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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public.

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2019 , and ending 12-31-2019

B Check if applicable:
- ☑ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
SWEDISH HEALTH SERVICES

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
1801 LIND AVE SW ATTN TAX DEPT

City or town, state or province, country, and ZIP or foreign postal code
RENTON, WA 98057

D Employer identification number
91-0433740

E Telephone number
(206) 682-2550

G Gross receipts $ 2,567,747,661

F Name and address of principal officer:
MIKE BUTLER
1801 LIND AVE SW ATTN TAX DEPT
RENTON, WA 98057

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.SWEDISH.ORG

K Form of organization: ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1908

M State of legal domicile: WA

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO IMPROVE THE HEALTH AND WELL-BEING OF EACH PERSON WE SERVE.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	15
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	13,506
6	Total number of volunteers (estimate if necessary)	**6**	990
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	1,783,553
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	291,603

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	13,991,719	15,260,345
9	Program service revenue (Part VIII, line 2g)	2,413,362,515	2,406,383,535
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	23,584,978	19,403,158
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	55,747,472	109,689,207
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	2,506,686,684	2,550,736,245
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	7,047,230	7,171,563
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	1,147,638,075	1,091,951,496
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	984,706,877	1,046,469,290
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	2,139,392,182	2,145,592,349
19	Revenue less expenses. Subtract line 18 from line 12	367,294,502	405,143,896

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	3,294,448,322	2,473,425,909
21	Total liabilities (Part X, line 26)	2,620,745,209	1,759,701,594
22	Net assets or fund balances. Subtract line 21 from line 20	673,703,113	713,724,315

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

Signature of officer — Date: 2020-11-09

JO ANN ESCASA-HAIGH EVP/ASSISTANT TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
				P01286320

Firm's name ▶ ERNST & YOUNG US LLP — Firm's EIN ▶ 34-6565596

Firm's address ▶ 560 MISSION STREET SUITE 1600
SAN FRANCISCO, CA 94105 — Phone no. (415) 894-8000

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III . . . . . ☑

1 Briefly describe the organization's mission:

TO IMPROVE THE HEALTH AND WELL-BEING OF EACH PERSON WE SERVE.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☑ No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 1,706,995,063 including grants of $ 7,171,563) (Revenue $ 2,495,243,717)

See Additional Data

4b (Code:) (Expenses $ including grants of $) (Revenue $)

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O.)

(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses ▶** 1,706,995,063

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D,* Part I	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D,* Part III	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D,* Part VI.	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	Yes	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f		No
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b	Yes	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L,* Part I	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L,* Part I	25b		No
26	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part II*	26		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? *If "Yes," complete Schedule L,* Part III	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? *If "Yes," complete Schedule L, Part IV*	28a		No
b	A family member of any individual described in line 28a? *If "Yes," complete Schedule L, Part IV*	28b		No
c	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? *If "Yes," complete Schedule L, Part IV*	28c		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V ☑

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	696		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	13,506		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	Yes
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.			**16**	No

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*
Check if Schedule O contains a response or note to any line in this Part VI . . . . . ☑

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	15		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	15		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5		No
6	Did the organization have members or stockholders?		6	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		7a	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		7b	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?		8a	Yes	
b	Each committee with authority to act on behalf of the governing body?		8b	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*		9		No

Section B. Policies (*This Section B requests information about policies not required by the Internal Revenue Code.*)

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	Yes	
13	Did the organization have a written whistleblower policy?	13	Yes	
14	Did the organization have a written document retention and destruction policy?	14	Yes	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a		No
b	Other officers or key employees of the organization	15b		No
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	Yes	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	Yes	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed▶ WA

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶JO ANN ESCASA-HAIGH 3345 MICHELSON DRIVE SUITE 100 IRVINE, CA 92612 (949) 381-4000

Part VII **Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response or note to any line in this Part VII . . . . . ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

See instructions for the order in which to list the persons above.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								8,193,124	42,992,417	6,816,106

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 2,824

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	**3**	Yes	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	**4**	Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	**5**		No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
DYNACARE NORTHWEST INC PO BOX 14954 SEATTLE, WA 981140954	LAB SERVICES	26,876,530
MCNAUL EBEL NAWROT AND HELGREN 600 UNIVERSITY ST STE 2700 SEATTLE, WA 981013143	LEGAL SERVICES	15,776,066
CELLNETIX LABS LLC PO BOX 94344 SEATTLE, WA 981246644	LAB SERVICES	6,419,761
THE POLYCLINIC 1145 BROADWAY SEATTLE, WA 981224299	MEDICAL SERVICES	5,970,418
US ANESTHESIA PARTNERS WASHINGTON 1229 MADISON ST STE 1440 SEATTLE, WA 981043538	MEDICAL SERVICES	5,839,337

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 105

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII . . . . . ☐

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts					
1a Federated campaigns	1a				
b Membership dues	1b				
c Fundraising events	1c				
d Related organizations	1d	12,463,690			
e Government grants (contributions)	1e	2,796,655			
f All other contributions, gifts, grants, and similar amounts not included above	1f				
g Noncash contributions included in lines 1a - 1f: $	1g				
h **Total.** Add lines 1a-1f		15,260,345			
Program Service Revenue	Business Code				
2a NET PATIENT REVENUE	621110	2,394,446,407	2,394,446,407		
b HOSPITAL FEE	621110	10,598,594	10,598,594		
c JV INCOME	900099	1,338,534	1,171,421	167,113	
d					
e					
f All other program service revenue.					
g **Total.** Add lines 2a–2f		2,406,383,535			
3 Investment income (including dividends, interest, and other similar amounts)		7,150,516			7,150,516
4 Income from investment of tax-exempt bond proceeds					
5 Royalties					
	(i) Real	(ii) Personal			
6a Gross rents	7,012,052				
b Less: rental expenses	6,431,176				
c Rental income or (loss)	580,876				
d Net rental income or (loss)			580,876		580,876
	(i) Securities	(ii) Other			
7a Gross amount from sales of assets other than inventory	14,253,354	2,857,617			
b Less: cost or other basis and sales expenses	4,858,329	0			
c Gain or (loss)	9,395,025	2,857,617			
d Net gain or (loss)			12,252,642		12,252,642
Other Revenue 8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	8a				
b Less: direct expenses	8b				
c Net income or (loss) from fundraising events					
9a Gross income from gaming activities. See Part IV, line 19	9a				
b Less: direct expenses	9b				
c Net income or (loss) from gaming activities					
10a Gross sales of inventory, less returns and allowances	10a	6,374,698			
b Less: cost of goods sold	10b	5,721,911			
c Net income or (loss) from sales of inventory		652,787		179,251	473,536
Miscellaneous Revenue	Business Code				
11a PHARMACY REVENUE	446110	59,385,170	58,908,775	476,395	
b INTERAFFILIATE REVENUE	900099	18,158,173			18,158,173
c CLINICAL TRIALS	900099	11,797,584	11,797,584		
d All other revenue		19,114,617	18,153,823	960,794	
e **Total.** Add lines 11a–11d		108,455,544			
12 **Total revenue.** See instructions		2,550,736,245	2,495,076,604	1,783,553	38,615,743

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☑

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	7,171,563	7,171,563		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	948,907,039	851,922,684	96,984,355	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	74,058,253	913,277	73,144,976	
9 Other employee benefits				
10 Payroll taxes	68,986,204	17,247,162	51,739,042	
11 Fees for services (non-employees):				
a Management	15,374	850	14,524	
b Legal	1,467,296	61,037	1,406,259	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	1,034,477		1,034,477	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	233,925,345	183,952,509	49,972,836	
12 Advertising and promotion	3,133,000	241,954	2,891,046	
13 Office expenses	62,555,230	50,044,184	12,511,046	
14 Information technology	1,342,823	1,064,657	278,166	
15 Royalties				
16 Occupancy	139,818,102	107,543,165	32,274,937	
17 Travel	4,858,776	3,938,043	920,733	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	3,127,557	2,432,002	695,555	
20 Interest	43,844,118	1,743,278	42,100,840	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	88,694,053	50,795,120	37,898,933	
23 Insurance	447,745	235,015	212,730	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	385,181,246	380,998,954	4,182,292	
b TAXES & LICENSES	34,697,075	8,833,596	25,863,479	
c HOSPITAL FEE	31,453,290	31,453,290		
d OTHER DIRECT EXPENSES	4,615,520	3,520,842	1,094,678	
e All other expenses	6,258,263	2,881,881	3,376,382	
25 **Total functional expenses.** Add lines 1 through 24e	2,145,592,349	1,706,995,063	438,597,286	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing	90,164,334	1	33,830,921
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net	2,413,129	3	1,220,468
	4	Accounts receivable, net	296,664,140	4	357,671,240
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7	Notes and loans receivable, net	580	7	4,080
	8	Inventories for sale or use	35,862,896	8	38,383,247
	9	Prepaid expenses and deferred charges	10,232,263	9	4,240,982
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 2,084,962,475			
	b	Less: accumulated depreciation — 10b: 887,490,950	1,194,917,506	10c	1,197,471,525
	11	Investments—publicly traded securities	439,538,495	11	484,934,338
	12	Investments—other securities. See Part IV, line 11		12	
	13	Investments—program-related. See Part IV, line 11	137,840,102	13	147,788,496
	14	Intangible assets	62,883,069	14	62,236,764
	15	Other assets. See Part IV, line 11	1,023,931,808	15	145,643,848
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	3,294,448,322	16	2,473,425,909
Liabilities	17	Accounts payable and accrued expenses	220,505,516	17	197,946,164
	18	Grants payable		18	
	19	Deferred revenue	37,234,356	19	1,576,294
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23	Secured mortgages and notes payable to unrelated third parties	0	23	75,020,690
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	2,363,005,337	25	1,485,158,446
	26	**Total liabilities.** Add lines 17 through 25	2,620,745,209	26	1,759,701,594
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**			
	27	Net assets without donor restrictions	576,125,826	27	604,770,724
	28	Net assets with donor restrictions	97,577,287	28	108,953,591
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.			
	29	Capital stock or trust principal, or current funds		29	
	30	Paid-in or capital surplus, or land, building or equipment fund		30	
	31	Retained earnings, endowment, accumulated income, or other funds		31	
	32	Total net assets or fund balances	673,703,113	32	713,724,315
	33	Total liabilities and net assets/fund balances	3,294,448,322	33	2,473,425,909

Part XI Reconcilliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI . . . . . ☑

1	Total revenue (must equal Part VIII, column (A), line 12)	1	2,550,736,245
2	Total expenses (must equal Part IX, column (A), line 25)	2	2,145,592,349
3	Revenue less expenses. Subtract line 2 from line 1	3	405,143,896
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	673,703,113
5	Net unrealized gains (losses) on investments	5	49,314,639
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-414,437,333
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	713,724,315

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII . . . . . ☐

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

Additional Data

Software ID:

Software Version:

EIN: 91-0433740

Name: SWEDISH HEALTH SERVICES

Form 990 (2019)

Form 990, Part III, Line 4a:

SEE SCHEDULE O.PROVIDENCEON JULY 1, 2016, PROVIDENCE HEALTH & SERVICES (PHS) AND ST. JOSEPH HEALTH SYSTEM (SJHS) ENTERED INTO A BUSINESS COMBINATION AGREEMENT TO FORM PROVIDENCE ST. JOSEPH HEALTH (PROVIDENCE). BY COMING TOGETHER, PROVIDENCE SEEKS TO BETTER SERVE ITS COMMUNITIES THROUGH GREATER PATIENT AFFORDABILITY, OUTSTANDING CLINICAL CARE, IMPROVEMENTS TO THE PATIENT EXPERIENCE AND INTRODUCTION OF NEW SERVICES WHERE THEY ARE NEEDED MOST. TOGETHER, OUR CAREGIVERS SERVE IN 51 HOSPITALS, 1,085 CLINICS ACROSS ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON.THE FOUNDERS OF BOTH ORGANIZATIONS WERE COURAGEOUS WOMEN AHEAD OF THEIR TIME. THE SISTERS OF PROVIDENCE AND THE SISTERS OF ST. JOSEPH OF ORANGE BROUGHT HEALTH CARE AND OTHER SOCIAL SERVICES TO THE AMERICAN WEST WHEN IT WAS STILL A RUGGED, UNTAMED FRONTIER. NOW, AS WE FACE A DIFFERENT LANDSCAPE A CHANGING HEALTH CARE ENVIRONMENT WE DRAW UPON THEIR PIONEERING AND COMPASSIONATE SPIRIT TO PLAN FOR THE NEXT CENTURY OF HEALTH CARE.PROVIDENCE HEALTH & SERVICESIN 1856, MOTHER JOSEPH AND FOUR SISTERS OF PROVIDENCE ESTABLISHED HOSPITALS, SCHOOLS AND ORPHANAGES ACROSS THE NORTHWEST. OVER THE YEARS, OTHER CATHOLIC SISTERS TRANSFERRED SPONSORSHIP OF THEIR MINISTRIES TO PROVIDENCE, INCLUDING THE LITTLE COMPANY OF MARY, DOMINICANS AND CHARITY OF LEAVENWORTH. RECENTLY, SWEDISH HEALTH SERVICES, KADLEC REGIONAL MEDICAL CENTER AND PACIFIC MEDICAL CENTERS HAVE JOINED PROVIDENCE AS SECULAR PARTNERS WITH A COMMON COMMITMENT TO SERVING ALL MEMBERS OF THE COMMUNITY. ST. JOSEPH HEALTH SYSTEMIN 1912, A SMALL GROUP OF SISTERS OF ST. JOSEPH LANDED ON THE RUGGED SHORES OF EUREKA, CALIFORNIA TO PROVIDE EDUCATION AND HEALTH CARE. THEY LATER ESTABLISHED ROOTS IN ORANGE, CALIFORNIA, AND EXPANDED TO SERVE SOUTHERN CALIFORNIA, NORTHERN CALIFORNIA AND TEXAS. THE HEALTH SYSTEM ESTABLISHED MANY KEY PARTNERSHIPS, INCLUDING A MERGER BETWEEN LUBBOCK METHODIST HOSPITAL SYSTEM AND ST. MARY HOSPITAL TO FORM COVENANT HEALTH IN LUBBOCK, TEXAS. RECENTLY, AN AFFILIATION WAS ESTABLISHED WITH HOAG HEALTH TO INCREASE ACCESS TO SERVICES IN ORANGE COUNTY, CALIFORNIA. PROGRAM SERVICE ACCOMPLISHMENTS:SINCE 1910, SWEDISH HAS BEEN THE REGION'S HALLMARK FOR EXCELLENCE IN HEALTHCARE. IN FACT, IN AN INDEPENDENT RESEARCH STUDY CONDUCTED BY THE NATIONAL RESEARCH CORP., SWEDISH IS CONSISTENTLY NAMED THE AREA'S BEST HOSPITAL. SWEDISH HAS GROWN TO BECOME THE LARGEST NONPROFIT HEALTHCARE PROVIDER IN THE GREATER SEATTLE AREA WITH MORE THAN 13,000 EMPLOYEES, MORE THAN 4,300 PHYSICIANS AND 900 ACTIVE VOLUNTEERS.*FIVE HOSPITAL CAMPUSES (BALLARD, CHERRY HILL, EDMONDS, FIRST HILL AND ISSAQUAH). SWEDISH EDMONDS IS A SEPARATE CORPORATION UNDER THE SWEDISH HEALTH SERVICES "UMBRELLA AND FILES A SEPARATE FORM 990.*AN AMBULATORY CARE CENTER FEATURING AN EMERGENCY DEPARTMENT, AND URGENT AND PRIMARY CARE CLINICS IN REDMOND AND MILL CREEK.*SWEDISH MEDICAL GROUP, A NETWORK OF MORE THAN 180 PRIMARY-CARE AND SPECIALTY CLINICS LOCATED THROUGHOUT THE PUGET SOUND.*AFFILIATIONS WITH COMMUNITY HOSPITALS AND PHYSICIAN GROUPS.IN ADDITION TO GENERAL MEDICAL AND SURGICAL CARE, SWEDISH IS KNOWN AS A REGIONAL REFERRAL CENTER, PROVIDING SPECIALIZED TREATMENT IN AREAS SUCH AS CARDIOVASCULAR CARE, CANCER CARE, NEUROSCIENCE, ORTHOPEDICS, HIGH-RISK OBSTETRICS, PEDIATRIC SPECIALTIES, ORGAN TRANSPLANTATION AND CLINICAL RESEARCH.BUT SWEDISH IS NOT JUST FACILITIES, RESEARCH AND NEW TECHNIQUES. IT'S ABOUT PEOPLE COMING TOGETHER TO PROVIDE THE MOST COMPASSIONATE CARE POSSIBLE. FROM NURSES AND PHYSICIANS TO SOCIAL WORKERS AND DIETICIANS, THE DEDICATED TEAMS AT SWEDISH ARE DEFINING ON A PERSONAL LEVEL WHAT EXCELLENCE REALLY MEANS.IMPROVING THE HEALTH AND WELL-BEING OF THE COMMUNITY IS CENTRAL TO THESWEDISH MISSION.SWEDISH IS KNOWN AS A REGIONAL REFERRAL CENTER, PROVIDING AN EXTENSIVE RANGE OF SPECIALIZED TREATMENT:*ONCOLOGY - SWEDISH CANCER INSTITUTE*CARDIOVASCULAR CARE - SWEDISH HEART & VASCULAR INSTITUTE*NEUROLOGICAL CARE - SWEDISH NEUROSCIENCE INSTITUTE*ORTHOPEDIC CARE - SWEDISH ORTHOPEDIC INSTITUTE*OBSTETRICS (OB) AND HIGH-RISK OB - WOMEN AND CHILDREN'S SERVICES*CLINICAL RESEARCH*PEDIATRICS - SWEDISH PEDIATRIC SPECIALTY CARE*PRIMARY CARE - SWEDISH PHYSICIANS*SURGERY*DIGESTIVE HEALTHPHARMACY AND LAB SERVICES ARE ALSO PROVIDED TO SWEDISH HEALTH SERVICES PATIENTS.

