determination is made, additional personnel and interventional capabilities should be recruited as appropriate to the patient's needs.

Washington State Department of Health

Hospital Emergency Response Guideline
For Acute Coronary Syndrome (ACS)
LEVEL II Cardiac Center

Purpose: To ensure hospital preparedness when receiving ACS patients while limiting unnecessary use of hospital resources.

1. **Cardiac Activation:** For STEMI, CPA-ROSC from presumed ischemic heart disease, and patients with hypotension or pulmonary edema, i.e., patients who meet Immediate Field Criteria on the Prehospital Cardiac Triage Destination Procedure.

   All necessary components of the hospital-based emergency response to ACS should be initiated as soon as notified by EMS of an impending transport of these major ACS patients.

   These components should include the following within the hospital's scope of capability:

   a. Identify primary nurse and physician, or, where applicable, mid-level provider, who will meet the patient upon arrival.

   b. Identify most appropriate available bed in ER to receive patient.

   c. Recruit additional team members as resources allow and are required to provide for rapid evaluation and immediate care of the patient. These may include but are not limited to the following:

      - Respiratory Therapist
      - Pharmacist
      - Radiology Technician
      - EKG Technician

   d. Prepare to initiate fibrinolytic therapy for appropriate patients.

   e. Prepare for initiation of therapeutic hypothermia for appropriate CPA-ROSC patients.

   f. Identify the closest Level I Cardiac Center, determine the most rapid means of critical care transport, and activate the transport system.

   g. Initiate early consultation with a receiving emergency physician/cardiologist at the Level I Cardiac Center to which the patient will be transferred.

Hospital Emergency Response Guideline
For Acute Coronary Syndrome (ACS)
LEVEL II Cardiac Center

2. **Cardiac Alert**: For UA/NSTEMI and patients who have a prehospital high risk score of FOUR or greater on the Prehospital Cardiac Triage Destination Procedure.

   These patients should receive an immediate evaluation by the in-house elements of the cardiac team to further evaluate the possibility of a time-critical ACS being responsible for the patient's symptoms.

   The components of this response should include the following within the scope of capability of the receiving hospital:

   a. Identify primary nurse and physician or, where applicable, mid-level provider, who will meet the patient upon arrival.

   b. Identify most appropriate available bed in ER to receive patient.

   c. Recruit additional team members as resources allow and are required to provide for the rapid evaluation and immediate care of the patient. These may include but are not limited to the following:

      - Radiology Technician
      - EKG Technician
      - Lab Technician

   d. Initiate ACS 'rapid rule out' pathway.

   e. Identify the closest Level I Cardiac Center and initiate early consultation with a receiving physician.

   f. Determine the most rapid means of critical care transport and activate the transport system.

The intent of this guideline is to ensure a comprehensive response to obvious critical ACS patients while avoiding excessive recruitment of resources for patients who need further *immediate* evaluation to determine the likelihood that their symptoms are from ACS. Once that determination is made, additional personnel and interventional capabilities should be recruited appropriate to the patient's needs.

Exhibit 10

Job Descriptions

Cath Lab Technologist

While you're busy impacting the healthcare industry, we'll take care of you with benefits that may include health/dental/vision, FSA, matching retirement plans, paid vacation, adoption assistance, annual bonus eligibility, and more!

CHI Franciscan and Virginia Mason are now united to build the future of patient-centered care across the Pacific Northwest. That means a seamlessly connected system offering quality care close to home. From basic health needs to the most complex, highly specialized care, our patients can count on us to meet their needs with convenient access to the region's most prestigious experts and innovative treatments and technologies.

Job Summary
Performs diagnostic and therapeutic examinations of the heart and blood vessels under the direction of a licensed physician. Work includes but is not limited to (1) reviewing and/or recording pertinent patient history and supporting clinical data; (2) preparing patients for testing (3) performing appropriate clinical procedures and obtaining a record of anatomical, pathological, and/or physiological data for interpretation by a physician; (4) participating in interventional cardiovascular catheterization and/or cardiac electrophysiology procedures, including balloon angioplasty, stent insertion, radiofrequency ablation, and pacemaker and/or implantable defibrillator insertion (5) compiling a foundation of data that is interpreted by physicians in order to make a correct anatomic, physiologic, and pathologic diagnosis for each patient.

Education/Experience:

- Graduation from an accredited school of Radiological Technology, and one year of recent related work experience which may be obtained through practical education/training; OR
- Graduation from an accredited school of Cardiovascular Technology

License/Certification:

- Registered Cardiovascular Invasive Specialist 1 (RCIS), with Cardiovascular Credentialing International (CCI) and license to practice in the state of Washington, OR
- American Registry of Radiological Technologists (ARRT).
- Current American Heart Association healthcare provider BLS Certification.
- ACLS certification required.

Cath Lab RN

While you're busy impacting the healthcare industry, we'll take care of you with benefits that may include health/dental/vision, FSA, matching retirement plans, paid vacation, adoption assistance, annual bonus eligibility, and more!

CHI Franciscan and Virginia Mason are now united to build the future of patient-centered care across the Pacific Northwest. That means a seamlessly connected system offering quality care close to home. From basic health needs to the most complex, highly specialized care, our patients can count on us to meet their needs with convenient access to the region's most prestigious experts and innovative treatments and technologies.

Job Summary:
This job is responsible for providing cath lab nursing care of adult patient populations undergoing cardiac procedures in the cath lab to include inpatient, outpatient and emergent.
Work is performed under standards of safety and care that provide instruction/guidance for taking care of issues and patient needs in the absence of a physician. Requires the use of judgment and critical thinking skills in making decisions regarding patient care (within the scope of practice), including knowledge and integration of available standards, resources and data, and in the efficient utilization of staff/resources. Work involves continuous contact with physicians, patients, patient families, community agencies, patient care staff and management. An incumbent is accountable for the quality of care provided to patients, and has the authority to direct care, provide education, seek resources at the unit/department level, and delegate appropriate tasks.

Education/Experience:

- Graduation from an accredited school of nursing, BSN preferred
- One year of related work experience in an acute care setting is preferred.
- If assigned to the Procedure area - previous cardiac cath Lab experience or a minimum of two years experience within the past three years in an acute care setting, i.e., ICU, PCU, PACU ER.
- Intra-Aortic Balloon Pump experience preferred.

License/Certification:

- Current licensure as a Registered Nurse issued by the Washington State Board of Nursing.
- Current American Heart Association Healthcare BLS Certification
- Current Advanced Cardiac Life Support (ACLS) certification or within six months of hire
- CCRN (Certification in Adult Critical Care) RN preferred
  IV competency must be attained within four months, training is available.

Exhibit 11

PCI Partnering Agreement

ELECTIVE PCI PARTNERING AGREEMENT
BETWEEN ST. JOSEPH MEDICAL CENTER
AND
ST. FRANCIS HOSPITAL

This Elective Percutaneous Coronary Interventions ("PCI") Partnering Agreement ("Agreement") is entered into this XXX day of XXXX, between **St. Joseph Medical Center** (Tertiary Hospital"), and **St. Francis Hospital** ("Transferring Hospital"). For purposes of this Agreement, Tertiary Hospital and Transferring Hospital shall be referenced to as the "Parties". This Agreement shall become effective upon successful award of a joint certificate of need from The State of Washington's Department of Health to the Transferring Hospital to continue to perform elective PCIs.

Transferring Hospital enters into an agreement with Tertiary Hospital to provide cardiac surgery back-up and support for patients undergoing elective PCI without on-site cardiac surgery at the Transferring Hospital and to facilitate continuity of patient care and the timely transfer of patients and records from the Transferring Hospital to the Tertiary Hospital. Accordingly, the Parties agree as follows:

1. The Transferring Hospital shall secure signed, informed consents for adult elective PCIs from all program patients. The consent forms will explicitly communicate to the patients that the intervention is being performed without on-site surgery back-up and address risks related to transfer, the risk of urgent surgery, and refer to this established Partnering Agreement.

2. If a determination is made by the attending physician that a patient requires transfer from the Transferring Hospital to the Tertiary Hospital, the Tertiary Hospital shall accept the referred patient promptly subject to available capacity and personnel at the Tertiary Hospital, as more fully described below.

3. The Transferring Hospital shall have responsibility for obtaining the patient's consent to the transfer to the Tertiary Hospital prior to the transfer, if the patient is competent. If the patient is not competent, the Transferring Hospital shall obtain either the consent of the patient's family member or his/her legal representative/guardian. If such consent is not possible, the Transferring Hospital shall obtain the consent of the attending physician. In any event, the patient or, if indicated, the patient's family member or legal representative/guardian shall be contacted prior to the transfer of the patient, except in cases of emergency.

4. The Transferring Hospital and the Tertiary Hospital shall coordinate, to the extent possible, the availability of surgical teams and operating rooms at the Tertiary Hospital so that for all hours that elective PCIs are being performed at the Transferring Hospital, there is a reasonable likelihood that the Tertiary Hospital has the capacity to immediately accept a referral. The Parties acknowledge and agree that nothing in this Agreement imposes an obligation on the Tertiary Hospital to maintain an available cardiac surgical suite twenty-four hours a day, seven days a week.

5. During times of high census wherein the Tertiary Hospital's ability to accept a patient referral is impacted by lack of bed availability or a closed emergency department ("ED"), the Tertiary Hospital will notify the Transferring Hospital and elective procedures will be rescheduled as long as in the attending physician's assessment such delay does not compromise the patient's care and condition.

6. The Transferring Hospital shall have the responsibility for transferring the patient to the Tertiary Hospital and shall use qualified personnel and necessary equipment, including medically appropriate life support measures, during the transfer. Further, the Transferring Hospital shall:

a. Maintain a signed transportation agreement with a qualified vendor that provides expeditious transport for any patient experiencing complications during an elective PC! that requires a transfer to the Tertiary Hospital. A qualified vendor is one whose transport staff is ACLS certified. The Transferring Hospital 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 the Tertiary Hospital 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 the parties' quality assurance programs. The staff and cost of internal resources used for such drills will be the responsibility of the Transferring Hospital. The cost of any external resources required for such drills will be the responsibility of the Transferring Hospital.

The Tertiary Hospital shall not have any financial obligation or liability whatsoever under this Section 6.

7. The Transferring Hospital shall send with each patient transferred from the Transferring Hospital to the Tertiary Hospital, at the time of transfer, the medical information necessary to continue the patient's treatment without interruption. Said information shall include, but is not limited to, all medical 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, and any other essential identifying and administrative information. All patient information transferred by the Transferring Hospital to the Tertiary Hospital shall be in accordance with federal and state privacy mandates.

8. The Transferring Hospital will ensure that the physician performing the elective PC! communicates immediately and directly with the Tertiary Hospital's cardiac surgeon(s) about the clinical reasons for the urgent transfer and patient's clinical condition.

9. All transfers will be done in accordance with applicable federal and state laws and regulations and in accordance with the standards of The Joint Commission.

10. The Transferring Hospital and the Tertiary Hospital shall schedule cardiac patient care quality assurance conferences at least quarterly that involve case reviews of a significant number of pre-operative and post-operative PCI cases at the Transferring Hospital including a 100% review of all transport cases.

11. Charges for services performed by any of the Parties shall be collected by the Party rendering the service to the patient, third party payer, or other sources normally billed by the Party. No Party shall have any liability to the other for such charges, except to the extent such liability would exist separate from this Agreement. The Parties shall cooperate with each other in exchanging information about financial responsibility for services rendered by them to patients.

12. Prior to the transfer of a patient to the Tertiary Hospital, the Transferring Hospital shall make a written inventory of all valuables of the patient which shall accompany the patient in his or her transfer to the Tertiary Hospital. This written inventory shall be provided to the Tertiary Hospital upon admission of the patient. The Transferring Hospital shall be responsible for the transfer of the patient's valuables and, in accordance with the Tertiary Hospital's current policy, the Tertiary Hospital shall not be liable for the loss or damage to any personal valuables during the transfer including but not limited to money, jewelry, glasses, dentures, documents, clothing, or other articles of unusual value.

13. The Transferring Hospital agrees that the transfer of a patient pursuant to the Agreement shall not be predicated upon discrimination based on race, religion, color, national origin, age, sex, sexual orientation, physical condition, economic status, or any other status protected by applicable law. The Parties also agree that the transfer or receipt of a patient in need of emergency care shall not be based upon the patient's inability to pay for

services rendered by the transferring or receiving facility.

14. The Transferring Hospital shall indemnify, hold harmless and defend the Tertiary Hospital, its agents and employees from and against any claim, loss, damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Transferring Hospital, its agents and employees of any duty or obligation of the Transferring Hospitals under this Agreement.

15. The Tertiary Hospital shall indemnify, hold harmless and defend the Transferring Hospital, its agents and employees from and against any claim, loss, damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Tertiary Hospital, its agents and employees of any duty or obligation of the Tertiary Hospital under this Agreement.

16. The Parties shall maintain at their own expense comprehensive general and professional liability insurance and property damage insurance adequate to insure them against risks arising out of this Agreement, with limits no less than those customarily carried by similar facilities. Upon request, each Party shall furnish the other Party with evidence of such insurance. During the term of this Agreement, each Party shall immediately notify the other of any material change in such insurance.

17. Nothing in this Agreement shall be construed as limiting the rights of any Party to contract with any other facility or entity on a limited or general basis.