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROD F HOCHMAN MD FORMER PRESIDENT/CEO	0.00 60.00						X	0	9,697,491	1,217,351
MIKE BUTLER PRESIDENT	8.00 52.00			X				0	3,421,103	597,820
DEBRA CANALES FORMER EVP CAO PSJH	0.00 60.00						X	0	2,204,087	353,537
RHONDA MEDOWS MD FORMER PRESIDENT POP HEALTH / AYIN	0.00 60.00						X	0	1,888,838	274,454
CINDY STRAUSS SECRETARY	8.00 52.00			X				0	1,735,009	347,233
AMY COMPTON-PHILLIPS MD FORMER EVP CHIEF CLINICAL OFC PSJH	0.00 55.00						X	0	1,701,825	248,465
SAMUEL YOUSSEF CARDIAC SURGEON	50.00 0.00					X		1,878,200	0	45,531
VENKAT BHAMIDIPATI EVP/TREASURER	8.00 52.00			X				0	1,615,492	304,802
ERIC LEHR CARDIAC SURGEON	50.00 0.00					X		1,719,578	0	42,459
STEPHEN MONTEITH NEUROSURGEON	50.00 0.00					X		1,636,903	0	32,875

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JENS CHAPMAN ORTHOPEDIC SURGEON	50.00 0.00					X		1,527,811	0	51,308
LISA VANCE FORMER EVP REGIONAL CE OR	0.00 60.00						X	0	1,313,995	245,652
JOEL GILBERTSON FORMER EVP COMMUNITY PARTNERSHIPS	0.00 60.00						X	0	1,315,140	203,790
AARON MARTIN FORMER EVP CHIEF MKT/DIGITAL INNO OF	0.00 70.00						X	0	1,302,273	194,312
PATRICK RYAN SURGEON - CARDIOLOGY	50.00 0.00					X		1,430,632	0	44,170
GUY HUDSON MD CHIEF EXEC SWEDISH HEALTH SVCS	63.00 2.00				X			0	1,186,290	229,942
JO ANN ESCASA-HAIGH EVP/ASSISTANT TREASURER	6.00 54.00			X				0	1,188,910	217,824
TOM MCDONAGH FORMER VP/CHIEF INVESTMENT OFFICER	0.00 58.00						X	0	1,356,638	46,012
SHARON TONCRAY FORMER SVP/CHIEF LABOR EE COUNSEL	0.00 60.00						X	0	1,364,262	36,627
GREG TILL FORMER CHIEF PEOPLE OFFICER	0.00 65.00						X	0	1,166,513	196,967

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MIKE WATERS FORMER EVP AMBULATORY CARE NETWORK	0.00 65.00						X	0	1,049,713	159,733
JEFFERY JR ROBERT COO SWEDISH HEALTH SVCS	65.00 0.00				X			0	986,361	220,760
JOHN WHIPPLE ASSISTANT SECRETARY	8.00 52.00			X				0	905,646	235,831
JANICE NEWELL FORMER SVP/CHIEF INFORMATION OFFCR	0.00 60.00						X	0	1,071,876	18,740
OREST HOLUBEC FORMER SVP CHIEF COMMUNICATION OFCR	0.00 55.00						X	0	891,959	168,978
JIM WATSON ESQ ASSISTANT SECRETARY	6.00 54.00			X				0	843,494	137,810
MARY CRANSTOUN FORMER SVP TOTAL REWARDS TALENT ACQ	0.00 60.00						X	0	801,721	167,261
DAVID BROWN FORMER SVP CAO AMBULATORY CARE	0.00 55.00						X	0	797,114	164,344
DEBBIE BURTON FORMER SVP CHIEF NURSING OFFICER	0.00 60.00						X	0	710,092	170,287
KEVIN BROOKS COO FIRST HILL	60.00 0.00				X			0	641,441	164,046

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CHRIS BEAUDOIN COO ISSAQUAH	60.00 0.00				X			0	380,215	97,349
KASIA KONIECZNY COO BALLARD	60.00 0.00				X			0	307,936	71,785
STAN MOSER INTERIM CFO/SWEDISH REGION	50.00 0.00				X			0	226,405	49,327
DONALD ANDERSON JR ASSISTANT SECRETARY FOR ENROLLMENT	8.00 52.00			X				0	222,743	19,991
TERRY SMITH FORMER SVP/MANAGEMENT SVCS	0.00 0.00						X	0	156,620	13,839
TAMMY TEODOSIO FORMER ASSISTANT SECRETARY	8.00 52.00						X	0	133,465	24,894
DAVE OLSEN BOARD CHAIR	1.00 6.10	X						0	65,360	0
RICHARD BLAIR PAST CHAIR	1.00 6.80	X						0	50,360	0
ISIAAH CRAWFORD PHD DIRECTOR	1.00 3.20	X						0	46,550	0
DICK P ALLEN DIRECTOR	1.00 4.10	X						0	40,789	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MICHAEL HOLCOMB DIRECTOR	1.00 4.60	X						0	40,391	0
CAROLINA REYES MD DIRECTOR	1.00 5.10	X						0	40,360	0
MARY LYONS PHD DIRECTOR	1.00 3.70	X						0	40,360	0
CHARLES SORENSON MD DIRECTOR	0.10 5.00	X						0	30,360	0
PHOEBE YANG DIRECTOR	1.00 4.60	X						0	30,360	0
LYDIA MARSHALL DIRECTOR	0.10 5.00	X						0	22,860	0
KATHARIN DYER DIRECTOR	0.10 5.00	X						0	0	0
MICHAEL MURPHY DIRECTOR	0.10 5.00	X						0	0	0
SISTER DIANE HEJNA CSJ RN DIRECTOR	1.00 4.40	X						0	0	0
SISTER LUCILLE DEAN SP DIRECTOR	1.00 4.60	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SISTER PHYLLIS HUGHES RSM DRPH DIRECTOR	1.00 4.10	X						0	0	0

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)

9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:

10 ☐ An organization that normally receives: (1) more than 331/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations . . . . . _____

g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). .						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4. .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). .						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . **15**

16a **33 1/3% support test—2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test—2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 **Total support.** (Add lines 9, 10c, 11, and 12.). .						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**. . . . . ▶ ☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2019** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2018** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2019.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support tests—2018.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions . . . . ▶ ☐

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509 (a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer line 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).*	10b		

Part IV Supporting Organizations (continued)

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	**11a**		
b	A family member of a person described in (a) above?	**11b**		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* ***Part VI****.*	**11c**		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	**1**		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.*	**2**		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* ***Part VI*** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	**1**		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	**1**		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	**2**		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard.*	**3**		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**:

- **a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- **b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- **c** ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions)

2 Activities Test. **Answer (a) and (b) below.**

			Yes	No
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		

3 Parent of Supported Organizations. **Answer (a) and (b) below.**

a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

	Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1		
2	Recoveries of prior-year distributions	2		
3	Other gross income (see instructions)	3		
4	Add lines 1 through 3	4		
5	Depreciation and depletion	5		
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7	Other expenses (see instructions)	7		
8	**Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)	8		

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1		
a	Average monthly value of securities	1a		
b	Average monthly cash balances	1b		
c	Fair market value of other non-exempt-use assets	1c		
d	**Total** (add lines 1a, 1b, and 1c)	1d		
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI):			
2	Acquisition indebtedness applicable to non-exempt use assets	2		
3	Subtract line 2 from line 1d	3		
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by .035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

	Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2	Enter 85% of line 1	2		
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4	Enter greater of line 2 or line 3	4		
5	Income tax imposed in prior year	5		
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

Part V **Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations** (continued)

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**). See instructions	
7 **Total annual distributions.** Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions	
9 Distributable amount for 2019 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2019**	**(iii) Distributable Amount for 2019**
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in **Part VI**. See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in **Part VI**. See instructions.			
7 **Excess distributions carryover to 2020.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

Software ID:

Software Version:

EIN: 91-0433740

Name: SWEDISH HEALTH SERVICES

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of the organization	Employer identification number
SWEDISH HEALTH SERVICES	91-0433740

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

	(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
1					
2					
3					
4					
5					
6					

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-.		
i Subtract line 1f from line 1c. If zero or less, enter -0-.		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		15,524
j	Total. Add lines 1c through 1i			15,524
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
PART II-B, LINE 1:	THE LOBBYING EXPENDITURES REPORTED REPRESENTS THE PORTION OF DUES ALLOCATED TO SWEDISH HEALTH SERVICES.

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

		Held at the End of the Year
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other .....

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?. . . ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? . . . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c	Beginning balance	1c
d	Additions during the year	1d
e	Distributions during the year	1e
f	Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII . . . . ☐

Part V Endowment Funds.

Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

- a Board designated or quasi-endowment ▶ .....
- b Permanent endowment ▶ .....
- c Temporarily restricted endowment ▶ .....

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
(i) unrelated organizations . . . . . 3a(i)		
(ii) related organizations . . . . . 3a(ii)		
b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? 3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		222,997,726		222,997,726
b Buildings		908,886,521	301,980,957	606,905,564
c Leasehold improvements		179,528,751	94,897,634	84,631,117
d Equipment		592,735,906	490,612,359	102,123,547
e Other		180,813,571		180,813,571
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				1,197,471,525

Part VII Investments—Other Securities.
Complete if the organization answered "Yes" on Form 990, Part IV, line 11b.See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3)Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶		

Part VIII Investments—Program Related.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)INVESTMENT IN RECIPIENT ORGANIZATIONS	105,225,598	C
(2)INVESTMENT IN HEALTHCARE JOINT VENTURES	42,562,898	C
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 13.)* ▶	147,788,496	

Part IX Other Assets.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)RIGHT OF USE OPERATING LEASES	117,389,599
(2)THIRD PARTY SETTLEMENTS	6,232,566
(3)OTHER RECEIVABLES	1,094,536
(4)OTHER ASSETS	20,927,147
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	145,643,848

Part X Other Liabilities.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f.See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	1,485,158,446

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☐

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12.)			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line **1:**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18.)			5	

Part XIII Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☐ No

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activites per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
See Add'l Data					
3a Sub-total	0	0			44,319
b Total from continuation sheets to Part I . . .	0	0			0
c Totals (add lines 3a and 3b)	0	0			44,319

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ _____

3 Enter total number of other organizations or entities . . . . . ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☑ Yes	☐ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)*	☐ Yes	☑ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with Respect to Certain Foreign Corporations. (see Instructions for Form 5471)*	☐ Yes	☑ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)* .	☐ Yes	☑ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☐ Yes	☑ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990).*	☐ Yes	☑ No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

990 Schedule F, Supplemental Information

Return Reference	Explanation
PART III ACCOUNTING METHOD:	

Additional Data

Software ID:

Software Version:

EIN: 91-0433740

Name: SWEDISH HEALTH SERVICES

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
CENTRAL AMERICA AND THE CARIBBEAN			PROGRAM SERVICE	FOREIGN TRAVEL	2,465
EAST ASIA AND THE PACIFIC			PROGRAM SERVICE	FOREIGN TRAVEL	5,335

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
EUROPE (INCLUDING ICELAND & GREENLAND)			PROGRAM SERVICE	FOREIGN TRAVEL	34,997
MIDDLE EAST AND NORTH AFRICA			PROGRAM SERVICE	FOREIGN TRAVEL	1,522

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990EZ* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☑ Other 30000.0000000000 %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other ____ %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			17,530,260		17,530,260	0.820 %
b Medicaid (from Worksheet 3, column a)			318,504,509	205,948,354	112,556,155	5.250 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			336,034,769	205,948,354	130,086,415	6.070 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			8,227,178	2,905	8,224,273	0.380 %
f Health professions education (from Worksheet 5)			45,817,927	13,978,356	31,839,571	1.480 %
g Subsidized health services (from Worksheet 6)			28,919,248	19,748,991	9,170,257	0.430 %
h Research (from Worksheet 7)			32,543,888	10,673,830	21,870,058	1.020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,637,318		2,637,318	0.120 %
j **Total.** Other Benefits			118,145,559	44,404,082	73,741,477	3.430 %
k **Total.** Add lines 7d and 7j			454,180,328	250,352,436	203,827,892	9.500 %

Part II Community Building Activities

Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			538		538	0 %
3 Community support			1,175,541		1,175,541	0.050 %
4 Environmental improvements						
5 Leadership development and training for community members			5,444		5,444	0 %
6 Coalition building			15,746		15,746	0 %
7 Community health improvement advocacy			188,794		188,794	0.010 %
8 Workforce development			64,180		64,180	0 %
9 Other						
10 Total			1,450,243		1,450,243	0.060 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	663,623,408
6	Enter Medicare allowable costs of care relating to payments on line 5	6	875,253,653
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-211,630,245
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Yes	

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year? **4**

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group SWEDISH ISSAQUAH (4)

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	**2**		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	**3**	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	**6b**	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): SEE PART V, SECTION C			
b	☑ Other website (list url): HTTP://WWW.KINGCOUNTY.GOV/HEALTHSERVICES/HEALTH/DATA/KCHHC.ASPX			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	**8**	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
a	If "Yes" (list url): SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

SWEDISH ISSAQUAH (4)

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☐ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☑ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): SEE PART V, PAGE 8			
b	☑ The FAP application form was widely available on a website (list url): SEE PART V, PAGE 8			
c	☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V, PAGE 8			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

SWEDISH ISSAQUAH (4)

Name of hospital facility or letter of facility reporting group

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☑ None of these actions or other similar actions were permitted			
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	**19**		No
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring , denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):			
a ☑ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)			
b ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
e ☐ Other (describe in Section C)			
f ☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**21**	Yes	
If "No," indicate why:			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility's policy was not in writing			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

SWEDISH ISSAQUAH (4)

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**	Yes	
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group SWEDISH HEALTH SERVICES (GROUP A - 1-3)

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a ☑ Hospital facility's website (list url): SEE PART V, SECTION C			
b ☑ Other website (list url): HTTP://WWW.KINGCOUNTY.GOV/HEALTHSERVICES/HEALTH/DATA/KCHHC.ASPX			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url): SEE PART V, SECTION C **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

SWEDISH HEALTH SERVICES (GROUP A - 1-3)

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☐ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): SEE PART V, PAGE 8			
b	☑ The FAP application form was widely available on a website (list url): SEE PART V, PAGE 8			
c	☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V, PAGE 8			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

SWEDISH HEALTH SERVICES (GROUP A - 1-3)

Name of hospital facility or letter of facility reporting group

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☑ None of these actions or other similar actions were permitted			
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring , denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):			
a ☑ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)			
b ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
e ☐ Other (describe in Section C)			
f ☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	21	Yes	
If "No," indicate why:			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility's policy was not in writing			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

SWEDISH HEALTH SERVICES (GROUP A - 1-3)

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**	Yes	
	If "Yes," explain in Section C.		

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
See Add'l Data	

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? **150**

Name and address	Type of Facility (describe)
1 See Additional Data Table	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C:	IN DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE, FPG IS A KEY FACTOR. THE ORGANIZATION ALSO CONSIDERED CERTAIN ASSETS OF A PATIENT. IN ADDITION, A PATIENT'S SPECIAL CIRCUMSTANCES WERE ALSO CONSIDERED WHEN DETERMINING ELIGIBILITY, INCLUDING BUT NOT LIMITED TO, DISABILITY AND HOMELESSNESS.

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Form and Line Reference	Explanation
PART I, LINE 6A:	SWEDISH HEALTH SERVICES PREPARES AN ANNUAL REPORT AND IT IS PUBLICLY AVAILABLE AT HTTPS://WWW.SWEDISH.ORG/ABOUT/OVERVIEW/MISSION-OUTREACH/COMMUNITY-HEALTH-INVESTMENT/COMMUNITY-BENEFITS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7:	THE AMOUNTS REPORTED IN THE TABLE WERE CALCULATED USING THE ORGANIZATION'S COST ACCOUNTING SYSTEM. THE COST ACCOUNTING SYSTEM ADDRESSED ALL PATIENT SEGMENTS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G:	NO COSTS ATTRIBUTABLE TO PHYSICAL CLINICS WERE INCLUDED

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	SWEDISH PARTNERSHIPS:AFTER WE IDENTIFIED NEGATIVE HEALTH TRENDS IN OUR COMMUNITIES, SWEDIS H LAUNCHED AN INITIATIVE AIMED AT STRENGTHENING PARTNERSHIPS WITH AGENCIES WHOSE MISSIONS IMPROVE THE HEALTH OF OUR COMMUNITY.THE DEVELOPMENT OF THE COMMUNITY HEALTH NEEDS ASSESSME NT (CHNA) PROVIDED A SCIENTIFIC APPROACH TO ALLOCATING SPONSORSHIP FUNDS. THE CHNA IDENTIF IED AND PRIORITIZED COMMUNITY NEEDS WHICH IN TURN OFFERED A LITMUS TEST FOR IDENTIFYING PR OGRAMS/AGENCIES THAT IMPACT NEGATIVE HEALTH INDICATORS TRENDS.WE INSTITUTED A NEW SIMPLIFI ED APPROACH WHERE SPONSORSHIP DOLLARS WOULD BE MATCHED WITH AGENCIES THAT ADDRESS SPECIFIC HEALTH INDICATORS. THESE PARTNERS WERE OFFERED MULTIPLE-YEAR PARTNERSHIPS THROUGH AGREEME NTS THAT FOCUSED LESS ON THE FUNDS AND MORE ABOUT ENGAGEMENT. OUR VANGUARD PARTNERSHIP GRO UPS INCLUDE:- AMERICAN HEART ASSOCIATION- LIFELONG - MARCH OF DIMES- SOUND GENERATION- AME RICAN CANCER SOCIETY- PLYMOUTH HOUSING- NAMI WASHINGTON - AMERICAN DIABETES ASSOCIATION - NATIONAL MULTIPLE SCLEROSIS SOCIETY- COUNTRY DOCTOR AFTERHOURS CLINIC- SWEDISH COMMUNITY S PECIALTY CLINICBELOW ARE MORE DETAILS ON OUR UNIQUE PARTNERSHIPS.AMERICAN HEART ASSOCIATIO NTHE AMERICAN HEART ASSOCIATION (AHA) IS DEDICATED TO BUILDING HEALTHIER LIVES FREE OF HEA RT DISEASE AND STROKE THROUGH CUTTING-EDGE RESEARCH, PUBLIC AND PROFESSIONAL EDUCATION PRO GRAMS AND PUBLIC HEALTH. THE PARTNERSHIP WITH SWEDISH HAS ENHANCED OPPORTUNITIES TO EXPAND CPR TRAINING, COMMUNITY PRESENTATIONS OF ITS LIFE'S SIMPLE 7 CARDIOVASCULAR PROGRAM AND E XPAND PARTICIPATION IN WALKING AND DIET PROGRAMS OFFERED BY THE AHA.LIFELONG LIFELONG EMPO WERS PEOPLE LIVING WITH OR AT RISK OF HIV/AIDS AND OTHER CHRONIC CONDITIONS TO LEAD HEALTH IER LIVES. AS A COMMUNITY CARE PROVIDER, SWEDISH HAS PARTNERED WITH THE ORGANIZATION TO HO ST CONFERENCES FOCUSED ON PREVENTION, POLICY AND PRACTICE, ALONG WITH FORMING A MEDICAID E XPANSION WORK GROUP TO UNDERSTAND THE UPCOMING CHALLENGES AND OPPORTUNITIES WITH HEALTH-CA RE REFORM IN WASHINGTON.MARCH OF DIMESTHE MARCH OF DIMES WORKS TO IMPROVE THE HEALTH OF BA BIES BY PREVENTING BIRTH DEFECTS, PREMATURE BIRTH AND INFANT MORTALITY. LONG RECOGNIZED FO R PRENATAL, LABOR AND DELIVERY CARE, SWEDISH STAFF WORKS CLOSELY WITH MARCH OF DIMES TO IM PROVE EDUCATION AND SUPPORT FOR EXPECTING AND NEW PARENTS, ALONG WITH AN ACTIVE INVOLVEMEN T IN PUBLIC FUNCTIONS AND FUNDRAISING ACTIVITIES THROUGHOUT THE COMMUNITY.SOUND GENERATION SENIOR SERVICES PROMOTES POSITIVE AGING FOR OLDER ADULTS THROUGHOUT KING COUNTY. THROUGH ITS INTEGRATED SYSTEM OF QUALITY PROGRAMS AND SENIOR CENTERS THEY BUILD A JUST SOCIETY WHE RE AGING ADULTS AND THOSE WHO CARES FOR THEM CAN LIVE THEIR BEST LIVES. SWEDISH AND SENIOR SERVICES PARTNERSHIP EXTENDS ACCESS TO CARE TO 15 SENIOR HOUSING FACILITIES, CENTER AND C OMMUNITY GROUPS IN WAYS TO BUILD HEALTHIER COMMUNITIES.NATIONAL MULTIPLE SCLEROSIS SOCIETY THE PACIFIC NORTHWEST HAS THE HIGHEST RATES OF MULTIPLE SCLEROSIS IN THE UNITED STATES. ME DICAL PARTNERS ARE CRITICAL TO INCREASING ACCESS TO EDUCATION, EARLY TREATMENT PROTOCOLS A ND SCREENING. SWEDISH'S PHYSICIANS PARTICIPATE IN NUMEROUS COMMUNITY EVENTS TO PROVIDE INF ORMATION AND EDUCATION. ITS CHARITY CARE PROGRAM FUNDS CARE FOR UNINSURED PATIENTS AND THE SWEDISH MULTIPLE SCLEROSIS CENTER HOSTS REGULAR GROUP SUPPORT MEETINGS WITH INDIVIDUALS I N VARIOUS STAGES OF THE DISEASE.AMERICAN DIABETES ASSOCIATION DIABETES IS A GROWING CHRONI C ILLNESS ACROSS THE NATION. RESEARCH, EDUCATION AND PRESENTATIVE PROCESS SUPPORTS THE COM BAT OF THIS QUITE DISEASE AMONG YOUTH AND ADULTS. AMERICAN CANCER SOCIETYPARTNERSHIP IN SU PPORT OF SURVIVOR SUPPORT, OUTREACH, EDUCATION AND CLINICAL PROCEDURE. INTEGRATED MEDICAL AND THERAPIES ALL PATIENT TO LIVE LONGER AND HAVE A BETTER QUALITY OF LIFE. NAMI, THE NATI ONAL ALLIANCE ON MENTAL ILLNESS - WASHINGTON STATE PROVIDES GOVERNANCE, ADVOCACY AND FUNDR AISING SUPPORT FOR THE 19 NAMI AFFILIATE OFFICES, LARGE AND SMALL, THROUGHOUT THE STATE. N AMI'S MISSION IS TO IMPROVE THE QUALITY OF LIFE FOR ALL THOSE AFFECTED BY MENTAL ILLNESS. WE DO THIS BY PROVIDING A STATEWIDE, UNIFYING VOICE OF ADVOCACY AND COORDINATING THE DELIV ERY OF EDUCATION, SUPPORT AND RECOVERY. NAMI WASHINGTON TRAINS AFFILIATE VOLUNTEERS TO TEA CH AND LEAD NAMI'S PROGRAMS IN THEIR COMMUNITIESPLYMOUTH HOUSING'S MISSION IS TO ELIMINATE HOMELESSNESS AND ADDRESS ITS CAUSES BY PRESERVING, DEVELOPING, AND OPERATING SAFE, QUALIT Y, SUPPORTIVE HOUSING AND BY PROVIDING ADULTS EXPERIENCING HOMELESSNESS WITH OPPORTUNITIES TO STABILIZE AND IMPROVE THEIR LIVES.COUNTRY DOCTOR AND AFTERHOURS CLINIC:HEALTHCARE FOR THE HOMELESS IS A CRITICAL SERVICE FOR SEATTLE GROWING HOMELESS POPULATION SWEDISH PARTNER S WITH COUNTRY DOCTOR FOR PROVIDE HEALTH SCREENINGS, PRIMARY CARE AND REFERRAL. SWEDISH CO MMUNITY SPECIALTY CLINICTO FURTHER SWEDISH'S COMMITMENT TO SERVE THE UNINSURED, WE OPENED THE SWEDISH COMMUNITY SPECIALTY CLINIC AT THE SWEDISH/FIRST HILL CAMPUS IN SEPTEMBER 2010. THE FORMER MOTHER JOSEPH AND GLASER SPECIALTY CLI

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	NICS COMBINED AND PARTNERED WITH KING COUNTY PROJECT ACCESS (KCPA) TO PROVIDE EXPANDED SPE CIALTY CARE SERVICES TO OUR COMMUNITY.A SPECIALTY DENTAL CLINIC WITH MORE THAN 30 VOLUNTEE R ORAL SURGEONS AND DENTISTS WAS ADDED. THIS PROGRAM WAS DEVELOPED AND FUNDED THROUGH A UN IQUE COLLABORATION BETWEEN SWEDISH, PROJECT ACCESS NORTHWEST, SEATTLE-KING COUNTY DENTAL S OCIETY/FOUNDATION AND THE WASHINGTON DENTAL SERVICES FOUNDATION.OUR GOAL IS TO SET A NEW S TANDARD IN COMMUNITY HEALTH AND DEMONSTRATE THE IMPORTANCE OF CHARITY CARE TO OUR NONPROFI T MISSION EVEN IN TOUGH ECONOMIC TIMES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2:	THE ORGANIZATION ANALYZES ITS HISTORICAL EXPERIENCE AND TRENDS TO ESTIMATE THE APPROPRIATE BAD DEBT EXPENSE. DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE RECORDED PRIOR TO CALCULATING BAD DEBT EXPENSE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3:	THE ORGANIZATION RECOGNIZES THAT A PORTION OF THE UNINSURED OR UNDERINSURED PATIENT POPULATION MAY NOT ENGAGE IN THE TRADITIONAL FINANCIAL ASSISTANCE APPLICATION PROCESS. THEREFORE, THE ORGANIZATION ALSO USED AN AUTOMATED PREDICTIVE SCORING TOOL TO IDENTIFY AND QUALIFY PATIENTS FOR FINANCIAL ASSISTANCE FOR ACCOUNTS THAT WERE INITIALLY CLASSIFIED AS BAD DEBT. COLLECTION ACTIONS WERE NOT PURSUED ON THESE ACCOUNTS ONCE THEY WERE RECLASSIFIED BECAUSE RECLASSIFIED ACCOUNTS WERE GRANTED 100 PERCENT FINANCIAL ASSISTANCE (FREE CARE). AFTER THE RECLASSIFICATION, THERE WAS NO REMAINING AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER OUR FINANCIAL ASSISTANCE POLICY.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4:	AS A RESULT OF ADOPTING ASU 2014-09 , THE HEALTH SYSTEM CONTINUED TO MAINTAIN AN ALLOWANCE FOR BAD DEBTS RELATED TO PERFORMANCE OBLIGATIONS SATISFIED PRIOR TO JANUARY 1, 2018. THESE ACCOUNTS HAVE ALL BEEN FULLY RESOLVED, THEREFORE THE ALLOWANCE FOR BAD DEBTS HAS DECLINED TO $0 AS OF DECEMBER 31, 2019.THE HEALTH SYSTEM PROVIDED FOR AN ALLOWANCE AGAINST PATIENT ACCOUNTS RECEIVABLE FOR AMOUNTS THAT COULD BECOME UNCOLLECTIBLE. THE HEALTH SYSTEM ESTIMATED THIS ALLOWANCE BASED ON THE AGING OF ACCOUNTS RECEIVABLE, HISTORICAL COLLECTION EXPERIENCE BY PAYOR, AND OTHER RELEVANT FACTORS. THERE ARE VARIOUS FACTORS THAT CAN IMPACT THE COLLECTION TRENDS, SUCH AS CHANGES IN THE ECONOMY, WHICH IN TURN HAVE AN IMPACT ON UNEMPLOYMENT RATES AND THE NUMBER OF UNINSURED AND UNDERINSURED PATIENTS, THE INCREASED BURDEN OF COPAYMENTS TO BE MADE BY PATIENTS WITH INSURANCE COVERAGE AND BUSINESS PRACTICES RELATED TO COLLECTION EFFORTS. THESE FACTORS CONTINUOUSLY CHANGE AND CAN HAVE AN IMPACT ON COLLECTION TRENDS AND THE ESTIMATION PROCESS USED BY THE HEALTH SYSTEM. THE HEALTH SYSTEM RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICES ON THE BASIS OF PAST EXPERIENCE, WHICH HAS HISTORICALLY INDICATED THAT MANY PATIENTS ARE UNRESPONSIVE OR ARE OTHERWISE UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8:	THE ORGANIZATION DOES NOT REPORT MEDICARE REVENUES AND EXPENSES AS COMMUNITY BENEFIT.

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Form and Line Reference	Explanation
PART III, LINE 9B:	PATIENT ACCOUNTS WERE NOT FORWARDED TO COLLECTION STATUS WHEN THE PATIENT MADE A GOOD FAITH EFFORT TO RESOLVE OUTSTANDING ACCOUNT BALANCES. SUCH EFFORTS INCLUDE APPLYING FOR FINANCIAL ASSISTANCE, NEGOTIATING A PAYMENT PLAN, OR APPLYING FOR MEDICAID COVERAGE. PRIOR TO ADVANCING ANY ACCOUNT FOR EXTERNAL COLLECTION, THE ORGANIZATION PERFORMED AN EVALUATION TO IDENTIFY IF THE ACCOUNT QUALIFIED FOR FINANCIAL ASSISTANCE. ACCOUNTS FOR PATIENTS WHO QUALIFIED FOR FREE CARE WERE WRITTEN OFF AND COLLECTION EFFORTS WERE NOT PURSUED. THE ORGANIZATION'S COLLECTION POLICY ALSO APPLIED TO ACCOUNTS FOR PATIENTS WHO QUALIFIED FOR DISCOUNTED CARE.

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Form and Line Reference	Explanation
PART VI, LINE 2:	SWEDISH MEDICAL CENTER IS A MEMBER OF KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY (HHC) A COLLABORATIVE OF ALL 12 HOSPITALS AND HEALTH SYSTEMS IN KING COUNTY AND PUBLIC HEALTH-SEATTLE & KING COUNTY. HHC MEMBERS JOINED FORCES TO IDENTIFY THE MOST IMPORTANT HEALTH NEEDS IN THE COMMUNITIES THEY SERVE AND TO DEVELOP STRATEGIES THAT ADDRESS THOSE NEEDS. HHC MEMBERS HAVE ALSO WORKED TOGETHER TO INCREASE ACCESS TO HEALTHY FOODS AND BEVERAGES IN THEIR FACILITIES AND TO ADDRESS ACCESS-TO-CARE ISSUES BY ASSISTING WITH ENROLLMENT OF RESIDENTS IN FREE OR LOW- COST HEALTH INSURANCE. USING THE HHC ASSESSMENT AS A FOUNDATION, EACH OF SWEDISH HOSPITALS DEVELOPED ITS OWN CHNA AND IMPLEMENTATION STRATEGY REFLECTING THE FINDINGS FROM THE COLLABORATIVE COMBINED WITH THE FINDINGS OF THE LOCAL COMMUNITY.STAKEHOLDER SURVEYS WERE USED TO GATHER DATA AND OPINIONS FROM PERSON WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL. SECONDARY DATA WERE COLLECTED FROM A VARIETY OF LOCAL, COUNTY AND STATE SOURCES. SURVEY WAS AVAILABLE IN AN ELECTRONIC FORMAT THROUGH A SURVEY MONKEY LINK. THE LINK WAS DISTRIBUTED TO PARTNER ORGANIZATIONS WHO THEN DISTRIBUTED THEM TO COMMUNITY RESIDENTS AND TO LEADERS AND STAFF MEMBERS CARING FOR MEDICALLY UNDERSERVED, LOW-INCOME, IMMIGRANT AND MINORITY POPULATIONS. PAPER COPIES WERE ALSO MADE AVAILABLE TO COMMUNITY MEMBERS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3:	SWEDISH HOSPITALS ARE COMMITTED TO THE PROVISION OF HEALTHCARE SERVICES TO ALL PERSONS IN NEED OF MEDICAL ATTENTION REGARDLESS OF THEIR ABILITY TO PAY.EMPLOYEES ARE RESPONSIBLE FOR PROCESSING APPLICATIONS IN A RESPECTFUL AND COURTEOUS MANNER. PROCESSING SHOULD IN NO WAY DISCOURAGE PATIENTS FROM RECEIVING HEALTHCARE OR RESULT IN THE DELAYED PROVISION OF ESSENTIAL HEALTHCARE SERVICES. CHARITY CARE/FINANCIAL ASSISTANCE ARE AVAILABLE TO ANY ELIGIBLE PATIENT WITHOUT REGARD TO RACE, COLOR, SEX, RELIGION, AGE ORNATIONAL ORIGIN. ALL INTERACTIONS WITH PATIENTS MUST RESPECT THE INHERENTWORTH OF ALL PERSONS AND THEIR INDIVIDUAL DIGNITY.PUBLIC NOTICES:OUR FINANCIAL ASSISTANCE (CHARITY CARE) POLICY IS MADE AVAILABLE VIA WALLPOSTERS THAT ARE LOCATED IN REGISTRATION AREAS AND EMERGENCY DEPARTMENTS. LETTER SIZE POSTERS ARE ALSO AVAILABLE IN DEPARTMENTS AND HEALTH RESOURCE CENTERS.BROCHURES ARE AVAILABLE FOR DISSEMINATION OR UPON REQUEST AND ARE AVAILABLE IN SEVERAL LANGUAGES INCLUDING, BUT NOT LIMITED TO, ENGLISH, SPANISH, CHINESE, VIETNAMESE AND KOREAN. BROCHURES, APPLICATIONS AND THE SLIDING SCALE ARE AVAILABLE TO ANY PERSON REQUESTING THE INFORMATION WHETHER IN PERSON, BY MAIL OR BY TELEPHONE.TIMING OF APPLICATION:PATIENTS MAY APPLY FOR CHARITY CARE PRIOR TO SERVICE, AT THE TIME OF SERVICE OR AT ANY POINT IN THE BILLING PROCESS UP TO THE RESOLUTION OF THE ACCOUNT.IDENTIFICATION OF CHARITY CARE CANDIDATES:EVERY EFFORT IS MADE TO IDENTIFY PATIENTS WHO WOULD BENEFIT FROM CHARITY CARE AT THE EARLIEST POINT POSSIBLE. CARE FOR A PATIENT'S WELL-BEING IS AS IMPORTANT AS CARE FOR THEIR MEDICAL NEEDS. IT IS OUR GOAL TO DIMINISH A PATIENT'S WORRY OVER HEALTHCARE BILLS. EMPLOYEES MUST BE ALERT TOINDICATIONS THAT THE PATIENT OR FAMILY HAS CONCERNS ABOUT THEIR ABILITY TO PAY HEALTHCARE BILLS, EVEN IF THE PATIENT DOES NOT SPECIFICALLY ASK ABOUT CHARITY CARE OR FINANCIAL ASSISTANCE.GENERAL APPLICATION PROCESS:ONCE A PATIENT IS IDENTIFIED AS A CHARITY CARE CANDIDATE, THE PATIENT WILL BE INTERVIEWED. INTERPRETERS WILL BE OFFERED AND ARRANGED AS APPROPRIATE.

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Form and Line Reference	Explanation
PART VI, LINE 4:	SWEDISH FIRST HILL, SWEDISH CHERRY HILL AND SWEDISH BALLARD SERVE KING AND SNOHOMISH COUNTIES. THERE ARE TWELVE HOSPITALS SERVING THE COMMUNITY.- IN 2017, THE POPULATION IN THE TOTAL SERVICE AREA (PSA + SSA) WAS 2,846,268. - 21% OF THE POPULATION ARE CHILDREN AND YOUTH, AGES 0-17, AND 13.5% OF THE POPULATION ARE SENIORS, 65 YEARS AND OLDER. - AMONG COMMUNITY RESIDENTS, 61.4% WERE NON-LATINO WHITE, 18.1% ASIAN/PACIFIC ISLANDER, 9.1% WERE HISPANIC OR LATINO, 7.0% WERE AFRICAN AMERICAN OR BLACK, AND 5.8% WERE OF TWO OR MORE RACES/ETHNICITIES AND 3.5% WERE OTHER RACES/ETHNICITIES. - WITHIN SERVICE AREA HOMES, 67.3% OF RESIDENTS SPEAK ENGLISH ONLY. - HIGH SCHOOL GRADUATION RATES IN KING COUNTY ARE 80.5% AND IN SNOHOMISH COUNTY THEY ARE 79.5%. THESE RATES DO NOT MEET THE HEALTHY PEOPLE 2020 OBJECTIVE OF AN 87% HIGH SCHOOL GRADUATION RATE. - IN 2016, THE MEDIAN HOUSEHOLD INCOME FOR THE SERVICE AREA WAS $82,071, AND THE UNEMPLOYMENT RATE WAS 6%.- 4.1% OF SERVICE AREA HOUSEHOLDS AND 10.1% OF INDIVIDUALS ARE AT POVERTY LEVEL - WITHIN THE SERVICE AREA THERE ARE 1,071,149 HOUSEHOLDS. 34.7% OF RESIDENTS SPEND 30% OR MORE OF THEIR INCOME ON HOUSING, AND 34,255 PERSONS LIVE IN OVERCROWDED OR SUBSTANDARD HOUSING. - IN 2017 THERE WERE AN ESTIMATED 11,643 HOMELESS INDIVIDUALS IN KING COUNTY AND 1,066 HOMELESS INDIVIDUALS IN SNOHOMISH COUNTY. 52.9% OF THE HOMELESS IN KING COUNTY AND 51.7% IN SNOHOMISH COUNTY ARE SHELTERED. 23.8% OF THE HOMELESS IN KING COUNTY AND 36.3% IN SNOHOMISH COUNTY ARE CONSIDERED TO BE CHRONICALLY HOMELESS.- FOOD INSECURITY IS ONE WAY TO MEASURE THE RISK OF HUNGER. IN 2016 IN KING COUNTY, 12.2% OF THE POPULATION (254,200 PERSONS) EXPERIENCED FOOD INSECURITY. IN SNOHOMISH COUNTY, THE RATE OF FOOD INSECURITY WAS 10.9% (82,600 PERSONS). - IN THE FIRST HILL AND CHERRY HILL SERVICE AREAS, 4.5% OF COMMUNITY RESIDENTS WERE UNINSURED. 65.2% OF COMMUNITY RESIDENTS HAD PRIVATE (COMMERCIAL) INSURANCE, 18.1% OF RESIDENTS RECEIVED MEDICAID AND 12.1% OF THE POPULATION WERE COVERED BY MEDICARE.SWEDISH ISSAQUAHSWEDISH ISSAQUAH HOSPITAL IS LOCATED IN ISSAQUAH WASHINGTON, DESCRIBED AS A VIBRANT, EVER GROWING COMMUNITY NESTLED AT THE FOOT OF THREE MOUNTAINS WHERE I-90 MEETS THE URBAN BOUNDARY. - ESTABLISHED IN 1892, THE CURRENT POPULATION IS 1,451,299 (2017). THE POPULATION GREW BY 9.3% FROM 2011-2016. USING 2017 THE COMMUNITY IS COMPRISED OF 22.5% CHILDREN AND YOUTH; 15.6% YOUNG ADULTS, 49% ADULTS AND 12.9% SENIORS, 65 AND OVER- AMONG COMMUNITY RESIDENTS IN 2016, 59.7 % WERE NON-LATINO WHITE, 20.3 ASIAN/PACIFIC ISLANDER, 8.4% WERE HISPANIC OR LATINO, 6.8% WERE AFRICAN AMERICAN OR BLACK 5.3% WERE OF TWO OR MORE RACES/ETHNICITIES AND 3.2% WERE OTHER RACES/ETHNICITIES.- 8.9% OF INDIVIDUALS ARE AT POVERTY LEVEL, 9.9 OF AREA HOUSEHOLDS AND 19.6% OF INDIVIDUALS ARE CATEGORIZED AS LOW-INCOME WITH INCOMES BELOW 200%.- WITHIN SERVICE AREA HOMES, 65.1% SPEAK ENGLISH ONLY.- IN THE SERVICE AREA, 20.6% OF RESIDENTS, HAVE GRADUATED HIGH SCHOOL, 7.9% OF THE ADULT POPULATION HAS LESS THAN A HIGH SCHOOL DEGREE AND 46.7% HAVE A COLLEGE DEGREE.- IN 2016, 4.0 % OF COMMUNITY RESIDENTS WERE UNINSURED, 69% HAD PRIVATE (COMMERCIAL) INSURANCE, 15.4 % RECEIVED MEDICAID AND 11.6 % WERE COVERED BY MEDICARE.MAJOR EMPLOYERS INCLUDE COSTCO CORPORATE AND SWEDISH HOSPITAL. OTHER LOCAL HEALTHCARE PROVIDERS INCLUDE: - OVERLAKE HAS URGENT CARE IN ISSAQUAH - VIRGINIA MASON HAS A MEDICAL CENTER IN ISSAQUAH - UW MEDICINE HAS PRIMARY CARE IN ISSAQUAH - EVERGREEN HEALTH HAS PRIMARY CARE CLOSE TO ISSAQUAH IN SAMMAMISH THE CITY ANTICIPATES CONTINUED GROWTH WITH 3,916 ADDITIONAL HOUSING UNITS AND 17,517 JOBS BY 2031. SWEDISH HOSPITAL IS EXPECTED TO EXPAND TO ACCOMMODATE THE GROWTH.AS WITH MANY COMMUNITIES ON THE EASTSIDE OF LAKE WASHINGTON, ISSAQUAH HAS A MIX OF FAMILIES WITH CHILDREN, AS WELL AS A PROPORTIONATELY LARGE SENIOR POPULATION. TO MEET HEALTH NEEDS OF ISSAQUAH AND SURROUNDING COMMUNITIES, SWEDISH ISSAQUAH PROVIDES CARE FOR ALL AGES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5:	SENIOR LEADERSHIP COMMUNITY BOARD PARTICIPATION - SOUND GENERATION, AHA, CAPITOL HILL CHAMBER, SEATTLE WORKFORCE DEVELOPMENT, ACS, LIFELONG, COMPANIS, KCACH, HEALTHIERHERE, UNCF, CAMP TEN TREES, CAMPAINS, WELLSPRINGS.COMMUNITY HEALTH FAIRS - SOMALIA HEALTH BOARD, TET, NEIGHBORHOOD HOUSE, URBAN GAMES, BALLARD SEAFOOD FEST, SEATTLE STORM OUTREACH, YEAR UP RESOURCE FAIR, SEAFAIR TORCH LIGHT 8K AND 5K RUN, LIFE SUPPORT, AFRICAN AMERICAN MEN WELLNESS 5K, SUMMER RUN, MACK STRONG MEAL PROGRAMS COMMUNITY LUNCH ON CAPITOL HILL, LIFELONG DISTRIBUTION KITCHEN, FOOD BANK AT ST MARY'S, BYRD BARR, TREEHOUSE, SANDWICH DISTRIBUTION TO HOMELESS, IN-KIND DONATION OF CLOTHING, AND CARE PACKS MARY'S PLACE, BABY CORNER, YWCA, WELLSPRINGS, YMCA, COMMUNITY LUNCH ON CAPITOL HILL, KOREAN OLYMPICS, ACRS, NOURISHING NETWORK, LINKS, URBAN GAMES, COUNTRY DOCTOR, CLEM ELUM SCHOOLS IN-KIND DONATION MEDICAL SUPPLIES SEATTLE U, HEALTHCARE CAMP, MENS CLINIC, CLEAN SWEEP, CAMP TEN TREES, REDMOND'S CLINIC, FAMILY MEDICAL CLINIC, HEALTH SCHOLARS, PREP NURSES ASSOCIATION LATINO NURSES ASSOCIATION AND WA BUSINESS WEEK.EMERGENCY PREPAREDNESS KITS - CASCADE SCHOOL, SERVICE BOARD, CAPITOL HILL CHAMBER, SEATTLE STORM, FIRST HILL IMPROVEMENT ASSOCIATION, CAMP TEN TREES, URBAN GAMES.LGBTQ HEALTH - LGBTQ 101 - CME TANS HEALTH 101, LGBTQ+ HEALTH, CME, PRIDE DAY HEALTH AND COMMUNITY EDUCATION.ASK THE DR AND ASK THE RN EVENTS - URBAN GAMES.SENIOR LEADERSHIP COMMUNITY BOARDS PARTICIPATION - AMERICAN RED CROSS, ISSAQUAH CHAMBER OF COMMERCE, BELLEVUE COMMUNITY COLLEGE, AND ISSAQUAH SCHOOL BOARD AND EASTSIDE BABY CORNER.COMMUNITY HEALTH FAIRS - TASTE OF ISSAQUAH, SALMON DAYS, BELLEVUE DAY, MUSIC IN THE PARK, ISSAQUAH HIGH SCHOOL.MEAL PROGRAM YWCA FOOD BANK, ISSAQUAH COUNTY FOOD PANTRY.IN- KIND DONATIONS MEDICAL EQUIPMENT AND SUPPLIES.EMERGENCY PREPAREDNESS LIFE SUPPORT, SCHOOLS AND COMMUNITY CENTERS.COMMUNITY EDUCATION SUICIDE PREVENTION AND EDUCATION.PARTNERSHIP WITH THE PROGRAMS SUCH AS ACT, TAVON AND ENCOMPASS THAT SUPPORT INDIVIDUALS WITH DISABILITIES AND SPECIAL NEEDS SO THEY CAN THRIVE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6:	ON JULY 1, 2016, PROVIDENCE HEALTH & SERVICES (LEGACY PHS) AND ST. JOSEPH HEALTH SYSTEM (LEGACY SJHS) ENTERED INTO A BUSINESS COMBINATION AGREEMENT. BY COMING TOGETHER, PROVIDENCE ST. JOSEPH HEALTH SEEKS TO BETTER SERVE ITS COMMUNITIES THROUGH GREATER PATIENT AFFORDABILITY, OUTSTANDING CLINICAL CARE, IMPROVEMENTS TO THE PATIENT EXPERIENCE AND INTRODUCTION OF NEW SERVICES WHERE THEY ARE NEEDED MOST. TOGETHER, OUR CAREGIVERS SERVE IN 51 HOSPITALS AND OVER 829 CLINICS ACROSS ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	WA