18. This Agreement shall be in effect on the date of certificate of need approval and shall continue until terminated as follows: (i) any Party may terminate this Agreement immediately upon a breach of its terms by another Party, or (ii) any Party may terminate this Agreement without cause by giving the other Party not less than ninety (90) days written notice.

19. This Agreement may be signed in counterparts each of which will be considered an original.

20. This Agreement shall be interpreted and construed in accordance with the laws of Washington State and any action to enforce the Agreement shall be in Pierce County, Washington.

21. This Agreement embodies the entire agreement of the Parties relating to transfer of patients from the Transferring Hospital to the Tertiary Hospital, and supersedes all prior agreements, representations, and understandings of the Parties. This Agreement may only be modified or amended in writing. Amendments and modifications must be signed by all Patties to be effective.

22. Should any provision of this Agreement be found by any court to be invalid or unenforceable for any reason, the invalidity or unenforceability of such provision shall not affect the validity of the remaining provisions of the Agreement, unless such invalidity or unenforceability would defeat an essential business purpose of

this Agreement, in which case the Agreement shall be terminated.

23. Except as through the operation of law, no Party may assign or transfer this Agreement without the written consent of the other Parties.

24. Nothing in this Agreement shall in any way affect the independent operation of any Patty, nor create an employer/employee, principal/agent, or joint venture/partnership relationship.

25. In transferring patients pursuant to this Agreement, the Parties shall comply with the federal Emergency Medical Treatment and Active Labor Act of 1985 ("EMTALA"), contained in 42 U.S.C. § l395dd, as may be amended, and all related federal and state regulations.

26. If any Party is a corporation, company, association, partnership, government agency or any other type of legal entity, each individual executing this Agreement on behalf of such entity represents and warrants that he or she is duly authorized to execute and deliver this Agreement on behalf of such entity, and that this Agreement shall be binding upon said entity in accordance with its terms.

TERTIARY HOSPITAL: ST. JOSEPH MEDICAL CENTER

By:
Name:
Title:

TRANSFERRING H OSPITAL: ST. FRANCIS HOSPITAL

By:
Name:
Title:

Exhibit 12

Emergency Transport Agreement

MEDICAL TRANSPORTATION SERVICE AGREEMENT

This **MEDICAL TRANSPORTATION SERVICE AGREEMENT** ("Agreement") is entered into as of the 1st day of April, 2023 (the "Effective Date") by and between **Virginia Mason Franciscan Health**, a Washington State nonprofit corporation, on behalf and for the benefit of its named affiliates below ("VMFH") and **Olympic Ambulance Service, Inc.**, a Washington State profit corporation ("Group"). VMFH and Group are collectively referred to in this Agreement as the "Parties," and singularly as a "Party".

RECITALS

A. VMFH is a health system that provides comprehensive health care to patients in its service area through its clinics and affiliated hospitals, which include: St. Joseph Medical Center ("SJMC"); St. Elizabeth Hospital ("SEH"); Harrison Medical Center, d/b/a St. Michael Medical Center ("SMMC"); Highline Medical Center, d/b/a St. Anne Hospital ("SANH"); St. Anthony Hospital ("SAH"); St. Clare Hospital ("SCH"); St. Francis Hospital ("SFH"); and Virginia Mason Medical Center ("VMMC"). This Agreement applies to the following VMFH's hospital(s): **SJMC**, **SEH**, **SMMC**, **SANH**, **SAH**, **SCH**, and **SFH** (also referred to as "Participating Hospital" or "Hospital"), which are able to provide access to emergency and non-emergent medical care to individuals requiring such services; and

B. Group provides emergent and non-emergent medical transportation and related services; and

C. VMFH, through Participating Hospitals, is also a provider of health care services to patients who require medical transportation services ("Medical Transport Services"), and desires to obtain Medical Transport Services for its patients; and

D. Group desires to provide such services and has the necessary equipment, training, expertise, professional certifications, and licenses to do so.

NOW, THEREFORE, the Parties agree as follows:

AGREEMENT

1. PURPOSE OF AGREEMENT. Group agrees to provide Participating Hospitals with Medical Transport Services in accordance with the description and definitions the Parties have mutually agreed upon and detailed in **Exhibit A (**"Services"), attached hereto and incorporated herein, and in accordance with the terms and conditions set forth in this Agreement.

2. TERM. This Agreement shall be for an initial term of **Two (2) Years** from the Effective Date (the "Initial Term"). Thereafter, this Agreement shall automatically renew for additional one (1) year terms (each a "Renewal Term"), unless notice of an intention to not renew is provided to the other Party at least thirty (30) days prior to the end of the then current term. (The Initial Term and any Renewal Terms are referred to herein as the "Term.")

3. TERMINATION.

3.1 Voluntary Termination. Either Party may terminate this Agreement without cause, by giving ninety (90) days written notice to the other Party. Each Party will be

PCI Addendum to Medical Transportation Service Agreement

To facilitate the expeditious transfer of patients who experience complications during elective PCIs that require transfer from Virginia Mason Franciscan Health St. Francis Hospital (St. Francis) to a backup hospital with on-site cardiac surgery the parties agreed to these Additional Operational Requirements:

1. Olympic Ambulance Service, Inc. (Olympic Ambulance) will agree to the expeditious transport by land of all patients who experience complications during elective PCIs at St. Francis that require transfer to a backup hospital with on-site surgery.

2. All Olympic Ambulance Critical Care Transport ("CCT") level staff will be certified at the advance cardiac life support certified ("ACLS") level.

3. During emergency transport, St. Francis will provide the necessary equipment and additional ACLS certified staff with the skills and experience to monitor and treat the patient en route and to manage an intra-aortic balloon pump when necessary. Olympic Ambulance will return staff and equipment to St. Francis.

4. Olympic Ambulance will dispatch emergency transportation immediately upon notification of a need for transport by St. Francis. Olympic Ambulance will use its best efforts to respond within twenty (20) minutes. Emergent transports for St. Francis will have priority over other non-emergency patients, such as scheduled transports, in the local area. The transport will be done by:

    a. The first preference will be to send a CCT ambulance staffed with Olympic Ambulance CCT level personnel to transport patients.
    b. In the event that a CCT ambulance is not available within a reasonable timeframe, a Basic Life Support ambulance and Olympic Ambulance BLS staffed crew will be dispatched with the care being maintained by St. Francis CCT level staff during transport to the backup hospital.
    c. In either case (CCT ambulance or BLS ambulance), St. Francis will send ACLS certified and experienced staff to monitor the patients and equipment in order to specifically manage patients with an intra-aortic balloon pump.

5. Olympic Ambulance and St. Francis will agree to total patient transportation time – from notification of the need to transport to arrival in the operating room at a backup hospital with on-site cardiac surgery – of 90 minutes or less.

6. Olympic Ambulance will participate in at least two annual timed emergency transportation drills with St. Francis and two (2) annual time emergency drills with St. Francis to ensure the timelines referenced within this agreement continue to be met.

required to meet its commitments under the Agreement to all patients for whom the transfer process has begun in good faith, and provided further that any obligations which arose prior to the termination shall continue and shall be governed by the terms set forth herein until satisfied.

3.2 **Involuntary Termination.** This Agreement shall be terminated immediately upon the occurrence of any of the following:

3.2.1 If either one of the Parties is destroyed to such an extent that the patient care provided cannot be carried out adequately;

3.2.2 If either one of the Parties loses its license or accreditation, or becomes an Excluded Provider under section 10 of this Agreement; or

3.2.3 If either one of the Parties is in default under any of the terms of this Agreement and fails to cure such default after receiving notice and reasonable opportunity to cure.

3.2.4 To the extent that any of the above-mentioned occurrences should happen to a specific Participating Hospital, this Agreement shall terminate as it applies to such Participating Hospital only;

4. **CERTIFICATIONS AND LICENSES.** Each Party shall maintain all certifications and licenses as required by all Applicable Law to perform its obligations hereunder.

5. **PERFORMANCE REVIEWS.** Group shall transport all patients received from Participating Hospitals as expeditiously as possible to their designated location. Group shall generate a final report to VMFH quarterly of its response times to each Participating Hospital. Group and VMFH agree to quarterly reviews of the reports submitted. The reviews shall include, at minimum, a Group Operations Director, Executive level sponsor from Group, VMFH emergency room representative, and an Executive level sponsor from VMFH. Reviews shall become monthly if Group incurred a penalty payment by failing to meet response times stipulated in the deliverables for the previous quarter. If response times are then met and no penalty is incurred, the reviews can return to quarterly.

   5.1 **Performance Penalty.** If Group fails to meet the deliverables as outlined in Exhibit A of this Agreement, Group shall agree to a quarterly Penalty Payment Schedule, starting after the first 120 days of this contract. The Penalty Payment Schedule will be as follows:

   - $1,000.00 per quarter for 85%-89% of deliverable.
   - $2,500.00 per quarter for 80%-84% of deliverable.
   - $5,000.00 per quarter for below 80% of deliverable.

6. **NO PAYMENT/REQUIREMENT FOR REFERRALS.** Nothing in this Agreement shall be construed to require either of the Parties to make referrals to the other Party. No payment shall be made under this Agreement in return for the referral of patients or in return for the ordering, purchasing or leasing of products or Services.

7. **PAYMENT FOR SERVICES.**

7.1 Compensation. Group shall be compensated by Participating Hospitals for services rendered to each Participating Hospital as set forth in **Exhibit B** ("Rate Schedule").

7.2 Billing. Group shall bill, whenever appropriate, the patient's insurance carrier or health plan, or the applicable federal, State or local agency, or the patient for self-pay, depending on which party has financial responsibility for the Medical Transport Services. Group shall only bill Hospital where Hospital is responsible for the Medical Transport Services, which shall be: (a) all intra-facility transports of inpatient Medicare DRG and Medicaid patients subject to Medicare and Medicaid rules and regulations regarding transports to a higher level of care; (b) for any members of managed care or capitated health plans where Hospital has assumed responsibility for paying for the Medical Transports Services; or (c) where the Hospital has specifically requested the Medical Transport Services for its own convenience and Hospital has specified that it will assume responsibility for payment (known as a "***Hospital Administered Decision***").

7.3 Non-Billing of Enrollee; Surcharges Prohibited. With regard to Section 7.2(b) above, except for any co-payments authorized under a managed care member's Evidence of Coverage, Group shall not, under any circumstances (including, without limitation, breach of this Agreement) bill, charge, collect a deposit from, or attempt to bill, charge, collect or receive any form of Surcharge, payment, compensation or reimbursement from, or have any recourse against any managed care member for Covered Services provided under this Agreement, and Group shall not attempt to seek reimbursement from managed care member or the State of Washington to collect sums owed to Group by VMFH or health plans. The requirements under this Section shall survive termination of this Agreement.

8. **INDEPENDENT CONTRACTOR STATUS/RELATIONSHIP OF PARTIES**. It is expressly agreed and understood by the Parties hereto that neither Party is an agent, partner, or joint venture with or of the other. The Parties to this Agreement are independent contractors. Neither Party is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Party, nor shall it in any way alter the control of the management, assets, and affairs of the respective Parties. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Party to this Agreement.

9. **LIABILITY AND INDEMNIFICATION.** Each Party shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Party. In the event that a claim is made against both Parties, each Party shall be responsible for its own proportionate share of damages, costs or expenses and it is the intent of both Parties to cooperate in the defense of said claim and to cause their insurers to do likewise. Both Parties shall, however, retain the right to take any and all actions they believe necessary to protect their own interests. Each Party shall indemnify and hold harmless the other against any and all liability for injury, loss, claims, or damages arising from the negligent operations, acts, or omissions of the Party, its agents, and employees.

10. **NO EXCLUSION/DEBARMENT.** Each Party hereby represents and warrants to the other that neither it nor its principles or employees are, or have been, excluded, debarred, suspended, proposed for debarment, or declared ineligible from participation in any federally funded program ("Exclusion"). Each Party shall immediately notify the other of any threatened or actual Exclusion. If a Party is so debarred, suspended, or excluded, this Agreement shall immediately and automatically terminate. Each Party shall indemnify and defend the other against all actions, claims, demands, liabilities, losses, damages, costs, and expenses, including reasonable attorneys' fees, arising directly of indirectly out of any Exclusion.

11. **NONWAIVER**. No waiver of any term or condition of this Agreement by either Party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

12. **GOVERNING LAW**. This Agreement shall be construed in accordance with an governed by the laws of the State of Washington applicable to agreements made and to be performed wholly within that state, irrespective of such state's choice-of-law principles. Venue for any action to enforce its terms shall be in Pierce County, or if the dispute involves a Participating Hospital, the county in which the Participating Hospital is located.

13. **INSURANCE**. Both Parties shall procure, keep and maintain throughout the term of this Agreement, at the Party's sole cost and expense, professional liability, errors and omissions and commercial general liability insurance in the amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. The Parties will furnish to the other, upon request, certificate(s) of insurance evidencing all of the herein specified policies of insurance with an insurer and with limits meeting the requirements of this Agreement. This section shall survive the termination of this Agreement.

14. **ASSIGNMENT**. This Agreement shall not be assigned in whole or in part by either Party hereto without the express written consent of the other Party.

15. **INVALID PROVISION**. In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

16. **AMENDMENT**. This agreement may be amended at any time by a written agreement signed by the Parties hereto.

17. **ENTIRE AGREEMENT**. This Agreement constitutes the entire agreement between the Parties and contain all of the agreement between them with respect to the subject matter hereof.

18. **BINDING AGREEMENT**. This agreement shall be binding upon the successors or assigns of the Parties hereto.