Additional Data

Software ID:
Software Version:
EIN: 91-0433740
Name: SWEDISH HEALTH SERVICES

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **4** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER–24 hours	ER–other	**Other (Describe)**	**Facility reporting group**
1	SWEDISH FIRST HILL 747 BROADWAY SEATTLE, WA 98122 WWW.SWEDISH.ORG/LOCATIONS 00000001	X			X		X	X			A
2	SWEDISH CHERRY HILL 500 17TH AVENUE SEATTLE, WA 98122 WWW.SWEDISH.ORG/LOCATIONS 60329940	X			X		X	X			A
3	SWEDISH BALLARD 5300 TALLMAN AVENUE NW SEATTLE, WA 98107 WWW.SWEDISH.ORG/LOCATIONS 00000001	X			X			X			A
4	SWEDISH ISSAQUAH 751 NE BLAKELY DR ISSAQUAH, WA 98029 WWW.SWEDISH.ORG/LOCATIONS 60256001	X						X		OUTPATIENT ER OPERATING UNDER HOSPITAL LICENSE	

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 5: SWEDISH ISSAQUAH TOOK INTO ACCOUNT INPUT FROMPERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVEDINCLUDING THOSE WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH.THOSE CONSULTED INCLUDE THE FOLLOWING:PUBLIC HEALTH SEATTLE AND KING COUNTYAMY LAURENT, EPIDEMIOLOGIST IIIISSAQUAH SCHOOLS FOUNDATION, CONGREGATIONS FOR THE HOMELESS, ISSAQUAH SCHOOLS CASE MANAGERS, PROVIDENCE MARIANWOOD AND EASTSIDE FRIENDS OF SENIORS ARE SOME ORGANIZATIONS WHO PROVIDED A VOICE FROM COMMUNITY MEMBERS, STUDENTS, FAMILIES AND SENIORS.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 6A: SWEDISH CHERRY HILL, SWEDISH FIRST HILL, SWEDISH BALLARD, SWEDISH EDMONDS, SWEDISH CANCER INSTITUTE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 6B: PUBLIC HEALTH - SEATTLE & KING COUNTY

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 11: THROUGH A PRIORITIZATION PROCESS ALIGNED WITH THE ORGANIZATION 'S MISSION SWEDISH ISSAQUAH WILL FOCUS ON THESE AREAS: MENTAL HEALTH, DRUG ADDICTION, OBES ITY AND DIABETES, HOMELESSNESS AND JOINT AND BACK PAIN.MENTAL HEALTH AND WELLNESS:IMPLEMEN T AND FACILITATE A NEW PROGRAM THAT PROVIDES MENTAL HEALTH PEER SUPPORT IN SWEDISH EMERGEN CY DEPARTMENTS (ED). THIS PROGRAM WILL BE ADAPTED FROM THE ED CONNECT PROGRAM IMPLEMENTED BY HOAG HOSPITAL NEWPORT BEACH ED IN PARTNERSHIP WITH THE NATIONAL ALLIANCE ON MENTAL HEAL TH (NAMI). IN 2019, DEVELOP A PSYCHOLOGY POSTDOCTORAL PROGRAM FOR PRIMARY CARE THAT WILL S ERVE ANYONE IN THE SWEDISH COMMUNITY IRRESPECTIVE OF THEIR ABILITY TO PAY, WHILE CREATING A MUCH NEEDED WORKFORCE TO SUPPORT INTEGRATED BEHAVIORAL HEALTH CARE. CONDUCT FIRST AID ME NTAL HEALTH WORKSHOPS IN THE COMMUNITY.DRUG ADDICTION SUBSTANCE ABUSE AND OPIOID USE DISOR DER:INITIATE A PILOT PROGRAM AT ANOTHER SWEDISH CAMPUS (BALLARD) EMERGENCY DEPARTMENT TO T RANSITION PATIENTS WITH OPIOID USE DISORDER (OUD) TO A SUBOXONE CLINIC FOR TREATMENT. THIS PILOT WILL BE MODELED OFF OF THE SWEDISH EDMONDS SUBOXONE PROGRAM. THE GOAL IS TO ADDRESS THE IDENTIFIED COMMUNITY NEED THROUGH ENHANCED TREATMENT OF PATIENTS PRESENTING WITH OUD WITH EVIDENCE-BASED GUIDELINES FOR WITHDRAWAL MANAGEMENT.OBESITY AND DIABETES:INCREASE AWA RENESS ON THE IMPORTANCE OF HEALTHY EATING AND EXERCISE AND REDUCE THE PREVALENCE OF CHILD HOOD OBESITY AND RISK OF DIABETES IN DIVERSE COMMUNITIES. OFFER AND FACILITATE DIABETES SC REENING TABLES - OBTAIN 'AT RISK' COMMUNITY MEMBERS (THOSE WHO SCREEN POSITIVE FOR DIABETE S PREDIABETES, OR WITH HIGH GLUCOSE LEVELS) WHO ARE GIVEN INFORMATION FOR APPROPRIATE FOLL OW UP (PRIMARY PROVIDER, SWEDISH DIABETES CENTER, YMCA, OTHER COMMUNITY CLINICS. OFFER MON THLY ONLINE COOKING CLASSES THROUGH FACEBOOK LIVE, #SWEDISHEATS.HOMELESSNESS:DEVELOP COLLA BORATIVE STRATEGIES WITH COMMUNITY-BASED ORGANIZATIONS AND CITY AND COUNTY ENTITIES ON PRO VIDING SUPPORT FOR FAMILIES EXPERIENCING HOMELESSNESS AND FOCUSED ON MOVING A PERCENT OF T HE HOMELESS FAMILIES TO STABLE HOUSING. ADDITIONALLY, THIS CONSORTIUM WILL WORK TO ADDRESS UPSTREAM HEALTH NEEDS, SUCH AS BEHAVIORAL HEALTH, AND SOCIAL DETERMINANTS OF HEALTH, SUCH AS EMPLOYMENT.JOINT AND BACK PAIN - JOINT AND BACK PAIN EDUCATION FOR PEOPLE IN THE SWEDI SH ISSAQUAH SERVICE AREA:DUE TO THE IMPACT OF JOINT AND BACK PAIN IN THE SWEDISH ISSAQUAH COMMUNITY, THIS INITIATIVE SEEKS TO INCREASE OUTREACH AND EDUCATION FOR INDIVIDUALS IMPACT ED BY JOINT AND BACK PAIN, WITH AN EMPHASIS ON NON-SURGICAL ALTERNATIVES. OTHER ACTION PLA NS TO ADDRESS THIS HEALTH CONCERN INCLUDE: FITNESS PRESENTATION AT GIBSON EK HIGH SCHOOL I N ISSAQUAH WITH A FOCUS ON HIGH SCHOOL STUDENTS AND PARENTS, SWEDISH SPORTS MEDICINE COMBI NE PRESENTATIONS AND JOINT AND BACK PAIN BOOTH AT BE WELL RESOURCE FAIR.A LIST OF COMMUNIT Y HEALTH NEEDS IDENTIFIED IN THE 2018 SWEDISH CHNA CAMPUS REPORTS MAY NOT BE ADDRESSED AS PART OF THE CURRENT CHIP: TEXT

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	ING WHILE DRIVING, CANCER, ENVIRONMENTAL FACTORS, ALZHEIMER'S DISEASE/DEMENTIA, TEETH AND ORAL HEALTH ISSUES, STROKE, CHILD ABUSE AND NEGLECT, SEXUALLY TRANSMITTED DISEASES, SMOKIN G, ETC. SOME OF THESE AREAS ARE OUT OF OUR SCOPE OF OUR CURRENT COMMUNITY HEALTH PROGRAM E XPERTISE, AND OTHER NON-PROFITS IN THE COMMUNITY ARE PROVIDING ROBUST SERVICES. NO HOSPITA L FACILITY CAN ADDRESS ALL HEALTH NEEDS PRESENT IN THE COMMUNITY HOWEVER, WE ARE COMMITTED TO OUR MISSION THROUGH SWEDISH COMMUNITY BENEFITS GRANTING PROGRAMS AND PARTNERING WITH L IKE-MINDED ORGANIZATIONS IN SERVICE TO OUR COMMUNITY.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 15E: ACCESS TO MULTI LANGUAGE RESOURCES IN THIS WEBSITE:WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 24: FOR NON-MEDICALLY NECESSARY SERVICES, A PATIENT MAY BE BILLED THE GROSS CHARGES.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 3E:THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THESIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THECHNA.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 7A:HTTP://WWW.SWEDISH.ORG/ABOUT/OVERVIEW/MISSION-OUTREACH/COMMUNITY-ENGAGEMENT/COMMUNITY-NEEDS-ASSESSMENT

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, SECTION B, LINE 10A:HTTPS://WWW.SWEDISH.ORG/ABOUT/OVERVIEW/MISSION-OUTREACH/COMMUNITY-ENGAGEMENT/COMMUNITY-NEEDS-ASSESSMENT/ASSESSMENTS-SITE-LIST

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, LINE 16A, FAP WEBSITE:WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, LINE 16B, FAP WEBSITE:WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH ISSAQUAH (4)	PART V, LINE 16C, FAP WEBSITE:WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B	FACILITY REPORTING GROUP A

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
FACILITY REPORTING GROUP A CONSISTS OF:	- FACILITY 1: SWEDISH FIRST HILL, - FACILITY 2: SWEDISH CHERRY HILL, - FACILITY 3: SWEDISH BALLARD

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3) PART V, SECTION B, LINE 5:	INPUT WAS TAKEN INTO ACCOUNT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED INCLUDING THOSE WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH. THOSE CONSULTED INCLUDE THE FOLLOWING:DR ARPAN WAGHRAY, IS A GERIATRIC PSYCHIATRIST AND SYSTEM DIRECTOR FOR BEHAVIORAL MEDICINE AT SWEDISH HEALTH SERVICES AND CHIEF MEDICAL OFFICER AT WELL BEING TRUST.MARGUERITE RO, KC PUBLIC HEALTH, PROVIDED A VOICE FROM COMMUNITY MEMBER REGARDING ACCESS AND SOCIAL DETERMINATE OF HEALTH. DON JENSON EXECUTIVE DIRECTOR COMMUNITY LUNCH ON CAPITOL HILL COMMUNITY HOT MEAL PROGRAM FOR UNHOUSED AND FOOD INSECURE POPULATION.TAMMY MESSINA MEDICAL TEAMS INTERNATIONAL DEVELOPMENT DIRECTOR AND COMMUNITY OUTREACH ADVISOR.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3) PART V, SECTION B, LINE 6A:	SWEDISH EDMONDS, SWEDISH ISSAQUAH, SWEDISH CANCER INSTITUTE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3) PART V, SECTION B, LINE 6B:	PUBLIC HEALTH - SEATTLE & KING COUNTY

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3) PART V, SECTION B, LINE 11:	SWEDISH HAS IDENTIFIED 5 SYSTEM WIDE PRIORITIES THAT WILL BE OUR FOCUS - DIABETES AND OBESITY, MENTAL HEALTH/BEHAVIORAL HEALTH, HOMELESSNESS, SUBSTANCE ABUSES, AND COMMUNITY EDUCATION.DIABETES/OBESITY:IN KING COUNTY, 7% OF 10TH GRADERS AND 8% OF ADULTS ON AVERAGE, 7% OF KING COUNTY ADULTS HAVE BEEN DIAGNOSED WITH DIABETES. OVER THE NEXT FEW YEARS, THE DIABETES TEAM WILL EXPAND ITS SERVICES AND HAS IDENTIFIED THE FOLLOWING COMPONENTS THAT WILL CONSTITUTE OUR COMPREHENSIVE PROGRAM: -INCREASE AWARENESS OF INDIVIDUALS WHO ARE AT RISK FOR DEVELOPING PREDIABETES INCLUDING SCREENINGS. IDENTIFY AND ACKNOWLEDGE ADDITIONAL AVENUES FOR IMPROVING KNOWLEDGE TO REDUCE AND PREVENT THE RISK OF DEVELOPING TYPE 2 DIABETES.-BALLARD ADDED IMBEDDED PSYCHIATRIC THERAPIST THAT PARTNERS WITH DIABETES AND BARIATRIC CARE.MENTAL HEALTH/BEHAVIORAL HEALTH:MENTAL ILLNESS IS A COMMON CAUSE OF DISABILITY. MENTAL HEALTH DISORDERS CAN HAVE A SERIOUS IMPACT ON PHYSICAL HEALTH AND ARE ASSOCIATED WITH THE PREVALENCE, PROGRESSION AND OUTCOME OF CHRONIC DISEASES. BALLARD ADDED IMBEDDED PSYCHIATRIC THERAPIST. -IMPLEMENT A NEW PROGRAM THAT PROVIDES MENTAL HEALTH PEER SUPPORT IN SWEDISH EMERGENCY DEPARTMENTS (ED)-MENTAL HEALTH FIRST AID TRAINING, HOMELESSNESS:A POINT-IN-TIME COUNT OF HOMELESS PEOPLE IS CONDUCTED EVERY YEAR IN EVERY COUNTY IN THE STATE. THE 2017 POINT-IN TIME COUNT ESTIMATED 11,643 HOMELESS INDIVIDUALS IN KING COUNTY AND 1,066 HOMELESS INDIVIDUALS IN SNOHOMISH COUNTY. 52.9% OF THE HOMELESS IN KING COUNTY, 23.8% OF THE HOMELESS IN KING COUNTY ARE CONSIDERED TO BE CHRONICALLY HOMELESS. TRENDS IN THE HOMELESS POPULATION INDICATE THE HOMELESS POPULATION HAS DECREASED FROM 2006 TO 2017, WHILE HOMELESSNESS HAS RISEN IN KING COUNTY. THE PROPORTION OF UNSHELTERED HOMELESS IN BOTH COUNTIES AND THE STATE HAS RISEN OVER TIME-DEVELOP ONGOING PARTNERSHIPS WITH COMMUNITY-BASED ORGANIZATIONS AND CITY AND COUNTY ENTITIES WHOSE FOCUS IS HOMELESSNESS AND PROVIDING SUPPORT FOR FAMILIES EXPERIENCING HOMELESSNESS IN KING COUNTY SUBSTANCE ABUSE:SMOKING IS A CONTRIBUTING CAUSE TO DISEASE AND DEATH. IT INCREASES THE RISK OF DEVELOPING HEART DISEASE, STROKE AND CANCER. ALCOHOL AND DRUG ABUSE HAS A MAJOR IMPACT ON INDIVIDUALS, FAMILIES, AND COMMUNITIES. THE EFFECTS OF SUBSTANCE ABUSE CONTRIBUTE TO COSTLY SOCIAL, PHYSICAL, MENTAL, AND PUBLIC HEALTH PROBLEMS.-INITIATE A PILOT PROGRAM AT THE BALLARD EMERGENCY DEPARTMENT (ED) TO TRANSITION PATIENTS WITH OPIOID USE DISORDER (OUD) TO A SUBOXONE CLINIC FOR TREATMENT.COMMUNITY EDUCATION:INCREASE OUTREACH AND ENGAGEMENT OPPORTUNITIES FOR COMMUNITIES IN AND AROUND THE BALLARD COMMUNITY. OUTREACH ACTIVITIES TO INCREASE AND IMPROVE AWARENESS AND EDUCATION AMONG THE INCREASING NUMBERS OF FAMILIES AND ADULTS.-PARTNER WITH BALLARD COMMUNITY EVENTS TO PROVIDE HEALTH EDUCATION AND OUTREACH TO THE COMMUNITY. WE WILL SELECT TWO TO THREE EVENTS DURING THE YEAR ADDRESSING ISSUES OF HEART HEALTH, DIABETES PREVENTION, HEALTHY BMI AND EXERCISE.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3) PART V, SECTION B, LINE 24:	FOR NON-MEDICALLY NECESSARY SERVICES, A PATIENT MAY BE BILLED THE GROSS CHARGES.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3)	PART V, SECTION B, LINE 3E:THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THESIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THECHNA.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3)	PART V, SECTION B, LINE 7A:HTTP://WWW.SWEDISH.ORG/ABOUT/OVERVIEW/MISSION-OUTREACH/COMMUNITY-ENGAGEMENT/COMMUNITY-NEEDS-ASSESSMENT

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3)	PART V, SECTION B, LINE 10A:HTTPS://WWW.SWEDISH.ORG/ABOUT/OVERVIEW/MISSION-OUTREACH/COMMUNITY-ENGAGEMENT/COMMUNITY-NEEDS-ASSESSMENT/ASSESSMENTS-SITE-LIST

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3)	PART V, SECTION B, LINE 16A:HTTPS://WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3)	PART V, SECTION B, LINE 16B:HTTPS://WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SWEDISH HEALTH SERVICES (GROUP A - 1-3)	PART V, SECTION B, LINE 16C:HTTPS://WWW.SWEDISH.ORG/PATIENT-VISITOR-INFO/BILLING/FINANCIAL-ASSISTANCE

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
1	1 - DIABETES EDUCATION AND NUTRITION - FIRST 1124 COLUMBIA ST SUITE 400 SEATTLE, WA 98104	EDUCATION
1	2 - EXPRESS CARE AT WALGREENS BELLEVUE 15585 NE 24TH ST BELLEVUE, WA 98007	EXPRESS CARE
2	3 - EXPRESS CARE AT WALGREENS BOTHELL 20812 BOTHELL EVERETT HIGHWAY BOTHELL, WA 98021	EXPRESS CARE
3	4 - EXPRESS CARE AT WALGREENS ISSAQUAH 6300 E LAKE SAMMAMISH PKWY SE ISSAQUAH, WA 98029	EXPRESS CARE
4	5 - EXPRESS CARE AT WALGREENS KIRKLAND 12405 NE 85TH ST KIRKLAND, WA 98033	EXPRESS CARE
5	6 - EXPRESS CARE AT WALGREENS LAKE FOREST PA 14352 LAKE CITY WAY NE SEATTLE, WA 98125	EXPRESS CARE
6	7 - EXPRESS CARE AT WALGREENS MERCER ISLAND 7707 SE 27TH ST MERCER ISLAND, WA 98040	EXPRESS CARE
7	8 - EXPRESS CARE AT WALGREENS RENTON 4105 NE 4TH ST RENTON, WA 98059	EXPRESS CARE
8	9 - BREAST IMAGING CENTER - FIRST HILL 1101 MADISON ST SUITE 310 SEATTLE, WA 98104	IMAGING CENTER
9	10 - CARDIOVASCULAR DIAGNOSTIC IMAGING - CHER 550 17TH AVE SUITE 630 SEATTLE, WA 98122	IMAGING CENTER
10	11 - MEDICAL IMAGING - BALLARD 5350 TALLMAN AVE NW 2ND FLOOR SEATTLE, WA 98107	IMAGING CENTER
11	12 - MEDICAL IMAGING - CHERRY HILL 500 17TH AVE SEATTLE, WA 98122	IMAGING CENTER
12	13 - MEDICAL IMAGING - FIRST HILL 747 BROADWAY 4TH FLOOR EAST SEATTLE, WA 98122	IMAGING CENTER
13	14 - MEDICAL IMAGING - ISSAQUAH 751 NE BLAKELY DRIVE 1ST FLOOR ISSAQUAH, WA 98029	IMAGING CENTER
14	15 - MEDICAL IMAGING - MILL CREEK 13020 MERIDIAN AVE S EVERETT, WA 98208	IMAGING CENTER

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
16	16 - MEDICAL IMAGING - REDMOND 18100 NE UNION HILL ROAD REDMOND, WA 98052	IMAGING CENTER
1	17 - PETCT IMAGING AT SWEDISH CANCER INSTITU 1221 MADISON STREET SUITE 150 SEATTLE, WA 98104	IMAGING CENTER
2	18 - WOMEN'S IMAGING CENTER - BALLARD 5300 TALLMAN AVE NW 2ND FLOOR SEATTLE, WA 98107	IMAGING CENTER
3	19 - LAB PATIENT SERVICES CENTER AT SWEDISH M 13020 MERIDIAN AVE S 2ND FLOOR EVERETT, WA 98028	LAB
4	20 - OUTPATIENT PHARMACY - FIRST HILL 1221 MADISON ST SEATTLE, WA 98104	PHARMACY
5	21 - BAINBRIDGE ISLAND PRIMARY CARE 945 HILDEBRAND LANE NE SUITE 100 BAINBRIDGE ISLAND, WA 98110	PRIMARY CARE
6	22 - BALLARD PRIMARY CARE 5350 TALLMAN AVE NW SUITE 301 SEATTLE, WA 98107	PRIMARY CARE
7	23 - BALLINGER PRIMARY CARE 6007B 244TH ST SW MOUNTLAKE TERRACE, WA 98043	PRIMARY CARE
8	24 - BELLEVUE PRIMARY CARE 1200 112TH AVE NE SUITE B100 BELLEVUE, WA 98004	PRIMARY CARE
9	25 - CENTRAL SEATTLE PRIMARY CARE 1600 E JEFFERSON ST JEFFERSON TOWER S SEATTLE, WA 98122	PRIMARY CARE
10	26 - CLE ELUM PRIMARY CARE 214 W 1ST ST CLE ELUM, WA 98922	PRIMARY CARE
11	27 - DOWNTOWN SEATTLE PRIMARY CARE 800 5TH AVE SUITE P100 SEATTLE, WA 98104	PRIMARY CARE
12	28 - FACTORIA PRIMARY CARE 12917 SE 38TH ST SUITE 100 BELLEVUE, WA 98006	PRIMARY CARE
13	29 - GREENLAKE PRIMARY CARE 7210 ROOSEVELT WAY NE SEATTLE, WA 98115	PRIMARY CARE
14	30 - ISSAQUAH PRIMARY CARE 751 NE BLAKELY DRIVE 5TH FLOOR ISSAQUAH, WA 98029	PRIMARY CARE

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
31	31 - KINGSTON PRIMARY CARE 25989 BARBER CUT OFF ROAD KINGSTON, WA 98346	PRIMARY CARE
1	32 - KLAHANIE PRIMARY CARE 4560 KLAHANIE DRIVE SE SUITE 400 ISSAQUAH, WA 98029	PRIMARY CARE
2	33 - MAGNOLIA PRIMARY CARE 2450 33RD AVE W SUITE 100 SEATTLE, WA 98199	PRIMARY CARE
3	34 - MERCER ISLAND PRIMARY CARE 3236 78TH AVE SE SUITE 200 MERCER ISLAND, WA 98040	PRIMARY CARE
4	35 - MILL CREEK PRIMARY CARE 13020 MERIDIAN AVE S EVERETT, WA 98208	PRIMARY CARE
5	36 - PINE LAKE PRIMARY CARE 22707 SE 29TH ST SAMMAMISH, WA 98075	PRIMARY CARE
6	37 - QUEEN ANNE PRIMARY CARE 2211 QUEEN ANNE AVE N SEATTLE, WA 98109	PRIMARY CARE
7	38 - REDMOND PRIMARY CARE AND URGENT CARE 18100 NE UNION HILL RD SUITE 200 REDMOND, WA 98052	PRIMARY CARE
8	39 - RENTON PRIMARY CARE 911 N 10TH PLACE RENTON, WA 98057	PRIMARY CARE
9	40 - RICHMOND BEACH PRIMARY CARE 604 NW RICHMOND BEACH ROAD SHORELINE, WA 98177	PRIMARY CARE
10	41 - SAND POINT PRIMARY CARE 4540 UNION BAY PLACE NE SEATTLE, WA 98105	PRIMARY CARE
11	42 - SNOQUALMIE PRIMARY CARE 37624 SE FURY ST SNOQUALMIE, WA 98065	PRIMARY CARE
12	43 - SOUTH LAKE UNION PRIMARY CARE 510 BOREN AVE N SEATTLE, WA 98109	PRIMARY CARE
13	44 - WEST SEATTLE PRIMARY CARE 3400 CALIFORNIA AVE SW SUITE 300 SEATTLE, WA 98116	PRIMARY CARE
14	45 - ACUTE REHABILITATION UNIT 500 17TH AVE 6-EAST SEATTLE, WA 98122	REHAB & PHYSICAL THERAPY

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
46	46 - OUTPATIENT REHABILITATION - BALLARD 5300 TALLMAN AVE NW 1SOUTH SEATTLE, WA 98107	REHAB & PHYSICAL THERAPY
1	47 - OUTPATIENT REHABILITATION - CHERRY HILL 500 17TH AVE SUITE 100 SEATTLE, WA 98122	REHAB & PHYSICAL THERAPY
2	48 - OUTPATIENT REHABILITATION - FIRST HILL 1229 MADISON ST NORDSTROM TOWER SUITE SEATTLE, WA 98104	REHAB & PHYSICAL THERAPY
3	49 - OUTPATIENT REHABILITATION - ISSAQUAH 751 NE BLAKELY DRIVE SUITE 4010 ISSAQUAH, WA 98029	REHAB & PHYSICAL THERAPY
4	50 - OUTPATIENT REHABILITATION - MILL CREEK 13020 MERIDIAN AVE S SUITE 310 EVERETT, WA 98029	REHAB & PHYSICAL THERAPY
5	51 - OUTPATIENT REHABILITATION - REDMOND 18100 NE UNION HILL RD SUITE 310 REDMOND, WA 98052	REHAB & PHYSICAL THERAPY
6	52 - OUTPATIENT REHABILITATION - RENTON 916 10TH PLACE N RENTON, WA 98057	REHAB & PHYSICAL THERAPY
7	53 - OUTPATIENT REHABILITATION - WEST SEATTLE 3400 CALIFORNIA AVE SW SUITE 100 SEATTLE, WA 98116	REHAB & PHYSICAL THERAPY
8	54 - PHYSICAL THERAPY - FACTORIA 12917 SE 38TH ST SUITE 208 BELLEVUE, WA 98006	REHAB & PHYSICAL THERAPY
9	55 - ANTICOAGULATION CLINIC - FIRST HILL 601 BROADWAY SUITE BR117 SEATTLE, WA 98122	SPECIALTY CLINIC
10	56 - BEN AND CATHERINE IVY CENTER FOR ADVANCE 550 17TH AVE SUITE 540 SEATTLE, WA 98122	SPECIALTY CLINIC
11	57 - BONE HEALTH AND OSTEOPOROSIS - FIRST HIL 601 BROADWAY SUITE 600 SEATTLE, WA 98122	SPECIALTY CLINIC
12	58 - BRAIN AND SPINE SPECIALISTS 1600 E JEFFERSON ST JEFFERSON TOWER S SEATTLE, WA 98122	SPECIALTY CLINIC
13	59 - CANCER INSTITUTE GYNECOLOGIC ONCOLOGY AN 1101 MADISON ST SUITE 1500 SEATTLE, WA 98104	SPECIALTY CLINIC
14	60 - CANCER INSTITUTE TREATMENT CENTER - FIRS 1221 MADISON ST 3RD FLOOR SEATTLE, WA 98104	SPECIALTY CLINIC

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
61	61 - CANCER REHABILITATION - FIRST HILL 1229 MADISON SUITE 1050 SEATTLE, WA 98104	SPECIALTY CLINIC
1	62 - CARDIAC REHABILITATION - CHERRY HILL 550 17TH AVE JAMES TOWER CENTER FOR HE SEATTLE, WA 98122	SPECIALTY CLINIC
2	63 - CARDIAC SURGERY 1600 E JEFFERSON ST SUITE 110 SEATTLE, WA 98122	SPECIALTY CLINIC
3	64 - CARDIOVASCULAR WELLNESS - CHERRY HILL 550 17TH AVE JAMES TOWER SUITE 100 SEATTLE, WA 98122	SPECIALTY CLINIC
4	65 - CENTER FOR BLOOD DISORDERS AND STEM CELL 1221 MADISON ST 10TH FLOOR SEATTLE, WA 98104	SPECIALTY CLINIC
5	66 - CENTER FOR COMPREHENSIVE CARE 515 MINOR AVE SEATTLE, WA 98104	SPECIALTY CLINIC
6	67 - CENTER FOR HEARING AND SKULL BASE SURGER 550 17TH AVE SUITE 540 SEATTLE, WA 98122	SPECIALTY CLINIC
7	68 - CENTER FOR PERINATAL BONDING AND SUPPORT 1101 MADISON SUITE 500 SEATTLE, WA 98104	SPECIALTY CLINIC
8	69 - CEREBROVASCULAR CENTER 550 17TH AVE SUITE 110 SEATTLE, WA 98122	SPECIALTY CLINIC
9	70 - COLON & RECTAL CLINIC - BALLARD 1801 NW MARKET BALLARD CAMPUS SUITE 207 SEATTLE, WA 98107	SPECIALTY CLINIC
10	71 - COLON & RECTAL CLINIC - FIRST HILL 1101 MADISON ST FIRST HILL CAMPUS SUIT SEATTLE, WA 98104	SPECIALTY CLINIC
11	72 - COMMUNITY SPECIALTY CLINIC 801 BROADWAY HEATH BUILDING SUITE 901 SEATTLE, WA 98122	SPECIALTY CLINIC
12	73 - COUNTRY DOCTOR WALK-IN AFTER-HOURS CARE 550 16TH AVE SEATTLE, WA 98122	SPECIALTY CLINIC
13	74 - DEEP BRAIN STIMULATION 550 17TH AVE SUITE 540 SEATTLE, WA 98122	SPECIALTY CLINIC
14	75 - ENDOCRINOLOGY - FIRST HILL 1124 COLUMBIA ST SUITE 400 SEATTLE, WA 98104	SPECIALTY CLINIC

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(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
76	76 - ENDOCRINOLOGY - WEST SEATTLE 3400 CALIFORNIA AVE SW SUITE 210 SEATTLE, WA 98116	SPECIALTY CLINIC
1	77 - EPILEPSY CENTER 550 17TH AVE CHERRY HILL CAMPUS JAMES SEATTLE, WA 98122	SPECIALTY CLINIC
2	78 - FUNCTIONAL RESTORATION 600 BROADWAY SUITE 580 SEATTLE, WA 98122	SPECIALTY CLINIC
3	79 - GASTROENTEROLOGY - FIRST HILL 1221 MADISON ST SUITE 1220 SEATTLE, WA 98104	SPECIALTY CLINIC
4	80 - GOSSMAN ADVANCED HEALTHCARE SIMULATION 600 BROADWAY SUITE 100 SEATTLE, WA 98122	SPECIALTY CLINIC
5	81 - HEAD & NECK SURGERY 1101 MADISON ST SUITE 850 SEATTLE, WA 98104	SPECIALTY CLINIC
6	82 - HEART & VASCULAR - BALLARD 1801 NW MARKET ST SUITE 207 SEATTLE, WA 98107	SPECIALTY CLINIC
7	83 - HEART & VASCULAR - CHERRY HILL (4TH FLOO 550 17TH AVE SUITE 450 SEATTLE, WA 98122	SPECIALTY CLINIC
8	84 - HEART & VASCULAR - CHERRY HILL (6TH FLOO 550 17TH AVE SUITE 680 SEATTLE, WA 98122	SPECIALTY CLINIC
9	85 - HEART & VASCULAR - FACTORIA 12917 SE 38TH ST SUITE 100 BELLEVUE, WA 98006	SPECIALTY CLINIC
10	86 - HEART & VASCULAR - KENT 23914 100TH AVE S KENT, WA 98031	SPECIALTY CLINIC
11	87 - HEART & VASCULAR - SEQUIM 840 NORTH 5TH AVE SUITE 2400 SEQUIM, WA 98382	SPECIALTY CLINIC
12	88 - HEART & VASCULAR - WEST SEATTLE 3400 CALIFORNIA AVE SW SEATTLE, WA 98116	SPECIALTY CLINIC
13	89 - HIP AND PELVIS CENTER 600 BROADWAY SUITE 340 SEATTLE, WA 98122	SPECIALTY CLINIC
14	90 - IBD CENTER 1221 MADISON ST SUITE 1220A SEATTLE, WA 98104	SPECIALTY CLINIC

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
91	91 - JOHN L LOCKE JR ADVANCED CARDIAC SUPPO 1600 E JEFFERSON ST SUITE 600 SEATTLE, WA 98122	SPECIALTY CLINIC
1	92 - MATERNAL AND FETAL SPECIALTY CENTER - FI 1229 MADISON NORDSTROM TOWER SUITE 750 SEATTLE, WA 98104	SPECIALTY CLINIC
2	93 - MAXILLOFACIAL SURGERY 600 BROADWAY SUITE 460 SEATTLE, WA 98122	SPECIALTY CLINIC
3	94 - MEDICAL ONCOLOGY - FIRST HILL 1221 MADISON ST ARNOLD PAVILION SUITE SEATTLE, WA 98104	SPECIALTY CLINIC
4	95 - MIDWIFERY - FIRST HILL 1101 MADISON ST SUITE 700 SEATTLE, WA 98104	SPECIALTY CLINIC
5	96 - MOVEMENT DISORDERS 550 17TH AVE SUITE 540 SEATTLE, WA 98122	SPECIALTY CLINIC
6	97 - MULTIPLE SCLEROSIS CENTER 1600 E JEFFERSON ST A LEVEL SEATTLE, WA 98122	SPECIALTY CLINIC
7	98 - MUSCULOSKELETAL SERVICES - RENTON 916 N 10TH PLACE RENTON, WA 98057	SPECIALTY CLINIC
8	99 - NEUROLOGIC RESTORATION - CHERRY HILL 550 17TH AVE SUITE 540 SEATTLE, WA 98122	SPECIALTY CLINIC
9	100 - NEUROLOGY - CHERRY HILL 550 17TH AVE SUITE 400 SEATTLE, WA 98122	SPECIALTY CLINIC
10	101 - NEURO-OPHTHALMOLOGY 1600 E JEFFERSON ST SUITE 205 SEATTLE, WA 98101	SPECIALTY CLINIC
11	102 - NEUROSURGERY - CHERRY HILL 550 17TH AVE SUITE 500 SEATTLE, WA 98122	SPECIALTY CLINIC
12	103 - OBGYN SPECIALISTS - FIRST HILL 1101 MADISON ST SUITE 700 SEATTLE, WA 98104	SPECIALTY CLINIC
13	104 - OFFICE OF DR ZHAO AND DR GOLDBERG 1221 MADISON SUITE 1020 SEATTLE, WA 98104	SPECIALTY CLINIC
14	105 - ONCOLOGY SOCIAL WORK - ISSAQUAH 751 NE BLAKELY DR SUITE 1090 ISSAQUAH, WA 98029	SPECIALTY CLINIC

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
106	106 - ORTHOPEDIC INSTITUTE - FIRST HILL 601 BROADWAY SEATTLE, WA 98122	SPECIALTY CLINIC
1	107 - OTOLARYNGOLOGY - BALLARD 1801 NW MARKET ST SUITE 411 SEATTLE, WA 98107	SPECIALTY CLINIC
2	108 - OTOLARYNGOLOGY - FIRST HILL 600 BROADWAY SUITE 200 SEATTLE, WA 98122	SPECIALTY CLINIC
3	109 - PAIN SERVICES - FIRST HILL 600 BROADWAY SUITE 530 SEATTLE, WA 98122	SPECIALTY CLINIC
4	110 - PAIN SERVICES - ISSAQUAH 751 BLAKELY DRIVE SUITE 4010 ISSAQUAH, WA 98029	SPECIALTY CLINIC
5	111 - PALLIATIVE CARE AND SYMPTOM MANAGEMENT C 1221 MADISON ST 2ND FLOOR SEATTLE, WA 98104	SPECIALTY CLINIC
6	112 - PALLIATIVE CARE CLINIC - CHERRY HILL 550 17TH AVE SUITE 400 SEATTLE, WA 98122	SPECIALTY CLINIC
7	113 - PEDIATRIC NEUROSCIENCE 600 BROADWAY SUITE 400 SEATTLE, WA 98122	SPECIALTY CLINIC
8	114 - PEDIATRIC SPECIALTY CARE - SEATTLE 1101 MADISON MADISON TOWER SUITE 800 SEATTLE, WA 98104	SPECIALTY CLINIC
9	115 - PEDIATRIC THERAPY 1229 MADISON ST NORDSTROM TOWER SUITE SEATTLE, WA 98104	SPECIALTY CLINIC
10	116 - PEDIATRICS - MEADOW CREEK 6520 226TH PL SE SUITE 100 ISSAQUAH, WA 98027	SPECIALTY CLINIC
11	117 - PEDIATRICS - REDMOND 8301 161ST AVE NE SUITE 204 REDMOND, WA 98052	SPECIALTY CLINIC
12	118 - PEDIATRICS - WEST SEATTLE 4744 41ST AVE SW SUITE 101 SEATTLE, WA 98116	SPECIALTY CLINIC
13	119 - PITUITARY CENTER 550 17TH AVE SUITE 400 SEATTLE, WA 98122	SPECIALTY CLINIC
14	120 - PLASTICS AND AESTHETICS 901 BOREN AVE CABRINI MEDICAL TOWER SU SEATTLE, WA 98104	SPECIALTY CLINIC

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(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
121	121 - RADIATION ONCOLOGY - FIRST HILL 1221 MADISON ST ARNOLD PAVILION 1ST FL SEATTLE, WA 98104	SPECIALTY CLINIC
1	122 - RADIATION ONCOLOGY - SWEDISH CANCER INST 16233 SYLVESTER RD SW SUITE 110 BURIEN, WA 98166	SPECIALTY CLINIC
2	123 - RADIATION ONCOLOGY - SWEDISH CANCER INST 400 S 43RD STREET RENTON, WA 98055	SPECIALTY CLINIC
3	124 - RADIOSURGERY CENTER - CHERRY HILL 550 17TH AVE SUITE A10 SEATTLE, WA 98122	SPECIALTY CLINIC
4	125 - SLEEP MEDICINE - BALLARD 1801 NW MARKET ST SUITE 207 SEATTLE, WA 98107	SPECIALTY CLINIC
5	126 - SLEEP MEDICINE - CHERRY HILL 550 17TH AVE JAMES TOWER LEVEL A20 SEATTLE, WA 98122	SPECIALTY CLINIC
6	127 - SLEEP MEDICINE - NORTH SEATTLE 1536 N 115TH ST MCMURRAY BUILDING SUI SEATTLE, WA 98133	SPECIALTY CLINIC
7	128 - SLEEP MEDICINE - WEST SEATTLE 3400 CALIFORNIA AVE SW SUITE 210 SEATTLE, WA 98116	SPECIALTY CLINIC
8	129 - SPECIALTY CARE BELLEVUE 1200 112TH AVE NE SUITE B250 BELLEVUE, WA 98004	SPECIALTY CLINIC
9	130 - SPECIALTY CARE RENTON 910 N 10TH PLACE RENTON, WA 98057	SPECIALTY CLINIC
10	131 - SPINE SPECIALISTS AT SNI 550 17TH AVE JAMES TOWER 5TH FLOOR SEATTLE, WA 98122	SPECIALTY CLINIC
11	132 - SPINE SPORTS & MUSCULOSKELETAL MEDICINE 1750 112TH AVE NE BUILDING 3 SUITE D25 BELLEVUE, WA 98004	SPECIALTY CLINIC
12	133 - SPINE SPORTS & MUSCULOSKELETAL MEDICINE 1600 E JEFFERSON ST JEFFERSON TOWER S SEATTLE, WA 98122	SPECIALTY CLINIC
13	134 - SURGICAL SPECIALISTS - BALLARD 1801 NW MARKET ST BALLARD PROFESSIO AL SEATTLE, WA 98107	SPECIALTY CLINIC
14	135 - SURGICAL SPECIALISTS - CHERRY HILL 1600 E JEFFERSON ST SUITE 305 SEATTLE, WA 98122	SPECIALTY CLINIC

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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How many non-hospital health care facilities did the organization operate during the tax year?_____