19. **JEOPARDY**. Notwithstanding anything to the contrary herein contained, in the event the performance by either Party hereto of any term, covenant, condition, or provision of this

Agreement jeopardizes the licensure of either Party, their participation in the payment of reimbursement from the Medicare, state-sponsored Medicaid program, Blue Cross, or other reimbursement or payment programs, or their full accreditation by The Joint Commission or any other state or nationally recognized accreditation organization, or the tax-exempt status of either Party, any of its property or financing (or the interest of income thereon, as applicable), or if for any other reason said performance should be in violation of any statute, ordinance, or be otherwise deemed illegal, or be deemed unethical, either Party may, at its option: (i) terminate this Agreement immediately; or (ii) initiate negotiations to resolve the matter through amendments to this Agreement, and if the Parties are unable to resolve the matter within thirty (30) days) thereafter, may, at its option, terminate this Agreement immediately.

20. **ETHICAL AND RELIGIOUS DIRECTIVES.** Group shall not cause CommonSpirit Health to fall out of compliance with the United States Conference of Catholic Bishop's *Ethical and Religious Directives for Catholic Health Care Services*, available at: http://www.usccb.org/.

21. **STANDARDS OF CONDUCT**. Group shall not cause VMFH or its affiliates to fall out of compliance with the CommonSpirit Health's *Standards of Conduct* as set forth in the *Our Values in Action, Policy and Reference Guide*, available at:

    https://www.commonspirit.org/content/dam/commonspirit/pdfs/CommonSpirit_ComplianceBooklet07-16-21_vf-s.pdf

22. **ACCESS TO RECORDS.** If required by 42 U.S.C. & 1395x(v)(l)(I), until the expiration of four (4) years after the termination of this Agreement, Group shall make available, upon written request by the Secretary of the Department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement through the subcontract with a value or cost of $10,000 or more over a twelve (12) month period, such subcontract shall contain the same requirements.

23. **COMPLIANCE WITH ALL LAWS AND REGULATIONS**. Group shall comply with all applicable laws, rules, and regulations.

24. **RECORDS AND CONFIDENTIALITY**. All medical records maintained by each Party with respect to Services provided hereunder are owned by, and the property of, that Party. The Parties shall cooperate fully with each other by maintaining and making available, to the extent permitted by state and federal law, all necessary records in order to assure that both Parties will be able to meet all requirements for participation and payment associated with public or private third-party payment programs, including, but not limited to, matters covered by the Medicare and Medicaid programs. Each Party shall maintain the confidentiality of such records made available by the other Party as many be required by state and federal law, including, but not limited to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder governing the privacy of protected health information ("HIPAA"), as amended.

25. **NO THIRD PARTY RIGHTS**. This Agreement has been made and is made solely for the benefit of the Parties hereto and their respective successors, and permitted assigns. Nothing in this Agreement is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the Parties to it and their respective successors and permitted assigns;

provided however that any entity controlled by, under control of, or under common control with VMFH, shall be a third party beneficiary as to VMFH's rights and remedies. Nothing in this Agreement is intended to relieve or discharge the obligation or liability of any third persons to any Party to this Agreement.

26. **NOTICES**. All notices or other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been delivered to a Party upon personal delivery to that Party or: (i) twenty-four (24) hours following electronically confirmed delivery by facsimile transmission to the telephone number provided by the Party for such purposes; (ii) twenty-four (24) hours following deposit for overnight delivery with a bonded courier holding itself out to the public as providing such Services, with charges prepaid; or (iii) forty-eight (48) hours following deposit with the U.S. Postal Service, postage prepaid, and in any case addressed to the Party's address set forth below, or to any other address:

If to VMFH:

Virginia Mason Franciscan Health
1145 Broadway, Suite 1200
Tacoma, WA 98402
Attn: James Terwilliger, SVP and COO

If to Group:

Olympic Ambulance Service, Inc.
601 West Hendrickson Road
Sequim, WA 98382-3015
Fax:_____
Attn:_____

With a Copy to:
CommonSpirit Health
Attention: Vice-President Legal Team and
Division General Counsel
MS 07-00
1145 Broadway, Suite 1150
Tacoma, WA 98402
Fax: 253-680-4056

Either Party may change the notification addresses listed above with proper written notice.

27. **PROVISIONS FOR DISASTER SUPPORT.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument. Facsimile or electronic copies of originally executed signature pages shall serve for all purposes as originally executed signatures pages.

28. **COUNTERPARTS; COPIES OF SIGNATURES**. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument. Facsimile or electronic copies of originally executed signature pages shall serve for all purposes as originally executed signature pages.

29. **ADVICE OF COUNSEL**. Each Party hereby acknowledges: (i) having fully read this Agreement in its entirety; (ii) having had full opportunity to study and review this Agreement;

(iii) having been advised that counsel for VMFH has acted solely on VMFH's behalf in connection with the negotiation, preparation, and execution hereof; (iv) having been advised that all Parties have the right to consult and should consult independent counsel respecting their rights and duties under this Agreement; and (v) having had access to all such information as has been requested.

30. **CONFLICTS OF INTEREST**. Group shall notify VMFH immediately of any current or potential conflict of interest between VMFH and any other person or entity for which Group performs or is contemplating performing Services, whether as an employee, independent contractor, volunteer or otherwise. Group shall provide VMFH with all information reasonably requested by VMFH to determine, in VMFH's sole discretion, if a conflict exists. If VMFH determines a conflict exists, at its option, VMFH may either waive such conflict or, upon written notice, immediately terminate this Agreement.

31. **BACKGROUND CHECKS**. Group shall conduct a background investigation including, without limitation, criminal convictions, with respect to all of Group's employees who perform the Services, prior to commencement of Services (using a VMFH approved screening process) unless otherwise agreed, in accordance with VMFH policy. Group shall provide copies of such background checks to VMFH prior to the commencement of Services.

32. **AUTHORITY TO EXECUTE**. By signing below, each Party warrants and represents that it has the legal authority to bind the Parties and their respective assigns, successors and representatives to the terms of this Agreement.

IN WITNESS WHEREOF, Group and VMFH have hereunto caused this Agreement to be executed the day and year first above written.

VIRGINIA MASON FRANCISCAN HEALTH

By:_____
Printed Name:_____
Title:_____
Dated:_____

OLYMPIC AMBULANCE SERVICE, INC.

By:_____
Printed Name:_____
Title:_____
Dated:_____

EXHIBIT A

SERVICES

The description of Services provided by Group includes, but are not limited to, the following:

Group will provide 24/7 CCT, ALS, BLS, and Wheelchair Van transports.

Infrastructure

Initial infrastructure provided by Group will be the following:

- 15 ambulances, 6 wheelchair vans committed to serving Participating Hospitals 24/7.
- 24/7 dedicated Communications Center staffed with 4 Dispatchers.
- VMFH Transfer Coordinator.

Deployment Summary

Participating Hospitals will receive service from 15 total ambulance resources as follows:

- 2 ambulances will continue service to St. Michael Medical Center out of Kitsap County
- 12 ambulances will be operating within a shared Participating Hospital only pool across the broader health system
- 1 ambulance will be positioned in Enumclaw as more of a dedicated satellite model to St. Elizabeth with depth support from the rest of the shared pool.

As many as 5 critical care resources will be strategically positioned near specific facilities geographically to provide a combination of critical care, ALS, and occasional BLS transportation. Peak Hour CCT & BLS resources will be positioned on site of facilities in a state of readiness, shifting facilities as needed, while 24/7 resources will circulate from the shared pool, backfilling peak positions, and or providing backup to stacked transport requests.

4-6 Wheelchair Vans will provide service to Participating Hospitals 24/7.

Deliverables

Olympic will provide consistent deliverables across all Participating Hospitals at least 90% of the time:

- Non-Emergent Ambulance request is on scene within 60 minutes or less of agreed upon time.
- Emergent Ambulance request is on scene within 30 minutes or less of agreed upon time.

EXHIBIT B

RATE SCHEDULE

In consideration for Services provided, Group shall be compensated as follows:

1. Rates for Wheelchair Van and Courtesy Shuttle Transportation:
    - Forty Five Dollars ($45.00) plus Four Dollars and Forty Cents per mile.
    - Twenty Dollars applied after hours (Monday through Friday 5pm-9am) and weekends.

2. ED Waiting Room & Triage Support (EMT rate)
    - $45.00 per hour
    - $67.50 per hour on Group recognized holidays

3. Rates for Ambulance Transportation:
    - Authorized ambulance transports that are determined as VMFH responsibility for payment will be billed at the current Medicare allowable rates for ALS, BLS, and SCT emergent and non-emergent plus mileage (i.e DRG transports or special hospital requests) at the time service is rendered. All charges for ambulance transports shall be in accordance with the most current definitions of each level of service as set forth by the Centers for Medicare and Medicaid Services (CMS). The rates set forth shall increase annually by the same percentage as the Ambulance Inflation Factor (AIF), published annually by CMS. These charges are the same amounts charged to Medicare but reflect a discount off amounts charged to other payers. The amount of this discount will be appropriately reflected on invoices prepared by Group.

PCI Addendum to Medical Transportation Service Agreement

To facilitate the expeditious transfer of patients who experience complications during elective PCIs that require transfer from Virginia Mason Franciscan Health St. Francis Hospital (St. Francis) to a backup hospital with on-site cardiac surgery the parties agreed to these Additional Operational Requirements:

1. Olympic Ambulance Service, Inc. (Olympic Ambulance) will agree to the expeditious transport by land of all patients who experience complications during elective PCIs at St. Francis that require transfer to a backup hospital with on-site surgery.

2. All Olympic Ambulance Critical Care Transport ("CCT") level staff will be certified at the advance cardiac life support certified ("ACLS") level.

3. During emergency transport, St. Francis will provide the necessary equipment and additional ACLS certified staff with the skills and experience to monitor and treat the patient en route and to manage an intra-aortic balloon pump when necessary. Olympic Ambulance will return staff and equipment to St. Francis.

4. Olympic Ambulance will dispatch emergency transportation immediately upon notification of a need for transport by St. Francis. Olympic Ambulance will use its best efforts to respond within twenty (20) minutes. Emergent transports for St. Francis will have priority over other non-emergency patients, such as scheduled transports, in the local area. The transport will be done by:

    a. The first preference will be to send a CCT ambulance staffed with Olympic Ambulance CCT level personnel to transport patients.
    b. In the event that a CCT ambulance is not available within a reasonable timeframe, a Basic Life Support ambulance and Olympic Ambulance BLS staffed crew will be dispatched with the care being maintained by St. Francis CCT level staff during transport to the backup hospital.
    c. In either case (CCT ambulance or BLS ambulance), St. Francis will send ACLS certified and experienced staff to monitor the patients and equipment in order to specifically manage patients with an intra-aortic balloon pump.

5. Olympic Ambulance and St. Francis will agree to total patient transportation time – from notification of the need to transport to arrival in the operating room at a backup hospital with on-site cardiac surgery – of 90 minutes or less.

6. Olympic Ambulance will participate in at least two annual timed emergency transportation drills with St. Francis and two (2) annual time emergency drills with St. Francis to ensure the timelines referenced within this agreement continue to be met.

Exhibit 13

Quality Assurance/Quality Improvement Plan

Virginia Mason Franciscan Health St. Francis Hospital

Quality Assurance/Quality Improvement Plan

Elective and Emergent PCI

PURPOSE

The purpose of the quality improvement plan for elective PCI is:

1. Provide for a process for ongoing review of the outcomes for adult elective PCIs.
2. Provide a system of patient selection that will result in outcomes that are equal to or better than benchmark standards.
3. Provide for a process of formalized review of pre and post-operative patient care with partner surgical backup hospital including all patients transferred for surgical intervention.
4. Provide a process for reporting elective PCI information to the Washington State Department of Health or entity designated by the Washington State Department of Health.
5. Document, assess and improve the emergency transport processes and timeframes.

POLICY/PROCEDURE

St. Francis Hospital's Elective PCI QA/QI Committee (PCI Improvement Committee) oversees all QA/QI activities as they relate to the Elective PCI Program. This Committee is comprised of Quality/Clinical Effectiveness staff, Cardiologists, Medical Directors and Cath Lab staff and oversees all of the below QA/QI activities:

- St. Francis Hospital holds formalized case reviews with St. Joseph Medical Center that include preoperative and post-operative elective PCI cases, including all transferred cases. Specifically:
    - The PCI Improvement Committee meets quarterly and is comprised of the following participants:
        - Quality Assurance/Clinical Effectiveness Leader
        - Cardiology Medical Director
        - Cath Lab Manager/Supervisor
        - Cardiology Quality Manager
        - Interventional Cardiologist
        - Plus designated staff as committee deems appropriate
    - The Elective PCI Improvement Committee is a part of the hospitals' Quality Assurance Program and abides by all relevant committee standards and reports to:
        - Performance Quality Leadership Group
        - Hospital Quality Council
    - The Elective PCI Improvement Committee is required to prepare a report at least quarterly that includes the results of all performance monitoring activities. The Committee makes recommendations to the Cardiac Leadership Team and Cath Lab Manager to resolve any identified problems. The data, including COAP data

and analysis, are evaluated to determine if performance meets the standard of care, and/or the initiation of performance improvement activities may be beneficial.
    - Results of the performance review, including action plans and outcomes, are forwarded to the Performance Quality Leadership Group and the Hospital Quality Council for inclusion in the hospital's Quality Programs. Additional actions will adhere to the hospital Quality, Peer Review and Medical Executive processes.
    - The PCI Improvement Committee and its work are protected by Washington State Statute RCW 70.41.200.