	Name and address	Type of Facility (describe)
136	136 - SURGICAL SPECIALISTS - FIRST HILL (BROAD 801 BROADWAY SUITE 300 SEATTLE, WA 98122	SPECIALTY CLINIC
1	137 - SURGICAL SPECIALISTS - FIRST HILL (MADIS 1221 MADISON ST ARNOLD PAVILION SUITE SEATTLE, WA 98104	SPECIALTY CLINIC
2	138 - SURGICAL SPECIALISTS - WEST SEATTLE 3400 CALIFORNIA AVE SW SUITE 300 SEATTLE, WA 98116	SPECIALTY CLINIC
3	139 - SWEDISH FAMILY MEDICINE - BALLARD 1801 NW MARKET ST SUITE 403 SEATTLE, WA 98107	SPECIALTY CLINIC
4	140 - SWEDISH FAMILY MEDICINE - CHERRY HILL 550 16TH AVE SUITE 100 SEATTLE, WA 98122	SPECIALTY CLINIC
5	141 - SWEDISH FAMILY MEDICINE - FIRST HILL 1401 MADISON ST SUITE 100 SEATTLE, WA 98104	SPECIALTY CLINIC
6	142 - SWEDISH ORGAN TRANSPLANT AND LIVER CENTE 1124 COLUMBIA ST SUITE 600 SEATTLE, WA 98104	SPECIALTY CLINIC
7	143 - THORACIC SURGERY - FIRST HILL 1101 MADISON ST SUITE 900 SEATTLE, WA 98104	SPECIALTY CLINIC
8	144 - TRUE FAMILY WOMEN'S CANCER CENTER - 5TH 1221 MADISON ST 5TH FLOOR SEATTLE, WA 98104	SPECIALTY CLINIC
9	145 - TRUE FAMILY WOMENS CANCER CENTER - 6TH F 1221 MADISON ST 6TH FLOOR SEATTLE, WA 98104	SPECIALTY CLINIC
10	146 - VASCULAR SURGERY - BALLARD 1801 NW MARKET ST SUITE 207 SEATTLE, WA 98107	SPECIALTY CLINIC
11	147 - VASCULAR SURGERY - FIRST HILL 801 BROADWAY 5TH FLOOR SUITE 500 SEATTLE, WA 98122	SPECIALTY CLINIC
12	148 - VASCULAR SURGERY - WEST SEATTLE 3400 CALIFORNIA AVE SW SEATTLE, WA 98116	SPECIALTY CLINIC
13	149 - WEIGHT LOSS SERVICES - FIRST HILL 1124 COLUMBIA ST SUITE 400 SEATTLE, WA 98104	SPECIALTY CLINIC
14	150 - WOUND HEALING CENTER 540 16TH AVE SEATTLE, WA 98122	SPECIALTY CLINIC

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments and Individuals in the United States

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☑ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 39

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 1

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						

Part IV **Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

Return Reference	Explanation
PART I, LINE 2:	DESCRIPTION OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS IN THE APPLICATION FOR SUPPORT, A DETAILED EXPLANATION OF THE KIND OF SERVICES PROVIDED TO THE COMMUNITY ALONG WITH SPECIFIC FINANCIAL DATA IS REQUESTED. IF THE APPLICATION FOR SUPPORT IS APPROVED, A LETTER IS SENT INDICATING THE AMOUNT OF THE SUPPORT ALONG WITH A REQUEST FOR DOCUMENTATION OF HOW THE FUNDS WERE USED, ALONG WITH A REPORT OF THE NUMBER OF CHILDREN/FAMILIES SERVED OVER THE YEAR. GRANTS MADE TO AFFILIATED FOUNDATIONS ARE MONITORED ON A MONTHLY BASIS AS THE FINANCIAL STATEMENTS OF THESE ORGANIZATIONS ARE READILY AVAILABLE. OTHER GRANTS ARE MADE THAT COMPLY WITH THE MISSION AND FURTHER THE TAX-EXEMPT PURPOSE OF THE ORGANIZATION.

Additional Data

Software ID:
Software Version:
EIN: 91-0433740
Name: SWEDISH HEALTH SERVICES

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SWEDISH MEDICAL CENTER FOUNDATION 2208 SECOND AVENUE SUITE 100 SEATTLE, WA 98121	91-0983214	501(C)(3)	5,497,310	0			OPERATIONAL SUPPORT
SOUND GENERATIONS 2208 SECOND AVENUE SUITE 100 SEATTLE, WA 98121	91-0823767	501(C)(3)	51,400	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE AMERICAN HEART ASSOCIATION 710 2ND AVENUE SUITE 900 SEATTLE, WA 98104	13-5613797	501(C)(3)	50,000	0			SPONSORSHIP
PROJECT ACCESS NORTHWEST 1111 HARWARD AVENUE SEATTLE, WA 98122	20-4377921	501(C)(3)	50,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CAREERWORKS INC 601 UNION ST STE 3030 SEATTLE, WA 98101	82-2896556	501(C)(3)	50,000	0			SPONSORSHIP
LIFELONG AIDS ALLIANCE 210 S LUCILE ST SEATTLE, WA 98108	91-1215715	501(C)(3)	40,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MARCH OF DIMES FOUNDATION 1904 THIRD AVENUE SUITE 230 SEATTLE, WA 98101	13-1846366	501(C)(3)	34,000	0			SPONSORSHIP
COUNTRY DOCTOR COMMUNITY CLINIC 500 19TH AVENUE E SEATTLE, WA 98112	23-7100868	501(C)(3)	30,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ROTARY CLUB OF MERCER ISLAND PO BOX 1 MERCER ISLAND, WA 98040	91-6062594	501(C)(4)	30,000	0			SPONSORSHIP
AMERICAN DIABETES ASSOCIATION 2815 EASTLAKE AVENUE EAST SEATTLE, WA 98102	13-1623888	501(C)(3)	25,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SEAFAIR FOUNDATION 600 BROADWAY SUITE 610 SEATTLE, WA 98122	26-1233489	501(C)(3)	25,000	0			SPONSORSHIP
FOUNDATION FOR PRIVATE ENTERPISE EDUCATION 923 POWELL AVENUE SW RENTON, WA 98057	91-1048245	501(C)(3)	20,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
PACIFIC NORTHWEST RESEARCH INSTITUTE 720 BROADWAY SEATTLE, WA 98122	91-0667886	501(C)(3)	20,000	0			SPONSORSHIP
GIRLS ON THE RUN OF PUGET SOUND 1404 E YESLER WAY SUITE 201 SEATTLE, WA 98122	84-1618574	501(C)(3)	20,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNITED NEGRO COLLEGE 1805 7TH ST NW WASHINGTON, DC 20001	13-1624241	501(C)(3)	20,000	0			SPONSORSHIP
SUSAN G KOMEN PUGET SOUND 112 FIFTH AVENUE N SEATTLE, WA 98109	91-1624040	501(C)(3)	20,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MEDICAL TEAMS INTERNATIONAL PO BOX 10 PORTLAND, OR 97207	93-0878944	501(C)(3)	18,750	0			SPONSORSHIP
NATIONAL MULTIPLE SCLEROSIS SOCIETY 192 NICKERSON STREET SUITE 100 SEATTLE, WA 98109	13-5661935	501(C)(3)	15,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN CANCER SOCIETY INC 2120 1ST AVENUE N SEATTLE, WA 98109	13-1788491	501(C)(3)	15,000	0			SPONSORSHIP
RENTON TECHNICAL COLL 3000 NE 4TH ST RENTON, WA 98056	91-1590751	501(C)(3)	15,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CASCADE BICYCLE CLUB 7787 62ND AVENUE NE SEATTLE, WA 98115	91-2165219	501(C)(3)	13,850	0			SPONSORSHIP
NORTHWEST HOPE & HEALING FOUNDATION PO BOX 16069 SEATTLE, WA 98116	20-0799737	501(C)(3)	11,950	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE LEUKEMIA & LYMPHOMA SOCIETY INC 5601 6TH AVENUE SOUTH SUITE 180 SEATTLE, WA 98108	13-5644916	501(C)(3)	10,000	0			SPONSORSHIP
NORTHWEST KIDNEY CENTERS PO BOX 3035 SEATTLE, WA 98114	91-6057438	501(C)(3)	10,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ARTHRITIS FOUNDATION 4145 SW WATSON STE 350 BEAVERTON, OR 97005	58-1341697	501(C)(3)	10,000	0			SPONSORSHIP
ASIAN COUNSELING AND REFERRAL SERVICE 3639 MARTIN LUTHER KING JR WAY S SEATTLE, WA 98144	91-0916176	501(C)(3)	20,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
COMMUNITY LUNCH ON CAPITOL HILL 1710 11TH AVENUE SEATTLE, WA 98122	05-0566668	501(C)(3)	10,000	0			SPONSORSHIP
SEATTLE CENTER FOUNDATION 305 HARRISON STREET SEATTLE, WA 98109	91-1003385	501(C)(3)	10,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE FRIENDSHIP CIRCLE OF WASHINGTON 2737 77TH AVENUE SE SUITE 101 MERCER ISLAND, WA 98040	91-2173196	501(C)(3)	10,000	0			SPONSORSHIP
INTERNATIONAL COMMUNITY HEALTH SERVICES PO BOX 3007 SEATTLE, WA 98114	91-0947084	501(C)(3)	10,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CANCER LIFELINE 6522 FREMONT AVENUE NORTH SEATTLE, WA 98103	91-6182951	501(C)(3)	10,000	0			SPONSORSHIP
CAMP TEN TREES 1122 E PIKE ST 1488 SEATTLE, WA 98122	01-0923793	501(C)(3)	10,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
LUTHERAN COMMUNITY SERVICES NW 4040 S 188TH ST SUITE 300 SEATAC, WA 98188	93-0386860	501(C)(3)	8,000	0			SPONSORSHIP
CROHN'S & COLITIS FOUNDATION INC 9 LAKE BELLEVUE DRIVE SUITE 203 BELLEVUE, WA 98005	13-6193105	501(C)(3)	8,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
YWCA OF SEATTLE-KING COUNTY-SNOHOMISH COUNTY 1118 FIFTH AVENUE SEATTLE, WA 98101	91-0482890	501(C)(3)	7,508	0			SPONSORSHIP
LIFE SUPPORT PO BOX 264 CLE ELUM, WA 98943	20-0413954	501(C)(3)	7,500	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ALLIANCE FOR EDUCATION 509 OLIVE WAY SEATTLE, WA 98101	91-1508191	501(C)(3)	7,500	0			SPONSORSHIP
WASHINGTON POISON CENTER 155 NE 100TH ST STE 100 SEATTLE, WA 98125	94-3214597	501(C)(3)	6,000	0			SPONSORSHIP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CLALLAM COUNTY PUBLIC 1015 GEORGIANA ST PORT ANGELES, WA 98362	91-6001709	501(C)(3)	5,500	0			SPONSORSHIP
CITY OF SEATTLE 600 FOURTH AVE SEATTLE, WA 98104		GOVT	30,000	0			SPONSORSHIP

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Schedule J (Form 990)

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title	**(B)** Breakdown of W-2 and/or 1099-MISC compensation			**(C)** Retirement and other deferred compensation	**(D)** Nontaxable benefits	**(E)** Total of columns (B)(i)-(D)	**(F)** Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

Return Reference	Explanation
PART I, LINE 1A	PROVIDENCE EXPENSE REIMBURSEMENT PROCEDURES INCLUDE THE FOLLOWING POLICIES: TRAVEL FOR COMPANIONS SPOUSE OR COMPANION TRAVEL. TRAVEL EXPENSES INCURRED BY A PROVIDENCE EMPLOYEE'S SPOUSE OR COMPANION WILL NOT BE REIMBURSED BY PROVIDENCE UNLESS THE SPOUSE OR COMPANION IS REQUIRED TO, OR INVITED TO ATTEND A PROVIDENCE SYSTEM-SPONSORED MEETING, OR FOR TRAVEL RELATED TO RELOCATION. RELOCATION-RELATED VISITS SHOULD NOT EXCEED TWO RELOCATION-RELATED VISITS, UNLESS APPROVED BY THE EXECUTIVE VICE PRESIDENT, CHIEF ADMINISTRATIVE OFFICER OF PROVIDENCE. REIMBURSEMENT OF THESE EXPENSES IS LIMITED AND MAY BE CONSIDERED A TAXABLE BENEFIT BY THE IRS AND IF SO, ARE INCLUDED ON THE EMPLOYEE'S FORM W- 2. JOEL GILBERTSON - $2,565 MARY CRANSTOUN - $2,565 PERSONAL SERVICES PROVIDENCE OFFERS FINANCIAL PLANNING SERVICES AS AN OPTIONAL BENEFIT TO EMPLOYEES AT VICE PRESIDENT LEVEL AND ABOVE. THE AMOUNTS REPORTED FOR THE FINANCIAL PLANNING SERVICES ARE INCLUDED AS TAXABLE INCOME ON SCHEDULE J, PART II, COLUMN B (III) - OTHER REPORTABLE COMPENSATION ON THE FORM 990 FOR THE EMPLOYEES WHO PARTICIPATE.
PART I, LINE 3	DESCRIPTION OF PROCESS TO REVIEW COMPENSATION PAID TO TOP MANAGEMENT OFFICIAL THE ORGANIZATION'S CHIEF EXECUTIVE OFFICER/TOP MANAGEMENT OFFICIAL IS PAID BY ITS TAX-EXEMPT PARENT, PROVIDENCE ST. JOSEPH HEALTH, AND IS DISCLOSED AS A PERSON PAID BY A RELATED ORGANIZATION. SEE SCHEDULE O, PART VI, LINE 15A FOR THE PROCESS USED BY WESTERN HEALTH CONNECT.
PART I, LINES 4A-B	THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS IN 2019: TOM MCDONAGH - $491,471 SHARON TONCRAY - $421,300 JANICE NEWELL - $ 330,112 ENTITIES WITHIN THE PROVIDENCE SYSTEM SPONSOR NON-QUALIFIED SUPPLEMENTAL EXECUTIVE RETIREMENT PLANS FOR CERTAIN EXECUTIVES. THE PLANS PROVIDE FOR EMPLOYER CONTRIBUTIONS BASED ON A PERCENTAGE OF EXECUTIVE BASE SALARY AND, DEPENDING ON THE PLAN, ARE SUBJECT TO EITHER A THREE YEAR, AGE 59 1/2 OR A FIVE YEAR, AGE 65 VESTING SCHEDULE. UNTIL THE EXECUTIVE PROVIDES THESE SUBSTANTIAL FUTURE SERVICES, THESE SUPPLEMENTAL RETIREMENT CONTRIBUTIONS ARE AT RISK, AND WILL BE FORFEITED IF THE EXECUTIVE LEAVES THE ORGANIZATION BEFORE REACHING HER OR HIS VESTING DATE. THE SUPPLEMENTAL RETIREMENT CONTRIBUTIONS ARE INCLUDED IN COLUMN (C) AS A NONTAXABLE BENEFIT IN THE YEAR THE CONTRIBUTION IS CREDITED TO THE EXECUTIVE'S ACCOUNT, AND ARE INCLUDED AGAIN ON THE FORM 990 IN COLUMN (B)(III) IF AND WHEN THE AMOUNT BECOMES VESTED IN A FUTURE YEAR, AS THE FORM 990 REQUIRES. THE FOLLOWING INDIVIDUALS RECEIVED A PAYOUT DURING THE CURRENT YEAR: ROD F. HOCHMAN, MD - $1,378,122 MIKE BUTLER - $795,755 DEBRA CANALES - $613,775 RHONDA MEDOWS, MD - $283,794 CINDY STRAUSS - $344,018 AMY COMPTON-PHILLIPS, MD - $227,086 LISA VANCE - $103,747 JOEL GILBERTSON - $169,849 AARON MARTIN - $206,029 TOM MCDONAGH - $561,877 JO ANN ESCASA-HAIGH - $156,837 SHARON TONCRAY - $636,374 GREG TILL - $83,902 JOHN WHIPPLE - $146,592 MIKE WATERS - $155,073 JEFFERY (JR) ROBERT - $167,046 JANICE NEWELL - $289,417 OREST HOLUBEC - $156,821 MARY CRANSTOUN - $79,124 DAVID BROWN - $143,978 DEBBIE BURTON - $57,156 CHRIS BEAUDOIN - $187 STAN MOSER - $10,072
PART I, LINE 7	NON-FIXED PAYMENTS THE PROVIDENCE EXECUTIVE COMPENSATION COMMITTEE (OF THE BOARD) HAS APPROVED AN EXECUTIVE COMPENSATION PHILOSOPHY THAT CLOSELY TIES AN EXECUTIVE'S COMPENSATION TO PERFORMANCE BOTH THE PERFORMANCE OF THE ORGANIZATION AND THE PERFORMANCE OF THE EXECUTIVE. THERE IS NO GUARANTEE THAT THIS PART OF A LEADER'S COMPENSATION WILL BE PAID IF THE PERFORMANCE OF THE ORGANIZATION OR OF THE INDIVIDUAL DOES NOT MEET THE PERFORMANCE STANDARDS FOR PAYMENT, NO PERFORMANCE-BASED PAYMENT IS MADE. THIS APPROACH IS REFLECTED IN PROVIDENCE'S LEADERSHIP ANNUAL INCENTIVE PLAN, WHICH IS A PERFORMANCE-BASED ANNUAL INCENTIVE PLAN THAT AFFORDS PARTICIPATING EXECUTIVES THE OPPORTUNITY TO EARN "AT RISK" COMPENSATION THROUGH PERFORMANCE AGAINST VERY CHALLENGING GOALS. PAYOUTS WILL BE AWARDED BASED ON GOALS RELATED TO STRATEGIC OBJECTIVES, FISCAL STEWARDSHIP AND QUALITY OF CARE THESE GOALS ARE SET BEFORE THE YEAR BEGINS AND ARE VERY CHALLENGING. THE EXECUTIVE COMPENSATION COMMITTEE REVIEWS AND APPROVES EACH YEAR'S PERFORMANCE GOALS TO MAKE SURE THEY ARE SUFFICIENTLY CHALLENGING, AND TO MAKE SURE THE GOALS ARE DESIGNED TO HELP PROVIDENCE MEET ITS MISSION AND STRATEGIC PURPOSES. EACH YEAR THE PSJH BOARD EXECUTIVE COMPENSATION COMMITTEE REVIEWS THE INCENTIVE PERFORMANCE AND MUST CERTIFY THE ACHIEVEMENT OF PERFORMANCE GOALS BEFORE ANY AWARDS ARE PAID OUT. WHEN REVIEWING AND APPROVING TOTAL COMPENSATION FOR EXECUTIVES, THE EXECUTIVE COMPENSATION COMMITTEE INCLUDES INCENTIVE AWARDS, TO MAKE SURE THAT COMPENSATION IS REASONABLE AND WELL-SUPPORTED BY MARKET DATA. THE COMMITTEE CONSISTS ONLY OF DIRECTORS WHO ARE FREE OF CONFLICTS OF INTEREST, AND THE COMMITTEE RELIES ON MARKET SURVEY DATA GATHERED BY AN INDEPENDENT CONSULTANT. THE COMMITTEE CONDUCTS THIS REVIEW AND APPROVAL PROCESS IN A MANNER THAT IS IN ACCORDANCE WITH IRS REQUIREMENTS FOR COMPENSATION OF TAX-EXEMPT ORGANIZATION LEADERS, AND IN ACCORDANCE WITH THE BEST GOVERNANCE PRACTICES IN THE INDUSTRY.