- Elective PCI outcomes will be included in the WA State Clinical Outcomes Assessment Program (COAP). Outcomes will be benchmarked against the statewide outcome data and included in case review meetings and presented quarterly to the PCI Improvement Committee including recommendations on how to resolve any identified problems.
    - Specific benchmarks include at least the following:
        - Risk Adjusted Mortality
        - Incidence of Vascular Complications
        - Thienopyridine on Discharge (Patients with Stents)
    - COAP works with member hospitals in perfecting performance improvement initiatives of PCI Programs within the State of Washington.

- Cardiologists use the Society for Cardiac Angiography guidelines for patient, lesion and case selection to determine which patients are suitable candidates for elective PCI.

- St. Francis Hospital ensures the safe transportation of elective PCI patients experiencing complications including:
    - Maintaining a signed transportation agreement with a vendor who will expeditiously transport patients who experience complications during elective PCIs.
    - Ensuring that transport staff are advanced cardiac life support certified.
    - Providing the equipment and staff with the skills and experience to monitor and treat the patient en route and to manage an intra-aortic balloon pump (IABP).
    - Initiation of emergency transportation within twenty minutes of the initial identification of a complication.
    - Ensuring that the time from the decision to transfer the patient with an elective PCI complication to arrival in the operating room will be less than one hundred twenty minutes.

Appendix 1

Audited Financials

COMMONSPIRIT HEALTH

Consolidated Financial Statements as of and for the Years Ended June 30, 2023 and 2022 With Report of Independent Auditors

COMMONSPIRIT HEALTH

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Building a better working world

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ey.com

Report of Independent Auditors

The Board of Stewardship Trustees
CommonSpirit Health

Opinion

We have audited the consolidated financial statements of CommonSpirit Health (CommonSpirit), which comprise the consolidated balance sheets as of June 30, 2023 and 2022, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of CommonSpirit at June 30, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CommonSpirit's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about CommonSpirit's ability to continue as a going concern for a reasonable period of time.

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

Other Information

Management is responsible for the other information. The other information comprises the Management Discussion and Analysis of Financial Condition and Results of Operations but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

Ernst & Young LLP

September 21, 2023

COMMONSPIRIT HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2023 AND 2022 (in millions)

Assets	2023	2022
Current assets:		
Cash and cash equivalents	$ 1,677	$ 2,592
Short-term investments	539	596
Patient accounts receivable, net	4,899	4,472
Provider fee receivable	931	693
Other current assets	2,733	3,296
Total current assets	10,779	11,649
Long-term investments	16,483	16,087
Property and equipment, net	17,189	15,876
Right-of-use operating lease assets	1,676	1,715
Ownership interests in health-related activities	3,114	3,038
Other long-term assets, net	2,631	1,949
Total assets	$ 51,872	$ 50,314

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2023 AND 2022 (in millions)

Liabilities and Net Assets	2023	2022
Current liabilities:		
Current portion of long-term debt	$ 1,966	$ 1,619
Demand bonds subject to short-term liquidity arrangements	247	247
Accounts payable	1,342	1,481
Accrued salaries and benefits	1,512	1,831
Provider fee payable	342	225
Medicare advances	-	793
Other accrued liabilities - current	3,473	3,435
Total current liabilities	8,882	9,631
Other liabilities - long-term:		
Self-insured reserves and claims - long-term	1,138	1,066
Pension and other postretirement benefit liabilities	2,255	2,501
Derivative instruments	77	150
Operating lease liabilities	1,586	1,626
Other accrued liabilities - long-term	648	750
Total other liabilities - long-term	5,704	6,093
Long-term debt, net of current portion	16,147	13,561
Total liabilities	30,733	29,285
Net assets:		
Without donor restrictions - attributable to CommonSpirit Health	18,960	18,808
Without donor restrictions - noncontrolling interests	1,062	1,079
With donor restrictions	1,117	1,142
Total net assets	21,139	21,029
Total liabilities and net assets	$ 51,872	$ 50,314

See notes to consolidated financial statements.

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2023 AND 2022 (in millions)

	2023	2022
Operating revenues:		
Net patient revenue	$ 30,866	$ 30,490
Premium revenue	1,394	1,156
Revenue from health-related activities, net	203	139
Other operating revenue	1,961	2,038
Contributions	82	84
Total operating revenues	34,506	33,907
Operating expenses:		
Salaries and benefits	18,292	18,170
Supplies	5,539	5,588
Purchased services and other	10,062	9,523
Depreciation and amortization	1,438	1,463
Interest expense, net	573	459
Total operating expenses	35,904	35,203
Operating loss	(1,398)	(1,296)
Nonoperating income (loss):		
Investment income (loss), net	1,034	(971)
Income tax expense	(34)	(72)
Change in fair value and cash payments of interest rate swaps	79	179
Other components of net periodic postretirement costs	64	324
Other	(4)	(11)
Total nonoperating income (loss), net	1,139	(551)
Deficit of revenues over expenses	$ (259)	$ (1,847)
Less excess (deficit) of revenues over expenses attributable to noncontrolling interests	55	(1)
Deficit of revenues over expenses attributable to CommonSpirit Health	$ (314)	$ (1,846)

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2023 AND 2022 (in millions)

	Without Donor Restrictions		With Donor Restrictions	Total Net Assets
	Attributable to CommonSpirit Health	Noncontrolling Interests		
Balance, June 30, 2021	$ 19,646	$ 1,187	$ 1,065	$ 21,898
Deficit of revenue over expenses	(1,846)	(1)	-	(1,847)
Contributions	-	-	122	122
Net assets released from restrictions for capital	46	-	(46)	-
Net assets released from restrictions for operations and other	-	-	(75)	(75)
Change in funded status of pension and other postretirement benefit plans	995	-	-	995
Other	(33)	(107)	76	(64)
Increase (decrease) in net assets	(838)	(108)	77	(869)
Balance, June 30, 2022	$ 18,808	$ 1,079	$ 1,142	$ 21,029
Excess (deficit) of revenue over expenses	(314)	55	-	(259)
Contributions	-	-	122	122
Net assets released from restrictions for capital	50	-	(50)	-
Net assets released from restrictions for operations and other	-	-	(68)	(68)
Change in funded status of pension and other postretirement benefit plans	452	-	-	452
Other	(36)	(72)	(29)	(137)
Increase (decrease) in net assets	152	(17)	(25)	110
Balance, June 30, 2023	$ 18,960	$ 1,062	$ 1,117	$ 21,139

See notes to consolidated financial statements.

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2023 AND 2022 (in millions)

	2023	2022
Cash flows from operating activities:		
Change in net assets	$ 110	$ (869)
Adjustments to reconcile change in net assets to cash provided by (used in) operating activities:		
Depreciation and amortization	1,438	1,463
Changes in equity of health-related entities	(267)	(189)
Deconsolidation of joint venture	-	51
Noncash special charges and other	47	52
Change in fair value of swaps	(99)	(238)
Change in funded status of pension and other postretirement benefit plans	(452)	(995)
Pension cash contributions	(1)	(19)
Changes in certain assets and liabilities:		
Accounts receivable, net	(423)	(345)
Prepaid and other current assets	(328)	5
Changes in broker receivables/payables for unsettled investment trades	68	206
Provider fee assets and liabilities	(121)	277
Accounts payable	(120)	(170)
Accrued salaries and benefits	(352)	(110)
Medicare advances	(807)	(1,719)
Other accrued liabilities	252	(26)
Self-insured reserves and claims - long-term	(10)	44
Other, net	316	(704)
Cash used in operating activities before net change in investments	(749)	(3,286)
Net (increase) decrease in investments	(246)	4,010
Cash provided by (used in) operating activities	(995)	724

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2023 AND 2022 (in millions)

	2023	2022
Cash flows from investing activities:		
Purchases of property and equipment	$ (1,288)	$ (1,486)
Investments in health-related activities	(109)	(105)
Business acquisitions, net of cash acquired	(706)	(138)
Proceeds from asset sales	560	276
Cash distributions from health-related activities	153	86
Other, net	21	(35)
Cash used in investing activities	(1,369)	(1,402)
Cash flows from financing activities:		
Borrowings	2,717	118
Repayments	(1,198)	(211)
Swaps cash collateral received	25	101
Distributions to noncontrolling interests	(158)	(110)
Contribution by noncontrolling interests	63	43
Cash provided by (used in) financing activities	1,449	(59)
Net decrease in cash and cash equivalents	(915)	(737)
Cash and cash equivalents at beginning of year	2,592	3,329
Cash and cash equivalents at end of year	$ 1,677	$ 2,592
Supplemental disclosures of cash flow information:		
Cash paid for interest, net of capitalized interest	$ 568	$ 473
Supplemental schedule of noncash investing and financing activities:		
Property and equipment acquired through finance lease or note payable	$ 1,454	$ 33
Investments in health-related activities	$ 76	$ 21
Accrued purchases of property and equipment	$ 99	$ 73

See notes to consolidated financial statements.

1. ORGANIZATION

CommonSpirit Health is a Colorado nonprofit public benefit corporation exempt from federal and state income taxes. CommonSpirit Health is a Catholic health care system sponsored by the public juridic person, Catholic Health Care Federation ("CHCF").

CommonSpirit Health owns and operates health care facilities in 24 states and is the sole corporate member (parent corporation) of other primarily nonprofit corporations. CommonSpirit Health and substantially all of its direct affiliates and subsidiaries have been granted exemptions from federal income tax as charitable organizations under Section 501(c)(3) of the Internal Revenue Code. As of June 30, 2023, CommonSpirit Health is comprised of approximately 2,200 care sites, consisting of 142 hospitals, including academic health centers, major teaching hospitals, and critical access facilities, community health services organizations, accredited nursing colleges, home health agencies, living communities, a medical foundation and other affiliated medical groups, and other facilities and services that span the inpatient and outpatient continuum of care. An additional 20 hospitals are operated through unconsolidated joint ventures. CommonSpirit Health also has offshore and onshore captive insurance companies. The accompanying consolidated financial statements include CommonSpirit Health and its direct affiliates and subsidiaries (together, "CommonSpirit").

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

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

Inventories – Inventories, primarily consisting of pharmacy drugs and medical and surgical supplies, are stated at the lower of cost or net realizable value, determined using the first-in, first-out method. Inventories are recorded in other current assets in the accompanying consolidated balance sheets. See Note 6.

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

Assets and Liabilities Held for Sale – Assets and liabilities held for sale represent assets and liabilities that are expected to be sold within one year. A group of assets and liabilities expected to be sold within one year is classified as held for sale if it meets certain criteria. The assets and liabilities held for sale are measured at the lower of carrying value or fair value less cost to sell. Such valuations include estimates of fair values generally based upon firm offers, discounted cash flows and incremental direct costs to transact a sale (Level 2 and Level 3 inputs). These balances are recorded within other current assets and other accrued liabilities - current, respectively. See Notes 3, 6 and 12.

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

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

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

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

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

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

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

Liquidity – Cash and cash equivalents, short-term investments, patient and other accounts receivable, broker receivables, and provider fee receivables are the financial assets available to meet expected expenditure needs within the next year. Additionally, although intended to satisfy long-term obligations, management estimates that approximately 80.6% and 80.7% of the CommonSpirit Health Operating Investment Pool, LLC ("CSH OIP"), as stated at June 30, 2023 and June 30, 2022, respectively, could be utilized within the next year, if needed. CommonSpirit also has credit facility programs, as described in Note 13, available to meet unanticipated liquidity needs.

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

Property and Equipment – Property and equipment are stated at cost if purchased and at fair market value upon receipt if acquired through a business combination or donated, or upon the date of impairment, if impaired. Depreciation of property and equipment is recorded using the straight-line method. Amortization of finance lease assets is included in depreciation expense, over the shorter of the useful life of the asset or the lease term.

Estimated useful lives by major classification are as follows:

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

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

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

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

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

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

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

Self-Insurance Plans – The liability for self-insured reserves and claims represents the estimated ultimate net cost of all reported and unreported losses incurred through June 30. Actuarial estimates of uninsured losses at June 30, 2023 and 2022, have been accrued as liabilities and include an actuarial estimate for claims incurred but not reported ("IBNR"). CommonSpirit has insurance coverage in place for amounts in excess of the self-insured retention for workers' compensation and professional and general liabilities. The current and long-term portions of these liabilities are reflected accordingly in other accrued liabilities - current and other accrued liabilities - long-term in the accompanying consolidated balance sheets.

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

Patient Accounts Receivable and Net Patient Revenue – Patient service revenue is reported at the amounts that reflect the consideration CommonSpirit expects to be paid in exchange for providing patient care. These amounts

are due from patients, third-party payors (including health insurers and government programs), and others, and include consideration for retroactive revenue adjustments due to settlement of audits and reviews. Generally, performance obligations for patients receiving inpatient acute care services and outpatient services are recognized over time as services are provided. Net patient revenue is primarily comprised of hospital and physician services.

Performance obligations are generally satisfied over a period of less than one year. As such, CommonSpirit has elected to apply the optional exemption provided in Financial Accounting Standards Board Accounting Standards Update ("ASU") No. 2015-14, *Revenue From Contracts with Customers (Topic 606)*, and is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period.

CommonSpirit determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with CommonSpirit's financial assistance policy, and implicit price concessions provided to uninsured and underinsured patients. CommonSpirit determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy, and historical experience. CommonSpirit determines its estimate of implicit price concessions based on its historical collection experience with these classes of patients using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. CommonSpirit relies on the results of detailed reviews of historical write-offs and collections in estimating the collectability of accounts receivable. Updates to the hindsight analysis are performed at least quarterly using primarily a rolling 18-month collection history and write-off data. Subsequent changes to estimates of the transaction price are generally recorded as adjustments to net patient revenue in the period of the change.

Subsequent changes that are determined to be the result of an adverse change in a third-party payor's ability to pay are recorded as bad debt expense in purchased services and other in the accompanying consolidated statements of operations and changes in net assets. Bad debt expense for 2023 and 2022 was not significant.

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

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

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

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

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

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

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

Financial Assistance (Charity Care) – Charity care is free or discounted health services provided to persons who cannot afford to pay and who meet CommonSpirit's criteria for financial assistance. The amount of services written off as charity quantified at customary charges was $2.0 billion for 2023 and 2022. CommonSpirit estimates the cost of charity care by calculating a ratio of cost to usual and customary charges and applying that ratio to the usual and customary uncompensated charges associated with providing care to patients who qualify for charity care. This amount is not included in net patient revenue in the accompanying consolidated statements of operations and changes in net assets. The estimated cost of charity care associated with write-offs in 2023 and 2022 was $487 million and $473 million, respectively. See Note 20.

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

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

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

Total net assets with donor restrictions are $1.1 billion as of June 30, 2023 and 2022. Of these net assets with donor restrictions, endowment net assets totaled $302 million and $295 million in 2023 and 2022, respectively. Endowment assets, which are primarily to be used for equipment and expansion, research and education, or charity purposes, include donor-restricted funds that CommonSpirit must hold in perpetuity or for a donor-specified period. Changes in endowment net assets primarily relate to investment returns, contributions, and appropriations for expenditures. CommonSpirit preserves the fair value of these gifts as of the date of donation unless otherwise stipulated by the donor. Donor-restricted endowment funds are classified as net assets with donor restrictions until those amounts are appropriated for expenditure. CommonSpirit considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund, (2) the purposes of the organization and the donor-restricted endowment fund, (3) general economic conditions, (4) the possible effects of inflation and deflation, (5) the expected total return from income and the appreciation of investments, (6) other resources of CommonSpirit, and (7) the investment policies of CommonSpirit.

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

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

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

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

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

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

CommonSpirit's taxable entities did not have any material unrecognized income tax expense as of June 30, 2023 and 2022. CommonSpirit reviews its tax positions quarterly and has determined that there are no material uncertain tax positions that require recognition in the accompanying consolidated financial statements.

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

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

Special Charges - Included within purchased services and other are certain non-routine, nonrecurring costs that are unusual in nature. These costs, referred to as special charges, primarily relate to impairment of long-lived assets, certain contract termination costs, certain integration activities that are specific to long-term value capture efforts, and severance costs related to system-wide reductions in force. Amounts recorded for the periods ended June 30, 2023 and 2022, are not material to the consolidated financial statements.

Related Parties - CommonSpirit includes institutions that participate in student financial assistance programs authorized by Title IV of the Higher Education Act of 1965 (Title IV, HEA Program). In order to participate in Title IV, HEA Program, the institutions must comply with standards outlined in 34 C.F.R. 668 Subpart B. As required under this standard the institutions participating in this program have policies in place regarding the identification and disclosure of any transactions with related parties and do not have any material related-party transactions for the year ended June 30, 2023 and 2022.

Subsequent Events – CommonSpirit has evaluated subsequent events occurring between the end of the most recent fiscal year and September 21, 2023, the date the consolidated financial statements were issued. See Notes 3 and 13.

3. ACQUISITIONS, AFFILIATIONS AND DIVESTITURES

Colorado – In February 2023, CommonSpirit and AdventHealth announced that they have agreed to transition to direct management of their respective care sites that comprised Centura Health (the "Transition"). Following the Transition, CommonSpirit will directly operate and manage its hospitals and affiliated clinics in Colorado, western Kansas and Utah, and AdventHealth will directly operate and manage its Adventist hospitals and their affiliated clinics in Colorado. The Transition was finalized in August 2023, and is not expected to have a material effect on the financial condition or operations of CommonSpirit, taken as a whole.

In February 2023, CommonSpirit entered into an asset purchase agreement to acquire substantially all of the assets of a regional health system, including five hospitals, over 40 clinics, and other ambulatory services in Utah for total consideration of $705 million and initiation of a 15-year master lease agreement for real property on which the primary health care facilities are located, with minimum annual payments of approximately $95 million. This master lease agreement is recorded as a finance lease, within long-term debt in the consolidated financial statements. The transaction closed in May 2023. The facilities acquired will support the mission and strategy to better serve the health care needs of the communities in Utah.

The following summarized the fair value estimate of the assets acquired and liabilities assumed as of the acquisition (in millions):

Current assets	$	34
Property and equipment, net		75
Right of us operating lease assets		1
Other long-term assets, net		610
Other accrued liabilities - current		(9)
Operating lease liabilities		(6)
Total contribution of net assets	$	705

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

Iowa – In September 2022, CommonSpirit sold the facilities and assets of MercyOne, a regional health system in Iowa, to Trinity Health for a gross purchase price of $613 million. MercyOne had operated under a JOA between Trinity Health and CommonSpirit. A net loss on sale of $23 million was recognized in the year ended June 30, 2023. As of June 30, 2022, certain assets and liabilities of MercyOne are classified as held for sale, within other current assets and other accrued liabilities - current, respectively, in the accompanying consolidated balance sheet.

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

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

4. COVID-19 PANDEMIC

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

The CARES PRF funds provided stimulus in the form of financial aid to cover extensive emergency funding to hospitals and providers through existing mechanisms to prevent, prepare for, and respond to COVID-19. For the years ended June 30, 2023 and 2022, $265 million and $27 million, respectively, has been recognized within other operating revenue as earned.

Additional relief to address the continued impact of COVID-19 was provided through the American Rescue Plan Act of 2021 ("ARP Rural"). For the years ended June 30, 2023 and 2022, CommonSpirit has received approximately $2 million and $149 million, respectively, of ARP Rural funds in the form of grants recorded as other operating revenues in the consolidated statements of operations and changes in net assets.

Prior to June 30, 2022, CommonSpirit received $2.8 billion in funds under the Medicare Accelerated and Advance Payment Program. These payments were advances that were recouped by withholding future Medicare fee-for-service payments for claims until the full accelerated payment had been recouped. As of June 30, 2023, no amounts are recorded as a liability related to Medicare advances. As of June 30, 2022, $793 million was recorded as a current liability in Medicare advances.

CommonSpirit had deferred approximately $416 million of employer payroll taxes through June 30, 2022, pursuant to the Paycheck Protection Program and Health Care Enhancement Act, of which $208 million was paid in both December 2021 and December 2022.

For the years ended June 30, 2023 and 2022, CommonSpirit recorded $194 million and $67 million, respectively, net of expenses, of ERC revenue. These payroll tax credits relate to qualified wages paid from March 13, 2020, through September 30, 2021, and are recorded in other operating revenue in the consolidated statements of operations and changes in net assets.

All grants and tax credits recorded are subject to subsequent audits by the applicable regulatory agencies providing the funds.

5. NET PATIENT AND PREMIUM REVENUE

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

	2023	2022
Inpatient services	49%	50%
Outpatient services	51%	50%

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

	2023	2022
Government	$ 16,087	$ 15,480
Contracted	12,415	12,787
Self-pay and other	2,364	2,223
Net patient revenue	$ 30,866	$ 30,490

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

Total net patient and premium revenues by service line are as follows for the years ended June 30 (in millions):

	2023	2022
Hospitals	$ 28,455	$ 27,712
Physician organizations	3,027	3,171
Long-term care and home care	268	295
Other	510	468
Total net patient and premium revenue	$ 32,260	$ 31,646

6. OTHER CURRENT ASSETS

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

	2023	2022
Inventories	$ 819	$ 795
Receivables, other than patient accounts receivable	883	583
Broker receivables for unsettled investment trades	535	576
Assets held for sale	-	908
Prepaid expenses	440	372
Other	56	62
Total other current assets	$ 2,733	$ 3,296

7. CASH AND INVESTMENTS

CommonSpirit's cash and investments include consolidated membership interests in the CSH OIP as of June 30, 2023 and 2022. Short-term and long-term investments also include assets limited as to use set aside by CommonSpirit for future long-term purposes as outlined below (in millions):

	2023	2022
Cash and cash equivalents	$ 1,677	$ 2,592
Short-term investments	539	596
Long-term investments	16,483	16,087
Total cash and investments	18,699	19,275
Less:		
Held for self-insured claims	1,885	1,758
Under bond indenture agreements for debt service	66	78
Donor-restricted	589	579
Other	703	613
Total assets limited as to use	3,243	3,028
Unrestricted cash and investments	$ 15,456	$ 16,247

8. FAIR VALUE MEASUREMENTS

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

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

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

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

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

	2023			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Total**
Assets				
Cash and short-term investments	$ 1,961	$ 258	$ -	$ 2,219
U.S. government securities	911	673	-	1,584
U.S. corporate bonds	44	598	-	642
U.S. equity securities	1,867	1	-	1,868
Foreign government securities	-	72	-	72
Foreign corporate bonds	4	224	-	228
Foreign equity securities	1,769	5	-	1,774
Asset-backed securities	-	172	-	172
Private equity	5	-	73	78
Multi-strategy hedge funds	1	-	-	1
Real estate	28	7	-	35
Community Investment Program	-	-	155	155
Other investments	169	267	-	436
Assets measured at fair value	$ 6,759	$ 2,277	$ 228	9,264
Assets at NAV				9,435
Total assets				$ 18,699
Liabilities				
Derivative instruments	$ -	$ 135	$ -	$ 135
Other	2	-	97	99
Total liabilities	$ 2	$ 135	$ 97	$ 234

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

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

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

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

valuation techniques, such as the income or market approach. CommonSpirit classifies all such investments as Level 2.

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

The fair value of collateral held under securities lending program is classified as Level 2. The collateral held under this program is placed in commingled funds whose underlying investments are valued using techniques similar to those used for the marketable securities noted above. Amounts reported do not include noncash collateral of $561 million and $56 million as of June 30, 2023 and 2022, respectively.

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

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

The following table and explanations identify attributes relating to the nature and risk of investments for which fair value is determined using a calculated NAV as of June 30, 2023 (in millions):

		NAV Practical Expedient	Unfunded Commitments	Redemption Frequency (If Currently Eligible)	Redemption Notice Period
Private equity	(1)	$ 1,416	$ 1,388	-	-
Multi-strategy hedge funds	(2)	2,298	-	Daily, Weekly, Monthly, Quarterly, Semi-annually, Annually	1 - 90 days
Real estate	(3)	1,194	134	Quarterly	45 - 90 days
Commingled funds - debt securities	(4)	1,077	78	Daily, Monthly, Quarterly	1 - 90 days
Commingled funds - equity securities	(5)	3,450	-	Daily, Weekly, Bi-Weekly, Monthly, Quarterly	1 - 90 days
Total		$ 9,435	$ 1,600		

(1) This category includes private equity funds that specialize in providing capital to a variety of investment groups, including, but not limited to, venture capital, leveraged buyout, mezzanine debt, distressed debt, and other situations. There are no provisions for redemptions during the life of these funds. Distributions from each fund will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2023, to be over the next 15 years.

(2) This category includes investments in hedge funds that pursue diversification of both domestic and foreign fixed income and equity securities through multiple investment strategies. The primary objective for these funds is to seek attractive long-term, risk-adjusted absolute returns. Under certain circumstances, an otherwise redeemable investment or portion thereof could become restricted. The following table reflects the various redemption frequencies, notice periods, and any applicable lock-up periods or gates to redemption as of June 30, 2023:

Percentage of the Value of Category (2)		Redemption	Redemption Notice	Redemption Locked Up Until	Redemption Gate % of Account
Total	Subtotal	Frequency	Period	(if applicable)	(if applicable)
6.8%	6.8%	Annually	60 days	up to 2 years	up to 50.0%
47.9%	2.3%	Quarterly	45 days	up to 2 years	up to 20.0%
	30.0%	Quarterly	55- 65 days	up to 2 years	up to 12.5% - 25.0%
	15.6%	Quarterly	90 days	up to 1 year	up to 12.5% - 25.0%
31.0%	19.9%	Monthly	30 - 45 days	-	up to 16.7% - 25.0%
	11.1%	Monthly	90 days	-	up to 20.0%
3.4%	3.4%	Weekly	3 days	-	-
1.6%	1.6%	Daily	1 day	-	-
9.3%	9.3%	None	None	up to 2 years	-

(3) This category includes investments in real estate funds that invest primarily in institutional-quality commercial and residential real estate assets within the U.S. and investments in publicly traded real estate investment trusts. Investments representing 17% of the value of investments in this category do not have provisions for redemptions during the life of these funds. Distributions will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2023, to be over the next 15 years.

(4) This category includes investments in commingled funds that invest primarily in domestic and foreign debt and fixed income securities, the majority of which are traded in over-the-counter markets. Also included in this category are commingled fixed income funds that provide capital in a variety of mezzanine debt, distressed debt and other special debt securities situations. Investments representing approximately 18 % of the value of investments in this category do not have provisions for redemptions during the life of these funds. Distributions will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2023, to be over the next eight years.