Additional Data

Software ID:
Software Version:
EIN: 91-0433740
Name: SWEDISH HEALTH SERVICES

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1ROD F HOCHMAN MD FORMER PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	2,116,529	6,126,469	1,454,493	1,187,824	29,527	10,914,842	3,819,383
1MIKE BUTLER PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	1,445,448	1,133,982	841,673	571,275	26,545	4,018,923	1,472,737
2DEBRA CANALES FORMER EVP CAO PSJH	(i)	0	0	0	0	0	0	0
	(ii)	893,126	651,636	659,325	336,204	17,333	2,557,624	929,511
3RHONDA MEDOWS MD FORMER PRESIDENT POP HEALTH / AYIN	(i)	0	0	0	0	0	0	0
	(ii)	941,139	618,340	329,359	254,421	20,033	2,163,292	577,152
4CINDY STRAUSS SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	823,797	528,043	383,169	321,803	25,430	2,082,242	640,817
5 AMY COMPTON-PHILLIPS MD FORMER EVP CHIEF CLINICAL OFC PSJH	(i)	0	0	0	0	0	0	0
	(ii)	800,363	630,228	271,234	219,836	28,629	1,950,290	608,504
6SAMUEL YOUSSEF CARDIAC SURGEON	(i)	1,206,637	651,466	20,097	19,600	25,931	1,923,731	0
	(ii)	0	0	0	0	0	0	0
7VENKAT BHAMIDIPATI EVP/TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	1,050,394	523,975	41,123	280,148	24,654	1,920,294	319,593
8ERIC LEHR CARDIAC SURGEON	(i)	1,141,197	557,737	20,644	15,853	26,606	1,762,037	0
	(ii)	0	0	0	0	0	0	0
9STEPHEN MONTEITH NEUROSURGEON	(i)	923,546	709,331	4,026	19,600	13,275	1,669,778	0
	(ii)	0	0	0	0	0	0	0
10JENS CHAPMAN ORTHOPEDIC SURGEON	(i)	819,355	670,311	38,145	19,600	31,708	1,579,119	0
	(ii)	0	0	0	0	0	0	0
11LISA VANCE FORMER EVP REGIONAL CE OR	(i)	0	0	0	0	0	0	0
	(ii)	783,943	383,946	146,106	220,810	24,842	1,559,647	282,049
12JOEL GILBERTSON FORMER EVP COMMUNITY PARTNERSHIPS	(i)	0	0	0	0	0	0	0
	(ii)	556,867	551,880	206,393	175,653	28,137	1,518,930	319,671
13AARON MARTIN FORMER EVP CHIEF MKT/DIGITAL INNO OF	(i)	0	0	0	0	0	0	0
	(ii)	677,199	396,342	228,732	188,750	5,562	1,496,585	430,874
14PATRICK RYAN SURGEON - CARDIOLOGY	(i)	1,051,058	356,050	23,524	19,600	24,570	1,474,802	0
	(ii)	0	0	0	0	0	0	0
15GUY HUDSON MD CHIEF EXEC SWEDISH HEALTH SVCS	(i)	0	0	0	0	0	0	0
	(ii)	737,879	445,789	2,622	209,155	20,787	1,416,232	182,968
16JO ANN ESCASA-HAIGH EVP/ASSISTANT TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	722,963	270,658	195,289	209,155	8,669	1,406,734	427,495
17TOM MCDONAGH FORMER VP/CHIEF INVESTMENT OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	24,798	219,548	1,112,292	29,571	16,441	1,402,650	644,223
18SHARON TONCRAY FORMER SVP/CHIEF LABOR EE COUNSEL	(i)	0	0	0	0	0	0	0
	(ii)	0	272,921	1,091,341	5,620	31,007	1,400,889	771,066
19GREG TILL FORMER CHIEF PEOPLE OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	588,318	457,763	120,432	169,131	27,836	1,363,480	199,046

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21MIKE WATERS FORMER EVP AMBULATORY CARE NETWORK	(i)	0	0	0	0	0	0	0
	(ii)	538,503	255,592	255,618	148,230	11,503	1,209,446	290,614
1JEFFERY JR ROBERT COO SWEDISH HEALTH SVCS	(i)	0	0	0	0	0	0	0
	(ii)	605,035	187,756	193,570	192,674	28,086	1,207,121	270,659
2JOHN WHIPPLE ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	470,433	259,537	175,676	210,397	25,434	1,141,477	300,654
3JANICE NEWELL FORMER SVP/CHIEF INFORMATION OFFCR	(i)	0	0	0	0	0	0	0
	(ii)	0	325,436	746,440	17,430	1,310	1,090,616	426,198
4OREST HOLUBEC FORMER SVP CHIEF COMMUNICATION OFCR	(i)	0	0	0	0	0	0	0
	(ii)	467,371	231,245	193,343	141,823	27,155	1,060,937	260,468
5JIM WATSON ESQ ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	467,350	370,314	5,830	103,753	34,057	981,304	0
6MARY CRANSTOUN FORMER SVP TOTAL REWARDS TALENT ACQ	(i)	0	0	0	0	0	0	0
	(ii)	461,694	221,414	118,613	143,504	23,757	968,982	190,925
7DAVID BROWN FORMER SVP CAO AMBULATORY CARE	(i)	0	0	0	0	0	0	0
	(ii)	400,767	231,141	165,206	137,229	27,115	961,458	251,637
8DEBBIE BURTON FORMER SVP CHIEF NURSING OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	397,242	224,453	88,397	141,638	28,649	880,379	158,120
9KEVIN BROOKS COO FIRST HILL	(i)	0	0	0	0	0	0	0
	(ii)	411,388	100,000	130,053	142,406	21,640	805,487	0
10CHRIS BEAUDOIN COO ISSAQUAH	(i)	0	0	0	0	0	0	0
	(ii)	314,318	48,649	17,248	74,302	23,047	477,564	48,836
11KASIA KONIECZNY COO BALLARD	(i)	0	0	0	0	0	0	0
	(ii)	266,681	40,384	871	62,644	9,141	379,721	40,384
12STAN MOSER INTERIM CFO/SWEDISH REGION	(i)	0	0	0	0	0	0	0
	(ii)	207,894	0	18,511	45,297	4,030	275,732	10,072
13DONALD ANDERSON JR ASSISTANT SECRETARY FOR ENROLLMENT	(i)	0	0	0	0	0	0	0
	(ii)	200,073	22,110	560	10,673	9,318	242,734	22,110
14TERRY SMITH FORMER SVP/MANAGEMENT SVCS	(i)	0	0	0	0	0	0	0
	(ii)	114,323	36,002	6,295	8,227	5,612	170,459	0
15TAMMY TEODOSIO FORMER ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	115,500	0	17,965	12,772	12,122	158,359	0

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART V, LINE 15	INDIVIDUALS LISTED AS OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION THAT ARE PAID BY A RELATED ORGANIZATION ARE COMMON LAW EMPLOYEES OF THE RELATED ORGANIZATION. IT IS THE INTENTION OF PROVIDENCE AND THE FILING ORGANIZATION TO MAKE INFORMATION ACCESSIBLE AND TRANSPARENT, REPORTING THOSE EMPLOYEES OF A RELATED ORGANIZATION WHO HAVE OFFICER AND KEY EMPLOYEE RESPONSIBILITIES TO THE FILING ORGANIZATION. THE RELATED ORGANIZATION COMMON LAW EMPLOYEES ARE INCLUDED IN THE RELATED ORGANIZATIONS SECTION 4960 TAX ANALYSIS AND REPORTING.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	CLASSES OF MEMBERS OR STOCKHOLDERS WESTERN HEALTH CONNECT IS THE SOLE CORPORATE MEMBER OF SWEDISH HEALTH SERVICES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	CLASSES OF PERSONS AND THE NATURE OF THEIR RIGHTS SWEDISH HEALTH SERVICES HAS A TIERED GOVERNANCE IN WHICH THE CORPORATE MEMBERS RESERVE THE RIGHT TO APPOINT DIRECTORS TO THE SWEDISH HEALTH SERVICES BOARD. ALL TRUSTEE NOMINATIONS THAT COME FROM THE SWEDISH HEALTH SERVICES BOARD AS NOMINATIONS MUST BE APPROVED BY WESTERN HEALTH CONNECT, AS THE CORPORATE MEMBER.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	CLASSES OF PERSONS, DECISIONS REQUIRING APPROVAL & TYPE OF VOTING RIGHTS THE FOLLOWING POWERS RESIDE WITH THE CORPORATE MEMBER: 1) TO ADOPT OR CHANGE THE MISSION, PHILOSOPHY, AND VALUES, INCLUDING THE STRATEGIC PLAN AND MISSION STATEMENT. 2) TO AMEND OR REPEAL THE ARTICLES OF INCORPORATION OR BYLAWS. 3) TO APPROVE THE ACQUISITION OF ASSETS, THE INCURRENCE OF INDEBTEDNESS OR THE LEASE, SALE TRANSFER, ASSIGNMENT OR ENCUMBERING OF ASSETS EXCEEDING A SPECIFIED THRESHOLD, OR THE SALE OR TRANSFER OF ANY PROPERTY WHICH MAY HAVE HISTORICAL OR RELIGIOUS SIGNIFICANCE. 4) TO APPROVE THE DISSOLUTION OR LIQUIDATION. 5) TO APPROVE THE ANNUAL OPERATING AND CAPITAL BUDGETS. 6) TO APPOINT THE CERTIFIED PUBLIC ACCOUNTANTS. 7) TO APPROVE THE CLOSURE OF ANY INSTITUTION OR MAJOR ENTITY OR WORK OF THE CORPORATION.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	PROCESS TO REVIEW FORM 990 THE FORM 990 WAS PREPARED BASED ON INFORMATION RECEIVED FROM VARIOUS DEPARTMENTS OF THE ORGANIZATION INCLUDING THE FINANCE TEAM, HUMAN RESOURCES, PAYROLL, COMPLIANCE AND THE GENERAL COUNSEL'S OFFICE. THE ORGANIZATION ENGAGED AN OUTSIDE ACCOUNTING FIRM TO PREPARE THE RETURN. THE RETURN HAS BEEN REVIEWED BY AN OFFICER OF THE ORGANIZATION. A FULL COPY OF THE FORM 990 WAS PROVIDED TO ALL BOARD MEMBERS PRIOR TO FILING WITH THE IRS. THE AUDIT COMMITTEE OF THE PARENT ORGANIZATION IS PROVIDED AN ANNUAL UPDATE ON THE TAX REPORTING PROCESS AND KEY DISCLOSURES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST PROVIDENCE TAKES THE ISSUE OF CONFLICTS OF INTEREST, AND INDEPENDENT UNCONFLICTED DECISION-MAKING, VERY SERIOUSLY. PROVIDENCE HAS A COMPREHENSIVE CONFLICT OF INTEREST POLICY AND INTEREST DISCLOSURE POLICY, AND CAREFULLY AND THOROUGHLY ADMINISTERS THESE POLICIES. BOARD MEMBERS, SPONSORS, SENIOR LEADERS AND KEY EMPLOYEES ARE REQUIRED TO DISCLOSE ANY ACTUAL OR POTENTIAL CONFLICT OF INTEREST IN ACCORDANCE WITH THE PROVIDENCE CONFLICT OF INTEREST POLICY, AND SO THAT THE INDIVIDUAL SATISFIES HIS OR HER FIDUCIARY OBLIGATIONS TO THE ORGANIZATION. DISCLOSURES ARE MADE ANNUALLY, AS WELL AS ANY TIME AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST ARISES. PROVIDENCE CHIEF LEGAL OFFICER AND/OR THE PROVIDENCE CHIEF RISK OFFICER, REVIEW ALL DISCLOSURES. WHERE APPROPRIATE, THE CEO AND/OR THE BOARD CHAIR WILL REVIEW CONFLICT OF INTEREST SITUATIONS THAT INVOLVE SENIOR LEADERSHIP OR A BOARD MEMBER OTHER THAN THE CHAIR. PROVIDENCE CHIEF LEGAL OFFICER AND/OR CHIEF RISK OFFICER REVIEW MATTERS WHERE CONFLICT IS DIFFICULT OR CANNOT BE READILY RESOLVED AND PRESENT RECOMMENDATIONS TO THE APPROPRIATE BOARD COMMITTEE OR THE CEO, FOR DISCUSSION AND RESOLUTION. WHEN APPROPRIATE, THE INDIVIDUAL WITH THE REAL/POTENTIAL CONFLICT THAT IS BEING REVIEWED MAY PARTICIPATE IN THE DISCUSSION BUT IS EXCUSED FROM THE MEETING, AND FROM ANY FINAL DISCUSSION AND VOTE, WHEN A DECISION IS BEING MADE ON WHETHER A CONFLICT EXISTS, OR WHEN THE ACTION GIVING RISE TO THE CONFLICT OF INTEREST IS DECIDED. WHERE APPROPRIATE, THE CHIEF RISK OFFICER OR CHIEF LEGAL OFFICER WILL PROVIDE PLAN TO MANAGE CONFLICTS AND AVOID PARTICIPATION BY THE CONFLICTED INDIVIDUAL IN THE MATTER GIVING RISE TO THE CONFLICT OF INTEREST. AUDITING AND MONITORING OF THIS PROCESS IS DONE REGULARLY. ALL DOCUMENTATION OF CONFLICT OF INTEREST DISCLOSURES IS RETAINED IN ACCORDANCE WITH ORGANIZATION RETENTION POLICY.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	PROCESS FOR DETERMINING COMPENSATION THE ORGANIZATION'S CHIEF EXECUTIVE OFFICER/PRESIDENT/ EXECUTIVE DIRECTOR IS PAID BY A RELATED ORGANIZATION, PROVIDENCE ST. JOSEPH HEALTH, AND IS DISCLOSED AS A PERSON PAID BY A RELATED ORGANIZATION. IT IS PROVIDENCE'S INTENTION TO MAK E FINANCIAL INFORMATION ACCESSIBLE AND TRANSPARENT. ALTHOUGH THE FILING OF FORM 990 PROVID ES INSIGHT INTO HOW PROVIDENCE ACHIEVES ITS MISSION, DELIVERS ITS PROGRAMS AND STEWARDS IT S FINANCES, DECIPHERING THE INFORMATION DIRECTLY FROM FORM 990 CAN BE CHALLENGING. THE FOL LOWING PARAGRAPHS PROVIDE FURTHER INFORMATION ABOUT THE PROCESS WE USE TO DETERMINE COMPEN SATION FOR TOP MANAGEMENT, OFFICERS AND KEY EMPLOYEES. PROVIDENCE HAS A SINGLE FIDUCIARY B OARD, WITH RESPONSIBILITY FOR FINANCIAL OVERSIGHT ASSOCIATED WITH FULFILLMENT OF THE PROVI DENCE MISSION, DEVELOPING SYSTEM POLICIES, PROTECTING THE ASSETS ENTRUSTED TO THE ORGANIZA TION AND OVERSEEING THE STRATEGIC AND OPERATIONAL AFFAIRS OF PROVIDENCE'S LEGAL ENTITIES. PROVIDENCE ALSO MAINTAINS A NETWORK OF COMMUNITY ENTITY BOARDS WITH RESPONSIBILITY FOR QUA LITY OF CARE OVERSIGHT, COMMUNITY RELATIONS, ADVOCACY AND COMMUNITY NEEDS ASSESSMENTS. PRO VIDENCE HAS A CONSISTENT COMPENSATION PHILOSOPHY FOR ALL OF ITS SENIOR EXECUTIVES, INCLUDI NG ALL OFFICERS. SALARIES FOR SENIOR EXECUTIVES ARE REVIEWED AT LEAST ANNUALLY BY THE EXEC UTIVE COMPENSATION COMMITTEE, WHICH IS A COMMITTEE OF THE PROVIDENCE BOARD CONSISTING ONLY OF OUTSIDE, INDEPENDENT DIRECTORS. THE COMMITTEE MAKES SURE, AT EACH OF ITS MEETINGS, THA T NO MEMBER OF THE COMMITTEE HAS A CONFLICT OF INTEREST AS TO ANY EXECUTIVE WHOSE COMPENSA TION IS REVIEWED BY THE COMMITTEE. THE EXECUTIVE COMPENSATION COMMITTEE RETAINS AN INDEPEN DENT CONSULTANT EACH YEAR TO REVIEW SALARIES OF THOSE IN THE MOST SIGNIFICANT LEADERSHIP R OLES IN THE ORGANIZATION. PART OF THE CONSULTANT'S ROLE IS TO REVIEW AN EXTENSIVE ARRAY OF COMPENSATION SURVEYS OF LARGE, NOT-FOR-PROFIT HEALTH CARE SYSTEMS IN THE UNITED STATES. P ROVIDENCE IS ONE OF THE LARGER HEALTH SYSTEMS IN THE COUNTRY, AND AS SUCH, THE BOARD BENCH MARKS EXECUTIVE COMPENSATION AGAINST OTHER LARGE, NOT-FOR-PROFIT HEALTH SYSTEMS THAT ARE S UBSTANTIALLY SIMILAR TO PROVIDENCE IN SIZE AND COMPLEXITY (SUCH AS HAVING A SIMILAR AMOUNT OF ANNUAL NET REVENUE). ADDITIONALLY, BECAUSE PROVIDENCE OFTEN LOOKS TO GENERAL INDUSTRY FOR LEADERS IN CERTAIN FUNCTIONAL AREAS, PROVIDENCE ALSO TAKES INTO CONSIDERATION GENERAL INDUSTRY MARKET DATA IN THESE SPECIAL SITUATIONS. BASE SALARIES FOR PROVIDENCE EXECUTIVES ARE GENERALLY TARGETED TO THE "MEDIAN" LEVEL OF THE MARKET DATA (WHERE HALF THE SALARIES I N THE DATA ARE LOWER AND HALF THE SALARIES IN THE DATA ARE HIGHER), AS IDENTIFIED BY THE I NDEPENDENT CONSULTANT AND REVIEWED WITH THE EXECUTIVE COMPENSATION COMMITTEE. THE PRESIDEN T/CEO UTILIZES THE MARKET INFORMATION PROVIDED BY THE CONSULTANT ALONG WITH FORMAL PERFORM ANCE EVALUATIONS, TO DETERMINE SALARY RECOMMENDATIONS FOR OTHER SENIOR EXECUTIVES. THIS PR OCESS INCLUDES A RIGOROUS ANAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	YSIS OF THOSE RECOMMENDATIONS WITH THE EXECUTIVE COMPENSATION COMMITTEE AS A PART OF THE R EVIEW AND APPROVAL PROCESS. TOTAL COMPENSATION IS TIED CLOSELY TO PERFORMANCE OF THE ORGAN IZATION AND THE INDIVIDUAL. PERFORMANCE INCENTIVES ALLOW EXECUTIVES TO EARN ADDITIONAL COM PENSATION IF THEY HELP LEAD PROVIDENCE IN ACHIEVING SPECIFIC ORGANIZATIONAL GOALS FOR FURT HERING PROVIDENCE'S OPERATING COMMITMENTS AND STRATEGIC OBJECTIVES. THE BOARD OF DIRECTORS CONDUCTS A THOROUGH REVIEW PROCESS TO ENSURE PERFORMANCE INCENTIVES ARE ALIGNED WITH APPR OPRIATE MARKET PRACTICES. THE BOARD'S PROCESS FOR SETTING, REVIEWING AND APPROVING EXECUTI VE COMPENSATION FULLY COMPLIES WITH IRS STANDARDS (TO ASSURE THAT ALL COMPENSATION IS CONS IDERED REASONABLE) AND REFLECTS BEST GOVERNANCE PRACTICES IN THE INDUSTRY. THE PROCESS WAS LAST COMPLETED IN 2020.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY AVAILABLE TO THE PUBLIC UPON REQUEST. THE PROVIDENCE COMMUNITY BENEFIT REPORTS, FINANCIAL REPORTS, CONSOLIDATED AUDITED FINANCIAL STATEMENTS, AND PHILANTHROPY REPORTS ARE ALSO AVAILABLE ON THE PROVIDENCE INTERNET SITE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	AGENCY & CONTRACT LABOR: PROGRAM SERVICE EXPENSES 37,694,314. MANAGEMENT AND GENERAL EXPENSES 3,032,180. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 40,726,494. BILING & COLLECTIONS: PROGRAM SERVICE EXPENSES -506. MANAGEMENT AND GENERAL EXPENSES 21,684. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 21,178. GENERAL CONSULTING FEES: PROGRAM SERVICE EXPENSES 43,357,019. MANAGEMENT AND GENERAL EXPENSES 20,159,529. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 63,516,548. MEDICAL DIRECTOR & MED PHYSICIAN FEES: PROGRAM SERVICE EXPENSES 30,873,138. MANAGEMENT AND GENERAL EXPENSES 4,929,511. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 35,802,649. OTHER PATIENT SERVICES: PROGRAM SERVICE EXPENSES 43,456,534. MANAGEMENT AND GENERAL EXPENSES 7,053,877. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 50,510,411. REPAIRS & MAINTENANCE: PROGRAM SERVICE EXPENSES 28,572,010. MANAGEMENT AND GENERAL EXPENSES 14,776,055. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 43,348,065.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	NET ASSET TRANSFERS BETWEEN RELATED TAX-EXEMPT ORGANIZATIONS -380,782,271. OTHER -33,655,062.

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SWEDISH HEALTH SERVICES

Employer identification number
91-0433740

Part I **Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ARNOLD CONDOMINIUM LLC 747 BROADWAY SEATTLE, WA 98122 42-1679118	OWNER ASSOCIATION	WA	3,827,625	0	N/A
(2) INSYTU LLC 747 BROADWAY SEATTLE, WA 98122 83-3651693	HEALTHCARE	WA	290,429	0	N/A
(3) SWEDISH HEART INSTITUTE MEDICAL GRP LLC 747 BROADWAY SEATTLE, WA 98122 91-1911869	PHYSICIAN CLINIC	WA	34,641,568	10,318,260	N/A
(4) SWEDISH PHYSICIANS LLC 600 UNIVERSITY STREET SUITE 1200 SEATTLE, WA 98101 91-1942315	PHYSICIAN CLINIC	WA	130,868,144	38,980,093	N/A

Part II **Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No

Part III **Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) Disproprtionate allocations? No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) General or managing partner? No	(k) Percentage ownership

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) Section 512(b)(13) controlled entity? No

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

		Yes	No
1 During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	1a		No
b Gift, grant, or capital contribution to related organization(s)	1b	Yes	
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k		No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m		No
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	Yes	
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p		No
q Reimbursement paid by related organization(s) for expenses	1q	Yes	
r Other transfer of cash or property to related organization(s)	1r	Yes	
s Other transfer of cash or property from related organization(s)	1s	Yes	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. (see instructions).