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

9. PROPERTY AND EQUIPMENT, NET

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

	2023	2022
Land and improvements	$ 2,100	$ 2,098
Buildings	15,488	13,182
Equipment	10,432	9,783
Total	28,020	25,063
Add: Construction in progress	2,202	2,418
Less: Accumulated depreciation	(13,033)	(11,605)
Property and equipment, net	$ 17,189	$ 15,876

10. OWNERSHIP INTERESTS IN HEALTH-RELATED ACTIVITIES

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

As of June 30, 2023 and 2022, CommonSpirit has investment interests of 65% and 50% in JOCs based in Colorado and Ohio, respectively. As of June 30, 2022, CommonSpirit had an investment interest of 50% in a JOC based in Iowa. CommonSpirit's interests in the JOCs are included in ownership interests in health-related activities in the accompanying consolidated balance sheets and totaled $326 million and $523 million at June 30, 2023 and 2022, respectively. CommonSpirit recognizes its investment in all JOCs under the equity method of accounting. The JOCs provide varying levels of services to the related JOA sponsors, and operating expenses of the JOCs are allocated to each sponsoring organization. See Note 3.

Other Ownership Interests in Health-Related Activities – In addition to the JOCs above, CommonSpirit has significant ownership interests that are accounted for under the equity method and reflected in the accompanying consolidated balance sheets in ownership interests in health-related activities. CommonSpirit's significant ownership interests are as follows:

- CommonSpirit's ownership interest in Conifer was 23.8% as of June 30, 2023 and 2022. Conifer provides revenue cycle services and health information management solutions for a portion of CommonSpirit's acute care operations.

- CommonSpirit's ownership interest in Premier Health was 22% as of June 30, 2023 and 2022.

The following table summarizes the financial position and results of operations for the significant health-related activities discussed above, unless otherwise specified, which are accounted for under the equity method, as of and for the 12 months ended June 30, or a portion of the periods thereof while held by CommonSpirit (in millions):

	2023			
	Hospitals	JOCs	Other	Total
Total assets	$ 2,557	$ 1,046	$ 2,697	$ 6,300
Total liabilities	1,501	447	192	2,140
Total net assets	1,056	599	2,505	4,160
Total operating revenues, net	2,038	547	1,266	3,851
Excess (deficit) of revenues over expenses	(100)	(181)	362	81
Investment at June 30 recorded in ownership interests in health-related activities	214	326	970	1,510
Income (loss) recorded in revenue from health-related activities, net	(43)	(92)	76	(59)

	2022			
	Hospitals	JOCs	Other	Total
Total assets	$ 2,731	$ 1,606	$ 2,358	$ 6,695
Total liabilities	1,484	661	215	2,360
Total net assets	1,247	945	2,143	4,335
Total operating revenues, net	1,959	932	1,257	4,148
Excess (deficit) of revenues over expenses	(138)	(183)	295	(26)
Investment at June 30 recorded in ownership interests in health-related activities	257	523	894	1,674
Income (loss) recorded in revenue from health-related activities, net	(27)	(91)	58	(60)

Other than the investments described above, ownership interests totaling $1.6 billion and $1.4 billion as of June 30, 2023 and 2022, respectively, are not material individually to the consolidated financial statements.

11. OTHER LONG-TERM ASSETS, NET

Other long-term assets, net, consist of the following at June 30 (in millions):

	2023	2022
Notes receivable, primarily secured	$ 56	$ 50
Goodwill	962	358
Intangible assets - definite-lived, net	123	120
Intangible assets - indefinite-lived	661	657
Donor-restricted assets	517	521
Other	312	243
Total other long-term assets, net	$ 2,631	$ 1,949

Goodwill is measured as of the effective date of a business combination as the excess of the aggregate of the fair value of consideration transferred over the fair value of the tangible and intangible assets acquired and liabilities assumed. See Note 3.

Intangible assets consist primarily of trademarks, trademark agreements, noncompete agreements, certificates of need, and other contracts, and are recorded at fair value using various methods based on the nature of the asset. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

Goodwill and intangible assets whose lives are indefinite are not amortized and are evaluated for impairment at least annually or when circumstances indicate a possible impairment may exist. $12 million of impairment on goodwill and intangibles was recorded for the year ended June 30, 2023. No impairment on goodwill or intangible assets was recorded for the year ended June 30, 2022.

The aggregate amortization expense related to intangible assets is $10 million and $11 million for the year ended June 30, 2023 and 2022, respectively, and is recorded in depreciation and amortization on the accompanying consolidated statements of operations and changes in net assets. Estimated amortization expense related to intangible assets is $9 million in 2024, $8 million in 2025, 2026, 2027 and 2028, and $82 million thereafter.

12. OTHER ACCRUED LIABILITIES - CURRENT

Other accrued liabilities – current consists of the following at June 30 (in millions):

	2023	2022
Construction retention and contracts payable	$ 71	$ 140
Liabilities held for sale	-	250
Liabilities due to medical groups and physicians	74	76
Capitation claims	115	110
Due to government agencies	75	119
Accrued interest expense	166	144
Operating lease liabilities	264	263
Self-insured reserves and claims	453	467
Broker payables for unsettled investments trades	975	948
Due to unconsolidated affiliates	50	62
Other	1,230	856
Total other accrued liabilities - current	$ 3,473	$ 3,435

13. DEBT

The CommonSpirit Health Master Trust Indenture ("CommonSpirit MTI") has an Obligated Group, which is comprised of the former Dignity Health Obligated Group and CHI entities (collectively, the "CommonSpirit Obligated Group"). The CommonSpirit Obligated Group represents approximately 87% and 85% of consolidated revenues of CommonSpirit as of June 30, 2023 and 2022, respectively.

Debt, net of unamortized debt issuance costs, discounts and premiums consists of the following at June 30 (in millions):

	2023	2022
Under the CommonSpirit MTI:		
Fixed rate debt:		
Fixed rate revenue bonds payable in installments through 2053; interest at 3.00% to 7.00%	$ 4,954	$ 4,938
Fixed rate taxable bonds payable in installments through 2065; interest at 1.55% to 6.46%	7,748	7,747
Taxable term loan payable in 2025; interest at 2.95%	250	250
Total fixed rate debt	12,952	12,935
Variable rate debt:		
Direct purchase bonds payable in installments through 2029; interest set at prevailing market rates (5.11% at June 30, 2023)	90	101
Floating rate notes payable with mandatory tender through 2025; interest set at prevailing market rates (5.41% at June 30, 2023)	153	153
Variable rate demand bonds payable in installments through 2047; interest set at prevailing market rates (2.30% to 4.30% at June 30, 2023)	247	247
Auction rate certificates payable in installments through 2042; interest set at prevailing market rates (4.01% to 4.50% at June 30, 2023)	240	240
Variable rate term loans payable through 2024; (5.77% to 6.09% at June 30, 2023)	695	-
Bank line of credit maturing in 2028; interest set at prevaling market rates (6.00% at June 30, 2023)	606	156
Commercial paper notes with maturities ranging from 6 to 210 days at June 30, 2023; interest set at prevailing market rates (5.25% to 5.95% at June 30, 2023)	851	553
Total variable rate debt	2,882	1,450
Total debt under CommonSpirit MTI	15,834	14,385
Other:		
Various notes payable and other debt payable in installments	789	699
Finance lease obligations	1,737	343
Total debt	18,360	15,427
Less amounts classified as current	(1,966)	(1,619)
Less demand bonds subject to short-term liquidity arrangements	(247)	(247)
Total long-term debt	$ 16,147	$ 13,561

Scheduled principal debt payments, net of discounts and premiums, and considering obligations subject to short-term liquidity arrangements as due according to their long-term amortization schedule, for the next five years and thereafter, are as follows (in millions):

	Long-Term Debt Other Than Demand Bonds	Demand Bonds Subject to Short-Term Liquidity Arrangements	Total Debt
2024	$ 1,879	$ 97	$ 1,976
2025	1,645	-	1,645
2026	858	-	858
2027	442	-	442
2028	1,229	-	1,229
Thereafter	9,976	150	10,126
Subtotal	16,029	247	16,276
Finance lease obligations	1,737	-	1,737
Premium and Issuance cost, net	347	-	347
Total	$ 18,113	$ 247	$ 18,360

Fixed Rate Revenue Bonds – CommonSpirit has fixed rate revenue bonds outstanding, substantially all of which may be redeemed, in whole or in part, prior to the stated maturities without a premium.

Fixed Rate Taxable Bonds – CommonSpirit has taxable fixed rate bonds that are due in August 2023, October 2024, 2025, 2029, 2030, 2049, and 2050 and November 2024, 2027, 2040, 2041, 2042, 2052 and 2064 as of June 30, 2023. Early redemption of the debt, in whole or in part, may require a premium depending on market rates.

Fixed Rate Taxable Term Loan – CommonSpirit has a taxable fixed rate term loan due in April 2025.

Taxable Commercial Paper – CommonSpirit has a commercial paper program that permits the issuance of up to $881 million in aggregate principal amount outstanding, with maturities limited to 270-day periods. The commercial paper program is backed by CommonSpirit's self-liquidity program, which is comprised of CommonSpirit's cash management and operating investment programs and dedicated bank lines of credit to ensure the availability of funds to purchase any commercial paper that the remarketing agent is unable to remarket.

Floating Rate Notes – CommonSpirit has floating rate notes ("FRNs") that bear interest at variable rates determined weekly and monthly. These FRNs are subject to mandatory tender on predetermined dates.

Variable Rate Direct Purchase Bonds – CommonSpirit has variable rate direct purchase bonds placed with holders that bear interest at variable rates determined monthly based upon a percentage of the Secured Overnight Financing Rate ("SOFR"), plus a spread. These bonds are subject to mandatory tender on predetermined dates.

Variable Rate Demand Bonds – CommonSpirit has variable rate demand bonds ("VRDBs") that are remarketed weekly and may be put at the option of the holders. Two of the four series of VRDBs are backed by bank letters of credit, while the remaining two series of VRDBs are supported through CommonSpirit's self-liquidity program (as discussed above). The bank letters of credit and the self-liquidity program ensure the availability of funds to purchase any bonds tendered that the remarketing agent is unable to remarket. CommonSpirit maintains bank letters of credit of $150 million as credit enhancement for the VRDBs to ensure the availability of funds to purchase any bonds tendered that the remarketing agent is unable to remarket. CommonSpirit has $97 million in VRDBs that are not supported through bank letters of credit but through the self-liquidity program. The letters of credit to support the $150 million of VRDBs, which can be used anytime, expire in March 2024.

Variable Rate Taxable Loan – CommonSpirit has two taxable variable rate term loans that bear interest at variable rates based on the Secured Overnight Financing Rate ("SOFR"), plus a spread. The two loans are due in April 2024.

Auction Rate Certificates – CommonSpirit has $240 million of auction rate certificates ("ARCs") that are remarketed weekly. The certificates are insured by Assured Guaranty. Holders of ARCs are required to hold the certificates until the remarketing agent can find a new buyer for any tendered certificates.

Notes Payable to Banks Under Credit Agreements – CommonSpirit maintains a $900 million syndicated line of credit facility for working capital, letters of credit, capital expenditures and other general corporate purposes. The amount outstanding under the syndicated credit facility was $606 million as of June 30, 2023. This credit facility expires in March 2028.

CommonSpirit maintains $190 million in dedicated lines of credit to support the organization's self-liquidity program, to be used to fund tenders of VRDBs and maturing principal of commercial paper due to a failed remarketing. The lines of credit expiration dates are August 2023 and December 2023. No amounts have been drawn.

CommonSpirit also maintains an $35 million single-bank line of credit facility to be used for the issuance of standby letters of credit. The credit facility expires in March 2028. No amounts have been drawn.

2023 Financing Activity – In October 2022, CommonSpirit issued $807 million of taxable fixed rate bonds at par, with repayments of $507 million and $300 million to be made in November 2027 and 2052 respectively. Proceeds were used to refund $800 million of taxable fixed rate bonds and pay cost of issuance expenses.

In October 2022, CommonSpirit issued $497 million of tax-exempt fixed rate bonds, at a premium. Proceeds were used to reimburse for prior capital expenditures and to fund future capital expenditures. The bonds mature in November 2052.

In November 2022, CommonSpirit drew $150 million on its syndicated line of credit for working capital purposes.

In December 2022, CommonSpirit drew $300 million on its syndicated line of credit for working capital purposes.

In December 2022, CommonSpirit issued $297 million of taxable commercial paper notes to redeem in full, the California Health Facilities Financing Authority Revenue Bonds, Series 2014B.

In March 2023, CommonSpirit renewed its $900 million syndicated line of credit. This credit facility expires March 2028.

In March 2023, CommonSpirit renewed and renegotiated its single bank line of credit facility used to issue standby letters of credit. The credit facility amount was reduced from $85 million to $35 million and will expire in March 2028.

In April 2023, CommonSpirit entered into two short-term loans of $350 million and $345 million with two separate banks to fund certain acquisitions.

In May 2023, CommonSpirit renewed the $90 million Colorado Health Facilities Authority Variable Rate Direct Placement bonds, Series 2013C to December 2028.

In May 2023, CommonSpirit redeemed in full $9 million of the Colorado Health Facilities Authority Variable Rate bonds, Series 2015A.