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 91-0433740
Name: SWEDISH HEALTH SERVICES

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 61-1573313	HEALTHCARE	TX	501(C)(3)	12,I	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 46-1259908	HEALTHCARE	CA	501(C)(3)	12,III	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 46-3516417	HEALTHCARE	TX	501(C)(3)	12,I	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2765566	HEALTHCARE	TX	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2897026	HEALTHCARE	TX	501(C)(3)	7	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 84-4273963	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 82-2913146	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2743883	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1082119	UNEMPLOYMENT	WA	501(C)(3)	12,I	PHS WA	Yes	
PO BOX 5128 EVERETT, WA 982065128 94-3264605	TRANS. CARE	WA	501(C)(3)	10	N/A		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-4322584	SUPPORT	CA	501(C)(3)	7	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 20-1910170	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
2800 SOUTH 192ND ST 104 SEATAC, WA 98188 27-3133200	HEALTHCARE	WA	501(C)(3)	7	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 20-3856995	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1 HOAG DRIVE NEWPORT BEACH, CA 92658 45-3583707	HEALTHCARE	CA	501(C)(3)	12,I	HMHP	Yes	
2081 BUSINESS CENTER DR STE 195 NEWPORT BEACH, CA 92663 45-2982422	SUPPORT	CA	501(C)(3)	7	HHF	Yes	
1 HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92658 33-0676831	HEALTHCARE	CA	501(C)(3)	10	HMHP	Yes	
330 PLACENTIA AVE NEWPORT BEACH, CA 92663 95-3222343	FUNDRAISING	CA	501(C)(3)	7	HMHP	Yes	
1 HOAG ROAD BOX 6100 NEWPORT BEACH, CA 92663 95-1643327	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2133781	HEALTHCARE	TX	501(C)(3)	10	CHS	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1307555	HEALTHCARE	WA	501(C)(3)	3	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-4260130	HEALTHCARE	WA	501(C)(3)	7	PHS SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-2003593	HEALTHCARE	WA	501(C)(3)	7	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-4291515	HEALTHCARE	CA	501(C)(3)	4	PSJHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-6033089	SUPPORT	WA	501(C)(3)	12,III	KRMC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 23-7005501	SUPPORT	WA	501(C)(3)	7	KRMC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-0655392	HEALTHCARE	WA	501(C)(3)	3	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0844408	IMAGING SVCS	CA	501(C)(3)	10	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 26-4021016	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2220963	HEALTHCARE	TX	501(C)(3)	7	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1562797	SUPPORT	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-2054035	RESEARCH	WA	501(C)(3)	7	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2428911	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2246348	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2426010	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-1643360	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 20-0799737	SUPPORT	WA	501(C)(3)	12,I	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 56-2290878	HEALTHCARE	WA	501(C)(3)	10	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-3544877	HEALTHCARE	CA	501(C)(3)	7	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 92-0093565	HEALTHCARE	AK	501(C)(3)	7	PHS WA	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1940286	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1789266	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0800140	SUPPORT	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0692907	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 47-3385506	SUPPORT	WA	501(C)(3)	7	N/A		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 31-1744654	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1549796	HEALTHCARE	WA	501(C)(3)	12,II	PSJH		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-0231793	HEALTHCARE	MT	501(C)(3)	3	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 51-0216587	HEALTHCARE	OR	501(C)(3)	3	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 51-0216586	HEALTHCARE	WA	501(C)(3)	3	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1303277	HEALTHCARE	WA	501(C)(3)	3	PMWHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 55-0828701	MEDICAID	OR	501(C)(4)	N/A	PHP	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 32-0014330	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1433382	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0863097	HEALTHCARE	OR	501(C)(4)	N/A	PPP	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 51-0216589	HEALTHCARE	CA	501(C)(3)	3	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0921990	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 27-2552749	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-2077378	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 51-0224944	HEALTHCARE	CA	501(C)(3)	7	PHS SOCAL	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-1554288	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0283773	HEALTHCARE	CA	501(C)(3)	12,I	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-3079515	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057	RELIGIOUS ORG	WA	501(C)(3)	1	N/A		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1188119	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0889144	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 31-1629656	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1861964	HEALTHCARE	WA	501(C)(4)	N/A	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-1231494	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 31-1584166	SUPPORT	WA	501(C)(3)	10	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-1684082	HEALTHCARE	CA	501(C)(3)	3	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-4542216	HEALTHCARE	CA	501(C)(3)	3	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0927320	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-2171539	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-3244854	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-1244422	HEALTHCARE	WA	501(C)(3)	12,III	N/A		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-3078543	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-0463482	HEALTHCARE	MT	501(C)(3)	3	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 45-2841492	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1097056	SUPPORT	WA	501(C)(3)	7	PHS W WA	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-0575982	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-3264139	HEALTHCARE	CA	501(C)(3)	10	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0261016	HEALTHCARE	CA	501(C)(3)	7	PTCH	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 93-1003750	HEALTHCARE	OR	501(C)(3)	12, I	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-1243669	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-2779313	HEALTHCARE	CA	501(C)(3)	7	RMH	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-1384665	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-6100079	SUPPORT	CA	501(C)(3)	7	PSJHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-1231005	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 61-1502822	PHYSN COLLAB	WA	501(C)(3)	7	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 26-2612415	SHELL CORP	MT	501(C)(3)	1	PHS WA		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-1643383	RELIGIOUS ORG	CA	501(C)(3)	1	N/A		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 68-0395200	HEALTHCARE	CA	501(C)(3)	3	SRMH	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 27-1666576	RELIGIOUS ORG	CA	501(C)(3)	1	SSJO		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-4791043	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-3589356	HEALTHCARE	CA	501(C)(3)	12,I	PSJH		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0143024	HEALTHCARE	CA	501(C)(3)	10	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0185031	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 68-0331084	HEALTHCARE	CA	501(C)(3)	10	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-1156596	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-1643359	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-1643324	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 94-3176618	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-1914489	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-1653181	HEALTHCARE	TX	501(C)(3)	7	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 23-7056976	HEALTHCARE	MT	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-0233495	EDUCATION	MT	501(C)(3)	10	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 27-2305304	HEALTHCARE	WA	501(C)(3)	3	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-0983214	HEALTHCARE	WA	501(C)(3)	7	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 27-3139262	HOLDING CO	WA	501(C)(3)	12,I	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 83-3972614	HEALTHCARE	CA	501(C)(3)	3	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1180824	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1293869	SUPPORT	CA	501(C)(3)	10	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 91-1214491	SUPPORT	OR	501(C)(3)	10	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-0231777	EDUCATION	MT	501(C)(3)	2	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 45-4171900	SHELL CORPORATION	WA	501(C)(3)	12,II	PHS W WA	Yes	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
20TH STREET SURGERY LLC 1301 20TH STREET STE 140 SANTA MONICA, CA 90404 73-1735618	AMBULATORY SURG	CA	N/A									
BROADWAY IMAGING LLC 500 W BROADWAY MISSOULA, MT 59802 52-2405971	MEDICAL IMAGING	MT	N/A									
CENTER FOR MATERNAL NEWBORN AND CHILD 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-3526875	HEALTHCARE	CA	N/A									
CLACKAMAS RADIATION ONCOLOGY CENTER LLC 4400 NE HALSEY ST BLDG II 495 PORTLAND, OR 97213 26-0381897	RADIATION ONCOL	OR	N/A									
COASTAL ASC HOLDINGS LLC ONE HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92663 81-0986844	HEALTHCARE	CA	N/A									
COVENANT LONG-TERM CARE LP 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 20-5033419	HEALTHCARE	TX	N/A									
BRIDGEPORT MEDICAL IMAGING (BMI) 4400 NE HALSEY 495 PORTLAND, OR 97213 26-0796953	IMAGING DIAG.	OR	N/A									
CENTER FOR MEDICAL IMAGING (CMI) 4400 NE HALSEY 495 PORTLAND, OR 97213 20-0477972	IMAGING DIAG.	OR	N/A									
FULLERTON SURGICAL CENTER LP 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 47-0927394	AMBULATORY SURG	CA	N/A									
GREATER VALLEY MEDICAL BUILDING LP 501 S BUENA VISTA ST BURBANK, CA 91505 95-4570858	REAL ESTATE - MOB	CA	N/A									
HCSA PROPERTIES LLC 1600 M STREET NW AUBURN, WA 98001 46-0620892	REAL ESTATE RENT	WA	SHS	UNRELATED	167,112	8,554,709		No	167,112		No	56.000 %
HERITAGE INVESTMENT GROUP I LLC 500 S MAIN STREET STE 1000 ORANGE, CA 92868 27-1000061	INVESTMENTS	CA	N/A									
HOAG ORTHOPEDIC INSTITUTE ONE HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92658 61-1588294	HEALTHCARE	CA	N/A									
IMAGING ASSOCIATES LLC 3650 PIPER STREET STE A ANCHORAGE, AK 99508 20-3906048	MEDICAL IMAGING	AK	N/A									
INLAND IMAGING LLC 801 S STEVENS ST SPOKANE, WA 99204 91-1855796	MEDICAL IMAGING	WA	N/A									

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							Yes	No		Yes	No	
LSC REAL PROPERTY LLC 2301 QUAKER AVENUE LUBBOCK, TX 79410 47-4646059	REAL ESTATE	TX	N/A									
METHODIST DIAGNOSTIC IMAGING 4005 24TH STREET LUBBOCK, TX 79410 75-2343261	HEALTHCARE	TX	N/A									
NEWPORT IMAGING CENTER 360 SAN MIGUEL NEWPORT BEACH, CA 92660 33-0191776	HEALTHCARE	CA	N/A									
NEWPORT SURGICAL PARTNERS LLC 27271 LAS RAMBLAS 350 MISSION VIEJO, CA 92691 39-2060266	HEALTHCARE	CA	N/A									
OREGON ADVANCED IMAGING LLC 881 OHARE PARKWAY MEDFORD, OR 97504 45-0471748	MEDICAL IMAGING	OR	N/A									
OREGON OUTPATIENT SURGERY CENTER 7300 SW CHILDS RD TIGARD, OR 97224 22-3883387	AMBULATORY SURG	OR	N/A									
PETCT IMAGING AT SWEDISH CANCER INSTITUTE LLC 1221 MADISON STREET SEATTLE, WA 98104 20-3132044	MEDICAL IMAGING	WA	SHS	RELATED	892,768	619,073		No			No	63.000 %
PHS INVESTMENT TRUST SHORT TERM INVESTMENT PORTFOLIO 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-2701056	INVESTMENTS	WA	N/A									
PROV RADIATION ONCOLOGY DEVELOP ASSN 4400 NE HALSEY 495 PORTLAND, OR 97213 26-0682491	REAL ESTATE - MOB	OR	N/A									
PROVIDENCE CHILDREN'S NEONATAL SERVICES 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 47-0918549	NEONATAL CARE	WA	N/A									
PROVIDENCE HOUSE HEARING HEALTH CENTERS LLC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057	HEALTHCARE	CA	N/A									
PROVIDENCE IMAGING CENTER JOINT VENTURE 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 92-0118807	MEDICAL IMAGING	AK	N/A									
PROVIDENCE ST JOSEPH HEALTH LONG TERM PORTFOLIO 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 82-3190634	INVESTMENTS	WA	N/A									
PROVIDENCE SURGERY CENTER LLC 902 N ORANGE ST MISSOULA, MT 59802 84-1401625	AMBULATORY SURG	MT	N/A									
PROVIDENCESILVERTON REHAB LLC 4400 NE HALSEY 425 PORTLAND, OR 97213 48-1287267	REHAB SERVICES	OR	N/A									

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

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							Yes	No		Yes	No	
PROVIDENCE UCLA USP SURGERY CENTER JV 15305 DALLAS PKWY STE 1600 LB 28 ADDISON, TX 75001 32-0503030	AMBULATORY SURG	CA	N/A									
PROVIDENCEUSP SOUTH BAY SURGERY CENTERS 15305 DALLAS PKWY STE 1600 LB 28 ADDISON, TX 75001 47-5064486	AMBULATORY SURG	CA	N/A									
PROVIDENCEUSP SURGERY CENTERS LLC 11550 INDIAN HILLS ROAD 160 MISSION HILLS, CA 91345 20-0684116	AMBULATORY SURG	CA	N/A									
RADIATION THERAPY INNOVATIONS LLC 1221 MADISON STREET 1ST FL SEATTLE, WA 98104 30-0553035	HEALTHCARE	WA	SHS	RELATED	6,059,631	2,140,269		No		Yes		50.000 %
REDMOND AMBULATORY SURGERY CENTER LLC 805 MADISON ST STE 901 SEATTLE, WA 98104 81-3558711	AMBULATORY SURG	WA	SHS	RELATED	-426,163	2,631,453		No		Yes		49.000 %
SANTA ANA MOB LLC 1800 QUAIL STREET STE 100 NEWPORT BEACH, CA 92660 75-3205306	REAL ESTATE - MOB	CA	N/A									
SHA LLC 12940 NORTH HIGHWAY 183 AUSTIN, TX 78750 75-2569094	HEALTHCARE	TX	N/A									
SJO ASC HOLDINGS LLC 1140 W LA VETA AVE ORANGE, CA 92868 82-1655501	HEALTHCARE	CA	N/A									
ST JOSEPH PHYSICIAN VENTURES I LLC 1100 WEST STEWART DRIVE ORANGE, CA 92868 45-4521884	REAL ESTATE	CA	N/A									
ST JOSEPHSATELLITE DIALYSIS CENTERS LLC 300 SANTANA ROW STE 300 SAN JOSE, CA 95128 81-4657391	HEALTHCARE	CA	N/A									
ST JUDE SURGICAL CENTERS LLC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 82-3352570	AMBULATORY SURG	CA	N/A									
SURGERY CENTER AT TANASBOURNE LLC 11221 ROE AVE STE 300 LEAWOOD, KS 66211 20-8187971	AMBULATORY SURG	KS	N/A									
TARZANA PEDIATRIC VENTURES LLC 18321 CLARK ST TARZANA, CA 91356 82-1308306	HEALTHCARE	CA	N/A									
THE MADISON SPOKANE INN LLC 15 WEST ROCKWOOD BLVD SPOKANE, WA 99204 84-1606484	HOTEL SERVICES	WA	N/A									
YELM MEDICAL OFFICE BUILDING 2840 CRITES ST SW STE 104 TUMATER, WA 98512 26-3685020	REAL ESTATE - MOB	WA	N/A									

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
1221 MADISON STREET OWNERS ASSOC 747 BROADWAY SEATTLE, WA 98122 20-1954319	OWNERS' ASSOC.	WA	N/A	C					No
AMERICAN UNITY GROUP LTD 90 PITTS BAY ROAD PEMBROKE BD	CAPTIVE INSURANCE	BD	N/A	C					No
AYIN HEALTH SOLUTIONS INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 83-3037172	HEALTHCARE	DE	N/A	C					No
BLUETREE NETWORK INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 90-0872936	HEALTHCARE	WI	N/A	C					No
BOURGET HEALTH SERVICES INC 101 W 8TH AVE TAF C-9 SPOKANE, WA 99220 91-1354431	CLIN/MED LAB	WA	N/A	C					No
CARON HEALTH CORPORATION 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 81-0486082	MED PHYS SVCS	MT	N/A	C					No
COMMUNITY TECHNOLOGIES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 84-4722399	IT SVCS	DE	N/A	C					No
DATU HEALTH INC AND SUBSIDIARIES 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 46-3070062	IT SVCS	DE	N/A	C					No
ENGAGE IT SERVICES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 84-4058573	IT SVCS	DE	N/A	C					No
HOAG MANAGEMENT SERVICES INC 1 HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92658 33-0731587	HEALTHCARE	CA	N/A	C					No
HOAG PHYSICIAN PARTNERS 16148 SAND CANYON AVE IRVINE, CA 92618 83-4276044	HEALTHCARE	CA	N/A	C					No
LUBBOCK METHODIST HOSP PRACTICE MGMT 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2578995	INACTIVE	TX	N/A	C					No
LUBBOCK METHODIST HOSPITAL SVCS 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 75-2118585	HEALTHCARE	TX	N/A	C					No
LUMEDIC ACQUISITION CO INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 83-3881097	HEALTHCARE	WA	N/A	C					No
MISSION VIEJO MEDICAL VENTURES 27800 MEDICAL CENTER RD MISSION VIEJO, CA 92691 33-0212905	HEALTHCARE	CA	N/A	C					No

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								Yes	No
PERFORMANCE HEALTH TECHNOLOGY LTD 3993 FAIRVIEW INDUSTRIAL DR SE SALEM, OR 97302 93-1211733	HEALTHCARE	OR	N/A	C					No
MEDIREVV INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 20-8783763	HEALTHCARE	DE	N/A	C					No
PHN HOLDINGS 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 46-1814184	STRAT PLAN SVCS	CA	N/A	C					No
PIONEER INNOVATIONS INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 36-4818191	HEALTH INNOVATNS	WA	N/A	C					No
PROVIDENCE ASSURANCE INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 20-8194071	CAPTIVE INSURANCE	AZ	N/A	C					No
PROVIDENCE GLOBAL CENTER LLP 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 98-1516461	IT SVCS	IN	N/A	C					No
PROVIDENCE HEALTH CARE VENTURES INC 101 W 8TH AVE TAF C-9 SPOKANE, WA 99220 90-0155714	CLIN/MED LAB	WA	N/A	C					No
PROVIDENCE HEALTH NETWORK 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 80-0886966	PREPAID HEALTH	CA	N/A	C					No
PROVIDENCE HEALTH VENTURES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0122216	INVESTMENT	CA	N/A	C					No
PROVIDENCE PHYSICIAN SERVICES CO 101 W 8TH AVE TAF C-9 SPOKANE, WA 99220 91-1216033	HEALTHCARE	WA	N/A	C					No
PROVIDENCE RCM GROUP 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 84-4686520	HOLDING COMPANY	DE	N/A	C					No
PROVIDENCE SERVICES GROUP INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 84-4704409	HOLDING COMPANY	DE	N/A	C					No
ST JOSEPH HEALTH 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 46-2340232	HOLDING COMPANY	CA	N/A	C					No
ST JOSEPH HEALTH SOURCE INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 46-1900168	HEALTHCARE	CA	N/A	C					No
ST JOSEPH PROF SVCS ENTERPRSES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 33-0155323	HEALTHCARE	CA	N/A	C					No

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(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
VINSERRA INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 95-3943315	INVESTMENTS	CA	N/A	C					No
WESTERN HEALTHCONNECT VENTURES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 80-0953654	INVESTMENTS	WA	N/A	C					No
ENDOSCOPY CENTER OF SOUTHERN CALIFORNIA 1301 20TH ST STE 280 SANTA MONICA, CA 90404 95-2880495	HEALTHCARE	CA	N/A	S					No
GRADY BLOCKER LLC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 98057 84-2092143	HOLDING COMPANY	DE	N/A	C					No
PROVIDENCE ST JOSEPH HEALTH NETWORK 20555 EARL ST TORRANCE, CA 90503 82-3771547	HEALTHCARE	CA	N/A	C					No

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
SWEDISH MEDICAL CENTER FOUNDATION	B	5,497,310	COST
SWEDISH MEDICAL CENTER FOUNDATION	C	12,463,690	COST
SWEDISH EDMONDS	J	1,693,994	COST
PETCT IMAGING SWEDISH CANCER INSTITUTE	J	5,833,784	COST
PROVIDENCE HEALTH & SERVICES MONTANA	J	17,424,713	COST
PROVIDENCE HEALTH & SERVICES WASHINGTON	J	160,977	COST
SWEDISH EDMONDS	L	7,842,916	COST
PETCT IMAGING SWEDISH CANCER INSTITUTE	L	9,770,932	COST
PROVIDENCE HEALTH & SERVICES WASHINGTON	L	391,579	COST
RADIATION THERAPIES INNOVATION	L	85,827	COST
SWEDISH EDMONDS	O	2,685,932	COST
PACMED CLINICS DBA PACIFIC MEDICAL CENTERS	O	189,091	COST
PETCT IMAGING SWEDISH CANCER INSTITUTE	O	1,869,656	COST
PROVIDENCE HEALTH & SERVICES WASHINGTON	O	3,510,261	COST
PROVIDENCE HEALTH & SERVICES WASHINGTON	Q	109,596	COST
PROVIDENCE HEALTH & SERVICES WASHINGTON	R	893,823,416	COST
SWEDISH EDMONDS	R	10,092,737	COST
SWEDISH EDMONDS	S	118,222,171	COST