In July 2023, CommonSpirit drew $265 million on its syndicated line of credit for the redemption in full of the Catholic Health Initiatives Series 2013 Taxable Bonds.

In August 2023, CommonSpirit entered into a $265 million term loan to refinance the $265 million draw on its syndicated line of credit.

2022 Financing Activity – In November 2021, CommonSpirit drew $102 million on its syndicated line of credit for the redemption in full of the Kentucky Economic Development Finance Authority Fixed Rate Put Bonds, Series 2009B, and the Colorado Health Facilities Authority Fixed Rate Put Bonds, Series 2008D-3.

14. DERIVATIVE INSTRUMENTS

CommonSpirit's derivative instruments include 31 floating-to-fixed rate interest rate swaps and one basis swap as of June 30, 2023. CommonSpirit uses interest rate swaps to manage interest rate risk associated with outstanding variable rate debt. Under the floating-to-fixed rate swaps, CommonSpirit receives a percentage of SOFR, plus a spread, and pays a fixed rate. The basis swap allows CommonSpirit to receive a percentage of SOFR, plus a spread and pay a percentage of Securities Industry and Financial Markets Association ("SIFMA").

CommonSpirit's derivative instruments also include seven total return swaps as of June 30, 2023. CommonSpirit receives a fixed rate and pays a variable rate percentage of SIFMA, plus a spread. CommonSpirit uses these total return swaps to reduce interest expense associated with the fixed rate debt.

The following table shows the outstanding notional amount of derivative instruments measured at fair value, net of credit value adjustments, as reported in the accompanying consolidated balance sheets as of June 30, 2023 and 2022 (in millions):

	Maturity Date of Derivatives	Interest Rate	Notional Amount Outstanding	Fair Value
			2023	
Derivatives not designated as hedges:				
Interest rate swaps	2024 - 2047	3.2% - 4.0%	$ 1,877	$ (135)
Total return swaps	2024 - 2030	SIFMA plus spread	485	-
Total derivative instruments			2,362	(135)
Cash collateral			-	58
Derivative instruments, net			$ 2,362	$ (77)
			2022	
Derivatives not designated as hedges:				
Interest rate swaps	2024 - 2047	3.2% - 4.0%	$ 2,003	$ (234)
Risk participation agreements	2025 - 2029 with extension options	SIFMA plus spread	497	-
Total return swaps	2024 - 2030	SIFMA plus spread	321	-
Total derivative instruments			2,821	(234)
Cash collateral			-	84
Derivative instruments, net			$ 2,821	$ (150)

CommonSpirit held $1.9 billion notional amount of interest rate swaps and $485 million notional amount of total return swaps at June 30, 2023, which have a negative fair value of $135 million and a fair value deemed immaterial, respectively. CommonSpirit posted $58 million of collateral against the fair value of the interest rate swaps as of June 30, 2023.

CommonSpirit's interest rate swaps mature between 2024 and 2047. CommonSpirit has the right to terminate the swaps prior to maturity for any reason. The termination value would be the fair value or the replacement cost of the swaps, depending on circumstances. The derivative agreements have certain early termination triggers caused by an event of default or a termination event. The events of default include failure to make payment when

due, failure to give notice of a termination event, cash on hand dropping below a specified number of days, and defaults under other agreements (cross-default provision). Termination events can include credit ratings dropping below a defined minimum credit rating threshold by either party.

CommonSpirit has $160 million notional of interest rate swaps that are insured and have a negative fair value of $20 million as of June 30, 2023. In the event the insurer is downgraded below specified minimum credit rating, the counterparties have the right terminate the swaps if CommonSpirit Health does not provide alternative credit support acceptable to them within 30 days of being notified of the downgrade. If both the insurer and CommonSpirit Health is downgraded below a specified minimum credit rating, the counterparties have the right to terminate the swaps.

CommonSpirit has $1.7 billion notional amount of interest rate swaps that are not insured, of which the counterparties have various rights to terminate $264 million notional. These include the outstanding notional amounts of $104 million and $100 million at each five-year anniversary date commencing in September 2023 and March 2028, respectively. Swaps in the outstanding notional amounts of $60 million have mandatory puts in March 2028. The termination value would be the fair value or the replacement cost of the swaps, depending on the circumstances. These interest rate swaps with the optional and mandatory put options have a negative fair value of $21 million as of June 30, 2023. The remaining uninsured swaps in the notional amount of $1.5 billion have a negative fair value of $94 million as of June 30, 2023.

CommonSpirit has total return swaps in the notional amount of $485 million with a fair value deemed immaterial as of June 30, 2023.

In December 2022, CommonSpirit terminated a risk participation agreement in the notional amount of $295 million. The risk participation agreement was terminated at par and no gain or loss was realized. The underlying bonds, the California Health Facilities Financing Authority Revenue Bonds, Series 2014B were redeemed in full in conjunction with the termination of the risk participation agreement.

In April 2023, CommonSpirit oversaw the transition from London Interbank Offered Rate (LIBOR) to Secured Overnight Financing Rate (SOFR) based floating rate payments, which became effective on June 30, 2023. CommonSpirit effected the transition on a portfolio wide basis by adhering to the International Swaps and Derivatives Association 2020 Interbank Offered Rates Fallback Protocol.

In May 2023, CommonSpirit renewed a total return swap in the notional amount of $255 million to March 2030.

15. LEASES

CommonSpirit enters into operating and finance leases primarily for buildings and equipment and determines if an arrangement is a lease at inception of the contract. For leases with terms greater than 12 months, CommonSpirit records the related right-of-use ("ROU") asset and lease liability at the present value of lease payments over the contract term using a risk-free interest rate, subject to certain adjustments. CommonSpirit does not separate contract lease and non-lease components except for a class of underlying assets related to supply agreements, which include associated equipment. Certain building lease agreements require CommonSpirit to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU asset or lease liability. Lease costs also include escalating rent payments that are not fixed at commencement but are based on the Consumer Price Index or other measure of cost inflation. Future changes in the indices are included within variable lease costs. Certain leases include one or more options to renew the lease at the end of the initial term, with renewal terms that generally extend the lease at the then market rate of rental payment. Certain leases also include an option to buy the underlying asset at or a short time prior to the termination of the lease. All such options are at CommonSpirit's discretion and are evaluated at the commencement of the lease, with only those that are reasonably certain of exercise included in determining the appropriate lease term and lease type.

The components of lease cost, net for the year ended June 30 are as follows (in millions):

	2023	2022
Operating lease cost	$ 301	$ 298
Variable lease cost	101	181
Short-term rent expense	71	81
Amortization of right-of-use assets	53	33
Interest on finance lease liabilities	13	10
Sublease income	(13)	(10)
Total lease cost, net	$ 526	$ 593

Following is supplemental consolidated balance sheet information related to leases as of June 30 (in millions):

Lease Type	Balance Sheet Classification	2023	2022
Operating Leases:			
Operating lease ROU assets	Right-of-use operating lease assets	$ 1,676	$ 1,715
Operating lease obligations - current	Other accrued liabilities - current	264	263
Operating lease obligations - long-term	Operating lease liabilities	1,586	1,626
Finance Leases:			
Finance lease ROU assets	Property and equipment, net	1,700	299
Current finance lease liabilities	Current portion of long-term debt	88	38
Long-term finance lease liabilities	Long-term debt, net of current portion	1,649	305

Supplemental cash flow and other information related to leases for the years ended June 30 are as follows (in millions):

	2023	2022
ROU assets obtained in exchange for new operating lease liabilities	$ 222	$ 248
ROU assets obtained in exchange for new finance lease liabilities	1,449	58
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	316	312
Operating cash flows from finance leases	21	10
Financing cash flows from finance leases	53	34
Weighted-average remaining lease term:		
Operating leases	9 years	9 years
Finance leases	16 years	18 years
Weighted-average discount rate:		
Operating leases	2.3%	2.0%
Finance leases	3.8%	4.0%

Commitments related to operating and finance leases for each of the next five years and thereafter as of June 30, 2023, are as follows (in millions):

	Operating	Finance	Total
2024	$ 294	$ 152	$ 446
2025	281	147	428
2026	246	147	393
2027	193	143	336
2028	159	135	294
Thereafter	943	1,592	2,535
Total minimum future lease payments	2,116	2,316	4,432
Less: Imputed Interest	(266)	(579)	(845)
Total lease liabilities	1,850	1,737	3,587
Less: current lease liabilities	(264)	(88)	(352)
Total long-term lease liabilities	$ 1,586	$ 1,649	$ 3,235

16. INTEREST EXPENSE, NET

The components of interest expense, net, include the following (in millions):

	2023	2022
Interest and fees on debt	$ 613	$ 485
Capitalized interest expense	(40)	(26)
Interest expense, net	$ 573	$ 459

17. RETIREMENT PROGRAMS

CommonSpirit maintains defined benefit pension plans and other postretirement benefit plans that cover most Dignity Health and CHI employees. Benefits for both types of plans are generally based on age, years of service and employee compensation.

Certain of CHI's plans were frozen in previous years, and benefits earned by employees through that time period remain in the retirement plans where employees continue to receive interest credits and vesting credits, if applicable.

Actuarial valuations are performed for all of the plans. These valuations are dependent on various assumptions. These assumptions include the discount rate and the expected rate of return on plan assets (for pension), which are important elements of expense and liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover, and the rate of compensation increases. CommonSpirit evaluates all assumptions in conjunction with the valuation updates and modifies them as appropriate. In the years ended June 30, 2023 and 2022, the actuarial gains were primarily driven by the change in discount rate assumption.

Pension costs and other postretirement benefit costs are allocated over the service period of the employees in the plans. The principle underlying this accounting is that employees render service ratably over the period, and therefore, the effects in the accompanying consolidated statements of operations and changes in net assets follow the same pattern. Net actuarial gains and losses are amortized to expense on a plan-by-plan basis when they exceed the accounting corridor. The accounting corridor is a defined range within which amortization of net gains and losses is not required and is equal to 10% of the greater of the plan assets or benefit obligations. Gains or losses outside of the corridor are subject to amortization over the average employee future service period.

Contributions to the defined benefit pension plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to plan participants. CommonSpirit Health management believes the majority of its plans qualify under a church plan exemption, and as such, are not subject to Employee Retirement Income Security Act ("ERISA") funding requirements. CommonSpirit's funding policy requires that, at a minimum, contributions equal the unfunded normal cost plus amortization of any unfunded actuarial accrued liability. Contributions to these funded plans are anticipated at $174 million in 2024, which exceeds the funding policy minimum contributions.

The accumulated benefit obligation exceeds plan assets for the defined benefit plans and postretirement benefit plans in the aggregate for the years ended June 30, 2023 and 2022. The following summarizes the benefit obligations and funded status for the defined benefit pension and postretirement benefit plans (in millions):

	2023	2022
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 11,874	$ 14,389
Service cost	313	406
Interest cost	523	329
Actuarial gain	(512)	(2,566)
Settlements	(45)	(34)
Benefits paid	(628)	(650)
Benefit obligation at end of year	$ 11,525	$ 11,874
Accumulated benefit obligation	$ 11,080	$ 11,416
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 9,722	$ 11,082
Actual return on plan assets	540	(924)
Settlements	(22)	(26)
Employer contributions	104	240
Benefits paid	(628)	(650)
Fair value of plan assets at end of year, net	$ 9,716	$ 9,722
Funded status	$ (1,809)	$ (2,152)

The change in net actuarial loss of $452 million is included in the statement of changes in net assets for the year ended June 30, 2023. The actuarial losses for the years ended June 30, 2023 and 2022, are $442 million and $894 million, respectively.

The settlement component of net periodic benefit cost is recognized in the accompanying consolidated statements of operations and changes in net assets within nonoperating income (loss).

The following table summarizes the assumptions used to determine benefit obligations as of June 30:

	2023	2022
To determine benefit obligations:		
Discount rate	4.5% - 5.4%	3.7% - 4.9%
Rate of compensation increase	4.0%	3.8%
Weighted-average interest credit rate for cash balance plans and other applicable plans	7.4%	7.4%
To determine net periodic benefit cost:		
Discount rate	4.3% - 5.0%	0.5% - 3.1%
Expected return on plan assets	3.4% - 7.2%	3.8% - 7.1%
Rate of compensation increase	3.8%	3.8%
Weighted-average interest credit rate for cash balance plans and other applicable plans	5.0% - 9.2%	4.5% - 5.5%

The following table summarizes the components of net periodic benefit cost recognized in the accompanying consolidated statements of operations and changes in net assets (in millions):

	2023	2022
Service cost	$ 313	$ 406
Interest cost	528	329
Expected return on plan assets	(659)	(733)
Settlements	14	13
Net prior service credit amortization	(1)	(1)
Net actuarial loss amortization	54	68
Net periodic benefit cost	$ 249	$ 82

The service cost amount above is recorded in salaries and benefits on the accompanying consolidated statements of operations and changes in net assets. All other costs of net periodic benefit cost above are reflected in nonoperating income (loss) in the consolidated statements of operations and changes in net assets.

The following represents the fair value of plan assets, net, measured on a recurring basis as of June 30 (in millions). See Note 8 for the definition of Levels 1 and 2 in the fair value hierarchy and investments valued using the NAV practical expedient and discussion regarding fair value measurement. Amounts reported do not include noncash collateral of $524 million and $32 million as of June 30, 2023 and 2022, respectively.

	2023		
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Total**
Assets			
Cash and short-term investments	$ 193	$ 8	$ 201
U.S. government securities	763	51	814
U.S. corporate bonds	245	457	702
U.S. equity securities	721	1	722
Foreign government securities	-	24	24
Foreign corporate bonds	-	80	80
Foreign equity securities	988	2	990
Asset-backed securities	-	3	3
Real estate	8	-	8
Other	1	14	15
Assets measured at fair value	$ 2,919	$ 640	3,559
Assets at NAV:			
U.S. government securities			320
U.S. corporate bonds			813
U.S. equity securities			675
Foreign corporate bonds			85
Foreign equity securities			1,585
Private equity			1,440
Hedge funds			862
Real estate			516
Total assets			$ 9,855
Other plan assets (liabilities)			
Due from brokers for unsettled investment trades			36
Due to brokers for unsettled investment trades			(175)
Fair value of plan assets, net			$ 9,716

	2022		
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Total
Assets			
Cash and short-term investments	$ 479	$ 14	$ 493
U.S. government securities	329	24	353
U.S. corporate bonds	234	298	532
U.S. equity securities	795	2	797
Foreign government securities	-	10	10
Foreign corporate bonds	-	53	53
Foreign equity securities	1,024	1	1,025
Real estate	14	-	14
Other	8	-	8
Assets measured at fair value	$ 2,883	$ 402	3,285
Assets at NAV:			
U.S. government securities			120
U.S. corporate bonds			996
U.S. equity securities			563
Foreign corporate bonds			125
Foreign equity securities			1,682
Private equity			1,503
Hedge funds			1,074
Real estate			595
Total assets			$ 9,943
Other plan assets (liabilities)			
Due from brokers for unsettled investment trades			47
Due to brokers for unsettled investment trades			(268)
Fair value of plan assets, net			$ 9,722

The following table summarizes the weighted-average asset allocations by asset category for the pension plans:

	2023	2022
Cash and cash equivalents	2%	5%
U.S. government securities	12%	5%
U.S. corporate bonds	15%	15%
U.S. equity securities	14%	14%
Foreign corporate bonds	2%	2%
Foreign equity securities	26%	27%
Private equity	15%	15%
Other	14%	17%
Total	100%	100%

The asset allocation policy for the pension plans for 2023 is as follows: public equity, 45%; fixed income, 28%; private equity, 15%; hedge funds, 5%; real assets, 5%; and cash and opportunistic, 2%.

The asset allocation policy for the pension plans for 2022 is as follows: public equity, 49%; fixed income, 21%; private equity, 14%; hedge funds, 8%; real assets, 6%; and cash and opportunistic, 2%.

CommonSpirit's investment strategy for the assets of the pension plans is designed to achieve returns to meet obligations and grow the assets of the portfolios longer term, consistent with a prudent level of risk. The strategy balances the liquidity needs of the pension plans with the long-term return goals necessary to satisfy future obligations. The target asset allocation is diversified across traditional and non-traditional asset classes. Diversification is also achieved through participation in U.S. and non-U.S. markets, market capitalization, and investment manager style and philosophy. The complementary investment styles and approaches used by both traditional and alternative investment managers are aimed at reducing volatility while capturing the equity premium from the capital markets over the long term. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. Consistent with CommonSpirit's fiduciary responsibilities, the fixed income allocation generally provides for security of principal to meet near-term expenses and obligations. Periodic reviews of the market values and corresponding asset allocation percentages are performed to determine whether a rebalancing of the portfolio is necessary.

CommonSpirit's pension plan portfolio return assumptions for 2023 and 2022 were based on the long-term weighted-average returns of comparative market indices for the asset classes represented in the portfolio and expectations about future returns.

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2024	$ 1,217
2025	728
2026	739
2027	761
2028	778
2029 - 2033	4,044
Total	$ 8,267

CommonSpirit maintains defined contribution retirement plans for most employees. Employer contributions to those plans of $409 million and $407 million for 2023 and 2022, respectively, included in salaries and benefits in the accompanying consolidated statements of operations and changes in net assets, are primarily based on a percentage of a participant's contribution.

18. COMMITMENTS, CONTINGENT LIABILITIES, GUARANTEES AND OTHER

The following summary encompasses matters related to litigation, regulatory and compliance matters, and developments thereto.

General – The health care industry is subject to voluminous and complex laws and regulations of federal, state and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not necessarily limited to, the rules governing licensure, accreditation, controlled substances, privacy, government program participation, government reimbursement, antitrust, anti-kickback, prohibited referrals by physicians, false claims, and in the case of tax-exempt organizations, the requirements of tax exemption. Management believes CommonSpirit is materially in compliance with all applicable laws and regulations of the Medicare and Medicaid programs. Compliance with such laws and regulations is complex and can be subject to future governmental interpretation as well as significant regulatory action, including fines, penalties and exclusion from the Medicare and Medicaid programs. Certain CommonSpirit entities have been contacted by governmental agencies regarding alleged violations of Medicare practices for certain services. Additionally, certain CommonSpirit entities have identified and self-disclosed potential instances of noncompliance with applicable regulations. In the opinion of management after consultation with legal counsel, the ultimate outcome of these matters will not have a material adverse effect on CommonSpirit's consolidated financial statements.

In recent years, government activity has increased with respect to investigations and allegations of wrongdoing. In addition, during the course of business, CommonSpirit becomes involved in civil litigation. Management assesses the probable outcome of unresolved litigation and investigations and records contingent liabilities reflecting estimated liability exposure. Following is a discussion of matters of note.

Cybersecurity Incident – On October 2, 2022, CommonSpirit experienced a ransomware attack ("the Cybersecurity Incident") that impacted certain of its systems. Upon discovering the attack, CommonSpirit took immediate steps to protect its IT systems, contain the incident, begin an investigation, and maintain continuity of care. CommonSpirit engaged leading cybersecurity specialists to support its investigation, and notified law enforcement and the United States Department of Health and Human Services. In April 2023, CommonSpirit completed notifications to individuals whose data was potentially impacted by the Cybersecurity Incident.

The Cybersecurity Incident has had an estimated adverse financial impact of approximately $160 million to date, which includes lost revenues from the associated business interruption, the costs incurred to remediate the issues and other related business expenses, and is exclusive of any potential insurance related recoveries. We have notified and continue to consult with our insurance carriers, but are unable to predict the timing or amount of insurance recoveries at this time.

The organization is aware of lawsuits filed as potential class actions against CommonSpirit regarding the Cybersecurity Incident. There can be no assurance that the resolution of this matter will not affect the financial condition or operations of CommonSpirit, taken as a whole.

Seismic standards – The State of California issued seismic safety standards in 1994, with the final seismic upgrade requirements to be in place by 2030, of which the timelines have been amended on several occasions. The regulations called for a specific classification of structural building upgrades to be in place by January 2013. Buildings retrofitted or built to the new seismic standards may remain in an acute care service beyond 2030.

Each of the acute care service buildings at CommonSpirit's California facilities either: (1) already meets the standards in effect until 2030, (2) is not subject to these standards, (3) will not be used for acute care services beyond the extended deadline, or (4) is scheduled to undergo remediation before applicable deadline dates. The amount of capital required for meeting the 2030 standards, both structural and/or non-structural, is not yet determined, but is anticipated to be material.

In addition to the foregoing, in late 2014, the State of California's Office of Statewide Health Planning and Development department created a new seismic performance category allowing buildings that were previously required to be upgraded to meet the 2030 standards or decommissioned by 2030 to remain in use indefinitely if they could be retrofitted to meet certain new standards. CommonSpirit is undertaking the necessary evaluation of its buildings, to be completed by 2024, to test the viability of their continued use beyond 2030.

Long-term Contracts – CommonSpirit has entered into certain Master Services Agreements ("MSAs") with related parties for the purchase of revenue cycle management services that terminate in fiscal years 2031 and 2033. The agreements are amended from time to time and are subject to annual adjustments for inflation and achievement of certain performance levels, which reflect market terms. These amounts are recorded in purchased services and other in the accompanying statements of operations and changes in net assets. The MSAs are subject to significant penalties for cancellation without cause.

Purchase Commitments – CommonSpirit has entered into various agreements that require certain minimum purchases of goods and services, including management services agreements for information and clinical technology and sponsorship agreements, at levels consistent with normal business requirements. Excluding the long-term contracts noted above, outstanding unconditional purchase commitments were approximately $494 million at June 30, 2023.

19. FUNCTIONAL EXPENSES

CommonSpirit provides health care services, including inpatient, outpatient, ambulatory, long-term care and community-based services to individuals within the various geographic areas supported by its facilities. Expenses for these program services represent costs that are controllable by operational leadership. Support services include administration, financial services and purchasing, financial planning and budgeting, information technology, risk management, public relations, human resources, cash, debt and investment management, legal, mission services, and other functions that are supported centrally for all of CommonSpirit and are driven by CommonSpirit leadership.

Following is a summary of the program and support services provided for the years ended June 30, 2023 and 2022 (in millions):

	2023			
	Program Services - Health care	Support Services - Management and Administrative	Support Services - Fundraising	Total Expenses
Salaries and benefits	$ 17,079	$ 1,189	$ 24	$ 18,292
Supplies	5,375	164	-	5,539
Purchased services and other	8,953	1,049	60	10,062
Depreciation and amortization	1,270	168	-	1,438
Interest expense	477	96	-	573
Total operating expenses	$ 33,154	$ 2,666	$ 84	$ 35,904

	2022			
	Program Services - Health care	Support Services - Management and Administrative	Support Services - Fundraising	Total Expenses
Salaries and benefits	$ 17,068	$ 1,076	$ 26	$ 18,170
Supplies	5,436	152	-	5,588
Purchased services and other	8,269	1,185	69	9,523
Depreciation and amortization	1,301	162	-	1,463
Interest expense	384	75	-	459
Total operating expenses	$ 32,458	$ 2,650	$ 95	$ 35,203

20. UNSPONSORED COMMUNITY BENEFIT EXPENSE (UNAUDITED)

Unsponsored community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. These benefits (a) generate a low or negative margin, (b) respond to the needs of special populations, such as persons living in poverty and other disenfranchised persons, (c) supply services or programs that would likely be discontinued, or would need to be provided by another nonprofit or government provider, if the decision was made on a purely financial basis, (d) respond to public health needs, and/or (e) involve education or research that improves overall community health.

The unpaid costs of Medicaid/Medi-Cal includes $462 million and $225 million in direct benefit expense related to the California provider fee program in 2023 and 2022, respectively, and direct offsetting revenue related to the program of $968 million and $529 million for 2023 and 2022, respectively.

Benefits for the Poor include services provided to persons who are low-income or medically indigent and cannot afford to pay for health care services because they have insufficient resources and/or are uninsured or underinsured. Serving these populations helps to achieve health equity.

Benefits for the Broader Community refer to programs in the general communities that CommonSpirit serves, including but beyond those for low-income and vulnerable persons. Most services for the broader community are aimed at improving the health and welfare of the overall community. CommonSpirit provides services to nonprofit organizations that promote the total health of their local communities, including the development of and connection to health and social services, support for affordable housing and healthy food, increasing opportunities for jobs and job training, and expanding access to health care for uninsured and underinsured persons.

Financial Assistance (Charity Care) is free or discounted health services provided to persons who cannot afford to pay and who meet CommonSpirit's criteria for financial assistance.

Net Community Benefit, excluding the unpaid cost of Medicare, is the total cost incurred after deducting direct offsetting revenue from government programs, patients, and other sources of payment or reimbursement for services provided to program patients. Restricted revenue from grants, fees, and other sources of payment or reimbursement for services provided to patients, program participants and the community also are included in direct offsetting revenue. The comparable amount of net community benefit was $3 billion for 2022 and net community benefit, including the unpaid cost of Medicare, was $5 billion for 2022.

Following is a summary of CommonSpirit's community benefits for 2023, in terms of services to the poor and benefits for the broader community, which has been prepared in accordance with Internal Revenue Service Form 990, Schedule H and the CHA publication, *A Guide for Planning and Reporting Community Benefit* (dollars in millions):

	Unaudited			
	Total Benefit Expense	**Direct Offsetting Revenue**	**Net Community Benefit**	**% of Total Expenses**
Benefits for the poor:				
Traditional charity care	$ 487	$ (18)	$ 469	1.3%
Unpaid costs of Medicaid / Medi-Cal	9,058	(7,154)	1,904	5.3%
Other means-tested programs	17	(13)	4	0.0%
Community services:				
Community health services	91	(31)	60	0.2%
Subsidized health services	33	(11)	22	0.1%
Cash and in-kind contributions	44	-	44	0.1%
Community building activities	4	(1)	3	0.0%
Community benefit operations	12	-	12	0.0%
Total community services for the poor	184	(43)	141	0.4%
Total benefits for the poor	9,746	(7,228)	2,518	7.0%
Benefits for the broader community:				
Community services:				
Community health services	29	(7)	22	0.1%
Health professions education	381	(90)	291	0.8%
Subsidized health services	137	(64)	73	0.2%
Research	53	(43)	10	0.0%
Cash and in-kind contributions	15	(1)	14	0.1%
Community building activities	5	(1)	4	0.0%
Community benefit operations	5	-	5	0.0%
Total benefits for the broader community	625	(206)	419	1.2%
Total community benefits	$ 10,371	$ (7,434)	$ 2,937	8.2%
Unpaid costs of Medicare	8,627	(6,541)	2,086	5.8%
Total community benefits, including unpaid costs of Medicare	$ 18,998	$ (13,975)	$ 5,023	14.0%

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